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Waiting in the wings: Eligibility and enrollment in the state children's health insurance program
BYLINE: Selden, Thomas M; Banthin, Jessica S; Cohen, Joel W

Headnote:

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

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

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

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

DATA AND METHODS

The data for our analysis comprise 6,903 children age eighteen and under from the 1996 MEPS.⁶ MEPS is a stratified and clustered random sample of households, which, when combined with sample weights, is designed to yield nationally representative estimates for the noninstitutionalized civilian population regarding insurance coverage, medical expenditures, and a wide range of other healthrelated and socioeconomic characteristics.⁷ To make the data as representative of 1999 as possible, we adjust the MEPS sample weights using population growth factors by age, race/ethnicity, and sex.⁸ This is important given that the baby-boom "echo" is causing a disproportionate increase in the number of teenagers. Similarly, population growth is projected to be more rapid among Hispanic and black children-who also are more likely to be eligible for CHIP.

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

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

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

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

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

It is also true, however, that CHIP in 1999 may differ from Medicaid in 1996 in ways that our analysis is unable to capture. CHIP application processes may be simplified relative to Medicaid in 1996. Also, the higher federal matching rate for CHIP may provide states with the incentive to minimize application denials for eligible children, a problem believed to be widespread in the Medicaid program. CHIP may well entail less stigma than Medicaid, especially in cases where children would be eligible to enroll in separate state programs, and CHIP outreach in 1999 may be more effective than Medicaid outreach in 1996.

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

RESULTS

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

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

Nationwide, teenagers (ages thirteen to eighteen) are projected to represent 30.6 percent of all children age eighteen and under in 1999 (Exhibit 2).¹⁸ In contrast, the share of teenagers in the CHIP-eligible population is significantly higher at 39.4 percent. CHIP-eligible children also are projected to be more heavily Hispanic (29.5 percent) than the general population of children (15.5 percent). They also are more likely to be black (19.9 percent versus 15.9 percent on average in the population); however, this difference is not statistically significant. CHIP-eligible children in our projected sample are less likely than the average child to be in a family in which the family head is unemployed, because the program primarily targets children of the working poor. In addition, CHIP-eligible children are projected to be disproportionately located in the South.

(Table Omitted) Captioned as: EXHIBIT 1

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

SIMULATED ENROLLMENT. Total enrollment under the federal eligibility thresholds is projected to be 1.8 million children in the first half of 1999 (Exhibit 3). The corresponding total enrollment under the state plans is 1.5 million children. The federal total includes 1.0 million children who otherwise would have been without coverage during this period, as well as 0.4 million children who would be crowded out of private insurance. However, these projected changes in insurance status are estimated only imprecisely. Moreover, our projections, being based on the Medicaid expansions, do not incorporate

waiting periods, which can be expected to reduce CHIP enrollment among those otherwise covered by private insurance. Finally, the total includes our estimate that the availability of CHIP coverage might prevent as many as 0.4 million children from spending down to Medicaid eligibility.

We project that a substantial number of CHIP -eligible children would remain uninsured under either federal or state rules. The implied federal and state CHIP enrollment rates are 47 and 48 percent, respectively below the 59 percent enrollment rate among Medicaid expansion-eligible children in 1996.²⁰ The low take-up rates in our model reflect the fact that while the CHIP and Medicaid populations overlap to a considerable extent, CHIP -eligible children are more likely than Medicaid-eligible children are to have precisely those characteristics that are most strongly associated in Medicaid with low enrollment rates.

For instance, in our Medicaid sample family income and having at least one working parent are both negatively associated with program participation, yet when we compare CHIP -eligible children with Medicaid-eligible children we see that the former are more likely than the latter are to come from families with higher incomes and are far more likely to have a working parent. Similarly, whereas being a minority or having a disability is positively associated with Medicaid take-up, CHIP -eligible children are less likely than Medicaid-eligible children are to be minorities or to have disabilities. Also, while age is negatively associated with Medicaid enrollment, CHIP -eligible children tend to be older than Medicaid-eligible children. Indeed, the CHIP take-up rates derived from our projections are approximately the same as the 44 percent Medicaid take-up rate observed among expansion-eligible teenagers in 1996.²²

(Table Omitted) Captioned as: EXHIBIT 2 (Table Omitted) Captioned as: EXHIBIT 3

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

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

POLICY IMPLICATIONS

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

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

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

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

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

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How will we know if CHIP is working?

BYLINE: Riley, Trish

Congressional expectations may exceed states' ability to measure the effectiveness of their Children's Health Insurance Programs.

THE STATE CHILDREN'S Health Insurance Program (CHIP) was enacted in the last minutes of the 105th Congress. In its speed to meet the laudable goal of insuring more children, Congress may not have had the time to deliberate fully those provisions related to annual program reports and evaluations. As a result, the information that Congress seeks to obtain through statute may be difficult, if not impossible, for the states to provide.

Congress requires states participating in CHIP to complete annual reports and to submit an evaluation of the program to the secretary of the Department of Health and Human Services (HHS) by 31 March 2000. The HHS secretary will then submit a report to Congress by 31 December 2001. Generally, the law seeks information on the following aspects of CHIP implementation: (1) progress in reducing the numbers of low-income, uninsured children; (2) assessment of the operation of a state's plan; (3) specific program indicator data; (4) assessment of the state plan's effectiveness in increasing the number of children with creditable health coverage; (5) description and analysis of the effectiveness of elements of the state plan, including characteristics of children and families assisted, quality of coverage provided (including types of benefits provided), amount and level (including payment of part or all of any premium) of assistance provided by the state, service area, time limits for coverage of a child, the state's choice of health benefits coverage and other methods used for providing child health assistance, and sources of nonfederal funding; (6) assessment of the effectiveness of other public and private programs in increasing the availability of affordable, high-quality individual and family health insurance for children; (7) review and assessment of state activities to coordinate the plan with existing public and private programs; and (8) analysis of changes and trends in the state that affect the provision of accessible, affordable, highquality insurance and health care to children.

States simply may not be able to provide the breadth and depth of information included in these mandates. Although states are working aggressively to meet the law's requirements, they quickly point out that Congress has limited their administrative costs to 10 percent of program spending. This allowance must support outreach, all program management, and evaluation activities. Since these administrative dollars can only be earned when expenses are incurred for serving children, they have not been available up front to support essential start-up costs.

Can We Measure Accurately?

Several reporting requirements raise significant concerns. First, Congress wants to know how states progress in reducing the number of uninsured low-income children and in raising the number of children with creditable health coverage. What appears to be a simple and obvious request is highly controversial, for no agreement exists as to how many uninsured children now live in each state. The Current Population Survey (CPS), upon which Congress based its cost estimate and from which it determined the state CHIP appropriation, is widely viewed as inaccurate. The CPS provides a large national sample for

national-level estimates, but because state-level samples are very small for most states, the margin of error is quite large. Only New York, Texas, and California have more than 1,000 households with children with CHIP-level incomes (200 percent of the federal poverty level) in their sample. Even in these states officials do not have confidence in the estimates. The CPS undercounts Medicaid enrollment and fails to distinguish between whether a person lacks insurance at a point in time or at any time during the year. Thus, the survey overestimates the number of uninsured.

Other means to establish a baseline. Some states are conducting their own surveys. The Urban Institute's detailed study of thirteen large states will provide more accurate estimates of the uninsured for these states. The institute also will produce a national estimate, but it will not be applicable to all states. Although this study represents progress, for CHIP to succeed as a federal/state program (with matching state funds), every state will need to be able to demonstrate success in reducing the number of uninsured children.

The Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Health Care Policy and Research (AHCPR), provides more-comprehensive questions about insurance status and reports an even higher number of uninsured, low-income children than the CPS does. However, because of sampling size and method, MEPS also does not provide useful and reliable state-level data.

The National Center for Health Statistics (NCHS) State and Local Area Integrated Telephone Survey (SLAITS) allows states to identify and compare children with and without coverage. However, SLAITS is not now readily available, is quite costly, and is only available in English and Spanish. In addition, its data cannot be given directly to states. The NCHS has expressed interest in resolving these problems, but the time and money required to do so pose a sizable barrier.

States have had to decide how they will predict the number of uninsured, low-income children and report that number to HHS by 31 January 1999. However imperfect they are, these numbers form the baseline for determining states success or failure in meeting CHIP objectives. States are understandably apprehensive about their baselines. The CPS-based formula by which federal CHIP funds are allocated will change in fiscal year 2001 to reward states that reduce the number of uninsured children. Thus, funding decisions complicate states efforts to evaluate the real impact of CHIP.

Insurance Rates And CHIP

Even if an accurate baseline of uninsured children is found for all states, changes in the health care marketplace, employment trends, welfare reform, and health care costs also will affect rates of insurance coverage. Few, if any, states possess the technical capacity to track marketplace trends and draw conclusions about the impact of one program, CHIP, on reducing the rate of the uninsured. Since we cannot determine what would happen to the rates of low-income, uninsured children absent CHIP, how can we determine CHIP's impact on rates of coverage?

Crowding out private coverage. States raise concerns about the law's requirement to ensure that children with private coverage do not drop that coverage for public coverage, to guarantee that CHIP funding does not "crowd out" private and employment-based coverage. The law requires states to report on children's "access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends. States note that these "crowd-out" provisions raise important policy questions, such as, If congressional intent is to increase and improve coverage, does it really matter if a family chooses CHIP over employer-based or Medicaid coverage, and is it crowd-out if CHIP provides a better or more affordable benefit than a private plan would provide?

States' attempts to meet crowd-out provisions are hamstrung by other provisions in the law. For example, some suggest that low CHIP premiums create an incentive for families to drop private coverage. Those states argue in favor of charging higher premiums in CHIP, which mirror those in the private sector. However, the law limits cost sharing to 5 percent of a family's income. Others suggest that using CHIP to allow eligible children to buy in to available private coverage would strengthen employment-based coverage, but they point out that such provisions are, at best, difficult to implement and raise serious, long-term equity issues.

Evaluation requirements. States wonder out loud whether complex and costly data evaluation and analysis on crowd-out is justified. To track coverage before and after CHIP eligibility, states would likely need to ask more questions at application. Yet to increase the size of the application flies in the face of efforts to reach and enroll as many children as possible through a streamlined, simplified application process. To track what happens to children who disenroll from CHIP is likewise a complex and costly undertaking.

These tracking mandates require changes in current management information systems. Many states have made clear that given current demands to meet year 2000 (Y2K) compliance, any data and information changes required by CHIP simply must wait until next year. This is particularly true for Medicaid expansion programs.

Comparing State Data

Because CHIP is a state/federal program, states have flexibility in program design and scope. Many strategies have been set in each state plan to meet state-defined goals. Even if states report on how their programs are meeting those goals, it is unlikely that such reports will yield comparable or national data.

Finally, the considerable and costly federal reporting requirements may not address many key questions states want answered, such as, What outreach strategies work? What is the impact of a simplified application? Are eligible children receiving needed and appropriate care? How many children are enrolling and being retained? How are services being provided to special-needs children?

States have embraced the importance of accountability for CHIP resources. However, they recognize the scale of the hurdles ahead. States have agreed to convene a small work group to draft an evaluation report template of consistent reporting definitions. Such a document may provide standardization of reporting while allowing states to use those elements of the template that best reflect their CHIP program designs. The National Academy for State Health Policy (NASHP) will convene a work group this winter, in collaboration with the American Public Human Services Association and the National Governors' Association, and will work with states and the federal government to propose a reporting tool for states.

THE SPEED WITH WHICH this critically important new program was enacted and implemented is testimony to the commitment of Congress, the federal government, and states to find and serve uninsured children. However, some critical reporting and evaluation aspects have not been fully developed. The restriction on administrative funds constrains states capacity to comply with evaluation mandates. States cannot now go back-particularly given the limits on resources-to create baseline information. But to continue to debate the utility of various data sources could become a dangerous distraction, masking important information about how the program is working and serving children in need. All stakeholders must accept the limits of program reporting and evaluation, must work with the baseline data states established for themselves in January 1999, and must work together to get the best and most meaningful

information possible.

This paper reports on key concerns raised at a meeting convened 7-8 December 1998 by the National Academy for State Health Policy, with support from the David and Lucile Packard Foundation, of state CHIP officials, representatives of federal agencies, congressional staff, and children's advocates, to assist states in meeting CHIP reporting and evaluation obligations.

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Challenges in securing access to care for children

BYLINE: Halfon, Neal; Inkelas, Moira; DuPlessis, Helen; Newacheck, Paul W

ABSTRACT: Congressional approval of Title XXI of the Social Security Act, which created the State Children's Health Insurance Program (CHIP), is a significant public effort to expand health insurance to children. Experience with the Medicaid program suggests that eligibility does not guarantee children's enrollment or their access to needed services. This paper develops an analytic framework and presents potential indicators to evaluate CHIP's performance and its impact on access, defined broadly to include access to health insurance and access to health services. It also presents options for moving beyond minimal monitoring to an evaluation strategy that would help to improve program outcomes. The policy considerations associated with such a strategy are also discussed.

