

The Factors Shaping NC Health Choice and its Relationship with  
Community Care of North Carolina

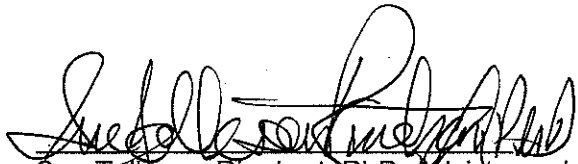
By

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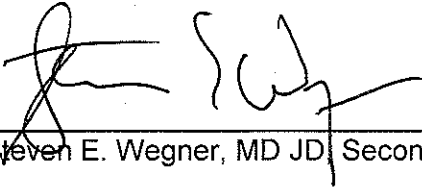
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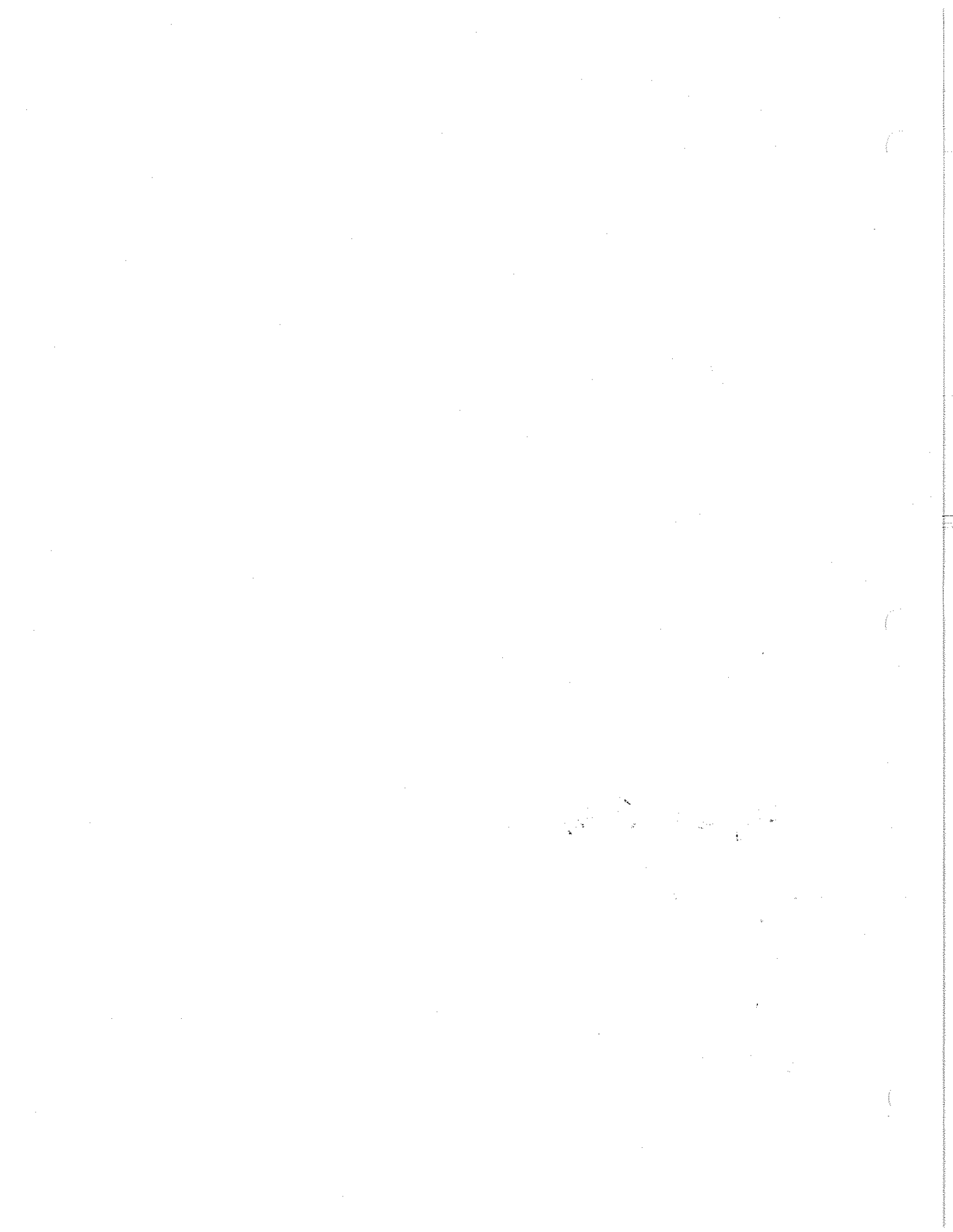
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## **Introduction: Expanding Children's Access to Care**

American policy governing children's health services changed in 1997 with the passage of legislation mandating that each state create a government-run health insurance program aimed at providing health care coverage for children of families earning too much to qualify for Medicaid and not enough to be able to independently purchase private insurance. (Lambrew 2007) States were afforded flexibility to develop a program that fit these simple criteria and some federal funding would be provided to states based on an algorithm using the state's number of uninsured children and average state income level (Gitterman et al. 2007). Out of a broad constellation of political and contextual variables, North Carolina developed and implemented NC Health Choice (NCHC) in 1998. This was a separate block-grant program; the state was not mandated to enroll eligible children if sufficient funding was not available. It would serve children from birth to age 18 in families earning between 100 and 200% of the federal poverty limit (FPL). It was also to be administered by the State Health Plan (SHP) and paid by a third-party payer, Blue Cross Blue Shield of North Carolina (BCBSNC). Over the subsequent decade, NCHC changed in response to internal or external pressures (Gitterman et al. 2007).

Community Care of North Carolina (CCNC) is a care management program first piloted in 1988 and implemented statewide on North Carolina Medicaid patients in 2006. The program is divided into fourteen networks across the state, each striving to maximize health benefits and reduce costs. These networks utilize care managers to promote appropriate health behaviors amongst individual higher-risk or chronic patients. Care managers are intended to ensure that their patients understand treatment regimens as well as appropriate utilization of specialist and emergency room care. The networks also fuel population-based efforts to reduce overall spending, such as requiring prior authorization for prescribing brand name medications over generic ones. In compensation for this added effort, and to reward providers for creating healthier patients, physicians and networks are given a per-member-per-month (PMPM) fee.(CCNC Website ; Steiner et al. 2008, 361; Willson 2005, 229-233)

Studies have shown CCNC to be highly effective at improving health outcomes while reducing state cost. CCNC reports a 21% increase in the numbers of asthmatic patients who have been staged and a 112% increase in asthmatics receiving the flu vaccine. In addition, asthmatics enrolled in CCNC had an average of 34% fewer hospital admissions and 8% fewer emergency department visits than did controls. The Mercer Human Resources Counseling Group projected that CCNC's strategies would produce savings of \$60 million dollars in 2003, \$124 million in 2004, and \$231 in 2005 and 2006.(CCNC Website ) As a result, North Carolina's unique solution to creating Medicaid medical homes has been widely touted as a success both locally and nationally.

With such an obviously successful structure for managing and improving care in place, would it not be reasonable to expect that state policymakers would extend CCNC 's portfolio to include NCHC children as well? In 2007, the General Assembly enacted the necessary enabling legislation to make CCNC responsible for managing the care of NCHC recipients. Beginning in March of 2007, NCHC was still administered by SHP and paid for by BCBSNC, but care managers and CCNC networks were to manage the patients' health. In July of 2009, however, the General Assembly reversed course, removing NCHC recipients from CCNC management.(Gitterman et al. 2007; Sack 2009, 1)

This study examines the political and circumstantial factors that contributed to the development of the initial NCHC program and shaped its subsequent triumphs and troubles. It also examines the role of these and other factors in the relationship between NCHC and CCNC, including what may have led to the decision to include – and later remove – NCHC under CCNC care management.

## **Methods: Deciphering the Policy Process**

I triangulated methods in order to understand the unfolding politics of NCHC. This section describes the methods I used to conduct a systematic review and critical appraisal of scholarly literature on the federal politics of CHIP legislation and to conduct in-depth interviews with elites who had particular knowledge of the North Carolina case.

### **Literature search**

To understand the scope of scholarly attention to the problem of understanding the politics of SCHIP, including pertinent variables and players influencing SCHIP implementation and reauthorization politics, I conducted a limited search of PubMed and JSTOR, databases of biomedical and social science literature, respectively. The details of the search and a critical appraisal table of the 34 articles included in the final review are in Appendix 1, Methods. In the pages to follow, I incorporate the remaining thirty-four relevant articles into a discussion of theoretical perspectives underlying public extensions of health services like SCHIP. Most articles touched on several categories of SCHIP reauthorization, such as lobbying and funding in reauthorization debates. They are discussed below according to their most prominent themes. This literature search strategy did not yield an exhaustive collection of scholarship on the politics of SCHIP implementation and reauthorization; however these articles provide some insight into the variables and players contributing to development and passage of this key piece of policy legislation.

A potential problem with looking to scholarly journals and periodicals for information on health politics is that the authors of these articles, mostly policy scholars and pediatricians, are more likely to be either liberal-leaning or oriented toward patient advocacy – or both. Most political scientists and public policy scholars inherently believe in the potential of government to do good, making it more likely that their analyses are grounded in perspectives that, albeit always with a critical eye, generally accept



the appropriateness of a reasonably broad scope of government. Pediatricians are likely to be both inherently oriented to, and trained for, child health advocacy.(Oberg and Zastrow 2004, 286-308) Because of the potential perspectives of the authors of most of this literature, then, this systematic review lends itself to gathering articles written from the perspective of supporting the SCHIP program and its underlying concepts. Another search may examine articles in more conservative magazines or newspapers to gain an understanding of an alternate perspective.

I present the results of this literature review and its accompanying critical appraisal table in Appendix 2: Literature Review.

### **Recruiting elites**

I identified potential respondents using a rolling reputational sampling process (Tansey 2007, 765-772). For my initial set of elites I chose people who were visible, had expertise about the policy, and could clearly be seen to represent at least one of five different policy domains: advocacy, bureaucracy, legislative politics, academe; and/or practice. I identified them in conversation with Dr. Steve Wegner and Dr. Sue Tolleson-Rinehart. These initial contacts, all of whom agreed to be interviewed, then provided me with the names and positions of others I should talk to. The list of elite respondents can be seen in Table A2-1. I stopped interviewing additional elites when I stopped gaining new information from the interviews and when interviewees stopped referring me to new contacts. I followed best practices for in-depth elite interviewing (Hochschild 2008). My open-ended interviews lasted from 30 minutes to an hour; I recorded them and transcribed them from the resulting digital files. I alone coded the interviews, based on the transcripts. Exact interview processes, including my contact messages, a copy of the interview protocol, and my codebook variables, are presented in Appendix 2.

I also spoke informally to others who, although not interview respondents, helped me understand SCHIP policy processes. Those individuals' remarks are cited in the following pages as "personal communications" rather than as interviews.

The analysis below is a synthesis of the scholarly literature, elite perspectives, and my own careful reading of US and NC primary documents.

## **Results**

Overall, NCHC's disengagement from CCNC was not an isolated decision. In truth, none of the changes to NCHC were isolated decisions. Instead, they grew from circumstances related to the very structure of the CHIP program, and that structure itself emerged from the state's political environment of the state at the time.

### **NCHC's beginnings**

The structure of NCHC in its early years was born of a constellation of interacting variables and contexts; had one of these been absent, the ultimate design of the program would have been different. Federal CHIP legislation was passed at a time when North Carolina was already considering means to creating a safety net health insurance program for children (Vitaglione and Silberman interviews). BCBSNC already managed a program called Caring for Children, aimed at providing insurance for the same populations CHIP would later target: those children in families earning too much to qualify for Medicaid but not enough to afford private insurance (Shore and Silberman interviews). There were several active and powerful advocacy groups in the state interested in promoting programs to improve children's access to good health coverage. North Carolina Pediatrics Society was most involved in advocating for children's health (Shore, Simms, and Vitaglione interviews), but groups such as Action for Children, North Carolina Institute of Medicine, the Academy of Family Physicians, and Covenant with

North Carolina's Children and were all also influential at the time (Shore, Vitaglione, and Dixon interviews). Several state legislators, including state Senator Purcell and state Representative Verla Insko were also strong voices for children's health in the General Assembly (Shore, Simms, Insko, Vitaglione, Dixon interviews). Meanwhile, Governor Jim Hunt was very "child-oriented" (Vitaglione interview) and the secretary of DHHS was Dave Bruton, a former pediatrician. Bruton and Hunt had already begun the process of organizing state policymakers into a task force aimed at developing such a proposal when federal CHIP legislation passed and focus could be turned to making state policy align with federal funding (Vitaglione and Silberman interviews). This group's history of cooperation helped to develop a congenial atmosphere that made the process of setting to work on recommendations easier and friendlier after CHIP's passage. Tom Vitaglione, then the head of children's health at DHHS, was charged with helping lead this task force along with Gordon DeFries of the North Carolina Institute of Medicine. Mr. Vitaglione later recalled the deep feelings of trust in these meetings, attributing this largely to members' understanding that all valid viewpoints would be considered and multiple final recommendations would be sent on to the executive branch (Vitaglione interview).

