

HCFA	Beneficiaries	Plans & Providers	States	Researchers	Students
Medicare	Medicaid	CHIP	Customer Service	FAQs	Search

Children's Health Insurance Program



CALIFORNIA PRESENTATION

California (Mr. Joe Kelly, Mr. Ernesto Sanchez, and Dr. Terrence Smith)

Presented at the Technical Advisory Panel Meeting on November 18, 1998

Overview of California's CHIP Approach. California initially submitted its CHIP application to HCFA on November 20, 1997 and HCFA granted approval on March 24, 1998. California could receive nearly \$855 million in new funds for fiscal year 1998 that would be used during the first year of CHIP to insure up to 200,000 currently uninsured children. California, the State with the largest approved CHIP plan, is using its CHIP allocation to expand Medi-Cal, California's Medicaid program, and Access for Infants and Mothers (AIM), as well as to create the Healthy Families Program (HFP), a private children's health insurance program.

The California Department of Health Services administers Medi-Cal. California is using Medi-Cal funds to expand coverage to children between the ages of 14 up to 19 with family incomes at or below 100 percent of the Federal Poverty Level (FPL). AIM covers infants age 0 up to 1 with family incomes 200-250 percent of the FPL. Eligibility determinations for both programs are based on income only and family assets for children's coverage are disregarded (implemented March 1, 1998). In addition, effective November 1, 1998, Medi-Cal provides one month of continued eligibility when family income increases or a family moves. Since July 1998, over 25,000 children have enrolled in Medi-Cal through the CHIP program enhancements.

HFP was created to provide coverage for low-income, uninsured children between the ages of 1 up to 19 with family incomes 100-200 percent of the FPL. HFP is administered by the Managed Risk Medical Insurance Board (MRMIB) and delivers services through a managed care system that utilizes a purchasing pool. The MRMIB also oversees the AIM program and administers the insurance purchasing pool and the insurance purchasing credit for children whose families have access to employer-sponsored coverage. Children enrolled in HFP can choose from 26 health plans, 4 dental plans, and one vision plan. Most of the health plans are HMOs, with one or two preferred provider organizations (PPO) participating. HFP determinations are made once a year. All children in a family must be enrolled in HFP and are required to pay the first month and stay in the purchasing pool for six months.

Children in HFP and in the AIM program receive the same benefits as California's State employees under the California Public Employees Retirement System (CalPERS), California's State employee benefit package. CalPERS includes dental and vision coverage, screening and initial treatment services through the Child Health and Disability Prevention (CHDP) program, and treatment services for severely ill children in a non-managed care delivery system. With cost sharing, those enrolled in HFP are charged the same fees as California's Title XIX program. Most copayments are \$5, with an annual cap of \$250; there are no charges for prenatal, well baby, well child, or immunization services.

Healthy Families Program. Ernesto Sanchez, Manager for the MRMIB, began the presentation by describing the current status of children's health insurance in California. Presently, there are some 9 million children in California, of which:

- 53 percent are covered through employer based plans (4.876 million);
- 25 percent are covered through Medi-Cal (2.345 million);
- 17 percent are uninsured (1.604 million, 400,000 of whom are estimated to be eligible for the HFP); and
- 3 percent are covered through privately purchased insurance (291,000).

As described above, the HFP is a low cost insurance program for children in low wage families. Based on statistics from the University of California at Los Angeles (UCLA), 62 percent of the estimated 400,000 children are Latino; 18 percent are White; 11 percent are Asian American; and 9 percent are African American. Additionally, 73 percent have parents who are employed full-time for a full year, 77 percent have two-parent families, and 22 percent have single parents.

HFP Enrollment. More than 40,000 children are enrolled in HFP and the breakdown of enrollment includes 39 percent Latino, 24 percent Asian/Pacific Island, 23 percent White, and 3.5 percent African American. The median income of children enrolled in HFP is 153 percent of the FPL and the number of children per family is 1.8 or more. Mr. Sanchez noted that public charge' and immigration are problems in California, resulting in the lower than expected 39 percent of Latinos enrolled in HFP.

HFP Application. Spurred by pressure from consumer and advocacy groups, California has revised its 28-page application to be a joint application for HFP and Medi-Cal. Because of issues related to determining Medicaid eligibility, HFP requests applicants' permission to forward their applications to Medi-Cal if they are found to be ineligible for HFP/CHIP (see next paragraph). California has established a system of enrollment entities that are staffed by trained and certified individuals who are reimbursed by the State. The State provides an enrollment incentive of \$50 for each successfully completed application. Thirty-seven (37) percent of the applications processed include a request for payment of the application assistance fee. Seventy-two (72) percent of processed applications without assistance requests are successful, while 79 percent of processed applications with assistance requests are successful. Mr. Sanchez indicated his belief that most individuals can easily complete the application by themselves. Two of the hardest issues to overcome in the application process are the verification of income and family size.

Perception of HFP. To date, HFP has been well received. Initial indications are that families are enthusiastic about the benefits and costs of HFP and ineligible families have been seeking information even when they know they are not eligible. California conducted focus groups in Santa Clara to assess families' reactions to HFP. Findings indicated that some individuals believed that "HFP was too good to be true" (such as discounted premiums) or asked "What is the catch?"

A component of creating a seamless health care system is the partnering of HFP with Medi-Cal in which HFP forwards applications deemed ineligible for HFP to Medi-Cal for processing. Approximately 60 percent of HFP ineligible applications are Medi-Cal eligible but only 30 percent of these individuals permit (check and initial the box) HFP to forward their application to Medi-Cal. Reasons for this low percentage may include:

- Previous bad experiences with Medi-Cal eligibility or provider;
- Medi-Cal has a negative stigma (Medi-Cal is associated with welfare and sounds like Medicaid while HFP is associated with family pride); and
- Issue of pride (some families, particularly among immigrant populations, do not want government handouts but have a desire to "provide for their family" by paying the HFP premiums).

Generous Funding Available at the State Level/Estimate of HFP Target Population Reduced by 31 Percent. During fiscal year 1998-99, California's State budget includes adequate funding to enroll 200,000 children by June of 1999. This target enrollment number of 200,000 by June 1999 used 580,000 eligibles as a base. However, the base of eligibles changed. In the fall of 1997, the data showed that 580,000 children were eligible, but in the spring of 1998, the data showed that 400,300 children were eligible. The revised target is to enroll 140,000 eligible children by June 1999. The differences in data could be attributed to:

- Revised base number of eligibles (minus 18,000);
- Technical corrections to methodology (minus 35,500);
- Application of income disregards to more accurately identify Medi-Cal eligibles (minus 65,000); and
- Adjustment for immigrants after August 1996 and undocumented immigrants (minus 61,200).

Since California's CHIP application was approved in March 1998, enrollment numbers have increased each month. In July and August 1998, 5,000 eligible children enrolled each month and in September and October 1998 over 10,000 children enrolled. California predicts that it will reach its target number of 140,000 children by June 1999.

California's Outreach and Education Efforts for CHIP and Medicaid. Mr. Joe Kelly, from California's Medi-Cal office, continued the presentation by describing California's joint outreach and education efforts between HFP and Medi-Cal. California began conducting HFP/Medi-Cal outreach activities to target the 400,000 children eligible for HFP and 600,000 children eligible for Medi-Cal on February 15, 1998, prior to obtaining official HCFA approval. California's outreach efforts have concentrated on: educating families in the various populations about HFP and Medi-Cal (e.g., the importance of prevention and the availability of State programs); motivating eligible families to enroll in HFP or Medi-Cal as appropriate; and assisting families with the application process. To achieve these goals, California has invested \$21 million dollars in outreach education-\$9 million for traditional media outreach initiatives and \$12 million for community-based outreach activities.

Traditional Outreach Efforts. Traditional outreach efforts to date include, but are not limited to:

- Advertising the HFP and Medi-Cal's toll-free number (1-888-747-1222) on television, radio, busboards, and billboards. The toll-free number, which has received over 150,000 calls, is managed by trained staff to help families complete their application and to take application requests.
- Creating "Slim Jims" brochures in English and Spanish.
- Promoting HFP and Medi-Cal through a "tri-fold" (in 11 different languages) with tear-out postcards to request an application.
- Establishing MRMIB and Healthy Families Web Sites (www.mrmib.ca.gov and www.healthyfamilies.ca.gov).

Community-Based Outreach Efforts. California has taken a grass-roots approach to outreach and has created relationships with community partners, who are the local players in the community. Community partners include, but are not limited to, schools, clinics, CBOs, physicians, insurance agents, tax preparers, and day care centers. These community partners educate their respective populations about the availability of HFP and Medi-Cal. To date, California has enrolled 2,027 community-based entities, staffed by approximately 10,917 certified application assistants who have successfully completed a comprehensive HFP and Medi-Cal training workshop. The workshop explains the application process step-by-step and prepares application assistants to answer typical questions that they are likely to be asked. Application assistants are also given a comprehensive workshop manual; California is in the process of developing a Spanish version of the manual. Telephone application workers are also available to do in-take and process applications over the phone.

Incentives. As mentioned above during Mr. Sanchez's presentation, California uses financial incentives, grants, and incentive payments as a primary means to recruit providers to participate in HFP. Providers receive an incentive of \$50 for each application they successfully process. California is trying to move the two incentive approaches towards a performance-based approach. In the spring of 1998, California conducted a pilot outreach program in San Diego that focused on performance-based standards in enrolling families into the Medi-Cal program. Other communities are now implementing such programs.

Corporate Sponsorships-The Most Successful Approach. Corporate sponsorships, on a pro bono basis, have been California's strongest and most successful outreach strategy. Many corporate businesses have agreed to be active in California's HFP/CHIP efforts in order to maximize exposure. For example,

- RiteAid promotes CHIP by displaying tear-off fliers and Raley's, a grocery store chain, has printed the HFP logo on bags. Other corporate sponsorships include: Bel Air Markets, Food For Less, Vitasoy, Bay Area Rapid Transit (BART), Edison International, Los Angeles Metropolitan Transit Authority, Founder's Bank, and Ranch 22 Markets.

Strategy to Increase Enrollment-Four Point Plan. By mid-September 1998, 12,000 children were enrolled in HFP. California's outreach initiatives and enrollment numbers received negative publicity for not reaching or targeting the proper communities. On October 6, 1998 in Los Angeles, California unveiled a Four Point Plan to increase enrollment: 1) revise the joint application form (including translating into ten languages other than English) and the application process, 2) strengthen community outreach and education, 3) expand outreach to the Latino community, and 4) increase corporate sponsors. Each of the four points is discussed below.

