Contract No.: HHS-100-01-0002
MPR Reference No.: 8782-071

Congressionally Mandated Evaluation of the State Children's Health Insurance Program

Site Visit Report: The State of North Carolina's Health Choice for Children Program

November 2002

Corinna Hawkes and Embry Howell

The Urban Institute

Submitted to:

U.S. Department of Health and Human Services
The Office of the Assistant Secretary for Planning and Evaluation
Hubert Humphrey Building, Room 443E.1
200 Independence Avenue
Washington, DC 20201

Project Officer:
Stephen Finan

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
(609) 799-3535

and

The Urban Institute
2100 M Street, NW
Washington, DC 20037

Project Director:
Judith Wooldridge

I. PROGRAM OVERVIEW

North Carolina has a separate state SCHIP program, one of just 16 in the nation. The plan was submitted in May 1998 and approved the following July, effective October 1, 1998 (Table 1). Named *NC Health Choice for Children*, the program extends coverage to children in families above the Medicaid eligibility limit and below 200 percent of the federal poverty line (Table 2).

Health Choice is not a Medicaid program but contains many characteristics of Medicaid for children (termed *Health Check*[1] in North Carolina). The enrollment process is administered by the Medicaid agency, the Department of Medical Assistance (DMA), and the enrollment system is identical to that used by *Health Check* for children. *Health Choice* benefits, though administered via the State Employees Health Plan (SEHP), are almost identical to those of Medicaid. However, in *Health Choice* services are delivered via a fee-for-service model, while Medicaid uses a non-capitated primary care case management (PCCM) model. Also, *Health Choice* requires cost sharing while Medicaid does not. Critically, too, *Health Choice* is not an entitlement program, and is budgeted on that assumption.

This case study is based primarily on information gathered during a visit to North Carolina in December 2001 as part of the Congressionally-Mandated Evaluation of the State Children's Health Insurance Program. During the 5-day visit, 14 interviews were carried out with a broad range of key informants at the state and local level, including state program administrators, Governor's staff, state legislators and staff, child advocates, health care providers, local social services staff, and staff of various organizations involved in outreach and enrollment. (See Appendix A for a complete list of key informants.) In addition to our interviews in the state capitol of Raleigh, we gathered information about local implementation in four local areas—the counties of Duplin, Henderson, Durham and Guilford. Duplin is a very rural county in the eastern part of the state accounting for 0.6 percent of the state's 8 million residents. Population density is 55

---

[1] *Health Check* is a term that, while used in outreach to represent children's Medicaid broadly, originally referred to the state's Early Periodic Screening, Diagnosis, and Testing (EPSDT) program. Outreach workers throughout the state contact Medicaid families to assure children are screened regularly.

people per square mile, and the minority population is 32.3 percent of the population. Duplin has the fastest growing Hispanic population in the state, increasing from 4 percent in 1997 to 15 percent today. Henderson County, in the western part of the state, is also a rural county. It has 1.1 percent of the state's total population and a minority, primarily Hispanic, population of 4 percent. In contrast, Durham County, in the Piedmont part of the state, is dominated by the city of Durham, a town of 187,035 people in a county of 223,314 (2.7 percent of the state's total). Forty percent of the county's population is African American. Guilford County is also in the Piedmont and has 5.2 percent of the state's population, most of whom are concentrated in the towns of Greensboro and High Point. The county has a wide range of immigrants, and 3.8 percent of its population is Hispanic. All minorities make up 35 percent of the total population.

II. BACKGROUND AND HISTORY OF SCHIP POLICY AND POLICY DEVELOPMENT

In June 1997—with the support of Governor Jim Hunt and the Secretary of the Department of Health and Human Services—the N. C. Institute of Medicine formed a Task Force on Child Health Insurance. The likely passage of national SCHIP legislation lent urgency to the task force efforts. The task force was jointly chaired by the head of the state office of Children's Special Health Services and a prominent member of the North Carolina Pediatric Society. The task force report of November l997 did not specify a detailed plan design but it did recommend a set of core principles that continue to guide the SCHIP program (*Health Choice)*. The task force recommended:

- A program that would be "seamless" with Medicaid, in terms of a simplified and combined application process, and a common set of providers who serve both groups;
- An intensive outreach campaign to find and enroll eligible children;
- Comprehensive benefits that emphasize prevention; and
- No, or nominal, cost-sharing for families over 150 percent of poverty.

While the report was silent on the issue of whether the SCHIP program should be a Medicaid expansion plan or a separate program, it did point to the State Employee Health Plan (SEHP) as a possible model that could be augmented with benefits that are critical for children, such as dental and vision services. In large part due to the task force's leadership, there was a strong emphasis on assuring adequate services for children with special health care needs.

Governor Hunt and the Secretary of the Department of Health and Human Services developed a proposed SCHIP plan based on many of the task force's recommendations. They recommended a "Medicaid look-alike" plan with coverage up to 200 percent of poverty and minimal cost-sharing. They also recommended that children currently holding insurance should be allowed to drop their coverage and enroll in the SCHIP immediately (that is, not have a waiting period before they could enroll). Governor Hunt placed such a high priority on passage of state enabling legislation that he called a special session of the North Carolina legislature to consider SCHIP.

The North Carolina legislature meets in odd years in a “long session” of several months to set a biennial budget. It then reconvenes in even years for a “short session” to make modifications to the two-year budget and consider urgent legislation. Since the l997 legislature was no longer in session when the federal SCHIP legislation passed and the state’s task force report was completed, the Governor was concerned that the upcoming short session of l998 would yield insufficient time for consideration and passage of state SCHIP enabling legislation. Consequently he called a special session for April, l998, hoping that it would be quite short, given the preparation from the task force.

The N.C. Senate, which had a Democratic majority in 1998, passed the Governor’s bill on the first day of deliberation. However, the House of Representatives did not come to a quick decision. At the time of the debate, the N.C. House had a new Republican majority, and certain key representatives were opposed to aspects of the task force’s recommended approach. An alternative plan by the Republicans had several key features that contrasted with the Governor’s plan, including an upper income level of 185 percent of poverty, a 12-month waiting period, and higher cost-sharing. The prolonged debate led to a partisan and lengthy 6-week special session.

The opposing factions did agree that the state should have a children’s health insurance plan, and that it should be designed to maximize the federal funding that would be available to the state for that purpose. It was also apparent that a Medicaid expansion would not be politically feasible, since a majority of both parties did not want another entitlement program in a time of budgetary distress. Using the State Employees Health Plan both as a benefit benchmark and for administration was agreed upon as a reasonable approach to developing a “Medicaid look-alike” without an entitlement.

Prolonged discussion and compromise led to a program design that resembled the governor’s proposal except that it included a waiting period[2] and somewhat higher enrollment fees and copayments.[3] The benefits package was scaled up to Medicaid by augmenting the SEHP package with dental, vision, and hearing service coverage, plus additional wrap-around benefits for children with special needs. There was, in fact,

---

[2] Initially 6 months, reduced to 2 months in 1999, and then dropped completely effective January 2002.

[3] More detail on the law and plan benefits is provided in later sections and at www.dhhs.state.nc.us/dma/cpcont.

particular concern that children with special needs should be covered for all their requirements. For this purpose, $20 million was set aside to fund such wrap-around services.

Once the state legislation passed in May, l998, North Carolina submitted its state plan to HCFA (now CMS) for review and the plan was subsequently approved in July l998. In spite of its contentious start, the implementation of SCHIP *(Health Choice)* proceeded rapidly after the legislation passed. Program administration and oversight were quickly established using a three-pronged approach, with the Division of Medical Assistance being responsible for enrollment, the Children's Health Section of the Division of Public Health responsible for outreach, and the State Employees Health Plan for benefits and claims processing.[4] To accomplish such a rapid start, state officials drew heavily on the experience of other states with things such as the level of cost sharing to be used, and emphasized a simple and streamlined approach to program administration. Consequently, all procedures—including a short joint Medicaid/*Health Choice* application—were in place for the start of enrollment in October 1998.

To budget for the program, the state's fiscal staff decided to multiply the number of children who would be likely to enroll by an actuarial estimate of the annual cost per child based on the State Employee's Health Plan. Thus, a budget was developed using the federal CPS estimate of the number of uninsured children in families with incomes below 200 percent of poverty (71,000 children). Since state officials assumed that not all children would participate, the state budget was set to accommodate 66,000 children. About half were anticipated to be below the cost-sharing limit of 150 percent of poverty.

With an intensive outreach campaign throughout the fall and winter of l998-l999 enrollment rapidly rose to close to the projected target. In addition, more children enrolled who were below 150 percent of poverty (with no cost sharing) than initially anticipated. While this did not cause budget difficulty in the first year of the program, as the second year proceeded and enrollment continued to climb, legislators and their fiscal staff became alarmed at the possible implications for the state budget. It became apparent by the end of state fiscal year 2000 (June 2000) that such growth could not be sustained.

---

[4] The State Employees Health Plan contracts with Blue Cross Blue Shield (BC/BS) of North Carolina to process claims.

Mid-way through the third year of the program, in January 2001 when the legislature was out of session, state matching funds were depleted and the only alternative was to freeze program enrollment at 68,000 children. State officials had by then concluded that the federal CPS estimate of the number of eligible children was incorrect, a major factor—along with the state's budget difficulties—that led to the enrollment freeze. Counties were encouraged to continue accepting applications and a statewide waiting list was established.

When the legislature came back into session in spring 2001, facing the ongoing freeze in SCHIP *(Health Choice)* enrollment, the debate over financing *Health Choice* was again prominent on the legislative agenda. By that time, however, the program had developed strong support within both parties and from many sectors, and Democrats had regained a slim majority in the House of Representatives. A unique coalition of lobbyists from the advocacy and physician communities joined forces to push for lifting the enrollment freeze, increasing funding in order to cover more children, and dropping the waiting period. These changes were enacted in summer 2001, and the enrollment freeze was lifted effective October 1, 2001.

We heard from many individuals that North Carolinians are proud of *Health Choice*. They cite the recent legislative support and program expansion—in an era of fiscal stringency—as an example of the program's popularity across the state. The positive characteristics of the program that are almost universally viewed as leading to that popularity are local outreach initiatives, ease of enrollment, seamlessness with Medicaid, generous benefits, and a private-sector image that is not stigmatizing. Each of these features is described in more detail in the following sections.

III. OUTREACH

POLICY DEVELOPMENT

The state placed responsibility for Health Choice outreach in the hands of the Women's and Children's Health section in the Division of Public Health (DPH/WCH). This group had experience in organizing outreach programs for children with special health care needs, and the necessary infrastructure to begin outreach quickly. Members of the Child Health Insurance Task Force met with the DPH/WCH staff to begin to develop outreach policies as soon as the SCHIP legislation passed. They drew up a series of principles to guide the development of outreach policy, stating that outreach should:

- Be "seamless" between *Health Choice* and *Health Check* (that is, be one and the same);
- Take place predominantly at the community level; and
- Be consumer-friendly.

