

Table of Contents

Section 1.	General Description and Purpose of the State Child Health Plans	-2-
Section 2.	General Background and Description of State Approach to Child	
	Health Coverage	-3-
	2.1	-3-
	2.2	-4-
	2.3	-11-
Section 3.	General Contents of State Child Health Plan	-13-
	3.1	-13-
	3.2	-15-
Section 4.	Eligibility Standards and Methodology	-18-
	4.1	-18-
	4.2	-24-
	4.3	-24-
	4.4	-26-
Section 5.	Outreach and Coordination	-30-
	5.1	-30-
	5.2	-36-
Section 6.	Coverage Requirements for Children's Health Insurance	-37-
	6.1	-37-
	6.2	-38-
	6.3	-55-
Section 7.	Quality and the Appropriateness of Care	-57-
	7.1	-57-
	7.2	-62-
Section 8.	Cost Sharing and Payment	-64-
	8.1	-64-
	8.2	-64-
	8.3	-67-
	8.4	-67-
	8.5	-68-
	8.6	-68-
Section 9.	Strategic Objectives and Performance Goals for the Plan Administration	-70-
	9.1	-70-
	9.2	-70-
	9.3	-72-
	9.4	-77-

9.5	.....	-78-
9.6	.....	-80-
9.7	.....	-81-
9.8	.....	-81-
9.9	.....	-81-
9.10	.....	-83-
Section 10.	Annual reports and Evaluations	-86-
10.1	.....	-86-
10.2	.....	-86-
10.3	.....	-88-
10.4	.....	-88-
Attachment A:	Child Demographics	-89-
Attachment B:	Benefit Plan	-92-
Attachment C:	Actuarial Certification	-107-
Attachment D:	Hospital Tax Exhibits	-114-
Attachment E:	<i>HealthPrint</i>	-129-

**State Child Health Plan Under Title XXI of the Social Security Act
State Children's Health Insurance Program**

[Required under 4901 of the Balanced Budget Act of 1997 (New Section 2101(b))]

State/Territory: The State of Utah
Organization: Department of Health
Address: Martha B. Cannon Health Bldg.
288 North 1460 West
Salt Lake City, Utah 84116
Supervising Official: Rod L. Betit

Rod L. Betit
Executive Director
Department of Health

April 1, 1998
Date Signed

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

Michael O. Leavitt, Governor
The State of Utah

April 1, 1998
Date Signed

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

SECTION 1. GENERAL DESCRIPTION AND PURPOSE OF THE STATE CHILD HEALTH PLANS (SECTION 2101)

The state will use funds provided under Title XXI primarily for:

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103);¹ OR
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); OR
- 1.3. A combination of both of the above.

¹While the state has designated CHIP as a state insurance plan under subsection 1.1., the DOH is still pursuing the use of VFC vaccines for CHIP eligibles which HCFA has disallowed to date. As a result of the continuing investigation and pursuit of this reasonable objective, the state may wish to change its designation to subsection 1.3 at a later date in order to access VFC.

SECTION 2. GENERAL BACKGROUND AND DESCRIPTION OF STATE APPROACH TO CHILD HEALTH COVERAGE (SECTION 2102 (A)(1)-(3)) AND (SECTION 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

The following table presents Utah's current estimates on the number of children 0-18 years of age in the state population, the number uninsured, the total number insured, the number insured by public means (Medicaid), and the number insured by private plans. The population estimates are based on the *Health Status Survey*, conducted by the Department of Health, Office of Public Health Data. See Attachment A for further methodology and statistical detail.

Insured and Uninsured Utah Children by Poverty Level, Age, Race/Ethnicity, and Wasatch Front Residence; Age 0-18, 1998 ¹					
Demographic Subgroups	Population Distribution ¹	Number of Uninsured Children [*]	Number of insured Children ¹	Number Insured by Medicaid ²	Number Insured by Private Plans ²
1998 Utah Population	736,109	62,500	673,600	34,400	639,200
Household Poverty Level					
<100%	64,041	12,500	51,500	21,700	29,800
100%-133%	68,458	10,600	57,900	4,600	53,200
133%-200%	168,569	20,800	147,800	3,500	144,300
Over 200%	435,777	19,300	416,560	4,600	411,900
Total, Children <= 18	736,109	62,500	673,600	34,400	639,200
Age Group					
Less than 1 year	42,398	3,400	39,000	4,100	34,900
1 to 5 years	198,924	22,600	176,300	12,100	164,200
6 to 12 years	258,358	23,000	235,400	8,600	226,700
13 to 18 years	236,429	13,800	222,600	10,100	212,500
Total Children <= 18	736,109	62,500	673,600	34,400	639,200
Race/Ethnicity					
American Indian - N	6,625	1,000	5,600	700	4,900
Hisp	8,833	200	8,600	0	8,600
Asian/Pac. Island - N	3,681	600	3,100	800	2,300
Hisp	665,443	51,400	614,000	28,900	585,100
Black - N Hisp	52,264	10,000	42,300	3,300	39,000
white - N Hisp	736,109	62,500	673,600	34,400	639,200
Hispanic					
Total Children <= 18					

Demographic Subgroups	Population Distribution ¹	Number of Uninsured Children ²	Number of insured Children [*]	Number insured by Medicaid ²	Number insured by Private Plans ¹
Urban/Rural Residence					
Wasatch Front (Urban) ¹	562,344	45,500	516,800	24,400	494,400
Non-Wasatch Front (Rural)	173,765	17,000	156,800	10,000	146,700
Total, Children <= 18	736,109	62,500	673,600	34,400	639,200

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (section 2102)(a)(2)

It is important to understand the backdrop to CHIP; the state's undertaking to provide health coverage for the uninsured children of the state prior to the implementation of CHIP. The state legislature, at the request of Governor, Michael O. Leavitt, created the Health Policy Commission (HPC) to direct and oversee health care reform efforts based on the Governor's blueprint for reform: *HealthPrint* (See Attachment E for a copy of *HealthPrint*). The Governor sits a chairman of the HPC.

One of the primary, and first goals of *HealthPrint* was to expand Medicaid to provide coverage all children between the ages of 11 and 17 below the federal poverty level. This occurred in 1994. Also in 1994, insurance reforms included coverage for dependents up to the age of 26; guaranteed renewability; and a high-risk pool for coverage of high-risk children and adults having chronic, severe medical problems, but being ineligible for Medicaid.

In 1995, Medicaid was expanded to cover all aged, blind and disabled below 100% of the federal poverty level. Insurance reforms during this, and subsequent years included pre-existing conditions waivers, portability, and the establishment of community rating bands.

The state and the HPC has made steady progress of providing health care to children, reducing the number of uninsured children in Utah from 10.19% in 1991 to 8.57% in 1996. The implementation of CHIP fits in nicely with the continuing efforts of the state to provide coverage for all children in the state.

Many of the steps discussed in 2.2.1 and 2.2.2 are a result of the state's

commitment to provide better health coverage for its population and have been propelled by the health care reforms initiated by the Governor and the HPC.

To ensure coordination of state and private efforts described under subsections 2.2.1 and 2.2.2, the state has made a determination that CHIP needs to, and will be administered by the Department of Health

2.2.1. *The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):*

The Department of Health (DOH), through its Division of Health Care Financing (DHCF) has participated for many years in exceptional outreach efforts to reach children eligible for public health insurance programming. The department views outreach efforts as an opportunity to enhance the overall public health mission of the department. Outreach means not only carrying out an active seeking of Medicaid eligible clients, but a different way of treating families once enrolled.

Seeking Medicaid clients:

Since eligibility determination for Medicaid-only clients was transferred to the DHCF two years ago, the division has actively formed relationships with public programs that would be logical places for families to apply for Medicaid. The division takes referrals from such public organizations and from division on-site from the following programs:

Maternal and Child Health Block Grant — All local city and county health department clinics are staffed by on-site Medicaid worker(s) who take applications and maintain cases for any person wishing to apply. Offices are clearly marked and clinic front desk staff routinely refer individuals interested in applying for Medicaid to the on-site worker. Over one-half of the Medicaid workers are bi-lingual, speaking both Spanish and English.

WIC — all WIC clinics in urban areas located in city and county health clinics have a Medicaid worker available on site.

Training and presentationsto the WIC staff occur on a regular basis in all areas of the state. The WIC offices have Medicaid applications available to clients.

Head Start — AllHead Start registrations in the urban areas are staffed with Medicaid workers. In Salt Lake, each Head Start location is assigned to a DOH community administrative unit from which it receives personalized application assistance and training in addition to taking applications at registration.

Community and Migrant Health Centers — Each center in an urban area has an on-site Medicaid worker who takes applications and maintains all cases for any person who wishes to apply. Offices are clearly marked and clinic front desk staff routinely refer individuals interested in applying for Medicaid to the on-site worker. Over half of the Medicaid workers are bilingual, speaking both Spanish and English.

Special state programs — On-site Medicaid workers are assigned to the Family Health Services Children's Special Needs Clinic and to the main office in Salt Lake City for the developmentally disabled/mentally retarded waiver clients of the Division of Services for People with Disabilities (DSPD).

Overall, the number of community locations where a client can apply and maintain eligibility for Medicaid has risen in four years from zero to over thirty-three locations.

Change in how Medicaid clients are treated:

Medicaid staff are encouraged to view medical assistance as part of a preventative, public health focus. DOH eligibility workers do not stop with an eligibility determination; they are charged with finding clients access to medical care. The practical result of this change in focus is a significant reduction in paperwork for clients, high marks on customer service from clients, and a "de-linking" in family minds of medical assistance from the more traditional welfare programs. DOH staff have become medical resource experts for their communities.

In addition, Medicaid clients can choose their office, worker, and form of interview (in person or by telephone) in the Salt Lake area;

staff are encouraged to make Medicaid service for eligible clients an easy, friendly process by removing paperwork barriers for continued participation;

a telephone interviewing unit with a toll free number, specializing in foreign languages, is available to any client in Utah;

staff uses telephone interviewing extensively to reduce the "hassle" factor of office visits.

The following DOH programs and relationships are in place:

Baby Your Baby (BYB):

Baby Your Baby is a statewide outreach campaign which encourages early prenatal care and well child care, and promotes awareness of other important maternal and child health issues. Baby Your Baby began in 1988 and is one of the most successful public/private partnerships in the state. Partners include the Utah Department of Health, KUTV—the local CBS affiliate, Intermountain Health Care, and the Williard L. Eccles Charitable Foundation. The campaign consists of broadcast television and radio elements, including public service announcements and news programs, print support materials, and a 1-800 hotline. The Baby Your Baby hotline is an integral part of this outreach campaign. Each year, the hotline answers more than 18,000 calls, refers an average of 7,000 women for prenatal care, and 800 children for well child care. The hotline number is advertised on television and radio, newspapers, posters, pamphlets, telephone directories/yellow pages, and through various educational and promotional materials. Utahns recognize Baby Your Baby as a highly effective public education and health care referral system. A Dan Jones & Company survey showed that Baby Your Baby enjoys a 92% name recognition throughout the state. Baby Your Baby has received more than 50 awards including the prestigious Healthy Mothers/Healthy Babies National Recognition for the best sustained public information campaign in America.

Check Your Health:

The Check Your Health campaign began in 1995. The current objective of the campaign is to help parents make wise choices about their family's health care and to make families aware that

financial assistance is available through Medicaid's Child Health Evaluation and Care Program (CHEC). Public service announcements instruct viewers to call the Check Your Health hotline if they need help getting preventive health and dental care for their family. This campaign currently features a regular rotation of different television and radio public service announcements.

In connection with this campaign, the department recently developed the "CHECK DECK", a set of handy cards which provide information about how to stay healthy and how to make good decisions about health care services. The cards cover preventive health care, managed care, and health promotion topics. Check Decks are advertised on television and are distributed free-of-charge throughout the state.

The Check Your Health hotline receives about 1,000 calls a year.

Hotline Staffing:

A staff of four individuals; one coordinator and three "resource specialists," answer calls from the Baby Your Baby and Check Your Health hotlines. These health department employees are not medically trained, but possess excellent telephone and communication skills. The majority of calls received through the hotlines are resource and referral in nature. However, when calls of a more medical nature are received, medical professionals within the health department act as backup. The hotlines use AT&T's Language Line when translation services are needed.

Every Child by Two:

The Every ***Child by Two*** statewide Task Force was formed in 1993, to address the low immunization levels among two year olds in Utah. Using an immunization mobile clinic called the Care -A-Van, and a statewide media campaign, the campaign educates parents about immunizations, reminds them to immunize their children, and has a hotline for further information.

Women Infants and Children's Program (WIC):

WIC has clinics located statewide that serve 46,462 children ages 0-5 years who are at or below 185% of poverty. Only half of the

WIC clients are currently on Medicaid. All WIC clinics in urban areas located in City/County Health clinics have a Medicaid worker available on site. Training and presentations to WIC staff occur on a regular basis in all areas of the state. WIC offices have Medicaid applications available to all clients.

Maternal and Child Health Block Grants (MCH) to Local Health Departments:

MCH funded well child clinics, offered in 51 sites statewide, identify and refer Medicaid eligible children to eligibility workers. All urban City/County Health Department clinics are staffed by on-site workers who take applications and maintain cases for persons who wish to apply.

Early Intervention Programs:

Early Intervention Programs, providing services in 19 sites statewide, identify and refer Medicaid eligible children to eligibility workers.

Children With Special Health Care Needs Clinics (CSHCN):

CSHCN clinics identify and refer Medicaid eligible children to eligibility workers. These clinics currently serve many uninsured children throughout the state. They also refer children to the High Risk Insurance Pool.

Fostering Healthy Children Program:

Fostering Healthy Children is a program provided under contract to the Department of Human Services for children in foster care and other placements. The program routinely links children with health services and providers.

School and Education Sites:

School sites and school nursing staff routinely link children and families to health services and providers. School based and school linked health centers, at three sites in the state, offer identification and referral of Medicaid eligible children. One Medicaid eligibility worker is currently placed in a highly impacted elementary school in

an urban area. Medicaid workers staff all Head Start registrations in the urban areas. In Salt Lake, each Head Start location is assigned to a DOH community administrative unit from which it receives personalized application assistance and training in addition to taking applications at registration.

Smile Factory:

The *Smile Factory*, implemented in 1986, is a dental prevention program provided in at risk elementary schools. The program is now associated with the Families Agencies Communities Together (FACT) initiative (See 2.2.2.). The program provides dental screenings by a local dentist or state dental hygienist. Children are provided with fluoride prescriptions as needed and FACT or school nurses link children needing care to local dental providers. The program links children with Medicaid as needed.

2.2.2. *The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:*

The Utah Department of Health has many public private partnership initiatives currently in place to identify and offer enrollment to all uncovered children who are eligible to participate in public health insurance programs. The following Department of Health public private partnership initiatives are currently in place:

Hospital Sites:

All of the major hospitals serving low-income persons have on-site Medicaid eligibility workers. Small facilities have itinerant services available to their clients.

Children With Special Health Care Needs Clinics (CSHCN):

CSHCN clinics identify and refer Medicaid eligible children to eligibility workers. These clinics currently serve many uninsured children through the state. They also refer children to the High Risk Insurance Pool. Primary Children's Medical Center and Shriners Hospital have CSHCN clinics that provide identification of uninsured children needing specialty care.

Blue Cross/Blue Shield Caring Program:

The *Caring Program* currently seeks to provide basic health insurance coverage to children not eligible for Medicaid in Utah. It covers the cost through private donations.

School Based/Linked Health Centers:

Utah currently has three school based elementary health centers that are funded through public private partnerships. School based and school linked health centers, at three sites in the state, offer identification and referral of Medicaid eligible children.

Families Agencies and Communities Together Initiative (FACT):

FACT is a statewide interagency initiative that provides comprehensive wrap around services to children and families through school based programs and 29 county Local Interagency Councils. The site based teams are in 107 Chapter I elementary schools and identify children who are eligible for Medicaid and refer to eligibility workers. Medicaid eligibility workers are currently located in two of these low income schools. The sites at the local level bring together many unique public private partnerships that serve to outreach to children and families.

Conferences and Community Events:

Each year many are reached in unique public private partnerships with community advocacy groups. The Utah Issues Annual Conference and the Care Fair implemented by the Junior League are two examples of this. The programs routinely link children and their families with health services and providers.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)

The DOH has close working relationships with many low income community organizations (Association for Utah community Health Centers, Utah Issues, United Way, city and county health departments), and most large medical and insurance providers in the state. Close ties are maintained

with the Department of Workforce Development where many low income families will have contacts. The DOH has an extensive network of workers in hospitals, clinics, community health centers, and city and county health departments across the state. The department would use these extensive contacts, networks, and inter-departmental relationships to investigate and procure creditable coverage for children. Results on available creditable coverage would be provided to families, in addition to the information provided on CHIP eligibility, through the means set forth in Section 2.2.

CHIP enrollment will be done by every DOH Medicaid worker. The worker will first complete a Medicaid evaluation to determine Medicaid eligibility before certifying the individual for CHIP.

--	--	--	--

SECTION 3. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN (SECTION 2102)(A)(4))**3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)**

Within the Department of Health, the DHCF currently contracts with six managed care organizations to provide medical care for children enrolled in Medicaid, and residing in urban areas; i.e., the Wasatch Front, which includes Davis, Salt Lake, Utah and Weber counties. The list includes:

IHC Health Plans,
 Med Utah (Regence Blue Cross / Blue Shield of Utah),
 UnitedHealthCare of Utah,
 University Health Network,
 PacifiCare of Utah, and
 American Family Care.

These managed care organizations have extensive provider networks that operate in the four urban counties and include all the major hospitals, physician groups and clinics (both primary care and specialists), and specialty providers such as home health, physical therapy, and hospice. The experience of the Bureau of Managed Care (BMC), within the DHCF, in contracting with multiple managed care organizations demonstrates an ability to develop and maintain provider networks. The availability of these extensive networks within the managed care organizations improves access and continuity of care provided Medicaid enrollees.

In the rural areas of the state—outside Weber, Davis, Salt Lake and Utah Counties—the DHCF purchases services from providers on a fee-for-service basis. The network of rural Medicaid providers and their participation is extensive. The DHCF recently conducted a study on rural primary care physicians and their participation in the Medicaid program. The study was conducted to demonstrate to the federal government that Medicaid reimbursement rates were sufficient to ensure physician participation in the program. The results of the study show that participation in the Medicaid program by physicians who serve children—family and general practitioners, and pediatricians—is virtually 100%. There is no reason why CHIP enrollees will not enjoy the same rate of participation.

As the agency designated to implement the Utah Child Health Insurance

Program, the DOH will offer its long-time experience in working with managed care organizations and negotiate contracts with any willing provider to serve CHIP enrollees in both urban and rural areas of the state. Offering services through more than one network of providers will give CHIP enrollees greater access and continuity of care through a greater choice of health care providers.

Additionally, the DHCF will explore the feasibility of contracting with insurers having plans which cover the rural areas of the state to provide coverage with the premiums being paid by the program.

The issues of language and hours of service barriers will be critical in serving CHIP enrollee. Current Medicaid contracts require interpretive services to be provided. For example, current contracts state:

The contractor will minimize, with a goal to eliminate, enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities...The contractor shall provide interpretive services for languages on an as needed basis. These requirements shall extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the contractor and contractor providers and receive coverage benefits. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate....

Materials written in a language other than English are a contract requirement of HMOs/MCOs when the non-English speaking population represents 5% of the total population.

The DHCF also has contracts with the Catholic Community Services and International Rescue Foundation to provide interpretative services for Medicaid recipients. If necessary, DHCF will develop additional contracts with these organizations to serve the new CHIP population.

Hours of service barriers are a general problem of the current health delivery system—public or private. The DHCF and its contracting HMOs use Community Health Centers, extended hours clinics, and urgent care centers to partially address this systemic problem. In addition, divisional contracts hold the HMOs/MCOs responsible for all covered emergency

services 24 hours a day and 7 days a week, whether services were provided in or out of the respective managed care organization. Contracts also state:

The Contractor will provide services which are accessible to Enrollees and appropriate in terms of timeliness, amount, duration, and scope.

Standards for waiting times for appointments and office waiting times have been established with all contracting HMO/MCOs. These standards are monitored.

The described requirements and standards will be part of the contracts the department develops with participating managed care organizations/HMO's to serve the Children's Health Insurance Program.

All of the above areas are part of the state's HMO Quality Assurance Monitoring Plan and are monitoring during annual on-site reviews. CHIP will be included in this monitoring.

10% set-aside of federal funds — As described in the HCFA letter of February 24, 1998 from Sally K. Richardson, the DOH recognizes the the many serious health conditions and diminished access to health care of American Indian children. The DOH is planning to use the allowable 10% side-aside funds to assist in the administration of the program. Additionally, the set-aside funds will enable the department to provide special outreach efforts to these children and to provide some non-traditional services to Indian children who qualify for CHIP; services which come from the community itself, defined by the community.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (section 2102)(a)(4)

Quality care is cost-effective care. The DHCF has established internal procedures to ensure that quality care is delivered in a cost-effective manner. Two of the most important procedures are outlined in the HMO contracts, and are overseen through contract monitoring. The DHCF contracts require each HMO to have a utilization plan. The plan must include aspects that guard against the unnecessary use of services, as well as to ensure that services are provided, when necessary. Careful and

close monitoring by the DOH is essential for the fair implementation and operation of HMO plans.

Each contracting HMO/MCO has a utilization management department which conducts prior authorizations, concurrent review, prospective review and retrospective review. The health plans conduct quality assurance activities to identify both overutilization and underutilization of services.

Evaluation of the utilization review activities are part of the quality assurance monitoring of the DOH, conducted in several ways.

First, an annual on-site review is conducted following the Utah State HMO Quality Assurance Monitoring Plan. During these reviews, the utilization management activities are evaluated by examining processes, studies, and quality improvement activities resulting from studies and grievance reports. Along with staff from the DHCF, staff from the Division of Community and Family Health Services—with expertise in maternal and child health, children's health, and children with special health care needs—address quality and utilization issues concerning maternal and child populations, as well as others, during the on-site reviews. Staff identifies deficiencies and offers suggestions for improvement following the on-site review.

Secondly, the DHCF health program representatives (HPRs) located at various family support offices serve as patient advocates to assist clients in accessing services. HPRs keep a list of providers who contract with the various HMOs and the HPRs may contact the HMO on the client's behalf.

Lastly, the DHCF has a complaint/grievance program that allows clients and providers to call and voice their problems. The DHCF staff works with the HMO/MCO's to resolve the problems and issues where a client may not be getting home health services or other services directly affecting the client's care are usually resolved within 24 hours. These existing monitoring procedures will be extended to CHIP.

A procedure that is in place for utilization review for fee-for-service clients has several components. One component is the Superior System Utilization (TSU) waiver granted by the federal government. Normally, the DHHS requires that hospital utilization be monitored according to strictly defined federal regulations. Since the DHCF found those regulations inadequate and burdensome for the division and its providers, a waiver request was submitted. The DHHS accepted the suggested alternative plan which has been renewed several times. This plan is used to monitor the utilization of

hospital services by clients and CHIP participants will be added as a stratified segment of the TSU waiver. Mandatory reviews by category of service are another component of utilization control. Each month, a statistically reliable sample is taken from selected programs and reviewed to determine if the care provided was medically necessary. If a situation appears questionable, an in-depth examination is done. If services are provided which are deemed not medically necessary, the provider is notified, additional information is requested, and the process is pursued until either the DHCF is satisfied or the funding is recouped from the provider. Such reviews will be carried out on CHIP enrollees. Still another important component is the focused review. Through the federally approved SURs, and by specific referral, the DHCF is able to identify situations which require evaluation. Accordingly, divisional staff focus attention on selected areas of interest. Focused reviews are valuable in ensuring proper utilization of services. Focused reviews will be a primary technique in utilization control in CHIP. While coverage for CHIP enrollees will be provided by any willing managed care plan. With the plans having the responsibility for such reviews, It would be impossible to describe each plan's specific approach, but these DHCF internal procedures show the level of sophistication that DOH will expect from the plans providing coverage to CHIP enrollees.