The task force created a set of several possible CHIP structures, sending them on for Secretary Bruton's and Governor Hunt's consideration. The executive branch ultimately endorsed a proposal to create CHIP by expanding Medicaid to include children of higher income levels, thus broadening the entitlement program and ensuring that federal funds would always been available to the program. The Democrat-run state Senate quickly endorsed this proposal.

Despite all of the favorable influences readying the state to expand children's health insurance coverage, North Carolina did have one countervailing force: from 1995 to 1999, North Carolina's House of Representatives was controlled by Republicans, for the first time since at least 1931 (General Assembly Website 2008, 1). House Republicans opposed a Medicaid expansion, fearing that such an entitlement program would lead to unpredictable (and no doubt increased) levels of enrollment and

increased commitment of state funds (Shore and Sexton interviews). Ultimately, the spirit of compromise cultivated in the development of this legislation prevailed, leading to a separate block-grant program termed NC Health Choice that would cover children of families earning between 100 and 200% of the federal poverty limit (FPL) and would only receive a specified level of funding without entitling eligible children for enrollment. In an effort to reduce the stigma of Medicaid amongst some middle-income families, the program was to be administered by the State Health Plan (SHP) and to be paid for by Blue Cross Blue Shield of North Carolina (BCBSNC) (Simms, Insko, Sexton, Vitaglione interviews). The task force, legislators, and other advocates worked to mold this block-grant legislation into something as nearly comprehensive and complete as that of Medicaid, simply without the entitlement provision (Simms and Vitaglione interviews). Ultimately, both sides were satisfied with the program's final structure. Tom Vitaglione recalled initial worries that a block-grant program would not reach be as comprehensive and effective as a Medicaid expansion. "The surprise was that they allowed us over six weeks of negotiation to actually develop a program that was just as good, just a different name. To some extent, because it was not called Medicaid, the stigma – to the extent there would have been one – in the middle class community was not there." (Vitaglione interview)

### **NCHC's Evolution**

Inevitably, many of the struggles and resultant changes to NCHC grew from its original structure and organization. Great state interest in expanding care coverage to uninsured children led to well-organized, highly effective grassroots outreach (Shore, Sexton, and Vitaglione interviews), so successful that it created unanticipatedly high enrollment (Shore, Sexton, Insko, and Vitaglione interviews). Carolyn Sexton co-chaired the Outreach and Enrollment subcommittee of the task force. She recalls how that committee's understanding of North Carolina's racial, geographical, and cultural diversity lead it to pursue a grassroots approach to informing the public about NCHC, "so that the message could be

tailored to the part of the state that you're working in and that they were hearing the message from people they trusted" (Carolyn Sexton interview). Initial projections predicted that there were 71,000 uninsured children in North Carolina, and federal budgetary allowances were provided accordingly; however enrollment had reached 72,000 in the program's first year and nearly 148,000 by 2006 (Gitterman et al. 2007, ). Consistently high annual levels of enrollment ultimately led to on-going budgetary constraints and crises. In January 2001, North Carolina became the first state to freeze CHIP enrollment entirely, only opening to eligible children on a waitlist in July of that year, and not opening to all eligible children until October. Program advocates worried that such a freeze would undermine the program's credibility. Carolyn Sexton spoke passionately of enrollment freezes. She said "2001 was a very glum year for us...If you're a family that has a child enrolled in this program and it closes new enrollment, what does that say to you about the stability of the program? ...That was the worst that it got right there" (Sexton interview). This low point in NCHC's development stemmed from the compromise with House Republicans over structure in 1998; had North Carolina created a Medicaid expansion program, enrollees would have been entitled to federal funding. Likewise, as an entitlement, enrollment could not be halted for eligible children. Of course, it is uncertain what effect such an entitlement would have on the state budget and other programs; federal funds are not exhaustive and the state would be required to find a means to pay for a burgeoning population of children covered under state government-run insurance.

To try to prevent future, similar freezes, the legislature made cost-saving measures during times of budgetary stress. In 2005, children up to 6 years of age in families making between 100 and 200% of FPL were transferred from NCHC to Medicaid, making North Carolina's CHIP a hybrid block-grant and entitlement program. Those children enrolled in Medicaid were also included in the state's renowned Community Care of North Carolina (CCNC) care management program, shown to improve patient outcomes while saving the state unnecessary medical costs. This move also freed up more federal CHIP-

authorized funds for the remaining 6 to 18 year-olds in NCHC. At this time, both of North Carolina's houses were controlled by Democrats and the Governor was also Democratic, presumably lessening the resistance to a shift toward entitlement.

The 2001 enrollment freeze was the only instance in which the program halted all enrollment but there have been limitations ever since. The General Assembly repeatedly capped increases in the numbers of new eligible children that could be enrolled in the NCHC program through the first decade of the 21<sup>st</sup> century. For example, in the 2008-2009 fiscal year, enrollment was not to exceed 15,000 additional children (Lichstein et al. 2009, 310; Anonymous 2008, ). When outreach organizations anticipated that enrollment might reach this cap, they generally were required to halt enrollment. Such caps were not infallible at preventing budget overruns. Often when authorities announced that enrollment would be stopped on a particular date, enrolling agencies would hurry to enroll eligible patients at a heightened pace, ultimately resulting in higher-than approved enrollment levels (Insko interview).

Financial struggles influenced the evolution of NCHC in other ways. When the program first began, participating providers were reimbursed based on the SHP's fee structure, which was comparable to that of private insurance and higher than that of Medicaid. Legislators felt that these higher payments to providers would further reduce the stigma of government-run health insurance and increase access by increasing the number of providers willing to accept NCHC patients. In 2005, the payment structure was altered to match that of Medicaid (Shore, Simms, and Keir interviews). Some advocates and legislators feared that this change would impair access and care, but pediatricians and family physicians remained amenable to the changing fee structure (Shore and Keir interviews). Some specialists, particularly dentists, resisted these reduced fees and consequently some stopped providing care for NCHC enrollees. Jeffrey Simms, former assistant director of Medicaid in North Carolina, speculated that pediatricians' ongoing support and advocacy for NCHC and other programs for children stems from

differences in these physicians' underlying motivation; they are a "unique breed," more interested in patient outcomes than financial bottom lines (Simms interview).

### **NCHC's inclusion in CCNC**

Not surprisingly, the factors contributing to NCHC's inclusion in CCNC mirror those affecting previous NCHC changes, and also came about from the original structure of the program. The program was struggling to meet rising demand with limited funds and thus sought to reduce its costs. CCNC has been shown to improve health outcomes while lowering overall cost in Medicaid recipients, a very similar patient population to that of NCHC. CCNC thus seemed the perfect fit to help lower overall NCHC costs and ultimately allow a greater quantity of patients to be included under its care (Insko, Keir, and Levis interviews). At the same time, CCNC itself was riding considerable momentum from its successful pilot programs, Carolina Access II and III, and its cost-saving first year statewide. Its leaders were very interested in expanding to improve health outcomes in additional populations, particularly those of the vulnerable lower income pediatric population (Levis and Insko interviews). CCNC leadership actively participated in including NCHC under its management.

There was very little opposition by policymakers and providers, who already viewed CCNC as successful at curbing costs and improving health outcomes in the Medicaid population (Simms and Dixon interviews). Physicians were largely relieved to be able to utilize care management for their high-risk or chronic care patients covered under NCHC (Simms, Silberman, and Levis interviews). In addition, some legislators and advocates perceived that those physicians caring for CCNC patients were implementing quality improvements and evidence-based protocols for all of their patients, regardless of insurance status. Providing them with a formalized PMPM legitimizes or formalizes that relationship (Sexton, Vitaglione, and Shore interviews). BCBSNC may have felt some frustration over needing to create and demonstrate variables which they had not previously (Denise Levis interview), but overall

other stakeholders did not find them as oppositional to the union of NCHC and CCNC (Simms and Levis interviews).

### **What went wrong**

In July 2009, NCHC was removed from CCNC's care management by the General Assembly.

What went wrong? If CCNC is so successful at saving state money on Medicaid patients, a state-run health insurance program serving primarily children, why would its application to similar NCHC patients be halted?

Ultimately, NCHC's unrealized potential under CCNC resulted from its original structural arrangement making BCBSNC the program's third-party payer. Because NCHC payments run through BCBSNC, that company is responsible for creating and maintaining claims data on its patients. CCNC's improvements are data-driven; it needs to be able to identify which patients are at highest risk in order to specifically target their health behaviors. The BCBSNC claims data are primarily for billing purposes, not for research or improvement, and the data are in many cases less comprehensive and identifiable than are the DMA-run databases of Medicaid. Despite meetings between BCBSNC and CCNC executives (Denise Levis interview), the payer (BCBSNC) was never able to give the care management organization (CCNC) quite the data it needed to manage patients. Without the fine-grained data it needed, CCNC was unable to manage NCHC patients' care, or achieve improvements in this population as it continued to do for its Medicaid clients (Simms, Sexton, Dixon, Silberman, and Levis interviews). This proved frustrating for CCNC and NCHC leadership, and may have for BCBSNC as well; it is uncertain whether the cumbersomeness of collecting new data outweighed the benefit of having its patient population managed externally to BCBSNC (Denise Levis interview).

BCBSNC's role as payer for NCHC may have interfered with the program's ability to manage the program in another way, by interfering with CCNC's ability to institute utilization management. Care



managers could encourage NCHC patients to access their primary medical home before seeking specialty care, and CCNC could encourage NCHC providers to prescribe generic medications before brand name ones, but it could not mandate these changes; unlike under Medicaid, unadvised visits or treatments were still reimbursed (Dixon, Silberman, and Keir interviews). This further hampered CCNC's efforts to curb costs.

In July 2009, the General Assembly recognized that CCNC networks were not able to fulfill their assigned task of managing the health of the NCHC population, and stopped paying the networks the PMPM although, interestingly, the legislative revision continued to pay the PMPM to individual physicians (Lee Dixon interview). This may be because, as mentioned above, there is a perception that physicians with CCNC patients are implementing quality improvements and evidence-based protocols for all of their patients, not just those covered under Medicaid. However, in the implementation of these legislative revisions, both the networks and the physicians stopped receiving PMPMs from DHHS. I have not been able to transpire with these payments; it may simply have been an administrative oversight in interpreting the legislation. It may also be that someone supposed that if CCNC providers are already implementing quality improvements for all of their patients, an additional PMPM for NCHC patients would not change health outcomes or reduce costs. Some have also said that as children under 6 years old from families earning between 100 and 200% of FPL receive coverage under Medicaid – and thus under CCNC care management – these families learn to alter health behaviors for older siblings or children aging into NCHC (Carolyn Sexton interview); this may have also influenced the perceived value of PMPM payments to NCHC physicians and networks.

## **Discussion: Implications for the future**

Policy does not happen in a bubble. Overall, NCHC's disengagement from CCNC was not an isolated decision. In truth, none of the changes to NCHC were isolated decisions. Instead, they grew inevitably from the very structure of the CHIP program, and that structure was formed by the prevailing political dynamics in the state at the time. Seemingly simple federal and state-level compromises of early years undermined and complicated the program at every step.