State administrators believed that seamless outreach would allow SCHIP to build on existing outreach infrastructure and prevent duplication with *Health Check* outreach. Both programs could be marketed to the same family, considering that different children in the same family might be eligible for different programs and that children might age out of one program and into the other. For example, as shown in Table 2, an infant whose family's income was 160 percent of poverty would be eligible for Medicaid, but would become eligible for Health Choice at age one.

Critically, too, the group wanted a grassroots, community-based approach to outreach, as warranted by the state's significant regional variations and traditions of local governance. Each of North Carolina's 100 counties was thus asked to form an "outreach coalition" as the entity responsible for designing and implementing local efforts. Apart from relatively small one-time grants from the state ($200,000 in all was disbursed statewide), the coalitions were to be self-funded.

North Carolina allocated less money to outreach than many other states, largely because they decided not to develop a statewide mass media campaign (although there was some limited television and radio advertising). Consequently, the outreach budget was $900,000 in the first year and has been $650,000 per year subsequently. According to state officials, a media campaign would have been too expensive and, given the variations at the local level, ineffective.

In order to expand the scope of the outreach effort, the state convened a state-level coalition called the *Health Check/NC Health Choice for Children* Outreach Committee as the policy-developing entity. The committee, which has met regularly from August 1998 onward, is made up of representatives from the state and counties, advocates, pediatricians, children's organizations and minority groups. The committee decided that outreach should concentrate on the development of print materials and a statewide hotline. The NC Healthy Start Foundation (NCHSF), a private charity with almost a decade of experience in statewide health outreach efforts, received a contract to complete these tasks for $500,000. Other partnerships also formed at the state level. Specifically, the American Social Health Association (ASHA) received a subcontract from the NCHSF to expand a hotline—the NC Family Resource Line—that was already in place for Title V programs. In addition, the NC Foundation for Alternative Health Programs, associated with the state's Office of Rural Health, applied for and obtained a Covering Kids grant from the Robert Wood Johnson Foundation for a five county pilot program.

Outreach strategies were also developed for specific ethnic groups and children with special health needs. A Latino workgroup was convened as a subcommittee of the *Health Check/NC Health Choice for Children* Outreach Committee to develop specific outreach policies for Latino communities.[5] The Division of Public Health also applied for funding from the Duke Endowment for outreach to minority populations, and subsequently received $300,000 over a two-year period to fund six multi-county minority projects. Finally, state administrators perceived an unmet need for information about *Health Choice* on the part of families of children with special needs, and thus dedicated $150,000 of state outreach funds to a helpline for them. Outreach was also targeted to

---

[5] Of note, non-citizen children are not covered by *Health Choice*, even if they are permanent residents.

providers. A special Provider Taskforce was convened to maximize provider education and involvement in *Health Choice*.

North Carolina needed to develop a new outreach policy when the decision was made to implement the enrollment freeze. At the statewide level, they continued with "maintenance" outreach—sending out brochures upon request, for example—but ceased more proactive methods such as mailings. Instead, they allocated time to working with the Covering Kids efforts to improve existing enrollment procedures such as redesigning the application form. State administrators did not try to influence local policy, so different coalitions assumed different strategies in face of the freeze. Though the freeze has now been lifted, outreach is still being maintained at a lower level than when the program began, and administrators are in the process of deciding what outreach strategies should be in the future.

STATEWIDE / MEDIA EFFORTS

The main aim of the statewide campaign in North Carolina was to support efforts at the local level through the development of print materials, hotlines and a limited number of television and radio spots. The first part of the process was to develop a name and key message for the program. To do so, the North Carolina Healthy Start Foundation (NCHSF) was asked to conduct a limited survey and look to the experience of other states for guidance. They found that a positive and simple image was of key importance. The name *NC Health Choice for Children* was chosen to communicate the substance of the program as clearly as possible, and the key message was that "affordable health insurance is available for the children of working parents."

The second part of the process was to design a logo. Based on the decision that *Health Choice* be marketed seamlessly with *Health Check*, the "check" logo already in place for *Health Check* was adopted and both *Health Check* and *Health Choice* written on either side. The logo was also designed so that it could be "pulled apart" into separate *Health Check* and *Health Choice* logos if the counties wished to do so.

Print materials and mailings. The NCHSF developed a range of materials to advertise *Health Choice*, including brochures, fact sheets, posters, and envelope stuffers.

All the materials were brightly colored, and bore photographs of smiling children and parents along with the logo and the NCHSF hotline number. Pictures of children with special needs were also incorporated into some of the materials. The NCHSF also produced a *Health Choice* handbook to inform enrollees about how to use the program, and to provide education about reenrollment, benefits and appropriate utilization.

The NCHSF distributed these materials as widely as possible. All the materials were mailed out to each county outreach coalition; numerous healthcare facilities; professional association members; child care and school personnel; community organizations; and any other organization which requested them. Over a million sets of print materials were sent to approximately 900 organizations statewide. Other parts of state government were also asked to display and distribute materials. For example, the Department of Motor Vehicles displayed posters in all its offices, and the IRS Volunteer Tax Assistance Sites provided information to families. The WIC program printed information about *Health Check* and *Health Choice* on its recertification mailers, and the state's Universal Childhood Vaccine Distribution Program distributed outreach packets to providers. Finally, the print materials were distributed through the school system. School flyers were sent home with all North Carolina children, once during the 1998/99 school year and once again in 1999/2000.

At first, all the print materials distributed were produced in English and translated into Spanish. A few months into the program, however, the state developed a campaign with the assistance of the Latino workgroup specifically aimed at the Hispanic population. Called the "Ana Maria" campaign, the print materials feature a "real life" mother, Ana Maria, speaking the words displayed and posing with her husband and child. The slogan is different from the English brochure. The Spanish brochure reads "It's true, affordable health insurance for your children", while the English brochure reads, "You work hard… finding free or low cost health insurance just got easier".

Hotlines. Three toll-free hotlines were set up for *Health Choice* in North Carolina. The number printed on the outreach materials is that of the NC Family Health Resource Line run by the American Social Health Association. Staff of the hotline—open between 9am and 7pm Monday through Friday—provide basic information on

Health Check and *Health Choice* in both English and Spanish, and mail single copies of print materials and the application form to families upon request. They also provide general parenting and health information. A second hotline is the Children with Special Health Care Needs Helpline. Staffed by a single worker within the Children's Special Health Services of DPH/WCH, the helpline is designed to provide specific information about the services available to children with special needs enrolled in *Health Choice*. The third hotline is designed for children enrolled in the program who have queries concerning benefits. Run by the benefits provider, Blue Cross / Blue Shield (BC/BS) of North Carolina, the hotline deals with questions from families on benefits coverage and from providers on benefits and billing. It also deals with verification of eligibility, replacement of lost insurance cards, and claim forms.

Media. A limited number of television and radio advertisements discussing enrollment and reenrollment into *Health Choice* were strategically placed in areas where enrollment numbers were lower than the state average. Radio advertisements were also provided to every county and aired as public service announcements on more than 2,150 stations. Press releases were regularly distributed to the media to highlight the enrollment and progress in the program.

When the freeze was implemented in North Carolina, the NCHSF hotline staff continued to take telephone calls and send out print materials, but program staff ceased the more proactive enrollment activities such as mailings and attending conferences. Instead, DMA and DPH/WCH staff allocated their time to working with Covering Kids on longer-term projects, most notably the simplification of enrollment and reenrollment processes. At the time of the site visit, outreach was still being maintained at this reduced level, despite the freeze having been lifted for over two months. Program staff were still discussing whether and when to return to more proactive outreach efforts.

COMMUNITY-BASED EFFORTS

The key strategy of the state administration for outreach in North Carolina was to give responsibility to local, volunteer coalitions. They bolstered this strategy by applying for grants from Covering Kids and the Duke Endowment for special initiatives. The structure of these three complementary elements is described in greater detail below, followed by examples of their activities.

Local (County) Coalitions. With seamlessness at the heart of their design, state administrators asked each county Department of Social Services (DSS)—the entity responsible for Medicaid *(Health Check)* outreach and enrollment to form a local outreach coalition. Using either an existing coalition or forming a new one, DSS agencies were asked to gather together diverse groups of individuals including those from the counties' Departments of Health (DoH), public and private non-profit organizations, community groups, churches, schools, businesses, providers and daycare centers. State staff felt that many counties were already in a strong position to form a coalition given the existing ones in place for Smart Start (an early childhood/daycare program).

Each county varied in the type of coalition it formed. In some counties, DSS agencies spread their net widely, inviting numerous providers, volunteer groups and health-based organizations to join the coalition. In others, an existing health-based coalition was asked to develop outreach strategies. Yet others limited their coalition to DSS and DoH staff, and drew more heavily on existing *Health Check* outreach workers. Common to most of the coalitions was the leadership by the DSS, involvement of the DoH, and the inclusion of providers. Apart from a one-time grant from the state, the coalitions were self-funded, drawing on existing staff and volunteers, and applying for extra funding and gifts-in-kind from local organizations.

Covering Kids (CK) and Duke Endowment Grants: Although the Covering Kids grant was obtained by a statewide entity, the NC Foundation for Alternative Health Programs, 80 percent of the funding was allocated to five pilot counties for outreach at the grassroots level. The counties—Buncombe, Cabarrus, Edgecombe, Forsyth and Guilford—used their funding to develop and test pilot outreach strategies which could be applied to the rest of the state. This "laboratory" model was implemented in order to allocate the time and money to develop new approaches that were unavailable to state administrators. Frequent teleconferencing between the pilots and the state was used to ensure that the results from the pilots were communicated to other counties throughout the state.

Representatives from child care, faith, business, education, provider and special population groups were asked to join the CK coalitions. In four of the counties the DSS was the CK grantee, and thus led the CK-funded coalition. In the remaining county (Guilford), a local foundation obtained the grant but the DSS lead the CK coalition.

The $300,000 received from the Duke Endowment funded six minority-focused outreach projects. Two projects targeted American Indian Communities—the Eastern Band of the Cherokee Nation and the Lumbee—in a total of 10 counties; one project targeted the African American population in four counties through the "Hope for Kids" program; and three projects targeted the Hispanic population: Programma Esperanza in three counties, Project ACCESS in eight counties, and the New Hanover County Partnership for Children in six counties.

Local Strategies. Between them, the local coalitions and the Covering Kids and Duke Endowment funded projects implemented a wide range of outreach strategies at the local level. Generally, both Medicaid (*Health Check*) and *Health Choice* information was included. Typically they took one or more of the following (not mutually exclusive) approaches:

- ***Developing and distributing outreach materials:*** Every local coalition had access to the state's printed materials. Many counties also developed their own materials, such as pamphlets, street billboards and child-friendly giveaways like stickers, pencils and magnets, as a means of advertising *Health Choice* along with the telephone number of the local DSS and DoH. The number was sometimes a specifically designated "hotline", and sometimes just the general DSS number. These materials were then distributed to the community through businesses, child care centers, community agencies, churches, schools and providers. They were also handed out at presentations and exhibitions.

