UTAH TITLE XXI PROGRAM
FACT SHEET

Name of Plan:	**Utah's Children's Health Insurance Program**
Date Plan Submitted:	April 2, 1998
Date Plan Approved:	July 10, 1998
Effective Date:	August 3, 1998
Date Amendment #1 Submitted:	January 28, 1999
Date Amendment #1 Disapproved:	November 29, 1999
Date Amendment #2 Submitted:	March 1, 2002
Date Amendment #2 Approved:	June 25, 2002
Date Amendment #2 Effective:	December 15, 2001; January 1, 2002; February 1, 2002
Date Amendment #3 Submitted:	November 14, 2002
Date Amendment #3 Approved:	April 2, 2004
Date Amendment #3 Effective:	July 1, 2002; July 1, 2003
Date Amendment #4 Submitted:	June 1, 2005
Date Amendment #4 Approved:	August 25, 2005
Date Amendment #4 Effective:	July 1, 2005
Date Amendment #5 Submitted:	August 29, 2007
Date Amendment #5 Approved:	November 27, 2007
Date Amendment #5 Effective:	July 1, 2007
Date Amendment #6 Submitted:	August 12, 2008
Date Amendment #6 Approved:	April 3, 2009
Date Amendment #6 Effective:	July 1, 2008
Date Amendment #7 Submitted:	April 17, 2009
Date Amendment #7 Approved:	July 15, 2009
Date Amendment #7 Effective:	April 17, 2009
Date Amendment #8 Submitted:	July 28, 2009
Date Amendment #8 Approved:	May 2, 2011
Date Amendment #8 Effective:	July 1, 2009
Date Amendment #9 Submitted:	September 1, 2010
Date Amendment #9 Approved:	May 2, 2011
Date Amendment #9 Effective:	July 1, 2010

Background

- On July 10, 1998, CMS approved Utah's separate child health program, which provides coverage for children under age 19 with family income at or below 200 percent of the Federal Poverty Level (FPL).

Amendments

- On November 29, 1999, CMS disapproved a State plan amendment (SPA) to add cost sharing for families with incomes below 100 percent of the FPL. The State requested approval to apply the same cost-sharing schedule for families with incomes below 100 percent of the FPL that was previously approved for families with incomes from 100 to 150 percent of the FPL.

- The State's second amendment submitted on March 1, 2002, allowed the State to establish an enrollment cap of 24,000 enrollees; require premiums and increase copayments for enrollees above 100 percent of the FPL; disregard the child's income when determining family income; and modifies the dental, vision and hearing services within the benefit package.

- The State's third amendment submitted on November 14, 2002, updates and amends the SCHIP State plan to indicate the State's compliance with the final SCHIP regulations. The amendment also restored dental benefits to the pre-January 2002 level, and revised the State's enrollment cap by raising the limit from 24,000 enrollees on average to 28,000 enrollees on average.

- The State's fourth amendment submitted on June 1, 2005, raises the enrollment cap from 28,000 to 40,000 enrollees and added an exception to the 90-day crowd out period. Additionally, clarifications were made to explain the renewal process, clarify the disenrollment process for failure to pay quarterly premiums, and describe the process to notify families of their cost-sharing maximum and the procedures a family must follow once their maximum has been reached.

- The State's fifth amendment submitted on August 29, 2007, decreases the amount of time applicants have to pay cost sharing, increases premiums and cost sharing and modifies the scope of some of the benefits.

- The State's sixth amendment, submitted on August 13, 2008, makes changes to its enrollment procedures, cost sharing, and benefits. Specifically, the SPA provides open enrollment throughout the year rather than limiting enrollment to specified periods, changes the deadline for applicants to provide verification to determine eligibility from 45 to 30 days, increases cost sharing, and changes benefits. The State requests a retroactive effective date of July 1, 2008.

- The State's seventh amendment, submitted on April 17, 2009, provide for a new source of state funds from a Robert Wood Johnson Foundation (RWJF) grant. These funds will be used to fine tune Utah's outreach program by working closely with

school nutrition programs for low income children and by reaching out to multicultural communities.

- Utah's eighth amendment, submitted on July 28, 2009, increases premiums and cost sharing, and imposes a $15 fee for late premium payment for families above 150 percent of the Federal poverty level (FPL). Through this SPA, Utah demonstrated compliance with section 504 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) which requires States to grant individuals, enrolled in separate child health programs a 30-day grace period to pay any required premium before enrollment is terminated. This SPA is also a good faith effort toward meeting the mental health parity requirements in section 502 of CHIPRA. Utah's eighth amendment has a retroactive effective date of July 1, 2009.

- Utah's ninth amendment, submitted on September 1, 2010, makes additional changes to the State's cost-sharing requirements by increasing coinsurance requirements for dental services, and raising copayments for upper income enrollees for specialist visits, urgent care, vision and hearing screening, physical therapy, and mental health outpatient visits. Utah's SPA number 9 also comes into compliance with section 501 of CHIPRA, by providing dental coverage that is equal to a benchmark dental package (Utah's dental plan with the largest commercial, non-Medicaid enrollment). Utah's ninth amendment has a retroactive effective date of July 1, 2010.

Children Covered Under the Program

- The State reported that 62,071 children were ever enrolled in its program during Federal Fiscal Year 2010.

Administration

- The Utah Department of Health administers the Utah Children's Health Insurance Program. CHIP contracts with two managed care organizations to provide medical care for children enrolled in CHIP. These managed care organizations have extensive provider networks throughout the State.

