SCHIP EXPENDITURES THROUGH FFY 2000 AS COMPARED TO FFY 1998 ALLOTMENTS

STATE	Actual/ Estimated SCHIP Expenditures				FFY 1998 ALLOTMENT	AMOUNTS OF UNEXPENDED FFY 1998 ALLOTMENTS	AMOUNTS OF EXPENDITURES IN EXCESS OF FFY 1 ALLOTMENTS
	FFY 1998	FFY 1999	FFY 2000	ESTIMATED CUMULATIVE EXPENDITURES THRU FFY 2000*			
ama	2,433,172	22,930,303	60,655,000	$86,018,475	$85,975,213		$43,262
ca	0	3,806,310	12,933,000	$16,739,310	6,889,296		$9,850,014
Arizona	0	8,836,785	30,724,000	$39,560,785	116,797,799	$77,237,014	
Arkansas	0	680,106	1,832,000	$2,512,106	47,907,958	$45,395,852	
California	1,985,740	67,747,222	196,100,000	$265,832,962	854,644,807	$588,811,845	
Colorado	987,999	9,036,470	18,850,000	$28,874,469	41,790,546	$12,916,077	
Connecticut	0	12,301,470	13,258,000	$25,559,470	34,959,075	$9,399,605	
Delaware	0	787,038	1,297,000	$2,084,038	8,053,463	$5,969,425	
District of Columbia	0	498,585	9,133,000	$9,631,585	12,076,002	$2,444,417	
Florida	6,356,287	51,006,205	171,376,000	$228,738,492	270,214,724	$41,476,232	
Georgia	0	7,428,825	39,110,000	$46,538,825	124,660,136	$78,121,311	
Hawaii	0	0	0	$0	8,945,304	$8,945,304	
o	1,366,142	3,913,959	6,504,000	$11,784,101	15,879,707	$4,095,606	
Illinois	6,081,658	14,730,876	17,516,000	$38,328,534	122,528,573	$84,200,039	
Indiana	0	61,716,155	52,946,000	$114,662,155	70,512,432		$44,149,723
Iowa	276,280	10,562,724	20,256,000	$31,095,004	32,460,463	$1,365,459	
Kansas	0	8,790,887	20,348,000	$29,138,887	30,656,520	$1,517,633	
Kentucky	0	17,825,116	87,491,000	$105,316,116	49,932,527		$55,383,589
Louisiana	0	10,361,817	18,098,000	$28,459,817	101,736,840	$73,277,023	
Maine	0	5,617,064	9,327,000	$14,944,064	12,486,977		$2,457,087
Maryland	692,200	13,558,964	20,667,000	$34,918,164	61,627,358	$26,709,194	
Massachusetts	0	35,385,895	51,150,000	$86,535,895	42,836,231		$43,699,664
Michigan	657,830	14,918,731	24,560,000	$40,136,561	91,585,508	$51,448,947	
Minnesota	0	7,189	51,000	$58,189	28,395,980	$28,337,791	
Mississippi	0	8,092,064	73,604,000	$81,696,064	56,017,103		$25,678
Missouri	0	19,708,219	55,300,000	$75,008,219	51,673,123		$23,335,096
Montana	0	599,351	9,316,000	$9,915,351	11,740,395	$1,825,044	
Nebraska	4,100	3,769,747	11,737,000	$15,510,847	14,862,926		$647,921
