WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Preliminary Performance Review

Childrenís Health Insurance Board (CHIP)

The West Virginia Childrenís Health Insurance Board Provides a Necessary Function

Despite Good Performance, the CHIP Board Should Develop Contingency Plans for Potential Funding Shortfalls

June 2003
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June 9, 2003

The Honorable Edwin J. Bowman
State Senate
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The Honorable J. D. Beane
House of Delegates
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Parkersburg, West Virginia 26104

Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a *Preliminary Performance Review of the Children's Health Insurance Board (CHIP)*, which will be presented to the Joint Committee on Government Operations on Monday, June 9, 2003. The issues covered herein are "The West Virginia Children's Health Insurance Board Provides a Necessary Function;" and "Despite Good Performance, the CHIP Board Should Develop Contingency Plans for Potential Funding Shortfalls."

We transmitted a draft copy of the report to the Children's Health Insurance Board on May 20, 2003. We held an exit conference with CHIP on May 27, 2003. We received the agency response on May 30, 2003.

Sincerely,

John Sylvia

JS/wsc

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CHIP is financially stable and its costs per child were under budget in FY 2002.

The West Virginia Children's Health Insurance Board has provided oversight and guidance to the West Virginia Children's Health Insurance Program since 1998, when CHIP was created to provide health insurance to low income children. The Board has designed and implemented a comprehensive health insurance program for low-income children that during the past year provided coverage to over 35,000 children in West Virginia. The program is currently stable, fiscally sound and its costs per child were actually under budget in FY 2002.

The Board has made policy decisions to close gaps in benefit coverage, extend income eligibility, limit annual and lifetime benefits, enact cost-sharing and streamline payment operations. In addition, the Board has encouraged routine medical and dental visits through prevention campaigns and targeted outreach to counties and age groups where a higher percentage of children are still not covered by health insurance.

Notwithstanding the important direction which the CHIP Board has provided, there are three minor operational functions which could be improved. These involve the annual establishment of the Board calendar, the delivery of an annual report that currently is not being made, and the appointment of a sixth citizen member as required by revisions in *Code*. The Legislative Auditor concludes that there is a need for the CHIP Board to continue.

Issue 2: Despite Good Performance, the CHIP Board Should Develop Contingency Plans for Potential Funding Shortfalls.

The CHIP actuary is currently projecting a $20 million shortfall in federal funding for the West Virginia program in 2007. The CHIP Board has not decided upon, or substantively discussed contingency plans to implement in order to protect the fiscal stability of the CHIP program.

The CHIP actuary is currently projecting a $20 million shortfall in federal funding for the West Virginia program in 2007. This is the final year of the first 10 year Congressional funding cycle for all of the states. This projection is being made during a period of state budget problems, congressional budget changes, rising CHIP enrollments and rising health care costs. The CHIP Board has not decided upon, or substantively discussed contingency plans to implement in order to protect the fiscal stability of the CHIP program. Some changes may require amendments to the state CHIP plan which must be approved by the federal government before implementation, so the time required to make these changes could be extensive.

In nine other states, CHIP programs have had to make comprehensive changes in order to survive. The CHIP programs in Oklahoma and Missouri were threatened with elimination during the FY 2004 budget development process. The Legislative Auditor finds that the CHIP Board should spend an adequate amount of time on contingency planning during the present period of program stability before a crisis develops.

Recommendations

1 The Legislature should consider continuing the Children's Health Insurance Board.

2 The Board should ensure that a report which meets the requirements outlined in Code be submitted annually to the Governor and Legislature.

3 The Board should ensure that an additional citizen member is added, as required by Code.

4 The Board should set an annual calendar for Board meetings each year.

5 The Board should begin the process of developing a contingency plan by 2005, which would allow for changes to the State Plan to be submitted to CMS and accepted.

Review Objective, Scope and Methodology

This Preliminary Performance Review of the Children's Health Policy Board, renamed the Children's Health Insurance Board, is required and authorized by the West Virginia Sunset Law, Chapter 4, Article 10, Section 5 of the West Virginia *Code* as amended. The Board, expanded in 2000 to become an eleven member body, is composed of citizen and agency members. Two ex-officio members represent the House and the Senate. The Board is charged with developing plans for health services or health insurance specific to the needs of children. It is also charged with bringing fiscal stability to the Children's Health Insurance Program through the development of an annual plan.

Objective

The objective of this audit is to determine the effectiveness of the Board in providing fiscal stability in the face of projected funding shortfalls. In addition, the audit reviewed the Board's conformance to mandates in *Code* and its development of an insurance program to meet the needs of the state's eligible children.

Scope

In the first four months of 2003, the Legislative Auditor assessed the composition, functioning and interaction of the Board. This assessment emphasized actions taken by the Board in light of actuarial projections relating to West Virginia's CHIP program, national analyses of funding problems relating to CHIP programs and contingency actions taken by other state's CHIP programs.

Methodology

The Legislative Auditor examined state and federal *Code* requirements for the CHIP program, the State's CHIP plans, amendments, benefit plan and annual fiscal plans; attended two 2003 Board meetings and reviewed all written minutes and some taped proceedings for 2000-2002. The Legislative Auditor also conducted personal and telephone interviews with Board members, the executive director, executive assistant, chief fiscal officer and actuary of the program, in addition to reviewing documents provided by the agency. This report was also developed using national policy analyses and Congressional reports, and State budget, labor and food stamp information. Every aspect

of this evaluation complied with Generally Accepted Government auditing Standards (GAGAS).

