CHIP INFO

THE HENRY J. KAISER FAMILY FOUNDATION

LEGISLATIVE SUMMARY

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

December 1997

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

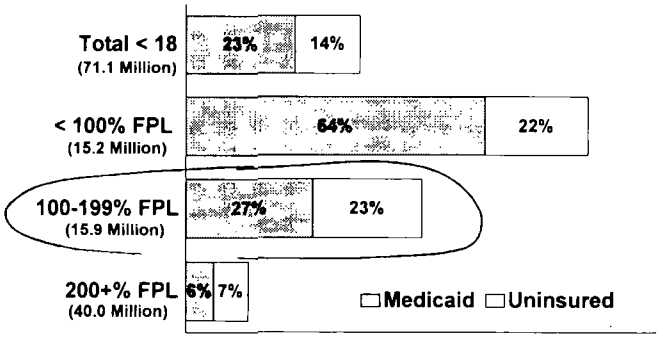
Nearly 10 million children are uninsured, often resulting in difficulties in obtaining needed health care. To expand coverage to low-income uninsured children, Congress enacted the State Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33). This new program allocates $20.3 billion in federal matching funds over five years to states to expand insurance for children. States can use the federal funds to expand coverage either through a separate state program or by broadening their Medicaid programs -- or both.

ELIGIBILITY

The intent of CHIP is to expand health insurance coverage to uninsured children under age 19 in families with incomes below 200% of poverty (Figure 1). Children with private insurance or who are covered by or qualify for Medicaid are ineligible for CHIP, as are those who are residents of public institutions or whose families are eligible for state employee health benefits.

Figure 1

Health Insurance Coverage of Children, by Poverty Level, 1995



Note: Federal Poverty Level (FPL) is $12,158 for a family of three.
Source: Employee Benefits Research Institute, 1996.

Undocumented children and legally resident children arriving in the U.S. after August 22, 1996 are ineligible for coverage but may qualify for emergency Medicaid assistance. States that implement their child health insurance programs through Medicaid may use federal funds to cover legally resident children in the country prior to August 22, 1996.

States that choose to operate a separate state child insurance program can establish eligibility based on geographic area, age, income and resources, residency, and disability status, as well as limit duration of coverage. States cannot exclude children based upon a preexisting condition or diagnosis, and cannot cover higher income children before lower income children.

If states use the Medicaid option, children become entitled to full Medicaid coverage. States that have already broadened Medicaid income eligibility levels above 150% of the federal poverty level (FPL) can expand coverage to children up to 50 percentage points above the current level. For example, a state with eligibility set at 175% FPL could expand to 225% FPL.

BENEFITS AND COST-SHARING

The benefit package options available to states fall into three general categories: Benchmark, benchmark-equivalent, or Medicaid.

- **Benchmark Packages:** States can offer one of three existing benefit packages: including the Federal Employees Blue Cross/Blue Shield PPO plan; coverage available to state employees; or coverage offered by the HMO with the state's largest commercially enrolled population.

- **Benchmark-Equivalent Coverage:** States can use a package with aggregate value greater than or equal to a benchmark plan. Hospital, physician, laboratory and x-ray, and well baby/child services must be included at a value at least actuarially equivalent to the benchmark benefit package. If prescription drugs, mental health, vision, and hearing services are included in the benchmark plan, then they must be part of the benchmark-equivalent coverage with a value of at least 75% of the benchmark plan's actuarial value.

- **Medicaid:** States that expand Medicaid must provide the complete benefit package, which includes well-child care, immunizations, prescription drugs, doctor visits, hospitalization, and EPSDT, as well as long-term care for disabled children. The Medicaid benefit package for children is broad and should satisfy the benchmark requirement in a state that administers a separate CHIP program.

The Secretary has the authority to approve a different benefit package that is determined to be appropriate for low-income children. The existing New York, Florida, and Pennsylvania child health programs are deemed to satisfy federal requirements for benefits.

Under the new CHIP program, states cannot impose cost-sharing for preventive services including well-baby and well-child care and immunizations. For children with family incomes at or below 150% FPL, cost-sharing must be "nominal" as under the Medicaid statute. Medicaid currently permits premiums of $15 to $19 per month per family and co-payments of up to $3 per service.

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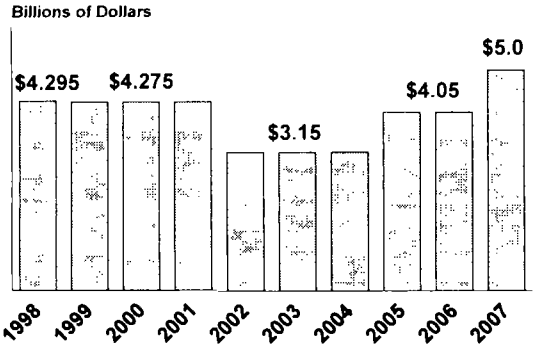
Cost-sharing for children with incomes above 150% FPL can be imposed based on an income-related sliding scale, but total cost sharing cannot exceed 5% of family income. Coverage can be provided directly by the state Medicaid program, an insurer, or any other entity qualified by the state.

FINANCING

The BBA authorizes $20.3 billion in federal funds from FY 1998 through FY 2002 and $19.4 billion over the second five years. Over the ten-year period, the funds are allocated as follows: $4.295 billion in FY 1998, $4.275 billion per year in FY 1999-2001, falling to $3.15 billion annually in FY 2002 through 2004, and then rising to $4.05 billion from FY 2005 through 2006, and reaching $5 billion for 2007, for a total of $40 billion.

Figure 2

Federal Allocations for SCHIP, FY 1998-2007



Source: Federal Register, 1997.

Annual federal allocations to states are based on the states' share of low-income and uninsured children using estimates from the Current Population Survey, conducted by the U.S. Census Bureau. The allotment formula changes over time to adjust for reductions in the number of uninsured children.

States do not receive their allotments automatically. States must have their child health plan approved by HHS and are required to contribute state funds in order to draw down, or "match" their federal allotment. The state share cannot include beneficiary cost-sharing and is subject to the same provider tax and donation limitations specified in the Medicaid statute.

Under the new state program, states receive an "enhanced" federal matching rate based on their Medicaid matching rate. The CHIP enhanced rate essentially reduces by 30 percent the share states pay as compared to what they would contribute under their Medicaid match. For example, a state with a federal match of 60% under Medicaid would receive an "enhanced" rate of 72% under the new program. In essence, the state would pay 28 cents of every dollar spent under the new children's program. No state may receive a matching rate greater than 85% and the minimum annual payment for a state is $2 million.

States can receive an enhanced matching rate for providing Medicaid coverage to an expanded group of children. All Medicaid rules, including the entitlement to coverage, would apply to the newly covered group of children. States would continue to receive the regular Medicaid matching rate after their CHIP allotment was depleted.

While the states have considerable latitude in designing a structuring their CHIP programs, there are some limits on w federal CHIP payments can be used for:

- No more than 10 percent of federal and state spending can be used for outreach, administrative costs or direct service payments to clinics or hospitals. The Secretary can authorize waivers to allow states to create community-based programs or to purchase family coverage.

- If states create a new program, they cannot adopt Medicaid eligibility criteria that are more restrictive than those in effect as of June 1, 1997. If states expand coverage under Medicaid, they must maintaintain eligibility standards in effect as of March 31, 1997.

- Maintenance of effort is also required in state-only programs in New York, Pennsylvania, and Florida.

- Abortions cannot be covered by federal or state funds except to save the life of the mother or in the case of rape or incest.

CHILD-RELATED MEDICAID PROVISIONS

In addition to the creation of the new state child health insurance program, several changes to Medicaid were made to strengthen coverage for children under the Balanced Budget Act of 1997. States can now opt to:

- **Extend presumptive eligibility to children** -- This means that services provided to uninsured children will be covered by Medicaid before eligibility determination is complete. For children who are determined to be eligible for the new program, the costs will be paid through new program funds.

- **Offer 12 month continuous eligibility to children** -- States can choose to provide up to one year of continuous eligibility for children under Medicaid, regardless of any changes in family income during that period.

- **Accelerate the phase-in to cover poor children born before September 30, 1983.** In the past, states could cover these children under Section 1902(r)(2) at state option or through a Section 1115 waiver. The BBA of 1997 clarifies this option. Some 27 states have used these options to expand coverage to older children.

States must also restore Medicaid eligibility to disabled children who lost SSI under the 1996 welfare reform legislation. The Balanced Budget Act also includes numerous provisions that grant states increased flexibility over their Medicaid programs. These include the ability to mandate managed care enrollment without a waiver, greater control over provider payment through the repeal the Boren Amendment, and a phase-out of cost-based reimbursement for Federally Qualified Health Centers.

The Balanced Budget Act (BBA) of 1997 creates new options for states to strengthen and expand Medicaid coverage for children. The new State Children's Health Insurance Program (CHIP) was enacted as part of the Balanced Budget Act (BBA) of 1997. This new capped federal program allocates $20.3 billion over five years in the form of a matched grant to states to expand coverage to uninsured low-income children through either a separate state program or by broadening Medicaid -- or both. The funds became available on October 1, 1997 and are targeted to uninsured children under 19 with income below 200% of poverty who are not eligible for Medicaid or not covered by private insurance.

Provisions of the Balance Budget Act also included some important changes to Medicaid. It clarifies the state Medicaid option to accelerate the phase-in for children born before September 30, 1983. In addition, the new law gives states the option to extend presumptive eligibility to children, meaning that services provided to low-income uninsured children will be covered by Medicaid before the Medicaid eligibility determination process is complete. States can also offer 12 month continuous eligibility to children, regardless of any changes in family income during that period.

SERVICES AND COSTS

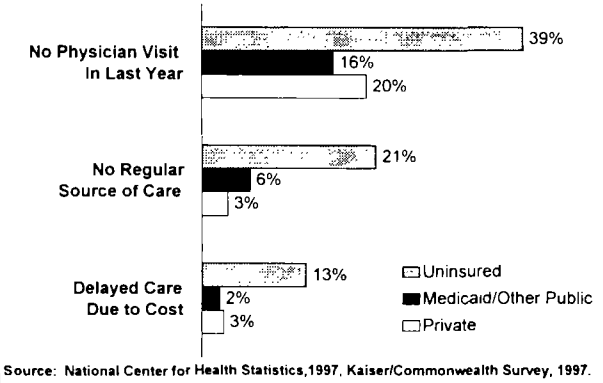
Federal guidelines require that Medicaid cover a comprehensive set of services with nominal or no cost-sharing for children. Access to these services is important because poor children experience more health problems than more affluent children. Children with Medicaid are eligible to receive physician and outpatient services, prescription drugs, inpatient hospital care, and long-term care services.

Medicaid coverage also entitles children to early and periodic screening, diagnostic, and treatment (EPSDT) services including a comprehensive health and developmental history and physical exam, immunizations, laboratory tests including blood lead levels, and health education. Children found to have conditions requiring further attention are covered for needed treatment.

The importance of health insurance in securing access to health care services is well documented. Despite their complex health and social needs, children with Medicaid coverage have access to care that is similar to higher income privately insured children (Figure 3).

Figure 3

Access to Care for Children by Insurance Status, 1993



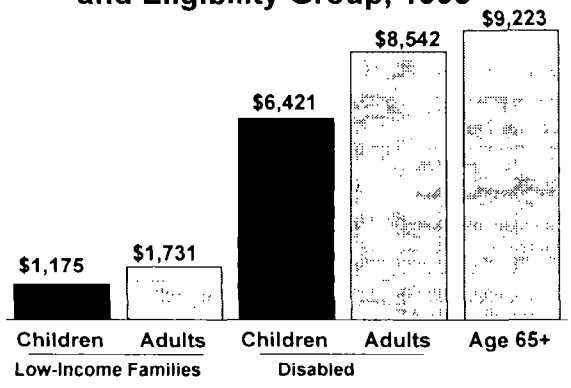
Source: National Center for Health Statistics,1997, Kaiser/Commonwealth Survey, 1997.

In 1995, Medicaid spent $25.4 billion on health care services for 17.5 million children in low-income families and about $7.1 billion for one million disabled children. The majority (93%) of the expenditures for non-disabled children are for acute care services, with one third for inpatient hospital care.

While low-income children represent half of the 35 million Medicaid beneficiaries, they account for only 16.7% of overall Medicaid spending. In 1995, Medicaid spent an average of $1,175 per low-income child enrolled in the program. On average, children cost less to care for than older Medicaid beneficiaries, but some disabled children have very costly health and long-term care needs. Medicaid spent an average of $6,421 per year per child qualifying on the basis of disability (Figure 4).

Figure 4

Medicaid Spending Per Enrollee By Age and Eligibility Group, 1995



SOURCE: The Kaiser Commission on the Future of Medicaid, 1997.

ISSUES AND CHALLENGES

Expanding Coverage. To broaden coverage of low-income uninsured children, Congress enacted the new State Child Health Insurance Program and included provisions to allow states to facilitate enrollment and continuity of coverage under Medicaid. Key issues facing state Medicaid agencies include how the new children's program will be structured, financed, and implemented, as well as how it will be integrated with or build on the state's existing Medicaid program.

Participation. An estimated 3 million of the 9.8 million uninsured children are eligible for but not enrolled in Medicaid. This is largely due to enrollment barriers or lack of awareness of the program. States can streamline the eligibility process and facilitate enrollment. For example, 25 states allow mail-in eligibility applications and 29 states have dropped the asset test. Medicaid eligibility policy has also changed markedly as a result of the 1996 welfare law, which eliminated the automatic link between cash assistance and Medicaid. Ongoing and intensified outreach and educational efforts will be necessary to assure that all the children who are eligible for assistance under Medicaid are enrolled.

Managed Care. In 1996, 40% of beneficiaries were enrolled in managed care, mostly low-income children and their parents. The BBA of 1997 expands state flexibility by allowing states to mandate Medicaid managed care enrollment without requiring states to obtain a Section 1115 or 1915(b) waiver. States will still need a waiver to mandatorily enroll special needs children, but will be able to enroll other non-disabled children. Managed care has the potential to improve access to preventive and primary care, but given the vulnerable nature of the Medicaid population, it requires careful implementation and monitoring to assure quality and access.

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID FACTS

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

November 1997

MEDICAID'S ROLE FOR CHILDREN

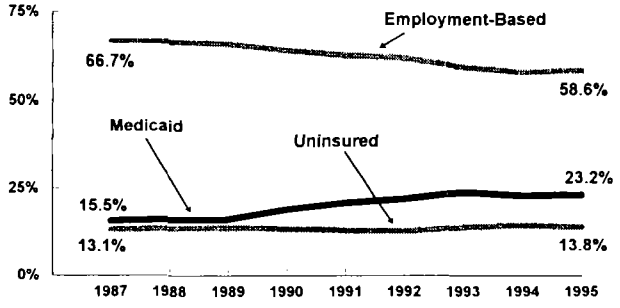
1/4 of all children.

In 1995, 17.5 million children – one-quarter of all children under age 18 -- had Medicaid coverage for health care services. Medicaid, the federal/state health program for the poor, pays for a broad range of services for children including well-child care, immunizations, prescription drugs, doctor visits, and hospitalization, and a range of long-term care services for children with disabilities.

Medicaid plays a particularly strong role for low-income children, covering two-thirds (64%) of all poor children and a quarter(27%) of children with incomes between 100% and 199% of the federal poverty level (FPL). While employer-based insurance coverage of children declined from 1987 to 1995, expansions in Medicaid have resulted in greater coverage of children in low-income families (Figure 1). During this same period, Medicaid enrollment grew from about 10 million -- 15.5% of all children -- to 17.5 million children (23.2%).

Figure 1

Trends in Coverage for Children, 1987-1995



Note: Children under age 18
SOURCE: Employee Benefit Research Institute, 1997.

Despite the importance of Medicaid today, about 10 million children are uninsured. Lack of insurance is particularly high among low-income children. Seventy percent of uninsured children are in families with incomes below 200% of poverty. The new State Child Health Insurance Program, enacted as part of the Balanced Budget Act of 1997, is intended to provide coverage to this group.

ELIGIBILITY

Being poor does not automatically qualify a child for Medicaid. In the past 15 years, Medicaid eligibility for children has been broadened considerably through federal legislation and state optional expansions. Prior to 1986, Medicaid primarily served children who received AFDC cash assistance. Today, children qualify for Medicaid based on their age and income.

Medicaid coverage is especially prominent among young children, covering 33% of infants and 29% of children ages 1 to 5. Because recent expansions focused on young children, older children are less likely to qualify for Medicaid. Medicaid covers 22% of children between the ages of 6 to 12 years and 17% of teens between the ages of 13 to 18 years.

Medicaid Coverage of Children:

States are mandated to cover certain groups of children based on age and income criteria. By 2002, all states will be required to have phased-in coverage of children under age 19 with incomes below poverty. States can choose to expand Medicaid eligibility beyond federal minimum standards by raising age and income levels for children (Figure 2). They can also use Section 1115 research and demonstration waivers to broaden eligibility. In total, 41 states have expanded Medicaid coverage to children in one or more age or income levels. Federal coverage requirements for children are as follows:

Up to age 6 with family incomes up to 133% FPL. For infants, 35 states have chosen to expand coverage beyond 133% FPL and 13 have expanded for children age one to six.

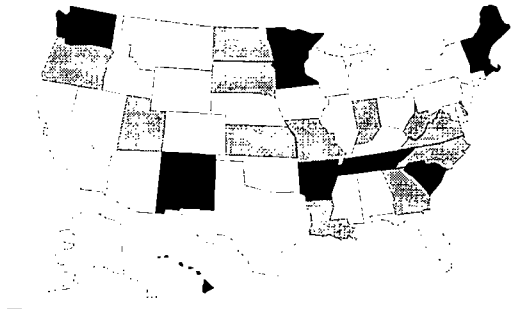
Age 6 to 14 with family incomes below 100% FPL. Fifteen states have opted to expand eligibility beyond 100% FPL.

Age 15 to 19 if family income meets the AFDC criteria of August 1996 (state average is 41% of FPL) with coverage phased-in for poor children born before 9/30/83. 25 states have opted to accelerate this phase-in to cover older children up to age 18 with income below 100% FPL (Figure 2).

Children with disabilities also qualify for Medicaid assistance on the basis of SSI eligibility. Medicaid covers about 1 million additional children with physical or mental disabilities.

Figure 2

States Opting to Accelerate Coverage of Poor Children, 1997



SOURCE: National Governors' Association, 1997

Because states established varied Medicaid income eligibility levels for children, and because of state variations in per capita income there is considerable variation in Medicaid coverage, ranging from 13% of children in Colorado to 47% in West Virginia. Similarly, Medicaid pays for 39% of all births nationally, but coverage varies from 21% of births in Massachusetts to 61% in Georgia.

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NATIONAL ACADEMY
for STATE HEALTH POLICY

Charting CHIP:

Report of the First National Survey of the
Children's Health Insurance Program

Executive Summary

On August 7, 1997, President Clinton signed the Balanced Budget of Act of 1997, creating the state Children's Health Insurance Program (CHIP). Designed to provide increased access to health coverage for children in families with incomes too high to qualify for Medicaid but too low to afford private family coverage, the CHIP program will provide billions of dollars in matching funds to states over the next 10 years. In doing so, it has the potential to expand health insurance coverage to millions of America's low-income children.

Within a year of CHIP's creation, nearly every state had submitted a plan to the Health Care Financing Administration, detailing how it intended to implement CHIP and requesting approval from the Health Care Financing Administration (HCFA) for its plan. However, CHIP is a "work in progress," and it is anticipated that amendments to state plans will change the scope of the program overtime.

In an effort to chart the first year of CHIP activity, to establish a baseline for further study of the CHIP programs, and to share information among states, the National Academy for State Health Policy conducted during the summer of 1998 a detailed survey of CHIP activity in each state. The results of that survey are summarized here and detailed in the accompanying report as well as in state-by-state comparisons of each CHIP program.

This report offers a baseline of information about the new CHIP program. It provides an initial analysis of who is being served by CHIP, how they learn of the program and become enrolled, and what services they receive. In addition, the survey results provide an in-depth look at how states have structured their CHIP programs, how they are working to assure access and quality, and how they will conduct ongoing evaluations of their programs. It is important to remember, however, that much of the information contained here is preliminary. Only half of the 46 state plans included in this report had received HCFA approval at the time the surveys were conducted in June and July of 1998; only 24 had actually been implemented and were enrolling children.

Nonetheless, the enormous data and detail contained here reveal some larger truths: CHIP has presented a tremendous opportunity and a daunting challenge to states as they have sought—with limited administrative funds and time—to design and implement the largest public health care expansion program in decades. That they have tackled this work with energy and creativity and the desire to develop programs that address the unique needs and realities of their individual

states is evident in the tremendous variety of program designs that have been submitted to HCFA.

Clearly, much work remains to be done: CHIP is in its developmental stages. Now that states have designed their programs and begun to enroll children, they must turn greater attention to such issues as access, quality, and evaluation.

Key findings

Within 12 months of CHIP's enactment, 46 states (a number that includes the District of Columbia, but not Alaska, Hawaii, Vermont, Washington, or Wyoming) had submitted CHIP plans to HCFA for the agency's approval. Twenty-three had opted to expand their Medicaid program to cover additional children; 13 had chosen to create a stand-alone, state-designed CHIP program; and 10 had designed programs that combined both options.

- CHIP is not a homogeneous program but a funding source supporting to date 56 different programs in 46 states. The ten states with combination programs have, in effect, two CHIP programs within their state. Consequently, this report examines 56 CHIP programs in 46 states: 33 Medicaid CHIP expansions and 23 state-designed CHIP programs.

All but three states reported using managed care to deliver services to some or all of their CHIP population. Alabama, North Carolina, and West Virginia use only fee-for-service programs to serve CHIP beneficiaries. However, Alabama has a combination program and reported that it would use risk in its Medicaid CHIP expansion program but not in its state-designed program.

Thirteen of the 46 states with CHIP plans reported enrolling a total of 433,916 children by the summer of 1998. By December of 1998, HCFA reported more than a doubling of this number with nearly a million new enrollees.

States are using CHIP to ensure that all children within a low-income family are eligible for insurance coverage regardless of their age, eliminating the different age group eligibility levels that are a part of Medicaid

- How states plan to determine a child's eligibility for CHIP is one good indicator of the diversity of approaches states are taking in designing their programs and the complexity of the task before them. The seemingly simple tasks of deciding what counts as income and who may be counted as a family member for purposes of eligibility have resulted in a broad array of eligibility policies in the states.
- States are also working to ensure continuity of care: 70 percent of state-designed CHIP programs and 30 percent of Medicaid CHIP expansions offer either 6 or 12 months of continuous eligibility.
- While CHIP has helped ensure that all low-income children are eligible for coverage, states vary on whether or not children in the same family will be covered in the same program.

To minimize crowd-out, the majority of states use a waiting period to ensure that children with previous coverage have been uninsured for a period of time before enrolling in CHIP; however, most allow exemptions from these waiting periods for various reasons.

Cost-sharing is also an area of wide diversity and experimentation in CHIP programs, reflecting different state policy goals.

- 87 percent of state-designed CHIP programs require some amount of cost-sharing.
- The majority of states allow a grace period before disenrolling for failure to pay cost-sharing.
- More than one-third of the states that require cost-sharing have adopted a "shoe box" system for tracking a family's expenses. Families are instructed to save all receipts for medical care and to notify the appropriate party when receipts total 5 percent of family income.

States are working to link and coordinate their CHIP and Medicaid programs. This is most evident in efforts to ensure that eligible children are identified and enrolled in the appropriate program. Those efforts include joint applications and coordinated eligibility review processes for CHIP and Medicaid.

- Other linkages are also being forged. Nearly a quarter of all state-designed CHIP programs require participating providers and plans to serve both CHIP and Medicaid enrollees.
- 56 percent of state-designed CHIP programs are administered by the same agency as the Medicaid program.

States are laying the foundation to develop quality oversight–but have not yet achieved it for state-designed programs–by requiring significant and appropriate data collection.

For more information on *Charting CHIP: Report of the First National Survey of the Children's Health Insurance Program* or to order a copy of the full report ($70 for government/nonprofit, $125 for all others), please contact:

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Charting CHIP: Report of the First National Survey of the Children's Health Insurance Program was written by Cynthia Pernice, Trish Riley, Helen Pelletier, and Neva Kaye and was funded by The David and Lucile Packard Foundation.

Proposal for the Allocation of Florida's Children's Health Insurance (Title XXI) and Tobacco Settlement Funds

from the

Florida Conference of Black State Legislators

in collaboration with

The Florida Statutory Teaching Hospitals

The University of Florida, Health Sciences Center

The University of South Florida, College of Medicine

Florida A & M University, School of Public Health

Consultants:

Florida Department of Health

Agency for Health Care Administration

Children's Medical Services

10/23/97 DRAFT

Summary

The health of Florida's children is primary to the social and economic stability of Florida's communities and, hence, to Florida's future. Yet too many of Florida's children remain without health insurance or access to basic medical services. Moreover, most of the children are at risk of developing one or more health behaviors that contribute to preventable disease and mortality, such as tobacco use, yet few programs exist to reduce these risks and improve the health of Florida's children.

This proposal highlights the medical and behavioral health problems confronted by children in the state, including barriers to existing health insurance programs, and proposes concrete solutions to the problem of uninsurance among Florida's children as well as the medical risks associated with tobacco use and exposure.

Expanding Children's Health Insurance: *Children First*

A new and comprehensive health insurance program is proposed, *Children First*, that will incorporate currently existing programs (e.g., Medicaid, Healthy Kids, etc.) into one program for which children between the ages of 0 and 19 will be eligible for health coverage. This program will be funded by Title IXX and XXI funds and will include participation by traditional Medicaid and Healthy Kid providers, as well as other insurance products and provider networks. The purpose of the program is to ensure access to both health insurance and health care providers at a low cost to all working families. The program would provide comprehensive benefits to all eligible children, regardless of the ultimate funding or insurance source. Moreover, it would improve the integration of health care providers across regions of the state to fill gaps in services.

Tobacco Settlement Programs

Florida's tobacco settlement comes at an ideal time to provide targeted outreach and media attention, as well as focused medical interventions to prevent tobacco use among children and to reduce the negative health effects of tobacco use by children and adults. This proposal outlines three major initiatives to ameliorate the effects of tobacco on Florida's population: Community Collaborative Grants, Multi-year Health Programs, and Multi-Year Programs to expand medical outreach via telemedicine and to evaluate the impact of the tobacco and child health insurance programs on the health of children in Florida.

Through the multi-year health programs, grants will be awarded, via a competetive bidding process, in three areas: 1) smoking cessation ($10 million); 2) children and

adolescent substance abuse ($10 million); and 3) programs to underserved populations ($10 million). The smoking cessation projects should provide community and subpopulation-specific interventions, that have been tested and evaluated, to help youth and their families who use tobacco to stop. The children and adolescence substance abuse services grants will target effective multi-substance abuse prevention programs, especially those that include strong mental health and behavioral health components. The grants for underserved communities should deliver needed medical services for minority communities as well as medically-complex children and their families.

The Community Collaborative Grants will also be allocated via a competitive bidding process, but targets community-based groups and agencies that have a history of community service and that develop collaborative projects with other groups or agencies in their communities. These grants will target three areas of interest: 1) Asthma prevention and management for youth ($33 million); 2) Diabetes screening and management for youth ($33 million); and 3) Outreach and media campaigns targeting tobacco use prevention and cessation ($33 million).

The Multi-year programs to expand medical outreach and outcomes assessment are focused in two primary areas. First, to aid in the delivery of needed medical services and health education in remote communities in Florida, a pilot telemedicine project will be funded ($8 million) to bridge communities and medical centers. To evaluate the impact of the children's health insurance expansions and tobacco intervention programs, a consortium of health outcomes researcher will be funded 5 years ($20 million).

Mission Statement

To improve the health of Florida's children, especially minority children who are at greatest risk of preventable disease and morbidity, by closing gaps in the health insurance safety net, by developing programs that target diseases which disproportionately affect minorities, and by providing targeted health programs that will both reduce the number of children who use tobacco and reduce the morbidity of children currently affected by tobacco.

Values

- Maximize the number of children covered by health insurance
- Cover all poor families under 200% of the federal poverty line
- Create seamless system of insurance enrollment
- Provide continuous coverage for at least 1 year
- Provide easy access to enrollment for working families (e.g., after-hours, mail-in)
- Offer services to WAGES participants as early as possible
- Assure coverage and services to all children, especially (minority) disadvantaged children
- Assure family choice in health care providers and support the development of provider-family relationships
- Improve the health of Florida's children through the delivery of health prevention, education and primary care services
- Institute cost-effective means of improving population health (i.e., insurance, school-based health education)
- Involve local agencies and providers in service delivery planning
- Evaluate the impact of expanded health insurance and prevention on short- and long-term health outcomes
- Implement minority-focused health programs

Background: Child Health and Tobacco-Related Health Problems

In 1998, more than 823,000 of Florida's children are projected to be uninsured. This absence of health insurance leads to insufficient preventative health care for children, incomplete childhood immunizations and screening, and the inappropriate use of hospital emergency rooms as a source of primary care services. Indeed, otitis media (ear infection) is one of the most common child problems presented at emergency rooms.

National studies show that children with no health insurance are 6 times as likely to go without medical care than those with private insurance, and uninsured children are more likely to have at least one unmet health need than insured children (25% vs. 8%; National Health Survey, 1997). And the absence of health insurance and a regular source of care does not just affect the poorest of the poor. Of children with unmet health care needs, 28% came from families with income of $20,000-35,000, and 21 percent came from families with incomes above $35,000 – a total of 49% of all those with unmet needs!

Furthermore, the implementation of welfare reform in Florida in 1996 has moved many poor Floridians into the workplace, but many of the jobs secured by this population do not provide health insurance, nor do they pay sufficient to allow a family to purchase private insurance. Moreover, work demands have limited the ability of families who may be eligible to apply or recertify for Medicaid. Consequently, the proportion of working poor persons who have access to or income for health insurance is only anticipated to decrease in coming years. And as adult and family coverage declines, so does children's coverage, leading to a less healthy foundation for the future of Florida.

The Minority Communities of Blacks and Hispanics

While the overall rates of uninsurance in Florida are disturbing, the absence of health insurance for minority groups is even more significant. The minority communities of Black and Hispanic Floridians are particularly disadvantaged in terms of health insurance and access to health care. Black and Hispanic children are significantly more likely to be uninsured and without a regular source of care than are white children. This insurance disadvantage, compounded by income inequities, have led to greater disease among Black and Hispanic children than among white children.

Smoking rates among Hispanic youth are or great concern, as 19.4 percent of Hispanics ages 12-17 smoked cigarettes in the preceding year. This was less than the 25.9% of whites in the same age group but considerably more than the rate of 9.8% for African American Adolescents.

Tobacco related problems are at epidemic levels in this country. Cancer rates are soaring. Several studies have documented a rising lung cancer rate among Hispanic males. For example, the Colorado Tumor Registry reported a 132% increase in lung cancer rates among Hispanic men between 1970 and 1980, compared to a 12-percent increase among white men.

These communities need special attention and targeted interventions to help raise the levels of health insurance coverage to those at least equal with White Floridians and to improve the appropriate delivery of care to these communities.

Diseases of Special Concern

Health insurance provides individuals and families and opportunity to access standard private and public health care services for primary preventative and acute health services. However, many insurance plans or health programs (e.g., Medicaid) are not designed to deliver services targeted to help children and their families avert health problems for which they may be at particular risk. For example, diabetes and asthma are two major health conditions that can be prevented in some cases and may be controlled to a great extent through targeted family interventions and education. However, outside of the office or hospitalization for an acute episode, health care providers do not have sufficient resources or incentives to provide adequate family follow-up or behavior management education. Consequently, many children remain at risk of life-threatening episodes of these diseases due to inadequate medication control, poor diet or exposure to second-hand smoke, for example, which could have been affected by targeted family education programs.

To reduce the risks of preventable disease and avoidable hospitalizations, regional and local projects are needed across the State to implement and test interventions targeted at major childhood diseases. A selected set of these diseases, many of which are the most deadly and/or the most costly to the state in terms of health care costs and human resource loss, are identified and described briefly below to provide background for the proposed child health insurance and tobacco settlement plan

Diabetes

There is an epidemic of non-Type 1 diabetes among youth in the Black and other minority communities which is known to be related to obesity and inactivity. The Florida regional program for children and youth with diabetes has observed a phenomenal increase in non-type 1 diabetes in minority children.

Tobacco is a major risk factor for secondary complications of diabetes, which includes kidney, cardiovascular and eye disease. Preventing tobacco use helps prevent diabetes complications later in life.

A significantly larger proportion of the non-white population die of diabetes than the white population. Approximately 32 per 100,000 non-white women compared to approximately 22 per 100,000 white females (Florida Vital Statistics Annual Report, 1995), and the death rate has increased over the past decade.

While Florida has been a pioneer in treating diabetes, many more programs are needed across the state, especially those that do community outreach in the schools and communities. Behavioral health programs, including weight control and exercise regimens are needed for youth. Screening for non-type 1 diabetes is also needed

Asthma

The prevalence of asthma among youth is growing, with children under age 15 accounting for more hospitalizations than all other age groups. In 1990, $3.6 billion was spent on medical care for asthmatics nationally. 56% of this was for hospital care – most of which could have been prevented by improved disease management.

Environmental pollutants, including second-hand tobacco smoke, are known to contribute significantly to the incidence and course of childhood asthma. One study has shown that as much as 34 percent of asthma is attributed to maternal smoking. Significant public education about the contributions of tobacco use to asthma among children is needed, as is programs to help parents manage their children's asthma.

AIDS

One person is diagnosed with AIDS in Florida every hour. Florida ranks third among the states in the number of reported AIDS cases, with 59,125 cases reported through December 1996. The minority communities have been disproportionately affected by AIDS. Blacks and Hispanics in Florida comprise 58% of adult AIDS cases and 89% of pediatric AIDS cases. The most recently available data show that of the 1639 cases of pediatric aids in Florida, 63% are children under the age of 5, 14% are between the ages of 5 and 12, and 22 percent are aged 13-19 (Department of Health, September, 1997).

The Impact of Tobacco on Florida's Youth

Tobacco use and its affects have been particularly harmful to Florida's minority children. Although African-American children and adults use tobacco at lower rates than whites, the morbidity and mortality associated with tobacco use is significantly greater among blacks.

Smoking rates among Hispanic youth are or great concern, as 19.4 percent of Hispanics ages 12-17 smoked cigarettes in the preceding year. This was less than the 25.9% of whites in the same age group but considerably more than the rate of 9.8% for African American Adolescents.

Tobacco related problems are at epidemic levels in this country. Cancer rates are soaring. Several studies have documented a rising lung cancer rate among Hispanic males. For example, the Colorado Tumor Registry reported a 132% increase in lung cancer rates among Hispanic men between 1970 and 1980, compared to a 12-percent increase among white men.

The Plan for Child Health Insurance Expansions in Florida

I. Outreach and Enrollment

Objective: ***Florida's child health program will be seamless to and family-friendly; the program, including Medicaid, will be renamed to generate greater acceptance by the public; funding sources will be "transparent" to families.***

Discussion

Although slightly more than one-half of Florida's 1.5 million Medicaid patients are children, nearly 294,000 uninsured Florida children are eligible for, but not enrolled in the current Medicaid program. Families choose not to enroll in Medicaid for many reasons. For example, families have reported the following types of problems:

- difficulty enrolling in the program;
- lack of information about the program;
- the stigma associated with Medicaid and government assistance ("welfare");
- the enrollment process can be burdensome, particularly the extensive requirements for income verification;
- families who cycle on and off Medicaid for categorical reasons may get "lost" in the system;
- lack of transportation to enrollment sites; and
- inconvenient hours of operation at enrollment sites.

Several states have taken steps to address these problems. For example, some states have rolled all of their child health programs, including Medicaid, into a single program with a new name to remove the stigma associated with the Medicaid program. Delaware, for instance, calls its program the Diamond State Health Plan. South Carolina not only renamed its program, but also created a user-friendly, simplified eligibility form that serves as the required documentation for all of its child health programs.

The following example, while not intended to be prescriptive, describes some of the elements of a simplified outreach and enrollment process.