Nevada	0	4,110,173	7,726,000	$11,836,173	30,407,067	$18,570,894	
New Hampshire	0	902,090	3,040,000	$3,942,090	11,458,404	$7,516,314	
Jersey	3,541,153	19,615,743	63,216,000	$86,372,896	88,417,899	$2,045,003	
New Mexico	0	767,955	4,277,000	$5,044,955	62,972,705	$57,927,750	
New York	50,078,965	239,428,023	453,004,000	$742,510,988	255,626,409		$486,884,579
North Carolina	0	34,921,018	68,411,000	$103,332,018	79,508,462		$23,823,556
North Dakota	0	75,874	2,049,000	$2,124,874	5,040,741	$2,915,867	
Ohio	8,638,128	35,871,992	51,400,000	$95,910,120	115,734,364	$19,824,244	
Oklahoma	0	0	48,077,000	$48,077,000	85,699,060	$37,622,060	
Oregon	391,947	7,246,681	13,198,000	$20,836,628	39,121,663	$18,285,035	
Pennsylvania	10,101,407	38,649,651	68,061,000	$116,812,058	117,456,520	$644,462	
Rhode Island	0	2,321,095	3,788,000	$6,109,095	10,684,422	$4,575,327	
South Carolina	26,275,768	43,205,043	45,961,000	$115,441,811	63,557,819		$51,883,992
South Dakota	52,032	1,494,027	2,589,000	$4,135,059	8,541,224	$4,406,165	
Tennessee	0	0	39,722,000	$39,722,000	66,153,082	$26,431,082	
Texas	1,308,701	38,490,850	77,950,000	$117,749,551	561,331,521	$443,581,970	
Utah	0	7,994,253	14,513,000	$22,507,253	24,241,159	$1,733,906	
Vermont	0	524,624	1,452,000	$1,976,624	3,535,445	$1,558,821	
Virginia	0	4,992,151	24,935,000	$29,927,151	68,314,914	$38,387,763	
Washington	0	0	1,556,000	$1,556,000	46,661,213	$45,105,213	
West Virginia	3,110	1,075,534	11,181,000	$12,259,644	23,606,744	$11,347,100	
Wisconsin	0	2,067,151	15,553,000	$17,620,151	40,633,039	$23,012,888	
Wyoming	0	0	824,000	$824,000	7,711,638	$6,887,638	
Total States Only	$ 121,232,619	$898,372,005	$2,056,622,000	$3,076,226,624	$4,224,262,500	$1,915,873,320	$767,837,444
Puerto Rico	0	17,238,668	9,850,000	$27,088,668	$9,835,550		$17,253,118
Guam	0	0	375,812	$375,812	375,812		$0
Virgin Islands	0	250,148	279,000	$529,148	279,175		$249,973
American Samoa	0	641,100	0	$641,100	128,850		$512,250
N. Mariana Islands	0	0	0	$0	118,113	$118,113	
Total Comm. And Territori	0	18,129,916	10,504,812	$28,634,728	$10,737,500	$118,113	$18,015,341
Total States and Comm. A	$121,232,619	$916,501,921	$2,067,126,812	$3,104,861,352	$4,235,000,000	$1,915,991,433	$785,852,785