Other procedures and methods are employed to foster proper utilization. These include, but are not limited to, referrals and coordination with the Utah Division of Investigations, Medicaid Fraud and Abuse (DIMFA). When negotiation and education are used with no effect on chronic and persistent patterns of abuse, the DHCF coordinates with the DIMFA. Should circumstances within CHIP require actions concerning fraud and abuse, the lines of communication, cooperation and coordination are well established and functional. Since CHIP is funded through state and federal dollars, and since medical programs have seen some problems with illegal behavior, this existing arrangement with the DIMFA is definitely an advantage to CHIP.

--	--	--	--	--

SECTION 4. ELIGIBILITY STANDARDS AND METHODOLOGY. (SECTION 2102(B))

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

4.1.1. Geographic area served by the Plan:

CHIP assistance will be available statewide.

4.1.2. Age:

Children under the age of 19 will be eligible for CHIP assistance. The month a child turns 19 years old will be the last month of eligibility.

4.1.3. Income:

Except as specifically excluded in this section, all gross earned income of any household member will be counted as family income for determining CHIP eligibility including, but not limited to, wages, salaries, commissions, self-employment income, and income paid under a contract.

Except as specifically excluded in this section, all gross unearned income of any household member will be counted as family income for determining CHIP eligibility including, but not limited to, public assistance payments, child support, alimony, Social Security benefits, pensions, unemployment compensation, workers compensation, and interest.

The following income is excluded from family income:

1. Income which is required to be excluded from income under other federal statutes;
2. Unearned income paid in-kind to a household member such as payments made to a third party for food, shelter, clothing, or other needs;
3. Bona fide loans;
4. Death benefits to the extent the funds are spent on

the deceased person's last illness, funeral or burial expenses;

5. Reimbursements of Medicare premiums made by the Social Security Administration or by the state Department of Health;
6. Educational income such as grants, scholarships, fellowships, educational loans, and work-study income provided the individual is enrolled in an educational program;
7. Needs-based veteran's pensions;
8. Reimbursements for expenses incurred by the individual; and
9. Child care assistance paid under Title XX of the Social Security Act.
10. The first **\$1,620** of earned income a child earns in a year will be excluded from household income if the child meets the following criteria:
 - a) the child is a student who is regularly attending school, which includes secondary school, post-secondary school, vocational and trade schools;
 - b) the child is under age **19**; and
 - c) the child is not the head of the household.

The child must be attending school at the time of application for CHIP, or be expected to return to school during the certification period to receive this exclusion. The \$1,620 exclusion applies to income expected to be earned during the 12 month certification period for CHIP eligibility.

The following income will be counted as family income:

1. Rental income except that the following expenses may be deducted:

- a) taxes and attorney fees needed to make the income available,
 - b) upkeep and repair costs necessary to maintain the current value of the property,
 - c) interest only on a loan or mortgage secured by the rental property; and
2. The value of income paid in-kind for which the individual performed a service or which is provided as part of the individual's wages from employment.

Income Standard:

Gross countable family income must be equal to or less than 200% of the federal poverty guideline for a family of the size involved.

Budgeting:

The department shall determine family income prospectively for the upcoming certification period at the time of application and at each recertification for continuing eligibility. Gross income of all household members which is not excluded is counted as family income. The department shall determine the household's average monthly income for the upcoming 12-month certification period based on last year's income, or an estimate of the average monthly income the household expects to receive. Income which ~~is~~ received ~~less~~ often than monthly will be prorated over the certification period to determine an average monthly income. The best estimate may be a monthly amount that is expected to be received each month of the certification period, or an annual amount which is prorated over the certification period.

If income is received weekly, the average weekly amount is multiplied by 4.3 to obtain a monthly amount. If income is received every other week, the average bi-weekly amount is multiplied by 2.15 to obtain a monthly amount.

Farm and self-employment income is determined by using the individual's recent tax return forms. The annual income is

divided by **12** to determine the monthly income for the upcoming certification period. If prior tax returns are not available, the department shall request income and expense information from the most recent period of time for which an individual has records. Expenses will be deducted from gross income to determine the countable income of the individual. For self-employment and farm income, the department will deduct the same expenses from gross income which the Internal Revenue Service allows as deductions.

4.1.4. ☒ Resources (including any standards relating to spend downs and disposition of resources):

There will be no resource test for CHIP eligibility.

4.1.5. ☒ Residency:

Citizenship and Alien Status.

1. To be eligible to receive CHIP benefits, an individual must be a citizen of the United States or a qualified alien as defined in Public Law **104-193 (401)** through **(403)**, **(411)**, **(412)**, **(421)** through **(423)**, **(431)**, and **(435)**, and amended by Public Law **105-33(5302)(b) & (c)**, **(5303)**, **(5305)(b)**, **(5306)**, **(5562)**, **(5563)**, and **(5571)**.
2. Hmong or Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and who are lawfully admitted to the United States for permanent residence, and their family members who are also qualified aliens, may be eligible for CHIP benefits regardless of their date of entry into the United States.
3. A qualified alien, as defined in Pub. L. No. **104-193 (431)** and amended by Pub. L. **105-33(5302)(c)(3)**, **(5562)**, and **(5571)**, admitted into the United States prior to August **22, 1996**, may receive Child Health Insurance Program benefits.
4. A qualified alien, as defined in Pub. L. No. **104-193**

(431) and amended by Pub. L. 105-33(5302)(c)(3), (5562), and (5571), newly admitted into the United States on or after August 22, 1996, may receive Child Health Insurance Program benefits after five years have passed from the person's date of entry into the United States.

State Residency.:

1. To be eligible to receive benefits from the Child Health Insurance Program, a child must be a resident of the state of Utah. The definition of residency for CHIP will be based on the residency of the parent(s) of the child. Utah residency for an adult or an emancipated individual is a matter of intent and domiciliary: if the individual is residing in Utah and intends to be a resident.

Proof of residency may include the school records of the child, parental items such as utility bills, or a signed declaration by the parent. Any dispute over residency will be settled based on the physical presence of the child at the time of application.

2. An American Indian child in a boarding school and a child in a school for the deaf and blind are residents of the state where their parents or legal guardian reside.
3. An individual is a resident of the state if they are temporarily absent from Utah for purposes of employment, schooling, vacation, medical treatment, or military service.

4.1.6. ☒ *Disability Status (so long as any standard relating to disability status does not restrict eligibility):*

Disability is not a consideration in the determination of disability. CHIP benefits are provided to an eligible child regardless of disability or medical condition.

4.1.7. ☒ *Access to or coverage under other health coverage:*

A child who is covered under a group health plan or under

other health insurance coverage including coverage which is available through a parent's or legal guardian's employer, as defined by HIPAA, is ineligible for CHIP coverage. If a parent has access to health insurance at a premium equal to, or less, than the CHIP premium, the child is ineligible for CHIP.

4.1.8. ☒ *Duration of eligibility*

The eligibility period will begin with the date of application and will end on the last day of the twelfth calendar month after the month an application is received. The continuing eligibility period will last for twelve calendar months (Refer to "*Recertification/ Termination of Coverage*, page XXX).

Coverage for a child who turns 19 years of age will end on the last day of the month in which the 19th birthday occurs.

4.1.9. ☒ *Other standards (identify and describe):*

Household Composition:

1. The following individuals who reside together must be included in the household for purposes of determining the household size and whose income will be counted, whether or not they are eligible to receive benefits:
 - a. A child who meets CHIP age requirement,
 - b. Siblings, half-siblings, adopted siblings, and step-siblings of the child who meets ~~CHIP~~ age requirement if such individuals also meet CHIP age requirement,
 - c. Parents of any child who is included in the household size,
 - d. Children of any child who is included in the household.
2. Any individual described in number 1 who is temporarily absent solely by reason of employment, school, training, military service, or medical treatment, or who will return home to live within 30 days from the date of application is part of the household.

- 3. Household members who **do** not qualify for CHIP due to their alien status must be included in the household size and their income will be counted.
- 4. If an individual is caring for a child of his or her former spouse, in the case where a divorce has been finalized, the household may include that child in the household if the child resides in the home and meets CHIP age requirement.

Institutional Status:

Residents of public institutions or of institutes for mental disease are not eligible to receive CHIP benefits.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1. *These standards do not discriminate on the basis of diagnosis.*

The state hereby makes this assurance.

- 4.2.2. *Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.*

The state hereby makes this assurance.

- 4.2.3. *These standards do not deny eligibility based on a child having a preexisting medical condition.*

The state hereby makes this assurance.

4.3. Describe the methods of establishing eligibility and continuing enrollment. Section 2102)(b)(2))

Enrollment Procedures:

To apply for CHIP benefits, individuals may file an application in person, over the telephone, or through the mail. A combined, newly named form will be used to apply for both Medicaid and CHIP. Applications will be accepted at any Department of Health, Bureau of Eligibility Services local

office, outreach location, or telephone unit. Applicants may also apply for CHIP through the mail. The date of the application shall be the day the signed application form is received. When applying over the telephone, the application date will be the date of the telephone contact.

After receiving an application, eligibility workers will complete an interview with the applicant in person or by telephone. The eligibility worker will request any information necessary to determine eligibility. Such information must be provided by the applicant within thirty (30) calendar days of the application. The application is complete on the date that all required information is received. Eligibility workers will determine eligibility for Medicaid first. If the applicant is not eligible for Medicaid, a determination of CHIP eligibility will be made.

A determination of eligibility must be made within 30 days of the date of application.

Re-certification/Termination of Coverage:

The department will complete a re-certification of CHIP eligibility in the twelfth month following the month of application. Recertification forms will be mailed to the recipient in the 11th month of the certification period. The recipient must complete the recertification forms and return them to the Bureau of Eligibility Services worker by the first working day of the recertification month. If the child continues to be eligible, coverage will continue for an additional 12 months.

If the recipient returns the recertification forms and/or required verifications after the end of the recertification month, the department will treat it as a new application for CHIP benefits. Coverage for continued benefits will begin on the date the recertification form and/or verifications are received by the department, if the child continues to be eligible.

CHIP coverage will terminate for the following reasons:

- a) the child reaches the age of **19**;
- b) the child becomes eligible for Medicaid;
- c) the child is deceased;
- d) the child no longer resides in the state and is not expected to return;
- e) the child has coverage or access to coverage under a group health plan or other health insurance coverage; or
- 9** the child has entered a public institution or an institute for mental disease.

In addition, eligibility will not be renewed upon annual re-certification for all of the above reasons, or if the family's gross countable income exceeds the eligibility criteria.

During the 12-month CHIP eligibility period, recipients of CHIP benefits are required to notify the agency if any of the above mentioned circumstances change, except a change in income. These changes must be reported within 10 days of the date the client learns about the change. If these changes occur during the 12-month CHIP eligibility period, CHIP eligibility will end on the last day of the month in which it is determined that the child no longer qualifies for CHIP. For children who turn 19 during the 12 month certification period, their eligibility will end on the last day of the month in which their 19th birthday occurs.

Case Closure or withdrawal:

CHIP benefits will be terminated upon recipient request or when the recipient is no longer eligible. An applicant may withdraw an application for CHIP benefits any time prior to approval of the application.

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (section 2102)(b)(3)(A))

Applications for CHIP benefits will be taken and processed by Medicaid eligibility workers. The application will request information about health insurance coverage for the children in the household, including information about available coverage whether or not the applicant has elected such coverage. Workers will interview applicants to determine if there is any available health insurance coverage for any of the children. The first step of the eligibility determination process will be to determine if any of the children qualify for Medicaid. Since Medicaid eligibility workers will be processing all CHIP applications, they are qualified to make the Medicaid determinations. Any child who is eligible for a Medicaid program (except for the Medically Needy program with an unmet spenddown) will be enrolled in Medicaid.

Any child who is found to have insurance coverage available or who

is already covered by a group health plan or other health insurance coverage will be determined ineligible for CHIP. The eligibility worker will still complete a Medicaid determination for such children.

The department will exchange information with other state agencies which may have information about the availability of insurance coverage for children applying for or determined eligible for CHIP. This exchange of information will help identify possible coverage which may not have been disclosed during the application process, or which may become available at some later time during the certification period. Information exchanges may include exchanging information with the Office of Recovery Services, the Department of Workforce Services, and the Department of Human Services. The agency may also contact the parents' employers to request information about the availability of health insurance coverage for the children.

Clients are required to report to the department any time an eligible child begins to be covered under a health insurance plan and if insurance coverage becomes available. At each recertification, the client will be asked if any of the children now have access to or are covered by a group health plan or other health insurance coverage.

4.4.2. *That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B)*

As explained above in 4.4.1, Medicaid eligibility workers will be processing CHIP applications. The first step to determining eligibility for CHIP is to determine if any of the children in a household are eligible for a Medicaid program. If a child is found to be eligible for Medicaid, the child will be enrolled in the Medicaid program instead of CHIP. If the child is found to be eligible only for a medically needy Medicaid program requiring a spenddown of excess income, the family will be informed about such eligibility and asked if they want to meet the spenddown each month. If the family chooses to meet the spenddown each month, the child will be enrolled in Medicaid. If the family does not meet the monthly spenddown, the child will be evaluated for CHIP eligibility.

Any time a family reports a change which could cause an eligible child to become eligible under a Medicaid program, the eligibility worker will review the case to determine if the child qualifies for Medicaid. If the change causes a child to be eligible for Medicaid, then the child will be moved from CHIP to the Medicaid program.

At each recertification for CHIP eligibility, the eligibility worker will determine if any of the children can qualify for Medicaid before determining if they are eligible for CHIP. Any child who is eligible for Medicaid at recertification will be enrolled in the Medicaid program.

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans.
(Section 2102)(b)(3)(C))

The CHIP application will ask whether the applicant has been covered either under individual coverage, or under an employer-sponsored coverage, during the three months prior to application for CHIP. An applicant will be ineligible for CHIP if the applicant has voluntarily terminated either employer-sponsored, or individual coverage within the three months prior to the application date for coverage under CHIP. However, an applicant who is involuntarily terminated from employer coverage is eligible for CHIP without a three month waiting period.

Both the CHIP application, and the eligibility worker, will inform the applicant that any concurrent coverage under a health benefit plan (including group or individual coverage) will deem the applicant ineligible for CHIP. The eligibility workers will verify this information with the families' employers, if necessary.

Employer coverage is defined for purposes of this section as an employer-sponsored health benefit plan where such employer contributes at least 50% of the cost of the employee's premium.

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care improvement Act, 25 U.S.C. 1603(c).
(Section 2102)(b)(3)(D))

Children who are covered by Indian Health Services will be eligible for CHIP coverage. CHIP policies will specify that such children are

--	--	--

eligible. Outreach efforts discussed in sections 5.1 will help identify and reach the Indian populations in the state so they are informed about CHIP and have access to apply.

Funds from the 10% set-aside will be used for outreach and to provide non-traditional services for eligible Indian children.

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

Please see section 2.2 and section 5.1. These sections discuss various outreach efforts, community awareness efforts, and partnerships with private health care providers.

--	--	--	--	--	--

SECTION 5. OUTREACH AND COORDINATION (SECTION 2102(c))

Describe the procedures used by the state to accomplish:

5.1 Outreach to families of children likely to be eligible for assistance or under other public or private health coverage, to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

The Department of Health views the outreach effort as an opportunity to enhance the overall public health mission of the department. The department will work to insure that transportation, language, and hours of service barriers do not prevent access. The department will use existing relationships to help identify potentially eligible children by inviting agencies to help design an outreach process that is tailored to their constituency's needs with the objective to reach all children who Medicaid cannot cover.

Identification of Target Populations of Potential CHIP Enrollees

Current Medicaid families — The DOH anticipates designing and scheduling a computer match of families already on Medicaid who have children without coverage; cases where younger children are covered because of the higher limits, with older children who are not; cases where families are spending down to cover a large medical bill and will cease coverage after the crisis is over; households in which one member is receiving medical coverage for a disability, while other children are not covered.

Current child care families — The department is discussing with the Department of Workforce Services the possibility of a computer match on child care cases without Medicaid. The income limits are 185% of poverty for child care.

Notification Strategies for Potential Clients

Identification through allied agencies — The department has begun to identify potentially eligible children by inviting allied agencies to help us design an outreach process tailored to the needs of their respective constituencies (See the last part of this section for a region by region listing of agencies). By such planning, the department expects agency awareness to be raised on the resources of both CHIP and of Medicaid program, in general.

Identification through church groups — The department has identified key

--	--	--

contact individuals in every major religious denomination in the state. The department will explore cooperative ventures to notify clients of potential benefits through whatever means religious leaders feel are appropriate for their respective congregations.

Identification through schools — The department believes one of its best resources will be elementary schools. Two schools currently have eligibility workers on-site, and plans call for a significant expansion in the number in the next year. Flyers from the PTA and the school administration will be sent home with the children. In addition, many of Medicaid staff have school age children. They will be asked to work directly with their children's school to offer the program.

General press coverage of existing outreach network — The DOH will publicize the Medicaid and CHIP network through community presentations and press coverage informing residents that Utah has in place an extensive network of community sites—ninety-eight locations to date—in place for eligibility determinations for access to medical care. DOH workers are in hospitals, community health centers, local health departments, Department of Workforce Services offices and many other allied agencies. Every worker in every location will act as that site's information specialist for CHIP and determine eligibility for the program. Managers for each area will track and tabulate these activities for a summary State report.

Development of advertising material — Brochures and flyers designed specifically for CHIP will be developed. Current Medicaid media products will be re-designed to include CHIP and used in the existing outreach programs sponsored by the DOH. EPSDT kids will be screen for direct mailings from the department. The following Department of Health outreach campaigns are currently in place:

- Baby Your Baby (KUTV)
- Baby Your Baby Parent Newsletters
- Check Your Health (KUTV)
- Child care licensing
- Ethnic Health Advisory Committee
- Every Child by 2 (KTVX)
- FACT
- Fit Kids
- Head Start
- Hotline (for all Media Campaigns)
- Local health department (51 sites statewide)
- Maternal and Child Health Block Grants (MCH)

Medicaid eligibility workers
Preschool
School/School nurse
WIC (serves **46,462** children ages **0-5** years, <185% of poverty)
UMA, Pediatric Society

The department will also ask that the Department of WorkForce Services to modify their PSA's to give information on the new program.

In addition to the aforementioned and described (Section **2.2.2**) activities, the following Department of Health outreach initiatives are also in place and will be expanded to target children who may be eligible for CHIP:

Early Intervention Programs — Early intervention programs, providing services in 19 sites statewide, identify and refer Medicaid eligible children to eligibility workers.

Children With Special Health Care Needs Clinics (CSHCN) — CSHCN clinics identify and refer Medicaid eligible children to eligibility workers. These clinics currently serve many uninsured children through the state. They also refer children to the High Risk Insurance Pool.

School and Education Sites — School sites and school nursing staff routinely link children and families to health services and providers. School-based and school linked health centers, at three sites in the state, offer identification and referral of Medicaid eligible children. In all sites various education and promotional materials are readily available. In Utah, of those children not having insurance, it is estimated that 58.6% are school aged. Utah will seek to include an insurance question on school registration forms and applications for free and reduced meals. School staff (Nurses, Counselors, Psychologists, Social Workers) will be provided training on identification of children without health insurance and linking them to eligibility and services.

Adolescents — Current outreach methodologies will be updated to reach middle and older teens statewide since they are different than those for preschoolers. Homeless adolescents will be contacted through the Homeless Youth Center. The state SSDI projects which targets adolescent health will include an insurance question on all surveys and forms. Questions about insurance could be added to college assistance applications for in-state schools.

--	--	--	--	--

Dental Health – The *Smile* Factory program can be expanded to cover more at-risk and highly impacted schools potentially covering K-12. The school sites would be identified by the dental health program in collaboration with local communities and agencies. These schools could be visited every other year. The program offers a vital component for dental health education, prevention, and referral. The program could include an insurance question on permission forms and follow-up materials. Current outreach methodologies will be updated to reach middle and older teens statewide.

Ethnic Populations – Medicaid has an agreement on a proposal with the Navajo Nation to place an on-site Navajo speaking Medicaid eligibility worker at the Monument Valley Medical Clinic. This worker would also serve the Montezuma Creek clinic. Both locations are traditional sites for tribal members to seek medical services.

Outreach will be done to Hispanic populations. Many of those who primarily speak only Spanish, are low-income, and are without health insurance for their children. Services for those who are qualified will be made through an enduring partnership with the Summer Education programs of the State Office of Education, programs within the Health Department in the Child, Adolescent and School Health Program, and with public private partnerships and contracts with groups outreaching to this population such as Holy Cross Ministries.

Hospital and Medical Care Sites – **All** of the major hospitals serving low-income persons have on-site Medicaid eligibility workers. Small facilities have itinerant services available to their clients. Local groups will be engaged to develop networks of community health care providers, hospitals, clinics, emergency rooms, pharmacies, and other health care agencies to distribute information on Medicaid and CHIP.

Child Care Arena – In Utah, those children ages 0-5 years not having insurance, it is estimated that 41.4% would be eligible for CHIP. Child care subsidy with the Department of Workforce Services could reach eligible clients who use cash out assistance for child care services. Child care licensing and child care providers offer potential sites of access.

Housing Assistance – Organizations that provide housing assistance or rental assistance will be asked to disseminate information about the

program and the referral process to potentially eligible families. Insurance questions could be added to applications for housing subsidy and in low income apartment complexes.

Worksite Outreach — Projects will be developed that target outreach activities to employers that do not offer health insurance coverage for their employees in collaboration with Workforce Services.

Community Based Organizations — Community based organizations will be asked to disseminate information about the program and the referral process to potentially eligible families. These organizations could include, but not limited to:

- After school programs
- Boys and girls clubs
- County recreation programs
- County extension programs
- Adult and community education programs
- Community centers
- Places of worship.

Regional Information Centers — In addition, the DOH will establish regional information centers with toll free calling staffed by at least two individuals to answer CHIP questions, mail application packets, and direct callers to the nearest local office.

Statewide Outreach Efforts — In addition to the mass marketing efforts already in place, plans are being developed or work is being done on contacting any organization or group in the state interested in CHIP. An objective is to clearly identify the DOH as the organization that will provide to any organization desiring CHIP information with presentations and eligibility determination. The DOH is already working with many organizations and is planning on contacting many more. While listing all of the agencies and organizations in Greater Salt Lake would be a herculean task, a sample list of organizations in the more rural parts of the state include:

- Boy Scouts of America
- City centers
- City managers in the rural regions
- Community Action programs
- Community councils
- Community health centers

- Community nursing services
- Community United Methodist Church
- County crisis centers
- County fairgrounds
- Day care centers
- Deseret Industries
- Division of Children and Family Services
- Elementary school clinics
- Family clinics
- Family counseling services
- Family dental plans
- Head Start and other pre-school centers
- Hill Air Force Base, Family Support
- Intermountain Specialized Abuse Treatment Center
- Libraries
- Local churches
- Local health clinics
- Local health departments
- Local mental health centers
- Low-Income housing complexes
- New York Life
- Planned Parenthood
- Regional and local hospitals
- Rescue missions
- School districts
- Social Security Administration
- Sport registration centers
- Swanson Foundation
- UnitedWay
- Universities and colleges
- Utah Power and Light
- Weber State University Dental Hygiene Program
- WIC enrollment sites
- YCC

A special project involving the Edison elementary school in Salt Lake City is a noteworthy example of the direction the DOH is taking. It is a cooperative venture comprising a variety of community groups, Community and Family Health Services, and the Graduate School of Nursing at the University of Utah. The project will link eligibility for Medicaid and CHIP with other community health resources and school nursing to improve the health outcomes of children.