Figure 1 — Simplified Child Health Plan Outreach and Enrollment Process

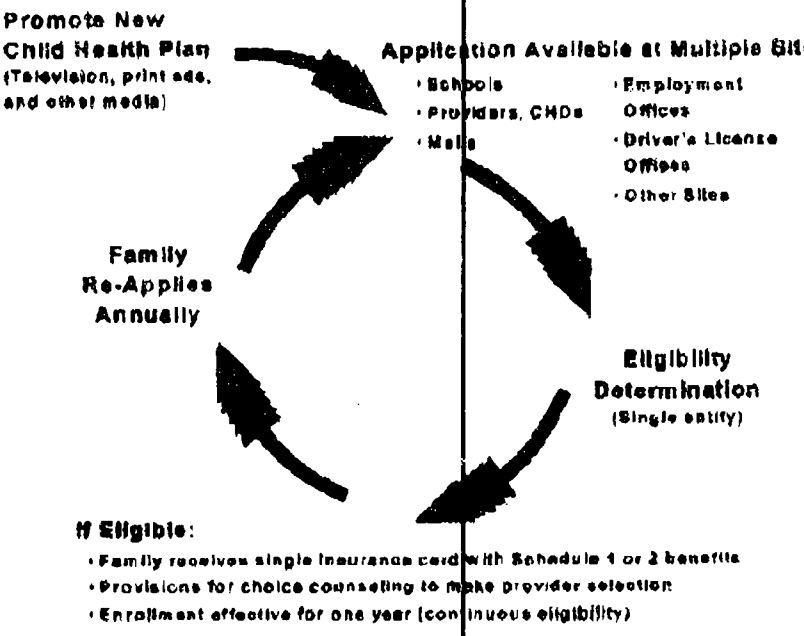


Figure 2 — Simplified Eligibility Determination

Figure 2: "Children First" Health Plan

Eligibility and Benefits

Eligibility	Eligibility
0-6 200% FPL*	6-19 100-200% FPL
6-19 100% FPL	Benefits
Benefits	• Schedule 2 Providers
• Schedule 1 (Traditional Medicaid Benefits)	• Florida Healthy Kids
Providers	• Direct Contractors/Service Networks
• HMOs or Medipass (choice counseling)	• Schedule 1 Providers
• CMS Network for children with special health care needs	• Insurers
	• Others

* FPL-Federal Poverty Level

Proposals

- Identify a single entity to be responsible for administering all aspects of Florida's new child health program, including eligibility determination.
- Require the Departments of Health, Children and Families, and the Agency for Health Care Administration, in conjunction with families and other affected parties, to develop a single simplified eligibility form that will serve as the required documentation for all programs included in Florida's new child health plan.
- Require these entities to work together to create a new umbrella name for Florida's child health plan that includes the traditional Medicaid program, as well as other programs financed with Title XIX or Title XXI funds
- Require these agencies to ensure that applicants are enrolling in Florida's new child health plan, and that the enrollment process is kept separate from the financing source (e.g., children enroll in the "child health plan," not in "Medicaid" — Title XIX is the financing source, not the program).
- Require these entities, working with community organizations, families and advocacy groups, to develop specialized outreach initiatives targeted to specific populations (e.g., young children, school age children, teenagers, parents/caregivers).
- Ensure that outreach activities involve community organizations and include a variety of sites (e.g., health care provider offices, schools, churches, WAGES/employment offices, malls, driver's license bureaus). Involve community-based workers in outreach efforts.
- Require providers to accept Medicaid and Medicare.

Fiscal Note

Costs indeterminate. However, Title XXI allows a state to use a percentage of its federal funds for outreach and administration.

Eligibility

Objective: ***Florida will establish uniform child health eligibility standards targeted to ensuring that the maximum number of low-income children have access to health care coverage under the new child health plan.***

Discussion

Title XXI of the federal Balanced Budget Act of 1997 creates a new child health insurance program. This new program presents unprecedented opportunities not only to expand eligibility to more groups of uninsured, low-income children, but also to retool Florida's child health programs into a seamless, family-friendly system.

Medicaid

Eligibility for Florida's major child health program for families with low incomes — Medicaid — is governed by numerous categorical requirements. Currently, Medicaid eligibility ranges from 185 percent of the federal poverty level for infants to a dramatic decline of only 28 percent of poverty for children over age 14. By law, states must increase eligibility to 100 percent of poverty for children born after September 30, 1983, to age 19.

Current Medicaid Child Eligibility Coverages		
Age	Poverty Level	Annual Income for Family of Four
0 up to 1	185% FPL	$29,693
1 through 5	133% FPL	$21,347
6 through 14	100% FPL	$16,050
15 up to 19	28% FPL	$ 4,494

Coverage of Children Up to Age 19. States have the option to cover children born after September 30, 1983, with family incomes below 100 percent of poverty up to age 19 through the regular Medicaid program at the enhanced federal match rate. For Florida, the Title XXI enhanced match rate is about 69 percent federal and 31 percent state. The major advantage of exercising this option is that it removes the historic inequity in the Medicaid program between low-income children based on their age. It would allow Florida to cover the estimated 55,000 uninsured children between the ages of 15 and 19 who would not otherwise be eligible for Medicaid benefits.

The total cost of implementing the 15 to 19 coverage provision would decline from a high in FY 1998-99 of $22.3 million ($6.9 million state/$15.4 million federal) to only $284,000 in FY 2002-03 ($89,000 state/$195,000 federal).

Presumptive Eligibility. Presumptive eligibility, in which an applicant is deemed to be covered by Medicaid while the application is being processed, currently is only available to pregnant women and infants. Presumptive eligibility for all children who apply for health benefits means that providers who treat these patients during the application processing period would be paid for those services even if the applicant is ultimately determined to be ineligible for benefits.

Continuous Eligibility. Florida Medicaid does not offer continuous eligibility for its patients. Continuous eligibility (also called guaranteed eligibility or 12-month eligibility) means that once an applicant is deemed eligible for Medicaid benefits, he or she does not have to lose coverage even if the family's income changes. The lack of continuous eligibility contributes to the cyclical nature of Medicaid, in which an individual may be eligible for benefits for a few months and then become ineligible if the family's income changes. If the family's income falls low enough to again qualify for benefits, the family must reapply. This cycle of going on and off Medicaid has a negative impact on continuity of care, increases the probability that an eligible family may not reapply for benefits, and increases the risk that individuals will not receive vital preventive health care services.

Florida Healthy Kids

Eligibility for another major child health program, Florida Healthy Kids, is based on qualifying for the federal free and reduced school lunch program. Florida Healthy Kids currently operates projects in 19 counties and six additional counties are in the planning stages. Florida Healthy Kids provides subsidized health insurance coverage for about 39,000 children.

Counties that choose to initiate a Healthy Kids project must contribute a local match. Match rates currently range from five percent in the first year to 20 percent by the fifth year, with a longer phase-in for rural counties. The matching requirement has created participation barriers for a number of counties that lack sufficient local resources to "buy into" the program, particularly rural counties. Some counties that already participate have indicated that the financial burden of the local match may be too much for them to continue their programs.

Figure 3 — Current Eligibility for Medicaid and Florida Healthy Kids

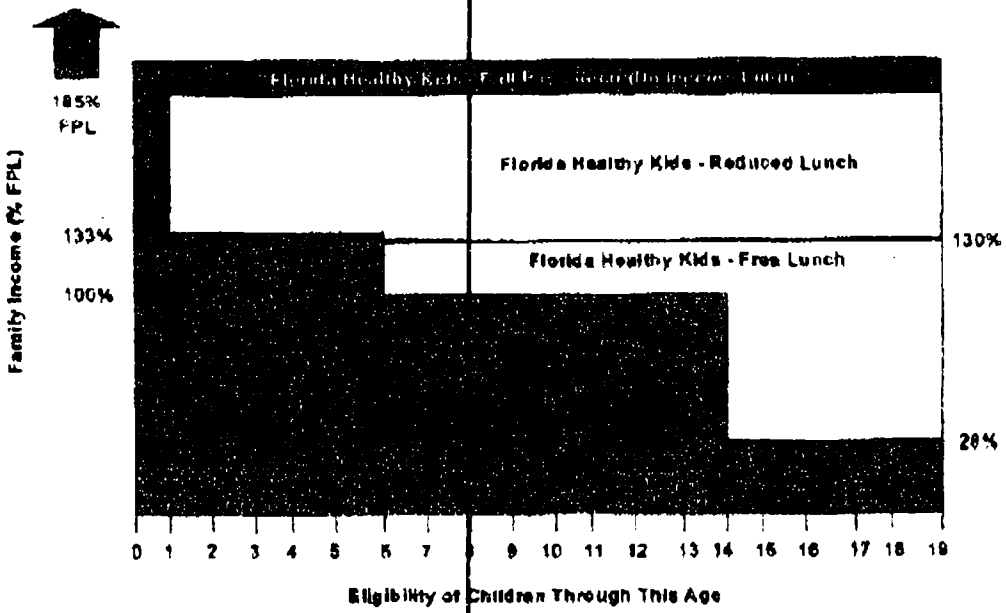
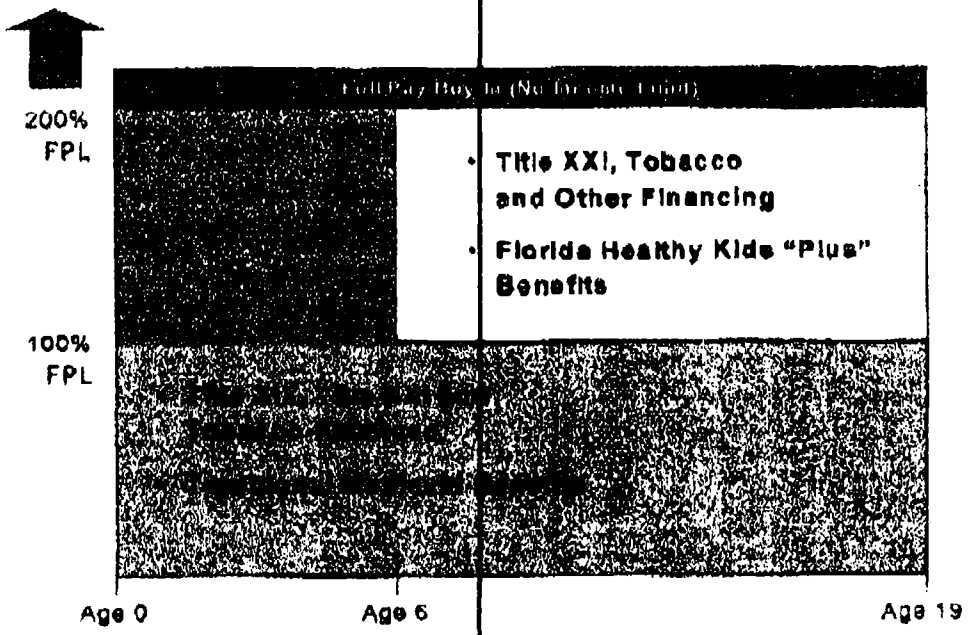


Figure 4 — Proposed Eligibility for Florida's New Child Health Plan



Proposals

- Increase eligibility for the traditional Medicaid program to 200 percent of the federal poverty level without asset tests for all children up to age 6.
- Increase eligibility for the traditional Medicaid program to 100% of the federal poverty level without asset tests for all children ages 15 to 19
- Set eligibility for other child health programs financed with Title XXI funds (e.g., Florida Healthy Kids) at 200% of the federal poverty level without asset tests for children ages 6 to 19.
- Require all programs in Florida's new child health plan to implement 60 days of presumptive eligibility for children who apply for coverage.
- Institute 12-month continuous eligibility for all children who apply for any of Florida's new child health plan services
- Direct Florida Healthy Kids to modify, reduce or eliminate the local match requirements for counties based on factors such as, but not limited to, the percentage of people in poverty, per capita income, and the level of the county's tax base in order to increase participation levels.

Fiscal Note

Estimated Cost of Eligibility Proposals (in millions)						
Issue	FY 1997-98 (January 1 implementation)			FY 1998-99		
	Total	Federal	State	Total	Federal	State
Increase Medicaid eligibility to 200% FPL (0 to 6)	$5.9	$4.1	$1.8	$36.3	$25.0	$11.3
Expand Medicaid to 100% FPL (15 to 19)	$3.4	$2.3	$1.1	$22.3	$15.4	$6.9
*Expand Florida Healthy Kids Eligibility to 200% FPL (6 to 19)	$48.0	$33.0	$15.0	$117.8	$81.2	$36.6
Institute 12-month continuous eligibility (0 to 19)	$38.3	$21.4	$16.9	$76.6	$42.7	$33.9
Implement 60 days of presumptive eligibility for all children	Minimal fiscal impact anticipated assuming that the majority of presumptively eligible children will, in fact, be eligible for Title XIX or Title XXI services after the eligibility determination is complete.					
Modify/reduce Florida Healthy Kids local match for counties	Indeterminate. Cost depends on the amount and number of counties not participating in local match					
Source: Agency for Health Care Administration, Medicaid Program.						

*Assumes current Florida Healthy Kids benefit package.

Service Delivery Networks

Objective: ***Create Service Delivery Networks to improve health service availability; expand health care access at reduced costs by direct contracting with Academic Health Centers and Community Health Centers to provide targeted services.***

Discussion

Keeping our children and their families healthy requires more than just health insurance or financial access to health care. Rather, this goal is more effectively achieved through the development of integrated service delivery networks (Pediatric Network or PEDS-NET) which provide the full gamut of health needs for our children and their families. A PEDS-NET is composed of one or more plans and one or more groups of providers that not only address the acute health needs of children, but also emphasize prevention, disease management, care coordination, and case management.

Proposal

Multiple PEDS-NET's will be needed to reach all of Florida's children. Licensed indemnity plans, HMO's, PPO's, CMS, and other traditional providers will be eligible to form these networks. Networks must be able to provide timely convenient access to age appropriate primary care providers and specialists. In many instances elements of several networks will develop agreements with highly specialized centers to provide tertiary care.

Similarly primary care networks may work with CMS and the emerging CMS network to integrate the children with special needs into the delivery system. CMS has a long history of developing standards and providing access to specialty care for children with special needs. CMS may provide both primary and specialty care for groups of children through existing primary care programs and the CMS network. Alternatively CMS may function as providing wrap around coverage and services for children and families with special needs in a manner which compliments the PEDS-NET which provides for the more routine care of its members.

Recognizing the unique position of the teaching hospitals/programs and the public health units, options for direct contracting will be available. This option will allow these institution the opportunity to form PEDS-NET's which continue to serve the high risk populations as they have done for so many years. Direct contracting will also allow the teaching institutions the opportunity to preserve an appropriate patient population base necessary to meet their missions of education and research.

All entities who receive funds from any of the elements described in this proposal will be required to furnish encounter level data to a data collection and analysis center selected by the state to provide both quality and cost oversight. Quality and cost review may utilize nationally recognized tools of analysis such as HEDIS or HEDIS-like system, but must meet the NCQA standards.

Child Health Insurance Benefit Package

Objectives: ***Provide a comprehensive and cost-effective set of pediatric screening and Preventative services, as well as primary care and in-patient services.***

Discussion

"All newborns, infants, children, adolescent patients through the age 21 years and pregnant women must have access to comprehensive health care benefits that will ensure their optimal health and well-being" (AAP 1995). The American Academy of Pediatrics recommends that a comprehensive set of services that should be included in the health plan benefit offered by all private and public insurers, and that these services should be delivered by appropriately trained and board eligible/certified providers of pediatric care, including primary, medical subspecialty, and surgical specialty pediatric care.

Proposal

Based on the recommendations of the American Academy of Pediatrics and in light of real cost-constraints the following services should be included in the health care plan for all children.

- Medical care, including A) health supervision with its preventative care and immunizations according to the AAP's "Recommendations for Preventative Pediatric Health Care" and B) diagnosis and treatment of acute and chronic illness, developmental disabilities, learning disorders and behavioral problems;
- Surgical care
- Mental health, substance abuse, and services for other psychosocial problems including therapy, crisis management, day treatment and residential care. This should also include evaluations and treatment of learning disabilities and related disorders such as Attention Deficit Hyperactivity Disorder (ADHD)
- Emergency medical and trauma care services for children
- Inpatient hospital and critical care services for children
- Pediatric critical care, pediatric medical subspecialty and pediatric surgical specialty consultations occurring either in the inpatient or outpatient settings
- Family planning services
- Pregnancy services
- Care of all newborn infants

- Laboratory and pathology services, including screening for metabolic and other congenital disorders
- Anesthesia services
- Home health care services
- Intermediate of skilled nursing facility care in lieu of hospital care
- Hospice care
- Case management and care coordination integrated with child's primary care provider and family as required by those with special health care needs
- Medical and social services to evaluate and treat suspected child physical and sexual abuse in both inpatient and outpatient settings
- Transfer to a hospital or health facility
- Prescription drugs, medical and surgical supplies and special nutritional supplements, including but not limited to those prescribed under national clinical trials for AIDS/HIV and other conditions

Regarding Mental Health and Substance Abuse Services, the Florida Council for Community Mental Health recommends the following, which should be included in a benefit package:

- A basic benefit of 30 days of inpatient/residential care and 40 outpatient visits that allows for flexibility based on clinical needs (e.g., trade off of 1 inpatient day for 2 outpatient days, etc.)
- A special needs plan for children with severe emotional disturbance or substance abuse problems whose treatment needs exceed the basic benefits. This plan should offer the same mental health and substance abuse benefits as those available to children enrolled in Florida's Medicaid program (up to 45 days of inpatient care and a range of outpatient treatment options)

Fiscal Note: Costs are estimated based on the Florida Healthy Kids benefit package.

COMMUNITY COLLABORATIVE GRANTS

Objective: *Fund grants to local community organizations across the State for the development of solutions to local health problems among youth, with a focus on health prevention and education, and assessment of the impact of these programs.*

Discussion

Florida's recent tobacco settlement gives the state a unique opportunity to improve the health of its citizens. Tobacco *use* kills more people than any other addiction and smokers start in their youth. Every year, tobacco kills more people than AIDS, homicide, traffic crashes, fires and drownings - combined. In Florida, tobacco-related diseases account for 85 deaths each day; tobacco is the number one preventable cause of death in the State.

Nationally, more than 3,000 children become addicted to cigarettes every day. Because of the massive campaigns aimed at young people, our youth are constantly at risk to pick up this deadly habit. Tobacco use is also a gateway drug to other substance abuse. For example, the use of marijuana among youth is up 17 percent.

Tobacco has been particularly harmful to African-Americans and other minorities in the State. African-American's suffer from tobacco-related diseases at higher rates than whites, even though they are *less likely* to smoke. In Florida, 16.3% of black adults, compared to 23.9% of white adults smoke cigarettes. Yet, African-American men and women have a higher incidence of respiratory system, esophagus and oral cavity cancers than do white men and women.

As of 1990, 23% of Hispanic adults (aged 18 and older) smoked cigarettes, including 30.9% of men and 16.3% of women, according to the National Health Interview survey. Smoking prevalence in the 20-24 age group was 20.7% for Hispanics, which as less than the 28.3% for whites but more than the 17.3% for African-Americans.

A vital part of improving community health outcomes is through investment in grassroots programs and projects developed in Florida's communities. Because Florida's communities are so diverse, with each reflecting unique patterns of social, economic and health characteristics of the area, local community groups are often the best equipped to design and implement effective health interventions. Local Healthy Start Committees and similar community groups have shown that this approach not only helps to assure the 'buy-in' of community members and leaders but it results in more effective program implementation and follow-up.

These programs must be based on a thorough assessment of the local children's health care needs, as well as their cultural preferences and behavior patterns, and must include some tracking of service delivery and program impact.

The Community Collaborative Grants will be allocated via a competitive bidding process, but targets community-based groups and agencies that have a history of community service and that develop collaborative projects with other groups or agencies in their communities. These grants will target three areas of interest:

1) Asthma prevention and management for youth ($33 million);
2) Diabetes screening and management for youth ($33 million); and
3) Outreach and media campaigns targeting tobacco use prevention and cessation ($33 million).

These projects should provide both strong health education components but also community-appropriate health intervention components. They should also have special focus on the minority communities, both black and Hispanic, who are adversely affected by these diseases.

1) Asthma

OBJECTIVE: Florida's poor and minority population will be provided enhanced education in the prevention and treatment of asthma.

Discussion

Asthma now afflicts about 14.6 million Americans, including 5 million children. It is the most common chronic illness affecting children in the United States, with the cost estimated at $1.79 billion dollars in 1990. Data from the National Health Interview Survey (NHIS) indicate that the prevalence increased 33% between 1981 and 1988, from 3.2% to 4.3% of all children younger than 18 years of age. Several recent studies have documented that while hospitalization rates for most childhood conditions have declined, hospitalization rates for asthma increased between 1970 and 1987. Moreover, studies from several countries, including the United States have demonstrated increased rates of mortality due to asthma, with the most recent US study showing increasing mortality rates especially for children 4 through 14 years of age (Halfon, et al 1993).

Nonwhite children, children living in urban areas, and the poor seem to be disproportionately affected, raising questions about the access and quality of available health services for asthmatic children. Poor children living in inner cities are not only more likely to be hospitalized because of asthma, but are more likely to receive routine care in emergency departments.

OBJECTIVE: Florida's communities will be educated on the factors contributing to asthma severity.

Discussion

Tobacco smoke is the most important environmental indoor irritant and is a major precipitant of asthma symptoms in children and adults (Abbey et al, 1993; Greer et al. 1993; Jindal et al. 1994; Leuenberger et al. 1994). Jindal and colleagues (1994) found that

exposure of adults to environmental tobacco smoke is associated with decreased levels of pulmonary function, increased requirements for medication, and more frequent absences from work. In addition, exposure to maternal smoke has been shown to be a risk factor for the development of asthma in infancy (Arshad and Hide 1992) and childhood (Frischer et al. 1992).

Recent studies indicate that exposures to high levels of house-dust mite antigen (Sporik et al. 1990; Peat et al. 1993) and environmental tobacco smoke (Martinez et al. 1995) are associated with an increased incidence of asthma among infants. This suggests that reducing these exposures may result in reduction in the incidence of asthma.

For successful long-term asthma management, it is essential to identify and reduce exposures to relevant allergens and irritants and to control other factors that have been shown to increase asthma symptoms and/or precipitate asthma exacerbations. These factors fall into four categories: inhalant allergens, occupational exposures, nonallergic factors and other factors.

Proposed Solution: The development of community-based, family-centered, comprehensive service programs that can provide a full continuum of needed services to the asthmatic child and his or her family.

Community Collaborative partnerships such as: Community Health Centers, teaching or local community hospitals, churches, Area Health Education Centers, local health departments, schools as well as other local not-for profit organizations should be encouraged to submit applications for funding.

Funding source: Tobacco Settlement Outreach Funds

2) Diabetes

OBJECTIVE: Florida's minority population will be afforded enhanced education in the prevention and treatment of diabetes

Discussion

There is a national epidemic of non-Type 1 (non-insulin dependent) diabetes affecting Florida's Black community and other minority communities (Hispanic, Native American), according to pediatric experts with Florida's regional program for children and youth with diabetes. The increase is attributed to increasing obesity and inactivity, risk factors that are especially common among the youth of these communities.

African American youth with typical Type I-insulin dependent diabetes (which is also increasing in frequency), are confronted with special problems, even though Type I diabetes typically is more prevalent among white youth. For example, compliance with the treatment regimen is hindered by limited financial resources for medications, proper diet and other socioeconomic factors.

A disproportionate number of the non-white population die of their diabetes. In Florida, approximately 32 per 100,000 non-white women afflicted by the disease will succumb to it, compared to approximately 22 per 100,00 white women per year (Florida Vital Statistic Annual Report, 1995).

According to another study "delay in diagnosis and treatment for diabetes complications may increase the likelihood of more severe morbidity and disability" Data is limited on the full extent of the toll upon African Americans due to complications related to diabetes. However, the data suggests diabetes increases the risk of cardiovascular disease (including heart disease and stroke) and hypertension. Cigarette smoking also is viewed as a risk factor increasing the likelihood of diabetes and for secondary complications of diabetes such as kidney, cardiovascular and eye disease.

Because diabetes ranks in the top five as an underlying cause of death among adults, early intervention is critical. This can be achieved through proactive identification of a predisposition toward the disease and reconfiguration of nutrition and fitness patterns.

OBJECTIVE: Respond to the diabetes "epidemic" by engaging the participation of a statewide network of community based health clinics, state-funded healthcare programs, public schools, churches and community-based centers

Discussion

A seamless system of healthcare comprised of multiple partners or team members can insure continuity in the education and treatment of diabetes among Florida's minority population. Such a network would include (but not be limited to) the following organizations/agencies:

- Children's Medical Services
- private clinical enterprises educational and outreach
- local churches
- local public schools
- local community centers
- community based health clinics

Network Mechanics
Network participation would be engaged as appropriate in three basic program components:

Identification

* Children predisposed to non-Type 1 diabetes can be identified before onset of the disease by the risk factors of obesity, inactivity and positive family history. This requires funds for data collection via interviews, and data compilation, as well as follow-through activities such as blood testing.

Agencies involved: public schools, Florida Department of Health
Education

* Lifestyle/behavioral modification is essential in the both the prevention and treatment of the disease; programs directed toward weight control and enhancing the exercise regimen among youth would be managed through the network Agencies involved: public schools, Florida Department of Health, community based health clinics, Children's Medical Services, private clinical enterprises.

* Relating to the minority community the danger of diabetes and the importance of preventing the disease requires information-sharing and awareness building; a targeted communications campaign will facilitate this component

Agencies involved: Children's Medical Services; Florida Camp for Children and Youth with Diabetes; private clinical enterprises; Area Health Education Centers (AHECs); local churches; local public schools; local community centers; community based health clinics

Treatment

* Healthcare providers would participate in delivery of treatment and other clinical services to diabetes patients; the network will facilitate a comprehensive team approach to diabetes treatment, involving nurses, psychologists, social workers, and dietitians as well as physicians

Agencies involved: Children's Medical Services; private clinical enterprises such as Shands HealthCare; community based health clinics

3) Outreach and Media

Objective: ***To provide a comprehensive outreach media campaign to reduce the positive impact of tobacco advertising on minority groups.***

Discussion

In 1989, American tobacco companies spent an estimated $421 million dollars on outdoor advertising. In 1989 and 1990, surveys in Baltimore, Detroit and Washington, D.C. confirmed what residents had been saying all along - billboard companies are saturating low-income, minority neighborhoods with tobacco ads. The Detroit Planning Commission found the 55% to 58% of the billboards in inner city neighborhoods were selling alcohol and tobacco, while the Baltimore study found that 76% of the ads in black neighborhoods advertised tobacco and alcohol, compared with just 20% in white neighborhoods. These surveys supported earlier findings in St. Louis, San Francisco, New Orleans, Philadelphia, Atlanta and other cities.

The campaign to maintain and increase the base of smokers among minorities goes well beyond billboards and professional sports arenas, however. Event marketing abounds, such as sponsorship of the Kool Jazz Festival and Salem Music Legends.

Unemployment, lack of education and little or no awareness of tobacco's health risks

contribute to tobacco use among Latinos. Less educated persons are more likely to smoke and Latinos have the fewest average years of education among U.S. ethnic groups. Many Latinos, by virtue of their immigration, have little formal education and at least 25% speak little or no English.

Cultural nostalgia is a major theme in advertising to Latinos, and there seems to be a deliberate practice of influencing beliefs and behaviors by appealing to the traditions, images and norms that many Latinos grow up with.

Cigarette smoking is a socially acceptable behavior among Latinos and many consider the offer of a cigarette to be a polite gesture. The importance of smoking with friends or at social gatherings is greater for Latinos than for other groups.

The tobacco industry exploits each of these cultural traits in ad campaigns aimed at Spanish-speaking people.

Black, Hispanic, Asian and Native-american communities are targeted by the tobacco companies for strategic advertising. The results will continue to be devastating, in terms of the health effects, to these groups, unless a comprehensive campaign to combat the advertising efforts is mounted.

Proposal

Ethnic specific grassroots and statewide advertising campaigns must be funded to penetrate the targeted audiences. One such proposal is listed below:

University of Florida Center for Efficacy Testing

This Center would develop and execute a system for testing existing and new teenager-directed tobacco-use and smoking prevention advertising. This work will provide a framework for better understanding how Florida teenagers react to anti-tobacco advertising, enabling the State of florida to a) better utilize the many existing anti-tobacco television and radio commercials developed for programs in other states, and b) gain insights to enhance the development of new commercials created specifically for use in Florida. Direct testing will identify effective advertisements. The advertisements will be available to target prevention activities for all of Florida's diverse population of youths. Prevention will be state-wide, focused at adolescents and efficacy will be directly demonstrated.

Cost: $5,000,000

Multi-Year Health Programs

Objective: ***To reduce tobacco use and its affects on Florida's children, with special targeting of programs to racial and ethnic minorities.***

Discussion

Substance abuse represents an important public health problem, causing significant dysfunction and suffering in affected individuals and their families, and is associated with staggering costs to society. Most of what is known about the implications of substance abuse and about its prevention and treatment is directed at adults. Yet, attitudes toward substance abuse begin to be formed in childhood, and substance use patterns often get established during adolescence, pointing to the importance of these years in substance abuse prevention efforts. General yough educaiton campaigns have been implemented for prevention purposes, such as the Drug Abuse Resistance Education program (DARE), but have shown little evidence of actually reducing drug use. This may be in part the result of not targeting these efforts at youths most susceptiable to drug use. Certain groups of children and adolescents are at greatly increased risk for developing substance abuse, notably children with disruptive behavior disorders such as attention deficit hyperactivity disorder or conduct disorder. Thus, children with these mental health disorder represent important targets for specific primary drug abuse prevention efforts.

The reduction of the effects of tobacco on children in Florida should be accomplish through a multi-modal approach to the prevention and intervention of tobacco use, targeting youth who are highly likely to start tobacco use, as well as other substances.

Proposal

Through the multi-year health programs, grants will be awarded, via a competetive bidding process, in three areas:

1) smoking cessation ($10 million),
2) children and adolescent substance abuse ($10 million); and
3) programs to underserved populations ($10 million).

1) Smoking Cessation

The smoking cessation projects should provided community and subpopulation-specific interventions, that have been tested and evaluated, to help youth and their families who use tobacco to stop. Programs for smoking cessation should focus on behavior modification and impacting the youth as well as their family. These programs should be available in schools and other settings that are conducive to youth and family participation.

2) Children and adolescent substance abuse

The children and adolescent substance abuse services grants will target effective multi-substance abuse prevention programs, especially those that include strong mental health and behavioral health components.

An example program is the "Multi-Modal Substance Abuse Prevention Project for High Risk Youth" developed by Dr. Regina Bussing, a psychiatrist at the University of Florida. This study will develop and test a tarteted drug abuse prevention intervention aimed at elementary school students at high risk for future substance abuse. The intervention will be based on the premise that the nuclear family plays a fundamental role in modeling substance use attitudes and behaviors for children and thuse needs to be included in prevention efforts. The study calls for the detection and treatment of mental disorders in the family as part of the substance abuse prevention strategy. The intervention basically consists of 3 components: 1) substance abuse education for children and families with an initial core curriculum and subsequent booster sessions; 2) assessment and treatment of mental health disorders of children and family members, including possible existing substance abuse in caregivers; and 3) integration of individual intervention messages into school, community and neighborhood education campaigns for substance abuse prevention. Public elementary schools will serve as the sampling from for the study. Selected schools will be randomly assigned to intervention or control status.

Cost: $4,000,000

3) Underserved Populations

The grants for underserved communities should deliver needed medical services for minority communities as well as medically-complex children and their families.

Multi-Year Programs to Expand Medical Outreach and Outcomes Assessment

Objective: ***The objective of this program is to improve the linkages between medical and schools and communities that need services; and to assist the state in the on-going evaluation and modification of children's health programs by providing a Statewide, comprehensive outcomes assessment of implemented programs.***

Discussion

Critical health knowledge and services, as well as data on the outcomes of medical services, are often unavailable to the communities that need it most and are sometimes lacking from health planning activities and documents. Projects are needed to bring medical expertise into the schools and to rural communities, and telemedicine is one vehicle that can help accomplish this. In addition, quantitative data on the impact of health care programs on health status are needed to provide support and direction to new health prevention programs.

The Multi-year programs to expand medical outreach and outcomes assesament are focused in two primary areas. First, to aid in the delivery of needed medical services and health education in remote communities in Florida, a pilot telemedicine project will be funded ($8 million) to bridge communities and medical centers.

Telemedicine

A block grant to demonstrate the efficacy of telemedicine in selected school systems and/or communities to enhance the health status of its children though preventative health and educaiton functions. The grant could demonstrate the utility of telemedicine as a diagnostic instrument in school age children.

Outcomes Assessment

To evaluate the impact of the children's health insurance expansions and tobacco intervention programs, a consortium of health outcomes researchers from the University of Florida, University of South Florida, Florida A & M University and Nova Southeastern, will direct the project. The cost of the effort will be approximately $20,000,000 for the five year period.

The Outcomes Assessment will include the tracking of, at minimum, the following measures.

Health Care Outcomes

A. Outreach and Enrollment - Reduction in number of uninsured children and pregnant adolescents.

B. Eligibility - reduction in the number of under insured children and pregnant adolescents.

C. Comparison of coverage plans for health status and educational outcome indicators.

D. Maintenance of tertiary high intensive, high acuity pediatric health care in teaching hospitals

E. Reduction in tobacco-related disease among children.

Education

A. A reduction in the adolescent pregnancy rate.

B. A reduction in the rate of diagnosis of new AIDS related cases in at risk minority populations

C. A reduction in adolescence tobacco usage rate.

Health Status Outcomes

A. A reduction in perinatal morbidity and mortality.

B. A reduction in the emergency room visit and hospitalization rate for diabetes and asthma

C. Increased compliance with vaccination standards.

D. A decrease in the number of abused women and children.

E. Reductions in tobacco-related illness among youth.

Centers for Disease Control and Prevention

OVERVIEW

The Centers for Disease Control and Prevention (CDC) has been active in the fight against disease for over half a century. The mission of CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. As such, CDC works through partnerships with state and local health departments, educational institutions, and other private and public organizations to ensure healthy lives in a healthy world..

CDC has a long and unique history in this country and throughout the world of preventing disease and disability in children. In fact, CDC spends close to half (42%) of its total $2.8 billion budget on activities related to children. Current child health activities at CDC include research, surveillance, and interventions with an emphasis on prevention in immunization, lead poisoning, birth defects, tobacco control, adolescent and school health, infectious diseases, violence, unintentional injuries, nutrition, physical activity, sexually transmitted diseases, oral health, developmental disabilities, and chronic diseases such as asthma.

Considering the immense scope of CDC child health activities, the agency is limited in the number of programs which offer direct services to children. In the broadest of terms, CDC's children's outreach activities can be placed in five categories: immunization, childhood lead poisoning prevention, sexually transmitted disease prevention, HIV/AIDS prevention, unintentional injury prevention, and youth work-related/farm-related safety.

Immunization

CDC uses two mechanisms in its outreach activities for immunization: Section 317 grant funding and the Vaccines for Children Program (VFC). CDC's National Immunization Program also maintains a hotline to answer any question concerning immunization or vaccine. From March 1997 to March 1998, the hotline handled over 30,000 calls.

Childhood Lead Poisoning Prevention

Using communities with demonstrated high risk for lead poisoning, CDC funds a grant program aimed at screening at-risk children, identifying the source of the exposure, monitoring medical and environmental management of lead-poisoned children, and educating the family members/community about the effects of lead poisoning. It is estimated that there are over 1 million children in the nation with elevated blood lead levels. In 1996 alone, CDC programs in state and local health agencies screened over 1.8 million children.

Sexually Transmitted Disease Prevention

CDC currently funds several cooperative agreements to screen young women for STDs. Rates of chlamydia and gonorrhea are highest among 15-19 year olds and STDs facilitate the sexual transmission of HIV. Clinics and screening projects nation-wide serve well over a quarter of a million women under 20 years of age each year.

HIV/AIDS Prevention

CDC has a variety of programs aimed at reaching high-risk youth associated with HIV/AIDS. During FY 1997, an estimated $58.7 million was allocated to youth-serving programs at state, local, and community levels, including 94 Community-based Organizations (CBOs). Of particular interest is the National AIDS Hotline which received 65,333 calls from persons under 18 years of age (the figure is not available for the Spanish speaking lines).

Unintentional Injuries

Bicycle helmet usage and residential fire protection (through the use of smoke detectors) are two unintentional injury programs whose target population is children. Through a grant program, CDC funds states to conduct public education programs on bicycle helmet safety, helmet give-aways, neighborhood canvassing, multi-lingual educational materials, etc. Residential fire protection through the use of smoke detectors is aimed most specifically at low-income households with children under 5 and adults 65 and older. Grantees make use of outreach workers for door-to-door canvassing or other forms of public assistance programs (WIC, Head Start, etc.) to identify those in need.

