Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-141 – Department of Medical Assistance Services
Family Access to Medical Insurance Security Plan
January 8, 2003

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.G of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the Proposed Regulation

The proposed regulations will permanently establish the Family Access to Medical Insurance Security (FAMIS) plan, which replaced the Children's Medical Security Insurance Plan (CMSIP) on August 1, 2001 under emergency regulations. Since then further modifications have been made to the FAMIS program which were implemented on September 1, 2002 under another set of emergency regulations. Compared to CMSIP, the proposed permanent FAMIS program modifies the maximum income eligibility levels, the application procedures, cost sharing requirements, the health benefits package, the outreach activities, and establishes a Medicaid look-alike reimbursement methodology. This report compares the former permanent regulations governing the CMSIP program and the FAMIS rules that became effective on August 1, 2001 while referencing most recent changes that became effective through an emergency regulation on September 1, 2002.

Estimated Economic Impact

These regulations contain rules for providing publicly subsidized health insurance coverage to uninsured children. The main goal of providing coverage to uninsured children is to improve low-income children's access to and utilization of basic health services. According to census data, 13.8% and 12% of children were uninsured in 1995 and 2000, respectively.[1] [2] Also, the research in this area provides evidence that uninsured children's access to and utilization of basic health services are low.[3] [4] For example, uninsured children are 18% more likely to have no usual source of care, 5% more likely to not receive or to postpone care, and their families are 17% more likely to feel not confident about getting the needed care relative to children enrolled under Medicaid. Similarly, it is found that uninsured children are 14% less likely to use medical services than insured children. Among children who use medical services, uninsured have 15% fewer physician visits than insured. Uninsured children receive 30% fewer outpatient visits and 15% to 25% fewer inpatient days relative to insured children. Uninsured children are also less likely to be immunized and more likely to be hospitalized for conditions that can be averted.

Additionally, the empirical research points out that the majority of uninsured children are members of low-income families. It is found that a little over half of the uninsured children (54%) live in households with income less than 185% of the federal poverty level and almost 23% of uninsured children live in households below the federal poverty level.[5] This indicates that the number of uninsured is directly related to the level of income. As income decreases the risk of being uninsured increases. The risk also increases with the age of the child. The children age 13 to 18 are found to be 33% more likely to be uninsured relative to those under six.

The economic rationale for improving uninsured children's access to and utilization of basic health services relies on the notion that providing these services is a good investment for the society. Early prevention of illnesses through immunizations or basic care is most probably cost effective. If left untreated, even common illnesses can lead to more serious and costly

[1] Weil, Alan, 1997, "The New Children's Health Insurance Program: Should States Expand Medicaid?" Urban Institute.
[2] Kaiser Commission on Medicaid and the Uninsured, 2002, "Health Coverage for Low-Income Children."
[3] Ibid.
[4] Holahan, John, 1997, "Expanding Coverage for Children," Urban Institute.
[5] Dubay, Lisa and Genevieve M. Kenney, 1997, "Lessons from the Medicaid Expansions for Children and Pregnant Women: Implications for Current Policy," Testimony Before the House Committee on Ways and Means, Subcommittee on Health.

health care services such as emergency room visits and hospitalizations. Healthy children could do better in schools and eventually be more productive members of the society. Additionally, the government-funded children's insurance provides some financial relief to working uninsured families. Government sponsored health coverage for uninsured children may also be justified on the grounds that while adults may choose to remain uninsured, children themselves are not responsible for decisions about their coverage. Finally, the federal dollars that are used for children's insurance under FAMIS probably substitute the high-cost emergency room visits paid by state indigent care funds and benefit the Commonwealth.

Background

In 1997, the federal government initiated the health coverage for uninsured children by creating the State Children's Health Insurance Program (SCHIP) and authorized $40 billion in federal matching dollars to low-income uninsured children. This is the largest expansion of health coverage provided by the federal government since 1965 when Medicaid and Medicare were created. Virginia's share from these federal funds is about $70 million per year or about $692 million over the 1997-2007 ten-year authorization period. [6] These funds are provided through Title XXI of the Social Security Act which has an enhanced match rate of 66% compared to Medicaid match rate of 51%. The goal of the program is to provide health insurance to uninsured children whose family income is too high to qualify for Medicaid.

The federal rules provide wide discretion to the states in program development and implementation. States have the option to expand the Medicaid program for uninsured children, design and create a new program, or do both. Both options have their advantages and disadvantages. Medicaid has an existing network of providers, an established system to handle enrollment, education, appeals, rate settings, claims payment, and fraud prevention. By expanding Medicaid, the Commonwealth may benefit from the existing program and delivery structure while loosing flexibility of implementation since such a program must mirror Medicaid services to its other clients. In contrast, establishing a separate program would allow the Commonwealth to foster innovative strategies in service delivery, benefit package, cost sharing,

[6] Joint Legislative Audit and Review Commission of the Virginia General Assembly, 2002, "A report of Selected Programs in the Department of Medical Assistance Services."

reimbursement methods, application procedures, at the expense of forgoing the possible utilization of an existing structure and delivery system. As of June 2000, 16 states and the District of Columbia chose to expand Medicaid coverage, 16 states established a separate program, and 17 states combined both approaches.[7]

The Commonwealth's Children's Medical Security Insurance Program (CMSIP) became effective in October 1998. The CMSIP was a Medicaid look-alike program. Prior to CMSIP, Medicaid was the primary provider of healthcare to indigent children in Virginia. However, Medicaid is available only to children with family incomes below 100% of federal poverty line for older children and below 133% for younger children. According to 2001 data, there are more than 130,000 uninsured children with family incomes at or below 200% of the federal poverty line not covered by Medicaid.[8]

To serve these children, CMSIP was implemented in October 1998. The initial goal of the program was to enroll 63,200 uninsured children as quickly as possible. The number of enrolled children was 10,231 in June 1999, 23,587 in June 2000, and 31,905 in June 2001. The growth in enrollment was significant, but fell short of the initial objective. The performance of the CMSIP program was hindered by ineffective outreach efforts, problems in administration and design, stringent eligibility criteria, and a complicated enrollment process.[9] CMSIP failed to reach its enrollment goal and resulted in forfeiture of $55 million in federal matching dollars as of June 2001.

