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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	re: Chris Jennings (partial) (1 page)	01/30/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20146

FOLDER TITLE:
CHIP [Children's Health Insurance Program] Outreach [Folder 2]

2012-0463-S
rc729

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Outreach 1800 line

7 states are READY.

MA almost.

OK & OH; techie issues —

need to choose how to hook up; enrollment brokers issues

call volumes; etc.

Joan: WH secured $ for contract, understanding for $ in budget

draft proposal for other funds

- what if it's not enough ($36,000)

timing HHS ready on ads →

put Jan on hold?

redistributing $ → line.

enough $ for 10 states

mtg HHS & Jan — NGA

need non-
profit to
get involved

mtg early
next week
HHS Melissa S. (HCFA)
Vicki R. Marcia
Jeanne
NGA Jan Klein

Jan
institutionaliz.

Vicki
process
planning
for Jan.

Outreach 1800 line

7 states are READY.

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redistributing $ → line.

enough $ for 10 states

mtg HHS & Jan — NGA

hooking up all 50?

30 more States w/ POTS lines
remaining States working
to get on line

what to say
① not hooked up yet
② early 99
③ MCHB

check on MCHB lines
w/ Peter Van Dyke

funding

need state date for
funding

45 States → Jan
POTS line for 40 states
getting them in →
need. survey for EXACT # they

Joy: begin on January.

date: MLK day kickoff

mtg next week?

scheduling request — 10 days
Ann Lewis memo

Caring folks on Th 10:30

OUTREACH

no media plan ASPA

how long
how much
how much $ needed | before mtg

Vicki
Melissa
HCFA

range of funding

Joy needs someone from ad council

6247854

info re: #s.

National Governors' Association
Center for Best Practices
444 North Capitol Street
Suite 267
Washington, D.C. 20001 - 1512

Telephone (202) 624-5300
http://www.nga.org/Center

Date: 10/26/98 Time: 2:34:38 PM Pages: 2

To: Devorah Adler Fax Number: 4565557

From: Joy Horner

Subject: Conference Call

Note: Here it is...
Joy

To: **NGA National Children's Health Insurance Hotline Contacts and Press Secretaries in Colorado, Delaware, Idaho, Indiana, Massachusetts, Oklahoma, Ohio, Pennsylvania, South Carolina, and Utah**

From: **Joan Henneberry, Becky Fleischauer, and Joy Horner**
National Governors' Association

RE: **Conference Call for Phase I States about timeline, launch, and the radio campaign**

Please join us in a conference call with press secretaries and state agency contacts to discuss the Phase I launch of the National Children's Health Insurance Hotline. This month your state will join nine other states in the inaugural flight of a national toll-free helpline to provide information and referrals to parents of children eligible for new children's health insurance programs and Medicaid.

The goal of the call will be coordinating the launch of the hotline with a radio campaign sponsored by the U.S. Department of Health and Human Services (HHS). Scripts of the radio and print PSA's are attached and will be discussed during the call. We will also be distributing state-specific press releases for your review if you choose to use them. Press secretaries will be invited to share their ideas for coordination and plans for marking the launch in their own states. NGA aims to build on an ongoing communication strategy to position states as leaders in expanding health insurance to uninsured kids.

Finally, the call provides NGA and HHS the opportunity to offer their assistance and forge lines of communication as states determine their plans to launch the number.

Speakers: Joan Henneberry, Program Director, Health Policy Studies,
Center for Best Practices, NGA
Becky Fleischauer, NGA manager of media relations
Melissa Skolfield, Assistant Secretary for Public Affairs in HHS

The date and time of the call is **Tuesday, October 27th, 2:30-3:30 p.m. EST** and the call in **number is 1-800-521-7211**. Tell the operator you are calling in for the NGA conference call. **code 4162.**

Please RSVP by calling Joy Horner at (202) 624-7854 or by responding via e-mail Jhorner@nga.org

ADDRESSEE: (Name, Organization, Address)	**FROM:** (Name, Organization, Address)
Devorah Adler (202)456-5707 Fax(202)456-5557 **Phone:** _____	Joyce Somsak Faxed By: Gwen Mack (Sec.) 410-786-6641 **Phone:** 410-786-5221

TOTAL PAGES: (Without Cover)	**ADDRESSEE'S FAX MACHINE PHONE NUMBER:** (If Known)	**DATE:**
5	Joyce's Fax 410-786-9665	11-3-98

REMARKS:

IF FAX MACHINE RETRANSMISSION IS NECESSARY PLEASE CALL:

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(Name) (Phone)

_____ **Mail copies to:** _____

Location: _____

_____

_____ **Retain copies in files.**

CHIP MEDIA OUTREACH PILOTS
Reaching Out to Families with Uninsured Children Through Television

Background

- In February 1998, President Clinton issued an Executive Memorandum calling upon the Federal Departments to develop options for assisting in the education of families and the enrollment of children in Medicaid and the new Children's Health Insurance Program (CHIP). An intradepartmental workgroup, chaired by HHS, has been formed to coordinate activities and report quarterly on results.

- Currently 12 Federal Departments are working together on plans to use existing Federal programs to reach out to the families of eligible children. The current participating Departments include Health and Human Services, Treasury, Agriculture, Education, Labor, Housing and Urban Development, Interior, Commerce, Justice, Environmental Protection Agency, Small Business Administration and the Social Security Administrations. We expect more to becoming involved in this effort.

- Within HHS, an interdepartmental workgroup has been working to coordinate CHIP outreach activities. Commitments were made in the report to the President on outreach strategies and activities. Departmental activities include, but are not limited to: creating websites so that States and children's advocacy organizations can access information on CHIP, providing access to training on CHIP, identify and develop public and private partnerships to conduct outreach.

- One of HCFA's commitments was to conduct media outreach to the eligible population, with particular emphasis on reaching minority populations. The partnership between HCFA and the District of Columbia, the State of Maryland, WJLA Television, The American Hospital Association, Safeway, and The March of Dimes is one part of HCFA's commitment.

- This television campaign in the DC metropolitan area will be the first of 7 to be launched this fiscal year. Television campaigns will also be launched in the States of Alabama, Arizona, Ohio, Oklahoma, Michigan and New Jersey in an effort to assist these States in reaching out to minority families.

CHIP Communication Pilot Summary by State

- Each state in the HCFA media outreach pilot was selected for its plan to target a certain minority group within the state and its readiness to enroll children. The state had to plan parallel activities to support a tv media campaign.

A summary of the specific state media plans follow.

DISTRICT OF COLUMBIA/MARYLAND

The District of Columbia and Maryland are pilot sites for the airing of a television spot developed in partnership with WJLA Channel 7, the American Hospital Association (AHA), the March of Dimes, Safeway and HCFA. Maryland and the District have developed strategies to be implemented in conjunction with the airing of the spots. Strategies to target African-Americans and Hispanics include partnering with public and private entities; working with local hospital associations, providers, the schools; training staff and other key stakeholders; developing and distributing materials in English and Spanish; working with the provider and faith communities; and Safeway (CHIP information will be distributed at 130 area stores).

ALABAMA

Alabama's Department of Public Health (DPH) CHIP communication project is an outreach pilot that will be conducted in south central Alabama. The goal of the project is to increase the number of African-American children who enroll in Alabama's Medicaid expansion program- ALL Kids. Alabama DPH will partner with other State agencies, state hospital associations, American Academy of Pediatrics, and the Alabama Academy of Family Practice to conduct outreach activities in conjunction with airing the HCFA developed television spot. Some of the activities DPH will conduct at their expense as a part of the pilot include: utilizing outstationed workers to provide information to prospective recipients and their families and to assist in completing the application; dedication of a toll-free number within the ALL Kids enrollment office; and follow-up of incomplete applications. DPH will also retain a consulting firm in order to develop a long-term marketing strategy which evaluates and builds upon this pilot project

ARIZONA

Arizona Health Care Cost Containment System (AHCCS) is partnering with the Arizona Partnership for Infant Immunization (TAPII), Children's Action Alliance, St. Luke's Charitable Health Trust, and other community groups to inform Hispanic families of the availability of health insurance for children. Results from focus groups conducted with Hispanic families by AHCCS indicate that outreach materials must be visual and contain few words. Therefore, AHCCS proposes to air the HCFA produced spot on Spanish language television targeting their urban Hispanic population in Maricopa and Pima (Phoenix and Tucson) counties. AHCCS will add a tag line with local information to make the spot unique to Arizona.

MICHIGAN

Michigan's Department of Community Health CHIP communication pilot is a proposal to specifically target Michigan's CHIP - MIChild - outreach message to African-American women in southeast Michigan. The geographic area to be targeted is the City of Detroit and its surrounding suburbs including Wayne, Oakland and Macomb counties. The proposal is to purchase air time on local and cable television stations. The broadcast will reach 98.9% of the intended market at a frequency of 6.3 times in a 6 week period.

The Department will partner with associations, community based organizations, schools, media, faith based organizations, business partners and health providers to maximize their outreach efforts. In addition, the State is committing $2 million to the development of materials; the development of TV, radio and transit signage; matching (and exceeding) HCFA's purchase of air time; the placement of advertisements about MIChild; the funding of local MPCB's to develop local outreach plans and distribution and the distribution of materials through all Michigan schools in addition to in-kind costs being covered to administer the outreach. Michigan is using its own produced spots, but will show the Department seal and Michigan's seal in airing the spots.

NEW JERSEY

New Jersey's CHIP communication pilot is a proposal to increase Hispanic and African-American enrollment in New Jersey's CHIP program - NJ Kidcare- and Medicaid through comprehensive communication and outreach efforts. The pilot will be conducted in the urban center of Newark. This pilot is a joint venture between the Association for Children of New Jersey (ACNJ) and the Office of NJ KidCare. ACNJ and NJ KidCare office plan to utilize their existing network of community organizations to organize forums in the targeted communities on children's health insurance.

As part of the pilot ACNJ plans to use the HCFA produced spot for the targeted communities in New Jersey with local information appended. These spots will then be distributed to local television and cable stations to be aired for an extended period. In addition, they will also develop radio spots in the form of 15 and 30 seconds spots focusing on NJ KidCare.

OHIO

The State of Ohio's goal is to target uninsured minority children to be enrolled in Healthy Start, Ohio's Health Insurance Option for Children. While Ohio has enrolled 43,000 children since January 1, 1998, there are still 90,000 uninsured children residing in the State. The campaign for the tv spot will target African-American children in the Cleveland and Northeast Ohio area. Ohio is partnering with a variety of statewide and local organizations and is applying a wide range of strategies in order to inform families about the availability of health coverage for children. Partners include, but are not limited to: the Ohio Minority Health Commission, the Ohio Council of Churches, Ohio Family & Children First, Head Start, Planned Parenthood Agencies, North American Indian Cultural Centers, and Ohio Employment Services. To ensure meeting their goal, the Ohio partnership's will be airing the HCFA developed television spots in conjunction with airing radio and publishing newspaper ads, distributing packets to update legislators, supporting counties in the continued development of local strategies (to date 62 counties have submitted strategic plans), providing informational packets to church leaders and working with schools.

OKLAHOMA

Low-income uninsured American Indian children in Mayes County (Tulsa area) are the target audience of Oklahoma Health Care Authority's (OHCA) communication pilot. OHCA and tribal community leaders and members are working closely in partnership with public and private entities in an effort to develop specific outreach strategies. To date, strategies in the Salina and Locust Grove include working with Head Start, restaurants and other employers, schools, Cherokee Nation Clinic and Salina Health Clinic and social service agencies serving these communities. Planned activities include staffing exhibit booths at special events (e.g., health fairs, seminars, etc.), developing and distributing print materials (flyers, postcards, posters, and fact sheets) and training relevant stakeholders. In conjunction with the planned television campaign using the HCFA developed television spots with local information tag lines, OHCA also plans to develop a radio spot to be aired on stations that cater to the target population. Local community leaders will be used.

Colin Powell's radio ads ready for Jan.

1st Lady's Ads done radio & t.v.

CHILDREN'S OUTREACH STATUS REPORT

November 3, 1998

Chris says call Carper, re: NGA office help; it's great. want him to attend.

NOVEMBER ACTIVITIES

- **Technical Testing of the New 1-800 Number.** The Insure Kids Now Hotline (1-877 KIDS NOW) was tested last week in the eight Phase-One States: Colorado, Pennsylvania, Utah, Indiana, Delaware, Idaho, and South Carolina. The only State reporting technical difficulties was Idaho and the problem was quickly identified and resolved. Although the line was not tested in Massachussetts last week, it will be tested in Massachussets early next week and the State is expected to participate in Phase One. Now that they have some practical experience, NGA is increasingly confident that they can implement the line in all 50 States by January.

MA 11/11 ←

- **Media Campaign in the Phase-One States.** DHHS has worked with Media Network to develop radio ads in each of the Phase One States. These ads will be aired beginning November 9 and run for approximately 4 to 5 weeks. They emphasize the importance of health insurance coverage for children and encourage the listener to call the hotline. DHHS is working with the Governor's offices in the eight States to help develop press releases and coordinate media coverage as the hotline is unveiled. wk of 11/16

2 in Spanish, 2 target rural

no private buy-in

30 see script

local match.

1,000 spots in 4 wk period

- **Media Campaign to Target Minorities.** DHHS, together with WJLA, the American Hospital Association, Safeway, and the March of Dimes, has developed television ads targeting minority viewers and encouraging them to apply for health insurance for their children. These ads will all run for 4 weeks and will use the State toll-free numbers (since these State may not yet be hooked up to the national number.) The media markets for this campaign include:

did they work w/ minority groups? unsure. get info from Joyce.

