Michigan's State Children's Health Insurance Plan (SCHIP)

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The Problem

Most recent figures (1997-99) indicate that approximately 136,000[14] children from low-income families in Michigan are not covered by any form of health insurance, despite the fact that virtually all are eligible for public insurance programs. In addition, barriers to enrollment for some families still exist, access to care for those who are covered is uneven, and cuts in outreach funding mean that community organizations are under-utilized as means for reaching out to uninsured children and their low-income families. Unless these problems are corrected, Michigan will lose ground in its efforts to ensure that all children have health insurance coverage.

Approximately one-fourth of children in Michigan benefited from public health insurance coverage in 2001. Of these:

- 647,644 (23.6%) were enrolled in ***Medicaid*** and
- 26,065 (1.0%) were enrolled in ***MIChild***[15]

The State Children's Health Insurance Program (SCHIP) extends health insurance coverage to children in low-income families who are not eligible for Medicaid, using a combination of state and federal funds

While public health insurance has contributed to the well-being of Michigan's low-income children, more remains to be done to ensure that all Michigan's children have access to health care. The State Children's Health Insurance Program (SCHIP) is one program seeking to reduce the number of children without health insurance.

The Federal SCHIP Program

What is SCHIP[16]?

The State Children's Health Insurance Program (SCHIP) extends health insurance coverage to children in low-income families who are not eligible for Medicaid, using a combination of state and federal funds. Authorized by Congress in 1997 under Title XXI of the Social Security Act, SCHIP was the first major federally funded health program to be established since Medicare and Medicaid in 1965.

Unlike Medicaid, SCHIP is not an ***entitlement program*** but instead comes to states in the form of a ***block grant.*** Once the federal allocation has been spent, the state may choose to pick up the total cost of services, cap enrollment, or reduce benefits. However, the ***federal match rate*** is higher than it is for Medicaid. Prior to SCHIP, Michigan had piloted the Caring Program for Children, which offered insurance to children not eligible for Medicaid. In 1998, this program was incorporated into Michigan's SCHIP program.[17]

What is the target population for SCHIP?

SCHIP extends coverage to children who:

- Are under age 19 years,
- Are uninsured,
- Are not eligible for Medicaid, and
- Live in families whose incomes are at or below 200% of the ***Federal Poverty Level (FPL)***.[18] [FPL was $18,400 for a family of four in 2003].

To ensure that states did not use SCHIP funds to supplant existing funding for child health programs, they are required to maintain eligibility for Medicaid at the level in effect on June 1, 1997, and must maintain the same level of spending on child health programs that was expended in 1996.[19]

How may states implement SCHIP?

The legislation allows states to have considerable flexibility in structuring their program. States may use SCHIP funds to either:

- Expand the state's Medicaid program
- Create or expand a separate state program with certain benefit criteria
- Use a combination of the above options

SCHIP funds were used to expand eligibility for* Healthy Kids*, Michigan's Medicaid program for children, and to establish* MIChild*, a program modeled after the state employees' health plan

This structure allows states electing to develop separate programs to adopt certain features of private insurance such as deductibles, premiums, and cost sharing; however, the legislation places strict limits on how much money families may be required to pay. About one third of the states opted to use a combination model, while an additional third created a separate program.[20] Michigan chose the combination model, creating a Medicaid expansion program and a separate state program.[21]

How is SCHIP funded?

Congress authorized funding of approximately $40 billion over 10 years with the minimum allocation to a state being $2 million in any year.[22] States receive a federal match for state funds expended. Within certain limits, states choosing the separate program option may impose cost sharing. Michigan's SCHIP Plan, which was approved by the US Department of Health and Human Services on April 7, 1998, was one of the first combination models approved.

Is SCHIP an effective program?