- ***Presentations and exhibitions:*** DSS officials often gave presentations about SCHIP *(Health Choice)* to various organizations, including local councils, professional associations, businesses, providers and schools. They exhibited at local malls, community fairs and rallies.

- ***School outreach***: Many counties worked with the schools to ensure that every child took a *Health Choice* flyer home with parental mailings and report cards. Some also sent out information to children on the Free and Reduced Price School Lunch Program. Presentations were given at PTA meetings and to school principals. School nurses were asked to tell uninsured children about the program.

- ***Provider outreach:*** Print materials and posters were displayed in provider and DoH offices. If an uninsured child came in, an intake worker would refer them to Medicaid or *Health Choice*. Some providers—mainly in public clinics—also handed out or assisted with applications. We heard that children generally were seen even if they were not yet insured.

- ***Local media***: Many counties paid for or received free air time on local radio and cable TV stations. Obtaining newspaper coverage via press releases and news conferences was also a popular strategy.

- ***Coordination with Health Check Coordinators:*** Prior to being involved with *Health Choice,* coordinators assisted clients with Medicaid enrollment. Many counties involved these coordinators in outreach for *Health Choice* by asking them to hand out print materials, inform community agencies about the program, and assist with *Health Choice* applications.

- ***Placing application forms at numerous sites:*** Most counties placed mail-in application forms at numerous sites outside DSS and DoH offices, including providers' offices, schools, public libraries and child care centers.

To provide more specific examples, here follows in brief the strategies adopted by the counties interviewed during the site visit.

- ***Duplin County.*** Duplin County was allocated just $1,700 by the state to perform outreach. The coalition in the county was small, made up solely of DSS and DoH employees. Given the large geographic size of the county, the coalition decided to purchase items that could be distributed throughout the county, rather than purchase, for example, a billboard in a single location. The DoH thus contracted with a vendor to produce bibs, squeezy balls, sippy cups and pencils with the *Health Choice* logo and the DSS and DoH telephone numbers. Along with the printed literature given to them by the state, these materials were distributed throughout the county by clinics, schools, social workers, businesses, daycare centers, as well as during parades and health fairs. The county also utilized *Health Check* coordinators to inform uninsured children about *Health Choice* and to help with program applications, as did the intake workers at the widely used DoH clinic.

- ***Durham County.*** In contrast to Duplin County, DSS staff in Durham County set out to form an expansive coalition by writing to "everyone we thought should be involved" including a variety of private and public providers, the DoH, Carolina Access, and local community-based organizations, including one primarily concerned with access and another with strong links to the Hispanic community. The coalition decided to "blitz" the community with as much information as possible. To do so, they started with a press conference with local legislators, and proceeded over the next few months to distribute application forms in a wide range of public buildings; give flyers to every child in every public school; set up tables at shopping malls and public functions to hand out literature; negotiate with the city water authority to place 70,000 *Health Choice* flyers in with water bills; and advertise on local radio and cable. They also took out a newspaper advertisement with the help of a small grant. The (now defunct) “Hope for Kids” organization, funded by the Duke Endowment, also carried out door-to-door distribution of materials and held a rally.

- ***Guilford County:*** After receiving $3,000 in funding from the state, the DSS agency pulled together a local coalition including a staff member from the DoH and providers. Shortly thereafter a local organization, the Community Health Foundation, received a Covering Kids grant and subsequently became part of the coalition. The grant funded the employment of one full-time *Health Choice* eligibility worker at the DSS, and one half-time worker at the Foundation. The workers focused on outreach to schools through the Free and Reduced Price School Lunch Program and on outreach to childcare providers. Alongside the activities of Covering Kids, DSS staff carried out a community-wide education program. Private pediatricians were told about the program, and at the local pediatric clinic an eligibility worker was employed to take applications. The coalition also educated school nurses about *Health Choice*, and the nurses subsequently integrated educating children about the program into their daily routine. The DSS agency carried out a series of trainings with local community-based organizations to allow them to help with the application, and *Health Check* coordinators also were asked to assist families with *Health Choice* enrollment. Applications were spread widely in public buildings. Radio advertisements were funded by the local Healthy Start Foundation, and editorials were written for local newspapers. Americorps volunteers, supported by the Duke Endowment, were also active in outreach to the Hispanic population.

- ***Henderson County.*** The DSS agency in Henderson County received $2,000 for outreach from the state. This was used to fund a long-term public service announcement billboard on a major highway. For their main outreach activities, however, county staff turned to an existing coalition, the Partnership for Health, a coalition of local providers originally funded by the Duke Endowment to carry out a Community Needs Assessment. The Partnership seemed like a good fit owing to its previous work on outreach. In addition, it brought in a team not associated with the DSS agency, which was thought to be off-putting to certain constituents. Together with the DSS and DoH, the Partnership made up the Henderson County outreach coalition. The coalition decided to pursue a number of activities very intensively in the eight weeks after the roll out of the program. First, they printed flyers, with costs covered by Pardee Hospital, and partnered with Wal-Mart and K-mart to place the flyers in their plastic shopping bags. They also printed place mats to go onto the trays of fast food restaurants. The coalition asked providers to advertise the program, most notably the two largest pediatric practices. They also contacted school principals, who, in turn asked teachers to educate children about *Health Choice* in the classroom,

> and gave them flyers to take home. DSS officials handed out information at local malls and held booths at county fairs. Radio and cable TV donated free airtime. Eligibility workers were also outstationed in the local hospital and clinic to inform parents of uninsured children about *Health Choice* and help them with applications.

When the freeze was implemented in North Carolina, county coalitions made their own decisions on how to modify their outreach strategies. Some decided to continue with their previous efforts and added children to the waiting list, while others decided to reduce the time allocated to outreach.

EXPERIENCES AND LESSONS LEARNED

There is a high level of satisfaction with the effectiveness of outreach efforts in North Carolina at both the state and local levels. State officials report that the printed materials have been successful in spreading the word throughout local communities, as shown by the large amount of literature disseminated—1.3 million documents—and displayed throughout the state. The availability of Spanish language materials was seen by all informants as a positive step in a state with little experience with the settled Hispanic immigrant population, although one local coalition did complain that the state-developed materials had been very slow in coming.

The hotline was described by NCHSF as being “inundated.” In the first nine months of the program there were approximately 67 calls per day, and in the following year 77 a day, rising to 87 a day a year later. Around 20 percent of the calls were from Hispanic families. At first the hotline had insufficient capacity to answer all calls, but these problems have largely been overcome; there were no complaints about the service at the local level. State officials were also satisfied with the success of the statewide “special needs” helpline. The staff person reported that she was able to spend extensive time with each caller, thus meeting the need for a comprehensive information source for children with special needs enrolled in SCHIP and Medicaid.

Another aspect of outreach statewide universally cited as encouraging enrollment growth was the involvement of providers. Most physicians and clinics in the state accept SCHIP and, as a result of the work of the Provider Taskforce and/or the local outreach coalitions, are educated about the program. Both state and local officials claimed this was how many parents of uninsured children found out about the program. “The providers are key,” said one state administrator. “If providers feel good about the program, they will tell people about it, and people will want to enroll because they know they can go to their preferred doctor.”

The lack of a statewide media campaign was viewed by key informants in either of two ways. To the majority of informants, including state administrators, legislative staff and—though this was not their initial view—advocates, enrollment success had clearly proven that a large media campaign was unnecessary. However, three local informants stated that they would have liked to have seen more statewide media coverage. The strongest opinion was voiced in Durham, where local officials believed that a statewide “branding” campaign would have clarified to the community that *Health Choice* was not a local DSS welfare program.

Using local coalitions for outreach was the strategy viewed as having the greatest success. A typical description was: “they are doing a great job.” Respondents described successful outreach coalitions as follows:

- Including dedicated people who work well together;
- Including the DSS in the process;
- Using a seamless outreach between *Health Choice* and *Health Check*
- Including the provider community;
- Finding sites where people take notice of printed materials, such as fast food restaurants;
- Getting people involved who can work *Health Choice* outreach into their normal workday activities;
- Using personal contact with the harder-to-reach population;
- Using a wide variety of strategies.
- Encouraging friendly competition between counties to meet their enrollment targets.

In addition, one coalition representative noted that the state-issued county enrollment target had stimulated competition between the counties, and thus created an incentive for more outreach.

Not every county experienced immediate success despite their consistent efforts. For example, in Durham County a community-wide information campaign did not initially stimulate rapid enrollment. This was attributed to the fact that many community residents prefer personal contact and do not trust the DSS. The county worked hard to overcome these barriers by locating application sites in community-based organizations. The county was very close to reaching its enrollment target at the time the freeze was implemented.

Although Guilford County met its enrollment target, certain strategies pursued under the Covering Kids grant proved to be very costly. The strategy to reach children on the Free and Reduced Priced School Lunch Program—23,000 in—all relied on a computer matching system. This approach resulted in the enrollment of only 7 children, and sending out 30,000 flyers at a cost of between $3,000 and $4,000 elicited a total of only 66 completed application forms.

Reaching the Hispanic population was also reported to be a challenge. There were reports throughout the state that illegal immigrants were fearful of being identified by authorities when they applied for *Health Choice*, even if their children were citizens. State administrators and advocates were also worried that parents were assuming that a child enrolled in *Health Choice* would constitute a "public charge," though we heard no evidence of this fear at the local level. Advocates felt that the lack of coverage for certain legal non-citizen children was a problem, and an issue that should be addressed. Despite these issues, generally state administrators reported that they were pleased with outreach to the Hispanic population and with the proportion of Hispanics enrolled (6 percent), although advocates and clinic providers stated that more could be done.

Significantly, we heard many stories about the negative impact of the freeze on outreach. When the freeze was implemented in January 2001, the intensity of outreach efforts was deliberately reduced at the state level, and, for the most part, at the local level. At the state level the effect of the freeze on outreach was said to be "very painful." As the NCHSF put it: "We felt like we were dead in the water. We couldn't run an outreach campaign for a program that was closed." Although the Foundation continued with "maintenance outreach," the number of requests for information declined.

At the local level, the experience of the freeze on people involved with outreach was described as “devastating.” Responses to questions about the effect of the freeze included: “It took the wind out of me completely; it was awful;” “We had worked so hard and done so well and now we had to ask people to wait;” and “It was a time of a real loss of trust in the program.” These comments sum up the anger that was experienced by outreach staff when the freeze was announced. The actual practical impact on outreach, however, tended not to be so extreme, although this varied between counties. In Guilford County, outreach activities “came to a grinding halt” because the coalition did not want to raise people’s hopes. Yet the DSS did continue to take telephone calls and send out applications when requested. In Henderson and Duplin Counties the message was to “keep applying,” since DSS staff assumed that the freeze would eventually be lifted. Brochures and applications were still distributed, and the outstationed workers remained in place. The freeze did not appear to significantly reduce the number of families applying for *Health Choice*.