  - Michigan: Ads targeting African-Americans will begin airing in the Detroit media market the week of 11/9 on the WB Network in prime time and on cable during the day.
  - Arizona: Ads in both Spanish and English targeting Hispanics began airing on 11/3 in the Tuscon media market.
  - Alabama: Ads targeting African-Americans began airing in the Mobile media market the week of 10/26.
  - New Jersey: Ads in both Spanish and English targeting Hispanics will begin airing during 1/99 in the Newark media market.
  - Ohio: Ads targeting African Americans will begin airing on 11/9 in the Columbus media market.
  - Oklahoma: Ads targeting Native Americans will begin airing during 1/99 in the Tulsa media market.

• service organizations that meet w/ United Way → coalition. Karen Feinstein from FA.

- District of Columbia, Maryland, and Virginia: - Ads targeting African Americans began airing on 10/7 in the Columbus media market. Because the media market overlaps several States, the ads tell viewers to call the Channel 7 toll-free number, which refers the caller to the correct numbers for the State and DC programs.

NATIONAL IMPLEMENTATION IN JANUARY

- **National testing and implementation of the 1-800 number.** NGA is on schedule to implement the KIDS NOW hotline in January. Testing should take place in late November and early December.

- **Private sector contributions**. As part of our national effort to educate families, health professionals, and other social service providers about this new resource, a number of private corporations have tentatively committed to advertising the new hotline and conducting other outreach activities. Listed below are our corporate partners and their expected (but not yet confirmed) contributions.

  - American Medical Response will include the 1-800 national outreach campaign materials on all ambulances and other transport vehicles, such as school buses. They will display outreach posters and have brochures available.

  - The National Association of Chain Drug Stores will include 1-800 national outreach campaign materials with each prescription filled. Additionally, NACDS will display outreach posters and have brochures available in each of its stores.

  - The American Hospital Association will distribute and incorporate the 1-800 national campaign materials into their "Campaign for Coverage" and will reproduce materials when they receive camera ready material.

  - Bonneville International Corporation has agreed to produce and run radio spots about Insure Kids Now on its radio stations as part of its existing AP commitment. Bonneville will run the spots for approximately one year at key times during the year (e.g., back to school time, etc.) Bonneville will also encourage Eddy Fritz of the NAB to disseminate the spots to all NAB members for airing. Bonneville encouraged AP to highlight this initiative during the NAB conference in Seattle in October.

  - USA WEEKEND has agreed to do an editorial on CHIP that will run in September or October 1998. The editorial will include the 1-800 national number.

  - Safeway agreed to incorporate the 1-800 national campaign message onto their grocery bags.

  - Pfizer agreed to incorporate the 1-800 message onto their patient/parent resource publication, mailings to their pediatricians, and in their Pharmacy Assistance Program.

- Schering Plough has committed to funding for the media campaign.

- Glaxo Wellcome has agreed to help in North Carolina's specific outreach efforts by including information about CHIP and the national hotline into their existing outreach efforts, including the reduced and no-cost pharmaceuticals program and the Healthy Start Foundation.

- Bell Atlantic provided the funding for 1-800-Number.

- National Community Pharmists Association will put information on Initiative out to membership.

- In addition, Cisco, General Mills, SmithKline Beecham, Gerber, All State Insurance, Bank Boston, Taco Bell, All State Insurance, AT&T, NFL, NBA/WNBA, Nike, Eli Lilly, Schering Plough.

Event

1st Lady

VP

Public Liason

possibly MLK day;
national day of service

Jen will do memo for scheduling request.

Barbra doesn't want to talk to folks w/o a date.
do they need a timeframe? yes;
a couple of weeks → one month
to put in their products.

CHILDREN'S OUTREACH STATUS REPORT

November 3, 1998

NOVEMBER ACTIVITIES

- **Technical Testing of the New 1-800 Number.** The Insure Kids Now Hotline (1-877 KIDS NOW) was tested last week in the eight Phase-One States: Colorado, Pennsylvania, Utah, Indiana, Delaware, Idaho, and South Carolina. The only State reporting technical difficulties was Idaho and the problem was quickly identified and resolved. Although the line was not tested in Massachussetts last week, it will be tested in Massachussets early next week and the State is expected to participate in Phase One. Now that they have some practical experience, NGA is increasingly confident that they can implement the line in all 50 States by January.

- **Media Campaign in the Phase-One States.** DHHS has worked with Media Network to develop radio ads in each of the Phase One States. These ads will be aired beginning November 9 and run for approximately 4 to 5 weeks. They emphasize the importance of health insurance coverage for children and encourage the listener to call the hotline. DHHS is working with the Governor's offices in the eight States to help develop press releases and coordinate media coverage as the hotline is unveiled.

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  - Alabama: Ads targeting African-Americans began airing in the Mobile media market the week of 10/26.

  - New Jersey: Ads in both Spanish and English targeting Hispanics will begin airing during 1/99 in the Newark media market.

  - Ohio: Ads targeting African Americans will begin airing on 11/9 in the Columbus media market.

  - Oklahoma: Ads targeting Native Americans will begin airing during 1/99 in the Tulsa media market.

- District of Columbia, Maryland, and Virginia: - Ads targeting African Americans began airing on 10/7 in the Columbus media market. Because the media market overlaps several States, the ads tell viewers to call the Channel 7 toll-free number, which refers the caller to the correct numbers for the State and DC programs.

NATIONAL IMPLEMENTATION IN JANUARY

- **National testing and implementation of the 1-800 number.** NGA is on schedule to implement the KIDS NOW hotline in January. Testing should take place in late November and early December.

- **Private sector contributions**. As part of our national effort to educate families, health professionals, and other social service providers about this new resource, a number of private corporations have tentatively committed to advertising the new hotline and conducting other outreach activities. Listed below are our corporate partners and their expected (but not yet confirmed) contributions.

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  - Bonneville International Corporation has agreed to produce and run radio spots about Insure Kids Now on its radio stations as part of its existing AP commitment. Bonneville will run the spots for approximately one year at key times during the year (e.g., back to school time, etc.) Bonneville will also encourage Eddy Fritz of the NAB to disseminate the spots to all NAB members for airing. Bonneville encouraged AP to highlight this initiative during the NAB conference in Seattle in October.

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- In addition, Cisco, General Mills, SmithKline Beecham, Gerber, All State Insurance, Bank Boston, Taco Bell, All State Insurance, AT&T, NFL, NBA/WNBA, Nike, Eli Lilly, Schering Plough.

Joy & Joan / Liss. Update
Mtg time

CHILDREN'S OUTREACH STATUS REPORT

November 24, 1998

NOVEMBER ACTIVITIES

- **Successful Implementation of Phase One.** The Insure Kids Now Hotline (1-877 KIDS NOW) was implemented during the last week of October and is now up and running in eight States: Colorado, Pennsylvania, Utah, Indiana, Delaware, Idaho, and South Carolina. The only State reporting technical difficulties during the initial testing period was Pennsylvania, and the problem was quickly identified and resolved.

- **Media Campaign in the Phase-One States.** DHHS has worked with Media Network to develop radio ads in each of the Phase One States. These ads will be aired beginning November 9 and run for approximately 4 to 5 weeks. They emphasize the importance of health insurance coverage for children and encourage the listener to call the hotline. DHHS is working with the Governor's offices in the eight States to help develop press releases and coordinate media coverage as the hotline is unveiled.

- **Technical Testing of the New 1-800 Number Continues.** Now that they have some practical experience, NGA is increasingly confident that they can implement the line in all 50 States by January. As of November 23, AT&T began technical testing in an additional eleven States (Alaska, Arizona, California, the District of Columbia, Kansas, Louisiana, Maryland, Minnesota, New Hampshire, Nevada, and Vermont).

- **Media Campaign to Target Minorities.** DHHS, together with WJLA, the American Hospital Association, Safeway, and the March of Dimes, has developed television ads targeting minority viewers and encouraging them to apply for health insurance for their children. These ads will all run for 4 weeks and will use the State toll-free numbers (since these State may not yet be hooked up to the national number. The media markets for this campaign include:

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NATIONAL IMPLEMENTATION IN JANUARY

- **National testing and implementation of the 1-800 number.** NGA is on schedule to implement the KIDS NOW hotline in January. Currently, 42 States have committed to participate. NGA is still waiting for responses from Washington, Virginia, South Dakota, Oregon, Kentucky, Hawaii, Florida, and Oklahoma. Technical testing of the line has begun, and will continue into late December.

- **Private sector contributions**. As part of our national effort to educate families, health professionals, and other social service providers about this new resource, a number of private corporations have tentatively committed to advertising the new hotline and conducting other outreach activities. Listed below are our corporate partners and their expected (but not yet confirmed) contributions.

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magazines w/ 3mo. deadlines.

Commitment from NBA & NFL, WNBA

Family Circle.

min. mags.

mtg week of 7th broadcasting folks to push this — mtg w/ time investment w/ HRC.

radio. Spanish

affected by SOTU event date.

Mid Jan 10 — 15th

faith community.

health reporters briefed by HRC.

network news people individual interviews.

networks do radio as well.

Vicki's list of minority radio.

BCBS; state org looking for new mission.

Story in mtg w/ faith community.

① Tony
② kids groups
③ faith community
④ foundation mtg

} press $

provider 12/2 10am.

12/10 Fed Int. Ag. mtg budget policies for outreach.

next Mon or Tuesday

Insure Kids Now

1-877-KIDS-NOW

You love your children and work hard to help them grow up strong and healthy. But like many parents, you haven't been able to give them health insurance. Now you can do something about it because there's a new nationwide effort called INSURE KIDS NOW. Call our toll-free number. Don't let your kids go another day without health coverage.

Low-cost or free health insurance for kids is here now.

Insure Kids Now

1-877-KIDS-NOW

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001. schedule	re: Chris Jennings (partial) (1 page)	01/30/1999	P6/b(6)

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Clinton Presidential Records
Domestic Policy Council
Devorah Adler
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FOLDER TITLE:
CHIP [Children's Health Insurance Program] Outreach [Folder 2]

2012-0463-S
rc729

RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Chris Jennings'Schedule
Friday
January 29, 1999

9:30 - Tobacco State Menu -Rm 211
w/Cynthia Rice

11:30 - Lunch w/Laurie McGinley
"Oval Room"

1:00 - Privacy Mtg - **Rm 472**

2:30 - Nursing Home Mtg
Rm 476
****
Saturday
January 30, 1999

Catholic Health Assn
12:15 - Lunch
12:45 - Briefing
(30 minutes-speak; 15 minutes Q &A)
Marriott Wardman Park Hotel
2660 Woodley Ave. NW
Jack Bresch will meet Chris in Lobby
Jack's P6/(b)(6) HM

[001]

focus group

TV: NBC
ABC

radio -
disney
bonneville

430 msg mtg

JCHV UNT. JANUARY 18
TO AUTHOR

publication date 3/9

Waiting In The Wings: Eligibility And Enrollment In The State Children's Health Insurance Program

New data from the Medical Expenditure Panel Survey show that 3.1 million children are eligible for coverage under CHIP. Will states enroll them?

BY THOMAS M. SELDEN, JESSICA S. BANTHIN, AND JOEL W. COHEN

FEDERAL INITIATIVES begun in the late 1980s expanded Medicaid coverage, providing insurance to millions of children in low-income families. Nevertheless, overall rates of uninsurance among children have remained high.[1] To help combat this problem, Congress in 1997 passed the State Children's Health Insurance Program (CHIP), allocating approximately $24 billion over five years to provide health insurance coverage to low-income children who are not already eligible for Medicaid.

CHIP offers states an enhanced matching rate (up to a capped amount) and provides states with considerable flexibility in finding the best ways of identifying and enrolling CHIP-eligible children without crowding out private insurance coverage.[2] States have been given the option of expanding traditional Medicaid, creating separate programs, or implementing combined approaches. Also, states that create new CHIP programs are permitted to impose modest premiums, copayments, and waiting periods (such as requiring a three-to-six-month period of uninsurance before eligibility for CHIP). States are permitted to set income thresholds that are lower than the maximum allowed under federal law, or they can exceed the federal ceiling by applying generous "income disregards."[3] In fact, most states are choosing to impose waiting periods and are setting lower income thresholds than are allowed under federal law.[4] Two states, Wyoming and Washington, declined to submit any CHIP plans for the first year.[5]

Given the considerable diversity among state plans for CHIP implementation, we have used newly available data from the 1996 Medical Expenditure Panel Survey (MEPS) to simulate CHIP eligibility and enrollment. These data were not available during the debate surrounding CHIP's enactment, yet they provide what we believe is the best available source of household data on insurance coverage, health status, and socioeconomic characteristics. Our results highlight the critical dependence of CHIP's success on states' eligibility rules and outreach efforts.

DATA AND METHODS

The data for our analysis comprise 6,903 children age eighteen and under from the 1996 MEPS.[6] MEPS is a stratified and clustered random sample of households, which, when combined with sample weights, is designed to yield nationally representative estimates for the noninstitutionalized civilian population

Thomas Selden and Jessica Banthin are economists, and Joel Cohen is a senior research manager, at the Agency for Health Care Policy and Research, Center for Cost and Finance Studies, in Rockville, Maryland.

regarding insurance coverage, medical expenditures, and a wide range of other health-related and socioeconomic characteristics.[7] To make the data as representative of 1999 as possible, we adjust the MEPS sample weights using population growth factors by age, race/ethnicity, and sex.[8] This is important given that the baby-boom "echo" is causing a disproportionate increase in the number of teenagers. Similarly, population growth is projected to be more rapid among Hispanic and black children—who also are more likely to be eligible for CHIP.