* Based on State submitted actual expenditures through FFY 1999 and State submitted estimates for FFYS 2000.
Forms HCFA-21C @ 2/29/00 and February 2000 HCFA-37

FY98REDST.XLS 3/30/00

Several States had accomplished significant eligibility expansions prior to the enactment of SCHIP, either through the use of section 1115 demonstration authority or through section 1902(r)(2). With the exception of Connecticut and New Hampshire, all of these States have expressed interest in various forms of section 1115 demonstration proposals for SCHIP. A short description of each of these States is provided below.

Hawaii

- Hawaii's pending amendment requests a six month limit on eligibility for the QUEST-NET program. This program is currently not time limited and, therefore, the proposal is a reduction in the State's maintenance of effort.

- QUEST-NET covers children whose family income becomes too high for QUEST, the State's Medicaid program. Children eligible for QUEST-NET are not eligible for SCHIP because they were eligible for Medicaid under the standards in effect on 3/31/97.

Maryland

- The State continues to pursue coverage for children who were previously in their "KidsCount" demonstration, which ended on June 30, 1998. One possible option is that this could be done under title XXI section 1115 authority.

Minnesota

- Prior to SCHIP, the State covered children up to 275 percent of the Federal Poverty Level (FPL). The State's approved SCHIP plan expanded Medicaid coverage to children under age 2 in families with incomes from 275 percent of the FPL to 280 percent of the FPL. This SCHIP plan allowed the State to have access to its allotment while planning for future expansion.

- In May 1998, Minnesota submitted a section 1115 demonstration proposal requesting SCHIP funding for children already covered under their existing section 1115 demonstration. That request was denied on the grounds that it was not appropriate to consider waivers of the new SCHIP program at that time. Minnesota is still expressing interest in submitting a demonstration proposal, although no specific proposal has been discussed recently.

New Mexico

- Prior to SCHIP, New Mexico provided coverage to children through age 18 up to 185 percent of the FPL. The State's approved SCHIP plan expands Medicaid eligibility for uninsured children from birth through age 18 from 186% to 235% of the FPL. Waivers of title XIX were granted to permit nominal cost sharing for children in this income category.

- New Mexico also submitted a SCHIP amendment to provide a variety of preventive and intervention services to all Medicaid eligible children. This amendment was denied on July 8, 1999 because under title XXI, States may not receive enhanced FMAP for children who would have been Medicaid eligible

under the title XIX State plan in effect on March 31, 1997. New Mexico submitted a request for reconsideration of this decision. A hearing was scheduled but the State requested a continuance. They have contacted OGC to discuss a settlement. Discussions are being scheduled for later this month. Additional waivers of title XXI would be needed for New Mexico to do what it is proposing.

Rhode Island

- Prior to SCHIP, the State covered children through age 8 up to 250 percent of the FPL. The State's approved SCHIP plan covers children age 9 through 18 to 250% FPL. They also have approval to cover all uninsured children from 250% to 300% FPL but have not implemented this portion because State legislation is needed.

- In November 1999, the State submitted a draft SCHIP amendment to provide enhanced dental services and supplemental family support services for children with special needs to all Medicaid eligible children. Following discussions with HCFA, the State is aware they would need section 1115 waivers of title XXI in order to obtain enhanced FMAP for these services in the case of children who are eligible for regular Medicaid. Their proposal is under discussion as it relates to future section 1115 policy.

Tennessee

- Prior to SCHIP, Tennessee had no upper eligibility level; however, enrollment was closed to all except regular Medicaid eligibles. A technical amendment to title XXI permits SCHIP coverage to children who are newly enrolled after enrollment was reopened in April 1997. The State has been unable to cover most of these children under SCHIP because aspects of the demonstration do not meet title XXI requirements.

Vermont

- Prior to SCHIP, Vermont covered children up to 225 percent of the FPL. The State originally submitted a SCHIP plan on March 16, 1998, but withdrew it on August 5, 1998. This proposal would have required waivers of Title XXI provisions to cover the bulk of the population proposed in the plan (insured children and adults with Medicaid-eligible children). HHS rejected Vermont's request for waivers on the grounds that it is not appropriate for HHS to waive Title XXI provisions until States have first had an opportunity to implement a SCHIP program, and have some evaluation of their program. Prior to SCHIP, Vermont was already covering children to 225% FPL.

- HCFA worked with Vermont to develop a strategy to cover the populations included in the State's original SCHIP application. Vermont's approved SCHIP plan created a separate state health insurance program to cover uninsured children

up to age 18 in families with incomes between 225 and 300 percent of the FPL. Insured children with family income between 225% and 300% of the FPL, and adults with Medicaid-eligible children with family income between 150 and 185% of the FPL are now covered, through amendments to Vermont's section 1115 demonstration, under the Medicaid program at the regular Federal Medical Assistance Percentage (FMAP.).

Washington

- Prior to SCHIP, Washington was covering children up to 200 percent of the FPL. For this reason, the State initially delayed in submitting a SCHIP plan. The State believes they were disadvantaged by the maintenance of effort requirements under title XXI and pursued a technical correction to the SCHIP legislation to reflect this. Although HCFA provided technical assistance in this effort, the State was unsuccessful.

