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001. memo	Jeanne Lambrew to Jennifer Klein (partial) (1 page)	08/10/1996	P6/b(6)

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FOLDER TITLE:
CHIP [Children's Health Insurance Program]: Administration Proposal Development of 8/96-2/97

2012-0463-S
rc727

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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From Jeanne Lambrew
To: Chris Jennings 1/31/97

Kids' Option:
Grant Program to States

- HCFA would grant $750 million per year to selected states that introduce a Medicaid buy-in program.
  - This program would fund Medicaid buy-in programs for children between the mandatory coverage levels and 185% of poverty.
  - States that have not already expanded Medicaid to children above the mandatory levels could apply.
  - States would design both the maximum state spending and what comprises the state share of the matching payments.
    - States may budget for the program. In its application, it can specify that it will only contribution a certain dollar amount or cover a certain number of children. However, it cannot discriminate against types of children (e.g., limit enrollment to certain employees' children).
    - States may work with communities, employers and other private groups to fund the state share of the cost of coverage.
  - The Federal financing of this proposal would build upon the Medicaid per capita cap.
    - Like under the per capita cap, states' costs per child would be matched to a limit.
    - However, it differs from the per capita cap in two important respects. First, the Federal government would match the portion of the per capita costs after the family contribution has been subtracted. This allows the Federal and state governments to share in the savings from the family contribution. Second, total payments would be limited by the state-specific limit and the overall $750 million.
    - If the state does not reach its funding limit, the money reverts to the Federal government to be reallocated to other states.
  - Family would contribute to the cost of children's coverage on a sliding scale basis (e.g., a families whose income is halfway between 133 and 185% of poverty would pay half of the state's per capita limit per child).

What do you think? A little scary, but better than your original Grant program

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Advantages:

- **Targeted**: Only goes to states with no expansions; targets for working poor (100-185% poverty); limits employer crowd out through sliding scale family contribution and cutoff at 185%.

- **Limited**: The total spending is limited.

- **Leverages private money**: Uses not only state but family and possibly private contributions to stretch the Federal dollars.

- **Modeled on state experience:** Builds on successful buy-in programs like MinnesotaCare and Washington Basic Health Plan. Allows creative financing like state-funded programs in Pennsylvania and Florida. Lets states expand within a budget through limits like those used in TennCare or the home and community-based care program.

- **Protects Medicaid**: The Federal matching rate per child in Medicaid and the grant program is the same, limiting the incentives to shift costs to the new program. Additionally, the Medicaid benefits package would be kept intact, the Medicaid managed care plans could be used, and additional administrative costs would be low.

- **Moves closer to Congressional proposals**: Proposals like Kennedy's and possibly Chafee's have buy-in programs. A child tax credit could also be used in tandem with a buy-in program.

Disadvantages:

- **Sets precedent to limit the entitlement:** The juxtaposition of a capped state entitlement with an individual entitlement could jeopardize the latter.

- **Allowing more liberal definition of state match could hurt Medicaid**: Again, the carryover effect of these rules to Medicaid could undermine the restrictions on the use of provider taxes and donations.

- **State may perceive it as a new waiver program**

- **Not much money**: Since the total grant amount is not big, it may hard to decide how to allocate (which states).

November 26, 1996

TO: Nancy-Ann Min
Chris Jennings
Glen Roselli
Meredith Miller
Mark Miller

FROM: Christy Schmidt

SUBJECT: Child Health Proposals

The attached papers deal with the child health proposals that will be discussed at tomorrow's 10:00 AM meeting.

Attachments

1. **Enhance Child/Family Health Coverage and Services (an Overview)**

2. **Fulfilling the Promise of Medicaid for Eligible Children and Working Families Who are Already Eligible for Medicaid**

3. **Grants to States to Support Innovative Partnerships to Insure Children**

4. **Expand Investment in School Health Programs to Serve the Health Needs of Children and Adolescents**

5. **Partnership for Children and Working Families Through Targeted Funding for Consolidated Health Centers (CHCs)**

Cutler problem
MOA

about 3 million Medicaid
— private sector dropping

ENHANCE CHILD/FAMILY HEALTH COVERAGE AND SERVICES

Today, 10 million--14 percent--of children are uninsured. Children may be uninsured because their parents are unemployed, because their parents' employers do not offer health insurance to their children, or because their parents cannot afford to purchase health insurance for themselves or their children.

Many more children are underinsured, with limited access to critical preventive and primary care services. They may live in urban or rural areas that are underserved by private providers, or they may lack the insurance and other resources necessary to access care.

To address the reasons why children may be uninsured requires a multi-dimensional approach: increase insurance coverage through Medicaid, enhance partnerships with the states and private sector to help provide insurance for children, and expand access to community based care.

I. Increasing Insurance Coverage

Work with states to continue to fulfill the promise of Medicaid for children who are already eligible under current law.

- Fulfill the promise of Medicaid for eligible children and working families who are already eligible for Medicaid through administrative and legislative changes that expand enrollment of Medicaid eligible children; provide states with incentives and options for expanding Medicaid to working families; create new optional eligibility categories for individuals adversely affected by the new welfare law; and market Medicaid enrollment to the public. Specific provisions include improve the eligibility process to ensure that eligible children are enrolled; expand outreach; accelerate enrollment of children's poverty-related eligibility groups; create new optional eligibility categories for legal immigrants and non-pregnant adults with families; establish a marketing campaign.

II. Enhance Partnerships with States and the Private Sector to Help Insure Children

Provide grants to states to support innovative partnerships to insure children

- Numerous states have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. Under this proposal, the federal government would provide matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs. States would be given wide latitude in program design but would be required to assure the receipt of critical services related to immunization, injury prevention, well-child care, and other related services to reduce morbidity and mortality.

III. Expand Access to Community-Based Services

Enhance funding for communities through school-based or school-linked health centers.

- Expand funding for new school-based health centers. This initiative would provide school age children with comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, health education and preventive dental care. Communities would have the option of expanding services to the parents and siblings of the school's students; would be encouraged to link to other appropriate programs, including Healthy Start, state Maternal and Child Health, Head Start, Community Schools, and Empowerment Zones/Enterprise Communities; and would be encouraged to develop billing systems to collect third party payment and enable centers to participate in a community-wide health care delivery system.

- In addition this initiative would support school-linked health centers. School-based health centers may not be the right choice for every community. School-linked health centers can serve students from several schools in a particular catchment area and provide continuity of care as students are promoted to the next school. School-linked health centers provide services that might not be as comprehensive in scope as a school-based health center, but can be targeted to specific community needs.