Background

In 1997 Congress established the State Childrenís Health Insurance Program to cover uninsured children in families with income that is low, but above Medicaid eligibility levels. States were allowed to choose between three benefit options in developing programs: 1) expanding Medicaid, 2) creating a separate state insurance program, or 3) devising a combination of the two approaches.

A Childrenís Health Insurance Board was created in 1998 to develop an insurance program in West Virginia and to ensure the programís fiscal stability. The Board was originally composed of five citizen members, two agency directors, and two ex-officio legislative members. The agency directors were from PEIA and DHHR; the legislative members included a member from the Senate, and a member from the House of Delegates. In 2000, legislation was enacted to add the Director of the West Virginia Childrenís Health Insurance Program to the Board as Chairman, with voting powers. Also in 2000, a sixth citizen member was to be added to the Board; however, this position is currently vacant.

Through the past five years, the West Virginia Childrenís Health Insurance Program has been guided by the West Virginia Childrenís Health Insurance Board.

West Virginia Creates Childrenís Health Insurance Program

With the aid of the West Virginia Childrenís Health Insurance Board, West Virginia moved quickly to participate in this insurance effort. West Virginiaís original health insurance plan was submitted in 1998. At first, the state simply covered young children (ages 1-5) by expanding the eligibility requirements for Medicaid. The stateís second phase of childrenís health insurance created a *separate* plan to cover older children (ages 6-18). **Finally, the state withdrew entirely from the Medicaid expansion and covered all children under its separate plan.**

Over time, the plan evolved further. West Virginia Childrenís Health Insurance Program (CHIP) now uses the Public Employees Insurance Agencyís Preferred Benefit Plan as ìbenchmark coverage.î In addition, West Virginia has increased its coverage to low income families, and covers children up to their 19th birthday. Cost-sharing for families that met certain income levels was imposed through moderate fees for medical visits. Also, pharmacy costs and benefit limits were approved. **Through the past five years, the West Virginia Childrenís Health Insurance Program has been guided by the West Virginia Childrenís Health Insurance Board in making these changes.**

CHIP Funding is Received from the Federal and State Government

In creating the childrenís health insurance programs, Congress appropriated $39.7 billion to be distributed among participating states over a 10 year period (1998-2007). The funding design also required states to contribute a portion of funds to their childrenís health insurance programs. The federal match for each state dollar contributed is calculated under a formula[1]. The federal allotment for federal fiscal year 2003 will be $18.55 million. In comparison, the stateís match this year will be $7.2 million.

Federal spending requirements are complex. All states are first required to spend the oldest money received from the federal government in order toqualify for redistributed money[2] in following years. States have three years to spend each one year allotment, but after three years must return unspent money so that it may be redistributed. For example, if West Virginia receives $1,000,000, and only spends $800,000 in three years, the state must give back the unspent $200,000.

With the growth in enrollment of children in CHIP, West Virginia was able to spend all of its 2000 federal allotment, and is presently spending its 2001 allotment. Because West Virginia was able to spend the 2000 federal allotment, the state recently received a redistribution ìbonusî and will begin spending this money in late June or early July 2003. However, this bonus redistribution is only available until the end of the federal fiscal year. On October 1, 2003 West Virginia will begin spending its federal 2002 allotment.

Childrenís Health Insurance Programs in Other States

State CHIP programs have been established in all 50 states, the District of Columbia and five territories. As of December 2002, 21 are Medicaid expansions, 20 are separate state programs and 15 use a combination approach. Nationally nearly five million children have enrolled in state CHIP programs.

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[1] *Based on a combination of the number of low-income children, and low income uninsured children in the state and includes a cost factor of the average health service industry wages in the state compared to the national average. States receive a higher federal contribution for CHIP than for Medicaid for every dollar of state funds spent.*

[2] *Redistributed money is money that is awarded to the state after certain spending requirements are met.*

Issue 1

The West Virginia Childrenís Health Insurance Board Provides a Necessary Function.

Issue Summary

The West Virginia Childrenís Health Insurance Program (CHIP) operates with the authority of the Childrenís Health Insurance Board. Since 1998, the program has been developed to provide health insurance to low income children. The Board has accomplished the task of designing and implementing a comprehensive health insurance program for children, and during the past year, over 35,000 West Virginia children received health coverage under CHIP. The program was actually under budget in FY 2002. There are some minor operational functions that should be addressed by the Board. The Board should develop a calendar of meetings to help members attend more frequently by having advance notice. Also, the Board should regularly submit an annual report and should appoint an additional citizen member, as required by *Code*.

The Board has accomplished the task of designing and implementing a comprehensive health insurance program for children, and during the past year, over 35,000 West Virginia children received health coverage under CHIP. The program was actually under budget in FY 2002.