Youth Work-related/Farm-related Safety

CDC currently funds several community education projects focusing on young workers' safety and the hazards of farm work. Several of these grantees strive to reach unique groups of farming and ranching using culturally sensitive approaches.

STRATEGIES FOR EDUCATING WORKERS

Because most of workers involved with CDC projects are grantees, CDC feels the best strategy for educating these outreach workers is a tailor-made mailing which will focus on how a grantee in a particular program might become involved in CHIP and how they can assist in outreach. For instance, an outreach worker in the lead screening program who visits a high-risk home to screen children for lead poisoning would also be encouraged to hand out information on CHIP and possibly a mail-in application form. Another example is an occupational safety and health official who visits migrant communities and farms to educate the workers on farm safety.

Another approach that CDC is proposing is some type of national meeting with state and local health officials and state and local school education officials. Although it is possible that both of these groups have had extensive dealings in devising their state's CHIP plan, opportunities for input and feedback should be afforded to any one of these groups which might be instrumental in outreach.

EDUCATING FAMILIES AND ENROLLING CHILDREN

CDC has several strategies for actually reaching and enrolling children in Medicaid and CHIP. Perhaps most importantly is the use of the state and local health departments and state and local education agencies. CDC is the only federal public health agency with grant relationships with all fifty state health agencies and all fifty state education agencies as well as most of the nation's largest cities. Each of the State agencies have access to a large number of children through several different programs. CDC will encourage each of these agencies to ensure that a child is enrolled some type of program every time a child is seen for whatever reason.

Another strategy involves using the national 800 number being set up for the CHIP program. CDC has an extensive inventory of publications, pamphlets, educational materials, etc. which routinely make their way into the states. An effective use of the 800 number would be to publish the 800 number on all printed material sponsored by CDC.

Approximately 96,209,000 hits have been received on CDC homepage just in the past year. CDC intends to provide a hot-link directly to the HCFA website for those wishing to learn more about the program.

Several non-governmental agencies currently assist CDC with our school-based education programs throughout the states. Among the organizations are the National Network of Runaway and Youth Services; Advocates for Youth; the National School Health Education Coalition; and Girls Incorporated. These types of groups are in a unique position to reach a large number of children in a variety of settings. CDC proposes that these types of groups assist in outreach through the use of educational materials, enrollment applications, etc.

CDC is currently in the process of establishing the hot-link to HCFA and will soon begin preparing the informational letters to grantees. Additional resources are required to conduct educational meetings.

COORDINATION WITH OTHER PROGRAMS

CDC has several non-children's health programs which by nature lend themselves to reaching children in need. One such example is the breast and cervical screening program. CDC sees this program as a link to mothers and grandmothers who may be interested in learning more about CHIP or who are Medicaid eligible. The diabetes screening programs also afford an opportunity to reach fathers, mothers, and other family members.

family-oriented.

Two important CDC programs with direct links to children but do not actually serve children are the teen pregnancy program and the prenatal smoking cessation program. Both of these programs could provide for immediate enrollment in either CHIP of Medicaid.

CONCLUSION

Although traditional health departments do not see the large numbers of low-income families they once did, the state and local health agencies remain a critical link in the effort to identify and enroll eligible children into either CHIP or Medicaid.

Through our other grantees, CDC is also in a unique position to reach and assist in providing information and enrollment forms to a large number of children. Except in the case of national meetings with the health officials and school officials, little in the way of monetary resources is needed. One of CDC's strengths is information dissemination, and CDC would require access to all outreach materials from all involved agencies (i.e., informational pamphlets, mail-in applications, etc.).

HEALTH CARE FINANCE ADMINISTRATION

I. AGENCY PROGRAMS THAT SERVE MIDDLE TO LOW INCOME CHILDREN

The Health Care Financing Administration (HCFA) is a Federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program (Title XVIII of the Social Security Act); **Medicaid** (Title XIX of the Social Security Act); and the **State Children's Health Insurance Program (CHIP)** (Title XXI of the Social Security Act). HCFA is the largest purchaser of health care in the U.S. - serving 72 million Medicaid and Medicare beneficiaries and their families. HCFA's mission is to assure health care protection for beneficiaries.

Medicaid is a jointly funded cooperative between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. It is the largest program providing medical and health related services for low income Americans. Within broad national guidelines which the Federal government provides, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program.

In FY 1996, Medicaid served approximately 22 million children and 9 million adults who care for these children. The 22 million children served by Medicaid represent about 30% of America's children. Of these, about 10 million are Caucasian, 5 million are African American, 300,000 are Native American, 600,000 are Asian American, 5 million are Latin American and over 1 million are of unknown ethnicity. About one-third of all babies born in the United States are covered by Medicaid.

Although children constitute nearly half of all Medicaid beneficiaries, they account for approximately 16% of program expenditures. The Federal and State Medicaid expenditures for FY 1996 amounted to $160 billion. The States contributed $69 billion (43%) and the Federal government $91 billion (57%).

Title XXI provides $24 billion in Federal matching funds over the next 5 years to assist States provide health care coverage to the nation's estimated 10 million uninsured children. This is the largest expansion of insurance for low-income children since the enactment of Medicaid in 1965, and it is among the Clinton Administration's most significant health care achievements. HCFA, in cooperation with the Health Resources and Services Administration (HRSA) has administrative responsibility for the State Children's Health Insurance Program.

II. PLANS FOR CHILDREN'S HEALTH OUTREACH

A. CURRENT ACTIVITIES IN CHILDREN'S HEALTH OUTREACH

HCFA, in conjunction with HRSA, held one national and eight regional conferences (which

included all 10 regions) during January and February 1998, providing information on various aspects of CHIP including a dynamic expert panel on outreach and marketing strategies. Attendees included Federal, State and local officials, national and local organizations and associations, providers, advocacy groups and vendors.

HCFA ROs are organizing interagency/interdepartmental workgroups reflective of the Central Office (CO)Interagency Children's Health Outreach Taskforce to provide CHIP education to all Federal partners and grantees and to plan State specific meetings to further promote coordinated outreach strategies germane to individual States and engaging both the public and private sectors.

All HCFA ROs are providing ongoing technical assistance to States, as requested, regarding outreach as an essential part of the State Plan and holding teleconferences with State staff during initial development stages of CHIP plans.

The regions are working with minority advocacy groups/organizations to identify appropriate guidelines for cultural competence required in conducting outreach to special populations and reducing barriers for enrolling minority populations.

HCFA Regional Administrators are actively promoting collaboration among respective States in development of CHIP plans as well as encouraging them to utilize the State agencies, organizations, and networks in reaching out and identifying potentially eligible children for enrollment in the State programs.

ROs are working with their States to identify all potential outreach funds for CHIP and to assist States to identify innovative methods to expand and target their Medicaid/CHIP outreach efforts.

Central Office (CO) staff are involved with the other Federal agency workgroup members in the development of a brochure and other materials to provide workers who administer and operate Federal programs with information about children from low income working poor families who may be eligible for health insurance.

HCFA is developing partnership roles with existing programs, such as Medicare's Information, Counseling and Assistance (ICAs) grantees, who currently provide information to potential Medicare and Medicaid beneficiaries, and promoting opportunities for them to simultaneously engage in outreach to children for Medicaid/CHIP enrollment.

HCFA staff are assisting the Taskforce by convening an interagency subgroup to explore simplification of the eligibility process across agencies as well as identifying and addressing potential barriers to such simplification.

HCFA is participating in an interagency subgroup with other Federal agencies responsible for providing services to Native Americans to identify and establish a coordinated outreach effort for this population.

B. EDUCATING WORKERS ABOUT MEDICAID AND CHIP

Federal Workers

HCFA is preparing an E-mail note, to be disseminated to all HCFA staff, describing the Federal Outreach Workgroup effort for Medicaid/CHIP.

HCFA and HRSA hold bi-weekly conference calls with Regional HHS Staff. There are points of contact (POCs) for each HCFA/HRSA RO. POCs organize and disseminate information to their respective RO staffs. The agenda is open to allow for free exchange and discussion.

ROs are continuing to receive feedback from CHIP conference participants. This information will be used to help develop CHIP outreach strategies.

The HCFA CHIP Steering Committee meets on a regular basis to discuss CHIP issues and to keep HCFA CO and RO management up-to-date on all CHIP activities.

State Workers

HCFA offers guidance and direction to States through various vehicles. The series of recent CHIP letters on financing, crowd out and outreach, ways to improve the enrollment/eligibility process, questions and answers, and meetings with State officials promote CHIP as a vehicle for improving childrens' health status. This is a critical part of HCFA's role in educating State workers.

HCFA prepared a State Medicaid Directors letter (dated January 23, 1998) highlighting new and existing opportunities for outreach to uninsured children. The letter described examples of and options for successful outreach and enrollment and Federal funding available for these activities. All CHIP letters are on the HCFA Internet site and HCFA will continue to post information and issuances as they are released.

Where appropriate ROs are working with National American Indian tribes in an attempt to define means to provide HCFA with correct counts of uninsured American Indian children.

HCFA RO staff participate regularly in public forums on CHIP Plan development and are encouraging States and partners to share successful outreach models and strategies with one another and disseminating this via the Internet, conferences, in public forums, in working together at the grassroots level, etc.

RO staff are identifying innovative State outreach efforts (e.g., the use of Multi-Purpose Collaborative Bodies (MPCB) to develop outreach programs specifically targeted to the needs of individual communities and awarding State grants to community organizations for targeted outreach.) ROs will follow up with specific States to share their experiences with others.

Other Workers

The New York RO has participated in meetings with the NY Chapter of the National Association of Social Workers, the Women's Club of the city of New York and Grant Makers in Health to discuss the CHIP program.

C. EDUCATING FAMILIES AND ENROLLING CHILDREN IN MEDICAID AND CHIP

HCFA realizes that it is more important than ever that States have and pursue options to conduct educational activities and enrollment of children in a wider array of community settings. HCFA is encouraging, promoting and providing administrative funding for "presumptive eligibility", the outstationing of eligibility workers in communities, the use of mail-in applications, simplifying the Medicaid application and eligibility process, using a single application for Medicaid and CHIP, eligibility screening, and the granting of 12-month continuous eligibility. An Interagency eligibility workgroup is currently exploring ways to coordinate these activities by identifying potential barriers and possible solutions to overcome them.

The agency has offered to assist States and local communities by facilitating the exchange of information regarding successful outreach endeavors and information related to enrollment simplification. Information on these topics, especially examples of promising strategies currently practiced or being considered in various places, has been shared with our partners through numerous vehicles (i.e., Internet, State Medicaid Director letters, conferences, etc.)

HCFA Regions are providing marketing materials to various City locations frequented by potentially eligible families as well as providing technical assistance on a variety of program areas to assist States to successfully implement this important program.

D. COORDINATION WITH OTHER PROGRAMS

All HCFA ROs are participating in HHS inter-agency workgroups to share knowledge of the program, identify means to assist each other in training our respective audiences, and to provide comments on CHIP State Plan Amendments. We continue to encourage and work with States to build effective outreach programs that assure children eligible for CHIP/Medicaid are identified and enrolled.

Regions are working with States to improve coordination and linkages across public and private child health care programs.

ROs are providing updates to Maternal and Child Health interagency Regional Taskforces.

III. PROPOSED OUTREACH ACTIVITIES

HCFA facilitates partnership development and network building between other federal agencies,

private and voluntary organizations, such as the American Hospital Association's Campaign for Coverage, the Department of Education, the National Education Association and the National Teachers Association to leverage resources committed to outreach activities associated with building a successful enrollment strategy for reaching uninsured children.

HCFA's Communications Office will launch a coordinated effort with other HHS components and States to develop a variety of media strategies directed at various subpopulations and minorities and in support of the State operated children's programs. They will solicit best practices from a wide array of sources on outreach/enrollment, quality and access strategies and disseminate information by:

- Establishing a clearing house for information collection and dissemination; and
- Continually updating the HCFA Internet site with descriptions of best practices along with contacts for additional information.

HCFA will prepare CHIP information and educational material, containing the national 800 Medicaid/CHIP number, to be included in the Medicare initial enrollment package. Central Office will include the Medicaid/CHIP National 800# in the National Medicare Hotline Agent/partner referral data. A special HCFA Customer Service Representative will access the data and provide the 800# information to callers inquiring about CHIP.

The Center for Medicaid and State Operations staff will work with the Center for Beneficiary Services to share information regarding both Federal and State CHIP outreach efforts with Advocacy groups on a regular basis and encourage them to become active participants in all outreach efforts (both Federal, State, city, local and private).

Through its existing contract, HCFA will enlist the support of Barents Group to provide technical assistance in developing and testing messages including effective means of communicating these messages in various communities. Contractor support will assist HCFA and State Medicaid/CHIP Agencies identify ways of coordinating respective roles and enhancing and assisting State Agencies in developing successful outreach strategies.

HCFA ROs will be undertaking a myriad of activities over the next several months aimed at educating all HCFA and other Federal agency RO staff, government leaders, providers, funding agencies and service organizations. Among these efforts are:

- training courses,
- outreach conferences which focus on facilitating partnerships among, government entities, advocates, providers, parents and other stakeholders to network, exchange ideas and models, and come away with fresh approaches to Medicaid and the new CHIP legislation,
- Federal Interagency forums to focus on strategies/ways agencies can disseminate Medicaid/CHIP information to State/county/local staff,
- presentations to be made at other agencies' staff meetings and conferences,
- CHIP updates Maternal and Child Health Interagency Regional Taskforces, and

- establishing RO Consortia Workgroups for outreach.

CO staff will schedule a demonstration of the HUD Community Planning software for the CHIP Steering Committee and other interested HCFA personnel. This software package has the potential for assisting States in identifying those areas with the greatest number of potential eligibles. States can then more accurately target their outreach efforts. We are exploring the possibility of providing each State a copy of this software for $249 per State Medicaid agency.

HCFA ROs will provide a number of training sessions to Medicaid State agencies on this initiative, stressing the need for intensive outreach in both Medicaid and CHIP. This issue will be a continuing agenda item for RO Medicaid State Representative site visits as they occur. They also will host State Medicaid Director's meetings at which the Medicaid/CHIP outreach effort will be extensively discussed with the States detailing our expectations from their standpoint, and requesting formal State itineraries for planned activities and due dates. State responses should outline their commitments and plans to enroll uninsured children in this effort, with target dates and anticipated increases in enrollees.

Central Office will participate in the Historically Black Colleges and Universities (HCBUs) Conference and the Tribal Colleges and Universities (TCUs) Conference and EXPO, to provide CHIP information.

This Spring HCFA will publish **Child Care and Medicaid, Partners for Healthy Children,** a guide to provide information and technical assistance to child care programs regarding the importance of health care and how child care programs may help to enroll children in Medicaid and CHIP.

This summer, HCFA will provide a CHIP article which will be published in the quarterly newsletter of the **Healthy Mothers/Healthy Babies** national coalition. This article will describe how this national organizations' local chapters can help in CHIP and Medicaid outreach efforts.

HCFA RO staff will work with their Federal counterparts to identify other sources for outreach and intake of applications which currently exist (including WIC, Head Start, health Departments, perinatal providers, advocacy groups, managed care organizations, SSA field offices and other "enrollment centers").

Region Offices will give presentations on a regular basis to Medicare contractors and various provider organizations as part of their Balance Budget Act Legislation updates.

HCFA will continue to pursue the activities cited in Section II.C.- Current Outreach Activities to educate families and enroll children in Medicaid and CHIP.

HCFA will work with the Social Security Administration to place Title XXI literature in local Social Security Offices. This should be accomplished by mid-summer.

ROs will work with their respective interagency workgroups to discuss outreach strategies and determine how together they can make certain that low income families are made aware of the Medicaid/CHIP programs, while not duplicating Federal efforts.

In the fall, HCFA and ACF plan to publish a guide for Head Start Programs to provide information and technical assistance regarding enrolling Head Start and Early Head Start children in Medicaid and CHIP.

IV. STATUTORY OR REGULATORY BARRIERS

Medicaid has no mandated outreach requirements and while CHIP requires a State to describe outreach and coordination efforts, ultimately, we cannot mandate effective programs because neither Title XXI nor XIX detail any specific statutory language that would make a State noncompliant. Without specific regulatory or statutory language it is difficult to ensure that best practices in outreach are utilized.

There are confidentiality issues surrounding the voluntary disclosure of a child's social security number for enrollment purposes. Since Medicaid requires an SSN for enrollment, it may cause some States hardship to meet the screen and enrollment requirement of CHIP. A State must enroll a child in Medicaid, even if they apply for CHIP, if they are found Medicaid eligible. The child would likely face a delay in coverage because the eligibility determination process will be lengthened.

There is no funding available for the development of outstationed workers training programs geared towards outreach workers hired for CHIP/Medicaid expansion implementation.

The outstationing of eligibility workers to sites such as Head Start Offices, WIC Offices, child care centers, schools, etc. may be perceived as increasing workloads for this staff.

States now have the option of allowing eligibility workers for Head Start, WIC and child care subsidies under the Child Care Development and Block Grant to give children temporary CHIP and Medicaid eligibility. Under the CHIP program this authority may be extended to the 638 Tribal Health Program Workers who perform eligibility determinations for American Indians. However, if the CHIP program is an extension of the State Medicaid program, since these workers are not specified, they cannot make this determination for the Native American population.

States are required by law to review all eligible Title XIX children, however, there is no State accountability to assure States are compliant in this requirement.

Women's

DRAFT

Indian Health Service

I. The Indian Health Service(IHS) is an agency within the Department of Health and Human Services. It is the principle agency with responsibility for the provisions of health care services to the approximately 2.5 million American Indians and Alaska Natives living in the United States. The agency has responsibility for direct clinical medical services, Contract Health Services, and serves a major advocacy role for obtaining needed clinical, preventive, and rehabilitative services for American Indians and Alaska Natives. The Indian People are among the most disadvantaged minority in this country not only in economic indicators, but in all aspect of health status which demonstrate marked disparities when compared with the general US population. This also includes marked disparities in education levels. All of the funds which are appropriated by Congress are directed toward American Indians and Alaska Natives health care needs. The IHS works in a decentralized format, with 12 regional administrative units which are subdivided in 75 service units scattered through the US. The IHS participates in all federal programs including collection of third party resources (M&M and private insurance), and has great interest in Title XXI, Children Health Insurance Program, (CHIP).

II. PLANS FOR CHILDREN'S HEALTH OUTREACH

A. Current activity in Children's Health Outreach

-- Distribution of all HCFA communication to the Area Business Offices, and Clinical Staff.

-- Instruction on the use of Internet to enhance communication

-- Support to the tribes on participation at the state meetings on CHIP

-- Review of the state proposals by the HQ and Area Staff

-- Contribution to " Comment request on the CHIP" by various organizations

-- Active participation in HHS workgroups on the CHIP

B. Education of Federal and Tribal Workers

-- The Director, IHS has a special Initiative on Youth, which has highlighted the health status indicators and plans to address these issues.

-- Information distribution has been through the infrastructure of the agency via division of Health Administration, Division of Managed Care, and thru Division of Clinical and Preventive Services.

-- Discussions with state employees have been through regional meeting with the Tribes and community members. This includes the Western Governors Assoc., who issues a resolution with "3 Points" focusing on AI/AN children.

-- Great emphasis has been place on consultation with the Indian Tribes and Alaska

Native Corporations in providing information on the program.

C. The information on CHIP has been included in all major Indian media outlets, and it has been a major topic of discussion in all meetings between the agency and the tribal leaders.

D. IHS has been working with HCFA to improve communication on the issues between the agencies and in working on operational aspects of the program. The agencies have met on a regular basis since the inception of the program and are scheduled to continue these meetings in the future.

The IHS has also initiated interaction with the Bureau of Indian Affairs social service workers at the local and regional levels to increase the interaction between the two agencies.

The IHS is committed to working with the Interagency workgroup and will help direct a subgroup addressing specific needs of the American Indian and Alaska Native youth who are eligible for participation in the Title XXI program.

The IHS HQ's has a small workgroup that is reviewing all state proposals for specific references which may impact on Native American And Alaska Native youth.

E. Statutory or Regulatory Barriers

-- At the regional meetings and the questions asked by some states... There is concern that the Indian Youths who uses IHS as their primary care source may not be considered uninsured ... and found not eligible for CHIP by uniformed state workers who don't know that IHS benefits are discretionary.

-- IHS serves in an advocacy role and does not have authority to help enroll clients, and works to only refer to the state officers ... the Indian Patient sometimes think of IHS as being no different than other Federal or State agencies and think that presenting information to IHS will suffice in getting enrolled.

-- Dialogue with the states often have to go through the HHS sister agency route (ie Baltimore) rather than regional or local setting which cause some concern because HCFA tells the States this is their program, . "we want to know what you want to do", .. However, in our discussion at the agency level there seems to be a desired level of interaction and more specific interpretation of the program guideline. This leads to some confusion for us when we meet with the tribes and the specific state workers.

From: LINDA SANCHES <lsanches@OSASPE.DHHS.GOV>
To: Washington.DC1(JBonney)
Date: 3/23/98 10:56am
Subject: SAMHSA report on children's health outreach -Reply -Forwarded

Received: from SAMHSA-Message_Server by SAMHSA.GOV
with Novell_GroupWise; Thu, 19 Mar 1998 17:08:39 -0500
Message-Id: <s5115117.074@SAMHSA.GOV>
X-Mailer: Novell GroupWise 4.1
Date: Thu, 19 Mar 1998 17:08:20 -0500
From: Sheri Rucker <SRucker@ngmsmtp.samhsa.gov>
To: lsanches@OSASPE.DHHS.GOV
Subject: SAMHSA report on children's health outreach -Reply

Hi,
I have requested information from all division heads re: outreach activities and expect to have by COB Monday. I think by Wed. at the very latest I can send you a complete more up-to date report. If this is already too much let me know.
Thanks for your help and it was great talking with you earlier.
s

Substance Abuse and Mental Health Services Administration

I. SAMHSA is an independent agency within the Department of Health and Human Services. SAMHSA consist of three centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). In Partnership with States and others, SAMHSA strives to address the needs of individuals with substance abuse and mental illnesses and address community risk factors which contribute to these illnesses. With respect to substance abuse, activities are intended to reduce incidence and prevalence, improve access to prevention and treatment programs, enhance effectiveness of services, and reduce personal and community risks. With respect to mental health, activities are intended to promote recovery and improve the quality of life for

adults with serious mental illness and children with a serious emotional disturbance and improve the overall mental health of the Nation's people by promoting access to and increasing the development of systems of integrated, comprehensive, community-based services for adults with a serious mental illness and children with a serious emotional disturbance.

SAMHSA's mission within the Nation's health system is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order ro improve health and reduce illness, death, disability, and cost to society. disturbance.

II. Agency Programs That Serve Middle To Low-income Children

Center for Substance Abuse Prevention: Program Descriptions: FY 1998

Community Partnership Program
The Community Partnership Program supports and empowers communities, schools and families to join together and work towards solving their own problems e.g., substance abuse, violence, HIV/AIDS, drunk driving, school failure, delinquency, etc. Community Partnership grants permit representatives from government, business, health, religion, academia, schools, criminal justice, and other individuals to join together to assess, design, and implement community-wide prevention efforts.

High Risk Youth
The High Risk Youth Demonstration grant program supports the demonstration of innovative and effective models for the prevention of alcohol and drug use among high-risk youth. This program serves as the principle national vehicle for establishing what works in preventing substance abuse among high-risk populations. These grants are community based and differ with respect to (1) type of grantee; (2) age, race/ethnicity, risk factors of the target population; (3) setting for the project; (4) rural or urban environment; and (5) number and types of intervention strategies.

Predictor Variables
The program is designed to enhance knowledge about preventing substance abuse by determining the kinds of interventions that will be effective in changing the developmental path for children at risk of substance abuse and linking them with appropriate developmental stages. The studies are designed to answer the following research question: At what developmental stage(s) does enhancement of each of the variables being investigated prove most effective in preventing/reducing negative behaviors that are predictive of substance abuse?

In FY 1996/7, CSAP awarded 11 grants designed to study four behavioral characteristics and/or patterns of behavior in childhood and adolescence that are predictive of more serious forms of adult disorders, including substance abuse. These variables studied are: social competence, self-regulation and control, school bonding and academic achievement, and parental/care giver involvement.

Managed Care and Vulnerable Populations Cooperation
In September, 1996, SAMHSA's three Centers (CSAP, CSAT and CMHS) funded the first set of fifteen cooperative agreements (five per center) to study the impact of managed care on vulnerable populations. The program is designed to enhance knowledge about how managed care in the public sector affects the provision of substance abuse (SA) and mental health (MH) prevention and treatment services. The purpose of this cooperative agreement program is to generate knowledge on 1) the types of SA and MH services provided in managed care environments for publicly f

>>> LINDA SANCHES <lsanches@OSASPE.DHHS.GOV> 03/18/98 05:26pm >>>
Sheri: I tried severak times to call you at the number listed in the departmental locator but couldn't reach a real person or get a voicemail. please let me know your actual phone number.

I would like to touch base with you about your agency submission, make sure you are clear on the guidance Jenny and I sent out yesterday. as you

know, we need reports friday morning. I'd appreciate it if we could touch base in the morning.

thank you!

NATIONAL GOVERNORS ASSOCIATION

February 18, 1998

Contact: Becky Fleischauer
202/624-5364

Nation's Governors are Proud Partners in Effort to Expand Health Insurance to America's Children—

"States Act Quickly to Seek Out and Enroll Uninsured Children"

Washington, D.C.—The nation's Governors are proud partners in achieving the goal of extending health insurance to America's children. The Governors applaud President Bill Clinton and Congress in helping to meet that goal and are pleased to be partners in today's Washington, D.C., Children's Hospital news conference highlighting the need to provide children with health insurance.

First Lady Hillary Rodham Clinton and U.S. Health and Human Service Secretary Donna Shalala listen as President Bill Clinton applauds nation's governors for their efforts to expand health coverage to uninsured children.

Under the new State Children's Health Insurance Program (S-CHIP) included in the Balanced Budget Act of 1997, states are making it a top priority to locate uninsured children, educate families about taking advantage of the new program, and make enrollment easy. S-CHIP gives states access to $24 billion in federal grants over the next five years to create meaningful and comprehensive health insurance programs for previously uninsured children. The most important criteria that will be used to judge the success of the new children's health program is a decline in the number of uninsured children. State strategies to find, reach, and enroll children in health insurance programs will be key in achieving that goal, and early indications look promising. In the first year alone, states are projecting they will enroll more than 2.5 million currently uninsured children. More than one quarter of the states have or plan to have programs up and running by the end of March.

Governors remain committed to ensuring that children eligible for Medicaid benefits receive those benefits. Beyond that, reaching the population of children living in working, low-income families presents a new challenge for the nation. The federal government, states, and communities will need to work together to develop outreach strategies that inform and educate working families and while preserving their pride and self-respect. The Governors believe that a constructive solution to the difficult problem of locating and signing up millions of uninsured children lies in a joint federal-state-local partnership.

In March the National Governors' Association (NGA) Center for Best Practices will release an *Issue Brief* discussing outreach and enrollment of children in the new State Children's Health Insurance Program (Title XXI) and Medicaid. This paper will outline the requirements of the Title XXI legislation for conducting outreach efforts, coordinating and facilitating enrollment with Medicaid, and identifying state and national options for funding. This *Issue Brief* will describe successful state efforts to streamline enrollment and reduce administrative barriers for parents and families, describes statewide media and awareness campaigns for health assistance and health promotion, and highlight best practices for outreach activities. Following are highlights of state success stories that will be described in the upcoming *Issue Brief.*

Seeking Out and Enrolling Every Eligible Child

An impressive array of outreach activities is already at work across the nation. The creation of S-CHIP through the Balanced Budget Act provides an opportunity to coordinate these outreach strategies to find and enroll every child. States are aggressively locating uninsured families, educating families about taking advantage of the new program, and making enrollment easy. Sometimes this process is as simple as giving the program a name that attracts low-income working families whose children are uninsured. Successful outreach programs have found that health insurance programs are more attractive to low-income working families if they are not associated with welfare programs. Marketing names like Arkansas' Arkids, California's Healthy Families, Florida's Healthy Kids, New Jersey KidCare, South Carolina's Partners for Healthy Children, and Vermont's Dr. Dynasaur, provide the opportunity to educate the public about the availability of health insurance for children and at the same time send a message promoting healthy behaviors and prevention. Many states are working with schools and sending letters signed by the Governor home with every school child.

Acting Quickly to Insure Children
The first day new funding for states was available—October 1, 1997—several states began enrolling children in the new program. This action was initiated *before* the first Title XXI children's health insurance program plan was even approved by the federal government's oversight agency, the Health Care Financing Administration (HCFA). Several states took these bold steps to enroll children immediately, banking on negotiating approval of their plans with HCFA and receiving the new enhanced federal matching funds.

- **Florida** increased enrollment in the Florida Healthy Kids program by 25 percent since October 1997 because of an increased state appropriation. Florida plans to build on this increase when their Title XXI plan is approved by HCFA. In anticipation of its approval, Florida has put systems in place to fully utilize their Title XXI funds to launch an aggressive outreach and marketing campaign.
- **Idaho** will mail more than 5,000 postcards to families who are no longer eligible for cash assistance under the new welfare program, Temporary Assistance to Needy Families (TANF), to advise them of expanded Medicaid eligibility. Since October 1, Idaho has enrolled 755 new children into Medicaid--that represents 2.5 percent of potentially eligible children.
- **South Carolina** initiated aggressive outreach and enrollment. Since an expansion in August 1997, 30,000 additional children have enrolled in Medicaid, 27 percent of the state's targeted population. By comparison, in the previous six months, 9,000 children were enrolled in Medicaid.
- **New York** made remarkable progress in expanding the Child Health Plus program through aggressive marketing and outreach. Since June 1997, New York experienced a fourfold increase in the number of new children enrolled per month, increasing from about 1,200 children in June to 5,000 in December.

Developing State Plans - Best Practices Underway in the States
California Gov. Pete Wilson proposed a multipronged outreach strategy in the state's children's health plan. California is positioned to conduct a multimedia campaign and a primer for the business and provider community, as well as to forge contracts with community-based organizations to identify and help families enroll their children into Medi-Cal and the new Healthy Families insurance program. California is considering offering a $25 one-time bonus to organizations and individuals that successfully enroll children into the insurance program.

Colorado Gov. Roy Romer is using technology to extend the reach of his state's program. Colorado will market information about the new Child Health Plan Plus on the Internet, where the public can access information about the program and complete applications on line. Most public libraries have computers with access to the Internet that can be used by families without home personal computers.

Connecticut Gov. John G. Rowland has proposed an ambitious approach to enroll children eligible for Medicaid and for the new HUSKY Plan (Healthcare for UninSured Kids and Youth). The state is using radio and television ads, a direct mail campaign to all households with incomes

below 300 percent of the federal poverty level, brochures and flyers, videos, web sites, and presentations by state staff.

Florida Gov. Lawton Chiles' Healthy Kids program relies heavily on partnerships with schools to identify and enroll eligible children. Marketing materials are written at a fifth-grade reading level and are available in several languages. Florida took advantage of an eligibility database to identify more than 80,000 children who receive food stamps but are not eligible for Medicaid. The Florida Healthy Kids Corporation plans to reach out to those families with information and application forms.

Illinois Gov. Jim Edgar continues to guide planning efforts for expansion of the Illinois Child Health Initiative. In phase one, the state will make special efforts to identify eligible migrant children and homeless children through community-based organizations that provide food and shelter to homeless families. Children with special health care needs and children living in rural areas will also be the focus of targeted outreach efforts.

Massachusetts Gov. Argeo Paul Celluci proposes to offer mini-grants to community-based organizations to find and enroll traditionally hard-to-reach populations, including adolescents, seasonal workers, and young parents. Provider outreach and education is being coordinated with the Massachusetts Medical Society and Hospital Association. MassHealth is a combined Medicaid and state-designed health insurance program.

Michigan Gov. John Engler plans to award funds to counties for outreach and marketing of the new MIChild health insurance program for children. The state will require the counties to involve key stakeholders including public health agencies, schools, hospitals, temporary employment agencies, Head Start, food banks, churches, the business community, and neighborhood associations.

Ohio Gov. George V. Voinovich made increasing enrollment into Ohio's Healthy Start Medicaid program a top priority. Gov. Voinovich held numerous news conferences to announce and advertise expanded eligibility. Ohio is also sending thousands of flyers, posters, and mail-in application forms to medical centers, hospitals, schools, childcare centers, Head Start programs, and social service offices and has established a new toll free children's health insurance helpline. Since January 1, 1998, 12,120 additional children have been enrolled into their Medicaid program.

Oklahoma Gov. Frank Keating's SoonerCare Plus and SoonerCare Choice programs are now expanded to cover approximately 100,000 children and 4,000 pregnant women. Major changes have been made to the application form that is now just one page, front and back, with processing time reduced to less than three weeks.

South Carolina Governor David M. Beasley spearheaded a comprehensive outreach effort that included contacting every school district, working with providers and pharmacies, and streamlining enrollment forms and procedures. The Governor held four news conferences to kick off the new health insurance program for children—Partners for Healthy Children. The program uses a one-page, bright yellow form that is easy to complete and can be mailed in with copies of pay stubs or tax forms to meet income eligibility requirements. South Carolina is also using existing databases with income and age information to match up potentially eligible children.

Table 1 summarizes seven proven effective strategies states have employed to simplify and ease the enrollment process, which have subsequently increased enrollment of pregnant women and children into Medicaid. For those states that will be creating a new state-designed insurance program with their Title XXI funds, these proven strategies can easily be implemented and applied.

Table 2 outlines the campaigns and the effective efforts that states employ to make pregnant women and families aware of medial assistance programs.

Table 1. Strategies employed to simplify and ease the enrollment process

State	Dropped the Assets Test	Shortened Application	Mail-In Eligibility Forms	Available at Multiple Sites	Submit at Other Sites	Combined Forms	Presumptive Eligibility for Pregnant Women
Alabama	*	* a	*	*	*		
Alaska	*	*	*	*	*		
Arizona	*			*	*	*	
Arkansas		*	* c	*	*		*
California	*	* b		*	*		*
Colorado	* a	*	*	*	*		*
Connecticut	*	* c	*	*	*		*
Delaware	*	* b	*	*		*	* 8
Florida	*	*		*			*
Georgia	*	*	*	*	*		*
Hawaii	*	*	* c	*			
Idaho				*			*
Illinois	*	*	*	*			*
Indiana	* 1		*	*		*	
Iowa		*		*	*		*
Kansas	*	* 4					
Kentucky	*	* a		*		*	
Louisiana	*	* a		*	*		*
Maine	*		*	*		*	*
Maryland	*	*		*	*	*	
Massachusetts	*	* b	*	*			*
Michigan	*	*	*	*	*	* 6	
Minnesota		*	*	*			
Mississippi	*	*	*	*	*		
Missouri	*	*		*		*	*
Montana				*			
Nebraska	*	*	*	*			*
Nevada		*		*			
New Hampshire	*	*	*	*			*
New Jersey	*	*	*	*	*		*
New Mexico	*	*	*	*			*
New York	* 2	*		*	*	*	*
North Carolina	*	*	*				*
North Dakota	*		*	*			
Ohio	*	*	*	*	*	*	
Oklahoma		*	* a	*	*		*
Oregon	*	*	*	*	*		
Pennsylvania	*	* a	* a	*		*	*
Rhode Island		*		*	*	*	
South Carolina	*	*	* 5	*	*		*
South Dakota	*	*				*	
Tennessee	*	* b		*			*

Texas	* 3	*		*	*	* 7	
Utah		*	*	*	*	* 7	*
Vermont	*	*	*	*	*	*	
Virginia	*	*	*	*	*	*	
Washington	*	* c	*	*			
West Virginia	*	*	*	*	*		
Wisconsin	*	*	*	*	*		*
Wyoming		* b	*	*	*	*	*
TOTAL	**40**	**44**	**33**	**47**	**27**	**18**	**27**

Notes to Table 1.

a For women only

b Applies to entire Medicaid population

c For children only

1 Indiana is reinstating the assets test for pregnant women.

2 New York has dropped the assets test for children born after August 30, 1983.

3 Texas has dropped the Assets test for pregnant women only.

4 Kansas is in the process of redesigning their application form.

5 South Carolina's mail-in application forms are for the new Title XXI program only.

6 Michigan uses a joint income calculation form for WIC and MICH-Care (Medicaid program for pregnant women).

7 Texas and Utah have combined the Medicaid application with TANF and Food Stamps.8 Delaware began presumptive eligibility in 1997.