In response to low enrollment and program design issues, the 2000 General Assembly adopted legislation to restructure CMSIP, renaming the program the Family Access to Medical Insurance Security (FAMIS) plan. The FAMIS program was implemented under emergency regulations in August 2001. Where CMSIP was a Medicaid look-alike program, FAMIS has a Medicaid look-alike package in those areas without contracted managed care health insurance providers and has another package modeled after the private sector and resembling a private healthcare insurance plan, in areas where managed care providers are available. Also in September 2002, Medicaid eligibility was expanded to 133% of federal poverty level for children

[7] Kaiser Commission on Medicaid and the Uninsured, 2001, "CHIP program Enrollment."
[8] Joint Legislative Audit and Review Commission of the Virginia General Assembly, 2002, "A report of Selected Programs in the Department of Medical Assistance Services."
[9] Ibid.

6-19 through a separate regulatory action and FAMIS started covering children with higher income levels up to 200% of federal poverty level. This change shifted many children who would otherwise be served under FAMIS to Medicaid expansion group. The program still continues to operate under the emergency regulations. This proposed action will replace the emergency FAMIS regulations with permanent regulations.

This report primarily focuses on the changes that already took place during the transition from CMSIP to FAMIS as of August 1, 2001. In addition, some other changes became effective since then. These newer changes are the secondary focus of this report and are discussed where appropriate. FY 2001 is used as a reference year for CMSIP and FY 2002 is used as reference year for FAMIS. Since these changes have been in effect for a while, most of their economic effects are already realized. In FY 2002, the total FAMIS expenditures were approximately $50.7 million. A synopsis of the children's insurance program under CMSIP and FAMIS is provided in the following table.

Summary Statistics: CMSIP vs. FAMIS

Group	*Variable*	*CMSIP (FY 2001)*	*FAMIS (FY 2002)*	*Change*
Total	Average Monthly Enrollment	28,551	37,007	29.6%
Fee-for-Service	Average Monthly Enrollment	18,542	13,456	-27.4%
	Average Annual Expenditure per Child Enrolled	$1,343	$1,552	15.6%
	Average Monthly Expenditure per Child Enrolled	$114	$147	28.9%
Managed Care	Average Monthly Enrollment	10,008	23,551	135.3%
	Average Annual Expenditure per Child Enrolled	$1,023	$1,245	21.7%
	Average Monthly Expenditure per Child Enrolled	$85	$101	18.8%

Source: The Department of Medical Assistance Services

These statistics indicate that the total enrollment in children's insurance grew by 29.6%. Although the fee-for-service enrollment decreased by about 5,000, the increase in the managed

care enrollment outweighed this decrease. Per capita average medical expenditures also appear to have increased significantly for both the fee-for-service and managed care populations.

One of the important economic effects expected from expansion of FAMIS insurance coverage is the substitution of publicly funded healthcare for private insurance. This is often referred to as "crowding out." Crowding out occurs when rational individuals substitute a costless alternative provided by the government for an otherwise costly service. For instance, if the government provides free bread, individuals would not purchase bread out of their pocket, but would rather rely on the government. In other words, government funds spent on bread would crowd-out, or replace out of pocked expenditures on bread.

Similarly, the FAMIS expenditures for children's insurance will likely replace, or crowd out some of the privately funded children's insurance. Crowding-out is relevant because its presence may hinder improvements in access to care and may lead to higher program costs than expected. The magnitude of this effect would increase with the income eligibility level, the failure in preventing the substitution of FAMIS for private coverage, high premium cost sharing, and generosity of the benefit package.[10] The challenging trade off is that without these features, the ability of FAMIS to reach its objective will be limited. There does not seem to be a solution in the current literature to eliminate this problem without creating inequities in access to coverage. Thus, some level of substitution of public coverage for private coverage may be an unavoidable effect of any program designed to make sure that those eligible individuals who need health coverage get it.

The FAMIS program contains a number of policies such as a waiting period to reduce crowding out. In addition, there do not appear to be any good empirical studies of the magnitude of substitution of publicly provided insurance for privately provided insurance resulting from this program. As noted elsewhere in this report, a large fraction of this population is not covered by private health insurance. This fact, by itself, greatly reduces the potential for substitution.[11] It is, then, quite possible that, while the incentives for crowding-out do exist, their actual impact may be small.

[10] Dubay, Lisa and Genevieve M. Kenney, 1997, "Lessons from the Medicaid Expansions for Children and Pregnant Women: Implications for Current Policy," Testimony Before the House Committee on Ways and Means, Subcommittee on Health.

[11] Similarly, the sizes or significances of the potential crowding out associated with each particular change discussed later in this report are unknown due to lack of studies in this area.