- The State eventually submitted and had a SCHIP plan approved to cover children through age 18 from 200 to 250 percent of the FPL. The State may pursue waivers in the future if they believe our policy would permit SCHIP funding for children below 200 percent of the FPL.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE GENERAL COUNSEL

FAX

DATE: April 19 2000

TO: Tim Westmoreland & Cindy Mann

FAX: 358-3403 \(410) 786-8534

FROM: **Anna D. Kraus**

PHONE: **202/690-7741**

FAX: **202/690-7998**

REMARKS:

NUMBER OF PAGES: 6 **(including cover sheet)**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The General Counsel
Washington, D.C. 20201

April 19, 2000

NOTE

TO: Timothy Westmoreland, Director
Center for Medicaid and State Operations

FROM: Harriet S. Rabb

Attached to this note is a memorandum that sets out the argument against HCFA providing SCHIP waivers under the circumstances you have hypothesized. Because it is possible that going forward with such waivers would prompt a challenge to that decision, the attachment rehearses, in the strongest terms, the arguments that could be arrayed against the waivers.

Of course, we can and will discuss the counter proposition.

April 19, 2000

MEMORANDUM

SUBJECT: Section 1115 and Medicaid/SCHIP Demonstration Projects

The question presented is whether HCFA has authority to approve a Title XIX demonstration project pursuant to § 1115 of the Social Security Act (Act) under which federal Medicaid matching funds (authorized by Title XIX of the Act) would be paid at an enhanced federal medical assistance percentage (FMAP) for costs of medical assistance to populations that are not within the definition of "optional targeted low income children." Under the Medicaid program (Title XIX of the Social Security Act), enhanced FMAP is available only for medical assistance expenditures for optional targeted low-income children. §1905(u)(2)(A), (B) of the Social Security Act.[1] The purpose of the demonstration project would be to allow a State to expand its Medicaid program to include populations beyond "optional targeted low income children" and, significantly, to receive enhanced FMAP for the State's expenditures for services provided under that expansion,[2] using the federal matching rate for services under the Title XXI State Children's Health Insurance Program (SCHIP).

As explained below, this memorandum concludes that § 1115(a)(2) does give HCFA the authority to allow a State to expand the class of persons covered under its Title XXI SCHIP program. With respect to a State's Title XIX Medicaid program, while that authority would permit an expansion that includes individuals who are not optional targeted low-income children, it does not provide authority for an enhanced matching rate for those individuals. Waiver authority available under § 1115(a)(1) does not permit alteration of the Medicaid FMAP or expansion of the definition of "optional targeted low income children." Nor does the §1115(a)(2) authority to treat demonstration costs as

---

[1] Expenditures under the Medicaid program for other classes of beneficiaries are made at a lower (not enhanced) FMAP. By contrast, expenditures under Title XXI of the Social Security Act ("the State Children's Health Insurance Program") are all matched by an enhanced FMAP.

[2] The amounts paid to a State as enhanced FMAP under the Medicaid program are counted against the State's capped SCHIP allotment.

matchable expenditures permit HCFA to apply the enhanced FMAP under Title XIX to a population beyond the statutory definition of "optional targeted low income children."

Discussion

A. Section 1115 Authority Described

Section 1115(a) of the Act contains two relevant provisions providing authority to the Secretary, who has delegated her authority to HCFA, to approve a demonstration project. HCFA may grant waivers under §1115(a)(1) and has authority to extend federal matching to costs not otherwise matchable (CNOM) under §1115(a)(2).[3]

Section 1115(a)(1) provides authority to waive compliance with any of the State plan requirements imposed on the State by the relevant statute. Such a waiver can act only to relieve a State's obligation to comply with the statutory requirement. The waiver authority does not permit HCFA to substitute a new term in the statute for one that is waived. Thus, waiver authority is not an avenue for expanding the scope of a statutory program.