Table 2. Efforts states employ to make pregnant women and families aware of medial assistance programs.

State	Program Name	Toll Free Hotline	Radio Campaign	Print Media	TV Campaign	Coupons or Incentives	Private/ Corporate Assistance	School-Based Efforts
Alabama	Healthy Beginnings	*						*
Alaska	Healthy Alaskans	*						
Arizona	Baby Arizona	*	*	*			*	*
Arkansas	Campaign for Healthier Babies/ Connectcare	*	*	*	*	*	*	
California	BabyCal	*	*	*	*		*	*
Colorado	Family Healthline/Baby Care Kids Care	*		*	*		*	
Connecticut	Healthy Start	*	*	*				
Delaware	Resource Mothers	*						
Florida	Help them thrive birth to five/ Healthy Baby Helpline	*						
Georgia	Right from the Start	*	*		*	*		*
Hawaii	Mothers Care for Tomorrow's Children	*	*	*	*	*	*	
Idaho	Careline	*					*	

Illinois	Help Me Grow Campaign	*		*				*
Indiana	Prenatal & Family Care Coordination	*		*	*	*	*	
Iowa								
Kansas		*			*			
Kentucky		*	*	*	*		*	*
Louisiana	Partner's for Healthy Babies		*	*	*		*	
Maine	Maine Children's Alliance							
Maryland	Maternal and Child Health Hotline	*	*	*	*			*
Massachusetts								*
Michigan		*						
Minnesota	Child & Teen Checkups Program			*	*			
Mississippi	Take Care / Delta Futures	*	*		*	*		*
Missouri	Temporary Medicaid Pregnancy Program	*		*				
Montana	Healthy Mothers Healthy Babies	*	*	*	*	*	*	
Nebraska	Healthy Mothers Healthy Babies Helpline	*	*	*	*		*	*
Nevada	Baby Your Baby	*		*	*	*	*	
New Hampshire	Lets Be Health Smart	*		*				
New Jersey								
New Mexico	New Mexico Outreach/ From Day One	*	*	*	*		*	*
New York	Child Health Plus	*	*	*	*		*	*
North Carolina	First Step/Healthcheck	*	*	*	*	*	*	
North Dakota	North Dakota Health Tracks	*		*				*
Ohio	Help Me Grow	*				*	*	*
Oklahoma		*	*		*		*	*
Oregon		*						
Pennsylvania	Healthy Beginnings Plus					*		*
Rhode Island	RIte Care	*						*
South Carolina	Careline	*				*	*	
South Dakota								
Tennessee	TennCare/ Campaign for Healthier Babies	*	*	*	*	*	*	*
Texas		*						
Utah	Baby Your Baby Program	*	*	*	*	*	*	*
Vermont	Healthy Babies	*		*			*	*
Virginia		*						*
Washington		*				*	*	*
West Virginia		*	*	*	*			*
Wisconsin	Healthy Start Pregnancy Outreach	*		*	*			
Wyoming	Help Me Grow/ Safe Kids/ Best Beginnings	*		*	*		*	
TOTAL		**X2**	**19**	**27**	**2X**	**1X**	**23**	**23**

—End—

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CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)
HCFA/HRSA POINT OF CONTACT

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STATES IN EACH REGION

I.	BOSTON	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	VI.	DALLAS	Arkansas Louisiana New Mexico Oklahoma Texas
II.	NEW YORK	New Jersey New York Puerto Rico Virgin Islands	VII.	KANSAS CITY	Iowa Kansas Missouri Nebraska
III.	PHILA.	Delaware Dist. of Columbia Maryland Pennsylvania Virginia West Virginia	VIII.	DENVER	Colorado Montana North Dakota South Dakota Utah Wyoming
IV.	ATLANTA	Alabama North Carolina South Carolina Florida Georgia Kentucky Mississippi Tennessee	XI.	SAN FRAN.	American Samoa Arizona California Guam Hawaii Nevada
V.	CHICAGO	Illinois Indiana Michigan Minnesota Ohio Wisconsin	X.	SEATTLE	Alaska Idaho Oregon Washington

WE NEED YOUR HELP TO REACH OUT TO IMPROVE THE HEALTH OF OUR NATION'S CHILDREN

[logo]

you can help children in your state get free or low-cost health insurance

DID YOU KNOW --- THAT OVER 10 MILLION CHILDREN (BIRTH TO AGE 19) IN AMERICA WHO HAVE NO HEALTH INSURANCE?

- Most of these children are now or soon will be eligible for some type of government health insurance.

PURPOSE OF THIS BROCHURE:
To provide workers who administer or operate Federal programs with information about how children from low income working poor families may be eligible for health insurance.

- More than 3 million of these children are eligible for Medicaid but are not enrolled and remain uninsured.

- Several million more are eligible for the new State Children's Health Insurance Program (CHIP). Most States will develop and implement programs in 1998.

We need your help in identifying and enrolling children eligible for health insurance. Many of these children or their parents may be participants in the programs you administer.

This brochure explains the government program options, which children are eligible, where you can get more information and how you can help.

WHAT IS CHIP?

The Children's Health Insurance Program (CHIP) is a jointly-funded, Federal-State program designed to provide health insurance to children in families who have too much income to qualify for Medicaid and too little income to pay for private insurance.

CHIP gives States a fixed amount of funds to cover children through:

- a new State insurance program;

- Medicaid expansion to cover eligible children at higher family incomes; or

- combination of the two.

States are now developing and implementing these health insurance programs to reach uninsured children. Names of State health programs will vary as States seek innovative ways to reach eligible children.

WHAT IS MEDICAID?

Medicaid is a jointly-funded, Federal-State program that covers 20 million of America's poorest children. Many more children are eligible but have not enrolled and are not covered.

Both the CHIP and Medicaid programs provide comprehensive health insurance coverage at no or minimal cost to children under 19 in lower income families.

Families that lose or are denied other public assistance may still be eligible for health coverage (e.g., children in families who lose cash assistance, disabled children denied Supplemental Security Income, etc.)

HOW YOU CAN HELP?

By identifying children who participate or whose parents participate in programs you administer may be eligible for Medicaid or CHIP.

- When working with parents and families, ask them if their children have health insurance coverage.
- If not, then inform them that their children may be eligible for health insurance assistance and give them contact information.

HOW CAN YOU IDENTIFY CHILDREN THAT MAY BE ENROLLABLE?

Here's how you can help in identifying children who may be eligible for the new health insurance program.

- **States set income levels** within general guidelines. In 1998, children in a family of three:
  - may be eligible for Medicaid with incomes up to $18,000 per year ($1,500/month) if under age 6 and $13,000 per year ($1,085 / month) if age 6 or above .
  - may be eligible for CHIP (varies) with incomes up to $26,000 per year ($2,170 / month) .

Income limits are higher in some States and of course for families with more children. Many States have not begun enrollment in CHIP but all have Medicaid programs.

HOW CAN YOU ASSIST FAMILIES TO ENROLL CHILDREN?

In some States, you can enroll children in designated offices.

- **Presumptive eligibility**: States now have the option to allow eligibility workers for Head Start, WIC and child care subsidies under the Child Care and Development Block Grant to give children temporary Medicaid and CHIP eligibility.
- **Outstationing eligibility workers**: States may receive Federal funds to place eligibility workers in your offices.

Check with your State Medicaid and/or CHIP agency to see if you can participate in these enrollment options or simply refer potentially eligible children to these offices.

FAMILIES WHO APPEAR ELIGIBLE SHOULD CALL THE FOLLOWING NUMBER FOR MORE INFORMATION:

STICKER WITH STATE'S MEDICAID NUMBER # OR THE NEW NATIONAL 8OO #

HOW YOU CAN LEARN MORE?

Information on Medicaid & CHIP: National information is available through:

- Call: 410/786-xxxx
- Write: CHIP, HCFA, 7500 Security Blvd. Baltimore, MD 21244-1850
- Contact: HCFA Regional Offices
- Internet: www.hcfa.gov

State information on CHIP will become available as States implement their programs. State Medicaid information is available through:

STICKER MEDICAID STATE OFFICE #

DON'T FORGET: ASK AND REFER!

Draft: 25 March 1998

INTERAGENCY CHILDREN'S HEALTH OUTREACH TASKFORCE

PURPOSE

Today health care coverage remains a major issue for many families. Over ten million children are without health insurance coverage in the United States, the largest number ever reported by the Census Bureau. About 90% of all uninsured children come from working households. Their parents work, pay taxes, and meet commitments but cannot afford health care coverage.

Many poor children eligible for CHIP and/or Medicaid are currently in contact with one or more Federal programs, making these programs appropriate markets for reaching out to uninsured children. Most children are enrolled in child care programs, Head Start and schools. Many participate in school breakfast and lunch programs. Others are enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Federal Food Stamp Program. They attend public health clinics for immunizations and health care. Their parents interact with the IRS, the Bureau of Unemployment and HUD.

The Federal Government is well positioned to do more to assist the States and the private sector in developing and implementing outreach activities to ensure the enrollment of eligible children in health insurance programs. This report contains the current and proposed outreach activities and the coordinating efforts of each Department and Agency in the Federal Government involved with low-income families and children.

BACKGROUND

Every child in the United States deserves a bright future. Access to quality, affordable health care is a significant step toward that future. The Balanced Budget Act of 1997, a bipartisan effort, provides $24 billion dollars to extend health care coverage to children over the next five years. The State Children's Health Insurance Program (CHIP), Title XXI of the Social Security Act, defines the parameters of the new program to insure the poor children of the United States. The Federal Government has established basic guidelines for the program but States have significant latitude and flexibility to create a specific program to meet their individual State needs. The law allows up to 10% of the state expendature for administration, outreach, and direct health services. An essential component to the success of CHIP is *outreach.*

Outreach is a dynamic process to identify, enroll and assure appropriate use of health care services. Paramount to the success of CHIP is the development of effective communication networks to get the message of each State's program to every uninsured child and family in the state. Most importantly, parents, children, communities and providers need to know about the programs and how to enroll. Legislation is only the first step to resolving the problems of the uninsured. The legislation must be translated into action and the information about the program needs to be widely publicized and disseminated. This will asssure that families have information about the program, the enrollment process and access to comprehensive systems of health care. Outreach involves reaching out to potential clients and informing them of the program, facilitating their enrollment in the program and finally, educating them to use the program. Outreach calls for network building across America to involve all providers, purchasers, public and private sector, schools, religious institutions, child care centers, communities, with all working together to form

dynamic networks for information dissemination for the benefit of uninsured children. Outreach at the Federal level begins with all Federal Agencies working together to educate all Federal workers about the growing problem of uninsured children. They must work with the States and local governments to meet the ultimate outreach goal of maximum enrollment. Effective outreach requires enlisting the help of the community in devising new outreach strategies geared to diverse populations, advertising widely on billboards, television and radio, and involving community health advocates, children's agencies and parents' networks to spread the word. It calls for streamlining the application and enrollment/eligibility process by shortening forms, accepting mail-in applications, speeding up processing, and placing eligibility workers at convenient locations. Use of a joint application form for different programs will enhance coordination of resources across programs serving the same children.

PRESIDENT'S DIRECTIVE

. Why are these children without health coverage? The barriers are immense. Families don't know about the programs. The application process is long and arduous and beyond the ability of many families. The stigma of social welfare remains strong in many areas. The President's challange is to remove the barriers, educate everyone involved with children about the programs and, ultimately, enroll every elegible child in a health care plan.

The President has issued an Executative Directive to each Federal Department with programs that focus on children to become involved in an intensive interagency outreach effort, beginning with: 1) identifying all employees and grantees who work with the children, 2) developing and implementing an educational strategy to insure the employees and grantees are educated about

the availability of Medicaid and the CHIP program, 3) developing an Agency specific plan as part of the Administration-wide outreach plan and (4 identifying any statutory or legislative barriers which impact identification and enrollment of uninsured children in a State program. The final directive is to the Department of Health and Human Services to serve as coordinating Agency for the development of a report of these activities and to ensure that Federal interagency activities are complementary, aggressive, and consistent with the overall initiative to cover uninsured children.

INTERAGENCY TAKSFORCE PROCESS

The Interagency Children's Health Outreach Taskforce with representatives from the eight Departments (Health and Human Services, Agriculture, Education, Housing and Urban Development, Interior, Department of Labor, Treasury, and Social Security Administration) convened on 26 February 1998 by the Domestic Policy Council staff. The Department of Health and Human Services is the coordinating Agency for preparing the report detailing each Departments plan. The Taskforce agreed to meet on a weekly basis to discuss agency specific programs, to coordinate effective education programs for the Federal Agencies involved in the endeavor, and to elicit education and outreach strategies which each Agency could be responsible for implementing. A 90 day agenda and timeline was established in addition to Agency specific assignments and subgroups. Each Agency was tasked with developing an action oriented report focusing on programs that serve low-income children. Several subgroups were formed to address specific issues such as Native Americans, minorities, eligibility requirements across programs and joint communications strategies. The Agency report includes a description of the programs serving middle to low-income children and the current and proposed children's health outreach activities. Included in this are specific efforts each Department is commited to carry out to

educate workers about Medicaid and CHIP and its activity coordination with other programs. The report includes recommendations and a suggested implementation time table from each of the eight participating Departments.

PLEASE NOTE: THIS IS A DRAFT. SEVERAL ADDITIONS TO THE PROPOSED OUTREACH SECTIONS ARE FORTHCOMING FROM HRSA'S BUREAUS.

CHILDREN'S HEALTH INSURANCE OUTREACH
HEALTH RESOURCES AND SERVICES ADMINISTRATION

- INTRODUCTION

The Health Resources and Services Administration (HRSA) directs national health programs which improve the health of the Nation by assuring quality health care to underserved, vulnerable and special-need populations and by promoting appropriate health professions workforce capacity and practice, particularly in primary care and public health. HRSA's Bureaus take an active role in working to achieve this goal.

The Bureau of Primary Health Care

The mission of the Bureau of Primary Health Care (BPHC) is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations who experience financial, geographic, or cultural barriers to care. BPHC funds a number of programs in order to achieve this goal.

The Community Health Center Program (CHC) is a Federal grant program funded under Section 330 of the Public Health Service Act to provide access to case-managed, family-oriented preventive and primary health care services for people living in rural and urban medically underserved communities. The CHC program makes grants to public and nonprofit private entities for the development and operation of CHCs. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population. They tailor the services provided to the needs of the community.

The Health Care for the Homeless Program (HCH) seeks to improve access by homeless individuals to primary health care and substance abuse treatment. HCH grantees are encouraged to develop, or actively participate in, local coalitions of health care providers and social service agencies. This involvement has been important in identifying community resources for the provision of shelter, food, clothing, employment training, and job placement for homeless individuals.

The National Health Service Corps (NHSC) seeks to increase access to primary care services for people in health professional shortage areas by assisting in the development, recruitment, and retention of community-responsive, culturally competent primary care providers. The NHSC is committed to the team approach of providing primary and preventive care to people living in health professional shortage areas. The primary health care team includes primary care physicians, nurse practitioners, physician assistants, certified nurse-midwives, dentists, dental hygienists, and mental health professionals including clinical psychologists, clinical social workers, marriage and family therapists, and psychiatric nurse specialists.

The Maternal and Child Health Bureau

The Maternal and Child Health Bureau (MCHB) provides leadership, partnership, and resources to advance the health of all our Nation's mothers, infants, children, and adolescents-including families with low income levels, those with diverse racial and ethnic heritages and those living in rural or isolated areas without access to care. The Maternal and Child Health Bureau administers three major programs: the Maternal and Child Health Block Grant, Healthy Start, and the Emergency Medical Services for Children Program.

The Maternal and Child Health Services Block Grant has three components: formula block grants to 59 States and territories, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS) grants. The purpose of the block grants to the States is to create Federal/State partnerships to develop service systems in our Nation's communities to meet critical challenges in maternal and child health.

The Healthy Start Initiative funds the development of programs and strategies to reduce infant mortality in targeted high-risk communities, and the replication of program successes across the Nation.

The Emergency Medical Services for Children Program funds grants to the States to develop or enhance EMS programs for children with critical illnesses and life-threatening injuries.

HIV / AIDS Bureau

The HIV/AIDS Bureau administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act was signed into law on August 18, 1990 to improve the quality and availability of care for people with HIV/AIDS and their families. The Bureau funds a number of programs to benefit low-income, uninsured and underinsured individuals and families affected by HIV/AIDS, including:

Title I provides formula and supplemental grants to EMAs that are disproportionately affected by the HIV epidemic. These areas are eligible for Title I formula grants if they have reported more than 2,000 AIDS cases in the preceding 5 years, and if they have a population of at least 500,000.

Title II provides formula grants to States, the District of Columbia, Puerto Rico and eligible U.S. territories to provide health care and support services for people living with HIV disease. Grants are awarded to the State agency designated by the governor to administer Title II, usually the health department. Title II funds may be used to support a wide range of services, including home and community-based health care and support services, continuation of health insurance coverage through a Health Insurance Continuation Program (HICP), pharmaceutical treatments through an AIDS Drug Assistance Program (ADAP), local consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services, and direct health and support services.

Title III of the CARE Act supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. Medical, educational, and psychosocial services are designed to prevent the further spread of HIV/AIDS, delay the onset of illness, facilitate access to services, and provide psychosocial support to people with HIV/AIDS.

Title IV programs coordinate HIV services and access to research for children, youth, women, and families in a comprehensive, community-based, family-centered system of care.

Office of Rural Health Policy

HRSA's Office of Rural Health Policy works within the DHHS and with other Federal agencies, States, national associations, foundations, and private-sector organizations toseek solutions to health care problems in rural communities. It also assists the Secretary in developing rural health finance policy. In particular, the office advises the Secretary on how the Medicare and Medicaid programs affect access to health care for rural populations. The office also examines the rural implications of Federal and State health care reforms.

- CURRENT OUTREACH ACTIVITIES

Activities to Educate Workers about Medicaid and CHIP

BPHC, HIV / AIDS, and MCHB have sent comprehensive letters to all their grantees and the PCA/PCOs about CHIP, Medicaid, and outreach issues as well as the need for grantee participation in the collection of data on outreach efforts and children's insurance status.

BPHC has identified successful, easily replicable outreach models for uninsured children and special populations. These models will be printed in HRSA's *Reaching Our Children*, which is currently in the clearance process.

BPHC has worked with NACHC, ASTHO, PCA/PCOs, NACCHO, NCSL to deliver important messages on outreach and children's health to the community health centers.

Several Healthy Start outreach and case management programs have placed a major emphasis on linking eligible women and their infants/children to all entitlement programs to which they are eligible. To enable grantee and/or contract workers and providers of care to provide such linkages, grantees have had to provide education to all "front line" staff on entitlement resources available and what general eligibility criteria are for each type of program.

Title V programs are required to support to support a toll-free telephone number to provide infomration about providers and practicioners who deliver health care services under Title V and Medicaid to the target population.

BPHC has modified the UDS to include information relevant to outreach and children's insurance status. This information will be valuable to central and regional office staff as outreach strategies are implemented.

Activities to Educate Families and Enroll Children in Medicaid and CHIP

MCHB has close direct working constacts with organizations representing families, particularly Family Voices, which represents families of children with special health care needs.

All BPHC and ORHP grantees provide clients with application assistance for Medicaid and other programs.

All Ryan White grantees are required to assess clients for eligibility for Federal, State or private health coverage before providing Ryan White CARE Act funded services.

MCHB works with Family Voices and a number of councils to identify and enroll children with special health care needs in Medicaid.

BPHC has initiated a joint HCFA- HRSA multi-state demonstration project to expand Medicaid enrollment, particularly among children and pregnant women by improving the utilization of outstationed eligibility workers in FQHCs. Beginning in twelve States, the demonstration pilot will encourage comprehensive and innovative approaches to Medicaid enrollment through FQHCs, and document the impact of eligibility services provided through an FQHC on improving Medicaid enrollment.

Coordination with Other Programs around Medicaid and CHIP

BPHC has commissioned the Texas Association of Community Health Centers (TACHC) to work with PCAS in the five States receiving the largest CHIP allotments. TACHC will work with the PCAs in each State to assess CHIP opportunities, to collect and disseminate information and data about BPHC-supported programs and their services to children, and document the impact of the CHIP design/implementation on BPHC-supported programs. Effective strategies for ensuring BPHC-supported program participation in CHIPs will be identified, shared, and replicated in other States.

As part of all case management and many outreach programs, the front line workers and their supervisors assure linkages within and among programs serving the HS population. This often includes linking health care providers with each other, such as substance abuse providers with primary care. Linkages across provider networks have also been developed, such as connecting health care providers with social service agencies or with non-traditional providers such as churches or small community-based organizations. As part of the Year 02 Continuation Application Guidance, HS has indicated that grantees are expected to coordinate with state and local agencies on resource availability, especially Medicaid and CHIP.

Title V programs are required to coordinate their activities with other programs that serve mothers and children, including Medicaid, EPSDT, WIC, health and developmental disability programs, and family planning programs. States are directed to use their grant funds to develop a simplified joint application for programs that serve children.

MCHB and BPHC have been meeting with a number of national organizations that affect their target populations at the national level, including NACHC, ASTHO, PCA/PCOs, NACCHO, NCSL, the MCH/Medicaid TAG, the MCH / ACF TAG, and the Secretary's Advisory Council on Infant Mortality.

State Offices of Rural Health are encouraged to work with existing programs and coordinate activities across the range of state and federal initiatives that help serve rural populations.

- PROPOSED OUTREACH ACTIVITIES

Activities to Educate Workers about Medicaid and CHIP - Federal

HAB could develop a *Policy Directive* requiring grantees to educate appropriate staff about State-specific Medicaid and CHIP eligibility requirements and develop procedures for facilitating client enrollment. Case managers, benefits counselors, social workers, and others who assess eligibility for services or make referrals for services could receive special training. No new resources are needed, and it would be completed in 5 months.

BPHC is beginning NHSC training programs around community based issues and outreach with field and state offices. This will serve as a vehicle for delivering messages about CHIP, Medicaid, and outreach. No new resources are necessary and the programs should be completed by July 30, 1998.

Provision of technical assistance on child health and outreach to BPHC supported programs focused on identification and enrollment of uninsured and special population children. This project could be completed by October 1, 1998 and would require $50,000 of new resources.

BPHC is convening an outreach conference in Washington D.C., June 17-19, 1998. The conference will provide workshops on funding mechanisms and policy recommendations for outreach, and special skills building sessions for outreach workers. Issues around CHIP and Medicaid will be included in panel discussions and workshops. Attendees will include policy makers, community health workers, out stationed eligibility workers, health center executives, HMO and private health industry representatives, and key persons from non-profit and community based organizations.

BPHC intends to provide technical assistance on child health and outreach to BPHC-supported programs and other Community Based Organizations. The technical assistance will focus on how to find the uninsured and special population children, how to facilitate the enrollment of these children into Medicaid or CHIP, and how to break down the barriers to ensure these children have access to care.

Activities to Educate Workers about Medicaid and CHIP - State

BPHC is developing a campaign to educate all of its BPHC-funded School Health Programs on CHIP and Medicaid eligibility and enrollment.

BPHC intends to disseminate State-based Medicaid and CHIP information to families through its BPHC-funded health centers. In addition, center providers will be available to provide information and educate families, and brochures on CHIP and Medicaid coordinated at the Department level will be available. The brochures will be multilingual and culturally competent.

Activities to Educate Workers about Medicaid and CHIP - Other

BPHC development of a campaign to educate school health programs about CHIP and Medicaid eligibility and enrollment. This should be developed by Summer 1998 and would require an additional $20,000.

Activities to Educate Families and Enroll Children in Medicaid and CHIP

BPHC intends to integrate eligibility determination and enrollment services into the School Health Program. This will be accomplished as of Fall 1998 and will require an additional $50,000.

BPHC is in the process of collaborating with the "Every Child by Two" program to assist with the identification of Medicaid and CHIP eligible children. This will be in coordination with the Administration for Children and Families.

Coordination with Other Programs around Medicaid and CHIP

Appropriate Ryan White staff could be trained to assess eligibility for Medicaid or CHIP and enroll families in these programs. Similarly, Medicaid/CHIP eligibility workers could be on-site at locations where women and children receive HIV/AIDS services. However, this would need to be negotiated on a State by State basis.

BPHC is exploring the opportunity for collaboration with the "Together with Tots" program to assist in the identification of Medicaid and CHIP eligible children. Collaboration will begin in the summer 1998.

BPHC and the Border Health Program are exploring the opportunity for a demonstration project that will integrate behavioral health and primary care services for at risk children ages 0-7 in two border health centers. Outreach to children will be a critical component of the program and the evaluation. This also builds on the collaborative work between BPHC and SAMHSA on the Starting Early Starting Smart demonstration projects. This project will begin in FY 1999 and will cost $250,000 per border setting. Two border settings are proposed.

BPHC is exploring the opportunities for collaboration with the EZ/EC program within DHHS to assist with the identification of Medicaid and CHIP eligible children.

Children's Health Insurance Program (CHIP) Outreach
The Administration for Children and Families

ACF, together with its partners -- states, localities, and non-profit organizations, supports strategies and creates opportunities for low-income and disadvantaged families and individuals to lead economically and socially productive lives, for children to develop into healthy adults and for communities to become more prosperous and supportive of their members. Because of its vast human services networks with states, local and tribal government organizations, community-based organizations, child care and Head Start Centers, ACF is in a unique position to assist in providing information, outreach and enrollment services to assure that eligible children actually get enrolled in CHIP and Medicaid.

Our major program offices, as well as our ten regional offices, have submitted specific CHIP outreach plans. These plans identify the following major areas for ACF focus: coordination efforts with federal and state health agencies (including ACF involvement on regional interagency CHIP committees); review by ACF of State CHIP plans; general information dissemination regarding CHIP; technical assistance and training to ACF staff and partners regarding CHIP and outreach opportunities; and assistance with a national media campaign.

I. Agency Programs That Serve Middle To Low-income Children

Child Care ($3.1 billion): assists low-income families and those transitioning off public assistance to obtain child care that is safe, healthy and affordable so that they can work or attend training/education programs.

*Target population: All children under the age of 13 and *all you youth under court supervision, older you that are mentally and/or physically challenged to the age of 19. (*serving older youth, over age 13 is a State option)*

Child Support ($12 billion): locates parents, establishes paternity and support obligations and modifies and enforces those obligations (to assure financial support is available to children) through State agencies who administer the program.

*Target population: All children birth through *age of majority. (age at which a state determines a minor is an adult, varies)*

Child Welfare ($292 million): funds State programs that provide services focused at assisting at-risk children and their families in achieving the best and most appropriate outcomes for the children: preventive intervention services to strengthen the family unit; services to move children more rapidly from foster care to safe, permanent homes; and reunification services to facilitate the return home of the child if in the child's best interest.

Target population: All children, newborns to 18 years of age that may be at risk for abuse and/or neglect.

Foster Care ($3.5 billion)/ Adoption Assistance ($701 million) /Independent Living ($70

million): for children who cannot remain safely in their homes, foster care provides a stable environment that assures a child's safety and well-being while their parents attempt to resolve the problems that led to the out-of-home placement or when the family cannot be reunified, until the child can be placed permanently with an adoptive family. Independent Living programs provide education and employment assistance, training in daily skills, and individual and group counseling to youth reaching adulthood.

Target population: All children that are in foster care and teenagers who were or are in foster care ages 16+.

Head Start/Early Head Start ($4.35 billion): provides comprehensive child development services to children and families, primarily for preschoolers from low-income families through grants to local, public and private nonprofit agencies.

Target population: Low income, pre-school children ages three to five. At least 10% of the enrollment opportunities in each program must be made available to children with disabilities.

Temporary Assistance for Needy Families ($16.5 billion): promotes work, responsibility and selfsufficiency and strengthens families through funding of State-designed and administered programs that provide support to needy children and move their parents into work.

Target population: All families that meet new public assistance criteria according to "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996"

Youth Programs ($58.6 million): support services from local agencies to reduce sexual abuse of runaway, homeless and street youth; provide alternate activities for at-risk youth and further the goal of providing safe passages for the nation's youth, giving them the tools they need to successfully move from childhood to adulthood by stimulating positive development and preventing high-risk behavior. (A major focus includes looking at what works in all areas of development and disseminating best practices and proven products.)

Target population: Provides shelter, food, clothing, counseling and other supports to 80,000 + young people ages 11 through 18.

II. Plans for Children's Health Outreach

A. Current Activities in Children's Health Outreach

ACF staff are participating in interagency implementation/planning committees at Regional and Central Office levels.

ACF is reviewing State CHIP plans, in cooperation with HCFA, to ensure that ACF constituencies are being included.

Development of Website links to HCFA's CHIP site.

ACF program offices are writing Dear Grantee/Colleague letters to inform these organizations about CHIP implementation and the importance of their involvement in the process.

ACF is discussing the importance of involvement in CHIP implementation at grantee meetings and conferences.

ACF staff participated in Regional CHIP Conferences hosted by HCFA.

B. Educating Workers about Medicaid and CHIP

Federal Workers

ACF Regional staff have have been working with HCFA staff to brief on CHIP implementation and progress.

Conducting monthly ACF CHIP update meetings that involve representatives from regions and central office staff.

Distributing information and materials from HCFA on CHIP to all ACF offices.

During regularly scheduled Regional/Central Office video conferences and calls include updated information on CHIP.

State Workers

Develop and distribute Information Memorandums/Dear Colleague letters to State Welfare/ACF Program Directors.

Invite and encourage them to participate in conferences and forums that contain CHIP information and updates.

Other Workers

In cooperation with HCFA staff, provide grantees and contractors with CHIP information and briefings. (i.e., Understanding enrollment application procedures, etc...)

Invite and encourage grantees and contractors to participate in conferences and forums that contain CHIP information and updates.

Make CHIP a part of grantee and contractor meetings, conferences and forums.

Provide updates on CHIP implementation in news letters and bulletins that are targeted toward ACF programs, grantees and contractors.

C. Educating Families and Enrolling Children in Medicaid and CHIP

Educating Families

Encourage State IV-D offices to routinely petition court and administrative authorities to include CHIP information in new and modified child support orders.

Have public displays and distribution of CHIP (HCFA produced) promotional materials at prominent and visable locations in States where ACF programs/grantees/contractors are located. (i.e., Welfare/TANF Offices, Head Start/Early Head Start program locations, Tribal Government Offices, etc...)

Periodic mailings to families with children in IV-D cases, especially those that have children with no health coverage.

Focus CHIP promotional efforts in those communities that have families considered to be "underserved" by State Primary Care Access Plans and Empowerment Zone/Empowerment Community initiatives.

Supplement TA contractor for CHIP outreach activities to allow them to outreach to urban Indians, off reservation groups and Native Hawaiians and Pacific Islanders.

Assisting with Enrollment

Encourage ACF programs, grantees and contractors to provide CHIP/Medicaid enrollment applications to customers/clients.

D. Coordination with Other Programs

Department of Health and Human Services

Coordinate efforts/work with HRSA and HCFA as they begin to outreach to their clients and constituents.

Participate in any DHHS working groups/committees that will assist in the implementation of CHIP when necessary and possible.

Other Agencies

Collaborate with other Federal partners in helping to identify potential customers and in determining the best ways to serve this population.

III. Statutory and Regulatory Barriers

Concerns about he length of proposed joint Medicaid/CHIP enrollment applications in some States. (i.e, California)

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STATES of HEALTH

Community Catalyst *Volume 8, No. 7, December 1998*

Children's Health Insurance Programs: Strategies for Outreach and Enrollment

In tandem with Medicaid, the State Children's Health Insurance Program (CHIP) could cover most of the 11 million uninsured children in the United States. Nearly half of children without insurance are eligible for existing Medicaid programs, and an estimated 4 million more will be eligible under new CHIP rules.[1] The key to moving toward universal coverage for children is outreach—making sure that every child who qualifies for the programs gains access to them. This issue of States of Health discusses some of the most effective strategies for achieving that goal.

This summer, California launched Healthy Families, its Children's Health Insurance Program, with a $21 million media campaign. Yet in the first month, only 5,000 of the year's target of 200,000 people enrolled—2.5 percent. A Los Angeles HMO with enrollment projections in the thousands enrolled only 18 people.[2]

Those figures imply a dismal failure, yet there is good information from potential enrollees about its cause—and about the kinds of outreach and program changes that might produce better results. In focus groups, parents of Medicaid-eligible children told interviewers why they hadn't signed children up, despite a strong desire to have insurance for their children.

Your views are important.
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One of many reasons was a misunderstanding about eligibility. For example, some parents thought they didn't qualify because they had a job. Other parents thought the program was expensive, with out-of-pocket costs they might not be able to afford. Many parents were repelled by the stigma attached to participation and an application process they perceived as burdensome, demeaning, and an invasion of privacy.[3]

For parents, these apprehensions added up to a convincing argument against enrolling their children in Medicaid, an argument that also serves as a lesson for other states and other public insurance programs.

Getting the Word Out

Outreach should serve a broad purpose. It should be used to inform and enroll children not only for CHIP but also for Medicaid and any other public or private insurance programs for which children are eligible.[4] In addition, outreach should ensure that the families of children already enrolled in health insurance programs have information about the whole range of available services—such as the thorough diagnostic and treatment services known as EPSDT.[5]

Across the country, stakeholders—including health care and social service providers, community, religious and service organizations, unions and employers—are collaborating with state Medicaid and human service agencies to improve outreach and enrollment for children's health insurance programs. Advocates agree that such collaboration is a key to success, and the broader the better.

In Mississippi, for example, with both a new CHIP and an expanded Medicaid program, representatives of 130 organizations organized by Catholic Charities are going through the enrollment process step-by-step. In the process, they are turning up problems and barriers; task forces are making recommendations to the state for removing those obstacles to enrollment.

This is not the only kind of collaboration taking place. In Ohio, the health consumer group, UCAHN/Ohio, is working with unions to reach members whose children are eligible. Many low-wage union members, working as janitors, hotel laundry workers, or nursing home aides, receive either no health benefits or benefits for themselves only. UCAHN/Ohio, along with the Cleveland-area AFL-CIO, Jobs with

Snapshots of America's Families

Health

Health Insurance Coverage of Children

Niall Brennan

John Holahan

Genevieve Kenney

A large number of children in the United States lack health insurance and may therefore have difficulty obtaining the health care services they need.

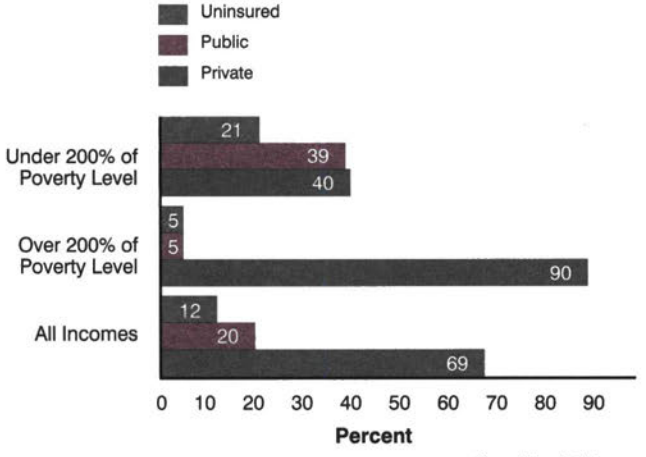
The State Children's Health Insurance Program (CHIP), enacted in 1997 in response to concerns about this situation, gives grants to states to initiate and expand health insurance programs for children in low-income families.

To examine health insurance coverage of children immediately prior to the implementation of CHIP, parents were asked a series of questions about their family's health insurance coverage at the time of the survey, including whether it was private or public. The rates of uninsurance reported here are lower than those commonly reported, based on the Census Bureau's Current Population Survey (CPS), because of differences in the questions asked (see Appendix).

Nationally, 12 percent of children were uninsured. The rate of uninsurance differed dramatically by family income: 21 percent of children in low-income families (below 200 percent of the federal poverty level) were uninsured, compared to 5 percent of children in families with higher incomes, a statistically significant difference. The type of health insurance coverage also varied significantly by family income: 39 percent of children in low-income families had some form of public coverage (primarily Medicaid and other state programs), versus 5 percent of children in families with higher incomes. Moreover, only 40 percent of low-income children had some form of private coverage (either employer-sponsored or privately purchased), compared to 90 percent of higher-income children, a statistically significant difference.

