

Federal Interagency Task Force Meeting
February 23, 2000
Room 100, Old Executive Office Building

Tentative Agenda

- I Welcome and Introductions - Claude Earl Fox, HRSA, Cindy Mann, HCFA, Jeanne Lambrew, National Economic Council
- II Updates - Cross-departmental/Agency Activities
 - State Children's Health Insurance Program and Medicaid outreach and enrollment; public charge - Tina Cheatham, HRSA
 - Insure Kids Now! Campaign (private partners) and national toll free number - Joy Kauffman, HRSA
 - Insure Kids Now! Through Schools and Fall Back to School Campaign- Bridget Bradley, Education; Lisa Graves, Justice
 - Census/HCFA - Letter to the States - Jessamy Taylor, HRSA (for George Burnette, Commerce, who is unable to attend)
 - President's Memorandum on School-based Outreach for Children's Health Insurance Programs - Marcia Brand, HRSA and Chris Howe, HCFA
- III Updates - Departments and Agencies - A Quick Review of Progress Towards Meeting Goals Outlined in the October 12, 1999 Report to the President
 - HHS (HCFA, HRSA, SAMHSA, ACF, CDC, ATSDR, AHRQ, IHS, Regions)
 - Agriculture
 - Commerce
 - Education
 - Environmental Protection Agency
 - Housing and Urban Development
 - Justice
 - Interior
 - Labor
 - Social Security Administration
 - Treasury
- IV New Task Force Members
 - National Performance Review - Pam Johnson
 - Center for National Service - Thea Kachoris (or her designee)
- V Issues/Barriers/Next Steps - Earl Fox, Cindy Mann, Jeanne Lambrew

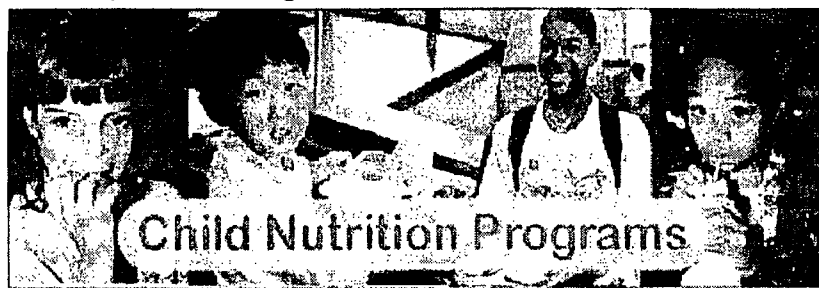
USDA CHIP OUTREACH EFFORTS

New CHIP Outreach Strategies/Activities

- In February, the Child Nutrition Division issued to its State agencies 12 different language translations of the prototype free and reduced price school meal application with a separate Medicaid/CHIP parental consent form, which gives schools permission to disclose information from their school meal application to Medicaid/CHIP agencies. The translations are also available on the FNS Web Site at www.fns.usda.gov/cnd
- National office Food Stamp Program (FSP) and Medicaid staff members are meeting to develop strategies to link FSP and CHIP outreach efforts and create joint messages to customers about the FSP and CHIP. National FSP and Medicaid staff members are encouraging State agencies to provide their Medicaid customers with part 1 of the FSP application form. Also, States are being asked to provide Part 1 of the FSP application to CHIP employees who may work in other Departments of the State.
- FSP and Department of Education staff members are meeting to explore ways to implement FSP and CHIP outreach efforts. Staff members are considering strategies that can be used to create joint messages about food stamps and health care coverage.
- USDA agencies with programs or outreach to rural areas are collaborating to design a dissemination model for information such as CHIP. Many USDA agencies have offices or program outreach in more than 3100 counties across the United States. By accessing these networks, information of interest to rural or farm populations, migrant workers, or other underserved groups can be increased.
- The Cooperative State Research, Education, and Extension Service (CSREES) of USDA is partnering with the Bureau of Primary Health Care to expand information about the Children's Health Insurance Program. Special emphasis is being given for outreach to rural and farm populations. Discussions are underway on a collaborative project with CSREES, the Bureau, and corporate partners who produce agricultural products.
- The Healthy People....Healthy Communities National Initiative of the Cooperative Extension System of CSREES has a goal to expand health care access by sharing information about CHIP and Medicare with families. To assess what has been done to share information on CHIP, a survey will be distributed to Extension staff and "dissemination techniques" will be shared throughout the system.
- CSREES will sponsor a national health and safety conference for Cooperative Extension System staff. The May 2000 conference will feature a workshop and an exhibit on CHIP. This effort will reach 125 land-grant system staff across the United States.

Ongoing CHIP Outreach Efforts

- On an ongoing basis, we continue to provide Medicaid/CHIP information and materials to State agencies and cooperators. For example, we continue to update State agencies as CHIP State Plans/amendments are approved by HHS. Electronic and print messages are distributed periodically to motivate State agencies and Cooperative Extension System community-based educators to make families aware of CHIP.
- On an ongoing basis, State agencies, grantees and cooperators providing direct program services to families refer families to Medicaid/CHIP or make Medicaid/CHIP applications available on site.
- On an ongoing basis, we include Medicaid/CHIP presentations at national meetings with State agencies, associations and cooperators, and agency representatives participate in national meetings sponsored by advocacy groups.
- We continue to collaborate with Federal agencies to facilitate Medicaid/CHIP outreach and enrollment, such HHS and Education to facilitate school-based outreach and enrollment.
- In response to emails and letters from the public about our programs, we continue to provide educational messages about CHIP and refer individuals to the CHIP national toll-free hotline number.

U. S. Department of Agriculture

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- **Afterschool Snacks** are now available to children and teenagers in after-school programs through the National School Lunch Program and the Child and Adult Care Food Program.
- **National School Lunch Program** provides nutritious lunches and the opportunity to practice skills learned in classroom nutrition education.
- **School Breakfast Program** provides nutritious breakfasts to promote learning readiness and healthy eating behaviors.
- **Special Milk Program** offers milk to children who do not have access to other meal programs.
- **Summer Food Service Program** serves healthy meals and snacks to low-income children during long school vacations.
- **Child and Adult Care Food Program** provides nutritious meals and snacks to infants, young children, and impaired adults who receive day care.
- **Nutrition Education and Training** is a nutrition education component of USDA's food assistance programs for children.

Also:

- **Free and Reduced-Price Application Materials** - available in English, Spanish, Hmong, Russian, Vietnamese, French, Portuguese, Chinese, Thai, Japanese, Creole, Cambodian, and Laotian.
- **Team Nutrition** provides schools with nutrition education materials for children and families, and technical assistance materials for school food service directors, managers, and staff. State agency partners provide training and technical assistance to support these programs in local schools.
- **Children's Health Insurance Program (CHIP)** provides health insurance to low-income children who do not qualify for Medicaid and have no health insurance. (Administered by DHHS.)

Henry
info

WAIVER OF MEAL BENEFIT FORM INFORMATION

Dear Parent/Guardian:

There is now affordable health insurance for children. Now, most families who work hard to make ends meet can get low-cost or free health insurance for their children.

Children with health insurance are more likely to receive needed vaccinations and get treated for illnesses. Without treatment, these illnesses can slow a child's learning and have life long effects. If you do not have health insurance for your child, check the box below to receive information about free and low-cost health insurance for children. **It is important to understand that you are not required to release this information. Its release is strictly voluntary.**

Health Insurance ☐ Yes. I want health insurance for my child. Program officials may give information from my Meal Benefit Form to Medicaid or officials of the State health insurance program for children. Medicaid and State health insurance program officials may use the information to help determine whether my child is eligible for benefits under Medicaid or the State health insurance program. Medicaid or State health insurance program officials may contact me for more information.

I understand that you will be releasing information from the Meal Benefit Form for my child. I give up my rights to confidentiality for this purpose only.

I certify that I am the parent/guardian of the child.

**Signature of
parent/guardian** _____

**Printed name of
parent/guardian:** _____

Address: _____



[Handwritten signature]

Early Childhood Today™

February 2000 Vol. 14 No. 5

The Magazine for All Early Childhood Professionals
www.earlychildhoodtoday.com

Best Software for Higher-Level
Thinking by Warren Buckleitner

Thinking,
Doing,
Learning: The Joy of

Soothing Infants
and Toddlers
by Alice Sterling Honig, Ph.D.

\$2.95 US/\$3.25 CAN

EARLY CHILDHOOD TODAY FEB

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VERY NCE

SCHOLASTIC

ECT Reports

New Preschool Curriculum From Scholastic

In *The Scholastic Five Senses Preschool Curriculum* (Scholastic Inc., 1999; \$99), author Pamela Haussner Harvey introduces a fun, developmentally appropriate, and fully integrated learning program organized through a child's earliest and most complete set of learning tools: his five senses. Geared to children ages two to four, the curriculum's activities focus on cultivating a child's sense of smell, sight, touch, taste, and hearing through physical exploration, while working to maximize opportunities for language development and learning. Children express themselves through poems, songs, music, and games and explore answers to questions like: "Why is this lemon so sour?" and "What makes this sandpaper so rough?" The strength of the program lies in its ability to accommodate all children, including those whose first language is not English. An introductory unit, *My World: Discovering the Five Senses*, includes a three-week warm-up program that helps set the stage for sensory learning. The curriculum kit also contains five individual sense unit books that organize activities around eight disciplines: room enhancement, circle time, art, music and games, cooking, large motor, fine motor, and science. Included, as well, are two professional books on training and staff development and observation and assessment, which offer teachers classroom tips, resources and materials, and advice on planning and structuring activities. To order, call 800-SCHOLASTIC. (Books are also available individually; \$9.95 to \$14.95.)



Low-Cost Health Insurance for Children

The U.S. Department of Health and Human Resources is reaching out to families of the six million children who are eligible for free or low-cost health insurance through their state's Children's Health Insurance Program (CHIP). Through its Insure Kids Now! program, HHR is promoting a toll-free number, 877-KIDS-NOW, which connects callers

to their state information center. CHIP programs differ from state to state, but Insure Kids Now! representatives can tell callers whether they are eligible and, if so, how to apply.

Early childhood educators can help spread the word by displaying the number on posters, pamphlets, and fliers at their centers and by distributing CHIP

applications to parents. Teachers can also arrange for state representatives to speak to parents and staff about the program. For more information about Insure Kids Now! go online to www.insurekidsnow.gov. You can also access fliers, brochures, and other promotional materials in both English and Spanish at www.hrsa.gov/childhealth.

Snacking on Calcium

More than half of American children are not getting enough calcium, according to the American Academy of Pediatrics. Calcium is essential for building strong bones and for staving off rickets—a disease that can cause bone deformities. Doctors recommend that children consume about 800 mg of calcium each day, or the equivalent of three eight-ounce servings of milk or other dairy foods (such as yogurt and cheese), and green leafy vegetables. Teachers can boost a child's calcium intake by serving milk as a snack-time beverage instead of fruit juices.



CAR SAFETY AWARENESS WEEK

The National SAFE KIDS Campaign is taking car seat safety out on the road during Passenger Safety Week, February 13–19. During that time, a fleet of new, fully equipped child-passenger safety vans will make its way into communities across the country, bringing car seat Check Up events to parents and caregivers at child care facilities as well as youth centers and shopping malls. The Campaign estimates that among the 60% of children who are restrained in car seats, 85% are restrained incorrectly. Forty percent of children still ride completely unrestrained. For information about Check Ups in your area, contact the National SAFE KIDS Campaign: 1301 Pennsylvania Ave., NW, Suite 1000, Washington, DC, 20004-1707, (202) 662-0660; or online at www.safekids.org.

1888 ASK HRSA

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IV New Task Force Members

- National Performance Review - Pam Johnson
- Workers.gov - Access America Site for Workers - Joyce Somsak, HRSA
- Center for National Service - Thea Kachoris (or her designee)

V Issues/Barriers/Next Steps - Earl Fox, Cindy Mann, Jeanne Lambrew

Thank you → States
radio
activity
Open minority
Open
1997
KIDSTON

calendar date
for event; EDS stuff to do.

quarterly
basis
spending's
not
spending



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

FEB 18 2000

Dear State Health Official:

I am writing to inform you of an important opportunity to ensure that individuals (and their families) who are temporarily hired by the Census Bureau to assist in Census 2000 do not lose eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP) because of the income they receive from employment by the Census Bureau.

Census 2000 offers a unique work opportunity for those receiving Temporary Assistance for Needy Families (TANF) and other low-income individuals to earn money while receiving training and developing valuable work skills. These skills can provide an important foundation for entering the work force or advancing within the work force. The Census Bureau is working hard to recruit low-income individuals for census work, and one of the key elements of recruiting is ensuring the availability of health care coverage for workers and their families.

The Census Bureau will hire more than half a million people to complete Census 2000 activities. Under the President's welfare-to-work initiative, the Census Bureau aims to hire thousands of TANF beneficiaries. In many neighborhoods, TANF beneficiaries are a focus of the recruitment effort. These TANF beneficiaries, as well as a great number of the other individuals who Census hires may be Medicaid beneficiaries, have children who are enrolled in Medicaid or SCHIP, or may be uninsured and interested in applying for these programs.

The Census 2000 recruitment and hiring effort is already underway. If hired by the Census Bureau, many of the people and their children may remain eligible for Medicaid because of protections afforded by transitional Medicaid benefits or they may be eligible for SCHIP. However, others may lose or fail to qualify for Medicaid or SCHIP because of temporary Census Bureau earnings unless States exempt income from temporary Census Bureau wages for purposes of Medicaid and SCHIP eligibility.

We encourage you to take advantage of the flexibility offered under Medicaid and SCHIP to ensure that families' continue to have access to health coverage. States have the option under title XIX and title XXI to disregard earnings when making eligibility determinations; and States can disregard specific types of income such as those earnings generated by employment with the Census Bureau. States need only file an amendment to their Medicaid and/or SCHIP State plan; no waiver is required.

Page 2 - State Health Official

Since hiring is already underway, we have tried to facilitate the State plan amendment process. States can use the State Medicaid and/or SCHIP plan template page that accompanies this letter, indicating the State's desire to disregard this income for eligibility purposes, and return the page(s) to your Health Care Financing Administration (HCFA) Regional Office. These amendments will be approved upon receipt by HCFA (and can be effective as of the first day of the calendar quarter submitted). We encourage you to return these plan amendments as quickly as possible.

In addition, please consider ways to utilize this unique opportunity to follow up on the Census 2000 effort by reaching and enrolling families and children in need of health care coverage. The Census Bureau estimates that there will be several million potential applicants for the Census 2000 positions. In every State that adopts the proposed State plan amendments, publicity of the Census 2000 Medicaid and SCHIP exemptions can reach thousands of individuals.

If you have any further questions, please contact Jennifer Ryan of HCFA's Center for Medicaid and State Operations at (410) 786-1304.

Sincerely,



Timothy M. Westmoreland
Director

Enclosures

cc:

All HHS Regional Directors
All HCFA Regional Administrators
All HCFA Associate Regional Administrators
for Medicaid and State Operations

George Barnett
United States Census Bureau

Brett Ewig
Association of State and Territorial Health Officials

Lee Partridge
American Public Human Services Association

Matt Salo
National Governors' Association

Joy Wilson
National Conference of State Legislatures

DRAFT

Revision: HCFA-PM-00-1
February 2000

Supplement 8A to Attachment 2.6-A
ADDENDUM

State Plan Under Title XIX of the Social Security Act

State: _____

**LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT**

For all eligibility groups not subject to the limitations on payment explained in section 1903(f) of the Act*: All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

* Less restrictive methods may not result in exceeding gross income limitations under section 1903(f).

DRAFT

Revision: HCFA-PM-00-1 Supplement 12 to Attachment 2.6-A
February 2000 ADDENDUM

State Plan Under Title XIX of the Social Security Act

State: _____

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

_____ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

_____ The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

DRAFT -- ADDENDUM TO SECTION 4.**STATE CHILDREN'S HEALTH INSURANCE PROGRAM
STATE PLAN TEMPLATE****Section 4. Eligibility Standards and Methodology (section 2102(b))****4.1.3. _____ Income: _____**

_____ All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

Worker.gov – An Access America Website

Vice President Gore's **Access America** initiative is using information technology to deliver comprehensive government services to Americans and to dramatically increase government productivity. See for example, <http://www.accessamerica.gov>, <http://www.business.gov/>, <http://www.students.gov>, <http://www.seniors.gov>, and the ten most requested services from Social Security (<http://www.ssa.gov/top10.html>).

Workers.gov, an Access America website for workers, part of the overall initiative, will be a single gateway and consolidated web site for American workers and their families to access a wide range of internet-based services, information, and transactions. The five core categories of the underlying database are: **Job Services, Support Systems, Learning Opportunities, Rights and Protections, and Money Management.**

The primary customers of this site are individual workers and their families -- including workers looking for higher-wage jobs, workers looking for family support services, welfare-to-work clients, the underemployed, youth seeking their first job, retired folks returning to the work force, those with special needs, and those looking for new career opportunities. Others who may find this site useful include front-line staff in one-stop job centers, at workforce investment boards, or in other offices that directly serve workers and their families. A design team from the U. S. Departments of Labor, Education, Health and Human Services, Defense, and Agriculture, and the Office of Personnel Management and the National Partnership for Reinventing Government (NPR) are creating this knowledge-based system.

The site will have three phases:

- (1) Information links, services, transactions - May 2000
- (2) Limited key word search capability - Labor Day 2000
- (3) Natural language, question-asking capability - Labor Day 2001

Please help us design this site by answering the five questions below and giving us feedback about the initial core categories, the sub-topics and the possible video training clips listed on the next page. THANKS.

Basic Questions:

1. What kinds of information are workers and their families seeking? Please be specific.
2. Of the information workers and their families seek, what are the 3 most important categories of information?
3. If we add video clips to this site, what training topics would you recommend?
4. What web sites should be linked to Access America for Workers?
5. We are looking for models of great web sites that are clearly written, well organized, and provide important information. What one or two sites do you suggest we look at?

Five Draft Content Categories:

1. **Job Services:** Job Bank, Talent Bank (resumes), self-assessments, TANF (Assistance to Needy Families), job interview skills, and information on new jobs, career change, career advancement and building a career plan.
2. **Support Systems:** Your Health (health information, health insurance), TANF (Assistance to Needy Families), unemployment insurance, day care, elder care, food stamps, family medical leave, information on adequate and safe transportation to work, housing, enterprise zones, migrant workers, career counseling, welfare to work, and other support mechanisms.
3. **Learning Opportunities:** Basic skills, family literacy centers, technical skills, ESOL, special needs, leadership, yellow pages of training and educational organizations, skill profiles, lifelong learning, on the job training, on line tutoring, and skills required to succeed in the new economy.
4. **Rights and Protections:** Employee and employer rights and protections, safety, wages, hours, legal assistance, employee assistance, discrimination, special needs.
5. **Money Management:** Federal and state taxes, earned income tax credit, financial aid for education or training, credit management, money management, retirement planning, inheritance planning, social security, and investing.

Video Tutorials

1. Using the Internet
2. Preparing for a great job interview
3. Understanding the skills needed for a technology job

Benefits and Support Services

Insurance

Health Insurance:

General information on health insurance coverage:

<http://www.dol.gov/dol/pwba/public/health.htm>

<http://www.dol.gov/dol/pwba/public/pubs/health/interim-pg.html>

Rights to purchase insurance

Insuring your family

When you change jobs

Health insurance for your children: (<http://www.insurekidsnow.gov/>)

Covering health care costs

Medicare and workers

General Health Information <http://www.healthfinder.gov/>

Unemployment Insurance: <http://www.doleta.gov/programs/ui bene.htm>

Disability Insurance: <http://www.wdsc.org/disability/>

Life Insurance

Financial Help: Safety Net Services

Workers may need additional help for their families or themselves. A number of programs can provide a safety net for workers and their families.

Food assistance

Health insurance

Child Support

Welfare to Work

Education Loans

Tax Credits

Energy Assistance <http://www.acf.dhhs.gov/programs/liheap/start.htm>

Housing

Mortgage and Lending Information (FHA, etc)

Home Insurance

Fair Housing and other Rights

Transportation

Subsidized Programs

Family Care

Child Care

Elder Care

Family Medical Leave

Child rearing

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Welcome to Workers.gov a single gateway and consolidate web site that will serve as a single point of contact for American workers and their families to access a wide range of interbase services, information, and transaction.