While crowding out occurs with almost any programs that offer public assistance, economic effects of FAMIS crowding out may not be as significant for Virginia as those under other programs. The 200% of federal poverty level for FAMIS eligibility results in lower "acceptable" level of crowding out because most low-income families do not have children's insurance to begin with. More importantly, under FAMIS, potential crowding out of private coverage will be financed 66% from federal funds and the Commonwealth will finance only one third. One dollar crowding out in private insurance will save the families exactly one dollar which will increase the federal dollars coming to the Commonwealth by 66 cents, and increase state expenditures by 33 cents. Moreover, crowding out will likely provide some financial relief to parents with children, which could be considered as a form of subsidy to low-income families.

The remainder of this report provides individual analyses for changes in eligibility, application process, cost sharing requirements, employer sponsored health insurance, benefits package, outreach activities, and reimbursement methods.[12]

Eligibility

The eligibility criteria define the population of children who may qualify for health insurance assistance and consequently have a direct effect on the number of children enrolled. There are some notable differences in the eligibility criteria between CMSIP and FAMIS, which are summarized below.

The FAMIS plan increases the maximum income eligibility level from 185% to 200% of the federal poverty income guidelines. This income eligibility criterion is consistent with 36 other states that have set the eligibility criteria at or above 200% of federal poverty level.[13] Currently, 200% of the federal poverty income level for a family of four is $36,200 per year or $3,017 per month. FAMIS also counts many sources of income disregarded (or excluded) under CMSIP. These include a $90 earned income disregard per month, a disregard for childcare paid, and a disregard from child support income received. Increasing income eligibility and eliminating the income disregards at the same time have opposite effects on the number of

[12] Most of the programmatic comparisons between CMSIP and FAMIS are adopted from the JLARC report.
[13] Ross, Donna Cohen, Laura Cox, 2000, "Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," Kaiser Commission on Medicaid and the Uninsured.

Differences in Eligibility Criteria: CMSIP vs. FAMIS

CMSIP	*FAMIS*
• Family income less than 185% of federal poverty level, allowing certain income disregards • Income does not include stepparents income • Child must be uninsured for 12 months (good cause exceptions apply) • Cooperation with child support enforcement required	• Family income less than 200% of federal poverty level, not allowing income disregards • Income includes stepparents income • Child must be uninsured for 6 months (good cause exceptions apply) • Cooperation with child support enforcement is not required *Changes in September 2002:* • Added an affordability exception for six-month waiting period • Do not consider absent parents' employment or insurance status

eligible for enrollment. Since many families in CMSIP were able to use income disregards to reduce their countable income and therefore qualify, increasing the income eligibility level while removing income disregards is estimated to have a small effect on enrollment. Also, these changes do not apply to children enrolled under CMSIP. They may remain enrolled under FAMIS as long as they meet the old eligibility requirements under CMSIP program.

Establishing an income cut off for FAMIS benefits rather than reducing benefits on a sliding scale may reduce some individuals' incentives to accept promotions and higher paying positions. A small change in income may qualify or disqualify some families if their income is slightly above or below the income cut off for eligibility. Those who are slightly above the cut off may intentionally reduce their income to qualify for FAMIS if the gains in insurance benefits exceed the lost income. Similarly, those who are slightly below the cut off may intentionally pass up opportunities to increase their income in order for not to loose the FAMIS coverage if the additional income does not exceed the FAMIS benefits. If this occurs, as expected, such a behavior would further crowd out private insurance. Shifting the income cut off from 185% of federal poverty level to 200% would expose different families to this potential disincentive to work. However, this change affects probably only a small number of families and consequently the size of the crowding out will likely be small.

In the new FAMIS plan, stepparents are included in the definition of family for financial eligibility purposes. CMSIP followed Medicaid policy and did not count the stepparent's income

[14] Ross, Donna Cohen, Laura Cox, 2000, "Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," Kaiser Commission on Medicaid and the Uninsured.

when determining eligibility of the child. The Department of Medical Assistance Services (the department) believes that stepparents are part of the family unit and their income should be used in determining the family's financial situation. Opponents of this policy note that stepparents are not legally responsible for the care of their stepchildren and that this policy discourages remarriage. Also, adding stepparents' income is likely to reduce the number of children potentially eligible for FAMIS thereby decrease enrollment in the program. This change illustrates an inherent trade-off between providing coverage for families who could otherwise afford insurance and excluding children whose stepparents choose not to provide health insurance. No empirical evidence can be found, however, to indicate which of these effects is larger.

CMSIP required a child to be uninsured for 12 months before becoming eligible for coverage; FAMIS reduces that period to six months. The standard used by 13 states is a six-month waiting period while the rest of the states with the exception of Alaska either have less than 3-month or no waiting period.[15] The waiting period is designed to discourage families from dropping private health insurance and substituting state-supported insurance or to reduce potential crowding out. So, reducing the time children must be without insurance before being eligible for FAMIS would likely increase crowding out, but also contribute to enrollment of intended beneficiaries. The choice of the waiting period must be a balance between the potential effects. There is insufficient data to determine the count of additional crowding out and additional enrollment, but both will undoubtedly occur.

The requirement for cooperating with the division of child support enforcement is no longer mandatory for eligibility as it was under CMSIP. Under CMSIP, failure on the part of custodial parents to cooperate meant that children would not be eligible to participate in the program. According to the department, this created a barrier for families to enroll in the program. Many of these parents had informal payment or support agreements with the absent parent and were unwilling to contact with the absent parent to secure an approval. The reason for unwillingness was that many of these families were concerned that these informal support agreements would be abandoned while trying to get the absent parent's approval. The statutory

[15] Ross, Donna Cohen, Laura Cox, 2002, "Enrolling Children and Families in Health Coverage: The promise of Doing More, Kaiser Commission on Medicaid and the uninsured.

changes in 2001 removed this potential barrier and probably contributed to increased enrollment in the FAMIS program.

