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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Janet Odonnell to Barbara Wooley re: SSN and DOB (partial) (1 page)	02/22/1999	P6/b(6)
002. fax	Jean Glenn to Barbara Wooley re: SSN and DOB (partial) (1 page)	02/19/1999	P6/b(6)

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FOLDER TITLE:
CHIP [Children's Health Insurance Program] Outreach [Folder 6]

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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]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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b(1) National security classified information [(b)(1) of the FOIA]
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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]

THE WHITE HOUSE

WASHINGTON

November 5, 1999

Francia Smith
Vice President, Consumer Advocate
United States Postal Service
475 L'Enfant Plaza SW
Washington, DC 20260-2200

Dear Ms. Smith:

I am writing to ask for your help in the President's initiative to provide health insurance to children. There have been reports that local post offices in Michigan and Florida have fined school districts for using the non-profit rate in mailing information to families on Medicaid and the Children's Health Insurance Programs (CHIP). In part, this is understandable since each state calls the program something different (see attached list of program names) and CHIP was just created in 1997. However, this is creating fear among schools and others participating in our outreach efforts.

CHIP provides a new, affordable health insurance option for families with too much income to qualify for Medicaid but too little to afford private health insurance for their children. Because few families know about this option, the President has asked a large number of organizations, including schools, to participate in a national campaign to educate families. Only with a sustained, public-private effort can we ensure that families learn about these critical programs and sign their children up.

We are hoping that you can be of assistance in informing post offices that Medicaid and CHIP are indeed public programs and asking that they check with state officials before issuing fines. My staff has spoken with your staff about this issue, and concluded that the best way to do this is may be in the *Postal Bulletin*. As you requested, we have attached draft language to that end.

Your help would be greatly appreciated. Please feel free to call if you need additional information.

Sincerely,

Thanks so much !!!

Christopher C. Jennings
Deputy Assistant to the President
For Health Policy

cc. Odette Horne

SUGGESTED DESCRIPTION OF CHILDREN'S HEALTH PROGRAMS

The Administration and virtually all states have launched a nationwide campaign to enroll uninsured children in Medicaid and the Children's Health Insurance Program (CHIP), government-sponsored health insurance programs. These programs may have different names in your state (see attached list). They provide free or low-cost health insurance to poor and working class children with premium assistance from the Federal and state governments. To increase enrollment of uninsured children, the President has asked a large number of organizations, including schools, to help educate families about these programs. Many are conducting mailings of educational information and applications on these public health insurance program.

Since Medicaid and CHIP are public programs, school district mailings of educational material are eligible for the non-profit postal rate. If you have questions, please call your state health office to confirm the program name before issuing a fine. Thank you.

NAMES OF STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

Each state has a Children's Health Insurance Program (CHIP) that provides health insurance to children whose families make too much to qualify for the Medicaid program but are unable to afford private insurance. The CHIP program is a public program which is financed through a combination of state and Federal dollars. However, in order to avoid the stigma which is sometimes associated with the receipt of public assistance, states have given their programs different names which may not make them easily identifiable as public programs. The names of the 50 state CHIP programs are listed below.

AL	AL-Kids
AK	Kids Care
AR	ARKids First
	ConnectCare
AZ	KidsCare
CA	Healthy Families/Medi-Cal
CO	Child Health Plan
CT	HUSKY
	HUSKY Plus (special needs kids)
DC	Healthy DC Kids
DE	Delaware Healthy Children
FL	Healthy Kids
GA	PeachCare
IN	Hoosier Healthwise
IL	Child Health Initiative
IA	HAWK-I
KS	Health Wave
KY	K-CHIP
LA	LA CHIP
MA	MassHealth

ME	CubCare
MD	Kids Count
MI	MIChild
MO	Managed Care Plus (MC+)
MS	CHIP
MT	CHIP
NE	Kids Connection
NH	Healthy Kids Silver
	Healthy Kids Gold
NJ	NJKidCare
NV	Nevada Check-Up
NY	CHPlus
NC	Health Choice for Children
OK	SoonerCare
OR	Oregon Health Plan
PA	PA CHIP
RI	RIteCare
SC	Partners for Healthy Children
TN	TennCare
VA	Children's Medical Security Insurance Plan
VT	Dr. Dynasaur
WA	Healthy Options
WI	BadgerCare
WY	KidCare

In Hawaii, Idaho, Minnesota, Ohio, South Dakota, Texas, New Mexico, North Dakota, West Virginia and Utah, the CHIP program is either part of the Medicaid program or does not have a special name assigned to it.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

February 23, 1999

Contact: HCFA Press Office
(202) 690-6145

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Overview: *Proposed by President Clinton and passed as part of the historic, bipartisan Balanced Budget Act of 1997, the Children's Health Insurance Program (CHIP) is the largest single expansion of health insurance coverage for children in more than 30 years. Today, nearly 11 million American children -- one in seven -- are uninsured. To reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, this new initiative set aside $24 billion over five years for states to provide new health coverage for approximately 3 million children. To improve the health of our nation's children, the President has challenged the public and private sectors to work together to educate families and help them enroll their children in CHIP or in Medicaid.*

CHIP is a partnership between the federal and state governments that will help provide children with the health coverage they need to grow up healthy and strong. Each state has an allotment of funds based on the number of uninsured children in the state, and the states can draw on a single year's allotment for up to three years. To help states find the parents of eligible children, states are able to use a percentage of their federal funds to expand outreach and ensure that all children eligible for CHIP, as well as Medicaid, are enrolled. The program also includes important cost-sharing protections so that families will not be burdened with heavy out-of-pocket expenses. At President Clinton's insistence, the CHIP program requires that states use this new money to cover uninsured children -- and not replace existing health coverage.

Funds for the program became available to the states on October 1, 1997, and HHS is working closely with states to approve plans in accordance with the new law. States can receive federal matching funds only for actual expenditures to insure children.

Most state CHIP plans have been approved. *Since CHIP implementation began on October 1, 1997, 53 states and U.S. territories have submitted CHIP plans for approval by the Department of Health and Human Services. CHIP plans have been approved for 50 states and U.S. territories. In order of approval they are: Alabama, Colorado, South Carolina, Florida, Ohio, California, New York, Illinois, Michigan, Connecticut, New Jersey, Missouri, Rhode Island, Oklahoma, Massachusetts, Pennsylvania, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, the Virgin Islands, the District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky, Alaska, Vermont, New Mexico, and Hawaii. The following state plans have been submitted and are under review: Tennessee, Guam, and American Samoa. In addition, 11 states have submitted and had amendments approved to expand their CHIP plans. According to states' estimates, 2.5 million children will be covered by October 2000.*

EXPANDING CHILDREN'S ACCESS TO HEALTH COVERAGE

The federal-state Children's Health Insurance Program (CHIP), created under the new Title XXI of the Social Security Act, expands health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. It builds on Medicaid, the federal-state health insurance program that covers approximately 36 million low-income individuals, including 18 million children. Under Medicaid, states currently cover children whose family incomes range generally from below the FPL to as high as 300 percent of poverty. The majority of states cover children in families between 100 and 150 percent of the FPL. In the CHIP program, states may either cover children in families whose incomes are above the Medicaid eligibility threshold but less than 200 percent of poverty, or within 50 percentage points over the state's current Medicaid income limit for children.

Ensuring Meaningful Health Benefits. CHIP gives states flexibility in targeting eligible uninsured children. States may choose to design new child health insurance programs, expand their Medicaid programs, or create a combination of both. States choosing a new children's health insurance program may offer one of the following benchmark plans: the standard Blue Cross/Blue Shield Preferred Provider Option offered by the Federal Employees Health Benefit Program; a health benefit plan offered by the state to its employees; or the HMO benefit plan with the largest commercial enrollment in the state. A state may also choose to offer the "equivalent" of one of the benchmark plans. If a state chooses this option, its plan's total actuarial value must be at least equal to the benchmark plan's and it must include: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and X-ray services; and, well baby/child care services, including immunizations. In addition, if the plan a state chooses as its benchmark includes coverage for prescription drugs, mental health services, vision care, and hearing-related expenses, the state's "equivalent" plan must include similar benefits. Under the law, New York, Pennsylvania and Florida can continue to offer their current benefit packages (with some modifications to comply with the law's cost-sharing protections). States choosing the Medicaid option must offer the full Medicaid benefit package for children.

Limiting Patient Costs. Patient out-of-pocket costs for this program are allowed but are limited. If a state expands its Medicaid program, then existing Medicaid limits apply to the newly enrolled children. If a new health plan is developed, premiums for families whose income is under 150 percent of the poverty level cannot exceed $19 per family per month and copayments must be nominal. Cost sharing is not permitted for well-child, well-baby visits. For families with incomes above 150 percent of poverty, cost-sharing must be based on an income-related sliding scale with an annual total for all children not to exceed five percent of the family's income.

Preventing Cost Shifting. To prevent states from shifting children from the traditional Medicaid program to CHIP, states may not restrict the Medicaid eligibility standards for children that were in place on March 31, 1997. In addition, states must enroll all children who meet Medicaid eligibility rules in the Medicaid program rather than in the new CHIP plan. All states must design their programs to prevent private cost shifting as well. In their child health plans, states must describe methods they will use to prevent "crowd out" or the shifting of children from private insurance to CHIP.

ACCESSING FEDERAL FUNDING

States are eligible to receive an enhanced federal matching rate for CHIP. The funds are drawn from an "allotment" for state programs that expand access to targeted, low-income children under the CHIP program. To access the allotment, plans must be approved by the Secretary of Health and Human Services. Funds will be allocated to each participating state according to their number of uninsured low-income children, accounting for regional cost differences. Available final state allotments for fiscal year 1998 and reserved allotments for fiscal year 1999, which were published in the *Federal Register*, range from $3.5 million to $855 million. States may draw on a single year's allotment for up to three years, and they may use up to 10 percent of the CHIP benefit expenditures for outreach and certain administrative costs. To access the fiscal year 1998 allotment, states must have their CHIP plans approved by the Secretary of Health and Human Services by Sept. 30, 1999. The fiscal year 1999 budget includes $4.275 billion for fiscal year 1999 state allotments.

The Department of Health and Human Services (HHS) is working closely with states as they design CHIP plans that meet the requirements of the new law. HHS has written to each state outlining the program, and has published a preliminary check-list of information states must submit to HHS when applying for their allotments; and answers to the most commonly asked questions from states about how to develop their children's health insurance programs. The department works with states to expedite the development and implementation of state CHIP plans.

EXPANDING OUTREACH

The Clinton Administration has made significant efforts to reach out to families whose children qualify for CHIP. These efforts include:

The Announcement of an Historic Public and Private Commitment to Provide Outreach. On February 23, 1999, the President announced unprecedented new contributions from the private and public sector to help ensure that all children who are eligible for health insurance receive it, including:

- **A new toll-free number, 877-KIDS-NOW, that directs families around the nation to their state enrollment centers.** The President announced that the National Governors' Association, with a grant from Bell Atlantic, has established a national toll-free number to help states reach working parents of uninsured children. The number, 877-KIDS-NOW, will automatically direct callers to their state's enrollment agency.

- **A national radio advertising campaign to promote the *Insure Kids Now* Campaign.** HHS is sponsoring a $1 million national radio advertising campaign to promote the 877-KIDS-NOW toll-free number and to complement states' outreach efforts. The campaign includes a four-week paid radio campaign and public service announcements to be distributed throughout each state.

  A pilot program of the radio advertising campaign was implemented last fall. The nationwide campaign began February 23, 1999, and will run through mid-March in 11 states. The radio campaign will air in other states in April and May.

- **The *www.insurekidsnow.gov* Web site links parents to eligibility and enrollment information.** HCFA launched a Web site, *www.insurekidsnow.gov*, which offers parents a phone number to call for information on children's health insurance coverage in their state, information on how to apply

for coverage, and guidelines for whether they might qualify for their state's plan. In addition, visitors can see and hear messages from First Lady Hillary Rodham Clinton, the nation's governors and other messages about the importance of health insurance for children.

- **Mobilizing Federal Agencies and Federal Employees.** The Federal Interagency Task Force on Children's Health Insurance Outreach released an outreach training kit for use by workers from all federal departments that will participate in the *Insure Kids Now* campaign. The task force was charged by President Clinton in February 1998, to support CHIP and Medicaid outreach and enrollment. The kit contains a presentation outline, posters, and materials that can be used as handouts. In addition, federal departments have promised to distribute more than 140,000 outreach posters to their grantees, field offices, and human services agencies.

Ongoing Outreach Activities

Presidential Directive to Launch a Government-Wide Effort to Enroll Uninsured Children. As the first step in his public-private children's health outreach campaign, the President directed relevant federal departments in February 1998, to commit to outreach activities aimed at enrolling uninsured children in state health insurance programs. In June of 1998, this Federal Interagency Task Force on Children's Health Insurance Outreach prepared a report to the President, outlining activities that federal agencies would undertake to identify and help to enroll in children in Medicaid or other health insurance programs prior to June 1999. The President charged the HHS Secretary with oversight of the implementation of this outreach initiative.

Since then, each of the 10 departments has been actively engaged in outreach activities focused in three areas: educating their workforce; educating families about state health insurance programs; and coordinating cross-agency and public-private efforts to identify and enroll children in these programs. For example, the Department of Agriculture has distributed CHIP information to WIC programs in states. HUD- sponsored Neighborhood Networks centers, which provide computer training at no cost to residents of more than 400 HUD-assisted multifamily housing developments, have started serving as an access point to download Federal and State information about Medicaid and CHIP.

$45 million in commitments from private foundations across the country. The Robert Wood Johnson Foundation will spend $45 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to $10 million over the next 5 years on studies to help understand why eligible children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and in collaboration with the American Academy of Pediatrics, will mobilize corporations such as SmithKline Beecham and Schering Plough, as well as local communities nationwide, in children's health outreach efforts.

Corporate and advocacy organizations reach out to uninsured children. Procter and Gamble, the manufacturer of Pampers diapers, has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, providing information about available health insurance options. Grocery stores and chain drug stores across the country will provide information about the new toll-free number to their customers. The National Education Association will launch an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

CHIP builds on the Clinton Administration's long standing commitment to improving health care for children. The President has issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. In addition, the President recently announced that in 1996, over 90 percent of America's toddlers received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal the Administration set in 1993. And the FDA recently released a rule that requires manufacturers to do studies on pediatric populations for new prescription drugs as well as those currently on the market.

Since 1993, HHS has approved Medicaid waivers for 18 states for comprehensive health care reform projects that have allowed states to control costs and expand coverage. In addition, HHS has approved requests from 19 states for Medicaid waivers as part of larger welfare reform projects, as well as 25 local Medicaid demonstration projects. *When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured.*

Combined, this administration's efforts will help assure that children get the healthy start they need to live long and productive lives.

STATE CHIP PROGRAMS

Descriptions of approved state CHIP programs follow:

Alabama

Alabama could receive as much as $86 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is implementing its CHIP plan in two phases. The first phase expanded Medicaid eligibility to uninsured children under 19 years of age whose family incomes do not exceed 100 percent of the FPL. The AL-Kids program, the second phase, is a separate state children's health insurance program that expands coverage to children up to age 19 whose family income is between 100 and 200 percent of the FPL. AL-KIDS offers coverage comparable to the HMO with the largest insured commercial, non-Medicaid enrollment in the state. With both phases, Alabama expects to insure 36,000 children by September 1999. Alabama is hiring extra outreach workers to increase the number of children located and enrolled in Medicaid. Information on the new program is being advertised through newspapers, public service announcements and through the school system. Alabama was the first state approved on January 30, 1998 and its amendment was approved August 18, 1998.

Alaska

Alaska could receive as much as $7 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Alaska is expanding its Medicaid program for its CHIP plan. Previously, the state covered children up to age 1 in families with incomes up to 185 percent of the FPL, children 1-6 in families with incomes up to 133 percent of poverty, and children ages 6-19 in families with incomes up to 100 percent of poverty. The state is using its Title XXI funds to expand Medicaid coverage to children in families with incomes up to 200 percent of the FPL. Eligible children receive the full Medicaid benefit package and there are no cost sharing requirements. To reach eligible children, the state is working with local governments, schools, health care providers, tribal entities, and non-profit corporations serving children. The state plans to implement expanded eligibility on March 1, 1999 and it expects to enroll 4,900 children by October 2000. Alaska's plan was approved December 11, 1998.

Arizona

Arizona could receive as much as $117 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Arizona is using its CHIP allotment to create, KidsCare, a new health insurance program that covers children from birth through age 15. Income eligibility will increase over time, beginning at 150 percent of the FPL and rising to 175 percent on July 1, 1999, then to 200 percent from 2000 through 2007. The state expects to insure nearly 50,000 children by September 2000. Enrollees receive coverage through established Arizona Health Care Cost Containment System plans and state employee health maintenance organizations that elect to participate in the program. American Indians may choose to receive services through the Indian Health Service as well. Participants pay a $5 copayment for non-emergency use of the emergency room. To assist with outreach, the state has created an Outreach Coordinator position and has sent applications to organizations that serve low-income children. Arizona's CHIP plan was approved on September 18, 1998.

Arkansas

Arkansas could receive as much as $48 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is using its CHIP allotment to expand Medicaid coverage to nearly 3,600 children who would otherwise not have health insurance. It covers children born after September 30, 1982 and prior to October 1, 1983, whose family income is at or below 100 percent of the FPL. Arkansas is currently considering how to structure the second phase of its Title XXI program to cover even more children. The state currently has a Medicaid section 1115 waiver, ARKids First, that serves children through age 18 with family incomes up to 200 percent of the FPL. Outreach activities include radio and TV ads, a direct mail campaign, a toll-free number and print advertising. Arkansas was approved on August 6, 1998.

California

California could receive as much as $855 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is expanding its Medicaid program, known as Medi-Cal, by implementing an income disregard and by making children under age 19 eligible if they have family incomes at or below 10 percent of the FPL. The state is also expanding its current state program, known as Access for Infants and Mothers (AIM), which covers infants up to age 1 from 200 percent to 250 percent of poverty. Through CHIP, California is also expanding its Healthy Families program, which provides coverage for children age 1-19 with family incomes from 100 percent to 200 percent of the FPL. California estimated it will insure 500,000 children by the end of fiscal year 1998. As part of its outreach efforts, California is subcontracting for a media campaign with private and community-based organizations, health brokers and insurance agents to directly identify and assist potential enrollees in filling out the joint application form for the Medi-Cal and Healthy Families program. In addition, California is conducting a provider education campaign to support its outreach effort. California's plan was approved on March 24, 1998.

Colorado

Colorado could receive up to $42 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is expanding children's access to health coverage by building on its own Colorado Child Health Plan. The state expects to cover a total of 23,000 children under this non-Medicaid managed care plan by the third year. The benefit package includes services such as hospital and emergency room transport, inpatient services, medical office visits and prescription drugs. Coverage is provided to children from birth through age 17 for families whose income is at or below 185 percent of the FPL. The state is publicizing the program through press releases, public service announcements, schools, employers, county agencies and regional and social agencies. Colorado's plan was approved on February 18, 1998.