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Workers.gov

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[Council for Opportunity in Education](#)
[College Opportunities On Line \(COOL\)](#)
[America's Learning Exchange](#)
[Consumer Information Center — Education](#)

career development

[Corporation for National Service — Americorps](#)
[America's Job Bank](#)
[Consumer Information Center — Employment](#)
[Current Job Openings, Office of Personnel Management](#)
[Bureau of Labor Statistics](#)
[Occupational Outlook Handbook](#)

military service

[Be All You Can Be — Join The Army ROTC, Air Force](#)
[U.S. Coast Guard](#)
[The Few, The Proud, The Brave — The Marines](#)
[The U.S. Navy](#)
[Always Ready, Always There — The National Guard](#)

pay for your education

[The Student Guide \(ED\)](#)
[Student Financial Assistance Programs](#)
[America's Learning Exchange](#)
[Financial Aid Advisor](#)
[Corporation for National Service — Americorps](#)
[Project EASI, Easy Access for Students and Institutions \(ED\)](#)

volunteer service

[The Peace Corps](#)
[Corporation for National Service — Americorps](#)
[HUD Volunteer Center](#)
[Volunteer in the National Forests](#)
[National Health Service Corps](#)

fast links:**[AAFS Strategic Plan](#)**

public charge campaign
get information out on letterhead
spanish language campaign in 5 states

Insure kids Now
220,000 calls in last year
only 2 states don't rollover



Forthcoming Activities

Articles:

- **American College of Obstetricians and Gynecologists** will print an article highlighting the new adolescent poster that will be distributed to their 39,000 members.
- **Consumer Federation of America, Generations United, and the Housing Assistance Council** will publish an article in their national newsletter.
- **Scholastic-Coach and Athletic Director** will publish an article in the magazine.

Presentations at Conferences:

- **National Rural Health Association:** Presented to approximately 30 national organizations and corporations in February 2000.
- **Child Welfare League of America:** will distribute information about Insure Kids Now at their national conference with 2000 attendees in March 2000 and created a hotlink to insurekidsnow.gov.
- **Food Research and Action Center:** will present to national hunger advocates and leaders in February 2000.
- **Head Start National Conference:** will present two sessions about CHIP, Medicaid and Insure Kids Now and have a print ad in their conference guide for the 10,000 attendees in April 2000.
- **Neighborhood Networks- HUD:** will present at their national conference in the fall of 2000.

Distributing resources:

- **Environmental Health Center National Safety Council** will play Insure Kids Now radio ads during their regular enviro-minute spots
- **Agency for Healthcare Research and Quality (Formerly AHCPR)** will distribute 100 posters to their contacts.
- **Kellogg Foundation-Community Voices** distributed posters and bumper stickers.

What have national corporations and organizations done to promote Insure Kids Now?

February 2000-Joy Kauffman-BPHC, HRSA

Company/ Organization	Action
ABC/ WJLA	Ran television ads and news stories promoting Insure Kids now hotline and health insurance for kids.
American College of Emergency Physicians	Promoted CHIP through their website, state chapters and internal publications. ACEP Chapters in FL, NJ and PA have been active in CHIP promotion.
American College of Obstetricians and Gynecologists	Alerted its 39,000 members to the potential of CHIP to increase insurance coverage for and access to health care for youth, particularly adolescents, whom many of them serve. ACOG has done this through newsletter articles, posting information on the ACOG website, and letters to the section chairs. ACOG has also encouraged HRSA to spotlight adolescents in their outreach and enrollment efforts and assisted HRSA in convening a meeting on CHIP and adolescents.
American College of Physicians-American Society for Internal Medicine	Sent out information to 75 chapters across the nation. They now have a campaign about the uninsured planned for this spring.
American Dental Association	Ran articles in the ADA News that reaches 73% of all practicing dentists in the US. Promotes Insure Kids Now on the website.
American Dental Hygienists' Association	Distributed 11,000 free toothbrushes with the Insure Kids Now message on them to children in targeted areas across the country. Promoted CHIP in a magazine that reaches 80,000 dental hygienists nationwide.
American Friends Service Committee	Provided literacy kits to rural women in West Virginia that contain study materials and information about CHIP.
American Hospital Association	Distributed over 5000 Insure Kids Now Posters to hospitals nationwide in October 1999. Participated in the National Back to School Campaign with the United Way of America and McDonald's.
American Medical Response, Inc.	Developed a customized logo to be used in promotional materials and promoted CHIP at several community oriented EMS awareness days.
America's Promise	Promoted Insure Kids Now on the website that receives over 700,000 hits per month and in a publication that goes out to 5,000 individuals and organizations nationwide.
Association of Maternal and Child Health Programs, The	Created a hotlink to the Insure Kids Now website. Published a story about Insure Kids Now in the national newsletter and issued a press release.
Catholic Charities USA	Established an initiative called Children's Health Matters working on enrollment and simplification of enrollment.

Company/ Organization	Action
Children's Defense Fund	Collaborated with the Kmart and Martha Stewart, Inc. to launch Child Health Now, a three-month campaign in CT, NJ, and NY to promote health coverage for children. The campaign promoted the Insure Kids Now hotline, inspired over 100 health fairs, and ran from mid-September to mid-November. Launched the Student Outreach Project (SHOUT) at Columbia University to train students to work with CBOs to provide enrollment assistance.
Evangelical Lutheran Church in America/Division of Church and Society	Distributed information to 11,000 congregations and put a link to Insure Kids Now on their website.
General Motors	Donated \$5 million of child safety seats to families in low-income communities through appropriate national organizations. Included with these safety seats will be information on how families can receive additional healthy start access to health safely in vehicles. Finally, while GM employees have long been active in their communities, GM will also work closely with America's Promise as it develops a more formal volunteer process at GM
Hope for Kids	Educated families of 138,570 uninsured children regarding health insurance options and helped to enroll 6,758 of them.
Kids Korner Gift	Redirected over 15,000 calls to the 1-877-KIDS-NOW number (they own 1-800 and 1-888-KIDS NOW).
Kmart Corporations-	Distributed Insure Kids Now Brochures to all Kmart pharmacies nationwide. Aired PSAs in Kmart locations September through December 1999. Printed the Insure Kids Now message on 35 million checkout bags during September 1999. Launched a three-week, tri-state campaign with CDF, Martha Stewart, Inc. and March of Dimes in CT, NJ, and NY.
March of Dimes	Promoted Insure Kids Now on banners at over 1,000 WalkAmerica sites reaching 1 million volunteers and 20,000 corporate donors. Collaborated with Kmart to promote coverage during a one-day campaign and will continue collaboration with Kmart pharmacies. Conducted various local activities including educational and policy forums, grassroots outreach and media campaigns. Featured CHIP in a direct mail that was sent to 1.5 million individuals. Promoted Insure Kids Now through the Back to School Campaign.
Martha Stewart, Inc	Collaborated with the Children's Defense Fund and with Kmart to launch Child Health Now, a three-month campaign in CT, NJ, and NY to promote health coverage for children. The campaign promoted the Insure Kids Now hotline and ran from mid-September to mid-November.
McDonald's	The DC Regional Office supported the effort to enroll children on Insure Kids Now day at 26 McDonald's in DC, MD, VA, and WV.
National Association of Chain Drug Stores	Distributed over 35,000 posters to and background information for pharmacists at chain drug stores across the country in partnership with Johnson & Johnson. Launched a focused campaign to increase awareness in Virginia.
National Council of Catholic Women	Distributed information through a magazine with 11,000 circulation.

Company/ Organization	Action
National Council of Churches of Christ	Distributed information to their 33 members representing 52 million members nationwide.
NETWORK	Distributed information in their magazine with 10,000 circulation.
Parmalat USA Corporation, Inc.	Distributed Insure Kids Now information on over 10 million milk containers in CT, NJ, and NY.
Pfizer Inc./ Pediatric Health-	Distributed Insure Kids Now information on 25,000 PDR Pediatric Resource Guides that are sent to pediatrician's offices across the country. In addition, in collaboration with Kmart the Guides were sent to all Kmart pharmacies.
Public Education Network	Distributed information to 45 local education funds, which represent 5 million children. Promoted Insure Kids Now on website and through a list serve reaching over 2000 people.
Safeway Inc.	By the end of March 2000, 9.1 million shopping bags will be distributed to customers in 13 states plus DC through 679 stores. Sponsored ads for the Insure Kids Now Campaign reaching 6.9 million households in the DC and Baltimore area during the fall of 1999.
Schering-Plough	Provided a grant to the City of Elizabeth, NJ through which 400 children have been enrolled. Promotes CHIP on website for school nurses (www.schoolasthma.com) providing a hyperlink to state applications. Provided internet-accessible laptop computers to 150 school nurses in New Jersey and is collaborating with America's Promise to equip other school nurses with laptops.
Scholastic, Inc.	Printed and article in the February 2000 version of Early Childhood Today which is distributed to 53% of all child care centers, reaching 3.5 million kids (55,000 paid circulation, 264,000 readership) and committed to run Insure Kids Now ads in several publications.
SmithKline Beecham	Granted 1.5 million dollars to projects that assist children and parents in accessing health care and enrolling in CHIP.
Union of American Hebrew Congregations	Distributed information about CHIP via brochures and e-mail.
United Jewish Community	Distributed information about CHIP via brochures and e-mail.
Vision USA (American Optometric Association)	Offered free vision screening through their state chapters and includes information about Insure Kids Now to and CHIP and Medicaid coverage to the people they serve.
Woman's Missionary Union	Distributed information to 300 leaders nationwide.
Wyeth-Lederle Vaccines (Burson-Marsteller)	Formed a CHIP working group made up of national children's advocacy groups and developed a CHIP Outreach Tool Kit. Sponsored research to determine children's health priorities, assess awareness of CHIP, evaluate existing outreach materials and determine the access to care and utilization once a child is enrolled. Developed a CHIP Communications Handbook including best practices, assessment tools, and a resource directory.
YMCA	Featured CHIP in a fax alert that reaches over 4,000 staff and volunteers. Promoted CHIP at annual Healthy Kids Day and at national conferences.

Cindy:

Here is the chart on redetermination periods.

As I said in my voicemail, most states have their Medicaid and separate CHIP programs in sync on this point. They are more likely to vary on whether 12 months is continuous or not.

So here's what it looks like:

- California, Georgia, New Jersey, West Virginia, and Wyoming have shorter redetermination periods in Medicaid than in their separate CHIP programs.
- Minnesota has a 6 month redetermination period for "regular" Medicaid and 12 months for MinnesotaCare. (Tennessee may be doing this, as well. They have 6 months redetermination in Medicaid and say the redetermination period for TennCare is set on a 'case by case' basis. We need to check this out further.)
- Arkansas has 12 month redetermination in "regular" Medicaid and 12 month continuous eligibility in ArKids First.
- Florida has 12 months continuous eligibility for children under age 5 in Medicaid; 12 month redetermination for older children in Medicaid and all children in the separate CHIP program.
- Colorado, Delaware, Illinois, Iowa, Nevada, North Dakota and Pennsylvania have 12 month redetermination in Medicaid and 12 months continuous eligibility in their separate CHIP programs.
- New York has 12 months continuous eligibility in Medicaid and 12 months redetermination in its separate CHIP program.

I hope this is helpful.

Donna



CENTER ON BUDGET AND POLICY PRIORITIES

December 14, 1999

Redetermination Periods Medicaid for Children and CHIP-funded Separate State Programs (SSP)

	Redetermination Period
Alabama	12 months*
Alabama SSP	12 months*
Alaska	6 months
Arizona	12 months*
Arizona SSP	12 months*
Arkansas ¹	12 months
California	3 months (status review) 12 months (reaffirmation)
California SSP	12 months*
Colorado	12 months
Colorado SSP	12 months*
Connecticut	12 months*
Connecticut SSP	12 months*
Delaware	12 months
Delaware SSP	12 months*
District of Columbia	12 months
Florida ¹	12 months
Florida SSP	12 months
Georgia	6 months
Georgia SSP	12 months
Hawaii	12 months
Idaho	12 months*
Illinois	12 months
Illinois SSP	12 months*
Indiana	12 months*
Iowa	12 months
Iowa SSP	12 months*
Kansas	12 months*
Kansas SSP	12 months*
Kentucky	12 months
Kentucky SSP	12 months
Louisiana	12 months*
Maine	6 months
Maine SSP	6 months
Maryland	12 months
Massachusetts	12 months
Massachusetts SSP	12 months

820 First Street, NE, Suite 510, Washington, DC 20002

Tel: 202-408-1080 Fax: 202-408-1056 center@center.cbpp.org <http://www.cbpp.org> HN0026

Michigan	12 months*
Michigan SSP	12 months*
Minnesota ¹	6 months
Mississippi	12 months*
Missouri	12 months
Montana	12 months
Montana SSP	12 months
Nebraska	12 months*
Nevada	12 months
Nevada SSP	12 months*
New Hampshire	12 months
New Hampshire SSP	12 months
New Jersey	6 months
New Jersey SSP	12 months
New Mexico	12 months*
New York	12 months*
New York SSP	12 months
North Carolina	12 months*
North Carolina SSP	12 months*
North Dakota	12 months
North Dakota SSP	12 months*
Ohio	6 months
Oklahoma	6 months
Oregon	6 months
Oregon SSP	6 months
Pennsylvania	12 months
Pennsylvania SSP	12 months*
Rhode Island	12 months
South Carolina	12 months*
South Dakota	12 months
Tennessee	6 months
Texas	6 months
Utah	12 months
Utah SSP	12 months
Vermont	6 months
Virginia	12 months
Virginia SSP	12 months
Washington	12 months*
West Virginia	3 months
West Virginia SSP	12 months*
Wisconsin	12 months
Wyoming	6 months
Wyoming SSP	12 months*

Source: Center on Budget and Policy Priorities Survey of State Officials, October 1999.

* Denotes 12-month continuous eligibility — child is enrolled for 12 months, regardless of changes in family income or circumstances.

1. Arkansas: Eligibility for children enrolled in Medicaid (pre-expansion) is redetermined every 12 months. Children enrolled in ARKids First — the Medicaid expansion program — receive 12 months of continuous eligibility.

2. Florida: Children under age 5 enrolled in Medicaid receive 12 months of continuous eligibility. Eligibility for other children in Medicaid, and in the state's separate CHIP program, is redetermined every 12 months.

3. Minnesota: Eligibility for children in Medicaid (pre-expansion) is redetermined every 6 months. Eligibility for children in MinnesotaCare — the Medicaid expansion program — is redetermined every 12 months.

National Health Law Program

1101 14th Street, NW, Suite 405

Washington, DC 20005

Phone: (202) 289-7661

Fax: (202) 289-7724

FAX TRANSMISSION COVER SHEET

Date: December 29, 1999

From: CLAUDIA SCHLOSBERG

To: SEE LIST BELOW

Fax:

Re: SCHIP PROGRAM PROPOSED RULES

YOU SHOULD RECEIVE 7 TOTAL PAGES. IF YOU DO NOT RECEIVE ALL OF THE PAGES, PLEASE CALL (202) 289-7661. THANK YOU.

William J. Clinton, President of the United States - (202) 456-1121

Albert Gore, Jr., Vice President of the United States - (202) 456-7044

Christopher C. Jennings, Deputy Assistant to the

President for Health Policy Development - (202) 456-5557

Robert "Ben" Johnson, Assistant to the President and Director

of the President's Initiative for One America - (202) 456-2577

Margaret A. Hamburg, M.D., ASPE - (202) 690-7383

David Satcher, MD, Ph.D., Surgeon General - (202) 690-6960

Thomas E. Perez, HHS/Director, OCR - (202) 619-3818

Nancy-Ann Min Deparle, Administrator, HCFA - (202) 690-6262

Nathan Stinson, Jr., M.D., Ph.D., M.P.H., HHS/PHS/Deputy

Assistant Secretary for Minority Health - (301) 443-8280

Claude E. Fox, M.D., M.P.H., Administrator, HRSA - (301) 443-1246

John M. Eisenberg, M.D., Administrator, AHRQ - (301) 594-2168

HARD COPY TO FOLLOW

FOR ADDITIONAL INFORMATION, PLEASE CONTACT LIONEL NIOUS, 202-289-7661

December 29, 1999

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

The undersigned organizations write to you regarding the proposed new rules implementing the State Children's Health Insurance Program (SCHIP), published in the Federal Register for public comment on November 8, 1999. At the outset, we want to applaud the Department's decision to incorporate basic consumer protections into the regulations. The right to apply for assistance, to have applications processed in a timely manner, to be informed about benefits, participating providers and coverage decisions, and to have access to a fair process to resolve disputes are necessary to ensure that the SCHIP program's promise of health care coverage is more than an illusion.

As organizations who have worked hard at both the national and local levels to link low-income children to SCHIP, however, we are gravely disturbed that the Department has failed to seize this opportunity to begin mandating the collection of data that is critical to understanding how minority children are being served within the SCHIP program. While the proposed SCHIP regulations require state reporting of program expenditures, certain statistical data and an assessment of performance, conspicuously absent is any requirement to report information about the race, ethnicity and primary language spoken by enrollees.

Our daily experiences, supported by the government's own research, plainly establish that minority children are at highest risk to be without access to health insurance and health care. According to the Agency for Healthcare Research and Quality, Hispanic children are more likely to be uninsured than any other racial or ethnic group; while African American and Asian and Pacific Islander children are more likely than white children to be uninsured. Recognizing the special vulnerability of minority children, the U.S. Congress recently enacted legislation to improve SCHIP data collection by directing the Secretary of Commerce to produce statistically reliable annual State data on the number of low-income children who do not have health insurance and to categorize such children by family income, age, *race and ethnicity*. However, unless the Department also requires states to report SCHIP enrollment by race, ethnicity and

primary language spoken in a uniform manner, the opportunity to understand how and if SCHIP is meeting the needs of uninsured minority children will be lost.

There are several other compelling reasons why the Department should mandate the collection and reporting of data that identifies the race, ethnicity and primary language spoken of children in SCHIP programs. Of utmost importance is the need to ensure that federally funded SCHIP programs are operated in compliance with federal civil rights laws, including Title VI of the Civil Rights Act of 1964. As you know, Title VI prohibits discrimination on the basis of race, color, or national origin by any entity which receives federal financial assistance. Regulations implementing Title VI mandate that the Department *require* federal fund recipients to collect and report to HHS information sufficient to document compliance with the law. The authority to decide when, how and what data is reported is clearly vested in the Department.

Additionally, the collection and reporting of data on race, ethnicity and primary language spoken is needed to assist the Department to meet its goal of eradicating racial and ethnic disparities in health care by the year 2010. Absent a commitment to require the reporting and collection of data, the Department lacks the tools to measure its own progress and ultimately, to meet its stated goal.

Finally, requiring states to collect and report data that identifies the race, ethnicity and primary language spoken of children enrolled in SCHIP will help to build the comprehensive minority health database recommended by the U.S. Commission on Civil Rights in its recent report, "The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination and Ensuring Equality." Finding current data collection efforts wanting, the report recommends that the Department create the comprehensive database and take other action to improve its data collection efforts.

We recognize that there may be resistance to requiring federally-assisted health providers to report and collect racial and ethnic data. However, many states already require that this data be reported. Furthermore, given the amount of data that HCFA currently requires health providers to collect and report (and that health providers collect for their own marketing and management purposes), we do not believe that the reporting of data regarding race, ethnicity and primary language imposes significant, additional costs or administrative burden. Surely, data that is routinely collected by courts, police departments, schools, the U.S. Census Bureau and all other federally-supported institutions also can be collected by the Department.

In sum, we urge you to take this opportunity to include in the final rule a requirement that states report the race, ethnicity and primary language spoken by children enrolled in SCHIP. We also believe it is important to provide assurances that the privacy and confidentiality of information pertaining to individuals be safeguarded so that the information is not used for improper purposes. These additions to the mandated reporting requirements will have a profound and positive impact on our ability to ensure that all income-eligible children, regardless

of race or ethnicity, will be linked to health insurance and that racial disparities in health care are, indeed, being addressed by federal fund recipients.