A recent change in FAMIS added an "affordability" exception as a good cause reason for skipping the six-month waiting period. With this change the child does not have to wait six months to be eligible for FAMIS if the family can document that the cost of the private insurance they dropped exceeds 10% of their income. This exception recognizes that some families may be paying high premiums and cannot continue to keep their insurance, and so the child should not be left uninsured. This exception explicitly provides for the substitution of public for private insurance when the financial burden on the family is too high and, in exchange, aims to provide some financial relief to the low-income families. Also, this amendment is expected to eliminate a potential barrier and contribute to enrollment in the program.

Similarly, another recent change removed the requirement to consider absent parents' insurance status when determining eligibility. Earlier emergency regulations prohibited children from participation in FAMIS when their absent parent was an employee of the state or a local governmental entity, had access to family coverage under the Virginia State Employees Health Insurance Plan and the employer contributed toward the cost of the family coverage. Under the new changes, information on the employment and insurance status of the absent parent are not collected. This change is also expected to eliminate a potential barrier and contribute to enrollment in FAMIS while reducing the incentive of absentee parent to provide coverage and could increase crowding out by some small but unknown amount. The department points out that counting coverage by an absent, and probably unwilling, parent as a condition for coverage would prevent coverage of a child for reasons substantially beyond the control of the present parent.

Application Process

Complexity of the application process has a direct effect on enrollment. As the complexity increases, the number of applications decreases. In fact, one of the main reasons for the failure of CMSIP reaching its enrollment goal is believed to be the cumbersome application process. The differences in application processing are summarized below.

Differences in Application Process: CMSIP vs. FAMIS

CMSIP	*FAMIS*
• Single application for Medicaid and CMSIP	• Separate application for Medicaid and FAMIS
• Application is processed by local departments of social services	• Application is processed by FAMIS call center (CPU) and application can be made over the phone (later mailed for signature), or by fax
• Full Medicaid eligibility determination is conducted prior to determining eligibility for CMSIP	• Screened for Medicaid eligibility first and Medicaid likely recipients are referred to Medicaid unit at CPU or local departments of social services
• Eligibility is determined within 45 days	• Upon receiving signed and completed application, for most, eligibility is determined within 10 days
• Verification requirements are extensive	• Verification requirements are minimal *Changes in September 2002:* • Require the use of a single application for Medicaid and FAMIS • Allow local departments of social services to process applications • Allow an adult relative caretaker to file an application

CMSIP relied on local Departments of Social Services to process applications and enroll participants. This system was difficult to manage since it involved training personnel and distributing program information at over 120 local social services offices around the state. Monitoring implementation of the program and tracking the status of applications was also difficult under this system. FAMIS creates a central processing unit (CPU) for administration of the program. The CPU distributes applications and program information, maintains a call center and multiple electronic interfaces, responds to inquiries, receives and processes applications for eligibility, and provides personal assistance to callers, monitors cost sharing, provides reports, and is responsible for provider and health plan enrollment. The CPU was created to simplify eligibility determination and enrollment process.

Creating one centralized office for all aspects of the application process allows for specialized staffing and training and provides more access to detailed data on applications, including reasons for case denials. Due to the increased efficiency, the time period for processing an application decreased for most completed applications from 45 days to 10 days. Because it may take potential clients significant amounts of time to actually *complete* an

application, the delay from the start of the application process to final approval can take considerably longer.

Changing the contact point for the program also reduces stigma associated with welfare or public assistance programs that might have existed when the program was administered by local departments of social services. Also, CPU responds to applications on the phone and mails the application forms for signature instead of conducting face-to-face interviews which was encouraged under CMSIP. Additionally, the documentation required for verification is minimal compared to CMSIP. For example, the verification of income disregards was no longer a requirement under FAMIS. Relying on mail and minimal verification requirements reduces transaction costs and encourages enrollment.

As the transaction costs decrease, overall net benefits from the FAMIS program increase. Finally, there is a federal requirement that children be screened for Medicaid prior to completing the application for FAMIS. So, there is an additional spillover benefit of finding children eligible for Medicaid among the increased applications. Overall, the changes seem to have simplified and expedited the eligibility determination and application process and increased the enrollment in the FAMIS program.

Currently, CPU receives about 20,000 calls concerning status of applications, questions, or concerns about the providers and about 4,500 to 5,000 new or renewal applications per month for FAMIS. Approximately 40% of the new applications are determined to be more likely to be eligible for Medicaid and referred to the Medicaid unit located at the CPU.

A part of the costs associated with the new CPU is being funded with money that was previously provided to local social service agencies to assist with eligibility determinations and applications. Because the administrative costs increased from $2.2 million to $5 million with the increase in enrollment, the additional costs that can be solely attributed to changes in the application procedure cannot be isolated. However, in May 2001, the department paid $3 million for a two-year contract to manage enrollment and application procedures.

Currently, there are approximately 30 full time and part time employees hired by the contractor. They are divided between the telephone operators, eligibility staff, mailroom, data entry, and administrative positions. The number of staff fluctuates to meet the high call volumes such as during back to school. The department also maintains a Medicaid unit at the CPU. The

Medicaid unit is staffed by state employees because only a government employee can enroll a child in Medicaid, and the eligibility process is more complicated. There is a supervisor and five staff in this unit. They were all new hires. Most were hired with the implementation of FAMIS in August 2001 and others were added as FAMIS grew. The department also employs a contract monitor who is located at the CPU.