Children are considered to have insurance if they held coverage at any time during the survey round (typically, four to five months long). Thus, children are classified as uninsured only if they continuously lacked coverage during the entire round. By examining uninsurance spells of this length, we eliminate transitory periods without coverage, focusing instead on spells that are long enough to have serious adverse health consequences. Because the estimates in this paper are constructed from aged round-level data, they are best interpreted as representative of the first four to five months of 1999.

■ SIMULATING ELIGIBILITY. CHIP eligibility is based in part on being ineligible for Medicaid. For this reason, we begin by simulating Medicaid eligibility following the method used in our previous research.[9] The Medicaid and CHIP simulations both use data on individuals and families regarding age, earned income, marital status, employment status, and family structure.[10] In simulating CHIP eligibility for 1999, we incorporate the federally mandated expansion of Medicaid eligibility under federal mandates to children born after 30 September 1983 in families with incomes under 100 percent of the federal poverty level.

The next step is to apply the CHIP income tests to the remaining sample of Medicaid-ineligible children. We simulate three different scenarios concerning CHIP income thresholds: (1) children eligible using the federal CHIP income limits of 200 percent of poverty (or fifty percentage points above the existing state Medicaid threshold, whichever is greater); (2) children eligible if states were to implement income disregards up to 300 percent of poverty (as in Connecticut and Missouri); and (3) children eligible under actual state plans approved or submitted as of August 1998.[11]

■ SIMULATING CHIP ENROLLMENT. To simulate CHIP enrollment, we use the sample of Medicaid-eligible children to estimate a multivariate behavioral model of the choice among Medicaid coverage, private insurance coverage, or no insurance. We then apply this model to the CHIP-eligible population to obtain enrollment predictions for CHIP coverage, private insurance, and no coverage. Included in the enrollment model are variables pertaining to the child's age, race/ethnicity, sex, disabilities, and health condition, as well as family-level variables such as family earned income, family composition, the education level and employment status of the family head, U.S. census region, and urban residence. We include both uninsured and privately insured children in our simulation, thereby allowing for the possibility that CHIP coverage will crowd out private insurance.

■ USING MEDICAID PARTICIPATION TO PROJECT CHIP ENROLLMENT. Our approach projects CHIP enrollment for 1999 based on the Medicaid expansion experience as of 1996. We believe that this experience is relevant for CHIP because of the substantial overlap between the Medicaid expansion-eligible and CHIP-eligible populations. The Medicaid expansions have been implemented unevenly across states and across age groups within states, so that CHIP-eligible children and Medicaid-expansion children share many of the same characteristics. Indeed, 90 percent of all children who are eligible for CHIP under the state plans would have been eligible for Medicaid rather than CHIP had they lived in states that fully implemented the Medicaid expansions allowed under federal law. The Medicaid experience also may be relevant insofar as 55 percent of all CHIP-eligible children would be covered through Medicaid expansions or Medicaid look-alike coverage

under current state plans.

It is also true, however, that CHIP in 1999 may differ from Medicaid in 1996 in ways that our analysis is unable to capture. CHIP application processes may be simplified relative to Medicaid in 1996. Also, the higher federal matching rate for CHIP may provide states with the incentive to minimize application denials for eligible children, a problem believed to be widespread in the Medicaid program.[11] CHIP may well entail less stigma than Medicaid, especially in cases where children would be eligible to enroll in separate state programs, and CHIP outreach in 1999 may be more effective than Medicaid outreach in 1996.[13] ~~CHIP's focus on the children of two-parent working families also might be an advantage in terms of outreach and enrollment.~~

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The differences between Medicaid and CHIP that are listed above can be expected to increase CHIP enrollment relative to our projections. However, there also are differences, such as CHIP premiums and waiting periods for children who previously were covered by private insurance, that may have the opposite effect. Many states are charging premiums for at least some children, and although these premiums are in most cases below the maximum levels allowed under federal legislation, low-income families may be very sensitive to the price of coverage.[14] In addition, transitions between private coverage and uninsurance occur with relatively high frequency among low-income families.[15] Although waiting periods tend to reduce the number of children crowded out of private coverage, they also can reduce enrollment among children who would have lost their private coverage even in the absence of the CHIP program.

RESULTS

■ **CHIP ELIGIBILITY.** Using the federal maximum CHIP income thresholds, we project that there will be 3.1 million uninsured children eligible for CHIP in 1999 (Exhibit 1).[16] Our forecast is very close to estimates obtained using data from the Current Population Survey (CPS) in earlier years.[17] In addition, we project that there will be 8.8 million children with private insurance who, apart from having private coverage, would qualify for CHIP based on their family incomes.

If we disregard income up to 300 percent of the poverty guidelines, the number of uninsured children who would be eligible for CHIP rises to 5.2 million. Using the current state plans, however, causes our projection to fall to 2.6 million. These results highlight the fact that the total number of children made eligible for CHIP depends critically on the programs that states choose to implement.

Nationwide, teenagers (ages thir-

3

EXHIBIT 1
Children Eligible For The State Children's Health Insurance Program (CHIP), By Eligibility Criteria And Insurance Status, 1999 Projections

Eligibility group	N	Population (millions)	Uninsured (millions)	Privately insured (millions)
Children eligible under federal CHIP income thresholds-standard income disregards	1,116	11.87	3.07 (0.34)	8.80 (0.52)
Children eligible using income thresholds at 300 percent of poverty	2,293	26.71	5.19 (0.44)	20.52 (0.91)
Children eligible under state plans as of August 1998[a]	855	9.44	2.58 (0.31)	7.55 (0.57)

SOURCE: Authors' calculations using aged 1996 Medical Expenditure Panel Survey (MEPS) Round 1 data.
NOTE: Standard errors in parentheses were bootstrapped to correct for complex design of the MEPS sample and for sampling error underlying estimates of the multivariate simulation model.
[a] State plans are from National Governors' Association (1998). See Note 11 in text.

teen to eighteen) are projected to represent 30.6 percent of all children age eighteen and under in 1999 (Exhibit 2). In contrast, the share of teenagers in the CHIP-eligible population is significantly higher at 39.4 percent. CHIP-eligible children also are projected to be more heavily Hispanic (29.5 percent) than the general population of children (15.5 percent). They also are more likely to be black (19.9 percent versus 15.9 percent on average in the population); however, this difference is not statistically significant. CHIP-eligible children in our projected sample are less likely than the average child to be in a family in which the family head is unemployed, because the program primarily targets children of the working poor. In addition, CHIP-eligible children are projected to be disproportionately located in the South.

Perhaps as interesting as the characteristics that define CHIP-eligible children are some of the similarities they have with other children. They have only a slightly greater likelihood than children in general of being in families with single parents, and this difference is not statistically significant. Perhaps more importantly, there is virtually no difference between CHIP-eligible children and other children with respect to the frequency of health problems and/or disability.

■ SIMULATED ENROLLMENT. Total enrollment under the federal eligibility thresholds is projected to be 1.8 million children in the first half of 1999 (Exhibit 3). The corresponding total enrollment under the state plans is 1.5 million children. The federal total includes 1.0 million children who otherwise would have been without coverage during this period, as well as 0.4 million children who would be crowded out of private insurance. However, ~~the standard errors for both estimates are relatively large, so~~ projected changes in insurance status are estimated only imprecisely. Moreover, our projections, being based on the Medicaid expansions, do not incorporate waiting periods, which can be expected to reduce CHIP enrollment among those otherwise covered by private insurance. Finally, the total includes our estimate that the availability of CHIP coverage might prevent as many as 0.4 million children from spending down to Medicaid eligibility.[19]

We project that a substantial number of CHIP-eligible children would remain uninsured under either federal or state rules. The implied federal and state CHIP enrollment rates are 47 and 48 percent, respectively—below the 59 percent enrollment rate among Medicaid expansion–eligible children in 1996.[20] The low take-up rates in our model reflect the fact that while the CHIP and Medicaid populations overlap to a considerable extent, CHIP-eligible children are more likely than Medicaid-eligible children are to have precisely those characteristics that are most strongly associated in Medicaid with

EXHIBIT 2
Selected Characteristics Of CHIP-Eligible And All Children, 1999 Projections

Characteristic	CHIP-eligible children	All children
Total population (millions)	3.07	76.40
Teenager (age 13–18)	39.4% (3.5)	30.6% (0.7)
Hispanic	29.5 (4.0)	15.5 (0.9)
Black	19.9 (5.1)	15.9 (1.0)
Unemployed family head	7.0 (2.4)	14.1 (0.7)
Single-headed family	33.9 (4.7)	27.4 (1.0)
Health problem or disability	16.2 (2.4)	15.5 (0.5)
South	49.9 (5.4)	34.3 (1.5)

SOURCE: Authors' calculations using aged 1996 Medical Expenditure Panel Survey (MEPS) Round 1 data.
NOTES: State Children's Health Insurance Program (CHIP) eligibility was determined assuming federal rules using standard income disregards. Standard errors in parentheses are corrected for complex design of the MEPS sample.

EXHIBIT 3
Simulated State Children's Health Insurance Program (CHIP) Enrollment (Millions), By Eligibility Criteria And Baseline Insurance Status, 1999 Projections

	Eligible under federal CHIP program	Eligible under state plans as of August 1998[a]
CHIP enrollees by original insurance status		
Uninsured	1.03 (0.30)	0.90 (0.26)
Privately insured	0.44 (0.37)	0.31 (0.31)
Medicaid medically needy	0.36 (–[b])	0.32 (–[b])
Total	1.83 (0.21)	1.53 (0.17)
CHIP-eligible children remaining uninsured	2.04 (0.26)	1.89 (0.21)

SOURCE: Authors' calculations using a pool 1996 Medical Expenditure Panel Survey (MEPS) Round 1 data.
NOTE: Standard errors in parentheses were bootstrapped to correct for complex design of the MEPS sample and for sampling error underlying estimation of the multivariate simulation model.
[a] State plans are from National Governors' Association (1998). See Note 11 in text.
[b] Not applicable. Estimate based on Medicaid administrative data. See Note 19 in text.

low enrollment rates.[21]

For instance, in our Medicaid sample family income and having at least one working parent are both negatively associated with program participation, yet when we compare CHIP-eligible children with Medicaid-eligible children we see that the former are more likely than the latter are to come from families with higher incomes and are far more likely to have a working parent. Similarly, whereas being a minority or having a disability is positively associated with Medicaid take-up, CHIP-eligible children are less likely than Medicaid-eligible children are to be minorities or to have disabilities. Also, while age is negatively associated with Medicaid enrollment, CHIP-eligible children tend to be older than Medicaid-eligible children. Indeed, the CHIP take-up rates derived from our projections are approximately the same as the 44 percent Medicaid take-up rate observed among expansion-eligible teenagers in 1996.[22]

Our CHIP projections show a possible effect on enrollment of CHIP being targeted solely at children (rather than entire families). Medicaid take-up rates among children in waiver states where Medicaid expansions have covered the entire family are nineteen percentage points higher than among similar children in states where the expansions pertain only to children and pregnant women. Since CHIP eligibility is limited to the children in low-income families, one would therefore expect lower CHIP enrollment rates than if the whole family were made eligible.

To view these projections from a different perspective, it is useful to calculate the crowd-out rates implied by our simulations. Although federal statutes require states to implement safeguards to prevent crowd-out, our simulations, based as they are on the Medicaid experience, do not account for such controls. Using federal eligibility thresholds, the implied crowd-out rate is 24 percent (21 percent under state rules).[23] Thus, while our enrollment projections are consistent with crowd-out rates that fall approximately at the midpoint of the range of estimates in the Medicaid crowd-out literature, actual CHIP crowd-out rates may be lower than those predicted by our model.[24]

POLICY IMPLICATIONS

We project that during the first half of 1999, 3.1 million uninsured children will be eligible for CHIP under the maximum federal income thresholds—approximately one of every four uninsured children nationwide. For this reason, we believe that CHIP provides an important opportunity for providing health insurance to children in low-income families who otherwise would be uninsured. Indeed, if one adds these 3.1 million uninsured CHIP-eligible children in 1999 to the 4.7 million uninsured children who were eligible for but not enrolled in Medicaid in 1996, we see that pub-

lic programs are now in place to cover nearly two-thirds of all uninsured children in the country.

To make this many children eligible for CHIP, however, states must expand eligibility to income levels above those ~~now allowed~~. Under current state plans, we project that only 2.6 million uninsured children will be eligible for CHIP. This number may grow over time, however. Some states are expanding CHIP eligibility in phases and have limited their initial income thresholds to levels lower than those allowed under federal law. In subsequent years these states may well extend eligibility to more children. Indeed, the federal legislation allows states to extend CHIP eligibility to more than five million uninsured children by ~~lifting income limits~~.

> *"Perhaps the most important factor influencing both CHIP and Medicaid enrollment is the effectiveness of outreach efforts."*

Of course, making children eligible for public coverage is only the first step. Our enrollment simulation and analysis reveal that CHIP-eligible children frequently have characteristics that are associated with low enrollment rates among Medicaid-eligible children. In comparison to Medicaid-eligible children, CHIP-eligible children tend to be older; less concentrated among minorities; and more likely to be in two-parent, working families with higher levels of education and higher incomes. Also, children only (not their parents) would be eligible to enroll in CHIP. Based on the Medicaid experience, these factors suggest that states may have difficulty enrolling uninsured children into CHIP, thereby highlighting the importance of states' decisions regarding outreach, premiums, waiting periods, and application procedures.

Of course, it can be risky to extrapolate directly from the Medicaid expansions to CHIP. On the one hand, actual CHIP enrollment may be greater than our Medicaid-based projections since CHIP may entail less stigma than Medicaid. On the other hand, CHIP enrollment also may be lower than we project if waiting periods are long or if the CHIP premiums dissuade parents from enrolling their children.

