Children's Basic Health Plan

Annual Report
State Fiscal Year 2004

Submitted by
The Medical Services Board

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PREFACE

The Medical Services Board respectfully submits the following annual report to the Joint Budget Committee and the Senate and House Health, Environment, Welfare, and Institutions Committees of the Colorado General Assembly. The report covers state fiscal year (SFY) 2004, which spans from July 1, 2003 to June 30, 2004, and is in accordance with C.R.S. 25.5-1-303 (7). The statute states the following:

> …the board shall report annually to the Joint Budget Committee of the General Assembly and the Health, Environment, Children and Families Committee of the Senate and the Health, Environment, Welfare and Institutions Committee of the House of Representatives on the implementation and performance of the Children's Basic Health Plan program, including but not limited to the extent to which private sector strategies and resources are effectively used as part of the program.

In response to this legislative mandate, the Medical Services Board requested the assistance of staff at the State of Colorado Department of Health Care Policy and Financing (Department). Information for this report was obtained by reviewing all relevant documents and interviewing key individuals involved in the administration of the plan.

EXECUTIVE SUMMARY

The Children's Basic Health Plan (CBHP) is a public/private partnership providing subsidized health insurance for children in low-income families who are not eligible for Medicaid and have incomes at or below 185% of the federal poverty level. The program is administered by the Department of Health Care Policy and Financing, which contracts with private vendors for many program services. In FY 03-04, the program was appropriated $75,752,510 by the Legislature to serve an average monthly enrollment (AME) of 52,965 clients.

Due to State budget constraints, the appropriated CBHP AME did not allow for "natural growth" of enrollment in the program. To manage enrollment in the program to the appropriation, CBHP instituted an enrollment cap for children from November 1, 2003 through June 30, 2004. During this period, new enrollments into the program were suspended, although current eligible clients were allowed to renew their membership and keep continuous health care coverage.

In October 2002, the CBHP program was expanded to include pregnant women 19 years and older who met the other eligibility guidelines. Due to budget constraints, enrollments of this population into the program were suspended from May 2003

through June 30, 2004 as required by SB03-291. However, CBHP and a temporary State only prenatal program continued to serve the women already enrolled in the program through their delivery and postpartum care, much of which spanned into FY 03-04.

During FY 03-04, the Department began investigating the feasibility of streamlining the CBHP and Medicaid family and children's programs through a federal waiver. The Department studied ways to simplify the eligibility process for clients, judiciously purchase health care, and maintain sound benefit levels. Initial findings show this project is feasible, and the Department is now moving forward with the necessary tasks to operationalize the project.

The program continues to improve on its ability to use the best aspects of both public and private sectors to offer low cost health insurance to working families by contracting for services, partnering with public and private organizations and easing the burden on working families.

A COMMITMENT TO CHILDREN: PROGRAM OVERVIEW

State Children's Health Insurance Programs Nationwide

Created in 1997 under Title XXI of the Social Security Act, the State Children's Health Insurance Program was allocated $48 billion nationally, over ten years, to expand health care coverage to uninsured children. The program enables states to insure children from working families with income or resources too high to qualify for Medicaid but too low to afford private health insurance, with some latitude to adjust upper-income limits.

The authorizing federal legislation allows states considerable discretion in designing a program to meet their particular needs. As of July 1, 2004, all 50 states, the District of Columbia, and five U.S. Territories had implemented a State Children's Health Insurance Program covering nearly four million children. Of these states, 19 have created a separate child health program, 19 have expanded Medicaid, and 18 have developed a combination of the two.

Children's Basic Health Plan of Colorado

The State of Colorado has a stand-alone Children's Health Insurance Plan; it is not a Medicaid expansion program. The program was enacted as the Children's Basic Health Plan (CBHP) through C.R.S. 26-19-101, et seq., and is marketed as the Child Health Plan *Plus* (CHP+).

CBHP provides statewide-subsidized health insurance coverage for low-income children under 19 years of age who are not eligible for Medicaid and whose families have incomes at or below 185% of federal poverty level. For example, a family of four can make up to $2,906 per month. The program offers a wide variety of services including:

- Check-ups and shots;
- Other doctor visits;
- Hospitalization and hospital services;
- Prescribed medications;
- Mental health services;
- Hearing aids;
- Eyeglasses; and
- Dental care.

