DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE: 3/5

TO: Devorah Adler
fax: _____

FROM: Ellen Dahl
Office of the Assistant Secretary for Public Affairs
Tel: 202/690-7578, Fax: 202/690-5673

TOTAL NUMBER OF PAGES SENT: 6
(including cover page)

COMMENTS:

On Monday, there will be an article in Health Affairs on CHIP. Here are the FINAL Q+As.

Laurie Boeder is the point of contact in the Dept.

Hope all is well! -Ellen

Suite 647-D 200 Independence Ave SW Washington, DC 20201

Q's and A's for Health Affairs article

Revised 3/1/99

Q: Does the department agree with the article on CHIP published in Health Affairs?

A: First of all, the main conclusion of the Health Affairs article is that comprehensive and effective outreach is of critical importance to CHIP and we certainly agree with that. The article raises some interesting issues and its results highlight the significant role that outreach can play.

However, as the authors make clear in the Health Affairs article, their estimates are based on the Medicaid experience. The article's projections are based on the assumption that states would administer CHIP in exactly the same way as they administer the Medicaid program. In fact, most states have developed new approaches for their CHIP programs, and together, the 50 state and territorial plans approved to date anticipate providing health insurance coverage for more than **2.5 million** currently uninsured children by September 2000. Eleven states have already expanded their original CHIP plans through amendments, showing how states are continuing to use this opportunity to bring health care to uninsured children.

To help ensure that eligible children get enrolled in CHIP, and in Medicaid, the federal government recently announced several new outreach initiatives. These include a nationwide toll-free number to provide families with essential information; placing the toll-free number on corporate products, such as grocery bags and diaper products; airing public service announcements on television; launching a $1 million paid radio campaign; enlisting the help of grass-roots organizations; and stepping up activities by federal organizations that interact with low-income families. The toll-free number is 1-877-KIDS-NOW, and the Web site is *www.insurekidsnow.gov*.

Q: Do you believe the Health Affairs article's estimate that CHIP will only reach 1.5 million children (*some reporters may quote the 1.8 million figure*) is correct?

As we said before, it is in part because of research like this that the Department is committed to an aggressive outreach program and it is because of the CHIP outreach programs currently under way that we believe more than 1.5 million children will enroll in CHIP. Together, the 50 state and territorial plans approved to date anticipate providing health insurance coverage to about **2.5 million** currently uninsured children by September 2000. In addition, eleven states have already expanded their original CHIP plans through amendments showing how states are continuing to use this opportunity to bring health care to uninsured children.

[BACKGROUND: The article itself notes that projected changes in insurance status are estimated only "imprecisely" and that "Some states are expanding CHIP eligibility in phases and...may well extend eligibility to more children."]

Q: Are states imposing waiting periods and setting lower income thresholds than are allowed under current law?

Some states are requiring that previously insured children be uninsured for a short period of time before they are enrolled in CHIP – generally 3 to 6 months -- in an effort to avoid "crowd-out." Both the CHIP statute and the department's guidance, in fact, stipulate that programs must be designed in such a way to discourage families with coverage from dropping private plans in favor of CHIP.

And while many states have initially set eligibility thresholds below the maximum eligibility level (200 percent of poverty, or 50 percent above their current Medicaid level) at least 11 states have then come back to file amendments expanding their original eligibility threshold and thus covering more children.

[BACKGROUND: Only 11 **[HCFA please check]** states require that children be uninsured for a period of time before they are eligible for CHIP, usually 3 to 6 months. In most of these states, children who lose coverage involuntarily are not affected, and can enroll in CHIP right away.]

Q. The Health Affairs article predicts that some 400,000 children will drop their private insurance coverage in order to enroll in CHIP. What is the department's position on this? Aren't you trying to avoid crowd-out?

A. The Health Affairs article is careful to explain that their crowd-out estimates reflect the Medicaid model which makes no effort to prevent private insurance crowd-out. The authors clearly state that, "actual CHIP crowd-out rates may be lower than those predicted by our model."

In fact, the department is aggressively enforcing the law's provisions designed to avoid crowd-out. In every state where we believed the risk of crowd out was significant, we've insisted that programs include features to discourage families from dropping private plans in favor of CHIP. That is why some states are requiring that children be uninsured for a short period of time before they are eligible for CHIP. Even in states where we believed the risk of crowd out was minimal, we have still insisted that states monitor their programs to be sure that no substitution occurs.

The federal CHIP law allows states a lot of flexibility in designing ways to minimize

"crowd-out." This variation will help us learn which approaches work best in balancing the need to avoid crowd-out with the desire to enroll the maximum number of uninsured children.

Q: What do you mean by "effective outreach?" What are the new approaches that states are taking with CHIP in comparison to Medicaid?

A: States are experimenting with a range of outreach initiatives and marketing campaigns for CHIP. Maryland has experienced higher than expected enrollments in CHIP during its first months - one of their outreach initiatives was to put CHIP advertising on fast food restaurant tray liners. North Carolina had success recruiting eligible children into their CHIP program by canvassing local churches during the holiday season. Connecticut plans to put CHIP brochures in tax literature and car registration packets and send leaflets home with school children.

There are also things that states are doing to make both CHIP and Medicaid reach out to all eligible children. For example, several states are making use of streamlined application procedures. Louisiana is replacing its 14 page Medicaid application with a two- page application for both Medicaid and its CHIP program.

To help ensure that eligible children get enrolled in both programs, the federal government recently announced several new outreach initiatives. These include a nationwide toll-free number to provide families with essential information; placing the toll-free number on corporate products, such as grocery bags and diaper products; airing public service announcements on television; launching a $1 million paid radio campaign; enlisting the help of grass-roots organizations; and stepping up activities by federal organizations that interact with low-income families. The toll-free number is 1-877-KIDS-NOW, and the Web site is www.insurekidsnow.gov.

Q: What evidence is there that CHIP is meeting its goal of providing insurance to low-income children of working parents?

A. We are extremely encouraged that 47 states have already begun implementing CHIP, and plan to enroll approximately 2.5 million children by September 2000. We are also confident that the national commitment to the program by the private sector will complement ongoing federal and state efforts to make this program a success.

The Department agrees with the study that the opportunity exists to expand the number of children who are eligible for CHIP, and we are currently working with states to accomplish this objective. Note also that the way CHIP was designed, any funds that are not expended in the initial years of the program can be applied to later years - years in which states are planning to phase in more expansive eligibility rules.

Q: The article shows that if states set income thresholds at 300 percent of poverty then a much larger number of uninsured children would be eligible. Is this allowed under federal law? Does the department recommend this approach? Which states have gone so high in setting income thresholds?

A: One of the program's best features is that it provides states with a wide range of options for CHIP implementation. This flexibility should help us to learn what works and what doesn't as we seek to solve the problem of children without health insurance. Not all states have moved as aggressively as others in implementing CHIP, but as states are gaining experience with the program, we are seeing more and more expand their CHIP eligibility rules to encompass larger groups of children.

[BACKGROUND: Technically, the federal law allows states to set CHIP income thresholds at 200 percent of poverty or 50 percentage points above current Medicaid eligibility thresholds, whichever is higher. So, under the federal law, some states are currently allowed to go as high as 250 percent of poverty. In addition, the federal law provides the authority for states to define family income including what income may be "disregarded." Some states have used this authority to establish a higher income threshold for their CHIP plan.]

Q: What about problems with current Medicaid programs? Earlier work by the same researchers pointed to the large number of children who remain uninsured despite being eligible for Medicaid. Isn't that a larger issue than CHIP enrollment rates? What steps are being taken to get these Medicaid eligibles enrolled?

A: The Administration is committed to improving awareness of Medicaid as well as CHIP. For example, we recently announced the Insure Kids Now campaign, a toll-free number and media campaign to help families get access to both Medicaid and CHIP. Last year, we revised our regulations to permit states to extend Medicaid to low income two-parent working families even if the principal wage earner worked more than 100 hours per month. And we are also working with states to identify model outreach strategies, program operations, coverage expansions and Medicaid policies designed to increase the number of people eligible for Medicaid who actually receive it. Louisiana, for example, is replacing its 14 page Medicaid application with a 2-page application for both Medicaid and its CHIP program.

The President's Fiscal Year 2000 budget outlines some additional initiatives that would improve Medicaid awareness and potentially enroll thousands more children in Medicaid as well as CHIP:

· HHS is proposing to broaden states' ability to use a special $500 million Medicaid fund, enacted in the 1996 welfare reform law and aimed at outreach for children losing welfare, to fund outreach to other children eligible for Medicaid and to new children eligible for

CHIP. [This is expected to increase Medicaid spending by $345 million over the next five years, including both administrative expenses and benefits.]

· The President's budget proposes allowing states to extend Medicaid to low-income children up to age 21 who were in foster care but who 'age out' of that system at age 18. This would help assure health care for this vulnerable population as they continue to prepare for adulthood, just as older children living in their own families can be covered under a parent's insurance policy. Each year, about 16,000 youths age out of foster care and 9,000 more leave the foster care system and run away.

· In addition, we are proposing to remove outreach costs from the 10 percent cap states have on administrative costs for the CHIP program. Instead, states could spend up to 3 percent of their total allotment on outreach. This initiative, which is scored at $875 million, would give states more flexibility in designing outreach campaigns to reach families.

HHS is also working with the Federal Interagency Task Force and throughout its own individual agencies to build on our current outreach efforts. For example, HRSA plans to hold a conference to train Spanish-speaking health workers on CHIP and Medicaid in five states - California, New Mexico, Arizona, Texas and Florida.

Q: Whether the short term enrollment is 1.5 million or 2.5 million children, both figures are much lower than some initial estimates. Is CHIP overbudgeted? Or, was CHIP poorly designed?

A. It is important to recognize that CHIP represents a fundamental change in the way we provide public coverage to uninsured children. A change of this magnitude can be expected to take time. The way CHIP was designed, any funds that are not expended in the initial years of the program can be applied to later years. And we are confident that enrollments will grow over time. So, it would be wrong to conclude that CHIP is overfunded. The challenge now is to get the word out and to build on successful models of outreach in order to get these eligible children enrolled.

* Today, we approved phase II of its CHIP plan as well as an 1115 waiver that moves

DRAFT
Qs on BadgerCare
CHIP and 1115 waiver

1.Q. Exactly what has HCFA approved for Wisconsin today and how is it different from the plan the agency rejected earlier?

A. Last year, we approved the state's phase I of its CHIP plan--a Medicaid expansion for children ages 15-18—and suggested a way for the state to cover adults. We have worked with the state to develop a plan that meets the requirements enacted by Congress. In fact, it's very similar to the proposal we made to the state last year. Today we are approving an additional plan that The plan approved today meets the state's goal of insuring low-income *families* through a state-wide health care delivery system known as BadgerCare. This expansion is different from the state's original proposal because it uses a two-step process to achieve this goal through a new CHIP expansion and a waiver of Medicaid rules.

Phase II of the Wisconsin CHIP program will provide health insurance coverage to children up to age 18 in families with incomes up to 185 percent of the federal poverty level (FPL). The plan approved today builds on Phase One of the state's CHIP plan--a Medicaid expansion that was approved by HHS on May 29, 1998.

As a companion to their CHIP Phase II plan, HHS today also announced the approval of a Medicaid Section 1115 waiver that will allow the state to enroll the parents of CHIP-eligible children in the state's Medicaid program. The state also received approval to use CHIP funds to buy employer-sponsored coverage for families in instances where the cost of the employer coverage is no greater than the cost of covering a child through regular BadgerCare.

In its first proposal, the state had asked to cover both children *and* adults through the CHIP program. This is extremely difficult to accomplish under the federal CHIP statute's cost-effectiveness test (just described above). Since Congress intended CHIP funds only to subsidize insurance for children, we suggested to the state that they could apply the CHIP allotment to an expanded Medicaid program and enroll parents in Medicaid through a Section 1115 waiver. We have worked closely with the state to bring the plan design into compliance with the federal CHIP law and we are pleased with the final design of BadgerCare.

2. Q. How much money is available to the state?

A. When the Department approved the first phase of Wisconsin's CHIP plan, it became eligible to receive as much as $38 million in funds for fiscal year 1998. That same allotment will be applied to this new expansion. HCFA will soon publish state allotments for fiscal year 1999.