Perhaps the most important factor influencing both CHIP and Medicaid enrollment is the effectiveness of outreach efforts. Since 1996, the year of our data, states have been experimenting with and implementing a wide range of methods to improve Medicaid outreach. Successful initiatives include school-based enrollment, streamlined application processes, and mass media campaigns. In addition, the 1999 White House budget proposal seeks $900 million in federal funding over five years to help improve Medicaid outreach.[25] Many of the more successful Medicaid outreach strategies may be directly applicable to CHIP. Moreover, the two programs may complement each other, with improved Medicaid outreach helping to identify more CHIP-eligible children and vice versa.[26] Together, Medicaid and CHIP clearly offer the potential to substantially increase access to health insurance for children in low-income families. The challenge now is to get the eligible children enrolled.

The authors are grateful for the helpful suggestions of Ross Arnett III, Gary Claxton, John Eisenberg, Holly Harvey, John Holahan, John Moeller, Alan Monheit, Liliana Pezzin, Patrick Purcell, Robert Stewart, Robin Weinick, Samuel Zuvekas, and two anonymous referees. They are also extremely grateful for the expert programming assistance of Devi Kurlkineni. The authors are responsible for any remaining errors. The views expressed in this paper are those of the authors, and no official endorsement by the Department of Health and Human Services or the Agency for Health Care Policy and Research is intended or should be inferred.

NOTES

1. J. Vistnes and A. Monheit, *Health Insurance Status of the Civilian Noninstitutionalized Population: 1996*, MEPS Research Finding no. 1, Pub. no. 97-0030 (Rockville, Md.: Agency for Health Care Policy and Research, 1997).
2. For additional details regarding the design of CHIP, see F. Ullman, B. Bruen, and J. Holahan, *The State Children's Health Insurance Program: A Look at the Numbers*, Occasional Paper no. 4 (Washington: Urban Institute Press, 1998) and S. Rosenbaum et al., "The Children's Hour: The State Children's Health Insurance Program," *Health Affairs* (January/February 1998): 75–89.
3. States allow certain amounts to be netted out of income before testing for program eligibility. Amounts disregarded in this way typically include child care costs, transportation to and from work, and child support receipts.
4. White House, *Implementation of the Children's Health Insurance Program: Six Month Progress Report*, a report of the National Economic Council/Domestic Policy Council (Washington: U.S. Government Printing Office, 1998); *CHIP Check-Up: A Healthy Start for Children* (Washington: Children's Defense Fund, 1998); and National Governors' Association, *Implementation of Title XXI* (www.nga.org/MCH/Implementation.htm, 21 August 1998).
5. American Healthline, "Statelines—Washington: Turns Down Federal Kiddiecare Funds," 10 March 1998.
6. For full details of our methodology, see T. Selden, J. Banthin, and J. Cohen, *Projecting Eligibility and Enrollment for the State Children's Health Insurance Program*, Pub. no. 99-R025 (Rockville, Md.: Agency for Health Care Policy and Research, 1998), available from the authors or the AHCPR Web site (www.meps.ahcpr.gov/hmes/papers). We subset the sample to exclude children in families with elderly members or active-duty military personnel, where we define families as the household members who would be eligible for coverage under most family health insurance policies. Although some CHIP-eligible children may be in families headed by elderly persons, we do not yet have access to the pension and other retirement income data that would enable eligibility simulation for these cases. In total, we exclude observations representing approximately 0.5 million uninsured children nationwide, some of whom may be eligible for Medicaid or CHIP.
7. See J. Cohen et al., "The Medical Expenditure Panel Survey: A National Health Information Resource," *Inquiry* 33, no. 4 (1996/97): 373–389; and S. Cohen, "Sample Design of the 1996 Medical Expenditure Panel Survey Household Component," MEPS Methodology Report no. 2, Pub. no. 97-0027 (Rockville, Md.: AHCPR, 1997).
8. U.S. Bureau of the Census, *Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1995 to 2050*, Current Population Reports, P25-1130 (Washington: U.S. GPO, 1996).
9. T.M. Selden, J.S. Banthin, and J.W. Cohen, "Medicaid's Problem Children: Eligible but Not Enrolled," *Health Affairs* (May/June 1998): 192–200.
10. Throughout the analysis we treat family income as exogenous, whereas families may in reality adjust their incomes to gain CHIP eligibility. On the one hand, CHIP may free the families of some Medicaid-enrolled children to earn more income without losing access to publicly subsidized coverage for their children. On the other hand, some higher-income families may reduce their earnings if by doing so they are able to gain eligibility to CHIP. In both cases, the number of CHIP-eligible children would increase relative to our projections. The implicit assumption in our analysis, however, is that the value of the CHIP benefit would be too small to induce substantial numbers of additional families to respond in these ways.
11. In the first scenario we disregard child care payments of $100 (1996 dollars) per month per child age ten and under in families where the family head and all other members over age eighteen are employed (up to a maximum of $250 per family). Also, we subtract from earned income $90 per month of employment-related expense for each employed adult.

    State plans are from NGA, *Implementation of Title XXI*. In total, forty-seven states plus the District of Columbia had plans that were sufficiently developed to be included (including Wyoming and Washington, which decided not to participate in CHIP in the first year). The remaining three states were assigned the modal plan, whereby CHIP eligibility was simulated for all Medicaid-ineligible children age eighteen and under in families with incomes (net of standard disregards) below 185 percent of the poverty guidelines. For states where income disregards were not specified, we applied the same disregards that we use to simulate the federal CHIP program.
12. General Accounting Office, *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate*, GAO/HEHS-96-129 (Washington: GAO, 1996).
13. Also, Medicaid allows retroactive enrollment (thereby covering the preenrollment expenditures for a particular episode of care), whereas non-Medicaid CHIP programs typically do not. This might induce some families to enroll in CHIP, whereas they might not have enrolled in a

plan with retroactivity.

14. CHIP Check-Up; P. Diehr et al., "Will Uninsured People Volunteer for Voluntary Health Insurance? Experience from Washington State," *American Journal of Public Health* 86, no. 4 (1996): 529–532; A. Gauthier and S. Schrodel, *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform* (Washington: Alpha Center, 1997); L. Kii and T. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington: Urban Institute, 1997); and K. Thomas, "Are Subsidies Enough to Encourage the Uninsured to Purchase Health Insurance? An Analysis of Underlying Behavior," *Inquiry*, 31, no. 4 (1994): 415–425.
15. L. Blumberg, L. Dubay, and S. Norton, "Did the Medicaid Expansions for Children Displace Private Insurance?" Working Paper (Washington: Urban Institute, 1997).
16. All standard errors in this paper are corrected for the complex design of the MEPS sample.
17. Ullman et al., *The State Children's Health Insurance Program*; S. Flint, S. Tang, and B. Yudkowsky, *Medicaid Eligibility and Implications for SCHIP Participation* (Washington: American Academy of Pediatrics, 1998); and K. Thorpe and C. Florence, *Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured* (New York: Commonwealth Fund, 1998).
18. Exhibit 2 uses the CHIP population defined by applying the federal income thresholds to family incomes net of the standard disregards defined in Note 10.
19. This is a very rough estimate obtained from data on the number of medically needy children (Health Care Financing Administration, *Medicaid Program Statistics, HCFA-2082 Report* www.hcfa.gov/medicaid/mstats.htm, 1998) with the MEPS distribution by family income of children with health problems and/or disabilities. For additional details, see Selden et al., *Projecting Eligibility and Enrollment*.
20. To compute implied take-up rates, we use the enrollment projections from Exhibit 4 to divide (1) the total number of CHIP enrollees by (2) total CHIP enrollees plus CHIP-eligible children who remain uninsured (2.04 million). An alternative approach would be to calculate the take-up rate as the percentage of otherwise uninsured children who enroll. That approach, however, would ignore children switching from other sources of insurance and would be inconsistent with take-up rate estimates for the Medicaid population. The 59 percent enrollment rate for Medicaid expansion–eligible children is reported in Selden et al., "Medicaid's Problem Children."
21. Similar results can be found in L. Dubay and G. Kenney, "The Effects of Medicaid Expansions on Insurance Coverage of Children," *Future of Children* 6, no. 1 (1996): 152–161; and L. Shore-Sheppard, "Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage," Working Paper no. 361 (Princeton: Industrial Relations Section, Princeton University, 1995).
22. Selden et al., "Medicaid's Problem Children."
23. To compute the crowd-out rate, we use the simulated enrollment figures presented in Exhibit 4 to divide (1) the change in the number of children covered by private insurance (0.44 million) by (2) the total number of CHIP enrollees (1.83 million).
24. See J. Holahan, "Crowding Out: How Big a Problem?" *Health Affairs* (January/February 1997): 204–206.
25. White House, *Implementation of the Children's Health Insurance Program*, and White House, *Budget of the United States Government, Fiscal Year 1999* (Washington: U.S. GPO, 1998).
26. For more on the effect that CHIP may have on Medicaid take-up, see Ullman et al., *The State Children's Health Insurance Program*.

Insure Kids Now Hotline

Prepared by the National Governors' Association

Survey Results as of February 1, 1999

✖ = DON'T BUY AIR TIME

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State	Toll-Free Number	Program	Hours of Operation	Group Size	Spanish	V. M.
Alabama	888-373-KIDS	Other-CHIP Private insurance program	Mon.-Fri. 8:00 to 5:00	16	yes	Yes-
Alaska	888-318-8890	Medicaid	Mon.-Fri. 8:00 to 5:00- extended once CHIP is implemented	3	limited	Yes
Arizona	1-877-764-5437	KidsCare (Title XXI)	24 hours bilingual	20	yes	yes
Arkansas	1-888-474-8275	Other-ARKids First (Title XIX 1115 Waiver)	Mon.-Fri. 8:00 to 4:30	4	Yes but limited	Yes
California	888-747-1222	Medicaid and Title XXI	Mon.-Fri. 8:00 to 8:00 (PST)	48	Yes	Yes
Colorado	800-688-7777	Title V	Mon.-Fri. 8:00 to 5:00	4	yes	Yes
Connecticut	877-284-8759 (877-CT-HUSKY)	CHIP hotline and Medicaid (children under 185% FPL, non-cash)	Mon.-Fri. 8:00 to 7:00	5	Yes	Yes
Delaware ✖ Delay for 4-6 months	800-996-9969	Health Benefits Manager	Mon.-Fri. 8:00 to 4:30		Yes	No
District of Columbia	800-666-2229		8:30-4:45 M-F	4	Yes	Yes
Florida ✖ DO NOT BUY TIME!!	(888) FLA-KIDS Doesn't want to participate!					
Georgia Technical Problems	877-427-3224	CHIP Program (PeachCare)	Mon.-Fri. 7:30 to 7:30	12	Yes	Yes
Hawaii	Doesn't have a statewide hotline yet.					
Idaho	800-926-2588	Title V, Medicaid, Idaho CareLine	Mon.-Fri. 7:00 to 6:30	3	Yes	Yes
Illinois	1-800-323-4769 (GROW)	Title V/Other-General	Mon.-Fri. 8:00 to 7:00	15	No	Yes-

State	Toll-Free Number	Program	Hours of Operation	Group Size	Spanish	V. M.
Indiana	800-889-9949	Other-Hoosier Healthwise Helpline	Mon.-Fri. 8:00 to 7:00 Sat. 8 to noon	16	Yes	Yes
Iowa	800-257-8563	Hawkeye-ESI	24 hours per day	16	Yes	Yes
Kansas	800-792-4884	Health-Wave-SCHIP	7 to 7 M-F 8 to 5 Sat.	48	Yes	Yes
Kentucky !!!!	800-635-2570	Medicaid	8am -4:30pm	4	No	yes
Louisiana	877-252-2447	LaCHIP	8-5 M-F	7	No	No
Maine	800-432-7338	Other-Portland Regional Office of the Dept. of Human Services	Mon.-Fri. 8:00 to 5:00	6	No	No
Maryland	800-456-8900	Title V and Medicaid	Mon.-Fri. 8:30 to 5:00	20	No	No
Massachusetts	800-841-2900	MassHealth Customer Service Line	Mon.-Fri. 8:00 to 5:00	168	Yes	Yes
Michigan Working on Resolving issues	888-988-6300	Title XXI MIChild	M-F: 8-5 Title XXI M-W: 8-8 Th-F: 8-6 Sat: 9-1		Yes	Yes
Minnesota	800-657-3672	-Minnesota Care	Mon.-Fri: 7:00 to 5:00	48	Yes	Yes
Mississippi	800-421-2408	Medicaid	Mon.-Fri. 7:30 to 5:00	1	No	Yes
Missouri	888-275-5908	Other-MC+ Service Center	Mon.-Fri. 8:00 to 5:00	5 lines each		Yes
Montana ✖ DO Not Buy Time-	800-421-6667	Title V	Mon.-Fri. 9:00 to 5:00 MST	1	No	Yes
Nebraska	877-632-5437 (Neb Kids)	Other-Kids Connection/SCHIP	Mon.-Fri. 7:00 to 6:00		?	Yes
Nevada	800-360-6044	Other-Nevada Check up	Mon.-Fri. 8:00 to 5:00	3	Yes	Yes
New Hampshire	877-464-2447	Dedicated Children's Health Line	Mon.-Fri. 8:00 to 4:30	7	No	Yes
New Jersey !!!!	800-701-0710	Other-NJ KidCare (CHIP)	TWF 8:30 to 5:00 MTh 8:30 to 7:00	144	Yes	Yes