Although the freeze had been lifted for two months at the time of the site visit, current and future outreach strategies remained unclear at both the state and local levels. State administrators had not stepped up their outreach from the lower level maintained during the freeze. Nor were they clear how this would change in the future. At the local level, all the coalitions spoke of their reluctance to launch another big outreach effort because “if we get more children enrolled it might result in another freeze.”

IV. ENROLLMENT AND RETENTION

POLICY DEVELOPMENT

The ultimate aim of enrollment policy in North Carolina was to keep SCHIP *(Health Choice)* and Medicaid *(Health Check)* as closely aligned as possible. In practice this meant giving the responsibility for enrollment to county DSS offices, and making the application process one and the same for the two programs, a situation often described as "seamless."

Before *Health Choice* was implemented, the Medicaid application required a face-to-face interview either at a county DSS office or an outstationed location. The application form was 17-pages long, and written documentation of income, deductions and the child's social security number were required for verification purposes.[6] A mail-in system was actually legally disallowed, a source of frustration for the staff administering Medicaid at the DMA who felt that the process could be more consumer friendly.

Thus when *Health Choice* was designed, DMA officials decided not to just add *Health Choice* onto the existing application form and keep the process as it was, but to take the opportunity to simplify it. Consequently, a two-page enrollment form and a mail-in process were designed (the introduction of *Health Choice* helped overcome the legal barriers). Documentation requirements remained the same as before.

As a result, the process of applying for *Health Choice* is now identical to that of Medicaid (see Tables 3 and 4). A child applying for either program is automatically screened for Medicaid, and then, if he/she is not eligible, for SCHIP.

As described earlier ("Background"), the state had established an enrollment target of 66,000 and by the summer of 2000 it was clear that the state would exceed its target. Fearing a budget shortfall, North Carolina thus became the first state to impose an enrollment freeze on a SCHIP program.

To implement the freeze, state administrators decided that children should still be allowed to apply, and that those determined to be eligible should be placed on a waiting

---

[6] Prior to Health Choice the DMA-5044 form was the application form for family and children's Medicaid. It is now completely out of use.

list until the freeze was lifted. They also decided that all those already enrolled should be allowed to re-enroll.

The freeze was implemented in January 2001, and soon after there was a decline in the number of children enrolled (reenrollment rates were less than 100 percent). At the same time, the waiting list increased in size. In July 2001 it became clear that the money saved by the enrollment declines could be allocated to children on the waiting list. Thus children on the waiting list were gradually enrolled from this point onward. On October 8, 2001 the freeze was lifted completely after a new funding allocation was passed by the North Carolina General Assembly, with a new budget sufficient for approximately 82,000 children.

ENROLLMENT PROCESS

To apply for *Health Choice*, parents can obtain an application form at a DSS office, by calling the statewide hotline number, or by picking one up at a third-party site, such as a hospital or county Department of Health. They can complete the form on their own, or ask for assistance from a DSS or DoH caseworker in person or (more likely) over the phone. Parents can also obtain assistance from DSS workers outstationed in clinics and hospitals.[7] Some counties also have community-based sites where applicants can obtain help with the form.

Once the form is complete, the parent can mail it to the local DSS office or deliver it in person. If the form is incomplete, the DSS caseworker telephones the applicant to obtain the additional needed information (Table 4). Once the form is complete, the child is screened for Medicaid; if eligible, they are enrolled and sent an informational packet from the DSS along with a paper card. If the child is not eligible for Medicaid, they are screened for *Health Choice*. If they are found to be eligible, they are enrolled and their information is passed to Blue Cross Blue Shield (BC/BS) of North Carolina, who then sends them an insurance card. The length of time this process requires varies by county,

---

[7] There were no specific expansions of the numbers of outstationed workers when *Health Choice* was implemented since there had been significant increases earlier as a result of the Medicaid expansions for pregnant women and children.

but usually takes less than one month. Respondents all felt that it is a very positive aspect of the program to have a simple point of application for both programs.

When *Health Choice* enrollment was frozen, the DMA set up a county workgroup to decide how the freeze should be implemented. Once this work group completed it deliberations, an administrative letter was sent to each county informing them of the new procedures and the changes required of their computerized enrollment systems. During the freeze, it was decided that counties were to continue to take applications. If the children were determined eligible for Medicaid, they were to be enrolled through the usual process. If they were determined to be *Health Choice* eligible, they were to be placed on a waiting list.

A policy was also formulated to facilitate the process of lifting the freeze. Officials felt that the fairest method was a "first-come, first-served" basis. Thus the first children placed on the waiting list—regardless of the county where they lived—were to be the first to be enrolled when the freeze was lifted. The process involved sending a "reactivation letter" to the parent of the child on the waiting list to check whether their details were the same as at the time of application. If so, the child is enrolled. If their circumstances had changed, the child would again be screened for eligibility. If the parent did not respond, the child's case was terminated.

REDETERMINATION PROCESS

Children enrolled in *Health Choice* are continuously eligible for 12 months. After the 12 months are over, a parent must reapply for *Health Choice* for their children. On the first day of the 11th month of enrollment, a reenrollment reminder letter is automatically generated by the state-level DMA (not the county-level DSS agency) and sent to the enrollee along with a form—the same as the original application—for the parent to complete. One month later the local DSS sends out an additional letter if the child has not yet re-enrolled. Counties may also remind parents in the form of letters, post cards or telephone calls. Parents fill out the application form and return it to their local county DSS along with their documentation of income. The process then proceeds as for initial enrollment. The state accepts applications up to 10 days after they are due, but after that the child is disenrolled if no application has been received. During the freeze, this reenrollment process continued as normal. Indeed reenrollment rates may have improved during this period, because DSS workers let parents know they could have difficulty enrolling later because of the freeze.

EXPERIENCES AND LESSONS LEARNED

In addition to the state's overall enrollment target (66,000 children), each county was assigned an enrollment target. Enrollment in the first year of the program was rapid—on average, 4,250 new children enrolled every month across all North Carolina counties. The number of enrollees increased steadily the following year although, as a result of children failing to reenroll, it increased at a lower rate (Table 5). Most counties reached their enrollment targets in the second year of the program, as did the state. State and local officials were very pleased with this rapid pace of enrollment, but at the same time, concerned that the target would be exceeded if growth continued at such a fast rate. Enrollment did in fact continue to grow, peaking at 72,000 in December 1999, 6,000 more than the target, and 1,000 more than the federal CPS estimate of the number of uninsured low-income children.

Good outreach and the seamless, easy enrollment system were the factors put forward to explain the rapid growth in enrollment, along with, as one state official put it, "the real need for the program" and the likely underestimation of the number of eligible children. The simplification of the application form was credited with making a big difference because it is "easier to fill out" and "more user-friendly" for both the DSS caseworkers and the family. County officials also credited the mail-in process for the success of enrollment because "people don't have to take time off work" and "can fill the form out at home." Rather then creating complexity, the use of local DSS offices as the mail-in point (rather than a centralized processing unit) was considered simple, user-friendly, and grounded in the community. The percentage of mailed-in forms accepted did, however, vary significantly between counties. The four counties we visited had 90 percent, 85 percent, nearly 50 percent, and a "minority" of forms mailed-in as a proportion of all their applications accepted. Statewide, DMA officials said that between

28 and 35 percent of all applications are mail-ins, a proportion lower than expected. (The remainder were submitted in person.)

The enrollment process has not been entirely without its challenges, however. Documentation of income for the self-employed was reported by county DSS staff to be the greatest challenge owing to the need to verify all revenues and expenses. By working with the applicants, however, this issue was rarely a cause for denial. Staff also reported that mailed-in application forms are often incomplete, the proportion ranging from a “majority” to a “minority” depending on the county. To overcome this, DSS caseworkers reported that they work with parents who have not fully completed their forms, and, as a result, just a very small percentage of children are actually denied because of incomplete applications. We also heard reports that Spanish speakers were finding it more difficult to fill out the form because the Spanish version is less clear than the English version. (For example, the Spanish version does not highlight that it is very important to include proof of income.)

In some counties, DSS officials decided to take additional steps to ease these challenges and allow parents to obtain help with the application at community-based enrollment sites. In Durham County, for example, people were finding it difficult to complete the application but at the same time were reluctant to come into the DSS for help. DSS staff thus asked community-based organizations to help parents in completing the applications because they believed that parents would be more likely to go to a “trusted voice” for help.

Reenrollment has proven to be less successful than initial enrollment. Since only about 50 percent of children re-enroll, state DMA officials described reenrollment as a “challenge.” The urban sites we visited retained fewer children in *Health Choice* than the rural ones. In Durham, retention was initially only 30 percent, and in Guilford County it was 50 percent. In the rural counties, Duplin and Henderson, the rate was much higher at 82 percent and “almost 100 percent” respectively. In the places where retention is low, key informants attribute it to the fact that people “just forget,” are “too busy,” “fill the form out too late,” “lose their reenrollment packets,” or simply “won’t re-enroll until their child gets sick." Dislike of the program or structural problems were not reported as causes.

DMA officials have been working to increase rates of retention by changing the design of state reminder notices, and local improvements have also been made. Durham paid particular attention to the issue; after allocating a staff member to coordinate reenrollment, the retention rate rose to 70 percent. Henderson County officials attribute their success, in part, to the efforts of a case manager at a major local pediatrician's office who has aggressively reminded patients to re-enroll.

One comment we heard repeatedly at the state and local level was that SCHIP *(Health Choice)* has led to a large increase in the number of children enrolled in Medicaid. Nearly 40,000 more children have enrolled in Medicaid since the implementation of *Health Choice*.[8] Although state officials are not able to attribute all of this increase to *Health Choice,* "there was definitely a spike in the number of children enrolled in Medicaid after we started *Health Choice*." This is further supported by the fact that, statewide, between 15 and 20 percent of children applying for *Health Choice* are ultimately enrolled in Medicaid. In some places figures are even higher. In Guilford and Duplin Counties, for example, around 50 percent of children applying for *Health Choice* are eligible for Medicaid. All the counties attributed the increase in Medicaid enrollment directly to *Health Choice* outreach and enrollment simplification. In Durham, for example, since the start of *Health Choice* the number enrolled in Medicaid has increased by 10,816. Since the number of adults in Medicaid has actually declined, this increase seems to be entirely due to increased enrollment of children.