Connecticut

Connecticut could receive approximately $35 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials will use to insure as many as 15,000 new children by June of 2000. The state is using its allotment to both expand its Medicaid population and create a new program based on the state employee's health plan. Under the state's HUSKY program, Medicaid eligibility has been expanded to include children ages 14 through 18 with household incomes of up to 185 percent of the FPL. Previously, the Medicaid program only covered children up to age 13 in families with incomes up to 185 percent of poverty. The state estimates that an additional 14,400 children will be added to the Medicaid program. The new health insurance program, Part B of HUSKY, is targeted toward children up to age 18 in families with incomes up to 235 percent of poverty. The state is applying an income disregard - setting aside certain types of income the family may have - effectively bringing coverage to 300 percent of poverty. Before income disregards are applied, HUSKY Part B charges families with incomes above 235 percent of poverty premiums of $30 per child, with an upper limit of $50 per family. Children with special physical and behavioral health needs receive those services under a special third part of the program, HUSKY Plus. Outreach for the state includes radio and TV ads, a direct mail campaign, brochures/flyers, video, a toll-free number, Web sites and state presentations and mail-in applications. Connecticut's plan was approved on April 27, 1998.

Delaware

Delaware could receive as much as $8 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Delaware is using its CHIP allotment to create a separate state children's health insurance plan which targets children under age 19 whose family incomes are less than 200 percent of the FPL. Coverage is provided through the state employee health plan and includes pharmacy services, mental health and substance abuse care. Monthly premiums are charged on a sliding scale based on income. Delaware officials estimate they will insure about 10,500 children by October 1999. Delaware's plan was approved on September 1, 1998.

District of Columbia

The District of Columbia could receive as much as $12 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The District is expanding its Medicaid program to children from birth to age 19 whose family income is less than 200 percent of the FPL. Enrollees receive the regular Medicaid benefit package and there is no cost sharing for families. The District anticipates enrolling nearly 8,400 children in its program, which is called Healthy DC Kids. As part of its outreach efforts, the District is setting up a telephone hotline to handle inquiries and has created a single, two-page, mail-in application for both Medicaid and CHIP. The District of Columbia's CHIP plan was approved September 17, 1998.

Florida

Florida could receive about $269 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Phase One of Florida's CHIP plan expanded Medicaid eligibility to children in families earning up to 100 percent of the FPL and expanded Florida's Healthy Kids program, a comprehensive program that was piloted in 20 counties, to additional counties. Phase Two created the Florida KidCare Program which consists of: expanding the Healthy Kids program on a state-wide basis and expanding eligibility for the program to children through age 18 in families with incomes up to 200 percent of FPL; creating the MediKids program to provide coverage for children up to age 5; creating the Children's Medical Services Network for children up to 18 with special needs; and expanding Medicaid to cover children ages 15 - 19 to 100 percent of FPL. The state is simplifying its enrollment form and enrollment process and is

developing an outreach strategy. State officials hope to enroll 175,000 children in the combined Florida Kidcare program by July 1, 1999. Florida received its plan approval on March 5, 1998, and its amendment approval for phase two on September 8, 1998.

Georgia

Georgia could receive as much as $125 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Georgia created a separate insurance program for children from age 0-18 whose families have incomes of less than 200 percent of poverty and who are not eligible for Medicaid. Enrollees receive benefits comparable to the current Medicaid package. There is no cost sharing for children under age 6; for children over age 6 there is a monthly premium of $7.50 for one child and $15 for two or more children. The state expects to insure 58,000 children by fiscal year 2000. Georgia's plan was approved September 3, 1998.

Hawaii

Hawaii could receive as much as $9 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state will use its CHIP allotment to expand Medicaid to cover children between ages 1 and 6 with incomes up to 185 percent of the FPL. Enrollees will receive the state's Medicaid benefit package and there will be no out-of-pocket costs to families participating in the program. Hawaii's CHIP plan builds on its Medicaid demonstration program -- QUEST -- which is attempting to provide universal coverage for residents who are not covered under the state's mandatory employer-sponsored insurance program. Hawaii will launch its CHIP plan in January 2000 and plans to submit amendments to expand the program to more children. For outreach activities, the state will collaborate with schools to provide Medicaid and CHIP information. Hawaii will also distribute Medicaid and CHIP information through health care providers, the unemployment office, the Office of Youth Services, places of worship, and activity-based organizations such as sports, scouts, and schools of Hula. In addition, the State will establish a toll-free information line, a Web site and a media campaign on the Medicaid/CHIP program. Hawaii expects to insure nearly 500 children by September 30, 2000. Its plan was approved January 19, 1999.

Idaho could receive as much as $16 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials will use to insure nearly 5,000 children. Idaho is using its new CHIP allotment to expand Medicaid eligibility to children up to age 19 in families with incomes up to 160 percent of the FPL. Due to state legislation, the income threshold is 150 percent of the FPL, effective July 1, 1998. The state has formed a task force to study ways of further expanding Idaho's CHIP program. Children in the Medicaid expansion receive the state's standard Medicaid benefit package, which includes inpatient and outpatient hospital services, inpatient psychiatric care, physician services, dental services, home health services, lab services, and prescription drugs. Outreach activities include mailing postcards to potential enrollees describing Title XXI. The mailing list is comprised of families who have lost cash assistance between April and December 1997. Idaho's plan was approved on June 15, 1998.

Illinois

Illinois could receive as much as $123 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials will use to insure 40,000 additional children over the next three years. With its CHIP allotment, Illinois is expanding Medicaid eligibility for children up to age 19 whose families have incomes at or below 133 percent of the FPL. Prior to the CHIP expansion, the income level for Medicaid

eligibility varied based on the age of the child. Under the new program, income thresholds have been equalized. State outreach efforts include reviewing automated records to identify eligible participants followed by the notification of those individuals. In addition, the Illinois Department of Public Aid is sending a notice to all non-assistance Child Support families informing them of the program and of locations where families can go to enroll their children. Illinois' plan was approved on April 1, 1998.

Indiana

Under the CHIP program, Indiana could receive as much as $71 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Indiana is using its allotment to expand its Medicaid program. The state estimates that it will insure as many as 58,000 more children by the year 2000. The program expands eligibility to children up to age 19 in families with incomes up to 150 percent of the FPL, and the state has formed a task force to study ways to further expand its CHIP program. Children in the Medicaid expansion population receive the state's standard Medicaid benefit package, which includes inpatient and outpatient hospital services, inpatient psychiatric care, physician services, dental services, home health care, lab services and prescription drugs. To raise awareness about the program, the state is launching a media campaign and conducting outreach through state and local government agencies and community organizations. Indiana's CHIP plan was approved on June 26, 1998.

Iowa

Iowa could receive as much as $32 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Iowa is using its new CHIP allotment to expand Medicaid by raising income eligibility in several different age categories. The Medicaid expansion allows children from age 6 - 18 in families whose incomes are up to 133 percent of FPL to enroll. The state's current Medicaid program covers infants up to one year of age whose families have incomes of up to 185 percent of FPL. The benefit package for CHIP is the same as the current Medicaid package, and the state will contract with an organization to run an outreach program. This outreach program works with community and statewide organizations including provider associations, advocacy groups, Native American Tribal Councils and refugee resettlement programs. Officials expect to insure 16,000 children by June 30, 1999. Iowa's plan was approved September 1, 1998.

Kansas

Kansas could receive as much as $31 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. With its CHIP allotment, Kansas is creating a separate insurance program called HealthWave for children through age 18 whose families have incomes of less than 200 percent of the FPL. The benefit package for children enrolled in CHIP is the same as that offered to state employees. Families with incomes above 150 percent of FPL must pay a monthly premium. Families with income between 151 and 175 percent of poverty pay $10 per month per family, and families between 176 and 200 percent of poverty pay $15 per month per family. The state targets low-income children for outreach through the public schools and is offering a toll-free number to access enrollment information. Kansas hopes to enroll 30,000 children by December 31, 1999. Kansas' plan was approved on September 1, 1998.

Kentucky

Kentucky could receive as much as $50 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Kentucky is using its allotment to both expand its Medicaid program and launch a separate insurance program called K-CHIP. Children ages 14-18 who are in families with incomes up to 100 percent of the FPL are enrolled in CHIP as a Medicaid expansion. Children through age 18 in families

with incomes up to 200 percent of the FPL, and who are not eligible for Medicaid, are enrolled in K-CHIP. The K-CHIP benefit plan is a benchmark equivalent to the Standard High Option HMO plan for state employees. Benefits also include all basic services such as inpatient and outpatient hospital services, physicians' surgical and medical services; laboratory and x-ray services, and well-baby and well-child care. There is some cost sharing, but costs cannot exceed 5 percent of family income. Families with incomes between 100 and 133 percent of the FPL pay a $10 premium for a six-month period. Families with incomes between 134 and 149 percent of the FPL pay a maximum premium of $20 for a six-month period. Families with incomes between 150 and 200 percent of the FPL pay a maximum of $120 for a six-month period, and payments can be made at $20 each month or $60 per quarter. To reach eligible children, the state is conducting a media campaign and outreach activities at schools, clinics, community centers, health fairs, health departments, and housing projects. Kentucky expects to enroll nearly 50,000 children by June 2000. Kentucky's plan was approved November 25, 1998.

Louisiana

Louisiana could receive as much as $102 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is using its allotment to expand Medicaid to children ages 6 through 18 whose family income is at or below 100 percent of the FPL. The benefit package is the regular state Medicaid program, and there is no cost sharing for families. The state has launched a large outreach campaign to educate potential CHIP enrollees. The campaign includes media advertising and mailing to specific target audience groups, including low-income working parents, current and former recipients of Families Independence-Temporary Assistance Program, children with special needs, Native Americans, and migrant children. Louisiana estimates it will enroll more than 28,000 children by the end of September 2000. Louisiana's plan was approved October 20, 1998.

Maine

Maine could receive as much as $12 million in federal funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is using its new funds to expand coverage to 10,400 children by July 2000 by combining both a Medicaid expansion and a statewide children's health insurance program, Cub Care. Through CHIP, Maine is expanding coverage to children through age 18 with family incomes up to 185 percent of the FPL. The Medicaid expansion covers children age one through 18 in families with incomes up to 150 percent of poverty. The Cub Care program covers children in families with incomes from 151-185 percent of poverty. State outreach efforts include targeted media and direct mail campaigns. Maine's plan was approved on August 7, 1998.

Marvland

Maryland could receive as much as $62 million in federal CHIP funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Maryland is expanding its Medicaid program to an estimated 15,500 uninsured children. Under the CHIP plan, children up to age 19 whose family incomes are below 200 percent of poverty can receive coverage. Children covered by CHIP receive the Medicaid benefit package. To reach families who might be eligible for CHIP, the state is launching a grassroots information dissemination campaign involving state agencies, advocacy and community groups and provider organizations. In addition, the state is launching a public media and advertising campaign to include television, radio, mass transit and newspaper advertising. Maryland's plan was approved on July 31, 1998.

Massachusetts

Massachusetts could receive as much as $43 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials are using to expand the state Medicaid program and to create a separate Family Assistance Plan. With its federal allotment, the state hopes to bring enrollment in the program to 37,000 children. Massachusetts provides the state's regular Medicaid benefit package to newly-enrolled children. The eligibility level for Medicaid was increased from the current 133 percent of FPL to children in families with incomes of up to 150 percent of poverty. The state is also using its CHIP funds to create the Family Assistance Plan for children with family incomes between 150 and 200 percent of poverty. Uninsured children with family incomes over 150 percent of poverty are eligible for either a "direct coverage option" or for financial assistance for families to purchase dependent coverage through their employers, the so-called "premium assistance option." The Family Assistance Program provides coverage equivalent to the insurance plan offered to federal employees in the state. These families pay a monthly premium of $10 per child with a family maximum of $30 per month. Outreach activities include school-based campaigns, distribution of promotional materials, and giving mini-grants to community organizations to help locate hard-to-find potentially eligible children. Massachusetts's was approved on May 29, 1998.

Michigan

Michigan could receive as much as $92 million in federal funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials are using to insure as many as 133,000 new children by September 2000. The state is using its allotment to implement MIChild. The program provides comprehensive health care coverage to all children under age 19 whose families have incomes at or below 200 percent of the FPL. The benefit package mirrors the state employees' plan and is administered by multiple managed care providers. MIChild imposes co-payments on families with incomes at or below 150 percent of poverty. Some co-payments apply for families between 151-200 percent of poverty. The state's outreach efforts include demographically targeted media campaigns and coordination with relevant community programs and agencies. Michigan's plan was approved on April 7, 1998.

Minnesota

Minnesota has been among the most progressive states in the nation in providing health insurance coverage for children and families. The approval of Minnesota's plan enables the state to lay the groundwork for its CHIP program, which makes available as much as $28 million for both fiscal year 1998 and fiscal year 1999. Minnesota currently covers approximately 50,000 children who would otherwise be uninsured. The state has accomplished this through a Section 1115 Medicaid waiver amendment, granted in 1995. The MinnesotaCare program provides health coverage to pregnant women and children with family incomes up to 275 percent of the FPL. Minnesota's plan was approved July 17, 1998.

Mississippi

Mississippi could receive as much as $56 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Mississippi is expanding Medicaid to cover children ages 15 through 18 in families with incomes up to 100 percent of the FPL. The state estimates it will enroll 12,000 children by the end of fiscal year 2000. Children receive the regular Medicaid benefit package and there are no cost sharing requirements. Mississippi also expanded its CHIP plan with an amendment that creates a new state health insurance program to cover children up to age 19 in families with incomes between 100 and 133 percent of the FPL. The benefit package for the new separate program is equivalent to that offered to state

employees, with the addition of vision, hearing and dental services. There is no family cost-sharing requirement. As part of an outreach plan, Mississippi is developing a broad-based media campaign that includes television, radio and print advertisements. In addition, it is providing information to community health care providers, hospitals, health clinics, Indian reservations and schools. Mississippi's plan was approved October 26, 1998, and its amendment was approved February 10, 1998.

Missouri

Missouri could receive as much as $52 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials will use to insure as many as 90,000 new children by June 30, 1999. Missouri is using its allotment to expand insurance coverage to children within the state's existing Medicaid managed care program, known as MC+. The program expands eligibility to children in families with incomes up to 300 percent of the FPL. Missouri's statewide health care reform demonstration plan was approved through a Section 1115 Medicaid waiver. It allows the state to slightly alter the Medicaid benefit package and also to enroll the CHIP children in Medicaid after the state's CHIP funds are exhausted. This Medicaid waiver also provides coverage for certain adults, including working parents leaving welfare and mothers who otherwise would have lost their Medicaid following childbirth. Outreach efforts are being coordinated at state offices in every county. Free materials are also available and are being distributed to other entities such as social welfare organizations, schools and health care providers. Missouri's plan was approved on April 28, 1998.

Montana

Montana could receive as much as $12 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Montana expects to insure 9,000 children by June 2000 by creating a statewide children's health insurance program. Children under age 19 with family income at or below 150 percent of the poverty level qualify for the Montana CHIP plan. The benefit package mirrors the state employee health plan, including prescription drugs, emergency room services, and mental health and substance abuse treatment services. For families with incomes at or above 100 percent of poverty, the state charges an annual enrollment fee of $12 for one child and $15 for families with two or more children enrolled. Copayments for some services are charged for families whose income is above 100 percent of FPL. Copayments are capped at $200 per family per year. Montana's plan was approved September 11, 1998.

Nebraska

Nebraska could receive approximately $15 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The first phase, Kids Connection Phase I, expanded Medicaid coverage to children age 15 through 18 whose family income is at or below 100 percent of the FPL. Enrollees in Phase 1 received the state's regular Medicaid benefit package. Kids Connection Phase I was expected to enroll about 1,000 children. The amendment, Kids Connection Phase II, expanded Medicaid eligibility to children under age 19 whose family incomes are up to 185 percent of the FPL. Kids Connection II is expected to reach 17,000 children by October 2000. To encourage enrollment, the state is working with advocacy agencies in disseminating pamphlets, brochures, and other types of information. Neither phase has cost-sharing for enrollees. The state's original plan was approved August 7, 1998, and an amendment was approved October 13, 1998.

Nevada

Nevada could receive as much as $30 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state created Nevada Check Up, a statewide health insurance program that provides coverage to

children up to age 18 in families with incomes at or below 200 percent of poverty. The state has estimated that the Nevada Check Up program will cover 43,500 children in its first year. To encourage enrollment, the state has simplified the CHIP application, which is being made available statewide through schools, child care facilities, family resource centers, social service agencies, and other locations where eligible children and/or their parents frequent. The state has also established a toll-free information number, which is listed on posters, marketing brochures, and the application form. Public service announcements are also being planned. Nevada's plan was approved on August 13, 1998.

New Hampshire

New Hampshire could receive as much as $11 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is using its CHIP allotment to expand its Medicaid program and launch a separate statewide children's health insurance program. Healthy Kids-Gold, or Phase I, expands Medicaid eligibility for newborns and infants up to age one in families with incomes up to 300 percent of the FPL. Healthy Kids-Silver, or Phase II, is a separate statewide health insurance plan that mirrors the benefit package offered to federal employees in the state. Healthy Kids-Silver is aimed at children ages 1 to 19 in families with incomes up to 300 percent of poverty. To expand its coverage to this level of family income, the state is applying an income disregard—setting aside certain types of income the family may have. The state expects to insure 4,000 children by September 2000. New Hampshire's plan was approved September 16, 1998.

New Jersey

New Jersey could receive approximately $88 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. State officials hope to insure as many as 102,000 children upon full implementation. The state is using its allotment to create NJKidCare which includes a Medicaid expansion and a new state CHIP plan. The Medicaid expansion provides comprehensive health care coverage to all children under age 19 whose families have incomes at or below 133 percent of the FPL. The new CHIP insurance program is targeted to children in families with incomes above 133 percent to 200 percent of poverty. The new program charges families a $15 per month premium. The state has a fourfold outreach effort which includes: public awareness, targeted outreach, community education, and consumer education. The state is also committed to targeting outreach to special populations such as HIV and the homeless. New Jersey's plan was approved on April 27, 1998.

New Mexico

New Mexico could receive as much as $63 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is using its allotment to expand its Medicaid program for children from birth to age 18 in families with incomes up to 235 percent of the FPL. Enrollees receive the Medicaid benefit package. Families with incomes between 186 and 235 percent of the FPL pay copayments of $5 for most services, but cost sharing cannot exceed five percent of a family's income. In accordance with the CHIP law, preventive services and prenatal care are exempt from cost sharing. Working with a private contractor, the state is conducting a public awareness campaign to inform potential enrollees. In addition, New Mexico is working with the Indian Health Service to assure CHIP access to American Indians. New Mexico expects to insure 5,000 children by September 30, 2000. Its CHIP plan was approved January 11, 1999.

New York

The state could receive as much as $255 million in new funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan, which state officials are using to insure as many as 360,000 additional children within the next three years. New York is expanding its existing CHPlus program, which currently provides insurance to children up to age 19 whose families have incomes at or below 185 percent of the FPL. The state was one of three states for which existing children's health coverage benefit packages were "grandfathered" into the CHIP legislation. CHPlus is a partnership between the state and private insurers with the state subsidizing private coverage for enrollees. The benefit package includes a full range of inpatient and outpatient services. The state's outreach activities include a statewide media campaign that will be conducted by the New York State Department of Health. New York's plan was approved on April 1, 1998.