3. Q. Will Wisconsin use CHIP dollars to cover adults? Won't this mean less money to help kids?

A. In writing the CHIP law, Congress allowed CHIP funds to be used to cover adults in extremely limited circumstances. Two tests must be met in order for states to cover families as well as children--the plan must not cost more than it would have cost to cover the child alone, *and* it must be designed in such a way to discourage families with coverage from dropping private plans in favor of the federally-supported CHIP program. The cost-effectiveness test is difficult, but not impossible to meet. The easiest way would be if a family has access to employer-sponsored insurance (ESI) that they otherwise cannot afford. If the employer subsidy of that coverage is high enough that the premium cost for the entire family would be no more than the state would have to spend to cover the child alone in a standard CHIP arrangement, then the state can spend CHIP funds to buy that coverage. The ESI plan must meet the benefit requirements established by CHIP. To date, the only state that has met this test and is purchasing ESI is Massachusetts.

4. Q. Will the BadgerCare benefit package always be at the Medicaid level?

A. Yes. Most BadgerCare coverage will be provided through Medicaid. In the event employer coverage is being purchased, the state has a seamless system that will provide any additional benefits needed to bring the plan up to the Medicaid standard.

5. Q. Is Wisconsin's approach unique?

A. Yes. The state has chosen a unique approach that is designed to keep working families together, and to provide incentives for working families to increase their earnings without losing Medicaid coverage. BadgerCare is also designed to strengthen, and work in concert with, the state's successful welfare reform program.

6. Q. The State originally proposed a cap on enrollment because of budgetary concerns, but the federal government said no. Didn't you back down?

A. No, the Department has not changed its position on enrollment caps. Because BadgerCare is financed through Medicaid--an entitlement program--a cap on enrollment is not permitted. While the Department can appreciate the state's wish to limit its financial exposure, adoption of the Medicaid option under CHIP entails a commitment to maintain the entitlement to eligibility that is fundamental to Medicaid--even after the state exhausts its CHIP allotment. HCFA understands the state's budgetary constraints, however. Under Medicaid law, if a state determines that enrollment may exceed its budgetary allowance, it can apply for federal approval to lower the income eligibility level for any new applicants. Wisconsin is free to exercise this option if it feels enrollment will exceed its budget.

7. Q. How does that differ from a cap?

A. The two are very different. Under the enrollment cap, children who are otherwise eligible for Medicaid could be prevented from entering the program because the enrollment cap had been exceeded. Medicaid is an entitlement program and denying care to those legally entitled to it is simply not allowed. If a state changes its enrollment, all children who are eligible under the new income requirements can still enroll. This preserves the entitlement component that is key to Medicaid.

8. Q. Why did HCFA object to the Wisconsin enrollment cap when it has approved caps elsewhere?

A. HCFA has never approved the kind of cap Wisconsin had proposed.

Background: If the question refers to Tennessee, the situation there is not the same. Under Tennessee's Medicaid Section 1115 waiver, a population of people *not otherwise eligible* for Medicaid were added to the Medicaid rolls. HCFA allowed Tennessee to limit that demonstration to a set number of individuals, 1.3 million. The critical difference between the two plans is that Tennessee continues to guarantee Medicaid coverage to those legally entitled to it--those in the demonstration would not otherwise be allowed to participate in Medicaid. In sharp contrast, Wisconsin had proposed to cap enrollment and deny coverage to children who were fully eligible for Medicaid.

9. Q. How will HCFA ensure that beneficiaries won't lose health coverage they are entitled to if the state rolls back eligibility levels?

A. All persons enrolled in BadgerCare will be allowed to remain in the program regardless of any changes in eligibility for *new* applicants. Families can remain in BadgerCare until their income reaches 200 percent of the federal poverty level.

10. Q. Couldn't such a rollback hurt lower-income families in comparison to those with higher incomes?

A. If the state changes the income cut-off for BadgerCare, a currently enrolled family with higher income could be grandfathered into the program while a lower-income family might be denied admission under new, lower eligibility rules. Because federal law allows states to make these kinds of changes HCFA had to approve the state's proposal. States, however, must stay within the federal mandatory minimum income levels of 133 percent of poverty for children from birth to age 5 and 100 percent of poverty for children ages 6-14.

11. Q. This proposal has been under review in various forms since September 1997. What took HCFA so long to approve it?

A. In fact, we approved the first phase of Wisconsin's plan in May 1998 and at that time offered the state an approvable way to cover the adults it wanted to include in BadgerCare. Wisconsin's proposal presented a complex coordination of two programs: a

Section 1115 Medicaid waiver and a Phase II CHIP plan. HCFA staff worked closely with state officials to craft a plan that met the state's coverage goals and stayed within the federal CHIP and Medicaid guidelines.

12. Q. Did HCFA waive provisions of Title XXI in approving BadgerCare?

A. No. All waivers that were granted were waivers of the Medicaid statute, as part of the Section 1115 portion of BadgerCare. The CHIP component of BadgerCare did not require waivers.

13. Q. Under BadgerCare, is it true that children can only enroll if they live with their custodial parent? Does that mean the child has to live in a traditional family?

A. No. Children do not need to be in a traditional family to enroll.

14. Q. Is it true that the federal government forced its program design on the state?

A. No. The BadgerCare program was implemented through a collaborative process. HCFA, state and local officials and members of the state's congressional delegation worked closely together to design a program that both met the state's coverage goals and the federal Medicaid and CHIP laws.

15. Q. Why does Wisconsin need Section 1115 waivers to implement BadgerCare?

A. In order to implement the full BadgerCare program, Wisconsin needed permission to deviate from standard Medicaid practices--permission granted by the Section 1115 waiver. Under the BadgerCare program Wisconsin will be: 1) expanding Medicaid coverage to custodial parents of Medicaid-eligible children; 2) imposing premiums on children above 150 percent of the FPL; 3) obtaining federal matching funds on expenditures resulting from the collection of premiums for the adult expansion population; 4) not providing retroactive eligibility for BadgerCare participants; and 4) using income and resource standards and methods which differ from current Medicaid law.

16. Q. Beyond the enrollment cap issue, what other issues were in contention with the state?

A. In addition to the enrollment cap, Wisconsin wanted to use CHIP dollars to cover adults. The CHIP funds are limited, and Congress provided very limited circumstances when those funds could be spent for adult coverage (see Q. 3). HCFA had to assure that funds spent from the Children's Health Insurance Program were being properly applied and that covering adults doesn't mean less money for children.

17. Q. What were the other significant issues in Wisconsin and how were they resolved?

A In addition to the enrollment cap, HCFA has been concerned about the following issues:

- Premiums: The state had requested federal matching funds for adult premiums under Medicaid. By allocating the premiums separately for adults and children, the state can receive federal matching funds for adult premiums under section 1115 authority. *Resolution:* Following discussions with the state, we came to a mutual agreement on the state's premium allocation methodology.

- Absent Parents: Initially, the state had requested the flexibility to cover absent parents through an 1115 waiver. While we are supportive of the state's goal to cover absent parents, we are concerned that their mechanism for generating savings under the waiver (by claiming Title IV-E targeted case management costs under Medicaid) is not viable. *Resolution:* HCFA and the state agreed to pursue this issue along a separate track so as not to delay the approval of BadgerCare.

- Tribal Cost-Sharing: The state sought a final policy determination on whether or not tribal members could be charged cost-sharing. *Resolution:* The Department is in the process of devising guidance for states regarding cost-sharing options for tribes under title XXI. The state has informed us that they do charge cost-sharing for this group -- which is permissible under the law -- and will continue to do so until they hear otherwise from HCFA.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

PHONE: (202)690-6102 FAX: (202)690-6167

Date: _____

From: Rob Stewart To: Deanna Archer

Division: _____ Division: _____

City & State: _____ City & State: _____

Office Number: _____ Office Number: _____

Fax Number: _____ Fax Number: _____

Number of Pages + cover _____

REMARKS: Tennessee letter.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF TENNCARE
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

June 1, 1998

Ms. Rose Hatten
Health Care Financing Administration
7500 Security Boulevard, Mail Stop C318-26
Baltimore, Maryland 21244

Dear Ms. Hatten:

Enclosed please find a copy of Tennessee's revised CHIP plan which is being submitted to Mr. Richard Fenton in the Family and Children's Health Programs Group at HCFA.

As you know, Tennessee's CHIP plan is an expansion to our existing Medicaid, or TennCare, program. We submitted a Title XIX State Plan Amendment in December 1997 to cover this expansion. It is now our understanding that a Title XIX State Plan Amendment is not required but that we do need to request an amendment to our Section 1115a (TennCare) waiver. This letter, accordingly, is a request to amend the TennCare waiver, effective October 1, 1997.

As you will note in the attached materials, we are proposing to add the following eligibility groups under CHIP:

1. Effective April 1, 1997, we re-opened enrollment in the Uninsured category to **children under the age of 18 who do not have access to insurance** either through their own employer or a family member's employer. Effective October 1, 1997, those children who enrolled in this category as of April 1, 1997, or later and whose family incomes are no greater than 200% of poverty are considered Tennessee's "CHIP children." Those children enrolling in this category at any time since the category was opened on April 1, 1997, and whose family incomes are greater than 200% of poverty are considered regular TennCare enrollees.

2. Effective January 1, 1998, we expanded the above category to include **children under the age of 19 who do not have access to insurance** either through their own employer or a family member's employer. Those children who have enrolled in this expanded category since January 1, 1998, and whose family incomes do not exceed 200% of poverty are also considered Tennessee's "CHIP children." Those children enrolling in this category whose family incomes are greater than 200% of poverty are considered regular TennCare enrollees.

2. Effective January 1, 1998, we opened enrollment for a limited time in the Uninsured category to **children under the age of 19 who have access to insurance** either through their own employer or a family member's employer, but who have not purchased this insurance and who have family incomes that do not exceed 200% poverty. The enrollment period for this group is January 1, 1998, through December 31, 1998. These children are also considered Tennessee's "CHIP children."

In addition to requesting an amendment to the TennCare waiver to add the above CHIP eligibility groups,

we are also requesting that the cost of this expansion which is funded by Title XXI be considered outside the budget neutrality cap for the TennCare waiver.

Your attention to this request is greatly appreciated. Please contact me if you have comments or questions.

Sincerely,

Wendy Long MD

Wendy Long, MD, MPH
Acting Director

cc: Patsy Evans, HCFA Region IV Office

CC:SB

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF TENNCARE
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

June 2, 1998

Mr. Richard Fenton
Deputy Director, Family and Children's Health Programs Group
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Fenton:

We have received your letter dated January 26, 1998, stopping the clock on our December 31, 1997, proposal for a State Children's Health Insurance Program. Over the past few months we have participated in a number of conference calls with HCFA representatives to learn what specific changes we needed to make. We very much appreciate the assistance of Rose Hatten in Baltimore and Patsy Evans in Atlanta in working through this process.

At their suggestion, we are re-formatting our proposal to fit the September 12, 1997, template proposed by HCFA. Since our program is an expansion of our existing Section 1115a waiver and therefore a Medicaid expansion, we understand that it is necessary for us to respond in detail only to Sections 2, 5, 9, and 10 of the template. We are aware that some clarification is needed in other areas, however, and we offer that clarification here.

There are two aspects of Tennessee's approved Section 1115a waiver which appear to be at variance with provisions of Title XXI. As you may know, Tennessee has already received approval from HCFA to count certain portions of premium revenues as matching funds. To change this arrangement for the premium revenues associated with SCHIP children would change the terms of the waiver and therefore create an unnecessary administrative burden for Tennessee. Second, Tennessee has already received approval from HCFA to implement certain cost-sharing arrangements for Uninsured and Uninsurable individuals (including children) with family incomes that exceed 100% poverty. Because of SCHIP, we have *reduced* cost-sharing arrangements for Uninsured children with family incomes between 100% and 200% poverty, but we have not eliminated them altogether except on preventive services, which have always been exempt from cost-sharing requirements. To change the existing cost-sharing requirements beyond what we have already done would change the terms of the waiver and create unnecessary confusion in the TennCare Program. Additionally, cost-sharing is one of the measures that have been suggested to combat "crowd out."

We do not believe it was the intent of SCHIP to undo the Section 1115a waiver process. Rather, we think it makes sense for these programs to work together to achieve their mutual goals of offering health insurance to as many uninsured low-income children as possible.