Program Goals

During SFY 2004, CBHP focused on the following goals:

- Improve health status for participants by assuring access to appropriate health care services;
- Institute an enrollment cap in order to stay within the budget;
- Maximize the effectiveness of CBHP as a public/private partnership.

Department of Health Care Policy and Financing

The Department of Health Care Policy and Financing is the agency responsible for three of Colorado's major, publicly funded health care programs:

- The Children's Basic Health Plan;
- The Colorado Indigent Care Program; and,
- Medicaid.

In SFY 2004, the Department was appropriated $75,752,510 for CBHP. (Please refer to the report section entitled "The Costs of Covering Children" for more information on funding.) By statute, the Department fulfills the following responsibilities:

- Establishes the schedule of benefits, rules and cost-sharing structures, and submission to the Medical Services Board for approval;
- Manages administrative and health-related service contractors;
- Conducts program evaluation and development;
- Coordinates with other public and private health care delivery and financing programs; and,
- Assures compliance with all related federal and state laws and regulations.

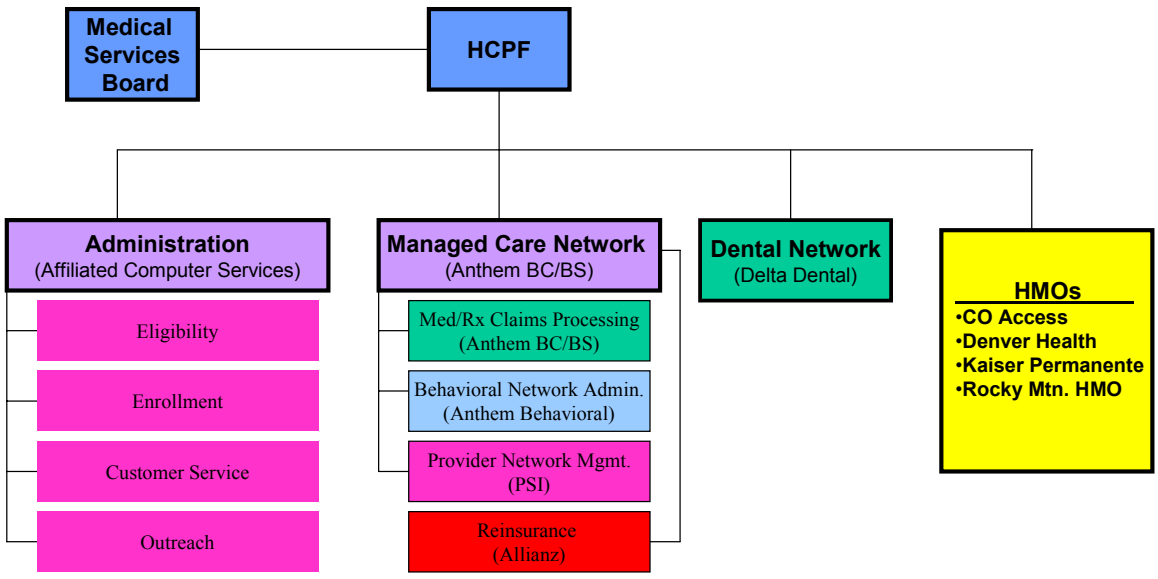
CBHP ADMINISTRATION

The CBHP, by statute and operation, is a non-entitlement, commercial-coverage health plan with largely privatized administration. (See FY 03-04 Administrative Structure Chart below.) Public/private collaboration and co-operation continue to be the hallmarks of CBHP.

Eligibility and Member Services

The Eligibility, Enrollment and Member Services Contractor (Affiliated Computer

SFY 2004 CHP+ ADMINISTRATIVE STRUCTURE



Services) currently fulfills the following contractual obligations:

- Eligibility and enrollment, including processing mail-in applications, outreach, and referring applicants to Medicaid or other resources;
- Statewide customer service, including application assistance, information, and problem resolution for CBHP plan members and agencies;
- Family enrollment fee administration; and
- Participation in and assistance with the Colorado Benefits Management System pilot.

FY 03-04 ELIGIBILITY REQUIREMENTS

Estimated Eligible Population

CBHP estimates 86,142 children are eligible for the program, including currently enrolled children. The estimate was derived from the Federal Current Population Survey and the Census Bureau, and included Colorado children at or below 185 percent of the federal poverty level but not Medicaid eligible.