### **Could things have been different?**

One could imagine a variety of circumstances that, had they been different, would have altered NCHC's course. First, had BCBSNC not been willing to participate in a government-run insurance program, perhaps the state would have selected an alternate payer with more accessible claims data that might more easily have served CCNC's performance improvement needs. Had the North Carolina House of Representatives had a Democratic majority when the federal CHIP legislation passed, perhaps the legislature would have approved an entitlement program such as a Medicaid expansion, avoiding problems of enrollment caps or incomplete patient data; CHIP children covered under Medicaid would automatically be enrolled in CCNC, potentially saving the state money and avoiding frustrating confusion over incorporating these similar populations. Finally, the spirit of collaboration and cooperation that colored the beginnings of NCHC fostered a sense of goodwill and congeniality; however perhaps it was this very congeniality that led to the compromise that established CHIP as a separate block-grant program. Had there been more divisiveness in the legislature and among stakeholders, perhaps no such compromise would have been reached, and North Carolina's CHIP program would have been forced through as a Medicaid entitlement program, avoiding many of its subsequent challenges and complications.

It is impossible to know whether any of these alternate situations would have been favorable. A Medicaid expansion or entitlement program could easily be riddled with its own set of complications and challenges. It is also difficult to discern precisely what early changes would mean to the future of the program; the above are simply guesses of how the course may have altered. All we do know is that North Carolina's CHIP program was born out of a specific, unique set of circumstances and that if these had been any different, the program itself would have ultimately been different.

### **What's to come?**

Several more recent administrative and legislative changes will affect NCHC and its future. First, in 2009 the General Assembly wrote to transfer administration of NCHC to Division of Medical Assistance (DMA); NCHC will remain a block-grant program rather than an entitlement, but BCBS will no longer administer or pay providers through the program. This transition will occur gradually over the next twelve months (Gen Assembly 108-70.21; Silberman interview). This will make the process of utilization management simpler. The DMA and DHHS will have the authority and ability to mandate that NCHC enrollees utilize their medical home, and that these medical homes utilize more cost-effective, evidence-based protocols (Dixon interview). This change may also serve to improve CCNC's ability to perform effective population care management on NCHC recipients through more usable claims data; several stakeholders anticipate that CCNC and NCHC will reestablish their relationship following this change in administration (Keir, Sexton interviews).

President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law in March 2009. PPACA expanded Medicaid eligibility to 133% of FPL and extended the life of the CHIP program through 2019. Under these new provisions, 6 to 18 year-olds covered under NCHC in families earning up to 133% of FPL will be moved to Medicaid, while those earning between 133 and 200% of FPL will remain in NCHC. It is uncertain exactly how these changes will influence NCHC's precise relationship

with CCNC's care management services, but it is possible that by moving more children from NCHC to Medicaid, a greater proportion of the block-grant funding will be left to enable enrollment of more NCHC.

### **Conclusions: What it All Means**

An unusual constellation of political and contextual factors contributed to North Carolina's initial implementation of federal CHIP legislature and to its subsequent evolution. Altering any of these likely would have changed the course of the program, potentially providing improved care to broader populations. North Carolina had a governor and secretary of Health and Human Services that were uniquely supportive and sympathetic to children's health issues, along with some consistently supportive advocacy groups and policymakers. At the same time, there was unique opposition to full-throttled expansion of care, with Republican majority in the House for the only time in a century. These unusual circumstances led to what may have been a missed opportunity for expanded entitled care for the state's children, and a step toward more universal coverage for children. The planned inclusion of NCHC under DMA administration and the passage of PPACA will likely clear some of the obstacles resulting from the program's initial structure; transferring of lower income children into Medicaid and eased utilization management of remaining NCHC enrollees will reduce cost and allow more children to participate in the program. However, unless NCHC is made a full entitlement program, enrollees will be subject to budgetary pressures; there will continue to be children eligible for the program that are not allowed to enter it.

## **Appendix 1: Historical Background**

### **SCHIP's National History**

SCHIP was created in 1997 following years of political and national debate about the feasibility and desirability of comprehensive health reform. President Clinton and Democrats were recovering from considerable political backlash following their failed attempt to create comprehensive health reform in the early 1990s. In response, Clinton devoted substantial time in his second term to create a bill with the newly-Republican Congress that aimed to expand health insurance options for uninsured children. SCHIP ultimately became a successful example of bipartisan legislature, containing components endorsed by Democrats and Republicans. Democrats successfully created a government-run insurance for children of families earning too much to qualify for Medicaid and too little to afford private insurance and Republicans allowed states flexibility while imposing financial limitations on the legislation to prevent unlimited, unchecked enrollment in the program.(Lambrew 2007, ) SCHIP was to be approved for a ten-year course from 1998-2007, and was mandatory. The federal government would help states with much of the program's funding, but states would have flexibility in determining how to best implement their programs. They could expand Medicaid to cover children of families earning a higher percent of the federal poverty limit (FPL), create independent SCHIP programs, or initiate some combination of the two.

Funding from the federal government would come in the form of block-grants, rather than as an entitlement program as is seen in Medicaid and Medicare; as a result not all children financially eligible for SCHIP would be provided coverage under SCHIP if funds ran out.(Lambrew 2007, ) The federal government determines each state's grant amount based on a formula including the state's average wage levels and its quantity of uninsured and low-income children, as determined by the Current Population Survey (CPS).(Gitterman et al. ) Block-grants were provided for 3-year periods, allowing a

state that had underutilized its funds for one year to use the surplus to cover a more costly year; all leftover funds after those three years would be returned to the federal government to be redistributed to consistently overspending states. In response, some consistently under-spending states chose to increase upper FPL limits, increasing eligibility and coverage but preventing subsequent surpluses from distribution to other states. (Lambrew 2007 ;Gitterman et al. ) One way states have worked to circumvent this funding barrier is to adopt SCHIP as a component of Medicaid. As Medicaid is an entitlement program, if block-grant SCHIP funding runs out for a state, the federal government would still provide lower-rate Medicaid funding for children of SCHIP-qualifying income strata, thus helping to offset the state's cost of miscalculation (Lambrew 2007).

Over its ten-year course, SCHIP covered millions of children not previously enrolled in any health insurance programs, considerably improving their health care access and health outcomes, and saving providers and states money in providing care to previously uninsured (Mann, Rowland, and Garfield 2003, 31-53). When it came time for its renewal in 2007, US Congress passed a bill quickly, but it was repeatedly vetoed by then-President Bush (Stolberg 2007, 36). Immediately following Barack Obama's inauguration in January 2009, he signed an SCHIP reauthorization, reallocating federal funds to the state programs.

### **North Carolina Health Choice**

As the federal government's compromised at SCHIP's creation between its Democratic president and Republican Congress, North Carolina too was forced to invoke bipartisan compromise to create the state's SCHIP program. In late 1997, Democratic Governor Hunt proposed that the state expand Medicaid to cover children of families earning between 100% and 200% of the federal poverty limit (FPL), requiring them to pay small co-payments for office visits or medications and no enrollment premiums. The Democrat-led state Senate soon embraced the governor's plan, but the Republican

House formed its own proposal. It recommended that the SCHIP serve as an extension of North Carolina's Teachers' and State Employees' Comprehensive Major Medical Plan (the "State Health Plan" (SHP)), covering children of families earning up to only 185% of the FPL, with higher co-payments for office visits and medications and sliding-scale premiums for families earning between 133 and 185% of the FPL. The House also proposed a waiting period between loss of private insurance and enrollment in SCHIP; this aimed to dissuade families from dropping private insurance to take advantage of the lower-cost government-sponsored option. Ultimately in April 2008 these groups passed a bill for a compromise program, North Carolina Health Choice (NCHC). NCHC would be jointly led by the Department of Health and Human Services (DHHS) and SHP. DHHS would manage budgetary issues, determine eligibility through its Division of Medical Assistance (DMA), and provide community outreach and education through its Department of Public Health, while SHP would actually administer benefits and process claims through Blue Cross Blue Shield of North Carolina (BCBSNC). The plan covered children of families earning up to 200% of the FPL, with no families paying premiums and only families earning between 150 and 200% paying modest co-payments on doctor visits and medication costs. The plan would also not require waiting periods, enabling families to enroll immediately after losing existing coverage. Physicians were to be reimbursed at BCBSNC rates, rather than at lower Medicaid rates. (Gitterman et al. )

From NCHC's inception, enrollment in the program exceeded projections and expectations. Grassroots organizations and advocacy groups were charged with spreading the word of the new insurance program, efforts which were supported and fueled by grants from organizations such as the Robert W. Johnson Foundation. In response to such unexpected growth and citing dwindling funds, DHHS froze SCHIP's enrollment in January of 2001, making North Carolina the first state to do so. (Mooneyham and Writer 2000, ) (Mooneyham and Writer 2000, ) Children were placed on a waiting list for enrollment if they had previously been on Medicaid but family's incomes rose above the 100% of

the FPL limit or if they had previously been on SCHIP but failed to reenroll within the appropriate time period. Children that would have qualified for SCHIP for other reasons, such as loss of private insurance, were not eligible for application at all. After NCHC enrollment decreased to tolerable amounts, children were allowed to enroll off the waitlist beginning in July 2001 and new enrollments were permitted started October 2001.(Gitterman et al. ;Anonymous)To prevent such future freezes, in 2003 the DHHS was granted the authority to reallocate funds as necessary. In 2005, the General Assembly lowered SCHIP reimbursement rates to Medicaid rates rather than those of BCBSNC.(Gitterman et al. )

As NCHC has aged, its eligibility requirements and programs have evolved. In 2005, children under 5 years of age in families earning between 100 and 200% of the FPL were shifted from NCHC to Medicaid. This made government-run insurance an entitlement in North Carolina for children aged less than 5 years in families earning less than 200% of the FPL, effectively transforming its SCHIP program from a block-grant only strategy to a combination one. Those children enrolled in Medicaid were also included in the state's renowned case management Medicaid program, Community Care of North Carolina (CCNC), which has been showed to improve patient outcomes while saving the state millions in unnecessary medical costs.(CCNC Website ;Chen 2009, 1) Beginning in March 2007, children 6-18 years old enrolled in NCHC also became eligible to access care with CCNC primary care physicians and case management, with NCHC paying CCNC's fare of \$2.50 per patient per month to cover case management for these NCHC patients.(Gitterman et al. ) In 2009, DHHS was given the legislative authority to discontinue providing CCNC fees for NCHC enrollees if it did not find sufficient evidence of case management service utilization.(Anonymous2009, ) Perhaps as a result, this case management coverage was discontinued for NCHC patients beginning in July of 2009, with officials citing NCHC budgetary constraints.(Sack 2009, 1)

In 2007, NCHC faced the same uncertainty as national SCHIP programs, in anticipating and following President Bush's veto of renewal federal funds for SCHIP. Republican US Senators from North



Carolina Dole and Burr called for a continuation of existing SCHIP coverage at that time, fearing that the alternative was expanded government-run insurance. (Senate, Elizabeth Dole, Senator, 2007, ;Senate, Richard Burr, Senator, 2007, ) In 2008, State Congress members debated over allocation of funds and enrollment allowances, with the state House requesting an addition 10,000 children be enrolled in the program with \$10.4 million in additional resources and the Senate proposing only a 2.4% increase with \$1.7 million allocated for its coverage. (Bonner 2009, 1) Ultimately Session Laws provided for enrollment growth 6% for the 2008-09 fiscal year, with an increase of up to 8.73% if federal funds be reallocated. (Anonymous2008, )

Following a recommendation by the North Carolina Institute of Medicine in 2007, the General Assembly passed a bill for a new child health insurance initiative termed NC Kids' Care. This program was to cover children of families between 200 and 250% (or 300%, in some versions) of the FPL, charging them premium and co-payments to maintain cost-sharing, and providing them with the same benefits provided under NCHC. Enrollment was not to exceed 15,000 children in the 2008-2009 fiscal year and was to be conditional upon availability of funds. (Gitterman et al. ;Lichstein et al. 2009, 310; Anonymous2008, ) As the program was written for before the onset of the current economic recession, it has not been put into practice in the state. (Gitterman et al. ) During that same session in which it created NC Kids Care, the General Assembly continued its tradition of annual NCHC enrollment caps, fearing limited federal SCHIP support as described above. (Lichstein et al. 2009, 310; Anonymous2009) While NC Kids' Care could have provided access to 9 to 14% of uninsured children in North Carolina (depending on a 250 or 300% upper limit of FPL), how did the state legislature think it feasible and affordable to extend coverage to new groups while limiting coverage to already-eligible ones? In the same article in which NCIOM promoted Kids Care, the organization also recommended removing enrollment caps for NCHC, but the legislature did not heed this advice. (Lichstein et al. 2009, 310) (Lichstein et al. 2009, 310) Why would it seek to provide insurance for middle class children before

ensuring coverage of lower-income ones? Indeed, ideally North Carolina would aim to ensure that all of its children had access to sufficient affordable care, but why would the state choose to attempt to expand before perfecting its existing government-run children's insurance plan? After President Obama's reauthorization of federal funds for SCHIP, NCHC still placed a cap on enrollment growth for the 2009-10 fiscal year at 9,098 children.(Anonymous2009, ) Presumably the decision to include this cap was influenced by the economic downturn of those years; however, it is uncertain what budgetary or economic changes could successfully fund enrollment for all of North Carolina's eligible children into NCHC.