According to county employees, a lot of the children now enrolled in Medicaid who originally applied for *Health Choice* would never have applied for Medicaid because of the welfare stigma surrounding the program. According to DMA officials, stigma is an issue statewide, but it is not nearly as big an issue as in many states. Our interviews in the counties seemed to confirm this view. Of the people who were determined to be eligible in Medicaid after applying for SCHIP *(Health Choice),* key informants universally

---

[8] This is probably an underestimate since it does not include children who were covered by Medicaid prior to the implementation of *Health Choice*, dropped Medicaid coverage, and then re-enrolled as a result of an application to *Health Choice*.

reported that only a very small minority asked for their application to be terminated. While some parents are initially resistant, “most end up being fine with it.” Key informants stated that in general *Health Choice* had probably reduced the amount of stigma surrounding the enrollment process for Medicaid, and eliminating the face-to-face interview had encouraged applications. An issue we heard about repeatedly was that *Health Choice* had been destigmatized by its association with private insurance. Significantly, it had a “proper insurance card” whereas Medicaid has a paper card mailed every month. There was a general consensus that introducing a plastic card for Medicaid would further reduce stigma for both families and providers.

The many positive reports we heard about the enrollment process for *Health Choice* were overshadowed somewhat by the negative reports of the freeze. During the freeze children did, as already indicated, continue to apply. In some counties the number applying dropped off; in others it was sustained. As a result, a total of 35,916 children went on to the waiting list during the freeze. Meanwhile the failure of some children to reenroll meant that the number of children enrolled in *Health Choice* declined during the freeze. Statewide the number of children enrolled dropped by almost 30 percent between January 2001 and October 2001, from 72,000 to 51,294. At the time of our visit in early December, two months after the freeze was lifted, the number of children enrolled had increased to 60,211, an increase described by DMA staff as “not dramatic.” In none of the counties we visited had enrollment yet rebounded to pre-freeze levels. In Durham County, for example, there were 1,303 children enrolled before the freeze, but 1,024 in November 2001. In Henderson County there were over 900 children enrolled before the freeze, but just over 800 in early December 2001. Also of note, after the freeze was lifted for the children on the waiting list, just 46 percent of the children (statewide) on the list actually ended up enrolling in *Health Choice*. Of the remainder, 22 percent were already in *Health Check* (Medicaid), 4 percent had become *Health Check* eligible, and 7 percent had gained private insurance. The remaining 21 percent did not respond to the reactivation letter.

One reportedly positive impact of the freeze was its impact on reenrollment; after the freeze the statewide average reenrollment rate rose to 75 percent from around 50 percent. County officials had heard of families who had allowed their coverage to lapse—

presumably on the assumption that they could enroll again any time—and then tried unsuccessfully to reenroll during the freeze (probably in the event of medical need). They suggested that many were fearful that this might happen to them, and were reenrolling in a more timely manner.

Although counties were back on track to enroll at least the number of children who were enrolled in *Health Choice* before the freeze, and likely more, everyone was fearful of another freeze. Most believed that the state—using federal CPS numbers—had underestimated the number of eligible children, and that there were thousands more eligible children than suggested by the targets. There was thus a great deal of uncertainty over whether another freeze might have to be implemented, if and when more than 82,000 children have enrolled in the program.[9]

---

[9] In July 2002, state officials report that enrollment has reached 84,857 and the state is likely to again impose a freeze on enrollment in September 2002.

V. CROWD OUT

POLICY DEVELOPMENT

The prospect that SCHIP might stimulate “crowd out,” or the substitution of public for private coverage, was a prominent concern during the design phase of *Health Choice*. It was, in fact, probably the issue that sparked the most debate in the special session leading up to the passage of the enabling legislation. Democrats felt that a waiting period would be an unfair barrier to enrollment, while Republicans felt that a waiting period was necessary to ensure that the program served those least able to access health insurance coverage. The compromise was the implementation of a six-month waiting period to make sure that the chronically uninsured were the first enrolled in the program, and it was planned that the six-month period would be replaced by a two-month waiting period six months later.

As soon as the program was implemented, advocacy groups began lobbying for the removal of the waiting period for children with special needs. They felt that the waiting period unfairly penalized low-income parents who had made great financial sacrifices to obtain private insurance for their children, and then were the least able to drop insurance for any period of time in order to enroll in *Health Choice*. The waiting period was successfully eliminated for these children beginning October 2000, two years after *Health Choice* began.

Advocacy groups continued to lobby for the elimination of the waiting period for all children. This became a more realistic goal when the North Carolina House of Representatives gained a Democratic majority in 2000. According to state officials, few children were denied coverage for *Health Choice* due to having private health insurance. In the absence of perceived crowd out, there seemed to be no solid reason for keeping the waiting period. In addition, because state employees must pay the full cost of dependent coverage under the SEHP, many felt it was fair that the state’s lowest wage employees be able to enroll their children in *Health Choice*. Thus, in contrast to the debates around the original legislation, the waiting period was eliminated with little controversy, effective January 2002.

POLICIES AND PROGRAM CHARACTERISTICS

The primary strategy employed by North Carolina to deter crowd out under *Health Choice* was the six- and later two-month waiting period. To determine a child's insurance status at the time of application, the *Health Choice* application first asked: *Does anyone in your house have health or medical insurance?* and then, *Did anyone lose or drop insurance coverage during the past 6 months?* These questions are still asked on the application form even though the waiting period has been dropped, as they provide a means of monitoring crowd out. In addition, a computer match is performed against the enrollment files of the state's largest insurance carriers. State officials report that between July 2001 and May 2002, only 2,629 of 31,592 denials (8 percent) were due to the family's having private health insurance. After the waiting period was dropped for children with special needs, but before that for all children, it was written into the legislation that children with special needs must present a signed doctor's statement or insurance statement to waive the waiting period.

Another anti-crowd out strategy adopted by the state was an annual enrollment fee of $50 per child ($100 max for the family) on the assumption that the fee should discourage some people from dropping private insurance and enrolling in *Health Choice*.[10]

EXPERIENCES AND LESSONS LEARNED

Because health insurance for dependents is rarely offered to low income workers in North Carolina, most informants believe that crowd out is not occurring in *Health Choice*. The only hard evidence for this belief relates to the change in the waiting period. When the waiting period was reduced from six months to two, it might have been expected that enrollment would surge, since families would be more willing to drop insurance for the shorter time period in order to enroll in *Health Choice*. Yet such a surge did not occur, confirming, according to state officials, that crowd out is not an issue.

---

[10] The enrollment fee applies only the children whose family income is above 150 percent of the federal poverty level.

When the waiting period was eliminated entirely for children with special needs, most state and local officials, advocates and legislators declared themselves “delighted.” To them the waiting period had been a penalty for those parents who had “made sacrifices to insure their children” and were then effectively barred from *Health Choice*. Yet the actual outcome of dropping the waiting period for children with special needs was never clear, because as soon as it was implemented the program-wide enrollment freeze went into effect. Now that the freeze has been dropped, state officials report that they expect the number of children with special needs who are enrolled in *Health Choice* to increase.

VI. BENEFITS COVERAGE

POLICY DEVELOPMENT

There was a commitment from the beginning to make *Health Choice* a “Medicaid look-alike,” that is, to make the coverage provided by SCHIP and Medicaid equivalent. This was accomplished by using the State Employees Health Plan (SEHP) as a benchmark, which is quite comprehensive for a private plan, and by augmenting it with dental, vision, and hearing service coverage. Additional benefits, essentially comparable to Medicaid, are provided for children with special needs.

Several factors were responsible for the consensus amongst legislators and administrators that the benefits package should be comprehensive for all children, including those with special needs. Early on in program development, concerns were expressed by the Governor’s Task Force—most notably from the administrator of the state’s Title V program for children with special needs and the Secretary of the Department of Health and Human Services—that SCHIP should have benefits as broad as available under Medicaid. (They were, in fact, initially supporters of a Medicaid expansion for this reason.) Given the additional strong support for broad benefits from child advocates and physicians, it was almost inevitable that the design of the benefits package for North Carolina’s SCHIP program would have an emphasis on assuring adequate services for children with special needs.[11]

Supporters of a comprehensive benefits package were initially concerned that the SEHP might not cover enough services. They thus lobbied heavily to include a component to provide “wrap around services” for children with special needs, essentially bringing the benefits very close to those available under Medicaid. In addition, they lobbied for a special budget to pay for the services available under this “wrap-around” program. Consequently, in a move quite unique among states, the administration set aside over $20 million per year to cover such services. After the program was implemented, however, it became evident that the SEHP plan benefits, as augmented, were sufficient

---

[11] A special report by Hill et al. 2001 discusses the North Carolina SCHIP special needs program in more detail.

for most children, including children with special needs.[12] Thus during the first full program year (state fiscal year 1999) only $368,140 was used for special needs services outside existing benefits. From then on, the set-aside budget was essentially combined with the full SCHIP *(Health Choice)* mainstream budget.

POLICIES AND PROGRAM CHARACTERISTICS

As noted, *Health Choice* adopted the SEHP benefit package which, along with dental, vision, and hearing services and additional services for children with special needs, is essentially equivalent to Medicaid benefits. As such, this provides broad coverage.

The similarity of the benefit package to Medicaid does not mean, however, that coverage is unlimited. For example, there is no coverage of case management, sports physicals, orthodontics, certain dental procedures such as complex extractions, or certain highly specialized special needs services such as van lifts and nutritional supplements. Prior approval may also be required, most notably for hospitalization and many elective surgeries. In addition, there are some benefit restrictions, for example on the number of preventive care visits (excepting for infants). Mental health and substance abuse visits are limited to 26 per year, which is reportedly a very generous limit compared to most private insurance plans. Mental health and substance abuse services are managed by Value Options, which also manages Medicaid's and the SEHP's mental health/substance abuse services. The limit is rarely exceeded by children, and with prior approval by Value Options it is possible to obtain more covered visits.

While there have been no dramatic changes to the benefit structure since the program began, there have been some small expansions, such as adding school-based services and expanding dental services to include sealants, extractions, crowns, and additional fluoride treatments. Pap smears were also added to the SEHP (and by default *Health Choice*) as was a mental health check-up.

---

[12] The special needs fund was never treated as a separate line item, and special needs children were never identified separately using rigorous criteria.

Coverage of reproductive health services has been controversial. Originally coverage of school-based health services was excluded due to the concern expressed by conservative legislators that family planning services would be provided in these settings. In March l999, school-based health services provided by health professionals were added to the benefit package. Maternity services are not covered, but due to the relatively high income eligibility level for maternity care under Medicaid, SCHIP-eligible adolescents are covered by Medicaid when they become pregnant. Family planning services are not explicitly stated as a benefit, but reportedly they often are covered as part of women's routine preventive care visits.

EXPERIENCES AND LESSONS LEARNED

We heard universally that the benefits package in North Carolina is "very good" or "excellent." People spoke especially positively about the dental, hearing, and vision coverage, which exceed the benefits extended by typical private plans in North Carolina. The physicians with whom we spoke also felt that children with special needs receive adequate services. Although getting approvals for services at times required some effort, they said it was no greater than experienced with children covered by private insurance or Medicaid. Advocates and physicians did not report any concerns about the folding in of the set-aside money for children with special needs into the mainstream budget.