North Carolina

North Carolina could receive as much as $80 million in new funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. North Carolina is using its CHIP allotment to create a separate state health insurance program to provide coverage to uninsured children whose family income does not exceed 200 percent of the FPL. The state expects to insure 35,000 children once the program is implemented. Families whose incomes are above 200 percent of poverty up to a maximum of 225 percent are able to buy into the program for one year. The benefit package is equivalent to that offered to state employees, plus Medicaid-equivalent benefits for children with special health care needs. North Carolina is improving outreach efforts by simplifying the application forms for both Medicaid and CHIP and by using existing public/private partnerships between local departments of health and social services. North Carolina's plan was approved on July 14, 1998.

North Dakota

North Dakota could receive as much as $5 million in new CHIP funds for both fiscal year 1998 and fiscal year 1999. The approval of North Dakota's plan enables the state to lay the groundwork for its CHIP program and to secure its CHIP allotment. The first phase of the state's program is estimated to enroll 500 children by October 1999 by expanding its Medicaid program to include 18 year old children whose family income is at or below 100 percent of the FPL. Currently, North Dakota's Medicaid program covers children age seven through 17 with family incomes at or below 100 percent of poverty. Children up to age 6 are eligible if their families have incomes at or below 133 percent of poverty. The benefit package is the same as the Medicaid program in the state. North Dakota's plan was approved October 8, 1998.

Ohio

Ohio could receive as much as $116 million in federal funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Ohio is expanding eligibility within its existing Medicaid program. The state is expanding Medicaid eligibility to cover children up to age 19 whose families have incomes at or below 150 percent of the FPL and is hoping to expand coverage to as many as 133,000 uninsured children by 1999. To encourage enrollment, the state is surveying community agencies on how they conduct Medicaid eligibility outreach, and develop media strategies for statewide education provided to Medicaid consumers and providers. Ohio's plan received approval on March 23, 1998.

Oklahoma

Oklahoma could receive as much as $86 million in new funds for both fiscal year 1998 and fiscal year 1999, which state officials are using to expand its Medicaid program. With its federal allotment, the state hopes to expand coverage to 71,000 children by the end of the program's first year. Oklahoma is providing the state's regular Medicaid benefit package to the newly-enrolled children. Oklahoma is providing Medicaid coverage to children born on or after October 1, 1983, with family incomes up to 185 percent of the FPL. The Oklahoma Health Care Authority is collaborating with other interested agencies in the state to develop a marketing and outreach plan. The plan consists of posters, public service announcements, fact sheets, press releases and outdoor advertising. Oklahoma's plan was approved on May 26, 1998.

Oregon

Oregon could receive as much as $39 million in new funds for both fiscal year 1998 and fiscal year 1999, which state officials estimate they will use to enroll approximately 17,000 children in their CHIP program by July 1, 1999. Oregon is expanding coverage to children from birth to age 6 with incomes between 133 percent and 170 percent of the FPL. Coverage is also being extended to children from age 6 to age 19 with family incomes between 100-170 percent of poverty. Children in the new CHIP program receive the same benefit package as children currently enrolled in the state's Medicaid section 1115 waiver demonstration. The benefit package includes inpatient and outpatient hospital services, inpatient psychiatric services, physician services, dental services, home health services, lab services, prescription drugs and other medically necessary services. Oregon is convening a task force of public and private partners to develop a consolidated Medicaid and CHIP outreach plan. Oregon's plan was approved on June 12, 1998.

Pennsylvania

Pennsylvania could receive as much as $117 million in new funds for both fiscal year 1998 and fiscal year 1999, which state officials are using to fund its existing Pennsylvania CHIP program. Pennsylvania is one of three states that had the benefit package of their existing state children's health program "grandfathered" under CHIP. State officials estimate that with the state's initial plan -- approved May 28 -- and amendment approved October 28, Pennsylvania will be able to insure 80-100,000 children by September 1999. The first phase provided coverage to children age one through 16 with family incomes at or below 185 percent of poverty. The amendment to Pennsylvania's CHIP plan expands eligibility for children from birth to age 18 in families with incomes up to 200 percent of the FPL. The benefit package includes a full range of inpatient services. Outreach activities in the state include canvassing local businesses, day care centers, school districts, hospitals, religious organizations, social service agencies and civic groups.

Puerto Rico

Puerto Rico could receive as much as $10 million in new funds for fiscal year 1998 and $39 million for fiscal year 1999 under the CHIP program. Puerto Rico is using its allotment to expand Medicaid coverage to children through age 18 in families with incomes below 200 percent of the commonwealth poverty level ($8,220 for a family of four). Federal CHIP-related funding allows Puerto Rico to cover approximately 20,000 children. Puerto Rico's program also includes children currently under its public health system, which receives no federal funding. Puerto Rico is also unique in that it has elected to contribute more money than the standard federal-state matching funds. Officials in Puerto Rico estimate CHP will cover 165,000 children. Puerto Rico is developing a number of outreach efforts, including

disseminating brochures, leaflets, and posters with information on the CHIP program; launching a broad-based media campaign; and appealing directly to eligible children and families. Puerto Rico's plan was approved June 26, 1998.

Rhode Island

Rhode Island could receive as much as $11 million for both fiscal year 1998 and fiscal year 1999, which state officials are using to insure as many as 3,000 children by the end of fiscal year 2000. Under the first phase of Rhode Island's plan, the state is using its allotment to expand its Medicaid program to provide comprehensive health care coverage to children between the ages of 8 and 15 whose family income is between 100 and 250 percent of the FPL. The program also covers children 15 to 18 whose families have incomes up to 250 percent of poverty. Rhode Island has expand benefits for uninsured children up to age 19 to 300 percent of the FPL. Beginning at 185 percent of the FPL, or about $30,432 for a family of four, families begin paying modest premiums or co-payments. In order to reach the target population, various outreach methods are taking place. The first phase of Rhode Island's outreach efforts, a public information campaign, will last four months. The second phase of outreach will include follow-up and evaluation activities which will last approximately six months. Rhode Island's plan was approved on May 8, 1998 and its amendment was approved February 4, 1999.

South Carolina

South Carolina had already begun to expand its Medicaid program when the new CHIP law was enacted, and could receive over $64 million in additional funds for both fiscal year 1998 and fiscal year 1999. The state is using its share of CHIP funds to expand its Medicaid program, and hopes to enroll an additional estimated 75,000 children. Regular cost-sharing rules apply and eligibility is being extended to children under age 19 whose family incomes are at or under 150 percent of the FPL. The state has placed eligibility workers in public schools, hospitals, clinics, pharmacies and other places frequented by families with potentially eligible children. South Carolina's plan was approved on February 18, 1998.

South Dakota

South Dakota could receive as much as $9 million for both fiscal year 1998 and fiscal year 1999. The state is using its CHIP allotment to expand its Medicaid program to insure 7,400 children in its first year. The state is increasing eligibility limits for children ages 6 to 18 from the current limit of 100 percent of FPL to 133 percent of FPL. The benefit package for children enrolled in CHIP is the same as that offered to other children in the state's Medicaid program. Families are charged for medical care under this CHIP program. The state is identifying eligible children and mailing their families applications. South Dakota's plan was approved on August 25, 1998.

Texas

Texas could receive as much as $561 million in new funds for both fiscal year 1998 and fiscal year 1999, which state officials estimate that they will use to enroll nearly 58,000 children in their CHIP program by October 1, 1999. Texas is using its allotment to expand Medicaid eligibility to children up to age 19 in families with incomes below 100 percent of the FPL. Texas currently covers children from birth to one in families with incomes up to 185 percent of poverty, ages 1-5 up to 133 percent of poverty, ages 6-14 up to 100 percent of poverty, and ages 15-19 up to 47 percent of poverty. Outreach activities include working with the entire network of public health providers to disseminate outreach materials to providers so that they may supply information to families with potentially eligible children. Texas' plan was approved on June 15, 1998.

Utah

Utah could receive as much as $24 million in new funds for both fiscal year 1998 and fiscal year 1999, which state officials estimate will insure 21,000 children in their CHIP program by 2000. Utah is using its CHIP allotment to create a separate state health insurance program to provide coverage to uninsured children up to age 19 whose family incomes do not exceed 200 percent of the FPL. The plan does have some cost sharing for services, but no premiums or enrollment fees are being charged. Copayments and out-of-pocket maximums are determined by income level. The state will use Medicaid eligibility workers already placed in 98 hospitals, community health centers, local health departments, and other allied agencies to determine CHIP eligibility. The state is doing outreach through community presentations, toll-free telephone lines, brochures, flyers and postcards. Utah's plan was approved July 10, 1998.

Vermont

Vermont could receive as much as $4 million in funds for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is creating a separate health insurance program to cover children up to age 18 in families with incomes between 225 and 300 percent of the FPL. Health services to children are delivered by the managed care organizations that currently provide services under the Vermont Health Access Plan, a Medicaid section 1115 waiver. An amendment to the Medicaid waiver was approved November 6, 1998, allowing the state to expand coverage to underinsured children up to 300 percent of the FPL. The benefits package for the Vermont CHIP program is the same as provided through the state's Medicaid program. The state charges beneficiaries a premium of $10 per month per household. Beginning July 1, 1999, providers will be allowed to charge a $10 copayment for office visits. No copayments will be charged for well-baby and well-child visits. Maximum cost sharing is not allowed to exceed 5 percent of a family's income. The state is integrating its outreach activities with the current outreach campaign for Medicaid, which includes advertising, brochures, flyers, and outreach through community health and social service providers. Vermont also offers a toll-free telephone line with information on Medicaid and CHIP. Vermont expects to insure 1,088 children by October 2000. Its CHIP plan was approved December 15, 1998.

Virginia

Virginia could receive as much as $68 million in federal funds for both fiscal year 1998 and fiscal year 1999 to create a separate children's health insurance plan, the Virginia Children's Medical Security Insurance Plan. The plan has two components, the first of which provides coverage for children under age 19 in families with incomes up to 150 percent of the FPL. The second phase, which will begin at a later date, will cover children under age 19 in families with incomes up to 185 percent of the FPL. The difference between the two components is that families with incomes between 150 and 185 percent of the FPL will have out-of-pocket costs imposed through an amendment to this plan. The benefit package is comprehensive and includes inpatient and outpatient care, laboratory services, and substance abuse treatment. To reach eligible children, the state is creating a single mail-in application for both programs. The state is also placing eligibility workers in different locations throughout the state, offering a toll-free hotline number, and coordinating with school districts and local agencies to distribute applications. Virginia estimates it will insure 54,000 children by October 2000. Virginia's plan was approved October 22, 1998.

Virgin Islands

The Virgin Islands could receive nearly $279,000 in new funds for fiscal year 1998 and about $1.1 million in fiscal year 1999. The territory is using its CHIP allotment to expand its Medicaid program to children receiving services through a territory-funded program. CHIP funds are helping to strengthen federal support for children's health in the Virgin Islands. The local government is not expanding eligibility, but the current income level for a family of four is $8,500 – or about half the level of states. The Virgin Islands' plan was approved September 17, 1998.

West Virginia

West Virginia could receive as much as $24 million in new funds for both fiscal year 1998 and fiscal year 1999. The state is using its CHIP allotment to expand Medicaid eligibility to children between the ages of one and five in families with incomes up to 150 percent of FPL. The state currently covers children up to 133 percent of the FPL. The newly covered children receive the regular Medicaid benefit package at no cost to their families. As part of the outreach efforts, the state is including Medicaid information in all free or reduced lunch and textbook applications and the state's toll-free 24-hour hotline includes information on the CHIP program. The state is currently planning an expansion. West Virginia's plan was approved on September 15, 1998.

Wisconsin

Wisconsin could receive as much as $41 million in new funds for both fiscal year 1998 and fiscal year 1999, which state officials will use to expand its Medicaid program. Phase One of the state's BadgerCare plan was estimated to cover an additional 2,000 children with expanded Medicaid eligibility to children ages 15-18 in families with incomes below 100 percent of the FPL. In addition, while the CHIP expansion provides health coverage to children, a waiver for the state's Medicaid program is allowing Wisconsin to enroll the parents of CHIP-eligible children in that program. State officials expect the second phase of the CHIP program to enroll an estimated 23,000 children by October 2000 and the Medicaid waiver to enroll 27,000 adults in BadgerCare. All eligible children receive the full Medicaid benefit package with no out-of-pocket costs for families. Wisconsin's outreach efforts include: public health agencies coordinated efforts with schools; the expansion of school-based clinics in 12 Milwaukee public schools; and inclusion of schools as potential outstation sites for Medicaid eligibility workers. Wisconsin's plan was approved May 29, 1998 and the amendment was approved January 22, 1999.

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NATIONAL GOVERNORS ASSOCIATION

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Raymond C. Scheppach
Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1512
Telephone (202) 624-5300
http://www.nga.org

October 15, 1999

Nancy-Ann DeParle, Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator DeParle:

As you work towards developing regulations for the Children's Health Insurance Program (CHIP), the Governors would like to express our interest in ensuring that any regulations will maximize the potential success of this priority program. We hope that the CHIP regulations will be crafted in the spirit of President Clinton's new Executive Order on Federalism, seeking to preserve state flexibility, foster innovation, and strengthen the state-federal partnership to reach our common goal of ensuring that our nation's children have access to quality health care.

Since enactment as part of the Balanced Budget Act of 1997, states have quickly moved to implement CHIP, without formal regulations, offering health coverage to children as soon as possible. The Health Care Financing Administration (HCFA) provided guidance to the states in the form of "Questions and Answers" and formal letters to state officials. It was on the basis of such documents that states developed their plans and on which the Department issued its approval. The Governors trust that forthcoming regulations will not prohibit state efforts based on previous HCFA guidance.

The Governors also expect that the guidelines will reinforce and expand state flexibility to develop the programs that will work best for each state. Congress gave states the option and flexibility to expand Medicaid or to develop new insurance programs based on private market models. While the nation's Governors remain committed to the Medicaid program and the people it serves, many Governors are interested in exploring other models of providing health insurance through CHIP. President Clinton's executive order reminds us "one-size-fits-all approaches to public policy problems can inhibit the creation of effective solutions." With this in mind, we trust that forthcoming regulations will not narrow available state options or impose additional burdensome requirements, but will seek to preserve the "healthy diversity" in public policy that the President has advocated.

In addition to these general themes, we would like to outline several specific priorities that we hope will be addressed in HCFA regulations and actions:

Waivers. States must have the flexibility to design and implement programs that reduce the number of uninsured children. To this end, the CHIP statute offers several options, including 1115 waiver authority. President Clinton, in his executive order, directs our attention to waiver authority as a means to increase opportunities for utilizing flexible policy approaches at the state level. For CHIP to be a successful and innovative program, states must have the ability to utilize full statutory authority, without artificial restrictions.

Cost Sharing. Congress explicitly stated certain specific parameters for CHIP, such as allowing cost sharing up to 5 percent. The Governors expect that the department will not move beyond its statutory authority in order to make these limitations more restrictive.

Employer-based Coverage. As more than 60 percent of Americans obtain health insurance at work, employer-based CHIP coverage is a natural opportunity to assist hard working families that cannot afford to accept insurance offered by employers for their children. Several barriers must be eliminated before states can effectively utilize this unique opportunity. (1) HCFA has required states to prove that employer-based coverage is actuarially equivalent to the state's CHIP package. Requiring actuarial equivalence determinations for every employer's health plan is an overly burdensome requirement. Developing a more efficient and effective comparative method or allowing for a waiver of the requirement, would ensure that more children receive access to health insurance. (2) HCFA has also required that an employer must contribute at least 60 percent of the cost of coverage. As a state's plan must meet HCFA's cost-effectiveness test, a hard and fast rule about percentages of employer contributions is not necessary. If a state can demonstrate cost-effectiveness while having employers contribute less than 60 percent, there is no reason for the arrangement to not be permitted.

Family Coverage. Significant evidence confirms that children are more likely to receive much-needed health care when the entire family has access to coverage. Many states would like to expand their CHIP programs to cover parents of CHIP kids with state dollars when covering parents does not meet the cost-effectiveness test for budget neutrality. Thus far, the department has not utilized its waiver authority to permit states to expand health insurance to parents of CHIP kids and reduce the rate of uninsured Americans.

Crowd-out. The pressure is on in the states to enroll eligible children in CHIP. But many states are frustrated that children must endure a prescribed period without insurance. States are developing innovative approaches to reducing crowd-out. A "one-size-fits-all" mandatory waiting period prior to enrollment for children that have recently lost access to health insurance may not always be necessary or appropriate. States should have the flexibility to enroll children without artificial time restraints that could stall program development and prevent children from receiving necessary health care as soon as possible.

The nation's Governors share with Congress and the Administration the goal of providing children with high quality and affordable health coverage. We hope that the regulations will reflect the letter and the spirit of the President's executive order on federalism, recognizing that "the states possess unique authorities, qualities, and abilities to meet the needs of the people." We look forward to continuing to work with you on providing for the health of our nations' children.

Sincerely,

Governor Don Sundquist
State of Tennessee
Co-Lead Governor on Health

Governor John Kitzhaber
State of Oregon
Co-Lead Governor on Health

Outreach Efforts

Outreach has been an important aspect of CHIP from the very beginning. In fact, the authorizing statute requires state plans to include an outreach component. Outreach, however, is not a traditional activity for Medicaid and public welfare programs, which generally have viewed their role as being to limit services to those who meet rigorous eligibility criteria, rather than to reach out proactively so as to serve as many individuals as possible. "Outreach is a whole new concept for us, but one that is working and one that is helping Medicaid and CHIP," says Sally Richardson, the HCFA official who oversees both Medicaid and CHIP.

In addition, CHIP must overcome the stigma associated with its connection to Medicaid—eligibility for which until 1996 was linked to eligibility for welfare. The Medicaid-welfare connection also was a problem in the late 1980s, when Medicaid was expanded to cover pregnant women and infants in families with incomes above traditional Medicaid-income ceilings. This was the first time Medicaid aggressively moved to enroll a population that had no connection to welfare, and states found a widespread hesitancy on the part of individuals to enroll, because doing so often necessitated application in person at a welfare office. Some states responded with a range of innovative strategies designed to separate their Medicaid expansion programs from welfare—including the actual enrollment process—as much as possible.

Now facing similar issues with CHIP, states are taking steps to streamline the process to allow individuals to enroll in the program without having to apply at a welfare office. These include "presumptive eligibility," through which health care providers can grant provisional eligibility while a formal application is being processed, and "outstationing," through which eligibility workers who can make formal eligibility determinations are placed directly in health care sites. Many states also distribute applications widely and allow applicants to submit them by mail rather than in person.

States are moving to differentiate CHIP programs from Medicaid in other ways as well. For example, several states are using different names for their CHIP program, such as MIChild in Michigan or Healthy Kids in Florida. In addition, several states are using identification cards that more closely resemble private insurance cards than Medicaid cards.