PROLOGUE: The State Children's Health Insurance Program (CHIP) is the most recent concrete step taken by the Clinton administration and Congress toward assisting the growing number of uninsured Americans. Passed in 1997 as part of the Balanced Budget Act (BBA), the program enables states to provide coverage for children in several ways. As states begin implementing their CHIP plans, it is important for policymakers to evaluate how well these plans are improving access to insurance as an important step toward access to appropriate health care. In this paper Neal Halfon and his colleagues present an access pathway model, tracing the various routes by which children can obtain the coverage they need. Using a model such as theirs enables a national evaluation that can take into consideration the heterogeneity of states' responses.

Halfon, a pediatrician, is professor of pediatrics at the School of Medicine and professor of community health sciences at the School of Public Health, University of California, Los Angeles (UCLA). He received his medical degree from UC Davis and a master of public health degree from UC Berkeley. Moira Inkelas, who holds a master of public health degree from UCLA, is a doctoral fellow at the RAND Graduate School. Helen DuPlessis, the second pediatrician on the author team, is associate medical director of LA Care Health Plan. She holds a medical degree from UC San Francisco and previously served as director of student medical services for the Los Angeles Unified School District. Paul Newacheck is professor of health policy and pediatrics at the Institute for Health Policy Studies and Department of Pediatrics, UCSF.

THE RECENT PASSAGE OF the State Children's Health Insurance Program (CHIP) represents a significant investment in children's health insurance. Yet questions have been raised about whether the program will reach a substantial portion of the nearly ten million children who are now uninsured.¹ Government estimates suggest that only a small proportion of potentially eligible children will actually become insured.² The effectiveness of CHIP in extending health insurance to uninsured children is an important public policy question, because any extension of CHIP funding past the program's ten-year authorization will depend on how well the program expands children's access to health insurance and care.

This paper presents an analytic framework and potential indicators for use by federal and state agencies to evaluate CHIP's impact on children's access. Access in this paper includes access to health insurance, as measured by enrollment and retention of coverage over time, and access to health services, as

measured by availability and use of services. We present a conceptual approach to evaluate and measure access; methodological challenges for evaluating the CHIP program; recommendations for a set of indicators and monitoring approaches; and a discussion of the challenges and opportunities that policymakers will face in moving this effort forward.

Background On Children's Health Insurance

CHIP, enacted as Title XXI of the Social Security Act, provides \$ 20.3 billion in federal matching funds as block grants to states in the years 1997-2002 and additional funds for the subsequent five-year period.³ CHIP targets uninsured children in low-income families and represents a compromise between those who advocated Medicaid as the vehicle for health insurance expansion and those who preferred a new, private-sector alternative. CHIP allows states to provide coverage to uninsured children by expanding Medicaid, by instituting a separate health insurance program, or by a combination of Medicaid expansion and a separate state program. Most states (twenty-five) have opted to expand Medicaid eligibility, while others are creating separate state child health insurance programs or expanding existing programs (thirteen states) or using a combination of Medicaid and separate state programs (ten states). Title XXI stipulates that at least 90 percent of the funds be used for the expansion of coverage and up to 10 percent, for administration and outreach. Although CHIP targets children with family incomes below 200 percent of the federal poverty level, special provisions exist for states that have already expanded coverage beyond that level or that plan to do so. Title XXI also includes provisions to give continuity of coverage once enrolled (through eligibility guarantees), to limit "crowding out" (substitution of CHIP coverage for existing private coverage), and to bolster faltering Medicaid programs by encouraging eligible children to enroll in Medicaid.

Although there is significant interest in evaluating CHIP's impact on children's access to care, the programs structure suggests a broader evaluation that extends to CHIP's impact on health insurance coverage for low-income children generally and its direct and indirect effects on enrollment in state Medicaid programs. Designed as a state-based program with a wide range of options and flexibility, CHIP will be implemented differently across states. Some states are implementing CHIP as the "middle story" of a three-story house by wedging CHIP between existing state Medicaid programs and private coverage. Others are using CHIP funds exclusively to promote enrollment in Medicaid for the estimated 4.7 million children who are potentially eligible yet remain unenrolled.

It thus will be difficult in most states to evaluate CHIP in isolation from Medicaid programs or to focus evaluations on incomeeligible children without considering children who may become eligible for CHIP as a result of family income fluctuations or changes in the family's employer-based coverage.

Opportunities And Challenges

Accounting for state options in a national evaluation. Good arguments can be made about the merits of one comprehensive, national evaluation of CHIP. However, several methodological issues need to be considered, given the variability in states design and implementation strategies. The general approach for measuring CHIP's impact on insurance status and access must be responsive to this variability. Observed variability in access across state CHIP programs may be attributable to state program options (for example, cost-sharing requirements) as well as to program implementation (for example, outreach efforts, access to providers, and such). In fact, some program options that states may exercise, such as cost sharing, lockout, and benefit limitations, are known from previous studies to pose significant barriers to access.

Measuring access across public insurance programs. CHIP's impact may extend beyond enrolled children. To fully capture this impact, evaluations must include indirect effects on states' total insurance coverage for children up to age eighteen through improved eligibility screening and Medicaid enrollment, at minimum. CHIP also may change the profile of coverage for children by causing crowd-out effects. Thus, there is an opportunity to evaluate CHIP's impact in terms of how many children enroll, but also to evaluate children's access to Medicaid and private health insurance in a combined effort to evaluate access for all low-income children.

Using measures to stimulate improvement. Access measures can be used not only to monitor program impact but also to stimulate ongoing improvement in a public insurance program's administrative and enrollment procedures.⁸ As CHIP evaluation strategies are developed, states can draw from experiences nationwide with the shortcomings of past Medicaid expansions by putting mechanisms in place to continuously improve outreach and enrollment. Analysis of insurance coverage estimates from the 1996 Current Population Survey (CPS) underscores the importance of these activities: Only 57.4 percent of the child population eligible for Medicaid as a result of Medicaid (noncash assistance) expansions was enrolled. Continuous quality improvement approaches are increasingly being used by health plans and by health care providers to stimulate improvement. Application of such techniques to improve outreach and enrollment procedures in public insurance programs are arguably long overdue.

Strengthening national monitoring of children's access.

As evaluation of CHIP's impact begins, there also is an opportunity to refine and expand national monitoring of children's access to and use of health care. Public and private data-collection activities could be improved by more uniformly collecting access and utilization measures and extending their use to monitoring CHIP.

Developing better measures of children's access. Finally, the implementation of CHIP provides an opportunity to develop and implement child-specific measures of access to care. Various governmental and nongovernmental agencies have greatly expanded their monitoring of access in recent years.⁹ However, much of this work has been focused on adults.¹⁰ As part of a public/private initiative to develop satisfaction measures through the Consumer Assessment of Health Plans Study (CAHPS), new survey questions on access to and satisfaction with care have been developed for children, and targeted survey instruments are being developed to focus on children with special health care needs. The CAHPS instruments or a subset of items could be built into CHIP evaluation tools and supplemented with items from other access domains to produce a useful set of access measures for children.

An Approach To Monitoring Access In CHIP

Access, a multidimensional concept, has been defined as the degree to which individuals or populations can obtain necessary health care. The original framework developed by Ronald Andersen and LuAnn Aday for studying access to care is still widely used today. This model highlights how the organization and availability of health care services, and the personal predisposing and enabling characteristics of individuals, interact in the health care system and affect access to care. These interactions influence how health services are used as well as consumers satisfaction with their care. Recent variations on this framework emphasize the role of agencies and institutions in affecting access and account for the hierarchies of accountability that are emerging in the health care system.

In this section we present a multistage approach to conceptualizing and monitoring access, using measures of access to health insurance and to care. The proposed measures focus on how determinants

of access contribute to overall CHIP outcomes: enrollment and retention, in the case of access to health insurance, and use of developmentally appropriate care, in the case of access to care. From a public policy viewpoint, it is important to consider how access can be improved; thus, the approach draws attention to ways that states can improve enrollment rates. Such procedures are critical components of a state's capacity to expand health insurance coverage.

We have developed an access pathway model (Exhibit 1) to assess CHIP's impact on children's access to health insurance and to medical care. The model provides a dynamic representation (from the perspective of a potential beneficiary) of the pathway to enrollment, obtaining services, and ultimately achieving desired health outcomes. The model, divided into two phases, illustrates key processes of outreach and education, enrollment, and use of services.

In this model, access is the product of multiple factors and processes that facilitate or hinder both enrollment in health insurance and use of health services. Viewing access as a pathway helps to identify the critical factors and processes that affect access and provides a useful framework to identify measures for evaluating both the effectiveness of enrollment and outreach and CHIP's impact on use of care and ultimately on children's health. The measurement strategy that we propose would include different measures for the enrollment phase and for the utilization phase. Because accountability for access resides at various levels of the health care system, much of the enrollment phase is the responsibility of state or local government agencies, whereas the utilization phase is largely the responsibility of the health plan and provider.

The Enrollment Phase

Evaluating the enrollment phase of the access pathway is particularly important because previous evaluations of Medicaid's education, outreach, and enrollment efforts demonstrate that many states fall far short of enrolling all children eligible for Medicaid." Moreover, children's initial enrollment and retention in private employerbased health coverage also has fallen short of its potential." The access pathway model illustrates four domains of CHIP program procedures that affect children's enrollment: (1) education and outreach, (2) initial enrollment, (3) retention, and (4) transition. To monitor the impact of enrollment procedures on children's access, we propose a measurement strategy that characterizes structural aspects of each procedure, the processes involved, and the expected and desired outcomes at each juncture and across the entire enrollment phase. Exhibit 2 presents examples of these measures.

Constructing measures. Several important measures require population-based estimates for the denominators. Examples include the proportion of children who are eligible to enroll, the proportion of eligible children who enroll in a specific time period, and the proportion of enrolled children who are continuously enrolled. Different denominators are required for enrollment measures because enrollment-phase processes target different populations. For example, education and outreach procedures target eligible children as well as those who may become eligible, while enrollment, retention, and transition procedures target only those enrolled in the program.

Data sources and measure development. Outcomes and process measures of enrollment would come largely from information, gathered directly from families (via surveys and focus groups), that captures knowledge of the program by families of enrolled children and families of eligible but unenrolled children, and that assesses families experiences with the enrollment process. In some cases, the data collection may target a population subgroup in which children's enrollment or family knowledge is a particular concern. Most structural measures would be derived from administrative data and from documents that describe state program procedures and protocols.

Enrollment-phase measurement is challenging because few standardized or routinely used measures exist and because sampling frames differ from those used to measure access to services. Given the new programmatic relationships that CHIP will create in many states, new measures will be needed to monitor new procedures, such as how well eligible children and families move between Medicaid and CHIP programs following changes in income or other eligibility requirements. Developing valid measures is vital because procedures put in place to facilitate movement between the programs could greatly affect CHIP enrollment.

In addition to the relatively straightforward structure, process, and outcome measures that we have specified, new or "stretch" measures may be considered. Stretch measures are those that characterize important structures, processes, or outcomes for which validity and/or feasibility has not been sufficiently demonstrated in either research or evaluation literature.¹⁸ An example is the level of integrating CHIP education and enrollment activities in schools; Women, Infants, and Children (WIC) nutrition programs; and Head Start.

The Utilization Phase

A number of measures have been implemented in national surveys and other evaluation programs to measure access to health services. Access is measured and described in various ways in the health services research literature. Some indicators directly measure it by characterizing utilization patterns. Examples of direct access measures are volume of physician visits, compliance with recommended preventive care schedules, and continuity of care with one provider. Other indicators indirectly measure access through proxies, such as provider availability, health outcomes, and patterns of health care use that suggest poor access to care.²⁰ Indirect measures of access include avoidable hospitalizations for conditions sensitive to ambulatory care, inappropriate emergency room use, and diagnosis rates for specific pediatric medical conditions that indicate lower quality of health screening.

Utilization measures and related indicators of access derived from the literature and past population surveys have been summarized elsewhere. These measures fall into several general categories that incorporate the most frequently cited access domains: (1) having a usual source of care and choice of providers; (2) physical access and travel and waiting time; (3) coverage of services; (4) availability of services (including having knowledge about a plan and how to get access to covered services), which includes programmatic characteristics that are specific to health plans or to providers (such as costs of using services); and (5) use of care (including use of as well as barriers to receipt of specific services).

If comparisons across states are to be achieved, a process is needed to select a core set of indicators from the many available access measures that are now in use. A core set of indicators should include representative measures for each major domain of access to care shown in the access pathway model.