- **Revise Joint Application and Application Process.** California's goal, in revising the application, was to shorten and simplify it to facilitate enrollment. California is almost finished revising its famous 28-page application. The 28-page application had received numerous complaints about the length and complexity ("more complicated than a tax form"), although the Medical Assistance Program had taken the position that it was a short application with a lot of explanation. The revised application, scheduled for release in late March/early April 1999, will be four pages and will be a joint application for both programs. A work group of staff, community partners, and advocacy groups set November 20, 1998 as a target date of releasing the final draft. Various focus groups are now testing the application in 11 different languages with form production to follow. In addition, qualified families will be permitted to pay the first month premium with a personal check, in addition to a money order or cashier's check.
- **Strengthen Community Based Outreach.** California's goal is to focus outreach activities on schools with the highest concentration of eligible children by doing three things: 1) enhancing financial incentives, 2) coordinating with schools, and 3) supporting active Enrollment Entities (Ees) to maximize enrollment. Financial incentives include increasing the Certified Application Assistant fee to \$50 for each successful application (effective November 1, 1998) and offering a bonus payment of \$250 for every ten enrollments from July 1, 1998 to October 31, 1998. Initiatives to target schools include creating partnerships between target schools and active enrollment entities; supporting schools interested in providing application assistance and direct enrollment support; giving unique training and support to the Los Angeles Unified School District; and coordinating enrollment activities and school events. Moreover, efforts to support active EEs to maximize enrollment include providing technical assistance, linking EEs and families that have requested applications, and ensuring underserved areas have sufficient EE coverage.
- **Expand Outreach to the Latino Community.** The Latino population is the largest population group eligible for HFP and Medi-Cal. One goal of California is to maximize the enrollment of Latino children. Latino outreach efforts include obtaining clarification of Federal INS policy in regards to HFP and the public charge' issue; distributing a Healthy Families Immigration Fact Sheet; providing monolingual training for Spanish-speaking Application Assistants; increasing the number of Spanish-speaking toll-free line operators; and printing more materials and advertisements in Spanish.
- **Increase Corporate Sponsors.** In California, there are over 31 million people and approximately 5 to 6 million are uninsured. Thousands of children, who were previously uninsured, are now covered. California has been involved in managed care for 25 years and over half of California's beneficiaries are in managed care. The challenge now is to encourage the managed care providers to also participate in HFP. There are a number of barriers that must be addressed in contracting with managed care organizations and assisting communities: public charge', administrative costs, and grants versus fees (communities want grants but Medi-Cal cannot give grants as it needs documentation of services provided).

Maternal and Child Health/Title V Outreach Efforts. Dr. Terrence Smith, the Section Chief of the

Program Policy Section of the Maternal and Child Health (MCH) Branch of California's Department of Health, concluded California's presentation by describing other outreach activities that California is conducting. MCH/Title V has strong working relationships with Child Health Initiatives, WIC, genetics, and rural health clinics. MCH/Title V has been working hard on CHIP initiatives and is excited about the wonderful opportunities CHIP has created to provide coverage to eligible uninsured children in California. Additional outreach activities include:

- Developing public health outreach activities when Medi-Cal managed care was implemented provided the experience needed to quickly and effectively mobilize outreach efforts among community groups for the Healthy Families Program.
- Implementing local MCH activities in each county to require them to have toll-free numbers. MCH/Title V workers have a script they can follow in answering callers' questions about HFP. In addition, each county has received HFP information, such as handouts, and a Resource Manual is being developed to promote consistency.
- Creating partnerships with organizations addressing teenage pregnancy problems.
- Working through the Comprehensive School Health Program to involve the support of school administration and teachers to promote and provide advice on Healthy Families.

California already has strong working relationships with various organizations and would like to continue working with them, including but not limited to:

- ***Continuing the WIC Partnership.*** WIC has been a great player in the HFP outreach initiative because California has a large, but well-developed, WIC program. The WIC program involves many agencies and receives approximately \$10 million a month in funding. With over 1 million WIC cases in the State, WIC willingly disseminates HFP and Medi-Cal information and materials.
- ***Working with Public Health Clinics.*** Primary care and rural health programs, which are decentralized in CA, have been quite helpful with outreach efforts. California passed a law requiring a demonstration in rural areas, including funding, and MCH is in the process of evaluating proposals that will receive mini-grants. MCH has found that it needs to provide these types of programs with some up-front funds to enable them to begin activities. Although the rural health demonstration is a step forward, there are concerns that California agencies did not have the staff or time to dedicate to outreach efforts.
- ***Connecting with the State EPSDT Program.*** California's EPSDT program providers have been given information on how to enroll children into HFP. The State also offers incentives, such as retroactively paying for screens and treatments received within the past 30 days.

Issues and Questions Raised During the Overview. The following issues were raised during California's presentation:

- ***Application Process.*** California was asked why an applicant must grant permission to forward his/her application to Medi-Cal for eligibility determination when the applicant is found to be ineligible for HFP but eligible for Medi-Cal. California noted that all HFP applications are processed centrally by a HFP administrative vendor. The HFP administrative vendor performs the calculations to determine whether or not an individual is eligible. Using the centralized HFP vendor expedites the application process given that HFP is on the fast track. Eligibility workers can check a space on the application denoting that the State should determine the appropriate program for an application. This type of approach has been popular among States because it offers differing choices of assistance.

California sought a legal opinion regarding the HFP administrative vendor's ability to determine eligibility for HFP and Medi-Cal. The legal opinion rendered was that the administrative person (the vendor) who makes the HFP determination is not a State employee and, therefore, should not

have access to the type of information needed to determine Medicaid eligibility because of issues and concerns with confidentiality. One solution is to continue the joint application process but to allow the HFP vendor access only to the information needed to determine eligibility for HFP. If an applicant's income level is too low, then the HFP administrative vendor would need permission from the applicant to forward the application to a Medi-Cal eligibility determiner.

- **Cultural Competency and Enrollment of Asian Pacific Islanders.** California was asked what is being done to address the cultural needs of children of Asian Pacific Islander descent. California has actively and successfully targeted the Asian Pacific Islander population that resides in the State. Many States are looking to California for advice. It was noted that 11 percent of Asian Pacific Islander children are eligible and 24 percent have enrolled. BEND, a Korean organization in San Francisco, has been conducting its own HFP and Medi-Cal media advertisements targeted towards minorities.



[Return to Outreach Information Clearinghouse Page](#)

Last Updated May 28, 1999

HCFA	Beneficiaries	Plans & Providers	States	Researchers	Students
Medicare	Medicaid	CHIP	Customer Service	FAQs	Search



Department of Health
& Human Services

HCFA	Beneficiaries	Plans & Providers	States	Researchers	Students
Medicare	Medicaid	CHIP	Customer Service	FAQs	Search

Children's Health Insurance Program



Technical Advisory Panel (TAP) To Address Development of School Based Outreach Programs - May 25, 1999

Purpose:

The purpose of this TAP was to discuss the school based outreach model which was implemented twice during the 1998-1999 school year by the Chicago Public Schools (CPS), and also to share ideas and strategies employed by other States in school based outreach.

State Participation:

Illinois, Michigan, South Carolina, Nevada and D.C. were invited to present their respective outreach models at this TAP and were represented by Medicaid/CHIP agencies, MCH and State Education representatives. Representatives from major metropolitan areas that have used the public schools as CHIP/Medicaid enrollment sites also participated.

Background to CPS Pilot:

The idea for the Chicago Public Schools Pilot was developed at the first DHHS Regional CHIP conference held in Kansas City, November 1997. Recognizing the impact of a child's health status on learning, and knowing that 35-40% of children from CPS had failed Vision Screening (20-25% National average) and Chicago has the highest mortality rate in the country for pediatric asthma, prompted the CPS to pursue the issue of identifying and enrolling uninsured children in Illinois' new KidCare program. Also, cognizant of the large number of children enrolled in the Free and Reduced Lunch Program (84% of students), school authorities subsequently embarked on an analysis of school enrollment data to identify uninsured children with the assistance of computerized mapping technologies. CPS data identified 219,000 children eligible for School Lunch and had no health insurance. This analysis, coupled with the income criteria available through the School Lunch Program (approximately 170,000 eligible students), targeted well over 100,000 children presumed to be uninsured and eligible for KidCare; many of whom came from Hispanic families.

Chicago Public Schools (CPS) KidCare Enrollment Campaign

As an official Medicaid *provider* in the State of Illinois, the CPS recognized the potential for implementing special outreach strategies to reach the large number of uninsured children. School authorities worked with the State of Illinois Medicaid Program (KidCare) and HCFA's regional office to design an all-out effort to assist in identifying and enrolling eligible children in the insurance program.

In November 1998, during the report card pick-up days (parents are required to be present at school), CPS launched its aggressive, school-based outreach campaign by providing enrollment assistance to eligible families at 589 public schools. The State Agency provided basic enrollment training to school representatives and volunteers from both public and private sector programs who offered to assist in this effort. Schools were expected to distribute in advance of the November 4-5 report card pick-up days KidCare (CHIP) material and enrollment applications for families to review prior to coming to pick up a child's report card. Simultaneously, Public Service announcements and other local media coverage promoted KidCare. Messages for print, TV and radio were translated into Spanish, Polish, Cantonese, Arabic and Urdu to meet the needs of Chicago's diverse ethnic communities. Approximately 14,000 children applied for KidCare as a result of November's campaign.

November Pilot results:

The CPS had only one month to prepare for this first Report Card Pick-Up Day campaign. Events did not run as smoothly as expected. Of the 589 schools, several were unable to distribute the KidCare materials to families in advance of parents coming to pick up their children's report cards, thus, many families were unaware of this special enrollment effort. The application was lengthy and cumbersome and there were several other problems needed to be corrected. As a result of this first campaign, 4,600 applications were submitted for 14,000 students. The State Agency determined 1,200 were eligible for enrollment, and claimed that many families had not completed the application and were confused with the number of personal questions being asked. Many signed and dated the application before it was completed -- a misunderstanding on the part of the CPS staff who assisted in this process. This resulted in several denials because the 45 day clock ran out. Finally, there was the issue of Public Charge and its effect on immigrant families who might enroll their children in KidCare. In a city with a large number of non citizen immigrant families, the Agency did not hear back from many families when they requested documentation of immigration status.

Lessons Learned from CPS - November Pilot:

- Significant numbers of volunteers are needed -- with special training provided
- Each school principal must have buy-in
- Enrollment application needs to be simplified and translated into multiple languages
- Color-coded applications were often Xeroxed (white) thus preventing appropriate monitoring
- Major fear among immigrant families of Public Charge
- Designated and adequate space needs to be available at each school
- Designated coordinator needed for each school
- Distribute sufficient numbers of posters, buttons, etc.

CPS - April Pilot:

Having addressed many of the problems encountered during the first pilot campaign, the second pilot was carried out on April 14-15, 1999. Well over 3,000 volunteers (school nurses, school social workers, advocates, hospital organizations, businesses, Federal/State/local government staff) were on hand to assist families fill out the KidCare application during report card pick-up at Chicago's 591 public schools.

Noteworthy changes this time around:

- The KidCare application was shortened to 2 « pages and will be processed centrally in Springfield (rather than the local DHS offices).
- April 12 - Governor Ryan hosted a press conference with high-level local, State and federal officials including Paul Vallas, CEO of Chicago Public Schools and Hannah Rosenthal, DHHS Regional Director. Governor Ryan and others announced their commitment to enrolling children into KidCare and to promoting the CPS outreach effort.
- Jewel (grocery store) placed the CPS/KidCare hotline on grocery bags and inserting informational leaflets in targeted stores and continued over the next few months.
- The Pastor's Network--127 city churches--agreed to "preach the gospel of KidCare" in their churches.
- Six Regional KidCare Sights were established at Regional Schools to sustain the effort through June 15. These sights were open from 2 PM to 7 PM, Monday through Friday and from 10 AM to 2 PM on Saturdays. In addition, five regional sites are open for summer school and six sites will be open in the fall.

Lessons Learned - Chicago Public Schools

- There is a need for extensive private and public partnerships. Schools alone cannot successfully

- identify, educate and enroll potential CHIP beneficiaries;
- Do not underestimate the need for resources and time to implement school campaigns (e.g., mass mailings put a crunch on staff time, need for copiers and phones, etc.);
- Immigrant populations require cultural sensitivity (e.g., need for multilingual volunteers and materials) and the establishment of trust surrounding public charge issues;
- There is a need for follow up after the application is sent out; perhaps several times;
- There is a need for provider and volunteer training to assist in the completion of the application process; these volunteers must be adequately trained so as not to mislead families;
- Schools principals have been identified as the most effective means of mobilizing support and coordinated efforts across school systems. They in turn involve staff such as school nurses, social workers and counselors.