Notably, however, the CHIP statute includes a cap on expenditures for outreach by states choosing to establish a state-designed program, rather than a Medicaid expansion. The statute limits the outreach funds that may be spent by these states to 10% of the total amount spent by the state on services. Unfortunately, this restricts outreach expenditures in the start-up phases of the program, just when these activities should be at their zenith. Such a cap is particularly ironic, in the view of many observers, since separate state-designed programs may be more attractive to potential enrollees because of the stigma associated with Medicaid-based efforts.

Next Steps

So far, at least, outreach efforts appear to have fallen short of their goals. During a press conference in late July, President Bill Clinton said he was "disappointed" that enrollment in CHIP is "a little slow." Commenting on recent data showing that program enrollment has recently reached the one million mark, Clinton said, "I would have thought by now we'd have almost three million...and we're well behind that."

A few days later, Clinton unveiled a multifaceted effort to boost CHIP enrollment. According to Clinton, the Department of Education is sending letters to school administrators nationwide asking that they take part in the effort. Educators are being asked to make CHIP enrollment part of the school registration process, distribute information at school functions and use applications for reduced-price school lunches to screen for CHIP enrollment. Other federal agencies are expected to become involved as well. The Department of Health and Human Services is developing a nationwide radio campaign to promote awareness of the program. And federal investigators will be sent to states to determine whether applicants have been unfairly denied coverage under CHIP—or Medicaid, enrollment in which has been falling since the enactment of welfare reform in 1996.

Beyond that, as the federal and state governments move to develop more extensive, and aggressive, outreach efforts around CHIP, it is vital that some outreach efforts be aimed at reaching the millions of uninsured adolescents who might be eligible. This could mean targeting printed materials to adolescents, making information available at places frequented by adolescents, conducting media campaigns aimed at adolescents and permitting eligibility determinations at service sites—such as family planning clinics—that see large numbers of young people. In addition, it means that materials developed for parents need to make clear that all their children—adolescents as well as younger children—finally may have a source of affordable insurance coverage.

The research on which this article is based was supported in part by the U.S. Department of Health and Human Services under grant FPR000057. The conclusions and opinions expressed in this article, however, are those of the author and The Alan Guttmacher Institute.

State CHIP Programs Up and Running, But Enrollment Lagging

States have moved swiftly to begin implementing the State Children's Health Insurance Program, which was enacted in 1997 in hopes of providing coverage to millions of uninsured children in the United States. All 50 states and the District of Columbia have secured federal approval for their plans. Most of the plans appear to cover family planning services and supplies for enrolled adolescents, giving the program enormous potential to help 2.7 million uninsured teenagers meet their reproductive health care needs. However, with the number of individuals actually enrolled in the program running well below expectations, attention has switched to the importance of outreach.

By Rachel Benson Gold

When hopes for large-scale health care reform were dashed in the early 1990s, Congress embarked on a series of more incremental—and, therefore, more politically feasible—moves to bring insurance coverage to at least some of the millions of Americans who lack it and to make existing coverage more comprehensive. Passage in 1997 of the State Children's Health Insurance Program (CHIP) was one of the boldest of these incremental moves. CHIP has at its disposal up to $40 billion in federal funds over 10 years to provide health coverage to many of the nation's estimated 12 million uninsured children and adolescents.

Although it was coverage of young children that provided the political momentum, CHIP is targeted at children up to age 19 in families with incomes below 200% of the federal poverty level. Included in that group are 1.3 million females and 1.4 million males—12% of all adolescents aged 13–18. According to the Guidelines for Adolescent Preventive Services issued by the American Medical Association (AMA), all of these adolescents need routine preventive care, including health guidance about sexual development and responsible sexual decisionmaking. At age 19, over three-fourths of females and 85% of males are sexually experienced; according to the AMA guidelines, sexually active teens also need screening for cervical cancer and sexually transmitted diseases, as well as access to family planning services and supplies.

Since the CHIP statute lays out broad outlines within which states may design and operate their own programs, states largely will determine the extent to which CHIP meets the reproductive health needs of enrolled adolescents. States determine age and income eligibility levels and often the benefits that will be provided.

According to a recent analysis by The Alan Guttmacher Institute (AGI) of the plans from all 50 states and the District of Columbia that have been approved by the Health Care Financing Administration (HCFA), 46 states plus the District of Columbia provide coverage to children up to age 19. Two states have lower age limits (16 years in Arkansas and 17 years in Oklahoma), but these states could still cover a significant number of adolescents. Two other states (Hawaii and Minnesota) cover only young children.

Twenty-eight states and the District of Columbia set an income ceiling between 151% and 200% of poverty (see table, page 8). Only 14 states cut off eligibility at 150% of poverty or below, while eight allow enrollees with incomes above 200% of poverty to qualify for coverage.

In addition, the federal statute allows states to determine overall program structure. Twenty-one states and the District of Columbia chose to expand eligibility for their Medicaid programs to cover children and adolescents eligible for CHIP. Sixteen states developed their own, separate programs. The 13 remaining states took a combination approach, typically providing Medicaid coverage to enrollees below a certain income level and state-designed (and often less-comprehensive) coverage to higher income enrollees (see map).

Coverage of Family Planning

The states' decisions on whether to expand Medicaid or create separate programs have important implications for the extent to which CHIP programs will offer covered adolescents access to family planning services and supplies. In the 22 jurisdictions with a Medicaid expansion, as well as in the Medicaid component of the 13 combination plans, enrollees are entitled to the full range of Medicaid-covered services, including maternity care and family planning services and supplies. (The federal Medicaid statute specifically mandates coverage of family planning services to "individuals of childbearing age," including "minors who can be considered to be sexually active.")

Medicaid offers other important protections to enrollees.

Children enrolled in Medicaid—including those enrolled through CHIP—may not be made subject to any cost-sharing requirements, such as copayments or deductibles. (The statute also specifically prohibits cost-sharing for family planning services or supplies.) In addition, Medicaid recipients enrolled in managed care plans may obtain family planning services and supplies from the provider of their choice, even if that provider does not participate in their managed care network.

In contrast to the detailed requirements of Medicaid, states choosing to implement CHIP through a separate program have wide latitude to design their own benefit packages. The statute permits—but does not require—the package to include coverage of family planning services and supplies. Significantly, however, most of the states that have chosen to create an entirely state-designed CHIP program or a combination program with a state-designed component appear to be including coverage of family planning services.

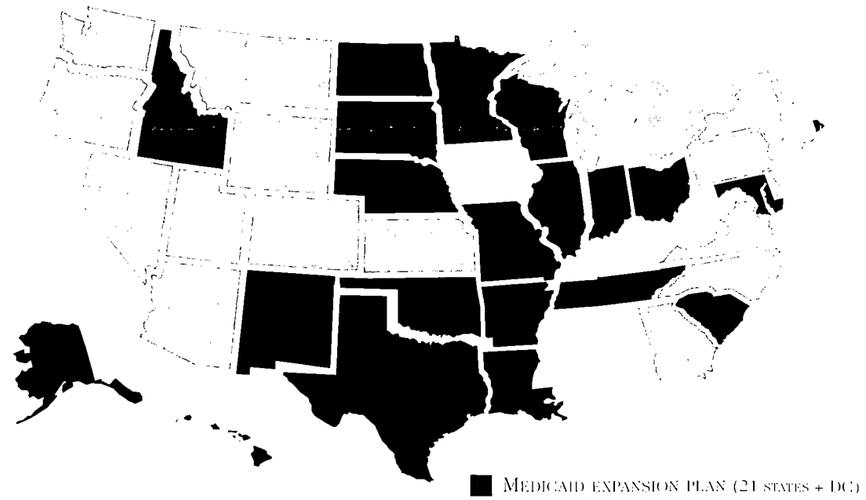
Of the 29 states that have some state-designed component of their program, 16 specifically indicate in their plans that family planning services will be covered for enrolled adolescents, according to the AGI analysis (see table). Most of the remaining state-designed programs simply declare that the general category "prenatal care and prepregnancy family planning services" will be covered but do not provide any additional information on the coverage of either of these two services. The extent to which these state programs actually include a range of family planning services under that broad rubric is not known at this point. Only one state indicates that it does not intend to cover the general category.

All of the state-designed programs cover prescription drugs in general, and 16 states specify in their plans that prescription contraceptive drugs will be covered. Georgia prohibits coverage of all contraceptive devices, however, and Utah specifically excludes the contraceptive implant, Norplant.

The state plans do not provide information on whether enrollees will be required to pay a portion of the cost when obtaining family planning services. However, a recent study by the federal General Accounting Office (GAO) indicates that state-designed programs generally require cost-sharing in an attempt, according to the GAO, both to control utilization and to promote "personal responsibility" for enrollees and their families.

That so many of the state-designed programs appear to cover family planning services and supplies has important implications for CHIP's future. Many observers believe that state-designed programs are likely to dominate the CHIP landscape in the future because they accord states greater latitude to control both benefits and cost. GAO estimates that as many as 14 of the original Medicaid CHIP programs were really "placeholders," designed to allow states to get a program up and running quickly while developing a state-designed program for implementation later.

How State CHIP Programs Are Structured



Key Components of Approved State CHIP Plans

State	Medicaid*	State-Designated Component		
	Income Ceiling	Income Ceiling	Inclusion of Family Planning Services	Inclusion of Contraceptive Drugs/Devices
Alabama	100%	200%	Unspecified	Unspecified
Alaska	200%	-----	-----	-----
Arizona	-----	200%	Specified	Specified
Arkansas	100%	-----	-----	-----
California	100%	200%	Specified	Specified
Colorado	-----	185%	Unspecified	Specified
Connecticut	185%	300%	Specified	Specified
Delaware	-----	200%	Specified	Unspecified
District of Columbia	200%	-----	-----	-----
Florida	100%	200%	Unspecified	Unspecified
Georgia	-----	200%	Specified	Unspecified†
Hawaii	185%	-----	-----	-----
Idaho	150%	-----	-----	-----
Illinois	133%	-----	-----	-----
Indiana	150%	-----	-----	-----
Iowa	133%	185%	Unspecified	Specified
Kansas	-----	200%	Specified	Unspecified
Kentucky	100%	200%	Specified	Specified
Louisiana	150%	-----	-----	-----
Maine	150%	185%	Unspecified	Unspecified
Maryland	200%	-----	-----	-----
Massachusetts	150%	200%	Specified	Specified
Michigan	150%	200%	Specified	Specified
Minnesota	280%	-----	-----	-----
Mississippi	100%	133%	Unspecified	Specified
Missouri	200%	-----	-----	-----
Montana	-----	150%	Specified	Specified
Nebraska	185%	-----	-----	-----
Nevada	-----	200%	Unspecified	Unspecified
New Hampshire	300%‡	300%‡	Unspecified	Specified
New Jersey	133%	350%	Specified	Specified
New Mexico	235%	-----	-----	-----
New York	-----	185%	Unspecified	Specified
North Carolina	-----	200%	Specified	Specified
North Dakota	100%	-----	-----	-----
Ohio	150%	-----	-----	-----
Oklahoma	185%	-----	-----	-----
Oregon	-----	170%	Specified	Unspecified
Pennsylvania	-----	200%	Not Covered§	Unspecified
Rhode Island	300%	-----	-----	-----
South Carolina	150%	-----	-----	-----
South Dakota	133%	-----	-----	-----
Tennessee	200%	-----	-----	-----
Texas	100%	-----	-----	-----
Utah	-----	200%	Specified	Specified**
Vermont	-----	300%	Unspecified	Unspecified
Virginia	-----	185%	Specified	Unspecified
Washington	-----	250%	Unspecified	Unspecified
West Virginia	150%††	150%††	Unspecified	Specified
Wisconsin	185%	-----	-----	-----
Wyoming	-----	133%	Specified	Unspecified

*Medicaid enrollees are entitled to a benefit package that includes family planning services and supplies. †Georgia specifically states that contraceptive devices are not covered. ‡New Hampshire's income ceilings for both the Medicaid and state-designed components are 300%; Medicaid covers from birth to age one, and the state-designed component covers ages 1–18. §Pennsylvania does not cover the general category "prenatal and prepregnancy family planning." **Utah specifically excludes coverage for the contraceptive implant, Norplant. ††West Virginia's income ceilings for both the Medicaid and state-designed components are 150%. Medicaid covers ages 1–5, and the state-deigned component covers ages 6–18.

Date: _____

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Jeanne Lambrew
Fax: 6A431

From: Anne Tumlinson

Number of Pages (excluding cover):

Subject: Transmitted to Congress 7/1 w/ other Medicaid budget proposals

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648

(ii) in subparagraph (B), by striking "subparagraph (A)(iii)(II)" and inserting "subparagraph (A)(iii)(I)".

SEC. 109. ADDITIONAL MEDICAID REBATES FOR GENERIC DRUGS FOR PRICE INCREASES IN EXCESS OF CPI.

(a) REQUIREMENT.—Section 1927(c) (42 U.S.C. 1396r-8(c)) is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (2), respectively, and relocating paragraph (3), as redesignated, after paragraph (2), as redesignated; and

(2) in paragraph (3), as redesignated

(A) in the caption, by striking "FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS";

(B) in subparagraph (A), in the matter preceding clause (i), by striking "a single source drug or an innovator multiple source drug" and inserting "a covered outpatient drug";

(C) in subparagraph (A)(ii)(II)—

(i) by striking "July 1, 1990" and inserting "the date specified in subparagraph (B)(i)"; and

(ii) by striking "September 1990" and inserting "the month specified in subparagraph (B)(ii)";

(D) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A)

the following new subparagraph:

"(B) BASE PERIOD; INFLATION MEASURING PERIOD.—For purposes of subparagraph (A), dates specified in this subparagraph are as follows—

"(i) July 1, 1990, in the case of a single source or innovator multiple source drug, and July 1, 1998, in the case of any other covered outpatient drug.

"(ii) September 1990, in the case of a single source or innovator multiple source drug, and September 1998, in the case of any other covered outpatient drug; and

(E) in subparagraph (C), as redesignated—

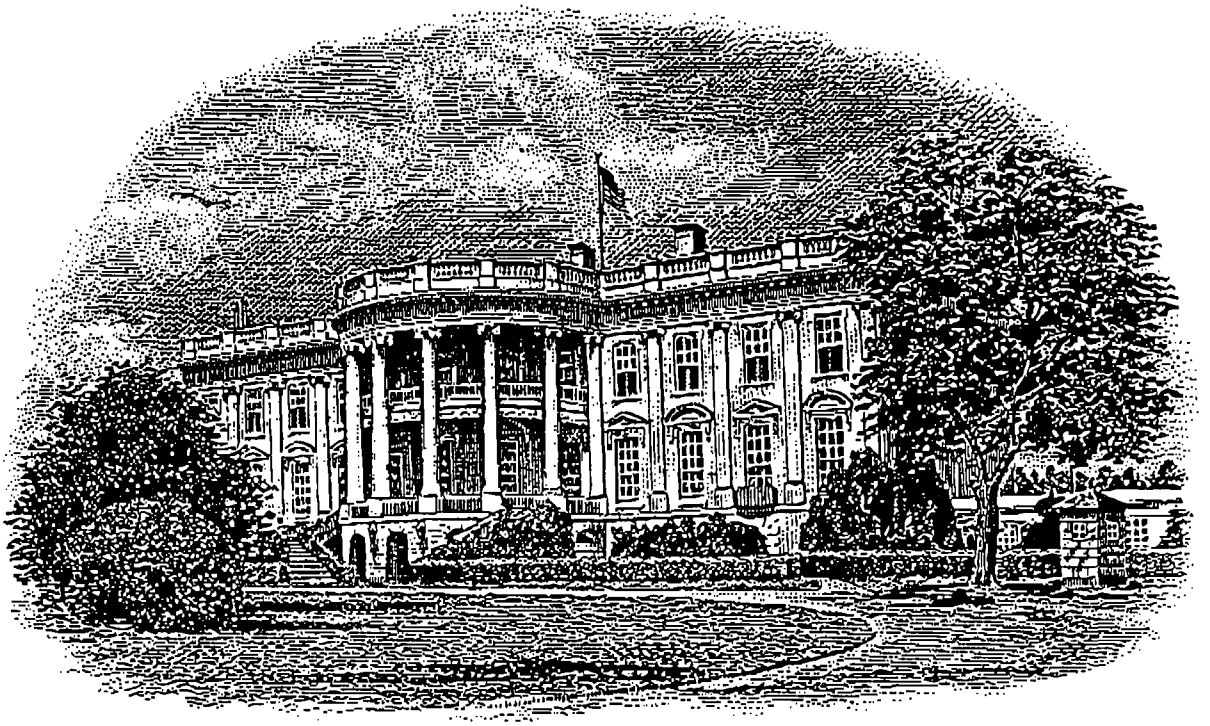
(i) by striking "the calendar quarter beginning July 1, 1990" and inserting "the calendar quarter beginning with the date specified in subparagraph (B)(i)"; and

(ii) by striking "September 1990" and inserting "the month specified in subparagraph (B)(ii)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective with respect to rebate periods beginning on and after October 1, 1990.

SEC. 110. INCREASED FEDERAL MATCH FOR ADMINISTRATIVE COSTS RELATED TO OUTREACH AND ELIGIBILITY DETERMINATIONS FOR CHILDREN AND FAMILIES.

THE WHITE HOUSE
OFFICE OF INTERGOVERNMENTAL AFFAIRS



Please Deliver To: Devorah Adler

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Fax Number: 6-5557

Sender: Jackie Lain phone: 456-5084

Comments: This is the follow-up material I mentioned

THE WHITE HOUSE
1600 Pennsylvania Ave, NW
Washington, DC 20500
202.456.2896 ph • 202.456.2889 fax

PETER MCLAUGHLIN
CHAIR

PHONE 612-348-7884
FAX 612-348-8701
TDD 612-348-7708

BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487

9/28/93

Lynn,

There's a lot to be gained, as we discussed, if the Vice President can get this thing moving to a positive result. We really feel burned on this, particularly the child advocates. We're being tryng to do the right thing here in Minnesota. Thanks for your help on this.

Cordially,

Peter

P.S. I've also included a copy of the letter from Governor Ventura to the President.

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PETER MC LAUGHLIN
COMMISSIONER

612-348-3065
FAX-348-8701

BOARD OF HENNEPIN COUNTY COMMISSIONERS

A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

September 28, 1999

Lynn Cutler
Assistant to the Vice President
The White House
Washington D.C. 20500

Dear Lynn:

As we discussed earlier, Minnesota is currently unable to access its Federal funding for the Children's Health Insurance Program (CHIP). Minnesota's allotment for federal fiscal year (FFY) 1998 is $28.4 million, and for FFY 1999 is $28.2 million. Our inability to receive funding is due to our existing MinnesotaCare health insurance program.

Since 1993, MinnesotaCare has reduced dependence on financial assistance and greatly decreased the number of uninsured children in Minnesota without adverse effects on the availability of insurance in the private sector. The largest number of MinnesotaCare enrollees reside in Hennepin County. The program should, in our view, be treated as a Children's Health Insurance Program and funded as such under Title XXI.