### **Community Care of North Carolina**

Community Care of North Carolina (CCNC) is the state's – and indeed the nation's – model of a successful patient-centered medical home. It organizes North Carolina's Medicaid patients into networks, and coordinates care and quality improvement for patients within that network, ultimately lowering costs and improving health outcomes. It slowly grew over decades from a small program in Wilson County in 1988 to a pilot program in nine sites in 1996 – Carolina Access II – to entire counties through Carolina Access III. In 2000, shortly after her appointment as secretary of the state's DHHS, Carmen Hooker Odum renamed Carolina Access as Community Care in North Carolina and in 2006 she deemed the program a success, recommending its statewide implementation.(CCNC Website ;Steiner et al. 2008, 361;Willson 2005, 229-233)

As of January 2010, there are more than one million CCNC enrollees from all 100 North Carolina counties distributed between 14 community health networks.(CCNC Website ) CCNC has since been widely deemed a success, saving taxpayers money and Medicaid recipients' health statuses. CCNC reports a 21% increase in the numbers of asthmatic patients that have been staged and a 112% increase in asthmatics receiving the flu vaccine. In addition, asthmatics enrolled in CCNC had an average of 34%

fewer hospital admissions and 8% fewer emergency department visits than controls.(CCNC Website )  
However, it is unclear from CCNC's description who these controls are and why they are not currently enrolled in CCNC as well. Diabetes patients were more likely to be referred for dilated eye exams of foot exams than those before initiation of CCNC.(CCNC Website )

CCNC also reports significant cost-savings under its guidance. An external evaluation by the SHEPS Center estimated that the state saved \$3.5 million dollars due to CCNC's asthma plan and \$2.1 million from its diabetes management program. The Mercer Human Resources Counseling Group projected savings of \$60 million dollars in 2003, \$124 million in 2004, and \$231 in 2005 and 2006.(CCNC Website )(CCNC Website ) Of course, these projections are potentially fallible. Mercer compared actual CCNC costs with projected Medicaid costs based on the years prior its statewide adoption. However, the economic, political, and medical fields had changed considerably in those years, meaning that actual Medicaid costs could have been different from projected, even without the adoption of CCNC. With the statewide application of CCNC there is minimal possibility of a valid control; therefore it is difficult to be certain of the magnitude and direction of CCNC's cost savings.

These and similar quality measures have lead to wide national recognition of CCNC, touting it as a step to fixing the country's healthcare, financial and quality woes of the country's healthcare system. In January 2009, the New York Times published an article on primary care difficulties in which CCNC was its primary example of medical home success.(Chen 2009, 1) In 2007, the program was awarded the Annie E. Casey Innovations Award in Children and Family System Reform by Harvard University's School of Government.(Easley 2007, )(Easley 2007, ) In 2008, the program was recognized as a Community in Action National Exemplary Award Winner by the Environmental Protection Agency for improving the quality of life for asthmatics.(CCNC Website )



## **Appendix 2: Literature Review on Politics of National CHIP Implementation**

The State Children's Health Insurance Program (SCHIP) is a federally mandated, state-run health insurance program that aims to provide coverage to uninsured children in families earning too much to qualify for Medicaid but not enough to be able to afford private insurance coverage. States are given the choice of whether to make SCHIP an entitlement program by including it as part of an existing Medicaid program, make it a block-grant program by creating a separate program, or make it a combination of the two strategies. As a block-grant program, the federal government gives states a pre-determined amount of money based on state characteristics; once that money runs out, states are not required to continue enrolling children until the next funding period. The program began in 1997 under President Clinton and at the time was lauded as a bipartisan compromise success. It maintained state flexibility while still improving health coverage and access for uninsured children. Since that time, SCHIP has received varying levels of support from policymakers and the public. (Oberlander and Lyons 2009, w399-410) The purpose of this literature review is to gain an understanding of the political issues and players that have influenced SCHIP's creation and evolution. This will help us gain a contextual framework into which we can add our understanding of the political issues and controversies surrounding North Carolina's implementation of SCHIP and its evolution on the state level.

### **Methods**

On March 24-27, 2010, I did a PubMed search using the terms "SCHIP," "CHIP," "State Children's Health Insurance Program," and "Children's Health Insurance Program" with the MeSH terms for "politics," which include "politics," "dissent and disputes," "political systems," and "lobbying." I included limits for English language and Human participants. and excluded all studies published before 1996, as earlier studies would not accurately address the current SCHIP program. The search with these limits yielded 35 results. I then searched JSTOR, a database of social science literature, with the terms

“SCHIP” and “politics,” limiting the search to include only those articles related to Health Policy, yielding another 17 articles. After reading the abstracts of the articles, I excluded articles if they did not directly address the politics of the SCHIP program.

If an article did not provide an abstract, I assessed its relevance using the Find function for the terms “children’s health insurance program” and a cursory evaluation of the theme of the piece, and excluded twelve articles using this strategy. Five articles were not easily accessible because the UNC Libraries do not have subscriptions to the journals. As the remaining articles appear to provide sufficient insight into the politics of federal CHIP implementation, exclusion of these articles should not interfere with overall quality of the literature search.

## Results

***Implementation of SCHIP.*** In 2009 following long-awaited reauthorization and expansion of SCHIP, Jon Oberlander wrote a high-quality review of the history of SCHIP and built upon its lessons to determine how best to implement subsequent health reform. Oberlander wrote that ultimately proponents were able successfully to implement SCHIP in 1997 because the program avoided controversy. It did so by preserving states’ rights, building upon existing programs, being led and driven by Congress, maintaining bipartisan support, keeping a modest scope, being financed incrementally, and compromising between varied political ideologies. Oberlander described SCHIP’s shortfalls under 1997 legislation, including that it left many children uninsured, families remained uncovered, and it led to increased premium costs. He also wrote of players influential in lobbying for SCHIP’s later reauthorization and expansion. At the time of SCHIP reauthorization and expansion, the program gained support from the American Medical Association, multiple insurance plans, the Pharmaceutical Research and Manufacturers of America, hospital groups, and governors. Despite this and widespread congressional support, President Bush vetoed the bill based on largely ideological grounds. Ultimately

Congress and President Obama reauthorized the use of federal funds for the program. Oberlander writes that multiple lessons of SCHIP could be applied to subsequent attempts at health reform. The speediness of 2009 authorization may speak to a different political environment than was seen in 2007; however SCHIP's struggles point to a deep ideological divide in American politics. The author also pointed out that financing broader coverage would be substantially more expensive. He concluded that there may be limits to how far incremental change could alter health coverage. (Oberlander and Lyons 2009, w399-410)

In 1998, Sardell and Johnson published a review of the politics of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs, including a brief explanation of their influence on the initial implementation of SCHIP legislation. They wrote that EPSDT influenced SCHIP implementation by providing a model of block-grant funding and by determining how best to guarantee coverage. EPSDT advocates also attempted to change the system and the future SCHIP program in such a way as to best benefit EPSDT policies. (Sardell and Johnson 1998, 175-205)

***Enrollment Successes and Barriers.*** Halfon, Inkelas, and Newacheck proposed that the most successful means of influencing politics and changing health policy is by studying the effects and successes of current policies. In 1999, the authors measured SCHIP enrollment, as a means of understanding the program's effects in order to enable effective future changes to that program and others. Their primary goal was to determine how and to what degree SCHIP reduced the numbers of uninsured children in each state. Their conceptual approach to monitoring and measuring SCHIP success involved use of enrollment measures to ascertain the degree of successful recruitment and retaining of eligible enrollees. The authors explained some of the practical challenges to measuring SCHIP's effects, including that appropriate measures have not yet been developed, the infrastructure in which such measures could be implemented is not well-defined, there currently is no national data

collection strategy, no funds are available to support such initiatives, and methods of retaining and transitioning children between programs has not yet been developed or tested.(Halfon, Inkelas, and Newacheck 1999, 181-204) Halfon's paper provides a largely theoretical understanding of how one should approach advancing SCHIP politically. As such, it is of only fair internal validity and applicability.

In 2001 Ullman and Hill utilized a more practical approach to analyze SCHIP enrollment. He and Hill performed a cross-sectional study to determine what relationship existed between SCHIP income eligibility criteria and states' characteristics. Ullman and Hill collected information about states' SCHIP plans and methods through information given by the National Conference of State Legislatures and the National Governors' Association. They compared this variable to states' percentages of low-income children based on Current Population Surveys of the US Bureau of the Census. They also compared these variables to the political party membership of each state's governor, either Democratic or Republican. The authors found that states with higher percentages of low-income uninsured children were associated with larger relative changes in eligibility income thresholds. Higher per capita personal income was associated with bigger increases in threshold levels. Intuitively, higher income thresholds for Medicaid prior to SCHIP were associated with smaller subsequent increases in income thresholds. Political affiliations were not statistically related to SCHIP expansions.(Ullman and Hill 2001, 1449-1451) Ullman's findings were not editorial or anecdotal, but rather the result of methodological study and peer-review. Their variables of political leaning are oversimplifications; a governor's political affiliation does not necessarily correlate to the political affiliations of the majority of the state's citizens or of its Congresspersons. As such, this study is of fair to good quality and provides a nice understanding of what state political factors and characteristics contribute to differences in SCHIP eligibility requirements.

In 2006, Howell and Hughes performed a smaller-scale comparative case study of two California counties in an attempt to extrapolate the political characteristics influencing SCHIP enrollment and barriers to enrollment. They did this by performing a series of interviews in each county with



stakeholders, county administrators, health plan administrators, enrollment assistors, advocates, health providers, and others. Howell and Hughes named lack of citizenship documentation as an important barrier to enrollment for children into any government-run insurance option in California. Even children legally residing in the country may not be enrolled in such programs due to parents' concerns about their own legal statuses or because of education and language barriers to navigating the system. The authors describe California's Children's Health Initiatives (CHI) as public insurance programs such as SCHIP coupled with intensive outreach, meant to cover all uninsured children and potentially provide a method of coverage for undocumented children. To determine eligibility and outreach efforts, they reviewed data of key characteristics of two Californian counties, Santa Clara and San Mateo. Santa Clara, the larger with higher percentages of impoverished children, began CHI implementation 2 years before San Mateo. They found that the two counties had equal levels of outreach for their CHI programs, but Santa Clara actively worked to retain their enrollees while San Mateo did not. In both counties, numbers of uninsured children decreased following implementation of CHIs; however Santa Clara maintained a greater percent decrease than San Mateo. Howell and Hughes conclude that as Santa Clara was the less wealthy of the two programs, even during economic difficulties communities can reduce the numbers of uninsured through strong leadership, collaboration, and creative financing.(Howell and Hughes 2006, 521-554) This case study was small, limiting its generalizability and making it of fair internal validity; however it provides a clear methodology for evaluating SCHIP enrollment and gives some understanding of the political factors influencing SCHIP policy.