Data Sources And Survey Mechanisms For Evaluation

Although the federal legislation that authorized CHIP requires states to report on enrollment of eligible children, no population-based national-data-collection mechanism is yet in place to monitor changes in children's enrollment and access. Ideally, one or more of the existing national health surveys might be used for this purpose.²⁴ No national survey now provides the necessary data for monitoring CHIP at the state level. Two ongoing national surveys with substantial access-to-care sections—the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS)—cannot generate statistically reliable state-level estimates for most states. The CPS is another potential source of data for

annual statelevel estimates of uninsured children. However, the CPS does not have a large enough sample size to monitor state-level changes in insurance status according to demographic and other important characteristics, and there are methodological difficulties in estimating insurance rates.⁶ Moreover, the CPS contains no access questions. Most major privately funded surveys, such as the Robert Wood Johnson Foundation's Health Tracking study, the Urban Institute's Assessing the New Federalism project, and the Kaiser/ Commonwealth Survey of Low-Income Families, are infrequently fielded, change formats across surveys, and are not large enough to permit state-level estimates for all states." However, these surveys could be used to focus on particular states or locales or could be modified to better meet state-level evaluation purposes.

A comprehensive approach to effectively assessing CHIP's impact on access to care would coordinate federal and state evaluation strategies. The federal government is ultimately accountable for the implementation of CHIP and should be encouraged to take the lead in the further refinement of these strategies. However, this agenda will require technical and financial support of states activities and recognition of states options and constraints. Here we outline a series of options that federal and state governments can consider.

Monitoring CHIP using national population-based surveys.

One data-collection option is to use the State and Local Area Integrated Telephone Survey (SLAITS). This population-based survey could be administered as a cross-sectional survey or could be organized in two or more phases to permit a longitudinal evaluation beginning with the initial CHIP implementation. A minimum sample size of approximately 2,000 potentially eligible children in each state would be adequate for basic access information. However, it may not be cost-effective to survey more than 100,000 persons nationally with representative estimates for all fifty states exclusively to evaluate CHIP (a voluntary program that may cover a total of three million children). Such state-level data collection might be better justified if it focused more broadly on all low-income families (below 200 percent of poverty) with children or if each round of the survey targeted different sets of states over time.

Another approach is to modify the NHIS to permit state-level estimates by oversampling in smaller states. To conserve costs, selected states could be oversampled on a rotating basis, which could permit annual estimates of CHIP's longer-term performance for ten to fifteen states each year. Or states could be selected based on the number of potentially eligible children, different program types, different state eligibility requirements, and different lockout provisions, or a combination of these and other characteristics of interest in CHIP programs. Another option is a hybrid approach using both NHIS augmentations in some states and SLAITS in others.

State-level monitoring approach. The federal government also could help states to set up routine monitoring efforts. These efforts could be based on a mixed strategy that uses encounter, enrollment, retention, and transition data; data from the Health Plan Employer Data and Information Set (HEDIS); and other administrative data sources. This approach would require a significant federal investment to develop the administrative reporting mechanisms that would help states to monitor their programs and implement the core data collection.

Some states would need to make more of an investment in improving their internal data collection, analysis, and reporting capacity related to children's health care coverage. Such internal datacollection capabilities are essential if states are to implement any type of quality-improvement mechanisms for improving enrollment and ongoing access expansion. Since states have limited funds for these purposes, additional financing from the federal government or other private funding partners would be needed. The

recently introduced Child Health Care Quality Research Improvement Act has designated funds that could support this process.

An opportunity also exists to coordinate the collection of access measures with ongoing private- or public-sector efforts within states. For example, individual states could integrate core data collection and reporting under CHIP with ongoing Medicaid and Title V reporting. States also could coordinate CHIP reporting with HEDIS reporting by health plans. A children's version of the CAHPS Access and Satisfaction Survey will be required as part of HEDIS in 1999. This instrument could be applied to all CHIP enrollees, whether in prepaid health plans or in fee-for-service systems and whether or not they use care in a particular time period. Using a common instrument such as CAHPS would provide important comparability across Medicaid, CHIP, and commercially/privately insured populations. Enrollment-phase measures would not be covered, however, and another survey instrument and sampling frame would be needed for these measures.

Refining And Developing Measures

Refining, selecting, and implementing access measures for use in all states to evaluate both the enrollment and utilization phases remains a significant task. An expert working group could be convened to build upon the access pathway framework and available measures and to identify common measures to include in a core data set for reporting on access. Such a working group could be convened by those federal agencies that are responsible for implementing and evaluating the CHIP legislation, in conjunction with states and organizations representing state governments (for example, National Governors' Association and National Conference of State Legislatures) and state health policymakers (National Academy of State Health Policy). This process could resemble other measurement selection processes, such as the National Committee for Quality Assurance's (NCQA's) HEDIS, by involving states as participants in the review and measure-selection process, but it would have a narrower focus and occur within a shorter time period.

Criteria for inclusion of measures in such a minimum data set would include relevance, validity, and feasibility. As in the NCQA's HEDIS process, the measurement-selection group should continue to meet periodically to review new "stretch" measures and to evaluate how well the initial measures are working. This type of process also could be used to expand measures of access more broadly to include new and better measures of access for low-income children covered by state Medicaid programs. Optimally, over the next five to ten years, such a measurement effort would yield a set of measures and data sets that would permit states to monitor the impact of CHIP and Medicaid on low-income children and families.

Although the process of developing measures and expert consensus is easily outlined, obtaining the financial support needed to implement a comprehensive monitoring approach is a considerable challenge. Issues to address include the federal role in underwriting such efforts, roles of private foundations, and opportunities for public/private partnerships in these efforts.

Policy Considerations

A number of policy issues must be resolved, in addition to the methodologic and technical issues we have outlined. A comprehensive, national evaluation strategy would need to incorporate common evaluation elements and approaches to allow cross-state comparisons in access, while building a set of customized measures useful to states that are implementing various program options. A national evaluation also will need to place state implementation and performance in the context of states administrative choices.

The Health Care Financing Administration (HCFA) plans to develop national performance standards, including access measures, that will be common across states. Title XXI only requires that HCFA mandate states to report on a limited measurement set that focuses on fiscal accountability and basic enrollment information. Because CHIP funding is provided through a capped block grant for a voluntary program, it is unlikely that all states would accept more stringent data-reporting requirements. Moving beyond basic required data collection, to include evaluation of enrollment, access, quality, and outcomes, will depend on states' choices.

Basic data collection or quality improvement? Moving a national evaluation effort forward requires reconciling what states are required to do to evaluate CHIP versus what they could do to improve their programs' effectiveness. States' options for evaluation can be viewed as a series of concentric circles. At the core, all states must report the minimum data set required by HCFA. A higher level of evaluation would capture the full impact of CHIP on the numbers of children who are insured and who remain uninsured, as well as the impact of CHIP and Medicaid-related changes in access to care. This level of evaluation would require an expansion of data collection to include population-based surveys. Finally, states could expand their evaluation activities even further to permit ongoing program improvement based on information on key procedures. For real-time quality improvement to be supported at the state level, greater data and information capacities would be required.

Evaluating access for all low-income children. States and the federal government also should consider how to use this opportunity to evaluate access to coverage and services for all low-income children potentially eligible for either Medicaid or CHIP. As states and the federal government consider the costs of these different evaluation options, the potential for cost efficiencies should be explored. By expanding the scope of evaluations to all low-income children, some economies of scale could be realized. Because the combined expenditures in any state for CHIP and Medicaid are sizable, a relatively small expenditure of allocated funds for evaluation and improved performance might be justified on several grounds. Such evaluation efforts should result in greater programmatic efficiencies, fewer administrative transitions and costs, and smaller numbers of children in and out of various insurance programs. States also may find that this new information allows them to maximize potential federal matching funds. Given that children living below 200 percent of poverty represent nearly 40 percent of all children, that these children carry the greatest burden of illness, and that the timely provision of health services can maximize longterm health development and save future costs, a broader and more inclusive evaluation strategy can be justified. Moreover, many states are using CHIP to expand and modify Medicaid coverage and are implementing new enrollment forms and procedures for both Medicaid and CHIP while also engineering linkages between Medicaid and new state CHIP plans to facilitate transitions.

WE HAVE OUTLINED FEATURES of an optimal national evaluation of CHIP, along with some key implementation options. However, a number of political issues still must be resolved. States and the federal government must agree on how to work together to accomplish the program's goals. In particular, they must collaborate in designing an evaluation strategy that meets federal needs for comparable outcome data across states as well as state-specific data needs for program impact evaluation and for program management and ongoing improvement purposes. States might find a federal partnership attractive if the federal government can provide financial support, critical technical support, and access to federal data-collection efforts.

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Health Line
March 22, 1999

CHIP: HEALTH AFFAIRS REVIEWS IMPLEMENTATION

Three articles in the current issue of Health Affairs take a look at whether the Children's Health Insurance Program is meeting its goal of reducing the number of uninsured children. In the first article, researchers use data from the 1996 Medical Expenditure Panel Survey to estimate that 3.1 million uninsured children from families earning up to 200% of the federal poverty level will be eligible for CHIP in 1999. Under current state plans, some of which have lower eligibility thresholds, 2.6 million children will be eligible. Hispanic children account for 29.5% of those eligible, and black children for 19.9%. Teenagers represent 39.4% of the CHIP eligible population. "CHIP eligible children are projected to be disproportionately located in the South," according to the analysis. However, the study predicts that under the current 200% federal eligibility threshold actual CHIP enrollment will be 1.8 million children in the first half of 1999 and under current state plans it will be 1.5 million children. The study concludes that outreach is critical to reaching unenrolled, eligible children (Selden et al., March/April 1999 issue).

BACK UP

In a separate piece, Trish Riley, executive director of the National Academy for State Health Policy, says that in its rush to enact the program, Congress may not have given enough attention to its provisions for reports and evaluations. As it stands, Congress requires participating states to submit annual reports and a comprehensive evaluation to HHS by March 2000. However, Riley says that states "simply may not be able to provide the breadth and depth of information included in these mandates." Congress capped states' outlays for CHIP administrative costs at 10%, and Riley says that most of the administrative funds are diverted to outreach efforts rather than program evaluation. One of the most controversial congressional requests is deceptively simple, says Riley: a state-level analysis of progress in reducing the number of uninsured children. Without an accurate way to predict the number of uninsured children -- the Current Population Survey, state-level samples, the Medical Expenditure Panel Survey and the National Center for Health Statistics survey are all considered either inappropriate for a state-level analysis or prohibitively expensive -- states must provide an "imperfect" estimate. Nonetheless, the figures provide the "baseline for determining states' success or failure in meeting CHIP objectives." States recognize "the scale of the hurdles ahead," concludes Riley, and she warns that "stakeholders must accept the limits of program reporting and evaluation" rather than dwell on the limitations of the data collection process (Riley, March/April 1999 issue).

THE NOT-SO-EASY ANSWER

In the final piece, Neal Halfon of the University of California-Los Angeles offers a model for tracking children's access to CHIP. Halfon develops a multistage approach to monitor access using a "pathway model" to track education and outreach, initial enrollment, retention and transition. Suggesting a comprehensive evaluation strategy for access that is coordinated on both the federal and state level, Halfon says that the "federal government is ultimately accountable for the implementation of CHIP and should be encouraged to take the lead." Calling for an expert working group to "build upon the access pathway framework," Halfon notes that the federal agencies responsible for CHIP implementation could work hand-in-hand with state agencies. Conceding that "a number of political issues still must be resolved" before the implementation of any national CHIP evaluation, Halfon concludes that states and the federal government must "collaborate in designing an evaluation strategy"

that meets evaluation requirements and serves "ongoing improvement purposes" (Halfon et al., March/April 1999 issue).

U.S. Newswire
March 15, 1999 14:57 Eastern Time

NHMA Joins White House to Target the Estimated 25 Percent of Uninsured Hispanic Children
CONTACT: Carol Castaneda, 703-351-5666, for the National Hispanic Medical Association

Officials of the National Hispanic Medical Association said they are teaming up with the White House in a new program aimed at insuring nearly 11 million children who lack health insurance -- an estimated 25 percent are Hispanic.

"One out of three Hispanics in this country have no health insurance and that figure is even higher for Hispanic children," said Dr. Elena Rios, president of the National Hispanic Medical Association (NHMA). "President's Clinton's program would help all parents make sure that each child in the nation has access to proper health care."

At the group's convention in Washington, D.C., March 19-21, the National Hispanic Medical Association also will launch several leadership programs, targeting Hispanic doctors, medical residents and medical students. Physicians from across the United States will gather here for the group's third annual convention called, "A National Agenda: Increasing The Number Of Healthy Hispanic Families."

"We want to identify doctors who are interested in becoming national leaders so they can help create policy programs that improve health care for Hispanic communities," said Rios, a Washington health policy expert.