Health Care Delivery System

- Health services in the urban areas (Davis, Salt Lake, Utah and Weber counties) and in the rural areas (all other counties) are delivered by Managed Care Organizations (MCOs).

Benefit Package

- Utah offers benchmark-equivalent coverage. The State's plan includes an actuarial analysis comparing the benefit package to the benefit plan provided to Utah State employees.

Crowd-Out Strategy

- The application requests information about health insurance coverage for the children in the household. Every SCHIP application is screened through the Medicaid eligibility determination process to determine if the child qualifies for Medicaid.

- A child is found ineligible for SCHIP if the child has been voluntarily terminated from health insurance coverage within the 3 months prior to the application date for coverage under SCHIP.

Exceptions to the 90-day ineligibility period are:

1. Voluntary termination of COBRA coverage.

2. Voluntary termination of coverage by a non-custodial parent.

3. Involuntary termination from a group health plan.

4. Voluntary termination of the State Health Insurance Pool (HIP)

5. Voluntary termination of health insurance coverage purchased after the previous SCHIP open enrollment period ended but before the beginning of the current open enrollment period and who met SCHIP eligibility requirements at time of purchase.

Premiums and Copayments, Effective July 1, 2010

Benefit	Family Income up to 100% FPL	Family Income 101%-150% FPL	Family Income 151%-200% FPL
Premium	None	$30/family/quarter	$75/family/quarter
Deductibles	None	$40/family	$500 per person /$1500 per family
Medical Benefits			
Hospital Inpatient	$50	$150 after deductible	20 % of approved amount after deductible
Ambulatory Surgical & Outpatient Hospital	$3	5% of approved amount after deductible	20% of approved amount after deductible
Ambulance	5% of approved amount	5% of approved amount after deductible	20% of approved amount after deductible
Physician Office visits	$3	$5	$20
Specialist visits	$3	$5	$35
Residential Treatment	5% of approved amount (25 day limit/year)	5% of approved amount (25 day limit/year)	50% of approved amount after deductible (25 day limit/year)
Physical Therapy	$3 (20 visit limit/year)	$5 (20 visit limit/year)	$35 after deductible (20 visit limit/year)
Prescriptions	$1 preferred generic drugs; $1 preferred brand name drugs; 5% of approved amount for non-preferred drugs	$5 preferred generic drugs; 5% of approved amount for preferred brand name drugs; 5% of approved amount for non-preferred drugs	$15 preferred generic drugs; 25% of approved amount for preferred brand name drugs; 50% of approved amount for non-preferred drugs
Surgeon	$0	5% of approved amount	5% of approved amount
Anesthesiologist	$0	5% of approved amount after deductible	20% of approved amount after deductible
Emergency Room	$3	$5; $10 non-emergency	$200; $400 out-of-network
Urgent Care Center	$3	$5	$35
Lab & X-ray Services Under $350	$0 for minor diagnostic tests and x-rays; $3 for major diagnostic tests and x-rays	$0 for minor diagnostic tests and x-rays; 5% of approved amount after deductible for major diagnostic tests and x-rays	$0 for minor diagnostic tests and x-rays; 20% of approved amount after deductible for major diagnostic tests and x-rays
Vision Screening	$3 (1 visit limit/year)	$5 (1 visit limit/year)	$35 (1 visit limit/year)
Hearing Screening	$3 (1 visit limit/year)	$5 (1 visit limit/year)	$35 (1 visit limit/year)
Mental Health			
Mental Health Inpatient	$50	$150 co-payment after deductible	20% of approved amount after deductible
Mental Health Outpatient	$3	$5	$35
Dental			
Deductible	$0	$0	$50/child; $150/family
Maximum Benefit	$1,000/ plan year	$1,000/plan year	$1,000/plan year
Basic Services (Fillings, Extractions, Oral Surgery)	$0	5% of approved amount	20% of approved amount after deductible
Major Services (Crowns, Bridges, Dentures, Endodontics, Periodontics)	5% of approved amount	5% of approved amount	50% of approved amount after deductible
Orthodontics (Orthodontics are not included in the annual maximum benefit)	5% of approved amount (12-month waiting period, $1,000 lifetime maximum)	5% of approved amount (12-month waiting period, $1,000 lifetime maximum)	50% of approved amount (12-month waiting period, $1,000 lifetime maximum)
Specialists	5% of approved amount	5% of approved amount	Provided by the plan

State Outreach and Enrollment Activities

- The State utilizes many strategies to identify and enroll eligible children. These activities include:

    - Computer matches of families already on Medicaid who have children without coverage and of families receiving child-care assistance without Medicaid.

    - Medicaid eligibility workers already in place in almost 100 locations determine eligibility for SCHIP. These eligibility determination sites are located in hospitals, community health centers, local health departments, Department of Workforce Services' offices and many other allied agencies.

    - Dissemination of information through community presentations, press coverage, toll-free telephone line, brochures, flyers and postcards. Information is also disseminated by housing assistance organizations, hospitals, medical-care sites, community-based organizations and other Medicaid outreach campaigns.

Coordination Between SCHIP and Medicaid

- The application contains the information necessary to determine eligibility for Medicaid and CHIP. The application is screened first for Medicaid eligibility prior to determining eligibility for CHIP.

Financial Information
Total FFY '11 CHIP Allotment -- $63,915,866
FFY '11 Enhanced Federal Matching Rate – 79.79%

Date Last Updated: CMS, CMCS, CAHPG, DCHIP, May 27, 2011