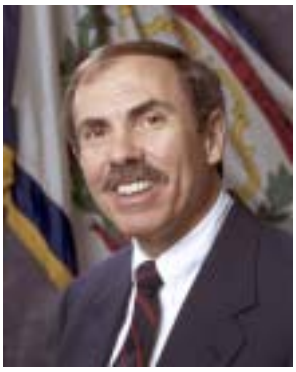
Expanding the West Virginia Children's Health Insurance Program through Increased Cost-Sharing

A Study by the West Virginia Children's Health Insurance Board as Required by House Bill 4412

West Virginia CHIP Children's Health Insurance Program

West Virginia
Children's Health Insurance Program



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September 21, 2004

The Honorable Bob Wise, Governor
State of West Virginia

The Honorable Earl Ray Tomblin, President
West Virginia Senate

The Honorable Robert S. Kiss, Speaker
West Virginia House of Delegates

The Honorable Members of the
Joint Committee on Government and Finance

Ladies and Gentlemen:

It is a privilege to submit to you our study on "Expanding the West Virginia Children's Health Insurance Program through Increased Cost-Sharing" to fulfill the requirement of House Bill 4412. This study is the result of work mostly carried out at both regular and special meetings of the West Virginia Children's Health Insurance Board on July 29, August 12, and September 16, 2004. I must gratefully acknowledge the work and efforts of Dave Bond of CCRC Actuaries, information provided by Sally Richardson, Executive Director of the WVU Institute for Health Care Policy, and the participation and interest of children's groups who attended the meetings and provided comments. Special thanks is due Tom Wilkerson and Lynn Gunnoe who advised me on drafting a process at the beginning of our work.

Any inquiries or comments concerning this study may be submitted in writing to the address above. Any requests for copies should be made to Brenda Jones at 558-2732. A copy will be posted on the WVCHIP website noted above after this date.

Sincerely,

Sharon L. Carte, MHS
Chairman
West Virginia Children's Health Insurance Program

Section I

The Mandate and Major Findings

West Virginia CHIP Children's Health Insurance Program

The Mandate and Major Findings of the Board

In conducting this study the West Virginia Children's Health Insurance Board (hereinafter referred to as "the Board") has taken as its mandate, both the overall language of House Bill 4412 (hereinafter referred to as "the bill" and is attached as Appendix 1) to explore "all available means" which could open participation in the West Virginia Children's Health Insurance Program (WVCHIP) to families at incomes as high as 300% of the Federal Poverty Level (FPL), and secondly, to specifically consider whether or not allowing families to cost share at 20% to 25% of the actual cost of coverage, would result in increased health coverage to children at no additional cost to State government. Other language also directs the Board to assess the "long term effect on the State budget" of a modified plan of cost-sharing.

Charging an affordable premium is another consideration mentioned in the bill, and whether the health plan can be modified to have cost-sharing in this form. Here the Board is fortunate to have available not only some data from a WVCHIP survey of parents of its participants, but also the work of the WVU Institute for Health Care Policy (hereinafter referred to as "the Institute") which had focus group results from its work and reports entitled "Closing the Gap," that was funded by a major grant from the Health Resources Services Administration to study issues concerning the uninsured.

The question of cost-sharing by WVCHIP participants is by its very nature a sensitive one since the major reason most surveyed respondents give for not having health care insurance is "affordability." The Board clearly notes that it is primarily working families we are addressing here, and the data and survey responses concerning issues of uninsured children and affordability show this also. Therefore, because the issue of cost-sharing and affordability are significant factors to these working families, the Board acknowledges that any cost-sharing becomes a barrier to some who must necessarily prioritize family resources in such a way as to make even this reasonable amount of cost-sharing prohibitive. The amount of cost-sharing then is a major determinant of how many families can be expected to take advantage of any expansion, if made available. Again, in reviewing this issue, the Board was able to examine information provided from previous year's data made available from the Institute's "Closing the Gap" study and has noted that these were in general agreement with more recent data generated for this study by WVCHIP's actuarial consultants, CCRC Actuaries.