Lastly, a simple, self-addressed postcard will be designed and widely distributed in agencies, schools, libraries, clinics, and other places where

people congregate, whereby families filling it out and mailing to the DHCF, would be contacted by an eligibility worker for an initial telephone screening on eligibility for CHIP.

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

Department of Health Medical workers will complete CHIP application process. The DOH will require all Department of Workforce Services workers to refer any case closed/denied for Medicaid for a CHIP eligibility review. All CHIP and Medicaid cases are recorded on the PACMIS computer system, so that case information will be easily accessible.

SECTION 6. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE (SECTION 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.7. The state elects to provide the following forms of coverage to children: (Check all that apply.)

6.1.1. Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1)). If checked, attach copy of the plan.

6.1.1.2. State employee coverage; (Section 2103(b)(2)). If checked, identify the plan and attach a copy of the benefits description.

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)). If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. *Benchmark-equivalent coverage; (Section 2103(a)(2)). Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.*

Attachment B provides the plan coverage, amount, scope and duration of services.

Attachment C provides the signed actuarial report.

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania]. Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

--	--	--

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

6.2. The state elects to provide the following forms of coverage to children; check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations: (section 2110(a))

6.2.1. Inpatient services (Section 2110(a)(1))

Scope of Coverage

Inpatient hospital medical and surgical care will be considered a covered benefit for a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility licensed and certified by the state of Utah.

Level of Coverage

For enrollees between 100% and 150% federal poverty level:

No co-payment or co-insurance due for inpatient and outpatient hospital services.

\$10.00 co-payment for each emergency department visit

For enrollees ^{between 100% & 200%} ~~above 150%~~ federal poverty level:

Inpatient and outpatient hospital services require co-insurance of 10% of the allowed amount. The allowed amount is the billed charge less 25%.

\$30.00 co-pay for each emergency room visit.

Exclusions

Hospital charges in conjunction with ineligible surgical procedures or related complications

Charges for treatment programs for enuresis (bed wetting) or encopresis.

Convenience items such as guest trays, cots, and telephone calls
Occupational therapy and recreational therapy

Whole blood, autologous (self) blood storage for future use

Hospital charges while on leave-of-absence

Charges incurred as an organ or tissue donor

Charges for custodial care, nutritional counseling, care, confinement or services in a transitional living facility, community reintegration

tion program, vocational rehabilitation, or services to re-train self care or activities of daily living.

6.2.2. Outpatient services (Section 2110(a)(2))

Scope of Coverage

Outpatient services are provided to enrollees at a licensed, certified hospital who are not admitted to the hospital. Services provided by a covered provider for medically necessary diagnosis and treatment of sickness, injury and other conditions. All services related to outpatient visits are covered, including physician services.

Level of Coverage

For enrollees between 100% and 150% of the federal poverty level:

%10 copayment for each emergency room visit (\$5 for physician services and %5 for hospital services.

For enrollees between 151% and 200% of the federal poverty level:

Co-insurance, 10% of the allowed amount. The allowed amount is the billed charge less 25%.

\$30.00 co-pay for each emergency room visit.

Exclusions

Same exclusions as in-patient services above.

6.2.3. Physician services (Section 2110(a)(3))

Scope of Coverage

Physician, physician-related, chiropractic and podiatry services provided to enrollees by a covered, licensed provider, for medically necessary and preventative services. Services provided directly by licensed physicians, or osteopaths, or by other licensed professional such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

The Health Plan shall provide to **CHIP** enrollees preventive screening services, including routine physical examinations and immuniza-

tions to all eligible children up to age **19**, in accordance with the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) periodicity schedules covered in full, with no co-payment or co-insurance required. The Health Plan will educate and encourage compliance with **AAP** periodicity schedules.

Level of Coverage

For enrollees between 100% and 150% of federal poverty level:

\$5.00 co-payment per medical visit.

No co-payment for well-baby care, well-child care and immunizations.

For enrollees between **151%** and 200% federal poverty level:

\$10.00 co-payment per medical visit.

No co-payment for well-baby care, well-child care and immunizations.

Exclusions

Eye glasses and contact lenses (with exception of one lens immediately following corneal transplant surgery or the contact lens necessary to treat keratoconus).

Examinations made in connection with a hearing aid.

Hormone injections or pellet implants (an allowance up to \$300 may be approved for injections when oral medication cannot be used).

Office visits in conjunction with hormone injections.

Charges for weight loss or in conjunction with weight loss programs.

Charges for medical hospital visits the same day or following a surgical procedure.

Charges for office visits in conjunction with allergy injection.

Health screening or services to rule out familial diseases or conditions without manifest symptoms.

Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.

Charges for nutritional counseling or analysis.

Charges for any injection when the material used is not identified.

Hypnotherapy or biofeedback.

Chiropractic or physical therapy primarily for maintenance care.

Injectable vitamins or their administration.

Experimental, investigational, or unproven medical practices.

Vision therapy.
 Tobacco abuse.
 Take-home medications from a provider's office.
 Treatment therapies for developmental delay or child developmental programs.
 Sublingual antigens.
 Roling or massage therapy.
 Hair transplants or other treatment for hair loss or restoration.
 Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD, or myofacial pain.
 Care, treatment, or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
 Charges for prolotherapy or chelation therapy. Office calls in conjunction with repetitive therapeutic injections.
 Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school.
 Medical or psychological evaluations for legal purposes such as custodial rights, paternity suits, disability ratings, etc., or for insurance or employment examinations.
 Charges for special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's practice.
 Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise program.
 Charges for sublingual or colorimetric testing.
 Charges which are dental in origin including care and treatment of the teeth, gums or alveolar process, endodontia, periodontia, orthodontia, prosthetics, dental implants, or anesthesia or supplies used in such care.
 Charges for pre-natal classes.
 Charges for the treatment of weak, strained, flat, or unstable feet; visits in connection with orthotics; palliative care or metatarsalgia or bunions; treatment for corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.

6.2.4. ☒ Surgical services (Section 2110(a)(4))

Scope of Coverage

All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery. Inpatient and outpatient surgical procedures.
 Anesthesia services and supplies.

Level of Coverage

0% co-insurance. Includes all services related to covered surgical procedures (i.e., physician services, anesthesia services and supplies, pre-surgical testing, surgical services and supplies, inpatient and outpatient facility services, etc.). Pre-surgical tests are covered if physician orders the tests; proper diagnosis and treatment require the tests; and surgery takes place within 7 days of testing. If surgery is canceled because of pre-surgical test findings or as a result of a second opinion on surgery, the cost of the test will be covered.

Exclusions

Charges for care, treatment or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.

Breast reconstruction, augmentation, or implant; except initial restoration made necessary as a result of cancer surgery performed in the preceding five years.

Capsulotomy, replacement, or repair of breast implant originally placed for cosmetic purposes, or any other complication of cosmetic or non-covered breast surgery.

Simple/subcutaneous mastectomy for benign disease or mastectomy for anything other than cancer, including reconstruction or complications.

Obesity surgery, such as gastric bypass, stomach stapling etc., including any present or future complications.

Cosmetic surgery.

Assisted Reproductive Technologies (ART's) including but not limited to In vitro Fertilization, Gamete Intra Fallopian Tube Transfer (GIFT), Embryo Transfer (ET), Zygote Intra Fallopian Transfer (ZIFT), or the storing of frozen sperm, eggs, or gametes for future use. Radial keratotomy, astigmatic keratotomy or other surgical treatment for correction of refractive errors.

Charges incurred as an organ or tissue donor.

Organ or tissue transplant (except cornea, kidney, kidney/pancreas, liver, bone marrow, stem cell, lung and heart, which may be considered with written pre-authorization).

Reversal of sterilization.

Trans-sexual operations.

Rhytidectomy (excision of wrinkles around the eyes).

Charges that are dental in origin: extraction of teeth, dental implants and crowns or pontics over implants, reimplantation or splint-

ing, endodontia, periodontia, or orthodontia, including anesthesia or supplies used in such care.

Complications as a result of other non-covered or ineligible surgery. Injection of collagen. Lipectomy, abdominoplasty, pannulectomy. Repair of diastasis recti. Non-FDA approved, experimental, or investigational procedures, drugs, and devices.

Pellet implantation; Liposuction; Chemical peel.

Charges for the treatment of weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.

Orthodontic treatment or expansion appliance in conjunction with jaw surgery.

Chin implant, genioplasty or horizontal symphyseal osteotomy.

Unbundling or fragmentation of surgical codes.

Injections of sclerosing solution for spider veins.

Rhinoplasty, except as a result of accidental injury in the preceding five years.

Laser assisted uvulopalatoplasty (LAUP).

Additional surgical fees are not eligible when a laser is used.

Anesthesia charges in conjunction with ineligible surgery.

Anesthesia administered by the primary surgeon.

Monitored anesthesia care (standby) except in conjunction with procedure 92982, angioplasty.

6.2.5. Clinic services (including health center services) and other ambulatory health care services (Section 2110(a)(5))

6.2.6. Prescription drugs (Section 2110(a)(6))

Scope of Coverage

Prescribed drugs and preparations provided by a licensed pharmacy (an approved list of covered name brand drugs will be established by an advisory board of medical professionals). Prescription medications must be authorized by a professional licensed to write prescriptions. Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices, except Norplant and infertility drugs.

Level of Coverage

For enrollees between 100% and 150% of the federal poverty level:

\$1.00 co-pay per prescription.

For enrollees between **151%** and 200% of the federal poverty level:

\$1.00 co-pay per prescription for generic drugs and brand name drugs on an approved list.

Coinsurance, 50% of the allowed amount for brand name drugs not on an approved list.

Exclusions

The fact that a provider may prescribe, order, recommend, or approve a prescription drug, service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition.

Drugs that are not medically necessary for condition.

Charges for the treatment of hair loss or restoration (Rogaine).

Experimental or investigational drugs.

Anorexiant/diet aids (with the exception of Dexedrine/Desoxyn/Obetrol for documented treatment of Attention Deficient Disorder in children under age **18**).

Any over-the-counter (OTC) drugs or drugs that do not require a prescription, except insulin.

Any drug not FDA approved.

Therapeutic devices or appliances.

Diagnostic agents.

Immunization agents, biological serum, blood, or blood plasma.

Prescriptions which an eligible person is entitled to receive from any governmental plan or medication prescribed as a result of an industrial injury or illness payable under Workers Compensation or employer's liability laws.

Medications taken by insured or dependents of the insured while in an institution which operates on its premises a facility for dispensing pharmaceuticals.

Any drug used for cosmetic purposes.

Drugs used by a second party.

Compounded drugs (a procedure that alters the FDA approved form of a legend drug.)

Replacement prescriptions resulting from loss, theft or breakage.

Delivery or shipping charges.

Medication furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.

Vitamins, minerals, food supplements, or homeopathic medicine.
 Mother's milk or special infant formulas.
 Anabolic steroids (used for muscle building).
 Medication prescribed as a result of an industrial (on the job) injury or illness payable under Worker's Compensation or employer's liability laws.
 Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
 Charges which the insured is not, in the absence of coverage, legally obligated to pay.
 Norplant and infertility drugs.

6.2.7. Over-the-counter medications (Section 2110(a)(7))

6.2.8. Laboratory and radiological services (Section 2110(a)(8))

Scope of Coverage

Professional and technical laboratory and x-ray services furnished by licensed and certified providers. All laboratory testing sites providing services under this contract, must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a **CLIA** identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

Level of Coverage Laboratory

For enrollees between 100% and 150% of federal poverty level:

No co-payment or eo-insurance is required for laboratory services.

For enrollees between 151% and 200% of federal poverty level:

No co-pay or co-insurance for laboratory services under \$50,
 Co-insurance, 10% of allowed amount for laboratory services over \$50,

Level of Coverage, X-Ray

For enrollees between 100% and 150% of federal poverty level:

No co-payment or co-insurance is required for x-ray services.

For enrollees between **151%** and **200%** of federal poverty level:

No co-pay or co-insurance for X-Ray services under \$100,

Co-insurance, **10%** of allowed amount for X-ray services over \$100,

Exclusions

Charges in connection with weight **loss** programs.

Health screening or services to rule out familial diseases or conditions without manifest symptoms are considered routine and are excluded from coverage.

Genetic screening except prenatal amniocentesis or chorionic villi sampling or as described in the Pre-Authorization Section above.

Charges incurred as an organ or tissue donor. Charges for sublingual or colorimetric testing.

Lab, x-ray, or diagnostic services which are unproven, experimental, or investigational.

Charges for hair analysis, trace elements, or dental filling toxicity.

Charges in conjunction with ineligible procedures, including pre- or post-operative evaluation.

Routine drug screening.

Routine HIV/AIDS testing.

Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

- 6.2.9. Prenatal care and pre-pregnancy family services and supplies
(Section 2110(a)(9))

Scope of Coverage

Family planning (including sterilization) and prenatal (including high-risk) services include disseminating information, counseling and treatment.

All family planning and prenatal services must be provided by or authorized by a physician, certified nurse midwife or nurse practitioner. Sterilizations are covered to the extent permitted by federal and state law and must meet the documentation requirements of **42 CFR 441**, Subparts **E & F**. **All** services must be provided in concert

with Utah Law. Prenatal services - see Section 6.2.1, 6.2.2, 6.2.3, 6.2.4, 6.2.6, and 6.2.8. Services for high-risk prenatal services.

Exclusions

Norplant, infertility drugs, in-vitro fertilization, genetic counseling. Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.

- 6.2.10. □ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Scope of Coverage

Inpatient mental health services are covered for a maximum 30 days per year. Residential treatment may be provided in lieu of inpatient care.

Level of Coverage

For enrollees between 100% and 150% of federal poverty level:

No co-insurance.

For enrollees between 151% and 200% of federal poverty level:

Co-insurance, 10% allowed amount for first 10 days,

50% of allowed amount for next 20 days.

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

Exclusions

Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.

Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.

6.211. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental health hospital and including community-based services (Section 2110(a)(1))

Scope of Coverage

Outpatient mental health services are covered for a maximum of 12 visits per year.

For enrollees between 100% and 150% of federal poverty level:

\$5 co-payment per office visit.

For enrollees between 151% and 200% of federal poverty level:

Co-insurance, 50% of allowed amount.

Exclusions

Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management, relaxation therapy, conduct disorders, oppositional disorder, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.

Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.

Office calls in conjunction with repetitive therapeutic injection.

Charges in conjunction with wilderness programs.

Inpatient charges for behavior modification, enuresis, or encopresis.

Psychological evaluations for legal purposes such as custody rights, etc.

Occupational or recreational therapy.

Hospital charges while on leave of absence.

6.2.12. ☒ Durable medical equipment and other medically-related or related devices (such as prosthetic devices, implants, eyeglasses, hearing aids, etc.)

benefit, even though it is not specifically listed as an exclusion. Following are some, but not necessarily all, items not covered, benefit, regardless of the relief they may provide for a medical condition:

Routine maintenance and care, cleaning solutions, batteries, upholstery repair, etc., of Durable Medical Equipment (DME) or prosthetics.

Maintenance, warranty, or service contracts.

Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.

Air conditioning.

Home physical therapy kits.

Whirlpool baths and other multipurpose equipment or facilities such as health spas, swimming pools, saunas, or exercise equipment.

Air filtration units, vaporizers, humidifiers.

Heating lamps or pads.

Charges for a continuous hypothermia machine, cold therapy, or ice packs.

Lift or contour chairs, vibrating chairs, or adjustable beds.

Dialysis equipment.

Orthotics, arch supports, shoe inserts or wedges, etc. Orthopedic corrective shoes. (Attachment of a brace or crossbar is not allowable).

Eye glasses/contact lenses

6.2.13. Disposable medical supplies (Section 2110(a)(13))

Level of Coverage

For enrollees between 100% and 150% federal poverty level:

No eo-insurance.

For enrollees between 151% and 200% of federal poverty level:

Co-insurance, 20% of allowed amount.

Exclusions

The fact that a provider may prescribe, order, recommend or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion.

6.2.14. Home and community-based health care services (See instructions for Section 2110(a)(14))

Scope of Coverage

Home health services, defined as intermittent nursing care provided by certified professionals (registered nurses, licensed practical nurses, etc.)

Private duty nursing, home health care.
Custodial care.
Respite care.
Travel or transportation expenses, escort services, or food services.
Charges for medical care rendered by an immediate family member
are subject to review by **CHIP** and may be determined by C
to be ineligible.

6.2.17. Dental services (Section 2110(a)(17))

Scope of Coverage

The following dental services based on American Dental Association (ADA) codes are covered:

00110 - 00130, 00274, 01120 (cleaning), 01201 & 01202 (fluoride), 01351 (sealants), 01510 - 01550, and 02100 - 02161 (fillings).

Level of Coverage

For enrollees between 100% and 150% federal poverty level:

No co-insurance.

with speech, hearing, and language disorders (Section 2110(a)(22))

Scope of Coverage

Treatment and services provided by a licensed physical therapist authorized by a physician. Screening services provided by a licensed medical professional to test for hearing loss. Hearing aids are covered only to improve an impairment due to a congenital defect. Services provided by a licensed medical professional, including speech therapy to restore speech **loss** or to correct an impairment if due to a congenital defect or an injury or sickness.

Level of Coverage

No co-insurance or co-payments.

Up to 16 visits per policy year (this may include occupational therapy for fine motor function).

Exclusions

Services outside the restrictions listed above.

6.2.23. Hospice care (Section 2110(a)(23))

Scope of Coverage

--	--	--	--	--

100% up to \$30 for 1 exam every 24 months for eye refractive examinations.

Hearing Services

Scope of Coverage

Screening services provided by a licensed medical professional test for hearing loss.

Levels of Service

100% up to \$30 for 1 examination every 24 months.

Hearing aids covered only to improve an impairment due to congenital defect.

6.2.25 Premiums for private health care insurance coverage (Section 2110)

6.2.26 Medical transportation (Section 2110(a)(26))

Scope of Coverage

Ambulance (air and ground) service for medical emergencies

experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.
Charges which the insured is not, in the absence of coverage, legally obligated to pay.
Charges for services, treatments or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
Charges for services, treatments or supplies received as a result of an act of terrorism occurring when the insured is covered by CHIP.
Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which is payable under workman's compensation or employer's liability laws.
Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
Charges made for completion or submission of insurance forms.
Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.
Shipping, handling, or finance charges.
Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.
Charges for expenses in connection with appointments scheduled and not kept.
Charges for telephone calls or consultations.

delivery system. The state may cross reference section E
- 6.2.28. (Section 2105(c)(2)(B)(I))

6.3. 2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above and Describe the cost of such coverage on an average child basis. (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))

6.3.2. Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low income children, if it demonstrates the following: (Section 2105(c)(2)(B)(iv))

--	--	--	--	--	--

licensing requirements, have a comprehensive quality assurance system in place, participate in internal and community quality improvement activities, and report performance and utilization data to CHIP. The In-Home Health Service will be exempt from state licensing requirements. The quality measurement activities will be designed to promote contractor accountability, community-based improvement opportunities, and to guide CHIP policy decisions.

Will the state utilize any of the following tools to assure quality? Check all that apply and describe the activities for any category utilized.

7.1.1. Quality standards

CHIP contractors will be required to have a current Certificate of Accreditation Authority, issued by the Department of Insurance, or be a health plan approved by the Department of Health, and submit a Quality Assurance Plan description to CHIP that summarizes the contractor's quality assurance system, including (but not limited to) the following standards for the entire range of clinical care and service delivery provided by the contractor:

- detailed quality objectives and a timetable for accomplishment

CHIP will require contractors to have in place protocols for approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory encounters meet pre-defined criteria.

7.1 .2. Performance measurement

Utah's Medicaid program has established a comprehensive quality measurement and accountability system for its HMO Medicaid clients. CHIP will build on these performance reporting initiatives for its enrollees. CHIP will require contractors to be accountable for their performance in meeting children's health needs. This accountability will be implemented through the contractor's implementation of organizational quality assurance and quality improvement initiatives (Sections 7.1.1 and 7.1.4), but also through the reporting requirements of CHIP and the Office of Health Data Analysis, comparative performance data, independently-verified performance measurement data, participation in standardized member satisfaction surveys conducted by DOH, and encounter/claims reporting requirements. CHIP will require contractors to annually report specific quality performance data to the Office of Health Data Analysis, consistent with existing

Access to Services

- Annual dental visit
- Membership survey questions: usual source of care, unmet needs, after-hours access, provider choice, delayed care

Use of Services

- Well child visits in the first 15 months of life
- Well child visits in the third, fourth, fifth, and sixth year of life
- Adolescent well-care visit
- Frequency of ongoing prenatal care

Access/Availability of Care

- Availability of dentists
- Availability of Interpretation services

Health Plan Stability

- Disenrollment
- Provider turnover
- Years in business/total membership

Membership Satisfaction

For the urban CHIP clients enrolled in Wasatch Front managed care plans, the Office of Health Data Analysis will conduct annual member satisfaction surveys from a randomly-selected sample of CHIP enrollees. This survey will be conducted by an independent survey research agency using a standardized survey instrument (e.g. Consumer Assessment of Health Plan Survey or CAHPS) modified according to CHIP program needs. The survey will be conducted in conjunction with the Annual Medicaid HMO Enrollee Satisfaction Survey in order to derive comparable data for benchmarking and quality improvement efforts.

- Enrollee's overall satisfaction with their health plan
- Enrollee's satisfaction with specific aspects of health plan services (access to care, quality of health care, cost sharing, and management of care)
- Enrollee's report of complaints or problems in the past 12 months, waiting times for appointments, actual or perceived delays in calling for information or advice, delays in approval of services

--	--	--	--

sis, validated by each data supplier, and used for analytic purposes including program quality assessment, quality improvement, monitoring of patterns of care through linkage with other data sources such as vital records, hospital utilization data bases, and eligibility files. All patient identifiable information will be considered confidential and all data handling and reporting activities will be conducted according to current policies in a secure environment.

7.1.3. ☒ Information strategies

CHIP enrollee education materials will be developed to ensure CHIP enrollees are informed of their benefits, their rights and responsibilities, comparative performance information about contractors, and other educational material about CHIP and its contractors. The contractors will be required to provide enrollees with provider network structure, grievance procedures and toll-free numbers, policies on referrals and after-hours care, and other information related to the contractor's organization. CHIP will require all of the contractor's written materials prior to distribution to CHIP enrollees and materials will be available in prose that is read and easily understood, in English and non-English.

enrollees

- description of methods and frequency of data collection
how these data are used to identify problems
promote improvement

CHIP will require contractors to participate in community quality improvement initiatives and focused studies that are intended to advance children's health in Utah. The contractor must have a contractual arrangement with an external quality improvement organization for the purposes of focused quality studies and community and CHIP-based quality studies during each year. Specific areas of study will be identified and required in the contract. In addition, providers and health plans will submit an annual submission of grievance/complaint information and will be subject to annual review/site visits by CHIP staff.

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (Section 2102(a))

Providers and health plans contracting with CHIP will establish and maintain a sufficient number and mix of providers (primary care and specialty practitioners) in geographically accessible locations for

Providers and health plans must have provisions for emergency care in network and can not require pre-authorization for life-threatening emergencies or penalties for seeking care outside of the network for life-threatening emergencies.

The network structural information will be reviewed annually and information will be linked with other measures of enrollee access, such as satisfaction surveys and health care utilization measures such as emergency room visits/1000, inpatient visits/1000, rates of ambulatory sensitive conditions, etc. This information will guide quality assessment, program planning, and targeted interventions.

8.2.3. Coinsurance

The following are the co-payment and co-insurance requirements for participation in CHIP.