Sincerely,

AIDS Legal Council of Chicago
Alliance for Children and Families, Washington, DC
American Federal of State, County and Municipal Employees
American Protestant Health Alliance
Arise Citizens' Policy Project, Montgomery, AL
Arkansas Advocates for Children and Families
Asian American Family Counseling Center, Houston, TX
Asian Health Services, Oakland, CA
Asian Pacific American Legal Center
Asian and Pacific Islander American Health Forum
Asian Pacific Policy & Planning Council, Health Committee
Association of Asian Pacific Community Health Organizations
Bazelon Center for Mental Health Law
Black Leadership Forum, Inc., Washington, DC
Blue Panthers, Eagle Point, OR
Blue Ridge Area Health Education Center, James Madison University, VA
California Program on Access to Care
Cambridge Economic Opportunity Council, Boston, MA
Camillus Health Concern, Miami, FL
Campaign for Better Health Care, Illinois
Center for Adolescent Health and the Law, Chapel Hill, NC
Center for Community Change, Washington, DC
Childhood Cancer Survivorship Network, Austin, TX
Children's Defense Fund, Washington, DC
Citizens for Missouri's Children
Coalition for the Welfare of Women and Children, Philadelphia, PA
Columbia Road Health Services, Washington, DC
Community Catalyst, Boston, MA
Community Legal Services, Inc., Philadelphia, PA
Community Service Society, New York, NY
Community Voices, Oakland, CA
Consumers for Affordable Health Care, Augusta, ME
Contact Center, Cincinnati, OH
Council on Asian Pacific Minnesotans
Department of Public Health, Hartford, CT
District of Columbia Primary Care Association
EFR's Iowa Institute for the Well-Being of Refugee Families

Family and Medical Counseling Service, Inc., Washington, DC
Family Violence Prevention Fund, San Francisco, CA
Farmworker Justice Fund, Inc., Washington, DC
Friends Committee on National Legislation (Quaker), Washington, DC
Georgia Office of Primary Care
Great Basin Primary Care Association, Carson City, NV
Greater Upstate Law Project, Rochester, NY
Health and Medicine Policy Research Group, Chicago, IL
Health Choice Network, Miami, FL
Human Services Agenda, Mississippi
Human Services Coalition, Miami, FL
Illinois Caucus for Adolescent Health
Illinois Coalition for Immigrant and Refugee Rights
Illinois Primary Health Care Association
International Community Health Services, Seattle, WA
Kentucky Task Force on Hunger
Kootenai Medical Center, Coeur d'Alene, ID
Korean American Coalition Sacramento Chapter, Davis, CA
Language Access Metro Project, St. Louis, MO
Latino Health Institute, Boston, MA
Legal Aid Society, New York, NY
Louisiana Health Care Campaign
Mexican American Legal Defense and Educational Fund, Los Angeles, CA
Maryland Disability Law Center
Massachusetts Immigrant and Refugee Advocacy Coalition
Massachusetts Law Reform Institute
Medical and Health Research Association of New York City
Mental Health Legal Advisors Committee, Boston, MA
Minority Health Coalition of Allen Co., Fort Wayne, IN
Mississippi Primary Health Care Association
Mountain States Group, Inc., Boise, ID
National Asian Pacific American Legal Consortium
National Association of Child Advocates
National Association of Community Health Centers
National Association of People with AIDS
National Association of Public Hospitals and Health Systems
National Black Caucus of State Legislators
National Caucus and Center on Black Aged, Inc.
National Council of La Raza
National Center for Youth Law
National Dental Association
National Health Law Program
National Hispanic Medical Association
National Immigration Law Center
National Medical Association

National Partnership for Women and Families
National Senior Citizens Law Center
Nebraska Appleseed Center for Law in the Public Interest
Nebraska Health and Human Services HIV Prevention Program
Neighbor to Neighbor
New Hampshire Citizens Alliance
New Jersey Immigration Policy Network
New York Immigration Coalition
NICOS Chinese Health Coalition, San Francisco, CA
North Carolina Fair Share
Northern California Lawyers for Civil Justice
Northwest Federation of Community Organizations, Seattle, WA
NOW Legal Defense and Education Fund, Washington, DC
Ocean State Action, Cranston, RI
Oregon Food Bank
Our Kids Count Coalition, Jonesboro, AR
Pacific Regional Psychological Associates, Hilo, HI
Palm Beach County Health Care District, West Palm Beach, FL
Peninsula Community Health Services, Bremerton, WA
Public Interest Law Center of New Jersey
Service Employees International Union
Somerbridge Immigrant Health Program at Cambridge Health Alliance, MA
Sommerville Center for Adult Learning Experiences, MA
Sommerville Community Health Agenda, MA
South Asian Network, Artesia, CA
South Carolina Appleseed Legal Justice Center
Summit Health Coalition, Silver Spring, MD
Summit Health Institute for Research and Education, Inc.
Tennessee Health Care Campaign
Tennessee Justice Center
Tennessee Valley Educators for Excellence
United Neighborhood Houses, New York, NY
Universal Health Care Action Network of Ohio
Urban League of Greater Hartford, Inc.
Vietnamese Mutual Association, Inc, Urbandale, IA
Washington State Child Care Resource and Referral Network
Western Center on Law and Poverty
Women's Health Institute, Boston, MA

Individuals*:

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Professor of Epidemiology and Biostatistics, University of California, San
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Leonard S. Rodberg, Professor, Urban Studies Department, Queens College/CUNY
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*Organizations included for identification purposes only

Copy to:

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Albert Gore, Jr., Vice President of the United States
Christopher C. Jennings, Deputy Assistant to the
President for Health Policy Development
Robert "Ben" Johnson, Assistant to the President and Director
of the President's Initiative for One America
Margaret A. Hamburg, M.D., ASPE
David Satcher, MD, Ph.D., Surgeon General
Thomas E. Perez, HHS/Director, OCR
Nancy-Ann Min Deparle, Administrator, HCFA
Nathan Stinson, Jr., M.D., Ph.D., M.P.H., HHS/PHS/Deputy
Assistant Secretary for Minority Health
Claude E. Fox, M.D., M.P.H., Administrator, HRSA
John M. Eisenberg, M.D., Administrator, AHRQ

December 16, 1999



Health Division



Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Route to:

Dan Mendelson
Dick Emery

ACTION:

Decision _____

Signature _____

Comment _____

As requested XX

Information _____

Needed By:

Date: ____ / ____ / ____

Time: ____ : ____ am/pm

Through:

Barry Clendenin
Mark Miller

BC

Phone: 202/395-4929

Fax: 202/395-7840

Room: NEOB #7001

Copies to: HFB Chron,

HD Chron, Ellen Balis

medicaid & CHIP

**Post this Document
on HD Intranet? _____**

Subject:

Medicaid and Children's Health
Insurance Program Baselines

From: Kate Kirchgraber, Anne Tumlinson and
Lillian Spuria

KK

AT

LS

The attached paper describes changes in the FY 2001 President's Budget Medicaid and Children's Health Insurance Program (CHIP) baselines compared to the FY 2000 Mid-Session Review baseline. This paper presents our preliminary analysis of the FY 2001 Medicaid and CHIP baselines, based on limited time for review. Subsequent review may reveal additional areas of concern.

CC: CHRIS ✓

JEANNE

DEVORA

Health Division Staff Analysis of the Medicaid and SCHIP FY 2001 President's Budget Baselines Compared to FY 2000 Mid-Session Review

Highlight: The CHIP baseline has changed significantly. The FY 2001 President's Budget CHIP baseline is approximately \$2.1 billion (10.3 percent) below the FY 2000 Mid-Session Review baseline for the FY 2001 - 2005 period. The average annual growth for this period decreased from 21.4 percent to 16.0 percent. The decrease in both spending and the annual growth rate reflects slower state program implementation and lower enrollment that previously anticipated and results in a slight downward reestimate of spending in each year across the five year budget window. It should be noted that this decrease in the baseline will result in increased costs for new budget initiatives related to expanding SCHIP enrollment and outreach.

It is also important to note that, under current law, SCHIP funds remaining unspent after a four-year period of availability are returned to the Treasury. The FY2001 baseline reflects a dramatic upward estimate of the amount of unspent funds expected to be returned to the Treasury.

The Medicaid baseline is slightly higher (1.8 percent) higher than last year. Prescription drug and community-based long-term care spending continue to be the fastest growing service categories. State and local administration spending has increased dramatically — by 22 percent over Mid-Session Review. We believe this increase is due, in part, to administrative claiming practices for school-based health services.

Medicaid Baseline

Summary of Medicaid Total Spending. The FY 2001 President's Budget Medicaid baseline is approximately \$12.9 billion (1.8 percent) higher than the FY 2000 Mid-Session Review baseline for the FY 2001 - 2005 period. (See table in Tab A.) The average annual baseline growth for this period increased from 7.7 percent to 7.9 percent.

The FY 2001 Medicaid baseline has changed very little from the FY 2000 Mid-Session Review. The reason the baseline has changed very little is because the FY 2000 Mid-Session Review baseline estimate for FY 1999 was very close the FY 1999 actual Treasury outlays (less than \$1 billion difference). Furthermore, HCFA received November, 1999 state estimates that closely match the FY 2000 Mid-Session Review estimates. Therefore, HCFA actuaries believe the FY 2000 Mid-Session Review baseline needed little additional adjustment.

Benefits. The FY 2001 President's Budget Medicaid benefits baseline is approximately \$6.4 billion (1 percent) higher than the FY 2000 Mid-Session Review baseline for the FY 2001 - 2005 period. The average annual baseline growth for FY 2001 through FY 2005 increased from 7.7 percent to 7.8 percent. The actuaries are assuming very similar trends for caseload, per capita spending, and

community-based long-term care as they did in the FY 2000 Mid-Session Review baseline but have increased their assumptions of spending growth for prescription drugs.

Long-Term Care and Prescription Drugs. The actuaries are reporting the fastest growing services in the Medicaid baseline are prescription drug spending and home and community-based waiver spending. Non-institutional long-term care spending has been growing very quickly, although it has slowed somewhat to a rate of nine percent in FY 1999. Even with the slight slow-down in spending, home care services will be almost half of all long-term care spending by 2009 --- compared to about 30 percent this year. Prescription drug growth has also been very high -- 16.7 percent -- in FY 1999. Drugs now represent seven percent of all Medicaid benefit spending. We are unsure whether drug spending growth is the result of price or utilization growth but we are checking.

Low-Income Medicare Beneficiary Program. You should be aware that the baseline has been lowered significantly again this year for the program that pays Part B premiums for certain low-income Medicare beneficiaries (Qualifying Individuals (QIs)). This program is designed somewhat like CHIP. The law provides for a limited allotment of federal funds for each state from FY 1998 through FY 2002. Two years ago, the actuaries assumed states would spend their entire allotments (\$1.5 billion over five years). Because states spent only \$5 million in FY 1998 relative to their 1998 allotments of \$200 million, the actuaries lowered the baseline for this program last year to \$435 million over five years. This year, the baseline assumes even less: \$240 million.

State and Local Administration. Estimates of Federal spending for state and local administration in the FY 2001 President's Budget are \$7.9 billion (22 percent) higher than the Mid-Session Review estimates for FY 2001 - 2005. The average annual growth in administration spending for this period increased a great deal from 6.4 percent to 10 percent. This dramatic change is due, in part, to HHS' and our decision to estimate spending that more closely reflects recent historical trends in administrative spending rather than state estimates of future spending. When constructing the baseline, HCFA assesses the states' estimates of spending. In the absence of any other information, HCFA will accept the state estimates of spending for the baseline and project outyear spending growth based on the growth in the estimates. The FY 2000 Mid-Session Review baseline included a slow-down in spending growth for administration because the most recent state estimates include very low growth between FY 1999 and FY 2000. Again this year, the state estimated administrative spending to be low in the next two years. Unlike last year, we made major adjustments to the state estimates because administrative spending growth shows no signs of slowing down from a steady growth of 15 percent per year since 1996.

Some general reasons for administrative spending growth are welfare reform-related systems and eligibility changes, changes in cost allocation rules, administrative spending for Medicaid CHIP expansions, and millennium computer costs. However, we believe incorrect administrative claiming for school-based health services may contribute a great deal to this continued high growth. We are working with HCFA and others (CBO) to develop a school-based health services baseline within the administrative spending baseline. In addition, we believe some states are claiming case management

services as administrative costs in mental health programs run by counties. Through this mechanism, states avoid provider qualification requirements and are able to shift state and local costs onto the federal government. We are working with HCFA to develop reporting requirements for these administrative activities so that we can better track them.

Vaccines for Children. Estimates of Vaccine for Children (VFC) spending in the FY 2001 President's Budget are \$1.4 billion (39 percent) lower than the Mid-Session Review Estimates for FY 2001-2005. The baseline has dropped, in large part, for two reasons: 1) one vaccine was removed from the VFC program because of concerns about its safety; and 2) estimates for a yet unlicensed vaccine recommended for use in the VFC program were removed. The baseline is expected to be readjusted upward in the future (i.e., Mid-Session Review) to reflect the cost of the vaccine once it is licensed by FDA.

State Children's Health Insurance Program (SCHIP) Baseline

The FY 2001 President's Budget State Children's Health Insurance Program (SCHIP) baseline is approximately \$2.1 billion (10.3 percent) below the FY 2000 Mid-Session Review baseline for the FY 2001 - 2005 period (Tab B). The average annual growth for this period decreased from 21.4 percent to 16.0 percent. The decrease in both spending and the annual growth rate reflects slower state program implementation and lower enrollment than previously anticipated and results in a slight downward reestimate of spending in each year across the five year budget window.

Based on state spending estimates for FY 2001, the baseline reflects a steadier level of year-to-year program spending than was assumed at mid-session. The FY 2000 MSR anticipated that states would increase SCHIP program spending by a substantial amount (47.4 percent) in FY 2001 and by smaller amounts in later years (7.5 percent in FY 2004 and 7.8 percent in FY 2005). The FY 2001 baseline, however, shows a more moderate increase of 30 percent in FY 2001 and nominal spending increases in later years (2.5 percent in FY 2004 and 2.4 percent in FY 2005.)

The decrease in the FY 2001 baseline from the level estimated in the FY 2000 MSR is primarily the result of changes in assumptions related to state spending behaviors stemming from two statutory SCHIP provisions. The first provision, Section 2104(a) of Title XXI of the Social Security Act, includes the schedule of annual SCHIP appropriations for states and reflects the fluctuating amount of funds available to states over a ten year period. Specifically, the size of the annual appropriations available for allotment to the states ranges from \$4.3 billion per year from FY 1998 to FY 2001, to \$3.2 billion per year from FY 2002 to FY 2004. At mid-session, it was assumed that states would use unspent funds from prior years to accelerate spending and enrollment each year through FY 2005, when funding levels return to the \$4 billion range. It is now believed, however, that states will adopt a more consistent level of spending and enrollment across the five year budget window.

The second provision, Section 2104(e) of Title XXI, provides that amounts allotted to states remain available for expenditure for three years and requires that any state allotments left unspent at the end of this period be redistributed among the states that have fully expended their allotments. Such funds are then available to states through the end of the fiscal year in which they are redistributed. FY 2001 will be the first year in which unspent SCHIP funds (from FY 1998) will be available for redistribution. At mid-session, when the actuaries believed that state spending levels would be higher than states now are estimating them to be, leftover CHIP funds were not expected to affect the baseline. Since actual spending levels for FY 1998 and FY 1999, as well as states' projected spending for FY 2000 are now known, however, the actuaries have determined that unspent funds will have a broad impact on the baseline.

While the FY 2000 MSR baseline estimate assumed that each year's appropriation would be fully spent by the end of the four-year period (the three-year availability period plus one-year redistribution), the HCFA actuaries now assume that some funds from FY 1998 through FY 2000 will never be spent and will be returned to the Treasury (see Table on next page). The November spending estimates indicate that there will be a substantial amount of FY 1998 funds (\$1.9 billion) left unspent at the end of FY 2000. While these funds will be redistributed to 18 states that will have fully expended their FY 1998 allotments by the end of FY 2000, it is still expected that some FY 1998 funds (\$750 million) will never be spent. This is largely due to the fact that the redistributed funds can only be spent in the year in which they are redistributed.

In FY 2002, the problem of unspent prior year funds grows, as fewer states will have fully expended the FY 1999 allotments which become available for redistribution in FY 2002. States that received redistributed FY 1998 funds will have spent those funds in FY 2001, since that is the only year in which they can be spent, instead of spending the remaining FY 1999 annual allotments in the last year of their regular availability. (In effect, the states that received FY 1998 redistributions in FY 2001 will lose the third year of availability of FY 1999 funds.) As a result, a large portion of FY 1999 funds will be carried into FY 2002 for redistribution. Since fewer states will have fully expended their FY 1999 allotments, however, fewer states (i.e., five) will be eligible for redistribution, and a large amount of funds (\$1.8 billion) will remain unspent and be returned to the Treasury.

✓ This problem is substantially mitigated in FY 2003, when it is expected that \$900 million in prior year funds will remain unspent and be returned to the Treasury. The problem is virtually eliminated in FY 2004, when the HCFA actuaries expect that state spending will "catch up" with the allotments and only \$70 million of prior year funds will remain unspent and be returned to the Treasury.

Estimate of Funds Subject to Return to the Treasury
(\$ in millions)

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	TOTAL
FY 2000 MSR	\$0	\$0	\$0	\$0	\$0	\$0
FY 2001 PB	\$750	\$1,800	\$900	\$70	\$0	\$3,520

Tables in Excel File or in Attachment:

Tab A: Medicaid Baseline Comparison: FY 1999 Mid-Session Review vs. FY 2000 President's Budget

Tab B: Children's Health Insurance Program Baseline

Tab A

Medicaid Baseline
FY 2000 Mid-Session Review vs. FY 2001 President's Budget
(Dollars in Billions)

		<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	Total 2001 - 2005	Growth 2000 - 2005
Benefits															
FY 2000 Mid-Session Review		104.0	108.3	115.9	124.5	134.2	145.1	157.3	170.8	185.2	200.5	216.5		677.0	
	<i>Growth</i>		4.1%	7.0%	7.4%	7.8%	8.1%	8.4%	8.5%	8.5%	8.2%	8.0%		7.7%	7.7%
FY 2001 President's Budget		102.1	109.272	116.4	125.5	135.7	146.7	159.1	172.7	187.5	202.7	218.8	236.0	683.5	
	<i>Growth</i>		7.0%	6.6%	7.8%	8.2%	8.1%	8.4%	8.6%	8.6%	8.1%	7.9%	7.9%	7.8%	7.8%
Outlay Change: FY 00 MSR to FY 00 PB		-1.9	0.9	0.5	1.0	1.5	1.6	1.8	1.9	2.3	2.2	2.3	236.0	6.4	
Percentage Change in Outlays		-1.9%	0.9%	0.5%	0.8%	1.2%	1.1%	1.1%	1.1%	1.2%	1.1%	1.0%		1.0%	
VFC															
FY 2000 Mid-Session Review		0.535	0.559	0.675	0.694	0.718	0.740	0.814	0.866	0.858	0.877	0.917		3.6	
	<i>Growth</i>		4.4%	20.9%	2.7%	3.6%	3.0%	10.1%	6.3%	-0.9%	2.2%	4.6%		7.8%	7.8%
FY 2001 President's Budget		0.464	0.465	0.469	0.453	0.449	0.417	0.423	0.429	0.393	0.400	0.411	0.422	2.2	
	<i>Growth</i>		0.3%	0.8%	-3.4%	-0.8%	-7.1%	1.2%	1.4%	-8.4%	1.9%	2.7%	2.7%	-1.9%	-1.9%
Outlay Change: FY 00 MSR to FY 00 PB		-0.071	-0.093	-0.206	-0.241	-0.269	-0.323	-0.392	-0.437	-0.465	-0.476	-0.506	0.422	-1.431	
Percentage Change in Outlays		-13.3%	-16.7%	-30.5%	-34.7%	-37.5%	-43.6%	-48.1%	-50.5%	-54.2%	-54.4%	-55.2%		-39.3%	
Administration															
FY 2000 Mid-Session Review		5.9	6.1	6.2	6.6	7.1	7.7	8.3	8.9	9.7	10.4	11.3		35.8	
	<i>Growth</i>		2.0%	2.1%	7.0%	7.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%		6.4%	6.4%
FY 2001 President's Budget		5.5	6.4	7.3	8.0	8.7	9.5	10.3	11.1	12.0	12.9	14.0	15.1	43.7	
	<i>Growth</i>		16.5%	13.8%	10.4%	8.6%	9.0%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	10.0%	10.0%
Outlay Change: FY 00 MSR to FY 00 PB		-0.5	0.3	1.1	1.4	1.6	1.8	2.0	2.1	2.3	2.5	2.7	15.1	7.89	
Percentage Change in Outlays		-7.8%	5.2%	17.3%	21.1%	22.8%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%		22.0%	
Net Outlays															
FY 2000 Mid-Session Review		108.6	115.0	122.8	131.8	142.0	153.5	166.4	180.6	195.7	211.8	228.7		716.5	
	<i>Growth</i>		5.9%	6.8%	7.3%	7.8%	8.1%	8.4%	8.5%	8.4%	8.2%	8.0%		7.7%	7.7%
FY 2001 President's Budget		108.0	116.117	124.175	133.968	144.900	156.610	169.763	184.202	199.857	216.038	233.191	251.534	729.4	
	<i>Growth</i>		7.5%	6.9%	7.9%	8.2%	8.1%	8.4%	8.5%	8.5%	8.1%	7.9%	7.9%	7.9%	7.9%
Outlay Change: FY 00 MSR to FY 00 PB		-0.61	1.2	1.4	2.2	2.9	3.1	3.3	3.6	4.1	4.3	4.5	251.5	12.9	
Percentage Change in Outlays		-0.6%	1.0%	1.1%	1.7%	2.0%	2.0%	2.0%	2.0%	2.1%	2.0%	2.0%		1.8%	

Tab B

CHIP Baseline
FY 2000 Mid-Session Review vs. FY 2001 President's Budget
(\$ in millions)