The Board finds that in answer to the specific language asking it to consider the question of whether we are able to finance additional health care coverage without any additional State funding, it must clearly answer, "no - not really." We say "not really" because the possibility does exist to allow families to pay 100% or all of the premium costs for this program which would still be more affordable than most commercial products. While the Board acknowledges this would no doubt benefit some small number of families that would struggle to make coverage a priority, it is an effort of questionable undertaking.

West Virginia receives slightly more than four federal dollars for every one dollar it spends to operate its current WVCHIP program at the 200% FPL income limit. While not explicitly stated in the bill, the Legislation apparently contemplated the possibility of an expanded program in which cost-sharing could supplement or be equivalent to

the State's funding share. This is clearly prohibited in federal regulations at this time, as explained in more detail further along in this report.

The Board could have chosen to conclude the study on this specific point - that current federal regulation will not permit health care coverage for additional uninsured children without additional State funds - but did not believe it should stop at this point.

The Board finds that further considerations are called for because:

1) Not to do so would violate the broader language of the bill (i.e. exploring "all available means").

2) Any additional State funding required is more than offset by the generous federal share that provides over four dollars for each one spent by the State. In the State Fiscal Year ending June 30, 2004, this amount was $28.9 million, and since the program began, a total of $97.5 million in federal funds has been spent in the State as a result of this program.

3) Additional expenditures necessary to allow more children to have health care coverage is a modest amount relative to the State's entire budgetary expenditures. Such additional expenditures, however modest, add funds at a four fold rate to the State's health care delivery system and help avoid uncompensated care costs.

4) Preventive services (particularly those accessed in early childhood) will result in long term savings through avoiding costs from disease or impairment that can result in more frequent or intensive services. The Board acknowledges that it is not aware of current research models or studies that can account or predict such savings over long time periods, but the value of prevention has been a strongly held belief since the program's inception nonetheless.

5) Cost-sharing in premiums does result in an overall savings to the program or expansion cost. While federal regulation does not permit public cost-sharing to replace or eliminate State funds as matching funds, it does allow, indeed require, that any savings achieved through cost-sharing be used to reduce or offset the total program cost (in both federal and state dollars).

6) The actuarial estimates generated for this study reflect that there are two mechanisms available to diminish or remove the long term effects of increasing costs to the State. These are: capping the number of participants allowed in a modified plan and 2) requiring cost-sharing as a percentage of premium to hold down the costs of medical cost inflation.

7) Producing the means to the lowest cost expansion was a clear mandate for the Board after ruling out the possibility of expansion with no additional State funds. One of the most difficult issues posed to the Board was that of whether or not to consider a lower cost approach by means of limiting or removing some benefits under the plan. After much discussion and even reviewing a scenario for a reduced dental benefit, the Board rejected modifying the benefit plan in any manner in favor of maintaining equitability in order to assure covered children have the greatest possible access to needed medical and dental services.

8) The Board finds that the value of having some form of graduated cost-sharing for all income levels is desirable, not only in terms of equitability for all participants; it is also an answer to the inequity experienced by those families just outside the qualifying income limits. Or as one comment from a children's public interest group put it, "How fair is it that one working family of four with an income just below the qualifying income limit can get full coverage for their children while another who makes $10 a month over gets no support at all?"

9) The Board discussed and is concerned about those lower income families presently covered under PEIA who, although receiving the benefit of a highly subsidized plan, nonetheless struggle with their cost-sharing burden. They also cannot access some benefits (primarily dental services) received by CHIP participants without additional cost-sharing on their part. Regrettably, this constraint is rooted in current federal regulation outside the purview of this Board. The Board hopes that it can be addressed at some future point in the context of other state and/or federal health care reform.

The remainder of the information and Board findings is found in Section II in the Q & A format. Some information in the Q & A format is expanded upon or supplemented in greater detail in the attachments found in the Appendices at the end of the report.

CONCLUSION:

Since July and August of this year, the Board has reviewed a great deal of information and numerous scenarios related to plan modification submitted by the actuarial consultants in preparation for this study. If the Executive Branch and the West Virginia Legislature were to decide in favor of expanding program access through cost-sharing, the Board recommends that a predetermined level of cost-sharing, such as shown in Scenario 3 in the actuarial estimates, would be the preferred scenario. It allows for coverage for the most children, but any sudden anticipated costs could be offset by adjusting premiums in order to protect the core program. The option of capping enrollment would also still be available as an ultimate means to control growth.