About 20 doctors will be selected for a leadership fellowship program each year in New York and Washington. During the program, fellows will attend New York University's Wagner Graduate School of Public Service where they will learn about state and federal health policies.

In the fall, a leadership program for medical residents will be launched in California. In Texas, a mentorship program for 100 Hispanic medical students was launched in January at the University of Texas Health Science Center in San Antonio. The program pairs Hispanic students with doctors for career guidance.

"One way Hispanic doctors can now serve as leaders in their communities is by getting the word out that children do not have to go without medical care," said Rios. "They can help spread the word that health care insurance is now available."

The Children's Health Insurance Program (CHIP) helps parents seek Medicaid or state health coverage for their children in a campaign called, "Insure Kids Now." For many families, their income is so low they cannot afford to buy health insurance, said Rios. Others may qualify for Medicaid but fail to apply due to language barriers, lack of knowledge, intimidation and other factors, she said.

"As a result, research shows that the uninsured are sicker than other people," said Rios. "Now there is a cure to this nationwide problem and all of us can help." More information about the program is available by calling toll-free 1-877-Kids-Now.

The National Hispanic Medical Association is a non-profit organization that represents Hispanic physicians and others dedicated to improving health care for Hispanics. 202-265-4297.

CHIP: WASHINGTON, TEXAS SENATES PASS BILLS

The Washington Senate passed a measure Thursday that would launch the state's Children's Health Insurance Program, which would leave Wyoming as the last state to jump on board the federal initiative, the Spokane Spokesman-Review reports. The Washington CHIP would require state spending of up to \$4 million to obtain \$7 million in federal matching funds over the next two years, insuring up to 9,000 children. Although the bill sailed through the chamber 38-7, it may fare worse in the House, "where Republicans last year killed a similar proposal and say they will try to do it again this year." Opponents contend that the upper limit for qualifying children, 200% to 250% of the federal poverty level (\$27,000 to \$34,000 for a family of three), is too high. State Sen. Joe Zarelli (R) argued that "people who would qualify are generally capable of buying their own insurance." The state Senate also approved Thursday a bill to expand the Basic Health Plan, which insures 90,000 children, in rural areas of the state, enabling the state Health Care Authority to offer the subsidized insurance without going through a managed care plan (3/12).

TEXAS EXPANDS CHIP

The Texas Senate passed a compromise plan Thursday to expand the state's CHIP, after weeks of political wrangling in the Senate health committee. Under the expansion, children up to age 10 from families earning up to 200% of the federal poverty level would qualify; children ages 11 to 17 would initially qualify only if their parents earned up to 150% of the federal poverty line, but if officials determined that the state could afford to expand the coverage to the older children, it would ease the income cap. The expanded coverage would be available to an estimated 471,000 children. The Austin American-Statesman reports that Democrats are taking issue with the initial restriction, arguing that "the state has enough money to provide the program to all children in families with income reaching 200% of the poverty level" (Elizondo, 3/12).

K- CHIP LAGGING

Fewer than one in ten uninsured Kentucky children eligible for the state's K-CHIP program have been enrolled, or slightly more than 6,000 of the 78,000 eligible, health officials told state lawmakers Thursday. "We're not up with other states, we're farther behind," said state Sen. Marshall Long (D). "My God, Mississippi is ahead of us in something," he said, charging Kentucky has failed to sufficiently advertise the program (Wolfe, AP/Owensboro Messenger-Inquirer, 3/12).

The Boston Globe
March 14, 1999, Sunday ,City Edition

Think big on Medicare;

BYLINE: By Robert Kuttner

The bipartisan Medicare commission is currently stalled over a proposal by its chairman, Senator John Breaux, Democrat of Louisiana, to turn the program into a voucher. Breaux wants eligible people to get a fixed sum, which they could use to buy whatever policies they could afford.

Most Democrats on the commission are holding out for additional benefits, such as prescription drug coverage. They also vetoed Breaux's initial proposal to raise the Medicare eligibility age.

But the problem with the Breaux plan is not the details. The whole approach is a terrible idea.

Government would "solve" Medicare as a budgetary issue - by displacing the costs onto elders. Less affluent people would be forced to settle for stripped-down policies (79 percent of the elderly live on less than \$25,000). The managed care industry would spend a fortune marketing its products to relatively healthier oldsters.

Instead of limiting benefits and putting elderly people at the mercy of the managed care industry, we should repair Medicare's solvency by gradually making it universal. There is probably enough money wasted in the current health system on marketing, risk-selecting, claims processing, and profiteering to cover everyone for roughly what we now spend while leaving 43 million Americans uninsured.

With an aging population, we might also elect to spend more of our total national income on health care. In an era of endless budget surpluses and rising national wealth, this is a perfectly reasonable choice. However, we should not favor the elderly - the only group that now enjoys universal coverage - at the expense of the rest of the population.

Paradoxically, we could stabilize Medicare's financing and protect the elderly - by expanding its coverage to all Americans:

First, let's cover kids. Children under 21 are relatively cheap to insure, because most don't get seriously ill. Government already pays a large share of kids' insurance, through a patchwork of programs that includes Medicaid and the new Children's Health Insurance Program (CHIP). About one child in four is already covered by government.

Edith Russell of the Economic Policy Institute calculates that it would take some \$60 billion a year to extend Medicare to every child in America. That figure doesn't count the net savings from folding the fragmentary system into a single program. It also doesn't count the cost of adding full preventive care and prescription drugs (the latter are covered under Medicaid but not Medicare).

The benefits, however, would be enormous. More than 10 million children now lack any kind of health insurance. They either go without care or they get treated in emergency rooms - the most expensive and inefficient venue for treatment.

Russell calculates that the cost of extending Medicare to all children could be financed by an additional

1.54 points on the employer share of the payroll tax. Before you scream "tax increase!" please recall that employers already pay for the insurance of some 55 percent of America's children through company-sponsored health plans.

Responsible employers, who now provide family coverage, would get a cut in their premium costs, which would substantially offset the increased taxes. Free-riding employers who do not provide coverage would pay an additional health tax, as they properly should. Since kids tend to stay well, adding children would supplement Medicare's financial reserves.

After letting the Medicare system digest the addition of children, let's next extend Medicare to people age 55 to 65, say, by 2003. These are people who often pay exorbitant premiums when they lose jobs and have to buy insurance privately.

The total cost of having Medicare pick up this age group would be about \$100 billion a year. But since most people in this group already have some kind of private insurance, the net cost to society would be far less.

Here again, if coverage were financed by new employer payroll taxes, it would be substantially offset by employer savings in insurance premiums. My own preference would be general revenue financing.

By now, half the population would have Medicare. There would be far fewer middlemen taking their slice, and people would have the free choice of doctor and hospital that Medicare offers.

In 2006 we could simply extend Medicare to the remaining population - those between 21 and 55. These people are also, on average, a lot healthier than the elderly and a lot cheaper to insure. And long term cost-containment works much more efficiently in a comprehensive system.

Voila! A solution to Medicare's financing - with universal coverage to boot.

The Houston Chronicle
March 05, 1999, Friday 3 STAR EDITION

76th TEXAS LEGISLATURE; Health insurance plan puts the youngest first; Bill would pay poor kids' premiums for 10 years

BYLINE: POLLY ROSS HUGHES, Houston Chronicle Austin Bureau

AUSTIN - Children aged 10 or younger who lack health care coverage take the highest priority under a children's health insurance plan adopted unanimously by a Senate panel Wednesday.

Senate Bill 445, which attempts to strike the middle ground in the politically explosive issue of children's health care for the working poor, could be taken up by the full Texas Senate next week, its sponsor predicted.

Under the bill, tax dollars would pay health insurance premiums from birth to age 10 if a child lives in a family with income up to 200 percent of the federal poverty level. That's \$ 33,600 for a family of four.

A band of Democrats in the House, however, insist the plan must cover all children at that poverty level, not just the youngest ones, since federal money is available. The Senate plan doesn't go that far, but leaves the door open for broader coverage later.

Fifty-five House Democrats have signed a petition saying that health care for kids is at least as important as tax breaks for the oil industry, declared an emergency by Gov. George W. Bush. Some have threatened to block the oil tax cut if their goals for children's health coverage are not met.

"I feel good in my heart that we have an excellent product, a responsible mechanism to address the needs of the uninsured children of the state," Senate sponsor Mike Moncrief, D-Fort Worth, said after the Senate Health Committee approved his bill.

"I think it would be a travesty to leave behind a legacy of failure," he added, explaining that the state should proceed with fiscal caution. "I don't know of a greater opportunity Texas has ever had or will ever have again to address the needs of so many, not just in this generation, but in future generations."

Politically, stakes are high. Texas ranks at least second in the nation for the number of uninsured children, and every dollar the state puts up for the Children's Health Insurance Program (CHIP for short) would be matched with three more from federal taxes. Plus, the state is sitting on a \$ 2.5 billion budget surplus and \$ 17.3 billion tobacco settlement, of which \$ 500 million a year is dedicated to children's health.

"I think a lot of Democrats believe that the problem of uninsured children in Texas is an emergency that is equally as important as the emergency the governor says exists in the oil industry," said state Rep. Kevin Bailey, D-Houston, head of the Legislative Study Group. "Our goal is just to make sure children's health is treated at least as importantly as the oil industry."

Officially, Bush has said he wants a clear signal from both the House and Senate before deciding what approach to take.

Under Moncrief's bill, children ages 11-18 would be covered only if their families' incomes did not

exceed 150 percent of poverty - \$ 26,300 for a family of four.

Medicaid, the federal health insurance for the poor, would continue to cover children in families the same size with incomes of \$ 16,800 or less.

"We certainly hope the health of these children isn't going to hinge on some political wheeling and dealing," said Lisa McGiffert, a Consumers Union analyst who testified in support of funding health coverage for all children in homes up to 200 percent of the poverty line. "It's about helping families who are working and can't afford health insurance for their kids. It should stand on its own."

Republican leaders estimate the insurance program would cost the state \$ 153 million for the first year, but in a worst-case scenario could escalate up to \$ 360 million a year as more people enrolled.

Meanwhile, House Republicans are willing to pay for coverage of children who are 8 years and younger in families with incomes up to 200 percent of the poverty level, said state Rep. Kenny Marchant, R-Coppell.

He added that he and other Republicans want to "safeguard against getting into a situation . . . where the federal government pulls its funding and we end up with an entitlement program."

PR Newswire
March 3, 1999, Wednesday

Children's Health Insurance Coverage is Related to Family Structure and Income

Between 1977 and 1996, the percentage of children who were uninsured increased substantially, but the increase occurred almost exclusively among children living with only one parent. In addition, the percentage of children in single-parent families with private health insurance increased over this period. However, they were still much less likely to have private insurance and more likely to be uninsured than children in two-parent households. These are the findings of a new study, published in the March 1999 issue of *Medical Care and Research and Review*, that examined health insurance trends, specifically focusing on the relationship between children's family structure and their health insurance coverage.

"This study shows that information on family structure can provide an additional gauge for determining which children are at increased risk of lacking health insurance," said Lisa A. Simpson, M.B., B.Ch., M.P.H., deputy administrator for the Agency for Health Care Policy and Research (AHCPR). "This knowledge can help in developing public policies that are targeted to reduce these gaps and improve the quality of health care services."

Today's findings pre-date implementation of the Children's Health Insurance Program, an effort initially proposed by President Clinton and launched in 1997 to provide coverage to more uninsured children. Working through states, CHIP is aimed especially at providing coverage to children in families with incomes too high to qualify for Medicaid. With \$24 billion set aside over five years, CHIP is the largest single expansion of health insurance coverage for children in more than 30 years.

The authors, Robin M. Weinick, Ph.D., and Alan C. Monheit, Ph.D., researchers at AHCPR, analyzed data from three nationally representative medical expenditure surveys conducted by AHCPR in 1977, 1987, and 1996. They found that family structure plays an important role in predicting children's health insurance coverage. For example, having two employed parents living in the same household greatly increased the chances of children having private insurance. These children also were less likely to be uninsured than those living in two-parent households with only one working parent or those living in single-parent households.

Other findings include:

- * Over this period, the percentage of children covered by private insurance declined, and the percentage of children with public coverage increased.

- * In 1996, over 20 percent of privately insured children whose single parent previously had been married received their coverage from a policyholder who did not live with them, most likely the children's other parent. This compares with a 1987 rate of only 5 percent.

- * Children whose single parents never married were far more likely to be publicly insured in 1987 and 1996 than those whose parents had been married at some point (65.4 percent versus 29.4 percent in 1987; 62.9 percent versus 30.3 percent in 1996).

- * The percentage of children in two-parent families with public coverage doubled between 1987 and 1996, from 6.1 percent to 12.7 percent. This increase was primarily among poor families and those with only one working parent, and was consistent with the expansions in the Medicaid program during this

period.