In contrast to §1115(a)(1), §1115(a)(2) authority permits expansions to new populations and services. Under this authority, federal matching funds are available for costs that would not ordinarily be included in the program. But this expansion authority does not authorize changes in the applicable matching rate. Under SCHIP, there is only one matching rate, and that rate applies to any expenditure that is included in the program. Under Medicaid, there are multiple matching rates, and the applicable rate for demonstration costs will depend on the nature of those costs. Demonstration costs that are "medical assistance under the State plan" would ordinarily be matched at the regular Medicaid FMAP rate. Costs that are not "medical assistance" would ordinarily be matched at the rate for administration of the State plan. And, because the enhanced FMAP is available under Medicaid only for expenditures for "optional targeted low

[3]Demonstration authority under § 1115(a) also extends to the SCHIP program. Section 2107(e)(2) of the SCHIP statute includes "Section 1115 (relating to waiver authority)" among the provisions that apply to a State "in the same manner as they apply to a State under title XIX." HCFA has interpreted this language to refer to both §§ 1115(a)(1) and (a)(2) because both authorities are often referred to jointly as waiver authority in common parlance.

income children," the enhanced FMAP rate would be available for costs of a demonstration project expansion population only to the extent that the population falls within the definition of "optional targeted low income children."

Under § 2107(e)(2) of Title XXI, § 1115 applies to a State under SCHIP "in the same manner as [it applies] to a State under Title XIX." While it has been argued that this language authorizes approval of any Medicaid demonstration project if a similar separate SCHIP demonstration could be approved under title XXI, this argument is not convincing. Leaving aside for the moment the precise meaning of "in the same manner," this argument is based on an inverted reading of § 2107(e)(2). That section directs that the application of § 1115 to Title XXI should be guided by the manner in which § 1115 is applied to Title XIX, and not vice versa. Therefore, § 2107(e)(2) affords no basis for expanding the application of § 1115 in a demonstration under Title XIX.

B. Application of Section 1115 to the Proposed Demonstration Project

Exercise of HCFA's authority under § 1115(a)(1) would not allow a State to expand the population covered by either its Title XXI or Title XIX programs. A State may be allowed to waive what would otherwise be its obligation, but may not rewrite the statute to expand a definition so that a broader category of expenditures could become matchable.

On the other hand, the § 1115(a)(2) CNOM authority is sufficient to authorize approval of a SCHIP demonstration (funded from the Title XXI appropriation) to expand the populations covered under a SCHIP program. Since there is only one federal matching rate under Title XIX – the enhanced FMAP – the State would be paid at the enhanced FMAP for these expansion populations.

Because of the structure of Title XIX, were HCFA to employ its § 1115(a)(2) CNOM authority to allow a State to expand the class of persons covered under its Medicaid program, such costs could be matched only at the State's regular Medicaid FMAP, not an enhanced FMAP. There is no authority in § 1115(a)(2) to alter or expand the category of expenditures that are subject to an enhanced FMAP. The enhanced FMAP in Title XIX is defined to apply only to expenditures described in §1905(u)(2)(A), which in turn includes only expenditures for medical assistance for optional targeted low-income children.

It may seem that the result of the foregoing analysis – i.e., that a State can be allowed to expand the class of persons covered under its SCHIP program, but cannot be allowed to effect that expansion through integration of those newly covered persons into its

Medicaid program at the enhanced FMAP – is anomalous and inconsistent with congressional intent. It does appear that the purpose of § 1905(u)(2)(A) was to allow a State to integrate its SCHIP population into its Medicaid program and to receive the SCHIP enhanced FMAP for the SCHIP population. Yet, as explained above, the language of the statute is written so that the expenditures eligible for enhanced FMAP under Title XIX are tied to the statutory definition of "optional targeted low income children." The statutory definition cannot be revised by exercise of the authorities granted under § 1115. That is, using § 1115(a)(2) authority to expand the scope of individuals who could be included under title XXI beyond optional targeted low-income children does not change the definition of a "targeted low-income child" for purposes of title XIX's enhanced matching authority.