Co-Payment Requirements for CHIP clients/enrollees at 700% of the federal poverty level

Hospital Services (inpatient, outpatient and emergency department):

- \$10 co-payment for each emergency department visit (\$5 for physician services and \$5 for hospital services).

Outpatient Office Visits:

- \$5 co-payment per visit. This includes physician, physician-related, mental health, physical therapy, speech therapy, chiropractic, and podiatry visits.

— Co-insurance, 10% of allowed amount.
allowed amount is the billed charge less 25%

— \$30 co-payment for each emergency department visit .

Outpatient Office Visits:

— **\$10** co-payment per visit. This includes physician, physician-related, physical therapy, speech therapy, chiropractic, and podiatry visits.

— No co-payment for well-baby care, well-child care and immunizations.

Laboratory and X-Ray Services:

— No co-payment or co-insurance for laboratory services under \$50.

— Co-insurance, 10% of allowed amount for laboratory above \$50.

— No co-payment or co-insurance for laboratory services under \$100.

— Co-insurance, 20% of allowed amount.

Dental Services:

— Co-insurance for dental fillings, 20% of allowed amount.

Mental Health Services, In-Patient Care:

— Co-insurance, 10% of allowed amount for first 10 days; 50% of allowed amount for next 10 days.

— Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

Mental Health Services, Out-Patient Care:

— Co-insurance, 50% of allowed amount

Out-of-Pocket Maximum:

— \$800 per family per year.

— If the out-of-pocket expenses exceed the family income, the family should contact the insurer.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
- 8.4.2. No cost-sharing applies to well-baby and well-child care including age-appropriate immunizations. (Section 2103(e)(2))
- 8.4.3. No child in a family with income less than **150%** of Federal Poverty Level will incur cost-sharing that is permitted under 1916(b)(1).
- 8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
- 8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
- 8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such as

Through the various information strategies such as the use of eligible workers to inform the enrollees, enrollees and their families will be informed as to the limits of their financial liability for the coverage.

Information brochures will be provided to all participating providers and distribution to their clients.

This information will include written requests for the families to inform the state whenever the 5% maximum is exceeded. The family will receive a refund in an amount equal to their excess payments.

8.6 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (see Section 2102(b)(1)(B)(ii)); **OR**

8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan that provides family coverage under a waiver (see Section 6 of the template). Pre-existing medical conditions are per-

--	--	--

Strategic objective 4.0

Ensure that CHIP-enrolled children receive high quality health services

Strategic Objective 5.0

Improve health status among children enrolled in the Utah CHIP

9.2. Specify one or more performance goals for each strategic objective identified: (section 2107(a)(3))

Performance Measures for Strategic Objective 7.0

- 1.1 By June 30, 1999, at least 10,000 previously uninsured low-income eligible children will be enrolled in the Utah CHIP.
- 1.2 By June 30, 2000, the percentage of Medicaid-eligible Utah children younger than 19 years of age who are enrolled in Medicaid will increase from 80 percent to 90 percent.
- 1.3 By June 30, 1999, the percentage of Utah children from birth to 5 years of age without health insurance will be decreased from 10 percent to 6 percent.

Performance Measures for Strategic Objective 3.0

- 3.1 By June 30, 2000, at least 50 percent of children who turned 15 months old during the preceding year and were continuously enrolled in the Utah CHIP from 31 days of age, will have received at least four well-child visits with a primary care provider during the first 15 months of life.
- 3.2 By June 30, 2000, at least 60 percent of three, four, five, or six year old children who were continuously enrolled in the Utah CHIP during the preceding year, will have received one or more well-care visits with a primary health care provider during the preceding year.
- 3.3 By June 30, 2000, at least **85** percent of two-year old children enrolled in the Utah CHIP will have received all age-appropriate immunizations. (using HEDIS measure definition)
- 3.4 By June 30, 2000, at least 90 percent of 13-year old children enrolled in the Utah will have received a second dose of MMR. (using HEDIS measure definition)
- 3.5 By June 30, 2000, at least 50 percent of CHIP-enrolled children

5.2 By June 30, 1999, a method will be established and a survey instrument developed and/or adapted for use in assessing overall health status among the Utah CHIP enrollees, over time and compared to other groups of children.

5.3 By June 30, 1999, a set of child health status indicators will be selected and methods established for ongoing data collection and monitoring of these indicators. During the selection of health status indicators, careful consideration will be given to the particular health problems and areas of concern which significantly impact selected subgroups such as American Indians and other ethnic minorities and children with special health care needs.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance taking into account suggested performance indicators as specified below or other indicators the state develops: (section 2107(a)(4)(A),(B))

In order to assess performance under the Utah CHIP plan and progress made toward achievement of stated performance goals, a number of indicators and/or performance measures have been identified. Selected

ers through fee-for-service contracts, the mechanism for collecting HE measures is not yet well established. However, it is anticipated that s a mechanism will be developed by the end of the first year of C implementation, and that client encounter data will be made available rural providers for review by CHIP administrative and quality assurance staff.

The Office of Public Health Data within the Utah Department of Health currently conducts a Health Status Survey of a representative sample of Utah families every 5 years. In order to gather better information specific to children, it is planned that a statewide children's health status survey will be developed, and conducted on an annual or biannual basis. This survey will include questions about insurance coverage, usual source of care, how many times during the previous year a family had difficulty in obtaining needed medical services for a child.

During the first year of CHIP implementation, a thorough review of existing child health status survey instruments that are available for use will be conducted by professional and technical staff from within the Division of Community and Family Health Services, the Office of Health Data Analysis.

provide oversight for the administration and data analysis of this survey.

In order to gather information about dental sealant placement among 5-year-old children and dental caries among 6 through 8 year-old children enrolled in CHIP, a screening will be conducted by qualified dental providers (either a dental hygienist or a dentist) of a representative sample of CHIP-enrolled children within this age group. Such a screening will be conducted once every other year, in order to collect baseline and comparative dental status information regarding this population of children. Oversight for these dental screenings will be provided by the Division of Community and Family Health Services.

See below for the selected performance measures that will be used to track progress and measure the impact of the Utah CHIP. The measures are numbered according to the specific performance goal to which they apply. (Please note that although Utah CHIP will be collecting all HEDIS measures relevant to children and adolescents, the only HEDIS measures listed below are those pertaining to identified Utah CHIP Performance Goals. For a complete listing of HEDIS 3.0 measures that Utah CHIP will be using, see Section 7. of this Plan.)

--	--	--	--	--

care (Performance Goal 2.1)	<p>source of care Same as above, but for selected subgroups, including ethnic minorities, American Indians, and children with special health care needs</p>
Unmet needs among CHIP enrollees and selected subgroups of CHIP enrollees (Performance Goal 2.3)	<p>Proportion of CHIP-enrolled children whose caretakers report their child having a usual source of care Same as above, but for selected subgroups, including ethnic minorities, American Indians, and children with special health care needs</p>
Children's access to dental services (Performance Goal 2.5)	<p>Proportion of CHIP-enrolled children whose caretakers report being unable to obtain some needed medical service for their child during the preceding year Same as above, but for selected subgroups, including ethnic minorities, American Indians, and children with special health care needs</p>

--	--	--

<p>Molescent Immunization status :PerformanceGoal 3.4)</p>	<p>Percentage of CHIP-enrolled children who turn age 13 years during the reporting year, who were continuously enrolled in CHIP for one year immediately preceding their 13th birthday, and who received a second dose of MMR by age 13 years. (HEDIS definition)</p>
<p>Dental sealants (Performance Goal 3.5)</p>	<p>Proportion of CHIP-enrolled children eight years of age who have received protective sealants at least one occlusal surface of a permanent molar</p>
<p>Rate of hospital readmissions for asthma among CHIP-enrolled children (Performance Goal 4.1)</p>	<p>Rate of repeat asthma-related hospitalizations CHIP-enrolled children</p>
<p>Satisfaction with care (Performance Goal 4.3)</p>	<p>Percentage of CHIP-enrolled survey respon- dents reporting overall satisfaction with their health care, as measured by a standardized c lient satisfaction survey (e.g., CAHPS)</p>

Dental caries among 6, 7, and 8 year old CHIP-enrolled children (Performance Goal 5.1)	Percentage of CHIP-enrolled 6 through 8 year-old children with untreated dental caries in primary or permanent teeth
--	--

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4.0 The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list
- 9.3.8. Performance measures for special targeted populations.

- 9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (section 2107(b)(1))**

The state hereby assures that it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.

9.5. ☒ *The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))*

The state hereby assures that it will comply with the annual assessment and evaluation required under Sections **10.1.** and **10.2.**

Evaluation of the Utah CHIP will be conducted through a collaborative effort involving CHIP administrative staff, the liaison for Indian health, the Office of Health Data Analysis, the Office of Public Health Data, and the Division of Community and Family Health Services within UDOH. In addition, child health experts and other representatives from the provider and consumer communities (e.g., physicians, mid-level providers, ethnic minority representatives, tribal health board representatives, parents, advocates) will be invited to participate in planning and implementing various evaluation activities.

One way in which the impact of CHIP will be assessed is through monitoring changes over time in the number of uninsured, low-income Utah children. Utah has conducted a health status survey, which includes measurement of health insurance coverage, every five years since **1986**. A baseline estimate of uninsured low-income Utah children has been calculated by applying the results of the **1996** Utah Health Status Survey to the **1998** Utah population estimate prepared by the Governor's Office of Planning and Budget. For future estimates of the number of uninsured children subsequent to CHIP implementation, a similar approach will be employed, using results from an annual child health status survey, yet to be developed. This survey (and/or set of survey questions) will measure not only insurance coverage, but also whether a child has a usual health care provider, and if the family has had difficulty in obtaining needed health care services for the child within the past year. The survey will also be designed to provide an indicator of a child's overall health status.

Program effectiveness will be evaluated on at least **two** levels. First,

the Utah CHIP will be measured against achievement of stated performance goals as defined in Section 9.3 of this Plan. In addition, a systematic assessment will be conducted of the impact of program policies, service quality, and cost on health outcomes of CHIP population. During the first year of the Utah CHIP implementation, a comprehensive plan for evaluating program effectiveness will be developed, to include effectiveness-evaluation questions, and a description of methods and data needed to conduct this component of evaluation. Also during the first year of program implementation, baseline data will be gathered which will be important in assessing the relationship between the economic and health outcome aspects of the program in the second year.

Overall program evaluation will be comprised of several components, including but not limited to:

- 1) the collection of data related to designated performance measures and comparisons of these data prior to CHIP implementation and at least annually thereafter;
- 2) monitoring of progress made toward achievement of performance goals, including those goals which are primarily process-oriented (e.g., establishment of a coordinated state-wide outreach program; selection and/or development of an appropriate child health status survey; selection of a set of quality of care and health status indicators); and
- 3) the comparison of selected quality of care and health status indicators among CHIP enrollees to other child population groups such as HMO and commercial child enrollees.

As previously mentioned within this section and within Section 7 (Quality and Appropriateness of Care), it is planned that the set of HEDIS 3.0 measures relevant to children and adolescents will be collected by Utah CHIP. Several performance goals for the Utah CHIP have been developed around HEDIS measures related to quality of care, such as well-child visits and immunizations. In addition to those HEDIS measures related to quality, it is planned that a set of quality of care and child health status indicators will be developed by involved UDOH staff and consultants during the first

year of CHIP implementation. At the point when required performance measures and standards have been decided upon at the federal level for all state CHIP programs, these will be integrated into the selected set of Utah CHIP indicators.

Satisfaction with the experience of care, also a HEDIS quality indicator, will be measured by the Office of Health Data Analysis, through utilization of the Consumer Assessment of Health Plans Survey (CAHPS)—referenced earlier in this Section, and in Section 7.

Data required for the tracking of the Utah CHIP performance related to various performance measures will be derived from several sources, some of which are already developed, and others which are yet to be developed. Data sources will include the following: CHIP eligibility file; hospital inpatient discharge records; child health status survey; Health Plan/HEDIS measures; CAHPS; review of paid dental claims; special oral health screenings on CHIP enrollees; and Health Plan descriptive information. The UDOH health information infrastructure will be expanded to accommodate CHIP information and evaluation needs.

The UDOH is integrating and standardizing major health data systems throughout the Department, and CHIP information initiatives will be consistent with these activities. The Office of Health Data Analysis and the Office of Public Health Data will work with the Utah CHIP staff, CHIP advisory committee(s), and the Division of Community and Family Health Services, to design a health information reporting system (including data collection, data management, and analytic support) that is consistent with public health data integration policies and structured to support the program and policy information needs.

The state will monitor in the annual distributions of health insurance among children by family income, age, geographical areas, ethnicity, and health status, to identify changes and trends in the state. Potential changes can be traced by the major data sources outlined above.

9.6. *The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))*

The state hereby assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit.

- 9.7. *The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.*

The state hereby assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

- 9.8. *The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))*

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(l) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1115 (relating to waiver authority)
- 9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. Section 1128A (relating to civil monetary penalties)
- 9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. Section 1132 (relating to periods within which claims must be filed)

- 9.9. *Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (section 2107(c))*

The Utah Health Policy Commission (HPC) was given the responsibility by the Governor to recommend options available to Utah for implementing CHIP and developing the required state plan. The HPC is comprised of 6 legislators, 6 members from the business and academic community, with the Governor serving as chair.

All HPC meetings are open to the public and are advertised through the following means:

1. a state-wide mailing to over **250** individuals and health care organizations;
2. an information hotline that includes details of all HPC meetings, and;
3. a fax to all parties that expressed an interest in CHIP's development.

The Health Policy Commission discussed CHIP during the following meeting dates: September **8, 1997**, September **22, 1997**, October **6, 1997**, November **3, 1997**, November **17, 1997**, December **1, 1997**, December **19, 1997**, and January **12, 1998**. During almost every meeting, the HPC received public input. (Meeting minutes are available upon request)

In addition to these meetings, the HPC held state-wide public hearings on a variety of issues, including CHIP. The basic elements of Utah's CHIP plan were presented to the public during these meetings. The public was encouraged to ask questions and give comments. The public hearings were held from October **28, 1997** through November **20, 1997** in locations including: Salt Lake City, Price, Monticello, Farmington, Richfield, St. George, Provo, Logan, Ogden, and Vernal.

In an effort to solicit even more input from the public, the HPC advertised and held another public hearing on December **9, 1997**, in Salt Lake City specifically devoted to a dialogue regarding CHIP. The benefit design and eligibility criteria were the most often discussed topics by the public in attendance during this 3-plus hours of discussion.

In October of **1997**, the HPC established a Benefit Design Work Group to recommend to the HPC the benefits and benefit levels that should be included in the CHIP benefit plan. This group has met eight times, to date. The group comprises a professor of economics, the executive director of the state's health plan, a representative of Utah Children (a children's advocate group), a pediatrician, an actuary, a general consumer, the insurance commissioner for the state, the medical director of the North Western Shoshone Indian tribe, the deputy director of the Health Department (also a pediatrician), and the executive director of the Utah Community Health Centers. These meetings were also open to the public. They were also included on the information hotline and interested parties were

sent a fax of the details of upcoming meetings, with a summary of past meetings. In addition to regular scheduled meetings, this group met several times with advocacy groups having specific interests in mental health, dental, and vision benefits.

Presentations of the CHIP plan were given to, and input was sought from several community groups including the Utah Coalition for People with Disabilities, Utah Issues (a low-income advocacy group), Utah Children, Kids Coalition, Utah Women's Legislative Council, Utah Health Insurance Association, Primary Children's Hospital, Utah Association of Local Health Officers, and the Jordan District Head Start Program.

The legislation authoring the Utah CHIP requires the creation of the Utah Children's Health Insurance Program Advisory Council (CHIPAC). The CHIPAC will advise the Health Department, who will administer the program, on benefit design, eligibility criteria, outreach, evaluation, and special strategies for under-served populations. A member from the general public is guaranteed a seat on this eight-to-eleven member board. This council will ensure an ongoing dialogue between CHIP administrators and the public, as Utah's CHIP continues to unfold.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

An estimated budget for state fiscal years 1999 and 2000 is given hereunder. The estimates are based on the proposed service package and the actuarial data received by the department.

CHIP Budget SFY 1999

	UP TO 100% OF POVERTY	100% UP TO 150% OF POVERTY	151% UP TO 200% OF POVERTY	TOTAL
ELIGIBLES	33	4,507	5,960	10,500
SERVICES				
DENTAL	\$1,414	\$193,080	\$255,326	\$449,820
IMMUNIZATIONS	\$673	\$91,943	\$121,584	\$214,200
INPATIENT HOSPITAL	\$10,415	\$1,422,409	\$1,880,976	\$3,313,800
MENTAL HEALTH	\$1,806	\$246,623	\$326,131	\$574,560
LAB AND X-RAY	\$408	\$55,707	\$73,666	\$129,781
MEDICAL SUPPLIES	\$416	\$56,788	\$75,096	\$132,300
OTHER SERVICES	\$444	\$60,574	\$80,102	\$141,120
<u>OUTPATIENT HOSPITAL</u>	<u>\$2,257</u>	<u>\$308,279</u>	<u>\$407,664</u>	<u>\$718,200</u>

PHARMACY	\$3,615	\$493,787	\$652,978	\$1,150,380
PHYSICIAN	\$3,869	\$528,401	\$698,750	\$1,231,020
VISION SERVICES	\$186	\$25,419	\$33,614	\$59,219
WELL CHILD CARE	\$1,564	\$213,632	\$282,504	\$497,700
TOTAL SERVICES	\$27,067	\$3,696,642	\$4,888,391	\$8,612,100
ADMINISTRATION				
DOH ADMINISTRATION	\$2,059	\$281,421	\$372,120	\$655,600
CHIP ADMINISTRATION- RFP	\$646	\$88,259	\$116,704	\$205,609
TOTAL ADMINISTRATION	\$2,705	\$369,680	\$488,824	\$861,209
TOTAL CHIP EXPENDITURES	\$29,772	\$4,066,322	\$5,377,215	\$9,473,309
REVENUES				
RESTRICTED GENERAL STATE FUNDS	\$5,838	\$797,406	\$1,054,472	\$1,857,716
FEDERAL FUNDS	\$23,934	\$3,268,916	\$4,322,743	\$7,615,593
TOTAL REVENUES	\$29,772	\$4,066,322	\$5,377,215	\$9,473,309

Blended PMPM cost for all poverty levels is \$68.35.

These are the services that the managed care organizations will be providing state-wide at a capitated rate still to be negotiated.

CHIP BUDGET SFY 2000

	UP TO 100% OF POVERTY	100 % UP TO 150% OF POVERTY	151 % UP TO 200% OF POVERTY	TOTAL
ELIGIBLES	66	9,014	11,920	21,000
SERVICES				
DENTAL	\$2,941	\$401,606	\$531,079	\$935,626
IMMUNIZATIONS	\$1,400	\$191,241	\$252,895	\$445,536
INPATIENT HOSPITAL	\$21,663	\$2,958,611	\$3,912,430	\$6,892,704
MENTAL HEALTH	\$3,756	\$512,976	\$678,353	\$1,195,085
LAB AND X-RAY	\$848	\$115,870	\$153,224	\$269,942
MEDICAL SUPPLIES	\$865	\$118,119	\$156,200	\$275,184
OTHER SERVICES	\$923	\$125,994	\$166,613	\$293,530
OUTPATIENT HOSPITAL	\$4,695	\$641,220	\$847,941	\$1,493,856
PHARMACY	\$7,520	\$1,027,077	\$1,358,193	\$2,392,790
PHYSICIAN	\$8,047	\$1,099,073	\$1,453,401	\$2,560,521
VISION SERVICES	\$387	\$52,873	\$69,918	\$123,178
WELL CHILD CARE	\$3,254	\$444,354	\$587,608	\$1,035,216
TOTAL SERVICES	\$56,299	\$7,689,014	\$10,167,855	\$17,913,168
ADMINISTRATION				
DOH ADMINISTRATION	\$2,141	\$292,678	\$387,005	\$681,824
CHIP ADMINISTRATION- RFP	\$2,200	\$300,734	\$397,656	\$700,590

TOTAL ADMINISTRATION	\$4,341	\$593,412	\$784,661	\$1,382,414
TOTAL CHIP EXPENDITURES	\$60,640	\$8,282,426	\$10,952,516	\$19,295,582
REVENUES				
RESTRICTED/GENERAL STATE FUNDS	\$11,894	\$1,624,515	\$2,148,226	\$3,784,635
FEDERAL FUNDS	\$48,746	\$6,657,911	\$8,804,290	\$15,510,947
TOTALREVENUES	\$60,640	\$8,282,426	\$10,952,516	\$19,295,582

Blended PMPM cost for all poverty levels is \$71.08 inflated into FY2000 dollars. These are the services that the managed care organizations will be providing state-wide at a capitated rata still to be negotiated.

State revenues to fund CHIP will be derived from the hospital tax reauthorized during the **1998** Utah legislative session as part of **HB 137** enacting the Utah Children's Health Insurance Program. An important point to make is that this is not a **new** tax, but continuation of an existing tax. Additional explanation and documentation of this tax is provided in Attachment D. Other pertinent documents have been provided directly to HCFA legal counsel.

SECTION 10. ANNUAL REPORTS AND EVALUATIONS (SECTION 2108)

10.1. *Annual Reports.* The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (section 2108(a)(1),(2))

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Please refer to Section 2.1.1 or Attachment A for the requested chart and data.

10.2. *State Evaluations.* The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

The state hereby assures the following checked items.

10.2.1. An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

--	--	--

- 10.2.2.2. The quality of health coverage provided including the types of benefits provided;
 - 10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;
 - 10.2.2.4. The service area of the state plan;
 - 10.2.2.5. The time limits for coverage of a child under the state plan;
 - 10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance, and
 - 10.2.2.7. The sources of non-Federal funding used in the state plan.
- 10.2.3. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- 10.2.4. A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. Recommendations for improving the program under this Title.
- 10.2.8. Any other matters the state and the Secretary consider appropriate.

- 10.3. *The state assures it will comply with future reporting requirements as they are developed.*

The state hereby assures that it will comply with future reporting requirements as they are developed.