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Broadcasting & Cable
March 1, 1999

White House unveils healthy dose of PSAs.

BYLINE: Albiniaak, Paige

CBS, Fox pass on White House photo op for new campaign

The White House joined broadcast networks, cable programmers and radio station owners last week in unveiling a media campaign to promote free health care for the nearly 11 million American children without health insurance.

NBC, ABC and Viacom were on hand as President Bill Clinton and First Lady Hillary Rodham Clinton announced details of the \$ 24 billion Children's Health Insurance Program (CHIP) , which was financed by Congress in the Balanced Budget Act of 1997.

CBS and Fox did not attend the event (BROADCASTING & CABLE, Feb. 22), but a CBS source said the network planned to participate in the PSA campaign. Fox was unavailable for comment. CBS and Fox chose not to make a public show of support for the White House's effort because they were unhappy with the administration's position that some broadcast ownership deregulation should be rolled back, sources said.

"Today, we're here to announce an unprecedented commitment from media to business, from the health care industry to grass-roots organizations, all over our nation, to inform families of these new health insurance options," Clinton said at the ceremony. "We begin with an all-out media campaign to reach as many families as possible."

Part of the health care initiative includes a multi-media public service announcement (PSA) campaign. Beginning last Wednesday, the administration began running radio ads in 45 states and PSAs on broadcast and cable networks. The goal was to encourage parents to sign their children up for Medicaid, for which 4 million uninsured children are eligible but not registered. For the remaining 7 million uninsured children not eligible for Medicaid, the administration has set up a tollfree number -1-800-698-4543-so parents can find out how to sign their kids up for free health care provided by the federal and state governments.

NBC will run its own PSA on the program featuring S. Epatha Merkerson of Law & Order. ABC, Viacom (which owns the Paramount Stations Group), Black Entertainment Television and Turner Broadcasting all will run PSAs produced by the federal Department of Health and Human Services. Hillary Clinton will be featured. The National Association of Broadcasters will make the PSAs available to all its member stations, and Univision will run a Spanish version of the ad.

Radio company Bonneville International Corp. has created six PSAs for radio that feature retired Army Gen. Colin Powell. Bonneville will run those PSAs on its 15 radio stations and distribute them nationally through the Ad Council. Bonneville plans to spend at least three years and \$ 7 million working with Powell's organization, America's Promise. That group is working to provide resources for the nation's five million children who are "at risk" because they do not have access to education, health care or safe recreation.

San Antonio Express-News
February 26, 1999, Friday , METRO

Texas seen near bottom in insuring kids

BYLINE: Cindy Tumiel; Express-News Staff Writer

Nearly one in four children in Texas has no health insurance, even though most of them have parents who work, a new study by a national health care consumer group says.

Texas has the second highest number of uninsured children among the 50 states, Families USA said in a report released Thursday.

The children are disproportionately Hispanic, and 88 percent of them have parents who work full time or part time, the study said. The report is additional fuel for childrens' advocacy groups that are currently lobbying the Texas Legislature to take maximum advantage of a new federal-state health insurance initiative.

Texas could extend coverage to 500,000 of the estimated 1.4 million uninsured children if it provides maximum matching funds for the Children's Health Insurance Program (CHIP).

The program provides \$3 in federal money for each \$1 in state funds pledged to help children whose parents earn too much to get Medicaid.

"There is no downside to this program. It should be funded at its full capacity," said Dr. Arthur Marlin, a pediatric neurologist and chief executive officer of Methodist Healthcare System.

He was one of a dozen CHIP supporters who gathered Thursday in Milam Park with officials of Families USA to talk about the study.

The consumer health advocacy group compiled data from 1995 through 1997 from a variety of sources, including Census Bureau population surveys, the Employee Benefit Research Institute and several state agencies.

It concluded that 1.4 million Texas children - 24 percent - have no health insurance. Nationally, 15 percent, or 11 million children, are uninsured.

"Of all the children in America who are uninsured, one in eight lives in Texas," said Ron Pollack, executive director of Families USA.

Only Arizona has a higher percentage of uninsured children - 25 percent - and only California has a greater number - 1.7 million uninsured children, Pollack said.

But those rankings could change, he said, since both states are about to take maximum advantage of CHIP, Pollack said.

"Therefore, Texas is likely to get to the very bottom," Pollack said.

To get full federal funding of \$500 million, Texas must structure its CHIP plan to cover children in

families earning up to 200 percent of the poverty level, about \$33,600 a year for a family of four.

As currently written, the state plan would cover only children in families with incomes less than 150 percent of poverty, about \$25,200 a year. At this level, just 270,000 Texas children would benefit.

The study found a disproportionate number of uninsured children in Texas are Hispanic - 55.5 percent.

Frances Teran, a representative of the Mexican American Unity Council, urged Gov. George W. Bush to join a growing coalition of state lawmakers who want Texas to beef up its CHIP proposal.

"Bush has reached out to the Latino community, and we are asking the governor to respond to the needs and the priorities of the Latino community," Teran said.

Without insurance to help pay doctor bills, working poor parents often delay medical treatment and can end up in an emergency room with a critically ill child, said Dr. Cynthia Beamer, who works at University Hospital.

Last year, Beamer said she treated a teen-ager with a ruptured appendix who had waited four days before coming to the hospital. His father tried treating his pain with over-the-counter antacids.

**Federal News Service
FEBRUARY 26, 1999, FRIDAY**

PREPARED TESTIMONY OF NANCY ANN DEPARLE ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH & HUMAN SERVICES BEFORE THE HOUSE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE GOVERNMENT MANAGEMENT, INFORMATION AND TECHNOLOGY SUBCOMMITTEE SUBJECT - YEAR 2000 CHALLENGE

Chairman Horn, Congressman Turner, distinguished committee members, thank you for inviting me here today to discuss my highest priority -- the Year 2000 computer challenge. I am happy to report today that, despite serious concerns about the Health Care Financing Administration's (HCFA) ability to meet this challenge, we are making remarkable progress. In fact, I am confident that HCFA's own Year 2000 systems issues will be resolved well before January 1, 2000.

Our foremost concern has been, and continues to be, ensuring that our more than 70 million Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries continue to receive the health care services they need. We are aggressively addressing Year 2000 issues in those systems over which we have responsibility. And we are engaging in an unprecedented outreach effort to raise awareness and provide information to those other parts of the health care system where we have little authority and control. I want to personally assure beneficiaries that the care they have come to expect from our programs will continue throughout the millennium transition.

Medicare is the most automated health care payer in the country. We process nearly one billion claims annually, most electronically. In fact, 97 percent of inpatient hospital and other Medicare Part A claims and 81 percent of physician and other Medicare Part B claims are submitted electronically to the Medicare claims processing contractors. Most claims are processed to payment by entirely electronic means. This high level of electronic billing has allowed us to achieve significant operating efficiency and cost savings. This reliance on automated systems, however, has made the Year 2000 computer fix a major challenge. Critical dates in computerized claims processing include the date a beneficiary became eligible, the date a patient was admitted or discharged from a hospital, the date a wheelchair rental began, or the date an enrollee entered a managed care plan.

Renovating all these systems has been complicated. Each system used by our programs and our 60-plus claims processing contractors, as well as interfaces with State Medicaid programs, banking institutions and some 1.3 million providers has to be thoroughly reviewed and renovated by those responsible for each particular system. Our renovation standards require that systems be tested individually, as well as with the exchanges they perform with other partners. To fix the Medicare systems alone, we have had to renovate some 49 million lines of internal and external systems code to find date-sensitive processes. We have had to repair all of our Medicare-specific software so it will work with new versions of vendor-supplied software. We have had to update the operating systems that drive the hardware we use with millennium compliant versions. We also have had to test and upgrade deficient operational hardware, including our telecommunications equipment and software. And we must assure that all data exchanges with thousands of our partners will function properly.

Contingency Planning

Although we fully intend to have our own systems ready long before January 1, 2000, we know we must be prepared in case any unanticipated problems arise. We are undertaking an extensive effort to develop contingency plans for all our mission-critical business processes. Our top priorities in developing these

plans are to:

- Process claims so as to be able to pay providers promptly;
- Prevent payment errors and potential fraud and abuse;
- Ensure quality of care; and
- Enroll beneficiaries.

Contingency planning is an Agency-wide effort with active participation of all of our most senior executives. We are closely following the GAO's advice on contingency planning which they outlined in their August 1998 guidance, Year 2000 Business Continuity and Contingency Planning and in their September 1998 report, Medicare Computer Systems --Year 2000 Challenges Put Benefits and Services in Jeopardy.

We recently completed the second phase of the contingency planning process by reviewing 280 Medicare business processes, performing risk and impact analyses, and identifying the potential impact of mission-critical failures. We are now in the third phase in which we will clarify and document our contingency plans and implementation modes, define events that will trigger use of the plans, as well as establish and train implementation teams should the need arise to execute the plans.

Protecting Beneficiaries

I must stress that our concern must always be focused first and foremost on protecting the beneficiaries and their continued access to care. Providers who fail to fix their own systems, and thus are unable to bill us for services, are strictly prohibited from billing beneficiaries. Beneficiaries are legally protected from liability for bills that Medicare would ordinarily pay, even if the provider is not Year 2000 compliant. To safeguard beneficiaries in the new millennium, we will provide them with a phone number to call to report any inappropriate billings they receive from providers or any difficulties they encounter in accessing care. Our beneficiaries are counting on us. Their health care needs will continue regardless of what day it is.

Concern for States and Providers

It is not enough for HCFA alone to be ready for the Year 2000. Health care provider computers and systems must be Year 2000 compliant in order for providers to be able to generate and submit bills to us. State computers and systems also must be Year 2000 ready for Medicaid and CHIP to continue uninterrupted payment of services. Many States and providers will meet the Year 2000 challenge on time. However, monitoring by us and the General Accounting Office (GAO) indicates that some States and providers could well fail. This is the first time any of us have had to deal with such a problem, and we at HCFA are eager to share the lessons we have learned along the way. We are providing assistance to the extent that we are able. But that likely will not be enough. This matter is of urgent concern, and literally grows in importance with each passing day.

Our own progress in meeting the Year 2000 challenge is due in large part to the outstanding effort and commitment of staff throughout HCFA and at our Medicare contractors. We have been greatly aided by wise counsel from the GAO, and especially by the expert IV&V contractors we hired, based on the GAO's recommendations, to ensure that our Year 2000 work is done correctly. And, importantly, we could not have come so far so quickly without the timely support and funding that Congress has provided.

Providers' Progress

Providers must ready their own systems for the Year 2000 in a timely manner if the health care system is to meet the millennium challenge completely and successfully. One of the first steps, and perhaps the easiest, is changing the format of Medicare claims to allow for 8-digit date fields. Our electronic claims

monitoring indicates that over 98 percent of Part B claims submitters (either physicians/suppliers or their billing agents) are submitting claims with 8-digit date fields. Fifty eight percent of Part A submitters (hospitals and other institutions or their billing agents) that submit claims electronically are also using the 8-digit fields.

It is essential that all providers address the Year 2000 issue. Thus, we recently announced that we would require all claims submitters to start using the 8-digit date format by April 5, 1999. Claims received on or after that date without the new format will not be accepted. That does not mean that providers need to be fully compliant by April 5, but it does mean that we want to be assured that they have started to prepare their systems by, at least, taking this first step. We recognize that providers should be able to test whether Year 2000- compliant claims can be accepted by our claims processing contractors. We are now instructing our claims processing contractors to begin testing with those providers throughout the country who want to submit future-dated claims. We are concerned that providers address other Year 2000 issues as well, not just billing and claims system issues. To ensure continued patient care, providers must take appropriate Year 2000 remediation steps to prepare biomedical devices, as well as clinical and other systems.

Provider Outreach.

Due to the critical need for providers to become Year 2000 compliant, we have launched a broad outreach campaign. Last month, in an unprecedented step, we mailed a letter to all 1.3 million providers serving our beneficiaries explaining the gravity of the Year 2000 problem and providing a checklist for what must be done to achieve compliance. Our provider outreach campaign features a special Year 2000 Internet site, www.hcfa.gov/Y2K, which includes some of the basic steps that can be taken by a Medicare provider or supplier, such as:

- Preparing an inventory of hardware and software programs and identifying everything that is mission-critical to their business operations;
- Assessing the Year 2000 readiness of their inventory as well as options for upgrading or replacing systems, if necessary;
- Updating or replacing systems important to business operations, if necessary;
- Testing existing and newly purchased systems and software and their interfaces; and
- Developing business continuity plans for unexpected problems. Our Internet site also includes links to other essential sites for providers, such as the Food and Drug Administration's Internet site on medical device compliance.

We have developed a speakers' bureau with staff trained to make presentations and answer questions on Year 2000 issues around the country. We are leading the Health Care Sector of the President's Council on Year 2000 Conversion, which includes working closely with provider trade associations and public sector health partners to raise awareness of the millennium issue and encourage all providers to become compliant. And our claims processing contractors are offering providers Year 2000 compliant electronic billing software for free or at minimal cost.