The newer changes aim to simplify the application process further and take advantage of the cooperation with the local departments of social services. One of these amendments will combine the application forms for Medicaid and FAMIS in a single document. Another change allows local departments of social services to process applications. Together these two changes result in a "no wrong door" application process for FAMIS and Medicaid eligible applicants. Under the earlier emergency regulations, separate application forms were required, FAMIS CPU received all applications, and local departments of social services were not involved in the FAMIS program. A family would have to guess whether their children would qualify for Medicaid or FAMIS, fill Medicaid or FAMIS application, and send it to FAMIS CPU or local departments of social services. Because eligibility rules such as counting stepparents' income and use of income disregards in Medicaid are different, this was not always an easy decision to make. If the family were wrong and applied to the wrong place, they would ultimately have to complete more forms and submit them to another entity. This resulted in a loss of valuable time for the applicants and discouraged many to further pursue their applications.

Under the newer rules, local departments of social services also determine eligibility for the FAMIS program within 45 days of the date the application was received. When a local department of social services receives a child health insurance application, the local agency first determines the child's eligibility for Medicaid. If the child is determined Medicaid ineligible, the local agency proceeds with a FAMIS eligibility determination and enroll eligible children in FAMIS. With the new changes, either the FAMIS CPU or local agency determines eligibility for both programs and enroll the child in the correct plan. Thus, the transaction costs associated with the FAMIS program probably decreased. Additionally, having local departments of social services involved in the process provides a local contact in every community where a family can receive assistance with such applications if they prefer. These changes are expected to improve the application and enrollment processes further and increase access to FAMIS.

Another new change permits the adult relative caretaker to file an application on behalf of a child. This requirement is also likely to increase children's access to FAMIS especially when their parents are absent.

Cost-Sharing

The enrollment in the FAMIS program largely depends on whether and how much the enrollees are expected to pay. Based on the economic theory it can be reliably stated that as the cost sharing increases, the enrollment in the program would decrease. There are some significant differences in cost sharing requirements between the two programs, which may affect enrollment. These are described below.

Differences in Cost-Sharing: CMSIP vs. FAMIS

CMSIP	*FAMIS*
• Co-payments are not required	• Co-payments are required; annual co-payment limit is $180 per family with income at or below 150% below poverty, or maximum 2.5% of the family income, and $350 per family with income above 150% poverty level, or maximum 5% of the family income. No co-payments are required for well-child and preventive services and families participating employer sponsored health insurance
• Monthly premiums are not required	• Initially, monthly premiums were required. Later, this requirement was eliminated.

The CIMSIP program did not require any cost sharing by recipients. The FAMIS program implements co-payments for some services received by FAMIS managed care recipients. There are no copays for the Medicaid look-alike benefit package, for preventive services such as well child check-ups, and for families participating in the employer sponsored health insurance plan. For most non-preventive services, copays are $2 or $5 depending on the family income level. Co-payments are higher for families with high incomes than for families with low incomes. Families with income below 150% federal poverty line pay $2 and those above pay $5. A few services such as hospital admissions require higher (e.g. $15 or $25) copays. The maximum amount of copays is $180 per year for families with income below 150%

federal poverty line, or maximum 2.5% of the family income, and $350 for those above with income up to 200% federal poverty line, or maximum 5% of the family income.

The main reason for co-payments is to encourage the efficient use of publicly funded healthcare resources. The economic theory indicates that free healthcare services will be used inefficiently. Charging a co-payment for some medical services would reduce the demand for these services relative to the demand for free care and discourage unnecessary care. The effects of the copays depend on their size. The FAMIS copays appear to be nominal. Available studies suggest that the economically optimal structure for cost sharing includes "a low [or possibly even zero] monthly premium, a high deductible for inpatient care (except, perhaps for young children), and co-payments targeting certain types of services (e.g. brand name vs. generic prescriptions) and certain sites of care (e.g. emergency room vs. physician office) to encourage a more cost-conscious use of resources."[16] While the proposed co-payment proposal reflects some aspects of the recommended structure, copays may be too small to significantly reduce overuse of expensive procedures. The FAMIS copays as a percent of income compare very favorably to standard copays required under private insurance plans. For example, for every dollar earned, a FAMIS recipient with a $2-copay and a $20,000-income pays four times less than a family with a $20-copay and a $50,000-income. Additionally, varying co-payments according to income level are likely to reduce the healthcare burden (health expenditures per dollar of income) on low income families and provide a more equitable disincentive to families with high and low incomes.

Additionally, copays may make FAMIS coverage somewhat less attractive and may reduce crowding out relative to what would result without any copays. However, as mentioned, the copays are relatively small. This leads to the expectation that copays would reduce crowding out by only a small amount.

Further, the procedures to implement copay requirements seem to be cost effective. Providers collect copays. The department does not maintain a database for the copays actually paid. If a family documents to the FAMIS CPU that they reached the maximum limit, they are relieved of any further copayments for the remainder of the year. Note that it may take up to 90

[16] Markus, Anne, Sara Rosenbaum, and Dylan Roby, 1998, "CHIP, health Insurance Premiums and Cost-sharing: Lessons from the Literature," The George Washington University Medical Center, Washington, DC.

visits for a low income FAMIS family to reach the maximum and be relieved of copays, which is not expected to occur in most cases. While most families would not reach the copay cap, assigning responsibility to families to track the annual copayments provides an option to families to take advantage of this provision while providing savings to the department in administrative costs that would otherwise be incurred.