- 10.4. *The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.*

The state hereby assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Insurance Status of Utah Children

by Poverty Level, Age, Race/Ethnicity and Wasatch Front Residence. Utahns Age 0-18, 1998.¹

Demographic Subgroup	Utah Population Distribution		Survey Estimates of Children Who Were Uninsured		Survey Estimates of Children Who Were Insured by Medicaid ⁴		Survey Estimates of Children Who Were Insured by Some Other Plan	
	Percentage Distribution	Number of Persons	Percentage of Children Who Were Uninsured ²	Number of Uninsured Children ³	Percentage of Children Who Were Insured by Medicaid ²	Number of Children Insured by Medicaid ³	Percentage of Children Who Were Insured by Other Plan ²	Number of Children Insured by Other Plan ³
1998 Utah Population, Age 0-18	100.0%	736,100	8.5% ± 1.5%	62,500 ± 11,300	4.7% ± 1.1%	34,400 ± 8,200	86.8% ± 1.9%	639,200 ± 13,700
by Household Poverty Level								
<100%	8.7%	64,000	19.6% ± 7.9%	12,500 ± 5,100	33.9% ± 9.5%	21,700 ± 6,100	46.5% ± 10.3%	29,800 ± 6,600
100%-133%	9.3%	68,500	15.5% ± 7.2%	10,600 ± 4,900	6.8% ± 5.0%	4,600 ± 3,400	77.7% ± 8.4%	53,200 ± 5,700
133%-200%	22.9%	168,600	12.4% ± 24.1%	20,800 ± 6,800	2.1% ± 1.2%	3,500 ± 1,900	85.6% ± 4.2%	144,300 ± 7,100
200%+	59.2%	435,800	4.4% ± 1.5%	19,300 ± 6,300	1.1% ± 0.7%	4,600 ± 3,100	94.5% ± 1.6%	411,900 ± 7,000
Total, Children <=18	100.0%	736,100	8.5% ± 1.5%	62,500 ± 11,300	4.7% ± 1.1%	34,400 ± 8,200	86.8% ± 1.9%	639,200 ± 13,700
by Age Group								
less than one	5.8%	42,400	8.0% ± 4.2%	3,400 ± 1,800	9.6% ± 3.9%	4,100 ± 1,700	82.4% ± 5.4%	34,900 ± 2,300
1 to 5	27.0%	198,900	11.4% ± 2.6%	22,600 ± 5,200	6.1% ± 1.9%	12,100 ± 3,700	82.6% ± 3.1%	164,200 ± 6,100
6 to 12	35.1%	258,400	8.9% ± 2.0%	23,000 ± 5,300	3.3% ± 1.1%	8,600 ± 2,800	87.7% ± 2.3%	226,700 ± 5,900
13 to 18	32.1%	236,400	5.9% ± 1.5%	13,800 ± 3,400	4.3% ± 1.6%	10,100 ± 3,800	89.9% ± 2.2%	212,500 ± 5,100
Total, Children <=18	100.0%	736,100	8.5% ± 1.5%	62,500 ± 11,300	4.7% ± 1.1%	34,400 ± 8,200	86.8% ± 1.9%	639,200 ± 13,700
by Race/Ethnicity								
Am Ind, N Hisp	0.9%	6,600	15.6% ± 15.2%	1,000 ± 1,000	10.3% ± 11.8%	700 ± 800	74.1% ± 20.2%	4,900 ± 1,300
Asn/PI, N Hisp	1.2%	8,800	2.7% ± 4.3%	200 ± 400	0.0% ± 6.1% ⁶	0 ± 500	97.3% ± 4.3%	8,600 ± 400
Black, N Hisp	0.5%	3,700	16.0% ± 23.1%	600 ± 900	21.6% ± 34.3%	800 ± 1,300	62.4% ± 36.0%	2,300 ± 1,300
White, N Hisp	90.4%	665,400	7.7% ± 1.5%	51,400 ± 10,200	4.4% ± 1.1%	28,900 ± 7,600	87.9% ± 1.9%	585,100 ± 12,400
Hispanic	7.1%	52,300	19.1% ± 9.4%	10,000 ± 4,900	6.4% ± 4.2%	3,300 ± 2,200	74.5% ± 9.9%	39,000 ± 5,200
Total, Children <=18	100.0%	736,100	8.5% ± 1.5%	62,500 ± 11,300	4.7% ± 1.1%	34,400 ± 8,200	86.8% ± 1.9%	639,200 ± 13,700
by Wasatch Front Residence⁵								
Wasatch Front	76.4%	562,300	8.1% ± 1.9%	45,500 ± 10,900	4.3% ± 1.4%	24,400 ± 7,900	87.6% ± 2.3%	492,400 ± 13,100
Non-Wasatch Front	23.6%	173,800	9.8% ± 1.7%	17,000 ± 3,000	5.8% ± 1.3%	10,000 ± 2,300	84.4% ± 2.1%	146,700 ± 3,700
Total, Children <=18	100.0%	736,100	8.5% ± 1.5%	62,500 ± 11,300	4.7% ± 1.1%	34,400 ± 8,200	86.8% ± 1.9%	639,200 ± 13,700

¹ 1996 Utah Health Status Survey data were used to estimate 1998 population counts.

² Plus or minus 95% confidence interval

³ Figures in these columns may not sum to the totals because of missing values on the grouping variables.

⁴ Primary insurance plan for the household was used to estimate the number of children insured by Medicaid. This method may underestimate the actual numbers.

⁵ Residents of Salt Lake, Utah, Weber, and Davis Counties

⁶ The confidence interval for this percentage was estimated using a different method.

Source: 1996 Utah Health Status Survey, Bureau of Surveillance and Analysis

STATE OF UTAH

STATE PLAN FOR CHILDREN'S HEALTH INSURANCE PROGRAM

Attachment A: Child Demographics
Sections 2.1 & 10.1



Department of Health
July 1, 1998

Uninsured Utah Children by Poverty Level, Age, Race/Ethnicity, and Wasatch Front Residence; Age 0-18, 1998 ¹						
Demographic Subgroup	Utah Population Distribution		Survey Estimates of Uninsured Children			
	Percentage Distribution	Number of Persons	Percentage of Uninsured Children ²	Number of Uninsured Children ¹	Percentage Distribution of Uninsured Children By Category	Number of insured Children ¹
1998 Utah Population	100.0%	736,109	8.5% ± 1.5%	62,500	100.0%	673,600
Household Poverty Level						
<100%	8.7%	64,041	19.6% ± 8.0%	12,500	19.8%	51,500
100%-133%	9.3%	68,458	15.5% ± 7.2%	10,600	16.8%	57,900
133%-200%	22.9%	168,569	12.4% ± 4.1%	20,800	32.9%	147,800
Over 200%	59.2%	435,777	4.4% ± 1.5%	19,300	30.5%	416,500
Total, Children <=18	100.0%	736,109	8.5% ± 1.5%	62,500	100.0%	673,600
Age Group						
Less than 1 year	5.8%	42,398	8.0% ± 4.2%	3,400	5.4%	39,000
1 to 5 years	27.0%	198,924	11.4% ± 2.6%	22,600	26.0%	236,300
6 to 12 years	35.1%	258,358	8.9% ± 2.0%	23,000	36.6%	
13 to 18 years	32.1%	236,429	5.9% ± 1.5%	13,800	22.0%	222,600
Total Children <= 18	100.0%	736,109	8.5% ± 1.5%	62,500	100.0%	673,600
Race/Ethnicity						
American Indian - N Hisp	0.9%	6,625	15.6% ± 15.3%	1,000	1.6%	5,600
Asian/Pac. Island - N Hisp	1.2%	8,833	2.7% ± 4.3%	200	0.3%	8,600
Black - N Hisp	0.5%	3,681	16.0% ± 23.2%	600	0.9%	3,100
White - N Hisp	90.4%	665,443	7.7% ± 1.5%	51,400	81.3%	614,000
Hispanic	7.1%	52,264	19.1% ± 9.5%	10,000	15.8%	42,300
Total Children <= 18	100.0%	736,109	8.5% ± 1.5%	62,500	100.0%	673,600
Urban/Rural Residence						
Wasatch Front (Urban)	76.4%	562,344	8.1% ± 1.9%	45,500	72.8%	516,800
Non-Wasatch Front (Rural)	23.6%	173,765	9.8% ± 1.7%	17,000	27.2%	156,800
Total, Children <= 18	100.0%	736,109	8.5% ± 1.5%	62,500	100.0%	673,600

¹1996 Utah Health Status Survey data were used to estimate 1998 population estimates.

²Plus or minus 95% confidence interval

¹Figures in these columns may not sum to the totals because of missing values on the grouping variables.

¹Residents of Salt Lake, Utah, Weber, and Davis Counties

**STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE
PROGRAM**

Attachment B: Benefit Plan



**Department of Health
July 1, 1998**

--	--	--

CHILDRENS HEALTH INSURANCE PROGRAM
Co-Payment Requirements
for CHIP enrollees **above** 100% of the federal poverty level

Hospital Services

\$10 co-payment for each emergency department visit (\$5 for physician services and \$5 for hospital services).

Outpatient Office Visits

This includes physician, physician-related, mental health, physical therapy, speech therapy, chiropractic, and podiatry visits.

\$5 co-payment per visit
No co-payment for well-baby care, well-child care and immunizations.

Prescription Drugs

\$1.00 co-payment per prescription

Out-of-Pocket Maximum

\$500 per family/year. If out-of-pocket maximum exceeds 5% of the family income, the family should contact the State. The family will be reimbursed for any excess amount paid.

Co-Insurance and Co-Payment Requirements
for CHIP clients/enrollees **above** 150% of the federal poverty level

Hospital Services (inpatient, outpatient and emergency department)

Co-insurance, 10% of allowed amount. The allowed amount is the billed charge less 25%.

\$30 co-payment for each emergency department visit

Outpatient Office Visits

This includes physician, physician-related, physical therapy, speech therapy, chiropractic, and podiatry visits.

\$10 co-payment per visit
No co-payment for well-baby care, well-child care and immunizations.

--	--	--

Laboratory and X-Ray Services

For laboratory services under \$50: No co-payment or co-insurance
For laboratory services above \$50: Co-insurance, 10% of allowed amount

For X-ray services under \$100: No co-payment or co-insurance
For X-ray services above \$100: Co-insurance, 10% of allowed amount

Prescription Drugs

For generic drugs and brand name drugs on an approved list: \$1.00 co-payment per prescription

For brand name drugs not on an approved list: Co-insurance, 50% of allowed amount

Vision Screening Services

100% coverage of allowed amount up to \$30

Hearing Screening Services

100% coverage of allowed amount up to \$30

Durable Medical Equipment and Supplies

Co-insurance, 20% of allowed amount

Dental Services

For dental fillings: Co-insurance, 20% of allowed amount

Mental Health Services

Inpatient Care: Co-insurance: 10% of allowed amount for first 10 days; 50% of allowed amount for next 20 days

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

Outpatient Care: Co-insurance, 50% of allowed amount

Out-of-Pocket Maximum

\$800 per family/year

If out-of-pocket maximum exceeds 5% of the family income, the family should contact the State. The family will be reimbursed for any excess amount.

NOTE: The allowed amount is billed charge less 25%, except for prescription drugs and durable medical equipment and supplies.

--	--	--	--

Covered Services

The Health Plan shall provide the following benefits to CHIP enrollees in accordance with benefits as defined in the Utah State Plan subject to the exclusions or limitations noted in this attachment. The State reserves the right to interpret what is in the State Plan. CHIP covered services can only be limited through utilization criteria based on medical necessity. The Health Plan shall provide at least the following benefits to CHIP enrollees.

The Health Plan is responsible to provide or arrange for all appropriate covered services on an emergency basis 24 hours each day, seven days a week. The Health Plan is responsible for payment for all covered emergency services furnished by providers that do not have arrangements with the Health Plan.

1. Hospital Services

a. Inpatient Hospital

Services furnished in a licensed, certified hospital.

b. Outpatient Hospital

Services provided to enrollees at a licensed, certified hospital who are not admitted to the hospital.

c. Emergency Department Services

Emergency services provided to enrollees in designated hospital emergency departments.

2. Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

3. Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice.

Services include:

- a. Eye refractions, examinations.
- b. One exam every 24 months.

4. Lab and Radiology Services

Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites providing services under this Contract must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

5. Physical Therapy/Chiropractic

Treatment and services provided by a licensed physical therapist or chiropractor. Treatment and services for physical therapy must be authorized by a physician. Coverage includes up to 16 visits per policy year. This benefit may include occupational therapy for fine motor function.

6. Hearing Services

Screening services provided by a licensed medical professional to test for and hearing loss. One exam every 24 months. Hearing aids covered only to improve an impairment due to a congenital defect.

7. Podiatry Services

Services provided by a licensed podiatrist.

8. End Stage Renal Disease - Dialysis

Treatment of end stage renal dialysis for kidney failure. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

9. Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound. Home health care is to be rendered by a Medicare-certified Home Health Agency.

10. Speech Therapy

Services provided by a licensed medical professional if therapy is to restore speech loss or to correct impairment if due to a congenital defect or an injury or sickness.

11. Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care is to be rendered by a Medicare-certified hospice.

12. Durable Medical Equipment and Supplies

Equipment and appliances used to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment. Durable medical equipment includes, but is not limited to, prosthetic devices.

13. Abortions and Sterilizations

These services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. Abortion services to unmarried minors must have written consent of the parent or legal guardian.

14. Organ Transplants

The following transplantations are covered for all enrollees: Kidney, liver, cornea, bone marrow, stem cell, heart and lung, unless amended under the provisions of the Health Plan contract.

15. Other Outside Medical Services

The Health Plan, at its discretion and without compromising quality of care, may choose to provide services in Freestanding Emergency Centers, Surgical Centers and Birthing Centers.

16. Transportation Services

Ambulance (ground and air) service for medical emergencies.

17. Preventive Services (Well-Child Care)

The Health Plan shall provide to CHIP enrollees preventive screening services, including routine physical examinations and immunizations.

The Health Plan shall provide preventive services to all eligible children and young adults up to age 19 in accordance with the American Academy of Pediatrics (AAP) periodicity schedules.

The Health Plan agrees to educate and encourage compliance with the AAP periodicity schedules. These efforts will include education and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHIP enrollees.

18. Family Planning Services

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law.

The following family planning services are not covered:

- Norplant
- infertility drugs
- in-vitro fertilization
- genetic counseling

19. Pharmacy Services

Prescribed drugs and preparations provided in a licensed pharmacy. Over the counter (OTC)

--	--	--

drugs are not covered. An approved list of covered name brand drugs will be established by an advisory board of medical professionals.

20. Mental Health

- a. Inpatient care (Residential treatment may be provided in lieu of inpatient care.)
-- 30-day maximum for inpatient/residential care per year.
- b. Outpatient services/visits
-- 30 visits per enrollee per year for outpatient services.

21. Dental Services

The following dental services based on American Dental Association (ADA) codes are covered:

00110 through 00130
00274
01120 (cleaning)
01201, 01203 (fluoride)
01351 (sealants)
01510 through 01550
02110 through 02161 (fillings,

Exclusions

*~ Hospital Exclusions

1. Hospital charges in conjunction with ineligible surgical procedures or related complications.
2. Charges for treatment programs for enuresis (bed wetting) or encopresis.
3. Convenience items such as guest trays, cots, and telephone calls.
4. Occupational therapy.
5. Recreational therapy.
6. Whole blood.
7. Autologous (self) blood storage for future use.
8. Hospital charges while on leave-of-absence.
9. Charges incurred as an organ or tissue donor.
10. Charges for custodial care.
11. Charges for nutritional counseling.
12. Charges for care, confinement, or services in a transitional living facility, community reintegration program, vocational rehabilitation, or services to re-train self-care or activities of daily living.

*~ Surgery Exclusions

1. Breast reconstruction, augmentation, or implant; except initial restoration made necessary as a result of cancer surgery performed in the preceding five years.
2. Capsulotomy, replacement, or repair of breast implant originally placed for cosmetic purposes, or any other complication of cosmetic or non-covered breast surgery.
3. Simple/subcutaneous mastectomy for benign disease or mastectomy for anything other than cancer, including reconstruction or complications.
4. Obesity surgery, such as gastric bypass, stomach stapling etc., including any present or future complications.
5. Cosmetic surgery.
6. Assisted Reproductive Technologies (ART's) including but not limited to Invitro Fertilization, Gamete Intra Fallopian Tube Transfer (GIFT), Embryo Transfer (ET), Zygote Intra Fallopian Transfer (ZIFT), or the storing of frozen sperm, eggs, or gametes for future use.
7. Radial keratotomy, astigmatic keratotomy or other surgical treatment for correction of refractive errors.
8. Charges incurred as an organ or tissue donor.
9. Organ or tissue transplant (except cornea, kidney, kidney/pancreas, liver, bone marrow, stem cell, lung and heart, which may be considered with written pre-authorization).
10. Reversal of sterilization.
11. Trans-sexual operations.

12. Rhytidectomy (excision of wrinkles around the eyes).
13. Charges that are dental in origin: extraction of teeth, dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, or orthodontia, including anesthesia or supplies used in such care.
14. Complications as a result of other non-covered or ineligible surgery.
15. Injection of collagen.
16. Lipectomy, abdominoplasty, pannulectomy.
17. Repair of diastasis recti.
18. Non-FDA approved, experimental, or investigational procedures, drugs, and devices.
19. Pellet implantation.
20. Liposuction.
21. Chemical peel.
22. Charges for the treatment of weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.
23. Orthodontic treatment or expansion appliance in conjunction with jaw surgery.
24. Chin implant, genioplasty or horizontal symphyseal osteotomy.
25. Unbundling or fragmentation of surgical codes.
26. Injections of sclerosing solution for spider veins.
27. Rhinoplasty, except as a result of accidental injury in the preceding five years.
28. Laser assisted uvulopalatoplasty (LAUP).
- 2%. Additional surgical fees are not eligible when a laser is used.

***~ Anesthesia Exclusions**

1. Anesthesia charges in conjunction with ineligible surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care (standby) except in conjunction with procedure #92982, angioplasty.

***~ Medical Visits Exclusions**

1. Eye glasses, and contact lenses (with exception of one lens immediately following corneal transplant surgery or the contact lens necessary to treat keratoconus).
2. Examinations made in connection with a hearing aid.
3. Hormone injections or pellet implants (an allowance up to \$300 may be approved for injections when oral medication cannot be used). Office visits in conjunction with hormone injections are not eligible.
4. Charges for weight loss or in conjunction with weight loss programs.
5. Charges for medical hospital visits the same day or following a surgical procedure.
6. Charges for office visits in conjunction with allergy injection.
7. Health screening or services to rule out familial diseases or conditions without manifest symptoms.

8. Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.
9. Charges for nutritional counseling or analysis.
10. Charges for any injection when the material used is not identified.
11. Hypnotherapy or biofeedback.
12. Chiropractic or physical therapy primarily for maintenance care.
13. Injectable vitamins or their administration.
14. Experimental, investigational, or unproven medical practices.
15. Vision therapy.
16. Tobacco abuse.
17. Take-home medications from a provider's office.
18. Treatment therapies for developmental delay or child developmental programs.
19. Sublingual antigens.
20. Rolfing or massage therapy.
21. Hair transplants or other treatment for hair loss or restoration.
22. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD, or myofacial pain.
23. Care, treatment, or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
24. Charges for prolotherapy or chelation therapy.
25. Office calls in conjunction with repetitive therapeutic injections.
26. Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school.
27. Medical or psychological evaluations for legal purposes such as custodial rights, paternity suits, disability ratings, etc., or for insurance or employment examinations.
28. Charges for special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's practice.
29. Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise program.
30. Charges for sublingual or colorimetric testing.
31. Charges which are dental in origin including care and treatment of the teeth, gums or alveolar process, endodontia, periodontia, orthodontia, prosthetics, dental implants, or anesthesia or supplies used in such care.
32. Charges for pre-natal classes.
33. Charges for the treatment of weak, strained, flat, or unstable feet; visits in connection with orthotics; palliative care or metatarsalgia or bunions; treatment for corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.

* ~ Lab and **X-Rays** Exclusions

1. Charges in connection with weight loss programs.
2. Health screening or services to rule out familial diseases or conditions without manifest symptoms are considered routine and are excluded from coverage,
3. Genetic screening except prenatal amniocentesis or chorionic villi sampling or as described in the Pre-Authorization Section above.
4. Charges incurred as an organ or tissue donor.
5. Charges for sublingual or colorimetric testing.
6. Lab, x-ray, or diagnostic services which are unproven, experimental, or investigational.
7. Charges for hair analysis, trace elements, or dental filling toxicity.
8. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluation.
9. Routine drug screening.
10. Routine HIV/AIDS testing.
11. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

* ~ Ambulance

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.

* ~ Home Health and Hospice Exclusions

1. Nursing or aide services which are requested for your Convenience or the convenience of your family, (i.e., bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter) which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not payable. This exclusion applies regardless of whether services were recommended by a provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial care.
5. Respite care.
6. Travel or transportation expenses, escort services, or food services.

* ~ Mental Health and Substance Abuse Exclusions

1. Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.
2. Charges for mental or emotional conditions without manifest psychiatric disorder or

non-specific conditions.

3. Office calls in conjunction with repetitive therapeutic injections.
4. Charges in conjunction with wilderness programs.
5. Inpatient charges for behavior modification, enuresis, or encopresis.
6. Psychological evaluations for legal purposes such as custodial rights, etc.
7. Occupational or recreational therapy.
8. Hospital charges while on leave of absence.

* ~ Durable Medical Equipment Exclusions

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

1. Routine maintenance and care, cleaning solutions, batteries, tires, upholstery repair, etc., of Durable Medical Equipment (DME) or prosthetics.
2. Maintenance, warranty, or service contracts.
3. Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.
4. Air conditioning.
5. Home physical therapy kits.
6. Whirlpool baths and other multipurpose equipment or facilities, health spas, swimming pools, saunas, or exercise equipment.
7. Air filtration units, vaporizers, humidifiers.
8. Heating lamps or pads.
9. Charges for a continuous hypothermia machine, cold therapy, or ice packs.
10. Lift or contour chairs, vibrating chairs, or adjustable beds.
11. Dialysis equipment.
12. Orthotics, arch supports, shoe inserts or wedges, etc.
13. Orthopedic or corrective shoes. (Attachment of a brace or crossbar is eligible).
14. Hearing aids (except as indicated under Covered Services).
15. Adaptive devices used to assist with activities of daily living, vocational or life skills.
16. Communicative equipment or devices, systems, or components.
17. Computerized assistive devices; communicative boards, etc.
18. Breast pumps.
19. Vitamins, minerals, food supplements, special infant formulas, or homeopathic medicine.
20. Blood pressure monitors.
21. Wrist alarms for diabetics.
22. Enuresis alarm systems.
23. Spinal pelvic stabilizers.
24. Orthopedic braces solely for sports activities.
25. More than one breast prosthesis for each affected breast following surgery for breast

cancer.

26. More than one lens for each affected eye following corneal transplant surgery.
27. More than two pair of support hose for a medical diagnosis per policy year.
28. Computer systems or components.
29. Environmental control devices, i.e., light switches, telephones, etc.
30. Replacement of lost, damaged, or stolen DME or prosthetics.
31. Eye glasses/contact lenses (except as described in Limitations Section).

*~ Pharmacy Exclusions

The fact that a provider may prescribe, order, recommend, or approve a prescription drug, service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

1. Drugs that are not medically necessary for condition.
2. Charges for the treatment of hair loss or restoration (Rogaine).
3. Experimental or investigational drugs.
4. Anorexiant/diet aids (with the exception of Dexedrine/Desoxyn/Obetrol for documented treatment of Attention Deficient Disorder in children under age 18).
5. Any over-the-counter (OTC) drugs or drugs that do not require a prescription, except insulin.
6. Any drug not FDA approved.
7. Therapeutic devices or appliances.
8. Diagnostic agents
9. Immunization agents, biological serum, blood, or blood plasma.
10. Prescriptions which an eligible person is entitled to receive from any governmental plan or medication prescribed as a result of an industrial injury or illness payable under Workers Compensation or employer's liability laws.
11. Medications taken by you or your dependents while in an institution which operates on its premises a facility for dispensing pharmaceuticals.
12. Any drug used for cosmetic purposes.
13. Drugs used by a second party.
14. Compounded drugs (a procedure that alters the FDA approved form of a legend drug.)
15. Replacement prescriptions resulting from loss, theft or breakage.
16. Delivery or shipping charges.
17. Medication furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
18. Vitamins, minerals, food supplements, or homeopathic medicine.
19. Mother's milk or special infant formulas.
20. Anabolic steroids (used for muscle building).
21. Medication prescribed as a result of an industrial (on the job) injury or illness payable under Worker's Compensation or employer's liability laws.

***~ General Exclusions**

1. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP.
2. Charges for educational material, literature, or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illness such as diabetes.
3. Charges for services primarily for convenience, contentment, or other non-therapeutic purpose.
4. Charges for unproven medical practices or care, treatment, or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
5. Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.
6. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.
7. Charges which the insured is not, in absence of coverage, legally obligated to pay.
8. Charges for services, treatments, or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
9. Charges for services or supplies received as a result of an act of war occurring when the insured is covered by CHIP.
10. Shipping, handling, or finance charges.
11. Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.
12. Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which, is payable under workman's compensation or employer's liability laws.
13. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
14. Charges for expenses in connection with appointments scheduled and not kept.
15. Charges for telephone calls or consultations.
16. Charges made for completion or submission of insurance forms.