I was pleased that some provider associations have recently announced their intention to assess the Year 2000 readiness of their membership and to step-up educational efforts on the critical nature of this problem. This is an essential undertaking. Quite simply, Year 2000 compliance cannot be a one-way street. Providers also must meet this challenge head on, or risk not being able to receive prompt payment from Medicare, Medicaid, or virtually any other insurer. We welcome Congress' help in making providers aware of the Year 2000 and energizing them to address their part of the problem. I invite you to help us identify opportunities to get the Year 2000 message across and encourage you to stress the

importance of this issue when you meet with providers. As I mentioned previously, we have established a special Year 2000 speakers' bureau with staff around the country prepared to speak and offer guidance. You may want to have them join you when you meet with providers, and let others know that they are available.

States' Progress

Our concern for States is as great as our concern for providers. For both, we do not have the authority, ability, or resources to step in and fix their systems for them. Our ten regional offices are monitoring the status of each State's remediation effort. We also have an expert IV&V contractor, TRW, to assist us in conducting on-site visits in every State to provide advice and validate assessments. This allows us to maintain an accurate picture of each State's progress. We have already done on-site visits in 16 States and the District of Columbia and expect to visit the remaining States by the end of April. The preliminary reports confirm earlier work by the GAO which strongly suggests that some States will not be ready on time.

We have asked all Medicaid and CHIP Directors to:

- Report the status of their Year 2000 compliance efforts;
- Document contingency plans for systems that may not be compliant; and Provide updates to HCFA's regional offices on States' progress.

It is each State's responsibility to take the steps it believes are appropriate to meet the needs of its Medicaid and CHIP beneficiaries. Our primary role is to assess, as best we can, each State's progress and to provide guidance. While we do not have the authority, ability, or resources to fix State systems, we can and do want to help. In addition to furnishing the services of TRW, we have developed technical assistance documents, and held regional meetings and workshops for States on how to develop contingency plans. We know that States and Congress share our goal of protecting all our beneficiaries throughout the millennium transition.

M2 PRESSWIRE
February 25, 1999

THE WHITE HOUSE Remarks by the President and the First Lady at children's health outreach event

MRS. CLINTON: Good afternoon. Thank you, please be seated. We are delighted to welcome you to the White House, to be part of this very exciting announcement and program. We have a number - well, actually, everyone here is a distinguished guest, and we have a number of members of Congress, representatives of many businesses and not-for-profit organizations. We're pleased to have representatives of the states, both governors, governors' spouses and staff from the National Governors Association.

This has been an extraordinary effort that has brought together literally every part of America. And I'm honored to join the President and all of you as together we take another important step forward in our efforts to make quality health care a reality for all of America's children.

The progress we've already made would not have been possible without many of you here in this room. I want to thank the Secretary of HHS, Secretary Donna Shalala, for her tireless leadership. I want to thank the two governors who are here with us on the stage, Governor Leavitt and Governor Carper, for making health care a bipartisan effort. And I'm particularly pleased to see a number of congressional leaders - some are en route and I believe the President will recognize everyone who is eventually here; but I know that Senator Hatch is here and Representative Sheila Jackson Lee is here and others, I'm told, are coming.

I'm also delighted that this effort has brought together advocates and business leaders in one common goal: to try to make sure that all of our children have the health care that they need.

I would like especially to acknowledge the health care advocates, the community leaders, the education groups, the business leaders, the not-for-profits, and especially the work of our religious groups, like Catholic Charities, who are doing such valuable work on behalf of children's health issues today.

Nothing better explains why we are here than the story of a woman I just met. Mary Smith is here with her two sons, Samuel Jr. and Thomas. And the Smith family really represent millions and millions of American families. Mary and her husband have both been working, but their employers either didn't provide health care coverage, or offered them private coverage they could not afford. So for three long and wearisome years their children had no health insurance. And every single day - particularly in the afternoons, when she knew her sons were out playing sports - Mary felt, in her words, that she was walking on eggshells, hoping and praying that nothing would happen to her boys.

Now, every parent can imagine how Mary and her husband felt. When our children are sick or hurt, the last thing we should have to worry about is whether we will have the financial resources to take care of their pain, to heal their wounds, lower their fevers, put them back on their feet.

Yet, as shocking as it may sound, almost 11 million children in America have no health insurance. Thanks to you, and with the support of the President, who made it a priority, and a bipartisan majority in Congress, that situation began to change on August 5, 1997, when the President signed into law the largest expansion in health care in over 30 years. That day, our nation committed \$24 billion to insure millions of uninsured children, and their parents, through a federal-state partnership. Today, more of America's families, including Mary's, are breathing easier because their children are

covered under the Children's Health Insurance Program, known as CHIP.

Creating CHIP was the critical first step in ensuring that our children receive the health care they need, from check-ups to immunizations to complicated surgery. But we recognized that fulfilling the promise of this legislation would not be done when the President signed it - in fact, that would just be the beginning of the hard work to make sure it could be implemented.

At least half of all uninsured children are eligible for federal-state health insurance programs, but too often their parents don't know or don't believe they qualify. As successful, for example, as Medicaid has been, an estimated 4 million eligible children are still not enrolled. Millions of others, like Mary's sons, have working parents and didn't know where to turn for health insurance. Sometimes people lose their coverage when a parent loses a job; sometimes the long, complicated forms just really seem too much for any family to face.

So over the past year we've carried on a sustained outreach effort in communities nationwide to help educate families about CHIP. And I'm very grateful for the work that all of you have done. I'd like to describe a particularly successful effort.

Last November, Chicago's public schools launched an aggressive, school-based outreach campaign aimed at the estimated 170,000 students who were eligible but not enrolled in the Illinois KidCare program. First they sent out enrollment information to every family who had children in the city's public schools. Then, on the day that Chicago requires parents to come to school - which I think is a very good idea - to pick up their child's report card, 3,000 volunteers were on hand to help eligible parents fill out the forms to get their children enrolled.

Everyone was involved, from teachers to social workers to counselors; from private corporations to advocacy groups. And they also had advertisements that were public service, on the media and the TV and the radio, translated into five different languages, including Cantonese and Arabic. And the result of this concerted campaign? About 14,000 children in Chicago applied for KidCare during that time period. And I know Paul Vallas, who is the CEO of Chicago's public schools, is here with us, and I want to congratulate him for creating such a model program.

This Chicago program shows what we can do when we work together, and when we really reach out to families and children, to make good on the promise that the President signed into law in August of 1997. There isn't any more important mission than ensuring that every parent has the peace of mind that Mary now has, to know her children are insured, and has the resources to back up that peace of mind.

I want to ask Mary and her sons to stand, so that we can acknowledge you. And I know teenage boys hate this so - (laughter) - we'll do it really quickly, Samuel and Thomas, but I want to acknowledge the family. (Applause.)

* * * * *

THE PRESIDENT: Thank you very much. Let me begin by saying how very much I appreciate all of you here who are a part of this historic day. I thank my longtime friend, Governor Carper, for his generous remarks and his great stories. He almost broke my concentration, though. I'll spend the rest of the day trying to remember what my first answer was to whether there was a noise when a tree falls in the forest. (Laughter.)

I thank you, Governor Leavitt, for your outstanding leadership, and your concern for our children. I'd like to, again, acknowledge the presence of Governor Angus King of Maine and Mary Herman; Governor and Mrs. Knowles of Alaska; Governor Vilsack of Iowa; Mrs. Rossello from Puerto Rico; Mrs. Underwood from West Virginia. And I thank all the members of the Governors' Conference who are here.

There's one private citizen here I would like to acknowledge, and that is Bud Chiles, the son of the late Governor Lawton Chiles of Florida, who has been very active in this endeavor, as well. I thank him.

We have a distinguished bipartisan delegation from the United States Congress here. Senator Hatch, here supporting his governor from Utah; Senator Specter from Pennsylvania; Congresswoman Diana DeGette from Colorado; Congresswoman Anna Eshoo from Northern California; Congresswoman Sheila Jackson Lee from Texas; Congressman Bart Stupak from the upper peninsula of Michigan. He is the only person in the room who thinks it is warm outside today. (Laughter.)

I'd also like to thank the Smith family for coming, and I hope the boys weren't too embarrassed to stand up. They look very healthy to me, and that's reassuring. (Laughter.) And I'd like to thank these beautiful children for being here - over here, and their families. When you think about what this is all about, just kind of look over there.

I want to thank the National Governors Association. I want to thank Secretary Shalala, who is indefatigable. If I ask her to do something, sooner or later I will come to regret it. (Laughter.) Because she will do it, and I will wind up doing whatever it is I'm supposed to do to make sure it gets done. She is not only the longest-serving person in her position ever, she is also the most energetic; and that is no disrespect to her predecessors. I have never known anybody with as much energy as she has - (applause) - with the possible exception of her mother, who I understand is still winning tennis tournaments in her 80s. (Laughter.)

I'd also like to thank the First Lady, without whom I probably would not know very much about these issues. When I met her in 1971, she was already obsessed with them. She took an extra year when we were in law school to work at the Yale Child Studies Center and the Yale University Hospital so that she could put her legal learning to work to help the health of our children.

When you talked about our home state having 38,000 people signed up, we have less than one percent of the population. That means if everybody was doing that well, we'd already have 4 million kids signed up for this program, and that is in no small measure due to a group called The Arkansas Advocates for Families and Children, which Hillary founded over 20 years ago now. So I thank her for all that she has done. (Applause.)

When the Congress passed the bipartisan balanced budget in 1997, it was a truly historic act, and most of the publicity that surrounded that endeavor came from the sheer relief the country felt that finally we had done something about the deficit. But it's important to point out that there were a lot of very important provisions within that very large law, but none more important than the \$24 billion allocated to provide health insurance. We estimated at that time

- to up to 5 million kids, which we estimated were at that time about half the uninsured children in our country.

It is inconceivable that a country with as much economic prosperity as we now enjoy, and the best

health care system in the world, would leave 10 million - now nearly 11 million - children without health insurance. We know many of them are eligible for Medicaid, but their parents don't know it. We know there are a lot of hard working families now whose incomes are too high to qualify for Medicaid, but they apply, or qualify, for the Children's Health Insurance Programs now that the states are operating around the country. But they don't know it.

Now, we knew when we signed this law into effect - I'll never forget Donna Shalala telling us, you know, we can pass this law, but we've already got - at that time - over 3 million kids eligible for Medicaid who don't sign up and don't know it. So we knew then that, to make the tree heard in the forest, to extend the governor's metaphor - to make the health insurance program more than an empty promise, we'd have to somehow get the word out to parents.

Last week - you've heard all these stories - last week, I had an incredible experience at a health care forum in New Hampshire. I met a woman named Christine Monteiro, who has run a small business with her husband - a solarenergy business - for 11 years. And, like all small businesses, she had her ups and her downs. But the hardest times came when her kids needed health care and they couldn't afford the health insurance.

She found out about it the way we don't want people to have to find out about it - even though better that she found about it than not. She had to take repeated visits to the doctor, with her child. And finally, a health care worker at the medical clinic told her that she might be eligible for New Hampshire's CHIP program. She applied immediately and found that her daughter's visits were all covered and she saved up to \$1,000 a month for a very serious illness for her child.

Christine and her family were lucky. Not everybody, even who would come into a medical facility, might know. This should not be a matter of luck. We're here because all of us, in our various roles in life, recognize that we have an obligation to use every possible tool, every possible response, to reach more of the hard working families like those you've heard about and seen today.

Government has a role to play; Secretary Shalala talked about it. Our national campaign is called "Insure Kids Now." We've already heard about the remarkable National Governors Association effort, working with our administration and Bell Atlantic. The national toll-free number - I'm going to say it again - I like to say toll-free numbers, you know, there's some chance it'll get on television if I say it. One of the few things I can think of to say that is subject to absolutely no controversy. I could stand up here for 10 minutes and just repeat the toll-free number. I'll say it again: 1-877-KIDSNOW. Not hard to remember and important not to forget.

As you've heard, because of the work of the NGA, you can get state-specific information. Because when the Congress set this program up in the Balanced Budget Act, and we strongly supported this, we realize we couldn't possibly design a program in Washington that would cover all the different circumstances that existed from state to state. So all these programs were set up and then approved state by state. So this is very, very important that we get this information out to people in the form in which it is most usable. And again, I want to thank Governors Carper and Leavitt for their leadership in this critical past year, and all the other governors for their support.

Secretary Shalala told you about some of the things we're doing at the federal level to reach more uninsured children. But let's be frank: to reach them all - to reach them all - everyone who can touch the life of a child or the child's parents needs to be involved in this effort.

