July 11, 1997

To: Workgroup, Children's Health Insurance and Other Investments

From: Lynn Cates, ASPE

Attached please find a rough summary of the talking points from our July 8, 1997, meeting. We have attempted to include all suggestions, but please let us know if any inadvertently were omitted, are misrepresented, or if you have additions. All comments will be appreciated. The list will be revised and expanded following today's meeting (Room 472) at 3 p.m. OEOB).

Please let me know if you will be involved in the subgroup drafting the final report. Subsequent drafting will probably involve carving-up the document and assigning sections to different office.

Please bring to the meeting today a rough estimate of costs for any options you have proposed.

If you have any questions, please contact me at:

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Thanks

DRAFT (July 11, 1997)

CHILDREN'S HEALTH INSURANCE AND OTHER HEALTH INVESTMENTS

Workgroup Report

INTRODUCTION

The charge of this workgroup is to devise a menu of options that would be appropriate for Department spending of the Tobacco Settlement's unallocated funds (approximately $100-200 billion). These funds represent the residual of the Settlement funds and the total amount is unpredictable for several reasons. First, funding for health projects will compete with civil judgements. Second, it is to be assumed that the states will claim at least a portion of these funds, because one of the reasons the states' attorneys general negotiated the Settlement was to obtain reimbursement for tobacco-related Medicaid expenses. Further, if the Settlement's goals of reducing tobacco use are successful, less money will be available in the future. Finally, it remains unclear whether or not the funds in the Settlement will be tax-deductible.

Options are not necessarily limited to those which are tobacco-related or Medicaid-related, but it is felt that since those are the two most important factors leading to the Settlement, projects related to either will be more likely to be endorsed.

GENERAL ISSUES

- Who should distribute the funds?
  (i.e., what proportion should be under federal control?)
- How should funds be distributed?
  (e.g., direct funding versus via government - and, if government, at what level - versus a combination)
- Targeting of funds
  (i.e., who should receive benefits from these funds?)
- What proportion of the funding should be devoted to tobacco-related conditions?
- How much of this money should be spent versus set aside to earn interest?
- Importance of not supplanting current funding (maintenance of effort)
- Accountability and cost-effectiveness of efforts
- Interrelationships among Settlement-funded programs and between Settlement-funded programs and currently available programs

PRIORITIES FOR FUNDING

It is anticipated, and highly desirable, that most of these options can be coordinated with each other, and with existing programs, for maximum impact. Further, they can all be designed to build upon a "base service" and primary care.

1. Public Health

- Safety nets
  Especially community health departments

- Infrastructure investment

- Public health training
  Including epidemiologists

- Information services
  Including monitoring, surveillance, and data systems
  Data collection, analysis and dissemination

- Prevention and health promotion
  (e.g., Healthy People 2000 and 2010)

- School- / community-based health education programs to integrate health care promotion, prevention and nutrition education and provide comprehensive education across diseases

- School- / community-based health centers to integrate health care services with education about health care promotion, prevention and nutrition

- Substance abuse and teen pregnancy prevention programs
  (e.g., combine programs for sex education with those for tobacco, alcohol and drug abuse)

- Environmental health
  Including environmental tobacco smoke

- Primary care needs for special populations
  (e.g., birth defects, HIV, etc.)

- Raising eligibility for Medicaid
  (e.g., up to 150-185% poverty for children in all states)

- Research to prevent non-tobacco related drains on Medicaid
  (e.g., birth defects, HIV)

- Dental services for adults and children

- Injury and violence

- Special health care needs of Indian tribes
  (e.g., a relatively small amount of money could have a major impact on diabetes programs)

2. Child Health

- Insurance
  It may be that sufficient funds will have been targeted to children's health insurance if the Senate's $8 billion is added to the $16 billion already proposed. However, these funds could be used to augment the program by funding relatively expensive outreach to the very hard to find populations, and increasing eligibility (e.g., up to 150-185% FPL).

- Link children to health services
  Especially high risk infants and children

- Integrate child support, children's health insurance and health care delivery
  Build infrastructure

- Expand the range of "T" in EPSDT
  Improve treatment delivery for all services, with particular emphasis on mental health/substance abuse, without supplanting current funding

- Health care services for non-Medicaid eligible low income children

- Screening for preventable childhood diseases / disabilities

- Integrate prenatal care with longitudinal follow-up of children
  (e.g., school-readiness)

- Child care
  Community after school programs with a link to health and nutrition. There is a real crisis and a lack of d\funding for those kinds of program. They can be tied to school cessation programs and community efforts. In the past child care has been more recreational, but there is an urgent need to make it more health and nutrition-related).

  Important target populations that currently are being ignored are middle school students and adolescents.

Babies are another important target population. About half of state require women with children under the age of one year to return to work (some as soon as 12 weeks). These babies are in high risk families already, and there are no provisions for child care. This should probably be coordinated with a prenatal component.

3. Adult Health

- Respite benefits
  Particularly for adults with disabilities due to tobacco use or ETS
- Federalize QMB
- Home / community-based waivers for conditions related to smoking
- Personal assistance waivers
- Primary care for underserved populations
  (e.g., graduated scale for Medicaid tied to FPL for populations like low income young adult males)
- Substance abuse / mental health services for women
- Diabetes initiatives
- Protease inhibitors for HIV/AIDS patients