In 1999 the Balanced Budget Refinement Act mandated the US Department of Health and Human Services (DHHS) to conduct an evaluation of SCHIP programs in ten states. Included in the evaluation are rates of SCHIP enrollment and disenrollment, SCHIP and Medicaid enrollment practices, and coordination between SCHIP and Medicaid. The complete results are due to be released to Congress in 2004. The most recent data from the evaluation is discussed in the following article, **SCHIP Turns Five: Gaining Ground, but Not Enough**.

Michigan's SCHIP Program: MIChild/Healthy Kids

Michigan used the combination SCHIP option to expand Medicaid and to establish a separate program. SCHIP funds were used to expand eligibility for ***Healthy Kids***, Michigan's Medicaid program for children, and to establish

MIChild, a program modeled after the state employees' health plan. The similarities and differences between these programs are described in this section and summarized in Table 1.

The enrollment process is coordinated for* MIChild *and* Healthy Kids*, and the family completes a joint application for coverage

Similarities

The two programs share common objectives and a common enrollment process. These will be described first.

Objectives

To increase the number of children in low-income families covered by insurance, Michigan has established four performance objectives for the program:

1) Enrolling the estimated 136,000 low-income uninsured children in either *Healthy Kids* or *MIChild*;

2) Obtaining accurate data regarding the quality of care providers are giving;

3) Facilitating enrollment by involving community organizations in outreach and educational activities; and

4) Providing a user-friendly application process.[23]

Enrollment process

The enrollment process is coordinated for *MIChild* and *Healthy Kids*, and the family completes a joint application for coverage. This process makes it easier for families to apply, as they do not have to know ahead of time which program they are eligible for.

To facilitate enrollment, Michigan has a "no wrong door" application process. This means that families can apply in a variety of places, including Family Independence Agency offices, local health departments, and other community sites. Families can also complete an electronic application online and receive an immediate temporary eligibility determination (see glossary - ***presumptive eligibility***). Re-enrollment forms for *MIChild* are preprinted and sent out to families for verification and signature before the end of the enrollment period (12 months for both programs).

Comparison of programs

Eligibility

Healthy Kids Medicaid expansion extends Medicaid coverage to children 16 to 18 years old with family incomes between 100% and 150% of FPL, a group previously not covered by Medicaid.

MIChild enrolls children from birth to 18 years living in families with incomes between 150% and 200% of FPL.[24] Many of those eligible for *MIChild* live in working families who do not have health insurance. When an application is approved, a child is eligible for 12 months for both programs.

Cost sharing

Healthy Kids imposes no premiums or co-payments for consumers, as they are not allowed by Medicaid rules. Families may have other coverage (e.g., employer-sponsored insurance) and still be eligible for *Healthy Kids*. The other coverage is billed first.[25]

Families in ***MIChild*** pay a $5 per family monthly premium, with total cost sharing not to exceed $60 per year. There are no co-payments for *MIChild*-covered services. Other coverage disqualifies the child for coverage under *MIChild*.[26]

	Healthy Kids Medicaid Expansion [28]	MIChild State-Designed Program
Eligibility		
Age of Child	16-18 Years	Birth-18 years [29]
Family Income	100-150% FPL	150-200% FPL
Time Covered	12 months	12 months
Retroactive Eligibility	Yes, for previous 3 months	No
Residency	State resident or migrant worker family	State resident or migrant worker family
Cost-sharing		
Premiums	None	$5 premium per family per month up to $60 per year
Co-payments for covered services	None	None
Access to other coverage	Ok - other coverage billed first	Other coverage disqualifies
Benefits		
Included	Standard Medicaid coverage	Similar to coverage of state employees
Type of Program	Entitlement	Capped enrollment is possible
Service Providers	Medicaid Qualified Health Plans, all of which are health maintenance organizations (HMOs), and fee-for-services	Managed care system through HMOs and licensed health insurerers/dental providers who offer a preferred provider product

Table 1: Comparison of Healthy Kids Medicaid and MIChild Programs

Benefits

Those enrolled in ***Healthy Kids*** Medicaid expansion, receive the standard Medicaid benefits package, including mental health, dental, substance abuse and vision services.