Of the 86,142 children eligible for the program, the Colorado General Assembly provided funding to assure services for an average of 52,965 children per month. This represents 61% of the estimated eligible children.

Eligibility Requirements

Children are eligible for CBHP if:

- They do not qualify for Medicaid;
- They are residents of Colorado;
- They have adjusted family incomes at or below 185 percent of the federal poverty level; and
- They do not have access to State employee health insurance benefits.

HEALTH CARE SERVICES DELIVERY

Health Maintenance Organizations

The Department currently contracts with four Health Maintenance Organizations. Health Maintenance organizations are available to 84 percent of the eligible population. In 39 Colorado counties, enrollees receive health care services through one or more of the following health maintenance organizations: Colorado Access, Denver Health Medical Plan, Kaiser Permanente, and Rocky Mountain HMO. These health maintenance organizations are under full risk contracts with the Department.

State Managed Care Network

The Department contracts directly with health care providers in counties where health maintenance organizations are unable to offer coverage. This network of providers is the State Managed Care Network.

CBHP enrollees may access benefits and services immediately upon program eligibility determination in every county of the state. This "pre-HMO enrollment period" is important because it enables

children to access services as soon as they are enrolled. These initial services are delivered statewide through the State Managed Care Network until enrollment in the family's choice of health maintenance organization is operationally possible, usually for one or two months.

The State Managed Care Network is comprised of over 2,650 providers: 1,551 primary care physicians, 1,097 specialists, 21 hospital contracts representing 44 service locations and a number of ancillary service providers, which include essential community providers.

In FY 03-04, the Department contracted directly with Anthem Blue Cross and Blue Shield for Administrative Services to manage the State Managed Care Network. Anthem Blue Cross and Blue Shield is responsible for claims administration, utilization review, pharmacy benefits, case management, and behavioral health benefits. Anthem Blue Cross and Blue Shield subcontracted with Policy Studies Incorporated for provider relations, training and contracting support, as well as provider customer service.

Dental Services

CBHP Dental benefits are administered by Colorado Dental Service, Inc. doing business as Delta Dental Plan of Colorado. The CBHP provides comprehensive dental benefits, including preventative care, oral surgery, and endodontics, with a $500 per child per year limit. Preventative care services have no co-insurance, while other services have a co-insurance of $5.00 or less.

Delta provides CBHP members a statewide network of over 800 dentists (85 percent of all licensed dentists in the state). In FY 03-04, Delta served an average of 2960 clients per month.

COST SHARING

CBHP requires enrollment fees and co pays from some of its clients. This cost-sharing mimics private insurance cost-sharing. Families with incomes under 100 percent of federal poverty level do not pay an enrollment fee or co-payments for services.

Families below 151 percent of the federal poverty level have no enrollment fee, but pay a small co-payment for provider visits and dental procedures, other than preventative care.

Families with incomes between 151 percent and 185 percent of the federal poverty level pay an annual enrollment fee of $25 for one child and $35 for two children or more, along with small co-payments for provider visits and dental procedures.

Promoting Preventive Care

There are no fees charged to clients for preventive medical and dental care. This encourages the use of cost-effective preventive services.

SFY 2004 ENROLLMENT

Enrollment

Due to State budget constraints, CBHP had to limit enrollment into the program for the first time in its history. The program was appropriated enough money to serve an average monthly enrollment of 52,965 clients. While this allowed for 9% more clients to receive services the previous year (the SFY 03 appropriated AME was 48,398) it was not enough to sustain natural growth in the program. In order to manage the program to the appropriation and as intended by the General Assembly, CBHP suspended new child enrollments into the program from November 1, 2003 through June 30, 2004. Eligible children who were already enrolled in the program could reenroll in the program during that time.

Notification of the upcoming suspension was accomplished through newspaper articles, the Colorado Indigent Care Program, the contractor, and community based organizations.

During the suspension of enrollment, CBHP still received applications and screened each one for Medicaid eligibility, consistent with federal law. If the applicant appeared to be Medicaid eligible, as many applicants are, the application was referred to the Medicaid eligibility technicians located at the Administrative Services vendor. The other applications were returned to the applicant with a letter explaining the suspension and encouraging them to reapply when new enrollments were opened again.