Section II

Specific Findings in Q & A Format

West Virginia CHIP Children's Health Insurance Program

For ease of reading and clarity, the remainder of issues and information reviewed by the Board are presented here in a question and answer format. The more general responses are supplemented and cross referenced to attachments in the Appendices to provide greater detail.

1) What is the most recent estimated number of uninsured children at the 250% FPL and 300% FPL household income levels?

A. For these numbers CHIP has used 2003 data made available from "Closing the Gap" reports in which the Lewin Group estimated the number of uninsured children between 200% - 250% FPL households to be 10,490 and the uninsured number in 250% - 300% FPL households to be 12,798. (See Appendix 2: "Number of Eligible Persons" as shown in the first column of Figure 4 provided by the Lewin Group.)

2) What are the qualifying income limits at the 250% FPL and 300% FPL levels?

A. A family of four in a household at the 250% FPL household limit qualifies if they make no more than $3,928 a month or $47,125 a year. In a 300% FPL income household these amounts are $4,713 a month or $56,550 per year. Further information on income limits is available in Appendix 3.

3) What do federal regulations say about the use of cost-sharing as a source of State's matching share?

A. Basically, regulations on federal financial participation (FFP) prohibit any state from using funds collected through cost-sharing to be counted as federal match. They are used to lower the total program costs as an offset. (See Appendix 4 CFR 457.224 "FFP: Conditions relating to cost-sharing.")

4) What cost-sharing do CHIP participants currently have and what federal restrictions apply to these?

A. To protect children's access to health care and particularly preventive services, federal regulation is particularly stringent. Regulation at CFR 457.520 explicitly prohibits states from applying any cost-sharing to preventive services such as co-payments for such services as well-baby or well-child exams by a physician, immunizations, routine dental visits, physicals, etc. (See Appendix 5.)

4) What cost-sharing do CHIP participants currently have and what federal restrictions apply to these? -*CONTINUED*-

Cost-sharing is more protected for lower income children (see Appendix 6 CFR 457.530) as a general principle. Also, for families at 101% FPL to 150% FPL income levels, there are specific maximums of $5 per individual service and a cumulative cost-sharing aggregate limit that cannot exceed the family's total income by more than 5%.

5) Are premiums charged by CHIP programs in other states and if so, how many states have them and what do they charge?

A. A recent survey by the Kaiser Commission on "Medicaid and the Uninsured" shows that 29 states currently charge a premium or an enrollment fee. Enrollment fees are typically nominal charges of $5 to $10 per family per month. Premiums range as high as $230 per month in Connecticut. (See Appendix 7.)

6) What data is available to show what West Virginia families at this income level would consider as an affordable premium?

A. In the West Virginia Health Care Survey 2001, in a response to the question concerning their willingness to pay for insurance for comprehensive coverage plan for children, 76% of respondents expressed willingness or interest to pay for plans costing less than $200 per month to cover an uninsured child. Only 9.3% responded that their willingness was to spend "nothing." (See Appendix 8 "Willingness to Pay.")

In conjunction with its most recent consumer survey of last year's WVCHIP families, 79% of respondents said they were willing to pay from less than $30 to $70 for adult coverage to obtain full family coverage when their child(ren) were covered by WVCHIP. (See Appendix 9 "Parent Interest in Health Care Coverage.")

7) With increased cost-sharing, would families still be asked to attest or demonstrate a lack of insurance for their children?

A. Yes, WVCHIP would still be concerned about having families drop existing insurance to participate in WVCHIP (sometimes referred to as "crowd out.") This means the criterion of having been without insurance for a six month period would still apply.

8) Would families who are currently prohibited from covering their children under CHIP because they qualify for coverage under PEIA (or other plans funded by county or municipal government) be eligible under an expansion with higher cost-sharing or 100% (full) cost-sharing?

A. No, families in these situations are still not eligible according to the regulations at CFR 457.310. (Please see a summary of this regulation in Appendix 10.)

9) If families were allowed to buy-in to CHIP at full cost, what would the estimated premium cost be?