		<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY2009</u>	<u>FY2010</u>	<u>Total</u> <u>2001-2005</u>	<u>Total</u> <u>2001-2010</u>
<u>Total Outlays</u>															
OMB MSR (6/99)		987	1,900	2,800	3,520	4,320	4,645	5,005	5,400	5,805	6,240	6,680	-	20,290	44,415
	<i>Growth</i>		92.5%	47.4%	25.7%	22.7%	7.5%	7.8%	7.9%	7.5%	7.5%	7.1%		21.4%	
FY01 President's Budget		1,000	2,000	2,600	3,300	4,000	4,100	4,200	4,200	4,200	4,400	4,400	4,900	18,200	40,300
	<i>Growth</i>		100.0%	30.0%	26.9%	21.2%	2.5%	2.4%	0.0%	0.0%	4.8%	0.0%	11.4%	16.0%	
Outlay Difference: OMB MSR to PB01		13	100	(200)	(220)	(320)	(545)	(805)	(1,200)	(1,605)	(1,840)	(2,280)		(2,090)	(4,115)
Percentage Difference in Outlays		1.3%	5.3%	-7.1%	-6.3%	-7.4%	-11.7%	-16.1%	-22.2%	-27.6%	-29.5%	-34.1%		-10.3%	
<u>CHIP Title XXI</u>															
OMB MSR (6/99)		987	1,425	2,100	2,640	3,240	3,485	3,755	4,050	4,355	4,680	5,010	-	15,220	33,315
	<i>Growth</i>		44.4%	47.4%	25.7%	22.7%	7.6%	7.7%	7.9%	7.5%	7.5%	7.1%		21.4%	
FY01 President's Budget		400	1,300	1,900	2,500	3,000	3,100	3,100	3,100	3,100	3,300	3,300	3,700	13,600	30,100
	<i>Growth</i>		225.0%	46.2%	31.6%	20.0%	3.3%	0.0%	0.0%	0.0%	6.5%	0.0%	12.1%	19.0%	
Outlay Difference: OMB MSR to PB01		(587)	(125)	(200)	(140)	(240)	(385)	(655)	(950)	(1,255)	(1,380)	(1,710)		(1,620)	(3,215)
Percentage Difference in Outlays		-59.5%	-8.8%	-9.5%	-5.3%	-7.4%	-11.0%	-17.4%	-23.5%	-28.8%	-29.5%	-34.1%		-10.6%	
<u>Medicaid Title XIX</u>															
OMB MSR (6/99)		-	475	700	880	1,080	1,160	1,250	1,350	1,450	1,560	1,670		5,070	11,100
	<i>Growth</i>			47.4%	25.7%	22.7%	7.4%	7.8%	8.0%	7.4%	7.6%	7.1%		21.4%	
FY00 President's Budget		600	700	700	800	1,000	1,000	1,100	1,100	1,100	1,100	1,100	1,200	4,600	10,200
	<i>Growth</i>		16.7%	0.0%	14.3%	25.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	9.1%	9.5%	
Outlay Difference: OMB MSR to PB01		600	225	-	(80)	(80)	(160)	(150)	(250)	(350)	(460)	(570)		(470)	(900)
Percentage Difference in Outlays			47.4%	0.0%	-9.1%	-7.4%	-13.8%	-12.0%	-18.5%	-24.1%	-29.5%	-34.1%		-9.3%	

The FY 2000 MSR includes a technical reestimate of the baseline to reflect the elimination of a double-counting of outlays between the CHIP and Medicaid accounts.
The Medicaid account already includes the \$450 million outlay related to CHIP spending in the Medicaid program.

HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:**

Ginni Hain
Devorah A.
Ellen D. 690-5673
Robin R ~~78~~

PHONE:

Cindy M. 6-8534

FROM:

Peter Harbage
OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726

FAX : 202-690-6262

TOTAL PAGES:

Nicole Rabner
456-9412

ADDRESSEE'S FAX MACHINE NUMBER:**DATE:****REMARKS:**

Final Foster Kids
SMD letter
Will go out @ 5:00 PM today



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

DEC 14 1999

Dear State Medicaid Director:

Since the beginning of his Administration, President Clinton has worked hard with Congress to provide health care coverage to more working families and children. As part of this effort, the President proposed new protections for children leaving foster care, and the President was pleased to sign the bipartisan Foster Care Independence Act of 1999 on December 14, 1999. This law makes critical improvements in how we serve older foster care children and in how help them prepare for adulthood.

While the Administration for Children and Families will soon provide your State with comprehensive information on this important law, I wanted to highlight how it gives you the flexibility to provide much needed health care coverage to foster children as they make their transition to independence. The law does this by creating a new optional Medicaid eligibility group. I strongly encourage you to take advantage of this new opportunity to provide health coverage to children who have been in foster care.

Children who have "aged out" of foster care face tremendous challenges. They often find themselves fully emancipated and on their own without the family support received by most individuals entering adulthood. Also, the incidence of homelessness, substance abuse, and pregnancy can be high in this population. Clearly, these children continue to need access to medical care. And yet, upon reaching their 18th or 19th birthday, many of these children lose their Medicaid coverage that protected them as foster care children.

However, it is now possible to continue to offer these children access to health care. The Foster Care Independence Act has established a new optional Medicaid eligibility group for children who are in foster care under the responsibility of the State on their 18th birthday. There are a series of options available to your State under the law to help these children, including the flexibility to:

1. Provide eligibility for all these children until they reach age 21 or only until age 19 or 20.
2. Not apply an income or resource test for these children. If the State does apply an income or resource test, then the standards and methodologies used cannot be more restrictive than those used for the State's low-income families with children eligible under section 1931 of the Act.
3. Only make those children eligible who were furnished foster care maintenance payments or independent living services under a program funded under title IV-E of the Social Security Act.

Page 2 - State Medicaid Director

Please note that the Congress and the President worked to ensure that these children receive the full Medicaid benefits package. All services, including Early and Periodic Screening, Diagnostic and Treatment services, must be provided to all children whom you cover under the new optional group.

Again, I urge you to elect this new option to ensure that children aging out of foster care have the health care that they need. We will issue more technical guidance on this matter through the Medicaid Manual. If you have any questions before then, please contact Cindy Mann, Director, Family and Children's Health Programs Group at 410-786-5647 if you need any assistance in establishing this eligibility group or have any questions.

Sincerely,



Timothy M. Westmoreland
Director

cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Senior Health Policy Analyst
National Governors Association

FFY 1999 State Estimated SCHIP and Medicaid Enrollment

- * The attached 1-page draft narrative (WordPerfect 6.1) provides a general description of the FFY 1999 State estimated SCHIP enrollment statistics, and will serve as the basis for HCFA's Press Office to use in preparing the official release of the FFY 1999 data.
- * Also attached is a chart (Microsoft Excel) that shows State-by-State estimated enrollment for SCHIP and Medicaid for every State with a SCHIP plan in operation during FFY 1999. It also includes information about plan implementation date, amendments, and upper eligibility. While we have provided all of this information on the chart, we envision that only selected columns from this chart would be included as part of the official data release.
 - Of the total 56 approved SCHIP plans, 53 plans were actually implemented on or before the close of FFY 1999 (September 30, 1999). Therefore, as reflected on the chart, enrollment statistics for SCHIP and Medicaid were not required for 3 States: Hawaii, Washington, and Wyoming.
- * The FFY 1999 State reported enrollment data included both electronic and oral estimates. The data was reviewed by CMSO Central Office staff, Regional Office SCHIP staff, and the HCFA Actuary. The narrative also compares FFY 1999 estimates for all States with the 12/98 HCFA release as well as the 6/99 Kaiser Family Foundation release.
- * The statistics for SCHIP and Medicaid as shown on the chart reflect, in aggregate, the unduplicated number of children ever enrolled in FFY 1999. Simply put, States were to enter the statistic for each child enrolled at any time during the fiscal year, and States were to count each child once, no matter how many times the child may have been enrolled during the year. This statistic is found on line #6 of the quarterly statistical reporting forms which States are currently required to send HCFA for their SCHIP and regular Medicaid programs -- HCFA forms 21E, 64.21E, and 64EC, accordingly.
- * Some States have not submitted their electronic SCHIP or Medicaid data for the 4th quarter and/or other previous quarters. States that did not submit their electronic statistical reports for 4th quarter or send/fax information so that Central Office could input States' data into the electronic system, provided oral estimates of the total number of children ever enrolled in their programs in FFY 1999. Accordingly, the FFY 1999 enrollment chart reflects State estimated SCHIP and Medicaid enrollment where data submissions were not available. As reflected on the chart, 9 States (AL, KY, MN, NM, NC, OK, SC, TN, VT) provided oral estimates of their SCHIP enrollment, representing approximately 191,000 of the nearly 2 million children enrolled in SCHIP.

- * The FFY 1999 enrollment chart also shows that of the 53 SCHIP plans in operation during FFY 1999, approximately 20.5 million children under age 19 were served by regular Medicaid (Title XIX). This represents a nominal decrease of about 600,000 from the HCFA Actuary's provisional FFY 1998 estimate of about 21.1 million children under age 19 in these same 53 States. Please note that States have until January 2000 to submit their regular Medicaid program statistics to HCFA (i.e., 2082 data). The HCFA Actuary is currently working to derive a comparable FFY 1997 Medicaid estimate for children under age 19 in these 53 States and Territories. (Note: HCFA's recently published *Medicaid Statistics* for FFY 1997 reflects a total of about 22.7 million children under age 21 enrolled in all States).
- * While the chart includes information on FY 1999 Medicaid enrollment, we are cautious about releasing this information for several reasons. While many States have reported anecdotally that a significant number of applicants for SCHIP are actually found eligible for and enrolled in Medicaid, it is impossible to accurately measure this "woodworking effect." Moreover, even assuming that SCHIP has had significant positive impact in regular Medicaid enrollment, we know that Medicaid enrollment for children has been dropping in the past few years. Therefore, the FY 1999 estimated enrollment must be considered in the larger context of declining Medicaid enrollment.
- * Prior to implementation of their SCHIP programs, New York had approximately 182,000 children enrolled in its health care system, and Pennsylvania had 57,277 children enrolled prior to SCHIP (Source: FFY 1998 SCHIP Annual Reports). We are currently inquiring with State staff to obtain this same statistic for Florida.

**Estimated Aggregate Enrollment Statistics for the State Children's Health
Insurance Program (SCHIP) and Medicaid for Federal Fiscal Year (FFY) 1999
(10/1/98 through 9/30/99)**

In 1997, the President, with bipartisan support from Congress, enacted the State Children's Health Insurance Program (SCHIP). The Balanced Budget Act of 1997 allocated \$24 billion over five years beginning in October 1997 to extend health care coverage to uninsured children through State-designed programs. SCHIP enables States to insure children in working families with incomes too high to qualify for Medicaid through either a separate State program, a Medicaid expansion, or a combination of both types of programs.

States have enthusiastically responded to SCHIP. HCFA is pleased to report that, as of September 30, 1999, it had approved SCHIP plans for all 56 States and U.S. Territories. The 56 approved plans consist of 16 separate SCHIP programs, 26 Medicaid expansions, and 14 combinations of both types of programs. Of the 56 approved plans, 53 plans were implemented as of the close of Federal fiscal year (FFY) 1999 which ended September 30, 1999.

- * According to State reported data, HCFA estimates that nearly 2 million children were served by SCHIP during FFY 1999. Of the 53 implemented plans in FFY 1999, over 1.2 million children were served by separate plans, and almost 700,000 children were served by Medicaid expansion plans.
- * Although reporting systems were not fully in place for all States in December, 1998, it appears that the number of children served by SCHIP in FFY 1999 has nearly doubled from the December, 1998 estimated levels.
- * While these numbers reflect the early implementation experience of most States, we expect these numbers to continue to increase as States fully implement and continue to expand their programs. As of December 13, 1999, HCFA has already approved 34 SCHIP plan amendments and an additional 13 amendments are under review.

Many of these amendments will result in a significant expansion in the number of children served by States beyond those served under the initial State plans. Finally, as States fully develop and implement effective outreach and program coordination strategies, and develop procedures to assure that children retain coverage for as long as they are eligible, HCFA expects continued increases in both SCHIP and regular Medicaid enrollment in FFY 2000 and beyond.

One of the intended goals of Title XXI is to identify and enroll children previously eligible for Medicaid but not enrolled. As a result of enhanced outreach to uninsured children, many States are identifying and enrolling a significant number of eligible children in the Medicaid program. Although there are no data on the number of children enrolled in Medicaid as a result of outreach to uninsured children, several States experienced significant Medicaid enrollment in FFY 1999 which they attribute to SCHIP-related outreach, streamlined eligibility processes, and Medicaid screening procedures.

- The 53 States and U.S. Territories with implemented SCHIP plans in FFY 1999 reported that nearly 20.5 million children were served by regular Medicaid during FFY 1999.

The attached chart reflects the total estimated number of children ever served by SCHIP and regular Medicaid during FFY 1999, as reported by States. This estimate consists of formal State quarterly statistical data submissions, and estimates of enrollment by those States that have not yet provided electronic data.

**State Children's Health Insurance Program (SCHIP)
and Medicaid
Aggregate Enrollment Statistics for FFY 1999**

STATE	DATE IMPLEMENTED 1\	STATE AMENDMENTS 2\	TYPE OF SCHIP PROGRAM			UPPER ELIGIBILITY 3\	STATE REPORTED SCHIP ENROLLMENT FFY 1999 (Total children ever served in FFY 1999) 4\		FFY 1999 TOTAL SCHIP	FFY 1999 MEDICAID CHILDREN 5\
			Separate Program	Medicaid Expansion	Combined Program		Separate Program	Medicaid Expansion		
TOTAL PLANS SUBMITTED = 56			16	26	14		1,284,387	693,163	1,977,550	20,494,924
1. Alabama 6\	02/01/98	08/18/98, 09/28/99			X	200%	25,738	13,242	38,980	242,732
2. Alaska	03/01/99			X		200%		8,033	8,033	53,421
3. American Samoa ~ >	04/01/99			X		Not Applicable			0	36,549
4. Arizona	11/01/98	05/21/99, 08/23/99, 12/01/99	X			200%	26,807		26,807	387,213
5. Arkansas	10/01/98	12/04/98 (p)		X		100%		913	913	155,504
6. California	03/01/98	06/29/98, 01/08/99 (p), 11/23/99, 12/09/99 (p)			X	250%	187,854	34,497	222,351	3,263,848
7. Colorado	04/22/98	09/21/99	X			185%	24,116		24,116	195,217
8. CNMI ~ + >	10/01/97			X		Not Applicable			0	6,045
9. Connecticut *	07/01/98				X	300%	5,277	4,635	9,912	167,892
10. Delaware	01/01/99	11/23/99	X			200%	2,433		2,433	52,617
11. District of Columbia	10/01/98			X		200%		3,029	3,029	100,749
12. Florida	04/01/98	09/08/98			X	200%	116,123	38,471	154,594	1,467,266
13. Georgia 7\	11/01/98		X			200%	47,581		47,581	685,336
14. Guam ~ + >	10/01/97			X		Not Applicable			0	8,747
15. Hawaii	01/03/00			X		185%		N/I	N/I	--
16. Idaho 8\	10/01/97	12/04/98		X		150%		8,482	8,482	72,121
17. Illinois 9\	01/05/98	11/10/98 (p)		X		133%	7,567	35,132	42,699	896,115
18. Indiana	10/01/97	09/22/99 (p)		X		150%		31,246	31,246	342,666
19. Iowa	07/01/98	06/16/99			X	185%	2,694	7,101	9,795	112,228
20. Kansas	01/01/99	04/01/99 (p)	X			200%	14,443		14,443	144,415
21. Kentucky ** ^	07/01/98	09/03/99			X	200%		18,579	18,579	309,722
22. Louisiana	11/01/98	08/27/99		X		150%		21,580	21,580	425,592
23. Maine *	07/01/98				X	185%	3,786	9,871	13,657	90,000
24. Maryland	07/01/98			X		200%		18,072	18,072	325,983
25. Massachusetts	10/01/97				X	200%	24,408	43,444	67,852	448,403
26. Michigan	05/01/98	06/29/98			X	200%	14,825	11,827	26,652	749,683
27. Minnesota **	10/01/98			X		280%		21	21	298,000
28. Mississippi ^	07/01/98	02/10/99, 09/22/99 (p)			X	133%		13,218	13,218	339,861
29. Missouri	09/01/98	09/11/98		X		300%		49,529	49,529	404,817
30. Montana	01/01/99		X			150%	1,019		1,019	69,313
31. Nebraska	05/01/98	10/13/98		X		185%		9,713	9,713	124,194
32. Nevada	10/01/98		X			200%	7,802		7,802	84,960
33. New Hampshire	05/01/98	03/25/99			X	300%	3,700	854	4,554	45,939
34. New Jersey	03/01/98	05/07/99, 08/03/99, 09/21/99 (p)			X	350%	43,824	31,828	75,652	413,756
35. New Mexico **	03/31/99			X		235%		4,500	4,500	248,181
36. New York	04/15/98	09/24/99	X			192%	519,401		519,401	972,188
37. North Carolina **	10/01/98	01/15/99, 06/23/99, 09/30/99	X			200%	57,300		57,300	642,500
38. North Dakota	10/01/98	11/12/99		X		100%		266	266	29,517
39. Ohio	01/01/98			X		150%		83,688	83,688	684,482
40. Oklahoma **	12/01/97	03/25/99		X		185%		40,196	40,196	60,772
41. Oregon	07/01/98	08/13/99 (p)	X			170%	27,285		27,285	238,339
42. Pennsylvania	05/28/98	10/29/98, 12/09/99 (p), 12/09/99 (p)	X			200%	81,758		81,758	813,407
43. Puerto Rico 10\ ~	01/01/98			X		200%		20,000	20,000	559,896
44. Rhode Island	05/01/98	02/05/99, 11/29/99 (p)		X		300%		7,288	7,288	67,706
45. South Carolina 11\	08/01/98			X		150%		45,737	45,737	292,388
46. South Dakota	07/01/98	10/29/99		X		140%		3,191	3,191	28,463
47. Tennessee **	10/01/97			X		100%		9,732	9,732	637,141
48. Texas	07/01/98	11/05/99			X	200%		50,878	50,878	1,585,918
49. Utah 12\	08/03/98		X			200%	13,040		13,040	206,255
50. Vermont **	10/01/98	08/11/99	X			300%	2,055		2,055	60,286
51. Virgin Islands * ~ 13\	04/01/98	11/09/99 (p)		X		Not Applicable		120	120	1,000
52. Virginia	10/22/98		X			185%	16,895		16,895	370,163
53. Washington	01/01/00		X			250%	N/I		N/I	--
54. West Virginia	07/01/98	03/19/99			X	150%	6,656	1,301	7,957	193,264
55. Wisconsin	04/01/99	01/22/99		X		185%		12,949	12,949	282,154
56. Wyoming	12/01/99		X			133%	N/I		N/I	--

**State Children's Health Insurance Program (SCHIP)
and Medicaid
Aggregate Enrollment Statistics for FFY 1999**

FFY 1999 Caveats and Data Limitations:

(Note: FFY 1999 enrollment statistics reflect unedited data as submitted by States to HCFA)

- 1\ Implementation date of the initial SCHIP plan. In some States the initial SCHIP plan involved a modest expansion of coverage. As of December 13, 1999, there are 34 States with approved amendments to expand their initial plans, and another 13 States have pending State plan amendments.
- 2\ Reflects approval date of State amendments. Some SCHIP amendments have implementation dates that may occur after actual approval dates. States with amendments submitted to HCFA and pending approval are denoted by (p) to indicate the date submitted.
- 3\ Reflects upper eligibility level of currently approved SCHIP plans and amendments. Upper eligibility is defined as a percent of the Federal poverty level (FPL). In 1999, FPL is \$16,700 for a family of 4. In general, States with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs can establish their upper eligibility levels net or gross of income disregards. Puerto Rico defines the upper eligibility limit as 200% of Puerto Rico's poverty level.
- 4\ State reported enrollment in FFY 1999 reflects formal State quarterly electronic statistical data submissions, and estimates by States in cases where electronic State quarterly data submissions were not available.
- 5\ Reflects the FFY 1999 total number of children ever served by the regular Medicaid program (Title XIX) in States with implemented SCHIP programs in FFY 1999.
- 6\ Alabama's enrollment for Medicaid expansion SCHIP and regular Medicaid is estimated.
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- 8\ Idaho's FFY 1999 Medicaid enrollment is not available; the data reflects the State's estimate for FFY 1998.
- 9\ Illinois is covering children under its proposed separate SCHIP program, the State plan amendment is pending.
- 10\ Puerto Rico's SCHIP allotment funded 20,000 children; another 44,324 children were funded with Territorial funds.
- 11\ South Carolina's enrollment for SCHIP and Medicaid reflects estimated enrollment from October, 1998 through July, 1999.
- 12\ Utah SCHIP enrollment for FFY 1999 reflects the total number of children ever enrolled in the fourth quarter.
- 13\ Virgin Island's SCHIP enrollment reflects the number of children for which health care claims were paid from the period 7/98 through 4/99.
- ^ As of September 30, FFY 1999, Kentucky and Mississippi had not yet enrolled children in their separate SCHIP programs.
- * State reported Medicaid enrollment is estimated.
- ** State reported SCHIP and Medicaid enrollment is estimated
- N/I "Not Implemented" ~ denotes States with approved SCHIP plans that have implementation dates after FFY 1999.
- Due to the unique nature of their SCHIP plans, the U S Territories and Jurisdictions cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.
- + Guam and the Commonwealth of the Northern Mariana Islands (CNMI) did not exceed their Medicaid funding caps, and therefore could not claim any SCHIP funding in FFY 1999.
- > Medicaid enrollment reflects total number of children eligible for Medicaid in FFY 1999, as estimated by the Territories/Jurisdictions (Source: HCFA form 37.7 for CNMI and Guam, and FFY 1999 Annual Determination Report for American Samoa).