A question arises whether the specific language of the statute can be overcome by looking to the purpose of SCHIP. Section 2101 states that the program's purpose is "to provide funds to States to enable them to initiate and expand child health assistance . . . through – (1) obtaining coverage that meets the requirements of section 2103, or (2) providing benefits under the State's Medicaid plan under title XIX, or a combination of both." It could be argued that this language should support an interpretation that any demonstration that could be approved under SCHIP should be within HCFA's authority to approve under Medicaid. Yet, while the two programs are related, Medicaid and SCHIP are separate under the statute and have distinct funding streams, program requirements, and federal matching provisions. It would be very hard to prove that the SCHIP purpose section either explicitly or by implication changes any of the distinctions between the programs and overrides the specific statutory language. While there may be ways to construe §1115 so that it applies evenly to both programs, the only way truly to achieve this result would be to apply §1115 more restrictively to SCHIP, to mirror Medicaid limitations.

Alternatives

Using the more expansive SCHIP authority with appropriate safeguards may enable HCFA to accomplish many of its policy objectives. HCFA could include terms and conditions in a SCHIP demonstration to ensure that an expansion population obtains or retains benefits and protections equal to those under Medicaid.

It would also be possible to develop a SCHIP-Medicaid demonstration under which the expenditures for the demonstration populations or services would be eligible for the enhanced FMAP under the SCHIP program until the SCHIP allotment is exhausted, and then those expenditures would be eligible for the regular FMAP under Medicaid. If the SCHIP demonstration were to include terms and conditions to ensure that the population

obtains or retains benefits and protections equal to those under Medicaid, it is possible that such a demonstration would be virtually indistinguishable from full Medicaid coverage of the demonstration population.

MARTIN OLAV SABO
5th District, Minnesota

2336 Rayburn House Office Building
Washington, D.C. 20515
(202) 225-4755

Commerce at the Crossings #286
250 Second Avenue South
Minneapolis, Minnesota 55401
(612) 664-8000

martin.sabo@mail.house.gov
http://www.house.gov/sabo/

COMMITTEE ON APPROPRIATIONS
Subcommittees:
Transportation (Ranking Member)
National Security
Foreign Operations

COMMITTEE ON STANDARDS OF OFFICIAL CONDUCT

DEMOCRATIC POLICY COMMITTEE
Vice-Chair

Congress of the United States
House of Representatives
Washington, D.C. 20515

FAX TRANSMISSION

Office of The Honorable Martin Olav Sabo
2336 Rayburn House Office Building
Washington, D.C. 20515
Phone: (202) 225-4755
Fax: (202) 225-4886

TO: Deborah Adler

FAX NUMBER: (202) 456-5557

DATE: 4/11/00.

TOTAL NUMBER OF PAGES (including cover): 6

FROM:

____ Congressman Sabo	____ Michael Erlandson	____ Marjorie Duske
____ Bonnie Gottwald	____ Alan Dillingham	✓ Lisa Tomlinson
____ Bethany Young	____ Robyn Hiestand	____ Travis Talvitie
____ Sharon Wagener	____ Don Ostrom	____ Ryan Nagle

COMMENTS:

As discussed, info. on Minnesota's S-CHIP waiver request will follow. — Lisa

If you do not receive all of the pages noted above, or if any other transmission problems occur, please call 202-225-4755.

STATE OF MINNESOTA
OFFICE OF GOVERNOR JESSE VENTURA
130 State Capitol • 75 Constitution Avenue • Saint Paul, MN 55155

March 28, 2000

Nancy Ann Min DeParle, Administrator
Health Care Financing Administration
314G Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, D.C. 20201

Dear Ms. Min DeParle:

When we met in Washington last month, I mentioned to you Minnesota's current difficulty with Title XXI, the State Children's Health Insurance Program (S-CHIP). I appreciate your willingness to help us resolve this issue.