The Enrollment Cap

The enrollment limitations in Colorado differed from those implemented in other states for two reasons:

1. The Health Insurance Flexibility and Accountability (HIFA) waiver that enabled the program to serve pregnant women prohibited the State from limiting enrollment of children while adult women were being enrolled and/or provided services under Title XXI, and
2. CBHP manages to an average annual enrollment- not a maximum enrollment during the year.

Enrollment in the prenatal program was suspended in May 2003, as soon as SB 03-291 was enacted. Women in the program were provided benefits throughout the course of their pregnancy and for two-month postpartum care, as the program was originally designed. The federal prenatal program under the HIFA waiver was suspended on October 31, 2003. Continued care was then provided under a state-only program (the state-only program was appropriated $284,044). The funding stream changed, but the care to clients was seamless. By suspending the Federal Prenatal HIFA waiver, Colorado was able to

implement the limitation on enrollment for children to allow the program to function within the appropriated budget for FY 03-04. The state spent a total of $566,420.01 on service for pregnant women from both the CBHP appropriation and the state-only appropriation.

Prior to November 1, 2003, enrollment was allowed to continue naturally. The upcoming new enrollment cap was publicized within Colorado in compliance with Federal noticing requirements. While the program had ceased marketing in the prior fiscal year, the notice of the enrollment limitations was widely communicated among the many community partners involved in the program. Enrollment began to grow both in response to the upcoming limitations and the normal back-to-school increases that have been reported in previous years.

Enrollment was allowed to grow in excess of the average monthly enrollment before the cap was instituted. However, this was expected and accounted for in the budgeting, knowing the cap would cause enrollment to drop.

This process is very different from enrollment caps instituted by other states. In other states, there is a maximum enrollment number for that period. Once that number was reached, no new clients would be accepted. As enrollment fell below the "cap," they were able to reopen enrollment periodically (through a variety of methods) to enable enrollment back up to the capped number. This approach was not possible for Colorado under the waiver process, which enabled CBHP to provide prenatal care for adult pregnant women. Colorado's enrollment reached almost 53,000 at its maximum in October, 2003. After that, it fell significantly and the program ended the year with an average monthly enrollment of 46,695.

The administration of a waiting list is complicated and increases administrative costs significantly. The State would have to provide to clients a description of the process for identifying which children will be given priority for enrollment and how children will be informed of their status on a waiting list. This is complicated because, with a waiting list, the child's status on the waiting list potentially can change monthly as children are enrolled from the waiting list and/or enrolled in Medicaid due to changes in family income. In addition, the CHP+ program would still have to screen applicant children for Medicaid eligibility and facilitate their enrollment into Medicaid, prior to putting them on a waiting list. Because children could potentially be on a waiting list for a number of months (in Florida and North Carolina, some children were on waiting lists for an excess of 6 months), the program has to reconnect with the family and obtain updated financial information and reconfirm their interest in the program.

"The CHP+ was a lifesaver for our family. Our son, who has a serious medical condition, received excellent care. The high quality of care gave him what he will need to have a full independent life as an adult."

CHP+ Mom

At the same time that the new enrollment limitations were being implemented, CBHP and its community partners made a concerted effort to maintain enrollment through the reenrollment process. As described in the Appendix, Enrollment Limitations, many states reported that reenrollment increased while enrollment limitations were in place because families understood the need to maintain their insurance for their children. In estimating the number of children who would reenroll during the year, CBHP provided conservative estimates using the experiences reported by other states.

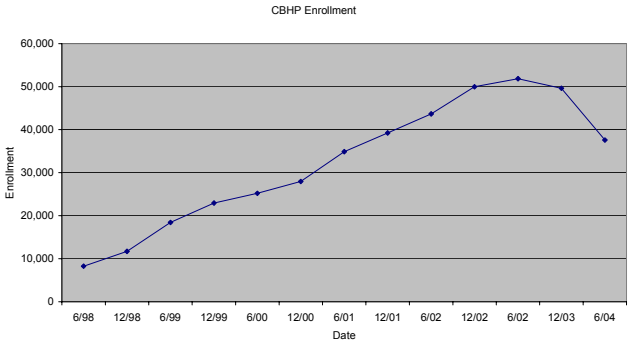
Application Submissions

On average, each application represents two children. Families can obtain applications from a variety of sources, including community health centers, schools, county departments of social services, and the CBHP Eligibility, Enrollment, and Member services vendor. Sixty-seven percent of clients mail their application directly to the vendor, while 25% of applications are received through community based organizations, and 11% are forwarded from the county departments of social services.