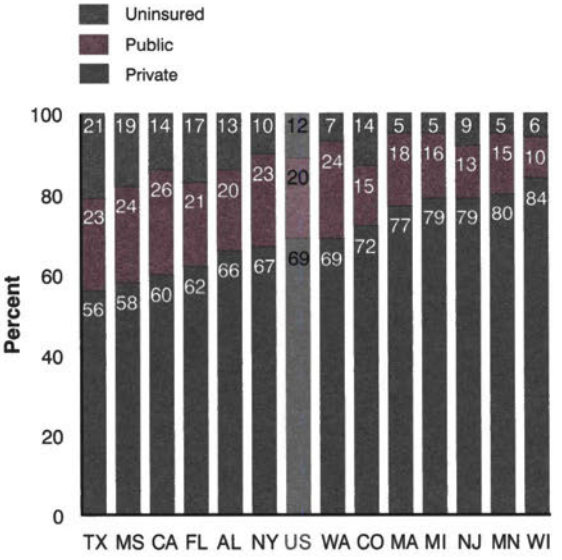
The likelihood of being uninsured varied considerably among the 13 states surveyed. Texas had the highest rate of uninsurance, 21 percent, and Massachusetts, Michigan, and Minnesota had the lowest, 5 percent. In the three states with the highest rates of

Health Insurance Coverage of Children, by Family Income, 1997



Source: Urban Institute

Health Insurance Coverage of Children, by State, 1997



Source: Urban Institute

Assessing the New Federalism

An Urban Institute Program to Assess Changing Social Policies

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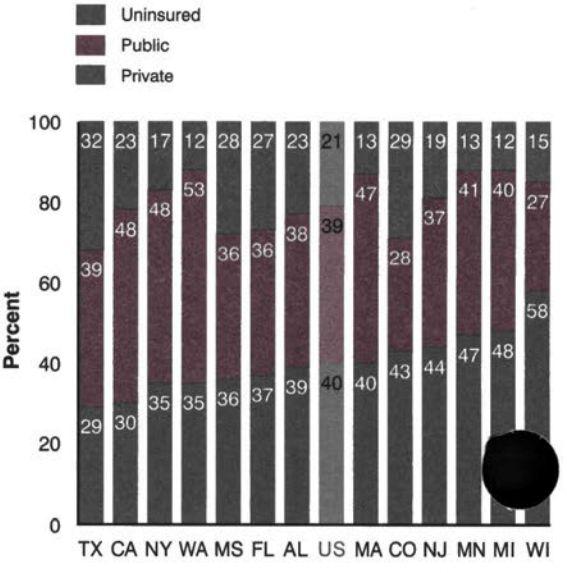
This *Snapshot* presents findings from the National Survey of America's Families (NSAF), a 1997 survey of 44,461 households with and without telephones that are representative of the nation as a whole and of 13 states. As in all surveys, the data are subject to sampling variability and other sources of error.

uninsurance—Florida, Mississippi, and Texas—private coverage was below the national average of 69 percent. In contrast, the four states with the lowest uninsurance rates—Massachusetts, Michigan, Minnesota, and Wisconsin—had private coverage rates above the national average. Among low-income children, the rate of uninsurance varied from 32 percent in Texas to 12 percent in Michigan and Washington.

While private plans are the leading source of health insurance coverage for all Americans, public insurance plays an important role, particularly for low-income children. Public coverage for these children varied from a high of 53 percent in Washington to lows of 27 percent and 28 percent in Wisconsin and Colorado, respectively. In some states, broad public coverage offset low rates of private coverage. For example, both California and Texas had below-average rates of private coverage, but California's public coverage was above the national average, whereas Texas's was not. As a result, the 23 percent uninsurance rate for low-income children in California was similar to the national average of 21 percent, while the 32 percent uninsurance rate in Texas was well above the national average.

Washington and New York were further examples: Both had below-average rates of private coverage for low-income children but above-average rates of public coverage. As a result, both had below-average rates of uninsurance. In contrast, Colorado, with private coverage similar to the national average and public coverage considerably below, had an uninsurance rate that was higher than the national average.

Health Insurance Coverage of Low-Income Children, by State, 1997



Source: Urban Institute

Children (%) Covered by Health Insurance, 1997

Type of Insurance	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
Private	39.2	29.8	42.5	37.1	39.9	47.9	46.8	35.8	44.1	35.0	28.6	34.9	58.0	39.7
Public	37.5	47.5	28.4	35.8	47.3	40.0	40.6	36.1	37.0	48.3	39.4	53.0	27.4	39.0
Uninsured	23.3	22.7	29.1	27.0	12.8	12.2	12.6	28.1	18.9	16.8	32.0	12.1	14.6	21.3
Over 200% of poverty level														
Private	91.2	90.3	87.4	84.1	93.1	94.8	94.3	87.8	92.9	91.3	83.4	88.3	95.9	90.1
Public	4.4	5.0	7.2	8.1	4.6	3.2	3.3	6.5	2.7	3.9	6.1	7.5	1.7	5.0
Uninsured	4.4	4.7	5.3	7.8	2.3	2.0	2.4	5.7	4.4	4.8	10.5	4.2	2.4	4.9
All incomes														
Private	66.2	60.0	71.9	61.5	77.1	78.8	80.0	57.9	78.8	66.8	56.2	69.2	83.7	68.6
Public	20.3	26.3	14.6	21.4	17.5	15.7	14.5	23.6	12.6	23.2	22.6	23.8	10.0	19.5
Uninsured	13.5	13.7	13.5	17.0	5.4	5.5	5.5	18.6	8.6	10.0	21.2	7.0	6.4	11.9

Figures in color represent statistically significant differences from the national average at the .05 confidence level. Figures in black are not statistically significantly different from the national average. All figures in text, charts, and table are rounded.

Source: Urban Institute

Snapshots of America's Families

Health

Health Insurance Coverage of Nonelderly Adults

Stephen Zuckerman

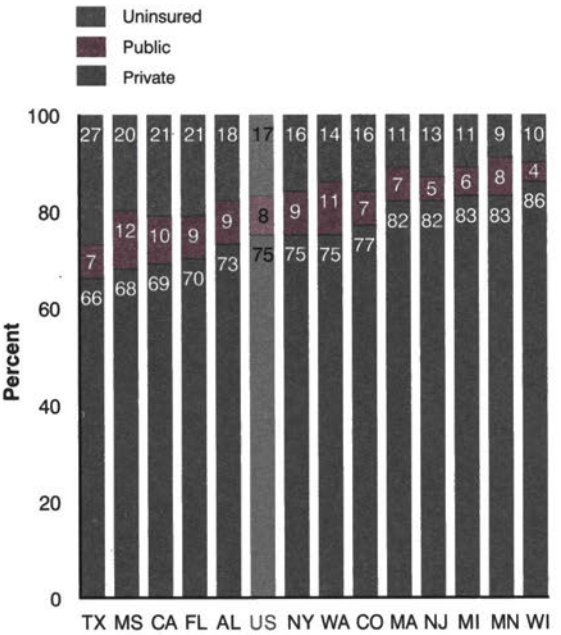
Niall Brennan

People who do not have health insurance often seek health care services later and receive less care than people who do have coverage. Most federal and state initiatives aimed at improving access to care have focused on extending insurance coverage. These programs have been developed with the recognition that, although most adults between the ages of 18 and 64 are enrolled in private health insurance plans, coverage is less likely to be provided by certain types of firms and to low-wage workers. Moreover, not all states are equally ambitious in their attempts to fill gaps in private coverage. As a result, health insurance coverage of nonelderly adults varies widely across the nation.

To document the extent of this variation, nonelderly adults were asked a series of questions about their health insurance coverage at the time of the survey, including whether it was private or public. The rates of uninsurance reported here are lower than those commonly reported, based on the Census Bureau's Current Population Survey (CPS), because of differences in the questions asked (see Appendix).

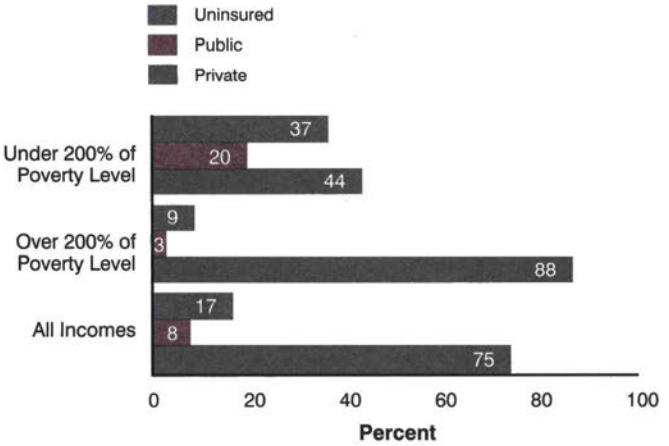
Nationally, 17 percent of nonelderly adults lacked health insurance coverage. In families with low incomes (below 200 percent of the federal poverty level), 37 percent of adults were uninsured. In contrast, 9 percent of adults with higher family incomes were uninsured, a statistically significant difference.

Health Insurance Coverage of Nonelderly Adults, by State, 1997



Source: Urban Institute

Health Insurance Coverage of Nonelderly Adults, by Income, 1997



Source: Urban Institute

Private health insurance was important in both income groups, even though their rates of coverage differed significantly: 88 percent of higher-income adults and 44 percent of low-income adults had such insurance. Public insurance programs, in contrast, covered only 20 percent of low-income adults and 3 percent of adults with higher incomes, a statistically significant difference.

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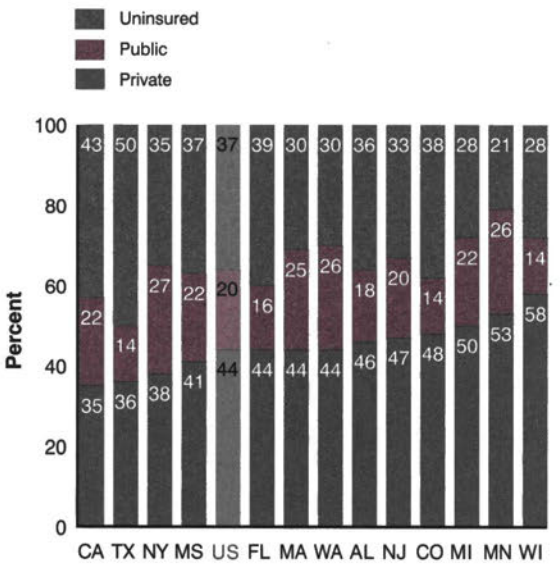
Patterns of insurance coverage varied widely across the 13 states surveyed. Among all nonelderly adults, the uninsurance rate ranged from 9 percent in Minnesota to 27 percent in Texas. Almost all of the disparity between these two states resulted from differences in private health insurance coverage. In fact, the five states with the highest rates of private coverage—Massachusetts, Michigan, Minnesota, New Jersey, and Wisconsin—also had the lowest rates of uninsurance. At the other extreme, the four states with the lowest rates of private coverage—California, Florida, Mississippi, and Texas—had the highest uninsurance rates. Only one state—Washington—had a lower uninsurance rate than the national average without a higher-than-average private coverage rate.

The differences in insurance coverage of low-income adults highlight the health policy choices made in several states. Private coverage of low-income adults was below the national average in California, New York, and Texas. However, New York's coverage of 27 percent of low-income adults through public insurance produced an uninsurance rate of 35 percent, which was comparable to the national average of 37 percent. California's 22 percent public coverage and Texas's 14 percent did not offset the deficiencies in private coverage. Consequently, both states had higher-than-average uninsurance rates for low-income adults—43 percent in California and 50 percent in Texas.

Wisconsin and Colorado offer an additional perspective on the role of private insurance in determining the uninsurance rate of low-income adults. Although each of these states covered only 14 percent of low-income adults through public programs, private coverage in each was above the national average. As a result, Wisconsin's 28 percent uninsurance rate was below the national average and Colorado's 38 percent was comparable to it.

Health Insurance Coverage of Low-Income Nonelderly Adults, by State, 1997



Source: Urban Institute

Nonelderly Adults (%) Covered by Health Insurance, 1997

Type of Insurance	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
Private	46.5	35.0	47.7	44.1	44.5	50.1	53.3	41.1	46.8	38.2	35.9	43.7	58.0	43.5
Public	17.9	22.0	14.4	16.5	25.3	21.5	25.7	22.1	19.8	27.2	14.2	25.9	14.1	19.9
Uninsured	35.6	43.1	37.9	39.5	30.2	28.4	21.0	36.8	33.4	34.7	50.0	30.5	27.9	36.6
Over 200% of poverty level														
Private	88.3	86.3	86.9	83.2	91.0	92.6	91.5	86.1	90.1	89.9	82.1	86.3	93.7	88.0
Public	3.6	4.1	4.6	5.3	2.2	1.6	2.7	5.2	2.0	2.1	3.8	5.8	1.5	3.3
Uninsured	8.1	9.6	8.5	11.5	6.8	5.8	5.8	8.7	7.9	8.0	14.1	8.0	4.8	8.7
All incomes														
Private	73.5	68.6	76.8	69.8	81.9	82.5	83.2	67.6	81.8	74.7	65.9	74.7	85.6	75.0
Public	8.7	10.2	7.1	9.1	6.7	6.3	7.7	12.2	5.5	9.5	7.4	11.2	4.4	8.1
Uninsured	17.9	21.2	16.1	21.1	11.4	11.2	9.1	20.2	12.8	15.8	26.7	14.1	10.0	16.9

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Source: Urban Institute

Snapshots of America's Families

Health

Confidence in the Ability to Get Children Medical Care

Shruti Rajan

Stephen Zuckerman

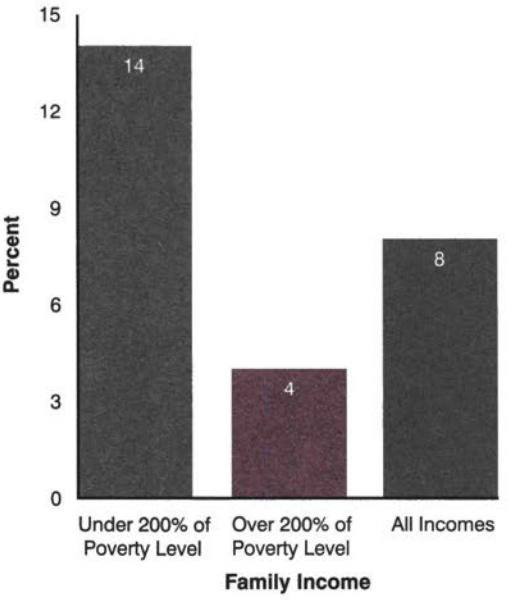
One way of assessing how well the health care system is serving children is by determining how confident parents are that they can get medical care for their children when they need it. If the persistent number of children lacking health insurance or the growing concern about the rights of patients in managed care has undermined parents' confidence, the system may not be meeting children's needs.

Parents were asked to rate their confidence about getting medical care for their children when needed by choosing the phrase that best described their feeling. Those who chose "not confident at all" or "not too confident" were classified as not confident.

At the national level, 8 percent of children under age 18 had parents who were not confident that they could get necessary medical care. However, there was a considerable difference in confidence between families with low incomes (below 200 percent of the federal poverty level) and those with higher incomes. Only 4 percent of children in higher-income families had parents who were not confident of their ability to obtain needed medical care, compared to 14 percent of children in low-income families. This is a statistically significant difference.

There was little variation in confidence among higher-income families across the 13 states surveyed, and few states differed from the national average. The one that differed most was Florida, where 8 percent of children from higher-income families had parents who were not confident about their ability to get needed care.

Children Whose Parents Are Not Confident of Getting Them Medical Care, by Family Income, 1997



Source: Urban Institute

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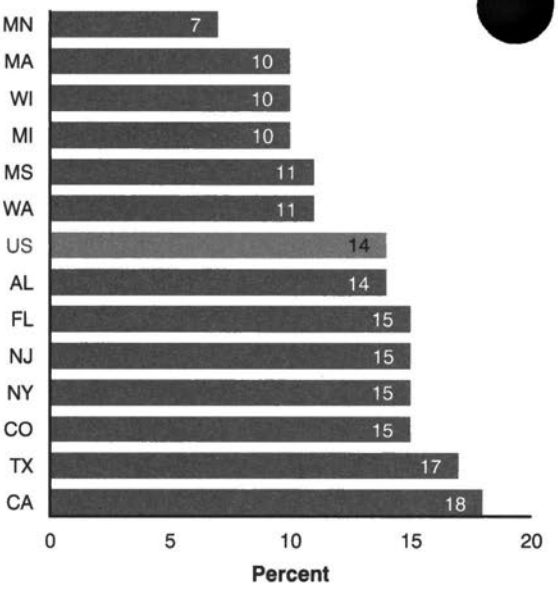
Among low-income families, confidence in the ability to get needed medical care for children varied considerably more. In six states, low-income parents were less likely than the national average to lack confidence: Massachusetts, Michigan, Minnesota, Mississippi, Washington, and Wisconsin. In California, 18 percent of low-income children had parents with no confidence in their ability to get care, above the national average of 14 percent.

Low-Income Children Whose Parents Are Not Confident of Getting Them Medical Care, by State, 1997



Source: Urban Institute

Children (%) Whose Parents Are Not Confident of Getting Them Medical Care, 1997

Family Income	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level	14.1	18.5	15.5	15.0	9.6	10.5	6.8	11.5	14.7	14.6	16.9	11.5	10.1	14.2
Over 200% of poverty level	3.7	4.5	4.6	8.0	3.2	3.7	2.4	4.8	4.3	5.1	5.0	3.9	2.2	3.9
All incomes	8.7	11.5	8.3	11.3	5.1	6.0	3.7	8.6	7.3	9.2	10.9	6.6	4.8	8.3

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Snapshots of America's Families

Health

Children and Nonelderly Adults with No Usual Source of Health Care

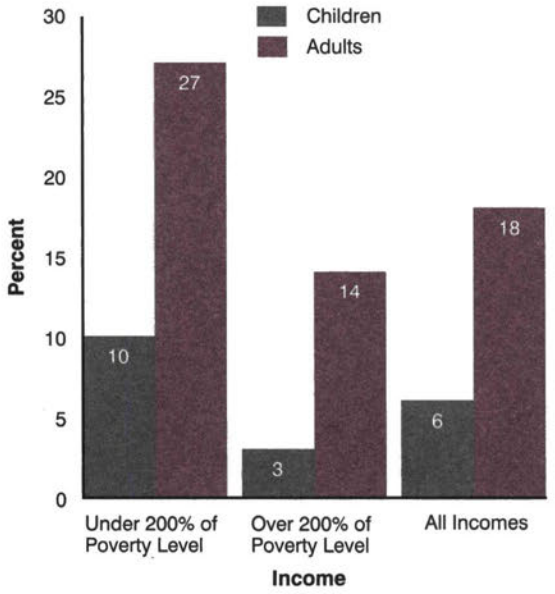
Niall Brennan

Shruti Rajan

People who lack a regular source of health care may not receive services when they need them, leading to missed diagnoses, untreated conditions, and adverse health outcomes. Maintaining regular contact with a health services provider can be difficult for low-income people, who are less likely to have health insurance coverage. People without insurance often rely on hospital emergency rooms, which can raise overall costs and lessen continuity of care.

To determine the percentage of children and nonelderly adults with no usual source of health care, adults were asked whether they and their children had a regular place or provider of care and where they received care. Those who reported that they had no regular provider or that they went to a hospital emergency room when they needed health services were defined as having no usual source of care. This was in contrast to individuals who reported that they received care at a doctor's office, a health maintenance organization (HMO), or a clinic.

Children and Nonelderly Adults with No Usual Source of Health Care, by Income, 1997



Source: Urban Institute

Nationally, adults were much more likely than children to have no usual source of care: 18 percent versus 6 percent, a statistically significant difference. This pattern held regardless of family income. However, there were large differences among adults and children across income groups. Adults in families with low incomes (under 200 percent of the federal poverty level) were almost twice as likely to lack a usual source of care as adults in higher-income families—27 percent compared to 14 percent. The disparity across income groups was even greater for children, with 10 percent of those in low-income families having no usual source of care versus 3 percent of those in higher-income families. Both of these differences are statistically significant.

Among the 13 states surveyed, there was little variation in the percentage of higher-income children who lacked a usual source of care. Only three states (Massachusetts, Minnesota, and Wisconsin) were lower than the national average of 3 percent, and no state was higher. In contrast, the percentage of children in low-income families with no usual source of care was above the national average of 10 percent in four states (Alabama, California, Florida, and Texas), with low-income children in Texas almost twice as likely as low-income children nationally to lack a usual source of care.

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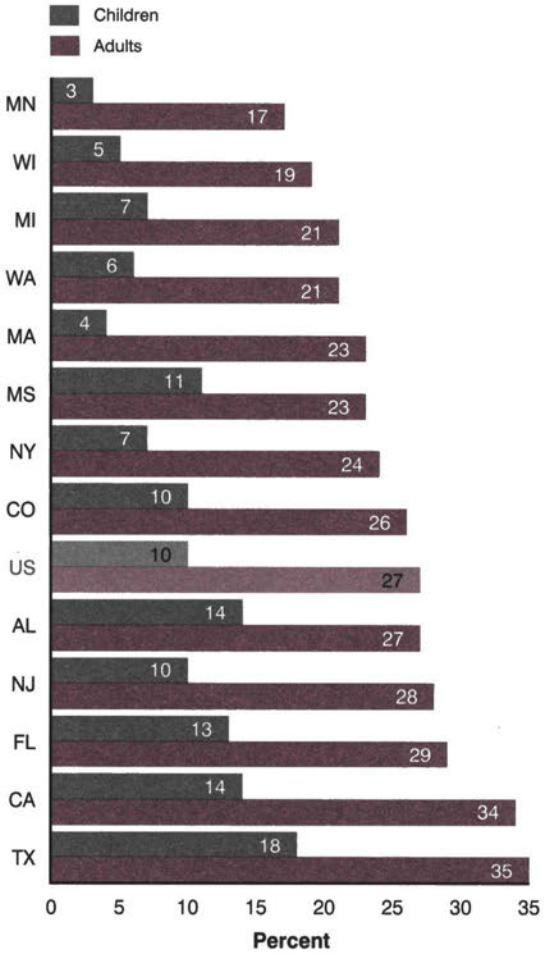
Low-Income Children and Nonelderly Adults with No Usual Source of Health Care, by State, 1997



Source: Urban Institute

The percentage of low-income adults with no usual source of care also varied considerably by state. In California and Texas, more than one-third had no usual source of care, a higher proportion than the national average. The percentage of low-income adults with no usual source of care was below the national average of 27 percent in Michigan, Minnesota, Mississippi, Washington, and Wisconsin.

Children (%) and Nonelderly Adults (%) with No Usual Source of Health Care, 1997

Age	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
Under 18	14.2	14.4	10.3	13.4	3.9	6.8	3.2	11.2	9.9	7.1	18.2	6.1	5.5	9.7
18–64	27.2	33.7	25.8	29.1	23.3	21.3	16.9	23.0	27.7	24.5	34.8	20.8	18.6	26.6
Over 200% of poverty level														
Under 18	4.3	3.8	3.1	3.6	1.9	3.2	1.8	3.9	3.0	2.9	4.6	2.5	1.7	3.3
18–64	13.6	15.3	12.7	17.8	11.3	12.1	8.5	15.3	14.2	13.9	16.7	10.9	8.4	13.8
All incomes														
Under 18	9.1	9.1	5.6	8.3	2.5	4.4	2.2	8.1	5.0	4.8	11.3	3.8	2.9	6.0
18–64	18.4	21.7	16.1	21.7	13.7	14.3	10.3	18.4	16.8	17.0	23.0	13.6	10.7	17.6

Figures in color represent statistically significant differences from the national average at the .05 confidence level. Figures in black are not statistically significantly different from the national average. All figures in text, charts, and table are rounded.

Source: Urban Institute

Health

Health Status of Nonelderly Adults and Children

Stephen Zuckerman

Stephen Norton

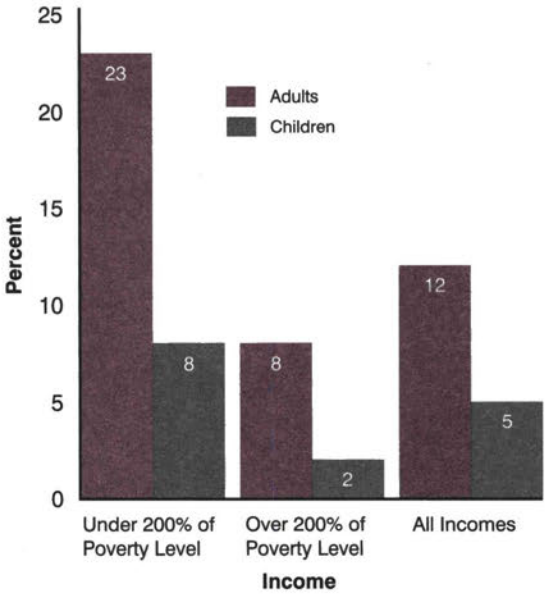
Health status affects many aspects of people's daily lives. For adults, poor health can reduce earnings, increase expenses for medical care, and make it difficult to care for their families. For children, poor health can limit their ability to attend school regularly and to interact socially with other children. Although health status depends on heredity, environment, and a wide range of other factors, policy makers may be able to improve health status by increasing access to medical care.

Differences in health status were determined by asking adults between the ages of 18 and 64 to classify themselves or their spouse and their children as generally being in excellent, very good, good, fair, or poor health.

Nationally, 12 percent of adults and 5 percent of children under age 18 were in fair or poor health, a statistically significant difference. This discrepancy in health status was consistent both in families with low incomes (below 200 percent of the poverty level) and in those with higher incomes. However, health status among adults and among children varied widely across income groups. Among adults, 8 percent of those in higher-income families were in fair or poor health, compared to 23 percent of those in low-income families, a statistically significant difference. Only 2 percent of children in higher-income families were in fair or poor health, compared to 8 percent of children in low-income families, another statistically significant difference.

Across the 13 states surveyed, there was little difference in health status within the higher-income group. In no state did the percentage of children in fair or poor health exceed the national average for this income group, and only in Alabama did the percentage of adults exceed the national average. In three states, the percentage of higher-income adults with fair or poor health fell below the national average—Colorado, Massachusetts, and Minnesota.

Nonelderly Adults and Children in Fair or Poor Health, by Income, 1997



Source: Urban Institute

Differences in health status were greater within the low-income group. The percentage of low-income adults in fair or poor health was significantly below the national average in Colorado, Minnesota, Washington, and Wisconsin. Low-income children in Minnesota and Wisconsin also appeared to be healthier than the national average, with 5 percent and 6 percent, respectively, in fair or poor health.

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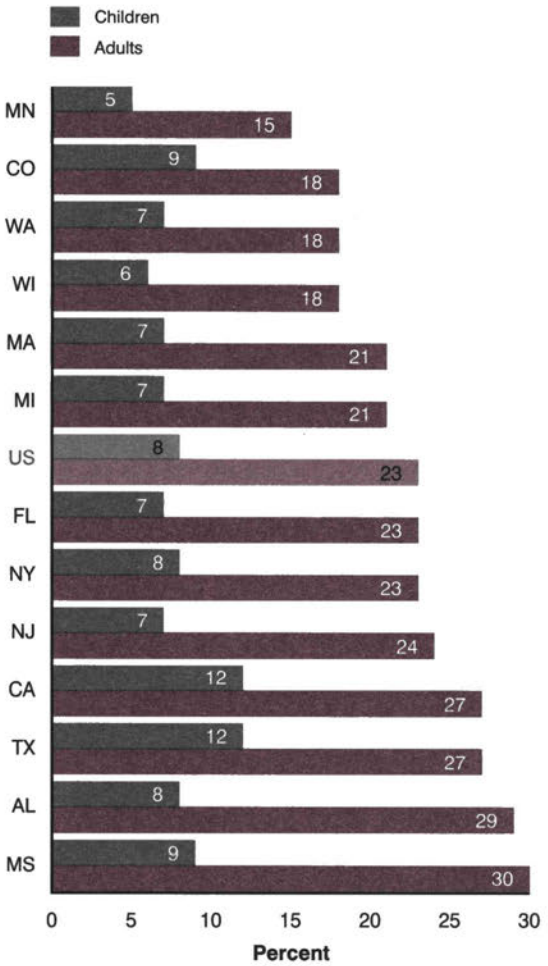
Low-Income Nonelderly Adults and Children in Fair or Poor Health, by State, 1997



Source: Urban Institute

In four states, the proportion of low-income adults in fair or poor health exceeded the national average: Alabama, California, Mississippi, and Texas. California and Texas also had a greater-than-average proportion of low-income children in fair or poor health.

Nonelderly Adults (%) and Children (%) in Fair or Poor Health, 1997

Age	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
18–64	29.0	27.5	18.2	23.2	21.0	21.5	15.3	29.7	24.0	23.4	27.0	18.2	17.9	23.1
Under 18	8.2	12.2	9.1	6.8	6.8	7.0	4.9	8.7	7.1	7.7	12.1	6.8	5.6	8.2
Over 200% of poverty level														
18–64	9.5	8.1	6.0	7.0	5.1	6.5	5.8	9.4	6.9	8.9	8.3	7.3	7.3	7.6
Under 18	2.6	2.5	1.5	2.5	1.1	1.6	2.1	2.1	2.3	2.2	3.1	2.0	1.8	1.9
All incomes														
18–64	16.4	14.8	9.1	12.5	8.2	10.0	7.8	17.7	10.2	13.1	14.9	10.2	9.7	12.1
Under 18	5.3	7.4	4.1	4.5	2.8	3.4	2.9	5.9	3.7	4.6	7.6	3.7	3.0	4.6

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Source: Urban Institute

Snapshots of America's Families

Income and Hardship

Poverty among Nonelderly Americans

Megan Gallagher

Gregory Acs

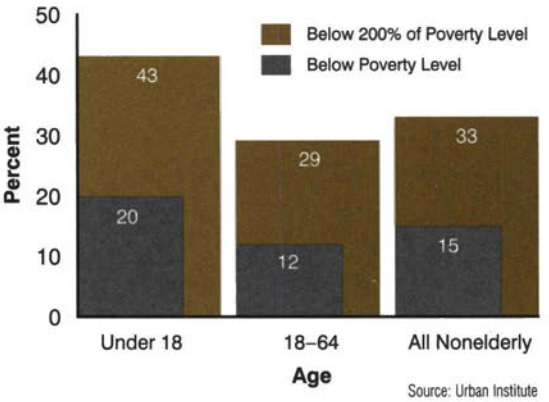
In 1776, Adam Smith defined poverty as the lack of those necessities that "the custom of the country renders it indecent for creditable people, even of the lowest order, to be without." Today, the federal poverty level represents the amount of cash income people require to meet their basic economic needs. For a single parent with two children, the poverty level was $12,641 in 1996. People living in families with incomes below the poverty level are deemed poor; those in families with incomes below 200 percent of the poverty level are considered low-income. Adults' reports of family income during the previous year were used to determine the share of people under the age of 65 living in poor and low-income families.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 produced changes in programs designed to assist low-income people receiving disability benefits, food stamps, cash assistance, and child support income. The poverty rate provides a simple way to monitor the economic well-being of people who depend on these programs. Nationwide, 15 percent of nonelderly people were poor and 33 percent were low-income.

Children were more likely to be poor than adults: The poverty rate reached 20 percent for children, compared to 12 percent for adults, a statistically significant difference. Furthermore, 43 percent of children lived in low-income families, whereas 29 percent of adults did.

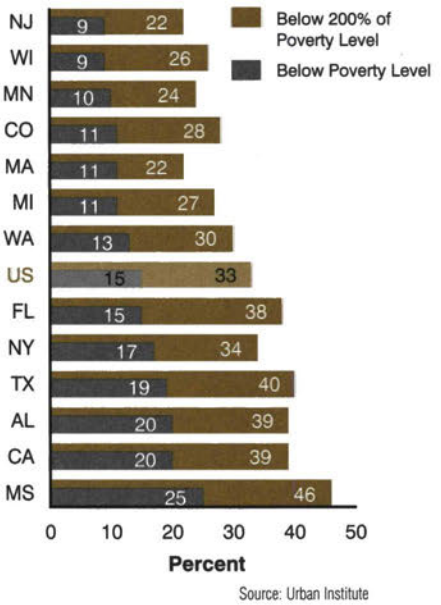
The poverty rate varied widely across the 13 states surveyed. The proportion of poor and low-income people was below the national average in Colorado, Massachusetts, Michigan, Minnesota, New Jersey, Washington, and Wisconsin. Of these seven states, three had poverty rates below 10 percent (Minnesota, New Jersey, and Wisconsin), and three had low-income rates below 25 percent (Massachusetts, Minnesota, and New Jersey). The poverty rate was higher than average in five states: Alabama, California, Mississippi, New York, and Texas. Mississippi had the highest poverty rate: One-quarter of all people in the state were poor.

Poor and Low-Income Nonelderly, by Age, 1996



Source: Urban Institute

Poor and Low-Income Nonelderly, by State, 1996



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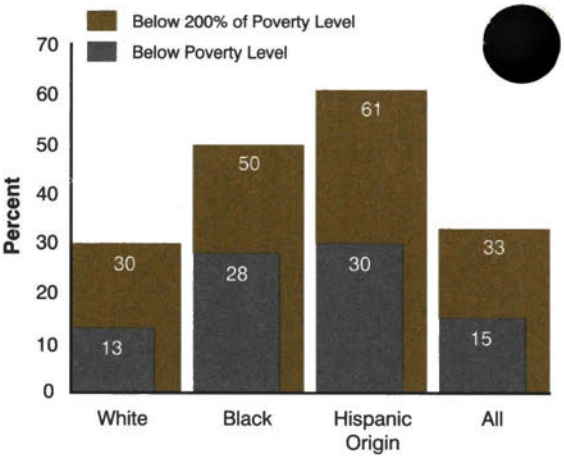
This *Snapshot* presents findings from the National Survey of America's Families (NSAF), a 1997 survey of 44,461 households with and without telephones that are representative of the nation as a whole and of 13 states. As in all surveys, the data are subject to sampling variability and other sources of error.

The poverty and low-income rates also varied widely by race and Hispanic origin. Nationally, 13 percent of whites lived in poverty, compared to 28 percent of blacks. Correspondingly, 30 percent of whites had low incomes, compared to 50 percent of blacks. In addition, poverty and low-income rates were significantly higher than the national average among people of Hispanic origin, regardless of race: Almost one-third were poor, and almost two-thirds were low-income.

Poor and Low-Income Nonelderly, by Race and Hispanic Origin, 1996



Source: Urban Institute

Poor and Low-Income Nonelderly (%), 1996

Income	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Below poverty level	19.9	19.8	11.4	15.3	10.8	10.8	9.6	24.6	9.4	16.9	18.9	12.7	8.9	14.8
Below 200% of poverty level	39.2	39.4	28.4	38.2	22.5	26.8	24.2	46.4	22.1	33.5	39.7	29.9	25.5	33.2

Figures in color represent statistically significant differences from the national average at the .05 confidence level. Figures in black are not statistically significantly different from the national average. All figures in text, charts, and table are rounded.

Source: Urban Institute

Snapshots of America's Families

Income and Hardship

Poverty among Children

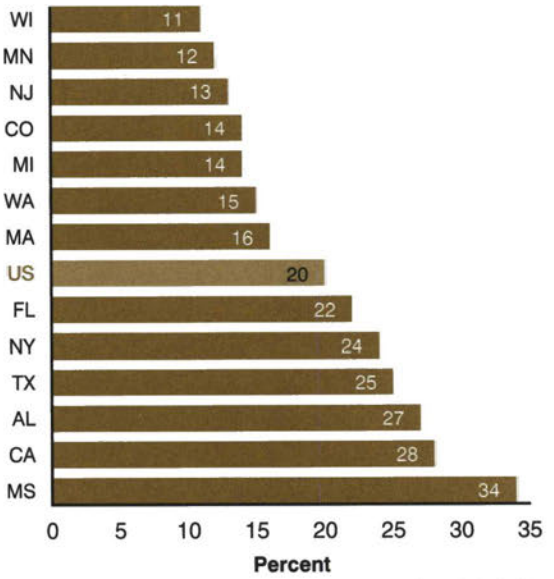
Megan Gallagher

Sheila Zedlewski

Because poverty is associated with inadequate nutrition and health care, the child poverty rate is frequently used as a tool by groups seeking to monitor the well-being of children. In fact, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires states to monitor child poverty rates as a means of assessing the effects of new state assistance programs for low-income families.