Create Partnerships for Children and Working Families Through Targeted Funding for Consolidated Health Centers (CHCs)

- Provide increased targeted funding for CHCs to enhance and expand services to working families and their children, including children enrolled in day care, Head Start programs, and schools. These funds would be directed to communities with high levels of uninsured children, including EZ/EC communities. Funds would be used to increase CHCs capacity to serve uninsured children and their families and to better meet the needs of those in their community whose insurance coverage is fragmented or incomplete. This could include extended hours, locations, and range of services. In addition to increasing their own capacity, CHCs would serve as a focal point for marshaling public and private community resources directed at child health and, with their partners, taking steps to mesh child health and related services into local integrated systems that serve children and their families.

Challenge the health care industry to work with communities to improve integration of school-based and school-linked health centers and consolidated health centers into a community's health care delivery system.

- Encourage managed care organizations and health insurers to work with communities to develop health care delivery settings for children such as school-based/linked health

centers. Managed care organizations could collaborate with community sponsors to create funding mechanisms to develop and operate school-based/linked health centers, and/or to designate school-based/linked health centers as a primary care delivery site. Work with managed care organizations and health insurers to devise a range of approaches for: (1) reimbursing school-based/linked health centers for the services they provide; (2) developing model billing systems that support these approaches.

IMPACT OF INCREMENTAL NEW FEDERAL FUNDING FOR CHILD/FAMILY HEALTH COVERAGE AND SERVICES

Federal Funding Level	Federal Challenge Grants--Children Insured[1]			Children Served--School Based Health Centers [2]	People (Children) Served--Consolidated Health Centers [3]
	Preventive Services	Preventive Services/ Primary Care	Comprehensive Coverage[4]		
$25 million	500,000	70,000	45,000	125,000	250,000 (110,000)
$50 million	1,000,000	140,000	90,000	250,000	500,000 (220,000)
$100 million	2,000,000	280,000	180,000	500,000	1,000,000 (440,000)

Assumes 50 percent match from non-Federal sources.

Covers costs of services received in SBHCs but not health care services received at other locations. Assume all costs borne through Federal grant funds at start-up. Offsets from Medicaid reimbursement and other funding sources possible over time.

Comprehensive primary and preventive health services. Based on average Federal grant share of CHC funding of approximately 30 percent, with Medicaid and other sources accounting for balance. Approximately 44 % of CHC users are children through age 19. .

Option includes hospitalization coverage.

Fulfilling the Promise of Medicaid for Eligible Children and Working Families Who Are Already Eligible for Medicaid

I. Description:

The Goal of this proposal is to increase Medicaid enrollment of eligible children and working families.

II. Specific Provisions:

1. *Expand enrollment of Medicaid eligible children.*

Improve Eligibility process to ensure that eligible children are enrolled (Administrative)

Working with States, HCFA will use the opportunity of the new Welfare Reform legislation to re-think the current rules and regulations related to Medicaid eligibility. The Welfare Reform legislation essentially creates a Medicaid-only eligibility system for low-income children and working families. While this eligibility system is based on the AFDC eligibility rules in place on July 16, 1996, the new law allows States to focus on simplifying and to some extent expanding eligibility using "less restrictive" methodologies. HCFA will work with States to ensure that these new methodologies are encouraged and adopted.

Expand outreach (Administrative)

Develop Federal-state partnerships to improve outreach to enroll Medicaid eligible children. HCFA will also work with others, such as the Public Health Services and its grantees, and the Department of Education and local schools, to expand Medicaid outreach to increase the enrollment of children who are already eligible for Medicaid but who have not actually been enrolled. Outreach efforts would be directed through schools and other community service providers, as well as health care providers. Additional Federal resources for implementation of expanded outreach would be considered.

Accelerate enrollment of children's poverty-related eligibility groups (Legislation)

Propose legislation for a State option to accelerate the phase-in of coverage (e.g. shorten phase-in to cover two age cohorts within a given year instead of one) so that more children would receive Medicaid coverage sooner. Legislation passed in the late 1980s and early 1990s extends Medicaid coverage to all poverty-level children under age 19, on a phase-in basis by FY 2002. Currently all children under the age of 14, below poverty, are eligible for Medicaid. Each year, approximately 250,000 additional children receive

Medicaid coverage through this phase-in. Over the next four years 1 million more children will become eligible for Medicaid. This option would increase the time frame for enrollment by two years.

2. *Provide states with incentives and options for expanding Medicaid to working families.*

1115 Demonstration waivers (Legislation)

Create a process for a "permanent extension" of statewide health care reform demonstrations. This proposal would allow states to "convert" demonstrations to state plan amendments.

Cost-sharing (Legislation)

Permit states to impose cost-sharing (e.g., premiums) on expansion populations within specific income brackets. The minimum level (floor) for this proposal would be 50 percent.

3. *Create new optional eligibility categories for individuals adversely affected by new welfare law:*

SSI and Legal Immigrants: Create an optional eligibility group for Medicaid for those who lose SSI cash assistance due to their immigration status. Some states are interested in continuing Medicaid coverage to legal immigrants who will lose Medicaid due to the welfare reform provisions, without having to use the current law options.

Non-pregnant adults with families: Create a new optional poverty-related category for non-pregnant women with children. This population is at the greatest risk of losing Medicaid due to the severing of Medicaid and welfare eligibility rules.

4. *Market Medicaid enrollment to the public*

Encourage/ develop partnerships between states, provider groups and foundations to develop public service announcements and appropriate print media to encourage children and families to seek information about Medicaid eligibility, to enroll in Medicaid, and to utilize appropriate services.

A "marketing campaign" would be particularly beneficial for informing families what steps need to be taken to continue Medicaid coverage for children and working families after implementation of the new welfare law.

III. Impact

The purpose of these proposals is to increase the number of eligible individuals (and potentially eligible individuals) enrolling in Medicaid and to expand Medicaid coverage to working families without health insurance.

In FY '95, there were approximately 41 million people eligible for medical assistance, however, only 36 million actually received services that fiscal year. Approximately 21 million children were eligible, and only 18 million received services.[5] There are a variety of reasons why this "gap" between eligibility and receipt of services exists and limited enrollment is one reason. The outreach proposal, federal grant proposal and marketing proposal would address this "gap" between eligibility and enrollment.