Of the applicants who renew after 12 months, 61 percent are determined eligible and are re-enrolled in the program.

Enrollment packets are sent out to current members 90 days prior to the end date of their enrollment period. Reminder post cards are sent 45 days later to those applicants who have not sent in renewal applications. This allows time for members to re-enroll without a gap in coverage and gives them time to find other insurance if they are not eligible.

CBHP TOTAL ENROLLMENT FROM June 1998-June 30, 2004 (GRAPH)



PRIVATE SECTOR PARTNERSHIPS

Community Outreach

CBHP has benefited from informal partnerships with many organizations that help promote CBHP: Community Health Centers, county nursing services, county departments of social services, managed care organizations, school based health centers, the Colorado Community Health Network, the Covering Kids and Families Coalition, and many others. These organizations assist by telling clients about the program, helping them enroll, and delivering quality health care.

With the enrollment cap in effect, the community partners curbed outreach for new clients, and focused on ensuring currently enrolled clients re-enroll in the program to maintain their benefits. The Covering Kids and Families Coalition assisted the program by conducting train-the-trainer sessions to help clients fill out applications completely, which enables clients to receive benefits more quickly.

Delta Dental Plan of Colorado Foundation

The Delta Dental Plan of Colorado Foundation provides funds to provide care for children who have or will exceed their maximum benefit. As of October 20, 2004, since January 1, 2004, the foundation provided $8,480 in additional services to children who exceeded the maximum benefit. Almost 3,300 additional children have received care through Delta Dental's Smile-a-bration program, some of whom were children who exceeded the CHP+ $500 dental benefit. Delta Dental's Smile-a-bration is a day of free dental care provided by dentists throughout the state of Colorado, as well follow-up care for those with severe need.

In calendar year 2003, the Delta Dental Plan of Colorado Foundation allocated an additional $75,000 in care for children who have or will exceed their benefit maximum of $500 per child per calendar year. In addition, the Delta Dental Plan of Colorado Foundation was awarded a $50,000 grant from the Horwich Foundation and the Mile High United Way to provide continuing care to those children that have reached their annual benefit maximum.

HEALTH CARE SERVICES: QUALITY, UTILIZATION AND EVALUATION

Program Evaluation

The Department is considering how, through more prudent purchasing, to take advantage of additional federal flexibility in providing services to Colorado's Medicaid and CBHP populations, without increasing General Fund expenditures or decreasing available benefits. As part of this ongoing work, the Department conducted several analyses to determine if there are opportunities to develop a streamlined program for children and families enrolled in Medicaid and CBHP.

- The Federal Health Resources and Services Administration and the Rose Community Foundation jointly funded an analysis to compare income eligible children enrolled in Medicaid and CBHP. While the study found differences in demographics and costs between the programs, there were similarities in the health status of the children, the services they use and the extent of services they use. Differences in costs were largely attributable to CBHP providing more services in an outpatient setting and Medicaid providing more services in an inpatient setting. However, despite those differences, services for children enrolled in Medicaid did not exceed the CBHP benefit package to any large degree.

- The Health Resources and Services Administration and the Rose Community Foundation also funded three studies to: review national "best practices" in public and private health care purchasing; analyze the current health care purchasing practices of Medicaid and CBHP; and to recommend a model for purchasing health care services for children and families in a streamlined program. While the recommendations in the studies provide a framework for more effective purchasing, they also identified significant operational considerations that need to be addressed in the development of a streamlined program.
- The Delta Dental Plan of Colorado Foundation funded an analysis to

assess the impact of the availability of dental services to children enrolled in CBHP. The University of Colorado School of Dentistry conducted the study and found that the program should be considered a successful first step toward improving the oral health of children. The study pointed to the 34.3% utilization rate in comparison with a 24% utilization rate in Medicaid and relatively large provider network, as examples. In addition, they recommended further evaluation in the areas of the:

- Provider Network
- Impact of the $500 maximum annual benefit
- Covered dental services

In SFY 2005, the Department will continue to assess the feasibility of streamlining the children and families Medicaid and CBHP programs, relying heavily on grant funding. Future work will focus on:

- designing a benefits package for physical, oral and behavioral health services;
- designing a delivery system that can provide services to the maximum number of eligible children and families;
- identifying potential expansion populations;
- developing actuarially sound rates for children and families and expansion populations;
- developing a system of purchasing health care for children and families;
- developing a partnership between employer-sponsored insurance and publicly funded insurance; and
- designing a business model that can support the streamlined program.