Finally, the copays may reduce the stigma associated with the program. It is possible that some recipient families will feel less like they are receiving assistance from a charity or from welfare. On the other hand, there is possibility that copays may create a barrier to some other families (especially to those with low incomes) to participate in the program. However, given the nominal copay structure, any such barrier will likely be very small.

Under the earlier emergency regulations, the FAMIS program implemented a set of monthly premiums ranging from $15 up to $45 for families with incomes above 150% federal poverty level to participate in the program. Similar to the copays the goal was to encourage efficient use of healthcare resources. However, monthly premiums constituted a significant barrier to enrollment and discouraged families from applying for FAMIS. Some other children lost their coverage because of failing to pay monthly premiums. Also, the department determined that the cost of collecting premiums exceeded the premium revenues. As a result, the FAMIS program does not charge premiums to enrollees or their families.

The removal of monthly premiums is likely to produce positive economic effects. It is worth noting that the success of premiums encouraging efficient use of resources is suspect. Once a family enrolls in FAMIS and pays premiums, it is a sunk cost for the family and unlikely to provide any incentives to use FAMIS insurance efficiently once the enrollment decision is made. Premiums would more likely discourage enrollment in the program. Also, a monthly premium is an instrument mainly to collect revenues. Since the objective of FAMIS cost sharing is to encourage efficient use of resources rather than collecting revenues from families, removing this requirement appear to be consistent with the overall program goal.

Employer-Sponsored Health Insurance

Employer sponsored insurance coverage is one of the largest sources of insurance for children nationwide. In 2000, 32% of low-income children were covered by employer-

sponsored health insurance.[17] FAMIS establishes a premium assistance program called Employer-Sponsored Health Insurance (ESHI) to provide coverage through this widely used source of children's insurance.

Differences in Premium Assistance: CMSIP vs. FAMIS

CMSIP	*FAMIS*
• No assistance is available with premiums to utilize employer sponsored health insurance	• Assistance with premiums to utilize ESHI when it is available and cost effective

The premium assistance program allows FAMIS-eligible families who have access to employer-sponsored health insurance coverage to enroll their children in their employers' health plan. The determination of eligibility for the ESHI component is somewhat labor-intensive. The department reimburses the family the cost of the premium payments if it determines that such enrollment is cost effective (i.e. the cost of covering the child under FAMIS would be more than the total cost of covering the child under the employer sponsored plan) and if the employer contributes 40% of the cost of family coverage. Payment is not approved if the enrollment is not cost effective. The FAMIS plan also provides supplemental coverage (wrap around services) needed to ensure that FAMIS ESHI children have equivalent health benefits to those provided under FAMIS. Participation is voluntary, and families may opt out of ESHI at any time and enroll their eligible children in a FAMIS health plan.

The ESHI program represents an alternative way of providing FAMIS benefits. Currently, the participation in ESHI component is very low. There are 23 families enrolled in and the average premium assistance payment from the department is $110. Low enrollment is partly attributed to the federal requirement that the employer contribute 40% of the family coverage. Employer contributions in many workplaces do not reach 40% of the total cost of coverage. Also, the participation in the ESHI component is generally not cost effective unless the family has an infant or several FAMIS eligible children. Finally, some families do not participate in the employer provided insurance because they cannot afford the employee share of the premium. Despite the low participation, ESHI provides an alternate way of providing

[17] Enrolling Uninsured Low-Income Children in Medicaid and Chip, 2002, Kaiser Commission on Medicaid and the Uninsured.

FAMIS benefits and its is completely voluntary. Families who determine that the benefits from participation exceed the costs are expected to take advantage of this option. Similarly, the department will make payments only if the participation is cost effective. Thus, if chosen by the family and approved by the department, this program will likely provide a net benefit both to the FAMIS enrollees and the department.

Benefits Package

Another factor that affects the enrollment in FAMIS is the value attached to benefits offered. The economic theory suggests that as the perceived benefits increase, more families would be willing to participate in the program. Currently, FAMIS program consists of two benefit packages: (1) a Medicaid look-alike benefit package, (2) a managed care benefit package. Whether children receive Medicaid look-alike or managed care benefit package depends on whether they live in a geographic area where managed care providers are available. Children living in areas where these providers are not available receive Medicaid look-alike benefits. These children will continue to receive Medicaid benefits package and will not be affected. Children living in areas where managed care providers are available receive a different benefits package. Thus, the choice of implementing a private sector like program as opposed to expanding Medicaid has some implications on the type of benefits offered to some children.

Generally, Medicaid offers a more comprehensive benefits package compared to those offered by health management organizations (HMO). Significant differences in the benefits provided to managed care population are compared below.

CMSIP was a Medicaid look-alike plan and the benefits reflected those offered in Virginia's Medicaid program. For children in certain geographical locations, FAMIS creates a new benefit package modeled after the Key Advantage benefit package offered to state employees. Services are delivered by HMOs under contract with the department in areas of the state where FAMIS HMOs exist and through fee-for-service providers in other parts of the Commonwealth.

Differences in Benefits for Managed Care Population: CMSIP vs. FAMIS

CMSIP	*FAMIS*
• Same benefits as the Medicaid program	• Benefits similar to those found in the private sector, based on State Employees' Key Advantage Health Benefits Package. Includes enhancements such as well-child from age six through 18 and therapies for special education students, but imposes limits on some services and does not cover some other services
• Utilizes Medicaid providers or Medicaid managed care entities and their provider networks	• Utilizes FAMIS managed care entities and their provider networks in most localities

For the managed care population, non-emergency transportation, case management services, intensive rehabilitative services, and the community behavioral health support services are no longer covered. Some of the mental health benefits have limitations not found under CMSIP. In short, there is likely to be a reduction in the amount of these services received by managed care children in the FAMIS program. While the reduction in the benefits reduces program costs, it also affects the perceived value of the program and reduces its appeal.