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE: 12/21/99TO: Jeanne Lombard
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Director, Special Projects
tel: 202/690-7854, fax: 202/690-5673TOTAL NUMBER OF PAGES SENT: 7
(including cover page)

COMMENTS:

Draft chart and background
on CHIP

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OUTLINE

Background on prog

New # enrollment

What extent # improved
surge in enrollment for
each state

~~How much # left for each state~~

How kids uninsured in each state
covered by plan

enrollment in separate
state vs. ME

quicker?

FFY 1999 State Estimated SCHIP and Medicaid Enrollment

- ▶ The attached 1-page draft narrative (WordPerfect 6.1) provides a general description of the FFY 1999 State estimated SCHIP enrollment statistics, and will serve as the basis for HCFA's Press Office to use in preparing the official release of the FFY 1999 data.
- ▶ Also attached is a chart (Microsoft Excel) that shows State-by-State estimated enrollment for SCHIP and Medicaid for every State with a SCHIP plan in operation during FFY 1999. It also includes information about plan implementation date, amendments, and upper eligibility. While we have provided all of this information on the chart, we envision that only selected columns from this chart would be included as part of the official data release.
 - Of the total 56 approved SCHIP plans, 53 plans were actually implemented on or before the close of FFY 1999 (September 30, 1999). Therefore, as reflected on the chart, enrollment statistics for SCHIP and Medicaid were not required for 3 States: Hawaii, Washington, and Wyoming.
- ▶ The FFY 1999 State reported enrollment data included both electronic and oral estimates. The data was reviewed by CMSO Central Office staff, Regional Office SCHIP staff, and the HCFA Actuary. The narrative also compares FFY 1999 estimates for all States with the 12/98 HCFA release as well as the 6/99 Kaiser Family Foundation release.
- ▶ The statistics for SCHIP and Medicaid as shown on the chart reflect, in aggregate, the unduplicated number of children ever enrolled in FFY 1999. Simply put, States were to enter the statistic for each child enrolled at any time during the fiscal year, and States were to count each child once, no matter how many times the child may have been enrolled during the year. This statistic is found on line #6 of the quarterly statistical reporting forms which States are currently required to send HCFA for their SCHIP and regular Medicaid programs -- HCFA forms 21E, 64.21E, and 64EC, accordingly.
- ▶ Some States have not submitted their electronic SCHIP or Medicaid data for the 4th quarter and/or other previous quarters. States that did not submit their electronic statistical reports for 4th quarter or send/fax information so that Central Office could input States' data into the electronic system, provided oral estimates of the total number of children ever enrolled in their programs in FFY 1999. Accordingly, the FFY 1999 enrollment chart reflects State estimated SCHIP and Medicaid enrollment where data submissions were not available. As reflected on the chart, 9 States (AL, KY, MN, NM, NC, OK, SC, ~~IN~~ VT) provided oral estimates of their SCHIP enrollment, representing approximately 191,000 of the nearly 2 million children enrolled in SCHIP.

- The FFY 1999 enrollment chart also shows that of the 53 SCHIP plans in operation during FFY 1999, approximately 20.5 million children under age 19 were served by regular Medicaid (Title XIX). This represents a nominal decrease of about 600,000 from the HCFA Actuary's provisional FFY 1998 estimate of about 21.1 million children under age 19 in these same 53 States. The HCFA Actuary estimates that 21.4 million children under age 19 were served in these same 53 States and Territories for FY 1997. (Note: HCFA's recently published *Medicaid Statistics* for FFY 1997 reflects a total of about 22.7 million children under age 21 enrolled in all States). Also, States have until January of each year to submit their regular Medicaid program statistics to HCFA (i.e., 2082 data) for the prior fiscal year.
- While the chart includes information on FY 1999 Medicaid enrollment, we are cautious about releasing this information for several reasons. While many States have reported anecdotally that a significant number of applicants for SCHIP are actually found eligible for and enrolled in Medicaid, it is impossible to accurately measure this "woodworking effect." Moreover, even assuming that SCHIP has had significant positive impact in regular Medicaid enrollment, we know that Medicaid enrollment for children has been dropping in the past few years. Therefore, the FY 1999 estimated enrollment must be considered in the larger context of declining Medicaid enrollment.
- Prior to implementation of their SCHIP programs, New York had approximately 182,000 children enrolled in its health care system, and Pennsylvania had 57,277 children enrolled prior to SCHIP (Source: FFY 1998 SCHIP Annual Reports). Florida estimates nearly 60,000 children were enrolled prior to SCHIP.
- In a 1996 report, "Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children," GAO found that enrollment in 1995 for Pennsylvania, Florida, and New York was as follows: New York: 98,500 children; Pennsylvania: 28,923 children; and Florida: 15,500 children. It is impossible, however, to know how many of these children are actually enrolled in SCHIP today.

Estimated Aggregate Enrollment Statistics for the State Children's Health Insurance Program (SCHIP) and Medicaid for Federal Fiscal Year (FFY) 1999 (10/1/98 through 9/30/99)

In 1997, the President, with bipartisan support from Congress, enacted the State Children's Health Insurance Program (SCHIP). The Balanced Budget Act of 1997 allocated \$24 billion over five years beginning in October 1997 to extend health care coverage to uninsured children through State-designed programs. SCHIP enables States to insure children in working families with incomes too high to qualify for Medicaid through either a separate State program, a Medicaid expansion, or a combination of both types of programs. 16?

States have enthusiastically responded to SCHIP. HCFA is pleased to report that, as of September 30, 1999, it had approved SCHIP plans for all 56 States and U.S. Territories. The 56 approved plans consist of 16 separate SCHIP programs, 26 Medicaid expansions, and 14 combinations of both types of programs. Of the 56 approved plans, 53 plans were implemented as of the close of Federal fiscal year (FFY) 1999 which ended September 30, 1999. 15? 25?

- According to State reported data, HCFA estimates that nearly 2 million children were served by SCHIP during FFY 1999. Of the 53 implemented plans in FFY 1999, over 1.2 million children were served by separate plans, and almost 700,000 children were served by Medicaid expansion plans.
- Although reporting systems were not fully in place for all States in December, 1998, it appears that the number of children served by SCHIP in FFY 1999 has nearly doubled from the December, 1998 estimated levels.
- While these numbers reflect the early implementation experience of most States, we expect these numbers to continue to increase as States fully implement and continue to expand their programs. As of December 13, 1999, HCFA has already approved 34 SCHIP plan amendments and an additional 13 amendments are under review.

Many of these amendments will result in a significant expansion in the number of children served by States beyond those served under the initial State plans. Finally, as States fully develop and implement effective outreach and program coordination strategies, and develop procedures to assure that children retain coverage for as long as they are eligible, HCFA expects continued increases in both SCHIP and regular Medicaid enrollment in FFY 2000 and beyond.

One of the intended goals of Title XXI is to identify and enroll children previously eligible for Medicaid but not enrolled. As a result of enhanced outreach to uninsured children, many States are identifying and enrolling a significant number of eligible children in the Medicaid program. Although there are no data on the number of children enrolled in Medicaid as a result of outreach to uninsured children, several States experienced significant Medicaid enrollment in FFY 1999 which they attribute to SCHIP-related outreach, streamlined eligibility processes, and Medicaid screening procedures.

- The 53 States and U.S. Territories with implemented SCHIP plans in FFY 1999 reported that nearly 20.5 million children were served by regular Medicaid during FFY 1999.

The attached chart reflects the total estimated number of children ever served by SCHIP and regular Medicaid during FFY 1999, as reported by States. This estimate consists of formal State quarterly statistical data submissions, and estimates of enrollment by those States that have not yet provided electronic data.

State Children's Health Insurance Program (SCHIP)
and Medicaid
Aggregate Enrollment Statistics for FFY 1999
(Actual)

701
p.1000

good bad states
allotment
uninsured kids in state

STATE	DATE IMPLEMENTED 11	STATE AMENDMENTS 21	TYPE OF SCHIP PROGRAM			UPPER ELIGIBILITY 31	STATE REPORTED SCHIP ENROLLMENT FFY 1999 (Total children ever served in FFY 1999) 41		FFY 1999 TOTAL SCHIP	FFY 1999 MEDICAID CHILDREN 15
			Separate Program 18	Medicaid Expansion 28	Combined Program 14		Separate Program	Medicaid Expansion		
TOTAL PLANS SUBMITTED = 56			18	28	14		1,284,387	583,163	1,977,550	20,484,924
1. Alabama 6A	02/01/98	08/18/98, 08/23/98			X	200%	25,738	13,242	38,980	242,732
2. Alaska	03/01/99			X		200%		8,033	8,033	53,421
3. American Samoa - >	04/01/99			X		Not Applicable		0	0	38,549
4. Arizona	11/01/98	05/21/98, 08/23/98, 12/01/98	X			200%	26,807		26,807	387,213
5. Arkansas	10/01/98	12/01/98 (p)		X		100%		912	912	155,504
6. California	03/01/98	05/28/98, 01/08/99 (p), 11/23/99, 12/03/99 (p)			X	250%	187,854	34,487	222,351	3,282,848
7. Colorado	04/22/98	09/21/99	X			185%	24,118		24,118	185,217
8. CNMI - >>	10/01/97			X		Not Applicable		0	0	6,845
9. Connecticut *	07/01/98				X	300%	5,277	4,836	9,912	167,882
10. Delaware	01/01/99	11/23/99	X			200%	2,433		2,433	52,517
11. District of Columbia	10/01/98			X		200%		3,029	3,029	100,749
12. Florida	04/01/98	03/08/98			X	200%	118,123	38,471	154,594	1,467,296
13. Georgia 71	11/01/98		X			200%	47,581		47,581	885,336
14. Guam - >>	10/01/97			X		Not Applicable		0	0	8,747
15. Hawaii	01/03/00			X		185%		NI	NI	
16. Idaho 8A	10/01/97	12/01/98		X		150%		8,482	8,482	72,123
17. Illinois 91	01/01/98	11/10/98 (p)		X		139%	7,567	35,132	42,699	886,115
18. Indiana	10/01/97	09/22/99 (p)		X		150%		31,246	31,246	342,686
19. Iowa	07/01/98	08/18/98			X	185%	2,594	7,501	9,985	112,228
20. Kansas	01/01/99	04/01/99 (p)	X			200%	14,443		14,443	144,415
21. Kentucky ** A	02/01/98	08/03/98			X	200%		18,579	18,579	308,722
22. Louisiana	11/01/98	08/27/98		X		150%		21,680	21,680	425,582
23. Maine *	07/01/98				X	185%	3,786	8,671	12,457	80,000
24. Maryland	07/01/98			X		200%		18,072	18,072	325,883
25. Massachusetts	10/01/97				X	200%	24,408	43,444	67,852	448,403
26. Michigan	05/01/98	06/29/98			X	200%	14,825	11,827	26,652	749,653
27. Minnesota **	10/01/98			X		280%		21	21	288,000
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45. South Carolina 11A	08/01/98			X		150%		46,737	46,737	292,386
46. South Dakota	07/01/98	10/26/98		X		140%		3,191	3,191	28,483
47. Tennessee **	10/01/97			X		180%		9,732	9,732	837,141
48. Texas	07/01/98	11/05/99			X	200%		50,878	50,878	1,585,819
49. Utah 121	08/03/98		X			200%	13,040		13,040	808,256
50. Vermont **	10/01/98	08/11/99	X			300%	2,055		2,055	80,286
51. Virgin Islands ** 131	04/01/99	11/09/99 (p)		X		Not Applicable		120	120	1,000
52. Virginia	10/22/98		X			185%	16,896		16,896	370,163
53. Washington	01/01/00		X			250%	NI		NI	
54. West Virginia	07/01/98	03/19/99			X	150%	6,556	1,301	7,857	193,284
55. Wisconsin	04/01/99	01/22/99		X		185%		12,948	12,948	282,154
56. Wyoming	12/01/98		X			139%	NI		NI	

subject
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question -
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out
yet

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as closely
almost
accurate

State Children's Health Insurance Programs (SCHIP)
and Medicaid
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13. Virgin Islands' SCHIP enrollment reflects the number of children for which health care claims were paid from the period 7/98 through 4/99.
14. As of September 30, FFY 1999, Kentucky and Mississippi had not yet enrolled children in their separate SCHIP programs.
15. State reported Medicaid enrollment is estimated.
16. State reported SCHIP and Medicaid enrollment is estimated.
17. "Not Implemented" - denotes States with approved SCHIP plans that have implementation dates after FFY 1999.
18. Due to the unique nature of their SCHIP plans, the U.S. Territories and Jurisdictions cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.
19. Guam and the Commonwealth of the Northern Mariana Islands (CNMI) did not exceed their Medicaid funding caps, and therefore could not claim any SCHIP funding in FFY 1999.
20. Medicaid enrollment reflects total number of children eligible for Medicaid in FFY 1999, as estimated by the Territories/Jurisdictions (Source: HCFA form 27.7 for CNMI and Guam, and FFY 1999 Annual Demonstration Report for American Samoa).

15-Dec-99

PAGE 07

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Most Uninsured Children Are in Families Served by Government Programs

EMBARGOED

by

Genevieve M. Kenney
Jennifer M. Haley
Frank Ullman

Number B-4 in Series, "New Federalism: National Survey of America's Families"

Note: Those wishing to print this report may find it easier to use the [PDF Version](#).

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Many children remain uninsured despite being eligible for public insurance coverage (Dubay and Kenney 1996; Selden, Banthin, and Cohen 1998). Estimates from 1996, prior to the implementation of the Children's Health Insurance Program (CHIP), suggest that as many as 40 percent of all uninsured children were eligible for but not enrolled in Medicaid (Selden et al. 1998). With the advent of national welfare reform and CHIP, the share of uninsured children who are eligible for public programs has likely risen.



Using estimates drawn from the 1997 National Survey of America's Families (NSAF), this brief examines the potential of certain federal programs for reaching the families of uninsured children. We focus here on four particular programs: the National School Lunch Program; the Special Supplemental Program for Women, Infants, and Children (WIC); the Food Stamp program; and the Unemployment Compensation Program.¹ The first three of these are operated by the U.S.

Department of Agriculture (USDA); the last is overseen by the U.S. Department of Labor. These programs rely on very different enrollment procedures and require different documentation as compared with Medicaid and CHIP. At the same time, they serve many families with children who should be eligible for Medicaid and CHIP.

Our findings suggest that almost three-quarters of all low-income uninsured children and about 60 percent of all uninsured children live in families that participate in the National School Lunch, WIC, Food Stamp, or Unemployment Compensation programs. The National School Lunch Program—serving families with about 4 million low-income uninsured children—appears to be a particularly efficient vehicle for identifying uninsured children who are eligible for Medicaid and CHIP.

Data and Methods

The NSAF is a national household survey that provides information on over 100,000 children and nonelderly adults representing the noninstitutionalized civilian population under age 65 (Brick et al. 1999). The NSAF oversamples the low-income population (those with incomes below 200 percent of the federal poverty level [FPL]) and the population in 13 states and provides reliable estimates for the nation. Detailed information on health insurance coverage and other characteristics was collected on up to two sampled children in each household (one age 5 or under and one between ages 6 and 17). The adult who knew the most about each child's education and health care—the primary caregiver—was the respondent. Interviewers asked primary caregivers about children's current and past year's enrollment in private and public insurance and followed up with a confirmation question if respondents did not identify

any coverage (Rajan, Zuckerman, and Brennan 1999).³ Overall, information was collected on 34,439 children.⁴

Participation in the National School Lunch⁵ and WIC⁶ programs was measured at the family level. If primary caregivers reported that at least one individual in the family received free or reduced-price lunches at school or participated in WIC in calendar year 1996, the family as a whole was considered a participant in the National School Lunch or WIC programs. Participation was measured by the enrollment of someone in the child's family, but not necessarily the sampled child whose insurance status was assessed. Therefore, our estimates of how many children can be reached through other programs assume that all children in the household are being reached, not just the child who participates. Participation in these two programs was only assessed for families with incomes that were estimated to be below 200 percent of the FPL based on information provided during the interview.⁷ A family's participation in the Food Stamp program was indicated by the reported receipt of benefits at the time the NSAF was administered in 1997; its participation in the Unemployment Compensation Program was demonstrated by the receipt of benefits in calendar year 1996. ^{8, 9}

We also assessed the demographic and socioeconomic characteristics of the uninsured children whose families participated in these programs. These characteristics include the child's age, race/ethnicity, and immigration status; the educational attainment of the primary caregiver; the family structure, income, and work status; and the region and state in which the family lived.

Extent of Program Participation

Table 1 shows the number of children in families that received benefits during 1996 or 1997 from any or all of the National School Lunch, WIC, Food Stamp, or Unemployment Compensation programs, along with the number of these children who were uninsured and who lived in families with incomes below 200 percent of the FPL. The proportions of low-income and all uninsured children covered by these programs are also presented. We find that an estimated 16.8 million low-income children resided in families in which at least one child received benefits from the National School Lunch Program during 1996. The NSAF indicates that almost 23 percent of low-income children residing in families that received benefits from this program in 1996 were uninsured at the time that the survey was administered in 1997 (3.9 million divided by 16.8 million). We estimate that about 3.9 million low-income uninsured children—60 percent of all low-income uninsured children and almost half of all uninsured children—resided in families that participated in the National School Lunch Program.

Approximately 9.2 million low-income children are estimated to reside in families that received benefits from the WIC Program during 1996. About 17 percent of the children living in these families—or 1.5 million children—were uninsured at the time of the survey. Altogether, about one in four low-income uninsured children live in families that received WIC benefits at some point during 1996. We estimate that the WIC Program could reach an additional 620,000 low-income uninsured children in families that do not participate in the National School Lunch Program.

According to the NSAF, approximately 8.6 million low-income children resided in families that received benefits from the Food Stamp program at the time of the survey. Only 8 percent of these children were uninsured, which means that about 651,000 low-income uninsured children live in families that received food stamps. We estimate that the Food Stamp program could reach an additional 68,000 low-income uninsured children who do not participate in the National School Lunch or WIC programs.

The NSAF also indicates that there were about 629,000 low-income uninsured children whose families received income from Unemployment Compensation programs in 1996. Among these uninsured children, about a quarter—or 158,000—lived in families that did not participate in the National School Lunch, WIC, or Food Stamp programs.

Altogether, 73 percent of all low-income uninsured children and 62 percent of all uninsured children lived in families that participated in the National School Lunch, WIC, Food Stamp, or

3.9
.62
.068

Unemployment Compensation programs. Thus, outreach efforts directed through these programs could target nearly three-quarters of low-income uninsured children, the vast majority of whom are likely to be eligible for Medicaid or CHIP coverage.