The department is looking forward to discussing options with the legislature in the next legislative session.

Quality Evaluation

After issuing a Request for Proposals for an External Quality Review Organization, the Department contracted with Health Services Advisory Group, Inc. The contract began September 1, 2004. The contractor will assist the Department's quality assurance activities by:

- providing recommendations for performance based contracting;
- credentialing of providers; and,
- Health Employer Data Information Set (HEDIS) measures calculations. HEDIS is a standardized measure of health care outcomes.

"Our family wants you to know what a lifesaver CHP+ has been for us. We became unemployed Feb 2003 and were able to get our daughter covered with your program. She is 17 and required a second GI surgery. There is just no way we could have gotten her health care without you. Between testing, counseling, emergency rooms, and surgery – she is doing better.

We are now employed with insurance coverage. Though she is still under doctor's care – <u>you all</u> helped save her life.

From the bottom of my heart I THANK YOU!"

CHP+ Mom

THE COSTS OF COVERING CLIENTS

The General Assembly appropriated and directed monies in FY 03-04 to the CBHP trust fund through several bills: SB03-019, SB03-258, SB03-282, SB03-291, and HB04-1331 footnotes. The total appropriation for the program costs was $75,752,510, of which $48,732,976 was Federal Funds and $27,019,534 was Cash Funds Exempt from the CBHP trust fund. The Tobacco Utilization Settlement Cash Fund appropriated $18,460,693 to the CBHP trust fund.

Due to budget constraints, SB03-291 required the program to limit services to an average monthly enrollment of no more than 52,964 children. Because the caseload dropped more quickly than projected, the program ended the year with an average monthly enrollment of 46,695. This resulted in program expenditures that were less than what was appropriated.

Benefit Costs

For SFY 2004, the Department received an appropriation of $87.65 per member per month to fund medical care costs, and $10.95 per member per month to fund dental care costs for an average monthly enrollment of 52,965 children.

Administrative Costs

The Department received an appropriation of $5,160,151 to fund contracted administrative functions for CBHP. Administrative functions include eligibility, enrollment, member services, family premium administration, and community outreach. This appropriation also included funds for necessary professional services for auditing, actuarial, and program evaluation services.

State law requires CBHP administrative expenditures to be below 10 percent. Since CBHP is required to screen every applicant for Medicaid eligibility, Medicaid pays for a substantial amount of CBHP administrative costs (approximately $2,694,350 in FY 03-04). After this adjustment, CBHP spent under 10 percent of its funds on administrative services.

	Funds expended
Medical	$51,777,409
Dental	$ 5,405,336
Administration	$ 4,338,633
State-only prenatal	$ 240,448

GLOSSARY

Appropriation

A legislative spending authority for a specific purpose, as contained in the Long Bill and special bills.

Cash Funds Exempt

Revenues that are exempt from the 'Taxpayers' Bill of Rights (TABOR) limitation such as: donations, collections from a previous year or revenues transferred from another agency.

Federal Funds

Matching revenues from the federal government based on a percentage of state expenditures.

General Fund

State revenues collected through taxation that are legislatively appropriated to various financial priorities statewide.

APPENDIX
ENROLLMENT CAPS/FREEZES
EXCERPTED FROM THE LITERATURE

The following information is excerpted from literature on the implementation of enrollment limitations in SCHIP Programs. Specifically, the material is from:

- State Experiences with Enrollment Caps in Separate SCHIP Programs
  National Academy for State Health Policy. C. Pernice, D. Bergman. February 2004.
- **Kaiser Commission on Medicaid and the Uninsured (Out in the Cold: Enrollment freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children by Donna Cohen Ross and Laura Cox 12/03)**

This information is provides some background on the strategies used by Colorado in implementing enrollment limitations.