Despite the budget stringency faced by *Health Choice*, there were no suggestions from any of our informants that the benefits package be restricted. Not one informant, for example, suggested that limiting the benefits would have been preferable to an enrollment freeze as a means of preventing over-spending. The benefits were, in fact, viewed by all as one of the program's greatest strengths. It remains to be seen, however, whether *Health Choice* can, given the state's budgetary pressures, continue to offer health benefits that are almost as generous as Medicaid and as generous or more generous than almost any other health insurance program in the state.

VII. SERVICE DELIVERY

POLICY DEVELOPMENT

Physicians were heavily involved in developing policy for *Health Choice* and were opposed to having the program adopt a managed care delivery model or a closed panel of providers. In North Carolina the Medicaid program has been slow to adopt managed care approaches, and it uses a Primary Care Case Management (PCCM) model of managed care rather than capitated HMOs. There are few HMOs, especially in rural areas. Consequently, SCHIP *(Health Choice)* became a fee-for-service program, following the delivery model of the SEHP into which it became incorporated.

POLICIES AND PROGRAM CHARACTERISTICS

1. Service Delivery Arrangements

Any physician, clinic, dentist, or other health care provider—public or private—who chooses to participate in *Health Choice* is allowed to do so. Any licensed provider is allowed to submit a bill for services. (This is in contrast to the Medicaid PCCM program, in which certain primary care providers function as primary care case managers and receive a monthly fee for each child.)

The reliance on private mental health providers under *Health Choice* is generally viewed as a strength. Medicaid has made some changes in the same direction in an effort to expand the availability of mental health services for children. However, while such services are covered, several informants said that there is a shortage of mental health outpatient providers in many parts of the state.

2. Payment Arrangements

Providers are paid according to usual and customary charges, using the payment schedule that is used for the SEHP. This is generous payment relative to Medicare and Medicaid, and on a par with most private plans. One source told us that Medicare and Medicaid pay only 54 percent of private sector rates on average. Another clinic reported that *Health Choice* was even better then private insurance in reimbursing for routine services, with *Health Choice* covering 86 percent of charges, and Medicaid and private insurance only covering 68 percent and 70 percent respectively. On the other hand, a hospital said that *Health Choice* was similar to Medicaid in payment for inpatient care.

The Department of Medical Assistance combines federal and state matching funds and pays $120.84 per month per child to the SEHP, which contracts with Blue Cross/Blue Shield (BS/BS) of North Carolina to administer benefits and make payments to providers. BC/BS does not assume any risk in this arrangement. At the end of each contract year, a reconciliation examines the amount paid by the SEHP to BC/BS relative to the amounts paid out. In the first years of the program, *Health Choice* provider payments were lower than anticipated.[13] Some of the savings in the reserve fund were used to cover more children (up to the approximately 72,000 children enrolled at the time of the freeze).

EXPERIENCES AND LESSONS LEARNED

North Carolina officials point to several design choices that have resulted in an administratively simple SCHIP program that has assured access to care to most needed services across the state. These are: (1) an unrestricted provider network; (2) use of the SEHP plan for payment administration; and (3) generous payment rates on a par with the private sector. Combined, these factors have created a program that is extremely popular among providers. Indeed, providers across the state are anxious to participate, with the exception of dentists in some locations. One provider commented: "*Health Choice* is a great payer; we wish we had more *Health Choice* children, because the program pays so well. Reimbursement is excellent, and we get paid timely and in full."

Respondents reported that access to services is generally regarded as very good under *Health Choice*. The influx of a new group of insured children did not place major strains on provider capacity statewide. Mental health and dental services are exceptions to this pattern in some locations. Some newly-entitled beneficiaries had difficulty finding providers in either the public or private mental health system. While dentists advised the

---

[13] Initially, monthly estimated cost per child was based on actuarial data for SEHP children.

state on the development of *Health Choice*, and dental benefits have improved since the program’s inception, the availability of dentists who serve *Health Choice* children remains limited in some places. Dentists were reported to prefer private patients who pay at the time of service, and many can fill their practices with such patients.

Pre-existing access problems also affected *Health Choice* children in certain locations and for certain types of services, even when these barriers were not directly attributable to *Health Choice*. In rural areas, there may be a very limited number of providers. For example, in Duplin County there are only two pediatricians, and otherwise families traveled about 50 miles to obtain services. In urban areas, private pediatricians may, for example, have a full practice and accept only a limited number of new patients, as was reported for the Duke University pediatric practice. Ethnic minorities, such as North Carolina’s rapidly growing Hispanic population, may have difficulty finding culturally appropriate services.

Also, some providers apparently misperceive *Health Choice* as associated with Medicaid, with which they may have had problems. In Guilford County a survey of pediatricians and family practitioners revealed that almost all pediatricians accepted *Health Choice* patients (while most did not accept Medicaid); in contrast, rates of acceptance of both *Health Choice* and Medicaid patients were low for family practitioners in the same county. Local informants attributed this difference to a more intensive educational campaign by the Pediatric Society about the difference between the two programs.

BC/BS has examined the utilization of *Health Choice* children and compared it to the “benchmark” utilization by SEHP children during the first two program years. BC/BS analysts found that utilization for most services was comparable between *Health Choice* children and SEHP children. However, use of inpatient hospital services was somewhat lower for *Health Choice* children, and their use of emergency rooms was twice as high. During the second program year *Health Choice* utilization was relatively stable compared to the first year. (Data are not yet available for the third program year.)

Providers seemed to like the fact that BC/BS administers claims payment, and they felt reassured that their bills will be paid in a timely way. This is another feature of the program that has contributed to its popularity in the provider community.

While service delivery is generally adequate and accessible for *Health Choice* patients, one area for concern was the reported underuse of preventive care and overuse of emergency rooms that is reflected in the utilization statistics for the first two program years. With its “any willing provider” fee-for-service system, North Carolina has no way of assuring that children have a primary care medical home. Also, while the Medicaid EPSDT system (*Health Check*) assures monitoring of whether children are receiving all preventive care services, there is no such monitoring under *Health Choice*.

The high use of the emergency room is a problem which is not easily solved with the *Health Choice* service delivery approach. This is in contrast to Medicaid’s PCCM model where use of the emergency room is restricted to care approved by a primary care provider. Working families may not be able to readily take their child to the doctor during regular office hours, and the current system provides little deterrent (other than a $20 copay for families with incomes over 150 percent of poverty) to using the ER as a service provider. Apparently many parents perceive the relative ease of access to emergency rooms as improved access to care over Medicaid, where the PCCM process restricts such access. We were also told that Hispanic families may more readily find Spanish-speaking providers in emergency rooms. Since this utilization pattern runs counter to the emphasis on prevention that has been a part of *Health Choice* from its inception, it is an issue that will probably be discussed as policy makers attempt to refine the program and make it more efficient.

VIII. COST SHARING

POLICY DEVELOPMENT

As mentioned earlier, one of the more contentious issues during the original legislative debate on *Health Choice* focused on the amount and type of cost sharing that would be required of beneficiaries. The Governor's Task Force recommended minimal or no cost sharing, but the Republican House majority preferred higher cost sharing. The resulting compromise led to a program with relatively low levels of cost sharing of two types: annual enrollment fees and copayments. These apply only to those families on incomes above 150 percent of the poverty level. This income level was recommended by the state fiscal staff who had carefully studied other state SCHIP plans that had received federal approval. They did not want to impose cost sharing on families with lower income levels and risk a delay in approval of the SCHIP plan.

To keep the program administratively simple, premiums were ruled out in favor of an annual enrollment fee. Also, since county-level Departments of Social Services were established as the organizations that would receive joint *Health Check/Health Choice* applications, it was decided that the enrollment fee would be kept by the counties as partial reimbursement for their efforts. (However, since enrollment fees are only collected for those above 150 percent of poverty, and since the proportion of enrolled families above that level has been lower than anticipated, we learned that there remains some dispute between the counties and the state as to whether counties are being fairly reimbursed for the additional enrollment activity they have taken on.)

POLICIES AND PROGRAM CHARACTERISTICS

Table 6 shows the level of cost sharing required in North Carolina's *Health Choice* program. As shown, the annual enrollment fee is $50 per child per year, to a maximum of $100 per family for families above 150 percent of the federal poverty level. The fee is collected by counties as a condition of eligibility. Throughout the life of the program, about 30 percent of enrollees have been children in families above 150 percent of poverty, less than initially anticipated.

Families between 200 percent and 225 percent of the federal poverty level who were previously enrolled in *Health Choice* also have the option to fully buy into the program at the time of re-enrollment. They pay the full premium, which is currently $120.84 per child, so the state does not subsidize their care. In December 2001, there were 83 children enrolled under this provision.

When county social service workers review the joint *Health Check*/*Health Choice* application they determine first whether the child is eligible for Medicaid or *Health Choice* and, if *Health Choice*, whether family income is above 150 percent of poverty. If so, the family is billed for the enrollment fee. Once the fee is paid to the county, the child is enrolled. In contrast to Medicaid, where retroactive eligibility covers a family's medical expenses for the prior 90 days, *Health Choice* coverage begins on the first day of the month in which the fee is paid. Thus, there is a potential delay if the submission of the enrollment fee is delayed. When the family applies for renewal of enrollment in *Health Choice* the process is repeated.

Some counties have obtained local funding from foundations to cover the enrollment fee so that families do not have to pay. In counties which have made such arrangements, such as Durham and Guilford Counties, there is no billing to the family, but rather a summary bill is sent to the foundation annually.

In terms of copayments, as shown in Table 6, $5 is charged for office/outpatient visits (including hearing, vision, and mental health/substance abuse visits), $6 for prescriptions, and $20 for emergency room visits. Preventive care (including dental care) is not subject to copayment. As with the enrollment fee, only families above 150 percent of poverty are required to make copayments.

It is the provider's responsibility to collect the copayments, and then Blue Cross/Blue Shield (BC/BS) deducts the copayment amount from the provider's payment. The BC/BS health insurance identification card states whether copayments are required for a particular child, and we were told that providers generally ask for the copayment at the time of service. We did not hear of any difficulties collecting copayments, and providers and others reported that parents do not mind paying these amounts for their child's care.

There is no way for the state or BC/BS to know how often and where copayments are and are not being collected, since there is no record of it on the bill. In any case, the copayment is a small portion of the patient's bill. This may explain why copayments are not a controversial issue with either providers or patients. In particular, there was some uncertainty about whether copayments are being routinely collected in all emergency rooms, which may partially explain why emergency room use is high.

EXPERIENCES AND LESSONS LEARNED

In North Carolina's *Health Choice* program, only about a third of enrollees fall into the cost sharing group above 150 percent of the poverty level. For the remainder, those below 150 percent of poverty, there is no cost sharing required. For those who do pay an enrollment fee and copayments, the levels are relatively low. Consequently, there is general support for this feature of the program. In a University of North Carolina study of families with children already enrolled in *Health Choice,* for example, only 2 percent of 987 families surveyed mentioned cost sharing (enrollment fee or copayments) as a problem for them.