For five years, the West Virginia Childrenís Health Insurance Program (CHIP) has been providing health insurance coverage for low income children. The CHIP program operates with the authority of the Childrenís Health Insurance Board, which was created to *ìdevelop plans for health services or health insurance that are specific to the needs of children and to bring fiscal stability to this program through the development of an annual financial plan ...ß5-16B-4(b).î* **This audit finds that the CHIP Board has created a program that is currently stable and fiscally sound.**

CHIP Board Has Given Important Direction to the CHIP Program

West Virginia CHIP is midway through the first federal funding cycle. The CHIP Board is charged with reviewing and adopting an annual fiscal plan that is in conformity with the CHIP budget and meets a state fiscal threshold of 90% of total available funds for the current fiscal year. In January 2003, CHIPís actuarial review showed that program expenditures were projected to remain well within the 90% cap. In addition, while the program has seen rising health care costs, the monthly cost per child is actually $7.71 less than anticipated in FY 2002.

The Board has been active in evaluating and refining the CHIP program. A summary of the CHIP Board accomplishments includes:

The West Virginia CHIP Board has actively participated in assessing benefit coverage, streamlining operations, initiating prevention campaigns and targeting eligible uninsured children.

- **Closing gaps in benefit coverage.** In 2001, the Board learned that CHIP did not cover ìwell child careî annual check-ups for children ages 7 to 9, and voted unanimously to change the benefit structure to include these children for annual check-ups.

- **Extending income eligibility.** The Board made policy decisions expanding income eligibility up to 200% of the Federal Poverty Level, which allows a family of four with an income of up to $36,800 to receive CHIP coverage.

- **Enacting benefit limits to protect the financial integrity of the program.** Benefit limits were enacted in June 2002, capping annual benefits at $200,000 and lifetime amounts of coverage at $1 million per child.

- **Enacting cost sharing for higher income families.** The Board initiated cost sharing with medical co-pays on a sliding scale of up to $35 for medical visits, and pharmacy co-pays on a sliding scale from no cost for generic brands up to $15 for non-preferred pharmacy prescriptions.

- **Streamlining operations.** The West Virginia CHIP program uses the same third party administrators as the Public Employeeís Insurance Agency for both medical and prescription drug benefits. Renewal forms have been simplified.

- **Creating online electronic enrollment capability from any location.** Computer programming is underway to allow online electronic enrollment from personal computers, libraries and doctorís offices. This should be functional in September 2003.

ï **Encouraging routine medical and dental visits.** CHIP has initiated two summer prevention campaigns, in 2001 and again in 2003, to encourage families and medical personnel to conduct well-child annual check-ups.

In 2002, over 35,000 children in West Virginia received health coverage through CHIP.

ï **Targeting outreach and supporting coalitions.** Finally, the program has been able to target its outreach efforts to counties and age groups where a higher percentage of children are still not covered by health insurance. CHIP has engaged in cooperative efforts with local health networks, county schools and medical providers to locate and enroll children.

In the past 12 months, CHIP provided health coverage for over 35,000 children[3]. In addition, unlike 37 other states, West Virginia has been able to spend its original federal allotments, which has allowed it to receive redistributed ìbonusî money. In April, the CHIP program learned that it was eligible for $18.8 million in these redistributed bonus monies. Although this amount must be spent after the current allotment being spent down (2001) is exhausted, and before the end of the federal fiscal year in September 2003, the CHIP program estimates that it will be able to spend between $5 and $6 million of the bonus money before it must be returned to the federal government.

West Virginia is one of 14 states eligible to receive ìbonusî money because it spent all of the 2000 federal allotment.

Minor Operational Issues of the CHIP Board

For the last calendar year most citizen Board members attended only

While the CHIP Board has provided important direction to the CHIP program, which has resulted in fiscal stability and lower than expected per-child health costs, several minor operations of the CHIP Board could be improved. These involve the Board meeting dates, delivery of the anuual report and appointment of another citizen board member. At present, the Board meeting dates are unpredictable. Meetings are not set by an annual calendar, and citizen members have found it hard to make long term plans without missing meetings. One citizen member noted: *ìI think Board meetings should be set in advance so that individual Board members can make plans that will not conflict. Presently, a lot of meetings are cancelled or postponed.î*

[3]*The "ever enrolled" number of all children covered during the year has been 35,000 and reflects children moving in and out of the program. The average number of children reflects those steadily covered, and this number(21,147) is used for actuarial forecasts.*

Minor operations of the Board needing improvement include the addition of a 6th citizen member to theBoard,the establishment of an annual calendar and the provision of an annual report to the Legislature.

For the last calender year most citizen Board members attended only three out of the five meetings held. In addition, an annual report required by *Code* is not being delivered to the Legislature, and a citizen member position, created by *Code* revisions in 2000, has not yet been filled.

Conclusion

The CHIP Board serves a necessary and important function in directing the development of CHIP program policies and procedures in addition to maintaining its fiscal stability. In five years it has presided over the creation of a childrenís health insurance program that has delivered health care services to over 35,000 of West Virginiaís low income children.

The Board has created a CHIP program which provides comprehensive health coverage for children, is available to many lower-income families in the state, provides financial protections to the program through limiting benefits and shares the cost burden through co-payments. Operations of the program have been streamlined, and the renewal process has been simplified. Enrollment is in the process of being simplified, and the prevention of chronic medical and dental problems through routine health visits is being encouraged. Uncovered children are being specifically targeted by location and age group for enrollment. However, a few minor operations of the Board could improve. Three areas that should be improved are: the lack of submission of the annual report, the lack of full citizen membership on the Board since *Code* revisions in 2000 and the lack of a calendar for Board meetings.