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE
PROGRAM

Attachment C: Actuarial Certification



Department of Health
July 1, 1998

**ACTUARIAL CERTIFICATION
CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
STATE OF UTAH**

PURPOSE: This certification is to demonstrate compliance of the Children's Health Insurance Program (CHIP) as designed and to be implemented by the State of Utah with the requirements of Title XXI with respect to the actuarial value of coverage of the plan proposed.

PLAN BENEFITS PROPOSED: *Two similar* benefit plans have been designed, based on the benefits provided to employees of the state of Utah - one for the children from families between **150%** and **200%** of the federal poverty limits, and the other for children from families between 100% and **149%** of the federal poverty limits.

The plan designed for the children from families between **150%** and **200%** of the federal poverty limits is as follows:

**Co-Insurance and Co-Payment Requirements
For CHIP clientdenrollees above 150%of the federal poverty level**

Hospital Services (inpatient, outpatient and emergency department)

Coinsurance 10%
\$30 copayment for each emergency department visit

Outpatient Office Visits

This includes physician, physician-related, physical therapy, speech therapy, chiropractic, and podiatry visits.

\$10 copayment per visit
No copayment for well-baby care, well-child care and immunizations.

Laboratory and X-Ray Services

For laboratory services under **\$50:** No copayment or coinsurance
For laboratory services above **\$50:** Coinsurance **10%**
For X-ray services under \$100: No copayment or coinsurance
For X-ray services above \$100: Coinsurance **10%**

Prescription Drugs

For generic drugs and brand name drugs on an approved list: \$1.00 copayment/Rx
For brand name drugs not on **an** approved list: Coinsurance **50%**

Vision Screening Services

100%coverage up to \$30

Hearing Screening Services

100%coverage up to \$30

--	--	--

Durable Medical Equipment and Supplies

Coinsurance 20%

Dental Services

For cleaning, oral exam and fluoride, **100%** coverage
For dental fillings: Coinsurance 20%

Mental Health Services

Inpatient Care:

Coinsurance **10%** for first **10** days
50% for next 20 days

Residential treatment in lieu of inpatient care may be substituted at same coinsurance.

Outpatient Care:

Coinsurance **50%**

Out-of-Pocket Maximum

\$800 per family/year, subject to a maximum of **5%** of the family income.

The plan designed for the **children** from families between **100%** and **150%** of the federal poverty limits is as follows:

Go-Payment Requirements

For CHIP client denrollees above 100% of the federal poverty level

Hospital Services

\$10 copayment for each emergency department visit
(**\$5** for physician services and **\$5** for hospital services)

Outpatient Office Visits

This includes physician, physician-related, mental health, physical therapy, speech therapy, chiropractic, and podiatry visits.

\$5 copayment per visit

No copayment for well-baby care, well-child care and immunizations.

Prescription Drugs

\$1.00 copayment per prescription

All Other Services Covered Under 160% Plan

No copayment or coinsurance

Out-of-Pocket Maximum

\$500 per family/year, subject to a maximum of **5%** of the family income.

BASIS FOR CALCULATION OF ACTUARIAL VALUE: The benchmark benefit package selected was the benefit plan provided to the employees of the state of **Utah**. The actuarial value for each of the above CHIP plans was primarily based on

the actual use of services (utilization), and the charge for those services (price factors), found for covered persons under the age of 19 covered under the Public Employees Health Plan (PEHP) for the State of Utah. PEHP covers approximately 45,000 such covered persons, geographically dispersed throughout the state comparable to the dispersion of the total state population.

Where comparable benefits did not exist under PEHP (such as well child visits and type of coverage for immunizations), utilization and price factors were drawn from actual data from managed health care plans in Utah covering typical commercial populations.

The calculation of actuarial value was made without incorporating any adjustments to utilization based on any of the following:

- e any utilization management implemented
- e the method of delivery of the benefits
- e the latent need of the population expected to be covered
- e the propensity of any population to use services in the absence of any financial disincentive
- e any variation from utilization by a standardized population with regard to the type of provider or setting of care used

As such, the calculation of actuarial value used a standardized set of utilization and price factors, from a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan.

The calculation did presume certain discounts from billed charge typical for similar programs already in effect in the state. In general, the discount assumed averaged 20%. The process used was to determine the expected claim cost per person per month (PMPM) by category of service, based on the following formula:

$$\begin{aligned} & [\text{Use per } 1000 \text{ persons per year}] \times [\text{charge per service} \times \text{discount} - \text{copayment}(\text{if} \\ & \qquad \qquad \qquad \text{any})] \\ & \qquad \qquad \qquad \times [1 - \text{coinsurance}(\text{if any})] / 12000 \end{aligned}$$

The sum of the PMPM amounts by category was then increased by the effect of the limitation on family out-of-pocket amounts. The value of the limitation of the out-of-pocket amounts was estimated based on an estimate of the frequency of family units by number of children, and the effect such out-of-pocket amount limitations would have had on existing insureds.

The attached Exhibit A details the specific utilization and price factor assumptions.

Actual claim costs per person per month for those covered under PEHP under the age of 19, plus 4% administration, were \$61.88 for the experience period used. "he

actuarial value of the benefits under CHIP for the population between **150%** and **200%** of the federal poverty level, using the above referenced standardized sets, plus **4%** administration, equaled **\$62.60** per person per month. The variation was **1.2%**, within the limits of variation to certify as to actuarial equivalence. For the benefit plan design for the population under **150%** of the federal poverty level, the benefit value exceeded that of the plan design for those at **150%** or more of the federal poverty level by **10.9%**.

CERTIFICATION: I, Joan P. Ogden, principal of Joan Ogden Actuaries, **am** a member of the American Academy of Actuaries. I have been retained by the Department of Health of the State of Utah for the evaluation of and rating for the Children's Health Insurance Plan.

I **certify** that there is no significant difference in the actuarial value of coverage of the CHIP plan identified above for the children **from** families between **150%** and **200%** of federal poverty levels and the actuarial value of the coverage of the benchmark benefit package. Further, the actuarial value of the coverage for the **CHIP** plan identified above for the children **from** families between **100%** and **150%** of federal poverty levels is **12.2%** above the actuarial value of the coverage for the benchmark benefit package.

Joan P. Ogden, QHA, FCA, MAAA
Consulting Actuary
Joan Ogden Actuaries
515 South 700 East, Suite 2B-1
Salt Lake City, Utah 84102
(801) 328-1717

EXHIBIT A

CATEGORY	FREQUENCY/1000/YR	BILLED CHARGE PER USE
ALLERGY TESTING	223	\$4.79
ALLERGY TREATMENT	231	\$13.39
AMBULANCE	2	\$420.58
CARDIOVASCULAR	3	\$369.21
CHEMOTHERAPY	1	\$87.79
CHIROPRACTOR	6	\$91.64
CONSULTS	40	\$136.73
CRITICAL CARE	6	\$254.93
DIALYSIS	2	\$195.75
DME	3	\$125.91
DRUGS	5750	\$19.80
EKG/ECG	3	\$46.31
ER	150	\$312.50
ER 1X SURG	5	\$324.78
ER 2X SURG	36	\$196.30
ER VISITS	150	\$108.66
GASTROENTEROLOGY	0	\$141.72
HOME HEALTH	3	\$120.55
HOSPITAL VISITS	136	\$91.73
IMMUNIZATIONS	1222	\$18.30
INFUSION THERAPY	0	\$89.02
INJECTIBLE DRUGS	72	\$25.91
INJECTIONS	19	\$15.78
IP 1X SURG	0	\$1,452.67
IP 2X SURG	2	\$1,971.63
IP 3X SURG	4	\$1,700.24
IP 4X SURG	3	\$1,639.73
IP 5X SURG	1	\$1,829.70
IP 6X SURG	9	\$2,430.55
IP MAT	1	\$1,464.15
IP MED	42	\$1,464.15
IP PSYCH/DRUG	13	\$976.10
IP SURG	33	\$1,464.15
LAB PC	74	\$70.95
LAB TOT	1698	\$27.75
MAT IP DEL C SECT	0	\$2,001.29
MAT IP DEL NORMAL	0	\$1,721.45
MAT IP NONDEL	0	\$621.12
MISC ALPHA CODES	101	\$4.80
MISCELLANEOUS	143	\$82.92
NEONATAL INTENSIVE CARE	2	\$345.40
NEUROLOGY	10	\$112.29
NORMAL NEWBORN CARE	56	\$121.21
OFFICE 2X SURG	33	\$78.23
OFFICE 3X SURG	5	\$124.27
OFFICE 4X SURG	9	\$249.15
OFFICE 5X SURG	3	\$156.99
OFFICE 6X SURG	19	\$81.93
OFFICE DERM SURG	94	\$69.53

CATEGORY	FREQUENCY/1000/YR	BILLED CHARGE PER USE
OFFICE VENIPUNCTURE	293	\$9.11
OFFICE VISITS	2765	\$51.62
OP 2X SURG	19	\$966.12
OP 3X SURG	4	\$485.41
OP 4X SURG	9	\$701.55
OP 5X SURG	1	\$731.40
OP 6X SURG	10	\$663.39
OP LAB	104	\$55.49
OP OTHER	3	\$394.36
OP SURG	12	\$1,281.13
OP XRAY	82	\$260.37
OPHTHALMOLOGY	48	\$63.00
OTHER	0	\$95.33
OTORHINOLARYNG	9	\$89.75
PHD/LCSW	249	\$88.65
PHYSICAL MED	42	\$68.22
PROLONGED SERVICES	1	\$168.16
PROSTHETICS	0	\$208.23
PSYCH	43	\$85.41
PULMONOLOGY	19	\$41.57
RADIOL PC	36	\$82.20
RADIOL TOT	311	\$130.19
REIMBURSABLE SUPPLIES	19	\$11.44
ROUTINE HEARING	36	\$36.60
ROUTINE PODIATRIC	0	\$30.60
ROUTINE VISION	170	\$36.60
SNF	7	\$122.01
SPECIAL SERVICES	93	\$31.13
SUPPLIES	50	\$38.06
WELL CHILD	947	\$55.00
DENTAL ORAL EXAM	750	\$18.82
DENTAL BITEWING X-RAYS	750	\$16.00
DENTAL PROPHYLAXIS	195	\$25.00
DENTAL TOPICAL APPLICATION OF FLUORIDE INCLUDING PROPHYLAXIS	555	\$37.00
DENTAL RESTORATIONS	311	\$39.69

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE
PROGRAM

Attachment D: Hospital Tax Exhibits



Department of Health
July 1, 1998

History of the Utah Provider Tax

Provided by Rod L. Betit
Executive Director
Utah Department of Health

In August 1993, the Utah legislature adopted a law authorizing a uniform tax on hospitals. The tax was imposed on adjusted patient days of the hospital at a rate specified by the Director of the Department of Health that would generate revenues not to exceed amounts prescribed in the statute. Proceeds from the tax are deposited into a special account to be used to help pay for hospital services under the Medicaid program.

The statute authorized the director to exempt hospitals from the tax to the extent authorized by a waiver granted by the federal agency. Pursuant to this authority, the director exempted psychiatric hospitals, rural hospitals, an HMO hospital, and a Shriner's hospital. Each of these exemptions was authorized by federal regulations provided that the resulting tax program satisfied numerical standards established in federal regulations. The state demonstrated in waiver applications submitted to the Health Care Financing Administration (HCFA) that it easily met the numerical standards.

There is a federal law requirement that a provider tax be applied uniformly to all providers. Initially, HCFA took the position that Utah's tax did not meet this requirement because it was imposed on a patient-day basis. Utah disagreed with this interpretation of the federal law. In late 1997, HCFA announced that it had changed its position and that it now regarded patient-day taxes as meeting the uniformity standard. However, prior to that reversal of HCFA's interpretation, Utah moved to convert its taxing methodology to a revenue based approach effective July 1, 1997.

Notwithstanding Utah's change to a revenue-based methodology, HCFA has never acted on Utah's pending applications to approve its taxes under the waiver provisions of the federal regulations. Utah is aware of no other issue raised by its waiver application that would interfere with approval.

The provider tax was scheduled to expire on June 30, 1998, but recently the Utah legislature extended the tax—though specifying a somewhat lower amount as the annual maximum. It also expanded the purpose for which the funds in the special account could be used, to include paying for services to children under the state's Title XXI Children's Health Insurance Program.

Utah's hospital tax is fully consistent with all federal requirements. It has been in place for five years, and will continue in force as a result of recent legislative action without any substantive change in its characteristics. There is no basis for believing that the proceeds of this tax may not appropriately be used to help finance the state's Children's Health Insurance Program under Title XXI of the Social Security Act.

March 26, 1998

TO: Mike Morgan, Manager, DHCF
FROM: Roy Dunn, Assistant Director, DHCF
SUBJECT: Hospital Tax

The purpose of this memorandum is to explain the hospital tax provisions of HB 137 (Utah Code 26-40-111). This law establishes the Children's Health Insurance Program (CHIP). The law retains the existing method of calculating the hospital assessment tax. The attached form is used to collect the current tax. It is emphasized that the current hospital calculation is .0044 times inpatient revenue and the July 1, 1998, replacement tax will be about .0032 times inpatient revenue. In the past, most of the hospital tax has been used to fund the Medicaid program, including HMO premiums. The replacement tax will be used primarily to fund CHIP, including HMO premiums. As indicated by the reduced percent used to calculate the tax, the amount of tax paid by hospitals will decrease. The basic formula of "inpatient revenue times a percent" remains.

Attachment

Definitions

“Gross Revenue” for any hospital during a particular measuring period means standard, no-discounted charges for all services rendered to patients by the hospital during a measuring period.

“Hospital” means any general acute hospital operating in the state of Utah as defined in Subsection 26-21-2(8), and any specialty hospital operating in the state of Utah as defined in Subsection 21-21-2(8) that may be engaged exclusively in rendering psychiatric or other mental health treatment.

“Hospital” does not include residential care or treatment facilities as defined in Subsections 62A-2-101(17), (18), and (20), health maintenance organization-owned services facilities, the Utah State Hospital or any rural hospital that operates outside of a metropolitan statistical area, a metropolitan area, or an urbanized area as designated by the U.S. Census Bureau.

“Inpatient” means a patient of a hospital who is admitted on an overnight basis.

“Inpatient day” means with respect to each hospital patient excluding patients in the nursery, skilled nursing and labor room, each 24-hour period during which a patient is an inpatient of the hospital.

“Inpatient services” means all services rendered by a hospital to a inpatient.

HB 137 (Enrolled)

CHILDREN'S HEALTH INSURANCE PROGRAM

1998 GENERAL SESSION

STATE OF UTAH

Sponsor: Peter C. Knudson

Mary Carlson

Gary F. Cox

AN ACT RELATING TO HEALTH; AMENDING THE MEDICAID RESTRICTED ACCOUNT; CREATING THE UTAH CHILDREN'S HEALTH INSURANCE PROGRAM; PROVIDING THE BASIC STRUCTURE OF THE PROGRAM; ESTABLISHING ELIGIBILITY REQUIREMENTS AND PROGRAM BENEFITS; ESTABLISHING THE GENERAL DUTIES OF THE DEPARTMENT OF HEALTH UNDER THE PROGRAM; CREATING AN ADVISORY COUNCIL; IMPOSING AN ASSESSMENT ON HOSPITALS TO FUND THE PROGRAM; CREATING A RESTRICTED ACCOUNT; PERMITTING THE DEPARTMENT TO CONTRACT WITH THE UTAH STATE RETIREMENT OFFICE TO PROVIDE HEALTH INSURANCE SERVICES IF NO PRIVATE BID IS ACCEPTABLE; AND REPEALING THE UTAH MEDICAID HOSPITAL PROVIDER TEMPORARY ASSESSMENT ACT.

This act affects sections of Utah Code Annotated **1953** as follows:

AMENDS:

26-18-402, as enacted by Chapter **108**, Laws of Utah **1996**

49-8-203, as enacted by Chapter **1**, Laws of Utah **1987**

49-8-204, as enacted by Chapter **200**, Laws of Utah **1988**

49-8-401, as last amended by Chapter **89**, Laws of Utah **1990**

ENACTS:

26-40-101, Utah Code Annotated **1953**

26-40-102, Utah Code Annotated **1953**

26-40-103, Utah Code Annotated **1953**

26-40-104, Utah Code Annotated **1953**

26-40-105, Utah Code Annotated **1953**

26-40-106, Utah Code Annotated **1953**

26-40-107, Utah Code Annotated **1953**

26-40-108, Utah Code Annotated **1953**

26-40-109, Utah Code Annotated **1953**

26-40-110, Utah Code Annotated **1953**

26-40-111, Utah Code Annotated **1953**

26-40-112, Utah Code Annotated **1953**

26-40-113, Utah Code Annotated **1953**

26-40-114, Utah Code Annotated **1953**

REPEALS:

- 26-36-101**, as enacted by Chapter **187**, Laws of Utah **1993**
- 26-36-102**, as last amended by Chapter **209**, Laws of Utah **1995**
- 26-36-103**, as enacted by Chapter **187**, Laws of Utah **1993**
- 26-36-104**, as last amended by Chapter **209**, Laws of Utah **1997**
- 26-36-105**, as last amended by Chapter **178**, Laws of Utah **1997**
- 26-36-106**, as last amended by Chapter **93**, Laws of Utah **1994**
- 26-36-107**, as enacted by Chapter **187**, Laws of Utah **1993**
- 26-36-108**, as enacted by Chapter **187**, Laws of Utah **1993**
- 26-36-109**, as last amended by Chapter **209**, Laws of Utah **1995**
- 26-36-110**, as last amended by Chapter **209**, Laws of Utah **1995**

This act enacts uncodified material. Be it enacted by the Legislature of the state of Utah:

Section ~~1~~ Section **26-18-402** is amended to read:

26-18-402. Medicaid Restricted Account.

- (1) There is created a restricted account in the General Fund known as the Medicaid Restricted Account.
- (2)
 - (a) Any general funds appropriated to the department for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and which are not otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account[, which is the proper account for the funds under Section **63-38-8**].
 - (b) The account shall earn interest and all interest earned shall be deposited into the account.
 - (c) The Legislature may appropriate monies in the restricted account to fund programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter **40**.

Section **2**. Section **26-40-101** is enacted to read:

CHAPTER 40. UTAH CHILDREN'S HEALTH INSURANCE ACT 26-40-101. Title.

This chapter is known as the "Utah Children's Health Insurance Act."

Section **3**. Section **26-40-102** is enacted to read:

26-40-102. Definitions. As used in this chapter:

- (1) "Assessment" means the hospital provider assessment established in Section **26-40-111**
- (2) "Child" means a person who is under **19** years of age.
- (3) "Eligible child" means a child who qualifies for enrollment in the program as provided in Section **26-40-105** .
- (4) "Enrollee" means any child enrolled in the program.

(5) "Freestanding ambulatory surgical facility" means an urban or rural nonhospital-based or nonhospital-affiliated licensed facility, as defined in Section 26-21-2, as an ambulatory surgical facility, with an organized professional staff that provides surgical services to patients who do not require an inpatient bed.

(6) (a) "Hospital" means any general acute hospital, as defined in Section 26-21-2, operating in this state.

(b) "Hospital" does not include:

(i) a residential care or treatment facility, as defined in Subsections 62A-2-101 (16), (17), and (19);

(ii) the Utah State Hospital;

(iii) any rural hospital that operates outside of a metropolitan statistical area, a metropolitan area, or an urbanized area as designated by the U.S. Bureau of Census; or

(iv) any specialty hospital operating in this state, as defined in Section 26-21-2 that is engaged exclusively in rendering psychiatric or other mental health treatment.

(7) "Hospital-based ambulatory surgical facility" means an urban or rural on-hospital campus or hospital-affiliated licensed facility with an organized professional staff that provides surgical services to patients who do not require an inpatient bed.

(8) "Plan" means the department's plan submitted to the United States Department of Health and Human Services pursuant to 42 U.S.C. Sec. 1397ff.

(9) "Program" means the Utah Children's Health Insurance Program created by this chapter.

Section 4. Section 26-40-103 is enacted to read: 26-40-103. Creation and administration of the Utah Children's Health Insurance Program.

(1) There is created the Utah Children's Health Insurance Program to be administered by the department in accordance with the provisions of:

(a) this chapter; and

(b) the State Children's Health Insurance Program, 42 U.S.C. Sec. 1397 et seq.

(2) The department shall:

(a) prepare and submit the state's children's health insurance plan before May 1, 1998, and any amendments to the federal Department of Health and Human Services in accordance with 42 U.S.C. Sec. 1397ff; and

(b) make rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act regarding:

(i) eligibility requirements;

(ii) program benefits;

(iii) the level of coverage for each program benefit;

(iv) cost-sharing requirements for enrollees, which may not:

(A) exceed the guidelines set forth in 42 U.S.C. Sec. 1397ee; or

(B) impose deductible, copayment, or coinsurance requirements on an enrollee for well-child, well-baby, and immunizations;

(v) the administration of the program; and

- (vi) the provider assessment, including:
 - (A) the factor for the assessment;
 - (B) the administration, collection, and enforcement of the assessment, including:
 - (I) auditing a provider's records; and
 - (II) imposing penalties for failure to pay the assessment as required; and
 - (C) reducing the amount of the assessment to the extent funds are deposited into the Hospital Provider Assessment Account created in Section 26-40-112 as a result of private contributions to the program.
- (3) Before July 1, 2001, the Governor's Office of Planning and Budget shall study the effectiveness of the department's administration of the program and report any findings to:
 - (a) the Health and Human Services Interim Committee of the Legislature;
 - (b) the Health Policy Commission; and
 - (c) the department.

Section 5. Section 26-40-104 is enacted to read: 26-40-104. Advisory Council.

- (1) There is created a Utah Children's Health Insurance Program Advisory Council consisting of at least eight and no more than eleven members appointed by the executive director of the department. The term of each appointment shall be three years. The appointments shall be staggered at one-year intervals to ensure continuity of the advisory council.
- (2) The advisory council shall meet at least quarterly.
- (3) The membership of the advisory council shall include at least one representative from each of the following groups:
 - (a) child health care providers;
 - (b) parents and guardians of children enrolled in the program;
 - (c) ethnic populations other than American Indians;
 - (d) American Indians;
 - (e) the Health Policy Commission;
 - (f) the Utah Association of Health Care Providers;
 - (g) health and disability insurance providers; and
 - (h) the general public.
- (4) The advisory council shall advise the department on:
 - (a) benefits design;
 - (b) eligibility criteria;
 - (c) outreach;
 - (d) evaluation; and
 - (e) special strategies for under-served populations.
- (5) (a)
 - (i) Members who are not government employees may not receive compensation or benefits for their services, but may receive per diem and expenses incurred in the performance of the member's official duties at the rates

established by the Division of Finance under Sections **63A-3-106** and **63A-3-107** .

- (ii) Members may decline to receive per diem and expenses for their service.
- (b)
- (i) State government officer and employee members who do not receive salary, per diem, or expenses from their agency for their service may receive per diem and expenses incurred in the performance of their official duties from the council at the rates established by the Division of Finance under Sections **63A-3-106** and **63A-3-107** .
 - (ii) State government officer and employee members may decline to receive per diem and expenses for their service.

Section 6. Section **26-40-105** is enacted to read: **26-40-105**. Eligibility.