Problems Encountered in April Campaign:

- There was a lack of understanding about health insurance and the importance of completing an application;
- Public Charge remains an issue for immigrant families.

Significant School-based outreach Strategies presented by Other States:

Nevada

- 70% of CHIP applicants learn about the program through the school system;
- Targeted School Nurses Association to distribute applications and provide bi-language assistance;
- Targeted free and reduced lunch program recipients as potential CHIP beneficiaries;
- Utilized Family Resource Centers, athletic programs and parent/teacher conferences as vehicles to distribute CHIP information; and
- Enlisted principals as leaders to coordinate school outreach efforts.

South Carolina

- Schools are most effective sites for identifying and enrolling children
- Incentive program - \$5 paid to each child with a completed application and pizza parties for schools with the most applications; competition helps!
- Applications from schools represent about two thirds of all CHIP applications;
- Various school employees were utilized in the outreach effort (e.g., athletic directors, guidance counselors and school nurses);
- Created fact sheet, including toll-free number, for principals to share with staff.

Michigan

- State representatives presented a short overview of their CHIP outreach efforts and stated that they were intending to learn about and begin implementing outreach through schools.
- Need one-on-one assistance to get people to sign up
- Learned that mail-in application is preferred by families who do not want to go to public agency

District of Columbia

- Letter sent to all principals announcing a school partnership kick-off Campaign; Application box in each principal's office;
- CHIP training provided for designated school staff;
- Mayor attended press event announcing the partnership and launching a poster/poetry contest;
- There will be ongoing enrollment events, such as report card parent/teacher conferences with extended hours. A recent such event resulted in 400 approved applications.



[Return to Outreach Information Clearinghouse Page](#)

Last Updated July 23, 1999

HCFA	Beneficiaries	Plans & Providers	States	Researchers	Students
Medicare	Medicaid	CHIP	Customer Service	FAQs	Search



Department of Health
& Human Services

TABLE 1. STATE CHILDREN'S HEALTH INSURANCE PROGRAM PLAN SUBMISSION AND APPROVAL DATES, JUNE 29, 1999

State/Jurisdiction	Original Title XXI Plan			Amendments	
	Submission Date	Approval Date	Program Start Date	Submission Date	Approval Date
Alabama	November 1, 1997	January 30, 1998	February 1, 1998	May 21, 1998	August 18, 1998
Alaska	August 31, 1998	December 11, 1998	March 1, 1999		
American Samoa	January 14, 1999	April 13, 1999	April 1, 1999		
Arizona	June 25, 1998	September 18, 1998	November 1, 1998	February 23, 1999	May 21, 1999
				May 26, 1999	
Arkansas	May 12, 1998	August 6, 1998	October 1, 1998	December 4, 1998	
California	November 19, 1997	March 24, 1998	March 1, 1998	April 1, 1998	June 26, 1998
				January 8, 1999	
Colorado	October 13, 1997	February 18, 1998	April 22, 1998	February 1, 1999	
Connecticut	January 21, 1998	April 27, 1998	July 1, 1998		
Delaware	June 30, 1998	September 1, 1998	January 1, 1999		
District of Columbia	May 11, 1998	September 17, 1998	October 1, 1998		
Florida	December 2, 1997	March 5, 1998	April 1, 1998	July 16, 1998	September 8, 1998
				December 2, 1998	
Georgia	May 29, 1998	September 3, 1998	November 1, 1998		
Guam	December 30, 1998	March 29, 1999			
Hawaii	October 22, 1998	January 19, 1999	January 3, 2000		
Idaho	February 13, 1998	June 15, 1998	October 1, 1997	October 13, 1998	December 4, 1998
Illinois	January 5, 1998	April 1, 1998	January 5, 1998	November 10, 1998	
Indiana	April 17, 1998	June 26, 1998	October 1, 1997		
Iowa	June 2, 1998	September 1, 1998	July 1, 1998	March 1, 1999	June 16, 1999
Kansas	July 15, 1998	September 1, 1998	January 1, 1999	April 1, 1999	
Kentucky	June 12, 1998	November 30, 1998	July 1, 1998	June 7, 1999	
Louisiana	July 31, 1998	October 20, 1998	November 1, 1998		
Maine	May 19, 1998	August 7, 1998	July 1, 1998		
Maryland	April 30, 1998	July 31, 1998	July 1, 1998		
Massachusetts	January 15, 1998	May 29, 1998	October 1, 1997		
Michigan	December 29, 1997	April 7, 1998	May 1, 1998	April 16, 1998	June 26, 1998
Minnesota	April 24, 1998	July 17, 1998	October 1, 1998	May 22, 1998	
Mississippi	July 29, 1998	October 26, 1998	July 1, 1998	August 4, 1998	February 10, 1999
Missouri	September 29, 1997	April 28, 1998	September 1, 1998	February 13, 1998	September 11, 1998
Montana	April 13, 1998	September 11, 1998	January 1, 1999		
Nebraska	May 13, 1998	August 7, 1998	May 1, 1998	July 31, 1998	October 13, 1998
Nevada	March 13, 1998	August 13, 1998	October 1, 1998		
New Hampshire	May 29, 1998	September 15, 1998	May 1, 1998	December 28, 1998	March 25, 1999
New Jersey	February 6, 1998	April 27, 1998	March 1, 1998	February 9, 1999	May 7, 1999
New Mexico	May 19, 1998	January 11, 1999	May 31, 1999	April 16, 1999	
New York	November 5, 1997	April 1, 1998	April 15, 1998	April 1, 1999	
North Carolina	May 13, 1998	July 14, 1998	October 1, 1998	October 21, 1998	January 19, 1999
				March 26, 1999	June 23, 1999
North Dakota	July 21, 1998	October 9, 1998	September 1, 1998		

TABLE 1. STATE CHILDREN'S HEALTH INSURANCE PROGRAM PLAN SUBMISSION AND APPROVAL DATES, JUNE 29, 1999 (CONTINUED)

State/Jurisdiction	Original Title XXI plan			Amendments	
	Submission Date	Approval Date	Program Start Date	Submission Date	Approval Date
N. Mariana Islands	May 27, 1999				
Ohio	December 23, 1997	March 23, 1998	September 1, 1998		
Oklahoma	January 23, 1998	May 26, 1998	December 1, 1997	February 17, 1999	March 25, 1999
Oregon	March 2, 1998	June 12, 1998	July 1, 1998		
Pennsylvania	November 3, 1997	May 28, 1998	May 28, 1998	August 14, 1998	October 29, 1998
Puerto Rico	March 31, 1998	June 26, 1998	September 1, 1998		
Rhode Island	January 5, 1998	May 8, 1998	May 1, 1998	November 10, 1998	February 5, 1999
South Carolina	December 3, 1997	February 18, 1998	August 1, 1998		
South Dakota	June 5, 1998	August 25, 1998	July 1, 1998		
Tennessee	January 2, 1998				
Texas	April 1, 1998	June 15, 1998	July 1, 1998	June 25, 1999	
U.S. Virgin Islands	July 1, 1998	September 17, 1998	April 1, 1998		
Utah	April 2, 1998	July 13, 1998	August 3, 1998	January 28, 1999	
Vermont	November 10, 1998	December 15, 1998	October 1, 1998	June 9, 1999	
Virginia	June 12, 1998	October 22, 1998	October 22, 1998		
Washington					
West Virginia	June 18, 1998	September 15, 1998	July 1, 1998	December 21, 1998	March 19, 1999
Wisconsin	March 12, 1998	May 29, 1998	July 1, 1998	March 12, 1998	January 22, 1999
Wyoming					
Total	54	52	49 ¹	33	19

Notes:

Washington and Wyoming have not submitted CHIP plans as of June 29, 1999.

Northern Mariana Islands' CHIP plan is pending approval.

¹ Number of programs implemented as of June 29, 1999.

TABLE 2. TYPES OF BENEFITS PACKAGES IN STATE CHIP PLANS, JUNE 29, 1999

State/Jurisdiction	Medicaid	Benchmark Coverage			Benchmark Equivalent Package	Secretary-Approved Coverage	Grandfathered Benefits Package
		FEHBP Equivalent Coverage	State Employee Coverage	HMO with Largest Insured Commercial Enrollment			
Alabama ^a	✓			✓			
Alaska	✓						
American Samoa	✓						
Arizona			✓				
Arkansas	✓						
California ^{a, b}	✓		✓				
Colorado					✓		
Connecticut ^{a, b}	✓		✓				
Delaware			✓				
District of Columbia	✓						
Florida ^a	✓						✓
Georgia					✓		
Guam	✓						
Hawaii	✓						
Idaho	✓						
Illinois ^a	✓					✓	
Indiana	✓						
Iowa	✓				✓		
Kansas			✓				
Kentucky ^a	✓		✓				
Louisiana	✓						
Maine ^a	✓						
Maryland	✓						
Massachusetts ^a	✓	✓					
Michigan			✓				
Minnesota	✓						
Mississippi ^{a, b}	✓		✓				
Missouri	✓						
Montana			✓				
Nebraska	✓						
Nevada				✓			

TABLE 2. TYPES OF BENEFITS PACKAGES IN STATE CHIP PLANS, JUNE 29, 1999 (CONTINUED)

State/Jurisdiction	Medicaid	Benchmark Coverage			Benchmark Equivalent Package	Secretary-Approved Coverage	Grandfathered Benefits Package
		FEHBP Equivalent Coverage	State Employee Coverage	HMO with Largest Insured Commercial Enrollment			
New Hampshire ^a	✓				✓		
New Jersey ^a	✓	✓					
New Mexico	✓						
New York							✓
North Carolina ^c			✓				
North Dakota	✓						
Ohio	✓						
Oklahoma	✓						
Oregon	✓						
Pennsylvania							✓
Puerto Rico	✓						
Rhode Island	✓						
South Carolina	✓						
South Dakota	✓						
Tennessee	✓						
Texas	✓						
U.S. Virgin Islands	✓						
Utah ^d			✓				
Vermont	✓						
Virginia						✓	
West Virginia ^a	✓		✓				
Wisconsin	✓						
Total	40	2	12	2	4	2	3

Key:

FEHBP = Federal Employee Health Benefits Plan

HMO = Health Maintenance Organization

Notes:

Washington and Wyoming have not submitted CHIP plans. Northern Mariana Islands' CHIP plan is pending approval.

^a Combination Medicaid and state-designed plans. Maine has uniform benefits for Medicaid and private plans; other states have different benefits for private plans.

^b California, Connecticut and Mississippi have additional benefits above the state employee benefits, generally vision, hearing and dental services. Connecticut has HUSKY Plus, which is a supplemental benefits package for children with special physical or behavioral health care needs.

^c North Carolina will use a Medicaid look-alike plan for children with special health care needs.

^d Utah will use one benefit package for children over 150 percent of the federal poverty level (FPL), and another package for those below 150 percent of the FPL.

Source: Data compiled from State Children's Health Insurance plans submitted to the Health Care Financing Administration.