Recommendations

1. *The Legislature should consider continuing the Childrenís Health Insurance Board.*

2. *The Board should ensure that a report which meets the requirements outlined in Code be submitted annually to the Governor and Legislature.*

3. *The Board should ensure that an additional citizen member is added, as required by Code.*

4. *The Board should set an annual calendar for Board meetings each year.*

Issue 2

Despite Good Performance, the CHIP Board Should Develop Contingency Plans for Potential Funding Shortfalls.

Issue Summary

The West Virginia Childrenís Health Insurance Board has created a program that is currently stable and fiscally sound. In January 2003, CHIPís actuarial review showed that program expenditures were projected to remain within 90% of total available funds for the current fiscal year. **However, the actuary is also projecting that a shortfall of $20 million from the federal allotment will develop in 2007**, the final year of the first congressional funding cycle. See Appendix B for the March 31, 2003 quarterly actuarial report. This projection is being made during a period of state budget difficulties, congressional budget changes, rising enrollments and rising health care costs.

The West Virginia CHIP program, currently financially sound, faces a possible $20 million federal deficit in 2007. While this deficit may not materialize, the CHIP Board needs to develop a contingency plan for protecting the CHIP program.

The $20 million projected deficit may be offset by bonus distribution monies that West Virginia is eligible to receive. However, these monies are severely restricted in terms of the time that they are available to be spent and the types of expenditures for which they may be used. **Despite the addition of these funds, it presently appears that a federal shortfall threatens the CHIP program.** Nine state CHIP programs have already experienced serious budget problems. Five of the nine experienced budget problems early in the development of their programs; four are presently coping with cuts to their programs due to recent cuts in their state budgets.

The CHIP Board, while aware of the impending deficit and the possible economic threats, has not decided upon or even substantively discussed contingency plans to implement if one or more of the potential threats to the program becomes a reality. However, the time required to make the needed changes could be extensive. The CHIP Board has a four-year time period in which to examine various options to protect the program. If the Board develops a contingency plan within the next two years, it will still have two years in which to submit an amendment to the State Plan for federal approval, and implement its agreed upon plans. **The CHIP Board should devote an adequate amount of time to contingency planning during the present period of program stability before a crisis develops.**

The CHIP program has had a positive performance to date; however, there are external problems developing that could significantly impact the programís financial stability. Even so, a survey of Board members and a review of Board actions indicates that forward planning for these potential problems is not being performed.

Potential CHIP Program Threats

Nine other states are already experiencing financial problems that threaten the existence of their CHIP programs.

The agency is dependent upon funding from both the state and the federal governments. This external reliance poses a risk to the program. One of the initial concerns of the Legislative Auditor is that CHIP programs in nine other states are already experiencing budget problems. Five of the nine began experiencing problems early in the establishment of the program; four have experienced threats to the program due to recent cuts in their stateís budget. Two of the states with state budget crises had CHIP programs that were initially eliminated by committee actions. In one state, the Governor found enough funding to save the program. In the other state, the program was allowed to continue by agreeing to establish co-pays for all CHIP participants.

Table 1 illustrates these problems and the actions taken by various states. It shows that such problems have developed with all three designs of the program: Medicaid expansions, separate programs and combined programs. Also, the size of the program is not a determining factor for problems; Utah, similar in size to West Virginia, has been affected. See Table 1.

Table 1
Nine States Already Experiencing Problems With CHIP

State	Size	Type	Problem
Montana	13,875	Separate	Reached state-established cap January 2001.
Rhode Island	19,515	Medicaid	Grew too rapidly. Used up all federal funds available.
Connecticut	21,346	Combined	State budget cuts.
Utah	33,808	Separate	Could not remain within budget.
Oklahoma	84,490	Medicaid	State budget cuts. Program elimination approved by its legislature. The governor found money in the budget to save the program.
Kentucky	93,941	Combined	Grew too rapidly.
North Carolina	120,090	Separate	Could not remain within budget.
Missouri	112,004	Medicaid	State budget cuts. Program elimination approved by House committee. The program was allowed to continue after agreeing to co-pays for all participants.
Texas	727,452	Combined	State budget cuts.
West Virginia	**35,949**	**Separate**	**No problems yet; within budget.**

Despite the problems of the states listed above, the Legislative Auditor finds that CHIP has been able to budget its funding to extend the financial stability of the program. However, while the Stateís program does not appear to have an immediate funding problem, a projected shortfall of $20 million from the federal allotment is expected to develop in 2007. See Appendix B for the March 31, 2003 quarterly actuarial report. **The Legislative Auditor has identified five areas of potential financial threat that could ultimately impact West Virginiaís program.** They include: state budget difficulties, a federal funding shortfall, congressional budget changes, rising enrollment within the program, and rising health care costs. A closer look at these areas follows:

The federal shortfall in 2007 depends on the CHIP enrollment remaining relatively steady, and does not include the addition of federal bonus awards.