The department states that the proposed benefit package is intended to reflect services covered under a commercial insurance plan. It is not clear why this is a desirable objective. Reduction in benefits reduces costs under FAMIS because uncovered services are not paid. One motivation for a less comprehensive plan could be providing services to more children, as the cost of insurance per children is lower due to reduction in benefits. However, enrollment in the program is currently below its target (although growing fast) and the resources are more than enough to serve children expected to enroll in the program in the near future. Also, probably some children with healthcare needs may be treated in indigent care hospitals in Virginia for conditions not covered in the current FAMIS benefits package. The main concerns are whether the Commonwealth will be able to take advantage of all federal funds available through this program, how many children will forego needed medical and mental healthcare because it is not covered, and how this affects other publicly funded programs such as indigent care and comprehensive services act. In some cases, reduction in benefits package would increase costs to the Commonwealth because the Commonwealth would pay the full costs for indigent care at state hospitals. Additionally, for those who do not substitute indigent care for FAMIS, it is very

likely that the cost of providing services to them would not outweigh their value to the Commonwealth since FAMIS services are offered at a 66% federal match rate. Since the care is being offered at a 2/3 discount from private costs, limiting FAMIS to a plan that mirrors a private plan may forgo significant potential economic gains. In short, unless the children's insurance coverage expanded to include currently uncovered services relative to those offered by Medicaid, choosing a commercial type of insurance may conflict somewhat with the goal of the program to increase children's access to healthcare.

Another feature of the FAMIS plan is that the proposed prescription drug benefit does not steer patients to generic drugs, a policy now frequently used to control prescription drug costs. Pharmaceutical costs to publicly funded health insurers such as Medicaid have been increasing dramatically in the last decade. Many alternative approaches are already developed and available to somewhat contain this rapid growth. One of the prominent approaches is to provide the generic equivalent of a brand name prescription drug whenever possible. Since the pharmaceutical expenditures under FAMIS will likely exhibit a similar growth pattern to that of Medicaid, there seems to be ample opportunity to increase the net benefits of the FAMIS program by containing pharmacy costs as much as possible through available means.

Outreach Activities

Outreach activities also affect participation in FAMIS as people become aware of the new program through these efforts. The fact that many FAMIS eligible children are currently not enrolled in the program highlights the significance of the outreach activities. According to a survey, about 88% of the families have heard of Medicaid or SCHIP and only 12% were unaware of both of the programs.[18] Of the 88% who were aware, 76% did not inquire about the program because they thought the child was ineligible, did not know enough about the program, did not want to deal with administrative hassles, or did not need or want the program. Of the 24% who inquired, only 66% applied for the program. Also, most advertising for children's insurance across states carried the messages indicating that the program was affordable, the program was for working parents like them, children do need health coverage, it is easy to enroll,

[18] Kenney, Genevieve, Jennifer Haley, 2001, "Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?" Urban Institute.

etc.[19] This study suggests that outreach efforts could be improved by incorporating key elements such as the dollar amount for eligibility, key services covered under the program, a description of enrollment process, etc.

The changes in the FAMIS program appear to have improved the design and accessibility of the program and removed barriers to enrollment. These improvements need to be communicated to eligible population through outreach activities. These activities include advertising through media, developing brochures, posters, and pamphlets, and developing and maintaining partnerships with private entities. The differences in the outreach activities pursued under the two programs are compared below.

Differences in Outreach Activities: CMSIP vs. FAMIS

CMSIP	*FAMIS*
• Outreach coordinated at the state level by the Department of Social Services	• Outreach coordinated at the state level by the department; FAMIS Outreach Oversight Committee created
• Outreach coordinated at the local level by the local departments of social services; the department provides limited funds for outreach and application assistance	• No outreach coordinated by the local departments of social services and no funds provided; however some localities continue some activities

Under FAMIS, the outreach and oversight committee seems to help centralize outreach activities. Currently, the department structures an outreach campaign that builds a statewide infrastructure to support community based and locality specific outreach initiatives. For the local outreach activities, the department cooperates with the Virginia Health Care Foundation (VHCF) to provide funding to statewide Project Connect outreach sites. The VHCF received $575,000 from the department for FY 2002 and 2003. There are 13 application assistance sites throughout the Commonwealth. Staff in these sites provides hands-on assistance to families applying for either FAMIS or Medicaid for their children and follow through with the case until the child is enrolled in the appropriate of the two programs. Additionally, these local outreach projects create or promote outreach in their communities through local media and community organizations.

[19] Perry, Michael, Vernon K. Smith, Catherine N. Smith, and Christina Chang, 2000, "Marketing Medicaid and SCHIP: A Study of State Advertising Campaigns," Kaiser Commission on Medicaid and the Uninsured.

In addition to the local projects, the department also supports more broad-based promotional campaigns (radio ads, bus ads, etc.) as well as other efforts through other state agencies or school systems. Recognizing the need for statewide awareness building initiatives and message consistency, the department contracted with the Ogilvy Worldwide Public Relations firm. The department required Ogilvy to conduct a statewide outreach campaign to include: (i) development of a clear and effective marketing message, (ii) development and dissemination of outreach materials, (iii) implementation of a statewide media campaign and regional outreach events, and (iv) statewide partnership building. The department has spent nearly $100,000 on the child health insurance program's awareness campaign, marketing and materials development, media, and program message strategy thus far in FY 2002 and 2003. The department anticipates spending an additional $200,000 through FY 2003. Because further program changes in this year's General Assembly session are anticipated, a major media campaign and the development of new promotional materials have been delayed until after the General Assembly session.