With respect to the "crowd out" requirements of SCHIP, we believe that we are in compliance with these requirements. Children must be uninsured in order to enroll in TennCare. In the past year since we opened

TennCare enrollment for uninsured children, we have enrolled about 27,000 children. Even with all the extensive outreach efforts described in this application, this number is less than half of the 68,000 children under age 18 estimated to be uninsured in November 1996 by the University of Tennessee Center for Business and Economic Research. Families presenting for services at local health departments (including those interested in TennCare) are routinely asked whether all of their children are insured. It does not appear that there has been any noticeable movement of children out of private insurance plans and into TennCare, and thus "crowd out" does not appear to be an issue in Tennessee. We have established an open enrollment period of January through March 1998 for uninsured children under age 19 who have access to health insurance but whose families have incomes that do not exceed 200% poverty. This open enrollment period has been extended and will be closed only when it appears that we have done all the outreach we can for this population. We will of course continue to monitor the enrollment of uninsured children in TennCare to make certain that "crowd out" does not become a factor.

I would also like to comment on the issue of public notice. The new SCHIP program has received a great deal of publicity in our State. Advocates were invited to meet with the Commissioner of the Department of Health and provide comments prior to the initial submission of the plan. The Governor has held press conferences describing the plan, and a summary of the plan has been posted on the TennCare website. Detailed information about the plan has been sent to all requesting it. A public hearing has been held on proposed rules for the program.

We are looking forward very much to implementing this program with the originally requested effective date of October 1, 1997. Please let us know if you have additional questions or comments.

Sincerely,

Wendy Long MD

Wendy Long, MD, MPH
Medical Director and Acting Director, Bureau of TennCare

BadgerCare health plan wins approval from U.S.

Program to provide Medicaid coverage to low-income families

By Amy Rinard
of the Journal Sentinel staff

January 23, 1999

Madison -- Uninsured children and parents in low-income families in Wisconsin will be eligible for health insurance coverage under the state's BadgerCare program, which won federal approval Friday after 15 months of negotiations.

State officials estimate that about 23,000 children would be eligible. In addition, BadgerCare will cover an estimated 27,000 adults.

"It's been an arduous battle, but it's been a good one," Gov. Tommy G. Thompson said in announcing that the federal government had approved the waivers needed to implement BadgerCare.

"It's about time. BadgerCare now will allow thousands of uninsured low-income working families to buy affordable health coverage for themselves and their children."

Thompson said he received a phone call from Donna Shalala, secretary of the U.S. Department of Health and Human Services, late Friday afternoon informing him of the approval.

"Coming on the heels of Wisconsin's big win in the Rose Bowl, this approval marks two big victories for Wisconsin in one month," Shalala, a former University of Wisconsin-Madison chancellor, said in a statement.

BadgerCare will provide Medicaid health care coverage to children and adults in uninsured families with yearly incomes below 185% of the federal poverty level. For a family of four, that income level is $30,400 a year.

To implement BadgerCare, the state needed several waivers from the federal government, which administers and finances Medicaid. Federal money will pay for about $44.6 million of the $71 million first-year cost of the program. State money will pay the remainder, minus families' premiums.

Families with incomes above 150% of the federal poverty level will be required to pay a monthly premium of 3.5% of family income for BadgerCare coverage. For example, for a family of four whose income is 185% of the poverty level, the premium would be $87 a month.

For families with incomes at or below 150% of the federal poverty level -- now $24,700 a year for a family of four -- no premiums will be required.

If a family enters the program with an income at or below 185% of the federal poverty level, that family will be able to continue in BadgerCare until its income reaches 200% of the poverty level.

Families with health insurance, or with access to health insurance through an employer that pays at least 80% of the cost of family coverage, will not be eligible for BadgerCare.

One of the last sticking points resolved during negotiations between state and federal officials was the state's insistence that BadgerCare participation be limited by the amount of money appropriated to the program.

Federal officials objected, arguing that capping the number of participants in any way could not be permitted because Medicaid is an entitlement program open to all who meet the eligibility requirements.

But Thompson has been a longtime opponent of entitlement programs, and the legislation that created BadgerCare specifically states that it could not be such a program.

In a compromise, federal officials agreed to allow the state to run the program within a set budget by lowering the income eligibility requirement -- thereby reducing the number of those eligible for BadgerCare -- if necessary to avoid going over budget.

"Our original BadgerCare proposal would have created waiting lists if we ran out of money," said Joe Leean, secretary of the state Department of Health and Family Services, which will administer the program.

"Now we won't have people on waiting lists; we'll just say, 'You make too much money to be eligible,' by lowering the enrollment threshold. This is not an entitlement program."

The program was to have been implemented on July 1, 1998, but it was delayed because state and federal officials could not reach agreement on several key provisions, including the number of people who could participate.

Hannah Rosenthal, Midwest regional director of Shalala's department, said the compromise over the cap on participants was key in finally winning federal approval for BadgerCare.

"I'm delighted that Wisconsin has decided to cover all children under BadgerCare rather than limiting it, which was what we always wanted," said Rosenthal, a former head of the Wisconsin Women's Council.

"It will have a profound effect on the health of our kids. It is wonderful for the children of Wisconsin and for low-income working families."

Rep. Tom Barrett (D-Wis.), who was instrumental in working with the Clinton administration to obtain the federal waivers, appeared at a Capitol news

conference with Thompson and Leean to announce the waiver approval.

"The state had some legitimate concerns about the cost to the state, and the federal government had some concerns about changing the fundamental nature of Medicaid," Barrett said.

"But in the end, the winners are the people in this state, the working poor who are trying to keep themselves self-sufficient."

In a statement from his office, Milwaukee Mayor John O. Norquist said the approval of BadgerCare was "wonderful news" for Milwaukee's workers and their families.

"For too long, our government has provided health insurance like Medicaid and Healthy Start only for those who don't work or for the very poorest of workers and children. But thanks to W-2 and Milwaukee's robust economy, many low-income workers and their families don't qualify for Medicaid and Healthy Start," Norquist said.

"BadgerCare goes a long, long way to fill the gap, making free to low-cost health care coverage available to thousands of Milwaukee families headed by workers who earn more than a poverty wage but who still lack -- and can't afford -- private health insurance."

Leean said his department would launch an extensive outreach effort to let people know they might be eligible for BadgerCare and how to apply for coverage under the program.

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H.R.827

Improved Maternal and Children's Health Coverage Act of 1999 (Introduced in the House)

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

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

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

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

SEC. 2. SIMPLIFIED OUTREACH AND ENROLLMENT.

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

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

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

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

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

`(3) acceptance and timely response to telephone inquiries and other electronic communications received through the national toll-free system established under section 3

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H.R.827

Improved Maternal and Children's Health Coverage Act of 1999 (Introduced in the House)

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

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

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

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

(2) MEDICAID CONFORMING AMENDMENT-

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

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

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

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

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

`(B) establishment and operation of an enrollment process that is coordinated with that under title XXI so that a family need only interact with a single agency in order

to determine whether a child is eligible for benefits under this title or title XXI; and

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

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

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

(c) FINANCIAL INCENTIVES TO PROMOTE APPROPRIATE ENROLLMENT-

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

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

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

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H.R.827

Improved Maternal and Children's Health Coverage Act of 1999 (Introduced in the House)

SEC. 3. FAMILY FRIENDLY COVERAGE AND ENROLLMENT.

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

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

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

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

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

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

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

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

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

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

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

(c) Prohibition of Waiting Periods-

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

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

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

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

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

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

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

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

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

`(5) DISENROLLMENT FOR NONPAYMENT OF PREMIUMS-

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

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

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

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H.R.827

Improved Maternal and Children's Health Coverage Act of 1999 (Introduced in the House)

SEC. 4. EXPANDED COVERAGE OPTIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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H.R.827

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

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

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

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

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

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

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

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

`(5) Subsection (a) of section 2103 (relating to required scope of health insurance coverage)

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

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

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

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

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

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child health plan under title XXI for--

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

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

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

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

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

(c) FINANCIAL INCENTIVES TO PROMOTE APPROPRIATE ENROLLMENT-

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

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

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Bill Summary & Status for the 106th Congress

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H.R.827
SPONSOR: Rep DeGette, Diana (introduced 02/24/99)

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TITLE(S):

- OFFICIAL TITLE AS INTRODUCED:
  A bill to amend titles XIX and XXI of the Social Security Act to improve the coverage of needy children under the State Children's Health Insurance Program (SCHIP) and the Medicaid Program.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Feb 24, 99:
Referred to the House Committee on Commerce.

STATUS: Congressional Record Page References

NONE

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Commerce

AMENDMENT(S):

NONE

COSPONSORS(23):

Rep Morella, Constance A. - 02/24/99
Rep Brown, Sherrod - 02/24/99
Rep Deutsch, Peter - 02/24/99
Rep Markey, Edward J. - 02/24/99
Rep Strickland, Ted - 02/24/99
Rep Barrett, Thomas M. - 02/24/99
Rep Boucher, Rick - 02/24/99
Rep Klink, Ron - 02/24/99
Rep Wynn, Albert Russell - 02/24/99
Rep Luther, Bill - 02/24/99
Rep Hall, Ralph M. - 02/24/99
Rep Engel, Eliot L. - 02/24/99
Rep Waxman, Henry A. - 02/24/99
Rep Pallone, Frank, Jr. - 02/24/99
Rep Stupak, Bart - 02/24/99
Rep Green, Gene - 02/24/99
Rep Capps, Lois - 02/24/99
Rep Towns, Edolphus - 02/24/99
Rep Gordon, Bart - 02/24/99
Rep Sawyer, Thomas C. - 02/24/99
Rep McCarthy, Karen - 02/24/99
Rep Eshoo, Anna G. - 02/24/99
Rep Gilman, Benjamin A. - 02/24/99

SUMMARY:

NONE

FACSIMILE

DATE: 3/5/99

TO: Deborah Adler
Sarah Bianchi

FAX #: 456-5557

FROM: Rebecca Werbel
Office of the Chief of Staff
Department of Health and Human Services

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

Internal q+a for Health Affairs article that will be out on Monday.

_____Pages [including this cover]

Draft Q's and A's for Health Affairs article

Revised 3/1/99

Q: Does the department agree with the article on CHIP published in Health Affairs?

A: First of all, the main conclusion of the Health Affairs article is that comprehensive and effective outreach is of critical importance to CHIP and we certainly agree with that. The article raises some interesting issues and its results highlight the significant role that outreach can play.

However, as the authors make clear in the Health Affairs article, their estimates are based on the Medicaid experience. The article's projections are based on the assumption that states would administer CHIP in exactly the same way as they administer the Medicaid program. In fact, most states have developed new approaches for their CHIP programs, and together, the 50 state and territorial plans approved to date anticipate providing health insurance coverage for more than **2.5 million** currently uninsured children by September 2000. Eleven states have already expanded their original CHIP plans through amendments, showing how states are continuing to use this opportunity to bring health care to uninsured children.

To help ensure that eligible children get enrolled in CHIP, and in Medicaid, the federal government recently announced several new outreach initiatives. These include a nationwide toll-free number to provide families with essential information; placing the toll-free number on corporate products, such as grocery bags and diaper products; airing public service announcements on television; launching a $1 million paid radio campaign; enlisting the help of grass-roots organizations; and stepping up activities by federal organizations that interact with low-income families. The toll-free number is 1-877-KIDS-NOW, and the Web site is *www.insurekidsnow.gov.*

Q: Do you believe the Health Affairs article's estimate that CHIP will only reach 1.5 million children (*some reporters may quote the 1.8 million figure*) is correct?

As we said before, it is in part because of research like this that the Department is committed to an aggressive outreach program and it is because of the CHIP outreach programs currently under way that we believe more than 1.5 million children will enroll in CHIP. Together, the 50 state and territorial plans approved to date anticipate providing health insurance coverage to about **2.5 million** currently uninsured children by September 2000. In addition, eleven states have already expanded their original CHIP plans through amendments showing how states are continuing to use this opportunity to bring health care to uninsured children.

[BACKGROUND: The article itself notes that projected changes in insurance status are estimated only "imprecisely" and that "Some states are expanding CHIP eligibility in phases and...may well extend eligibility to more children."]

Q: Are states imposing waiting periods and setting lower income thresholds than are allowed under current law?

Some states are requiring that previously insured children be uninsured for a short period of time before they are enrolled in CHIP – generally 3 to 6 months -- in an effort to avoid "crowd-out." Both the CHIP statute and the department's guidance, in fact, stipulate that programs must be designed in such a way to discourage families with coverage from dropping private plans in favor of CHIP.

And while many states have initially set eligibility thresholds below the maximum eligibility level (200 percent of poverty, or 50 percent above their current Medicaid level) at least 11 states have then come back to file amendments expanding their original eligibility threshold and thus covering more children.

[BACKGROUND: Only 11 **[HCFA please check]** states require that children be uninsured for a period of time before they are eligible for CHIP, usually 3 to 6 months. In most of these states, children who lose coverage involuntarily are not affected, and can enroll in CHIP right away.]