- (1) To be eligible to enroll in the program, a child must:
- (a) be a bona fide Utah resident;
 - (b) be a citizen or legal resident of the United States;
 - (c) be under **19** years of age;
 - (d) not have access to or coverage under other health insurance, including any coverage available through a parent or legal guardian's employer;
 - (e) be ineligible for Medicaid benefits;
 - (9) reside in a household whose gross family income, as defined by rule, is at or below **200%** of the federal poverty level; and
 - (g) not be an inmate of a public institution or a patient in an institution for mental diseases.
- (2) A child may not be determined to be ineligible to enroll in the program based on diagnosis or pre-existing condition.
- (3) The department shall determine eligibility and send notification of the decision within **30** days after receiving the application for coverage. If the department cannot reach a decision because the applicant fails to take a required action or there is an administrative or other emergency beyond the department's control, the department shall:
- (a) document the reason for the delay in the applicant's case record; and
 - (b) inform the applicant of the status of the application and time frame for completion.

Section 7. Section **26-40-106** is enacted to read: **26-40-106**. Program benefits. At a minimum, program benefits shall include:

- (1) hospital services;
- (2) physician services;
- (3) laboratory services;
- (4) prescription drugs;
- (5) mental health services;
- (6) basic dental services;

- (7) preventive care including:
- (a) routine physical examinations;
 - (b) immunizations;
 - (c) basic vision services; and
 - (d) basic hearing services;
- (8) limited home health and durable medical equipment services; and
- (9) hospice care.

Section 8. Section ~~26-40-107~~ is enacted to read: **26-40-107. Limitation of benefits.**
Abortion is not a covered benefit, except as provided in **42 U.S.C. Sec. 1397ee.**

Section 9. Section ~~26-40-108~~ is enacted to read: **26-40-108. Funding.**

- (1) The program shall be funded by federal matching funds received under, together with state matching funds required by, **42 U.S.C. Sec. 1397ee.**
- (2) Program expenditures in the following categories may not exceed **10%** in the aggregate of all federal payments pursuant to **42 U.S.C. Sec. 1397ee:**
- (a) other forms of child health assistance for children with gross family incomes below **200%** of the federal poverty level;
 - (b) other health services initiatives to improve low-income children's health;
 - (c) outreach program expenditures; and
 - (d) administrative costs.

Section 10. Section ~~26-40-109~~ is enacted to read: **26-40-109. Evaluation.**

- (1) The department shall develop performance measures and annually evaluate the program's performance.
- (2) The department shall report annually on its evaluation to the Health and Human Services Interim Committee of the Legislature and the Health Policy Commission before November 1.

Section ~~11~~. Section ~~26-40-110~~ is enacted to read: **26-40-110. Managed care -- Contracting for services.**

- (1) Services provided to enrollees under the program shall be delivered in a managed care system if services are available within 30 paved road miles of where the enrollee lives or resides. Otherwise, the program may provide services to enrollees through fee for service plans.
- (2) Before awarding a contract to a managed care system or fee for service plan to provide services under Subsection (1) or determining that no bid or proposal received in response to such a request is acceptable, the executive director shall report that information to and seek recommendations from the Health Policy Commission.
- (3) If after seeking the recommendation of the Health Policy Commission under Subsection (2), the executive director determines that no bid or proposal received in response to such

a request is acceptable or if no bid or proposal has been received in response to such a request, the department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1).

(4) Title 63, Chapter 56, Utah Procurement Code, shall apply to this section. Section 12.

Section 26-40-1 ■1 is enacted to read: 26-40-111. Provider assessment.

(1) Other than for the imposition of the assessment described in and utilized for the purposes of the chapter, nothing in this chapter affects the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under 26 U.S.C. Sec. 501(c), as amended, or other applicable federal law, or under any state law, or any activities of or property owned by any such provider with respect to exemption from ad valorem property taxes, income or franchise taxes, sales or use taxes, or any other taxes, fees, or assessments whatever, whether imposed or sought to be imposed by the state or any political subdivision, county, municipality, district, authority, or any agency or department thereof.

(2) For providers subject to the assessment imposed by this chapter, and also subject to the corporate franchise or incometax under Title 59, Chapter 7, all assessments paid under this chapter shall be allowed as a deductible expense under Title 59, Chapter 7.

(3) Beginning on July 1, 1998, a uniform, broad-based, quarterly rate of assessment is imposed on each hospital, hospital-based ambulatory surgical facility, and freestanding ambulatory surgical facility in accordance with department rule, which:

(a) may not exceed \$5,500,000 in the aggregate in any fiscal year; and

(b) shall be reduced to the extent that funds are deposited into the Hospital Provider Assessment Account created in Section 26-40-112 as a result of private contributions to the program.

(4) A reduction in assessment that occurs as a result of Subsection (3)(b) shall apply to as many subsequent **fiscal** years as is possible based on the total amount of funds deposited into the restricted account.

(5) The department shall forward proceeds from the assessment imposed by this chapter to the state treasurer for deposit into the Hospital Provider Assessment Account created in Section 26-40-112 .

Section 13. Section 26-40-112 is enacted to read: 26-40-112. Hospital Provider Assessment Account.

(1) There is created within the General Fund a restricted account known as the "Hospital Provider Assessment Account."

(2) The account shall be nonlapsing and consist of:

(a) proceeds from the assessment imposed in accordance with Section 26-40-111

(b) funds transferred from the Medicaid Hospital Provider Temporary Assessment Account;

(c) private contributions;

- (d) interest earned on monies in the **account**; and
 - (e) any funds received by virtue of the state's action for reimbursement of medicaid funds from tobacco manufacturers that are not restricted by use or purpose by:
 - (i) the federal government;
 - (ii) state or federal law; or
 - (iii) the terms of any settlement agreement, order, law, or related contract.
- (3) Funds in the account shall be appropriated by the Legislature to fund:
- (a) the program; and
 - (b) if funds remain after Subsection (3)(a), the Medicaid program.

Section 14. Section **26-40-113** is enacted to read: **26-40-113**. Intergovernmental transfers.

The assessment imposed by this chapter otherwise applicable to the University of Utah Hospital and to any other publicly owned or operated hospital may be provided by means of a quarterly governmental transfer to the department in lieu of payment and collection of the assessment.

Section 15. Section **26-40-114** is enacted to read: **26-40-114**. Repeal of assessment.

This assessment shall be repealed upon the certification by the executive director or court order that the sooner of the following has occurred:

- (1) the effective date of any existing or future action by Congress to disqualify the assessments from counting toward state funds available to be used to determine the federal financial participation in the program; or
- (2) the effective date of any decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state or of the federal government that has the effect of disqualifying the assessments from counting toward state funds available to be used to determine federal financial participation in the program.

Section 16. Section 49-8-203 is amended to read: 49-8-203. Eligibility for participation in program -- Optional for certain groups.

- (1) All employers of the state, its educational institutions, and political subdivisions are eligible to participate in this program, but this section does not require political subdivisions, school districts, or institutions of higher education, including technical colleges, to participate in the program.
- (2) The Department of Health may participate in this program for the purpose of providing program benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40, if the provisions in Subsection **26-40-110** (4) occur. If the Department of Health participates in the program under the provisions of this Subsection (2), all insurance risk associated with the Children's Health Insurance Program shall be the responsibility of the Department of Health and not the group insurance division or the retirement office.

Section 17. Section **49-8-204** is amended to read: **49-8-204**. Group insurance division - Establishment of separate risk pools - Rules governing admission to program. The group insurance division shall establish:

- (1) separate risk pools for state employees [and for], political subdivisions, and, if applicable, children enrolled in the Utah Children's Health Insurance Program, created in Title 26, Chapter 40, for purposes of providing the benefits permitted by this chapter; and
- (2) rules and procedures governing the admission of political subdivisions to the program.

Section 18. Section **49-8-401** is amended to read: **49-8-401**. Group insurance division -- Powers and duties.

- (1) The group insurance division of the retirement office shall:
 - (a) act as a self-insurer of employee group benefit plans and administer those plans;
 - (b) enter into contracts with private insurers to underwrite employee group benefit plans and to reinsure any appropriate self-insured plans;
 - (c) publish and disseminate descriptions of all employee benefit plans under this chapter in cooperation with the Department of Human Resource Management and political subdivisions;
 - (d) administer the process of claims administration of all employee benefit plans under this chapter or enter into contracts, after competitive bids are taken, with other benefit administrators to provide for the administration of the claims process;
 - (e) obtain an annual actuarial evaluation of all self-insured benefit plans and prepare an annual report for the governor and the Legislature describing the employee benefit plans being administered by the retirement office detailing historical and projected program costs and the status of reserve funds;
 - (f) consult with the Department of Human Resource Management and the executive bodies of other political subdivisions to evaluate employee benefit plans and develop recommendations for new or improved benefit plans;
 - (g) submit annually a budget which includes total projected benefit and administrative costs;
 - (h) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the self-funded employee group benefit plans as estimated by the board's consulting actuary;
 - (i) submit its recommended benefit adjustments for state employees upon approval of the board to the director of the Department of Human Resource Management. The Department of Human Resource Management shall include the benefit adjustments in the total compensation plan recommended to the governor required by Subsection **67-19-12 (6)(a)**;
 - (j) adjust benefits, upon approval of the board, and upon appropriate notice to the state, its educational institutions, and political subdivisions; [and]
 - (k) for the purposes of stimulating competition, establishing better geographical distribution of medical care services, and providing alternative health and dental

plan coverage for both active and retired employees, request proposals for alternative health and dental coverage at least once every three years[. Proposals], proposals which meet the criteria specified in the request shall be offered to active and retired state employees and may be offered to active and retired employees of political subdivisions at the option of the political subdivision[.]; and

(l) perform the same functions established in Subsections (1)(a),(b), (d), and (g) for the Department of Health if the group insurance division provides program benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40.

(2) Funds budgeted and expended shall accrue from premiums paid by the various employers. Administrative costs may not exceed that percentage of premium income which is recommended by the board and approved by the governor and the Legislature.

Section 19. Transfer of funds.

On the effective date of this act, any funds contained in the Medicaid Hospital Provider Temporary Assessment Account, created in Section 26-36-107 and repealed by this act, shall be transferred to the Hospital Provider Assessment Account created in Section 26-40-112 .

Section 20. Repealer. This act repeals:

Section 26-36-101, Short title.

Section 26-36-102, Legislative findings.

Section 26-36-103, Application of act.

Section 26-36-104, Definitions.

Section 26-36-105, Assessment, collection, and payment of Medicaid Hospital Provider Temporary Assessment.

Section 26-36-106, Reporting and auditing requirements.

Section 26-36-107, Restricted account -- Creation -- Deposits.

Section 26-36-108, Intergovernmental transfers.

Section 26-36-109, Repeal of assessment.

Section 26-36-110, Federal law compliance -- Provider participation -- Waiver requests.

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE
PROGRAM

Attachment E: *HealthPrint*



Department of Health
July 1, 1998

HEALTHPRINT: A BLUE PRINT FOR MARKET-ORIENTED HEALTH CARE

Executive Summary

Utah HealthPrint — a blueprint for market-oriented health care — is a realistic approach to accessing affordable health care, containing costs, and maintaining and improving quality.

The Target

- Healthprint will increase access to affordable insurance coverage for **all** Utahns.
- The spiraling rise in health care costs will be contained through enhanced competition.
- The high level of quality health care enjoyed by Utahns will be maintained and enhanced.
- Healthprint will receive broad community support because it provides **a** process for thoughtful reform of the health care system.

Principles

- The individual should be responsible for their own health coverage.
- Choice of provider should be decided by a cost-conscious consumer.
- The problems in the current market should be fixed by enhancing competition rather than setting up a government-run system.
- Health system reform should not require new taxes.
- Effective health system reform is a long-term, ongoing process.

Utah HealthPrint

Increase Access to Affordable Insurance

- Insurance will be portable when changing jobs.
- Insurers cannot exclude coverage of any preexisting medical condition from anyone who changes insurance plans.
- Insurers cannot cancel or refuse to renew coverage of a health insurance policy except for failure to meet contractual obligations, such as non-payment of premiums.
- Insurers will provide dependent coverage up to age 26.

- o Medicaid will be expanded to provide coverage for low-income individuals and be financed by the savings generated from managed care. Approximately 32,000 additional children will be covered in **1994**.
- Premiums will be rated on a modified community basis for small groups, allowing insurers to vary premiums only on the basis of age, gender and geography. To encourage prevention and healthy lifestyles, insurers could give individuals discounts to promote healthy behavior.
- o Pooling of risk will reduce the variation in premiums for small groups and individuals.
- o Choice of health plan will increase for employees working in small firms.

Contain Rising Health Care Costs

- A co-op will provide a platform for competition between health plans.
- o The co-op provides economies of scale to individuals and small group purchasers. The average administrative expense for groups under 5 is estimated as high as **40** percent of premium versus 5 percent for groups over 10,000.
- o The use of capitation as a reimbursement method for health plans will increase. Capitation reimburses the provider a fixed dollar amount for each person served in a fixed time period, regardless of the actual number or nature of services provided.
- o Medical savings accounts could be offered through the co-op.

Maintain and Enhance Quality

- o Utah HealthPrint anticipates an increase in quality as consumers receive information on medical outcomes and patient satisfaction with health plans.
- o Quality improvement must occur from the bottom up and not from a government-mandated top down approach.

Introduction

At the request of the Governor, the **1993** Utah Legislature established the Health Care Policy Option Commission to propose options for reforming the state's health care system. The Commission completed its work and issued a final report in December **1993**. The Governor has reviewed the health care reform options recommended by the commission and now introduces Utah Healthprint -- a blueprint for market-oriented health care. HealthPrint establishes a rational process for providing affordable health care coverage to all Utahns.

The Target

Utah HealthPrint will increase access to affordable insurance coverage for all Utahns. Individuals will not be turned down by health insurers because of a preexisting condition. Employees will not be locked into a job because of the fear of losing their health insurance. HealthPrint will change the rules of the marketplace in order to provide security of health care coverage for all Utahns.

The spiraling rise in health care costs will be contained through enhanced competition. Through increased consumer involvement and a change in provider incentives, the health care market would have increased price competition -- a proven method of cost control.

The high level of quality health care enjoyed by Utahns will be maintained. In fact, the quality of care will increase as providers make continuous improvements required by a competitive environment.

The enactment of HealthPrint will begin true health care reform in Utah. Many health reform plans look good on paper but never get tried. HealthPrint is a politically feasible solution because it provides a reasonable process for reforming the health care system.

Environmental Assumptions

In developing Healthprint, six major environmental assumptions were recognized and considered.

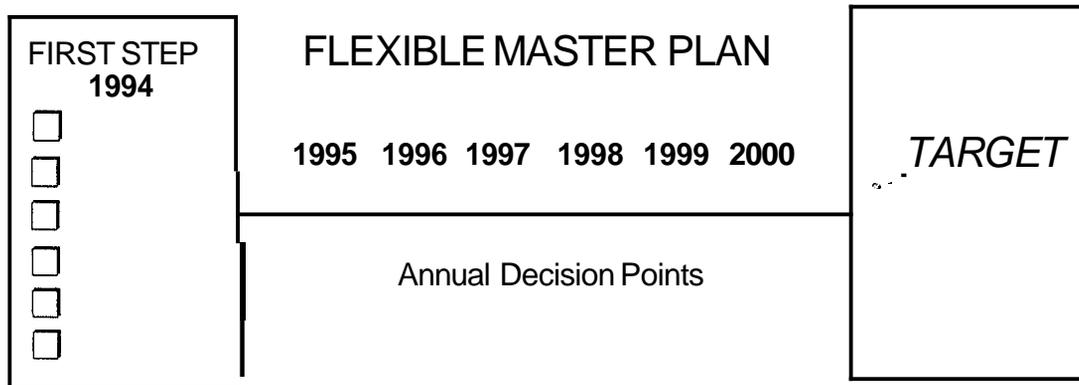
- Change will occur whether or not the state does anything. Through action, the state can influence the direction of the changes.
- The federal government plays a major role in health care reform whether we like it or not. A national plan could completely undo our state effort. Even without a national plan, exemptions and **waivers** are required from the federal government to implement state reforms.
- Because the current health care market is in flux, the reform process must be flexible and adaptive to change.
- The state is limited in its ability to address all the complex issues of health care in a 45-day legislative session. On the national level, tremendous resources have been devoted to the health care debate; it could span several years.
- Although they sound good, many of the recommended solutions are untried. The health reform process must allow testing of proposals and flexibility to change directions if they do not work.

- Health system reform will take sustained effort and leadership. The Governor is committed to lead the health care reform effort and keep the state moving toward its target of increased access to affordable care.

Basic Strategy

The basic strategy of Utah HealthPrint is to define a flexible master plan. This master plan is a blueprint of the many decisions that need to be made. Annual decision points will occur each 45 day legislative session. The Utah Legislature will debate and enact reforms each year to bring the state closer to the target. The state should take a major first step forward in 1994 to commit itself to the target and reform process. A mechanism to make the process succeed is the creation of the Health Policy Commission. As chair of the Commission, the Governor will work with legislators and other appointed members to study health system issues in the flexible master plan and make recommendations for each legislative session. The Commission would also recommend changes to the flexible master plan as shifts occur in the health care environment. Figure 1 illustrates this basic strategy.

Figure 1
Basic Strategy



Basic Decisions

In formulating the flexible master plan the following five basic questions had to be answered:

1. Should the employer or individual be responsible for coverage?
2. Should we fix the market or create a government-run system?
3. Should we implement comprehensive reform all at once (big bang) or follow a master plan (blueprint) that directs us to a target?
4. What level of choice should consumers have?
5. How do we pay for increased access?

These questions were answered as follows:

1. The individual should be responsible for their own health coverage.
2. We should fix the problems in the current market by enhancing competition rather than setting up a government-run system.
3. We should avoid the big bang theory of health care reform, which makes hundreds of complex decisions all at once. A flexible plan is a more reasonable approach than being locked into untried solutions.
4. The level of choice should be decided by the consumer purchasing the health care. We know that unlimited choice increases costs and restrictions lower costs. The consumer is most able to make this cost-conscious decision.
5. The four basic methods to finance reform, in order of preference, are: 1) savings, or doing more with what we have; 2) higher premiums; 3) general taxes; and, 4) cost shifting. All four methods will likely continue to finance health care for some time. However, no new taxes are required to implement Healthprint.

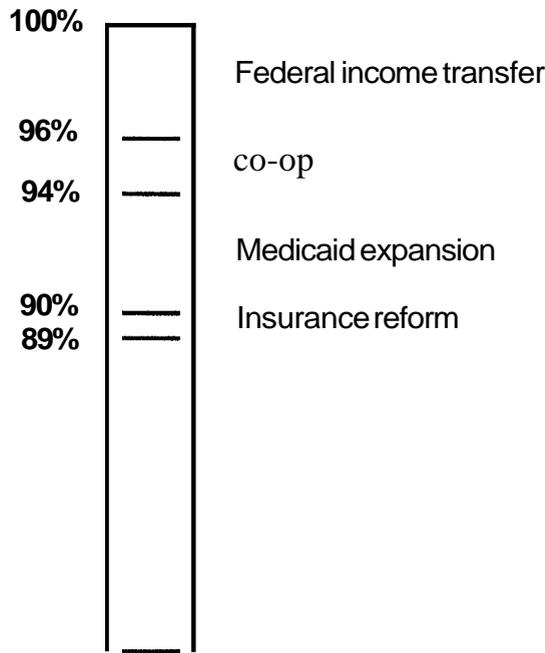
Flexible Master Plan

The flexible master plan addresses the goals of access, cost containment and quality. This blueprint contains today's ideas for reforming the health care system. The blueprint is flexible and expected to change as new information is available and as transformations take place in the health care market.

ACCESS

The three main strategies to increase access are: **1)** insurance reform, **2)** Medicaid expansion, and **3)** creation of a co-op. The federal government will need to be involved to allow the state to achieve universal coverage. Currently, **89** percent of Utahns have health insurance. Figure 2 illustrates the plan for expanding access to all Utahns.

Figure 2
Access Plan for Uninsured



Insurance Reform

The following insurance reforms will take place in **1994** as a part of our major "first step":

- Insurers will provide dependent coverage up to age **26**. Many college students who qualify as dependents do not have health insurance. This reform would require an insurance company to include them in the health plan.
- Premiums will be community rated for small groups, allowing insurers to vary premiums only on the basis of age, gender and geography. To promote prevention and healthy lifestyles, insurers could give individuals discounts for healthy behavior.

- Small groups will receive guaranteed renewability of insurance. Insurers could not cancel or refuse to renew coverage of a health insurance policy except for failure of the insured to meet contractual obligations, such as non-payment of premiums.

Additional insurance reforms would take place over the next few years. For example, insurers could not exclude coverage of any preexisting medical condition for anyone who changes insurance plans. A slight increase in insurance premiums is expected, initially, as a result of reforms. Eventually the increase will be offset by the decline in premiums due to HealthPrint's cost containment strategies.

Medicaid Expansion

The second method to increase access is through an expansion of the Medicaid program. Medicaid is a federally-aided program that is operated by the states. The program provides medical benefits for certain indigent or low-income persons in need of medical care. For every dollar the state pays, the federal government contributes three dollars. Medicaid would be expanded in following four phases and be financed by the savings generated from changing the way the system operates.

Phase I would provide coverage for all children age **11-17** who are living below the federal poverty level. The state health department estimates that this will provide coverage to approximately 32,000 additional children.

Phase II would provide medical coverage to all aged, blind, and disabled individuals below the federal poverty level.

Phase III would expand Medicaid to cover all others below the poverty level. A waiver from the federal government is necessary to allow expansion in phase III.

Phase IV of the Medicaid expansion would be a federal income transfer that subsidizes the insurance premium for those between **100** and **150** percent of the federal poverty level. This is an appropriate role for the federal government because the state does not have a sufficient tax base to finance a subsidy by itself. Universal access cannot be achieved without this federal income transfer.

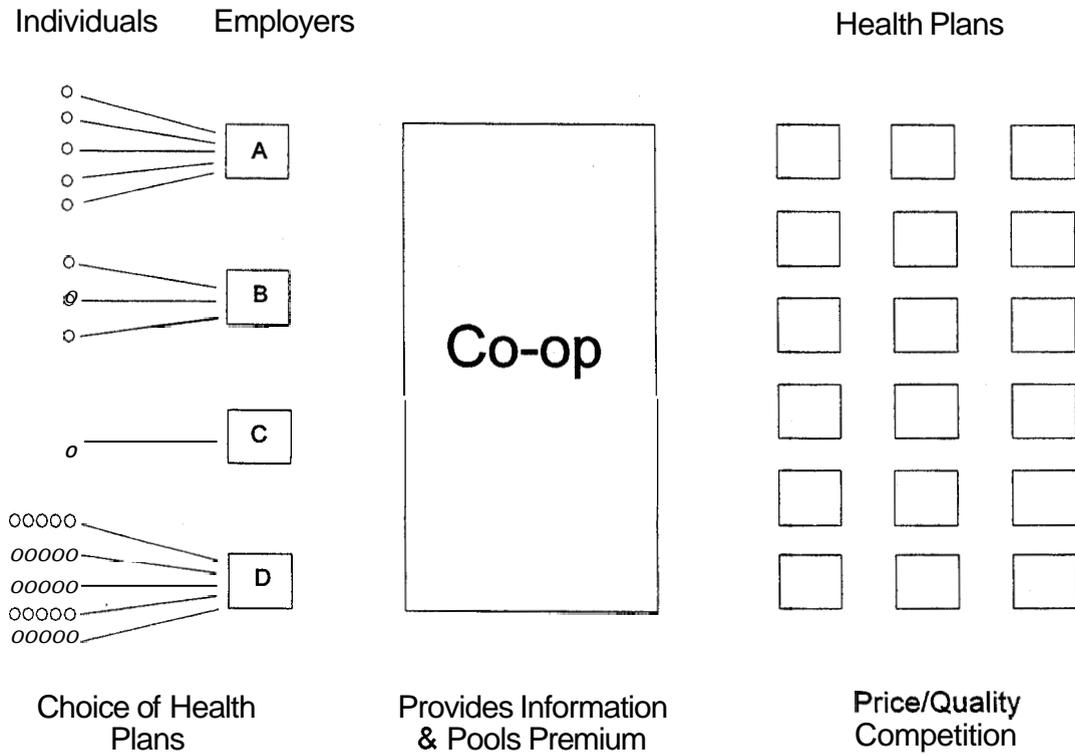
Phases I through III would be expanded through savings in the Medicaid program. Under the current Medicaid system, recipients can go to any provider, whenever and as often as they like. This blank-check system provides incentives for over utilization of health care services. The new system for Medicaid reimbursement is to provide health care in capitated, managed care settings. "Capitation" is a method of payment for health services in which an individual or provider is paid a fixed dollar amount for each person served, regardless of the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method used in health maintenance organizations. This places providers at financial risk, rather than the state, and gives providers incentive to keep their members healthy. Limited choice would remain for medical recipients because they could choose which capitated health plan to join.

co-op

The co-op is the sponsor for the small group and individual market. Individuals and small employers commonly lack access due to the unaffordability of insurance. The co-op would pool small groups and individuals to allow them to experience the same administrative economies of scale that large companies experience when purchasing health benefits. The co-op would also allow increased choice for employees

working in small firms. Currently, many who work for small employers have a choice of only one health plan. Through the co-op a choice of plans would be made available to employees of small employers. Figure 3 depicts how the co-op would function.