The Minnesota Department of Human Services submitted a waiver request to the Health Care Financing Administration in May of 1998. The waiver proposal was denied in July 1998 on the grounds that it was not appropriate to consider waivers of a new program. Since that time we have tried to find other ways to access these funds and have been unsuccessful. I have attached a document that provides a more complete overview of our efforts to find ways to implement CHIP in Minnesota.

I believe that sufficient time has elapsed for HCFA to reconsider its decision to deny Minnesota the requested waiver. The Minnesota Department of Human Services has developed a number of creative ways that these funds can be used to meet the objectives of Title XXI.

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I think that it is only equitable that Minnesota be able to receive those funds that were allocated by Congress over two years ago. We ought not be punished for our "good deeds" in providing health coverage for children. I would appreciate it you could ask HCFA staff to reconsider the Minnesota waiver request. Mary Kennedy, Medicaid Director for Minnesota (651-282-9921) has been briefed regarding our preliminary conversation and is eager to begin discussing implementation options.

Thank you for your help on this important issue.

Sincerely,

Peter McLaughlin
Hennepin County Commissioner

CC: Mary Kennedy

Enclosure

Minnesota and the Children's Health Insurance Program (CHIP) Overview

Key Issues

- Minnesota's past efforts and commitment to providing affordable health coverage puts the state at a disadvantage in accessing federal funding through Title XXI, the Children's Health Insurance Program. Minnesota's allotment for federal fiscal year (FFY) 1998 is $28.4 million, and in FFY 1999 is $28.2 million. Title XXI matching funds cannot be used for programs such as MinnesotaCare that existed prior to the Balanced Budget Act, with the exception of New York, Florida or Pennsylvania, whose programs were grandfathered into Title XXI.

- MinnesotaCare is an award-winning program which has reduced dependence on financial assistance and greatly decreased the number of uninsured children in Minnesota without adverse effects on the availability of insurance in the private sector. The program should be treated as a Children's Health Insurance Program and funded as such under Title XXI.

Action to date by Minnesota

CHIP plans

Initial state plan: On July 17, 1998, Minnesota received approval from HCFA for a CHIP plan, designed only to secure Minnesota's Title XXI allotment for FFY 1998. The plan expands coverage for infants under age 2 in the Minnesota Medical Assistance program, in families with income from 275-280 percent of poverty. The expansion will most likely cover less than 15 children, and uses only $50,000 of the $28.5-million allotment. The plan assures that Minnesota's CHIP allotments during the first three years will not be redistributed to other states.

Waiver proposal: Minnesota submitted a waiver proposal under Title Y-XI on May 22, 1998, in an effort to gain access to the state's full allotment. The proposal requested recognition of the MinnesotaCare program as a Title XXI Children's Health Insurance Program, to allow the state to draw enhanced matching funds on certain children in the MinnesotaCare program. Minnesota also requested a waiver of the 10-percent limit on administrative and other expenditures, to allow Minnesota to utilize alternative and creative strategies in providing health coverage for children who are eligible for MinnesotaCare, but for various reasons haven't

enrolled. The waiver proposal was denied in July 1998 on the grounds that it was not appropriate to consider waivers of a new program.

Third state plan effort: The 1998 Minnesota Legislature directed the Department of Human Services (DHS) to develop a proposal to subsidize insurance available from employers for low-income children ineligible for MinnesotaCare because they have access to insurance subsidized by an employer.

DHS staff met with insurance industry representatives, employers, consumers and other interested parties in the community during the fall of 1998, and, on December 11, 1998, met with the Legislative Commission on Health Care Access to advise them of the program requirements. Given the barriers in Title XXI to using CHIP funds to purchase private insurance, the Commission agreed not to submit a proposal to HCFA at that time.

Minnesota Legislature: During the 1999 session of the Minnesota Legislature, a bill was introduced by Senator Linda Berglin and Representative Bill Haas, proposing an employer-subsidized health coverage program for children, using Title XXI funding. The program would require families to contribute to the cost by paying a premium established by the MinnesotaCare programs sliding premium scale. The state would subsidize the balance of the employer's dependent health care premium, as well as all cost-sharing items in the employer's plan. Benefits in the employer's plan had to meet a benchmark test.

This bill did not pass, in large part because the federal contingencies on use of this money made administrative costs of such a program prohibitively expensive.

Other approaches

Congressional action: There are a few other states - Hawaii, Vermont, and Washington which had expanded their Medicaid programs up to or above 200 percent of poverty for all children, prior to the enactment of Title XXI, and now have difficulty utilizing CHIP funding. Washington has not submitted a CHIP plan, but the other two states have submitted modest plans to access their allotments. This indicates that there are serious design flaws in Title XXI, including:

- Failure to take into account state efforts made prior to Title XXI
- Restrictions on state flexibility as a result of the federal agency's misplaced concerns on crowd-out in the private sector

- Failure to facilitate use of subsidies for employers to offer dependent health coverage (for example, the benchmark coverage requirements and the requirement to determine Medicaid ineligibility)

- Adoption of cost-sharing limits highly complex to administer.

Current Options

Waivers: Minnesota can resubmit a request for waivers of Title XXI. This is the preferred option as it is simple and direct. Unfortunately HCFA has not been receptive to a discussion of waivers.

Possible Congressional actions: Minnesota has suggested the following options for amending Title XXI:

- Allow states to utilize 10 percent of their allotment for special health initiatives and direct provider payments, without regard to the amount of program expenditures for child health assistance.

- Allow states with Medicaid income levels above a certain threshold (for example, 200 percent of FPL) to use more than 10% of the allotment on special health initiatives and direct provider payments.

- Add express authority for HCFA to grant waivers of Title XXI provisions, and direct HCFA to exercise that authority under certain circumstances.

- Include the MinnesotaCare program in the group of state programs grandfathered into Title XXI.

Continuing state efforts: Minnesota will continue to evaluate all potential avenues to access this funding, but we are not optimistic about our ability to access CHIP funds if the status quo is maintained.

STATE OF MINNESOTA

OFFICE OF GOVERNOR JESSE VENTURA

130 State Capitol • 75 Constitution Avenue • Saint Paul, MN 55155

August 9, 1999

President William J. Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20001

Dear Mr. President:

You expressed at the National Governor's Association meeting that the Children's Health Insurance Plan (CHIP) has not effectively reduced the number of uninsured children nationwide. As we discussed yesterday, the State of Minnesota has been particularly frustrated, as we have been unable to access a large portion of our CHIP allotment because of unduly restrictive rules governing the use of CHIP funding.

In 1992, Minnesota created a program, MinnesotaCare, to provide comprehensive health coverage to uninsured families with incomes below 275 percent of the federal poverty level. In 1995, Minnesota received a Medicaid waiver that allowed for federal matching funds for children in that program. Consequently, Minnesota is prevented by law from using the CHIP allotment to provide health care for uninsured children who are eligible but not enrolled in the Medicaid and MinnesotaCare programs.

Despite programs such as MinnesotaCare, our state still has roughly 57,000 uninsured children below 200 percent of poverty who are eligible for Medicaid. With more flexibility to use CHIP funding for outreach and special health initiatives, our state could identify and reduce the barriers to enrolling uninsured children in the existing programs. Unfortunately, we have been unable to obtain the necessary waiver from HCFA to further capitalize on CHIP funds and achieve the goals of this important initiative.

We believe that allowing states like Minnesota to use some portion of the CHIP allotment for outreach and special health initiatives is entirely consistent with the purpose of this program. We would welcome your assistance in finding ways to better access CHIP dollars and ensure that our shared goal of fewer uninsured children is indeed realized.

Sincerely,

Jesse Ventura
Governor

Voice: (651) 296-3391 or (800) 657-3717 • Fax (651) 296-2089 • TDD: (651) 296-0075 or (800) 657-3598
Web site: http://www.governor.state.mn.us An Equal Opportunity Employer

PETER MC LAUGHLIN
COMMISSIONER

BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

fax transmittal

To: Lynn Cutler — From: Peter McLaughlin, Commissioner

Asst to VP — Fourth District Fax # (612) 317-6094

Fax: (202) 456-2889 — Date: 9-29-99

Phone: (612) 348-7884 — Pages: 8

Notes:

If there is any difficulty in the transmission of this fax please contact our office at the number listed above. Thank you.

PETER McLAUGHLIN
CHAIR

PHONE 612-348-7884
FAX 612-348-8701
TDD 612-348-7708

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FAX-348-8701

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Key Issues

- Minnesota's past efforts and commitment to providing affordable health coverage puts the state at a disadvantage in accessing federal funding through Title XXI, the Children's Health Insurance Program. Minnesota's allotment for federal fiscal year (FFY) 1998 is $28.4 million, and in FFY 1999 is $28.2 million. Title XXI matching funds cannot be used for programs such as MinnesotaCare that existed prior to the Balanced Budget Act, with the exception of New York, Florida or Pennsylvania, whose programs were grandfathered into Title XXI.

- MinnesotaCare is an award-winning program which has reduced dependence on financial assistance and greatly decreased the number of uninsured children in Minnesota without adverse effects on the availability of insurance in the private sector. The program should be treated as a Children's Health Insurance Program and funded as such under Title XXI.

Action to date by Minnesota

CHIP plans

Initial state plan: On July 17, 1998, Minnesota received approval from HCFA for a CHIP plan, designed only to secure Minnesota's Title XXI allotment for FFY 1998. The plan expands coverage for infants under age 2 in the Minnesota Medical Assistance program, in families with income from 275-280 percent of poverty. The expansion will most likely cover less than 15 children, and uses only $50,000 of the $28.5-million allotment. The plan assures that Minnesota's CHIP allotments during the first three years will not be redistributed to other states.

Waiver proposal: Minnesota submitted a waiver proposal under Title Y-XI on May 22, 1998, in an effort to gain access to the state's full allotment. The proposal requested recognition of the MinnesotaCare program as a Title XXI Children's Health Insurance Program, to allow the state to draw enhanced matching funds on certain children in the MinnesotaCare program. Minnesota also requested a waiver of the 10-percent limit on administrative and other expenditures, to allow Minnesota to utilize alternative and creative strategies in providing health coverage for children who are eligible for MinnesotaCare, but for various reasons haven't

enrolled. The waiver proposal was denied in July 1998 on the grounds that it was not appropriate to consider waivers of a new program.

Third state plan effort: The 1998 Minnesota Legislature directed the Department of Human Services (DHS) to develop a proposal to subsidize insurance available from employers for low-income children ineligible for MinnesotaCare because they have access to insurance subsidized by an employer.

DHS staff met with insurance industry representatives, employers, consumers and other interested parties in the community during the fall of 1998, and, on December 11, 1998, met with the Legislative Commission on Health Care Access to advise them of the program requirements. Given the barriers in Title XXI to using CHIP funds to purchase private insurance, the Commission agreed not to submit a proposal to HCFA at that time.

Minnesota Legislature: During the 1999 session of the Minnesota Legislature, a bill was introduced by Senator Linda Berglin and Representative Bill Haas, proposing an employer-subsidized health coverage program for children, using Title XXI funding. The program would require families to contribute to the cost by paying a premium established by the MinnesotaCare programs sliding premium scale. The state would subsidize the balance of the employer's dependent health care premium, as well as all cost-sharing items in the employer's plan. Benefits in the employer's plan had to meet a benchmark test.

This bill did not pass, in large part because the federal contingencies on use of this money made administrative costs of such a program prohibitively expensive.

Other approaches

Congressional action: There are a few other states - Hawaii, Vermont, and Washington which had expanded their Medicaid programs up to or above 200 percent of poverty for all children, prior to the enactment of Title XXI, and now have difficulty utilizing CHIP funding. Washington has not submitted a CHIP plan, but the other two states have submitted modest plans to access their allotments. This indicates that there are serious design flaws in Title XXI, including:

- Failure to take into account state efforts made prior to Title XXI
- Restrictions on state flexibility as a result of the federal agency's misplaced concerns on crowd-out in the private sector

- Failure to facilitate use of subsidies for employers to offer dependent health coverage (for example, the benchmark coverage requirements and the requirement to determine Medicaid ineligibility)

- Adoption of cost-sharing limits highly complex to administer.

Current Options

Waivers: Minnesota can resubmit a request for waivers of Title XXI. This is the preferred option as it is simple and direct. Unfortunately HCFA has not been receptive to a discussion of waivers.

Possible Congressional actions: Minnesota has suggested the following options for amending Title XXI:

- Allow states to utilize 10 percent of their allotment for special health initiatives and direct provider payments, without regard to the amount of program expenditures for child health assistance.

- Allow states with Medicaid income levels above a certain threshold (for example, 200 percent of FPL) to use more than 10% of the allotment on special health initiatives and direct provider payments.

- Add express authority for HCFA to grant waivers of Title XXI provisions, and direct HCFA to exercise that authority under certain circumstances.

- Include the MinnesotaCare program in the group of state programs grandfathered into Title XXI.

Continuing state efforts: Minnesota will continue to evaluate all potential avenues to access this funding, but we are not optimistic about our ability to access CHIP funds if the status quo is maintained.

STATE OF MINNESOTA

OFFICE OF GOVERNOR JESSE VENTURA

130 State Capitol • 75 Constitution Avenue • Saint Paul, MN 55155

August 9, 1999

President William J. Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20001

Dear Mr. President:

You expressed at the National Governor's Association meeting that the Children's Health Insurance Plan (CHIP) has not effectively reduced the number of uninsured children nationwide. As we discussed yesterday, the State of Minnesota has been particularly frustrated, as we have been unable to access a large portion of our CHIP allotment because of unduly restrictive rules governing the use of CHIP funding.

In 1992, Minnesota created a program, MinnesotaCare, to provide comprehensive health coverage to uninsured families with incomes below 275 percent of the federal poverty level. In 1995, Minnesota received a Medicaid waiver that allowed for federal matching funds for children in that program. Consequently, Minnesota is prevented by law from using the CHIP allotment to provide health care for uninsured children who are eligible but not enrolled in the Medicaid and MinnesotaCare programs.

Despite programs such as MinnesotaCare, our state still has roughly 57,000 uninsured children below 200 percent of poverty who are eligible for Medicaid. With more flexibility to use CHIP funding for outreach and special health initiatives, our state could identify and reduce the barriers to enrolling uninsured children in the existing programs. Unfortunately, we have been unable to obtain the necessary waiver from HCFA to further capitalize on CHIP funds and achieve the goals of this important initiative.

We believe that allowing states like Minnesota to use some portion of the CHIP allotment for outreach and special health initiatives is entirely consistent with the purpose of this program. We would welcome your assistance in finding ways to better access CHIP dollars and ensure that our shared goal of fewer uninsured children is indeed realized.

Sincerely,

Jesse Ventura
Governor

Voice (651) 296-3391 or (800) 657-3717 • Fax (651) 296-2089 • TDD: (651) 296-0075 or (800) 657-3598
Web site: http://www.governor.state.mn.us An Equal Opportunity Employer

THE PRESIDENT HAS SEEN
9-23-99

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Brain
Reed/EL
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Chris + return —
what shd
we do on this?
cc Eric
—BR

THE WHITE HOUSE

WASHINGTON

September 13, 1999

MEMORANDUM FOR THE PRESIDENT

FROM: CHARLES M. BRAIN CMB

SUBJECT: CONGRESSIONAL CORRESPONDENCE

Attached for your signature is a letter to Senator Edward M. Kennedy (D-MA), in response to his August 5 correspondence regarding efforts to enroll more children in the Children's Health Insurance Program (CHIP). Additionally, attached for your review is a copy of the Senator's incoming letter.

[redacted] Bruce / C Jennings

Before sending this, is it really responsive — Are there more things we should & can do that will really achieve goal?

BC

THE WHITE HOUSE

WASHINGTON

Dear Senator Kennedy,

Thank you for your recent letter regarding how to enhance our current efforts on children's health insurance outreach. As always, I appreciate your steadfast leadership in ensuring that all Americans have access to adequate health care coverage.

I certainly agree with you that the back-to-school time period offers a great opportunity to launch new efforts to identify and enroll eligible children in both Medicaid and CHIP. To that end, I have planned several efforts to take advantage of this opportunity to insure children. As you know, last month at the National Governors Association's (NGA) annual conference, I announced that the Department of Education and the National Association of Elementary School Principals sent letters to nearly 16,000 school superintendents and 27,000 elementary school principals asking them to commit to conducting on-site education and enrollment of uninsured children. Additionally, beginning in late September, the Departments of Health and Human Services and Education will hold regional meetings to bring together state officials, school systems, and groups to promote local school based outreach efforts. These meetings will lay the foundation for a national conference on school-based health insurance outreach, currently scheduled for mid-November. I will ensure that your ideas get incorporated into these efforts to institutionalize enrolling children in health insurance.

Our work to insure children is not limited to schools. We are continuing our public-private "Insure Kids Now" campaign to engage a range of citizens and organizations in outreach. At the NGA conference, I encouraged states to step up their outreach efforts, and I announced that the United Way will join the Departments of Justice and Health and Human Services to conduct aggressive community-based outreach in over 20 vulnerable cities. This joint action follows similar efforts by foundations, corporations, health care providers, consumer advocates and others in the private sector that include placing the toll-free number -- 1-877-KIDS NOW (1-877-543-7669) -- on corporate products and airing public service announcements on TV and radio. Also, my Federal Interagency Task Force on Children's Health Insurance Outreach implemented over 150 new activities to educate Federal workers and families nationwide about the availability of

Medicaid and CHIP. These activities include distributing hundreds of thousands of posters to health centers, providers, and Federal grantees nationwide; launching the new "insurekidsnow.gov" website; and providing thousands of employees with information, such as the new toll-free number, on their wage and earning statements. The second report by the Task Force is due out shortly, with a new set of actions to promote outreach.

We are also continuing to focus on outreach to legal immigrant children. Our public charge policy, which clarifies that the receipt of Medicaid or CHIP will not affect immigration status, has been well received not only by the immigrant community, but by public health experts, providers, and state and local governments. We have begun to publicize this clarification to eliminate the fear that previously deterred so many members of the immigrant community from applying for benefits for themselves and their children. To this end, INS and HHS together with members of your staff are currently designing an outreach campaign to further educate providers, immigration officials, and the immigrant community about our current policy on public charge.

Finally, I think it is essential to ensure that there are no barriers to enrollment. In the near future, my Administration will be conducting comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes to assess compliance with current law and to develop recommendations for improvements. As part of these reviews, HHS officials will stress the need for accurate and timely state data submissions. We are committed to ensuring that any barriers to enrollment and access to quality care that may exist as part of the state TANF, Medicaid, and CHIP are eliminated.

Once again, thank you for taking the time to share your thoughts on this issue, which is so important to me. For your review, I am enclosing a summary of our recent activities on outreach.

Sincerely,

Tom

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

THE CLINTON ADMINISTRATION'S COMMITTMENT TO PROVIDING HEALTH INSURANCE TO CHILDREN

THE IMPORTANCE OF CHILDREN'S HEALTH OUTREACH. Over 11 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. Over 4 million of these uninsured children are already eligible for Medicaid. However, many families are not aware that their children are eligible for Medicaid, and others have difficulty filling out the application. Similar problems could undermine the new Children's Health Insurance Program's goal to enroll millions of uninsured children.