State	Toll-Free Number	Program	Hours of Operation	Group Size	Spanish	V. M.
New Mexico					Yes	
New York	800-698-4543	Other-Funded through Title XXI allocation and state monies	Mon.-Fri. 8:00 to 6:00 Sat. & Sun. 12:00 to 5:00	3	Yes-AT&T	Yes,
North Carolina	800-367-2229		M-F 9am-7pm	6	No	Yes
North Dakota ✖ DO NOT BUY TIME!!	800-755-2604	Medicaid	Mon.-Fri. 7:30 to 5:00	3 oper.	No	Yes
Oklahoma ✖ DO NOT BUY TIME!!	800-987-7767	Medicaid-SoonerCare Helpline	M-F: 8-8 Sat: 8-noon		Yes	Yes
Ohio	800-324-8680	Medicaid	MWF: 8-8 S & S: 12-5 Including Holidays		?	Yes
Oregon	800-359-9517	CHIP	8 am-5pm	10	Yes	no
Pennsylvania	800-986-KIDS (5437)	Title V	Mon.-Fri. 8:00 to 6:00		Yes	Yes
Rhode Island	*1-800-346-1004	Other-RIte Care	Mon.-Fri. 7 to 7:00	3	Yes	Yes
South Carolina	888-549-0820	Medicaid (does managed care ?s, eligibility ?s	Mon.-Fri. 7:00 to 7:00		No	Yes
South Dakota						
Tennessee Waiting in info	800-669-1851	Medicaid (uninsured/ uninsurable population)	Mon.-Fri. 8:00 to 4:30 CST		No	No
Texas	800-252-8263	Medicaid	Mon.-Fri. 7:30 to 5:30	19	Yes	No
Utah	888-222-2542	Other-Title XXI	Mon.-Fri. 8:00 to 5:00		Yes- AT&T	Yes
Vermont	800-250-8427	Medicaid	Mon.-Fri. 8:00 to 5:00	24	No	No
Virginia	877-822-6747	Virginia Children's Medical Security Plan	24 hours/day		Yes	Yes

State	Toll-Free Number	Program	Hours of Operation	Group Size	Spanish	V. M.
Washington	none	Medical Assistance Adm. (Medicaid)	7 a.m. -5 p.m. M-F	22	No	Yes
West Virginia	888-983-2645	Governor's Cabinet on Children and Family	Mon.-Fri. 8:00 to 8:00	1	No	Yes
Wisconsin	800-362-3002	Medicaid	Mon.-Fri. 8:00 to 4:30	8	Yes-AT&T	No
Wyoming	800-994-4769 (Grow)	Other-Help Me Grow, Safe Kids	Mon.-Fri. 8:00 to 5:00		no	Yes

For more information please contact Joy Horner (202) 624-7854 or Joan Henneberry (202) 624- 3644 at the National Governors' Association.

HEALTH MANAGEMENT ASSOCIATES

Enrollment Increases in State CHIP Programs: December 1998 to June 1999

For:
The Kaiser Commission on
Medicaid and the Uninsured
July 30, 1999

Prepared by:
Vernon K. Smith, Ph.D.
Principal
Health Management Associates

This report was prepared for The Kaiser Commission on Medicaid and the Uninsured, as part of a study of trends in enrollment in Medicaid and State Child Health Insurance Programs. The views expressed are those of the author and do not necessarily reflect the views of The Kaiser Commision on Medicaid and the Uninsured.

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Enrollment Increases in State Child Health Insurance Programs:

December 1998 to June 1999

Introduction

When the Balanced Budget Act of 1997 created the opportunity two years ago, states moved quickly and aggressively to develop and implement their Title XXI—State Child Health Insurance Programs (CHIP). An estimated 2.6 million children are eligible for CHIP with an additional 4.8 million potentially eligible for Medicaid coverage but not yet enrolled (Selden et al., 1999). Now that almost all CHIP programs are enrolling children, there has been great interest in monitoring the pace at which states are bringing children into health coverage, bearing in mind that getting these new programs up and running is likely to take some time.

As part of a study of trends in enrollment in Medicaid and State Child Health Insurance Programs for The Kaiser Commission on Medicaid and the Uninsured, Health Management Associates gathered data on CHIP enrollment changes. As of December 1998, 40 states (including the District of Columbia) had begun enrolling children in CHIP programs. During the first half of 1999, many of these states increased enrollment substantially, and an additional seven states implemented and began to enroll children into their CHIP programs. Four states continue to move toward future implementation.

Over the six-month period spanning from December 1998 to June 1999, the number of children with health coverage under state CHIP programs increased by 55 percent. Based on enrollment data provided by the state officials in this survey, the number of children enrolled in CHIP increased from 833,433 to 1,291,700.

Data Collection

For this study, enrollment data were obtained by telephone directly from state officials responsible for administering the state CHIP programs. The data reflect enrollment statistics as of the end of June 1999 or in a few cases, the first of July 1999 and does not include all adjustments that will be made for retroactive enrollment. The baseline for comparison is December 1998. HCFA reported in April 1999 that almost one million children were enrolled by CHIP plans at the end of 1998. The focus of this survey was to determine the extent of growth in enrollment over the first half of 1999.

Officials were asked to report the number of children enrolled in their Child Health Insurance Program, and countable as covered under Title XXI, for December (or at the end of December) 1998 and for June (or at the end of June) 1999.

States do not yet report the enrollment data for CHIP in a uniform way, and it was necessary to use the data as reported by each state. It is expected that data reported in this survey may differ from data reported to HCFA or in other surveys. Some states reported the unduplicated number of children enrolled for the month while others reported the number enrolled on a specific date, such the last Friday in June. A few states reported data they had available for enrollment for a specific date in the first week of July 1999 or the number of eligibles for the quarter ending on December 31, 1998 and June 30, 1999. Acknowledging the data issues, a few states insisted on estimating the enrollment because it was not possible to provide a precise count. For this survey, states were not asked to identify whether enrollments were in a Medicaid expansion program or in a separate state program, only that the enrollment reflected enrollment in a Title XXI eligible category. Finally, these statistics do not include children newly enrolled in Medicaid as a result of CHIP outreach efforts.

Survey Results

Two significant findings emerge from the survey of state CHIP officials:

1. Enrollment in state CHIP programs increased significantly in the first six months of 1999. About 460,000 additional children were enrolled in CHIP, as total enrollment in CHIP programs increased from 833,433 to 1,291,700.

   - This large enrollment increase (55%) in such a short period of time reflects the priority states have placed on reaching eligible but unenrolled children as quickly as possible. In the course of discussing enrollment changes with each state, many officials stressed their efforts to effectively market the program in a way that will assist in finding and enrolling eligible children.

   - States continue to develop new phases of their CHIP programs. In many states, the initial effort was an expansion of Medicaid eligibility. This approach was often chosen because it was easier to implement quickly. However, many states now are preparing to implement separate CHIP programs, which requires more time for implementation.

   - Almost half of the growth in enrollment occurred in three states; enrollment grew by 81,590 in New York, by 78,802 in California, and by 44,815 in Florida. These increases in enrollment are due in part to earlier implementation dates and greater initial numbers of uninsured but eligible children in these states.

   - Nevertheless, growth in enrollment occurred across the country, with substantial percentage increases in many states with smaller population bases. For example, Georgia has now enrolled over 30,000 children. In addition, the pace of growth has accelerated in several states. In Florida, for example, enrollment in the first three months of 1999 increased by 24% from 56,265 to 69,821. In the second three months, enrollment increased by 45%, to 101,080.

2. In reporting their CHIP enrollment figures, many states also commented on how the unprecedented effort to find and enroll CHIP-eligible children has had a pronounced Medicaid case-finding effect.

   The CHIP enrollment statistics, as impressive as they are, do not come close to capturing the true picture of the number of children who have actually gained health coverage over the past six months. Many states are finding more than one new Medicaid enrollment for every CHIP enrollment. It was not possible from this study to quantify this phenomenon, but it is occurring across all states.

   - For example, Alabama reported that for every 100 applications for CHIP, 50 children were in fact enrolled in Medicaid, while 30 were enrolled in CHIP. The remaining 20 applications were found not eligible for either program. Alabama officials indicated that these proportions have been relatively constant from the start of the program.

   - Similarly, in Washington, DC, there are 1,924 children enrolled in CHIP, but officials report that 2,500 children have been enrolled in Medicaid. Under the Washington, DC plan, about 4,200 parents of these children have also received coverage under Medicaid.

   - In Michigan, of 53,252 applicants who were determined eligible for coverage, 41,751 were enrolled in Medicaid and 11,501 in CHIP.

   - In Arizona, there are 14,985 enrolled in CHIP on July 1,1999, and another 13,228 were enrolled in Medicaid after having applied for CHIP.

   Focusing only on CHIP enrollments also fails to account for the expanded number of children receiving health coverage due to state programs initiated prior to CHIP and therefore not eligible to be counted as CHIP enrollments.

- In Minnesota, the MinnesotaCare program covers children up to 275% of the Federal Poverty Level (FPL). Enrollment increased by 1,094 to 56,527 from December 1998 to June 1999. However, none of these enrollments were actually into CHIP as it has been implemented in Minnesota. The Minnesota CHIP program is a very small one, covering only eight children ages 0-2 from 275% to 280% of the FPL.

- Similarly, in Arkansas, the ARKids1st program covered 42,761children up to 200% of the FPL in June 1999, an increase of 5,956 from December 1998. The Arkansas CHIP program covered 712 children ages 16 to 18 in June 1999, up from 341 in December 1998.

Table 1 shows the change in state CHIP enrollment as reported by state officials.
Table 2 provides additional background information on each state's CHIP program.

References

Selden, T.M., Banthin, J.S., and Cohen, J.W. "Waiting in the Wings: Eligibility and Enrollment in the State Children's Health Insurance Program," *Health Affairs*, vol. 18, no. 2, March/April 1999, p. 126-133.

This report was prepared for The Kaiser Commission on Medicaid and the Uninsured, as part of a study of trends in enrollment in Medicaid and State Child Health Insurance Programs. The views, findings and conclusions expressed are those of the author and do not necessarily reflect the views of The Kaiser Commission on Medicaid and the Uninsured.

Table 1: State CHIP Enrollment as Reported by State Officials, December 1998 and June 1999

State	Number of Enrolled Children, Dec-98**	Number of Enrolled Children, Jun-99	Change in Enrollment	Percent Change
Alabama	22,102	32,626	10,524	48%
Alaska*	--	3,093	3,093	N/A
Arizona	3,710	14,985	11,275	304%
Arkansas*	341	712	371	109%
California	55,189	133,991	78,802	143%
Colorado	11,704	17,783	6,079	52%
Connecticut	7,460	10,150	2,690	36%
Delaware*	--	2,800	2,800	N/A
District of Columbia	569	1,924	1,355	238%
Florida	56,265	101,080	44,815	80%
Georgia^	--	31,085	31,085	N/A
Hawaii*	--	--	--	N/A
Idaho	2,937	3,541	604	21%
Illinois	26,877	38,586	11,709	44%
Indiana*	24,982	28,909	3,927	16%
Iowa	7,004	9,252	2,248	32%
Kansas	--	11,024	11,024	N/A
Kentucky*	1,145	9,000	7,855	686%
Louisiana	2,384	2,814	430	18%
Maine	4,729	6,404	1,675	35%
Maryland	9,192	14,494	5,302	58%
Massachusetts	30,912	46,867	15,955	52%
Michigan	10,204	17,256	7,052	69%
Minnesota*	8	8	0	0%
Mississippi	15,968	17,717	1,749	11%
Missouri	24,910	42,251	17,341	70%
Montana	--	943	943	N/A
Nebraska	3,764	5,192	1,428	38%
Nevada	2,782	6,545	3,763	135%
New Hampshire	--	1,426	1,426	N/A
New Jersey	20,153	33,548	13,395	66%
New Mexico	--	868	868	N/A
New York	270,683	352,273	81,590	30%
North Carolina	17,887	43,774	25,887	145%
North Dakota*	79	92	13	16%
Ohio	35,300	38,420	3,120	9%
Oklahoma*	18,000	25,000	7,000	39%
Oregon	10,366	12,608	2,242	22%
Pennsylvania	68,376	78,998	10,622	16%
Rhode Island	2,981	4,666	1,685	57%
South Carolina	34,026	42,198	8,172	24%
South Dakota	1,405	2,038	633	45%
Tennessee	--	--	--	N/A
Texas*	34,826	30,088	-4,738	-14%
Utah	2,038	4,656	2,620	129%
Vermont	406	1,095	689	170%
Virginia	1,420	12,138	10,718	755%
Washington*	--	--	--	N/A
West Virginia	351	3,382	3,031	864%
Wisconsin	--	3,400	3,400	N/A
Wyoming	--	--	--	N/A
Total Enrollment	**833,433**	**1,291,700**	**458,267**	**55%**

--: State did not have program in operation.

^ Georgia implemented pilot program with 4,000 children as of 12/98.

See notes on next page.

Source: Health Management Associates: Survey of state officials, July 1999.

* Notes:	
**	Dec-98 numbers in this survey may differ from earlier data reported to HCFA or in other surveys. See text for further explanation.
Alaska	Does not net out children with other insurance.
Arkansas	ArKids1st covered 42,761 children in 6/99, up 5,956 from 36,805 in 12/98, up to 200% of FPL. Title XXI covers only age 16 to 100% FPL.
Delaware	Jun-99 estimated by state.
Hawaii	Program to begin in 2000.
Indiana	Counts for quarters ending 12/31/98 and 6/30/99.
Kentucky	Jun-99 estimated by state to be 9,000 to 10,000.
Minnesota	MinnesotaCare covered 56,527 children in 6/99, up 1,094 from 55,433 in 12/98, up to 275% of FPL. CHIP covers only ages 0-2 from 275% to 280% of FPL.
North Dakota	Phase One coverage for 18 year olds only.
Oklahoma	Estimated by state.
Tennessee	State CHIP plan is pending approval.
Texas	Program covers only 15-18 year olds. The drop off in enrollment may reflect a number of factors, such as children aging out of the program, younger children becoming part of the expansion of Medicaid rather than entering CHIP, and normal cycling off of Medicaid.
Washington	Program to be implemented 1/2000.
Wyoming	Planning to implement program 12/99.