Enclosed is Minnesota's proposal for a demonstration project waiver under Title XXI. As you know, Minnesota has been a national leader in its commitment to provide accessible, affordable coverage for uninsured children, and it is my goal to see that all Minnesota children are insured by the end of my term.

We have approximately 50,000 uninsured children in this state who are in families with income of less than 200 percent of the federal poverty guidelines. While we recognize that Congress intended for S-CHIP funds to be used for program expansions, such an expansion in Minnesota would do nothing for those 50,000 low-income children. Those children are disadvantaged by our inability to participate in the S-CHIP program.

I am therefore requesting a section 1115 demonstration project waiver that will do the following:

- Provide for enhanced matching funds for enrollment of children in our programs that is over and above the number of children enrolled in October of 1998;

- Revise the current premium schedule in the MinnesotaCare Program so that the program is in compliance with the S-CHIP laws; and

- Allow us to use the remainder of the allotment for special health initiatives.

This proposal will allow Minnesota to focus on getting eligible children insured by targeting resources on reaching children whose families cannot or do not want to enroll in our existing programs.

Minnesota wants to work with our federal partners to make this happen. I urge you to consider this waiver request in a timely manner.

Thank you.

Sincerely,

Jesse Ventura
Governor

cc: Secretary Donna Shalala

Section 1 - Introduction and Executive Summary

Background

Congress enacted Title XXI, the State Children's Health Insurance Program (S-CHIP), with the express purpose of "providing states with the resources, flexibility, and tools they need to expand the provision of coverage and services to uninsured low income children."[1] The State of Minnesota has a long history of commitment, through public involvement, market reform, and state-subsidized programs, to reducing the rate of uninsurance in Minnesota, especially among children. President Clinton himself acknowledged that "Minnesota has shown exceptional leadership in implementing policies that ensure low-income children have access to meaningful, affordable health care," and that the MinnesotaCare Program was used as a model in designing S-CHIP.[2]

Through Medicaid Program expansions in the late 1980's and the Children's Health Plan, established in 1987 and renamed the MinnesotaCare Program in 1992, and through the health care reforms that began in the early 1990's, Minnesota has effectively reduced the rate of uninsurance, assisted many families on AFDC and TANF in moving into the work force, and has provided an option for people without reasonable means to obtain health care for their children. From 1990 to 1999, the rate of uninsurance among children under age 18 decreased significantly from 5.3 percent to 3.4 percent. We know that MinnesotaCare has not had a negative impact on the rate of insurance--there has been no measurable "crowd-out" effect despite the high income standards in this program.[3] During the same period, the national rate was rising.

In July 1995, the Health Care Financing Administration (HCFA) greatly enhanced Minnesota's efforts by granting approval of the MinnesotaCare Health Care Reform Waiver, which provided federal Medicaid funds for expenditures on behalf of pregnant women and children enrolled in MinnesotaCare. Due in part to the federal contribution, Minnesota has been able to improve the MinnesotaCare Program by increasing income standards and by expanding the benefit package.

Title XXI was designed to assist states to reduce the rate of uninsurance among lower-income children, but the funding is primarily available for states that provide coverage for children at income levels above their current income standards. Raising the income standard above the existing level--275% of poverty--is not the best solution to addressing the needs of uninsured children in this State. We have 48,000 uninsured children under age 19 in this State, approximately two-thirds of whom are in families with income below 200% of federal poverty.

---

[1] *State Children's Health Insurance Program (S-CHIP) Implementation Guide*, Chairman Tom Bliley, House Committee on Commerce, November 1997.

[2] Letter of December 6, 1999 from President Clinton to Governor Ventura.

[3] Call, K.T., *et al.*, "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," *Journal of the American Medical Association*, October 8, 1997, Vol. 278, No. 14.