Q. The Health Affairs article predicts that some 400,000 children will drop their private insurance coverage in order to enroll in CHIP. What is the department's position on this? Aren't you trying to avoid crowd-out?

A. The Health Affairs article is careful to explain that their crowd-out estimates reflect the Medicaid model which makes no effort to prevent private insurance crowd-out. The authors clearly state that, "actual CHIP crowd-out rates may be lower than those predicted by our model."

In fact, the department is aggressively enforcing the law's provisions designed to avoid crowd-out. In every state where we believed the risk of crowd out was significant, we've insisted that programs include features to discourage families from dropping private plans in favor of CHIP. That is why some states are requiring that children be uninsured for a short period of time before they are eligible for CHIP. Even in states where we believed the risk of crowd out was minimal, we have still insisted that states monitor their programs to be sure that no substitution occurs.

The federal CHIP law allows states a lot of flexibility in designing ways to minimize

"crowd-out." This variation will help us learn which approaches work best in balancing the need to avoid crowd-out with the desire to enroll the maximum number of uninsured children.

Q: What do you mean by "effective outreach?" What are the new approaches that states are taking with CHIP in comparison to Medicaid?

A: States are experimenting with a range of outreach initiatives and marketing campaigns for CHIP. Maryland has experienced higher than expected enrollments in CHIP during its first months - one of their outreach initiatives was to put CHIP advertising on fast food restaurant tray liners. North Carolina had success recruiting eligible children into their CHIP program by canvassing local churches during the holiday season. Connecticut plans to put CHIP brochures in tax literature and car registration packets and send leaflets home with school children.

There are also things that states are doing to make both CHIP and Medicaid reach out to all eligible children. For example, several states are making use of streamlined application procedures. Louisiana is replacing its 14 page Medicaid application with a two- page application for both Medicaid and its CHIP program.

To help ensure that eligible children get enrolled in both programs, the federal government recently announced several new outreach initiatives. These include a nationwide toll-free number to provide families with essential information; placing the toll-free number on corporate products, such as grocery bags and diaper products; airing public service announcements on television; launching a $1 million paid radio campaign; enlisting the help of grass-roots organizations; and stepping up activities by federal organizations that interact with low-income families. The toll-free number is 1-877-KIDS-NOW, and the Web site is www.insurekidsnow.gov.

Q: What evidence is there that CHIP is meeting its goal of providing insurance to low-income children of working parents?

A. We are extremely encouraged that 47 states have already begun implementing CHIP, and plan to enroll approximately 2.5 million children by September 2000. We are also confident that the national commitment to the program by the private sector will complement ongoing federal and state efforts to make this program a success.

The Department agrees with the study that the opportunity exists to expand the number of children who are eligible for CHIP, and we are currently working with states to accomplish this objective. Note also that the way CHIP was designed, any funds that are not expended in the initial years of the program can be applied to later years - years in which states are planning to phase in more expansive eligibility rules.

Q: The article shows that if states set income thresholds at 300 percent of poverty then a much larger number of uninsured children would be eligible. Is this allowed under federal law? Does the department recommend this approach? Which states have gone so high in setting income thresholds?

A: One of the program's best features is that it provides states with a wide range of options for CHIP implementation. This flexibility should help us to learn what works and what doesn't as we seek to solve the problem of children without health insurance. Not all states have moved as aggressively as others in implementing CHIP, but as states are gaining experience with the program, we are seeing more and more expand their CHIP eligibility rules to encompass larger groups of children.

[BACKGROUND: Technically, the federal law allows states to set CHIP income thresholds at 200 percent of poverty or 50 percentage points above current Medicaid eligibility thresholds, whichever is higher. So, under the federal law, some states are currently allowed to go as high as 250 percent of poverty. In addition, the federal law provides the authority for states to define family income including what income may be "disregarded." Some states have used this authority to establish a higher income threshold for their CHIP plan.]

Q: What about problems with current Medicaid programs? Earlier work by the same researchers pointed to the large number of children who remain uninsured despite being eligible for Medicaid. Isn't that a larger issue than CHIP enrollment rates? What steps are being taken to get these Medicaid eligibles enrolled?

A: The Administration is committed to improving awareness of Medicaid as well as CHIP. For example, we recently announced the Insure Kids Now campaign, a toll-free number and media campaign to help families get access to both Medicaid and CHIP. Last year, we revised our regulations to permit states to extend Medicaid to low income two-parent working families even if the principal wage earner worked more than 100 hours per month. And we are also working with states to identify model outreach strategies, program operations, coverage expansions and Medicaid policies designed to increase the number of people eligible for Medicaid who actually receive it. Louisiana, for example, is replacing its 14 page Medicaid application with a 2-page application for both Medicaid and its CHIP program.

The President's Fiscal Year 2000 budget outlines some additional initiatives that would improve Medicaid awareness and potentially enroll thousands more children in Medicaid as well as CHIP:

· HHS is proposing to broaden states' ability to use a special $500 million Medicaid fund, enacted in the 1996 welfare reform law and aimed at outreach for children losing welfare, to fund outreach to other children eligible for Medicaid and to new children eligible for

CHIP. [This is expected to increase Medicaid spending by $345 million over the next five years, including both administrative expenses and benefits.]

· The President's budget proposes allowing states to extend Medicaid to low-income children up to age 21 who were in foster care but who 'age out' of that system at age 18. This would help assure health care for this vulnerable population as they continue to prepare for adulthood, just as older children living in their own families can be covered under a parent's insurance policy. Each year, about 16,000 youths age out of foster care and 9,000 more leave the foster care system and run away.

· In addition, we are proposing to remove outreach costs from the 10 percent cap states have on administrative costs for the CHIP program. Instead, states could spend up to 3 percent of their total allotment on outreach. This initiative, which is scored at $875 million, would give states more flexibility in designing outreach campaigns to reach families.

HHS is also working with the Federal Interagency Task Force and throughout its own individual agencies to build on our current outreach efforts. For example, HRSA plans to hold a conference to train Spanish-speaking health workers on CHIP and Medicaid in five states - California, New Mexico, Arizona, Texas and Florida.

Q: Whether the short term enrollment is 1.5 million or 2.5 million children, both figures are much lower than some initial estimates. Is CHIP overbudgeted? Or, was CHIP poorly designed?

A. It is important to recognize that CHIP represents a fundamental change in the way we provide public coverage to uninsured children. A change of this magnitude can be expected to take time. The way CHIP was designed, any funds that are not expended in the initial years of the program can be applied to later years. And we are confident that enrollments will grow over time. So, it would be wrong to conclude that CHIP is overfunded. The challenge now is to get the word out and to build on successful models of outreach in order to get these eligible children enrolled.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR - 6 1995

Ms. Kathryn G. Allen
Associate Director
Health Financing and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Enclosed are the Department's comments on your draft report entitled, "Children's Health Insurance Program: State Approaches Are Evolving." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided extensive technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

for June Gibbs Brown
Inspector General

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report
"Children's Health Insurance Program: State Approaches Are Evolving"

The Department appreciates the opportunity to comment on the draft report by the U.S. General Accounting Office (GAO). This report provides valuable information to Federal and State policy-makers, advocacy groups and other interested parties on the status (as of January 1999) of implementation of the new State Children's Health Insurance Program (CHIP), with particular emphasis on 15 States that had been approved before January 1999.

The Department is pleased with GAO's finding that the States and the Federal Government have made considerable progress in implementing CHIP. In the year and a half since the program was enacted, the Department's Health Care Financing Administration (HCFA) has approved 51 CHIP plans (as of March 31, 1999.) We approved the first State plan, for Alabama, in January 1998--just 5 months after the legislation was signed. Of those 51 CHIP approvals, 14 create or expand a separate State CHIP program, 25 expand existing Medicaid programs and 12 use a combination of these two approaches. States and Territories have told HCFA that these programs have the potential to provide coverage for up to an estimated 2.5 million children by Fiscal Year (FY) 2000.

The Department agrees with GAO's finding that although CHIP plans were evenly divided as of January 1999 between Medicaid expansions and programs with a separate State CHIP component, the State design choices for CHIP will continue to evolve and more States will eventually include a separate, non-Medicaid component in their programs. The diversity of State approaches highlighted in the GAO report demonstrates the considerable flexibility that the law gives States to design programs that meet their unique needs. The Department also agrees with GAO's conclusion that since a number of State plans are not fully operational, it is too soon to evaluate the outcomes of the program. Nevertheless, we are actively working with our regional offices and the States through monitoring and technical assistance to assure that States will be able to accurately reflect the outcome of their programs over time. The HCFA Administrator recently sent a letter to the States stressing the need for States to file requested data in a timely manner.

As noted in the GAO report, a number of States have submitted and many more intend to submit amendments to their initial programs. As of March 31, we already have approved 13 amendments for eligibility expansions or program changes. Another 10 such amendments are under review. We believe that most States will eventually expand eligibility for children up to 200 percent of the Federal poverty level (FPL). Half of the

approved CHIP plans already expand coverage to above 200 percent of the FPL.

It is correct that the statutory requirements for CHIP present challenges for States wishing to adopt family coverage and subsidize employer-sponsored coverage. However, these requirements are also intended to offer important protections to enrollees, particularly in the areas of benefits and cost-sharing. We also believe that family coverage and employer buy-in together with providing coverage to the underinsured are likely to become more visible issues in the next year. As most States have secured their CHIP allotments with at least a "place-holder" plan as of March 1999, the Department shares GAO's view that they will begin to explore using some of the flexibility provided in the statute to achieve broader goals. For example, a number of States have indicated their interest in subsidizing the premium for purchase of employer-sponsored coverage. While this approach is complicated and has issues that are difficult to address, we will continue to work closely with States to develop appropriate resolutions. For example, HCFA recently sponsored a meeting with several key States to both address employer-sponsored coverage and to develop models that States considering this approach could use.

The Department has been impressed with the innovative outreach activities undertaken by the States to provide the public with information about the program as well as to simplify and streamline enrollment. As GAO shows, States have undertaken many different strategies to identify and enroll children. Outreach is key to the success of the program. We are working with States to gather and share outreach success stories and to help States address enrollment issues. We also recognize that States may need more funding for outreach because of the limit of a 10 percent cap on administrative expenditures. The President's FY 2000 budget includes proposals to allow States to spend additional funds on outreach. We will continue to work with States and to provide even more support as they enhance outreach efforts to identify eligible children and to ensure that these children receive appropriate care.

In addition, the President established the Interagency Task Force on Children's Health Insurance Outreach (Task Force) in February 1998, including eight Federal agencies. The Task Force published a report in June 1998 that proposed a coordinated outreach effort to identify and enroll uninsured children in CHIP and Medicaid. For example, the Department of Agriculture will be providing child health insurance information to all of their Agriculture extension service offices; the Social Security Administration is distributing posters and information to all of their local offices; and the Department will distribute information to all of their community and migrant health centers as well as Indian Health Service clinics. The Task Force will actively promote these efforts and will submit an updated report to the President in June on each agencies' innovative activities. A national media campaign was developed using radio and television to enhance States' efforts to increase enrollment. This includes the promotion of the national toll-free number, 1-877-KidsNow, a part of the "Insure Kids Now" initiative which includes

launching a new website, developing a series of public service announcements, and initiating other Federal outreach efforts.

We are also taking lessons learned from early successes in States and sharing them widely. We have issued two letters to States providing guidance on how to simplify and streamline the eligibility process. This guidance included a simplified model application form that can be used as a joint CHIP and Medicaid application. The HCFA is expanding its website to facilitate sharing outreach innovations. We have held several outreach conferences around the Nation to identify more innovative and successful strategies used by State and local communities. In addition, HCFA is sponsoring, with the Health Resources and Services Administration, a series of focus groups and technical advisory panels to share successful outreach innovations that States develop.

Finally, the Department agrees with GAO's assessment that the range of States' crowd out strategies demonstrates differing views among States about the importance of crowd out. The statute is clear that States must have strategies to ensure that CHIP does not substitute for existing coverage--public or private. To ensure that funds are used for uninsured children as required by the statute, we have worked with States on their CHIP plans to prevent crowd out. We are also working with States to gather information on the extent of crowd out in their programs and to identify the most effective strategies for measuring and preventing crowd out.

The Department looks forward to consulting with GAO as we work to achieve the objectives of CHIP in the future.