Table 1
Program Participation of Families with Uninsured Children, 1996-97

	Federal Income Guidelines	Children in Families Receiving Benefits ^a	Low-Income Children in Families Receiving Benefits ^a	Low-Income Uninsured Children in These Families ^a	Low-Income Uninsured Children in These Families Not Participating in Programs Above ^a	Low-Income Uninsured Children in These Families (%) ^a	All Un Ch The Fam (%)
National School Lunch Program ^b	Free meals if income below 130% FPL; reduced-price meals if income between 130% and 185% FPL	18,022,857 (342,367)	16,784,151 (338,257)	3,855,333 (186,263)		60.1 (1.8)	
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) ^c	Income below 185% FPL	9,847,941 (286,190)	9,191,740 (283,658)	1,529,649 (110,582)	617,715 ^f (63,348)	23.8 (1.6)	
Food Stamp Program ^d	Income below 130% FPL	8,903,522 (276,926)	8,578,058 (278,206)	651,377 (88,110)	67,935 ^g (15,724)	10.2 (1.3)	
Unemployment Compensation ^e		5,103,907 (199,172)	2,327,813 (149,640)	629,478 (80,651)	158,019 ^h (47,901)	9.8 (1.1)	
Participation in School Lunch, WIC, Food Stamp, or Unemployment Compensation Programs		26,622,157 (349,593)	22,335,896 (345,188)	4,699,003 (210,042)		73.2 (1.6)	

Source: Urban Institute tabulations from the 1997 National Survey of America's Families (NSAF). Note Insurance coverage is measured at the survey.

a. Standard errors for each estimate are given in parentheses. b. Represents children in families in which at least one child received benefits School Lunch Program in 1996.

c. Represents children in families in which at least one child received benefits from the WIC program in 1996.

d. Represents children in families that were receiving Food Stamp benefits at the time the NSAF was administered in 1997.

e. Represents children in families in which at least one person received Unemployment Compensation in 1996.

f. Represents low-income uninsured children in families that received WIC benefits but not School Lunch Program benefits.

g. Represents low-income uninsured children in families that received Food Stamp benefits but not School Lunch Program or WIC benefits.

h. Represents low-income uninsured children in families that received Unemployment Compensation but not School Lunch Program, WIC, or Stamp benefits.

Program Participation by Child and Family Characteristics

Table 2 presents the share of low-income uninsured children whose families participated in the School Lunch, WIC, Food Stamp, and Unemployment Compensation programs in 1996 or 1997, by various demographic and socioeconomic characteristics. Participation varies by program, by child and family characteristics, and by geographic location.

The School Lunch Program could reach a high proportion of low-income uninsured children who are school age; fully three-quarters of low-income uninsured children ages 6 to 11 and 65 percent of low-income uninsured children ages 12 to 17 live in families who participate. In contrast, only 38 percent of low-income uninsured children under age 6 live in families that

The capacity to reach low-income uninsured children through the School Lunch, WIC, Food Stamp, and Unemployment Compensation Programs varies by race and birthplace. Overall, 81 percent of Hispanic and 78 percent of black low-income uninsured children could be reached through these programs, while a smaller percentage of other, primarily white, non-Hispanic low-income children could be targeted (66 percent). A slightly higher proportion of low-income uninsured children in foreign-born families relative to uninsured children born in the United States, 76 percent versus 73 percent, could be National Survey of America's Families identified through these programs, although the proportions are not statistically different from one another. Overall, Hispanic children represent over one-third of all the low-income uninsured children whose families participate in any of these programs, while foreign-born children represent a smaller proportion, 13 percent, of uninsured children participating in any of these programs (results not shown).

Table 2 also shows that the capacity to direct Medicaid and CHIP enrollment efforts to low-income uninsured children through these programs varies across regions and states. Specifically, smaller percentages of low-income uninsured children in the Northeast could be reached through these programs relative to other regions of the country. Among the 13 states oversampled in the NSAF, Alabama, California, and Mississippi exhibit the highest percentage of low-income uninsured children who could be reached through these programs, at about 80 percent, while Massachusetts, Colorado, and Washington exhibit the lowest proportion, at about 61 percent.

	School Lunch Program ^a		WIC ^b		Food Stamps ^c		Unemployment Compensation ^d		Any of These Programs	
	(No.)	(%)	(No.)	(%)	(No.)	(%)	(No.)	(%)	(No.)	(%)
Child Characteristics										
Age										
0-5	750,155	38	950,634	48	166,680	8	141,556	7	1,344,959	6
6-11	1,600,824	75	286,925	13	170,786	8	225,583	11	1,677,171	7
12-17	1,504,354	65	292,089	13	313,911	14	262,340	11	1,676,873	7
Race/Ethnicity										
Hispanic	1,458,105	68	648,256	30	205,241	10	178,316	8	1,741,253	8
Black (non-Hispanic)	807,612	70	188,309	16	221,043	19	84,311	7	909,594	7
Other (non-Hispanic)	1,589,616	51	693,085	22	225,093	7	366,851	12	2,048,156	6
Immigration Status										
U.S. born	3,283,363	58	1,364,738	24	546,610	10	587,757	10	4,100,098	7
Foreign born	571,970	73	164,911	21	104,768	13	41,721	5	598,905	7
Family Characteristics										

Educational Status^f

No HS diploma or GED	1,641,659	70	620,443	26	290,301	12	207,254	9	1,895,474	8
HS Diploma or GED, no bachelor's degree	2,094,712	57	865,933	23	354,628	10	401,191	11	2,639,825	7
Bachelor's degree	118,961	35	43,272	13	6,448	2	21,034	6	163,705	4

Work status of parents(s)

Two full-time workers	683,261	65	225,691	22	39,697	4	211,220	20	835,654	8
One full-time worker	2,285,849	60	962,360	25	308,282	8	278,292	7	2,768,739	7
Part-time worker(s) only, no full-time workers	335,655	52	129,995	20	106,874	17	66,156	10	443,805	6
Not working	547,674	62	211,604	24	196,300	22	73,811	8	647,910	7

Family Structure

Single-parent household	1,376,979	61	432,532	19	342,711	15	210,820	9	1,649,338	7
Two-parent household	2,232,796	59	1,022,827	27	246,109	7	411,970	11	2,786,604	7
No parents in household	245,558	63	74,289	19	62,557	16	6,688	2	263,061	6

Family Income

Less than 50% FPL	688,303	62	299,040	27	268,947	24	35,038	3	826,989	7
50-100% FPL	1,265,554	65	497,365	26	241,962	12	265,863	14	1,496,907	7
100-150% FPL	1,322,484	63	512,626	24	73,120	3	148,726	7	158,877	7
150-200% FPL	578,992	46	220,617	18	67,348	5	179,851	14	776,230	6

Geographic Location**Region**

Northeast	365,972	51	130,622	18	66,737	9	80,500	11	460,227	6
Midwest	595,897	60	251,603	25	78,867	8	112,762	11	734,029	7
Midwest	595,897	60	251,603	25	78,867	8	112,762	11	734,029	7
South	1,705,665	61	560,906	20	336,514	12	185,737	7	2,065,097	7
West	1,187,800	63	586,517	31	169,258	9	250,480	13	1,439,650	7

State

Alabama	82,473	66	19,597	16	40,069	32	9,410	7	98,757	7
California	700,323	66	314,980	30	92,151	9	115,318	11	854,048	8
Colorado	53,083	51	14,650	14	9,235	9	4,938	5	64,400	6
Florida	248,409	53	128,574	28	38,531	8	14,847	3	317,709	6
Massachusetts	26,980	46	10,319	18	6,371	11	4,950	8	35,531	6
Michigan	58,910	56	13,329	13	8,337	8	17,428	17	77,356	7
Minnesota	24,786	54	12,170	26	1,412	3	5,584	10	33,091	7
Mississippi	85,077	67	28,723	23	37,214	29	12,025	9	100,324	7
New Jersey	65,136	57	12,791	11	10,663	9	13,998	12	79,603	6
New York	194,224	57	63,585	19	34,624	10	37,891	11	239,765	7
Texas	589,108	64	204,591	22	115,480	13	51,982	6	682,203	7
Washington	24,252	39	16,727	27	6,354	10	10,963	17	38,756	6

Wisconsin	35,203	55	10,135	16	3,284	5	10,478	16	41,634	6
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Source: Urban Institute calculations from the 1997 National Survey of America's Families (NSAF).
Note: Insurance coverage is measured at the time of the survey.
a. Represents children in families in which at least one child received benefits from the School Lunch Program in 1996.
b. Represents children in families in which at least one child received benefits from the WIC program in 1996.
c. Represents children in families that were receiving Food Stamp benefits at the time the NSAF was administered in 1997.
d. Represents children in families in which at least one person received Unemployment Compensation in 1996.
e. Standard error. f. Represents status of child's primary caregiver.

Policy Implications

Over the last several years, federal and state governments have been working to overcome barriers that prevent eligible children from gaining insurance coverage. Many resources are now being devoted to outreach efforts aimed at increasing Medicaid and CHIP enrollment among eligible uninsured children.¹⁰ Under CHIP, which was enacted in 1997, states are entitled to approximately \$40 billion through the year 2007 to expand insurance coverage for children and are mandated to develop outreach strategies as part of their CHIP plans. The welfare reform legislation of 1996, which "delinked" Medicaid from welfare, provided states with additional funds to ensure that children continue to receive Medicaid coverage under the new Temporary Assistance for Needy Families (TANF) program.

One federal effort has involved bringing together federal departments that serve children in order to identify ways to enroll more children in Medicaid and CHIP (DHHS 1998, 1999). The Interagency Task Force on Children's Health Insurance Outreach led a number of government agencies to identify ways to use other government programs to reach uninsured children (DHHS 1998, 1999). One of the problems in designing outreach strategies is the absence of information on how best to target outreach efforts. The analysis presented here suggests that government programs, especially those operated by the USDA, are indeed already serving families with large numbers of uninsured children and thus represent a very promising outreach tool—especially for reaching uninsured Medicaid-eligible children. Because fewer uninsured children in families with incomes between 150 percent and 200 percent of the FPL participate in these programs as compared with families with even lower incomes, our findings suggest that these programs will reach proportionally more Medicaid-eligible than CHIP-eligible children.

The key question is how to effectively use these programs to enroll uninsured children who are eligible for public health insurance (The Children's Partnership 1999). Florida has been recognized as one of the first states to utilize schools to reach uninsured children, and in 1996 the Florida Healthy Kids program was the recipient of the 1996 Innovations in American Government Award. Several states have modeled their CHIP programs after Florida's approach, but new complexities have been introduced under CHIP because states are now required to screen children for Medicaid eligibility and enroll eligibles in Medicaid. President Clinton has asked the secretaries of education, health and human services, and agriculture to identify effective school-based strategies that can be replicated throughout the nation (DHHS 1999).

Some localities are building outreach efforts around the School Lunch Program, which, according to the NSAF, serves the families of an estimated 60 percent of all low-income uninsured children. The USDA added a health insurance information box to its prototype application forms, although no information is available on how widely used the new prototype forms are. Other efforts have included sending informational flyers to parents and positioning trained volunteers at schools to answer questions and help complete applications (Pulos and Lee 1999). States that have attempted to coordinate children's health insurance coverage with the National School Lunch Program have faced a number of barriers, including the need to protect the privacy of lunch program applicants and the fact that Medicaid and CHIP programs require more information (e.g., details on income, other sources of health insurance, and immigration status) than the National School Lunch Program (Pulos and Lee 1999). One suggestion has been to use participation in the National School Lunch Program as presumptive proof of eligibility for health insurance ("A Sensible Way to Improve Kid Care" 1999). It will be important to identify how programs can successfully overcome these hurdles, because these data suggest that removing such barriers could yield substantial reductions in the number of children who are uninsured.

To be successful, outreach and enrollment efforts must address other barriers as well. Focus groups conducted in California in 1998 suggest that there are many reasons that uninsured children do not obtain public coverage (Lake Snell Perry & Associates 1998). The issues included confusion about the eligibility criteria, frustration with the enrollment process, the negative image associated with enrolling in a program so closely linked to welfare, and concerns about the quality of health care services available through public programs. An additional issue for immigrant families in California was the concern that enrollment could threaten their immigration status. Informing the parents who participate in the National School Lunch Program that their uninsured children are eligible for public coverage may be only one part of the solution; it may also be necessary to address these other concerns.

While these data indicate that the majority of uninsured children live in families that participate in other government programs, a large number of uninsured children—over 1.5 million—live in low-income families that do not participate in these programs. Identifying these children and getting them health insurance coverage may pose even greater obstacles. Recent evidence also suggests that growing numbers of children and families are not participating in other programs, such as Food Stamps, for which they are eligible (Zedlewski and Brauner 1999). If the objective is to provide insurance and other benefits to low-income children, new strategies may be required in the era of federal welfare reform.

Notes

1. Because of data issues, we do not report estimates of the number of uninsured children who live in families that participate in either the Head Start or the Section 8 Housing programs, although preliminary estimates suggest that only a small number of additional children would be reached. Data from the second round of the National Survey of America's Families will permit a more accurate assessment for Head Start and Section 8 programs and will allow an assessment of the number of uninsured children whose families received the Earned Income Tax Credit.
2. The 13 selected states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
3. In part, the inclusion of a con-firmation question in the NSAF reduces the number of children identified as uninsured to levels below those identified by the Current Population Survey (CPS). Differences between the NSAF and CPS may also arise because the NSAF collects data on insurance coverage at the time of the survey, but CPS data pertain to insurance coverage during the previous calendar year.
4. The household response rate for the NSAF is 70 percent (Brick et al. 1999). Responses to the interviews are weighted to reflect the design features of the sample, including the oversampling of low-income households in 13 states, and contain adjustments for nonresponse and undercoverage. We compute variance estimates using a replication method that adjusts for the survey's complex sample design. Flores-Cervantes, Brick, and DiGaetano (1999) describe this method and its application to the NSAF in detail. We use imputed data for health insurance, income, and other variables with missing values. Imputed values account for 1.3 percent or less of all observations for health insurance (Dipko et al. 1999).
5. Families with children age 5 or older were asked whether someone received benefits from the free or reduced-cost lunch program at school. The NSAF also assessed family participation in the School Breakfast Program. Ninety-seven percent of uninsured children with family participation in either program lived in families that received free or reduced-cost lunches; including breakfast-only families did not significantly change our estimates.
6. Families with children under age 6 were asked whether anyone received benefits from the WIC program.
7. An income measure defined during the administration of the survey was used for determining who would be asked the school lunch and WIC questions. Thus, we may be missing some families that participated in these programs, and a small portion (6 percent) of the families that responded to this question were reclassified as having incomes higher than 200 percent of the FPL.
8. Although insurance coverage and Food Stamp program participation reflect the family's status at the time of the survey, School Lunch, WIC, and Unemployment Compensation participation was measured for calendar year 1996. Thus, we may be missing some uninsured children whose families did not participate in these latter programs in calendar year 1996 but who participated at the time of the survey in 1997; at the same time, some of the children who were uninsured at the time of the survey may not have been uninsured at the time the family participated in these programs. However, since being currently uninsured and being uninsured during the last 12 months is highly correlated (the correlation coefficient is over 80 percent), there is a high likelihood that the child was uninsured when the family was participating in these programs.
9. To the extent possible, we have compared our estimates of program participants to administrative counts of participants. Our estimates appear reasonable when compared to administrative data, especially in light of

conceptual differences between the NSAF estimates and the administrative data. Government sources (U.S. Congress 1998) report that 14.6 million children received free or reduced-price lunches in calendar year 1996, while our data indicate that about 18 million children lived in families that received free or reduced-price lunches (we cannot identify who received free or reduced-price lunches in a family). Government statistics (DHHS 1999) indicate that 5.6 million children received WIC benefits each month in 1996, while our data indicate that 7.1 million children under age 6 lived in families that received WIC benefits at some point during 1996 (we cannot identify who received WIC benefits in a particular family). The NSAF reports that 8.9 million children lived in families that received food stamps at a point in time during 1997, while administrative records (DHHS 1999) indicate that about 9.6 million children received food stamps on a monthly basis in 1998. Administrative data on recipients of unemployment compensation do not indicate whether there are children under age 18 in the household and thus cannot be made comparable to the NSAF estimates. However, we estimate that about 6 million nonelderly adults received Unemployment Compensation benefits in 1996, while administrative data indicate that there were 8.1 million beneficiaries in that year (U.S. Congress 1998).

10. For a summary of outreach strategies, see Health Resources and Services Administration (1999).

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Medicaid-Welfare, Bjt,690**Federal audit finds states improperly denying Medicaid benefits**

WASHINGTON (AP) States are illegally denying Medicaid benefits to poor families being dropped from the welfare rolls, federal auditors have found. Medicaid's top administrator said Tuesday the errors are widespread and promised a crackdown.

"I was very disappointed when I saw this," said Nancy-Ann DeParle, head of the Health Care Financing Administration, which runs Medicaid. "I can't say whether these are significant willful failures or mistakes."

DeParle's comments come nine months after her agency warned states that strict welfare rules should not prevent families eligible for Medicaid from getting the government-sponsored health care benefits.

But many such Medicaid-eligible families have been dropped from the program as its rolls have continued to decrease along with the welfare rolls, officials said.

DeParle promised to investigate and force states to fix the problems once the audit is complete. Auditors thus far have investigated 40 states and found widespread problems, she said, declining to say exactly how many states had problems.

The problems include:

States not telling people they are eligible for Medicaid when they are discouraged from applying for welfare.

State computers that automatically wipe people off Medicaid when they leave welfare.

Caseworkers improperly hassling families who apply for Medicaid.

"It's surprising to us that states would think that's OK," DeParle said. "Some of them have not been complying with the law, and we're going to be taking corrective actions."

States realize they are not signing up everyone who is eligible for Medicaid, though they are not acting deliberately to keep people from the program, said Bill Waldman, executive director of the American Public Human Services Association, which represents state welfare and Medicaid agencies.

Still, he said, the states must work harder to correct it.

"I think that there's a real problem here," Waldman said. "There's no question about it."

The trouble has been that Medicaid and welfare once went hand in hand, but since a massive 1996 welfare overhaul, they have been guided by different philosophies.

Cash welfare is being actively discouraged, as states push people to find jobs and get off the rolls. Governors and President Clinton regularly trumpet falling welfare caseloads as evidence that the overhaul is helping families become self-sufficient.

But Medicaid, while also government aid for the poor, is viewed as a positive support for families, particularly for people who

Laurie

Mackey

HHS has only
preliminary
information
which they will
pull together &
send to us.

leave welfare for low-wage jobs that do not provide health insurance benefits. There is also growing concern about the number of Americans who don't have health insurance some 44 million at last count; families that lose Medicaid generally makes that problem worse.

There's a similar dynamic with food stamps, which are also seen as an important support for working poor families.

The problem is cultural and hard to fix, said Ron Pollack, president of Families USA, a liberal consumer group.

"The measure of one's success has been determined by how many people were dropped from the welfare rolls," he said. "How do you distinguish and say, 'Well, the reverse is true with respect to Medicaid and food stamps?'"

Pollack and other advocates have long complained about this. Families USA issued a study early this year estimating that 675,000 people lost Medicaid coverage and had no other health coverage in 1997 due to strict new welfare rules and improper implementation of them.

But that research was dismissed by many in the Clinton administration, Pollack said.

"A good number of people wanted to tout the success of welfare reform, and this might have been viewed as a blemish on that," he said.

In August, President Clinton expressed concern about the issue, but DeParle's comments Tuesday were the first to suggest the federal government may take action to force the states to fix the problem.

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Memorandum 4 page 5

To: Chris Jennings fax: (456-5557)
Jeanne Lambrew (456-2223)
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Barbara Woolley (456-6218)

Date: December 17, 1999

From: Marina L. Weiss
Jo Merrill

Information: ☒ Action: ☐

Re: Maternal and Child Health Proposals

Respond By:

Attached are two low-cost initiatives to improve maternal and child health that could be easily included in the President's budget proposal for 2001 and incorporated in his State of the Union Address. We think it would be an extraordinary legacy for President Clinton to have established the authority under federal law to provide health coverage for up to 95% of all pregnant women and to reduce the incidence of neural tube defects by 70 % or more.

Let us know if you need more information or clarification. We'd love to work with you to make this happen.

Attachments (2)



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Birth Defects Foundation*

1901 L Street, NW Suite 200
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**Proposal to Expand State Children's Health Insurance Program
to Include Pregnant Women**

Legislative Proposal:

The March of Dimes supports the following changes to the 1997 federal law that established SCHIP:

- giving states authority to enroll income-eligible pregnant women over age eighteen;
- automatically enrolling newborns if their mothers are enrolled in SCHIP; and
- allowing states to use the \$500 million approved for outreach as part of the 1996 welfare reform bill to encourage enrollment of women and children in Medicaid and SCHIP.

Impact if approved:

This SCHIP amendment would enable states to cover an additional 45,000 uninsured pregnant women each year – bringing the number of insured pregnancies to 95%.*

Rationale:

According to data compiled for the March of Dimes by the U.S. Census Bureau, in 1998 more than 12 million women of childbearing age – 20% – lacked health insurance. Lack of health insurance is a significant barrier to prenatal care and other maternity benefits.

SCHIP is the only major federal health program that covers infants but not pregnant women.

Prenatal care improves birth outcomes. National Center for Health Statistics has found that infants born to mothers who received no prenatal care or late prenatal care are nearly twice as likely to be low birthweight – LBW accounts for 10% of all health care costs for children.

Automatic enrollment of newborns whose mothers are enrolled in SCHIP would eliminate gaps in coverage and waiting periods for infants.