1998 STATE CHILDREN'S HEALTH INSURANCE PROGRAM

ANNUAL REPORT

NGA SUPPLEMENT

AS OF JUNE 29, 1999

TABLE 3. OUTREACH STRATEGIES IN STATE CHIP PROGRAMS, JUNE 29, 1999

State/Jurisdiction	Using Radio, TV, and Print Media	Using a Toll-Free Hotline	Outstationing Eligibility Workers	Involving Schools	Involving Employers	Using a Family-Friendly Web Site ¹	Involving the Business Community	Involving Health Care Providers	Using Community-Based Organizations
Alabama	✓	✓	✓	✓				✓	✓
Alaska	✓	✓	✓	✓	✓	✓		✓	✓
American Samoa ²									
Arizona ³	✓	✓	✓	✓		✓	✓	✓	✓
Arkansas	✓	✓	✓	✓		✓	✓	✓	✓
California	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	✓	✓	✓		✓	✓	✓
Connecticut	✓	✓	✓	✓		✓		✓	✓
Delaware	✓	✓	✓	✓	✓		✓	✓	✓
District of Columbia	✓	✓	✓	✓	✓		✓	✓	✓
Florida	✓	✓	✓	✓	✓	✓	✓	✓	✓
Georgia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guam ²									
Hawaii	✓	✓	✓	✓		✓	✓	✓	✓
Idaho	✓	✓	✓	✓				✓	✓
Illinois	✓	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓	✓	✓	✓	✓	✓		✓	✓
Iowa	✓	✓	✓	✓		✓		✓	✓
Kansas	✓	✓	✓	✓	✓		✓	✓	✓
Kentucky	✓	✓	✓	✓	✓		✓	✓	✓
Louisiana	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maine		✓	✓	✓		✓		✓	✓
Maryland	✓	✓	✓	✓		✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mississippi	✓	✓	✓	✓	✓			✓	✓
Missouri	✓	✓	✓	✓	✓	✓		✓	✓
Montana	✓	✓	✓	✓				✓	✓
Nebraska	✓	✓	✓	✓	✓	✓		✓	✓
Nevada	✓	✓		✓		✓	✓	✓	✓

CLINTON ADMINISTRATION ANNOUNCES THAT WITH TWO NEW STATE APPROVALS, CHILDREN'S HEALTH INSURANCE PROGRAM WILL TOP ONE MILLION COVERAGE MARK

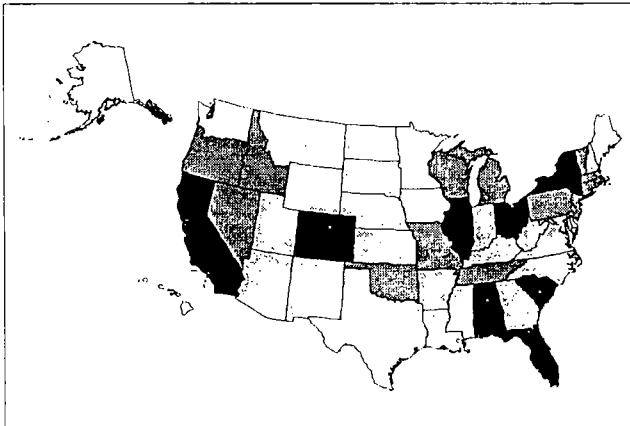
April 1, 1998

On the sixth-month anniversary of the Children's Health Insurance Program (CHIP), HHS Secretary Shalala, Domestic Policy Council Chair Bruce Reed, and National Economic Council Director Gene Sperling today announced the approval of New York's and Illinois's children's health expansions. With these new additions to CHIP, eight states have approved plans that will, when fully implemented, cover over one million children. The National Economic Council and the Domestic Policy Council also released a report that shows the rapid, successful implementation of the historic children's health program. Today the Administration:

- ✓ **Approved New York and Illinois.** The Clinton Administration announced the approval of New York's and Illinois's children's health plans. New York is expanding coverage to allow families with incomes below 185 percent of poverty to receive health insurance by paying a modest premium. Illinois's plan expands Medicaid to children in families up to 133 percent of poverty, and the state intends to submit a plan later this year to expand coverage up to 200 percent of poverty.
- ✓ **Announced That Approved Plans Will Provide Coverage for One Million Kids.** With the addition of New York and Illinois, eight states have approved CHIP plans. Taken together, these states estimate that their approved plans will provide health care coverage to over one million children.
- ✓ **Released an NEC/DPC Sixth-Month Anniversary Progress Report That Documents the Rapid Implementation of the New Children's Health Insurance Program.** The report released today shows the successful implementation of the Children's Health Insurance Program. On the six month anniversary of this historic program:
 - **Eight states have approved plans to insure one million children.** Alabama, California, Colorado, Florida, Illinois, New York, Ohio, and South Carolina have had their state plans approved. States estimate that their approved plans will cover over one million children.
 - **Another fifteen states have submitted Child Health Plans for approval.** Connecticut, Idaho, Massachusetts, Michigan, Missouri, New Jersey, Nevada, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Vermont, and Wisconsin have submitted children's health proposals to HHS for approval.

- **Almost all other states have a process in place to develop and submit plans to expand coverage to uninsured children.** Virtually every other state has working groups or task forces to design programs to expand health care coverage in ways that best meet their states' needs.
 - **States are taking advantage of CHIP's flexibility to develop innovative programs that meet the unique needs of their populations.** The new law allows states to design their CHIP programs to respond to the unique needs of their populations. States have taken varied and innovative approaches to implement the new law: 12 states have proposed to expand coverage through Medicaid, 6 have proposed a block grant, and 5 have proposed combinations of the two.
- ✓ **Underscored the Need for Outreach to Uninsured Children.** The rapid progress of the Children's Health Insurance Program will help millions of uninsured children get the health care coverage they need. This program, however, will not reach all uninsured children. There are currently four million uninsured children that are eligible but not enrolled in Medicaid. Today, the Administration reiterated its commitment to finding ways to cover these children:
- **Enrolling children in schools and child care sites.** The President's budget proposes to allow states to enroll children in the places where they spend time -- schools and child care sites.
 - **Involving the private sector.** The Administration is also advancing the major public/private initiatives that the President and the First Lady announced earlier this year. Representatives of providers, children's health groups, foundations, and a host of private sector entities, such as pharmacies and grocery stores, have made new commitments to help find and enroll these kids. The President and the First Lady will continue to build on these private/public sector initiatives to reach out to uninsured children.

Implementation of the Children's Health Insurance Program



- ✓ *Alabama*
- ✓ *Colorado*
- ✓ *South Carolina*
- ✓ *Florida*
- ✓ *Ohio*
- ✓ *California*
- ✓ *New York*
- ✓ *Illinois*

Missouri
Pennsylvania
Michigan
Tennessee
Rhode Island
Massachusetts
Connecticut
Oklahoma
New Jersey
Idaho
Oregon
Nevada
Wisconsin
Vermont
Puerto Rico

SIX-MONTH PROGRESS REPORT

APRIL 1, 1998

National Economic Council / Domestic Policy Council
The White House

SIX-MONTH PROGRESS REPORT ON THE CHILDREN'S HEALTH INSURANCE PROGRAM: OVERVIEW

SUCCESSFUL SIX-MONTH ANNIVERSARY. April 1, 1998 marks the six-month anniversary of the start of the Children's Health Insurance Program (CHIP). The Administration, Congress, State Governors and State Legislatures have been working aggressively to set up rules for the program, target uninsured children, develop plans for covering those children, and approve and implement those plans. After only six months:

- **8 States have approved plans to cover over 1 million children.** With the approval of New York and Illinois today, 8 States have approved plans which combined, according to their estimates, will cover over 1 million children. For several states (e.g., Alabama and Illinois), this is the first phase of their expansion, so that they will cover even more children in the future.
- **Another 15 States have submitted their Child Health Plans for approval.**
- **Almost all other States have processes in place to develop and submit their plans,** including pending legislation, task forces and public processes to determine the best way to cover uninsured children through CHIP.

UNIQUE APPROACHES. States have taken advantage of the flexibility of CHIP to design programs to suit their own children's needs. Of the States who have submitted plans:

- 12 States plan to expand through Medicaid,
- 6 States plan to expand through a State grant program, and
- 5 States plan to expand through a combination of a Medicaid and grant program.

Some States, like Florida, New York and (to some extent) Colorado, are building on existing State programs. Others, like Massachusetts, New Jersey and Connecticut, have designed new programs that, for example, subsidize employer-based coverage, create seamless Medicaid and grant programs through joint applications, and design a special benefits package for children with special needs.

IMPORTANCE OF OUTREACH. Aggressive implementation of CHIP will help many, but not all, of America's low-income, uninsured children. A recent study found that over 4 million uninsured children could be covered today through Medicaid. States must include in their Child Health Plan descriptions of their plans for outreach (increasing education about health insurance programs and simplifying the application and enrollment process). The President has also advocated for a public-private effort to increase enrollment in Medicaid and called for legislation that provides States additional funding and flexibility to conduct aggressive, effective outreach.

**CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
PROGRESS REPORT AS OF APRIL 1, 1998**

STATE	STATE PLAN		TYPE OF EXPANSION			UPPER ELIG- IBILITY*	STATE EST ENROLL- MENT
	Submitted	Approved	Medicaid	Grant	Combined		
U.S.	23	8	21	14	10	—	1,893,400
STATES WITH APPROVED PLANS			4	2	2		1,271,400
Alabama **	11/03/97	01/30/98	X			100%	20,000
Colorado	10/14/97	02/18/98		X		185%	23,000
South Carolina* *	12/08/97	02/18/98	X			150%	75,000
Florida	12/03/97	03/05/98			X	185%	120,000
Ohio **	12/23/97	03/23/98	X			150%	133,000
California	11/19/97	03/24/98			X	200%	500,000
Illinois **	01/05/98	04/01/98	X			133%	40,400
New York	11/05/97	04/01/98		X		185%	360,000
STATES WITH SUBMITTED PLANS			8	4	3	—	
Missouri	09/29/97		X			300%	
Pennsylvania	11/03/97			X		185%	
Michigan	12/29/97			X		200%	
Tennessee	01/02/98		X			200%	
Rhode Island	01/05/98		X			250%	
Massachusetts	01/15/98				X	200%	
Connecticut	01/21/98				X	300%	
Oklahoma	01/23/98		X			185%	
New Jersey	02/06/98				X	200%	
Idaho	02/13/98		X			160%	
Oregon	03/02/98			X		170%	
Nevada	03/11/98			X		200%	
Wisconsin **	03/12/98		X			100%	
Vermont	03/16/98		X			300%	
Puerto Rico	03/30/98		X			200%	
STATES IN THE PLANNING PHASE			9	8	5	—	
Alaska			X			200%	
Arizona				X		150%	
Arkansas			X				
Delaware				X		200%	
District of Columbia			X			200%	
Georgia					X	200%	
Hawaii							
Indiana							
Iowa					X	185%	

STATE	STATE PLAN		TYPE OF EXPANSION			UPPER ELIGIBILITY*	STATE EST ENROLLMENT
	Submitted	Approved	Medicaid	Grant	Combined		
Kansas					X	200%	
Kentucky				X		200%	
Louisiana					X	200%	
Maine					X	185%	
Maryland			X			200%	
Minnesota			X				
Mississippi							
Montana				X		150%	
Nebraska			X			185%	
New Hampshire							
New Mexico			X			235%	
North Carolina				X		200%	
North Dakota							
South Dakota			X			133%	
Texas							
Utah				X		200%	
Virginia				X		175%	
Washington				X			
West Virginia			X			150%	
Wyoming							

NOTES:

Estimated enrollment are States' unreviewed estimates of enrollment for when the program is fully implemented.

* Upper eligibility is defined as a percent of the Federal poverty standard. In 1998, this is \$16,450 for a family of 4.