This Facsimile is from the

Administration for Children and Families
370 L'Enfant Promenade S.W.
Washington, D.C. 20447-0001

Date: 1/29/99

This transmission consists of this cover plus 1 pages

To: Devora Adler

From: Kristin Debarolo

Phone:

Phone:

Fax: 456-5557

401-9229

Messages: Per your discussion with John (Monahan)

Administration for Children and Families
Phone: 401-9200 Fax: 401-5770

Ex. Sec.: 401-9211 Fax: 205-4891

DRAFT 1/29/99

TRANSITIONAL MEDICAID ASSISTANCE (TMA)

Q. In light of the Administration's commitment to maximizing health insurance coverage for low-income working families, why does your budget not include a proposal to remove the sunset on the transitional Medicaid benefit, which will expire at the end of FY 2001 under current law?

A. The Administration has always supported health care coverage for families moving from welfare to work. The President's FY2000 budget baseline for Medicaid reflects the fact that the authority for transitional Medicaid expires on September 30, 2001 under current law. While, as a general matter, potential legislative proposals are not reflected in the Medicaid budget projections for FY 2001-2004, this practice does not indicate that the Adminisration opposes the extension of the transitional Medicaid benefit if resources permit in the FY 2001 budget.

BACKGROUND: The Administration has always supported health care coverage for families moving from welfare to work. The President's FY2000 budget baseline for Medicaid reflects the fact that the requirement for TMA expires on September 30, 2001 under current law. As a general matter, the budget projections 2001-2004 regarding Medicaid do not reflect potential legislative proposals.

BACKGROUND: The FY2000 budget does include a proposal to remove burdensome reporting requirements that have posed an obstacle to families' participation in transitional Medicaid.

Talking Points on Reporting
4/16/99

Implementation Overview

- The following is an overview of the 52 approved States and Territories by quarter of implementation:

  -4 States implemented programs in FFY 1998, Quarter 1, FFY 1998 (ID, IN, MA, OK)

  -6 States/Territory implemented programs in FFY 1998, Quarter 2, FFY 1998 (OH, IL, AL, CA, NJ, PR)

  -9 States/Territory implemented programs in FFY 1998, Quarter 3, FFY 1998 (FL, NY, CO, MI, NE, NH, RI, PA, VI)

  -14 States implemented programs in FFY 1998, Quarter 4, FFY 1998 (CT, IA, KY, ME, MD, MS, OR, SD, TX, WV, SC, UT, MO, ND)

  -10 States/District of Columbia implemented programs in FFY 1999, Quarter 1, FFY 1999 (AK, MN, NV, NC, VT, VA, AZ, GA, LA, DC)

  -9 States/Territories have approved programs but have not yet implemented {began enrolling children} (DE, KS, MT, AK, NM, WI, HI, GU, AS)

  -There are three States and one Territory that have not yet been approved (TN, WA, WY, NMI)

Annual Report Submission Status

- 33 States must submit **full** Annual Reports for FFY 1999. Of these, 27 have been received in the CO. Almost all submissions include at a minimum the baseline estimate of uninsured (only three of the submissions do not currently include a baseline estimate for varying reasons). For example, Ohio has not submitted their estimate as they are still awaiting the results from a State-based survey.

- The 27 States that have submitted Annual Reports include: AL, CA, CO, CT, FL, ID, IL, IN, IA, MD, MA, MI, MS, MO, ND (currently baseline only), NE, NH, NJ, NY, OH (awaiting baseline), OK, OR, SC, SD, TX, UT, WV).

- We are currently in the process of reviewing these submissions.

Baseline Submission Status

- 19 States are required to only submit a baseline estimate of uninsured, low-income children as their Annual Report for FFY 1998 (Note: Hawaii will not be implementing until 2000).

- To date, we have received 16 of these 19 baseline estimates of uninsured children (note: several of these estimates are verbal reports deferring to the baseline estimate identified in their State plan). The 16 States that have submitted these baseline estimates include: AK, AZ, AR, DE, DC, GA, HI, KS, LA, MN, MT, NV, NM, NC, VA, WI. We are awaiting baseline estimates from AS, GU and VT.

- Several of the States required to only submit a baseline estimate have submitted an Annual Report with descriptive program information.

COLLECTION OF STATE BASELINE INFORMATION
4/16/99

- There are 52 States with approved plans; therefore, we expect **at least** 52 State baseline estimates of uninsured, low-income children.

- 33 of the 52 States are expected to provide HCFA with a **full** FFY 1998 annual report which includes a baseline estimate of uninsured, low-income children.

- 19 of the 52 States are required to **only** provide baseline estimates of uninsured, low-income children. (Note: Hawaii has not implemented their program, but they are still required to submit a baseline estimate).

- To date, we have in the Central Office **27 of 33 State Annual Reports and 16 of 19 baseline-only estimates.** However, most, but not all of these annual reports are complete, and not all of the baselines estimates and the methodologies are clear. In addition, several of the States required to only submit a baseline estimate have submitted an Annual Report with descriptive program information.

- Of the States that have submitted baseline estimates, 24 have submitted baseline estimates using the CPS; 2 States have used some other type of survey; 9 States have used State-specific surveys; and 8 State has submitted a baseline with no methodology or source. In addition, there were 3 annual reports that did not include a baseline estimate. Several States that have used CPS as the baseline have also incorporated other data surveys in the development of their baseline estimates (e.g., Oklahoma used CPS, a State survey, and Urban Institute Data).

- The majority of States that have submitted baseline estimates have used the CPS.

- It is not clear in all of the reports what is the denominator of the baseline estimate (e.g., age of children, poverty level of children, etc.) Some States have clearly identified what they were measuring while others did not. This varies widely from State to State.

- The sources for establishing baseline estimates are varied. States have used CPS data from varying years; some have pooled the data, while others have used the survey data from one year; and some States have used additional surveys along with CPS to develop their estimates.

- We are currently in the process of reviewing these and additional State submissions.

Table 1. Source of baseline estimates for annual reports and baseline only submissions

Baseline "Tool"	Source/Date	Baseline Only
1. Census' Current Population Survey (CPS)		
Alabama	1996	
Alaska	(no year listed)	✓
Arizona	1993-1995	✓
California	1998	
Colorado	1997	
Delaware	3-year average (no year listed)	✓
District of Columbia	(no year listed)	✓
Georgia	1994-1996	✓
Illinois	1996-1996 (with EBRI survey)	
Indiana	(no year listed)	
Iowa	(no year listed)	
Kansas	(no year listed)	✓
Massachusetts	1995-1997	
Missouri	1996	
Nebraska	1994-1996	
New Hampshire	1997	
New Jersey	1996-1997	
New York	1996-1997	
North Carolina	(no year listed)	✓
Oklahoma	1994-1996 CPS; Urban Data 1995; 1994 Oklahoma State Data	
South Carolina	FFY 1998 baseline was 110,000 for uninsured children under 200% of poverty	
South Dakota	(most recent data)	

Texas	1998	
West Virginia	Household Income Survey with pooled 1195-1996 CPS data (by The Lewin Group)	
2. Other Surveys		
Florida	1993 Rand data	
Montana	CDF data	✓
3. State Surveys		
Hawaii	1997 Hawaii Health Survey	✓
Idaho	1997 Idaho Kids Count Data	
Mississippi	State Data by Heritage Foundation	
Nevada	1992 State Survey Data	✓
North Dakota	1994 ND Task Force Survey	✓
Oregon	1998 Oregon Population Survey	
Utah	Utah Health Status Survey	
Virginia	1996 Virginia Health Care Foundation Survey	✓
Wisconsin	1995 State survey	✓
4. No Source Provided		
Arkansas	(no source for baseline provided)	
Connecticut	(no source for baseline provided)	
Louisiana	(no source for baseline provided)	✓
Maryland	(no source for baseline provided)	
Michigan	(no source for baseline provided)	
Minnesota	(no source for baseline provided)	✓
New Mexico	(no source for baseline provided)	✓
Ohio	(provided number with no source but are awaiting data from a State-based survey)	

UPDATE on Statistical Report Submissions
As of 4/16/99

- To date, 23 States have submitted some statistical reports (this means the State has submitted something, and this data is currently incomplete and may even be incorrect).

- Of these 23 States that have submitted some sort of statistical report, 15 of these States have submitted statistical data for every quarter in which they were required to report.

- Of these 23 States that have submitted some sort of statistical report, 18 of these States' submissions were used in the Enrollment Chart to be released next week. This means that these were the only States that submitted data for Quarter 4 of FFY 1998 (the unduplicated count of children for the entire year) and Quarter 1 of FFY 1999 (the unduplicated number of new enrollees for that quarter).

- Three of these 23 States have submitted statistical data in hard copy rather than through electronic submission (CA, MI, OR).

1999 Monthly Health Insurance Premiums

Once you have selected a plan, enter the three (3) digit code number that corresponds to that plan on the application in the boxes provided in Section II, #6 Plan Choice. Also, on the application, enter the name of the plan you have selected and the monthly premium as it appears on the chart below.

CODE	HMO	SINGLE		COUPLE		PARENT PLUS		FAMILY	
		Option A	Option B	Option A	Option B	Option A	Option B	Option A	Option B
021	Aetna	$168.00	$148.70	$376.10	$334.50	$252.00	$223.00	$420.10	$371.70
031	Alternative Health Delivery System	$225.92	$201.66	$508.34	$453.76	$338.88	$302.50	$564.82	$504.16
091	Bluegrass Family Health	$205.92	$171.60	$463.32	$386.10	$308.88	$257.40	$514.80	$429.00
101	CHA Health	$209.74	$167.22	$471.92	$421.24	$314.60	$250.82	$524.34	$466.04
161	Humana KPPA	$232.40	$216.12	$522.92	$486.30	$348.62	$324.20	$581.02	$540.34
151	Humana MBP	$202.64	$192.00	$456.62	$432.00	$304.42	$288.00	$507.36	$480.00
111	PacifiCare	$198.50	$180.00	$446.60	$405.00	$297.76	$270.00	$496.26	$450.00

CODE	POS	SINGLE		COUPLE		PARENT PLUS		FAMILY	
		Option A	Option B	Option A	Option B	Option A	Option B	Option A	Option B
022	Aetna	$177.40	$159.10	$399.20	$344.60	$266.20	$229.70	$443.60	$382.90
032	Alternative Health Delivery System	$236.64	$210.22	$532.46	$473.00	$354.98	$315.32	$591.62	$525.54
092	Bluegrass Family Health	$226.50	$188.76	$509.64	$424.70	$339.76	$283.14	$566.26	$471.90
102	CHA Health	$219.88	$196.26	$494.72	$441.60	$329.82	$294.40	$549.70	$490.66
342	Humana	$252.34	$239.64	$567.80	$539.14	$378.54	$359.42	$630.88	$599.06

CODE	PPO	SINGLE		COUPLE		PARENT PLUS		FAMILY	
		Option A	Option B	Option A	Option B	Option A	Option B	Option A	Option B
143	Humana	$196.46	$174.56	$442.06	$392.74	$294.72	$261.82	$491.18	$436.38
393	Anthem BC/BS Option 2000 Adv.	$228.64	$196.36	$514.90	$441.90	$343.26	$294.60	$572.10	$490.96

The employer contribution for health insurance for the 1999 plan year is $203.00 per month. Once you have selected a plan, subtract $203.00 from the premium listed in the chart above to determine the monthly amount for which you will be responsible. This amount will be deducted from your check.