Table 2: State Children's Health Insurance Program (CHIP) Plan Details, by State

State	Type of plan	Age levels	Income levels (as a % of FPL)	Implementation Date[1]
Alabama	Medicaid	0-19	100%	Feb-98
	Separate	0-19	200%	Sep-98
Alaska	Medicaid	0-19	200%	Mar-99
Arizona	Separate	0-19	200% (phased in)	Nov-98
Arkansas	Medicaid	0-19	100%	Oct-98
California	Medicaid	14-19	200%	Mar-98
	Separate	0-11 mo.	200-250%	Jul-98
		1-19	200%	Jul-98
Colorado	Separate	0-17	185%	Apr-98
Connecticut	Medicaid	14-15	185%	Jul-97
		16-18	185%	Jan-98
	Separate	0-19	185%	Jun-98
Delaware	Separate	0-19	200%	Feb-99
District of Columbia	Medicaid	0-19	200%	Oct-98
Florida	Medicaid	15-19	100%	Apr-98
	Separate	0-19	200%	Apr-98
Georgia	Separate	0-18	200%	Nov-98
Hawaii	Medicaid	1-6	134-185%	Jan-00
Idaho	Medicaid	0-19	150%	Oct-98
Illinois	Medicaid	0-19	133%	Jan-98
		0-1*	200%	Jan-98
Indiana	Medicaid	14-19	100%	Oct-97
		0-19	150%	Jul-98
Iowa	Medicaid	0-19	133%	Jul-98
Kansas	Separate	0-19	200%	Jan-99
Kentucky	Medicaid	14-19	100%	Jul-98
	Separate	0-19	200%	Jul-99
Louisiana	Medicaid	6-19	133%	Nov-98
Maine	Medicaid	1-5	133-150%	Jul-98
		6-19	125-150%	Jul-98
	Separate	0-19	151-185%	Aug-98
Maryland	Medicaid	0-19	200%	Jul-98
Massachusetts	Medicaid	0-1	200%	Oct-97
		1-19	150%	Aug-98
	Separate	0-19	150-200%	Oct-97
Michigan	Medicaid	6-19	150%	May-98
	Separate	0-19	200%	Sep-98
Minnesota	Medicaid	0-2	275-280%	Oct-98
Mississippi	Medicaid	15-19	100%	Jul-98
	Separate	6-19	100-133%	Jan-99
Missouri	Medicaid	0-19	200% (300% gross income)	Jul-98

State	Type of plan	Age levels	Income levels (as a % of FPL)	Implementation Date[1]
Montana	Separate	0-19	150%	Jan-99
Nebraska	Medicaid	15-18	100%	May-98
		0-19	185%	Sep-98
Nevada	Separate	0-18	200%	Oct-98
New Hampshire	Medicaid	0-1	185-300%	May-98
	Separate	1-19	185-300%	Jan-99
New Jersey	Medicaid	0-19	133%	Feb-98
	Separate	0-19	133-200%	Mar-98
New Mexico	Medicaid	0-19	186-235%	Aug-98
New York	Separate	0-19	185%	Apr-98
North Carolina	Separate	0-19	185%	Oct-98
North Dakota	Medicaid	17-19	100%	Oct-98
Ohio	Medicaid	0-19	150%	Sep-98
Oklahoma	Medicaid	0-18	185%	Dec-97 (phased in)
Oregon	Separate	0-6	133-170%	Jul-98
		6-19	100-170%	Jul-98
Pennsylvania	Separate	0-19	200%	May-98
		0-19	201-235%	May-98
Rhode Island	Medicaid	0-19	250%	May-98
South Carolina	Medicaid	0-19	150%	Oct-98
South Dakota	Medicaid	0-19	100-133%	Jul-98
Tennessee	Medicaid	0-19	200%	N/A
Texas	Medicaid	15-19	100%	Jul-98
Utah	Separate	0-19	200%	Aug-98
Vermont	Separate	0-18	225-300%	Oct-98
Virginia	Separate	0-19	150%	Oct-98
		0-19***	150-185%	Oct-98
Washington	None	N/A	N/A	N/A
West Virginia	Medicaid	1-6	150%	Jul-98
		6-19	150%	Mar-99
Wisconsin	Medicaid	15-18	100%	Jul-98
		0-18	185%	Jul-99
Wyoming	None	N/A	N/A	N/A

Source: Compiled by The Kaiser Commission on Medicaid and the Uninsured. Data from: National Governors' Association and National Conference of State Legislatures. State Children's Health Insurance Program: Annual Report. 1999; National Conference of State Legislatures: http://www.ncsl.org/programs/health/eligible.htm.

[1] As reported in state plan; implementation may have been delayed in some states.

* Includes prenatal care.

**Subsidized coverage.

***Program operates under 2 components.

HOUSE OF REPRESENTATIVES
WASHINGTON, D. C. 20515

DIANA DEGETTE
FIRST DISTRICT
COLORADO

7-23-99

Dear Chris-

I understand the President has voiced his concern about the slow enrollment rates in the CHIP program. I have introduced legislation, which has over 100 cosponsors, to improve outreach and enrollment in CHIP. I have enclosed the text of my bill, HR 827, and hope to work with you and the President to enroll more of the 4 million eligible children in the program.

Thanks, as usual for your dedication to kids' health.

Best regards,

Diana DeGette

HR 827 IH

106th CONGRESS

1st Session

H. R. 827

To amend titles XIX and XXI of the Social Security Act to improve the coverage of needy children under the State Children's Health Insurance Program (SCHIP) and the Medicaid Program.

IN THE HOUSE OF REPRESENTATIVES

February 24, 1999

Ms. DEGETTE (for herself, Mrs. MORELLA, Mr. WAXMAN, Mr. BROWN of Ohio, Mr. PALLONE, Mr. DEUTSCH, Mr. STUPAK, Mr. MARKEY, Mr. GREEN of Texas, Mr. STRICKLAND, Mrs. CAPPS, Mr. BARRETT of Wisconsin, Mr. TOWNS, Mr. BOUCHER, Mr. GORDON, Mr. KLINK, Mr. SAWYER, Mr. WYNN, Ms. MCCARTHY of Missouri, Mr. LUTHER, Ms. ESHOO, Mr. HALL of Texas, Mr. GILMAN, and Mr. ENGEL) introduced the following bill; which was referred to the Committee on Commerce

---

A BILL

To amend titles XIX and XXI of the Social Security Act to improve the coverage of needy children under the State Children's Health Insurance Program (SCHIP) and the Medicaid Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE- This Act may be cited as the `Improved Maternal and Children's Health Coverage Act of 1999'.

(b) REFERENCES TO SOCIAL SECURITY ACT- Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS- The table of contents of this Act is as follows:

Sec. 1. Short title; references in Act; table of contents.

Sec. 2. Simplified outreach and enrollment.

Sec. 3. Family friendly coverage and enrollment.

Sec. 4. Expanded coverage options.

SEC. 2. SIMPLIFIED OUTREACH AND ENROLLMENT.

(a) USE OF UNIFORM APPLICATION AND COORDINATED ENROLLMENT PROCESS-

(1) SCHIP PROGRAM- Section 2102 (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

`(d) DEVELOPMENT AND USE OF UNIFORM APPLICATION FORMS AND COORDINATED ENROLLMENT PROCESS- A State child health plan shall provide, by not later than the first day of the first month that begins more than 6 months after the date of the enactment of this subsection, for--

`(1) the development and use of a uniform, simplified application form which is used both for purposes of establishing eligibility for benefits under this title and also under title XIX;

`(2) an enrollment process that is coordinated with that under title XIX so that a family need only interact with a single agency in order to determine whether a child is eligible for benefits under this title or title XIX; and

`(3) acceptance and timely response to telephone inquiries and other electronic communications received through the national toll-free system established under section 3 of the Improved Maternal and Children's Health Coverage Act of 1999.'.

(2) MEDICAID CONFORMING AMENDMENT-

(A) IN GENERAL- Section 1902(a) (42 U.S.C. 1396a(a)) is amended--

(i) by striking the period at the end of paragraph (65) and inserting `; and', and

(ii) by inserting after paragraph (65) the following new paragraph:

`(66) provide, by not later than the first day of the first month that begins more than 6 months after the date of the enactment of this paragraph, in the case of a State with a State child health plan under title XXI for--

`(A) the development and use of a uniform, simplified application form which is used both for purposes of establishing eligibility for benefits under this title and also under title XXI;

`(B) establishment and operation of an enrollment process that is coordinated with that under title XXI so that a family need only interact with a single agency in order to determine whether a child is eligible for benefits under this title or title XXI; and

`(C) acceptance and timely response to telephone inquiries and other electronic communications received through the national toll-free system established under section 3 of the Improved Maternal and Children's Health Coverage Act of 1999.'.

(B) EFFECTIVE DATE- The amendments made by subparagraph (A) apply to calendar quarters beginning more than 6 months after the date of the enactment of this Act.

(b) NATIONAL TOLL-FREE INFORMATION LINE- The Secretary of Health and Human Services shall establish, in coordination with State agencies responsible for administration of State medicaid and child health insurance programs and by not later than the first day of the first month that begins more than 6 months after the date of the enactment of this subsection, for a national toll-free telephone number that individuals may access to obtain information on coverage of children under such programs.

(c) FINANCIAL INCENTIVES TO PROMOTE APPROPRIATE ENROLLMENT-

(1) EXPANDED AVAILABILITY OF FUNDING FOR ADMINISTRATIVE COSTS RELATED TO OUTREACH AND ELIGIBILITY DETERMINATIONS- Section 1931(h) (42 U.S.C. 1396u-1(h)) is amended--

(A) in the matter preceding paragraph (1), by striking `TRANSITIONAL' and all that follows through `COSTS' and inserting `INCREASED FEDERAL MATCHING RATE FOR ADMINISTRATIVE COSTS RELATED TO CERTAIN OUTREACH AND ELIGIBILITY DETERMINATIONS';

(B) in paragraph (2), by inserting `either' after `attributable' and by inserting before the period at the end the following: `or to administrative costs of determinations of the eligibility of children and pregnant women for benefits under the State plan under this title or title XXI, outreach to children and pregnant women likely to be eligible for such benefits, and such other outreach- and eligibility-related activities as the Secretary may approve';

(C) in paragraph (3), by striking `and ending with fiscal year 2000'; and

(D) by striking paragraph (4) and inserting the following:

`(4) ENCOURAGING USE OF LOCAL AND COMMUNITY-BASED ORGANIZATIONS IN OUTREACH AND ENROLLMENT ACTIVITIES- The Secretary shall establish a procedure under which, if States do not otherwise obligate the amounts made available under this subsection, local and community-based public or nonprofit organizations (including local and county governments, public health departments, community health centers, children's hospitals, and disproportionate share hospitals) may seek to have administrative costs relating to outreach and enrollment of children and pregnant women under this title and title XXI be treated as administrative costs of a State described in section 1903(a)(7), if such organizations have the permission of the State involved. A State may require such an organization to provide payment of such amounts as the State would otherwise be responsible for in order to obtain payment under this paragraph.'.

(2) USE OF 3 PERCENT OF SCHIP FUNDS AT 90 PERCENT FEDERAL MATCH FOR ENROLLMENT AND OUTREACH ACTIVITIES- Section 2105(b) (42 U.S.C. 1397ee(b)) is amended--

(A) by designating the matter following the dash as a paragraph (1) with appropriate indentation and with the heading `(1) IN GENERAL';

(B) by inserting `subject to paragraph (2)' after `(a)';

(C) by striking `(1)' and `(2)' and inserting `(A)' and `(B)', respectively; and

(D) by adding at the end the following paragraph:

`(2) SPECIAL RULE FOR CERTAIN ENROLLMENT AND OUTREACH ACTIVITIES-

`(A) IN GENERAL- For purposes of subsection (a), in the case of a State that meets the requirement of subparagraph (B), and subject to subparagraph (C), the `enhanced FMAP' is equal to 90 percent with respect to amounts expended on enrollment and outreach activities.

`(B) REQUIREMENTS- Subparagraph (A) shall only apply to a State if the State meets the following requirements:

`(i) NO ASSET TEST- The State does not impose an asset test for eligibility

under the State child health plan or under section 1902(l) with respect to children.

`(ii) COMPLIANCE WITH OUTSTATIONING REQUIREMENT- The Secretary finds that the State is providing for the receipt and initial processing of applications of certain individuals at facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B) consistent with the requirements of section 1902(a)(55).

`(iii) COMPLIANCE WITH SIMPLIFIED OUTREACH AND ENROLLMENT PROVISIONS- The Secretary finds that the State is providing for outreach and enrollment under this title and title XIX consistent

with the requirements of sections 2102(c), 2102(d), and 1902(a)(66).

`(C) LIMITATION TO 3 PERCENT OF ANNUAL ALLOTMENT- Subparagraph (A) shall not apply to amounts expended by a State in a fiscal year in excess of 3 percent of the amount of the amount of its allotment under section 2104 for that fiscal year.'.

(3) EFFECTIVE DATE- The amendments made by this subsection take effect on the date of the enactment of this Act and apply to expenditures made on or after the date of the enactment of this Act.

(d) ADDITIONAL ENTITIES QUALIFIED TO DETERMINE MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN- Section 1920A(b)(3)(A)(i) (42 U.S.C. 1396r-1a(b)(3)(A)(i)) is amended--

(1) by striking `or (II)' and inserting `, (II)'; and

(2) by inserting `eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State child support enforcement agency, a child care resource and referral agency, or a State office or private contractor that accepts applications for or administers a program funded under part A of title IV or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), or (IV) any other entity the State so deems' before the semicolon.