That said, consumers' reactions to the enrollment fee have been mixed. In the first year of the program there was evidence that some people could not afford to pay the fee and that this was a barrier to enrollment. County records show the number one reason why people were denied coverage was a failure to pay the enrollment fee. It is unclear whether the problem was the amount of money required or the administrative burden of having to send it in a separate submission after the application form. Local officials in one area we visited cited it as a cause of denials, but said that the problem had been eliminated when a local foundation offered to pay the fee. In two other local sites, however, DSS staff reported that they had no problem collecting the enrollment fee, although they had been concerned at the start of the program. Officials in one area reported that they actually feel that the enrollment fee creates "ownership" of the program.

Copayments have not been controversial. We were told that “families are happy to pay because it makes them like everyone else” and that copayments are not a problem because “they are low enough” and, moreover, they “do not appear to be a deterrent to utilization.” Consequently, there have been no discussions regarding eliminating copayments.[14] Many informants believe that the copays in fact appear to improve the image of the program, by making it similar to private insurance, without creating an extremely high cost burden for families.

Since the effect of the enrollment fee is unclear, and since dropping the enrollment fee would not have large financial implications for the *Health Choice* budget, state administrators have considered eliminating it.[15] However, because it is a source of county financing, county administrators still support charging the fee. Also, although advocates were against the fee because of the data indicating it was the major cause of denials, they have not taken it on as a major issue because the waiting period was viewed as being more important.

In conclusion, North Carolina’s experience is consistent with other states in showing that low levels of cost sharing are viewed as feasible for working families. Officials believe that their approach to cost sharing is not a major deterrent to either enrollment or utilization of services at this time.

---

[14] As part of addressing it’s current fiscal crisis, the state is now considering raising copayments and possibly imposing them for families below 150 percent of poverty.

[15] Only 7 percent of total *Health Choice* funding comes from these payments.

IX. FAMILY COVERAGE AND PREMIUM ASSISTANCE PROGRAMS

North Carolina is a state with relatively low levels of health insurance coverage, generally, and the demand for family coverage would be high if it were offered. However, the state's budget difficulties have precluded this option from being seriously considered under SCHIP, even by advocacy groups. The fact that the state is having difficulty appropriating enough funding to cover children means that there is little likelihood of adding parental coverage, or of asking for federal funding for such an expansion. Unless the state's budget difficulties subside (which is unlikely in the near term given the economy), this issue was reported to be "off the table" for the foreseeable future.

Although the original state enabling legislation allowed for the purchase of employer sponsored insurance under *Health Choice*, the state has not considered putting in place the procedures to implement a premium assistance program, because few low income families are offered family coverage. If they are offered such coverage, the premiums are very high, so this approach is viewed as unlikely to be cost effective, which is required for the premium assistance option.

X. FINANCING

Earlier chapters have discussed the freeze that took place in North Carolina's SCHIP program during 2001, so it is quite evident that fully financing *Health Choice* has been difficult. Originally the state set its budget forecast according to the estimated federal allocation, and tried to estimate the amount of state matching funds that would be needed to draw all the federal dollars. In order to maximize federal funding, the North Carolina legislature must appropriate 26 percent of the total *Health Choice* program budget, a percentage that is the state's SCHIP match rate. In North Carolina, SCHIP funds come from general state revenue, not from a special tax.

A budget estimate was developed by the state's fiscal staff using CPS estimates for the number of children eligible for SCHIP, assuming that only 90 percent would participate, and multiplied by an actuarial estimate of the annual cost per child based on State Employee's Health Plan children. The state also budgeted for the "SCHIP Dip" in federal funds that would occur in federal fiscal years 2002 through 2004. Consequently a state budget plan was developed that assumed phased-in enrollment that would leave enough federal carryover funds to continue covering the same number of children (at that time estimated to be 66,000) during the dip. Because the estimated number of children to be covered turned out to be low, the state budget estimates were correspondingly low. Since the state cannot carry over unspent state funds from year to year, it was not possible to use unspent funds from the first program year in the second year when the budget difficulties arose, even though extra federal money remained unspent and was carried over, and consequently available.

For this reason, the difficulties with financing have related primarily to state matching funds and not to the availability of federal funds. As shown in Table 7, North Carolina had not, by the end of Federal Fiscal Year 2000, begun to spend any of its FFY 2000 federal allotment, and still had a majority of the FFY 1999 allotment to spend. State budget analysts have examined the situation for FFY 2001 and forward, and have estimated that this situation will continue despite the state's efforts to maximize federal funds. State fiscal staff estimate that by FY 2004 there will be $89 million in federal funds that will remain unspent and be lost to the state unless national legislation allows for further carry-over.

While the estimated cost per child used in calculating the budget was actually somewhat generous in the initial years of the program, the number of enrollees was substantially underestimated, resulting in a state budget shortfall. In the summer of 2001, the legislature approved an additional $8 million for state fiscal year 2002 (which runs from July 2001 to June 2002) and an additional $12 million for state fiscal year 2003, to accommodate a new enrollment target of 82,000. This allowed the state officials to lift the enrollment freeze in October 2001.

It remains uncertain how fast enrollment will climb and to what level now that the freeze has been lifted. Consequently, it is unclear whether the state will spend all of its state appropriation for fiscal year 2002. If it is not spent, it will revert to the state's general fund and be used for other purposes.

North Carolina is still facing a very tough financial future, and all programs—including *Health Choice*—will be under scrutiny. We were told that most human services programs face either level funding or budget cuts, and that the SCHIP program was one of the few exceptions in actually receiving a budget increase. However, most of the people we interviewed felt that, as long as North Carolina was matching federal dollars and not spending state-only money for the program, the future of *Health Choice* would remain relatively secure, due to its widespread political popularity throughout the state.[16]

---

[16] Since the time of the site visit the state has continued to see enrollment climb and is considering another freeze to be imposed in September 2002.

XI. LESSONS LEARNED

A private sector image, generous reimbursement for providers, a simple enrollment process and efficient administration has made *Health Choice* a very popular program throughout North Carolina. Politicians, state and county agency staff, providers, advocates, community-based workers and families all sing its praises. This popularity has resulted in a shift of political support from the days of program design, when many members of the legislature, particularly more conservative representatives, were less supportive of the program. In spite of the state's recent budget woes and the implementation of an enrollment freeze, it appears that popular political support will lead to continued funding of *Health Choice*.

Beyond this generally positive outlook, there are other lessons that have been learned regarding the factors and program strategies that promote, or inhibit, the successful implementation of a child health insurance program. These lessons are summarized below.

- ***North Carolina has demonstrated that it is possible to design a separate SCHIP program and still reap many of the benefits that Medicaid-only programs enjoy.*** By merging Medicaid *(Health Check)* and *Health Choice* outreach and enrollment, the state has accomplished both seamlessness and a substantial reduction in the stigma associated with Medicaid. The state built on an existing infrastructure by placing enrollment functions in the hands of those who also enroll children into Medicaid. The family-friendly enrollment process, which greatly simplified the previous Medicaid enrollment process, is now identical for both programs. It has also made it easy for families to move back and forth between Medicaid and SCHIP. Reportedly, this enrollment system is popular with both families and state and county administrators, and has resulted in a large number of children enrolling in Medicaid who would not have otherwise done so.

- ***The freeze in North Carolina provides lessons about the advantages and disadvantages of a non-entitlement program.*** Even though state legislators were concerned about the freeze, they were nevertheless glad that they had the ability to control the budget of the program. The freeze, they said, was preferable to removing the budgetary control and making the program an entitlement like Medicaid. Other informants, however, saw the freeze as a sign of the problems of a non-entitlement program in terms of serving those in need, and would have liked to see the program as a "non-Medicaid entitlement."

- ***A grass roots county-based outreach program is a successful way to increase awareness of SCHIP, and may overcome the need for a statewide mass media campaign.*** The grassroots outreach for *Health Choice* was primarily delegated to volunteer coalitions at the local level which received relatively limited funding. Although a risky strategy, it was designed with an awareness of North Carolinians' desire for local community involvement. This approach paid off well, with most county coalitions meeting or exceeding their designated enrollment targets. All informants agreed that making use of an existing infrastructure—the Department of Health's Women's and Children's section and county-based coalitions—was an efficient means of stretching a small budget.

- ***The concern that the benefits package would be too narrow for low income children has not been borne out with experience.*** By adding coverage of vision, dental, and hearing services to the SEHP benefits package, a virtual "Medicaid look-alike" program was created. While there could be concern in times of budget stringency that such a broad benefit package should be restricted, we heard no discussion of this being proposed. Indeed, the broad benefit package seems to be universally accepted as a fundamental goal for the program.

- ***Actively involving providers in program design may be a key factor in providing broad access to care.*** Providers have been active throughout the design and implementation of North Carolina's *Health Choice.* They lobbied for a comprehensive benefits package, good reimbursement rates, and an open network of doctors. The result is a system that physicians like, and consequently most participate as *Health Choice* providers. Therefore, children enrolled in *Health Choice* reportedly have excellent access to care. A few more problems were reported with access to providers under Medicaid, most prominently with access to dental care. *Health Choice* appears to have had some spillover effects by improving access to mental health services in both *Health Choice* and Medicaid.

- ***Using Blue Cross/Blue Shield for benefits administration is viewed positively by families and providers.*** Having a Blue Cross/Blue Shield identification card promotes the private sector (de-stigmatized) image of the program, and providers appreciate the smooth administration of claims payment that results from this approach.

- ***North Carolina's streamlined approach to program administration is sound and effective.*** By choosing existing agencies and organizations to administer functions similar to those already underway, the state was able to get its program going quickly and operate it with relatively low administrative overhead. At the local level, the joint leadership of the county Departments of Social Services and Health were able to adapt existing programs for *Health Check* to *Health Choice*, and create a seamless enrollment approach that was considered to be successful. Using the State Employee Health Plan for benefits and claims payment administration also resulted in a streamlined benefits and payment system, with little increase in the state bureaucracy.

- ***Cost sharing at relatively low levels was generally viewed favorably, although the enrollment fee my pose a deterrent for some families.*** Most families (those below 150 percent of poverty) face no cost sharing under *Health Choice*, and higher income families are generally subject to relatively low levels of cost sharing. Still, there is a possibility that the enrollment fee will be dropped because it reportedly is a deterrent for some families, and it does not provide a very large revenue source for the program. Copayments, on the other hand, are widely accepted as de-stigmatizing and do not seem to deter families from using services, so there is no discussion of dropping them.