Benefits in ***MIChild*** resemble the state employees' health care plan and include mental health, dental, substance abuse, and vision services.

Service model and service providers

Healthy Kids services are delivered by Medicaid Qualified Health Plans, all of which are health maintenance organizations (HMOs), and through fee-for service providers.

MIChild services are delivered through a capitated managed care service delivery system by HMOs and licensed health insurers/dental providers who offer a preferred provider product. With 89.84% of beneficiaries (30,460 children) currently enrolled in a Blue Cross/Blue Shield Program, they are the largest provider in the state.[27]

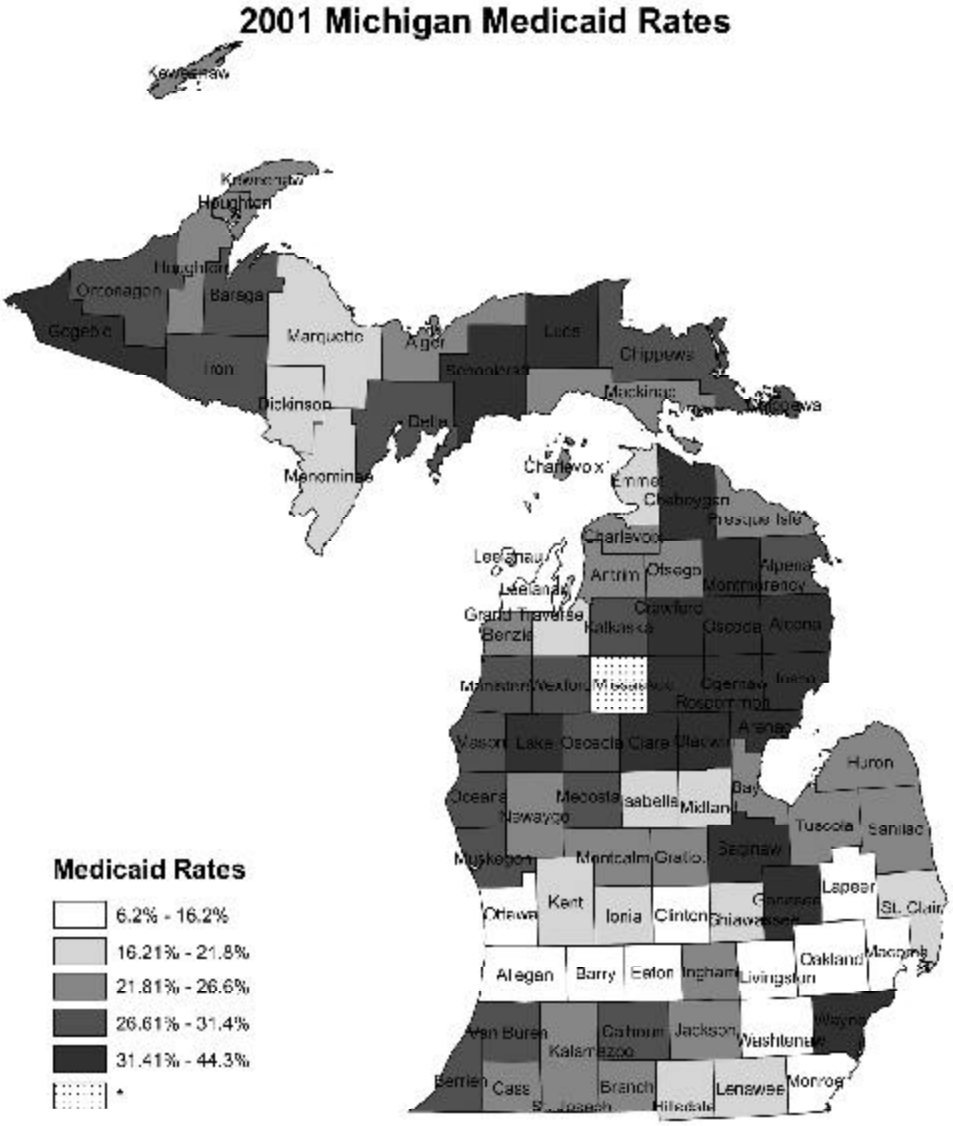
Enrollment to date

Between FYs 1998 and 2002, enrollment grew from 6,226 to 45,105 children.[30] Outreach activities for *MIChild* have also identified many uninsured children who are actually eligible for Medicaid. Between May of 1998 and September of 2002, 229,581 children who applied for *MIChild* were determined to be eligible