The state incentive proposals would encourage states to expand Medicaid coverage to low-income working families. Since 1993, HHS has approved 13 statewide health care reform demonstrations. Many of these demonstrations involve an expansion of Medicaid coverage to working families with near-poor income levels. Once all of these demonstrations are implemented, an additional 2.2 million individuals will receive Medicaid coverage due to the expansions.

IV. Administration and Congressional History on Issue

During the late 1980s and the early 1990s, congress passed legislation to expand Medicaid coverage to children and pregnant women. The phase-in of Medicaid coverage for children below poverty born after Sept. 30, 1983 was part of this expansion.

Although 2.2 million additional individuals will receive Medicaid coverage due to the statewide health care reform demonstrations, recent demonstration applications have focused on enrollment in managed care and not on expanded coverage.

V. Tables and Attachments

None

HCFA 2082 data

Grants to States to Support Innovative Partnerships to Insure Children

I. DESCRIPTION

The purpose of this initiative is to assist States in assuring that children have access to primary care, comprehensive health supervision and health promotion and disease prevention services and, at a State's option hospitalization coverage in a continuous manner. Through a new grant program, States would receive matching funds to work with communities, parents, providers, employers, and payers to implement cost-effective approaches to providing insurance and services for children who are uninsured or intermittently insured.

Numerous states have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. Development of some of these innovative efforts has been supported by the Federal Government through the Maternal and Child Health Bureau of the Health Resources and Services Administration and the Health Care Financing Administration. This new proposal provides federal matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs.

Despite expansions in Medicaid, significant numbers of children remain without any health insurance. Others are covered only intermittently as their parents' coverage by private insurance or Medicaid changes or are underinsured, lacking coverage for preventive or other services.

II. SPECIFIC PROVISIONS

The federal government would provide support to States to continue and expand innovative programs to provide insurance for uninsured children. States would be given wide latitude in program design, choosing whether their programs would provide insurance for preventive services and medical supervision; preventive services, medical supervision and ambulatory care; or more complete coverage including inpatient hospitalization insurance. The mix of participants and funding arrangements would vary from State to State. However, all projects would share the following characteristics:

- Encouraging the development of innovative and cost-effective approaches to provide insurance coverage and related services for children, particularly for vulnerable children and their families with limited access to quality health services. Initial efforts would target currently uninsured children and children uninsured for preventive services.

- Encouraging a seamless system that provides continuous health care for children, without regard to source of payment or enrolled health care plan for either the family or provider. This would protect the link between child and health care provider regardless of changes in family income, source of insurance or other change in child or family circumstances.

This would be a logical next step for States which have expanded Medicaid coverage for children through waivers and State only programs. All States would be encouraged to reach out to uninsured families to help assure that eligible children are enrolled in Medicaid and other families are aware of new insurance opportunities.

- Partnerships among community organizations, individuals, and agencies; Federal, State, and local governments; professional organizations; HMO's, managed care organizations, and insurance plans; foundations; employers and corporate leaders; and families to share their knowledge and expertise and commit the necessary resources for mutual problem solving, easy access to services and fair and timely reimbursement.

- Partnerships of pediatricians and other pediatric primary care health professionals and professionals in health, education, social services, government. and business to build self-sustaining programs to assure healthy children and families.

- The Federal Government would work with States to extend waivers and other flexibility to allow States to create innovative systems of health care for children.

- Projects would be tracked so that information would be available on topics such as the number of children covered by these programs, rates of uninsurance among children in participating States, and trends in employer coverage of child preventive services etc.

- Federal technical assistance would be available to assist in areas such as estimating costs of providing additional levels of expanded coverage; information about successful public private partnerships in insurance coverage; data system design; and program evaluation.

III. IMPACT

This proposal could be implemented in several ways, depending on the amount of Federal funding available. The options presented below are built on the following estimates of the costs of providing children. The cost of providing insurance for those preventive services recommended by the American Academy of Pediatrics is approximately $8 per child per month; for primary care and preventive services, based on the Blue Cross/Blue Shield standard option without hospitalization, is approximately $56 per child per month; when hospitalization coverage is added the cost is $90 per child per month. Additional funds would be needed to support collaboration building, data systems, administrative overhead and evaluation. In the grant program options discussed below, Federal support would be matched on a dollar for dollar basis by States through their choice of a mix of public, corporate and/or private contributions.

The number of children receiving coverage under grants from this proposal would depend on the extent of insurance coverage a State selects.

Option 1 No new funding

Federal actions would be limited to publicizing successful State efforts, convening groups of interested parties, providing information on the impact of State programs, providing technical assistance to the States and encouraging use of Federal funds from existing programs, such as the Maternal and Child Health Block grant, for this purpose.

Option 2 Pilot Program

Grants would be awarded on a competitive basis to 5 to 10 States to implement activities on a demonstration basis, with the possibility of expanding the program to remaining States in the future. Among criteria for selection would be factors such as need, as measured by rates of uninsurance among children, the extent to which proposed activities complement State Medicaid policies, support from State and private sector sources, innovative features, and diversity among the size of States selected and models tested.

Option 3 National Program

Grant funds would be available to all States which meet basic program criteria.

The following table illustrates approximate numbers of children who could receive insurance coverage of various types under this proposal at different funding levels, with an assumed 50 percent match rate.

Total Federal Grant Support	Insurance for Preventive Services Only	Insurance for Preventive Services and Ambulatory Care	Comprehensive Insurance Coverage
$25 million	500,000	70,000	45,000
$50 million	1,000,000	140,000	90,000
$100 million	2,000,000	280,000	180,000

Assuring the receipt of critical services related to immunization, injury prevention, well child care, primary care and other medical services will not only reduce morbidity and mortality and save significant costs associated with these conditions but will enhance child and family well-being.

IV ADMINISTRATION HISTORY

Expanding insurance and other health coverage for children has been a theme of the Clinton Administration. Several States, such as Hawaii and Rhode Island, have used 1115 waivers to restructure their Medicaid programs to expand coverage for children. This initiative provides a stepping stone for States who are seeking new ways of extending health insurance to the uninsured. This initiative differs from previous efforts by its strong emphasis on drawing into expansion efforts participation and resources from all concerned parties, public and private payers, providers, State and community leaders, and families .

Expand Investment in School Health Programs to Serve the Health Needs of Children and Adolescents

I. DESCRIPTION

Students often experience compromised access to health care services because of the combined barriers of poverty, a lack of health insurance and, in some areas, a lack of primary care providers.

To address this problem, school health programs provide preventive, medical and mental health services to elementary, middle and high school students around the country. They currently operate in many states, with the majority in rural and inner city communities where there are many medically underserved and uninsured children.