AVAILABLE HEALTH PLANS FOR 1999

KENTUCKY COUNTY	Aetna HMO	Aetna QPOS	Alternative Health HMO	Alternative Health POS	Anthem BCBS Option 2000 Adv PPO	Bluegrass Family Health HMO	Bluegrass Family Health POS
Allen							
Ballard						•	•
Bath						•	•
Boone	•	•					
Boyd				•			
Bracken							
Breckinridge			•	•			•
Butler							
Calloway					•		
Carlisle						•	•
Carter							
Christian					•		
Clay						•	•
Crittenden					•		
Daviess					•		
Elliott							
Fayette						•	•
Floyd						•	•
Fulton					•		
Garrard						•	•
Graves					•		
Green						•	•
Hancock					•		
Harlan							
Hart				•			
Henry			•	•			
Hopkins					•		
Jefferson	•	•	•	•			
Johnson						•	•
Knott						•	•

AVAILABLE HEALTH PLANS FOR 1999

KENTUCKY COUNTY	CHA Health HMO	CHA Health POS	Humana KPPA HMO	Humana MAP HMO	Humana POS	Humana PPO	Pacificare HMO
Allen	•	•				•	
Ballard							
Bath	•	•	•	•	•		
Boone				•	•	•	•
Boyd	•	•					
Bracken	•	•	•	•	•	•	
Breckinridge						•	
Butler	•	•				•	
Calloway							
Carlisle							
Carter	•	•					
Christian							
Clay	•	•	•		•	•	
Crittenden							
Daviess							
Elliott	•	•					
Fayette	•	•	•	•	•	•	
Floyd	•	•				•	
Fulton							
Garrard	•	•	•	•	•	•	
Graves							
Green			•			•	
Hancock							
Harlan	•	•					
Hart	•	•				•	
Henry			•	•	•	•	
Hopkins							
Jefferson	•	•	•	•	•	•	
Johnson	•	•				•	
Knott	•	•					

AVAILABLE HEALTH PLANS FOR 1999

KENTUCKY COUNTY	Aetna HMO	Aetna QPOS	Alternative Health HMO	Alternative Health POS	Anthem BC/BS Option 2000 Adv PPO	Bluegrass Family Health HMO	Bluegrass Family Health POS
Larue			•	•			
Lawrence							
Leslie						•	•
Lewis							
Livingston						•	•
Lyon						•	•
Magoffin						•	•
Marshall						•	•
Mason							
McCreary						•	•
Meade	•	•	•	•			
Mercer						•	•
Monroe							
Morgan							
Nelson	•	•	•	•			
Ohio					•		
Owen						•	•
Pendleton	•	•					
Pike						•	•
Pulaski							
Rockcastle						•	•
Russell							
Shelby	•	•	•	•			
Spencer	•	•	•	•			
Todd					•		
Trimble			•	•			
Warren							
Wayne							
Whitley						•	•
Woodford						•	•

AVAILABLE HEALTH PLANS FOR 1999

KENTUCKY COUNTY	CNA Health HMO	CNA Health POS	Humana KAPA HMO	Humana MAP HMO	Humana POS	Humana PPO	PacifiCare HMO
Larue	•	•	•	•	•	•	•
Lawrence	•	•				•	
Leslie	•	•				•	
Lewis	•	•					
Livingston							
Lyon						•	
Magoffin	•	•				•	
Marshall							
Mason	•	•	•	•	•	•	
McCreary						•	
Meade			•	•	•	•	
Mercer	•	•	•	•	•	•	
Monroe	•	•				•	
Morgan	•	•				•	
Nelson			•	•	•	•	•
Ohio							
Owen	•	•	•	•	•	•	
Pendleton				•	•	•	•
Pike	•	•					
Pulaski			•		•	•	
Rockcastle	•	•	•		•	•	
Russell	•	•	•		•	•	
Shelby			•	•	•	•	
Spencer			•	•	•	•	
Todd							
Trimble			•	•	•	•	
Warren	•	•				•	
Wayne			•		•	•	
Whitley	•	•	•		•	•	
Woodford	•	•	•	•	•	•	

02/28/99 13:33 ☎202 401 7321 HHS ASPE/HP ☑002/016
DEC-30-1998 16:56 HCFA FCHPG
12/30/98 15:10

1997 Comparative Rate Chart

If you are a state employee the state will contribute $185.00 per month toward your health insurance plan starting in 1997. On the back of this chart is a worksheet that will help you determine either how much you will owe per month for your health insurance, or how much you will have available to apply towards your flexible spending account. Please see your Benefit Coordinator if you have questions about Flexible Spending Accounts.

HMO

HMO	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
Advantage Care	172.66	156.31	148.66	135.12		396.16	358.84	343.77	310.40		254.16	228.65	222.30	200.72		436.50	395.85	376.77	342.01	
Alternative Health Delivery Systems	184.39	178.57	173.08	151.84		460.84	425.58	408.86	359.83		280.91	259.50	250.91	218.44		414.74	383.13	368.11	[illegible]	
Anthem BC/BS (Community Select)	184.22	170.10	162.87	149.82		438.07	404.82	389.87	342.20		265.08	244.85	235.87	207.83		383.10	368.14	348.85	307.07	
Anthem BC/BS (HMO KY)	198.42	183.80	176.58	154.89		472.18	436.16	420.18	368.81		287.43	265.52	255.81	234.38		422.51	380.31	376.02	330.04	
Anthem BC/BS (W. KY Health Adv.)	177.18	163.65	157.65	138.27		421.37	389.73	375.45	328.64		254.85	235.41	226.79	198.06		377.85	348.06	335.29	295.16	
Bluegrass Family Health	182.44	170.06	181.88	139.85		451.32	403.34	378.75	337.89		280.70	256.01	242.76	210.53		463.16	413.71	398.92	340.22	
CHA Health	177.96	165.13	146.21	127.40		406.80	352.07	[illegible]	299.16		263.39	220.78	206.67	[illegible]		397.04	346.10	333.97	284.24	
PHP Health Care	173.17	158.65	146.63	134.13	—	416.36	369.19	350.15	322.46		265.92	235.17	252.08	203.41		426.88	377.63	358.14	329.84	
HealthWise	196.19	179.94	172.74	152.85		469.80	431.88	405.85	358.84		306.59	281.27	270.02	238.03		498.72	467.08	438.80	385.62	
Humana Health Plans (KPPA)	185.09	172.30	166.08	139.90		414.81	386.40	368.79	318.87		308.41	288.36	275.96	233.86		517.71	482.48	461.74	391.30	
Humana Health Plans (MSBP)	178.88	166.71	159.54	136.20		400.99	373.71	357.54	303.08		298.80	278.47	266.60	225.84		500.39	466.25	444.20	378.13	
Prudential Health Care	162.78	147.63	138.08	118.80		370.19	335.71	316.05	270.14		290.35	263.31	247.89	211.88		386.84	350.80	330.25	282.25	

POS

POS	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
~~Advantage Care~~	183.90	164.34	154.64	140.02		427.44	377.52	355.24	321.84		273.17	244.12	239.72	207.88		465.46	415.85	391.41	354.39	
~~Adina~~	199.16	182.88	174.65	160.84		475.61	436.74	417.89	384.38		321.26	295.01	281.73	259.40		496.95	456.94	436.80	401.68	
Alternative Health Delivery Systems	198.64	177.25	170.48	152.66		458.84	420.04	404.00	361.74		278.70	256.16	246.37	220.60		412.95	378.19	363.74	325.70	
Anthem BC/BS (Community Option)*	181.54	175.42	168.72	151.07		455.69	417.94	401.89	358.41		275.60	252.48	242.94	217.44		408.82	374.60	360.19	322.62	
Anthem BC/BS (Option HMO)	185.10	178.68	170.51	152.89		484.48	435.39	405.86	364.01		282.82	259.02	247.18	221.64		416.61	380.63	368.24	325.71	
Anthem BC/BS (W. KY Health Select)	194.87	178.58	171.74	153.77		464.34	426.38	409.43	368.23		280.48	256.88	247.04	221.92		415.89	380.89	366.34	328.02	
~~Bluegrass Family Health~~	204.38	170.60	170.07	148.28		478.34	421.22	398.88	343.10		307.85	270.88	256.09	226.23		487.21	436.88	418.75	355.89	
~~CHA Health~~	[illegible]	164.44	158.82	136.06		428.13	373.30	348.48	306.59		262.40	234.84	219.08	192.21		420.87	385.86	348.40	301.80	
~~HealthWise~~	202.41	185.70	178.27	157.84		474.82	442.43	418.81	370.12		316.40	290.27	278.66	246.73		514.16	471.71	452.54	400.95	
Humana Health Plans	195.87	181.99	174.18	147.59		437.65	407.86	390.84	330.79		324.21	304.07	290.84	246.65		546.19	509.09	487.14	412.83	
Prudential Health Care	181.61	162.39	150.80	127.71		412.76	369.28	342.92	290.40		323.74	289.64	268.96	227.77		431.31	385.87	358.92	300.45	

*Note: Anthem Blue Cross & Blue Shield (Community Option) POS is listed differently on your Application and Rider Booklet as: Anthem Blue Cross & Blue Shield (Community Select) POS.

PPO

PPO	Single Only					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
Alternative Health Delivery Systems	190.91	180.70	148.63	113.61	94.59	452.38	380.89	358.34	269.22	224.14	276.89	232.23	208.22	164.18	136.69	407.31	342.85	300.18	242.40	201.80
Anthem BC/BS (Option 2000)	212.83	170.15	158.85	128.66	106.44	506.71	426.52	376.51	301.56	251.03	305.16	256.87	227.06	181.61	151.18	454.14	382.28	339.95	270.27	224.99
~~Anthem BC/BS (Option 2000/Advantage)~~	[illegible]	170.88	161.65	130.41	100.57	482.59	406.20	360.57	287.25	[illegible]	291.50	245.78	218.11	173.77	144.66	433.76	366.11	324.01	262.18	214.89
Humana Health Plans	164.79	152.16	137.09	119.80	102.01	358.78	312.82	281.85	246.87	211.78	258.72	228.52	214.91	187.43	161.48	476.96	440.41	396.81	346.16	296.16

Indemnity

Indemnity	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
~~Kentucky Kare~~	[illegible]	262.46	145.74	125.23	96.29	480.56	397.41	341.77	270.24	230.80	278.90	236.44	194.74	159.98	131.34	474.70	392.32	337.39	266.77	227.54

Plan Type Code Legend: EN = Enhanced SL = Standard Low SH = Standard High EC = Economy BU = Budget

1997

Accountable Health Plans

County	Region	Advantage Care HMO	Advantage Care POS	Aetna POS	Alternative Health Delivery Systems HMO	Alternative Health Delivery Systems POS	Alternative Health Delivery Systems PPO	Anthem BC/BS (Community Select) HMO	Anthem BC/BS (Community Option) POS*	Anthem BC/BS (HMO KY) HMO	Anthem BC/BS (Option HMO) POS	Anthem BC/BS (Option 2000) PPO	Anthem BC/BS (Option 2000 Adv.) PPO	Anthem BC/BS (W. Ky. Health Adv.) HMO	Anthem BC/BS (W. Ky. Health Select) POS	Bluegrass Family Health HMO	Bluegrass Family Health POS	CHA Health HMO	CHA Health POS	FHP Health Care HMO	HealthWise HMO	HealthWise POS	Humana Health Plans HMO (MBP)	Humana Health Plans HMO (MPPA)	Humana Health Plans POS	Humana Health Plans PPO	Kentucky Rare Indemnity	Prudential Health Care HMO	Prudential Health Care POS
Adair	7									•		•	•													•	•		
Allen	7							•	•			•	•													•	•		
Anderson	7		•							•		•														•	•		
Ballard	7									•																			
Barren	7							•	•			•	•													•	•		
Bath	7		•							•																			
Bell	7		•							•		•	•													•	•		
Boone	2			•						•	•	•	•			•	•	•	•	•	•	•	•	•	•	•	•		
Bourbon	6		•							•	•	•	•			•	•	•	•	•	•	•	•	•	•	•	•		
Boyd	1									•		•	•													•	•		
Boyle	7		•							•		•	•			•	•	•	•	•	•	•	•	•	•	•	•		
Bracken	7		•							•		•	•			•	•	•	•	•	•	•	•	•	•	•	•		
Breathitt	7		•							•		•	•			•	•	•	•	•	•	•	•	•	•	•	•		
Breckinridge	7		•				•			•																			
Bullitt	3		•				•			•		•	•													•	•		
Butler	7									•		•	•													•	•		
Caldwell	7									•		•	•													•	•		
Calloway	7									•		•	•													•	•		
Campbell	2		•							•		•	•													•	•		
Carlisle	7									•		•	•													•	•		
Carroll	7		•				•			•		•	•													•	•		
Carter	1									•		•	•													•	•		
Casey	7		•							•		•	•													•	•		
Christian	5									•		•	•	•	•											•	•		
Clark	6		•							•		•	•													•	•		
Clay	7		•							•		•	•													•	•		
Clinton	7							•	•			•	•													•	•		
Crittenden	1									•		•	•													•	•		
Cumberland	7							•	•			•	•													•	•		
Daviess	4									•		•	•													•	•		

* Note: Anthem Blue Cross & Blue Shield (Community Option) POS is like a Network on your Application and Rider Booklet as: Anthem Blue Cross & Blue Shield (Community Select) POS.