Today, we're here to announce an unprecedented commitment, from media to business, from the health care industry to grass-roots organizations, all over our nation, to inform families of these new health insurance options. We begin with an all-out media campaign to reach as many families as possible. NBC is unveiling a new prime-time PSA to raise awareness about Children's Health Insurance Program. Epatha Merkerson, one of the stars of NBC's "Law and Order," who appears in the PSA, is here with us today. Thank you very much for being here. (Applause.)

ABC and Viacom/Paramount will soon begin airing a PSA the First Lady made to inform families about the Insure Kids Now toll-free number. They have representatives here, I thank them. The National Association of Broadcasters will make the First Lady's PSA available to all of its member stations. Black Entertainment Television and Turner Broadcasting will also run the ad.

Before I go forward, I would just like to unveil the two PSAs here, for the first time. Let's take a look at them.

I'd also like to thank the representatives from Univision here. They will run a PSA in Spanish, made by HHS.

And we're not stopping there. Major corporations, from K-Mart and Ralph's Grocery to McDonald's, to General Motors; from the American Medical Response to Blue Cross/Blue Shield Association, to Pfizer, all of whom are represented here. It will help make sure that the Insure Kids Now toll-free number appears on grocery bags and restaurant place mats, on school buses and in doctors' offices. Even on the toothbrushes that dental hygienists give their patients.

And with the help of organizations like America's Promise, the United Way and a host of community-based groups, families will hear about health insurance from the people they trust the most - from teachers and principals, doctors and nurses, rabbis and ministers. Ultimately, of course, parents must take responsibility for their children's health. Our message must be: what you don't know about your children's health insurance options can hurt them.

It's up to you to find out if your child is eligible for this health insurance. So call the toll-free number: 1-887-KIDSNOW. Working together, we can reach those kids. Look at those kids there. There's over 10 million of them. They deserve to be as healthy as we feel today. And we can do it for them.

Thank you and God bless you. (Applause.)

M2 PRESSWIRE
February 24, 1999

President and First Lady launch the Insure Kids Now campaign

Today, the President and First Lady, along with Governors Carper and Leavitt and Secretary Shalala, launch the nationwide "Insure Kids Now" campaign designed to enroll eligible but uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP). Building on prior efforts, this campaign will engage a broad-based, bipartisan, public-private coalition to use a variety of means to educate and assist families in insuring their children. Initial activities include launching a nationwide, toll-free number set up by the National Governors' Association in partnership with the Administration and Bell Atlantic to provide families with essential information about Medicaid and CHIP; placing the toll-free number on corporate products; airing publicservice announcements on TV and radio; enlisting grass-roots organizations to get the word out; and stepping up activities by over 10 Federal agencies that interact with working families.

CHILDREN'S HEALTH INSURANCE INITIATIVE

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

Historic new options for children. In 1997, the President, with bipartisan Congressional support, created the Children's Health Insurance Program (CHIP), which devotes \$24 billion dollars over five years for health coverage for children. Today, 47 states have implemented CHIP; they expect to enroll over 2.5 million children by September 2000.

The challenge of enrolling children. Ensuring that all eligible children get enrolled in health insurance programs is a formidable challenge. Barriers like complicated applications, lack of coordination between programs, and misinformation about eligibility criteria prevent uninsured children from getting the coverage that they need. To remove these barriers, the President has taken numerous actions to encourage states to streamline their application and enrollment processes, accept mail-in applications, and place eligibility workers in convenient locations. He also ordered federal agencies to provide active assistance in enrolling children through their many programs serving working families.

NEW NATIONWIDE "INSURE KIDS NOW" OUTREACH CAMPAIGN

Building on last year's efforts, today the President and First Lady launch the "Insure Kids Now" public-private campaign. For the first time, major TV and radio networks, corporations, health care organizations, religious groups, and other community-based organizations will join federal agencies in disseminating information about children's health insurance.

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Publishing information about Insure Kids Now. This spring, USA Today will publish an editorial and Blue Cross/Blue Shield will publish a full page advertisement in the April issue of Time Magazine on children's health insurance. In addition, Pfizer, the American College of Emergency Physicians, the American Nurses Association, the United Way, the American College of Physicians, the National Collaboration for Youth, the Association of State and Territorial Health Officials, Wyeth Lederle, Kaiser Permanente, Volunteers of America, the March of Dimes, the Points of Light Foundation, Hope for Kids, the Veterans of Foreign Wars, the National Education Association, and religious organizations from across the country have agreed to put information on Insure Kids Now in their product handbooks, circulars, and mass mailings, as well as to distribute posters featuring the Insure Kids Now number to their clients and constituents. Print media is an effective educational tool, especially when used together with other media, because it allows the reader to reread and thoroughly digest the information.

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

Expanding federal efforts to promote children's health insurance outreach. The President's FY 2000 budget includes over \$1.2 billion to assist states to engage in children's health outreach activities. In addition, the Federal Interagency Task Force on children's health outreach has begun new outreach efforts include launching the new "www.insurekidsnow.gov" website; distributing 145,000 posters to over 20,000 health centers, providers, and other grantees; providing 92,000 USDA employees with information about outreach, including the new toll-free number on their wage and earning statements; and sending a letter and posters with the Insure Kids Now number to all 170 sites in the Department of Justice's Operation Weed and Seed program, a crime prevention and community revitalization initiative.

PR Newswire
February 24, 1999, Wednesday

**Catholic Health Association of the United States Supports the
Improved Maternal and Children's Health Coverage Act of 1999**

The Catholic Health Association of the United States (CHA) strongly supports, and asks Congress to pass, "The Improved Maternal and Children's Health Coverage Act of 1999" introduced by Representatives Diana DeGette (D-CO) and Constance Morella (R-MD). At a time when more than 11 million children still do not have health coverage, the legislation would increase enrollment of uninsured low-income children and pregnant women in Medicaid and the Children's Health Insurance Program (CHIP).

"CHA welcomes the DeGette-Morella legislation as a way to ensure that low-income children obtain and retain health coverage for which they are eligible," declared Rev. Michael D. Place, STD, CHA's president and chief executive officer. "The measure will reduce the number of uninsured and move the nation closer to a goal of accessible and affordable healthcare for all."

CHA strongly supports giving states the option of using CHIP funds health coverage for low-income pregnant women. This approach gives mothers critical access to prenatal care, which has proved successful not only in improving the health of children but also in reducing the cost of care later in a child's life.

One of the provisions CHA finds attractive is the additional flexibility given states under CHIP to cover legal immigrant children. In states with high proportions of uninsured children, such as Florida, California, and Texas, immigrants in many communities fear that applying for a public program such as Medicaid or CHIP could cause problems with immigration officials. This legislation will help reduce that fear for thousands of families.

CHA also endorses the legislation's provisions that simplify outreach and enrollment and those which expand coverage options. Specifically, CHA applauds provisions that require states to (1) develop and use uniform application forms; (2) coordinate enrollment between Medicaid, CHIP, and other programs, and (3) participate in a national toll-free telephone information line.

"We welcome the legislation's expansion of sites that states can use to enroll children in Medicaid and CHIP and funding of outreach and enrollment activities by community-based not-for-profit organizations," added Fr. Place. In addition to serving hundreds of thousands of children directly each year, Catholic healthcare is involved in efforts to identify low-income pregnant women and children eligible for Medicaid and CHIP and assist them in enrolling in the programs. "The Improved Maternal and Children's Health Coverage Act of 1999" will help expand these efforts.

The St. Louis-based Catholic Health Association of the United States is the national leadership organization of more than 1,200 Catholic-sponsored facilities and organizations. Founded in 1915, CHA's members make up the nation's largest group of not-for-profit healthcare facilities under a single form of sponsorship. For more information, visit the CHA Web site at www.chausa.org.

U.S. Newswire
February 23, 1999 12:02 Eastern Time

White House Fact Sheet on Insure Kids Now Campaign

Following is a fact sheet on the Insure Kids Now Campaign, released today by the White House:

Today, the President and First Lady, along with Governors Carper and Leavitt and Secretary Shalala, launch the nationwide "Insure Kids Now" campaign designed to enroll eligible but uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP). Building on prior efforts, this campaign will engage a broad-based, bipartisan, public-private coalition to use a variety of means to educate and assist families in insuring their children. Initial activities include launching a nationwide, toll-free number set up by the National Governors' Association in partnership with the Administration and Bell Atlantic to provide families with essential information about Medicaid and CHIP; placing the toll-free number on corporate products; airing public service announcements on TV and radio; enlisting grass-roots organizations to get the word out; and stepping up activities by over 10 Federal agencies that interact with working families.

CHILDREN'S HEALTH INSURANCE INITIATIVE

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

Historic new options for children. In 1997, the President, with bipartisan Congressional support, created the Children's Health Insurance Program (CHIP), which devotes \$24 billion dollars over five years for health coverage for children. Today, 47 states have implemented CHIP; they expect to enroll over 2.5 million children by September 2000.

The challenge of enrolling children. Ensuring that all eligible children get enrolled in health insurance programs is a formidable challenge. Barriers like complicated applications, lack of coordination between programs, and misinformation about eligibility criteria prevent uninsured children from getting the coverage that they need. To remove these barriers, the President has taken numerous actions to encourage states to streamline their application and enrollment processes, accept mail-in applications, and place eligibility workers in convenient locations. He also ordered federal agencies to provide active assistance in enrolling children through their many programs serving working families.

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**Federal Document Clearing House Congressional Testimony
February 23, 1999, Tuesday**

SECTION: CAPITOL HILL HEARING TESTIMONY

**TESTIMONY February 23, 1999 DIANNE FEINSTEIN SENATOR SENATE APPROPRIATIONS
LABOR, HEALTH AND HUMAN SERVICES, EDUCATION F2000 LABOR, HHS**

OPENING STATEMENT OF SENATOR DIANNE FEINSTEIN Hearing of the Subcommittee on Labor-HHS-Education Appropriations Welcome to the Subcommittee, Secretary Shalala. It is a pleasure to see you here. I look forward to working with you this year to address the many pressing needs that are the responsibility of your department. Your FY 2000 budget has some bright spots.....

I am also glad to see your request of \$1.4 billion for a five- year effort to improve enrollment in the Children's Health Insurance Program. My state has one of the highest uninsured rates in the country among children at 19 percent compared to the national rate of 15 percent, and enrollment in CHIP in California has lagged. However, as I have written you previously, I remain disappointed in your department's position that children in the 24 states that have established private or "combination" public private CHIP plans are no longer eligible to receive vaccines under the federal Vaccines for Children Program. I applaud you for recognizing that the Population is aging. With age comes more illness and disability and thus greater need for health care services. We need to fill in this major gap in our health insurance system and provide long-term- care. Your budget includes some needed new initiatives.

Additionally, as you know, we are currently in the third year of welfare reform, and I believe strongly that the early successes we experienced in moving families off the welfare rolls are giving way to tougher challenges. I saw evidence of this in December, when the Department of Health and Human Services announced that California and 16 other states failed to meet the two-parent work requirement under the Temporary Assistance to Needy Families program. In addition, signs are growing that federal child care subsidies for families on TANF will soon fall far short of demand. As welfare reform implementation continues, I want to be sure that states receive the resources they need to successfully move families from welfare to work. I also want to ensure that HHS is implementing the welfare reform law flexibly, with an eye toward helping states succeed rather than penalizing them for failure to attain rigid work requirements. TANF and child care issues will be a major priority for me this year. I must also call on you to help us address other problems. An estimated 43 million Americans have no insurance. California's uninsured rate is the 4th highest in the country. Medicare faces bankruptcy. How will we get it on a firm financial footing? While the death rate is declining and we have made great strides in treating AIDS, giving hope to people who formerly had little, AIDS incidence and deaths fall disproportionately on minorities. For example, African Americans, who comprise 12.7 percent of the U. S. population, account for nearly 60 percent of all new AIDS cases. And while the AIDS drug "cocktails" are effective for some people, they are unaffordable for many. Managed care

PR Newswire
February 23, 1999, Tuesday

Emergency Physicians Encourages Families to Participate In the Children's Health Insurance Plan

The American College of Emergency Physicians (ACEP) today applauded President Clinton and the National Governor's Association for encouraging families without health insurance to enroll in the Children's Health Insurance Program (CHIP). In a ceremony at the White House today, the President announced that a national toll-free telephone number to boost the enrollment of children in CHIP and Medicaid programs.

Over 10 million children lack health insurance and over half of these are eligible for Medicaid or for enrollment in the new CHIP insurance programs. Many families, with parents in the workforce, do not realize that they can qualify and get affordable health insurance for their children. In August 1997, Congress created the Children's Health Insurance Program, to address the problem of uninsured children. In the past two years, 48 plans have been approved, and a total of 51 states/jurisdictions (including the District of Columbia, Puerto Rico and the U.S. Virgin Islands) have submitted plans to HCFA. Additionally, in December 1997 President Clinton ordered a major effort to locate and sign up million of children who were eligible for Medicaid. Parents or guardians calling this toll free number will also be informed if they qualify for Medicaid.