ï **Federal funding shortfalls in West Virginia.** Actuarial forecasts showed a deficit situation of $20 million developing in FY 2007 due to a shortfall in federal funding. If this develops, the program will need additional federal funding beginning in FY 2007. This forecast is a projection based on the program having an average enrollment of 21,147 children and includes only the federally allotted money that the state expects to receive for each year through 2007. The forecast does not take into account any redistribution bonus monies because amounts are uncertain and unreliable. As more states spend their total allotments, there may be no bonus money available to West Virginia.

ï **Federal budget cutbacks.** Currently $2.7 billion of the federal funds allotted for childrenís health insurance programs have been eliminated from the federal budget. Since these monies were distributed to the states, and then returned by states unable to spend them within three years, the return of this money will not have an immediate impact on the future federal allotments. However, additional funding is already needed by some programs in other states that have grown rapidly but are ineligible for the redistributed bonus funds due to prior spending patterns.

West Virginia is experiencing budget problems that could impact its funding of the CHIP program.

ï **State fiscal problems.** West Virginia is experiencing budget problems that developed rapidly. In FY 2002 the state had a $14.4 million surplus. Just two years subsequent to this, the FY 2004 budget called for a 10% reduction across agencies **due to a forecasted shortfall of $200 million in revenues**. Although the CHIP program received its full funding request of $7.2 million for FY 2004, ongoing state fiscal problems could impact the amount of money available in the future for the 17% match.

The general economic downturn being experienced by the state could result in a higher than anticipated enrollment of children in CHIP.

ï **Rising enrollment.** This has been the cause of many problems for CHIP programs in other states. While the enrollment in West Virginia has remained between 20,000 and 21,282 since May 2001, this could change. A recent study by West Virginia University found that on any given day, 6.6% or 28,000 of West Virginiaís children are uninsured. Of this 6.6%, over 22,000 are in low income families, some of whom might qualify for Medicaid or CHIP. The general economic turndown being experienced by the state could result in a higher than forecasted enrollment of children. While the unemployment figures remain similar to a year ago, the number of jobs in the state has declined by 1,300 since March 2002. In addition, the number of food stamp recipients has increased by over 16% since 2001. Families losing income could become eligible for CHIP, causing the enrollment to swell beyond the CHIP programís funded capacity.

ï **Rising health care costs.** While West Virginia has seen benefits from instituting drug co-pays that reward the use of generic drugs, it has already experienced three consecutive years of double digit growth in health care. CHIPís annualized cost per child was $1,285 in 2001, $1,571 in 2002, and $1,561 in 2003. Health care costs alone may cause the CHIP program to be unable to expand coverage to remaining uninsured children, or to provide coverage to new uninsured children whose families become eligible due to reductions in family income.

Board is Aware of Threats, But Has Not Created Contingency Plan

A review of Board actions indicates that the Board is aware of many of the threats to the CHIP program. The Legislative Auditor reviewed the Boardís actions from January 2000 through February 2003. During this time, the Board implemented several measures to protect the fiscal stability of the program. Pharmacy co-pays were enacted for all CHIP participants[4] and benefit limits were established in July 2002.

[4]*Pharmacy co-pays were approved with an initial cost share for lower income families that was higher than the amount finally allowed by the Centers for Medicare and Medicaid Services (CMS). Because CMS did not allow the original pharmacy co-pay rates established by the Board, the savings to the program will be $475,000 less than anticipated.*

Despite these actions, the Board has not decided upon or even substantively discussed contingency plans to implement if one or more of the potential threats to the program becomes a reality. Here are the contingency measures mentioned during Board meetings:

The Board has been informed of possible deficits throughout the existence of the program, but it has not planned to protect the program.

- In November 2001, during a discussion of the reduction in the amount of the federal allotment to West Virginia, the actions to take if there was an increase in the cost per child were mentioned. The director noted there might be two actions to take: *to cap enrollment, or to seek additional funding.* **No further discussion about these actions took place.**

- In August 2002, the actuary reported that the projected federal shortfall in funding for 2005 had been reduced from over $7 million to under $3 million. One citizen Board member asked what should be done if the shortfall occurs, and another observed that the Board will have to make some decisions. The director noted that *other states have had to establish a waiting list.* **There was no further discussion or planning despite the forecasted deficit.**

- In February 2003, the Board learned that a deficit in federal funding is not projected until 2006. A citizen Board member asked *ìAt what point do we need to start planning for the 2006 and 2007 funding deficit?î* Various responses were made. The director noted that the Board should continuously monitor the fiscal reports, and possibly next year (2004), consider a plan to develop a possible waiting list or to cap enrollment. Another Board member stated that the Board should start looking at this issue either this summer or in the next year.

  The Legislative Auditor surveyed all of the Boardís voting members[5] in March 2003 to gain a further understanding of the Board memberís concerns toward the threats to CHIP. Several members expressed urgency in beginning the planning process, noting that while future funding issues have been raised, they have not been put on the Boardís agenda. One stated, *ì We should have been discussing these issues a year ago.î* Another noted, *ì We need to know [more] so we can increase or decrease benefits.*î Additional solutions to future

[5] *The Board is presently composed of five citizen members, three agency directors, and two ex-officio legislative members. The agency directors are from PEIA, DHHR(or designee) and WV CHIP; the legislative members include a member from the Senate, and a member from the House of Delegates.*

funding problems raised briefly during past Board meetings were mentioned by another Board member who stated that the Board has talked about enacting waiting lists or reducing eligibility.