SEC. 3. FAMILY FRIENDLY COVERAGE AND ENROLLMENT.

(a) ASSURING COORDINATION OF PEDIATRIC PROVIDERS WITHIN A FAMILY-

(1) IN GENERAL- Section 2103 (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

`(g) STEPS TAKEN TO COORDINATE PROVISION OF PEDIATRIC CARE WITHIN A FAMILY- To the extent a State child health plan provides coverage other than through providing benefits under the State's medicaid plan under title XIX, the State child health plan--

`(1) shall specify methods being used to ensure that children within a family who are eligible for assistance under the plan are allowed to be seen by the same pediatric provider or group of pediatric providers in a manner that permits the coordinated receipt of care by

children in the same family; and

`(2) shall include a description of such methods in each annual report submitted under section 2108(a).'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) applies on the date of the enactment of this Act and to reports submitted for years beginning with 1999.

(b) Reduction in Burden of Administering Cost-sharing Provisions-

(1) STATE RESPONSIBLE FOR ASSURING CAP ON COST-SHARING NOT EXCEEDED- Section 2103(e)(3) (42 U.S.C. 1397cc(e)(3)) is amended by adding at the end the following new subparagraph:

`(C) STATE AND CONTRACTORS RESPONSIBLE FOR APPLYING LIMITATIONS ON COST-SHARING- The State child health plan shall provide that responsibility for assuring compliance with the limitations on cost-sharing under this paragraph falls on the State and on its contractors, and not on beneficiaries and their families.'.

(2) STATE OPTION OF FLAT LIMIT ON OUT-OF-POCKET EXPENDITURES- Section 2103(e)(3)(B) (42 U.S.C. 1397cc(e)(3)(B)) is amended by inserting before the period at the end the following: `(or, at the option of a State, a limiting amount which is not greater $500)'.

(3) EFFECTIVE DATE- The amendment made by paragraph (1) takes effect on the date that is 30 days after the date of the enactment of this Act.

(c) Prohibition of Waiting Periods-

(1) IN GENERAL- Section 2102(b)(1)(B) (42 U.S.C. 1397bb(b)(1)(B)) is amended--

(A) by striking `and' at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting `; and'; and

(C) by adding at the end the following new clause:

`(iii) shall not permit the use of any mandatory waiting period (including any such period in order to carry out paragraph (3)(C)), unless the Secretary finds that the imposition of such a period would

not be contrary to the provisions of this title.'.

(2) EFFECTIVE DATE- The amendments made by paragraph (1) apply to assistance furnished on or after the date of the enactment of this Act.

(d) GRACE PERIOD BEFORE DISENROLLMENT FOR NONPAYMENT OF PREMIUMS-

(1) IN GENERAL- Section 2103(e) (42 U.S.C. 1397ee(e)) is amended by adding at the end the following new paragraph:

`(5) DISENROLLMENT FOR NONPAYMENT OF PREMIUMS-

`(A) NOTICE OF NONPAYMENT- If a State child health plan requires the payment of a premium for enrollment and such a premium is not paid on a timely basis, the State shall provide, before terminating coverage under the plan, for--

`(i) notice of nonpayment at such time and at the beginning of the last month of the State specified enrollment period described in subparagraph (C) if the premium is still unpaid at that time; and

`(ii) an opportunity for a hearing and a grace period (described in subparagraph (B)) in which the premium may be paid and no penalty will apply for the late payment.

`(B) GRACE PERIOD- The grace period under this subparagraph, in the case of nonpayment for a month--

`(i) before the last month of a State specified enrollment period described in subparagraph (C), is for the remainder of the State specified enrollment period; or

`(ii) for the last month of such period, is for a period of at least 1 month.

`(C) STATE SPECIFIED ENROLLMENT PERIOD- For purposes of applying this paragraph--

`(i) the State child health plan shall specify an enrollment period, which shall be a period of at least 3 months; and

`(ii) after each such enrollment period for an individual (if coverage is not terminated under the plan during such period), a new enrollment period (of the length specified in clause (i)) shall start again for the individual at the end of the previously specified enrollment period.

`(D) GOOD CAUSE WAIVER- The State child health plan shall establish rules allowing waiver for good cause of termination of enrollment for nonpayment of premiums.

`(E) PERMITTING APPLICATION OF WAITING PERIOD IN CERTAIN REENROLLMENT CASES- In the case of a child whose coverage under a State child health plan has been terminated under this paragraph for nonpayment of premiums and whose period of coverage under the plan without premium payment exceeded 1 month, the plan may require, as a condition of reenrollment under the plan, a waiting period that equals the number of months of such coverage without premium payment, but in no case may such a waiting period exceed 3 months.'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) applies to disenrollments occurring on or after the date that is 30 days after the date of the enactment of this Act.

SEC. 4. EXPANDED COVERAGE OPTIONS.

(a) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR SCHIP AND MEDICAID BENEFITS FOR CHILDREN LOSING MEDICAID OR SCHIP ELIGIBILITY-

(1) LOSS OF MEDICAID ELIGIBILITY- Section 1902(a)(66) (42 U.S.C. 1396a(a)(66)), as inserted by section 2(a)(2), is amended--

(A) by striking `and' at the end of subparagraph (B),

(B) by striking the period at the end of subparagraph (C) and inserting `; and'; and

(C) by adding at the end the following new subparagraph:

`(D) the automatic assessment, in the case of a child who loses eligibility for medical assistance under this title on the basis of changes in income, assets, or age, of whether the child is eligible for benefits under title XXI.'.

(2) LOSS OF SCHIP ELIGIBILITY- Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (C) the following new subparagraph:

`(D) that there is an automatic assessment, in the case of a child who loses eligibility for child health assistance under this title on the basis of changes in income, assets, or age,

of whether the child is eligible for medical assistance under title XIX;'.

(3) EFFECTIVE DATE- The amendments made by paragraphs (1) and (2) apply to children who lose eligibility under the medicaid program under title XIX, or under a State child health insurance plan under title XXI, respectively, of the Social Security Act on or after the date that is 30 days after the date of the enactment of this Act.

(b) OPTIONAL COVERAGE OF LOW-INCOME, UNINSURED PREGNANT WOMEN UNDER A STATE CHILD HEALTH PLAN-

(1) IN GENERAL- Title XXI is amended by adding at the end the following new section:

`SEC. 2111. OPTIONAL COVERAGE OF LOW-INCOME, UNINSURED PREGNANT WOMEN.

`(a) OPTIONAL COVERAGE- Notwithstanding any other provision of this title, a State child health plan may provide for coverage of pregnancy-related assistance for targeted low-income pregnant women in accordance with this section, but only if the State has established an income eligibility level under section 1902(l)(2)(A) for women described in section 1902(l)(1)(A) that is 185 percent of the income official poverty line.

`(b) DEFINITIONS- For purposes of this section:

`(1) PREGNANCY-RELATED ASSISTANCE- The term `pregnancy-related assistance' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women, except that the assistance shall be limited to services related to pregnancy (which include prenatal, delivery, and postpartum services) and to other conditions that may complicate pregnancy and shall not include prepregnancy services and supplies.

`(2) TARGETED LOW-INCOME PREGNANT WOMAN- The term `targeted low-income pregnant woman' has the meaning given the term targeted low-income child in section 2110(b) as if any reference to a child were deemed a reference to a woman during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

`(c) REFERENCES TO TERMS AND SPECIAL RULES- In the case of, and with respect to, a State providing for coverage of pregnancy-related assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

`(1) Any reference in this title (other than subsection (b)) to a targeted low income child is deemed to include a reference to a targeted low-income pregnant woman.

`(2) Any such reference to child health assistance with respect to such women is deemed a reference to pregnancy-related assistance.

`(3) Any such reference to a child is deemed a reference to a woman during pregnancy and the period described in subsection (b)(2).

`(4) The medicaid applicable income level is deemed a reference to the income level established under section 1902(l)(2)(A).

`(5) Subsection (a) of section 2103 (relating to required scope of health insurance coverage) shall not apply insofar as a State limits coverage to services described in subsection (b)(1) and the reference to such section in section 2105(a)(1) is deemed not to require, in such case, compliance with the requirements of section 2103(a).

`(6) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any pre-existing condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

`(d) NO IMPACT ON ALLOTMENTS- Nothing in this section shall be construed as affecting the amount of any initial allotment provided to a State under section 2104(b).

`(e) APPLICATION OF FUNDING RESTRICTIONS- The coverage under this section (and the funding of such coverage) is subject to the restrictions of section 2105(c).

`(f) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING PREGNANCY-RELATED ASSISTANCE- Notwithstanding any other provision of this title or title XIX, if a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the children's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan (or, in the case of a State that provides such assistance through the provision of medical assistance under a plan under title XIX, to have applied for medical assistance under such title and to have been found eligible for such assistance under such title) on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance.

During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).'.

(2) STATE OPTION TO USE ENHANCED FMAP FOR COVERAGE OF ADDITIONAL PREGNANT WOMEN UNDER THE MEDICAID PROGRAM- Section 1905 (42 U.S.C. 1396d) is amended--

(A) in subsection (b), by inserting `and in the case of a State plan that meets the condition described in subsections (u)(1) and (u)(4)(A), with respect to expenditures described in subsection (u)(4)(B) for the State for a fiscal year' after `for a fiscal year,';

(B) by redesignating paragraph (4) of subsection (u) as paragraph (5); and

(C) by inserting after paragraph (3) of subsection (u) the following new paragraph:

`(4)(A) The condition described in this subparagraph for a State plan is that the plan has established an income level under section 1902(l)(2)(A) with respect to individuals described in

section 1902(l)(1)(A) that is 185 percent of the income official poverty line.

`(B) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for women described in section 1902(l)(1)(A) whose income exceeds the income level established for such women under section 1902(l)(2)(A)(i) as of the date of the enactment of this paragraph but does not exceed than 185 percent of the income official poverty line.'.

(3) CONFORMING AMENDMENTS- Section 2102(b)(1)(B) (42 U.S.C. 1397bb(b)(1)(B)) is amended--

(A) by striking `and' at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting `; and'; and

(C) by adding at the end the following new clause:

`(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income child who is pregnant, if the State provides for coverage of pregnancy-related assistance for targeted low-income pregnant women in accordance section 2111.'.

(4) EFFECTIVE DATE- The amendments made by this subsection take effect on the date of the enactment of this Act and apply to allotments for all fiscal years.

(c) STATE OPTION FOR COVERAGE OF QUALIFIED ALIEN CHILDREN UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAMS-

(1) MEDICAID-

(A) CATEGORICALLY NEEDY- Section 1902(a)(10)(a)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended--

(i) by striking `or' at the end of subclause (XIII);

(ii) by adding `or' at the end of subclause (XIV); and

(iii) by adding at the end the following new subclause:

`(XV) who are described in section 1905(a)(i) and who would be eligible for medical assistance (or for a greater amount of medical assistance) under the State plan under this title but for the provisions of section 403 or section 421 of Public Law 104-193, but the State may not exercise the option of providing medical assistance under this subclause with respect to a subcategory of individuals described in this subclause;'.

(B) MEDICALLY NEEDY- Section 1902(a)(10)(C)(i)(I) (42 U.S.C. 1396a(a)(10)(C)(i)(I)) is amended by inserting `(and such criteria may provide for eligibility of individuals described in subparagraph (A)(ii)(XV))' after `medical assistance'.

(2) CHILDREN'S HEALTH INSURANCE PROGRAM- Section 2110(b) (42 U.S.C. 1397jj(b)) is amended--

(A) in paragraph (1)(A), by inserting before the semicolon `(including, at the option of the State, a child described in paragraph (3)(B))'; and

(B) in paragraph (3)--

(i) by striking `SPECIAL RULE- ' and inserting `SPECIAL RULES-

`(i) HEALTH INSURANCE COVERAGE- ' by indenting the remainder of the text accordingly; and

(ii) by adding at the end the following new subparagraph:

`(B) ELIGIBILITY FOR QUALIFIED ALIEN CHILDREN- For purposes of paragraph (1)(A), a child is described in this subparagraph if--

`(i) the child would be determined eligible for child health assistance under this title but for any or all of the provisions of sections 403 and 421 of Public Law 104-193; and

`(ii) the State exercises the option to provide medical assistance to the category of individuals described in section 1902(a)(10)(A)(ii)(XV).'.

(3) PROHIBITION ON SEEKING SUPPORT FROM SPONSOR- Section 213A(b) of the Immigration and Nationality Act (8 U.S.C. 1183a(b)) is amended by adding at the end the following new paragraph:

`(4) EXCEPTION FOR CHILD MEDICAID OR SCHIP ASSISTANCE- The preceding provisions of this subsection shall not apply to--

`(A) medical assistance furnished under the State plan under title XIX of the Social Security Act to an individual eligible for such assistance because of subclause (XV) of paragraph (10)(A)(ii) of section 1902(a) of such Act (42 U.S.C. 1396a(a)) or because of the reference to such subclause in paragraph (10)(C) of such section; or

`(B) child health assistance furnished under the State child health plan under title XXI of such Act to a child eligible for such assistance because of the provisions of section 2110(b)(3)(B) of such Act (42 U.S.C. 1397jj(b)(3)(B)).'.

(d) CLARIFICATION OF COVERAGE UNDER VACCINE FOR CHILDREN PROGRAM-

(1) IN GENERAL- Section 1928(b)(2)(A)(ii) (42 U.S.C. 1396s(b)(2)(A)(ii) is amended by inserting `, except that for purposes of this paragraph a child who is only insured under title XXI shall be considered as being not insured' after `not insured'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall take effect as if included in the enactment of the Balanced Budget Act of 1997.