***2007 Reauthorization and Expansion Attempt.*** A vast majority of articles located by the systematic review pertained to issues surrounding SCHIP's reauthorization process. Eleven articles dealt primarily with the anticipation of reauthorization in 2007 and concerns of a veto of the legislation by then-President Bush, while four articles responded to Bush's veto and its implication for future policy-

making. Two articles, Demske's 2006 and Pulcini's 2007 provide fair, more-objective, peer-reviewed accounts of events at that time. Demske writes of SCHIP's initial bipartisan compromise and its subsequent success in providing health insurance and health access to otherwise-uninsured children. She emphasizes that its initial implementation afforded great flexibility to state governments, which then served as a foundation for later disputes over the program's reauthorization. Opponents claim that states are using SCHIP funds to cover children not intended in the original legislation; some states are using federal funds to cover children of families earning up to 275% of the federal poverty limit (FPL), while the program was only intended to cover those up to 200% FPL. Demske claims that strain on the federal budget and misallocation of SCHIP resources would ultimately challenge the passage of reauthorization legislation.(Demske 2006, 130-132) Pulcini acknowledges SCHIP's successes and challenges in its reauthorization; yet, her 2007 article goes beyond these to promote expansion of the program beyond its previous form. She describes Georgetown University's Center of Children and Families' proposal, which proposed formally increasing SCHIP funding to cover additional children, strengthening Medicaid coverage, eliminating existing barriers to enrollment in SCHIP, and working harder to promote healthy development care. She also describes the Children's Defense Fund's position, that new SCHIP legislation should consolidate SCHIP and Medicaid into one program, include all children in families earning up to 300% of the FPL, allow children in families earning more to buy into the program, streamline enrollment processes, permit cost-sharing, and improve provider reimbursement.(Pulcini 2007, 29-30, 32)

Following Congress's passage of reauthorization and prior to Bush's veto of these bills, Wilensky published a brief review comparing the House of Representatives' and Senate's bills and explaining political issues surrounding them. She writes that the Senate bill was the more modest of the two, with a proposed \$35 billion increase in anticipated funding over 5 years and coverage of 4 billion not previously insured. In contrast, the House bill was to increase federal funding of SCHIP by \$48 billion,

drawing funds by reducing payments to providers through Medicare Advantage. She wrote that SCHIP reauthorization opponents claimed that the program had expanded itself to cover children of higher income levels than was intended in the original legislation. As a result, they created policies to require that more than 95% of children in families earning less than 200% FPL must be enrolled in a state's SCHIP plan before it could consider expansion to children in families >250%FPL. Other concerns included how to extend coverage to the uninsured and how to subsidize coverage for the insured.(Wilensky 2007, 36-37) This review was peer-reviewed and explained the positions of both sides of the discussion; however it was of limited scope and is therefore of poor-to-fair internal quality.

The remaining articles addressing SCHIP reauthorization prior to Bush's veto of the legislation were in the form of magazine journalism and editorials. As such, they are not peer-reviewed and are of limited academic value; however, they do provide insight into opinions and debates at that time. Ferman wrote extensively about concerns that SCHIP would be funded through a reduction in Medicare payments to physicians, as part of the proposed Child Health and Medicare Protection Act.(Ferman 2007, 44, 46, 49) Gorin and Moniz wrote an editorial to the *Journal of Health and Social Work* to explain that Bush opposed SCHIP expansion because he believed SCHIP should remain a program for low-income children only. They provided counter-arguments to this claim, explaining that an increase in funds in proposed SCHIP reauthorization legislation would be primarily to cover children that are eligible under current guidelines but are not enrolled due to enrollment caps. They also explained that healthcare was more expensive and that less employer coverage was available in 2007 than when the program was first established in 1997, fundamentally changing the rules of the game. They maintained that SCHIP is unlikely to undermine private insurance.(Gorin and Moniz 2007, 243-246)

Feeg wrote a letter from the editor to the *Journal of Pediatric Nursing* explaining her interpretation of SCHIP and its reauthorization process in 2007. Here she explained that Bush opposed reauthorization because he deemed the proposed legislation too expensive, he opposed increasing

taxes on tobacco to fund the program, and he was ideologically opposed to expanding the “federalization” of health care. She countered that SCHIP was a “good deal” because it extended coverage to otherwise uninsured populations, provided a means to assess physician and practice performance, provided state’s individual flexibility, potentially reduced smoking through tobacco taxation, improved children’s health care access and subsequent care, and provided a means to improve quality of care.(Feeg 2007, 299, 312)

Evans reported the results of a Commonwealth Fund survey of health economists and industry executives that found that a majority considered SCHIP a success and 88% supported expanding eligibility to children in families up to 300% of the FPL. The same survey found that 80% of respondents supporting extending coverage to low-income parents and 73% would support including impoverished childless adults. Evans reiterated others’ claims that Bush opposed the legislation because he believed SCHIP had outgrown its original intent, and sought to limited eligibility to children in families earning less than 200% of the FPL.(Evans 2007, 22-23)

Dobias wrote to *Modern Healthcare* in 2007 about anticipation of SCHIP reauthorization and Bush’s threatened veto of the bill. His first, in July of that year, described the financial squabbles surrounding SCHIP legislation at the time. He outlined the disagreement between the House, which proposed increasing funding to SCHIP \$50 to \$100 billion over five years, the Senate, which proposed a \$35 billion expansion over five years, and President Bush, whom opposed and hinted he would veto any SCHIP bill that he perceived would encourage those covered by private insurance from transferring their care to SCHIP.(Dobias 2007, 14)

One final highly editorializing article by Sloane about the potential political repercussions of threatened Bush veto appeared in *Modern Healthcare* in July 2007. He explained fear and frustration by GOP leadership at the time, as they anticipated a political backlash of the Republican president revoking support of legislation for children’s health. Sloane also claimed that some Democrats showed little

interest in compromising with the administration to create veto-proof proposals; by continuing to back bills calling for 10 to 12 times the budgetary increase the president said he would be willing to support, some Democrats may have been working to secure a political victory following Bush's backlash.(Sloane 2007, 20)

Overall, these articles show that bodies of Congress and the president all felt that SCHIP deserved some increase in funds, but they varied in the amount of funds they wished to allocate, with Congress supporting a much greater expansion than the president. Bush opposed broad expansion on practical terms, such as a tobacco tax and the original intent of the program, and also on ideological terms; he did not approve of broad government-run insurance programs and was willing to face bipartisan opposition to support his own political ideology.

**Response to Bush Veto.** Several articles were published in response to President Bush's 2007 veto of SCHIP authorization. As with most of the literature published in anticipation to this action, all responses to Bush's veto were in the form of magazine journalism or letters to the editor. As such they are not peer-reviewed and are of limited internal validity; however, they can be viewed as one perspective of ideologies and perspectives at that time. Overall the themes were similar to those anticipating Bush's veto; the president said he opposed the bill because it did not honor SCHIP's original intent, but many thought his real opposition was on ideological grounds against the federalization of health care.

Lubell's 2007 article in *Modern Healthcare* explained the bill and the reasons for Bush's veto of it. He wrote in October of that year of the healthcare industry's attempts to pressure Congress and the president into backing legislation that would support SCHIP expansion and reauthorization. They worked to convince Congress to override President Bush's veto or to work with the president to create a compromise bill. Lubell showed that Bush cited similar reasons for vetoing the bill as were anticipated;

he claimed that he wanted SCHIP to live up to its original intent of providing health coverage for only the poorest children. A White House spokesperson reiterated that claim, saying that the president sought to ensure that eligible children were enrolled in the program before expanding it to higher income brackets. Lubell quoted Bush as saying he would be willing to accept a bill providing slightly more than his demanded \$5 billion expansion, but only if he knew that money was intended to cover only the poorest children.(Lubell 2007b, 8-9)

In November of 2007, Iglehart published a letter to the editor in the *New England Journal of Medicine* following Bush's veto of SCHIP and Congress's failure to override that veto. Iglehart claimed that Bush's veto of SCHIP served as a symbol of greater ideology rather than counter of a specific policy. He wrote that this angered Congresspersons that had worked on the bill, as they felt the president was unwilling to compromise on the proposals and that he attacked the policy without offering possible alternatives. Republicans that had worked closely on the bill, such as traditionally-conservative Senator Grassley, were angry at President Bush for his claims that the bill was socialist. In response to Bush's claims that the bill might lead to crowd-out, Grassley countered that it discouraged such movement by reducing federal funds matching to states covering children in homes earning >300% FPL.(Iglehart 2007, 2104-2107)

Perrin's letter to the editor at *Ambulatory Pediatrics* in November of 2007 told a similar story. He wrote that the proposed legislation was to draw attention to quality improvement in practice, increase funding to promote enrollment in the program, and to refocus the program on its originally-intended audience: poor, uninsured children. He recognized that Bush's opposition to these policies largely centered on aforementioned concepts, such as increased federalization of care, concerns that higher-income families would be included in the program, and disagreement of whether a tobacco tax should be levied for the cause.(Perrin 2007, 405-406)

Finally in March of 2008, Naylor wrote to the *Journal of Clinical Therapeutics* of her perspective on the fall of 2007's SCHIP reauthorization and expansion programs. Much like Iglehart, Naylor believed that the primary motivation for Bush's veto was political ideology rather than more specific opinion about broadened enrollment eligibility or private insurance crowd-out. Naylor went on to explain that 2007 federal directives limited state flexibility of SCHIP. This guidance from the Centers for Medicare and Medicaid Services (CMS) required that states not be allowed to expand eligibility to families earning more than 250% of the FPL until it documented that 95% of eligible children living at <200% of the FPL be enrolled in the program, there was a minimum 1-year waiting period for those leaving private insurance, and that states were implementing strategies to avoid crowd-out. Naylor also described the positions of then-presidential candidates Hillary Clinton, whom supported tax credits to cover families costs and strengthened SCHIP, Barack Obama, whom endorsed mandatory coverage for children and expansion of SCHIP and Medicaid, and John McCain, whom supported insurance reforms and by fostering "competition and innovation." (Naylor and Lyles 2008, 556-559)

**2009 Reauthorization.** Health reform and SCHIP were central to the presidential election debates of 2007 and 2008. In November 2007, DoBias provided an overview of presidential primary candidates' positions. In it, he described Senator Joe Biden's view on SCHIP, that the program be expanded to cover families with incomes up to 300% of the FPL and young adults up to 21 years old rather than 18. Executive Director of Families USA, a powerful advocacy group that strongly supported increasing and improving health care access, stated that Biden's position was similar to that of other Democratic presidential contenders at the time. (DoBias 2007, 25) DoBias's article is not peer-reviewed and provides only a narrow view into presidential candidates' positions on SCHIP in 2007 and therefore is of poor quality; however it does give some understanding of opinions and political stances at the time.

Shortly after President Obama's inauguration in 2009, Congress passed and the president signed legislation extending and expanding federal funding of SCHIP. Feeg, Lubell, and Iglehart all responded with articles or editorials, continuing the story they began to tell in 2007. Again, despite their poor internal quality ratings, they provide an indication of political, medical, and national sentiment at the time and give some understanding of the politics of SCHIP renewal under the Obama administration.

Just as Congress had voted to pass SCHIP renewal legislation, Feeg wrote of the politics at the time and of the challenges to come. She wrote of states' difficulties in funding the program, and of proposals by at least 26 of those states to cut funding and eligibility for low-income government-run health insurance options, such as SCHIP. Feeg maintained that federal funding was vital to keeping such programs afloat. Feeg also agreed with many SCHIP opponents and proponents in claiming that national SCHIP programs need to ensure insurance coverage for the poorest children before proceeding to those in higher income brackets.(Feeg 2009, 9, 42)

Iglehart's letter to the *New England Journal of Medicine* wrote that the quick passage of SCHIP immediately after Obama's inauguration was an indication of the Democrats' power and their intention to fundamentally change healthcare and healthcare services over the next administration. Iglehart was also careful to point out that forty Republicans had voted for SCHIP legislation that January, implying potential bipartisan support for health care changes. Iglehart believed that the Democrats were successful in speedy SCHIP extension because it was seen as unfinished business from the previous administration; it would not be a sign of how quickly future proposal may pass through Congress. He wrote that under the 2009 law, states could enroll children in families up to 300% of the FPL at more favorable federal matching rate than had been supported under the previous administration. The new law also wrote that adults would be phased out of the program to make room for children, states could restore Medicaid coverage to eligible women and children for less than 5 years, and dental services



were added. Iglehart wrote that the law's opponents most opposed provisions to fund the bill through a tobacco tax and of the optional citizenship-verification component.(Iglehart 2009, 855-857)

***Lobbying and Interest Groups.*** A number of studies and articles mentioned in other sections explain the stakes and influence of lobbyists and interest groups in influencing SCHIP politics and resultant policy. These are described as components of the above discussions. Three articles found in this systematic review wrote primarily and specifically about interest groups' influence on the policy. In September of 1999, Hallam wrote of the forces working for and against SCHIP policy at the time. He described child health advocates, such as the National Association of Children's Hospital and Relation Institutions and the National Association of Children's Hospitals, which had worked to promote children's health coverage and Graduate Medical Education funds to support health as a means to improving children's capacity. In contrast, Hallam also described how advocates for low-income Medicare enrollees sued Health and Human Services, saying the department was spending too much money and time on CHIP and too little on buy-in programs for poor elderly. The author concluded that even children's health advocates must choose their battles carefully, as there was not enough time to pursue every children's health goal; some may choose to concentrate on enrolling eligible children in existing programs rather than expand those programs to cover greater proportions of the population.(Hallam 1999, 30-2, 35) This article is journalistic and not peer-reviewed; however it provides seemingly thorough and varied perspectives on the issue and as such is of poor to fair quality.