Why hasnít the Board acted?

Structural processes such as the meeting agenda may have hindered Board action.

The Board is aware of the threats to the CHIP program but has not taken action to plan for future problems that could occur. The cause of this inaction appears to be linked to the following reasons:

1. The meeting agenda provided by the executive director has covered current activities of the CHIP program and not provided time for future planning.

2. While a few Board members have brought up concerns about contingency planning, they have not been successful in creating discussion of possible changes.

3. The executive director has presented a ìsolutionî to the Board by mention of establishing a waiting list, which may have discouraged additional discussion and planning.

4. There has been a false sense of security because the financial performance of the CHIP program has cost less per person than the budget forecasts anticipated.

Adequate time must be devoted to planning

If a threat to the CHIP program materializes into a financial crisis for the program, the time needed to preserve the program may be limited. However, the time *required* to make the needed changes could be extensive. **An adequate amount of time should be devoted to assessing both the possible problem and the impact of the proposed solution on the program and on the enrolled children.**

Possible actions the Board could take

Some of the actions taken to preserve programs in other states may be considered by the Board to address the projected federal shortfall in 2007.

They are as follows:

- **Freeze, or cap enrollment.** Frozen enrollments stop enrollment for a period of time; capped enrollments set the number of enrollees allowed at a pre-determined level. Two of the programs froze enrollment early in the development of their programs, in effect capping the number of enrollees; a third *suspended* enrollment due to recent state budget cuts.

- **Waiting lists; short open enrollment periods.** Sometimes enacted in concert with frozen enrollments.

Other states have taken a variety of approaches to respond to threats to their CHIP programs.

- **Premiums.** One program initiated an annual premium charge of 4% of family income, while a second introduced monthly premiums.

- **Increase cost sharing amounts.** This would involve raising costs for the enrolled family, and would require approval by CMS.

- **Reduce benefits.** This would involve assessing the benefit package, and might have implications in maintaining the ìbenchmark equivalent programî which is federally mandated.

- **Lower eligibility standards.** A change in eligibility standards from 200% of FPL back to 150% would restrict the number of children eligible for this insurance coverage.

- **Limit application process.** Require all applications and renewals to take place at the welfare office only, in an effort to limit the size of the program.

Once a plan of action is determined by the Board, time may then be needed for the approval of policy changes through the federal and state governments.

Program Stability Allows Time for Contingency Planning

The CHIP Board has created a program that is currently stable and fiscally sound. However, the Board has not substantively addressed and planned for actions to take in the event that the program experiences: 1) a funding shortfall as a result of the stateís fiscal problems, 2) a larger than anticipated enrollment due to families losing income during the economic downturn, 3) a shortfall due to federal funding cutbacks, or 4) rising health care costs.

Before a crisis develops, the Board should carefully examine the various actions that it might approve, as well as the possible impacts on the children and families presently enrolled in the program and those needing to enroll in the program in the future. This planning should include decisions about:

Before a crisis develops, the Board should carefully examine the actions it might approve as well as the impact on the children currently enrolled in the program, and those needing to enroll in the future.

- whether to impose eligibility income level changes;
- whether, and how to expand cost sharing;
- whether to make benefit changes, and which might be reduced first;
- whether to impose enrollment freezes;
- if enrollment is frozen, whether to enact open enrollment periods or waiting lists;
- how to utilize the provision for a public-private partnership (provided in *Code*); and
- what time line would be needed to enact policy changes and allow amending the state plan.

Not only should these policy decisions be made as a matter of forward planning, but the order in which these actions should be taken should be decided before a crisis does not allow for careful consideration of possible scenarios.

Conclusion

West Virginiaís CHIP program is not immune to financial problems created by deteriorating economic conditions, turbulence within the health care industry and changing federal health care policies. The Board, while aware of these threats and the need to plan for future problems, has not made substantive plans to respond in the event that any of these circumstances create problems. Since some responses would require federal approval for policy changes, an adequate amount of time should be devoted to assessing both the possible problem, and the impact of the proposed solution on the program and the enrolled children.

Recommendation

5. *The Board should begin the process of developing a contingency plan by 2005, which would allow for changes to the State Plan to be submitted to CMS and accepted.*

Appendix A Transmittal Letter

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

May 20, 2003

Sharon Carte, Director
Children's Health Insurance Program
Building 3, Room 554
1900 Kanawha Blvd., East
Charleston, West Virginia 25305

Dear Ms. Carte:

This is to transmit a draft copy of the Preliminary Performance Evaluation of the Children's Health Insurance Board. This report is scheduled to be presented at the Sunday, June 8, 2003 interim meeting of the Joint Committee on Government Operations. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committee may have. If you would like to schedule an exit conference between May 21, 2003 and May 27, 2003 to discuss any concerns you may have with the report, please notify us to schedule an exact time. In addition, we need your written response by noon on May 28, 2003 in order for it to be included in the final report. If your agency intends on distributing additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, June 5, 2003 to make arrangements.