School health programs provide a wide range of services depending upon the needs of the communities, including primary care, physical examinations, injury treatment, immunizations, dental treatment, counseling, chronic illness management, substance abuse prevention, and health education.

II. SPECIFIC PROVISIONS

- Expand the **Healthy Schools/Healthy Communities** initiative to improve the health of children in a school setting. Through this Health Resources and Services Administration program sponsored by the Bureau of Primary Health Care in collaboration with the Maternal and Child Health Bureau, school-based primary health care sites have been developed in 26 communities to provide services for 24,000 children who are at risk for poor health, school failure, homelessness and other consequences of poverty. The program has been funded at $16.8 million over a three year period. New funds would be targeted to organizations to establish new school-based health centers in communities with high rates of uninsurance. Current sites link to both Healthy Start and Head Start sites. SBHCs funded under the new initiative would:

  - serve children of all ages from pre-kindergarten through grade twelve;
  - have the option of expanding services to the parents and siblings of the school's students;
  - link to other appropriate programs, including Healthy Start, Head Start, and community schools.
  - provide comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services,

health education and preventive dental care as well as linkage to other health care services and after-hours medical care;

- provide reproductive health services at the option of the community; and

- develop billing systems to enable center to participate in a community-wide health care delivery system.

- Expand the **Healthy Schools/Healthy Communities** initiative to support school-linked health centers. SBHCs may not be the right choice for every community. School-linked health centers can serve students from several schools in a particular catchment area. They also can provide continuity of care as students are promoted to the next school. Such centers provide an opportunity to target out of school youth and aid them in accessing health, psychosocial and other services. The location off school grounds allows greater flexibility for extending operating hours or operating during school vacations and the summer months. School-linked health centers can more easily avoid the controversy in some communities associated with the delivery of particular services, such as family planning or reproductive health services, on the school site.

- Expand funding for **Consolidated Health Centers** (CHCs) to work with communities to develop school-based or school-linked health programs. Recognizing the benefits of interactions between education and health efforts, many communities have established links between schools serving low-income children and CHCs to provide comprehensive health services to underserved children. Approximately 250 CHCs have developed school-based or school-linked health programs: approximately 75 school-based programs and about 175 school-linked programs.

- Encourage states to expand funding for school health programs through the **Title V Maternal and Child Health (MCH) Block Grant**. In 1994, 25 states invested $12 million in MCH block grant dollars and $22.3 million in state general funds for school health programs. Further funding targeted to the development of school-based/linked health programs would directly benefit many of the children who lack adequate health insurance coverage or access to health care services.

- Encourage managed care organizations to work with communities to develop and implement school health programs. Managed care providers in several states authorize SBHCs to provide health care services, then bill Medicaid directly. Managed care organizations may collaborate with community sponsors to create funding mechanisms in order to develop and operate SBHC organizations that designate the SBHC as the primary care clinic for school-aged children and their families.

- Work with managed care organizations and fee-for-service health insurers to devise a range of approaches for reimbursing school health programs for the services they provide and develop model billing systems that support these approaches.

- In order to assure integration of school health programs into the broader health care delivery system, the Department will provide technical assistance to help school health programs create effective linkages to Medicaid, managed care organizations, other insurers and private sector providers. The Department can:

  - identify steps the Department can take to facilitate Medicaid reimbursement for health services delivered in school health programs;

  - use the Medicaid Maternal and Child Health Technical Advisory Group to improve communication between state Medicaid Directors and Maternal and Child Health Directors on incorporating school health programs into Medicaid managed care and other payment arrangements;

  - use the 1115 waiver authority in Medicaid to encourage states to mandate Medicaid managed care providers to reimburse school health programs for services delivered;

  - distribute guidance to communities forming school health programs on becoming Medicaid providers and establishing linkages with health insurance and managed care organizations to devise a system of reimbursement for health services provided to students;

  - encourage state Medicaid programs to provide out stationed eligibility workers to schools with health programs;

  - encourage States and communities to develop linkages with private sector providers of care to supplement services provided in school clinics;

  - expand State Level Partnerships for School Mental Health Services and Centers for School Mental Health Technical Assistance and Training now supported by the Maternal and Child Health Bureau and encourage other efforts which seek to promote stronger linkages between schools and mental health and substance abuse service providers in both the public and private sector.

- Use the **Special Projects of Regional and National Significance (SPRANS)** Maternal and Children Health Block Grant set-aside to encourage states to conduct demonstrations to develop effective models which build the relationship between managed care organizations (including Medicaid managed care providers) and schools to ensure access to health care services for children and adolescents and to promote training and staff development for health professionals engaged in school health activities.

III IMPACT

The following chart presents total costs, numbers of clinics and numbers of students served which would result from increments of new funding. For purposes of this chart, all funding is assumed to come from grant support, although over time costs will be partially offset by Medicaid reimbursement. These estimates are based on data from the HRSA Healthy Schools/Healthy Communities Program and "School-Based Health Centers" by the National Conference of State Legislatures.

Federal Support for School Health Clinics	Number of Clinics ($200,000/clinic)	Number of Students ($200/student)
$25 million	125	125,000
$50 million	250	250,000
$100 million	500	500,000

IV. ADMINISTRATION HISTORY

This proposal builds on the Administration's support for efforts to expand the availability of health services for children through focused use of existing programs, including Medicaid, the Maternal and Child Health Block Grant, the Consolidated Health Center program and Healthy Schools/Healthy Communities, a program implemented during this Administration.

Partnerships for Children and Working Families through Targeted Funding for Consolidated Health Centers (CHCs)

I. DESCRIPTION

Federally funded CHCs provide comprehensive health care to 8.1 million people, the overwhelming majority of whom are low income and 44 percent of whom are children through age 19. Because CHCs must serve medically underserved areas and populations, they are located in communities where people lack access to health care and where much of the population lacks health insurance. Federal grant funds make up approximately 30 percent of CHC revenues and are used in large measure to subsidize care for the uninsured. Other sources of funding include Medicaid, Medicare, patient fees, and State, local and other sources. This proposal would target increased CHC funding to areas where there are high levels of uninsurance among children.

II. SPECIFIC PROVISIONS

Provide increased targeted funding for CHCs to enhance and expand services to working families and their children, including children enrolled in day care, Head Start programs and schools. These funds would be directed to communities with high levels of uninsured children, including EZ/EC communities.