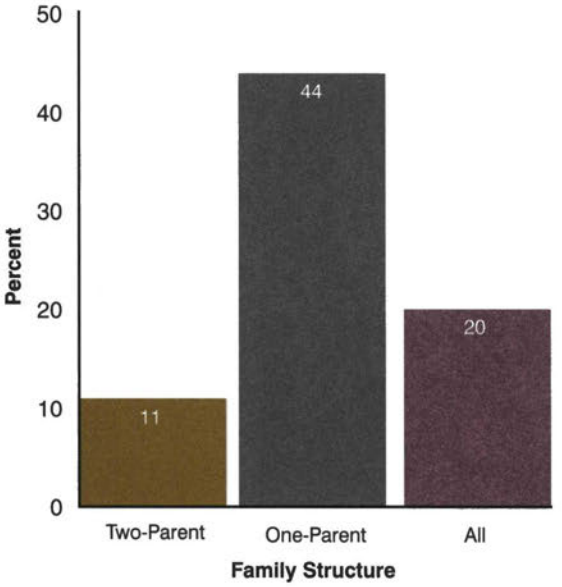
Adults' reports of family income during the previous year were used to determine the proportion of children living in families whose cash income falls below the federal poverty level. (For a single parent with two children, the poverty level was $12,641 in 1996.) While important, the poverty rate is a relatively blunt measure of children's well-being because it is limited to cash income. It excludes such government support as food stamps, housing assistance, and the earned income tax credit, as well as deductions from income tax for essential child care and health care spending.

Children below the Poverty Level, by State, 1996



Source: Urban Institute

Children below the Poverty Level, by Family Structure, 1996



Source: Urban Institute

Nationally, 20 percent of all children lived in a family with income below the poverty level. Child poverty varied considerably across the 13 states surveyed, with rates exceeding the national average in five states (Alabama, California, Mississippi, New York, and Texas) and falling below the average in seven states (Colorado, Massachusetts, Michigan, Minnesota, New Jersey, Washington, and Wisconsin). The range of poverty rates in these states was dramatic, with one in ten children in Wisconsin living in poverty, compared to one in three children in Mississippi.

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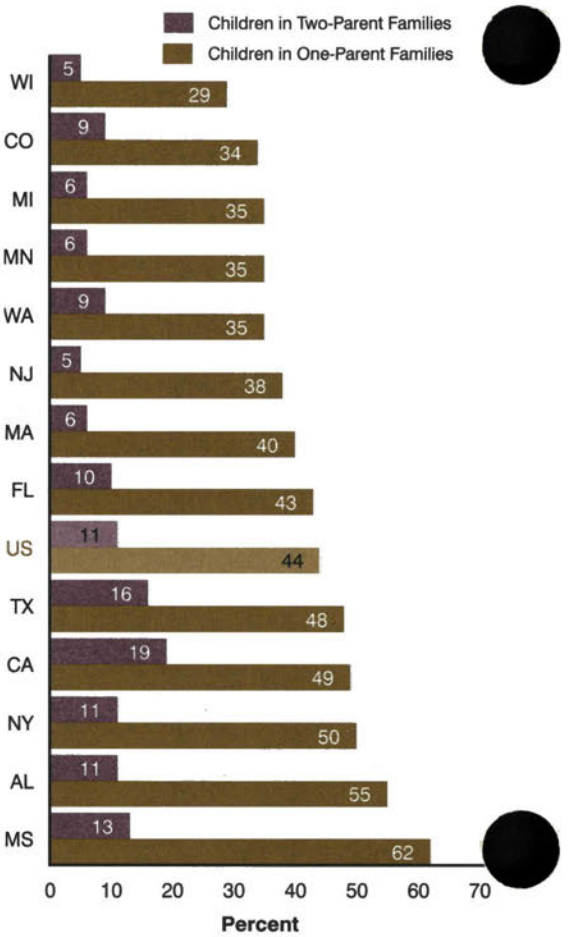
Children living with one parent were much more likely to be poor than children living with two parents—44 percent compared to 11 percent—because one-parent families typically rely on a lone adult for economic support. Even with support from the noncustodial parent, some children in one-parent families remain poor.

Mirroring the national figures, child poverty rates in the states also varied greatly by family structure. Nearly two-thirds of children living in one-parent families in Mississippi were poor, compared to less than one-third in Wisconsin. Poverty rates for children in two-parent families varied somewhat less, although rates were above the national average in California and Texas and below in Massachusetts, Michigan, Minnesota, New Jersey, and Wisconsin.

Children below the Poverty Level, by Family Structure and State, 1996



Source: Urban Institute

Children (%) below the Poverty Level, 1996

Family Structure	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
One-parent	55.0	49.3	34.3	42.7	40.3	34.7	34.8	61.9	38.5	50.3	47.8	34.7	29.2	44.1
Two-parent	10.5	19.3	8.7	9.5	6.2	5.5	6.3	13.0	5.1	10.9	16.0	9.3	5.1	10.5
All families	27.0	28.4	14.3	21.8	15.5	13.7	12.5	33.5	13.3	24.1	25.4	15.2	11.4	20.5

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Source: Urban Institute

Income and Hardship

Employment

Stephen H. Bell

Helping families and individuals become self-sufficient through increased employment is a major goal of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as well as many other federal and state income support programs. Many people receiving public support now face benefit reductions or termination if they are not working or preparing for work. Among those affected are adults in families receiving support from the Temporary Assistance for Needy Families program and childless adults receiving food stamps. Moreover, as public support for nonworking low-income Americans declines, the pressure on working low-income adults to remain employed increases.

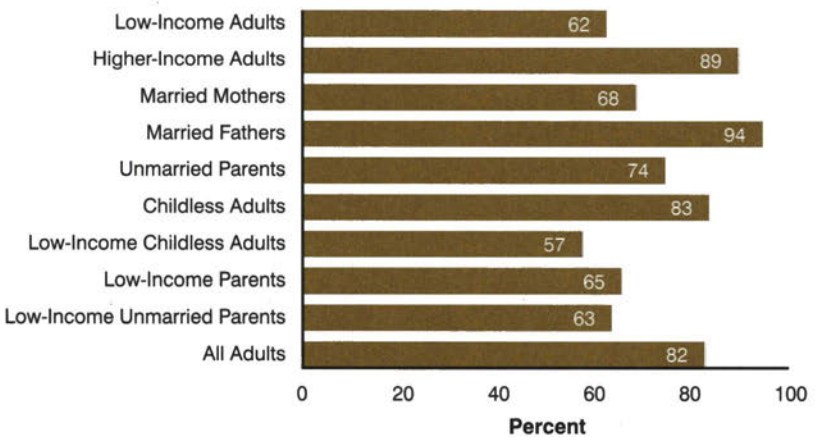
These changes prompt a number of questions about the role of work in low-income families. Do adults in these families work as much as the adult population at large? What share of low-income adults held jobs as federal welfare reform began? Did that share vary by state or by family type? To answer these questions, adults between the ages of 25 and 54 were asked about their current employment status when interviewed in 1997.

Nationally, 82 percent of adults worked in a full- or part-time job. In families with low incomes (below 200 percent of the federal poverty level), 62 percent of adults worked; 89 percent of adults in higher-income families worked, a statistically significant difference.

Employment rates varied by family situation and were particularly uneven among parents with children living at home. Married mothers were the least likely parents to work (68 percent did), whereas married fathers were the most likely (94 percent). Among unmarried parents, 74 percent worked. Although 83 percent of all childless adults had jobs, only 57 percent of low-income childless adults worked.

Low-income parents in general, and unmarried low-income parents in particular, worked considerably less than adults as a whole: 65 percent of all low-income parents and 63 percent of unmarried low-income parents had jobs.

Full-Time or Part-Time Employment of Adults Age 25–54, by Income and Parental Status, 1997



Source: Urban Institute

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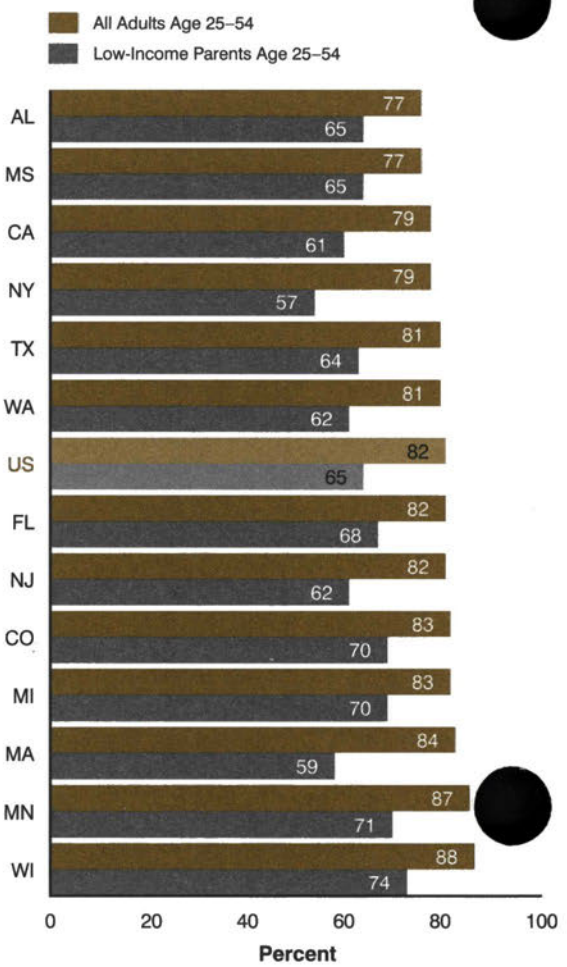
In the 13 states surveyed, employment of all adults ranged from 77 percent in Alabama and Mississippi to 88 percent in Wisconsin. Employment exceeded the national average of 82 percent in Colorado, Massachusetts, Minnesota, and Wisconsin and trailed the nation in Alabama, California, Mississippi, and New York.

Employment among low-income parents was lower than employment among all adults in every state studied, affirming the national trend across a variety of circumstances. In the majority of states, 60 percent to 70 percent of low-income parents held full-time or part-time jobs, about 15 percentage points lower than the rates for all adults in these states. Low-income parents fared particularly poorly in comparison with other adults in Massachusetts and New York, with less than 60 percent employed, but they matched the national average for low-income parents in Alabama and Mississippi, the states with the lowest employment overall.

Unmarried parents were the adults most likely to need public support, since they usually had low personal incomes and no second breadwinner or caregiver in the home and they were less likely to work than adults as a whole. In many of the states, as in the nation, around three-fourths of unmarried parents worked, but those rates were about 6 percentage points below the rate for adults in general. Only in Wisconsin did employment of unmarried parents (85 percent) nearly equal that of other adults (88 percent). Unmarried parents fared particularly poorly relative to other adults in Massachusetts and New York.

Full-Time or Part-Time Employment of All Adults and Low-Income Parents, by State, 1997



Source: Urban Institute

Adults (%) Age 25 to 54 Employed Full-Time or Part-Time, 1997

Parental Status	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
All parents	64.7	61.4	69.5	67.8	58.7	70.4	70.8	65.4	61.8	56.8	64.5	62.1	74.4	65.0
Over 200% of poverty level														
All parents	86.1	84.6	86.2	87.9	87.6	86.9	90.9	89.3	84.5	86.2	86.4	85.2	90.7	87.1
All incomes														
Unmarried parents	68.8	69.3	77.8	75.7	71.2	76.7	81.0	69.1	72.2	64.0	70.8	74.9	85.4	73.6
All parents	78.3	75.3	81.9	80.6	81.4	82.6	86.4	79.2	79.7	76.3	77.5	79.0	86.9	79.8
All adults	77.4	78.7	83.5	82.3	83.6	83.1	87.0	77.1	82.4	79.4	80.6	80.8	87.7	81.5

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Source: Urban Institute

Snapshots of America's Families

Income and Hardship

Affordability of Housing

Alyssa Wigton

David D'Orio

Recent public policy initiatives are aimed at promoting work so that families can pay for their basic needs. However, even people who work may have problems paying their housing expenses. The Department of Housing and Urban Development reported recently that many people working full-time at the minimum wage have difficulty affording decent-quality housing in the private rental market.

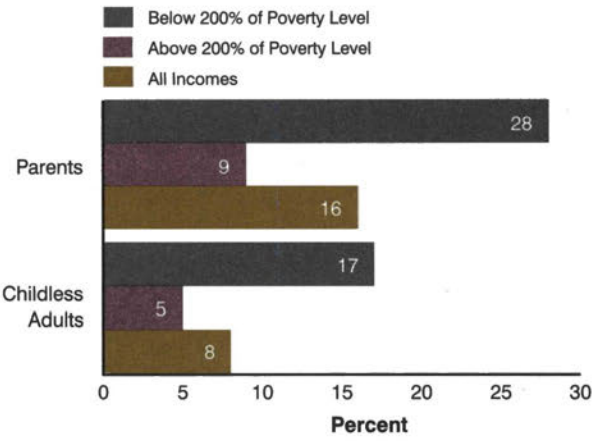
Because states now have increased flexibility in designing social support programs and their links to housing assistance, it is important to know how many people have difficulty affording housing. To arrive at an answer, parents and adults without children were asked whether they had experienced housing hardship – that is, whether they had been unable to pay their mortgage, rent, or utility bills at any time during the previous 12 months.

Nationally, 16 percent of parents had experienced housing hardship. Among families with low incomes (under 200 percent of the poverty level), 28 percent had experienced housing hardship, as opposed to 9 percent of families with higher incomes, a statistically significant difference.

Among the 13 states surveyed, 12 percent to 20 percent of all parents had experienced housing hardship. The percentage was higher than the national average in Alabama, New York, and Texas and lower than the national average in Colorado, Minnesota, and Wisconsin.

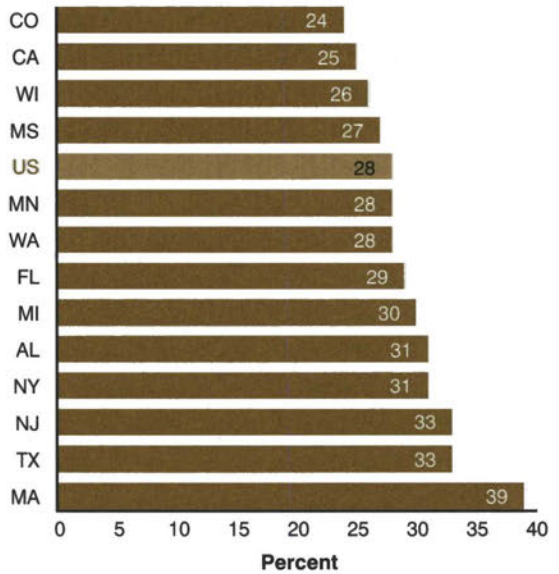
Of low-income parents, 24 percent to 39 percent had experienced housing hardship. Percentages exceeded the national average in Massachusetts, New Jersey, and Texas. Colorado was below the national average.

Adults with Problems Paying Their Mortgage, Rent, or Utility Bills, by Income and Parental Status, 1996–1997



Source: Urban Institute

Low-Income Parents with Problems Paying Their Mortgage, Rent, or Utility Bills, by State, 1996–1997



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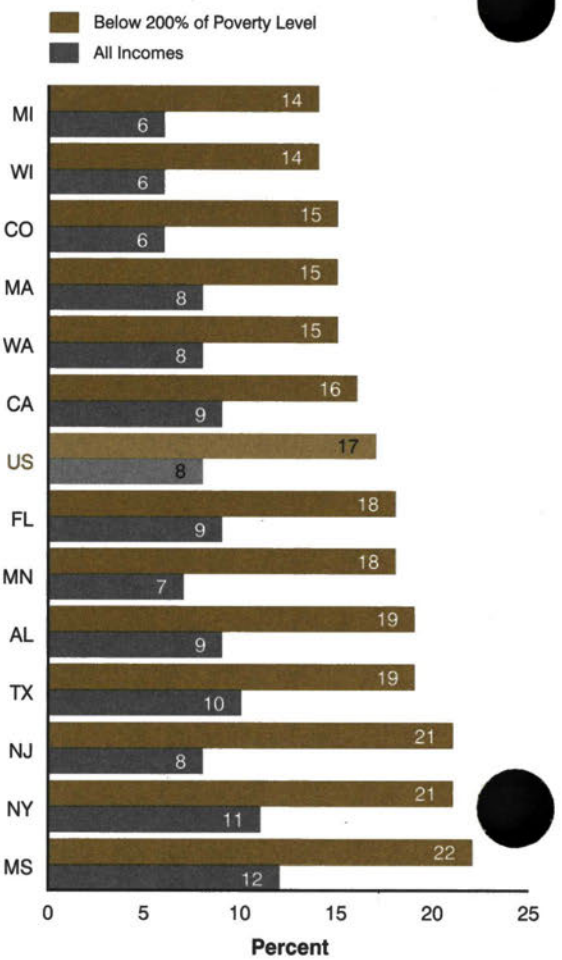
Nationally, 8 percent of adults without children reported that they had been unable to pay their mortgage, rent, or utility bills at some time during the previous 12 months. The rate was 17 percent for childless adults with low incomes, compared to 5 percent for childless adults with higher incomes, a statistically significant difference.

Across the states surveyed, 14 percent to 22 percent of low-income childless adults had experienced housing hardship. The percentage of these adults with housing hardship was higher than the national average in Mississippi and lower than the national average in Wisconsin. In all states, two to three times as many low-income as higher-income childless adults had experienced housing hardship.

Childless Adults with Problems Paying Their Mortgage, Rent, or Utility Bills, by Income and State, 1996–1997



Source: Urban Institute

Adults (%) with Problems Paying Their Mortgage, Rent, or Utility Bills, 1996–1997

Parental Status	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Parents														
Under 200% of poverty level	31.3	24.8	24.1	29.0	38.6	30.3	28.2	27.4	33.2	30.9	32.7	28.5	25.9	28.4
Over 200% of poverty level	8.9	8.8	8.5	9.8	9.1	9.0	8.0	7.9	8.9	12.6	9.3	11.1	7.3	9.1
All incomes	17.9	15.6	13.0	17.4	15.8	14.9	13.1	16.9	14.3	19.2	19.7	16.3	12.0	16.0
Childless Adults														
Under 200% of poverty level	18.9	15.6	14.7	18.0	15.4	14.1	18.4	21.6	21.4	21.0	19.5	14.8	13.5	17.1
Over 200% of poverty level	5.0	6.1	3.9	5.1	6.0	4.2	4.5	6.2	5.6	7.6	6.6	5.4	4.1	5.4
All incomes	9.5	8.9	6.5	9.1	7.6	6.3	7.1	11.8	8.3	11.0	10.2	7.8	6.0	8.3

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Source: Urban Institute

Snapshots of America's Families

Income and Hardship

Food Concerns and Affordability

Daniel E. McKenzie

Stephen H. Bell

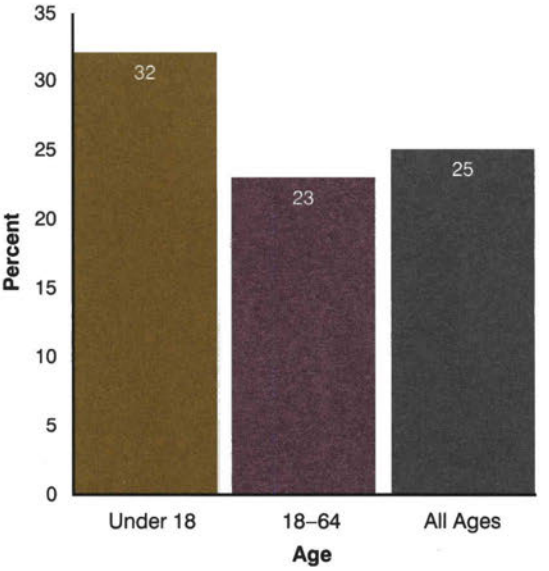
Most Americans eat regularly, without fear of running out of food because they lack money. In some households, however, limited buying power produces uncertainty about—and interruptions in—the availability of food. These situations heighten stress and can cause hunger or even poor nutrition. The nation's largest effort to ensure that families can buy food is the Food Stamp Program, which issues vouchers to low-income families.

To determine how many families worry about or experience difficulty buying food, adults between the ages of 18 and 64 were asked whether (i) they or their families worried that food would run out before they got money to buy more, (ii) the food they bought did run out, or (iii) one or more adults ate less or skipped meals because there wasn't enough money for food. These questions indicate financial stresses related to food but not caloric intake or adequacy of a family's diet.

Nationally, 75 percent of adults and children lived in families that had not experienced any of these food-related problems in the previous 12 months. Twenty-five percent of people lived in families that had experienced one or more of the three problems; of these, 20 percent had encountered shortages of food, and the remaining 5 percent had worried about shortages. Nearly 50 percent of people in low-income families (below 200 percent of the poverty level) experienced some worries about or difficulty affording food, compared to 14 percent of those in families with higher incomes, a statistically significant difference.

More children than adults lived in families that worried about or had trouble affording food: 32 percent, compared to 23 percent, a statistically significant difference. This disparity does not necessarily indicate that children's food intake was more constrained than adults'. Other research has shown that, as money runs out, adults reduce their own food consumption before that of their children.

Adults and Children in Families with One or More Food-Related Problems, by Age, 1996–1997



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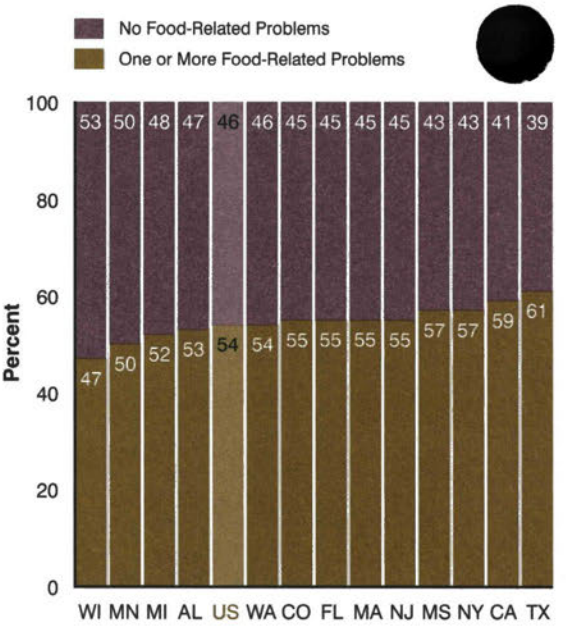
In each of the 13 states studied, around 50 percent of low-income children lived in families that worried about or had difficulty buying food, ranging from 61 percent in Texas to 47 percent in Wisconsin. Compared to the national average, fewer low-income children in Wisconsin lived in families of this kind, whereas more low-income children in California and Texas did.

Children in Low-Income Families with Food-Related Problems, by State, 1996–1997



Source: Urban Institute

Children (%) Living in Families That Worried about or Experienced Difficulty Affording Food, 1996–1997

Food Problems	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
None	46.6	41.1	44.7	44.9	45.0	48.1	49.9	43.0	44.8	42.6	39.5	45.9	53.2	46.1
Some	53.4	58.9	55.3	55.2	55.0	51.9	50.1	57.0	55.2	57.5	60.5	54.1	46.8	53.9
Over 200% of poverty level														
None	85.8	84.8	83.0	82.2	84.8	86.4	86.7	87.5	86.3	81.7	84.9	82.6	87.9	84.6
Some	14.2	15.2	17.0	17.9	15.2	13.6	13.3	12.6	13.8	18.3	15.1	17.4	12.1	15.4
All incomes														
None	67.0	63.1	69.9	64.3	72.8	73.4	75.7	61.8	74.3	64.8	62.4	69.4	76.7	68.2
Some	33.0	36.9	30.2	35.7	27.2	26.6	24.4	38.2	25.7	35.2	37.6	30.6	23.3	31.8

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Snapshots of America's Families

Adults' Environment and Behavior

Parental Participation in Volunteer or Religious Activities

Jennifer Ehrle
Child Trends

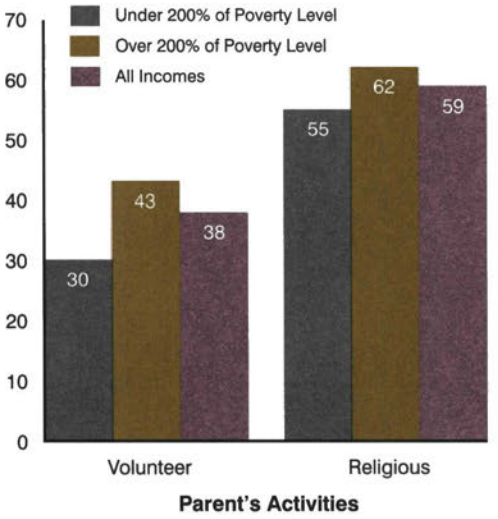
Kristin Moore
Child Trends

Developmental psychologists have long noted that parents serve as role models, shaping the behaviors and habits of their children. Children whose parents act as strong positive models may be more likely to withstand harmful pressures from peer groups. One way parents act as role models is by demonstrating citizenship through volunteer work. Another way is by participating in religious activities, which may enhance the importance of moral and spiritual values in their children's lives.

The new work requirements of welfare reform may make it harder for some low-income parents to find time for volunteer or religious activities. However, if a parent's work adds structure and routine to household functions, families might find it easier to incorporate such activities into their lives. In turn, the social support and structure these activities provide may help parents cope with the changes required by welfare reform. An additional benefit is that higher levels of volunteer work in a community may strengthen the private support system for families in need.

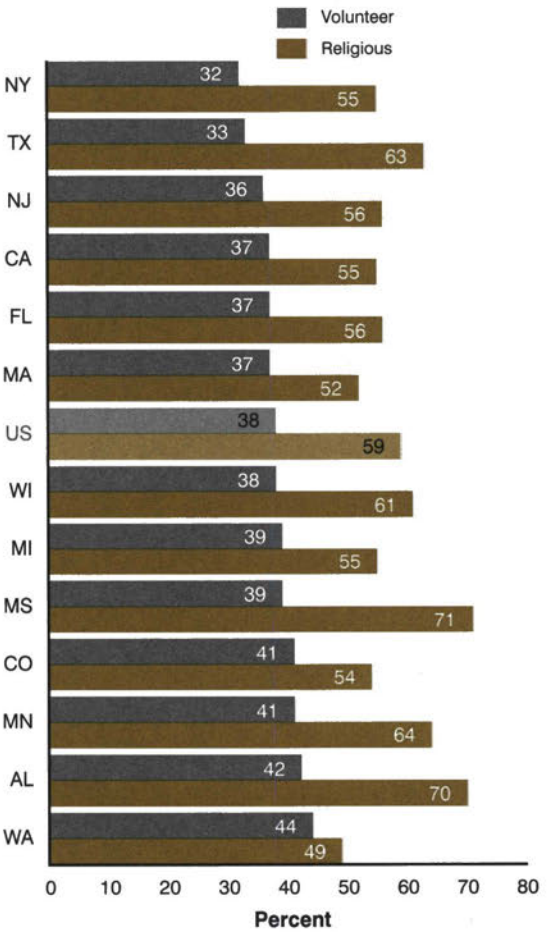
Nationally, 59 percent of children lived with a parent who reported participating in religious activities at least a few times a month, with 55 percent of low-income children (below 200 percent of the poverty level) and 62 percent of higher-income children in this category, a statistically significant difference. Thirty-eight percent of all children lived with a parent who volunteered a few times

Children Living with a Parent Who Participated in Volunteer or Religious Activities, by Family Income, 1997



Source: Child Trends and Urban Institute

Children Living with a Parent Who Participated in Volunteer or Religious Activities, by State, 1997



Source: Child Trends and Urban Institute

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a month, with 30 percent of low-income children and 43 percent of higher-income children in this category, a statistically significant difference.

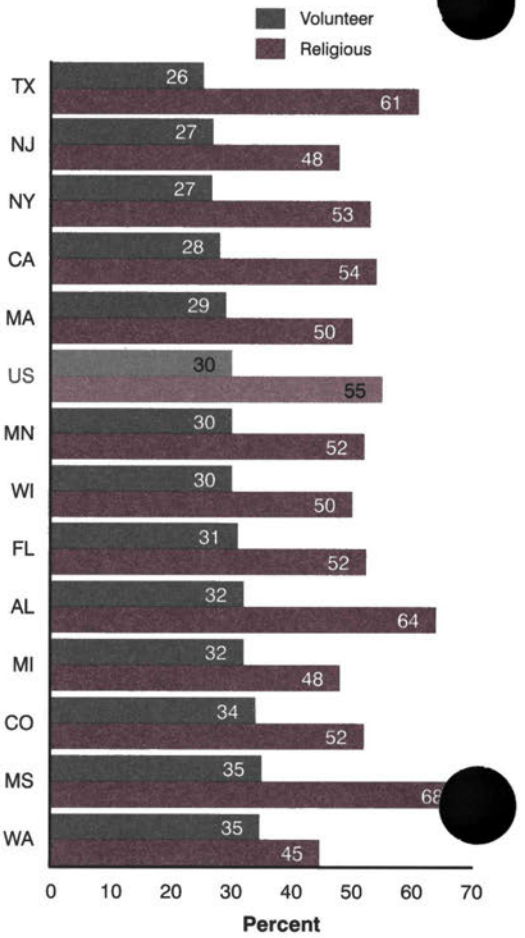
In the 13 states surveyed, 49 percent to 71 percent of children lived with a parent who participated in religious activities a few times a month or more. Percentages were above the national average in Alabama, Minnesota, Mississippi, and Texas and below in California, Colorado, Massachusetts, Michigan, New Jersey, New York, and Washington.

Between 32 percent and 44 percent of children lived with a parent who volunteered at least a few times a month. Percentages were above the national average in Alabama, Colorado, Minnesota, and Washington and below in New York and Texas.

Between 45 percent and 68 percent of children in low-income families lived with a parent who participated in religious activities a few times a month or more. Percentages were above the national average of 55 percent in Alabama, Mississippi, and Texas and below average in Michigan, New Jersey, Washington, and Wisconsin.

Of children in low-income families, 26 percent to 35 percent lived with a parent who volunteered a few times a month or more. In Mississippi, the percentage was above the national average of 30 percent, and in Texas it was below.

Low-Income Children Living with a Parent Who Participated in Volunteer or Religious Activities, by State, 1997



Source: Child Trends and Urban Institute

Children (%) Living with a Parent Who Participated in Volunteer or Religious Activities, 1997

Parent's Activities	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
Volunteer	32.4	28.5	33.8	30.6	29.4	31.6	29.5	35.5	27.1	27.5	26.5	35.1	30.0	30.5
Religious	63.8	53.9	51.9	51.9	50.2	48.0	52.1	68.0	48.4	52.7	61.0	45.5	50.3	54.7
Over 200% of poverty level														
Volunteer	51.8	46.2	45.0	43.5	39.9	42.3	46.1	43.8	40.2	36.2	38.4	49.5	41.1	43.3
Religious	74.9	56.7	54.4	60.6	52.9	58.7	69.2	75.9	58.6	57.2	64.9	50.3	66.4	61.9
All incomes														
Volunteer	42.5	37.4	41.1	37.3	36.8	38.7	41.1	39.0	36.4	32.4	32.5	44.3	37.5	37.8
Religious	69.6	55.3	53.5	56.4	52.1	55.1	64.0	71.4	55.7	55.2	63.0	48.5	61.2	58.8

Figures in color represent statistically significant differences from the national average at the .05 confidence level. Figures in black are not statistically significantly different from the national average. All figures in text, charts, and table are rounded.

Source: Child Trends and Urban Institute

Snapshots of America's Families

Adults' Environment and Behavior

Parental Aggravation

Kristin Moore
Child Trends

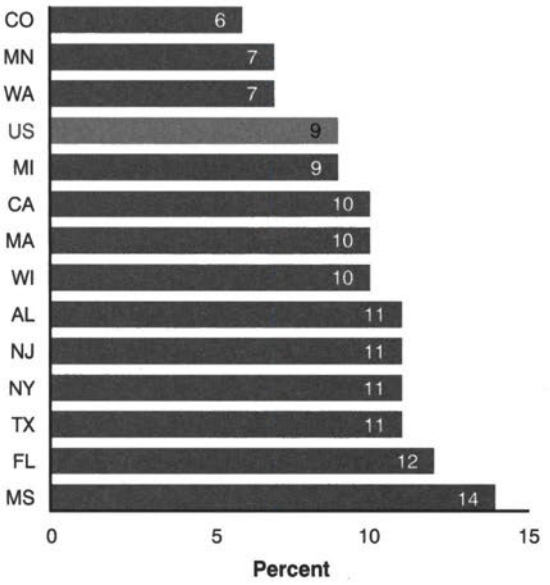
Jennifer Ehrle
Child Trends

High stress and aggravation in parents are associated with poor cognitive and socioemotional development of young children. In addition, maternal emotional distress has been linked to less responsive, even hostile, parenting practices.

Mandated employment, time limits on benefits, shifts in child care arrangements, and fluctuations in income are some of the challenges facing low-income parents under welfare reform. The added stress of these challenges may increase parental aggravation. However, work experiences that provide opportunities for social interaction, support outside the family, and economic self-sufficiency may reduce stress and hence parental aggravation.

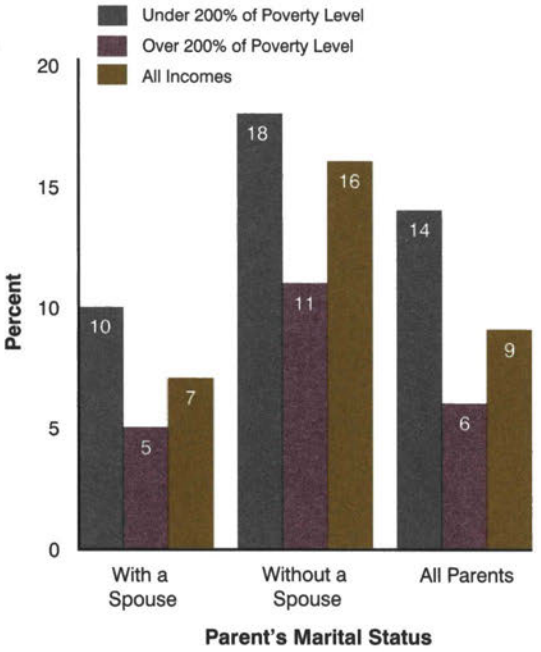
Aggravation was assessed on a scale that summed a parent's estimates of how often in the last month he or she felt a child was much harder to care for than most, the child did things that really bothered the parent a lot, the parent was giving up more of his or her life to meet the child's needs than expected, and the parent felt angry with the child.

Children Living with a Parent Who Felt Highly Aggravated, by State, 1997



Source: Child Trends and Urban Institute

Children Living with a Parent Who Felt Highly Aggravated, by Family Income and Parent's Marital Status, 1997



Source: Child Trends and Urban Institute

Nationally, 9 percent of all children lived with a parent who felt highly aggravated. Of children in families with low incomes (below 200 percent of the poverty level), 14 percent lived with such a parent, compared to 6 percent of children in families with higher incomes, a statistically significant difference. Children of parents who did not have a spouse were significantly more likely than other children (16 percent versus 7 percent) to be living with a highly aggravated parent.

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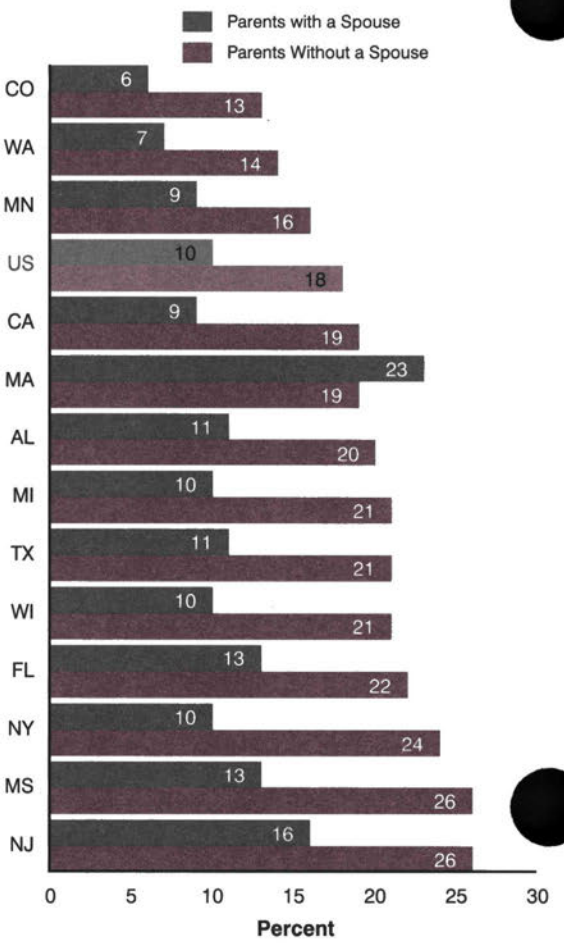
In the 13 states surveyed, 6 percent to 14 percent of children lived with a highly aggravated parent. In six of the states, the percentage was above the national average: Alabama, Florida, Mississippi, New Jersey, New York, and Texas. The percentage was below average in Colorado, Minnesota, and Washington.