INTENSIVE PUBLIC-PRIVATE OUTREACH EFFORTS TO IDENTIFY AND ENROLL ELIGIBLE CHILDREN. The President, Vice President, and First Lady have unveiled several public-private initiatives to identify and enroll eligible uninsured children in either Medicaid or CHIP, including:

Launching a new nationwide "Insure Kids Now" Outreach Campaign. This campaign will engage a broad-based, bipartisan, public-private coalition to use a variety of means to educate and assist families in insuring their children. Initial activities include:

- Unveiling the "1-877-KIDS NOW" Hotline. Together with members of the National Governors Association, the President unveiled 1-877 KIDS NOW, a toll free number developed by the NGA in partnership with Bell Atlantic and the Administration, to provide state-specific information about Medicaid and CHIP to families in all 50 states. Families calling this number will receive information about eligibility criteria, benefits, and how to apply for coverage.

- Running public service announcements on national television and radio about Insure Kids Now. NBC, ABC, Univision, Turner Entertainment, the National Association of Broadcasters, and Viacom/Paramount have begun to air public service announcements providing information about the importance of health insurance and promoting the Insure Kids Now number. Radio ads on Insure Kids Now will also be aired nationwide, starting with California, Utah, Colorado, Alabama, Arkansas, Illinois, Ohio, and North Carolina.

- Printing the Insure Kids Now toll free number on commonly used products. Building on a series of commitments made in 1998, K-Mart, General Motors, the American Dental Hygienists Association, and American Medical Response have pledged to put the new toll-free number on grocery bags, toothbrushes, diaper boxes, pharmaceutical products, child safety seats, and schoolbuses.

- Reaching out to enlist every school in the country in a back-to-school children's health outreach campaign. The President announced that the Department of Education and the National Association of Elementary School Principals will send letters to all 15,725 school superintendents and 27,000 elementary school principals asking them to get involved in children's health outreach. The letters include information on how schools can target and help enroll these children and a pledge form to document their commitments.

- Collaborating with the United Way of America, DOJ, and HHS in targeting 21 key cities in conducting outreach campaigns. The President announced that in September 1999, the United Way of America, HHS, DOJ, and Education will launch intensive outreach efforts that include: providing information in orientation packets; including CHIP information with school lunch applications; and hosting outreach events at school and community events. HHS will invest $1 million in a radio campaign to promote the Insure Kids Now toll-free number.

Releasing an Executive Memorandum ordering Federal Agencies to conduct new outreach activities. In an Executive Memorandum dated June 23, 1998, the President ordered the Departments of Health and Human Services, Treasury, Agriculture, Education, Labor, Housing and Urban Development, Interior, and the Social Security Administration to enact over 150 initiatives designed to help enroll millions of uninsured children in Medicaid or the new Children's Health Insurance Program (CHIP). The Task Force has begun new outreach efforts include launching the new "insurekidsnow.gov" website; distributing 145,000 posters to over 20,000 health centers, providers, and other grantees; and providing 92,000 USDA employees with information about outreach, including the new toll-free number, on their wage and earning statements.

New actions to assure families access to Medicaid, CHIP, and other benefits. On May 25, 1999, the Administration unveiled new regulations assuring families that enrollment in Medicaid or the new Children's Health Insurance Program (CHIP) and the receipt of other critical benefits, such as school lunch and child care services, will not affect their immigration status. The new regulation, effective immediately, clarifies a widespread misconception that has deterred eligible populations from enrolling in these programs and undermined the public health. In addition, Federal agencies will send guidance to their field offices, program grantees and to work with community organizations to educate the public about this new policy.

Reviewing Medicaid eligibility and enrollment processes in every state and promoting best practices. On August 9, 1999, the President instructed HCFA to launch comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes. These reviews, conducted by HCFA regional office staff, will include interviews with state officials and case file checks to assess compliance with current law and to develop recommendations for improvements. The review teams will also highlight best practices for ensuring that eligible families get Medicaid. These efforts build on recently released guidance encouraging states to reach out to children who are no longer eligible for cash assistance but are still eligible for Medicaid or CHIP.

Investing in new children's health insurance outreach. The President has included a $1 billion, 5-year initiative to fund outreach to enroll uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP) in his FY 2000 budget. These new funds will enable States to simplify enrollment systems, launch ad campaigns, educate community volunteers, outstation eligibility workers, and conduct outreach campaigns to identify and enroll uninsured children in both Medicaid and CHIP.

EDWARD M. KENNEDY
MASSACHUSETTS

THE PRESIDENT HAS SEEN
8-10-99

United States Senate

WASHINGTON, DC 20510-2101

August 5, 1999

The Honorable William Jefferson Clinton
President of the United States
The White House
Washington, DC 20500

Dear Mr. President:

I have spoken to you several times about a cause that is close to both of our hearts--guaranteeing health insurance coverage for all children. As you know, the vast majority of uninsured children today are eligible for either Medicaid or CHIP, but too many are not participating.

A recent report by the Kaiser Family Foundation found that CHIP enrollment has increased dramatically in the last six months--to 1.3 million--but is still only a fraction of those eligible. This school year will be the first full year in which the program is fully operational in all states. The back-to-school period offers a unique opportunity for a new initiative on enrollment in both CHIP and Medicaid, and can be the launching pad for a major effort for the entire upcoming year.

Under your leadership, the Executive Departments and Agencies have made significant efforts to enroll more children, and your staff have been working effectively on this issue. Here are some suggestions for the next few months:

- Appoint a high level White House coordinator, whose responsibility is to work with the Executive Branch, the states, the Congress, and voluntary agencies and organizations to enroll children in CHIP and Medicaid and to assure that enrolled children receive needed health services. This coordinator should have the same stature as the Director of the White House Office of National AIDS policy or the Y2K coordinator.

- Use the occasion of your address to the National Governor's Association on Sunday to urge greater efforts by states to enroll uninsured children. Many states are making worthwhile efforts, but the gap between what has been done and what could be done is still too wide. The practices that would have the greatest potential impact to encourage enrollment of children include presumptive eligibility for both programs, and assigning eligibility workers to schools, health centers, churches, day care centers, pre-schools, and other organizations.

- Use a Saturday radio address to encourage parents to enroll their children in CHIP and Medicaid as they prepare to go back to school.

- Encourage coordination of enrollment for school lunch programs and CHIP and Medicaid. Participation in school lunch programs is high, and the eligibility largely overlaps.

- Launch a campaign, working with the INS and voluntary organizations with ties to the immigrant community, to assure immigrant populations that enrolling their children in CHIP will not affect their immigration status. The INS agrees that this is the case, but a greater effort must be made to publicize this point and reassure parents, since a substantial proportion of uninsured children come from this community.

- Direct the Departments of HHS and Education and other appropriate agencies to hold joint regional conferences around the country this month, to bring together state officials, school systems and groups, advocates and others to launch an enrollment effort tied to back to school events. Governors and other local leaders should be asked to address these conferences as a way of strengthening their commitment to this goal. For school systems, the objective should be a system in which determining children's insurance status and enrolling them if they are uninsured is as routine as verifying that they have required vaccinations.

- HHS needs to insist that states provide better and more timely data on the progress of enrollments. Only with better data will it be possible to identify the trouble spots that need special attention.

I hope these suggestions are helpful. I was delighted with the focus you put on uninsured children in your recent press conference. The coming weeks offer an unparalleled opportunity to bring the goal of universal health insurance for children closer to reality.

Warmest regards -

Respectfully,

Edward M. Kennedy

Examples of Creative and Successful School-based Outreach Strategies That Governors Could Replicate

District of Columbia: A poster/poetry contest helped to raise awareness about need for and availability of health insurance. Application boxes are provided in principals' offices, and training is provided for selected school staff. Enrollment at events such as report care parent/teacher conferences is an effective strategy -- one such event resulting in 400 approved applications.

Idaho: The Hospital Consortium of North Idaho partners with 12 school districts in five counties as part of a federally funded demonstration project. As part of the project, the shared school nurse provides information about health coverage to families, and works with local Medicaid staff to ensure that families' applications are processed appropriately.

Illinois: Chicago Public Schools identified more than 200,000 children without health insurance, of whom more than 100,000 should be eligible for KidCare. The KidCare Enrollment Campaign has evolved into an innovative and aggressive school-based outreach campaign at over 600 public schools. Enrollment for health insurance at the time of report-card pick up was the focus of the successful campaign. Chicago Public Schools' experience provides important lessons on the need for public-private partnerships, and for cooperation across state agencies.

Nevada: Experience in Nevada shows that 70% of CHIP applicants learn about the program through the school system. Coordination with school lunch programs, athletic programs and parent-teacher conferences helps to spread the word about CHIP. School principals became effective leaders to coordinate school outreach efforts.

Massachusetts: Teenagers and their families, working with Health Care for All, helped to organize the Coaches' Campaign to focus on enrolling children who want to participate in school sports. Coaches learn about opportunities for health coverage for students during Red Cross CPR training for coaches and other school athletic staff.

Minnesota: Assistance with completion of Medicaid applications is available to families of new students at the Welcome Center operated by the Minneapolis Public Schools. During peak registration months of August and September, a Medicaid eligibility worker is outstationed at the Welcome Center.

Nebraska: In Nebraska, community health centers are permitted to enroll children who are presumed to be Medicaid eligible. Staff of Panhandle Community Services health center attended a parent information night at a Scotts Bluff elementary school and was able to directly enroll children by assisting parents to fill out Medicaid applications on site.

South Carolina: About two thirds of all CHIP applications originate in schools. School employees involved in the outreach effort included school nurses, athletic directors and guidance counselors. An incentive program encouraged applications with five dollars paid to each child with a completed application, and pizza parties for the schools with the most applications.

Utah: Families can apply for Medicaid at Edison Elementary School in Salt Lake City. After the Utah Department of Health discovered at an Edison school health fair that many students were suffering from untreated health conditions, a Medicaid eligibility worker was outstationed at the school five days a week. The worker also provides information in six other schools on parent teacher nights and to school counselors.

Washington: Seattle schools are organizing multiple approaches to increase enrollment of eligible children in Medicaid. School nurses and family support workers trained by the Washington Health Foundations's Child Health Access Program assist families with Medicaid applications. Families learn about the program from school-based promotional materials including letters, posters and activity at school events. Linkage with school-lunch program and other strategies for making insurance application a part of school routine are being explored.

West Virginia: Teaming up with community health centers provides additional resources for enrollment. New River Health Association operates four school-based health clinics and provides assistance to other school-based clinics in West Virginia. Health center staff provides families with application forms and offers assistance with the application process.

NATIONAL GOVERNORS' ASSOCIATION

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Vice Chairman

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Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1512
Telephone (202) 624-5300
http://www.nga.org

October 15, 1999

Nancy-Ann DeParle, Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator DeParle:

As you work towards developing regulations for the Children's Health Insurance Program (CHIP), the Governors would like to express our interest in ensuring that any regulations will maximize the potential success of this priority program. We hope that the CHIP regulations will be crafted in the spirit of President Clinton's new Executive Order on Federalism, seeking to preserve state flexibility, foster innovation, and strengthen the state-federal partnership to reach our common goal of ensuring that our nation's children have access to quality health care.

Since enactment as part of the Balanced Budget Act of 1997, states have quickly moved to implement CHIP, without formal regulations, offering health coverage to children as soon as possible. The Health Care Financing Administration (HCFA) provided guidance to the states in the form of "Questions and Answers" and formal letters to state officials. It was on the basis of such documents that states developed their plans and on which the Department issued its approval. The Governors trust that forthcoming regulations will not prohibit state efforts based on previous HCFA guidance.

The Governors also expect that the guidelines will reinforce and expand state flexibility to develop the programs that will work best for each state. Congress gave states the option and flexibility to expand Medicaid or to develop new insurance programs based on private market models. While the nation's Governors remain committed to the Medicaid program and the people it serves, many Governors are interested in exploring other models of providing health insurance through CHIP. President Clinton's executive order reminds us "one-size-fits-all approaches to public policy problems can inhibit the creation of effective solutions." With this in mind, we trust that forthcoming regulations will not narrow available state options or impose additional burdensome requirements, but will seek to preserve the "healthy diversity" in public policy that the President has advocated.

In addition to these general themes, we would like to outline several specific priorities that we hope will be addressed in HCFA regulations and actions:

Waivers. States must have the flexibility to design and implement programs that reduce the number of uninsured children. To this end, the CHIP statute offers several options, including 1115 waiver authority. President Clinton, in his executive order, directs our attention to waiver authority as a means to increase opportunities for utilizing flexible policy approaches at the state level. For CHIP to be a successful and innovative program, states must have the ability to utilize full statutory authority, without artificial restrictions.

Cost Sharing. Congress explicitly stated certain specific parameters for CHIP, such as allowing cost sharing up to 5 percent. The Governors expect that the department will not move beyond its statutory authority in order to make these limitations more restrictive.

Employer-based Coverage. As more than 60 percent of Americans obtain health insurance at work, employer-based CHIP coverage is a natural opportunity to assist hard working families that cannot afford to accept insurance offered by employers for their children. Several barriers must be eliminated before states can effectively utilize this unique opportunity. (1) HCFA has required states to prove that employer-based coverage is actuarially equivalent to the state's CHIP package. Requiring actuarial equivalence determinations for every employer's health plan is an overly burdensome requirement. Developing a more efficient and effective comparative method or allowing for a waiver of the requirement, would ensure that more children receive access to health insurance. (2) HCFA has also required that an employer must contribute at least 60 percent of the cost of coverage. As a state's plan must meet HCFA's cost-effectiveness test, a hard and fast rule about percentages of employer contributions is not necessary. If a state can demonstrate cost-effectiveness while having employers contribute less than 60 percent, there is no reason for the arrangement to not be permitted.

Family Coverage. Significant evidence confirms that children are more likely to receive much-needed health care when the entire family has access to coverage. Many states would like to expand their CHIP programs to cover parents of CHIP kids with state dollars when covering parents does not meet the cost-effectiveness test for budget neutrality. Thus far, the department has not utilized its waiver authority to permit states to expand health insurance to parents of CHIP kids and reduce the rate of uninsured Americans.

Crowd-out. The pressure is on in the states to enroll eligible children in CHIP. But many states are frustrated that children must endure a prescribed period without insurance. States are developing innovative approaches to reducing crowd-out. A "one-size-fits-all" mandatory waiting period prior to enrollment for children that have recently lost access to health insurance may not always be necessary or appropriate. States should have the flexibility to enroll children without artificial time restraints that could stall program development and prevent children from receiving necessary health care as soon as possible.

The nation's Governors share with Congress and the Administration the goal of providing children with high quality and affordable health coverage. We hope that the regulations will reflect the letter and the spirit of the President's executive order on federalism, recognizing that "the states possess unique authorities, qualities, and abilities to meet the needs of the people." We look forward to continuing to work with you on providing for the health of our nations' children.

Sincerely,

Governor Don Sundquist
State of Tennessee
Co-Lead Governor on Health

Governor John Kitzhaber
State of Oregon
Co-Lead Governor on Health

July 1999

Health Insurance Coverage in New York

A BRIEFING PAPER

Prepared by Greater New York Hospital Association

For more information, please contact
Rima Cohen, Vice President for Insurance Options Development, GNYHA

Overview

In spite of a booming economy, the number of uninsured New Yorkers continues to grow at a rapid pace. Over 3 million individuals in the State—19% of the nonelderly population—are currently uninsured, and a staggering 28% of New York City's nonelderly residents have no coverage. While the proportion of uninsured was well below the national average less than a decade ago, New York is now worse off than the nation as a whole by nearly any measure of health coverage. Absent significant policy changes, these trends are expected to continue unabated into the new millennium.

Growth has been particularly sharp in the number of uninsured who earn too much to qualify for Medicaid but too little to afford private coverage. New York began to tackle this problem last year when it expanded the popular Child Health Plus (CHP) program, which subsidizes coverage for uninsured children in low-income, working families. Unfortunately, there is no comparable program for working adults, leaving this group with few options if they cannot afford to purchase insurance on their own. Medicaid is the only statewide, subsidized insurance program for nonelderly adults, but generally only the very poorest qualify for the program. It is therefore not surprising that 75% of the uninsured in New York are between the ages of 18 and 65.

To address this problem, GNYHA and the 1199 National Health and Human Service Employees Union, SEIU developed the Family Health Plus (FHP) proposal. Building on the successful CHP foundation, FHP would use proceeds from New York State's share of tobacco settlement funds to extend subsidized coverage beyond children to uninsured families and single working adults. A broad coalition of organizations has formed to support the proposal, and in June 1999 the New York Assembly overwhelmingly passed FHP legislation. While neither the Senate Majority Leader nor the Governor has spelled out a specific strategy for expanding insurance, they both favor devoting a portion of tobacco settlement funds to health coverage.

For the first time in many years, a consensus appears to be forming around the need to expand affordable health coverage to working families, and supporters of FHP will continue to build on this momentum until this goal is attained.

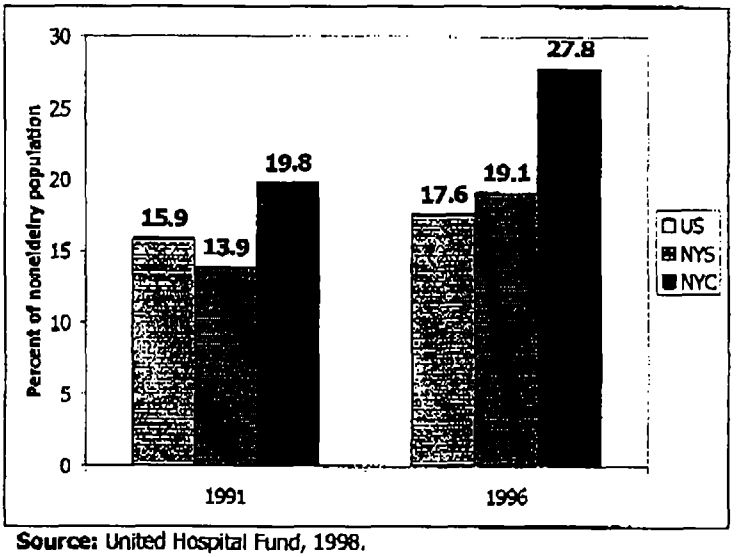
Background on the uninsured in New York

Over the past decade, New York's uninsured rate has grown rapidly. Currently, over 3.1 million New Yorkers—nearly one in five nonelderly residents—are uninsured, and 180,000 more individuals are added to the ranks of the uninsured each year. Absent significant policy changes, this trend is expected to continue into the new millennium.

While the proportion of uninsured has grown across the country, New York's uninsured rate has increased over three times faster than the national average over the past decade. New York entered the 1990s with an uninsured rate lower than the national average, but the proportion of uninsured is now higher and growing faster than in the rest of the nation.

The problem is particularly severe in New York City, where 28% of the nonelderly population is uninsured. As a result, the percentage of uninsured in New York is 50% higher than the national average.

Figure 1
Percent of nonelderly population without health insurance



Source: United Hospital Fund, 1998.