** States that have indicated that the plan submitted is only the first step in a broader expansion.

SOURCES:

HHS tracking documents and State plans

National Governors' Association Center for Best Practices. "State Implementation Plans of Title XXI: The State Children's Health Insurance Program as of March 12, 1998".

Children's Defense Fund. "Progress Report: Implementing the State Children's Health Insurance Program (CHIP)".

PROGRESS REPORT ON THE IMPLEMENTATION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program (CHIP) was created in the bi-partisan Balanced Budget Act on August 5, 1997. Less than two months later, on October 1, 1997, CHIP began. Today, April 1, 1998, marks the six-month anniversary of CHIP. This report reviews Federal and State progress toward achieving the goal of covering up to 5 million uninsured children.

CHILDREN'S HEALTH INSURANCE PROGRAM: ITS CREATION AND IMPLEMENTATION

Expanding health insurance to vulnerable Americans has been a long-standing goal of the President as well as many Republicans and Democrats in Congress. In his 1997 State of the Union, the President announced his support for covering up to 5 million uninsured children by both working to enroll eligible but uninsured children in Medicaid and expanding the funding for new, more flexible State-administered programs designed to cover millions of uninsured children. This funding — about \$24 billion in Federal funds over 5 years — was delivered in the Balanced Budget Act of 1997 that created the Children's Health Insurance Program (CHIP).

CHIP provides about \$4.3 billion in Federal funds annually for 1998 through 2001 for use in providing health insurance to "targeted low-income children." A targeted low-income child is, in general, an uninsured child whose family income is higher than Medicaid eligibility but lower than 200 percent of poverty (about \$32,000 for a family of 4). States may use the Federal funds to provide coverage through Medicaid, a State grant program, or a combination of the two. States that opt for a Medicaid expansion provide Medicaid's comprehensive benefits. State that choose to expand through a State grant program have flexibility in designing covered services and cost sharing within Federal guidelines. All States must include procedures to prevent the substitution of Federal funds for current State or private spending on health insurance.

To receive Federal funds, States must have an approved Child Health Plan. The content of these plans is mostly defined in the law, and includes items like the State's budget, proposed benefits, performance measures, and plans for outreach. States with approved plans receive Federal "allotments" or shares of the Federal funds, based on their proportion of low-income and uninsured children and an adjustment for geographic costs. These Federal funds require a State contribution as well. States contribute to CHIP at a matching rate that is 30 percent lower than its matching rate in Medicaid.

Since last August, the Department of Health and Human Services has worked with States, Congress, health care providers, children's advocates and other interested groups to develop guidelines for this program and to ensure that it is implemented expeditiously and well. As part of the process, the Department has sent letters to State officials, distributed answers to key questions, and held regional conferences to assure rapid, effective implementation of CHIP.

STATES' PROGRESS IN SUBMITTING PLANS

As of April 1, 1998, nearly half the States (23) have submitted Child Health Plans and 8 States have had their plans approved, including New York and Illinois today. Virtually all other States are planning to submit plans before the end of fiscal year 1998 (to receive a 1998 Federal allotment, State must have their plans approved in fiscal year 1998).

SUMMARY OF STATES WITH APPROVED PLANS

Eligibility and Estimated Enrollment. The eligibility for children for CHIP varies in the States with approved plans from 100 percent of poverty (Alabama) to 200 percent of poverty (California). In part, this wide range reflects the fact that 4 of the 8 States with approved plans (Alabama, Illinois, Ohio and South Carolina) are expanding in stages, meaning that they are planning modest expansions now, with plans for a second expansion later.

In total, States estimate that 1,271,400 children will be covered under their newly approved plans when fully implemented. This amount ranges from a high of about 500,000 in California — the State with the highest number of uninsured, low-income children — to 20,000 in Alabama. Since half of these States have indicated that their expansions are the first of two stages, even more children will be covered in these States in the future.

Type of Expansion. States have taken advantage of the choice that CHIP offers of expanding health insurance coverage for children through Medicaid, a State grant program, or a combination of the two. Of States with approved plans, 4 States will expand through Medicaid, 2 States through a State grant approach, and 2 States through a combination of the two. The 2 States that have expanded through State grant programs, New York and Colorado, are building upon existing programs. These States are using the extra funding to improve benefits, make the program accessible to all eligible children, and raise income eligibility.

Interestingly, all 4 of the States expanding through Medicaid have indicated that these expansions are first steps, with a second expansion in the works. At least 2 of these States (Alabama and South Carolina) have said that this second expansion will be through a State grant program.

The 2 States with combination programs, California and Florida, have accelerated the current-law phased-in coverage of all poor children by covering 15 to 18 year olds in Medicaid with family income up to 100 percent of poverty. They also will offer eligibility to children in families with income above Medicaid eligibility through a grant program. California is operating its grant program by allowing families access to a purchasing pool for coverage for children. Florida is expanding its Healthy Kids program State-wide. This program, which has been considered a model program nationwide, was developed at the local level and is school-based; enrollment is linked to the free and reduced-price lunch program.

Benefits. States that expand through Medicaid give children Medicaid benefits with no cost sharing. California's benefits are based on the State employee health benefits and families pay up to \$27 per month. Colorado's benefits are equivalent to the benchmarks in legislation, and premiums range from \$9 and \$30 per month. Florida and New York (along with Pennsylvania) had their State program's benefits grandfathered into law because of these program's success; premiums are up to \$15 per month in Florida and up to \$36 per month in New York.

Targeting Uninsured Children. States have taken several different approaches to assuring that Federal dollars are not substituted for private dollars already being spent on children's coverage. California has waiting period (a child must be uninsured for 3 months) for eligibility to prevent families from dropping private coverage to enroll in CHIP. Colorado prohibits children from being eligible if they have coverage in an employer-sponsored plan with at least a 50 percent employer contribution in the last 3 months. Florida will use an open enrollment period with a "fallback": if, after six month, there appears to be a problem with crowd out, the State will limit eligibility to children who have been uninsured for at least 3 months or who do not have access to employer-based coverage.

Outreach. States have proposed innovative ways of simplifying the application and enrollment process and educating families about their eligibility. California will launch a media and outreach initiative, involving community based organizations, schools, day care centers, and health providers. It will also pay a \$25 application assistance fee for each beneficiary that is enrolled in a program. South Carolina has focused on simplifying the application process for Medicaid and CHIP to make the programs more accessible. Most States intend on educating families about their eligibility through a non-health network that includes schools, churches, day care facilities, Child Care Resource and Referral Centers, homeless shelters, and through WIC and other public programs.

SUMMARY OF STATES WITH SUBMITTED PLANS

Although State plans usually change (sometime significantly) during the review process, the following is a brief overview of the types of plans in States that are currently under consideration.

Eligibility. Compared to States with approved plans, States with submitted plans cover children in higher income families. This is mostly because a number of these States (e.g., Rhode Island, Vermont, and Connecticut) had already expanded coverage through Medicaid to children just above the Medicaid mandatory eligibility levels. Wisconsin, which is expanding Medicaid to all poverty-level children, is the only one of these States that appears to be applying for a first stage of a larger expansion.

Type of Expansion. Eight of the States with submitted plans will expand through Medicaid, 4 through State grant programs, and 3 through a combination of the two. As in States with approved plans, the States with submitted combination plans are using Medicaid to cover lower income children and grant programs to cover higher income children. The major difference is that the new States are expanding Medicaid to children above poverty: to 133 percent of poverty in New Jersey, to 150 percent of poverty in Massachusetts, and to 185 percent of poverty in Connecticut.

Benefits. There is wide range of benefits standards proposed in the submitted but not yet approved State plans. Two States are using the Federal Employees' Blue Cross Blue Shield option, another 2 are using their State employee benefits plan, and other States are using the most popular HMO in the State, the State Medicaid benefits, and a grandfathered plan (Pennsylvania).

Targeting Uninsured Children. In addition to the strategies used by States with approved plans, States with submitted plans propose to prevent substitution of private spending by: ending eligibility for children who gain access to creditable health coverage (Oregon); maintaining a data base of employer coverage to assess whether families applying are eligible (Massachusetts); and include longer waiting periods for coverage (12 months in New Jersey).

Outreach. A wide range of ideas have been proposed by States with submitted plans, including: working with organizations like AARP, PTAs, and the School Nurse Association (Tennessee); using a single application for all children's health programs (Connecticut); giving grants to community-based organizations to help enroll hard-to-reach children (Massachusetts); and use of multi-cultural educational materials (most States).

STATES IN THE PLANNING PROCESS

Virtually all other States have task forces at work, bills being considered by their State legislatures, and tentative plans for expanding coverage to children through CHIP.

IMPORTANCE OF OUTREACH

In March, the Agency for Health Care Research and Policy released a new report that found that over 4 million uninsured children are eligible for Medicaid. There has been no conclusive study about why these uninsured children do not get enrolled in Medicaid, but several likely reasons include the difficulty of the application process, the "stigma" associated with Medicaid, and the lack of knowledge about the program.

Because of the importance of outreach, States must include a detailed description in their Child Health Plans about how they intend to educate families about CHIP and coordinate with Medicaid.

CONCLUSION

As study after study shows, a healthy childhood is essential to both the physical and intellectual development of children. Health insurance can play a key role in that development. The Children's Health Insurance Program represents the single largest expansion of insurance for children since Medicaid was created over 30 years ago. It targets the fastest growing group of uninsured children: those in working families that cannot afford health insurance.

This progress report shows that Governors, State legislators, health care providers, children's advocates and all other participants have made great strides in the six months since CHIP was implemented. Eight States have approved plans, another 15 have submitted plans, and virtually all other States are planning their children's health insurance expansions.

However, implementing CHIP alone will not significantly reduce the number of uninsured children. Medicaid outreach efforts are needed to ensure that all uninsured children who are eligible for Medicaid get enrolled. The President has made Medicaid outreach a priority. In February, the President directed all Federal agencies with programs that serve low-income families to come up with a plan by mid-May to use their workers to help find and educate families about health insurance. This Federal effort is being complemented by private sector activities. These include a campaign to educate families by creating a toll-free number that links families to their State's eligibility offices and promoting that toll-free number on grocery bags, labels on children's drugs, diaper boxes and other products that low-income families use.

In addition, the President has proposed policies in his FY 1999 budget to increase funding and flexibility for States to conduct innovative and effective outreach. One policy expands the Balanced Budget Act's "presumptive eligibility" option to allow workers at sites like schools and child care resource and referral centers to assist families in enrolling their children in Medicaid. Additionally, the President proposes broadening the use a special fund created for outreach for people moving from welfare to work. These policies, and others like them, provide needed support for States as we work together to ensure that all children who are eligible for health insurance get that coverage.

APPENDIX: SUMMARY OF ACTIVITIES IN STATES WITH SUBMITTED PLANS

STATES WITH APPROVED CHILD HEALTH PLANS

ALABAMA

On January 31, 1998, Alabama's plan to expand Medicaid to children 15 to 18 years old up to 100 percent of poverty was approved. The State considers this the first step in expanding coverage, and is planning to create a State grant program for children in families up to 200 percent of poverty this year.

CALIFORNIA

On March 24, 1998, California's "Healthy Families" plan was approved. California plans a combination of a Medicaid and State grant program expansion. It will: (1) expand Medi-Cal (its Medicaid program) to cover all poor children; (2) expand Access for Infants and Mothers (AIM) to cover infants up to 250 percent of poverty, and (3) create Healthy Families to cover children above Medi-Cal but below 200 percent of poverty. In the Healthy Families program, families can pay a premium to purchase coverage that is equivalent to the State employees plan plus dental and vision coverage. California will offer premium assistance through a purchasing pool. The State began its Medicaid expansion on March 1, 1998 and plans to begin the State grant program by July 1, 1998.