National Academy for State Health Policy (Overview 02/04)
Some states have chosen to contain costs by limiting enrollment in their SCHIP programs either by capping or freezing enrollment. An enrollment cap allows a state to establish a certain number of eligibility slots for children; as some children leave the program, new children are enrolled to take their place. An enrollment freeze, on the other hand, prevents new applicants from enrolling after a certain date. Enrollment declines as children leave the program and continues to decline until enrollment is reopened and new applications are accepted.

In instituting either an enrollment cap or freeze, states have relied on several different strategies for managing enrollment. One approach requires states to continue to accept applications and establish a waiting list from which to draw, as slots become available. (Medicaid home and community-based waiver programs use this method to fill the set number of slots identified in the waiver and approved by CMS.) States have also designated open enrollment periods, similar to those in the private health insurance market. Application and enrollment take place only during a time-limited period, which usually occurs once or twice per year. The time limit issue assures that open enrollment cannot continue to grow throughout the year and makes it unlikely that all potential eligibles can or will apply within the given time frame.

Kaiser Commission on Medicaid and the Uninsured (Out in the Cold: Enrollment freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children by Donna Cohen Ross and Laura Cox 12/03)
(This) survey of state enrollment freeze policies indicate that how an enrollment freeze is implemented matters.

When a state imposes a freeze, it stops enrolling eligible children in its SCHIP program. When a family submits an application on behalf of a child, the process initially proceeds as it would under normal circumstances. Under a part of federal law known as the "screen and enroll"

provision, the application is first screened to assess whether the child qualifies for Medicaid; children found eligible are enrolled in Medicaid. Children not eligible for Medicaid are then assessed to determine whether they qualify for SCHIP.

- The SCHIP-eligible children are put on a waiting list, as is the case in Alabama, Florida and Montana, or
- Families of the SCHIP-eligible children are notified that SCHIP enrollment is closed and they will have to re-apply on behalf of the child when enrollment reopens in the future. Colorado, Maryland, and Utah proceed in this manner.

Children who are already enrolled in SCHIP can retain their coverage as long as they recertify their eligibility and pay any required premium payments on time. If their families do not complete the renewal process on time or if their premium payments are not received on time, however, the child loses SCHIP coverage and becomes uninsured. If the family subsequently re-applies, the child will be placed on the waiting list or informed that enrollment is closed, depending on the state.

Generally, all new SCHIP applicants are subject to the enrollment freeze, with few or no exceptions. Some states may exempt one or a few specific categories of applicants from the freeze, such as the children of military personnel no longer on active duty who were previously enrolled in SCHIP.

- Newborns may be barred from the program and remain uninsured. In Colorado and Montana, newborns are exempt from the freeze if they have older siblings enrolled in SCHIP. (Utah is considering this policy.)
- Children who lose Medicaid coverage because their family income increases became uninsured. Under normal circumstances, children enrolled in Medicaid may "roll over" or transfer into their state's separate SCHIP program if their family income increases above Medicaid income limit but remains below SCHIP income limit.

  (In states with enrollment freezes, however, such children would generally be considered "new applicants" to SCHIP and would be subject to the enrollment freeze.)

- Six-year-olds and one-year-olds who previously were enrolled in Medicaid can become uninsured. The age-based eligibility structure of most states' children's health coverage programs puts young children enrolled in Medicaid at increased risk of becoming uninsured if a SCHIP enrollment freeze is in effect.
- Children subject to the freeze may lose the value of 12-month "continuous eligibility" and remain uninsured for part of the year.
- Children may be required to be uninsured for a period of time after the enrollment freeze is lifted.

In addition to informing the public at large about the enrollment freeze, there also is a need to inform current enrollees about the freeze and what they need to do to safeguard their child's eligibility . During the freeze, the importance of completing the renewal process on time and paying premiums on time increased emphasis. The headline on a notice "Renewing your children ON TIME is more important than ever.

State Experience with Enrollment Caps in Separate SCHIP Programs by Cynthia Pernice and David Bergman (02/04)

Among the other changes that an enrollment cap may require is a re-examination of processes. States reported that, while CMS does allow for waiting lists, states must still screen for Medicaid. States that have implemented an eligibility cap have also found it necessary to reeducate their customer service staff in order to properly convey the changes to families.