Funds would be used to increase CHCs' capacity to serve uninsured children and their families and to better meet the needs of those in their community whose insurance coverage is fragmented or incomplete. This could include extended hours, more locations, including schools, and expanded range of services provided.

In addition to increasing their own capacity, CHCs would marshall community resources directed at child health and, with their partners, taking steps to mesh child health and related services into local integrated systems that serve children and their families well. CHCs would receive targeted funds to form "Partnerships for Children and Working Families" by linking up with other community organizations, such as:

--managed care organizations to create stronger linkages to community based providers;

--community hospitals and academic health centers who are serving the targeted population and can provide stronger vertical integration of services;

--public health departments to assure that targeted populations receive appropriate service;

--local providers, schools, and other service providers to assure integration of all community service organizations; and

--local philanthropic organizations which may result from a shift in health care delivery systems from non-profit organizations to for-profit entities. This transition often establishes a foundation poised to serve the needs of disadvantaged populations.

Existing and new CHCs would work closely with State Maternal and Child Health programs and other community providers to identify special needs of children and working families in their communities and tailor services to the needs of local populations. Special emphasis would be placed on enabling services, such as transportation, linkages with schools and social service programs, such as WIC. Creative collaboration would be encouraged. For example, taxi companies could be encouraged to provide discounted fares to medical appointments.

III. IMPACT

By increasing Federal funding for CHCs, their capacity to serve the uninsured--children and their families--is expanded. The average Federal grant cost per CHC user is about $100, an additional investment of $100 million in grants to CHCs would expand their service capacity by 1,000,000, assuming "average" clientele and funding streams. Nationally approximately 44 percent of CHC users are children through age 19. Because funds would be targeted to geographic areas or population groups where levels of uninsurance among children are particularly high and/or growing, the actual increase in numbers served would depend on rates of uninsurance in the sites selected and could be somewhat smaller.

Federal Grant Support for CHCs	People Served--All Ages	Children Served
$25 million	250,000	110,000
$50 million	500,000	220,000
$100 million	1,000,000	440,000

IV. ADMINISTRATION AND CONGRESSIONAL HISTORY ON ISSUE

The Fiscal Year 1997 appropriation for CHCs is $802 million. In its preliminary submission to OMB for FY 1998, the Department requested $817 million for CHCs, which includes plans for 50 new delivery sites. CHCs were recently reauthorized by Congress with broad bipartisan support.

CHILDREN'S HEALTH INSURANCE ASSISTANCE

- This legislation authorizes the appropriation of $750,000,000 annually beginning in FY 1998 for grants to States to initiate and expand programs extending health insurance uninsured children ineligible for Medicaid to whom adequate, affordable health insurance coverage is unavailable.

- States will have broad latitude in designing their programs. The intent will be to supplement , not supplant existing efforts to insure children and to minimize the risk that of erosion of employer-sponsored insurance. States will set their own eligibility requirements, in terms of family income, and access to or coverage by private insurance. States will determine the age of children to be covered, which cannot exceed 21. Programs may be statewide or substate. States will also determine the range of benefits to be provided. States will submit for approval an initial application and annual amendments describing their programs. The application will describe:

  - o Health insurance needs for children within the State
  - o current efforts to address these needs, including Medicaid outreach activities
  - o public involvement in the design of the program and an ongoing process for such involvement
  - o the scope and elements of their program including:
    - -- service area
    - -- eligibility criteria
    - -- how screening will take place initially and on an ongoing basis to assure that only children eligible for the program participate and that those found through screening to be eligible for Medicaid are enrolled,
    - -- the benefits to be provided
    - -- number of children to be covered
    - -- projected cost per child
  - o a budget including the sources of non-Federal funds
  - o an assurance of adequate notice of program changes to affected families
  - o outreach and coordination efforts
  - o an assurance that data will be collected in order to assure annual assessment of the program and an evaluation.

- States will submit an annual report assessing their programs and shall submit amendments to the Secretary for approval at least annually and at any additional time there are significant program changes.

- Of the $750,000,000, 1.5 percent will be reserved for Puerto Rico, Guam, the Virgin Islands, American Samoa and the Northern Mariana Islands. The balance will be allocated among the States and the District of Columbia. Each State will receive a base award of $1,000,000. The remainder of funds will be allocated among the States based on their relative proportion of uninsured children, using a three year average from the Current Population Survey.

- This program is to be matched by the States with public or private funds. The legislation does not specify the sources for these funds. A State's matching percentage will be its Federal medical assistance percentage (FMAP). Funds will be used for insurance assistance.. At least 5 percent of a State's allocation will be used for outreach. An additional 5 percent may be used for administration.

- Each State must prepare an evaluation due in March 2000 assessing the effectiveness of the program in expanding insurance coverage. The Department will submit a report to Congress by the end of that year based on these State reports with recommendations as appropriate.

Total Pages: 16

LRM ID: RJP19

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

URGENT

Friday, February 14, 1997

LEGISLATIVE REFERRAL MEMORANDUM

TO:	Legislative Liaison Officer - See Distribution below
FROM:	Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT:	Robert J. Pellicci PHONE: (202)395-4871 FAX: (202)395-6148
SUBJECT:	HHS Proposed Draft Bill on Children's Health Insurance Assistance Act of 1997
DEADLINE:	Noon Wednesday, February 19, 1997

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: The attached draft language is designed for possible inclusion in the President's FY 1998 balanced budget bill.

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LRM ID: RJP19**SUBJECT:** HHS Proposed Draft Bill on Children's Health Insurance Assistance Act of 1997

RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: Robert J. Pellicci Phone: 395-4871 Fax: 395-6148
Office of Management and Budget
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

The following is the reponse of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _ _ _ _

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this reponse sheet

[TITLE XI--HEALTH CARE]

Subtitle G--Children's Health Insurance Assistance

This subtitle creates a new program of direct spending for Federal matching grants to States for innovative programs extending health insurance assistance to children for whom adequate and affordable insurance coverage is unavailable. Children served must be ineligible for Medicaid. $750,000,000 in Federal funding would be provided for fiscal year 1998 and each succeeding fiscal year. Funds will be matched using the Medicaid matching rate.

Funds will be allocated among the fifty States and the District of Columbia on the basis of Census Bureau data regarding the number of uninsured children in each jurisdiction. 1.5 percent of program funds will be allocated among the territories of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

States will have wide latitude in designing their program with reference to age, income and geographical areas. States may purchase extensive or limited health care benefits from State licensed insurers, including HMOs. States may serve children who are ineligible for any insurance or for insurance that meets their specialized needs, or for whom insurance is unaffordable. At least 5% of funds must be used for outreach activities. Each State will conduct an evaluation at the end of the second year of operation.