We request that your personnel treat the draft report as confidential and that it not be disclosed to anyone not affiliated with the agency. Thank you for your cooperation.

Sincerely,

John Sylvia

John Sylvia

Enclosure

C: Tom Susman, Acting Cabinet Secretary

Appendix B Actuarial Report

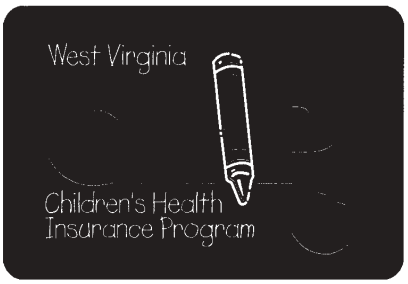
West Virginia Children's Health Insurance Program Fiscal Year 2003
March 31, 2003 Quarterly Report

Available Funding - Beginning of the Year	2003	2004	2005	2006	2007
Federal 1999	$0	$0	$0	$0	$0
Federal 2000	6,465,294	0	0	0	0
Federal 2001	21,144,989	1,770,424	0	0	0
Federal 2000 Limited Redistribution	0	5,300,000	0	0	0
Federal 2002	16,650,270	16,650,270	0	0	0
Federal 2003	18,550,788	18,550,788	13,333,791	0	0
Federal 2004	0	18,550,788	18,550,788	0	0
Federal 2005	0	0	18,550,788	18,188,440	0
Federal 2006	0	0	0	18,550,788	743,721
Federal 2007	0	0	0	0	18,550,788
State Original Funding	$2,089,324	$0	$0	$0	$0
State Funding 2002	0	0	0	0	0
State Funding 2003	4,843,475	1,463,002	0	0	0
State Funding 2004	0	7,122,654	2,460,108	0	0
State Funding 2005	0	0	7,200,000	2,834,059	0
State Funding 2006	0	0	0	8,600,000	3,814,509
State Funding 2007	0	0	0	0	9,700,000

Program Costs	2003	2004	2005	2006	2007
Medical Expenses	$19,875,413	$22,022,855	$24,225,140	$26,647,654	$29,312,420
Prescription Drug Expenses	4,958,542	6,043,717	7,312,897	8,848,606	10,706,813
Dental Expenses	3,349,656	3,711,570	4,082,727	4,491,000	4,940,100
Administrative Expenses	3,401,045	3,571,097	3,749,652	3,937,135	4,133,992
Program Revenues - Interest	$0	$0	$0	$0	$0
Program Revenues - Drug Rebates	275,000	286,000	297,440	309,338	321,712
Net Incurred Program Costs	$31,309,656	$35,063,239	$39,072,977	$43,615,057	$48,771,612
Net Paid Program Costs	31,009,656	34,617,239	38,595,977	43,073,057	48,154,612
Federal Share	$25,839,859	$28,937,691	$32,246,928	$35,995,506	$40,251,212
State Share of Expenses	5,469,797	6,125,548	6,826,049	7,619,550	8,520,401
Beginning IBNR	$3,200,000	$3,500,000	$3,946,000	$4,423,000	$4,965,000
Ending IBNR	3,500,000	3,946,000	4,423,000	4,965,000	5,582,000

Funding Sources - End of the Year	2003	2004	2005	2006	2007
Federal 1999	$0	$0	$0	$0	$0
Federal 2000	0	0	0	0	0
Federal 2001	1,770,424	0	0	0	0
Federal 2000 Limited Redistribution	5,300,000	0	0	0	0
Federal 2002	16,650,270	0	0	0	0
Federal 2003	18,550,788	13,333,791	0	0	0
Federal 2004	0	18,550,788	0	0	0
Federal 2005	0	0	18,188,440	0	0
Federal 2006	0	0	0	743,721	0
Federal 2007	0	0	0	743,721	0
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$20,956,703***
State Original Funding	$0	$0	$0	$0	$0
State Funding 2002	0	0	0	0	0
State Funding 2003	1,463,002	0	0	0	0
State Funding 2004	0	2,460,108	0	0	0
State Funding 2005	0	0	2,834,059	0	0
State Funding 2006	0	0	0	3,814,509	0
State Funding 2007	0	0	0	0	4,994,108
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***

Appendix C Agency Response



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May 30, 2003

John Sylvia
Director
West Virginia Legislature
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard East
Charleston, West Virginia 25305

Dear Mr. Sylvia:

Thank you for the recent draft copy of the Performance Evaluation of the West Virginia Children's Health Insurance Board. We appreciate the information imparted through this process and the opportunity afforded us to discuss the recommendations in our exit conference of May 27th. In response to the five recommendations we offer the following:

1. *The Legislature should consider continuing the Children's Health Insurance Board.*

   Response: Agreed.

2. *The Board should ensure that a report which meets the requirements outlined in Code be submitted annually to the Governor and Legislature.*

   Response: The West Virginia Children's Health Insurance Agency (Agency) has begun a review of these requirements and the necessary data and standard reporting needed for a more comprehensive annual report. The agency's next annual report submitted to the Governor and Legislature on January 1, 2004 will meet these requirements.

3. *The Board should ensure that an additional citizen member is added as required by Code.*

   Response: The Agency will submit a name(s) of a qualified individual for consideration prior to the next Board meeting.