Figure 3



COST CONTAINMENT

Medical costs are escalating at a rate that we cannot afford. Utah Healthprint envisions two major elements of cost containment. The first is enhanced competition through the co-op. The second is a greater use of capitation.

The co-op provides a platform for competition. It promotes price and quality competition among health plans by giving individuals information needed to make intelligent, cost-conscious choices. Small employers are too small to achieve administrative economies of scale that large corporations experience when purchasing health benefits. Average administrative expense for groups under five people is estimated as high as 40 percent of premium versus 5 percent for groups over 10,000 people. The co-op would provide these economies of scale to individuals and small group purchasers.

Under the co-op framework, use of capitation as a reimbursement method for health plans will increase. Capitation changes the provider incentive from offering unlimited services to providing services that will promote the health of patients in the long run. It is also likely that medical savings accounts would be offered through the co-op. Medical savings accounts (MSA) allow individuals to purchase a high-deductible

policy and put the premium cost differential into a medical savings account to pay for routine medical care. The funds in an MSA belong to the insured and, if unspent, accumulate over time as savings to pre-fund future health care needs.

QUALITY

As health system reform is undertaken, quality of care must not diminish. In fact, Utah Healthprint anticipates an increase in quality as health plans not only compete on price but are also measured on quality. Health plans will have incentives to continuously improve their processes to provide improved outcomes for their patients. Under a co-op, consumers would be provided information on patient satisfaction for each health plan. They would also be given information on differences in medical outcomes between health plans.

Quality improvement must occur from the bottom up and not from a government-mandated top down approach. Providers of care have an essential role in recognizing needed improvements, designing improvement strategies, and carrying out improvement projects. The most effective improvements will occur when energy is devoted to systematically identifying and improving specific, targeted care processes. Through such a process, a local hospital was able to reduce the infection rate for major abdominal surgery from 1.8 percent (the acceptable national average was 2 to 4 percent) to 0.4%, which increased customer satisfaction, reduced the length of hospital stay, and saved the hospital approximately \$750,000 in costs to the hospital in a single year. This quality improvement paradigm shows that it is possible to increase quality while decreasing costs. The quality approach recommended in Healthprint provides the incentives for such innovations.

Utah Healthprint

	1994	1995	1996
ACCESS	<p>Medicaid Expansion (L)</p> <ul style="list-style-type: none"> children ages 11-17 below 100% of poverty <p>Insurance Reform (L)</p> <ul style="list-style-type: none"> cover dependents to age 26 small group modified community rating guaranteed renewability <p>Uninsurable risk pool funding increased (L)</p> <p>Request federal tax change (L)</p> <ul style="list-style-type: none"> self-employed individuals <p>Medicaid waiver application</p>	<p>Medicaid expansion (L)</p> <p>aged, blind, disabled below 100% of poverty</p> <p>Insurance reform (L)</p> <p>preexisting conditions waived</p> <p>Public health plan (L)</p> <p>State tax change</p> <ul style="list-style-type: none"> self-employed <p>Medicaid waiver state approved/forwarded (L)</p>	<p>Medicaid expansion (L)</p> <p>adults below 100% of poverty (Medicaid waiver approved)</p> <p>Insurance reform (L)</p> <p>systemwide modified community ratings portability guaranteed issue risk adjustment mechanism</p> <p>Special populations plan (L)</p> <p>State tax change</p> <ul style="list-style-type: none"> individuals
COST CONTAINMENT	<p>Administrative simplification</p> <p>Designated benefits offering (L)</p> <p>Medicaid capitation</p> <ul style="list-style-type: none"> 40% of clients <p>Request federal tax change (L)</p> <ul style="list-style-type: none"> medical savings accounts 	<p>Electronic submission of claims</p> <p>Self-referral limitations (L)</p> <p>Medicaid capitation</p> <ul style="list-style-type: none"> 65% of clients <p>Tort reform (L)</p> <p>Anti-trust reform (L)</p> <p>Healthy lifestyles education (L)</p>	<p>Voluntary managed care promoted for companies with >50 employees</p> <p>Medicaid capitation</p> <ul style="list-style-type: none"> 100% of clients <p>Co-op created (L)</p> <ul style="list-style-type: none"> health plans approved medical savings account option
QUALITY	<p>Practice guidelines continued</p> <p>Data systems improved (L)</p>	<p>Quality process implementation begins (L)</p>	<p>Quality process implementation continued (L)</p> <p>Medical education reform (L)</p>
STUDY AND EVALUATION	<p>Create Health Policy Commission (L)</p> <p>Study items</p> <ul style="list-style-type: none"> federal reforms tort reform self-referral limitations anti-trust reform rural health care public health care quality process healthy lifestyles education medical ethics access/cost/quality monitoring insurance reform state tax equity 	<p>Commission evaluations and recommendation</p> <ul style="list-style-type: none"> review prior reforms recommend new reforms <p>Study items</p> <ul style="list-style-type: none"> federal reforms co-op special populations rural health care quality process medical education reform <ul style="list-style-type: none"> primary care financing education system insurance reform state tax equity 	<p>Commission evaluations and recommendation</p> <ul style="list-style-type: none"> review prior reforms recommend new reforms <p>Study items</p> <ul style="list-style-type: none"> federal reform rural health care alcohol/drug treatment long term care workers comp/auto health insurance alternatives to capitated reimbursement

(L) = Legislative action required.

Utah HealthPrint (continued)

1997	1998	1999	2000
Rural health plan (L) Alcohol/drug treatment plan (L)	long-term care plan (L)	Mental health plan (L)	Employee/individual mandate (L) Uninsurable risk pool integrated? (L)
Alternatives to capitated reimbursement (L) Co-op (L) • enrollment for individuals and employers with <50 employees	Workers Comp/auto health insurance integration (L) Public sector co-op? (L)	Medicare integrated? (L) Medicaid coop? (L)	Co-op (L) • enroll employers with 50-100 employees?
Health plan report cards			
Commission evaluations and recommendation • review prior reforms • recommend new reforms Study items • federal reforms • mental health • workers comp/auto health insurance? • long-term care • benefit plans review • public sector co-op?	Commission evaluations and recommendation • review prior reforms • recommend new reforms Study items • federal reforms • mental health • Medicaid co-op? • Medicare integrated? • benefit plans review	Commission evaluations and recommendation • review prior reforms • recommend new reforms Study items • federal reforms • co-op —effect on access/cost/quality —include employers with 50-100 employees? • employer/individual mandate? • uninsurable risk pool? • benefit plans review	Commission evaluations and recommendation • review prior reforms • recommend new reforms study items • federal reforms • effect on access/cost/quality • benefit plans review

(L) = Legislative action required

Glossary of HealthPrint Terms

1994

ACCESS

Medicaid expansion will provide medical coverage to all children under **18** years of age below the poverty level. This expansion will increase the number of children covered by approximately 32,000.

Insurance reform will require:

Dependent coverage to age 26 will require insurers to offer coverage for all unmarried tax dependents up to **26** years of age.

Small group community rating with modifications for age, gender and geography. Premium discounts may be given for healthy lifestyles;

Guaranteed renewability which will require insurers to renew all policies, unless the employer or insured individual fails to comply with contract requirements such as failure to pay premiums;

Uninsurable risk pool funding increased by \$1,500,000. This pool was established in **1990** to provide **low** cost access to health insurance for those who are denied adequate insurance and are considered uninsurable.

Changes in federal tax law will be requested to allow individuals purchasing insurance the same tax benefit as those who receive health insurance through their employer.

A **Medicaid waiver application** will be written to provide Medicaid coverage for all adults below the poverty level. The expanded coverage will be financed by savings in the Medicaid program.

COST CONTAINMENT

Administrative simplification will create efficiencies in the system. The Utah Health Information Network (UHIN) is a leading organization in the standardization of claim administration practices, electronic data interchange, and the establishment of an information repository.

A **designated benefits offering** will required insurers to not only quote a price on designated benefits, as well as offer the designated benefits plan to facilitate comparisons.

Medicaid capitation will provide cost savings as clients are moved into prepaid **HMO** and other managed care arrangements. In **1994**, forty percent of Medicaid recipients will be in a capitated system.

Changes in federal tax law will be requested to allow Medical Savings Accounts comparable tax treatment as other health plans.

QUALITY

Practice guidelines effort will continue through the Effective Practice Patterns Subcommittee which is working on the dissemination of practice guidelines.

Data systems will be improved to provide the information necessary to measure the effectiveness of Utah's health care system. As a first step, additional funding is recommended for the Utah Health Data Committee to begin work on establishing a central data repository.

STUDY AND EVALUATION

A **Health Care Commission** will be established to study health system issues and recommend additional reforms. This eleven-member commission will be chaired by the Governor. The commission has the responsibility to direct the efforts outlined in Utah Healthprint.

Study items for the commission for 1994 include:

- Federal reforms** - to monitor federal action and determine its impact on the state;
- Tort reform** - to study changes on tort law that would reduce defensive medicine;
- Self-referral limitations** - to study the need for health care professional limitations on self-referral;
- Anti-Trust** - to determine the need for and actions required for **state-action** immunity from anti-trust laws for the collaborative use of expensive medical equipment and for the establishment of approved health plans;
- Rural health** - to review the most appropriate delivery system for rural areas that will provide access to essential health care services;
- Public health** - to develop a public health plan that defines standards for public health and recommend improvements to the system;
- Quality process** - to define a quality system that continuously improves processes and provides appropriate consumer protection;
- Healthy lifestyles education** - to increase the awareness of healthy lifestyles for Utah residents;
- Medical ethics** - to determine the method for making ethical medical decisions;
- Access/Cost/Quality monitoring process** - to establish a **baseline** and process that measures the effects of reform on access, cost and quality ;
- Insurance reform** - to review the possible elimination of preexisting conditions; and
- State tax equity** - to determine how to give self-employed individuals the same treatment for health benefits that employees receive.

1995

ACCESS

Medicaid Expansion would cover all aged, blind, and disabled below the federal poverty level.

Insurance reform would be presented to the legislature and require:

Pre-existing conditions would be waived at the initiation of the program. Insurance coverage will have no exclusions or waiting periods on pre-existing conditions for continuously covered individuals.

The **Public Health Plan** developed by the Commission would be presented to the legislature.

A **State tax change** would be presented to the legislature and would allow self-employed individuals the same treatment for health benefits that employees receive.

The **Medicaid waiver** to expand access to adults below the poverty level would be presented to the state legislature for approval and forwarded to the United States Department of Health and Human Services.

COST CONTAINMENT

Electronic submission of claims would be implemented statewide. The Utah Health Information Network is developing standards to be used for electronic data interchange.

Self-referral limitations would be presented to the legislature.

Medicaid capitation would provide cost savings as clients are moved into prepaid HMO and other managed care arrangements. In 1995, 65 percent of Medicaid recipients will be in a capitated system.

Tort **reform** would be presented to the legislature in order to relieve the anxiety of legal action which has produced an environment of defensive medicine in the provider community.

State-action **exemption from anti-trust laws** would be presented to the legislature to encourage collaborative use of expensive medical equipment.

The **healthy lifestyles education** plan developed by the Commission would be presented to the legislature.

QUALITY

A system-wide **quality process** would be presented to the legislature to maintain the high level of quality enjoyed by Utah residents. This effort would be phased in over several years.

STUDY AND EVALUATION

Evaluation and recommendations for reforms would be ongoing task 6 of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items:

Federal reforms - to monitor federal action and determine its impact on the state;

Co-op - to determine the structure, membership, costs, benefit plans, guidelines for medical savings accounts and health plan approval criteria for the purchasing cooperative construct;

Special populations - to insure access for the homeless, migrant workers, and those who face geographic, cultural, linguistic and physical barriers;

Rural health - to review the most appropriate delivery system for rural areas that will provide access to essential health care services;

Quality process - to define a quality system that continuously improves processes and provides appropriate consumer protection;

Medical education reform - to increase the number of primary care professionals and determine the financing system for professional medical education.

Insurance reform - to review system-wide modified community rating, portability, and guaranteed issue; and

State tax equity - to determine how to give individuals the same treatment for health benefits that employees receive.

1996

ACCESS

Medicaid expansion would provide coverage to all adults whose income falls below 100% of poverty.

Insurance reform would be presented to the legislature and include:

System-wide modified community rating with modifications for age, gender and geography. Additionally, discounts to premiums may be given for healthy lifestyles;

Portability which allows an employee who is changing jobs to transfer their insurance and not lose coverage;

Guaranteed issue which requires that all insurers must accept all employer groups or individuals; and

A **risk adjustment mechanism** required by the likelihood of adverse selection.

A **special populations plan** developed by the Commission would be presented to the legislature. This plan will insure that all citizens with special needs and disabilities are provided access to health care services.

State tax change would be presented to the legislature to allow individuals the same treatment for health benefits that employees receive.

COST CONTAINMENT

Voluntary capitated managed care for companies with >50 employees would be promoted to obtain cost control for groups operating outside the co-op.

Medicaid capitation would reach 100% of Medicaid clients in 1996.

A **small employer purchasing cooperative** would be presented to the legislature to allow small employers and individuals economies of scale in the health insurance market. The co-op could offer health plans which have met state insurance solvency criteria. One of the health plans could be a medical savings accounts option, which would allow individuals to purchase a high-deductible policy and put the premium cost differential into a medical savings account.

QUALITY

A system-wide **quality process** would continue to be implemented to maintain the high level of quality enjoyed by Utah residents. This effort will be phased in over several years.

A **medical education reform** plan would be presented to the legislature to produce more primary care providers in Utah including physicians, nurses and other health care professions.

STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items for the commission in **1996** include:

Federal reforms - continue to monitor federal action and determine its impact upon the state;

Rural health - conclude the review of the most appropriate delivery system for rural areas that will provide access to essential health care services;

Alcohol/drug treatment - to determine the most appropriate system and reimbursement methods for alcohol and drug abuse treatment;

Long-term care - to review the long term care task force recommendations;

Workers compensation/auto health insurance - to determine the feasibility of merging workers compensation and auto health insurance under a single management structure.

Alternatives to capitated reimbursement - to study alternatives to capitated reimbursement systems, particularly in rural areas.

Benefit plans review - to review designated benefit plans which facilitate comparisons.

1997

ACCESS

The **Rural health plan** would be presented to the legislature.

The **Alcohol/Drug treatment plan** would be presented to the legislature.

COST CONTAINMENT

Co-op enrollment would be presented to the legislature for final approval and would occur for individuals and employers with fewer than **50** employees, who are purchasing insurance.

Alternatives to capitated reimbursement would be presented to the legislature.

QUALITY

Health plan report cards assessing the quality of care delivered by existing health plans would be published.

STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items for the commission for 1997 include:

- Federal reforms** - continue to monitor federal action and determine its impact upon the state;
- Mental health** - to develop a plan to improve the quality and access of mental health care;
- Workers compensation/auto health insurance** - to develop the plan to integrate worker's comp and auto health insurance into a single management structure based upon studies from 1996.
- Long term care** - to develop the plan for long term care based upon studies from 1996.
- Benefit plan review** - to review designated benefit plans which facilitate comparisons.
- Public sector co-op** - to study the need for a public cooperative as described above for private individuals seeking health insurance.

1998

ACCESS

The **long-term care** recommendations would be presented to the legislature.

COST CONTAINMENT

Workers Compensation and Auto insurance would be presented to the legislature depending on the result of the prior year study.

A **Public sector co-op** would be presented to the legislature depending on the result of the prior year study.

STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items of the Commission for 1998 include:

- Federal reforms** - to monitor federal action and determine its impact on the state;
- Mental health** - continue review and study of mental health reform implementation.
- Medicaid cooperative** - to study the feasibility and appropriateness of including the non-long term care portion of Medicaid into a purchasing cooperative;
- Evaluate Medicare** - to study the feasibility and appropriateness of integrating Medicare into Utah health reform efforts; and
- Benefit plan review** - to review designated benefit plans which facilitate comparisons.

1999

ACCESS

Mental health reform would be presented to the legislature.

COST CONTAINMENT

Medicare integration would be presented to the legislature depending on the outcome of the feasibility and appropriateness studies.

Enrolling **Medicaid recipients in a co-op** would be presented to the legislature depend on the outcome of the feasibility study. Long-term care would likely be excluded.

STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items of the Commission for 1999 include:

Federal reforms - to monitor federal action and determine its impact on the state;

Co-op - to determine effect, if any, of the co-op on access, cost and quality of health care. Also to assess the feasibility and appropriateness of including employers with 50-100 employees in the purchasing cooperative;

Employer/Individual mandate - to assess accessibility to health care and determine if there is a need for a employer/individual mandate to provide insurance;

Uninsurable Risk Pool - to assess the future need of the uninsurable risk pool.

Benefit plan review - to review designated benefit plans which facilitate comparisons.

2000

ACCESS

Employer/individual insurance mandates would be presented to the legislature if deemed necessary to achieve access goals.

The **uninsurable risk** pool would be presented to the legislature depending on the results of the prior year study.

COST CONTAINMENT

Co-op expansion to include employers with 50-100 employees would be presented to the legislature depending on the results of the prior year study.

STUDY AND EVALUATION

Evaluation and recommendations for reforms will be ongoing tasks of the Commission. The Commission would evaluate the effectiveness of prior reforms and recommend new reforms from the items studied during the year.

Study items of the Commission for the year 2000 include:

- Federal reforms** - to monitor federal action and determine its impact on the state;
- Access, cost containment, & quality** - to evaluate overall progress in achieving access, cost containment and quality; and
- Benefit plan review** - to review designated benefit plans which facilitate comparisons.

QUESTIONS & ANSWERS ON HEALTHPRINT

1. *Why do we need health care reform?*

Approximately 200,000 people in Utah are currently uninsured and may thus lack access to needed health care. Additionally, medical costs are rising at a rate that we cannot afford.

2. *Does the plan provide universal access to health care?*

Increased access to affordable insurance is the goal of Healthprint. The goal is to be achieved over a several years as actual savings are realized.

3. *What will the proposed health plan do to contain health care costs?*

Market forces, increased consumer responsibility, a co-op, administrative savings, capitation, and managed care are major cost containment strategies.

4. *Are employers mandated to provide insurance to their employees?*

No. The individual is responsible for having health insurance. Financial assistance would be provided eventually for those who are below 150 percent of the poverty level.

5. *Is a tax increase necessary to implement Healthprint?*

No new taxes are required.

6. *Will individuals have a choice of plans or choice of benefits within a plan?*

Yes, consumer choice will be preserved and enhanced for individuals and small group purchasers.

7. *Will individuals have a choice of provider?*

Yes, but the plan anticipates increased use of managed care and capitation. When a consumer joins a managed care plan, provider choices may be limited to those participating in the plan.

8. *What if I get sick during one year? Does that mean the insurer can drop my coverage or hike my premiums, like they often do today?*

No. Insurance reforms will be implemented over the next few years to preclude this from happening.

9. What is insurance reform?

Refers to the changing of current insurance laws and practices to require such features as guaranteed issue, modified community rating, and portability of insurance from job to job. It may also include prohibitions against pre-existing condition exclusions.

10. What is guaranteed issue?

Any person, regardless of age, health condition, etc., will be eligible to purchase a health care plan.

11. What is modified community rating?

A method of calculating health plan premiums allowing modifications in rates for age, gender and geography. Additionally, discounts to premiums may be given as incentives for healthy lifestyles.

12. What is portability?

Employees can change jobs without losing their health insurance. This eliminates "job-lock."

13. Will preexisting conditions be covered?

Yes, after all anticipated insurance reform is implemented.

14. Will my insurance premiums go up?

It depends. They will go up for some and down for others and for many individuals and employers remain the same. They would increase slightly as insurance reforms are implemented but will decline as small businesses benefit from participating in large purchasing pools.

15. What is a co-op?

The co-op is the sponsor for the small group and individual market. The co-op would allow a pooling of risk and reduce the variation in premiums for small groups and individuals. The co-op would increase choice to employees working in small firms with a menu of health plans made available to them. The co-op would give individuals and small groups the same access to benefits plans now enjoyed by employees of large employers.

16. What is the role of agents and brokers?

The role of agents and brokers is likely to change for this market segment. They could operate as benefits consultants to small employers in the enrollment of employees into the co-op.

17. How is the state plan different than the federal plan?

Clinton: Health care reform can be fixed all at once with hundreds of complex, interrelated decisions made correctly.

State: Health care reform is a process that will require a sustained effort to ultimately reach the goal of affordable access.

Clinton: Access would be expanded immediately and financed by estimated savings.

State: Access would be expanded as actual savings are realized.

Clinton: A National Health Board would be created to regulate and enforce the national plan.

State: A Health Policy Commission would study important issues and make recommendations to the legislature.

Clinton: Costs would be contained through a global budget in the form of premium caps. The National Health Board would enforce these budgets, which will likely lead to rationing of care.

State: Costs would be contained by increasing the competitive forces in the market place.

Clinton: Employers would be mandated to provide coverage for their employees. This would likely lead to job losses in industries that cannot currently afford to buy coverage.

State: Individuals have a responsibility for their own coverage. Subsidies would eventually be enacted to help individuals receive coverage.

18. How will a federal health plan influence the State plan?

Until a Federal health plan is approved, it is impossible to perceive the impact a Federal plan would have on the State plan.

19. How will the federal and state tax law be changed to benefit the self-employed and individuals?

The legislature will be asked to approve a change in State tax laws to allow self-insured and individuals to deduct the full amount of health insurance premiums.

20. What will be the effect of expansion on the Medicaid budget?

It is anticipated that expansion of Medicaid will be largely funded through savings due to Medicaid capitation, Medicaid client cost sharing, and utilization of funds now available through the Utah Medical Assistance Program.

21. Will the expansion of Medicaid reduce the scope of services?

Reductions are not anticipated at this time.

22. What does *capitation* mean?

A method of payment for health services in which an individual or provider is paid a fixed dollar amount for each person served, regardless of the actual number or nature of services provided to each person in a set period of time, usually a year. Capitation is the characteristic payment method in health maintenance organizations but is unusual for most private physicians' services.

23. What is a *medical savings account*?

Medical savings accounts (MSA) allow employer, self-employed individuals, and others to purchase a high deductible policy and put the premium cost differential into a medical savings account to pay for routine medical care. The funds in an MSA belong to the insured and, if not spent, accumulate over time as savings to pre-fund future health care needs.

24. Will the plan affect the *quality of health care*?

There is sufficient consumer choice in the plan to safeguard the present quality of care in the health system.