for public insurance. Of this total, 67,044 children (29.2%) received health insurance through the *MIChild* program, and the other 162,537 (70.8%) were transferred to the Medicaid program.[31]

How are *MIChild* and *Healthy Kids* funded and how much do they cost?

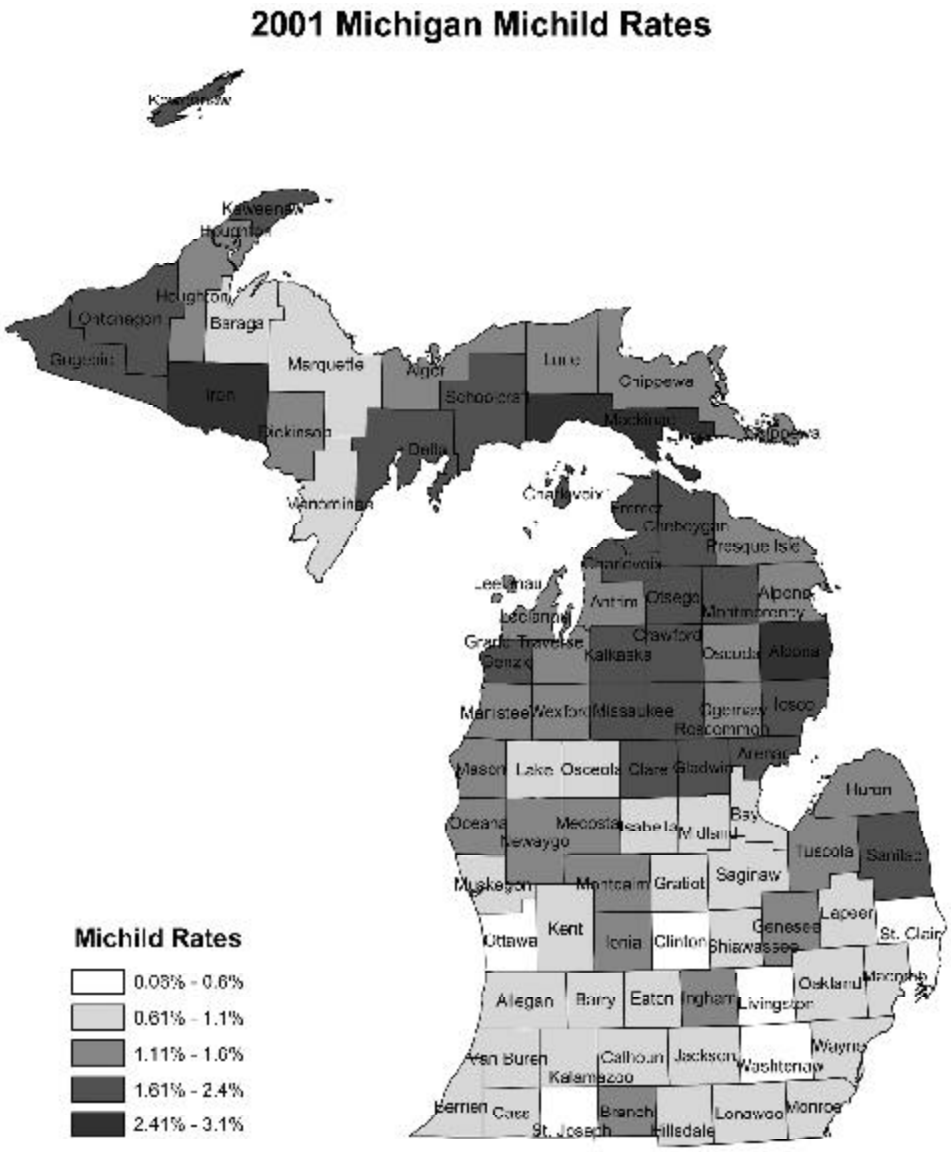
Michigan uses the general fund to finance the state's share of SCHIP and receives matching federal dollars.[32] In FY 2003, total expenditures for *MIChild* were $49,214,104, and the state's share was $15,359,646. For the *Healthy Kids* expansion portion of SCHIP, total expenditures were $25,992,204 with state's share being $8,112,167.[33] The federal match rate for SCHIP in FY 2003 was 68.79%, which is higher than the match for Medicaid dollars.[34] Total state expenditures for the SCHIP program represent only about one half of one percent of the state budget for FY 2003.