COLORADO

On February 18, 1998, "Colorado Child Health Plan Plus" was approved. Beginning on April 1, families with incomes above Medicaid eligibility and below 185 percent of poverty can pay premiums between \$9 and 30 per month to receive coverage equivalent to a benchmark plan. This builds on an existing State program called the Colorado Child Health Plan, which covered only outpatient services.

FLORIDA

On March 5, 1998, Florida's "Healthy Kids" expansion was approved. This combined plan makes poor children 15 to 18 years old eligible for Medicaid, and children between Medicaid and 185 percent of poverty eligible for the State grant program called Healthy Kids. Healthy Kids, which has been operational in several counties for the past few years, has its benefits grandfathered into CHIP by law, and charges families a premium up to \$15 per month for their children. Healthy Kids is a model build around school-based enrollment.

ILLINOIS

On April 1, 1998, Illinois's plan to expand Medicaid to children with family income up to 133 percent of poverty was approved. The State considers this the first step in expanding coverage, and is planning to submit a plan later in 1998 to cover children in families up to 200 percent of poverty.

NEW YORK

On April 1, 1998, New York's "Child Health Plus" plan was approved. It allows families with income up to 185 percent of poverty to pay a premium to purchase the Child Health Plus benefits which, like Florida and Pennsylvania's State programs, were grandfathered into law. This builds on the existing Child Health Plus program that has been operational for several years and was the largest State program in the nation prior to CHIP.

OHIO

On March 23, 1998, Ohio's plan to expand Medicaid to children up to 150 percent of poverty was approved. The State has indicated that it may consider this the first step in expanding coverage, and may expand more in the future.

SOUTH CAROLINA

On February 18, 1998, South Carolina's "Partners for Healthy Children" was approved. As of October 1, 1997, children in families with income up to 150 percent of poverty can enroll in Medicaid. South Carolina will also use the new Balanced Budget Act option to provide all Medicaid children with 12-month continuous coverage. The State is considering a second, grant program expansion to cover children between 150 and 200 percent of poverty.

STATES WITH SUBMITTED CHILD HEALTH PLANS

Note: The following descriptions are based on the first plan submissions. Any changes that occur informally or formally in the review process are not reflected in this document.

CONNECTICUT

On January 21, 1998, Connecticut submitted its “Husky” plan. This plan is a combined Medicaid and State grant program. It would expand Medicaid for children in families up to 185 percent of poverty, and would create a State grant program for children in families with income between 185 and 300 percent of poverty. The benefits in the State grant program would be equivalent to those of State employees. The plan also includes programs for children with special needs.

IDAHO

On February 13, 1998, Idaho submitted its plan to expand Medicaid up to 160 percent of poverty. The State has convened a task force to examine options for a second, State grant program expansion to cover children above 160 percent of poverty.

MASSACHUSETTS

On January 15, 1998, Massachusetts submitted its “MassHealth” plan, which is a combination of a Medicaid and State grant program expansion. Children in families with income up to 150 percent of poverty would be eligible for Medicaid, and children in families between 150 and 200 percent of poverty would be eligible for the State grant program. Families without access to employer-based insurance can pay for coverage through MassHealth Family Assistance, whose benefits are equivalent to the Federal Employees Health Benefits plan. Families with access to employer-based insurance would receive premium assistance to purchase that coverage. Massachusetts also proposes to have a program for children with disabilities with family income between 150 and 200 percent of poverty.

MICHIGAN

On December 29, 1997, Michigan submitted its “MIChild” plan. This State grant program would allow families with income up to 200 percent of poverty to pay a premium for coverage equivalent to that of State employees.

MISSOURI

On September 29, 1997, Missouri submitted an 1115 waiver, and on February 13, 1998, it submitted a Child Health Plan. The State plans to expand its Medicaid program up to 300 percent of poverty. Its waiver includes coverage for adults and a small change in the Medicaid benefits package (does not cover non-emergency medical transportation).

NEVADA

On March 11, 1998, Nevada submitted its “Nevada ✓ Check Up” plan. This State grant program will allow families with income up to 200 percent of poverty to pay premiums for coverage available in the largest HMO in the State.

NEW JERSEY

On February 6, 1998, New Jersey submitted its “NJ KidCare” proposal for a combined Medicaid and State grant program. Medicaid would be expanded to cover all children with family income up to 133 percent of poverty. Families with income between 133 and 200 percent of poverty can pay different levels of premiums to buy coverage equivalent to the Federal employees’ Blue Cross Blue Shield benefit. The State implemented these expansions in February and March.

OKLAHOMA

On January 23, 1998, Oklahoma submitted its “SoonerCare” plan to expand Medicaid to children in families with income up to 185 percent of poverty. This coverage expansion will be phased in over a three-year period.

OREGON

On March 2, 1998, Oregon submitted a plan to expand coverage through a State grant program to children with family income up to 170 percent of poverty. Children would receive coverage that is the same as what children receive under Oregon’s Medicaid waiver.

PENNSYLVANIA

On November 3, 1997, Pennsylvania submitted its Children’s Health Insurance Program (CHIP) plan. Like Florida and New York, Pennsylvania’s State program has been running for years and thus its benefits were grandfathered in the law creating CHIP. It plans to expand CHIP to children in families with income up to 185 percent of poverty.

PUERTO RICO

On March 30, 1998, Puerto Rico submitted its plan to expand Medicaid to 200 percent of poverty.

RHODE ISLAND

On January 5, 1998, Rhode Island submitted its "Rite Care" Medicaid expansion to cover children in families with income up to 250 percent of poverty. The State expanded coverage to these children before October 1 but after the statutory deadline, so its expansion may qualify for CHIP funding retrospectively.

TENNESSEE

On January 2, 1998, Tennessee submitted its plan to extend its existing Medicaid waiver program to children in families with income up to 200 percent of poverty. TennCare, which has been running since 1994, allows low-income families to buy into a modified Medicaid benefit. Because of budget constraints, it closed enrollment in 1995. TennCare opened enrollment for children in 1997 and expanded coverage for children again in January, 1998.

VERMONT

On March 16, 1998, Vermont submitted a combined CHIP and Medicaid 1115 waiver to expand Medicaid. The State now operates a waiver program called Dr. Dinosaur that covers children with family income up to 225 percent of poverty. Vermont is requesting to expand eligibility to children with family income up to 300 percent of poverty as well as uninsured parents with family income from 150 to 185 percent of poverty.

WISCONSIN

On March 12, 1998, Wisconsin submitted the CHIP portion of a more general Medicaid 1115 waiver called "BadgerCare." The plan would cover children 15 through 18 with incomes up to 100 percent of poverty through Medicaid. This is the first phase of a broader expansion to families with income up to 185 percent of poverty. Wisconsin is seeking to use CHIP funds to cover low-income adults and to subsidize dependent coverage in employer-based family plans in this broader expansion.

SOURCES

HHS tracking documents and State plans

Children's Defense Fund. (February 1998). "Progress Report: Implementing the State Children's Health Insurance Program (CHIP)". Washington, DC: Children's Defense Fund.

National Governors' Association Center for Best Practices. (March 1998). "State Implementation Plans of Title XXI: The State Children's Health Insurance Program as of March 12, 1998". Washington, DC: National Governors' Association.

National Governors' Association Center for Best Practices. (March 25, 1998) "Implementation of the State Children's Health Insurance Program Title XXI." Washington, DC: National Governors' Association.

Riley, Pernice & Mollica. (March 1998). "How will States Implement Children's Health Insurance Plans?" Portland, ME: National Academy for State Health Policy.

Weigers, Weinick and Cohen. (March 1998). "Children's health 1996." Rockville, MD: Agency for Health Care Policy and Research.

861-7297

LA Times
AP

406-9130
Amy
Goldstein

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

FUNDING

- **About \$24 billion between FY 1998- 2002, about \$50 billion over 10 years.**
 - Grant spending: \$20 billion over five years
 - Other spending: \$4 billion over five, including:
 - Coverage for new children enrolled in Medicaid because of the grant program's outreach and required referral of eligible children to Medicaid.
 - Medicaid options for 12-month continuous & presumptive eligibility.
 - Medicaid spending for SSI children who otherwise lose coverage due to welfare reform, two new diabetes grant programs, and revenue effects.
- **State Allotment:** Each state will receive a proportion of the total grant allotment (minus 0.25% spending on the territories). The proportion is determined by each participating state's share of the following:
 - 1998-2000: Product of (1) proportion of low-income, uninsured children and (2) geographic cost adjuster
 - 2001: Product of (1) 75% of the proportion of low-income, uninsured children; (2) 25% of the proportion of low-income children and (3) geographic cost adjuster
 - 2002-2007: Product of (1) 50% of the proportion of low-income, uninsured children; (2) 50% of the proportion of low-income children and (3) geographic cost adjuster.

States' allotments remain available to each state for three years. After that, any unspent funds are reallocated to states that have used up their allotments.

- **Matching payments:** Federal matching rates are increased to provide incentives for states to participate. As a result, states' contributions are 30% below their Medicaid state matching rate. Provider taxes, donations, other Federal spending, and premiums and cost sharing do not qualify as contributions eligible for Federal matching funds.

ELIGIBILITY

- Children whose income is up to 200% of poverty or 50 percentage points above the state's Medicaid eligibility (whichever is higher). Children who are Medicaid-eligible, privately covered, in prisons, or have parents who are state employees are ineligible.

BENEFITS

- **Services:** States may choose one of three benefits minimums:

- Plan equivalent to a benchmark plan
- Plan with the same actuarial value as a benchmark plan
- Secretary-approved plan.

Benchmark plans include:

- FEHBP Blue Cross / Blue Shield PPO option
- State employee health plan that is generally available
- HMO with the highest commercial enrollment in the state
- For NY, FL, and PA, their current state-only programs' benefit plans.

Actuarial equivalence option: States must (1) cover four basic services (inpatient & outpatient hospital services; physicians' surgical & medical; laboratory & x-ray; and well-baby/well-child care, including immunizations); (2) have an aggregate actuarial value (with adjustments) at least equal to the benchmark plan; and (3) assure that the plan's mental health, vision, hearing, and prescription drug benefits have at least 75% of the actuarial value of prescription drug, mental health, vision and/or hearing services in the benchmark plan.

Cost sharing: Cost sharing is limited depending on the family income:

- Below 150% of poverty: premiums no greater than those in Medicaid and cost sharing consistent with Medicaid but appropriately adjusted by the Secretary.
- Above 150% of poverty, premiums and cost sharing that do not exceed 5% of the family's income.

Administrative costs, outreach and direct services: Limited to no more than 10% of the states' expenditures in this program.

ACCOUNTABILITY

- **Maintenance of effort:** States cannot change their Medicaid eligibility from its level as of June 1, 1997 and must enroll eligible children in Medicaid. States also must continue their 1996 state spending on non-Federal health insurance programs.
- **Protections against substitution:** State must develop processes to assure that they are not replacing existing coverage. The program is always secondary payer.
- **Reporting requirements:** States must report annually on their success at covering uninsured children and coordination with other types of coverage.
- **Auditing and sanctions:** The Secretary has authority to withhold funds & audit programs as necessary to ensure that the funds are used for the intended purpose.
- **Fraud and abuse:** Certain Medicaid and Medicare provisions apply.