1997

Accountable Health Plans

County	Region	Advantage Care HMO	Advantage Care POS	Aetna POS	Alternative Health Delivery Systems HMO	Alternative Health Delivery Systems POS	Alternative Health Delivery Systems PPO	Anthem BC/BS (Community Select) HMO	Anthem BC/BS (Community Option) POS*	Anthem BC/BS (HMO KY) HMO	Anthem BC/BS (Option HMO) POS	Anthem BC/BS (Option 2000) PPO	Anthem BC/BS (Option 2000 Adv.) PPO	Anthem BC/BS (W. Ky. Health Adv.) HMO	Anthem BC/BS (W. Ky. Health Select) POS	Bluegrass Family Health HMO	Bluegrass Family Health POS	CHA Health HMO	CHA Health POS	FHP Health Care HMO	HealthWise HMO	HealthWise POS	Humana Health Plans HMO (MBP)	Humana Health Plans HMO (KPPA)	Humana Health Plans POS	Humana Health Plans PPO	Kentucky Kare Indemnity	Prudential Health Care HMO	Prudential Health Care POS
Edmonson	7							•	•																				
Elliott	7									•																			
Estill	7			•						•																			
Fayette	6			•						•																			
Fleming	7			•						•																			
Floyd	7									•																			
Franklin	7																												
Fulton	7									•																			
Gallatin	2									•																			
Garrard	7			•						•																			
Grant	2									•																			
Graves	7									•																			
Grayson	7									•																			
Green	7									•																			
Greenup	1									•																			
Hancock	7									•																			
Hardin	7									•																			
Harlan	7									•																			
Harrison	7			•						•																			
Hart	7									•																			
Henderson	4									•																			
Henry	7									•																			
Hickman	7									•																			
Hopkins	7									•																			
Jackson	7			•						•																			
Jefferson	5									•																			
Jessamine	6			•						•																			
Johnson	7									•																			
Kenton	2			•						•																			
Knott	7			•						•																			

* Note: Anthem Blue Cross & Blue Shield (Community Option) POS is filled differently on your Application and Rider Booklet as Anthem Blue Cross & Blue Shield (Community Select) POS.

1997

Accountable Health Plans

County	Region	Advantage Care HMO	Advantage Care POS	Aetna POS	Alternative Health Delivery Systems HMO	Alternative Health Delivery Systems POS	Alternative Health Delivery Systems PPO	Anthem BC/BS (Community Select) HMO	Anthem BC/BS (Community Option) POS*	Anthem BC/BS (HMO KY) HMO	Anthem BC/BS (Option 6HMO) POS	Anthem BC/BS (Option 2000) PPO	Anthem BC/BS (Option 2000 Adv.) PPO	Anthem BC/BS (W. Ky. Health Adv.) HMO	Anthem BC/BS (W. Ky. Health Select) POS	Bluegrass Family Health HMO	Bluegrass Family Health POS	CHA Health HMO	CHA Health POS	FHP Health Care HMO	HealthWise HMO	HealthWise POS	Humana Health Plans HMO (MBP)	Humana Health Plans HMO (REPPA)	Humana Health Plans POS	Humana Health Plans PPO	Kentucky Kare Indemnity	Prudential Health Care HMO	Prudential Health Care POS
Knox	7	•	•							•		•				•	•	•	•								•	
Larue	7				•	•	•																				•	
Laurel	7	•	•							•		•				•	•	•	•								•	
Lawrence	7									•		•															•	
Lee	7	•	•							•		•				•	•	•	•								•	
Leslie	7	•	•							•		•				•	•	•	•								•	
Letcher	7									•		•				•	•	•	•								•	
Lewis	7	•	•							•		•				•	•	•	•								•	
Lincoln	7	•	•							•		•				•	•	•	•								•	
Livingston	7																											
Logan	7							•	•																			
Lyon	7											•																
Madison	6	•	•							•		•				•	•	•	•								•	
Magoffin	7	•	•							•		•				•	•	•	•								•	
Marion	7									•		•				•	•	•	•								•	
Marshall	7									•		•				•	•	•	•								•	
Martin	7									•		•				•	•	•	•								•	
Mason	7	•	•							•		•				•	•	•	•								•	
McCracken	7									•		•				•	•	•	•								•	
McCreary	7	•	•							•		•				•	•	•	•								•	
McLean	7											•		•													•	
Meade	7									•		•		•													•	
Menifee	7	•	•							•		•				•	•	•	•								•	
Mercer	7	•	•							•		•				•	•	•	•								•	
Metcalfe	7							•	•																			
Monroe	7	•	•							•		•				•	•	•	•								•	
Montgomery	7	•	•							•		•				•	•	•	•								•	
Morgan	7									•		•				•	•	•	•								•	
Muhlenburg	7											•		•													•	
Nelson	7	•	•							•		•				•	•	•	•								•	

* Note: Anthem Blue Cross & Blue Shield (Community Option) POS is titled differently on your Application and Rider Booklet as: Anthem Blue Cross & Blue Shield (Community Select) POS.

1997

Accountable Health Plans

County	Nichelas	Ohio	Oldham	Owen	Owsley	Pendleton	Perry	Pike	Powell	Pulaski	Robertson	Rockcastle	Rowan	Russell	Scott	Shelby	Simpson	Spencer	Taylor	Todd	Trigg	Trimble	Union	Warren	Washington	Wayne	Webster	Whitley	Wolfe	Woodford
Region	7	7	3	7	7	3	7	7	7	7	7	7	7	7	6	7	7	7	7	7	7	7	7	7	7	7	7	7	7	6
Advantage Care HMO	•			•	•		•		•	•	•	•		•	•											•		•	•	•
Advantage Care POS	•			•	•		•		•	•	•	•		•	•											•		•	•	•
Aetna POS						•																								
Alternative Health Delivery Systems HMO			•													•		•				•			•					
Alternative Health Delivery Systems POS			•													•		•				•			•					
Alternative Health Delivery Systems PPO			•													•		•				•			•					
Anthem BC/BS (Community Select) HMO																	•							•						
Anthem BC/BS (Community Option) POS*																	•							•						
Anthem BC/BS (HMO KY) HMO	•			•	•	•	•	•	•	•	•	•	•	•	•				•							•		•	•	•
Anthem BC/BS (Option HMO) POS						•									•															•
Anthem BC/BS (Option 2000) PPO	•	•		•	•	•	•	•	•	•	•	•	•	•			•		•	•	•		•	•		•	•	•	•	
Anthem BC/BS (Option 2000 Adv.) PPO	•	•		•	•	•	•	•	•	•	•	•	•	•	•		•		•	•	•		•	•		•	•	•	•	•
Anthem BC/BS (W. Ky. Health Adv.) HMO		•																		•	•		•				•			
Anthem BC/BS (W. Ky. Health Select) POS		•																		•	•		•				•			
Bluegrass Family Health HMO	•			•	•	•	•	•	•	•	•	•	•		•				•						•			•	•	•
Bluegrass Family Health POS	•			•	•	•	•	•	•	•	•	•	•		•				•						•			•	•	•
CHA Health HMO	•			•	•	•	•	•	•		•	•	•		•		•				•			•				•	•	•
CHA Health POS	•			•	•	•	•	•	•		•	•	•		•		•				•			•				•	•	•
FHP Health Care HMO						•																								
HealthWise HMO	•	•	•	•	•				•	•	•	•	•	•	•	•	•	•	•	•		•		•	•	•			•	•
HealthWise POS	•	•	•	•	•				•	•	•	•	•	•	•	•	•	•	•	•		•		•	•	•			•	•
Humana Health Plans HMO (MBP)	•		•	•		•			•		•				•	•		•				•			•					•
Humana Health Plans HMO (RPPA)	•		•	•	•				•		•	•			•	•		•	•			•			•				•	•
Humana Health Plans POS	•		•	•	•				•		•	•			•	•		•	•			•			•				•	•
Humana Health Plans PPO	•	•	•	•	•	•	•	•	•	•	•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Kentucky Kare Indemnity	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Prudential Health Care HMO						•																								
Prudential Health Care POS						•																								

* Note: Anthem Blue Cross & Blue Shield (Community Option) POS is listed differently on your Application and Rider Booklet as: Anthem Blue Cross & Blue Shield (Community Select) POS.

1998 Comparative Rate Chart

The state contribution for health insurance for the 1998 plan year is **$194.50.**

HMO

	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
Advantage Care	196.76	169.18	161.12	145.48		439.44	375.58	359.60	324.66		269.90	247.78	237.38	214.34		477.34	408.00	390.66	352.92	
Aetna	165.42	148.90	139.84	120.50		376.94	339.26	316.36	274.50		284.70	238.24	222.18	192.84		424.40	391.06	356.18	309.18	
Alternative Health Delivery Systems	242.34	193.34	186.26	163.48		577.30	460.54	443.86	389.44		358.06	285.66	275.20	241.54		516.24	413.44	398.30	349.80	
Bluegrass Family Health	210.08	155.44	148.46	122.52		496.68	367.62	351.08	289.78		316.80	235.90	225.28	185.92		510.48	377.68	360.70	297.70	
CHA Health	188.38	164.22	153.72	134.86		431.22	375.88	351.84	308.72		271.60	236.76	221.62	194.44		422.86	368.60	345.04	302.72	
HealthSource	187.96	173.84	167.54	147.62		450.16	394.86	381.00	335.84		265.76	233.14	224.94	198.16		449.18	394.02	380.18	334.92	
Humana KPPA	205.12	181.16	162.94	155.04		482.48	431.00	412.48	349.54		346.92	323.32	309.42	282.22		573.66	534.80	511.80	433.72	
Humana MBP	188.46	175.64	169.10	142.46		424.94	396.04	379.00	321.18		316.78	297.08	284.30	240.94		527.30	491.42	470.28	398.54	
MedQuest Trover Health	218.80	197.92	186.84	167.84		512.88	463.74	437.78	392.78		307.36	277.90	262.34	235.38		537.38	485.88	458.66	411.64	
PacifiCare (FHP)	191.52	166.54	154.90	139.24		442.08	384.42	357.50	319.06		295.26	256.76	238.80	213.12		474.26	412.40	383.52	342.28	
Prudential Health Care	181.84	164.86	155.14	132.72		421.88	382.50	359.92	307.90		317.64	287.98	271.00	231.82		446.50	404.78	380.90	325.86	

POS

	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
Advantage Care	206.46	176.46	169.04	152.64		461.08	394.08	377.52	340.66		304.18	260.00	249.06	224.80		500.66	428.08	410.10	370.50	
Aetna	190.16	166.66	152.68	126.42		433.36	379.76	347.86	286.06		304.30	266.66	244.28	202.28		487.90	427.58	391.66	324.32	
Alternative Health Delivery System	235.56	187.92	180.74	161.64		561.10	447.64	430.54	385.50		348.02	277.66	267.06	239.12		503.72	401.66	388.50	346.06	
Bluegrass Family Health	223.52	163.66	155.90	128.64		528.64	387.58	368.72	304.00		339.20	248.68	236.58	195.06		543.10	398.18	378.82	312.30	
CHA Health	199.68	174.06	162.94	142.96		457.08	398.44	372.96	327.22		287.90	250.96	234.80	206.12		448.22	390.72	365.74	320.90	
HealthSource	210.14	184.34	177.66	156.58		477.66	419.16	404.44	356.30		282.14	247.48	238.80	210.36		476.82	418.28	403.58	355.64	
Humana Freedom Plan	185.02	161.76	173.94	147.40		439.72	408.60	392.18	332.36		329.86	307.42	294.20	249.32		545.62	508.60	486.64	412.40	
Prudential Health Care	202.76	181.36	168.30	142.54		470.40	420.74	390.46	330.72		354.16	316.78	293.98	248.98		497.62	445.28	413.22	350.00	

PPO

	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
Humana Health Plans	187.84	173.44	156.26	135.62	115.68	369.54	341.22	307.44	266.84	227.60	284.06	263.12	237.06	205.76	175.50	473.64	437.52	394.22	342.16	291.84

Indemnity

	Single					Couple					Parent Plus					Family				
	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU	EN	SH	SL	EC	BU
Kentucky Kare	262.50	216.92	188.56	147.52	125.62	619.84	512.24	440.54	348.34	297.12	355.42	293.74	252.82	199.74	170.36	608.28	502.72	432.32	341.84	291.58

Plan Type Code Legend: EN = Enhanced SL = Standard Low SH = Standard High EC = Economy BU = Budget

The s plan rates and offerings contingent upon an affirmative rate review pursuant to the Kentucky Insurance Code and any subsequent amendments that take effect during 1998.