A. Current estimates show this cost to be at around $206 per month per child***** or $2,472 a year the first year and to dip slightly to $2,376 the second year. The slight decrease is accounted for by the experience WVCHIP has seen from uninsured children coming into the program with some "pent-up demand" costs. (See Actuarial Estimates: Scenario 1.)

10) How many children are estimated to be enrolled under a full cost buy-in scenario?

A. Only as many as 44 would be served in the first full year with the number increasing to 410 after the fourth year. (See Actuarial Estimates: Scenario 1 as above.)

11) If families were permitted to buy-in at 20% premium costs for 250% FPL households and at 25% for 300% FPL households, what would premium costs be?

A. Premium costs would then decrease to about $40 per month per child* ($480 per year) for 250% FPL households and $50***** per month per child ($600 per year) for 300% FPL households. (See Actuarial Estimates: Scenario III.)

This is the equivalent of a per member per month (pmpm) cost to the program and is not equivalent to an estimated charge to the family that could vary according to family size.

12) How many children are estimated to be enrolled under a 20% and 25% buy-in scenario?

A. About 224 children from households at 250% FPL or lower and about 201 from 300% FPL or lower for a total of 425 in the first full year. The actuary estimates this may increase to 4,400 after four years. (See Actuarial Estimates: Scenario III.)

13) How many children would be covered under a capped program with cost-sharing participation rates at 20% - 25% and what would happen once the cap is reached?

A. This scenario proposes a cap at 3,000 children which could be reached the second year. At that point continuous enrollment would be stopped and enrollment would only occur at designated open enrollment periods after a certain number of disenrollments had occurred. (See Actuarial Estimates: Scenario II.)

14) How much is the estimated cost in State funds to expand the program at a 20% - 25% cost-share allowing for continued enrollment?

A. In the first full year serving an additional 425 children would cost an additional $69,164 and would increase to $1.86 million as enrollment grew to 4,400 by the fourth year. (See Actuarial Estimates: Scenario III.)

15) How much is it estimated to cost in State funds to expand the program at 20% - 25% cost-share allowing for an enrollment cap at 3,000 children?

A. In the first full year the cost is estimated to be the same as without any cap: 425 children enrolled at cost of around $69 thousand, but the cap of 3,000 enrollees would come into effect in the third full year and cost to the State would be held to about $1.27 million even after four full years. (See Actuarial Estimates: Scenario II.)

Section III

Scenarios Estimating Costs and Numbers of Participants

West Virginia CHIP Children's Health Insurance Program

CCRC Actuaries, LLC

West Virginia Children's Health Insurance Program

EXPANSION SCENARIOS

See Appendix 11 for full report.

September 2004

West Virginia Children's Health Insurance Program

Proposed Expansion to 250% and 300% of Federal Poverty Level
Coverage of Infants & Children Aged 1-19
Full Cost to 250% and 300% of Federal Poverty Level

Scenario I - Full Cost Buy-In to 250% and 300% of FPL

Enrollment	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
New Enrollees (200%-250% FPL)	50	135	79	56	44
New Enrollees (250%-300% FPL)	50	135	79	56	44
Total New Enrollees	100	270	158	112	88
Average Enrollment (200%-250% FPL)	22	114	181	204	205
Average Enrollment (250%-300% FPL)	22	114	181	204	205
Total Average Enrollment	44	228	362	408	410
Average Monthly Premium (200%-250% FPL)	$ 206.13	$ 198.25	$ 209.99	$ 228.53	$ 252.35
Average Monthly Premium (250%-300% FPL)	206.13	198.25	209.99	228.53	252.35