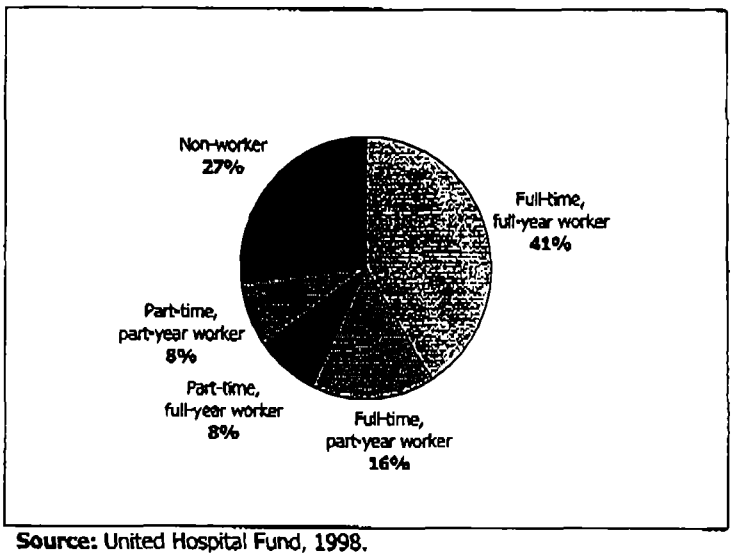
Characteristics of the uninsured

Contrary to common perceptions, the vast majority of the uninsured live in working families; nearly three-fourths of uninsured adults are employed at some point during the year and 40% work full-time, full-year. However, the uninsured also tend to be low-income, with two-thirds living in families that have incomes below 200% of the Federal poverty level (roughly $33,000 per year for a family of four).

Though much attention has been focused lately on uninsured children, 75% of the uninsured in New York are adults, and single childless adults are the group most likely to lack coverage. This situation reflects the long-standing direction of state and Federal policies, which call for much more generous coverage of children through public programs.

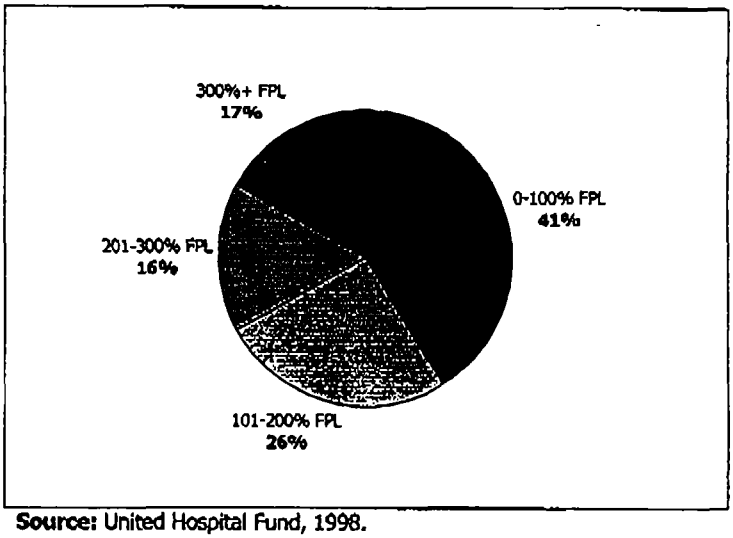
Citizenship status is another predictor of health insurance status. Among non-US citizens, 46% were uninsured in 1996 compared with only 15% of US citizens. Roughly one-third of New York's 3.1 million uninsured are immigrants.

Figure 2
Uninsured persons by employment status



Source: United Hospital Fund, 1998.

Figure 3
Poverty status of nonelderly uninsured



Source: United Hospital Fund, 1998.

Factors contributing to New York's uninsured problem:

Drop in private coverage

Key to the rapid growth in New York's uninsured population is the steady decline over the past decade in private health insurance coverage, both employer-sponsored and individually purchased insurance. From 1991 to 1996, the percentage of nonelderly New Yorkers with private insurance dropped eight percentage points—from 71% to 63%—compared to the national average, which dropped only three percentage points—from 72% to 69%—over the same period.

Research suggests two primary reasons for the decline in employer-sponsored insurance. First, firms that do offer health benefits have been steadily increasing employees' share of premium contributions, making coverage unaffordable for many workers. Second, employment growth in New York has been concentrated in smaller firms that are less likely to offer coverage to their employees. Indeed, workers in the smallest firms (under 25 employees) experienced the sharpest declines in coverage.

Low-income workers without employer-based insurance have few options for obtaining coverage. Medicaid is the only statewide public insurance program for nonelderly adults, but it is available only to the very poorest individuals. To qualify for the program, a parent with two children must earn less than $7,900 per year, and childless adults less than $4,300 per year. New York's private individual market, among the most expensive in the country, is equally inaccessible, with premiums averaging $3,400 per year for individuals and $10,000 for families.

Low participation in existing programs

Another factor contributing to the State's high uninsured rate is the low participation of eligible people in existing public insurance programs. Over 800,000 individuals—one-fourth of the uninsured population—are eligible for Medicaid or Child Health Plus but have not signed up for these programs. Often, these individuals fail to enroll because they are not aware they are eligible or they find the application process confusing and difficult.

Another likely cause of this low participation is the 1996 welfare reform law, which delinked Medicaid from cash assistance. Historically, welfare has been the main avenue to Medicaid eligibility; anyone eligible for welfare automatically received Medicaid. As a result of welfare reform, however, many former welfare recipients mistakenly think they are no longer eligible for medical assistance or simply fail to apply for health benefits in the first place. In only three years, from 1995 to 1998, Medicaid enrollment dropped by 300,000 people, a trend that is likely due in large part to the implementation of welfare reform.

New York's subsidized health insurance programs

New York State has a long-standing tradition of support for the health care of vulnerable populations. The State's two largest public health insurance programs for nonelderly residents—Medicaid and Child Health Plus (CHP)—provide comprehensive benefits, and recent eligibility expansions in these programs ensure relatively generous coverage for children. However, there has still been a net increase in New York's uninsured because these programs have failed to keep pace with both the decline in private coverage in the State and the recent increase in the number of eligible individuals losing Medicaid coverage. Following is a brief description of the major programs providing subsidized health coverage in New York.

Medicaid

With over 2.5 million enrollees, New York's Medicaid program is one of the largest in the country. The program offers comprehensive health benefits at no cost to individuals, with eligibility capped at roughly 54% of the poverty level for adults without dependent children, 87% for parents with dependent children, 185% for pregnant women, and 133% for children. While the benefits are generous, the low eligibility threshold for most adults makes the program accessible only to the poorest of the poor. In addition, a complex and confusing application process serves to deter enrollment of those who are eligible for the program. The delinking of Medicaid and cash assistance, as described earlier, has exacerbated this problem.

Child Health Plus

Child Health Plus is the largest non-Medicaid, publicly funded children's health insurance program in the country. CHP offers comprehensive, subsidized, private coverage to uninsured children in families earning less than 250% of the poverty level, with premium contributions determined on a sliding scale basis. Over 300,000 children are currently enrolled in the program and thousands more are signing up for CHP each month. The Federal Title XXI program finances 65% of CHP's budget and the State pays the remaining 35% share.

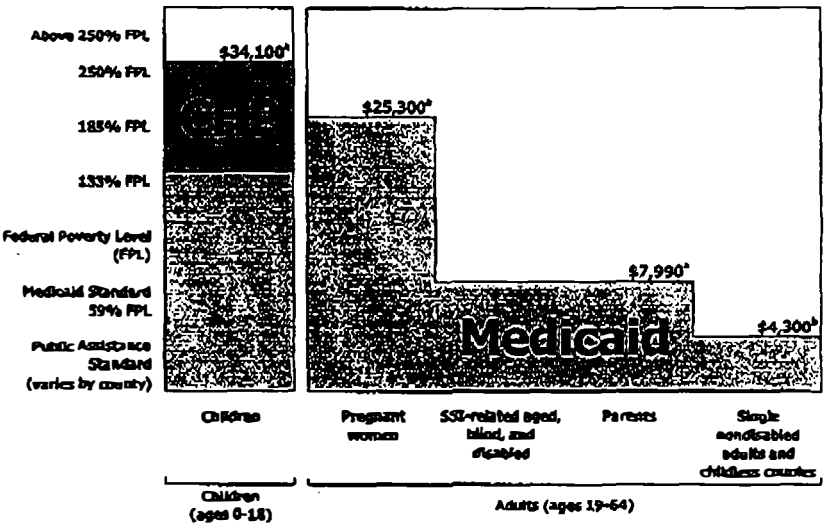


Figure 4
Eligibility levels for New York's public insurance programs

Notes: Income levels shown above are gross income for CHP and net income for Medicaid.
* Based on 1998 Health and Human Service poverty guidelines for three-person families.
* Based on 1998 Health and Human Service poverty guidelines for single adults.

Health insurance demonstration programs:

New York State also operates a number of small-scale health insurance subsidy programs for businesses and individuals. Overall, these initiatives have had only a minimal effect on the number of uninsured. However, the lessons learned from these programs can be useful in shaping future proposals to expand coverage.

New York State Partnership Program

The New York State Health Insurance Partnership Program (NYSHIPP) offers subsidies to small employers to cover 45% of a group health plan. The program is funded at $6 million per year and has enrolled just over 1,000 businesses (as of August 1998), with an average of two to three employees per firm. While NYSHIPP has a waiting list of firms interested in participating, this may be a function of the very limited available funds. The program has not been thoroughly evaluated, but similar programs in other states suggest that even generous subsidies fail to induce large numbers of businesses to offer coverage.

Regional Pilot Project

Through the $6 million Regional Pilot Project (RPP), the State subsidizes individuals and families for the purchase of private coverage from a limited selection of managed care plans. The program is similar to Child Health Plus, where families contribute to the cost of their coverage on a sliding scale, but unlike CHP, entire families and childless adults can participate. The program appears to be relatively successful at enrolling uninsured families, though it has not yet been thoroughly evaluated.

New York City demonstration programs

Over the past year, the New York City government has implemented two demonstration programs designed to expand or improve the quality of employer-provided health insurance: the New York Health Purchasing Alliance (NYHPA) and the Small Business Health Insurance Demonstration (SBHI).

NYHPA was started with a $1 million grant from the City that provided seed money to establish a small business health insurance purchasing alliance for the more than 200,000 small businesses across the City. The Alliance contracts with a variety of commercial managed care plans to provide employees of participating firms with a choice of plans that offer the same standard set of benefits. Employees benefit from a broad selection of insurers, while employers enjoy reduced administrative costs. Enrollment in NYHPA is expected to begin this year.

Also targeted at small employers is SBHI, a collaborative effort of the New York City Health and Hospitals Corporation (HHC) and the Group Health Incorporated (GHI) insurance company. Under the program, GHI provides very low-cost, comprehensive health insurance coverage to uninsured businesses. GHI reduces its costs by restricting patients to only HHC providers and by negotiating deep discounts with these facilities. The program has recently started enrolling businesses and currently covers 250 individuals.

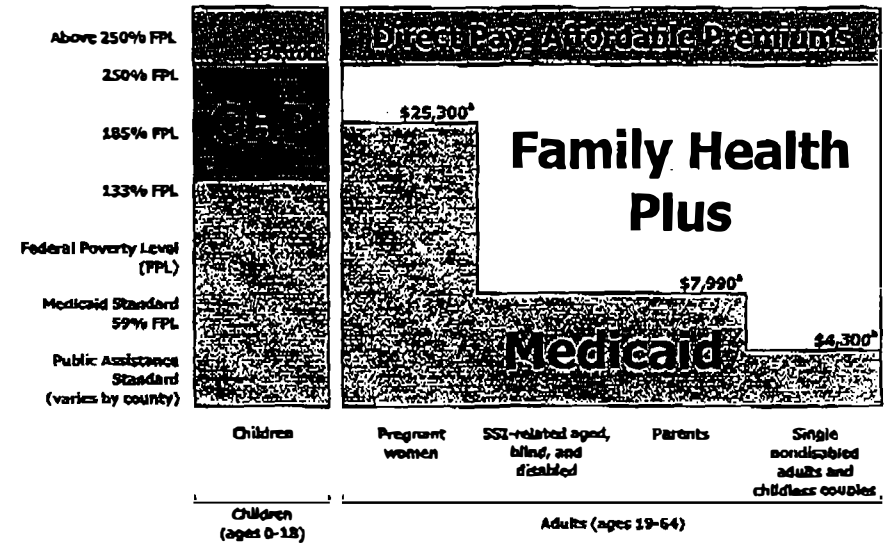
Family Health Plus

CHP for adults

To address the dearth of insurance options for working families without access to affordable employer-based coverage, GNYHA and 1199/SEIU jointly developed Family Health Plus (FHP), a proposal to make affordable health insurance available to New York's working families and individuals.

FHP builds on the successful foundation that Child Health Plus (CHP) now provides to children, extending subsidized, private insurance to the uninsured parents of CHP children and other working adults who do not qualify for Medicaid or Medicare. A separate provision of the proposal, targeted to those who can afford to purchase reasonably priced coverage, establishes a pool to lower premiums in the individual insurance market.

Figure 5
FHP proposal



Note: Income levels shown above are gross income for CHP and net income for Medicaid.
[a] Based on 1998 Health and Human Service poverty guidelines for three-person families.
[b] Based on 1998 Health and Human Service poverty guidelines for single adults.

Many aspects of FHP mirror the CHP program. For example, eligibility for FHP, like CHP, would be set at 250% of the poverty level; FHP's benefits and premium subsidies are based on CHP's benefit package and premium schedule; and, to the extent possible, health plans participating in FHP would also offer CHP and Medicaid coverage.

Simplification of New York's insurance programs

FHP would be coordinated with CHP and Medicaid to keep families in the same health plans and ensure seamless transitions between the programs. To advance this goal and to eliminate the barriers to enrollment in existing public programs, the FHP proposal calls for a simplified, uniform application process for all of New York's health insurance programs, and vigorous outreach and other measures to maximize family enrollment in the programs for which they are eligible.

Together, these proposals would reduce the administrative complexity of enrolling in public programs and guarantee access to affordable health coverage for all working New Yorkers with an income under 250% of the poverty level, regardless of age or family status.

FHP funding	Funding for FHP would include a portion of the proceeds from New York's $1 billion share of the national tobacco settlement and Federal funds available through a provision of the Federal welfare reform law allowing states to expand health coverage to working families.
Outlook for FHP passage	FHP got a boost earlier this year when GNYHA and 1199/SEIU joined with the New York State Health Care Campaign, a coalition of 75 health care and consumer groups, to push for passage of the bill. With the encouragement of this broad-based coalition, the Assembly included a version of the GNYHA/1199 FHP proposal in its "HCRA 2000" bill reauthorizing New York's expiring Health Care Reform Act. The Assembly's version of FHP is very similar to the GNYHA proposal, though its eligibility is more limited (200% of the poverty level for parents and 120% of poverty for childless adults). This FHP plan passed the Assembly with overwhelming support in June 1999. Neither Senate Majority Leader Joseph Bruno nor Governor George Pataki has released a proposal to expand health insurance coverage in New York. However, both have stated their support for using some portion of tobacco proceeds for health care, and Senator Bruno is currently developing his own health coverage expansion bill that will be funded by tobacco settlement proceeds. While obstacles to final enactment of a family health insurance program remain, the outlook for a coverage expansion is more positive than it has been in decades, and GNYHA/1199 will be mounting a vigorous campaign in the coming months in support of FHP. Passage of this proposal would once again make New York a model for the rest of the nation when it comes to serving the health care needs of vulnerable populations.

They have not submitted anything to HCFA yet.

Facts about the uninsured in New York, 1996	
	▫ **19.1% of New York State's nonelderly population is uninsured, compared with 17.6% for the rest of the country.**
New York City	▫ Nearly 28% of New York City residents are uninsured compared with 13% of other New York State residents.
	▫ New York City has 41% of the State's population and 60% of the uninsured.
Poverty	▫ More than two-thirds of the nonelderly uninsured live in families with incomes below 200% of the poverty level.
Age	▫ Nearly one-third of nonelderly single adults are uninsured.
	▫ Despite expansions in insurance programs for children, 15% of all children are uninsured.
Employment	▫ Full-time, full-year workers account for nearly 40% of the uninsured.
	▫ Nearly three-fourths of the uninsured were employed during the year.
Private coverage	▫ Private coverage among workers declined by 6.3 percentage points between 1990 and 1996.
Citizenship	▫ Nearly one-third of the uninsured are not US citizens.

Source: United Hospital Fund, 1998.

Statistics on the uninsured in New York, 1996

Uninsured by percentage (nonelderly)

United States	17.6%
New York State	19.1%
New York City	27.8%

Uninsured by number (nonelderly)

United States	41.3 million
New York State	3.1 million
New York City	1.8 million

Uninsured by employment status

Worked at some point during year	73%
Unemployed	27%
Worked full-time, full-year	41%

Percent distribution of the uninsured in various groups:

Uninsured by poverty status (by % FPL)

0-100	41%
101-200	26%
201-300	16%
301+	17%
Total	**100%**

Uninsured by age group

0-18	25%
19-64	75%
Total	**100%**

Uninsured by citizenship status

US citizen	68%
Non-US citizen	32%
Total	**100%**

Source: United Hospital Fund, 1998.

Q: Isn't welfare reform responsible for the drop in the number of uninsured children? What is the federal government doing about that?

A: This Administration has demonstrated an unprecedented commitment to reducing the numbers of the uninsured and would not take any action that would reduce access to health insurance for low income people. National welfare reform legislation was enacted in August 1996 and phased in by the states during 1997, so the numbers currently available say little about the effect of welfare reform on Medicaid coverage.

Beginning in 1993, President Clinton led the effort to reform welfare by granting waivers to 43 states allowing them to move families from welfare to work. In each waiver, the Administration insisted that states ensure continued Medicaid coverage for all eligible people at the same time they were promoting work. This reflected our commitment to expanding health coverage and our belief that health insurance is a crucial work support.

And as today's New York Times points out, the President insisted that the welfare reform law guarantee Medicaid coverage to all adults and children who would have been eligible prior to the law's passage (except for those adults who refuse to meet their work obligations). Recently, the Department revised its regulations to help families work their way off welfare by permitting states to extend Medicaid to low income two-parent families even if the principal wage earner worked more than 100 hours per month.

We are also working with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. We are also working with states to identify model outreach strategies, program operations, coverage expansions and Medicaid policies designed to increase the number of people eligible for Medicaid who actually receive it. The major new outreach effort announced today will also help states enroll eligible people in both Medicaid and the new Children's Health Insurance Program.

PUBLIC
EDUCATION
NETWORK

Celebrating 15 years of Local Education Funds 1983 - 1998

February 22, 1999

TO: Victoria Lynch – 5 pages

FR: Arnold F. Fege

RE: Public Education Network Commitment to disseminating the 1-800 Number Related to CHIPS

This is to notify you that the Public Education Network will commit to the following related to disseminating the 1-800 CHIPS number and national campaign:

1. Will display the number on its website
2. Notify the 43 local education funds of the number
3. Work with PEN's representatives participating in the CDC/DASH Comprehensive School Health Initiative in five communities. These sites are: Charleston, West Virginia; Lincoln, Nebraska; Shelburne, Falls, Massachusetts; Providence, Rhode Island; and Baton Rouge, Louisiana. (See the attached)

We look forward to working with you in your attempts to assure health care for low income and disadvantaged children and families. Excellent health care assures that children come to school ready to learn.