Uninsured newborns are more likely to be sick, yet receive fewer services in the hospital than newborns with insurance coverage. The increased levels of risk for newborns are thought likely to be due to lack of prenatal care for the uninsured mothers, who are also more likely to be black and Hispanic. (Institute of Medicine 1998, "America's Children: Health Insurance and Access to Care")

Enrollment of income eligible pregnant women would help with enrollment of older children. In 1995, the National Center for Health Statistics found that 56% of pregnant women had one or more older children.

* Source: Thorpe, Kenneth. "The Distribution of Health Insurance Coverage Among Pregnant Women 1990-1997," March 1999. Paper prepared for the March of Dimes.

Support for Proposal:

15 groups support this legislation – American Academy of Pediatrics, American Association of University Affiliated Programs for Persons with Developmental Disabilities, American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American Public Health Association, Association of Maternal and Child Health Programs, Association of Women's Health, Obstetric and Neonatal Nurses, Catholic Health Association, Council of Women's and Infants' Specialty Hospitals, National Association of Children's Hospitals, Association of County and City Health Officials, National Perinatal Association, National Women's Health Network, and Spina Bifida Association of America.

Congressional Interest:

Six bills that include this proposal are pending:

- H.R.827 / S 1646, "The Improved Maternal and Children's Health Coverage Act of 1999," by Representatives Diana DeGette (D-CO) and Connie Morella (R-MD); and Senators Blanche Lincoln (D-AR), Mary Landrieu (D-LA), Gordon Smith (R-OR), Evan Bayh (D-IN) and Dianne Feinstein (D-CA)
- S. 592 / H.R.1085, "The Healthy Kids 2000 Act," by Senator Christopher Bond (R-MO) and Representative Jo Ann Emerson (R-MO)
- S. 1717, "Mothers and Newborns Health Insurance Act," by Senators Christopher Bond (R-MO), John Breaux (D-LA), John McCain (R-AZ), Max Baucus (D-MT), Blanche Lincoln (D-AR), and Trent Lott (R-MS)
- H.R. 1843, "The Mothers and Newborns Health Insurance Act," by Reps. Henry Hyde (R-IL) and Nita Lowey (D-NY)
- **All House bills are endorsed by Congressional Caucus on Women's Issues.**

Estimated Cost:

Any adult SCHIP costs can be accommodated within current program funding levels.



**March
of Dimes**
Saving babies, together

*March of Dimes
Birth Defects Foundation*

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Proposal to Improve Birth Defects Prevention

The March of Dimes supports including full funding for Birth Defects Prevention Act and the Folic Acid Education Campaign in President Clinton's FY 2001 budget (\$40 million for birth defects prevention activities and \$20 million for folic acid education).

On April 21, 1998, President Clinton signed into law the Birth Defects Prevention Act of 1998 (P.L. 105-168), which established authority within CDC to provide surveillance, research and services aimed specifically at the prevention of birth defects. This bipartisan legislation passed the Senate by voice vote and passed the House of Representatives by a vote of 405 to 2.

Rationale:

Birth defects are the leading cause of infant mortality in the United States, responsible for about 8,000 infant deaths each year, and about 30% of all pediatric admissions to hospitals. The causes of about 75% of birth defects are unknown. Until these causes are known, prevention strategies cannot be developed.

CDC funds eight Centers for Birth Defects Research and Prevention, each receive approximately \$800,000 per year, to conduct epidemiological research on the prevention of birth defects. The centers are collaborating on the National Birth Defect Prevention Study, one of the largest case-control studies of birth defects ever conducted. Current funding is half of the level needed. If fully funded, the centers could accelerate the study, and undertake additional studies on the causes of birth defects.

CDC also provides technical assistance to states for establishing or improving birth defects surveillance programs. Eighteen states are receiving approximately \$100,000 a year for three years. However, the number of states interested in birth defects prevention is twice the number being supported. Additional federal resources would enable states to initiate and/or expand birth defects surveillance.

Each year an estimated 2,500 babies are born with neural tube defects. Data from the state of California found that the average lifetime cost for a child with spina bifida (a neural tube defect) was approximately \$294,000 (based on 1992 dollar values). Up to 70% of these birth defects could be prevented if all women of childbearing age followed the U.S. Public Health Service recommendation to consume 400 micrograms of folic acid daily. However, a March of Dimes national survey, conducted by the Gallup Organization, found that only 32% of women of childbearing age reported taking a multivitamin with folic acid daily. With additional funding, CDC could implement a national public and health professions education campaign designed to increase the number of women taking folic acid daily.

Congressional Interest:

The "Folic Acid Promotion and Birth Defects Act of 1999" (H.R. 2538 / S. 1384), introduced on July 15, 1999 by Representatives Lucille Roybal-Allard (D-CA) and Jo Ann Emerson (R-MO) and Senators Spencer Abraham (R-MI), Herbert Kohl (D-WI) and Christopher Bond (R-MO), authorizes the CDC to conduct a national health education campaign to promote folic acid. Currently the House bill has 159 cosponsors and the Senate companion bill has 26 cosponsors.

December 1999

covering Kids

12/17/99

Denora —

See p. 3 for mention of the
school initiatives — note new
address — Best,
Sarah

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Grantee News From Around the Country

Alaska: From its March kickoff through September, Denali KidCare has enrolled 11,956 children, achieving its three-year enrollment goal in only seven months.

Arizona: The Children's Action Alliance has published *Children Without Health Insurance: Listening to Arizona's Parents*, which provides information from focus groups with Arizona parents. To order a copy, contact the Children's Action Alliance at 602.266.0707 or email caa@azchildren.org.

Connecticut: Covering Connecticut's Kids is assisting with the Children's Defense Fund's tri-state (CT, NJ, NY) Kmart/Martha Stewart Living *Child Health Now!* outreach initiative. Participating Kmart stores are posting banners, distributing flyers and publicizing the national *Insure Kids Now* hot line number. Print, TV and radio advertisements featuring Martha Stewart also are being aired.

Georgia: On Saturday, August 21, the PeachCare for Kids program partnered with Kmart stores across Georgia for a statewide Back-to-School Sign-Up Day. The March of Dimes, Right from the Start Medicaid and Georgia Covering Kids all worked with PeachCare to make the event a success.

Hawaii: Aloha United Way's toll-free telephone number, funded

through the Hawaii *Covering Kids* grant, is up and running.

Idaho: The Idaho *Covering Kids* initiative reports that the Children's Health Insurance Program (CHIP) will remain a Medicaid expansion. The state also has replaced the previous 18-page enrollment form with a 4-page application for all programs.

Kentucky: Country singer Naomi Judd has been enlisted as the state's KCHIP spokesperson. Ms. Judd is promoting child health coverage through speaking engagements, TV and other public appearances.

Minnesota: Governor Jesse Ventura on October 13 pledged his commitment to insure all of the state's eligible children before the end of his term.

New Jersey: *Covering Kids* New Jersey on three Saturdays in October provided assistance with the Children's Defense Fund's tri-state Kmart/Martha Stewart Living *Child Health Now!* outreach initiative. The effort generated 300 applications and reached 3,000 families.

Oklahoma: The Oklahoma *Covering Kids* Partnership recently participated in a series of statewide discussions that elicited strategies for SoonerCare outreach, including: providing one-on-one application

assistance; conducting home visits; following up with families; and incorporating outreach opportunities into daily life activities.

Rhode Island: Rite Care, Rhode Island's Medicaid Managed Care Program, in July announced it had enrolled 12,000 new members in nine months, an increase of 15 percent.

West Virginia: In an op-ed published in the Charleston Daily Mail in August, the Rev. Nathan Wilson, Executive Director of the West Virginia Council of Churches (lead organization for *Covering Kids* in West Virginia), defended funding for the state's CHIP: "Insuring children is the right thing to do for fiscal as well as human reasons. . . . Has CHIP encountered some bumps in the road? Of course. What new initiative, public or private, doesn't?" Rev. Wilson wrote. "When I don't get my newspaper delivered on time due to an equipment breakdown, bad weather or human error, I don't conclude that we don't need newspapers." Δ

If you want to share news on *Covering Kids* activities in your state, please notify Kristine Hartvigsen at 803-779-2607 or via email at kristine@kidsouth.org.

Also . . .

- The U.S. Immigration and Naturalization Service has come out with a short-version flyer on public charge in English and in Spanish. Both versions can be found online at <http://www.ins.usdoj.gov/graphics/publicaffairs/presinfo4.htm#PublicCharge>.

- The Southern Institute on Children and Families, National Program Office for *Covering Kids*, has moved. Our new address is: 1821 Hampton Street, Columbia,



SC 29201. Please disregard the pre-printed address on this newsletter masthead. Future newsletters will reflect the changed address. Also, please note that our telephone and fax numbers remain the same.

- Please check the accuracy of your state's page on the CK website periodically and report corrections or breaking news to Kristine Hartvigsen at 803-779-2607 or kristine@kidsouth.org. Δ

Partners is a publication of *Covering Kids*: A National Health Access Initiative for Low-Income Uninsured Children. The National Program Office is located at 620 Sims Avenue, Columbia, South Carolina, 29205. Staff available to provide assistance are: Sarah Shuptrine, Director; Vicki Grant, Deputy Director; Kristine Hartvigsen, Communications Director; and JoAnn Prince, Administrative Assistant. They may be reached at 803.779.2607. For the latest information, visit the *Covering Kids* website at www.coveringkids.org.

Preparation of this newsletter was assisted by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey.

covering
Kids

Volume 1, Issue 2

PARTNERS

Fall/Winter 1999

Annual Meeting Celebrates 50 Statewide, 167 Community Grantees

Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children is a \$47 million program of The Robert Wood Johnson Foundation, with direction and technical assistance provided by the Southern Institute on Children and Families.

The program is designed to help states and local communities increase the number of eligible children who benefit from health insurance coverage programs. Working through broad state-local coalitions, this three-year initiative will facilitate state and local efforts to:

- Δ design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage programs;

- Δ simplify the enrollment processes; and

- Δ coordinate existing coverage programs for low-income children.

Given the microscope under which the State Children's Health Insurance Program (CHIP) initiative has been placed, the success of efforts to enroll uninsured children in both CHIP and Medicaid is paramount. Failure is unthinkable.

Covering Kids projects are on the front lines of this historic children's health coverage movement. In his introductory address to more than 320 people gathered for the *Covering Kids* First Annual Meeting in San Antonio September 29 – October 1, Robert Wood Johnson Foundation President Steven Schroeder spoke of the promise of the *Covering Kids* initiative and how it is being bolstered by the energy and enthusiasm demonstrated by *Covering Kids* grantees.

"This is a time when a lot of people are cynical about whether social change can occur. Those people need to come to meetings like this because there really is a can-do spirit here," Dr. Schroeder said. "In the world's wealthiest nation, we let 44 million people or so go without basic health insurance. We have tolerated it now for so long that we accept it as normal and maybe even right. And that, I know, pains all of you, and it certainly pains me. . . .

"As you know there is a tremendous underenrollment of eligible children who could be in Medicaid programs but are not," he continued. "While CHIP has been going forward, welfare reform has cut into Medicaid coverage for welfare mothers and their children. It's sort of like bailing with a leaky bucket."

Dr. Schroeder said the *Covering Kids* initiative is well-fortified to be a player in this high-stakes game, given the high caliber of *Covering Kids* grantees.

Final funding announcements this fall brought the total number of grantees to 50 statewide and 167 local pilot projects. In her remarks to the *Covering Kids* grantees, National Program Office Director Sarah Shuptrine put it into perspective.

"You stretch across the nation — in cities and rural and frontier areas. . . . Each statewide and pilot coalition represents a partnership of public and private agencies pledged to roll up their sleeves and tackle outreach, simplification and coordination issues.

(See ANNUAL MEETING, p. 2)

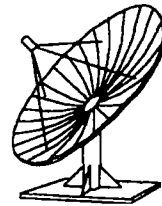
Satellite Feed Generates TV Coverage for *Covering Kids*

Covering Kids recently commissioned Home Front Communications to produce and broadcast a satellite news feed on October 19 to major television markets in Arizona, California, Georgia, Iowa and Texas.

Intended to generate news stories about child health coverage programs and how viewers can enroll their children, the feed provided TV stations with a "buffet" of videotaped interviews — including comments by U.S. Secretary of Education Richard Riley, NPO Director Sarah Shuptrine, American Academy of Pediatrics Past President Joel Alpert and a family whose children are enrolled in either CHIP or Medicaid. From this satellite buffet, news producers could put on their plate items needed to

serve up a news story, seasoning it with their own local interviews tailored to local audiences.

An additional feed, featuring a Spanish-language interview with Dr. Norma Parra, a pediatrician from Texas, was distributed November 3 to Spanish-language outlets.



All targeted stations were provided state-specific fact sheets and contact information for local *Covering Kids* and Medicaid/CHIP enrollment officials, as well as the toll-free telephone information hot line number serving their state.

As of November 29, the feed generated 117 television news stories about child health coverage on 41 stations in 28

markets. Small and rural markets were particularly receptive to the story, airing the majority of segments. Of the five target states, Texas received the most coverage overall.

This effort was so successful that it even generated some "bonus" coverage in two non-targeted states, Missouri and Illinois.

The Spanish-language feed generated 11 stories in the Houston, Los Angeles, Phoenix and Tucson markets. At press time, additional coverage still was being tallied.

As favorable results continue to be reported, *Covering Kids* is exploring the possibility of conducting additional satellite news feeds in cooperation with *Covering Kids* grantees. Δ

Annual Meeting (Continued from p. 1)

All in all, there are over 4,000 organizations serving on the *Covering Kids* coalitions nationwide," she told the assembly.

Medicaid expansions since 1986 and the passage of CHIP in 1997 were progressive measures, she continued. However, enacting progressive policies is only step one. "We've learned that there are no guarantees that progress in the policy arena will translate into progress in the real world."

Historically, the perception has been that Medicaid and other government-subsidized programs serve only the poorest citizens, primarily on public assistance. In reality, almost all citizens — even the well-to-do — have benefited from federal health coverage subsidies.

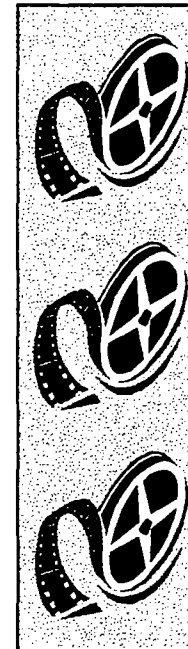
"We cannot overstate the importance of getting the word out that Medicaid and CHIP are not welfare programs," Shuptrine said. "The fact is that the biggest government-sponsored health coverage program is the employer-sponsored health coverage tax break, which is the way most Americans obtain health coverage."

There are many challenges facing *Covering Kids* in the development of uncomplicated, dignified and coordinated child health coverage programs, she told the group. But grantees are up to the challenge. They have the leadership skills, the energy and the tenacity to make it happen.

"The timing for the *Covering Kids* initiative could not be better. The attention currently being given to the need to find and enroll children is unprecedented," Shuptrine said. "Three years, the time allotted in our *Covering Kids* grants, is not a long time given the job that has to be done. And we must get it done." Δ

See page 3 for a listing of the most recent *Covering Kids* grantees, announced since the Spring issue of *Partners*.

A report on the *Covering Kids* First Annual Meeting will be disseminated in the coming months.



Now Playing In A Community Near You . . .

"The opportunity is here. The impact is real."

The new *Covering Kids* informational video, which made its debut at the Annual Meeting in San Antonio, features the personal insights and experiences of three families who have enrolled their children in CHIP or Medicaid health coverage programs. The 5-minute video communicates both the importance of health coverage and the availability of coverage plans such as Medicaid and CHIP.

Highlighting key national statistics on the uninsured, the video further supports its enrollment message with comments from a pediatrician, an elementary school principal, an employer and a school nurse.

Produced by the firm of Greer Margolis Mitchell Burns & Associates, under contract with *Covering Kids*, the video is an excellent tool for reaching audiences at school PTA or PTO gatherings, churches, local Chambers of Commerce, health clinic and community health center waiting areas, state and local food service association meetings, and at various other appropriate venues.

Free VHS copies of the video were sent to all grantees in late October. Additional copies are available for \$5 each, including shipping and handling. To request additional videotapes, contact Kristine Hartvigsen at 803-779-2607 or via email, kristine@kidsouth.org. Δ

School-Based Enrollment Initiatives Get Boost

Speaking at the Annual Meeting of the American Academy of Pediatrics on October 12, President Clinton directed federal officials to find eligible children in the nation's schools and sign them up for Medicaid and CHIP. He said health coverage outreach should become a routine part of schools' administrative activities, such as disseminating health coverage information with registration packets and school lunch program applications.

U.S. Secretary of Education Richard Riley has stepped out front on the child health coverage issue with his department's national *Insure Kids Now Through Schools* campaign, launched this fall.

At the AAP meeting, President Clinton also announced the release of a new report by the

Interagency Task Force on Children's Health Insurance Outreach. New outreach activities proposed in the report include:

- ⇒ Notifying grandparents about health insurance available for their grandchildren through Medicare mailings.
- ⇒ With help from the IRS, providing information on SCHIP and Medicaid to families filing their income tax returns.
- ⇒ Using AmeriCorps volunteers to educate families and link children to new health insurance options. Δ

A transcript of the President's address to the AAP is available on the internet at: <http://www.whitehouse.gov/WH/New/html/19991012.html>.

Covering Kids Grantee Announcements

Since the March issue of *Partners*, the following awards have been announced: Alabama, California, Hawaii, Idaho, Iowa, Louisiana, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Rhode Island, South Carolina, Utah, Vermont, Virginia, Wisconsin and Wyoming. These states bring the total number of *Covering Kids* statewide grantees to 50 nationwide. For details on all programs, visit the *Covering Kids* website at <http://www.coveringkids.org>.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE: _____

TO: Derorah
fax: _____FROM: Vicki Rivas-Vazquez
Director of Special Projects
tel: 202/690-7854, fax: 202/690-5673TOTAL NUMBER OF PAGES SENT: 6
(including cover page)

COMMENTS:

Here are HHS edits to Presidential Executive Memorandum + WH Fact Sheet.

Since there are ~~several~~ HHS announcements we would like to give the Secretary final WH Fact sheet before Tuesday morning. Please e-mail me final, so I can send it to her ~~over long weekend~~.

Thanks.

200 Independence Ave, SW, HHH 674D, Washington, DC 20201

1800
923 4216

THE CLINTON-GORE ADMINISTRATION TAKES NEW STEPS TO INCREASE ENROLLMENT OF UNINSURED CHILDREN

DRAFT: October 12, 1999

Today at an address to the American Academy of Pediatrics, the President will announce a number of new actions that focus on ^{identifying} finding and enrolling uninsured children in the Children's Health Insurance Program (CHIP) and Medicaid through schools. Just last month, the President ~~approved the last states' plan to implement CHIP~~. Now, he urges pediatricians as well as other health care providers, businesses, and community organizations to focus their energy on helping enroll eligible but uninsured children in these programs. To that end, the President will step up his "Insure Kids Now" campaign, a public-private partnership that he began shortly after the enactment of CHIP. He will:

announced the approval of the last state plan to implement CHIP, so that

all 50 states, 5 U.S. territories, and the District of Columbia have been approved.

^{Cabinet} Issue an executive memorandum that instructs Secretaries to develop strategies to integrate children's health insurance outreach into schools. Today, the

President will release an executive memorandum instructing the Secretaries of Health and Human Services, Education, and Agriculture to report to him in six months on steps to promote education and enrollment of uninsured children in schools. Schools are an ideal place to conduct outreach, as many states and communities have ^{through} demonstration. The President's action builds on these efforts by soliciting specific recommendations on how to make school-based outreach ^{happen nationwide throughout} the country.

- Send administrative guidance on CHIP ~~including~~ ^{This week,} options for school-based outreach to state health and education officials. Today, the Secretaries of Health and Human Services and Education will send a letter to every state Medicaid, CHIP, and Education Secretary describing the opportunities that CHIP offers for school-based outreach. It describes permissible funding options for outreach in schools; suggests that states take advantage of the option under CHIP to give children "presumptive eligibility" in schools; and ^{promotes} ~~describes~~ the upcoming national and regional conferences on school-based outreach. This new guidance will help states provide the necessary financial support and technical assistance that schools need as they begin to reach out to uninsured children.

- Announce that more than 700 schools and communities ^{of Education Dick} responded to the call to join the Insure Kids Now campaign. At the National Governors' Association meeting last August, the President announced that Secretary Riley was sending out letters to school superintendents and community leaders to ask them to conduct outreach and enrollment in Medicaid and CHIP as part of their back to school activities. More than 700 principals and superintendents in 47 states ^{have} committed to taking ~~at least one step~~ to help children, including providing information at parents' nights and registration; ^{adding} recruiting coaches to inform children about their health insurance options; and including CHIP/Medicaid ^{materials} information in their information to parents about immunization.

Since then, ^{or} in response,

sports

to immunization information sent to parents.