Projected Program Expense	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Medical Services (200%-250% FPL)	$16,539	$165,362	$273,089	$327,933	$355,521
Medical Services (250%-300% FPL)	16,539	165,362	273,089	327,933	355,521
Total Medical Services	$33,078	$330,724	$546,178	$655,866	$711,042
Prescription Drug Services (200%-250% FPL)	$4,925	$54,158	$98,385	$129,958	$154,980
Prescription Drug Services (250%-300% FPL)	4,925	54,158	98,385	129,958	154,980
Total Prescription Drug Services	$9,850	$108,316	$196,770	$259,916	$309,960
Dental Services (200%-250% FPL)	$3,017	$30,169	$49,825	$59,829	$64,862
Dental Services (250%-300% FPL)	3,017	30,169	49,825	59,829	64,862
Total Dental Services	$6,034	$60,338	$99,650	$119,658	$129,724
Medical Annual Cost (200%-250% FPL)	$24,481	$249,689	$421,299	$517,720	$575,363
Medical Annual Cost (250%-300% FPL)	24,481	249,689	421,299	517,720	575,363
Total Medical Annual Cost	$48,962	$499,378	$842,598	$1,035,440	$1,150,726
Administrative Expenses (200%-250% FPL)	$3,171	$26,393	$43,643	$53,422	$59,360
Administrative Expenses (250%-300% FPL)	3,171	26,393	43,643	53,422	59,360
Total Administrative Expenses	$6,342	$52,786	$87,286	$106,844	$118,720
Revenue Offsets:					
Prescription Drug Rebates	$887	$9,748	$17,709	$23,392	$27,896
Premiums (200%-250% FPL)	$27,209	$271,208	$456,088	$559,446	$620,775
Premiums (250%-300% FPL)	27,209	271,208	456,088	559,446	620,775
Total Premiums	$54,417	$542,416	$912,175	$1,118,892	$1,241,550
Total Cost	$0	$0	$0	$0	$0
Federal Share	$0	$0	$0	$0	$0
State Share	$0	$0	$0	$0	$0

West Virginia Children's Health Insurance Program

Proposed Expansion to 250% and 300% of Federal Poverty Level
Coverage of Infants & Children Aged 1-19
20% and 25% Cost Share to 250% and 300% of Federal Poverty Level Respectively
Cap at 3,000 Children

Scenario II - 20% & 25% Cost Share to 250% & 300% FPL (With Cap)

Enrollment	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
New Enrollees (200%-250% FPL)	500	1,346	384	384	384
New Enrollees (250%-300% FPL)	450	1,212	336	336	336
Total New Enrollees	950	2,558	720	720	720
Average Enrollment (200%-250% FPL)	224	1,139	1,579	1,579	1,579
Average Enrollment (250%-300% FPL)	201	1,024	1,421	1,421	1,421
Total Average Enrollment	425	2,163	3,000	3,000	3,000
Average Monthly Premium (200%-250% FPL)	$ 40.18	$ 40.20	$ 42.11	$ 47.01	$ 53.12
Average Monthly Premium (250%-300% FPL)	50.39	50.30	52.47	58.25	65.55
Projected Program Expense	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Medical Services (200%-250% FPL)	$165,390	$1,652,995	$2,350,248	$2,563,863	$2,826,001
Medical Services (250%-300% FPL)	148,849	1,487,790	2,108,018	2,287,033	2,510,431
Total Medical Services	$314,239	$3,140,785	$4,458,266	$4,850,896	$5,336,432
Prescription Drug Services (200%-250% FPL)	$49,243	$541,384	$846,718	$1,016,045	$1,231,923
Prescription Drug Services (250%-300% FPL)	44,319	487,276	759,453	906,339	1,094,357
Total Prescription Drug Services	$93,562	$1,028,660	$1,606,171	$1,922,384	$2,326,280
Dental Services (200%-250% FPL)	$30,174	$301,578	$428,788	$467,762	$515,588
Dental Services (250%-300% FPL)	27,156	271,438	384,595	417,255	458,014
Total Dental Services	$57,330	$573,016	$813,383	$885,017	$973,602
Medical Annual Cost (200%-250% FPL)	$244,807	$2,495,957	$3,625,754	$4,047,670	$4,573,512
Medical Annual Cost (250%-300% FPL)	220,324	2,246,504	3,252,066	3,610,627	4,062,802
Total Medical Annual Cost	$465,131	$4,742,461	$6,877,820	$7,658,297	$8,636,314
Administrative Expenses (200%-250% FPL)	$25,191	$251,020	$364,068	$406,433	$459,234
Administrative Expenses (250%-300% FPL)	22,744	226,076	326,695	362,715	408,138
Total Administrative Expenses	$47,935	$477,096	$690,763	$769,148	$867,372
Revenue Offsets:					
Prescription Drug Rebates	$8,421	$92,579	$144,555	$173,015	$209,365
Premiums (200%-250% FPL)	$54,000	$549,395	$797,964	$890,821	$1,006,549
Premiums (250%-300% FPL)	60,767	618,145	894,690	993,336	1,117,735
Total Premiums	$114,767	$1,167,540	$1,692,655	$1,884,156	$2,124,284
Total Cost	$389,878	$3,959,438	$5,731,373	$6,370,274	$7,170,037
Federal Share	$320,714	$3,257,033	$4,714,628	$5,240,187	$5,898,072
State Share	$69,164	$702,405	$1,016,745	$1,130,087	$1,271,965