GCL DRAFT 2/14/97

[TITLE XI--HEALTH CARE]

Subtitle G--Children's Health Insurance Assistance

SEC. 11801. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.--This subtitle may be cited as the "Children's Health Insurance Assistance Act of 1997".

(b) Table of Contents.--The Table of Contents of this subtitle is as follows:

SEC. 11802. PURPOSE; AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $750,000,000 for fiscal year 1998 and each succeeding fiscal year, to carry out a program of grants to States to enable them to initiate and expand innovative programs extending health insurance assistance to eligible children to whom adequate and affordable insurance coverage is unavailable.

SEC. 11803. DEFINITIONS.

For purposes of this subtitle:

(1) HEALTH INSURANCE ASSISTANCE.--The term "health insurance assistance" means payments under a State program under this subtitle, either to a health insurer or to the

parent, guardian, or other caretaker of an eligible child, for the purchase of coverage of the costs of health care items and services for such child.

(2) HEALTH INSURER.--The term "health insurer" includes any entity licensed to provide health insurance in a State (including any health maintenance organization or other managed care provider that provides health care to enrolled members on a risk basis).

(3) MEDICAID.--The term "Medicaid" means a State medical assistance program approved under title XIX of the Social Security Act.

(4) QUALIFIED CHILD. The term "qualified child" means an individual of any age under age 21 as determined by the State--

(A) who is ineligible for benefits under the State Medicaid program;

(B) who has no (or inadequate) health insurance coverage; and

(C) to whom adequate and affordable individual or family health insurance coverage is unavailable.

(5) SECRETARY.--The term "Secretary" means the Secretary of Health and Human Services.

(6) STATE.--The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

SEC. 11804. STATE PROGRAM.

(a) IN GENERAL.--Each State, in order to be eligible for payments for a fiscal year from its allotment under this subtitle, must meet the following requirements:

(1) INITIAL APPLICATION; AMENDMENTS.

(A) APPLICATION.--The State shall submit to the Secretary, and obtain the Secretary's approval of, an initial application, meeting the requirements of this section, to establish a program under this subtitle.

(B) AMENDMENTS.--The State, at least annually, and at additional times whenever there are significant changes in the program, shall submit to the Secretary, and obtain the Secretary's approval of, an amendment to the application, indicating any such changes from the program described in the initial application.

(C) DEADLINES FOR APPLICATIONS AND AMENDMENTS.--The State shall submit the application and annual amendments required under this paragraph--

(i) with respect to fiscal year 1998, before April 1, 1998, and

(ii) with respect to each subsequent fiscal year, before January 1 of that fiscal year,

(2) PROGRAM OPERATION.--The State shall have in effect in the State a program in accordance with the application (and any amendments) approved under paragraph (1) and with the requirements of this subtitle.

(3) ANNUAL REPORT.--The State shall--

(A) conduct an assessment of the operation of the State program under this subtitle in each fiscal year, including the progress made in reducing the number of uninsured and underinsured children; and

(B) report to the Secretary, by January 1 following the end of such fiscal year, on the result of such assessment.

(4) EVALUATION.--The State shall provide to the Secretary, by March 31, 2000, the evaluation described in section 11808(a).

(b) CONTENTS OF APPLICATION.--The application shall include the following:

(1) CURRENT NEEDS AND EFFORTS.--A description of--

(A) the health insurance needs the State's program is seeking to address, including information regarding the number of insured, uninsured and underinsured children in the State; and

(B) current State efforts to insure uninsured or underinsured children, including the steps the State is taking to identify and enroll all such children who are eligible to participate in the State Medicaid program.

(2) PROGRAM DEVELOPMENT PROCESS.--A description of the process used to involve the public in the design of the State's program and the State's plan for ensuring ongoing public involvement.

(3) PROGRAM DESIGN.--A statement detailing the scope and elements of the program, including:

(A) SERVICE AREA.--The geographic area or areas to be served.

(B) ELIGIBILITY RESTRICTIONS.--

(i) CRITERIA.--Any restrictions (which may not include restrictions based on preexisting medical conditions) on eligibility of qualified children (as defined in section 11803(4)) for health insurance assistance under the State program, including restrictions based on age, income, or access to or coverage by other health insurance,

(ii) SCREENING AND MEDICAID COORDINATION.--A description of procedures to be used

(I) to ensure (through both intake and followup screening) that only eligible children are furnished health insurance assistance under the State program, and

(II) to ensure that children found through the screening to be eligible to receive Medicaid will be enrolled in the State Medicaid program.

(C) HEALTH INSURANCE COVERAGE.--The nature of the health insurance assistance to be provided, including--

(i) the specific health care benefits to be provided (which shall meet such minimum standards, including standards for quality and scope of coverage, as the Secretary may establish).

(ii) the projected number of uninsured and of underinsured children to receive such assistance;

(iii) the projected amount to be paid per child; and

(iv) whether the program will pay all or a portion of the cost of health insurance.