In December, Dobias revisited the issue of reauthorization after Congress had passed the legislation but before Bush's final veto. He described the distaste and controversy of the bill at the time by multiple parties. The bill passed by Congress was to cost \$4.6 billion, while also temporarily reversing a bill to reduce providers' Medicare payments by 10%. He wrote that doctors were disappointed by the bill, seeing its six-month reauthorization as a temporary delay rather than solution. Legislators that had

supported it also struggled to support the bill, seeing it as having been diminished through persistent negotiations. In contrast, hospitals were to gain from the bill with decrease the minimum percentage of complicated medical diagnoses that inpatient rehabilitation services were to require. Despite all this, DoBias wrote that Bush was still expected to sign the bill into law.(DoBias 2007, 8-9)

In 2008, Lubell wrote to *Modern Healthcare*, describing hospitals' attempts to lobby Bush to prevent him from limiting Medicaid and SCHIP eligibility to children through a direction that would set conditions on states' ability to expand these programs to higher-income populations by preventing states from expanding coverage to children of families earning more than 250% of the FPL before ensuring greater than 95% enrollment of eligible children of families earning less than 200% of the FPL. American Hospital Association lobbyists feared that such restrictions on both programs would reduce insurance coverage for children, increasing emergency room utilization and increasing their cost of health care.(Lubell 2008, 12)

Finally in February of 2009 Lubell wrote of the implications that the new SCHIP authorization legislation would have for hospitals. The SCHIP bill had no provisions banning self-referral by physicians to physician-owned hospitals, thus continuing to allow physician to pad their pocketbooks while increasing the overall cost of care. Some estimate that self-referrals to physician-owned hospitals will cost Medicare \$1.2 billion over the proceeding decade. Physician Hospitals of America, representing physician-owned hospitals, remained cautiously optimistic while the American Hospital Association continued to support a ban on such self-referrals.(Lubell 2009, 8-9)

While not explicitly expressed in any of the articles listed here or elsewhere in this literature review, it may be reasonable to assume that the tobacco lobby had a substantial role in influencing SCHIP legislation, as many candidates opposed funding SCHIP through a tax on tobacco goods. Of course this may be a false assumption; opposition may have been an ideological one based politicians' view that no new taxes should be levied, even if they are being levied on the purchase of addictive,

carcinogenic substances. Opposition may also have been rooted in a desire to protect constituents' interests, especially in regions of high tobacco farming or much tobacco use. Determination of this issue would require exploration of documents not found in this systematic review.

### ***Funding.***

A variety of articles explained the politics of funding SCHIP and similar child health programs. They conclude that support for funding is largely determined by the political ramifications of doing so. In 2001, Gormley described the Health Care Financing Administration (HCFA)'s role in state government by examining four cases, one of which is the State Children's Health Insurance Program (SCHIP). Each case was to represent an issue with a different combination of salience and conflict. He went on to describe which methods of policy-making are most effective in creating change in each scenario. He interviewed former members of HCFA to determine characteristics of each program and members' perceptions of the program. He described SCHIP as being of high salience and low conflict; politicians are attentive to the issue given its salience, and also wish to claim credit for its creation and improvement because of its low conflict rating. As proof, he describes how Congress approved the legislation with lopsided margins, how advocacy groups that worried about cuts to Medicaid were assuaged by the possibility of improved and expanded Medicaid, how SCHIP minimized conflict by maximizing state flexibility, how Congress gave HCFA an enhanced match, and how states were permitted to choose whether they would collect premiums from members. In such scenarios of low conflict and high salience, Gormley writes that policy is best created with HCFA interacts with states in a collaborative manner.(Gormley and Boccuti 2001, 557-580)

Ku later wrote of a growing number of uninsured children due to loss of employer-sponsored insurance programs during that time. He wrote that the number of uninsured American increased by 1.4 million in the year 2001 alone, but that this number would have been substantially higher if it had not been for Medicaid and SCHIP programs. There had been increasing numbers covered under Medicaid and SCHIP during that time due to a worsening economy, increased Medicaid and SCHIP outreach to eligible-but-not-enrolled, and expanded eligibility through the programs. In contrast, he wrote of how state budget struggles had limited funding to Medicaid and SCHIP, leading some states to limit enrollment by reducing income thresholds for eligibility and stopping parents' eligibility under the programs. Such limitations under continued economic pressures were likely to increase the number of unemployed. Ku suggested that Congress could provide funding relief to states by increasing federal funding and by promoting use of generic pharmaceuticals.(Ku 2003, 359-367)

Blewett provided a high-quality, thorough 2007 review and case study to provide understanding of federal funding formulas, such as those used to allocate SCHIP matching funds. Here he used SCHIP as his primary case for study. Blewett explained that federal allocations were based on the number of low-income and uninsured children in a state (CCF) and a measure of the cost of health care in the state (HCF). He explained that the weighted value of uninsured versus low-income children has changed over time, but that in 2007 the two were weighted evenly. A primary problem of CCF is that it took into account only uninsured children, not those currently enrolled in SCHIP; as a result, the more uninsured children the state moved into the program, the less subsequent funding it would receive to cover them. A main problem with HCF was that it measures only per capita income, not taking other resources into account. Overall Blewett concluded that the primary concerns related to use of this federal funding are: 1)states that traditionally provided lower Medicaid match rates would be rewarded with largest increases in funding under SCHIP; 2) states that cover children under SCHIP that are in higher income brackets are creating a funding mismatch, as the formula only takes into account low-income children;

3) the formula relies on necessarily flawed survey data; 4) state citizens' failure to answer Census creates an error in baseline data; and 5) no performance measures are built into the formula.(Blewett and Davern 2007, 415-455)

In 2007 Lubell wrote a journalistic article for *Modern Healthcare* about Congress's efforts to find funding to continue and reauthorization SCHIP. This followed the Senate Budget Committee's approval of a \$50 billion increase in funds for the program over five years while Bush approved on a \$2 billion increase over that time. The article did not provide potential methods of providing such funding, but did raise concerns by the Federation of American Hospitals that Congress would fund the expansion by cutting providers' fees.(Lubell 2007, 12)

***Outcome Measures and Future Implications.*** Only one article found in this systematic review dealt primarily in performance measures, though others such as Feeg 2007's article also touched on the subject. Shi's 2000 program evaluation of SCHIP provided a good understanding variable implementation of the program as well as an idea of the program's quality outcomes. Shi based his evaluation on SCHIP's precursors, its design and delivery system characteristics, and performance indicators. He found that most states built upon existing program and structures, though this was not always the case. Most states claimed that their programs' primary goals were to reduce the numbers of uninsured in the state, while some others primarily sought to improve health status and quality of care for its enrollees. SCHIP programs largely neglected primary care or the promotion of primary care services in their original goals. On quality outcomes, Shi found that PWORA legislation accidentally led to kicking people off Medicaid; a computer system glitch removed many children from Medicaid once they exited welfare program, even if they were still eligible for health insurance coverage. Shi also found that SCHIP programs failed to provide coverage for recent immigrants.(Shi, Oliver, and Huang 2000, 403-446)

Berman wrote a 2007 review of SCHIP policy questions, with a discussion of the issues that would determine whether and how SCHIP might be expanded into universal children's health insurance coverage. First he described three potential universal programs: a single federal program to cover all children; a hybrid federal program to cover children not covered by private employer-based insurance, a program which would include those currently covered under Medicaid or SCHIP; and a wraparound program meant to capture and cover those not currently eligible for any current program. In determining which implementation strategy to promote, we should address multiple policy issues. First, should children be the first to be covered under a universal program? Support is greatest for covering children, but such an approach may be short-sighted. Second, should there continue to be private insurance systems? Private insurance may promote efficiency and innovation, but they diminish consistency and equity. Third, who should finance the program, the government or enrollees through premiums? Fourth, should there be an employer mandate, which would equalize employers' playing fields but also potentially increase unemployment by employers that are unwilling or unable to pay? Fifth, should individuals be mandated to purchase or subscribe to insurance policies? And finally sixth, what should be the basic benefits of the package? Berman's article is not experiment-based and may potentially exclude key elements of the politics of creating universal health insurance coverage. However he provides a thorough explanation of both sides of multiple issues and as such provides a piece of fair to good quality which policymakers may consider when taking strides toward universal coverage.(Berman 2007, 394-404)

### ***Conclusions.***

This literature review shows a changing political climate surrounding implementation of SCHIP and its reauthorization attempts and successes. Money has been the most influential factor in this debate; budgetary concerns and ideological differences of how much and whether to spend on the program

played the biggest role in its evolution and reauthorization process. Ideological differences on the scope of government also largely contributed to its continuation, while interest groups aimed to counter or influence those ideologies. These articles provide insight into what has influenced previous child health policies and what might influence such future policies.

## Appendix 3: Methods Appendix

### Interview Methods

I conducted 9 interviews between March 24 and May 21. All four of my initial interview contacts referred me to additional persons they believed could provide additional information on the topic, enabling me to create a rolling reputational sample. The initial respondents, and these secondary referral respondents, with the name of the person(s) referring me to them, are show in Table A3-1 below. Through Steve Shore's recommendation, I contacted and interviewed Carolyn Sexton, NC Health Choice's outreach coordinator through the Department of Health and Human Services. Through Representative Insko's recommendation, I contacted Melanie Bush, a staff member in fiscal research at the General Assembly, and Lee Dixon, the principal fiscal analyst at North Carolina General Assembly. Upon contact, Melanie Bush deferred to Lee Dixon, with whom I later spoke. Through Carolyn Sexton, I contacted and spoke with Tom Vitaglione, a lobbyist for Action for Children and a former Chief of the Children and Youth Section of North Carolina's Department of Health and Human Services. Jeffrey Simms referred me to Jill Milby, whom did not respond to two emails, Denise Levis Henson and Shelley Keir, the business manager of CCNC. Through Carolyn Sexton I contacted and interviewed Denise Levis, the director of quality improvement and senior consultant for Community Care of North Carolina.

I contacted each elite through a standardized email message, presented below. I sent one additional follow-up email message to those who had not responded to the initial message, and I stopped attempting to contact elites after this second email. I was unable to reach one person and two persons deferred to other experts; none of these were the sole representatives of a policy domain or perspective, leading me to conclude that my analysis is not materially affected by the absence of an interview with him or her.



## **Interviews**

Interview consisted of a series of open-ended questions, and lasted between 30 minutes and an hour. I asked the elites for permission to digitally record the interviews, to include their name in the final paper, and to include direct quotes. I informed them that they could revoke permission for these actions at any time during the interview. With permission, I recorded each interview on a digital voice recorder. I then transcribed these interviews, and sent these transcriptions to the elites for corrections or clarifications.

## **Codebook**

I categorized the information from the interviews into different types of responses and organized this in a codebook (available upon request). I also characterized the emphasis and/or certitude of each response, including this information in the codebook. This tool allowed me to organize and visualize the data, for later synthesis into the final paper.