Should you have additional questions, don't hesitate to call Richard Tagle, Director of the CDC/DASH Initiative or myself at 202 628-7460. I will call you with the PEN person who will be attending the White House event tomorrow.

Thanks for your help.

601 Thirteenth Street N.W.
Suite 900 North
Washington, D.C. 20005-3808
Telephone 202-628-7460
FAX 202-628-1893

FEB-22-1999 12:20 202 628 1893 P.01/05

OFFICE OF COMMUNICATIONS
OFFICE OF EXTERNAL AFFAIRS
4300 WEST HIGH RISE BUILDING
FAX NUMBERS: 410-966-2660
410-966-4871

Fax

To: Deborah Adler **From:** Martha Seabrooks

Fax #: 202 456 5557 **Total # Pages (Includes Cover):** 2

Phone: **Date:** 2/16/99

Subject: :

☐ **Urgent** ☒ **For Review** ☐ **Please Reply**

• **MESSAGE:**

My Phone # 410-965-4004

NOTE TO: Devorah Adler

SUBJECT: SSA Teachers Kits

This is in response to your telephone request earlier today. The SSA Teachers Kit is a self-instructional set of materials for teachers to use in high school classrooms. It includes five lesson plans, a teachers guide, a 24-minute video, fact sheets, and other handouts. The materials are designed to provide a basic understanding of Social Security programs young people can use now and in the future. SSA plans to print 15,000 to 20,000 kits before the September 1999 school year begins and Information on the Children's Health Insurance program will be included.

If you need additional information, please contact me at 410-965-4004 (Fax 410-966-2660).

Martha Seabrooks

Martha Seabrooks

Social Insurance Specialist
Office of Communications

cc: Michele C. Brand

NBC'S 'THE MORE YOU KNOW' PARTNERS WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN A CHILDREN'S HEALTH INITIATIVE

"Law & Order" Stars Benjamin Bratt & S. Epatha Merkerson Featured in New Public Service Announcement

Clinton Announced White House

NBC's "The More You Know" public service campaign has joined with the Department of Health & Human Services to inform parents of the Children's Health Insurance Program (CHIP). Today at the White House, the President launched the *Insure Kids Now* Outreach Effort, an initiative that will utilize both public and private sectors to raise awareness of CHIP. As part of *Insure Kids Now*, "The More You Know" has produced a public service announcement (PSA) featuring "Law & Order" stars Benjamin Bratt and S. Epatha Merkerson. The PSA is aimed at raising awareness of CHIP among parents in need of free or low cost health insurance and has a toll free number for viewers to call to enroll or to get more information. The new PSA will premiere on NBC, Wednesday, February 24th, during "Leeza" at 9:00am (ET).

"Children are our nation's greatest resource. Its our responsibility to insure that each child is afforded the opportunity to live a healthy life," said President William Jefferson Clinton at the launch of *Insure Kids Now*. "Through NBC's dedication to promoting awareness and providing information about children's health initiatives we can be secure millions of parents will know of resources available to help protect our nation's future."

"I am proud to be a participant in this outreach effort, as well as part of NBC, an organization that recognizes the importance of distributing important information to its viewers," said S. Epatha Merkerson, star of NBC's "Law & Order" and "The More You Know" PSA, who attended the White House launch of *Insure Kids Now*.

CHIP, introduced into law over a year ago, provides $24 billion over 5 years to help states offer affordable health insurance to millions of children in working families that make too much for Medicaid but too little to afford private coverage. The *Insure Kids Now* outreach effort is challenging foundations, corporations, health care providers, consumer advocates and many others in the private sector to make every effort to enroll uninsured children in CHIP.

"The More You Know" is NBC's long-standing commitment to its viewers and their communities to help educate and raise awareness of important societal issues. Through creative & innovative public service announcements (PSAs), over 200 NBC celebrities have effectively communicated over 70 issues. Topics range from substance abuse and violence prevention to teacher appreciation and staying in school and are aired in all dayparts including prime time, daytime, late night and Saturday morning. Special PSAs are produced in connection with the "Movie of the Week" and air during the movie's broadcast. Another element of the campaign is the Poster/Study Guides that are nationally circulated in schools and designed to further help students recognize the negative obstacles, such as peer pressure and substance abuse, which might divert them from their

educational goals. Carried by more than 200 local affiliates under the banner of "The More You Know," stations also implement numerous community outreach activities such as homework hotlines, volunteerism programs, adopt-a-school initiatives and health and education fairs. "The More You Know" is the longest-running, most comprehensive public service campaign in existence.

####

MEDIA CONTACT:
Kyle Kaino, NBC Corporate Communications, 212/664-3198

Cathy Hess <chess @ amchp.org>
02/22/99 01:01:29 PM

Record Type: Record

To: Barbara D. Woolley/WHO/EOP

cc:
Subject: Insure Kids Now - AMCHP commitments

Barbara, thanks for the invitation to tommorrow's event, and for the opportunity to share what AMCHP is doing to promote the campaign to reach and enroll children in CHIP. As you know, the Association of Maternal and Child Health Programs (AMCHP) represents all of the state public health agency programs across the country that focus on child health. The mission of these programs derives from Title V of the Social Security Act, the MCH Block Grant, which requires states to provide toll-free lines for parent advice, and to assist public insurance programs, including Medicaid and CHIP, to find and enroll eligible children.

AMCHP is committed to working with the White House, our colleague national partner organizations, and our members to spread the word about "Insure Kids Now". Specifically we will:

-Devote the front page of our upcoming newsletter Updates to the initiative. To be distributed in early March, the newsletter is mailed to over 500 national, state and local public health and related organizations and individuals.

- Add an ad banner for the campaign that will link to the federal website, on AMCHP's web site - www.amchp1.org

-Ask and assist all of our member public health agnecy program directors in all 50 states(as well as DC and territories) to offer their expertise in running toll-free lines, and their community based service providers to assist in the campaign (some of our members may be operating the state lines- we are trying to ascertain the exact number). We will do this through our newsletter, website, our upcoming annual meeting (Mar. 15-17 here in Washington), and in future, reports that share lessons learned among the states.

Please call or email me if [illegible]

On behalf of the President and the First Lady, we thank you for your interest in the Children's Health Insurance Plan Initiative's private sector partnership program. As you know, the President and the First Lady Hillary Rodham Clinton plans to announce your commitment during a White House event to raise awareness about children's health insurance plans. The event is scheduled for February 23 and the time and location is to be determined.

The White House plans to incorporate a summary of your commitment in press materials. To streamline efforts, please provide the following information and fax this form to Barbara Woolley at 202-456-6218 by February 19th. Thank you.

****

Name of company:

AMERICAN DENTAL ASSOCIATION

Summary if commitment/activity:

1) ADA ONLINE - This is ADA's homepage on the Internet; and/or

2) ADA News

Time frame during which commitment/activity will be implemented:

As soon as the information is available.

Location (nationwide/regional, etc.):

Nationwide

Company representative attending White House event:

Name: Thomas J. Spangler, Jr.

Work address/telephone number: 1111 14th St., N.W., Suite 1100
Washington, D.C. 20005
(202) 789-5177

If applicable, will you provide a visual for the event? If yes, please describe:

NO

To Deanah from: Neera

PRESIDENT CLINTON AND FIRST LADY HILLARY RODHAM CLINTON LAUNCH THE INSURE KIDS NOW CAMPAIGN PROMOTING CHILDREN'S HEALTH INSURANCE OUTREACH

DRAFT: February 23, 1999

Today, the President and the First Lady, along with Governors Carper and Leavitt and Secretary Shalala, launched the nationwide "Insure Kids Now" campaign designed to enroll every eligible but uninsured child in Medicaid and the new Children's Health Insurance Program (CHIP). Building on his efforts to ensure that it is easy and accssible for families to enroll their children, the President has engaged a broad-based, bipartisan, public-private coalition to use whatever means possible to educate and assist families in insuring their children. ~~This includes launching~~ a nationwide, toll-free number set up by the National Governors' Association in partnership with the White House and Bell Atlantic, allowing families to get essential information; airing public service announcements on TV and radio; ~~placing~~ the ~~toll-free~~ number on corporate products; ~~enlisting~~ grass-roots organizations to get the word out; and stepping up activities by over 10 Federal agencies that interact with working families. Altogether, these actions will make a major contribution towards the President's goal of covering up to 5 million uninsured children.

the center piece of the campaign is to

launch of

placement of the toll campaign to help

on their state programs no matter where they are.

CHILDREN'S HEALTH INSURANCE INITIATIVE

The President and First Lady have made improving children's health a priority. Studies show that children without health insurance are more likely to be sick as newborns, less likely to be immunized as preschoolers, and less likely to receive medical treatment when they are injured.

- **Historic, new options for children.** The President, with bipartisan Congressional support, created the State Children's Health Insurance Program (CHIP) in 1997, which devotes $24 billion dollars over the next five years for health coverage for children. Today, 47 states have implemented CHIP and expect that they will enroll over 2.5 million children when fully operational.

- **Greater challenge: enrolling children.** Ensuring that all eligible children get enrolled in health insurance is a formidable challenge. Barriers like complicated applications, lack of coordination between children's programs, and the perception that working families are not eligible prevent uninsured children from getting the coverage that they need. To remove these barriers, the President has taken numerous actions to encourage states to streamline their application and enrollment processes, accept mail-in applications, and place eligibility workers in convenient locations. He also ordered 8 Federal agencies, through their hundreds of programs that serve working families, to aggressively assist in enrolling children.

the focus of the campaign is to reach families, so all eligible families are covered through

NEW, NATIONWIDE "INSURE KIDS NOW" OUTREACH CAMPAIGN

Building on last year's efforts, today the President and First Lady launched the "Insure Kids Now" public-private campaign. For the first time, major TV and radio networks, corporations, health care organizations, religious groups, and other community-based organizations can join Federal agencies in raising awareness of the importance of children's health insurance.

- **Launching "1-877-KIDS NOW" Hotline.** Today, Governors Carper and Leavitt unveiled 1-877 KIDS NOW, a new toll free number developed by the National Governors Association in partnership with Bell Atlantic and the Administration, that provides state-specific information about Medicaid and CHIP to families in all 50 States. Families calling the line will speak with a person who can provide information about eligibility criteria, benefits, and how to apply for coverage. Beginning in October, HHS will assume responsibility for this line.

- **Running public service announcements on national television about Insure Kids Now.** Beginning tomorrow, to help surround families with information about Insure Kids Now, NBC, ABC, Univision, Turner Entertainment, the National Association of Broadcasters, and Viacom/Paramount will air public service announcements providing information about the importance of health insurance and ~~promoting the~~ Insure Kids Now number.

- **Airing radio advertisements about Insure Kids Now.** Today, the Deparment of Health and Human Services (HHS) will begin funding radio ads on Insure Kids Now in 45 States and DC, starting with California, Utah, Colorado, Alabama, Illinois, Ohio, Kentucky, North Carolina, New Jersey, Connecticut, and Maine. Later this year, Radio Disney and Bonneville will run similar ads nationwide. Radio advertisements reach over 77 percent of consumers daily, making them an incredibly effective way to reach the millions of families with children who are eligible for Medicaid or CHIP. In addition, when radio and television are used together as part of a larger educational campaign, over 70 percent of people remember the visual images of the television advertisement when hearing the radio advertisement.

- ~~**Publishing editorials and writing articles about Insure Kids Now.** This spring, USA Today will publish an editorial and Blue Cross/Blue Shield will publish a full page advertisement in the April issue of Time Magazine on children's health insurance.~~ In addition, Pfizer, the American College of Emergency Physicians, the American Nurses Association, the United Way, American College of Physicians, the National Collaboration for Youth, the Association of State and Territorial Health Officials, Wyeth Lederle, Kaiser Permanente, Volunteers of America, the March of Dimes, the Points of Light Foundation, Hope for Kids, the Veterans of Foreign Wars, the National Education Association, and religious organizations from across the country have agreed to put information on Insure

Kids Now in their product handbooks, circulars, and mass mailings, as well as distributing posters featuring the Insure Kids Now number to their clients and constituents. Print media is an effective educational tool, especially when used together with other media, because it allows the reader to reread and thoroughly digest the information.

- **Printing the Insure Kids Now toll free number on commonly used products.** Public service announcements and advertisements are only one component of a successful communications campaign. Building on a series of commitments made in 1998, K-Mart, General Motors, the American Dental Hygienists Association and American Medical Response have joined the Insure Kids Now campaign and have pledged to put the new toll free number on grocery bags, toothbrushes, diaper boxes, pharmaceutical products, child safety seats, and on the sides of buses.

- **New Federal efforts to promote children's health insurance outreach.** The President has both legislative and administrative proposals to help enroll children in Medicaid and CHIP, including Over $1.2 billion in his FY 2000 budget for children's health outreach, through proposals that will help states access additional funding for successful outreach activities, and new actions by the Federal Task Force on children's health outreach, including launching the new "InsureKidsNow.Gov" website today that provides information about state programs and the Administration's public-private outreach campaign; distributing 145,000 posters to over 20,000 health centers, providers, and other grantees; sending 92,000 USDA employees information about outreach on March 8 on their wage and earning statements, including the national toll-free number; and sending a letter and posters with the Insure Kids Now number from the Department of Justice to all 170 sites in Operation Weed and Feed, a crime prevention and community revitalization initiative.

Survey Results:

YMCA of the USA
Eden Fisher Durbin
(202) 835-9043

Summary of commitment:

1) Will place information and phone number for CHIPS program on HOTFAX – a national fax alert to over 4,000 staff and volunteers associated with YMCA
2) Will incorporate information and phone number for CHIPS program in Healthy Kids Day material. Healthy Kids Day is a national YMCA day that highlights kids health issues across the country at local YMCAs. Healthy Kids Day is April 10th.
3) Will distribute information and phone number at our YMCA Multi-Cultural, YMCA Program and YMCA City Agenda Conferences in the next 3-9 months.

All of these steps will be taken in the next 2 weeks to 9 months. The location will be country-wide. The information will be distributed to the over 2200 YMCAs across the country that serve 16 million people, including 8 million youth.

Families USA FOUNDATION

The Voice for Health Care Consumers

Fax Transmission

Date: 2/23/99

Time: 4:15pm

Dept. / Activity Code: 60 Project: 83

Number of Pages: 2 (including this cover sheet)

Please deliver this fax to:

Name: Barbara Wooley Org.: _____

Fax #: 456-6218 Phone: _____

Comments: _____

From: Vicky Pulos Ext.: 3618

1334 G Street, NW
Washington, DC 20005
Voice: (202) 628-3030
Fax: (202) 347-2417
e-mail: info@familiesusa.org

Deborah

From: Vicky Pulos
To: woolleyb_@a1.eop.gov
Date: Mon, Feb 22, 1999 11:59 AM
Subject: CHIP

Barbara,

Families USA will publicize the national 800 number in the following ways:
1. posting the number on our web page --www.familiesusa.org--our site receives about 12,000 hits per month

2. including the 800-number in the next issue of our newsletter--ASAP!--our newsletter is mailed to over 8,000 subscribers and covers all 50 states

3. including the 800-number in the next e-mail alert to our listserve which includes about 1700 people around the country

Families USA Foundation
1334 G Street, NW
Washington DC 20005
202-628-3030
info@familiesusa.org

Vicky Pulos
Families USA
202-628-3030

CC: Joan Alker

Martha Stewart **Living**

FACSIMILE

Martha Stewart Living Omnimedia
20 West 43rd Street
New York, NY 10036

DATE 2.22.99 TOTAL PAGES 2

TO Barbara Wooley

COMPANY The White House

PHONE

FAX 202.456.6218

FROM Janet O'Donnell

PHONE 212-827-8105

FAX 212-827-8102

MESSAGE

Revised copy to be faxed this afternoon.

If you have trouble with transmission of this fax, please call 212-827-8105.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Janet Odonnell to Barbara Wooley re: SSN and DOB (partial) (1 page)	02/22/1999	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 6]

2012-0463-S
rc731

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]

i/interns/Barbara/2
corp.
2R3chipcomms6

NAME OF COMPANY:
Martha Stewart Living Omnimedia, LLC

SUMMARY OF COMMITMENT/ACTIVITY:
MARTHA STEWART LIVING OMNIMEDIA LLC HAS COMMITTED TO PRODUCING PUBLIC SERVICE ANNOUNCEMENT (PSAs) FEATURING MARTHA STEWART TO SPOTLIGHT THE CHIP "800" NUMBER AND, WITH THE HELP OF CBS, TO AIRING THEM ON LOCAL TELEVISION AND RADIO STATIONS TO REACH FAMILIES ELIGIBLE FOR CHIP NATIONWIDE. THE COMPANY WILL ALSO PROVIDE CHIP-RELATED INFORMATION IN THEIR MAGAZINE, "MARTHA STEWART LIVING" AND ON THEIR "MARTHA STEWART LIVING" TELEVISION SHOW," AS WELL AS OFFER, IN PARTNERSHIP WITH KMART AND THE CHILDREN'S DEFENSE FUND (CDF), COMMUNITY-CENTERED OUTREACH AND IN-STORE INFORMATION AND INCENTIVE PROGRAMS FOR CHIP LATER THIS YEAR.

TIMEFRAME DURING WHICH COMMITMENT/ACTIVITY WILL BE IMPLEMENTED:
1999 with emphasis on fourth quarter

COMPANY REPRESENTATIVES ATTENDING WHITE HOUSE EVENT:
Martha Stewart, Chairman and Chief Executive Officer
Martha Stewart Living Omnimedia, LLC
20 West 43rd Street, New York, NY 10036
Phone: 212-827-8100
P6/(b)(6)
[001]

Sharon Patrick, President and Chief Operating Officer
Martha Stewart Living Omnimedia, LLC
20 West 43rd Street, New York, NY 10036
Phone: 212-827-8101
P6/(b)(6)

Email
Kim Widdess, Bronson Frick

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. fax	Jean Glenn to Barbara Wooley re: SSN and DOB (partial) (1 page)	02/19/1999	P6/b(6)

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Devorah Adler
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SmithKline Beecham

February 19, 1999

Barbara Wooley, Office of Public Liaison
Fax Number 202-456-6218

Name of Company: SmithKline Beecham

Summary of Commitment: SmithKline Beecham has participated and continues to participate with America's Promise and its efforts to catalyze private effort support for the CHIP Program.

We provided a $30,000 grant to provide America's Promise with the organizational capacity to interact with business and nonprofits in their efforts to market the CHIP program on a national level.

We provided $1.5 million in funds to support innovative and community-wide children's health programs in the communities that have made a commitment to the healthy start goal of America's Promise.

Timeframe: initiated support in 1997 and support will continue through 2000

Location: Nation-wide

Company Representative: Jean Glenn
Manager, Community Partnership
SmithKline Beecham
One Franklin Plaza
P.O. Box 7929
Philadelphia, PA 19101

At MS9
social office
X67136

P6/(b)(6)

[002]

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