- **Release a report on hundreds of outreach activities that 11 Federal agencies are conducting and adds Americorps to this Task Force.** Today, the Federal Interagency Task Force on Children's Health Insurance Outreach, created by the President in February 1998, reported their accomplishments and plans for additional activities. Highlights include:
 - **Adding Americorps to the Task Force.** Every Americorps volunteer will receive information on CHIP and Medicaid outreach techniques in their new member orientation training. In addition, Americorps will send a letter to every State Medicaid and CHIP agency to provide them with technical assistance in applying for assistance from Americorps volunteers. They expect these new efforts will result in the dedication of XX hours of public service to children's health insurance outreach. *upcoming*
 - **Reaching out to grandparents nationwide.** HHS and SSA are including information on CHIP and Medicaid in the COLA Notice and the "Medicare and You" handbook, which are sent to all 39 million Medicare beneficiaries annually. *Recognizing the importance of grandparents as caregivers, spell out*
 - **Reaching out to children exposed to public health hazards.** Federal public health professionals sent to communities at risk as a result of exposure to hazardous waste are now providing information on CHIP and Medicaid to the thousands of families they serve annually.
 - **Reaching children through the school lunch program.** USDA is including information on Medicaid and CHIP with the application for free and reduced price school lunches during the 1999-2000 school year sent to XXX schools.
 - **Educating Americans about CHIP.** In the coming months, DOJ will provide information to over 100,000 employees through their employee newsletter; HHS will send information to over 15,000 Head Start grantees; and an informational statement on CHIP and Medicaid will be printed at the bottom of the earnings and leave statements for 17,000 DOL employees.
- **Announce public-private partnership that dedicates over \$9 million in research funds to identify effective children's health insurance strategies.** Today, the President will announce that the ~~U.S. Agency for Health Care Policy and Research, The David and Lucille Packard Foundation, and the U.S. Health Resources and Services Administration~~ will join forces to fund over \$9 million in research *on how to evaluate* health insurance programs improve the quality of, and access to, care for low-income children. These projects will have a special focus on minority children and children with special health care needs. Their results will be widely disseminated to Federal and state policy officials and will provide guidance to refine Medicaid and CHIP to more effectively meet the needs of children. *health*

Department of Health and Human Services / Agency for Health Care Policy and Research and Health Resources and Services Administration, with the D-L-P Fdn...

to be consistent with other fonts on first two pages, this line should not be all in caps.

HISTORIC COMMITMENT TO CHILDREN'S HEALTH INSURANCE

OUTREACH. The Clinton-Gore Administration has a historic commitment to increasing health insurance coverage nationwide. In 1997, with bipartisan support from the Congress, the President created the Children's Health Insurance Program (CHIP), which provides \$24 billion dollars over the next five years to extend health care coverage to uninsured children. Soon thereafter, the Administration launched a broad-based, bipartisan, public-private campaign called Insure Kids Now, which includes a toll-free number to promote children's health outreach; public service announcements on national television and radio; and private sector commitments to print the Insure Kids Now toll free number on commonly used products, such as grocery bags and toothbrushes. In August 1999, in a speech at the National Governors' Association's annual meeting, the President announced new activities to expand the Insure Kids Now Campaign, including: reaching out to enlist every school in the country in a back-to-school children's health outreach campaign.

insurance

(1-877 KIDS NOW) and web site

in italics

— (insurekidsnow.gov)



Department of Health and Human Services
Public Health Service

AHCPR
Agency for Health Care Policy and Research
Executive Office Center, Suite 501
2101 East Jefferson Street
Rockville, MD 20852

FAX (301) 594-2283

*Deborah -
did I give this
to you yet?
I also want
you to email
the Event idea list
with as many details
as*

Date: 9/29/99

Time: 11 a.m.

To:

Jeanne Lambra

From:

Paula Zeller

Organization:

Organization:

AHCPR - Public Affairs *you've
been able to
add.*

Phone:

Phone:

301/594-6113

Fax:

202/456-7431

Comments:

Per your conversation
with Chris Williams

No.

of pages (not including cover sheet):

4

Sharon

**Press Release****DRAFT**
9/29/99

Agency for Health Care Policy and Research • 2101 East Jefferson Street • Rockville MD 20852

FOR IMMEDIATE RELEASE

October 12, 1999

DRAFT

9/29/99

AHCPR – Paula Zeller, 301-594-6113; pzeller@ahcpr.gov

Karen Migdail, 301-594-6120; kmigdail@ahcpr.gov

Packard – John Walker, 650-917-7122

HRSA – Mona Finch, 301-443-5630

**AHCPR, PACKARD FOUNDATION AND HRSA AWARD \$9.1 MILLION FOR STUDIES
DESIGNED TO IMPROVE HEALTH CARE FOR LOW-INCOME CHILDREN**

The U.S. Agency for Health Care Policy and Research (AHCPR), The David and Lucile Packard Foundation, and the U.S. Health Resources and Services Administration (HRSA) today announced a set of research studies that will help public health insurance programs and health care delivery systems improve the quality of, and access to, health care for low-income children. Overall funding will total \$9.1 million over three years for nine research projects.

AHCPR Deputy Administrator Lisa Simpson, M.B., B.Ch., and Eugene Lewit, Ph.D., Senior Program Manager in the Children, Families and Communities Program of the Packard Foundation, noted the studies are especially timely in light of the growth of managed care and other recent changes in the financing and delivery of health care, including the State Children's Health Insurance Program (CHIP). CHIP, enacted as part of the Balanced Budget Act of 1997, helps states offer affordable health insurance to uninsured children in working families that earn too much for Medicaid but too little to afford private coverage.

According to Dr. Simpson, "These studies will uncover which health insurance and delivery features work best for low-income children -- particularly minority children and those with special health care needs. "The studies should benefit CHIP as well as other public insurance programs and delivery systems, including Medicaid and state- and locally subsidized health insurance. "These projects emphasize policy relevance and dissemination, ensuring that they will provide timely information to policy makers," Dr. Lewit said.

(more)

-2-

Seven of the projects focus exclusively on or have separate analyses of children with special health care needs, and five explore disparities between minority and non-minority children. HRSA Administrator Claude Earl Fox, M.D., M.P.H., said, "These research projects mark an unparalleled effort to understand how to improve health care for vulnerable children, including children who remain uninsured, and the institutions that serve them."

An unusual aspect of this set of projects is that the principal investigators will participate in a Coordinating Committee that will undertake activities to strengthen individual studies, and make it possible for the results to be applied across locations, populations, and insurance design and organizational delivery system features. The Coordinating Committee will receive guidance from a Users Group, consisting of federal, state and local government representatives.

The following awards were made:

Provider Participation and Access in Alabama and Georgia. Principal investigator: Janet Bronstein, Ph.D., University of Alabama at Birmingham. \$1,88,628; 9/30/99 - 9/29/02.

This study will examine the effect of CHIP and Medicaid changes and expansions in Alabama and Georgia on provider availability and on low-income children's subsequent access to, utilization of, and satisfaction with health services. Two substudies, one of African-American children and one of children with special health care needs, will be undertaken.

Impact of Publicly Funded Programs on Child Safety Nets. Principal investigator: Peter Budetti, M.D., J.D., Northwestern University, Evanston, Ill. \$985,469; 9/30/99 - 9/29/02.

The purpose of this study is to look at the impact of Medicaid managed care and CHIP on the survival and financial viability of pediatric safety net providers.

Medicaid vs. Premium Subsidy: Oregon's CHIP Alternatives. Principal investigator: Janet Mitchell, Ph.D., Center for Health Economics Research, Waltham, Mass. \$872,321; 9/30/99 - 9/29/02.

This study will compare the access to, satisfaction with, and quality of health care of Oregon children who choose to enroll in the CHIP Medicaid-look-alike program, those who choose to enroll in the

(more)

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premium subsidy program, and those who remain uninsured. There will be a focus on Hispanics, who are disproportionately represented among the uninsured. Researchers will also investigate continuity of enrollment and the reasons that some fail to re-enroll in the CHIP program.

Special Health Care Need Children: CHIP Responsiveness. Principal investigator: Sara Rosenbaum, J.D., George Washington University, Washington, D.C. \$951,687; 9/30/99 - 9/29/02.

This study will explore how states exercise their flexibility in CHIP program design by describing eligibility criteria in freestanding CHIP programs and all managed care design features in CHIP programs nationwide. Researchers also will analyze the data from the National Health Interview Survey, the Medical Expenditure Panel Survey and the Area Resource File to model the impact of key benefit features on low-income children's access to and utilization of health care.

Evaluation of Kansas Healthwave. Principal investigator: Robert St. Peter, M.D., Kansas Health Institute, Topeka, Kan. \$614,290; 9/30/99 - 9/29/02.

The purpose of this study is to evaluate the impact of CHIP on low-income children's health care access, quality, utilization and status, including children who remain uninsured. This study will include a special focus on the vulnerable populations of rural, urban African-American and Hispanic children.

Access and Quality of Care for Low-Income Adolescents. Principal investigator: Elizabeth Shenkman, Ph.D., University of Florida, Gainesville, Fla. \$920,191; 9/30/99 - 9/29/02.

This is a study of the impact of the organizational features of Florida's CHIP plans and providers on adolescents' access to and quality of care, health and functioning, and expenditures, including a comparative analysis of minority and non-minority youths.

Health Care Access, Quality, and Insurance for CSHCN. Principal investigator: Nancy Swigonski, Ph.D., Indiana University, Indianapolis, Ind. \$1,118,744; 9/30/99 - 9/29/02.

This study will analyze the impact of Indiana's various CHIP arrangements on children with special health care needs regarding health care access, utilization, quality, satisfaction, expenditures, health outcomes and family impact.

New York's SCHIP: What Works for Vulnerable Children. Principal investigator: Peter Szilagyi, M.D., M.P.H., University of Rochester, N.Y. \$1,751,260; 9/30/99 - 9/29/02.

The purpose of this study is to assess the impact of New York's CHIP health plan features on enrollees' access, utilization and quality of care, including substudies of children with asthma and minority children. In addition, investigators will examine continuity of enrollment, the magnitude and reasons for loss of commercial insurance, the impact of CHIP on uncompensated inpatient care and the factors that cause some eligible families not to enroll.

(more)

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Analysis of Fee-for-Service vs. Managed Care CSHCN. Principal investigator: Janet Zimmerman, Ph.D., Michigan Public Health Institute, Okemos, Mich. \$667,369; 9/30/99 - 9/29/02.

This study will investigate the impact of a voluntary managed care program for children with special health care needs on Medicaid-eligible children.

AHCPR, a part of the U.S. Public Health Service, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost and broaden access to essential services. AHCPR sponsors and conducts research that provides evidence-based information on health care outcomes: quality; and cost, use and access. The information helps health care decision makers – patients and clinicians, health system leaders, and policymakers – make more informed decisions and improve the quality of health care services.

The David and Lucile Packard Foundation is a private family foundation founded in 1964. The Foundation provides grants in a number of program areas, including science, children, families and communities, population, conservation, and the arts.

HRSA, also a part of the U.S. Public Health Service, directs national health programs that improve the health of the Nation by assuring quality health care to underserved, vulnerable and special-need populations and by promoting appropriate health professions workforce capacity and practice, particularly in primary care and public health.

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Lead prevention

- **Reaching out to children exposed to ~~public health hazards~~.** The CDC is working with local lead poisoning prevention programs to incorporate children's health insurance outreach into their ongoing activities.
- **Reaching out to families in career transition.** In July 1999, DOL provided information on Medicaid and CHIP at their One-Stop Career Centers nationwide.
- **Educating hundreds of thousands of Americans about Medicaid and CHIP.** HUD, USDA, the Department of Education, DOL, and Treasury sent information on Medicaid and CHIP to 80,000 grant applicants and 25,000 property owners and managers; 270,000 parents, school administrators, teachers, and business and community leaders; 92,000 USDA employees; 158,000 Treasury employees.

Highlights of new Federal activities include: *new activities #*

- **Adding AmeriCorps to the Task Force.** Every AmeriCorps and AmeriCorps*VISTA volunteer working with youth and in health care settings will receive information on CHIP and Medicaid outreach techniques in their new member orientation materials. With this information, thousands of volunteers nationwide will be able to link uninsured children to the new health insurance options available.
- **Reaching out to grandparents nationwide.** Recognizing the importance of grandparents as caregivers, HHS and SSA are including information on CHIP and Medicaid in this fall's cost-of-living adjustment (COLA) notices and the "Medicare and You" handbook, which are sent to all 39 million Medicare beneficiaries annually.
- **Reaching families as they file their taxes.** During the upcoming tax filing season, the IRS will provide information on CHIP and Medicaid to over 8,000 Voluntary Income Tax Assistance site coordinators and volunteers assisting families in completing their income tax returns.

Announce public-private partnership that dedicates over \$9.5 million in research funds to identify effective children's health insurance strategies. Today, the President will announce that HHS and The David and Lucille Packard Foundation will join forces to fund over \$9 million in research on how health insurance programs improve the quality of, and access to, health care for low-income children. These projects will have a special focus on minority children, as 27.7% of Hispanic children and 17.6% of black children are uninsured. [JML – is there a better problem statement to justify these grants?]



*X New
Cmtnts
building
on over
150
previous
Cmtnts
are
incorp
into
report
including*

don't say "Ignore the Uninsured" —→

take out TANF - ME

A first line then budget

Congress has failed to enact
other critical initiatives in POTUS budget

TANF

Tobacco

Asthma/Disease Mgmt (AAP)

- **Issue an executive memorandum that instructs Cabinet Secretaries to develop strategies to integrate children's health insurance outreach into schools.** Today, the President will sign and release an executive memorandum ~~instructing the Secretaries of HHS, Education, and Agriculture to report to him in six months on steps the Federal government can take to institutionalize the use of the school lunch program and other routine school activities to identify and enroll uninsured children and to highlight successful ongoing programs.~~ Schools are an ideal place to conduct outreach, as many states and communities – such as ~~Alabama~~ ^{Indiana} and New Jersey, which target eligible children through the schools – have already demonstrated

(with its jurisdiction over children) directing

- **Send administrative guidance on CHIP funding options for school-based outreach to state health and education officials.** This week, the Secretaries of Health and Human Services and Education will send a letter to every state Medicaid, CHIP, and Education agency describing the financial, administrative, and technical assistance that CHIP offers for school-based outreach. It clarifies that states and schools can use the multi-billion dollar CHIP allotments to provide outreach in schools, suggests that states allow schools to provide immediate eligibility for Medicaid and CHIP to children who appear to be eligible for those programs, so that they can receive critical health care services right away; and promotes the upcoming national and regional conferences on school-based outreach.

detail on states (use to onsite environment)

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McDere guidance letter

- **Announce that more than 1,500 schools and communities responded to the call to join the Insure Kids Now campaign.** At the National Governors' Association meeting last August, the President announced that Secretary of Education Riley was sending out letters to school superintendents and community leaders to ask them to conduct outreach and enrollment in Medicaid and CHIP as part of their back to school activities. In response, more than 1,500 schools and communities in 47 states are implementing a wide range of steps to enroll children in CHIP programs have committed to taking new steps to help children, including providing information at parents' nights, registration, and school physicals and adding information on CHIP and Medicaid in letters sent to parents about immunization. In the upcoming months, both HHS and Education will work with states and schools to help them implement these new activities and to begin to identify best practices.

in Aug

Ed. Sec Call

request that they

- **Release the first annual Interagency Report on Children's Health Insurance Outreach detailing the hundreds of outreach activities that 18 Federal Departments and agencies are conducting.** Today, the Federal Interagency Task Force on Children's Health Insurance Outreach, created by the President in February 1998, reported on their accomplishments and proposed new activities to identify and enroll eligible children in CHIP. Federal accomplishments include:

last year

- **Reaching children through the school lunch program.** In August, USDA included Medicaid and CHIP information with the 1999-2000 prototype application for free and reduced price school lunches sent to over 94,000 schools nationwide. Over 25 million children use the free and reduced lunch program each day.

Over 150 million

① There are over 10 mil uninsured child nationwide. Although aggressive imp of CHIP has enrolled over 1 mil kids - 47 states expecting more - more must be done to ensure the success of the program. Today, POTUS will unveil

HIGHLIGHTS OF THE SECOND INTERAGENCY TASK FORCE REPORT ON CHILDREN'S HEALTH INSURANCE OUTREACH

In June of 1998, the President ordered eight Federal agencies to enact over 150 initiatives designed to help enroll millions of uninsured children in Medicaid or the new Children's Health Insurance Program (CHIP), and to report back to him ^{after} in one year on their progress.

Today, the Secretary of Health and Human Services delivered the Second Interagency Task Force Report on Children's Health Insurance Outreach to the President. This report and the recommendations were produced by the Departments of Health and Human Services, Agriculture, Commerce, Education, Housing and Urban Development, Interior, Labor, Justice and Treasury, and the Social Security Administration and Environmental Protection Agency. Taken together, these actions to identify and educate federal employees and grantees who work with families about the availability of CHIP and Medicaid coverage for children represent an unprecedented, cross-government commitment to provide affordable insurance to children.

THE TASK FORCE HAS EDUCATED THOUSANDS OF FEDERAL WORKERS AND GRANTEES ABOUT CHIP. Accomplishments include:

Promoted nationwide
Advertisement of the 1877 KIDS NOW toll-free line for children's health insurance outreach. HHS developed and distributed over 80,000 posters promoting the toll-free number.

Educating hundreds of thousands of Federal employees and grantees about Medicaid and CHIP. The Departments of Housing and Urban Development, Agriculture, Education, Labor, Treasury, Justice, and the Social Security Administration sent information on Medicaid and CHIP to:

- 80,000 grant applicants and 25,000 multi-family property owners and managers;
- 270,000 parents, school administrators, teachers, and business and community leaders;
- 92,000 USDA employees;
- 158,000 Treasury employees who work with low-income families;
- 13,000 employees in field offices; and
- all 170 sites in the Department of Justice's Operation Weed and Seed program, a crime prevention and community revitalization initiative.

Encouraged schools to link school lunch + health insurance program applications.
Reaching children through the school lunch program. USDA included Medicaid and CHIP information with the 1999-2000 prototype application for free and reduced price school lunches sent to over 94,000 schools nationwide.

Reaching out to children
Reaching out to children exposed to public health hazards. Federal public health professionals sent to communities at risk are now providing information on CHIP and Medicaid to the thousands of families they serve annually. In addition, the CDC is working with local lead poisoning prevention programs to incorporate children's health insurance outreach into their ongoing activities.

Educated *is seeking jobs*
Reaching out to families in career transition. In July 1999, DOL will provide information on Medicaid and CHIP at One-Stop Career Centers nationwide.

NEW FEDERAL EFFORTS TO REACH OUT TO UNINSURED FAMILIES AND THEIR CHILDREN. This year's report proposes new strategies for reaching out to uninsured children and their families. Proposals include:

Adding Americorps to the Task Force. Every AmeriCorps and AmeriCorps*VISTA volunteer working with youth and in health care settings will receive information on CHIP and Medicaid outreach techniques in their new member orientation materials. With this new information, thousands of volunteers nationwide will be able to link uninsured children to the new health insurance options available.

Encouraging *to enroll their grand children*
Reaching out to grandparents nationwide. Recognizing the importance of grandparents as caregivers, HHS and SSA ~~are~~ ^{will} include information on CHIP and Medicaid in upcoming Cost Of Living Adjustment Notices and the "Medicare and You" handbook, which are sent to all 39 million Medicare beneficiaries annually. Similar information is being distributed through the State Health Assistance Program Grantees, which provide many elderly individuals with information on government programs. Finally, HHS is working with the AARP to include information on Medicaid and CHIP in the booklets and brochures distributed to millions of members nationwide.

Reaching families as they file their taxes. During the upcoming tax filing season, the IRS will provide information on CHIP and Medicaid to the hundreds of Voluntary Income Tax Assistance site coordinators and volunteers assisting families in completing their income tax returns.

Conducting new efforts to reach Hispanic children. HHS is working with states to ensure that Spanish speaking operators are available for every toll free line linked to the national toll free number for children's health insurance outreach, 1877 KIDS NOW.

Working with groups dedicated to urban renewal to reach children at risk. HUD has developed a Children's Health Insurance Outreach Collaborative, with the Alpha Kappa Alpha Sorority, which has 850 chapters nationwide; HOPE for Kids, a volunteer organization with over 36,000 full and part-time volunteers nationwide; and the National Consortium for African American Children, an umbrella organization for 100 civic organizations to identify and enroll uninsured children in CHIP.

additional Federal employees and Medicaid
Educating Americans about CHIP. In the coming months, DOJ will provide information to over 100,000 employees; HHS will send information to over 15,000 Head Start grantees; and an informational statement on CHIP and Medicaid will be printed at the bottom of the earnings statements for 17,000 DOL employees.