Many of them are eligible but not enrolled in the existing programs. Our focus in Minnesota must be on reaching those remaining low-income uninsured children.

In addition, there are other needs that should be addressed. We know that racial and ethnic minorities in Minnesota have higher rates of uninsurance, in particular Hispanic people. We also know that American Indians experience higher rates of uninsurance. While we have been successful at reducing chronic uninsurance in Minnesota, we know we have been less successful at reducing the number of people who frequently move on and off of insurance.

PROJECT PROPOSAL

We acknowledge that Congress intended S-CHIP funding to be used to expand enrollment for uninsured children. Minnesota intends to maintain its existing efforts in providing health care to children. But at the same time, Congress created allotments to individual states that were intended to address unmet needs of states. These allotments were already weighted downward for states like Minnesota with lower rates of uninsurance. Minnesota should not be expected to expand coverage and address the unmet need without the use of the S-CHIP funds. We therefore propose the following expansions to our programs, that are targeted toward the real unmet need in this State, without requesting the refinancing of MinnesotaCare under S-CHIP, as we did in our first waiver request.

- **Enrollment.** Expenditures related to the number of children enrolled in MinnesotaCare above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

- **Presumptive Eligibility.** We propose to introduce the use of presumptive eligibility for all children under age 19 who apply for either MA or MinnesotaCare. The expenditures related to the additional eligibility months will be matched at the S-CHIP rate and will count against the allotment. This change requires enactment by the Legislature, and therefore would not be effective until October 1, 2001.

- **Premiums.** We propose to reduce MinnesotaCare premiums so that they do not exceed the Title XXI maxima. That involves eliminating the premiums for children in families with income below 150% of poverty, capping the existing premium schedule at 5% of family income, and eliminating premiums for American Indian people. This change requires enactment by the Legislature, and therefore would not be effective until October 1, 2001.

- **Special Health Initiatives.** We propose to use the remainder of the allotment for special health initiatives designed to improve the health of low-income children that fit within Minnesota's Public Health Improvement Goals 2004 for children and adolescents. We have identified a number of projects currently underway to improve access to dental care and to

improve the identification and treatment of children with mental health needs. We have also identified a number of areas of need that will serve as the basis for development of new special health initiatives, such as reducing exposure to lead poisoning, and reducing the disparity in health outcomes among ethnic and racial minority populations. We will reserve all federal revenue earned from the expansions and initiatives under this demonstration to be used for the improvement of children's health. Also, we will develop a procedure for the development of new initiatives that will involve participation from the public, consumers, advocates, providers, other government agencies, and the Legislature.

EVALUATION

States that are now just starting programs similar to MinnesotaCare will be, within a few years, in the same place that Minnesota is now. Minnesota provides an ideal opportunity to demonstrate and evaluate a variety of approaches to address the health care needs of children who remain uninsured. A number of questions could be answered, such as:

- Are there methods, such as targeted health initiatives and direct provider payments that are more effective than insurance products in reducing the disparity in health outcomes for racial and ethnic minority populations?
- What can we do to create continuity of care for those that do cycle on and off?
- What methods of outreach are more effective than others?
- What are the reasons that people who know about the program do not apply for it, and how can this be addressed?
- Is there a "natural rate" of uninsurance that will be reached, at which point unmet needs have to be met outside of a plan of insurance?

We cannot use Minnesota's $28 million annual allotment to answer these and other questions without HCFA's assistance.

CONCLUSION

MinnesotaCare has contributed greatly to the collective knowledge in this country about the uninsured–most notably, how to reduce the rate of insurance without negative impact on the rate of private insurance, and how to provide a safety net to prevent people from falling into greater dependency. But there is much to learn. Through the help of communities, advocates, health care professionals, consumers, academics, local governments, and the federal government, we can learn and do more. Minnesota's uninsured children should not be disadvantaged because the Title XXI allotment is not available to them.