*: Rate not calculated because of low incidence of events or unavailable data

Source: Kids Count in Michigan 2002 Data Book

The counties with the highest proportion of children enrolled in* MIChild *are not in the major urban areas but rather in the rural counties of the Northern Lower and Upper Peninsulas. On the other hand the major urban counties of Southeast Michigan, as well as portions of the Northern Lower and Upper Peninsulas have the highest proportion of children enrolled in Medicaid



Source: Kids Count in Michigan 2002 Data Book

Public health insurance coverage in Michigan in 2001

Although many more children are enrolled in Medicaid than in *MIChild*, the rates of enrollment for each program vary by region of the state. Figure 2 illustrates the rates of enrollment of children in Medicaid by county and Figure 3 illustrates the rates of *MIChild* enrollment. Counties with the highest rates of enrollment of children in Medicaid are found in the Northern Lower Peninsula, urban counties in Southeast Michigan (Wayne, Genesee, and Saginaw) and in parts of the Upper Peninsula. Counties with the highest proportion of children enrolled in *MIChild* are found in the Northern Lower and Upper Peninsulas.

Implications for policy

As noted, the counties with the highest proportion of children enrolled in *MIChild* are not in the major urban areas but rather in the rural counties of the Northern Lower and Upper Peninsulas. On the other hand, the major urban counties of Southeast Michigan, as well as portions of the Northern Lower and

Upper Peninsulas have the highest proportion of children enrolled in Medicaid. Some possible explanations for these distributions are presented in this brief. Some of these possible explanations are:

- Employers in rural areas may be less likely to offer employer-sponsored health insurance to low-income workers;
- The greatest proportion of very poor (Medicaid-eligible) families live in areas of concentrated urban or rural poverty in Michigan;
- Outreach efforts are not reaching the working poor families in some areas;
- Poor families in some areas of the state are less likely to want to enroll in "welfare" (i.e., Medicaid) programs;
- Some other unidentified factors.

Each of these explanations would have implications for policy. However, more data on family income and employment patterns, and family health care enrollment and utilization patterns will be needed to make policy decisions about effective strategies to reduce uninsurance rates among the poor and near-poor families of Michigan.

Public awareness about *MIChild*

A recent survey conducted by The Institute for Public Policy and Social Research at Michigan State University[35] asked residents if they were familiar with the *MIChild* Program. Almost half the respondents were not at all familiar with *MIChild*, especially those in Southeastern Michigan and the Upper Peninsula.[36]

These findings suggest that expanded outreach efforts are needed to accomplish Michigan's SCHIP enrollment goals.

Conclusion

Healthy Kids and *MIChild* constitute an important step toward providing health insurance coverage for *all* children in Michigan. More work remains to be done, however. Most recent available figures indicate some 136,000 poor children still have no health insurance in our state. In addition, access to children's health services is uneven, enrollment processes and services are not always user-friendly, and outreach efforts remain insufficient. Other articles in this report provide information relevant to these concerns, as well as policy alternatives to address these problems.