In low-income families, 9 percent to 21 percent of children lived with a highly aggravated parent. In five states, that percentage was higher than the national average: Florida, Massachusetts, Mississippi, New Jersey, and New York. In Colorado and Washington, it was lower.

In low-income families where the parent did not have a spouse, 13 percent to 26 percent of children lived with a highly aggravated parent. In three states, the percentage was above the national average of 18 percent: Mississippi, New Jersey, and New York; in Colorado, it was below average.

This four-item scale was adapted from a component of the National Evaluation of Welfare-to-Work Strategies (NEWWS), the evaluation of the Job Opportunities and Basic Skills (JOBS) program.

Low-Income Children Living with a Parent Who Felt Highly Aggravated, by Parent's Marital Status and State, 1997



Source: Child Trends and Urban Institute

Children (%) Living with a Parent Who Felt Highly Aggravated, 1997

Parent's Marital Status	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
With a spouse	11.4	9.3	6.1	12.9	22.5	9.9	9.3	12.8	15.6	10.4	11.1	6.8	10.4	10.5
Without a spouse	20.4	18.8	13.2	22.0	19.1	21.4	15.8	25.6	25.7	23.9	21.2	13.8	21.2	18.0
All parents	16.3	13.0	8.7	17.2	20.8	15.7	11.8	20.2	20.4	17.4	15.1	9.1	14.8	13.7
Over 200% of poverty level														
With a spouse	6.3	6.1	5.1	6.7	5.5	5.9	4.0	5.0	6.8	4.8	6.8	6.0	7.1	4.8
Without a spouse	11.3	13.4	5.0	7.9	9.3	9.4	8.0	4.9	13.9	13.7	8.2	10.2	8.7	11.2
All parents	6.9	7.3	5.1	6.9	5.9	6.3	4.4	5.0	7.5	6.2	7.0	6.4	7.3	5.6
All incomes														
With a spouse	7.9	7.4	5.4	9.0	8.7	6.8	5.2	8.1	8.5	6.5	8.5	6.2	7.9	6.6
Without a spouse	18.6	17.1	10.1	18.4	15.8	17.9	12.8	22.6	21.4	21.0	18.3	12.4	16.8	16.0
All parents	11.4	10.1	6.3	11.9	10.3	9.5	6.6	13.7	11.2	11.1	11.0	7.4	9.7	9.0

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Source: Child Trends and Urban Institute

Snapshots of America's Families

Adults' Environment and Behavior

Mental Health of Parents

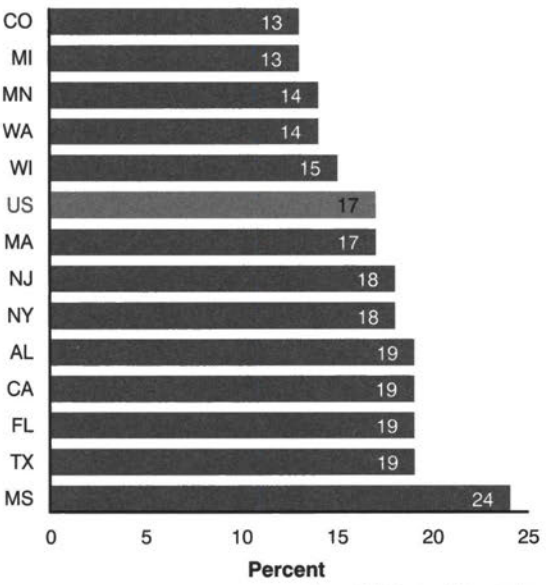
Jennifer Ehrle
Child Trends

Kristin Moore
Child Trends

A child's well-being depends in part upon the mental health of his or her parents. If a parent's mental health is compromised, he or she may be less able to nurture, love, care for, and pay attention to the child. Several studies indicate that single mothers on welfare with young children are at considerable risk of exhibiting symptoms of depression. Parents with such symptoms provide less emotional support and tend to employ harsh disciplinary practices. Further, children of depressed parents exhibit more behavioral problems, frequently display deficits in social and academic competence, and are in poorer physical health than children of nondepressed parents.

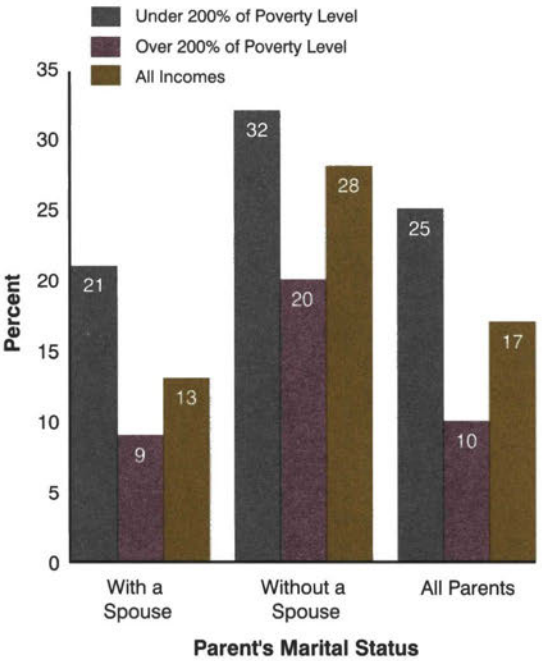
It is not certain how changes in welfare programs will affect the mental health of parents. Mental health may worsen if parents have difficulty obtaining or keeping a job or if they have difficulty complying with more demanding welfare program rules. On the other hand, mental health may improve if a parent's job enhances family income or the parent's social contacts. The effects may not become apparent until after parents have taken on new employment or reached welfare time limits.

Children Living with a Parent Whose Symptoms Suggested Poor Mental Health, by State, 1997



Source: Child Trends and Urban Institute

Children Living with a Parent Whose Symptoms Suggested Poor Mental Health, by Family Income and Parent's Marital Status, 1997



Source: Child Trends and Urban Institute

Parents were asked to rate their feelings of anxiety and depression, loss of behavioral or emotional control, and psychological well-being during the past month. A score of 67 or less out of 100 points was considered indicative of poor mental health.

Nationally, 17 percent of children lived with a parent whose survey responses suggested poor mental health. Of children in families with low incomes (below 200 percent of the poverty level), 25 percent lived with a parent who had symptoms of poor mental health, compared to only 10 percent of children in

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families with higher incomes, a statistically significant difference. Children of parents without a spouse were significantly more likely than other children to be living with a parent in poor mental health—28 percent versus 13 percent.

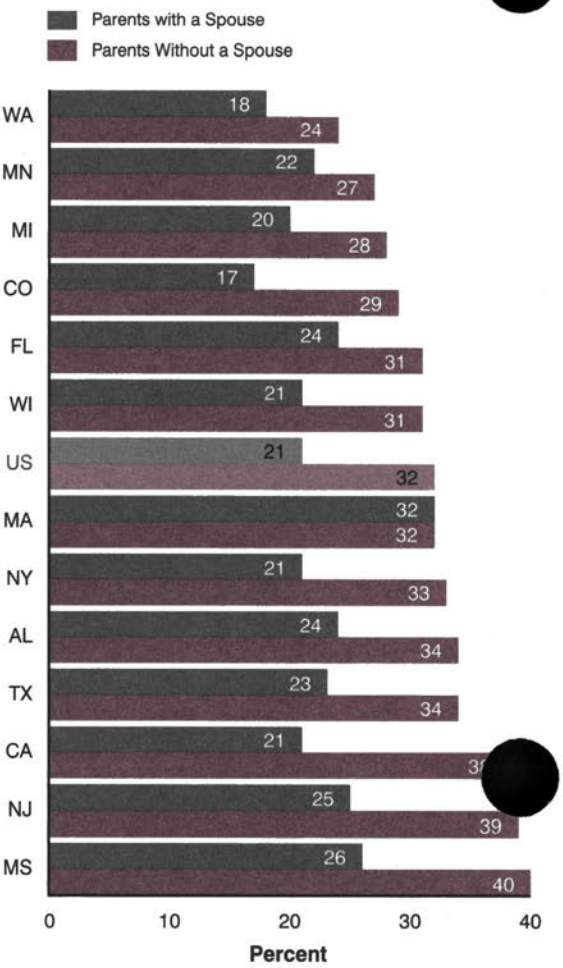
In the 13 states surveyed, 13 percent to 24 percent of all children lived with a parent who exhibited symptoms of poor mental health. Three states had higher percentages than the national average: Alabama, Florida, and Mississippi. Five states had percentages below the national average: Colorado, Michigan, Minnesota, Washington, and Wisconsin.

Of children in low-income families, 20 percent to 34 percent lived with a parent whose responses suggested poor mental health. The percentage of low-income children living with a parent in poor mental health was higher than the national average in Massachusetts, Mississippi, and New Jersey. The percentage was below the national average in Colorado and Washington.

In low-income families where the parent did not have a spouse, 24 percent to 40 percent of children lived with a parent who had symptoms of poor mental health. The percentage was above the national average in Mississippi and New Jersey. In Washington, it was below average.

The five-item mental health scale (MHI-5) was constructed for the Medical Outcomes Study (MOS) using questions from the 38-item Mental Health Inventory (MHI). Ware, J.E., and D.C. Sherbourne. 1992. The MOS 36-Item Short-Form Health Survey (SF-36). *Medical Care* 30:473–81.

Low-Income Children Living with a Parent Whose Symptoms Suggested Poor Mental Health, by Parent's Marital Status and State, 1997



Source: Child Trends and Urban Institute

Children (%) Living with a Parent Whose Symptoms Suggested Poor Mental Health, 1997

Parent's Marital Status	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
With a spouse	23.6	20.8	16.6	24.1	31.7	20.2	21.5	26.5	24.6	21.2	22.6	17.5	20.8	20.9
Without a spouse	33.5	37.9	28.6	31.1	32.1	28.2	26.7	40.2	38.9	33.3	33.6	24.0	31.2	31.6
All parents	29.0	27.5	21.1	27.4	31.9	24.2	23.5	34.4	31.4	27.5	27.0	19.7	25.0	25.4
Over 200% of poverty level														
With a spouse	9.2	8.7	7.7	9.6	9.3	7.3	8.6	10.7	11.1	9.2	9.4	9.9	9.1	8.7
Without a spouse	18.7	15.8	18.8	17.5	18.8	10.2	18.4	13.8	23.4	21.9	19.9	14.3	14.3	19.6
All parents	10.3	9.9	9.0	10.8	10.3	7.6	9.6	11.1	12.5	11.2	10.6	10.4	9.6	10.1
All incomes														
With a spouse	13.8	13.7	10.1	14.8	13.5	10.2	11.5	16.9	13.7	12.9	14.6	12.2	11.9	12.7
Without a spouse	30.7	31.3	24.9	27.5	27.6	23.0	23.6	36.3	33.2	30.1	30.6	20.2	25.2	28.1
All parents	19.3	18.6	13.2	18.8	16.8	13.2	13.8	24.5	17.9	18.3	18.7	13.7	14.5	16.6

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Source: Child Trends and Urban Institute

Snapshots of America's Families

Adults' Environment and Behavior

Attitudes Toward Welfare and Working Mothers

Kevin Wang

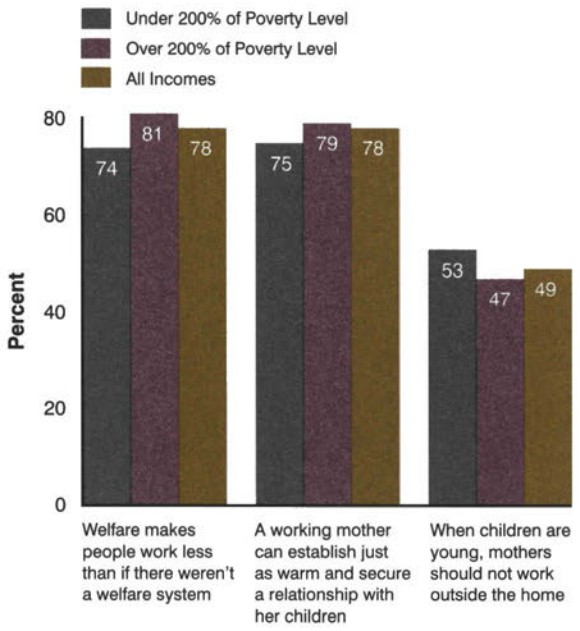
David D'Orio

Some critics of the welfare system have argued that welfare programs contribute to the creation of a society in which the values and beliefs of people receiving public assistance are fundamentally different from those of people not receiving public assistance.

To examine attitudes toward welfare and working mothers, parents were asked if they strongly agreed, agreed, disagreed, or strongly disagreed with the following statements: (i) Welfare makes people work less than they would if there weren't a welfare system; (ii) A working mother can establish just as warm and secure a relationship with her children as a mother who does not work; and (iii) When children are young, mothers should not work outside the home.

The responses reflect the attitudes of the parent or primary caregiver who knows the most about the health care and education of children in the household. Parents were classified as receiving public assistance if someone in their family was a beneficiary of the Temporary Assistance for Needy Families program (or its predecessor) or the Food Stamp Program at the time of the survey.

Parents Who Agreed or Strongly Agreed with Statements Regarding Welfare and Working Mothers, by Family Income, 1997



Source: Urban Institute

Nationally, 78 percent of parents agreed or strongly agreed that welfare provides a disincentive to work. Variation among the 13 states surveyed was slight: The greatest agreement was 81 percent, in Florida, while the least was 72 percent, in Massachusetts.

There was also little difference nationally by income group, although the difference was statistically significant. Seventy-four percent of parents with low family incomes (below 200 percent of the federal poverty level) agreed that welfare provides a work disincentive, compared to 81 percent of parents with higher family incomes. However, parents in families receiving public assistance were much less likely to agree that welfare provides a disincentive to work than parents in families not receiving public assistance: 64 percent versus 80 percent, respectively, a statistically significant difference.

Nationally, 78 percent of parents agreed or strongly agreed that working mothers can establish as warm and secure a relationship with their children as mothers who do not work. Again, there were only slight differences between the states, ranging from a low of 71 percent agreement in California to a high of 81 percent in Massachusetts and Minnesota.

There was also a statistically significant, but small, difference nationally by income, with 75 percent of parents from low-income and 79 percent of those from higher-income families agreeing or strongly agreeing that working mothers can establish as warm and secure a relationship with their children as mothers who do not work. There was almost no

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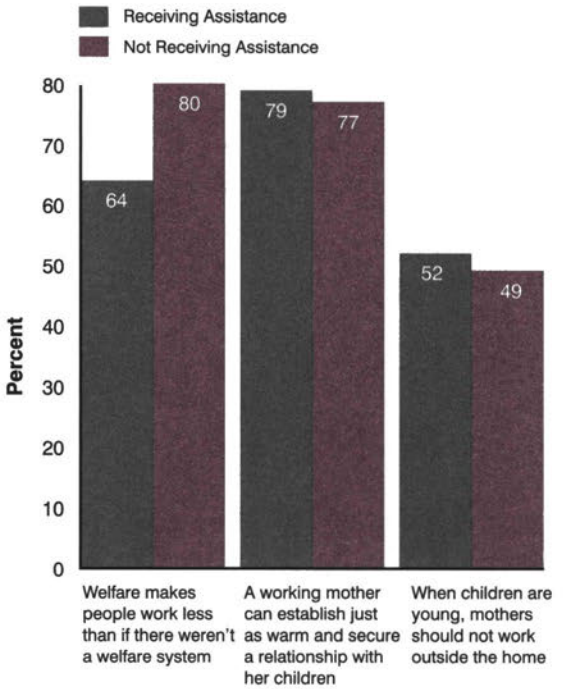
Parents Who Agreed or Strongly Agreed with Statements Regarding Welfare and Working Mothers, by Welfare Status, 1997



Source: Urban Institute

difference in agreement between parents in families receiving public assistance (79 percent) and those in families not receiving assistance (77 percent).

Finally, only 49 percent of parents nationally agreed or strongly agreed that when children are young, mothers should not work outside the home. This statement provoked more varied responses by state than the other two, ranging from 43 percent agreement in Wisconsin to 59 percent agreement in California.

Nationally, 47 percent of higher-income parents agreed or strongly agreed that mothers of young children should not work, while 53 percent of low-income parents did, a statistically significant, but modest, difference. There was also very little difference in agreement by welfare status. Fifty-two percent of parents in families receiving public assistance agreed or strongly agreed, compared to 49 percent of parents in families not receiving assistance.

Parents (%) Who Agreed or Strongly Agreed with Statements Regarding Welfare and Working Mothers, 1997

Statement	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Below 200% of poverty level														
Welfare makes people work less than if there weren't a welfare system	77.2	73.1	73.8	76.8	74.7	66.7	75.8	74.5	71.0	68.3	77.0	69.7	71.5	73.5
A working mother can establish just as warm and secure a relationship with her children	79.0	64.4	73.5	76.4	80.3	79.3	75.1	75.8	70.0	71.4	71.3	68.9	79.3	75.0
When children are young, mothers should not work outside the home	44.4	65.6	60.4	52.8	55.0	45.8	50.8	41.9	55.6	55.8	55.0	61.0	48.7	53.3
Above 200% of poverty level														
Welfare makes people work less than if there weren't a welfare system	83.2	77.0	78.6	83.8	71.6	77.2	78.1	85.9	75.8	77.2	82.8	76.0	75.4	81.1
A working mother can establish just as warm and secure a relationship with her children	77.6	76.8	76.6	79.1	81.5	80.0	83.3	77.1	82.8	82.5	77.6	78.5	80.5	79.4
When children are young, mothers should not work outside the home	45.7	53.2	47.4	45.9	41.9	45.2	40.8	46.4	46.6	43.0	45.0	52.2	40.9	46.7
All incomes														
Welfare makes people work less than if there weren't a welfare system	80.4	75.3	77.1	80.7	72.4	73.7	77.4	79.9	74.6	73.6	80.1	73.9	74.2	78.1
A working mother can establish just as warm and secure a relationship with her children	78.3	71.3	75.7	77.9	81.2	79.7	80.9	76.4	79.4	77.9	74.6	75.3	80.1	77.6
When children are young, mothers should not work outside the home	45.1	58.9	51.6	49.0	45.5	45.4	43.7	44.0	49.0	48.4	49.8	55.1	43.1	

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Source: Urban Institute

Snapshots of America's Families

Children's Environment and Behavior

Family Structure

Ariel Halpern

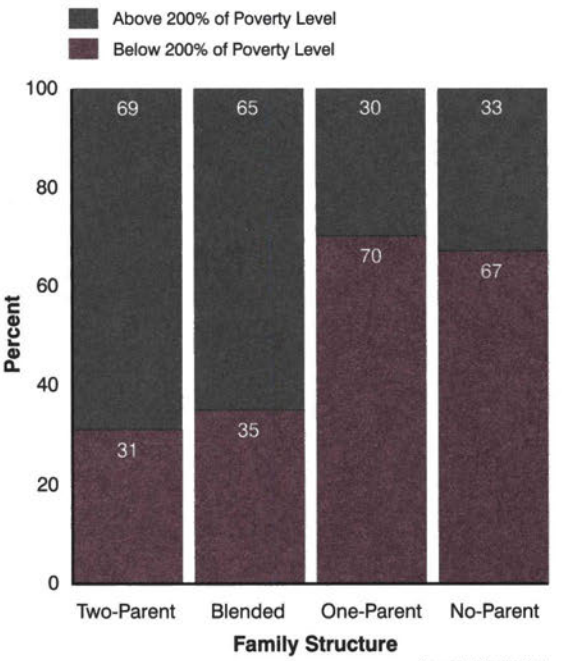
Leticia Fernandez

Rebecca Clark

Most American children live in two-parent families, whether biological or adoptive. Many children, however, do not live with both of their biological parents. Divorce and separation, births outside of marriage, remarriages, and child abuse or neglect are among the reasons these children spend at least part of their childhood with only one or neither biological parent.

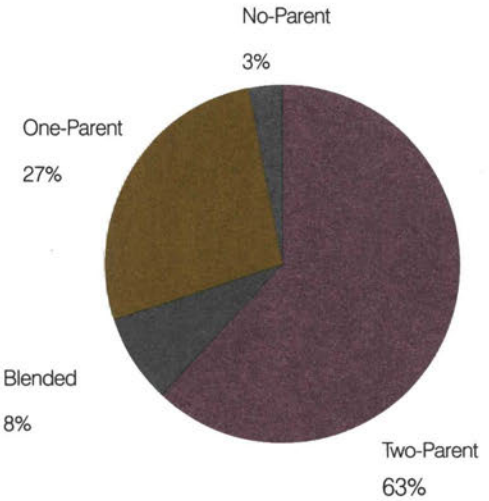
Families are the primary source of a child's economic and emotional resources, and the adults with whom children live are their earliest role models. The time and economic resources associated with raising children may be less for a single parent, especially if he or she is the only breadwinner. Children raised by two parents are more likely to benefit from higher household income and more attention from their parents. Recognizing the importance of family structure to the well-being of children, lawmakers have turned their attention recently to developing incentives for the formation and maintenance of marriage. The promotion of two-parent families is also a goal of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and of the Temporary Assistance for Needy Families program.

Children's Family Structure, by Income, 1997



Source: Urban Institute

Children's Family Structure, 1997



Source: Urban Institute

Primary caregivers were asked about their relationship to the children living in their household. On the basis of their responses, children were grouped into one of four types of families. Two-parent families consist of children living with two parents, whether biological or adoptive. Blended families contain one biological or adoptive parent married to one stepparent who has not adopted the child. (Children who have been adopted by the stepparent are likely to have greater access to the stepparent's resources than children who have not been adopted.) One-parent families are headed by a biological or adoptive parent and may or may not include an unmarried partner or related adults living in the household. Children

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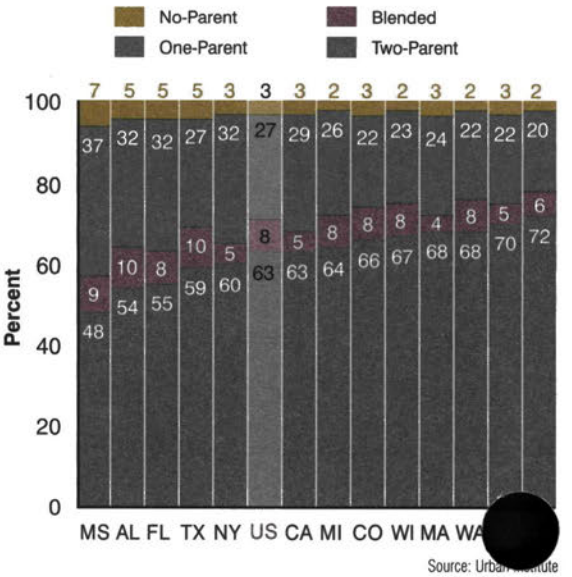
living with relatives other than their parents or with unrelated adults are grouped into the no-parent family category.

On the national level, 63 percent of children lived in two-parent families, and the vast majority of those parents were married—only 3 percent of children lived with two unmarried biological or adoptive parents. Twenty-seven percent of children lived in one-parent families. Relatively small percentages of children lived in the other family structures: 8 percent in blended families and 3 percent in no-parent families.

As pointed out above, children living in one-parent or no-parent families are far more likely to experience economic hardship than children raised in two-parent or blended families. Nationally, 31 percent of children in two-parent families and 35 percent of children in blended families had low incomes (below 200 percent of the poverty level), compared to 70 percent in one-parent families and 67 percent in no-parent families.

The structure of families with children also varies by state. Among the states surveyed, Minnesota had the highest proportion of children living in two-parent families, 72 percent, and the lowest proportion of children in one-parent families, 20 percent. In contrast, 48 percent of children in Mississippi lived in two-parent families, and 37 percent lived in one-parent families. Compared to the national average of 63 percent, six states had more children living in two-parent families: Colorado, Massachusetts, Minnesota, New Jersey, Washington, and Wisconsin. Fewer children in Alabama, Florida, Mississippi, and Texas lived in this type of family.

Children's Family Structure, by State, 1997



Source: Urban Institute

Children (%) Living in Various Family Structures, 1997

Family Structure	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Two-parent	53.8	63.1	66.4	54.6	68.2	64.2	72.3	47.7	70.1	60.3	59.0	67.9	66.6	62.6
Blended	9.6	5.1	8.4	8.2	4.2	7.7	5.9	8.8	4.9	5.0	9.5	8.2	7.7	7.6
One-parent	31.7	29.2	22.4	32.3	24.5	25.7	20.0	36.6	22.2	31.5	27.0	21.9	23.4	26.7
No-parent	4.9	2.6	2.9	5.0	3.1	2.4	1.7	7.0	2.9	3.2	4.5	2.1	2.3	3.2

Figures in color represent statistically significant differences from the national average at the .05 confidence level. Figures in black are not statistically significantly different from the national average. All figures in text, charts, and table are rounded.

Source: Urban Institute

Snapshots of America's Families

Children's Environment and Behavior

Children Born Outside of Marriage

Ariel Halpern

Elaine Sorensen

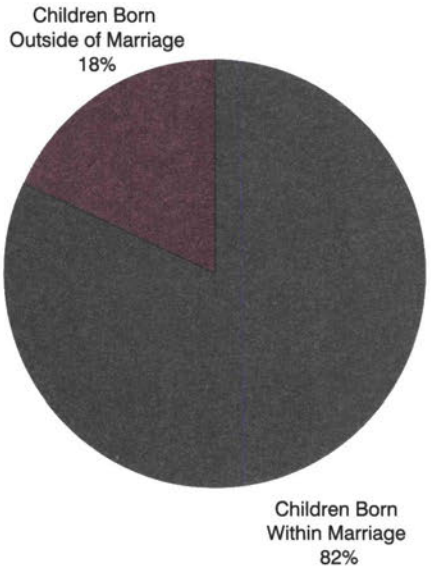
Between 1978 and 1996, the number of babies born to unmarried women doubled, from just over 500,000 to over 1.2 million. Although this dramatic rate of increase has slowed in recent years, 32 percent of all U.S. births are still to unmarried women. These children are more likely to be poor than children born to married women.

Legislators have made an effort to curb births outside of marriage. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for example, made it easier for states to design welfare programs that serve married parents as well as unmarried parents. It also established $20 million bonuses for the five states that show the greatest decrease in births to unmarried women and set aside $50 million for abstinence education.

To examine poverty among children born outside of marriage—defined here as children under age 18 born to unmarried parents who were not married to each other at the time of this survey—mothers were asked about their marital status when their children were born, whether they were currently married to the children's biological father, and their income. It is important to note that although 32 percent of births nationwide occurred outside of marriage in 1996, only 18 percent of all children under age 18 fell into this category. These figures differ both because the proportion of births outside of marriage has risen over the past 18 years and because some parents of these children later marry each other.

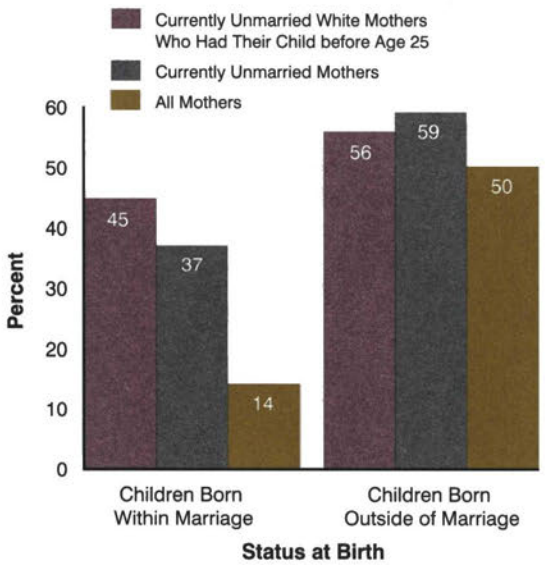
Nationally, 50 percent of children born outside of marriage lived in families with incomes below the poverty level, compared to 14 percent of children born within marriage, a statistically significant difference. Among all children living

Children Born Outside of and Within Marriage, 1997



Source: Urban Institute

Child Poverty, by Maternal Characteristics, 1997



Source: Urban Institute

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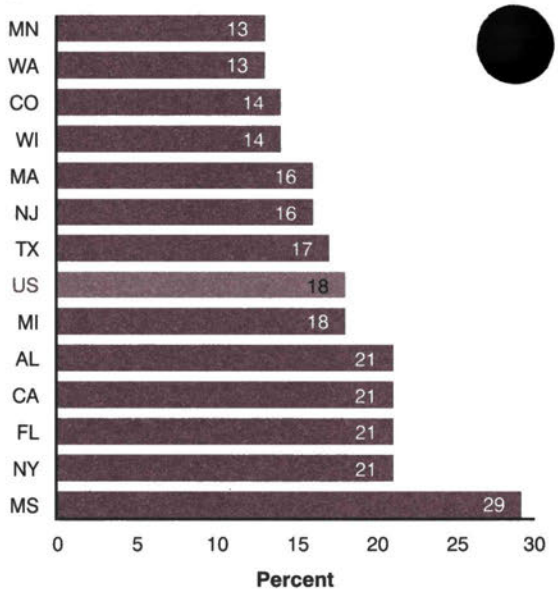
with just their mother, 59 percent of those born outside of marriage were poor, compared to 37 percent of those born within marriage, a statistically significant difference.

Including other maternal characteristics further reduced the differences in poverty rates between children born outside of and within marriage, but it did not eliminate them. For example, 56 percent of children who were born outside of marriage to a young (under 25) white woman were poor. In contrast, 45 percent of children born within marriage to a young white woman were likely to be poor, a statistically significant difference.

The proportion of children born outside of marriage varied among the 13 states surveyed. Mississippi had the highest, with 29 percent; Minnesota and Washington, at 13 percent each, had the lowest. Five states had a lower percentage of children born outside of marriage than the national average (Colorado, Minnesota, New Jersey, Washington, and Wisconsin), and five states had a higher percentage (Alabama, California, Florida, Mississippi, and New York).

Children Born Outside of Marriage, by State, 1997



Source: Urban Institute

Children (%) Born Outside of and Within Marriage, 1997

Parents' Marital Status	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Unmarried	20.6	21.1	13.8	21.4	16.4	18.5	12.8	29.2	16.1	20.8	16.9	12.8	14.4	18.2
Married	79.4	78.9	86.2	78.7	83.6	81.5	87.2	70.8	83.9	79.2	83.2	87.2	85.6	81.8

Figures in color represent statistically significant differences from the national average at the .05 confidence level. Figures in black are not statistically significantly different from the national average. All figures in text, charts, and table are rounded.

Source: Urban Institute

Snapshots of America's Families

Children's Environment and Behavior

High Engagement in School

Kristin Moore
Child Trends

Jennifer Ehrle
Child Trends

Brett Brown
Child Trends

Children's future economic status and productivity in the workforce are determined in part by their performance in school. Research has shown that children and adolescents who are highly engaged in school perform better in terms of test scores, attendance, and advancement from grade to grade. Studies also indicate that low-income children are less successful in school than children from families with higher incomes.

Changes in welfare are likely to prompt changes in the lives of low-income children that may affect their engagement in school. Children whose parents obtain stable employment may be better able to focus on schoolwork. Knowing that they need to work as adults, these children may become more engaged in the learning process. Conversely, children whose parents end up in unstable, low-paying jobs with shifting work schedules may find it harder to become engaged in the educational process.

To assess school engagement, parents were asked about the extent to which their children did schoolwork only when forced to, did just enough schoolwork to get by, always did homework, and cared about doing well in school. The responses to these four questions were combined to generate a measure of school engagement.

Nationally, 41 percent of all children were described as being highly engaged in school. In low-income families (below 200 percent of the poverty level), 34 percent of children were highly engaged, compared to 45 percent of children in higher-income families, a statistically significant difference.

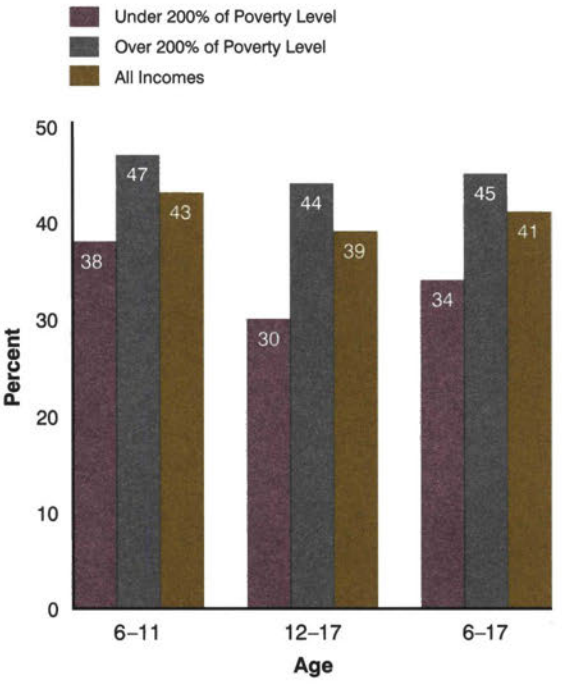
Differences in engagement by family income were evident in young children and in adolescents. Of children age 6 to 11, 38 percent in low-income and 47 percent in higher-income families were highly engaged. This gap widened somewhat for children between the ages of 12 and 17, with 30 percent and 44 percent, respectively, being highly engaged.

In the 13 states surveyed, 35 percent to 43 percent of all children were highly engaged in school. None of the states was above the national average, but four were below it: Alabama, California, Colorado, and Mississippi.

Among children from low-income families, 28 percent to 38 percent were highly engaged in school. Texas was above the national average; Alabama and Mississippi were below it.

For children age 6 to 11 in low-income families, 29 percent to 40 percent were highly engaged in school. None of the states surveyed was above

Children Highly Engaged in School, by Age and Family Income, 1997



Source: Child Trends and Urban Institute

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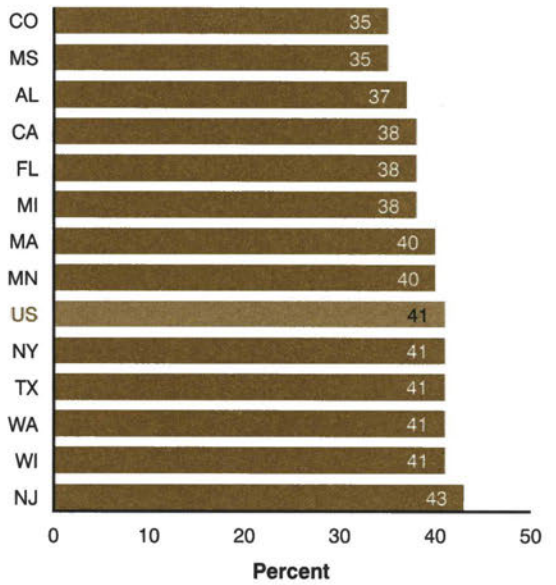
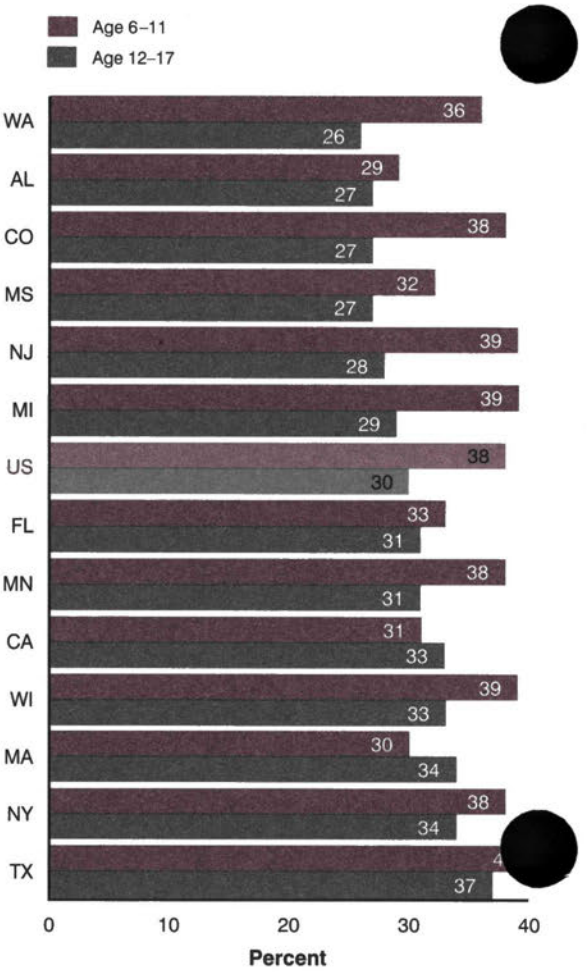
Children Highly Engaged in School, by State, 1997



Source: Child Trends and Urban Institute

Low-Income Children Highly Engaged in School, by Age and State, 1997



Source: Child Trends and Urban Institute

the national average of 38 percent, but Alabama, California, Massachusetts, and Mississippi were below it.