4. *The Board should set an annual calendar for Board meetings each year.*

Response: The Agency has set an annual calendar for quarterly meetings during the next fiscal year beginning July 1, 2003 and will provide this to the Board prior to its next meeting.

5. *The Board should begin the process of contingency planning in order to provide for an adequate amount of time to assess the possible problem and the impact of the proposed solution on the program and on the enrolled and yet-to-be enrolled children.*

Response:

The Agency closely monitors the financial standing of the West Virginia Children's Health Insurance Program (WVCHIP) through its monthly financial statements and through certified actuarial reviews made available to the Board on a quarterly basis, through year end fiscal statements to the Legislature, and budgetary requests made in October to the Governor and Legislature. We also believe this is reflected in an efficiently operated program which has seen its annual child care cost decrease from $1,571 per child at the end of November 2002 to $1,533 per child at the end of March 2003 according to WVCHIP internally-prepared financial statements. In addition, we would also offer the following considerations:

- **There is a limited number of children remaining without insurance coverage.**

  The 2002 survey by the WVU Institute for Health Policy and Research (a survey with a 95% confidence level) showed that only 6.6% or some 28,000 children remain without insurance coverage in West Virginia. Of this number, an estimated 18,000 or so would be eligible for WVCHIP or Medicaid. If as many as 60% of these were to enroll in WVCHIP, this puts the maximum total amount of fiscal growth that may be anticipated as follows:

  18,000 children x 60% = 10,800 remaining children eligible for WVCHIP

  10,800 children x $1,400 annual cost per child = $15.12 million total program cost

  $15.12 million x 82.53% federal match rate* = $12.48 million federal financial participation

$15.12 million total program cost - $12.48 million = $2.64 million program cost to state

An estimated <u>$2.64 million</u> maximum additional state funds would be required if all eligible children were enrolled

- **WVCHIP is a federal block grant program and not an open ended entitlement program.**

This means that in establishing WVCHIP, the federal government extended greater fiscal control to the states to exercise greater budgetary control by allowing them to cap programs at a designated level of expenditure, and not grow them if warranted by the state budgetary demands. This is not the case in Medicaid in which all eligibles must be provided benefits if qualified. The West Virginia Legislature was well aware of this when they authorized the WVCHIP in state code and was emphatic the new program should be a separate program and not a Medicaid expansion. Table I of the audit shows 9 other states "already experiencing problems" with their CHIP programs, and it also shows that 6 of these 9 either had Medicaid expansions or were combination programs. The decision to keep WVCHIP as a separate benefit program has permitted WVCHIP a greater fiscal control through actions such as increasing copayment schedules and creating benefit maximums as commercial models of insurance do. We believe this choice has paid off as shown by the fact that WVCHIP, not the smallest in size, is the only one of ten that has remained within budget and not had to act to restrict growth to remain in budget. Nonetheless, if circumstances were to rapidly change in the coming year or years prior to the projected deficit of 2007, the State does have the option to cap spending or freeze enrollment. Since this would require that West Virginia amend its State Plan filed under Title XXI, it would be prudent to plan for this a year in advance and to obtain necessary actuarial estimates.

- **The federal allocation formula provides a certain amount of protection against increased expenditures resulting from higher enrollment.**

The proportion of federal funding allocated to West Virginia each year is basically a reflection of its uninsured child population. This is why the State's federal allocation which was at $16.65 million in Federal Fiscal Year 2002 was increased to $18.55 in FFY 2003 - because the number of insured children had increased as a result of the averaging of the most recent three years of census projection data over that of the prior year. Of

course this is in proportion to what is occurring in all states: for example, if West Virginia's insurance coverage is holding steady while others loose coverage faster, their allocations will have the greater increase.

- **West Virginia's health care delivery system is made more stable through the addition of over $30 million in federal dollars and the avoidance of uncompensated care costs provided by WVCHIP.**

  We recognize that one of the main drivers of health care expenditures is the 42 million Americans who remain outside of health care coverage and the uncompensated health care costs that are passed along to the rest of the insured public - driving up costs - making premiums yet more unaffordable and adding to the pool of the uninsured. This financial death spiral can only be broken when major reform occurs at the federal level in the not too distant future. The additional dollars provided to West Virginia's health care delivery system through WVCHIP help maintain those rural hospitals and physicians who may be struggling under increased financial pressures from uncompensated care at a precarious time.

In summary, while we recognize the need for contingency planning as recommended, we also believe health care financing currently exists in a highly dynamic environment in which planning for changes too far in advance can result in the loss of time and resources needed to evaluate other options/opportunities that may arise. We agree we can begin to prudently plan for the potential deficit projected in 2007 sometime in the next two years as noted.

As you have requested, the West Virginia Children's Health Insurance Agency will be available to present to the Performance Evaluation Research Division on Monday, June 9, 2003 at 9 AM. Please let us know the location of this meeting as soon as it is set. Should you have any questions or need additional information prior to this date, please let me or Terry Harless know.

Sincerely,

Sharon L. Carte
Executive Director
WV Children's Health Insurance Program

Cc: Tom Susman, Acting Cabinet Secretary
Department of Administration