POSSIBLE IDEAS FOR CHILDREN'S HEALTH OUTREACH

October 31, 1997

1. General Importance of Outreach

Action: Announce guidance on outreach that includes a model single application form for both Medicaid and CHIP and a list of allowable outreach activities. Could also announce support for legislation to allowing states to access \$500 million TANF outreach funds for all children.

Place: South Carolina, Pennsylvania, Minnesota all use a single application form. Alternatively, Georgia and Massachusetts have broader, interesting outreach initiatives.

Description: DHHS sends periodic letters to states about its interpretations of the law for the Children's Health Insurance Program (CHIP). One letter could (1) clarify current law options for outreach; (2) encourage states to use a single application form for both programs; and (3) encourage states to use new Medicaid options for children (presumptive eligibility and 12-month guaranteed eligibility) that simplify enrollment. Attached to this letter would be a model single application form and a list of creative outreach activities that states have used.

We could also verbally announce our intent to broaden the use of the special funds in TANF for administrative simplification and outreach to all children. These TANF funds, capped at \$500 million, are available to match state activities like outreach at 90 percent, but are currently limited to costs associated with children (and adults) losing welfare, not all children.

Status: DHHS has a draft letter and model single application; it could probably be finalized by November 7, although they would like more time to work with states if possible..

2. Child Care Centers and/or Schools as Outreach Sites

Action: Require states to submit in their state child health plans a description of if / how they use child care sites and schools for outreach. Announce that we support changing the presumptive eligibility law to allow subsidized child care resource and referral centers and schools to determine presumptive eligibility.

Place: Massachusetts, Philadelphia, Maryland, Alabama and Washington State all have good child care / health care connections and could be highlighted. If the emphasis is on schools, Florida is the most likely site.

Description: To participate in CHIP, states submit "child health plans" for approval. These plans, by law, describe what they will do for outreach. We could add specificity to the instructions so that states describe if / how states use child care center and schools for outreach.

In addition, we could explicitly allow certain child care resource and referral centers and schools to determine presumptive eligibility. The Balanced Budget Act created an option for states to make children “presumptively eligible”. This means that health care providers and certain other people / sites can give children temporary (up to 2 months) Medicaid while waiting for Medicaid applications to be processed. We could change the list of people / sites who can determine presumptive eligibility to include schools and publicly funded “child care resource and referral centers” — places where most children spend time outside of the home.

Status: We have tentative internal agreement and NGA approval of these changes. The changes to the state child health plan would have to be announced in a letter to states, but this should not take more than a few days to write. Thus, this could happen at any time.

3. Getting child health insurance phone numbers in every phone book

Action: Announce an agreement by all major phone book companies to list their state and local numbers for getting Medicaid and CHIP information in the front of their phone books, using a clearly recognizable symbol.

Place: White House announcement with the CEOs of the phone book companies, or in California where they use a similar system today (UC Berkeley developed this for use in a Wellness Guide).

Description: The key to conducting outreach at the national level is to have a nationwide system to direct people to their state and local sources of information. One way to do this is to develop a clearly identifiable logo to use in national outreach efforts. This logo could be use in the front of phone books to flag the state or local telephone numbers that offer information and applications for Medicaid and CHIP.

Status: We are working on assessing the feasibility of this. Once we have a tentative agreement from these places, as well as a logo, we can announce this (probably within two weeks).

EXAMPLE:



Maine Medicaid Program: 207 / 883-6585
Maine Child Health Plus Program: 207 / 871-4403

4. National Steering Committee on Children’s Health Outreach

Action: Either announce the formation of such a committee, or conduct the first meeting itself.

Place: Probably the White House.

Description: For outreach to be successful, states who run Medicaid and CHIP must cooperate with the people interested in doing the work. We may be in the best position to mediate and coordinate this relationship. We could develop a Steering Committee that would conduct meetings to share information on state-specific activities, coordinate efforts across groups when appropriate, and, if funding is available, publish some type of newsletter about activities.

In particular, the Steering Committee could have meetings every several months that focus on one particular theme or type of outreach. Examples of the topics for such meetings include:

- **Businesses:** Invite business leaders to identify ways for employers to contribute, such as teaching them to educate low-wage employees about their options or encouraging them to offer in-kind contributions like simple enrollment software from the computer industry or advertisements on their products by restaurant chains and children's products companies.
- **Schools:** Invite PTA, NEA, school nurse representatives to see how they can participate and educate children and families.
- **Entertainment / sports:** Invite major celebrities or sports stars who could lend their ideas and talents to this effort.
- **Civic and / or religious groups:** Invite Girl and Boy Scouts; Little Leagues, church groups, etc to focus on outreach at the local level.
- **Media:** Invite major television networks, journalists to educate them about the program and get their input on how to best highlight the programs and get families involved.

Membership on this Steering Committee could include:

- | | |
|------------------------------------|---|
| - White House: First Lady? | - Grantmakers in Health: ? |
| - HHS: Shalala, Nancy Ann? | - RWJ: Sarah Shuptrine |
| - NGA: Ray Sheppach | - Volunteer America: Colin Powell |
| - NCSL: ? | - BC Caring Program: Charlie LaVallee |
| - CDF: Marian Wright Edelman | - AAP: |
| - March of Dimes: Marina Weiss? | - AMA: |
| - Families USA: Ron Pollack | - National Association of Children's |
| - Center on Budget: B Greenstein | Hospitals: Ann Langley |
| - Packard Fnd: Gene Lewitt | - AHA: |
| - Kaiser Foundation: Diane Rowland | - Ntl Assoc of Maternal & Child Health: |

Status: We have gotten positive feedback from NGA and some foundation staff. We basically have to decide if we want to do this. If so, we could hold a planning meeting in November at the White House or have a substantive meeting with one of the groups listed above as a kick-off. Given the competent staff of most proposed members, we could conduct this Steering Committee without a dedicated staff person. However, this depends on the Committee's agenda & ambition.

OTHER IDEAS:

Quality and Children's Health: Recommend (maybe require) that states use the Quality Commission's consumer bill of rights in their children's health program.

Crowd Out: Release guidance on ways to prevent crowd out with states that have used such policies successfully.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

FUNDING

- **About \$24 billion between FY 1998- 2002, about \$50 billion over 10 years.**
 - Grant spending: \$20 billion over five years
 - Other spending: \$4 billion over five, including:
 - Coverage for new children enrolled in Medicaid because of the grant program's outreach and required referral of eligible children to Medicaid.
 - Medicaid options for 12-month continuous & presumptive eligibility.
 - Medicaid spending for SSI children who otherwise lose coverage due to welfare reform, two new diabetes grant programs, and revenue effects.
 - **State Allotment:** Each state will receive a proportion of the total grant allotment (minus 0.25% spending on the territories). The proportion is determined by each participating state's share of the following:
 - 1998-2000: Product of (1) proportion of low-income, uninsured children and (2) geographic cost adjuster
 - 2001: Product of (1) 75% of the proportion of low-income, uninsured children; (2) 25% of the proportion of low-income children and (3) geographic cost adjuster
 - 2002-2007: Product of (1) 50% of the proportion of low-income, uninsured children; (2) 50% of the proportion of low-income children and (3) geographic cost adjuster.
- States' allotments remain available to each state for three years. After that, any unspent funds are reallocated to states that have used up their allotments.
- **Matching payments:** Federal matching rates are increased to provide incentives for states to participate. As a result, states' contributions are 30% below their Medicaid state matching rate. Provider taxes, donations, other Federal spending, and premiums and cost sharing do not qualify as contributions eligible for Federal matching funds.

ELIGIBILITY

- Children whose income is up to 200% of poverty or 50 percentage points above the state's Medicaid eligibility (whichever is higher). Children who are Medicaid-eligible, privately covered, in prisons, or have parents who are state employees are ineligible.

BENEFITS

- **Services:** States may choose one of three benefits minimums:

- Plan equivalent to a benchmark plan
- Plan with the same actuarial value as a benchmark plan
- Secretary-approved plan.

Benchmark plans include:

- FEHBP Blue Cross / Blue Shield PPO option
- State employee health plan that is generally available
- HMO with the highest commercial enrollment in the state
- For NY, FL, and PA, their current state-only programs' benefit plans.

Actuarial equivalence option: States must (1) cover four basic services (inpatient & outpatient hospital services; physicians' surgical & medical; laboratory & x-ray; and well-baby/well-child care, including immunizations); (2) have an aggregate actuarial value (with adjustments) at least equal to the benchmark plan; and (3) assure that the plan's mental health, vision, hearing, and prescription drug benefits have at least 75% of the actuarial value of prescription drug, mental health, vision and/or hearing services in the benchmark plan.

Cost sharing: Cost sharing is limited depending on the family income:

- Below 150% of poverty: premiums no greater than those in Medicaid and cost sharing consistent with Medicaid but appropriately adjusted by the Secretary.
- Above 150% of poverty, premiums and cost sharing that do not exceed 5% of the family's income.

Administrative costs, outreach and direct services: Limited to no more than 10% of the states' expenditures in this program.

ACCOUNTABILITY

- **Maintenance of effort:** States cannot change their Medicaid eligibility from its level as of June 1, 1997 and must enroll eligible children in Medicaid. States also must continue their 1996 state spending on non-Federal health insurance programs.
- **Protections against substitution:** State must develop processes to assure that they are not replacing existing coverage. The program is always secondary payer.
- **Reporting requirements:** States must report annually on their success at covering uninsured children and coordination with other types of coverage.
- **Auditing and sanctions:** The Secretary has authority to withhold funds & audit programs as necessary to ensure that the funds are used for the intended purpose.
- **Fraud and abuse:** Certain Medicaid and Medicare provisions apply.

456-5557

To: Paul
From: Margy

Re: Children's mental health

Date: July 17, 1997

the alternative to the Senate-passed children's mental health parity amendment contains the following four points:

- . Health coverage provided under the children's health initiative " shall include mental health services, including at least inpatient and outpatient services."
- . Coverage complies with the Mental Health Parity Act of 1996 with two exceptions:

the 1% exemption does not apply
there is no sunset provision
- . State shall make "all reasonable efforts" to provide mental health services through the full continuum of care.
- . Children's Mental Health Parity Incentive Grant:

States which certify to the Secretary of Health and Human services that they are providing mental health benefits under the children's health initiative which are "substantially equivalent" to the Grant set aside is capped at \$100 million annually.

The intent is to provide incentives rather than a mandate to the states to provide nondiscriminatory mental health benefits.

Coopers and Lybrand today released a counter argument to CBO's inflated analysis of cost and impact factors of the parity amendment. As we have discussed, CBO stated that 390,000 fewer children would be able to be covered due to the cost of parity. This means CBO assumed a 15-18% increased cost to a benefit package because of parity. This number stands in stark contrast to their score of the full parity amendment (that originally included substance abuse) of last year, which was 4%.

Coopers and Lybrand estimate that mental parity would more realistically mean that 51,000 fewer children would be covered and that the cost would be approximately 2%.

PROPOSED CHILDREN'S MENTAL HEALTH PROVISIONS:

1. Health coverage provided under the children's health initiative "shall include mental health services, including at least inpatient and outpatient services."
2. Coverage complies with Mental Health Parity Act of 1996; 1 percent exemption does not apply; sunset date of MH Parity Act of 1996 does not apply.
3. States shall make "all reasonable efforts" to provide mental health services through the full continuum of care.
4. Children's Mental Health Parity Incentive Grant:

States which certify to the Secretary of Health and Human Services that they are providing mental health benefits under the children's health initiative which are "substantially equivalent" to the medical/surgical benefits with respect to scope, duration, and cost sharing, may apply for additional funds to help defray the potential cost of such substantial equivalence.