Among 12- to 17-year-olds in low-income families, those highly engaged in school ranged from 26 percent to 37 percent. In Texas, the percentage was above the national average of 30 percent, but none of the states dropped below the national average.

The engagement scale was developed by Jim Connell and Lisa Bridges at the Institute for Research and Reform in Education.

Children (%) Highly Engaged in School, 1997

Age	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
6–11	28.6	31.4	38.1	33.1	30.4	38.6	37.9	32.5	39.5	37.8	39.7	35.5	38.8	38.2
12–17	27.1	33.1	27.4	31.0	34.1	28.7	30.7	26.6	27.8	33.8	37.2	26.3	33.4	29.8
6–17	27.9	32.1	33.4	32.1	32.2	34.0	34.6	29.7	34.2	36.0	38.5	31.5	36.3	34.4
Over 200% of poverty level														
6–11	44.6	43.5	39.5	45.9	41.9	42.4	42.6	47.7	50.3	46.6	38.8	50.3	44.5	47.1
12–17	44.5	44.2	32.7	40.2	45.2	37.3	40.6	36.2	42.5	42.4	47.0	41.5	41.3	43.8
6–17	44.5	43.8	36.2	43.1	43.4	39.7	41.5	41.4	46.7	44.5	42.8	45.9	42.8	45.4
All incomes														
6–11	36.5	37.5	39.0	39.9	38.4	41.0	41.2	38.6	47.3	42.7	39.2	44.9	42.5	43.3
12–17	37.3	39.4	31.0	35.9	41.9	34.7	38.0	31.1	38.5	39.1	42.5	36.9	39.1	38.6
6–17	36.9	38.4	35.2	37.9	40.1	37.8	39.6	34.8	43.3	41.0	40.8	41.1	40.8	41.0

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Source: Child Trends and Urban Institute

Snapshots of America's Families

Children's Environment and Behavior

Reading and Telling Stories to Young Children

Jennifer Ehrle
Child Trends

Kristin Moore
Child Trends

Child development specialists have long noted that reading books to children or telling them stories triggers their imagination and sharpens their literacy skills. Poverty may jeopardize the quality of the home environment, particularly by reducing the quality or amount of time parents have for literacy activities with their children. This can limit a child's readiness for school, putting him or her at an educational disadvantage.

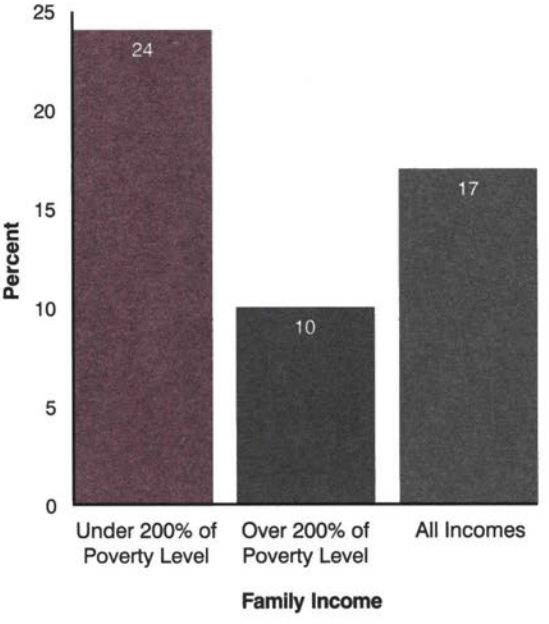
Under welfare reform, some low-income parents may find it more difficult to find time to read to young children because of the additional demands of job training and employment. However, for other parents, less worry about money and a more structured lifestyle may make daily reading more feasible. Monitoring these changes in family life will be important to shaping society's response to low-income children's cognitive needs.

Parents were asked how many days during the week they read or told stories to their children. Nationally, 17 percent of all children age 1 to 5 were read to or told stories fewer than three days per week. Children in low-income families (below 200 percent of the poverty level) were more than twice as likely as other children to fall into this risk category (24 percent versus 10 percent).

In the 13 states surveyed, 13 percent to 24 percent of children were read to or told stories fewer than three times a week. In three states, the percentages of children in this risk category exceeded the national average: California, Mississippi, and Texas. A lower-than-average percentage of children fell into this category in Colorado, Massachusetts, Minnesota, New Jersey, and Wisconsin.

Among low-income children in the surveyed states, 16 percent to 33 percent were read to or told stories fewer than three times a week. In California, Mississippi, and Texas, the percentage of children in this category exceeded the national average of 24 percent. In contrast, smaller-than-average percentages of low-income children fell into this category in Minnesota, New York, and Washington.

Children Age 1 to 5 Read to or Told Stories Fewer Than Three Days per Week, by Family Income, 1997



Source: Child Trends and Urban Institute

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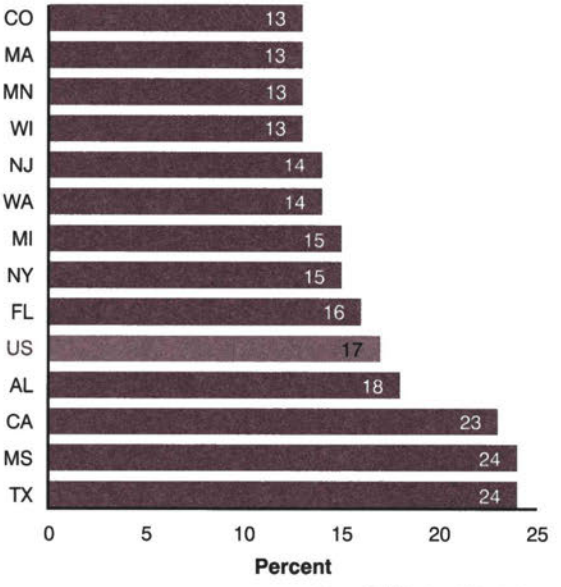
Children Age 1 to 5 Read to or Told Stories Fewer Than Three Days per Week, by State, 1997



Source: Child Trends and Urban Institute

Children (%) Age 1 to 5 Read to or Told Stories Fewer Than Three Days per Week, 1997

Family Income	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level	20.6	30.9	20.7	25.4	23.3	24.9	17.5	29.6	28.7	17.8	33.0	16.3	19.9	24.0
Over 200% of poverty level	14.7	12.9	8.9	7.5	7.7	9.3	10.9	15.3	7.5	12.8	13.6	12.1	9.2	10.5
All incomes	17.7	22.7	13.2	16.2	12.6	14.7	13.1	23.8	14.2	15.1	24.3	13.8	12.9	16.8

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Source: Child Trends and Urban Institute

Children's Environment and Behavior

Participation in Extracurricular Activities

Kristin Moore
Child Trends

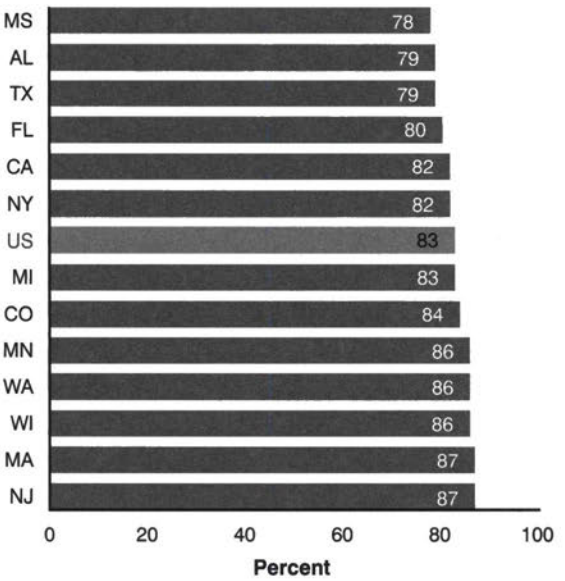
Jennifer Ehrle
Child Trends

Participation in extracurricular activities encourages personal accomplishment and the development of interpersonal skills.

For adolescents, these activities offer an opportunity to assume meaningful roles and responsibilities. The sense of efficacy gained from these experiences can be an important protective factor for children growing up under adverse circumstances. Research finds, for example, that participation in religious organizations and leadership in school clubs are associated with a lower risk of school-age motherhood.

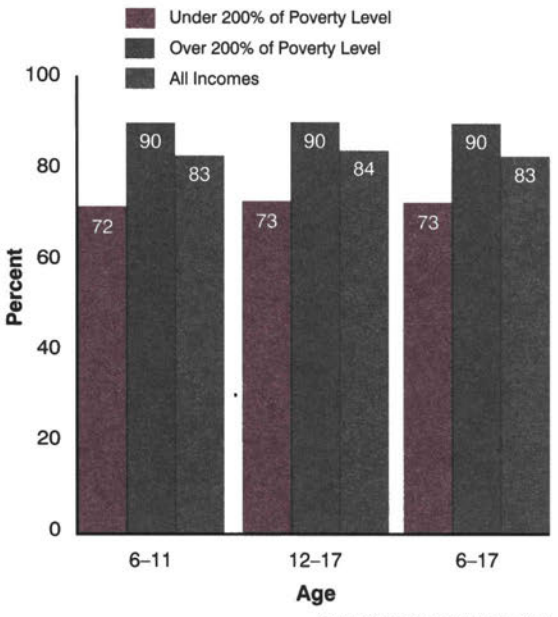
For many children, participation in extracurricular activities is not an option, because of economic constraints, limited opportunities in neighborhoods or schools, or a parent's need for assistance at home. Changes in welfare may affect family economic resources and family schedules. With more income, families may be able to afford activities and lessons for their children, or they may enroll children in schools where activities are more readily available. However, the demands of parental work may increase children's obligations at home, thereby limiting their participation in extracurricular activities.

Children Participating in Extracurricular Activities, by State, 1997



Source: Child Trends and Urban Institute

Children Participating in Extracurricular Activities, by Age and Family Income, 1997



Source: Child Trends and Urban Institute

Participation in extracurricular activities was assessed on the basis of parents' responses to questions about children's involvement in lessons, clubs, sports, or other activities. Children who participated in at least one of these activities in the past year were categorized as involved in activities.

Nationally, 83 percent of all children age 6 to 17 participated in at least one extracurricular activity, including clubs, sports, or lessons. Of children in families with low incomes (under 200 percent of the poverty level), 73 percent participated, compared to 90 percent of children in higher-income families, a statistically significant difference.

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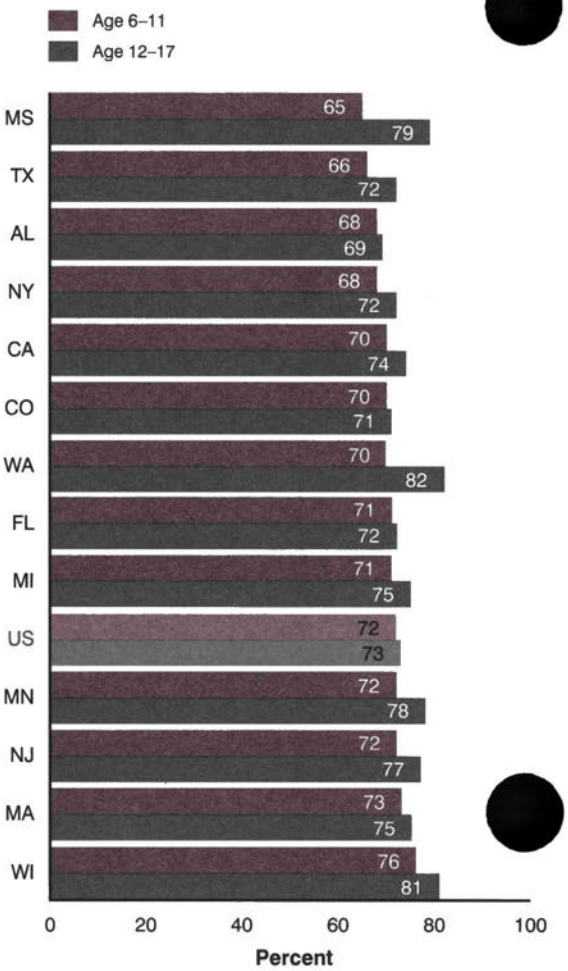
In the 13 states surveyed, extracurricular participation ranged from 78 percent to 87 percent. The percentage of all children participating was above the national average in Massachusetts, Minnesota, New Jersey, Washington, and Wisconsin. Participation was below the national average in Alabama, Florida, Mississippi, and Texas.

For children age 6 to 17 in low-income families, participation ranged from 68 percent to 78 percent. Only in Wisconsin was the percentage of children participating in activities above the national average of 73 percent. Participation fell below average in Texas.

For children age 6 to 11 in low-income families, participation in extracurricular activities ranged from 65 percent to 76 percent. None of the states surveyed had rates higher than the national average of 72 percent, but Mississippi and Texas had lower-than-average rates.

Participation by adolescents from low-income families ranged from 69 percent to 82 percent. Rates among these 12- to 17-year-olds were higher than the national average of 73 percent in Washington and Wisconsin, but no state percentages for this age group fell below the national average.

Low-Income Children Participating in Extracurricular Activities, by Age and State, 1997



Source: Child Trends and Urban Institute

Children (%) Participating in Extracurricular Activities, 1997

Age	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
6–11	68.2	70.0	70.1	71.0	72.7	70.7	72.1	65.0	72.2	68.2	65.6	69.8	75.9	72.5
12–17	68.6	74.4	70.6	71.9	74.7	75.0	77.5	78.9	76.7	71.8	72.3	82.4	81.0	73.4
6–17	68.4	71.9	70.3	71.4	73.6	72.7	74.7	71.7	74.3	69.8	68.7	75.3	78.3	72.9
Over 200% of poverty level														
6–11	88.6	91.1	92.4	89.3	94.5	86.3	91.6	85.2	92.6	91.1	89.0	89.8	89.2	90.4
12–17	88.9	91.4	87.9	86.3	91.5	89.0	89.7	87.5	91.1	92.0	87.6	92.2	88.5	89.9
6–17	88.8	91.2	90.2	87.8	93.1	87.7	90.6	86.5	91.9	91.6	88.3	91.0	88.8	90.2
All incomes														
6–11	78.2	80.7	84.6	80.7	88.0	80.7	85.6	73.2	86.9	81.0	77.9	82.5	84.6	82.7
12–17	80.5	84.1	82.4	79.4	86.5	84.7	86.5	82.9	87.1	84.1	80.6	89.2	86.3	83.7
6–17	79.4	82.3	83.6	80.1	87.3	82.7	86.1	78.2	87.0	82.5	79.2	85.7	85.5	83.2

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Source: Child Trends and Urban Institute

Snapshots of America's Families

Children's Environment and Behavior

Behavioral and Emotional Problems in Children

Kristin Moore
Child Trends

Jennifer Ehrle
Child Trends

Several family and neighborhood characteristics are associated with the development of behavioral and emotional problems in children.

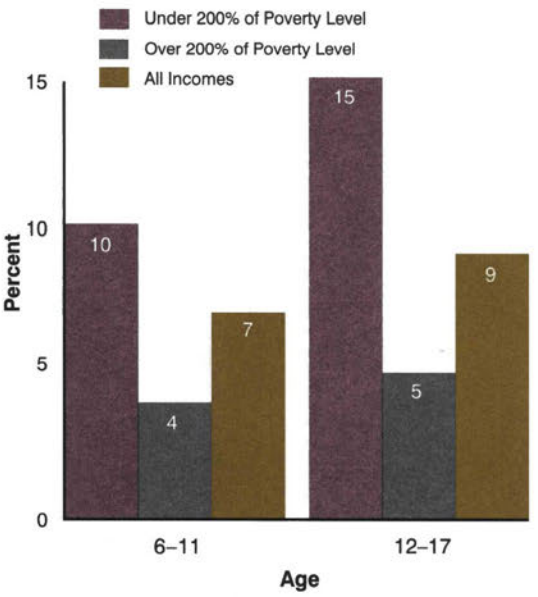
For example, studies have linked greater parental depression and stress with emotional and behavioral problems. Further, living in a neighborhood with more low-income residents is associated with a higher incidence of behavioral problems such as destroying property or feeling worthless.

If welfare reform results in low-income families living in improved communities and reduces parental stress and depression, behavioral and emotional problems in children may decline. However, if long or erratic hours of work reduce parental supervision and control or increase parental aggravation and stress, then children's problems may increase.

Parents were asked about the extent to which their children exhibited signs of external distress (not getting along with other kids, acting too young for their age, or lying and cheating) and internal distress (sadness, depression, or feelings of worthlessness) in the last month. A measure of behavioral and emotional problems was derived from their responses.

Nationally, 7 percent of children age 6 to 11 exhibited high levels of behavioral and emotional problems. That figure rose to 10 percent

Children with High Levels of Behavioral and Emotional Problems, by Age and Family Income, 1997



Source: Child Trends and Urban Institute

Children with High Levels of Behavioral and Emotional Problems, by Age and State, 1997

Source: Child Trends and Urban Institute

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in families with low incomes (below 200 percent of the poverty level). It dropped to 4 percent in families with higher incomes, a statistically significant difference.

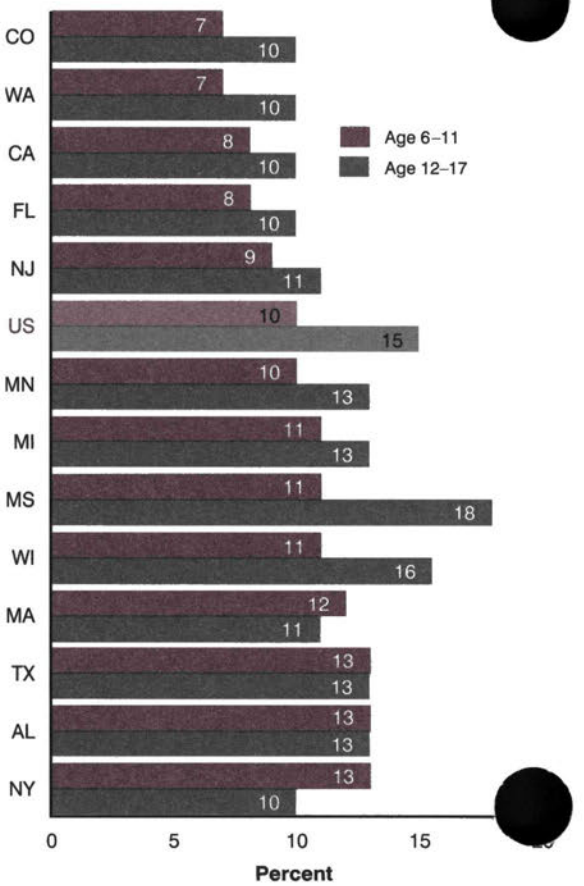
Nationally, 9 percent of 12- to 17-year-olds showed high levels of behavioral and emotional problems. Adolescents in low-income families were three times as likely to be troubled as adolescents in higher-income families—15 percent versus 5 percent, a statistically significant difference.

In the 13 states surveyed, 6 percent to 9 percent of all younger children and 6 percent to 12 percent of all older children had high levels of behavioral and emotional problems. None of the states had percentages above or below the national average in either age group.

In low-income families, the percentage of children age 6 to 11 with high levels of behavioral and emotional problems ranged from 7 percent to 13 percent. None of these percentages was above or below the national average.

Among adolescents in low-income families, high levels of behavioral and emotional problems ranged from 10 percent to 18 percent. None of the states surveyed had percentages above the national average, but three states had percentages below it: Colorado, Florida, and New York.

Low-Income Children with High Levels of Behavioral and Emotional Problems, by Age and State, 1997



Source: Child Trends and Urban Institute

Children (%) with High Levels of Behavioral and Emotional Problems, 1997

Age	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty level														
6–11	12.9	8.2	7.2	8.4	12.5	11.4	10.2	11.5	9.1	12.7	12.5	7.3	11.2	9.6
12–17	12.8	10.5	9.6	9.5	10.9	13.0	12.6	17.7	11.4	10.3	12.5	10.3	15.7	14.9
Over 200% of poverty level														
6–11	2.1	3.3	5.3	7.5	6.5	4.6	5.3	5.1	5.5	5.3	6.1	4.6	5.2	4.2
12–17	7.3	5.8	5.7	8.5	5.6	5.4	8.0	5.0	4.2	4.9	5.7	5.3	5.3	5.2
All incomes														
6–11	7.6	5.7	6.0	7.9	8.3	7.0	6.8	8.9	6.5	8.5	9.1	5.6	7.2	6.5
12–17	9.5	7.8	6.9	9.0	7.1	7.7	9.2	11.7	6.2	7.0	8.8	6.8	8.3	8.8

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Children's Health Insurance Program

New Jersey Outreach Practices

- Designed a family-friendly enrollment program which simplified the application process and developed a joint Medicaid/CHIP mail-in application.
- First State to be approved as an AmeriCorp VISTA volunteer project site; six outreach workers provide grassroots outreach to the community and assist in enrolling eligible children.
- Developed innovative partnerships with other State agencies.
- NJ KidCare is partnering with WIC agencies to do outreach and enrollment.
- Division of Motor Vehicles mails KidCare materials to families with driver's license and vehicle registration renewal forms.
- The Division of Taxation provides addresses of NJ residents meeting the NJ KidCare income guidelines. NJ KidCare mails program information to these families.
- The Department of Health and Senior Services provides birth registry data to NJ KidCare program and 1,500 new parents are notified weekly about NJ KidCare.
- There will be a check off box about NJ KidCare on the application for the Free and Reduced Cost Lunch program. Parents can indicate their willingness to receive information about NJ KidCare.
- Partnered with School Districts to provide NJ KidCare materials for distribution to parents through their children.
- Enrollment events held at schools during registration for Kindergarten and Pre-K and at other times.
- Trained school nurses and child study team members about eligibility criteria and application completion.
- Partner with Public Service Electric and Gas Company to provide outreach material. There are 16 customer service centers where information about NJ KidCare will be available. When a caller to PSE&G is on hold, there will be a recorded message about NJ KidCare. There will be a looped video tape about NJ KidCare playing in PSE&G Service Centers. PSE&G will insert information about NJ KidCare in customers' bills.

- Many legislative offices are enrollment sites and constituent relations staff are trained to assist in application completion.
- There is an extensive media campaign which includes radio, television and cable announcements about NJ KidCare. Also, there are billboards and bus posters announcing NJ KidCare. Over 500 movie theaters display a fifteen second informational-commercial about NJ KidCare before the feature movie.
- Partnered with over 500 community based organizations and faith based organizations. These include health care providers, social service agencies, home care agencies, cultural and civic organizations, etc.
- NJ KidCare has brokered with major food chains to provide information about NJ KidCare.

Return to Children's Health Insurance Program Page

Last Updated May 28, 1999

CHIP Database Search Results

Your State Query for **TX** has been submitted, the following is a summary of available information:

Name:
Title:
Organization: Department of Health and Human Services
Administration for Children and Families
Location:
Address:1200 Main Tower Building
City: Dallas
State:TX
Zipcode:75202
Phone: 2147679648 **Fax:** **Email:**

Name: William Archer M.D.
Title: Commissioner
Organization: Texas Department of Health

Location:
Address:1100 West 49th Street
City: Austin
State:TX
Zipcode:787567446
Phone: 5124587376 **Fax:** 5124587477 **Email:**

Name: Jack Baum D.D.S.
Title: Chief
Organization: Texas Department of Health
Bureau of Children's Health
Location:
Address:1100 West 49th Street
City: Austin
State:TX
Zipcode:787563179
Phone: 5124587700 **Fax:** 5124587203 **Email:** jbaum@wcl.tdh.state.tx.us

---

Name: Connie Berry
Title:
Organization: Texas Department of Health
Community Oriented Primary Care
Location:
Address:1000 W. 49th Street
City: Austin
State:TX
Zipcode:78756
Phone: 5124587771 **Fax:** 5124587235 **Email:** cberry@copc.tdh.state.tx.us

---

Name: Terry Faye Bleier
Title: Executive Director
Organization:TX Commission on Alcohol and Drug Abuse

Location: Suite 105
Address:9001 North IH 35
City: Austin

State:TX
Zipcode:787535233
Phone: 5123496601 **Fax:** 5128374123 **Email:** terry-bleier@tcada.state.tx.us

---

Name: Jose Camacho
Title: Executive Director
Organization:TACHC, Inc.

Location:
Address:211 E 7th Street, Suite 818
City: Austin
State:TX
Zipcode:78701
Phone: 5124768188 **Fax:** 5124767949 **Email:** jcamacho@tachc.com

---

Name: Laura Jordan
Title: Executive Director
Organization: Center for Rural Health Initiatives

Location:
Address:211 East 7th Street, Suite 915
City: Austin
State:TX
Zipcode:787671708
Phone: 5124798891 **Fax:** 5124798898 **Email:** laura.jordan@mail.capnet.state.tx.us

---

Name: Sister Mary Jane Strauch
Title:
Organization: Texas Rural Health Association

Location:
Address:6505 Almeda Road
City: Houston
State:TX
Zipcode:770212001
Phone: 7137418298 **Fax:** 7137474707 **Email:** maryjane@dpmicro.net

---

Name: Thomas Wells M.D., M.P.H.
Title:
Organization:
Region VI
Location:10th Floor, HRSA-4
Address:1301 Young Street
City: Dallas
State:TX
Zipcode:75202
Phone: 2147673003 **Fax:** 2147678049 **Email:** twells@hrsa.dhhs.gov

---

Name: Linda Wertz
Title: Medicaid Director
Organization: Health and Human Services Commission

Location:
Address:P.O. Box 13247
City: Austin
State:TX
Zipcode:78711

Phone: 5124246517 **Fax:** 5124246585 **Email:**

Thank you for searching the CHIP Online Database!

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CHIP Database Search Results

Your State Query for **CA** has been submitted, the following is a summary of available information:

Name:
Title:
Organization: Department of Health and Human Services
Administration for Children and Families
Location:
Address:50 United Nations Plaza Room 487
City: San Francisco
State:CA
Zipcode:94102
Phone: 4154378481 **Fax:** **Email:**

Name: Carmela Castellano
Title:CEO
Organization: California Primary Care Association

Location:
Address:1201 K Street, Suite 1010
City: Sacramento
State:CA
Zipcode:95814
Phone: 9164408173 **Fax:** 9164408172 **Email:** ccastellano@cpca.org

---

Name: Maridee A. Gregory M.D.
Title: Chief
Organization: California State Department of Health Services
Children's Medical Services Branch
Location:
Address:714 P Street, Room 750
City: Sacramento
State:CA
Zipcode:95814
Phone: 9166540832 **Fax:** 9166538271 **Email:**

Name: Fred Johnson
Title: Liaison
Organization: California Health and Welfare Agency
Rural Health Policy Council
Location:
Address:1600 9th Street, Room 439 C
City: Sacramento
State:CA
Zipcode:95814
Phone: 9166542991 **Fax:** 9166542871 **Email:**

Name: Andrew M. Mecca Dr.P.H.
Title: Director
Organization: Governor's Policy Council on Drug & Alcohol Abuse

Location:
Address:1700 K Street, 5th Floor, Executive Office
City: Sacramento

State:CA
Zipcode:958144037
Phone: 9164451943 **Fax:** 9163235873 **Email:**

Name: Tameron Mitchell
Title: Deputy Director
Organization: California State Department of Health Services
Primary Care and Family Health
Location:
Address:714 P Street, Room 450
City: Sacramento
State:CA
Zipcode:95814
Phone: 9166540265 **Fax:** 9166570796 **Email:** tmtchel@hw1.cahwnet.gov

---

Name: Doug Porter
Title: Deputy Director of Medical Programs
Organization: Department of Health Services

Location: Room 1253
Address:714 P Street
City: Sacramento
State:CA
Zipcode:95814
Phone: 9166540391 **Fax:** 9166571156 **Email:**

Name: Anna Ramirez
Title: Chief
Organization: California Department of Health Services
Office of Primary and Rural Health Care
Location:
Address:714 P Street, Room 550
City: Sacramento
State:CA
Zipcode:95814
Phone: 9166540348 **Fax:** 9166545900 **Email:**

Name: Ana Ramirez
Title:
Organization:CA Department of Health Services
Primary Care & Rural Hlth Systems Branch
Location:
Address:714 P Street, Room 550
City: Sacramento
State:CA
Zipcode:95814
Phone: 9166542334 **Fax:** 9166545900 **Email:** aramirez@hwl.cahwnet.gov

---

Name: Rugmini Shah M.D.
Title: Chief
Organization: California State Department of Health Services
Maternal and Child Health Branch
Location:
Address:714 P Street, Room 750
City: Sacramento
State:CA
Zipcode:95814

Phone: 9166571347 **Fax:** 9166573069 **Email:**

Name: Mary Smithberger
Title:
Organization: California Department of Education
Child Development Division
Location:
Address:560 J Street, suite 220
City: Sacramento
State:CA
Zipcode:95814
Phone: 9163231342 **Fax:** 9163236853 **Email:** msmithbe@smtp.cde.ca.gov

---

Name: Herrmann Spitzler
Title:
Organization: California State Rural Health Association

Location:
Address:770 Tenth Street
City: Arcata
State:CA
Zipcode:95521
Phone: 7078268779 **Fax:** 7078268638 **Email:**

Name: Jim Stratton M.D., M.P.H.
Title: State Health Officer
Organization: California Department of Health Services

Location:
Address:714 P Street
City: Sacramento
State:CA
Zipcode:958146401
Phone: 9166571493 **Fax:** 9166573089 **Email:** jstratto@dhs.ca.gov

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Your State Query for **MI** has been submitted, the following is a summary of available information:

Name: John Barnas
Title: Co-Director
Organization: Michigan State University
Center for Rural Health
Location:C 219 Fee Hall
Address:
City: East Lansing
State:MI
Zipcode:488241316
Phone: 5174321066 **Fax:** 5174320007 **Email:** barnas@com.msu.edu

---

Name: Larry Browm M.D.
Title: President
Organization: Michigan State Rural Health Association

Location:
Address:P.O. Box 845
City: East Lansing
State:MI
Zipcode:488260845
Phone: 5174321066 **Fax:** 5174320007 **Email:**

Name: Stephen Fitton
Title: Chief
Organization: Michigan Department of Community Health
Bureau of Child and Family Services
Location:
Address:3423 Martin Luther King Jr. Blvd.
City: Lansing
State:MI
Zipcode:48909
Phone: 5173358969 **Fax:** 5173359222 **Email:** fittons@state.mi.us

---

Name: Virginia R. Harmon
Title: Deputy Director
Organization: Michigan Department of Community Health
Community Living, Children, & Families
Location:
Address:3423 North Logan/MartinLuther King Jr. Blvd, room 218
City: Lansing
State:MI
Zipcode:48909
Phone: 5173359371 **Fax:** 5173358560 **Email:** harmon@state.mi.us

---

Name: Deborah Hollis
Title: Chief
Organization: Program Policy Division
Bureau of Substance Abuse Services
Location:
Address:320 South Walnut Street
City: Lansing

State:MI
Zipcode:48913
Phone: 5173350278 **Fax:** 5172412611 **Email:**

Name: David R. Johnson M.D., M.P.H.
Title: Chief Executive and Medical Officer
Organization: Michigan Department of Community Health

Location:
Address:3423 North Martin Luther King, Jr. Blvd.
City: Lansing
State:MI
Zipcode:48909
Phone: 5173358024 **Fax:** 5173359476 **Email:** johnsonj@state.mi.us

---

Name: Sandy Little
Title:
Organization: Family Independence Agency

Location:
Address:235 South Grand Avenue, Suite 504
City: Lansing
State:MI
Zipcode:48909
Phone: 5173353610 **Fax:** 5172419033 **Email:**

Name: Patricia Martin
Title:
Organization: University of Missouri

Location:119 Hillcrest Hall- Stephens Campus
Address:
City: Columbia
State: Missouri
Zipcode:65211
Phone: 5738840579 **Fax:** 5738840598 **Email:** hdfspm@showme.missouri.edu

---

Name: Sucanne Miel-Vken
Title:
Organization:MI Department of Health
Division of Managed Care
Location:
Address:3423 North Logan/ MLK Blvd.
City: Lansing
State:MI
Zipcode:48909
Phone: 5173359488 **Fax:** 5173359239 **Email:**

Name: Kim Sibilsky
Title: Executive Director
Organization: Michigan PCA

Location:
Address:2369 Woodlake Drive, Suite 280
City: Okemos
State:MI
Zipcode:48864

Phone: 5173818000 **Fax:** 5173818008 **Email:** sibilsky@pilot.msu.edu

Name: Robert Smedes
Title: Chief Executive Officer
Organization: Department of Community Health
Medical Services Administration
Location:
Address:400 South Pine
City: Lansing
State:MI
Zipcode:48909
Phone: 5173355001 **Fax:** 5713355007 **Email:**

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CHIP Database Search Results

Your State Query for **AL** has been submitted, the following is a summary of available information:

Name: Clyde Barganier DrPH
Title: Director
Organization: Alabama Department of Primary Health
Bureau of Planning & Resource Development
Location:RSA Tower, Suite 840
Address:P.O. Box 30317
City: Montgomery
State:AL
Zipcode:361303017
Phone: 3342065396 **Fax:** 3342065434 **Email:**

Name: Clyde Baringer
Title: Director
Organization:AL Department of Public Health
Office of Rural Health
Location:RSA Tower, Suite 840
Address:201 Monroe Street
City: Montgomery
State:AL
Zipcode:361303017
Phone: 3342065396 **Fax:** 3342065434 **Email:** cbaringer@adph.state.al.us

---

Name: William B. Deal M.D.
Title: Associate Dean
Organization: University of Alabama - Birmingham
Alabama Rural Health Association
Location: University Station, Meb 310
Address:
City: Birmingham
State:AL
Zipcode:35294
Phone: 2059341997 **Fax:** 2059340333 **Email:** medaoll@meb3.meb.meb.uab.edu

---

Name: Al Fox
Title: Executive Director
Organization: Alabama Primary Health Care Association

Location:
Address:6008 East Shirley Lane Suite A
City: Montgomery
State:AL
Zipcode:36117
Phone: 3342717068 **Fax:** 3342717069 **Email:**

Name: J. Christine Kendall M.S.W., M.B.A.
Title: Director
Organization: Alabama Department of Rehabilitation Services
Children's Rehabilitation Services
Location:
Address:2129 East South Boulevard
City: Montgomery

State:AL
Zipcode:361110586
Phone: 3342818780 **Fax:** 3342811973 **Email:** ckendall@rehab.state.al.us

---

Name: Thomas M. Miller M.D.,M.P.H.,
Title: Director
Organization: Alabama Department of Public Health
Bureau of Family Health Services
Location: The RSA Tower, Suite 1368
Address:
City: Montgomery
State:AL
Zipcode:361303017
Phone: 3342065675 **Fax:** 3342062950 **Email:** thosmiller@pol.net

---

Name: Rosemary Mobley
Title:
Organization:

Location: Gordon Persons Building Room 5333
Address:50 North Ripley Street
City: Montgomery
State:AL
Zipcode:36130
Phone: 3342428199 **Fax:** 3342420496 **Email:** rmobley@sdenet.alsde.edu

---

Name: O'Neill Pollingue
Title: Director
Organization: Department of Mental Health/ Retardation
Substance Abuse Services Division
Location:
Address:100 North Union Street
City: Montgomery
State:AL
Zipcode:36130
Phone: 3342423952 **Fax:** 3342420759 **Email:**

Name: Gwendolyn Williams
Title: Commissioner
Organization: Medicaid Agency

Location:
Address:501 Dexter Avenue
City: Montgomery
State:AL
Zipcode:361035624
Phone: 3342425600 **Fax:** 3342425097 **Email:**

Name: Donald E. Williamson M.D.
Title: State Health Officer
Organization: Alabama Department of Health

Location: The RSA Tower, Suite 1552
Address:201 Monroe Street
City: Montgomery
State:AL
Zipcode:361303017

Phone: 3342065200 **Fax:** 3342062008 **Email:** 72054.1120@compuserve.com

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