The department also works with Sign-Up Now (SUN) to provide community-based training sessions at the local level. These training sessions are targeted to community workers in a wide variety of local programs that are already working with families likely to have eligible children. Participants learn about both FAMIS and Medicaid for children, which children are eligible, how the community workers can help families apply, and how the workers can inform their clients, and conduct outreach in their community. The department committed $75,000 for SUN activities to help bring workshops, resource materials, and quarterly newsletters to over 4,000 local workers. This local training was particularly important, as Virginia's SCHIP program has undergone major changes in its four-year history.

The department currently employs four part-time employees as Community Outreach Coordinators/Liaisons. These employees provide FAMIS presentations including program updates and changes; they attend, represent, and participate in local, regional and statewide coalition meetings; and they perform as program liaisons with other state agencies, grantees, and businesses in the coordination of outreach and enrollment activities throughout the state. These part-time positions will cost the state an estimated $114,000 in FY 2002 and 2003 and these positions are a significant component of the outreach infrastructure in Virginia.

The department's outreach campaign is intended to serve as the infrastructure for local community-based outreach activities throughout the state. In addition, other outreach is supported through non-state sources. Several Virginia foundations help support outreach in their communities. For instance, the Virginia Health Care Foundation has a 4-year grant from the Robert Wood Johnson Foundation to support State Children's Health Insurance Program outreach in Virginia. Many significant outreach contributions are made by local business leaders, faith-based organizations, managed care entities, the provider community, and other interested and concerned organizations.

While there is no direct link between most outreach activities and resulting enrollment, according to the department, substantial increases in enrollment were realized during this year's back-to-school campaign. Over the 3-month period (August-October) a 25% increase in call volume to the FAMIS CPU, and a 35% increase in new applications filed were generated. This resulted in a net increase of 16,000 new children being enrolled in FAMIS and Medicaid child health programs in Virginia. In short, a significant portion of the increase in enrollment under the FAMIS program can be attributable to increased outreach efforts.

Reimbursement Methods

Reimbursement rates for services provided under FAMIS program are also an essential part of the program. Currently, reimbursements are largely based on Medicaid rates. Contracts with managed care entities are signed each year. Currently, managed care per capita rates are $107 per month for children with less than 150% of federal poverty level and $104 for those with higher incomes. In comparison, Medicaid pays $230 per month to HMOs per recipient. The cost of FAMIS managed care to the Commonwealth is considerably lower relative to Medicaid. Due to the federal matching rates, the state support for FAMIS is approximately $35 per child while it is approximately $117 under Medicaid. The FAMIS rate paid to HMOs is lower because it does not include aged, blind, and disabled population, there are more pregnancies with Medicaid population, there are copays with FAMIS, and fewer services covered under FAMIS. These differences reduce the reimbursement rates for services provided to FAMIS children. Additionally, payments to FAMIS providers are final. There is no retrospective cost settlement. The decision to make all payments prospective and not require a cost settlement process was to

provide administrative simplicity for the providers and the department. According to the department, collecting cost reports and completing cost settlements (requiring desk and field audits) is an expensive process for both providers and the department.

Significant improvements have been made since CMSIP especially in receiving applications, simplifying the eligibility process, and in outreach activities. The effects of these improvements seem to have increased enrollment so far and will likely to continue to do so even more. Many of these changes also reduce transaction costs, which further increases the enrollment and the net economic benefit per enrollment. However, these improvements focus on increasing enrollment prior to a child needing medical services and there is a limit on the potential increase in the enrollment that can be expected from this approach.

With these improvements, when the growth in enrollment reaches its plateau and if the actual enrollment is still below the desired enrollment at that time, perhaps reimbursement rates may be used as an additional tool to promote the use of healthcare resources by uninsured children. Such a hypothetical approach may focus on enrolling children or providing FAMIS benefits precisely when the children need medical services through cooperation of service providers. Possibilities include providing incentive payments to providers to refer uninsured children to FAMIS, or to provide services through FAMIS rather than indigent care. For example, in this hypothetical scenario, the department may provide a one-time incentive payment to providers and allow provider employees to perform initial processing of applications and all other necessary actions at an outstation except evaluating and making eligibility determinations. In this way, the providers would be offered a compensation for spotting potential FAMIS eligible children and helping enroll them exactly when the child needs healthcare services.

According to the department, providing incentive payments to providers on top of the Medicaid rates was not considered during the development of this proposal. Since there do not appear to be any obvious problems with conflicts of interest for those practitioners who may be in a position to recruit children into FAMIS, it may be hoped that some system of incentives may be considered in the future. Appropriately designed financial incentives have the theoretical potential to supplement the other outreach programs in a cost-effective way.

Businesses and Entities Affected

The proposed permanent regulations are expected to affect children enrolled in FAMIS, health care providers, the department, and the local departments of social services. As of June 2002, there were 43,681 children enrolled in FAMIS and the enrollment is expected to grow further.

Localities Particularly Affected

The proposed regulation will not uniquely affect any particular locality.

Projected Impact on Employment

As the FAMIS program grows, we can expect to see an increase in demand for labor in Virginia's healthcare sector.

Effects on the Use and Value of Private Property

Similarly, as the FAMIS program grows, we can expect to see an increase in healthcare provider revenues, profits, and consequently the value of their businesses. In addition, crowding out employer-sponsored insurance may positively affect the value of business owned by employers of FAMIS families if employers realize significant savings in their share of insurance premiums.