## **Interview Protocol**

### *Permission:*

Hello, I am Emily Vander Schaaf. Thank you so much for talking with me today. I am an MD/MPH candidate at the University of North Carolina at Chapel Hill. I am writing my master's paper on North Carolina Health Choice and its involvement with Community Care of North Carolina. I wanted to talk to you, given your extensive understanding of child health policy in the state.

My advisor on this project is Dr. Sue Tolleson-Rinehart, a faculty member in the Public Health Leadership Program and Pediatrics. Our ultimate goal is to publish the findings in a scholarly journal, in order to help people better understand children's health policy in the state. The UNC IRB has determined that my study is exempt from further review.

This interview will consist of several open-ended questions, and should last for about 20 minutes to an hour. I would like to record this interview on a digital voice recorder to ensure that I have the most accurate record of your comments. Would that be OK with you?

[verbal permission is noted on recording and transcript.]

(If so), Thank you!. You have the right to revoke recording permission at any time. I will plan to transcribe our conversation and will be happy to provide you with a copy of the transcript at your request.

I will not identify your comments by name in my final paper unless you grant me permission to do so today. If you do not, I will identify you by position only – for example “An SCHIP policy expert.” May I have your permission to include your name in my final paper? (If no: May I use your title instead?) May I also include direct quotes from you?

[verbal permission is noted on recording and transcript]

Thank you.

### **Interview Protocol**

#### **Background Questions**

To start out, I'd like to get a sense of your general perspective on and background in children's health and health policy.

Could you tell me a little bit about your involvement in children's health policy, advocacy, and North Carolina Health Choice?

#### **Characterizing North Carolina Health Choice**

Next I'd like to ask you some basic questions about North Carolina Health Choice.

I've tried hard to educate myself on the history of NCHC, but I'd appreciate having your own view of its history.

As you've just mentioned [if they do so spontaneously] which of the changes to NCHC do you think has been most important?

[Why is that?]

[IF R does NOT spontaneously mention any changes]: What about the change from being part of CCNC to leaving CCNC?

Has anything about the way NCHC developed been a surprise? What was surprising about it?

Why did this happen?

Why was it a surprise?

What would you say are the most influential forces shaping NCHC, including changes to it?

How do you believe most physicians and providers feel about NCHC?

[And why is that?]

[How does this differ from providers' views on Community Care of North Carolina or Medicaid?]

And how do you think most legislators view NCHC?

[What policymakers have been most involved in NCHC legislation?]

What is your view of private insurers' opinions of NCHC?

(As you mentioned) Blue Cross Blue Shield of North Carolina (BCBSNC) has been integral in NCHC and its payment system since NCHC's inception; how do you feel BCBSNC feels about the program?

[Do you think it would like to see any changes made? What sorts?]

What financial burdens have NCHC faced?

[How has it traditionally handled those?]

[Who do policymakers consult when assigning budgetary priorities?]

North Carolina Health Choice as part of Community Care of North Carolina

What is your understanding of NCHC's relationship with CCNC?

What do you think influenced NCHC's initial inclusion in CCNC?

Who worked to influence this decision?

How did legislators feel about it?

How did BCBSNC feel about it?

How did physicians feel about it initially?

Did these opinions change over time? How?

What do you think were stakeholders' expectations of NCHC's performance under CCNC?

[If appropriate] Were people expecting to measure its performance? How?

Were these expectations met?

Now I'd like to ask about NCHC's departure from CCNC in 2009. Would you give me your view of what happened then? [follow-up if needed: Who were the groups involved on each side – keeping NCHC in CCNC, or making it independent? What do you think people had at stake in their positions?]

And what about now? Do you sense any support for making NCHC a part of CCNC again? Do you see any likelihood of change?

### Closing

That's the end of my questions! Is there anything else you want me to know?

Thank you very much for your time! I greatly appreciate it! I will be happy to provide you with a copy of this interview's transcript, if you would like. Did you have any other questions you may have about my project? Thank you again!

TABLES AND FIGURES

Table A2-1. Critical Appraisal Table

Readings	Type of Article	Component of SCHIP	Quality of Article	Comments
Berman 2007(Berman 2007, 394-404)	Policy analysis	Expansion of SCHIP to universal coverage	Fair to Good  <i>careful consideration to both sides of issues</i>	<p>Describes factors influencing policy related to universal health insurance for children</p> <p>A description of potential universal programs to cover kids: 1) single federal program, 2) hybrid federal program (including kids currently on Medicaid/SCHIP), 3) wraparound program of kids currently uninsured</p> <p>Policy issues:</p> <ol style="list-style-type: none"> <li>1) Should universal coverage be children first? (support for kids vs. short-sighted)</li> <li>2) Should private insurance system remain? (efficiency/innovation vs. consistency/equity)</li> <li>3) Financing? (federal vs premiums)</li> <li>4) Employer mandate? (equitably evens employer playing field vs. increase unemployment)</li> <li>5) Individual mandate?</li> <li>6) Basic benefits package?</li> </ol>
Blewett 2007(Blewett and Davern 2007, 415-455)	Review with case-study	Funding	Good  Thorough overview	<p>Review of federal funding formulas, using SCHIP allocation as primary example</p> <p>Federal allocations based on 1) number of low-income and uninsured children (CCF), 2) measure of cost of health care in state (HCF)</p> <p>CCF: Weights of uninsured vs low-income has changed, but is now 50/50; concerns: 1) does not account for those enrolled in SCHIP (i.e. could lose funding if enroll kids-inverse incentives)</p> <p>Capacity: ability of states to provide resources, based on per capita income (problems: does not include other</p>

				resources  Concerns: 1) States w lowest Medicaid match rates awarded largest increases under SCHIP, 2) using funds for higher income levels creates mismatch between target population used to determine funding and actual beneficiaries, 3) reliance on survey data, 4) failure to answer Census biases data used (especially a problem if error in baseline data), 5) no specific performance measures built into funding formula
Demske 2006(Demske 2006, 130-132)	Review	Reauthorization, pre-Bush veto	Fair	History to provide insight into reauthorization process/outcomes  Key point: Lots of federal flexibility → states have made SCHIP into something other than feds originally intended (more than or less coverage than intended)
DoBias 2007-Winners and Losers(DoBias 2007, 8-9)	Magazine journalistic article	Reauthorization, pre-Bush veto	Poor  <i>not peer-reviewed</i>	Both legislators and physicians unhappy with the bill (largely for its temporality)  Legislator angered by temporariness; MDs want higher compensation
DoBias 2007-What candidates are saying(DoBias 2007, 25)	Magazine journalism	Expansion, as proposed by candidates	Poor  <i>not peer-reviewed</i>	Ideas on changing or expanding government-run care for children  Biden as candidate in 2007, proposing expanding SCHIP to 300% FPL
DoBias 2007 – Head to Head(Dobias 2007, 14)	Magazine journalism	Expansion/reauthorization	Poor  <i>not peer-reviewed</i>	Financial squabbles over funding SCHIP; Pres Bush’s opposition to proposals
Evans 2007(Evans 2007, 22-23)	Magazine journalism	Reauthorization, pre-Bush veto	Poor  <i>not peer-reviewed</i>	Bush’s opposition: SCHIP not living up to its original intention, wants to limit SCHIP to <200%FPL; would cut federal matching  Others want all children to be eligible, if only to stop missing the eligible but uninsured
Feeg 2007(Feeg 2007, 299, 312)	Letter from the editor	Reauthorization, pre-Bush veto	Poor	Bush opposes b/c: 1) federalizing health care, 2) too expensive, 3) tobacco tax to fund  Reasons why SCHIP is a good deal: 1) extends coverage, 2) performance measures, 3) state flexibility, 4) tobacco tax→



			<i>type</i>	Congress approved with lop-sided margins; advocacy groups worried that CHIP might adversely affect Medicaid enrollments but were assuaged by possibility to augment Medicaid; CHIP minimized conflict by maximizing state flexibility; Congress gave HCFA an enhanced match (promoted synergy/cooperation between states and HCFA), allowing states to choose whether premiums
Halfon 1999(Halfon, Inkelas, and Newacheck 1999, 181-204)	Program evaluation methodologies	<b>Enrollment</b>	Fair	<p>Methods of measuring SCHIP enrollment</p> <p>Measuring enrollment to measure success/impact of SCHIP and find appropriate policies for similar future moves</p> <p>Challenges: 1) measures not developed, 2) infrastructure not defined, 3) no national data collection strategy, 4) not clear funds, 5) retaining and transitioning kids not developed/tested</p> <p>Evaluation of coverage of eligibility should ask: to what degree does SCHIP reduce # of kids w/o insurance coverage?</p>
Hallam 1999(Hallam 1999, 30-2, 35)	Journalism	<b>Lobbying</b>	<p>Poor to fair</p> <p><i>Not peer-reviewed, but varied points of view</i></p>	<p>Slow to enroll kids in CHIP</p> <p>Low-income Medicare advocates sued HHS saying spending too much on CHIP and too little on buy-in programs for poor elderly</p> <p>Computer glitch kicking kids out of Medicaid even if still eligible if leave welfare</p> <p>“even the children’s lobby has had to choose its targets carefully”...not enough time</p> <p>Focus on getting kids enrolled that are already eligible</p>
Howell 2006(Howell and Hughes 2006, 521-554)	Case study	<b>Enrollment</b>	Fair	<p>CA counties as examples of expanding coverage</p> <p>Hispanic much less likely to be insured (partly: legality, language, understanding)</p>



				<p>Children's health initiatives to enroll kids in existing programs (if ineligible: new program)</p> <p>1.Governance: flexible, informal...strong leadership and communication</p> <p>2.Financing: challenge. Outreach, fundraising, premiums</p> <p>3.Outreach/Enrollment: involved social service agencies, enroll immediately or make appt to do it (not just educate)</p> <p>2 counties differed in enrollment in MediCal- equal levels of outreach, Santa Clara actively retains, San Mateo does not; Santa Clara higher poverty rate</p>
Iglehart 2007(Iglehart 2007, 2104-2107)	Editorial	Reauthorization, post-Bush veto	Poor	<p>Bush singled SCHIP out for veto as example, to signal that disapproved of government-run health insurance</p> <p>Senators most furious that Bush failed to compromise (i.e. by combined SCHIP with a tax credit); attacked it ideologically without offering alternatives</p> <p>-Grassley (conservative Republican) angry with Bush over socialism claims</p> <p>Bush concerned about crowd out; Grassley: compromise bill discourages states from covering higher-income kids by reducing matching for &gt;300%FPL</p>
Iglehart 2009(Iglehart 2009, 855-857)	Editorial	Reauthorization/expansion, post-Obama	Poor	<p>Emphasized Democrats' power and intention to change healthcare (1/14 vote had 40 Republicans...some bipartisan support)</p> <p>New provisions under 2009 law:</p> <ol style="list-style-type: none"> <li>1. states can enroll children in families up to 300%FPL at more favorable federal matching rate (rejected Republican proposal that would require covering 90% of eligible below 200%FPL before starting to cover higher</li> <li>2. phase out adults covered by SCHIP to make room for children</li> <li>3. states can restore Medicaid coverage to otherwise eligible kids/women in US for &lt;5 yrs (1996 law prohibited) (most "contentious")...option of verifying citizenship (opposed by Repub)</li> </ol>

				<p>4. Republicans opposed tobacco tax to fund it</p> <p>5. dental services added</p> <p>Speed of Democrat success due to seeing this as "unfinished business," not sign of success to come</p>
Ku 2003(Ku 2003, 359-367)	Review	Funding	Fair	<p>Falling insurance coverage b/c of loss of employer-sponsored insurance (#s uninsured rose 1.4 million in 2001)</p> <p>Would've fallen more if not for Medicaid/SCHIP; increased coverage under Medicaid and SCHIP b/c 1) worsened economy, 2) outreach, 3) expanded eligibility,</p> <p>Budget struggles limiting funding to Medicaid/SCHIP (some states have reduced income levels eligible, parents' eligibility)</p> <p>How Congress can provide state relief: 1) increase federal funding, 2) generic drugs/budgetary</p>
Lubell 2007 – Congress works to save SCHIP(Lubell 2007, 12)	Magazine journalism	Funding	Poor	<p>Congress looking for SCHIP funding</p> <p>Hospitals don't want to bear burden through decreased government payments</p>
Lubell 2007 – Waiting on SCHIP(Lubell 2007, 10-11)	Magazine journalism	Reauthorization, pre-Bush veto	Poor	Bush opposes covering adults (which had approved in original legislation)
Lubell 2007 – industry to save SCHIP(Lubell 2007b, 8-9)	Magazine journalism	Reauthorization, post-Bush veto  Lobbying	Poor	Healthcare industry: pressures Congress to compromise to reauthorize SCHIP
Lubell 2007 – SCHIP unsure when docks(Lubell	Magazine journalism/editorial	Reauthorization, Pre-Bush veto	Poor	Prediction that SCHIP will be reauthorized despite Bush's opposition