Grant Amount Times Percentage		$688 Million		Uninsured Children <21	Not in Poverty: Uninsured Children <21	Uninsured Children <19
	1996	1995	1994	Average	Average	Average
ALABAMA	$11.89	$16.86	$13.51	$14.10	$12.23	$13.70
ALASKA	$2.38	$2.10	$2.00	$2.16	$2.40	$2.25
ARIZONA	$18.41	$18.18	$14.88	$17.18	$15.82	$17.28
ARKANSAS	$9.35	$8.53	$10.56	$9.47	$9.62	$9.50
CALIFORNIA	$110.60	$122.67	$116.95	$116.75	$108.06	$117.60
COLORADO	$10.95	$8.85	$6.54	$8.80	$9.73	$9.22
CONNECTICUT	$5.93	$7.29	$6.57	$6.60	$7.17	$6.60
DELAWARE	$2.81	$2.35	$2.70	$2.62	$3.11	$2.48
DC	$2.64	$2.27	$2.67	$2.53	$2.46	$2.64
FLORIDA	$43.53	$38.18	$47.09	$42.88	$42.85	$43.81
GEORGIA	$21.63	$23.29	$20.37	$21.78	$22.39	$21.98
HAWAII	$2.58	$2.16	$2.84	$2.52	$2.67	$2.55
IDAHO	$3.89	$4.14	$4.73	$4.25	$4.69	$4.23
ILLINOIS	$21.53	$23.93	$27.43	$24.26	$26.86	$23.59
INDIANA	$15.70	$13.59	$11.44	$13.60	$15.68	$13.07
IOWA	$8.17	$7.05	$5.60	$6.95	$6.10	$7.03
KANSAS	$6.52	$5.15	$7.68	$6.43	$6.27	$6.39
KENTUCKY	$10.30	$9.90	$9.22	$9.82	$9.40	$10.10
LOUISIANA	$16.52	$15.77	$22.18	$18.11	$15.20	$18.60
MAINE	$4.48	$3.53	$3.61	$3.88	$4.36	$3.66
MARYLAND	$13.68	$11.44	$9.08	$11.43	$13.19	$11.37
MASSACHUSETTS	$9.36	$11.24	$10.83	$10.47	$12.13	$10.18
MICHIGAN	$16.85	$16.03	$16.80	$16.56	$17.67	$16.46
MINNESOTA	$5.83	$7.74	$6.64	$6.74	$7.55	$6.58
MISSISSIPPI	$12.25	$9.08	$10.43	$10.59	$9.35	$10.56
MISSOURI	$14.04	$9.10	$10.87	$11.34	$11.81	$11.16
MONTANA	$2.82	$2.85	$3.33	$3.00	$3.18	$2.88
NEBRASKA	$3.90	$4.37	$4.46	$4.24	$4.55	$4.08
NEVADA	$6.84	$5.37	$5.68	$5.96	$6.30	$6.00
N HAMPSHIRE	$2.26	$3.48	$3.19	$2.98	$3.28	$3.04
NEW JERSEY	$16.65	$16.63	$18.14	$17.13	$19.58	$16.93
NEW MEXICO	$10.52	$9.76	$8.70	$9.67	$8.67	$9.99
NEW YORK	$42.45	$47.33	$37.73	$42.56	$45.40	$42.15
N CAROLINA	$15.51	$15.22	$17.99	$16.22	$16.68	$15.48
NORTH DAKOTA	$1.70	$1.89	$2.61	$2.06	$2.25	$2.03
OHIO	$20.90	$22.41	$22.48	$21.92	$23.56	$21.84
OKLAHOMA	$13.92	$12.16	$17.92	$14.63	$13.76	$15.18
OREGON	$8.01	$8.66	$7.91	$8.20	$8.49	$8.18
PENNSYLVANIA	$20.75	$23.16	$22.69	$22.20	$22.88	$22.22
RHODE ISLAND	$3.15	$2.55	$2.89	$2.86	$2.92	$2.84
S CAROLINA	$12.20	$11.12	$11.03	$11.45	$10.53	$11.30
SOUTH DAKOTA	$2.13	$2.42	$3.01	$2.51	$2.50	$2.48
TENNESSEE	$16.73	$11.50	$9.88	$12.73	$12.59	$12.97
TEXAS	$88.94	$92.36	$80.99	$87.51	$82.99	$89.50
UTAH	$5.67	$5.14	$5.92	$5.57	$5.77	$5.75
VERMONT	$2.17	$1.55	$1.85	$1.86	$1.85	$1.83
VIRGINIA	$11.88	$12.63	$17.14	$13.85	$15.82	$14.43
WASHINGTON	$12.68	$11.96	$12.66	$12.43	$12.12	$10.24
WEST VIRGINIA	$4.16	$4.93	$7.20	$5.41	$4.41	$4.95
WISCONSIN	$8.51	$6.59	$7.61	$7.57	$7.34	$7.47
WYOMING	$2.47	$2.30	$2.54	$2.44	$2.54	$2.43
Total	$738.75	$738.75	$738.75	$738.75	$738.75	$738.75

TO: Jennifer Klein
FROM: Jeanne LAMBREW
RE: **Kids' program and costs**
DATE: August 10 1996

I am tentatively attaching a spreadsheet to give you a sense of the costs of the options. **They are not right**: we have to update the underlying data and assumptions in the original model. What they do show is that we can probably, with some work, get these estimates down to $15 billion to $18 billion. I can't say what the coverage looks like; for that, we really need Urban Institute.

There are two ways that the costs of the state optional program could be lowered: changing the policy and refining the estimating.

Policy Changes

- **Phase in**: The attached assumed all kids are eligible day one. There could be two phase in schedules:
  - (a) Bring kids 6 to 13 (today covered at 100%) to 133% PL, and then use the OBRA schedule to phase in the program for older children;
  - (b) Phase the program in for the 6 year olds for whom Medicaid offers coverage now at 133% PL.

  Note that this does not preclude states from using their own money to cover kids at higher levels / ages or opting not to participate since they can get a full Medicaid payment for kids at the upper income levels in their current programs.

- **Drop upper eligibility threshold to 200% of poverty**: The 240% upper limit was more of an historical artifact than scientifically based.

- **Change from monthly eligibility determination:** If we move to maybe a 6 month eligibility determination, the costs and coverage would be lower. This is more consistent with what many states do for Medicaid.

Technical Changes

- **Adjustment for states that would not participate**: The current estimates include all states. To be conservative, it might be useful to keep it this way, but CBO could assume that some states won't participate, thus lowering costs.

- **Revisit dropping assumptions and participation rates**: I will continue working on this. Once I figure out a plan, I'll let you know.

- **Use updated Urban Institute model**: The underlying data have changed since 1991 (what we used in 1994). I am not sure if this will increase or decrease costs, given high numbers of uninsured kids, but slower inflation projections. I think costs may go down.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Jeanne Lambrew to Jennifer Klein (partial) (1 page)	08/10/1996	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20462

FOLDER TITLE:
CHIP [Children's Health Insurance Program]: Administration Proposal Development of 8/96-2/97

2012-0463-S
rc727

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

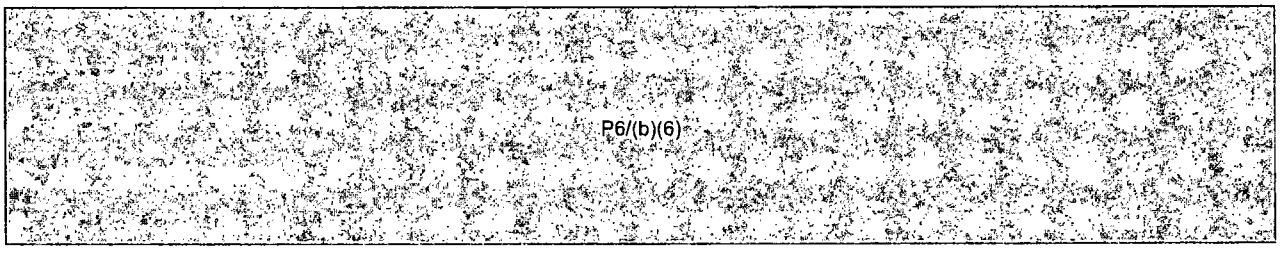
Other comments:

One of the cons for the state option — that kids who are currently state optional at higher income levels would now have to pay — is also a problem for the full federal subsidy program.