Available HEALTHREADY Plans

KENTUCKY COUNTY	Advantage Care HMO	Advantage Care POS	Aetna HMO	Aetna POS	Alternative Health HMO	Alternative Health POS	Bluegrass Family Health HMO	Bluegrass Family Health POS	CHA Health HMO	CHA Health POS
Adair	•	•							•	•
Allen									•	•
Anderson	•	•					•	•	•	•
Ballard									•	•
Barren									•	•
Bath	•	•					•	•	•	•
Bell	•	•					•	•	•	•
Boone			•	•					•	•
Bourbon	•	•					•	•	•	•
Boyd									•	•
Boyle	•	•					•	•	•	•
Bracken	•	•					•	•	•	•
Breathitt	•	•					•	•	•	•
Breckinridge					•	•				
Bullitt										
Butler									•	•
Caldwell									•	•
Calloway									•	•
Campbell									•	•
Carlisle									•	•
Carroll									•	
Carter									•	•
Casey	•	•					•	•	•	•
Christian										
Clark	•	•					•	•	•	•
Clay	•	•					•	•	•	•
Clinton	•	•					•	•	•	•
Crittenden									•	•
Cumberland									•	•
Daviess										
Edmonson									•	•
Elliott									•	•
Estill	•	•					•	•	•	•
Fayette	•	•					•	•	•	•
Fleming	•	•					•	•	•	•
Floyd							•	•	•	•
Franklin	•	•					•	•	•	•
Fulton									•	•
Gallatin									•	•
Garrard	•	•					•	•	•	•
Grant	•	•					•	•	•	•
Graves									•	•
Grayson										
Green							•	•		
Greenup									•	•
Hancock										
Hardin									•	•
Harlan							•	•	•	•
Harrison	•	•							•	•
Hart					•	•			•	•
Henderson										
Henry					•	•				
Hickman									•	•
Hopkins										
Jackson	•	•							•	•
Jefferson			•	•	•	•				
Jessamine	•	•					•	•	•	•
Johnson									•	•
Kenton									•	•
Knott	•	•					•	•	•	•

1998

Healthsource HMO	Healthsource POS	Humana KPPA HMO	Humana MBP HMO	Humana POS	Humana PPO	Kentucky Kare	MedQuest HMO	PacifiCare (formerly FHP)	Prudential HMO	Prudential POS
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Healthsource HMO	Healthsource POS	Humana KPPA HMO	Humana MBP HMO	Humana POS	Humana PPO	Kentucky Kare	MedQuest HMO	PacifiCare (formerly FHP)	Prudential HMO	Prudential POS
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Available HEALTH PLANS

KENTUCKY COUNTY	Advantage Care HMO	Advantage Care POS	Aetna HMO	Aetna POS	Alternative Health HMO	Alternative Health POS	Bluegrass Family Health HMO	Bluegrass Family Health POS	CHA Health HMO	CHA Health POS
Knox	•	•						•		•
Larue					•	•				
Laurel	•	•					•	•	•	•
Lawrence									•	•
Lee	•	•						•	•	•
Leslie	•	•					•	•	•	•
Letcher										
Lewis	•	•							•	•
Lincoln	•	•					•	•	•	•
Livingston									•	•
Logan	•	•					•	•	•	•
Lyon									•	•
Madison	•	•					•	•	•	•
Magoffin	•	•					•	•	•	•
Marion	•	•					•	•		
Marshall									•	•
Martin									•	•
Mason	•	•					•	•	•	•
McCracken									•	•
McCreary	•	•					•	•		
McLean										
Meade					•	•				
Menifee	•	•						•		•
Mercer	•	•					•	•	•	•
Metcalfe									•	•
Monroe									•	•
Montgomery	•	•					•	•	•	•
Morgan							•	•	•	•
Muhlenberg										
Nelson			•	•	•	•				
Nicholas	•	•					•	•	•	•
Ohio										
Oldham			•	•	•	•				
Owen	•	•					•	•	•	•
Owsley	•	•					•	•	•	•
Pendleton			•	•			•	•	•	•
Perry	•	•					•	•	•	•
Pike										
Powell								•	•	•
Pulaski	•	•					•	•		
Robertson	•	•					•	•	•	•
Rockcastle	•	•					•	•	•	•
Rowan							•	•	•	•
Russell	•	•							•	•
Scott	•	•					•	•	•	•
Shelby			•	•	•	•				
Simpson									•	•
Spencer					•	•				
Taylor							•	•		
Todd										
Trigg										
Trimble										
Union					•	•				
Warren										
Washington	•	•					•	•	•	•
Wayne	•	•								
Webster										
Whitley	•	•					•	•	•	•
Wolfe	•	•					•	•	•	•
Woodford	•	•					•	•	•	•

HEALTHPLANS

1998

Healthsource HMO	Healthsource POS	Humana KPPA HMO	Humana MBP HMO	Humana POS	Humana PPO	Kentucky Kare	MedQuest HMO	PacifiCare (formerly PHP)	Prudential HMO	Prudential POS
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KENTUCKY TALKING POINTS

Kentucky has requested that the Department reconsider our position that the majority of children of public employees in the State are ineligible for CHIP.

Background

- Title XXI prohibits the participation of children of employees of public agencies who are eligible to participate in a State health benefit plan. [Section 2110(b)(2)(B)]

- In question 99 of "The Administration's Responses to Questions About the State Children's Health Insurance Program" dated July 29, 1998, HCFA issued guidance that, in cases where there is no employer premium subsidy for any State health insurance coverage option in a public agency, the children could be covered under CHIP. In other words, if a State government provides a subsidy to employees for the purchase of insurance where some portion of that subsidy can be used to purchase dependant coverage, then that State may not enroll the children of State employees into Title XXI. In addition, the policy states our intention to issue a regulation specifying a maintenance-of-effort date for States that do subsidize coverage of dependent children. This means that a State could not alter its insurance policy in such a way that they would then make the children of state employee's eligible for Title XXI.

- This policy was arrived at after extensive consultation with the Office of General Counsel (OGC), discussions in the CHIP steering committee, and discussion with States by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to determine the potential effects of various policy options.

- At the time our policy decision was being made, Kentucky was informed that their public employees' children would likely be ineligible for CHIP due to the manner in which the State contributes to the cost of coverage. This was reiterated to them in October 1998 when they sent HCFA information about their benefit plans and requested our opinion on whether State employees' children could be eligible for their CHIP program.

- The State of Kentucky makes a defined contribution toward employees' purchase of benefits. For 1999, the State contribution is $203 per month. There are 10 plans with individual premiums that are less than the defined contribution amount. However, even though the State makes a defined contribution toward insurance coverage, it has structured employee benefits into "flexible spending accounts" that permit workers to use leftover money to meet their individual family's needs. As a result, the balance of the defined contributions that are greater than the cost of individual coverage can then be applied toward the cost of dependent coverage.

- In 1998 the defined contribution by the State was $194.50 per month and in 1997 it was $185. In those years there were more than twenty individual plans that could be purchased for less than the defined contribution amount. Each of these plans also offered four or five different benefit levels with premiums varying based on the level of coverage.

- There are fewer plans available in 1999 than in previous years. The State has also reduced the number of benefit options within each plan to two. The State reports that the initial bids from plans to provide coverage were significantly higher for 1999 than in previous years. As a result, the State restructured the benefit options, dropping the ones that offered the lowest premiums and least coverage, and rebid the contracts to obtain lower rates. The elimination of the least costly benefit options could be viewed of a reduced maintenance of effort by the State, even though the actual dollar amount the State contributes toward coverage has increased.

Current Status

- HCFA and ASPE, in conjunction with OGC, have reviewed material sent by the State describing contribution levels and available plans and benefit options. OGC has advised that it does not appear that children of employees are eligible for the State's health insurance payments could be eligible for CHIP under current federal policies. Because the amount of the State contribution exceeds the amount to cover individual employees under the available options, the family would be able to use some of that contribution toward the purchase of dependent coverage (even if the State contribution is inadequate for full payment of dependent coverage.)

- OGC believes there is no flexibility in the law beyond the guidance already provided to States. In addition, Congress has questioned our policy decision that some children of public employees may be eligible for CHIP if there is no employer contribution toward the cost of dependent coverage. Some members believe that this policy is inconsistent with the law.

- Two States, North Carolina and Mississippi, have been able to cover children of State employees under our current policies. (The Mississippi plan is still under review.) In those States, there is no employer contribution toward dependent coverage.

- We are willing to work with the State to identify those counties in which there has been no contribution toward dependent coverage. However, based on the extensive information provided to HCFA thus far, it seems that at least part of the employer contribution could be used dependent coverage in all counties. As a result, none of the state employee children are eligible for CHIP.

get MOE requirement
policy call

SEVENTEEN COUNTIES IN KENTUCKY

- Kentucky has stated that there are 17 counties where there is only one health plan available and that individual coverage in that plan costs more than the State's defined contribution.

- Paula Moore, in the Governor's policy and planning office, has clarified that the 17 counties are those in which Anthem Blue Cross/Blue Shield is the only plan. When the State first accepted bids for employees' health coverage this year, 17 counties had no plan available after the bidding was completed. The State then negotiated with Anthem to provide coverage in those counties. When the State says the cost of the plan exceeds the amount of the State contribution, they are referring to Option A under the Anthem plan. Option A is what the State calls a "standard" option.

- All health plans in Kentucky have an Option A and Option B. Option B has less coverage and higher deductibles than Option A.

- Anthem Option A costs $228.84 per month and is the only plan available in 17 counties. Anthem Option B costs $196.36 and is also available in those same 17 counties. The State contribution is $203 per month.

- Children of public employees in these 17 counties are ineligible for CHIP because the amount of the State contribution exceeds the amount to cover individual employees under Option B of the Anthem plan. The family can use some of that contribution toward the purchase of dependent coverage, even if the State contribution is inadequate for full payment of dependent coverage.

Kentucky CHIP – the Hill Perspective

- We have discussed the issue of coverage of children of State employees with the authorizing committee staff on the Hill.
- Both Democrats and Republicans have indicated that no additional flexibility should be provided in this instance.
- The staff are concerned about crowding out of coverage of State employees and substituting for current coverage.
- As you know, one of the key concerns with respect to this new program is that the new money must be used to cover children who are currently uninsured.
- Congress made the standard even higher for children who have access to State employee coverage, but do not actually have coverage.
- The authorizers say they structured the law this way intentionally, due to concerns about crowd-out.
- To address this issue, you would need to seek a legislative change which would require further discussion with the authorizers.
- We are willing to react to proposals you develop or provide technical assistance in developing a proposal if you wish, but please note that this does not mean that we are going to support the proposal.

1. Q. Will HCFA give Kentucky permission to cover the children of low-income state employees through its newly approved CHIP plan?

A. The law enacted last year specifically prohibits coverage of children of State employees in non-Medicaid CHIP programs. The only exception to this is for States that do not offer any subsidy toward the coverage of any dependents. Kentucky's approved CHIP plan will permit the State to cover nearly 50,000 uninsured children by June 2000 in the non-Medicaid component of their plan, even though children of low-income state workers cannot be covered. Kentucky's approved CHIP program also includes a Medicaid expansion for children ages 14 through 18 up to 100% of the federal poverty level that will cover an additional 23,000 children. Low-income State employees' children may be covered in that Medicaid expansion.

2. Q. Why were Mississippi and North Carolina permitted to cover children of low-income State employees in their CHIP programs?

A. Mississippi's approved CHIP plan is an expansion of the Medicaid program. As mentioned before, States may cover children of low-income State employees in Medicaid expansions. Mississippi's proposal for a non-Medicaid CHIP plan is under review. In addition, North Carolina and Mississippi do not provide any employer subsidy toward the cost of dependent coverage. This is the reason that North Carolina was able to cover children of low-income State employees in their non-Medicaid CHIP program and also the reason that Mississippi is proposing to do so.

3. Q. Why does the law prohibit coverage of low-income State employees children under non-Medicaid CHIP plans?

A. Congress was concerned about coverage under CHIP substituting for coverage under State employee health plans so they did not permit coverage for children who have access to State health benefit plans. While an exception has been made if the State makes no contribution toward the cost of dependent coverage, the authorizers of the CHIP legislation have indicated to us that no additional flexibility is available under the law. Congress would have to change the CHIP law for other children of state workers to qualify for CHIP.

4. Q. Kentucky says that they do not contribute toward the cost of dependent coverage of State employees. Why can't those children participate in CHIP?

A. Kentucky makes a defined contribution toward employees' purchase of benefits -- $203 for 1999. Employees can choose from among several health plan options with individual premiums that are less than the defined contribution amount. The balance of the defined contribution can then be applied toward the cost of dependent coverage. So there is some contribution from the State, even though it is not enough to cover the full cost of dependent coverage.