Grant set aside is capped at \$100 million per year for 5 years. Funds are allocated based on current formula in House bill (i.e., States have a maximum available to them for parity compliance); ~~States which have complied with~~

~~States which have complied with~~

July 15, 1997; 11:00 a.m.

United States Senate

97 JUL 17 11 9:19 WASHINGTON, DC 20510

Dear Conferee:

July 11, 1997

You may remember the great excitement we felt last Fall when the Senate voted unanimously to support the Domenici-Wellstone Mental Health Parity Act. This Act was signed into law by President Clinton on September 26, 1996.

With the passage of this act, the Congress took an important step forward in eliminating discrimination against those suffering from mental illness.

On June 27, 1997 as the Senate debated amendments and passed the budget reconciliation bill, we can take a second, important step. Recognizing that children and adolescents experience mental illness, Senators Domenici and Wellstone offered an amendment that requires nondiscriminatory insurance treatment for children with mental health disorders. The amendment was accepted by voice vote (amendment # 559).

The 105th Congress and the Administration have made a solid commitment to reducing the number of children without health insurance. We have all learned that children without insurance are less likely to receive health care and will suffer the inevitable consequences of poorer health and higher risk for illness.

Both the Senate and the House have made provisions for funds to be available for the States to expand their coverage of uninsured children. We are proud of this commitment, but see it as incomplete without protection for children and youth with mental illness.

Dr. Mary Jane England, President of the Washington Business Group on Health, testified on April 18, 1997 before the Senate Labor and Human Resources Committee's hearing on Improving the Health Status of Children. She stated that an estimated 20%, or 11 million, American children and adolescents have serious and diagnosable mental health disorders. Of these 11 million, approximately 2.5 million have a serious disorder such as major depression, childhood schizophrenia, manic-depressive illness, and obsessive-compulsive disorder that requires intensive service intervention.

Early recognition and treatment of emerging mental illness in children and adolescents can minimize more costly and prolonged treatments later in life. Children and adolescents can be helped to develop the skills necessary to function productively in their adult years. Untreated mental illnesses in children, on the other hand, lay the groundwork for less productivity and greater dependence on healthcare and social systems.

July 11, 1997

Page 2

The Domenici-Wellstone amendment requires health plans enrolling currently uninsured children through the use of federal funds provided in the form of a block grant to offer mental health benefits in a nondiscriminatory manner. Treatment limitations or financial requirements imposed on mental health benefits must be the same as those imposed on medical and surgical benefits. a health plan may use its customary strategies to manage care and provide coverage for those healthcare services seen as necessary.

The amendment does not require that health plans offer a mental health benefit. Health plans and states are free to use their usual and customary managed care strategies to manage the mental health benefit.

We are writing today to urge that this provision be retained in the conference proceedings on the budget reconciliation. We are proud of the progress Congress is making in de-mystifying and de-stigmatizing mental illness. As we provide for greater healthcare coverage for children, we believe we are at the moment to commit to the mental health of children.

Many states have passed legislation to end discrimination against children and adults with mental illness in the private marketplace. Since 1994, Republican and Democratic governors in New Hampshire, Rhode Island, Maine, Colorado, Indiana, Arkansas, and Vermont have signed parity measures into law.

Childhood mental and emotional disorders are as debilitating as childhood diabetes, heart disease, respiratory problems, and other pediatric conditions. As we ultimately expand health coverage for children, we believe this coverage should be for the whole child.

Please feel free to contact Margy Heldring (224-8455) in Senator Wellstone's office for more information.

Sincerely,

Tom Varchle
Tom Rabe

Patricia Leahy

Max Cleland
Heidi Land

July 11, 1997

Page 2

The Domenici-Wellstone amendment requires health plans enrolling currently uninsured children through the use of federal funds provided in the form of a block grant to offer mental health benefits in a nondiscriminatory manner. Treatment limitations or financial requirements imposed on mental health benefits must be the same as those imposed on medical and surgical benefits. A health plan may use its customary strategies to manage care and provide coverage for those healthcare services seen as necessary.

The amendment does not require that health plans offer a mental health benefit. Health plans and states are free to use their usual and customary managed care strategies to manage the mental health benefit.

We are writing today to urge that this provision be retained in the conference proceedings on the budget reconciliation. We are proud of the progress Congress is making in demystifying and de-stigmatizing mental illness. As we provide for greater healthcare coverage for children, we believe we are at the moment to commit to the mental health of children.

Many states have passed legislation to end discrimination against children and adults with mental illness in the private marketplace. Since 1994, Republican and Democratic governors in New Hampshire, Rhode Island, Maine, Colorado, Indiana, Arkansas, and Vermont have signed parity measures into law.

Childhood mental and emotional disorders are as debilitating as childhood diabetes, heart disease, respiratory problems, and other pediatric conditions. As we ultimately expand health coverage for children, we believe this coverage should be for the whole child.

Please feel free to contact Margy Heldring (224-8455) in Senator Wellstone's office for more information.

Sincerely,

Jim Jeffords
Celene Omato
Robert P. Finner

Paul Wellstone
Baker A. McArthur

James H. K. Hata

July 11, 1997

Page 3

Dan L. Egan

Jim Johnson

Herb Kelle
Chris Ortol

Dick Butler

Thos. G. Smith

Jack Reed
John T. Kelly

Garry Keil

John Dyer

Carl Levin

Patty Murray

Les Kerner

Pat Hollis

Jeff Kuyper

**Coopers
& Lybrand**Coopers & Lybrand L.L.P.
a professional services firm
Human Resource Advisory1100 Campanile Building
1465 Peachtree Street
Atlanta, Georgia 30308-3630telephone (404) 870-1100
facsimile (404) 870-1210

July 15, 1997

The Honorable William V. Roth, Jr.
Chairman
Senate Finance Committee
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

We have reviewed the CBO estimates for the average annual number of children covered under H.R. 2015 and H. R. 2014 (July 2, 1997; Table 10). Our analysis does not support the CBO level of reductions in the expected number of covered children when mental health parity is made a part of the proposal.

Using CBO's own numbers, the annual cost per child of the Children's Health Insurance Initiative (CHII), as passed by the Senate, over the five-year period (1998-2002) will be \$1,829 without mental health parity and \$2,155 with mental health parity. This represents an 18% increase in cost. But the CHII without mental health parity would still include basic mental health benefits. Under a basic Blue Cross Blue Shield Federal Employee Health Benefit (FEHBP) standard option plan design, children's mental health costs in total are estimated to be only 5.2%. There is no actuarial support for an additional 18% increase for going from standard benefits (100 days inpatient and 25 visits outpatient) to mental health parity.

CBO uses the same 18% cost increase (\$897 per child per year without mental health parity to \$1,061 per child per year with mental health parity) for the new enrollment of children under Medicaid, in the Senate passed proposal. These are children who already qualify for Medicaid but do not enroll. Medicaid already provides substantial mental health benefits that approximate parity through the Early and Periodic Screening, Detection and Treatment program (EPSDT). Thus, there should be no cost increase for a parity assumption when the core benefits are Medicaid.

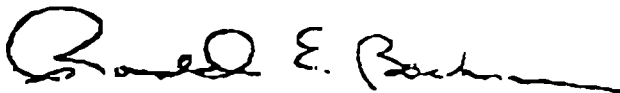
While it is unclear how CBO arrived at the added cost for mental health parity, it is clear that the assumption is substantially overstated. A Coopers & Lybrand analysis (June 1997) concluded that the cost for adding mental health parity to basic Blue Cross Blue Shield FEHBP standard option coverage is approximately 2%. Last year, CBO estimated mental health *and substance abuse* parity at a 4% cost increase over average commercial coverages.

The Honorable William V. Roth, Jr.
July 15, 1997
Page 2

Using CBO numbers, for the given total dollar expenditures of \$23.6 billion of CHII, 2,580,000 children could be covered. Coverage with mental health parity added would be 2% higher under our analysis, so approximately 51,000 fewer children could be covered for the same budgeted expenditure. However, under the CHII as passed by the Senate, 2,529,000 additional children would have comprehensive coverage that included mental health parity. This total is substantially higher than the 2,190,000 children under the CBO analysis. Stated another way, the Coopers and Lybrand estimate of the 51,000 reduction in covered children is substantially lower than the CBO estimate of 390,000. And, with regard to the CBO analysis of "new enrollment" under Medicaid, given that Medicaid already covers mental health with approximate parity, the CBO estimate of 90,000 fewer children covered under the parity proposal should be zero (0).

In summary, the CBO total estimate of 480,000 fewer children covered if a mental parity amendment is passed should be closer to 51,000 and therefore is likely overstated by 429,000.

Sincerely,



Ronald E. Bachman, FSA, MAAA
Principal
Coopers & Lybrand L.L.P.

July 8, 1997

The Honorable Bill Archer
U.S. House of Representatives
1236 Longworth House Office Building
Washington, DC 20515

Dear Congressman Archer:

We are writing to you because of your leadership role in the upcoming reconciliation conference. The undersigned organizations strongly support the inclusion of the following two items in the final version of the Balanced Budget Act of 1997.

First, the Domenici/Wellstone mental health amendment. The Amendment stipulates that states participating in the new Child Health Insurance Initiative Program provide nondiscriminatory mental health benefits. If mental health services are contained in insurance coverage offered through the Child Health Initiatives Program, they must be provided on a nondiscriminatory basis.

The cost of a nondiscriminatory mental health benefit would be nominal. Two independent actuarial firms (Milliman and Robertson and Coopers and Lybrand) have recently estimated that nondiscriminatory mental health benefits will increase average health plan costs by 1.8%-2.1% adding somewhere between \$2.32 and \$2.71 per child/per year to the cost of an average benefit package.

Secondly, we request that the Child Health Initiative Program at very minimum, be the equivalent to the Blue Cross Blue Shield Standard Option Plan. The Standard Option Plan is the one of the most popular policies offered through the Federal Employees Health Benefit Plan. Adoption of a package equivalent to the Standard Option Plan would assure a baseline standard of insurance coverage for low-income children insured by the Child Health Insurance Plan.

Thank you for considering our requests.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Association of Children's Residential Centers
American Association of Private Practice Psychiatrists
American Association of Psychiatric Services for Children
American Association for Psychosocial Rehabilitation
American Counseling Association
American Managed Behavioral Healthcare Association

American Medical Association
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
American Public Health Association
Association for the Advancement of Psychiatry
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health and Disability Law
Catholic Charities USA
Child Welfare League
Children and Adults with Attention Deficit Disorders
Children's Defense Fund
Clinical Social Work Federation
Coalition of Voluntary Mental Health Agencies
Council of Exceptional Children
Families USA
Family Service America
Family Voices
Federation of American Health Systems
General Board of Church and Society of the United Methodist Church
International Association of Psychosocial Rehabilitation
Latino Council on Alcohol and Tobacco
Mental Health Workers Without Borders
National Alliance for the Mentally Ill
National Association of Addiction Treatment Providers
National Association of Child Advocates
National Association of Counties
National Association Homes and Services for Children
National Association of Pediatric Nurse Practitioners
National Association for Psychiatric Health Systems
National Association of Psychiatric Treatment Centers for Children
National Association of Social Workers
National Council for Community Behavioral Healthcare
National Depressive and Manic Depressive Association
National Mental Health Association
National Women's Law Center
NETWORK, National Catholic Social Justice Lobby
Unitarian Universalist Association of Congregations
United Cerebral Palsy Association