2007a, 8-9)				Compromise: Bush proposed adding \$5 billion; Congress had asked for \$35 billion
Lubell 2007-SCHIP stalemate(Lubell 2007c, 8-9)	Magazine journalism	Reauthorization, post-Bush  lobbying	Poor	Kids use of ER for primary care due to failed SCHIP reauthorization  Lobbying by hospitals, against Bush
Lubell 2008(Lubell 2008, 12)	Magazine journalism	Lobbying, post-Bush veto	Poor	Hospital lobby to challenge Bush plan to further restrict Medicaid eligibility, under the directive intended for SCHIP  Hospital fear: increase ER utilization, higher healthcare costs  (under SCHIP restrictions, states can't expand coverage above 250%FPL unless enrolled 95% below 200%; can't cover over 250%FPL if decline in employer-sponsored >2% over 5 yrs)
Lubell 2009(Lubell 2009, 8-9)	Magazine journalism	Reauthorization, post-Obama	Poor	2009 bill did not include ban on physician self-referrals, specifically in physician-owned hospitals
Naylor 2008(Naylor and Lyles 2008, 556-559)	Editorial	Reauthorization, post-Bush veto	Poor	Divergent ideologies or fiscal realities?  SCHIP symbol of ideological divide (private vs govt)  Decreased state flexibility in 2007 (e.g. no coverage for >250%FPL unless >95% coverage of those <200%FPL)  Presidential candidates' positions on health care and its expansion
Oberlander 2009(Oberlander and Lyons 2009, w399-410)	Review	post-Obama reauthorization; re: <b>Politics of health reform</b>	Good	SCHIP successful in 1997 b/c it avoided controversy: 1) preserved states' rights, 2) built on existing programs, 3) driven by Congress, 4) bipartisan support, 5) modest scope, 6) incremental financing, 7) compromise  Problems: 1) many eligible remain uninsured, 2) families left uncovered, 3) increasing premium costs  Lobbying for reauthorization and expansion : support from AMA, insurance plans, PhRMA, hospitals, governors

				<p>Reauthorization: wide congressional support, Bush veto (most crucial factor) based on ideological grounds</p> <p>2009 Reauthorization: included coverage for those in nation &lt; 5 yrs</p> <p>Lessons: 1) speed of 2009 reauthorization could reflect new political environment, 2) deep ideological divide, 3) financing broad coverage more expensive, 4) limits to incremental health reform</p>
Perrin 2007(Perrin 2007, 405-406)	Letter from the Editor	Reauthorization, post 1 <sup>st</sup> Bush veto	Poor	<p>SCHIP is not entitlement program; therefore states cap enrollment</p> <p>Proposed new legislation: 1) attention to quality improvement, 2) more funding for enrollment, 3) refocus toward poorest kids</p> <p>Reasons for reauthorization disputes: 1) source of funding (tobacco tax), 2) increasing federalization of care, 3) concerns of included families with higher incomes</p>
Pulcini 2007(Pulcini 2007, 29-30, 32)	Review	Reauthorization, pre Bush veto  Lobbying	Fair	<p>Rallying nurses to help</p> <p>Not linked to TANF, reduced stigma</p> <p>Improved health and care access</p> <p>Proposed Expansions from Georgetown Center for Children and Families: 1) increase SCHIP funding to cover more kids, 2) strengthen Medicaid, 3) eliminate barriers to enrollment, 4) promote healthy development care</p> <p>Proposed Expansions from Children's Defense Fund: 1) consolidate SCHIP and Medicaid, 2) include up to 300%FPL, 3) allow &gt;300%FPL to buy-in, 4) unified package to cover all medical needs, 5) streamline enrollment, 6) cost-sharing, 7) improve provider reimbursement, 8) incentives to implement</p>

Sardell 1998(Sardell and Johnson 1998, 175-205)	review	EPSDT, its influence on SCHIP's creation	Fair	Political influence of EPSDT, including section influence of SCHIP creation  EPSDT influence: block-grant vs entitlement, how to guarantee coverage, attempts to change structure of the system to benefit EPSDT
Shi 2000(Shi, Oliver, and Huang 2000, 403-446)	Program evaluation	Outcome measures	Good	Evaluation based on 1) program precursors, 2) SCHIP design and delivery system characteristics, 3) performance indicators  Most states built upon existing programs/structures; most goals were to reduce #s of uninsured, some to improve health status and quality of care; largely neglected primary care in original goals;  Quality Outcomes: 1) PWORA accidentally led to kicking people off Medicaid; 2) not cover recent immigrants, 3) most NCQA measures are not child-specific
Sloane 2007(Sloane 2007, 20)	Magazine journalism	Reauthorization, pre- Bush veto	Poor  <i>very editorialized, not peer-reviewed</i>	Bush to veto because "step to government-run healthcare for all"; rationing, price controls  Potential political repercussions of Bush veto: 1) Republicans fear political backlash, 2) Democrats not compromising as much as could to promote own political gains
Ullman 2001(Ullman and Hill 2001, 1449-1451)	Cross-sectional study	Enrollment	Fair to good	Enrollment eligibility  Relationship between state characteristics/income and changes in income thresholds for SCHIP  Factors related to percent change in thresholds: 1) % low-income uninsured [higher→bigger increases], 2) per capita personal income [higher→bigger increases], 3) income eligibility thresholds before SCHIP [higher→smaller increases]  Limitations  Does not give ultimate final threshold levels, just percent change  High correlation (higher federal matching for lower starting income level)

Wilensky 2007(Wilensky 2007, 36-37)	Review	Reauthorization, post vote, pre veto	Poor to fair	About House and Senate bills and challenges to come  Senate bill: more modest; cover 4 billion uninsured, \$35 billion over 5 yrs  House bill: \$48 billion over 5 yrs; fund by reducing Medicare Advantage payments  Issues: 1) covering more than SCHIP originally intended, 2) must enroll 95% below 200%FPL before start coverage >250%FPL, 3) how to subsidize to insured and extend to uninsured,
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**Table A3-1. Initial and Secondary Interview Respondents**

<b>Name</b>	<b>Title</b>	<b>Domain(s)</b>	<b>Initial or Secondary contact</b>	<b>Date of Interview</b>
Steve Shore	Executive Director, NC Pediatrics Society	Child advocacy, professional practice	Initial; Carolyn Sexton; Tom Vitaglione	3/29/10
Jeffrey Simms	former Deputy Director, NC Office of Rural Health and Community Care; Asst Dir, NC Div of Medical Assistance  Current Director of Professional development at UNC Gillings School of Global Public Health	Bureaucracy (recently moved to Academe)	Initial	3/30/10
Verla Insko (D-Orange)	Member, North Carolina House of Representatives	Legislature	Initial	4/5/10
Pam Silberman	President, NC Institute of Medicine, Professor of Health Policy and Management	Advocacy; Academe	Initial; Carolyn Sexton	5/7/10
Carolyn Sexton	Currently public health consultant of Health Check/Health Choice –Outreach; formerly employed by DMA; co-chaired outreach committee of Task Force	Bureaucracy	Steve Shore	4/5/10
Tom Vitaglione	Former head of children’s health at DHHS; currently Senior Fellow in health and safety at Action for Children	Bureaucracy (recently moved to Advocacy)	Carolyn Sexton; Pam Silberman	4/9/10
Lee Dixon	Fiscal Analyst of General Assembly, specifically assigned to NCHC	Legislature	Verla Insko; Tom Vitaglione	4/19/10
Shelley Keir	Business Manager of CCNC, overseeing contracts	Bureaucracy	Jeffrey Simms	5/20/10
Denise Levis	Director of Quality Improvement of CCNC	Bureaucracy	Carolyn Sexton; Shelley Keir	5/21/10

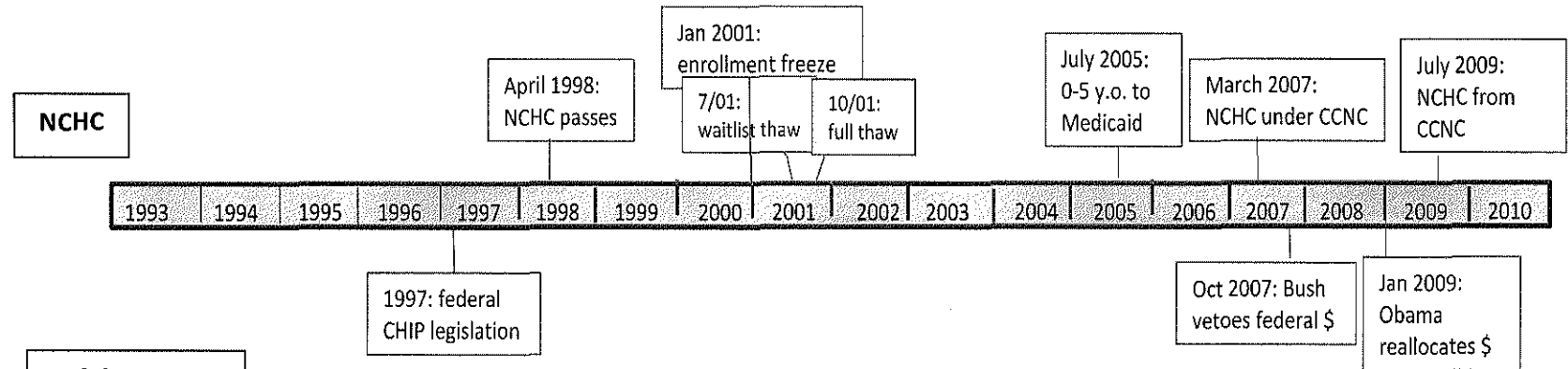
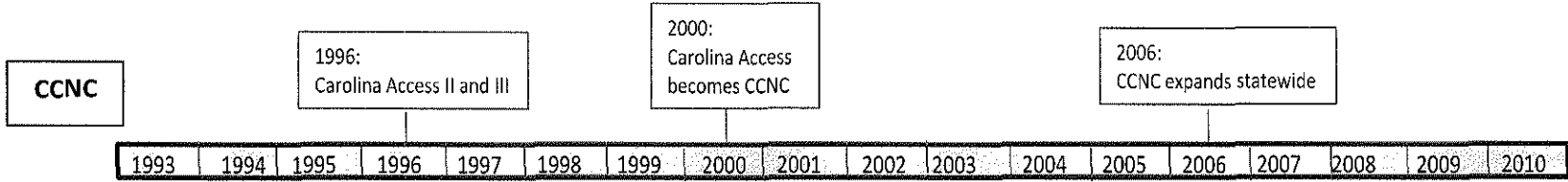
**Table A3-2. Codebook of Structured Interview Responses**

Respondents	Date	Position (LR)	Type of Interview (LR)	Hx w/ Health Policy (LR)	Involvement with NCHC (LR)	NCHC's beginnings (LR)	Good start 1-7 (LR)	Bad start 1-2 (LR)	Changes 1-6 (LR)	MDs' opinions on NCHC (LR)	NCHC Surprises (LR)	Influential forces (LR)	BCBS's opinions on NCHC (LR)	Legislators' views of NCHC (LR)

**(Table, cont'd)**

Relationship of CCNC and NCHC (LR)	Advocates for CC in NCHC (LR)	Stakeholders' expectations (LR)	Legislators' views of NCHC in CCNC (LR)	BCBS's opinion of NCHC in CCNC (LR)	Problems with NCHC in CCNC 1-2 (LR)	Why NCHC left CCNC (LR)





**NC Governors**



**NC Senate**



**NC House**



**Secretary of DHHS**



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