CCRC Actuaries, LLC 9/10/2004

West Virginia Children's Health Insurance Program

Proposed Expansion to 250% and 300% of Federal Poverty Level
Coverage of Infants & Children Aged 1-19
20% and 25% Cost Share to 250% and 300% of Federal Poverty Level Respectively

Scenario III - 20% & 25% Cost Share to 250% & 300% FPL (Without Cap)

Enrollment	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
New Enrollees (200%-250% FPL)	500	1,350	994	710	554
New Enrollees (250%-300% FPL)	450	1,215	913	652	509
Total New Enrollees	950	2,565	1,907	1,362	1,063
Average Enrollment (200%-250% FPL)	224	1,139	1,924	2,259	2,300
Average Enrollment (250%-300% FPL)	201	1,025	1,741	2,054	2,100
Total Average Enrollment	425	2,164	3,665	4,313	4,400
Average Monthly Premium (200%-250% FPL)	$ 40.18	$ 40.21	$ 42.84	$ 47.26	$ 52.88
Average Monthly Premium (250%-300% FPL)	50.39	50.27	53.60	59.12	66.01
Projected Program Expense	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Medical Services (200%-250% FPL)	$165,390	$1,653,624	$2,913,658	$3,687,804	$4,098,095
Medical Services (250%-300% FPL)	148,849	1,488,262	2,638,528	3,355,309	3,736,513
Total Medical Services	$314,239	$3,141,886	$5,552,186	$7,043,113	$7,834,608
Prescription Drug Services (200%-250% FPL)	$49,243	$541,591	$1,049,698	$1,461,458	$1,786,459
Prescription Drug Services (250%-300% FPL)	44,319	487,430	950,577	1,329,692	1,628,835
Total Prescription Drug Services	$93,562	$1,029,021	$2,000,275	$2,791,150	$3,415,294
Dental Services (200%-250% FPL)	$30,174	$301,693	$531,580	$672,819	$747,674
Dental Services (250%-300% FPL)	27,156	271,524	481,384	612,157	681,706
Total Dental Services	$57,330	$573,217	$1,012,964	$1,284,976	$1,429,380
Medical Annual Cost (200%-250% FPL)	$244,807	$2,496,908	$4,494,936	$5,822,081	$6,632,228
Medical Annual Cost (250%-300% FPL)	220,324	2,247,216	4,070,489	5,297,158	6,047,054
Total Medical Annual Cost	$465,131	$4,744,124	$8,565,425	$11,119,239	$12,679,282
Administrative Expenses (200%-250% FPL)	$25,191	$251,116	$451,013	$583,883	$665,097
Administrative Expenses (250%-300% FPL)	22,744	226,147	408,569	531,392	606,577
Total Administrative Expenses	$47,935	$477,263	$859,582	$1,115,275	$1,271,674
Revenue Offsets:					
Prescription Drug Rebates	$8,421	$92,612	$180,025	$251,204	$307,376
Premiums (200%-250% FPL)	$54,000	$549,605	$989,190	$1,281,193	$1,459,465
Premiums (250%-300% FPL)	60,767	618,341	1,119,765	1,457,138	1,663,408
Total Premiums	$114,767	$1,167,946	$2,108,954	$2,738,330	$3,122,873
Total Cost	$389,878	$3,960,829	$7,136,028	$9,244,980	$10,520,707
Federal Share	$320,714	$3,258,178	$5,870,096	$7,604,920	$8,654,334
State Share	$69,164	$702,651	$1,265,932	$1,640,060	$1,866,373

CCRC Actuaries, LLC 8/24/2004

Section IV

Appendices

West Virginia CHIP Children's Health Insurance Program