The GAO report does say that 62 percent of children on Medicaid have a parent who works.

Attached is a Minnesota fact sheet that I found interesting. I am looking closely at Washington and Minnesota to see what is going on; also New York's Child Plus program.

I am going to be at the Radisson St. Paul on Sunday and Monday morning. I can't quite find the phone number but I am sure it is in information. The room is in Judy's name (I also check my voice mail, so it might be easier to leave a message there if you need to). I originally planned to come back on Monday night, but the conference doesn't look that great, so I may be back on Monday afternoon with Judy. Please don't hesitate to call — it's not like I am going on vacation!



[001]

DRAFT PRELIMINARY Kids' Program Estimates

Fiscal Years, Billions of Dollars

	1997	1998	1999	2000	2001	2002	Total 1997-2002
Kids' Program: Using FEHB Full Premium							
Free to 133%, Phase-Out to 240% (1)		4.3	5.9	6.1	6.3	6.5	**29.1**
Excluding Costs of State Optional Medicaid Kids (1)		3.4	4.6	4.8	5.0	5.3	**23.2**
Kids' Program: Using Medicaid Per Capita							
Excluding Costs of State Optional Medicaid Kids (2)		2.9	3.9	4.1	4.3	4.5	**19.7**

Assumes October 1, 1997 implementation

Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

Note: Changing these estimates to an annual AGI saves approximately 20%.

These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

(1) Estimates from January 1995; they have only been changed to (a) eliminate 1997; (b) use current CPI.

(2) ROUGH APPROXIMATION: This is the full subsidy costs, without State Optional Medicaid kids, multiplied by the ratio of the CBO Medicaid spending per child by the FEHB premium for a single child. This does not take into account growth rate constraints.

10-Aug-96

State Programs

About the People Who Were Surveyed
Minnesota Care Members

Region
Overall, 30% of the MinnesotaCare members we interviewed live in the 7-county Twin Cities metro area, and 70% live in Greater Minnesota.

Health
Ratings of their own health: 29% "excellent," 40% "very good," 24% "good," 5% "fair," and 2% "poor."

Adults/Children
During the survey interviews, 16% gave ratings of adults' care only, 69% gave ratings of both adults' and children's care, and 15% gave ratings of children's care only.

Age, Education, Gender
The average (mean) age of MinnesotaCare survey respondents is 37. Overall, 16% are less than 30, 48% are in their thirties, 29% are in their forties, and 7% are 50 or older. Overall, 47% have a high school education or less, 37% have had some college or other education or training after high school, and 16% are college graduates. Overall, 22% are men, and 78% are women.

Length of Enrollment
Overall, 69% have been enrolled in MinnesotaCare for 2 years or less, and 31% have been enrolled for more than 2 years.

Own Contribution to Premium
Overall, 64% pay all of their MinnesotaCare premium themselves, 32% pay part of it, and 4% pay none of it.

How to Use this Web Site

If you're using Netscape or a browser that supports tables, please use these links to find out more about Minnesota Care Members' ratings of:

Overall Satisfaction
Benefits and Coverage
Handling of Members' Questions and Problems by the Plan
Overall Rating - Able to Get Care When Needed
Getting Appointments When Sick
Getting Medical Help by Phone, Evenings and Weekends
Medical Care Received by Adults
Medical Care Received by Children

If you're using another browser, including non-graphical browsers, please use these links:

Overall Satisfaction
Benefits and Coverage
Handling of Members' Questions and Problems by the Plan

TO: CHRIS JENNINGS
FROM: JEANNE LAMBREW

2/14/96

State Program for Kids

Eligibility: Kids in working families with income below 200 percent of poverty without insurance (previous 6 months) or access to employer-based insurance (previous 18 months). This includes Medicaid children in working families, except for SSI and institutionalized children. Coverage would be phased in.

Benefits: FEHBP Blue-Cross, Blue-Shield like package

Delivery System: State designed. States may cover children through Medicaid, State employee health plans, private HMOs or any other program suited to the State's circumstances.

Funding:

Federal: Federal Medicaid per capita cap amount for kids in the State

- Full amount for kids below 133 percent of poverty
- Partial amount for kids between 133 and 200 percent of poverty (for States that currently optionally cover these kids, they would get the full per capita, as under the per capita cap).

Note: A significant proportion of the total program funding would be a transfer from Medicaid to the new program. New spending would be for increased participation and States that do not now cover children at higher levels.

Participant: No premiums or cost sharing for children below 133 percent of poverty

Sliding scale premium for children 133 to 200 percent of poverty; co-payments for some services (not for preventive or primary care)

State/Private: The residual funding needed to assure that all eligibles receive the nationally-defined benefits package.

Discussion of Kids' Options

Why Kids:

- One of four uninsured is a child. Children are one of the fastest growing groups of uninsured.
- Probably have greater coverage per dollar spent than TU program [although I am not sure yet]
- Given the problems with the Chafee-Breaux amendment, this offers a substitute. Creates a uniform, national safety net of benefits and eligibility — the intent but the not effect of the OBRA '90 expansion.
- Counterbalances State reductions in welfare coverage

Why State Program:

- Less expensive than a full subsidy program since (a) only Federal share of per capita; (b) indexed through per capita cap; and (c) State optional.
- Given limited availability of new funding, allows States to use some current Medicaid funding in a more flexible program to pool for greater purchasing power.
- Builds on State Medicaid programs and other initiatives to cover children. Over 30 States have either State-only or public / private partnerships for coverage of children. Both Republican and Democratic governors have supported these initiatives; this is one of Chiles' and Romer's top issues.
- May reduce pressure on Medicaid for greater flexibility. If States can have more program flexiblity for healthy kids, they may not feel the same need to change the Medicaid program which would remain the source of coverage for kids with special needs.

Disadvantages:

- Likely to have some employer dropping.
- Advocates might feel that it goes back on EPSDT and other Medicaid protections
- If it becomes too flexible, it could do more harm than good by putting current Medicaid kids at risk.