(e) ELIMINATION OF FUNDING OFFSET FOR EXERCISE OF PRESUMPTIVE ELIGIBILITY OPTION-

(1) IN GENERAL- Section 2104(d) (42 U.S.C. 1397dd(d)) is amended by striking `shall be reduced by the sum of' and all that follows through `(2) the amount of payments under such section' and inserting `shall be reduced by the amount of payments under section 1903(a)(1)'.

(2) EFFECTIVE DATE- The amendment made by paragraph (1) first applies for allotments for fiscal year 1999.

(f) PROGRAM COORDINATION WITH THE MATERNAL AND CHILD HEALTH PROGRAM (TITLE V)-

(1) IN GENERAL- Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended--

(A) by striking `and' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting `; and'; and

(C) by adding at the end the following new subparagraph:

`(F) that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting.'.

(2) CONFORMING MEDICAID AMENDMENT- Section 1902(a)(11) (42 U.S.C. 1306a(a)(11)) is amended--

(A) by striking `and' before `(C)'; and

(B) by inserting before the semicolon at the end the following: `, and (D) provide that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting'.

(3) EFFECTIVE DATE- The amendments made by this subsection take effect on January 1, 1999.

END

National Governors' Association
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NGA *Center for Best Practices*

July 21, 1999

FAX MEMORANDUM

To:	Vicki Rivas-Vasquez (DHHS)	202-690-5673
	Joyce Somsack (HCFA)	410-786-9665
	Marcia Brand (HRSA)	301-443-1246
	Devorah Adler (WH)	202-456-5557
From:	Emily V. Cornell, NGA	
Re:	Call detail for June 1999	
Pages:	3	

Attached is the summary from AT&T that shows the call detail for the entire month of June 1999.

Total calls made in June 1999:	18,454
Average number of calls per weekday:	449
Average length of call:	2.17 minutes
Total calls made since February 23, 1999:	105,581

Call me at 202-624-7879 if you have any questions.

AT&T Advanced Features Executive Summary

AT&T

Account Number	Subaccount Number	Bill Date
999 006-5113 458	999 006-5113 458	Jul 1, 1999

Summary of Advanced Features Usage Daily Analysis

Date	Geographic Routing *	Time / Day Manager	Quick Call Allocator	Call Prompter	Network Queuing	NAA	Courtesy Response	ADR Busy	ADR Ring No Answer	Other Final Handling
Previous Usage	0	0	0	0	0	0	0	0	0	0
Jun 1 - Tue.	976	0	0	0	0	0	48	0	0	3
2 - Wed.	880	0	0	0	0	0	48	0	0	0
3 - Thu.	788	0	0	0	0	0	44	0	0	0
4 - Fri.	547	0	0	0	0	0	60	0	0	0
5 - Sat.	169	0	0	0	0	0	17	0	0	0
6 - Sun.	141	0	0	0	0	0	15	0	0	0
7 - Mon.	923	0	0	0	0	0	46	0	0	0
8 - Tue.	767	0	0	0	0	0	46	0	0	1
9 - Wed.	767	0	0	0	0	0	47	0	0	0
10 - Thu.	739	0	0	0	0	0	36	0	0	2
11 - Fri.	614	0	0	0	0	0	38	0	0	0
12 - Sat.	302	0	0	0	0	0	29	0	0	2
13 - Sun.	545	0	0	0	0	0	34	0	0	0
14 - Mon.	1,535	0	0	0	0	0	105	0	0	1
15 - Tue.	950	0	0	0	0	0	47	0	0	1
16 - Wed.	825	0	0	0	0	0	51	0	0	0
17 - Thu.	692	0	0	0	0	0	32	0	0	0
18 - Fri.	537	0	0	0	0	0	38	0	0	2
19 - Sat.	175	0	0	0	0	0	10	0	0	0
20 - Sun.	114	0	0	0	0	0	3	0	0	0
21 - Mon.	678	0	0	0	0	0	22	0	0	0
22 - Tue.	691	0	0	0	0	0	45	0	0	0
23 - Wed.	568	0	0	0	0	0	30	0	0	23
24 - Thu.	552	0	0	0	0	0	37	0	0	10
25 - Fri.	471	0	0	0	0	0	28	0	0	4
26 - Sat.	84	0	0	0	0	0	13	0	0	0
27 - Sun.	113	0	0	0	0	0	8	0	0	0
28 - Mon.	858	0	0	0	0	0	35	0	0	0
29 - Tue.	788	0	0	0	0	0	52	0	0	2
30 - Wed.	673	0	0	0	0	0	33	0	0	0
TOTALS	18,454	0	0	0	0	0	1,114	0	0	51

* Geographic Routing includes Country Code, Area Code, Exchange, and Caller Recognition Routing

AT&T Advanced Features Executive Summary

AT&T

Account Number	Subaccount Number	Bill Date
999 006-5113 458	999 006-5113 458	Jul 1, 1999

Daily Analysis

Date	Number of AT&T Complete Calls	Total Time hh:mm:ss	Average Call Length mmmm:ss.t	Number of Incompletes With Features Usage
Previous Usage	0	:00	:00.0	0
Jun 1 - Tue.	644	25:55:45	2:24.9	332
2 - Wed.	583	26:55:24	2:46.2	297
3 - Thu.	496	23:27:33	2:50.2	292
4 - Fri.	407	16:29:33	2:25.8	140
5 - Sat.	145	2:47:47	1:09.4	24
6 - Sun.	106	1:41:58	:57.7	35
7 - Mon.	541	23:13:55	2:34.5	382
8 - Tue.	588	22:59:23	2:28.7	179
9 - Wed.	593	25:29:59	2:34.8	174
10 - Thu.	567	24:34:26	2:36.0	172
11 - Fri.	486	21:54:01	2:42.2	128
12 - Sat.	257	5:16:09	1:14.2	45
13 - Sun.	441	6:34:51	:55.6	104
14 - Mon.	1,060	44:23:43	2:30.7	475
15 - Tue.	762	31:57:49	2:31.0	188
16 - Wed.	615	25:28:14	2:29.8	210
17 - Thu.	560	22:05:04	2:21.9	132
18 - Fri.	446	15:07:11	2:02.0	91
19 - Sat.	137	2:36:41	1:08.6	38
20 - Sun.	82	1:21:00	:59.2	32
21 - Mon.	567	20:16:45	2:08.7	111
22 - Tue.	514	20:08:40	2:21.0	177
23 - Wed.	449	16:21:13	2:11.1	119
24 - Thu.	395	14:51:10	2:15.0	159
25 - Fri.	350	12:37:45	2:09.9	121
26 - Sat.	63	1:02:02	:59.0	21
27 - Sun.	96	52:01	:32.5	17
28 - Mon.	494	18:23:05	2:15.9	356
29 - Tue.	578	21:37:15	2:14.6	210
30 - Wed.	448	18:02:01	2:26.9	225
TOTALS	15,468	514:13:39	2:17.4	4,986

Call Duration Distribution

Duration	Number of AT&T Complete Calls	Total Time hh:mm:ss
1 TO 30 Seconds	3,042	15:11:32
30+ TO 60 "	2,166	27:02:27
1+ TO 2 Minutes	3,351	80:51:19
2+ TO 3 "	1,777	72:02:27
3+ TO 5 "	1,612	105:42:52
5+ TO 10 "	1,815	137:05:42
10+ TO 30 "	317	73:03:28
30+ TO 60 "	7	0:04:15
60+ TO 120 "	1	1:11:36
OVER 120 "	0	:00

Management Statistics

Monthly Analysis

COMPLETE CALLS:	
Total Number of Calls Processed:	15,468
Total Time:	514:13:39
Average Length of Call:	2:17.4
Busy Area Code By # of Hours of Use:	713
Busy Area Code By # of Calls:	713
Busy Country Code by # of Hours of Use:	N/A
Busy Country Code by # of Calls:	N/A
**Busy Day By # of Hours of Use:	Monday - Jun 14
**Busy Day By # of Calls:	Monday - Jun 14
**Average Calls per Day:	449
**Average Hours of Use per Day:	17:08:27
**Average Calls per Weekday:	552
**Average Hours of Use per Weekday:	22:21:48
INCOMPLETE CALLS:	
Total Number of Calls:	4,986
Busy Area Code By # of Calls:	281
Busy Country Code By # of Calls:	N/A
**Busy Day By # of Calls:	Monday - Jun 14

** Previous usage not included in these statistics

National Conference:
School-Based Enrollment for
Children's Health Insurance Programs

Purpose:

The purpose of this conference is to bring together key education officials and State Children's Health Insurance Program (CHIP) and Medicaid administrators from the States and Territories, and others to capture the outcomes of the National Fall Back to School Campaign for Children's Health Insurance Outreach, and to examine methods for "institutionalizing" school-based enrollments. Conference participants would examine:

(1) linkages between health insurance, health care access and readiness for learning;
(2) schools as a vehicles to facilitate the enrollment of children in state administered health insurance programs;
(3) best practices in school-based outreach and enrollment for children's health insurance;
(4) barriers to school-based enrollment and strategies/models to resolve them; and
(5) recommendation for "institutionalizing" school-based enrollment.

Potential participants from the education arena:

- directors of the States' superintendents' association
- directors of States' school board association
- State education agency heads
- Leaders from PTA/PTO in each state
- Representatives of teacher associations
- Representatives from middle/high school athletic associations
- Representatives from tribal schools
- Migrant education
- Head Start
- Special education representatives
- Groups such as librarian groups; guidance counselor groups
- Channel One broadcasters
- School-based health providers

Potential participants from CHIP/Medicaid arena:

- CHIP/Medicaid administrators
- DHHS staff
- Department of Education staff
- Robert Wood Johnson grantees
- Representatives of eligibility workers groups
- Representatives from advocacy groups

Content to include:

- Overview presentation on uninsured children, Medicaid, CHIP
- USDA presentation on school lunch program and CHIP

- From the field, presentations on what works and what does not work, including the Chicago Public School system experience, Florida Healthy Kids (one of the first states doing school-based enrollment), others
- Break-out sessions by level (elementary, middle, high) to develop strategies by age group
- Sessions on developing partnerships
- Outreach funding
- Getting started: how do we work screening for and enrollment in health insurance into our existing school registration procedures
- Sustaining/institutionalizing school-based enrollments
- Working with parents

Logistics:

- one and one half day conference during November (to capture results of Fall campaign)
- Washington-based hotel
- Logistical support would be provided by HRSA, others

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear State Health Official:

The Department of Health and Human Services (HHS) is pleased to announce the new Health Care Financing Administration (HCFA) Ouutreach webpage that is linked to the existing HCFA Child Health Insurance Program (CHIP) website. The webpage includes **Information for Families** (links to http://www.insurekidsnow.gov) and an **Outreach Information Clearinghouse**. We look forward to HCFA's partners utilizing this Internet site as a forum for sharing their experiences regarding CHIP outreach activities and hope that you will find it beneficial. Below is a description of what you will find on the new webpage.

Information for Families

An Information for Families consumer-oriented Internet site was recently unveiled as part of the White House and National Governors Association's campaign to expand CHIP enrollment. It focuses on consumer friendly, State-specific CHIP information, links to consumer friendly State CHIP websites and the national CHIP information number (1-877-KIDS NOW).

Outreach Information Clearinghouse

The Outreach Information Clearinghouse provides HCFA's partners, as well as other interested parties, a forum for exchanging their outreach experiences with one another. Below is a description of the current links you will find at this new site.

- **Outreach Strategy Corner** - This category is designed to permit all interested parties to share outreach successes, strategies and challenges, so that all States and community based organizations and others engaged in outreach can provide a capsule description of their efforts, as well as contact information for further details. HCFA reserves the right to screen all postings.

- **Effective Outreach Strategies** - This item provides descriptions of successful State practices that may be adapted and utilized to reach uninsured children in other State programs. Tools and guides to assist in outreach are also included. States will consulted to assure that descriptions accurately reflect the State's outreach practices.

- **Outreach Conference Reports** - Includes summaries and complete reports, where available, of various outreach conferences.

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- **Official HCFA CHIP Outreach Guidance** - Includes items such as Dear State Health Official letters, HCFA guides, manual issuances, official reports, surveys, studies, and related policy issuances.

- **Upcoming Outreach Events** - This link allows interested parties to submit information about future activities (e.g., conferences, training, campaign kick-off events, etc.). Information can be submitted to *CHIPOutreach@hcfa.gov*.

- **HCFA Outreach Contacts** - Includes a list of regional office and central office outreach contacts, including phone numbers and e-mail addresses.

Our new website will be continually evolving. As we receive input and feedback, we plan to add items and sections to fulfill your needs. For example, we will be adding an eligibility simplification category under "Effective Outreach Strategies" in the near future. It will include examples of simplified applications, as well as other related information.

Again, we encourage all States, HCFA partners and other interested parties to share information on evolving and emerging outreach practices, successes as well as struggles, by utilizing the "Outreach Strategy Corner." In addition, we will continue to facilitate the exchange of information on State outreach programs in a timely manner, by publishing highlights on the "Effective Outreach Strategies" section. This medium will provide all of us the opportunity to learn from each other how to further pursue effective ways of reaching challenging segments of the population, to resolve outreach problems, and to test successful strategies.

Information on Outreach and the CHIP program can also be found on the Health Resources and Services Administration (HRSA) webpage (www.hrsa.dhhs.gov).

Thank you for your efforts. We look forward to even greater success with the enrollment process as we learn and share with one another. If you have questions or suggestions, please contact your HCFA regional office or Marge Sciulli of Central Office at (410) 786-0691.

Sincerely,

Sally K. Richardson