- ***Imposing an enrollment freeze on a successful program is a difficult experience for administrators and families, and is an indicator of the dangers of inaccurate budget allocations.*** As perhaps a victim of its own success at enrolling children and providing broad access to care, North Carolina was the only state at the time of our site visit that had implemented an enrollment freeze on its SCHIP program.[17] The experience was extremely discouraging for the staff involved with outreach and enrollment. State representatives attributed this situation primarily to the fact that more children were eligible than anticipated by the unreasonably low federal CPS estimates. While this may provide a lesson for only a limited number of states in regards to their SCHIP budget process, the North Carolina experience does provide a broader lesson about the dangers associated with estimating budget allocations from numbers that are subject to substantial sampling variability. At the same time, the commitment and efficiency of state and county administrators in implementing the freeze, and its subsequent removal, minimized some of the potential long-term damage to the program.

---

[17] Montana and Utah have since done so.

TABLE 1

SCHIP STATE PLAN AND AMENDMENTS

	Dates			
Document	Submitted	Approved	Effective	Description
Original Submission	5/14/98	7/14/98	10/1/98	A separate state health insurance program to provide coverage to children up to 200 percent of poverty
Amendment 1	10/21/99	1/15/99	9/30/98	To allow children who had coverage through the now-ceased Caring Foundation to obtain coverage without having to go through the waiting period
Amendment 2	3/26/99	6/23/99	3/12/99	To allow clinic services to include School-Based Health Centers
Amendment 3	7/12/99	9/30/99	7/1/99	To expand the dental benefit to include sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns and a second fluoride application
Amendment 4	8/3/00	10/19/00	5/1/00	To eliminate cost sharing for documented Native Americans
			10/1/00	To exempt special needs children from the 2-month waiting period if health insurance benefits had been terminated due to long-term disability or substantial reduction in or limitation of lifetime medical benefits
Amendment 5	11/21/00	2/16/01	1/1/01	To freeze program enrollment
Amendment 6			10/8/01	To eliminate the waiting period for all children

SOURCE: Centers for Medicare & Medicaid Services (CMS), *North Carolina Title XXI Program Fact Sheet.* CMS web site http://www.hcfa.gov/init/chpfsnc.htm

NOTES: SCHIP=State Children's Health Insurance Program (Title XXI).

TABLE 2

MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS,[a] EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL (FPL)

	Age (in Years)			
	Up to 1	1-5	6-15	16-18
Medicaid standards in effect 7/1/98	Up to 185%	Up to 133%	Up to 100%	Up to 100%
SCHIP Medicaid expansion	NA	NA	NA	NA
SCHIP separate child health program	185-200%	133-200%	100-200%	100-200%

SOURCES: Centers for Medicare & Medicaid Services (CMS), *North Carolina Title XXI Program Fact Sheet.* CMS web site http://www.hcfa.gov/init/chpfsnc.htm

NOTES: SCHIP=State Children’s Health Insurance Program (Title XXI). NA=Not applicable.

[a] Income standards are net of deductions

TABLE 3

SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	SCHIP	Medicaid[a]
Retroactive eligibility	No	Yes, 90 days from first day of month of application
Presumptive eligibility	No	Yes, pregnant women
Continuous eligibility	Yes (12 months)	Yes (12 months)
Asset test	No	Yes, except for SOBRA children
U.S. citizenship requirement	Yes	Yes

SOURCE: Centers for Medicare & Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: North Carolina*. March 2000 website: http://www.hcfa.gov/init/nceval98.pdf

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

[a] Children's coverage groups.

TABLE 4

APPLICATION AND REDETERMINATION FORMS, REQUIREMENTS AND PROCEDURES

Characteristic	SCHIP	Medicaid[a]
APPLICATION		
Form		
Joint form	Yes	Yes
Length	2 pages, front and back	2 pages, front and back
Languages	2 (English and Spanish)	2 (English and Spanish)
Verification Requirements		
Age	No	No
Income	Yes	Yes
Deductions	Yes	Yes
Assets	Yes	Yes
State residency	No	No
Immigration status	No	No
Social security number	Yes	Yes
Enrollment Procedures		
Mail-in application	Yes	Yes
Phone application	No	No
Internet application	Yes	Yes
Hotline	Yes	Yes
Outstationing	Yes	Yes
Community-based enrollment	Yes	Yes
REDETERMINATION		
Same form as application	Yes	Yes
Pre-printed form	No	No
Mail-in redetermination	Yes	Yes
Income verification required	No, unless has changed	No, unless has changed
Other verification required	Yes, if any changes	Yes, if any changes

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000; Centers for Medicare & Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: North Carolina*. March 2000 website: http://www.hcfa.gov/init/nceval98.pdf.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

[a] Children's programs.

TABLE 5

ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	Oct 2001[a]
Number ever enrolled in federal fiscal year (FFY)	-	57,300	103,567	-
Number enrolled at calendar year end (point in time)	17,887	55,723	72,024	60,211
Percent change in point-in-time enrollment	-	212%	+29%	-16%

SOURCE: Vernon K. Smith, *CHIP Program Enrollment: December 2000.* Kaiser Commission on Medicaid and the Uninsured, September 2001; Centers for Medicare & Medicaid Services (CMS), *State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999* website: http://www.hcfa.gov/init/fy99-00.pdf; North Carolina state figures obtained during site visit

[a] Most recent enrollment data available.

TABLE 6

COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee	Yes
<150% FPL	None
150-200% FPL	$50 per child per year; $100 maximum per family
200-225% FPL*	
Premiums by family income	
0-200% FPL	None
200-225% FPL*	$120.84 per child per month
Copayments	Yes
<150% FPL	None
150-200% FPL	$5 per office visit; $20 per emergency room visit; $6 for prescriptions; no copay for preventive care visits
Deductibles	None

SOURCE: N.C. Health Choice For Children Handbook, 2002.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI)

*Only available at renewal.

TABLE 7

SCHIP FEDERAL ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2000

FFY	Federal Allotment	Federal SCHIP Expenditures ($ millions)	Expenditures as Percentage of Allotment for the Year	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount ($ millions)
1998	$79.5	$0.0	0%	100%	
1999	$79.1	$34.9	44%	26%	
2000	$89.2	$65.5	73%	0%	$20.9

SOURCE: Centers for Medicare & Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, May 24, 2000; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending.* Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year.

APPENDIX A —KEY INFORMANTS

SCHIP administrators

June Milby, NC Health Choice Coordinator
Barbara Brooks, Assistant Director of the Division of Medical Assistance
Marjorie Morris
Department of Medical Assistance
Raleigh, North Carolina

Carol Tant, Director of Children’s Health Services
Carolyn Sexton
Rebecca Greenleaf Bailey
Lynda Dixon
Diane Tyson
Division of Public Health
Raleigh, North Carolina

Paul Sebo, Managed Care Director and Benefits Director for SCHIP
State Employees Health Plan (SEHP)
Raleigh, North Carolina

Bill Brasheer
Denise Baxter
Carrie Sloberg
Blue Cross Blue Shield
Chapel Hill, North Carolina

Charlotte Craven
Value Options Inc.
Raleigh, North Carolina

Sari Teplin
NC Foundation for Alternative Health Programs (Covering Kids grantee)
Raleigh, North Carolina

Janice Freedman
NC Healthy Start Foundation
Raleigh, North Carolina

Legislators / Legislative Staff

Phil Baddour
House Majority Leader (Democrat)
Raleigh, North Carolina

Carol Shaw
Legislative staff, Fiscal Research Division
Raleigh, North Carolina

Provider Taskforce

Dr Wally Brown, pediatrician and head of the taskforce
Steve Shore, director of NC Pediatric Society
Burton Horwitz, pediatric dentist
Stephanie Clark, NC Hospital Association

Providers

Dr Greg Bounds, Director
Sue Sutton, Finance Department
Donna Marston, Billing Department
Rhonda Cottle, Intake
Barbara, Pediatric Nurse
Goshen Medical Center
Fasion, Duplin County, North Carolina

Dr Schmidt, Lincoln Health Center
Ann Henry, Lincoln Health Center
Susan Epstein, Community Health, Duke University
David Covington, Duke Pediatrics
Alice Rothman, Duke Pediatrics
Durham, North Carolina

Brian Ellerby, Executive Director
Dr Marion Earles, Pediatrician
Guilford Child Health Inc.
Greensboro, Guilford County, North Carolina

Dr David Rubin
Private pediatrician
Greensboro, Guilford County, North Carolina

Dr Michael Dennis
Rainbow Pediatrics
Hendersonville, Henderson County, North Carolina

Advocates

Jonathan Sher, Executive Director
Child Advocacy Institute
Raleigh, North Carolina

Paula Wolfe, Senior Fellow /Chief Lobbyist
Child Advocacy Institute / N.C. Covenant for Children
Raleigh, North Carolina

Adam Searing, Advocate / Chair
NC Health Access Coalition / N.C. Covenant for Children
Raleigh, North Carolina

Outreach organizations and staff

Jim Reingruber, Volunteer Center of Durham
Janna Harton, Durham Health Partners
Angela Roberston, Carolina Access, based at Durham Community Health Network
Durham County Health Choice Outreach Coalition
Durham, North Carolina

Robin Lane
Bob Newton
Community Health Foundation (Covering Kids Grantee)
Greensboro, Guilford County, North Carolina

Sandy Smith, RN
Pardee Hospital,
Hendersonville, Henderson County, North Carolina

County Departments of Social Services and Departments of Health Officials

Millie Brown, Director
Elva Quinn
Duplin County Department of Social Services
Kenansville, Duplin County, North Carolina

Ila Davis
Duplin County Department of Health
Kenansville, Duplin County, North Carolina

Arnold Dennis, Health Choice eligibility
Dan Hutchings, Director of DSS
Gail Harris, Supervisor
Durham County Department of Social Services

Sue Gupthill, Child Health Supervisor
Durham County Department of Health

Janice Cardin
Guilford County Department of Social Services
High Point, Guilford County, North Carolina

Sandy Morgan
Donna Cook
Frank Verhaeghe
Henderson County Department of Social Services
Hendersonville, Henderson County, North Carolina

Researcher

Rebecca Slifkin
Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

REFERENCES

Centers for Medicare and Medicaid Services (CMS). *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: North Carolina*. March 2000

Centers for Medicare and Medicaid Services (CMS). *Memo from Center for Medicaid and State Operations to State, January 25, 2000.* Federal Register Notice, May 24, 2000

Centers for Medicare and Medicaid Services (CMS), *North Carolina Title XXI Program Fact Sheet.*

Centers for Medicare and Medicaid Services (CMS). *State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999*

Cohen Ross, D and Cox, L. *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000

Hill, I. Westpfahl Lutzky, A. and Schwalberg, R.. *Are We Responding to Their Needs? States' Early Experiences Serving Children with Special Health Care Needs under SCHIP*. Urban Institute, May 2000

N.C. Health Choice For Children Handbook, 2002

Smith, V.K. *CHIP Program Enrollment: December 2000.* Kaiser Commission on Medicaid and the Uninsured, September 2001