"Children without insurance tend to come to the emergency department as a last resort with acute medical conditions. These may have been prevented by better access to medical care, including regular checkups and immunizations," said Dr. John Moorhead, president of ACEP. "ACEP is participating in the campaign and believes it is vital that emergency physicians assist in notifying families about their eligibility in the programs."

"Consistently, those children who come to the emergency department, who lack health insurance, have more serious medical conditions," said Dr. Michael Rapp, president-elect of ACEP who attended the White House event to raise awareness about the CHIP program. "ACEP will encourage emergency physicians to distribute CHIP information in the emergency department, increasing awareness of the toll free number. By using the toll free number and they can be directly connected with their state programs to see if they can enroll in CHIPS or are eligible for Medicaid," Dr. Rapp added.

Beginning February 23, a toll-free number is available for the CHIP program: 877-KIDS-NOW (877-543-7669). Callers automatically will be connected to the Medicaid agency or health department of the states from which they are calling. Many states allow families to apply by mail.

The American College of Emergency Physicians is a medical specialty society representing nearly 20,000 physicians who specialize in emergency medicine. ACEP is dedicated to improving emergency care through continuing education, research, and public education. Headquartered in Dallas, Texas, ACEP has 53 chapters representing each state as well as Puerto Rico, the District of Columbia, and Government Services.

PR Newswire
February 23, 1999, Tuesday

**Bell Atlantic Assists in 'Insure Kids Now' Campaign;
Company Provides Funding to Establish 1-877-KIDS-NOW, Cornerstone of the President's National
Outreach Effort**

President William J. Clinton announced today that Bell Atlantic was instrumental in establishing a nationwide toll-free number that will help more parents obtain health insurance for their children.

This new number, 1-877-KIDS-NOW, was developed by the National Governors Association and funded by Bell Atlantic in partnership with the Administration to help the nation's 10 million children without health insurance. It provides information about health care options to families in all 50 states. "Bell Atlantic is proud to help make this hotline a reality," said Tom Tauke, senior vice president for government relations at Bell Atlantic. "We are happy to do our part to make sure that all children have access to health care."

The President cited Bell Atlantic during remarks at the White House as he launched the nationwide "Insure Kids Now" campaign designed to enroll eligible but uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP).

CHIP provides funds for coverage of working families' uninsured children. These families typically have too much income to qualify for Medicaid but too little to afford health insurance. Families calling this number will receive information about eligibility criteria, benefits, and how to apply for coverage.

Bell Atlantic is at the forefront of the new communications and information industry. With more than 42 million telephone access lines and 8.6 million wireless customers worldwide, Bell Atlantic companies are premier providers of advanced wireline voice and data services, market leaders in wireless services and the world's largest publishers of directory information. Bell Atlantic companies are also among the world's largest investors in high-growth global communications markets, with operations and investments in 23 countries.

The National Journal Group, Inc. Health Line
February 22, 1999

THE UNINSURED: COULD CHIP SERVE AS A MODEL?

The Los Angeles Times reports that while "(u)niversal coverage isn't coming any time soon," various states' Children's Health Insurance Programs "could provide a model for incrementally extending coverage to other groups of the uninsured." The Times looks at New York's Child Health Plus plan, which "is at the vanguard of a quietly effective initiative that's showing it is possible to move forward even without a national consensus for systemwide health care reform." CHIP programs have proven popular even in some of the most conservative states because "the working poor are a constituency both parties want to help," and because "the federal government agreed to pick up a larger share of the cost for (CHIP) than it does for Medicaid." In addition, states have been given "enormous freedom to design their own programs." And while enrollment in some of the plans has lagged, "the overall experience has been sufficiently positive that some health experts are now asking whether the states and Washington could adapt the partnership model they've built for children to cover more uninsured adults." Wisconsin Gov. Tommy Thompson (R) has been pushing the federal government to allow his state to use CHIP money "to insure the parents of the newly covered children," and "in New York, a coalition led by the Greater New York Hospital Association is pushing for legislation to cover low-income working adults through a state program modeled on the existing Child Health Plus." So far the federal government has been mildly receptive to the idea. HHS Secretary Donna Shalala, however, notes that it would be expensive to cover adults and might cause some employers to drop coverage. She said it was one of a variety of options worth exploring, adding, "We ought to encourage different ideas. I want to plant a lot of different kinds of flowers out there" (Brownstein, 2/22).

AP Online
February 23, 1999; Tuesday 17:12 Eastern Time

Clinton Wants More Kids on Medicaid
BYLINE: SONYA ROSS

With the aid of a toll-free hot line, President Clinton appealed Tuesday for poor parents to seek Medicaid or state health coverage for their children. "It's up to you to find out if your child is eligible," he said.

The president kicked off the national Insure Kids Now campaign, which seeks to educate families on obtaining coverage under Medicaid and the new Children's Health Insurance Program. The goal is to enroll the millions of children thought to be eligible.

"Our message must be: 'What you don't know about your children's health insurance options can hurt them,'" Clinton said. "But let's be frank to reach them all, everyone who can touch the life of a child or the child's parents needs to be involved."

He recited the campaign's toll-free number 1-877-KIDS-NOW _ and had the audience in the East Room repeat it with him.

"Not hard to remember, and important not to forget," Clinton said. "It's one of the few things I can think of to say that's subject to absolutely no controversy."

Along with first lady Hillary Rodham Clinton, Health and Human Services Secretary Donna Shalala and officers from the National Governors Association, Clinton unveiled two public service ads that would begin airing on television networks Wednesday.

In one ad, Mrs. Clinton speaks of how parents often want to give their children a bicycle or a dog, but the best thing they could provide is access to health care. "Every child should be covered," she says.

In the other, actors S. Epatha Merkerson and Benjamin Bratt, stars on the NBC drama "Law & Order," urge parents to at least determine if their children are eligible.

"Doing the best for your kids means what?" asks Bratt. "Keeping them healthy," replies Merkerson.

There also will be an ad in Spanish on Univision, to target the estimated 25 percent of uninsured Hispanic children, Clinton said.

Federal officials also planned to run radio ads in 45 states over a four-week period, beginning Tuesday in Alabama, California, Colorado, Connecticut, Illinois, Kentucky, Maine, New Jersey, North Carolina, Ohio and Utah. The campaign will be followed in the spring by an editorial on children's health insurance in USA Today and a full-page ad in Time magazine.

Clinton said it is "inconceivable" that the United States, with all its prosperity, has nearly 11 million children who lack health insurance. "They deserve to be as healthy as we feel today," he said.

The president has stated a goal of enrolling 5 million children in Medicaid or the state-based Children's Health Insurance Program, or CHIP, within five years. Last year, he directed several federal agencies to

find better ways to identify eligible children and sign them up.

Shalala compared CHIP to a newly opened restaurant "a few customers come in, but we have a lot of empty tables" and said the information campaign is necessary to make the program successful.

"CHIP is not a welfare program. It is a serious, substantial effort," Shalala said. "We all win when we keep our children healthy and make our economy strong."

Mrs. Clinton said parents often are deterred from seeking health benefits in the mistaken belief they are ineligible because they work, or because they are frustrated by the application process.

"Sometimes, the long, complicated forms just seem to be too much for a family to take," she said.

Clinton's proposed budget for fiscal 2000 includes \$1.2 billion to assist states in this children's health outreach initiative.

**Federal News Service
FEBRUARY 23, 1999, TUESDAY**

**PREPARED TESTIMONY OF THE HONORABLE DONNA SHALALA
U.S. SECRETARY OF HEALTH AND HUMAN SERVICES BEFORE THE SENATE COMMITTEE
ON APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES**

Good morning, Chairman Specter, Senator Harkin, and members of the Subcommittee. I am pleased to appear before you today to discuss the President's FY 2000 increase of \$100 million. Included in this amount is an increase targeted to communities to provide state of the art clinical care to an additional 10,000 people living with AIDS. In addition, the AIDS Drug Assistance Program (ADAP) will receive a \$35 million increase to help individuals gain access to combination drug therapy. The budget also continues to build on the effort initiated by the President and this Committee to address the AIDS crisis in minority communities. The budget for FY 2000 includes \$171 million for special initiatives that will be specifically targeted to HIV/AIDS prevention, treatment, and capacity development needs within the African-American and other racial and ethnic minority communities.

Medicare, Medicaid, and the Children's Health Insurance Program

Our budget also includes a variety of legislative proposals to expand access to Medicare and Medicaid for groups that would otherwise be denied health insurance for any number of reasons. It allows Americans ages 62 to 65 to buy into Medicare by paying a premium, provides a buy-in option for displaced workers ages 55 to 62 who have lost employer-provided health coverage, and allows retirees between the ages of 55 and 65 whose companies have reneged on their health benefits to buy into their company's health plan. Another proposal would give states the option of providing Medicaid coverage to legal immigrant children, pregnant women, and certain groups of immigrants with disabilities who have entered the United States after the enactment of the welfare reform legislation in 1996.

The Children's Health Insurance and Medicaid programs represent a valuable means of providing health insurance to poor children who might otherwise go without care. But many families are unaware that their children are eligible to receive care under these programs. Our budget will allow states to increase spending by \$1.2 billion over the next five years on benefits and outreach and give them additional flexibility to expand outreach efforts through development of new and innovative approaches.

Making Child Care Safe, Reliable, and Affordable

In millions of American families, both parents must work to support their children. In millions of others, single parents must work doubly hard to maintain family income. This Administration, working together with the Congress, has taken numerous steps to support families of all types, ranging from the Earned Income and Child Tax Credits to the Family and Medical Leave Act and the Children's Health Insurance Program. The next step we must take is to help all parents find child care that is safe, reliable, and affordable. This is not only important as a way to support the needs of working families. Safe, quality child care is essential to the healthy development of our children. Study after study provides evidence that investments in quality care can have major benefits for children, their families, and our society.

Let me thank you for having made a down-payment towards the President's child care initiative with \$173 million in quality funds and \$10 million for child care related research. The President's FY 2000 budget again includes a requested increase of \$10.5 billion in mandatory funding over five years for child care programs in HHS, as well as critical increases in the Departments of Treasury and Education. These additional funds will dramatically expand the availability of safe and affordable child care for working

families, as well as improve early learning and the quality and safety of child care. The Child Care and Development Block Grant was used to serve 1.25 million children in 1997. With these additional funds, we are committed to increasing the number of children served by more than one million by 2004.

U.S. Newswire
February 16, 1999 9:39 Eastern Time

HEADLINE: Stand for Children Day Theme Chosen in Response to Grassroots Call For Action

CONTACT: Eliza Leighton of Stand for Children, 202-234-0095 ext. 121 or Email: eliza(AT)stand.org

Stand For Children announced today that "Ready to Learn, Ready to Succeed" will be the platform for the fourth annual Stand For Children Day. Over one million people nationwide are expected to take part in over 1,500 Stand For Children Day events on and around June 1 as part of the growing grassroots movement working to improve children's education in and out of the classroom. At Stand For Children Day events people will be calling for immediate action to solve the education crisis in America which threatens to leave millions of children unprepared for the demands of the 21st century.

The "Ready to Learn, Ready to Succeed" platform means that in addition to caring and supportive parents, every child must have:

-- Health coverage. Children who can't see the blackboard, can't hear the teacher, or are distracted by pain can't learn to the best of their ability. Stand Day events will help children succeed by signing children up for health insurance under the new Children's Health Insurance Program (CHIP) .

-- Substantial new investments for affordable, quality child care. Young children need proper care and nurturance, stimulation, and early education to enter school ready to read and to succeed.

-- Safe, productive after-school activities. Enriching after-school programs can help the nearly five million young people who are home alone in the afternoon each week stay out of trouble, and also give them the extra boost they need to succeed in school -- and in life.

-- Schools that challenge all children. With small classes, skilled teachers, high standards, and involved parents, every child can perform at high levels. The supports and expectations, both in and out of school, can help all children succeed.

"Until every child goes to school ready to learn and ready to succeed, America's promise will never be realized. Each of us must make a commitment now to work in our community to put the education needs of children first," says Stand For Children executive director Jonah Edelman.

Across the country Stand For Children Day events will raise awareness about the urgent need for a holistic plan to get every child ready to learn, ready to succeed and push for federal legislative solutions such as expansion of the 21st Century Learning School Fund, new funding for school construction, and new investments in the Child Care Development Block Grant (CCDBG). In local communities, Stand For Children Day events will make direct improvements in the lives of children through renovation and construction of playgrounds, book drives, rallies, and children's resource fairs.

Stand For Children Day '99: Ready to Learn, Ready to Succeed will also join people from all over the world via a "Cyber-Stand For Children" on the World Wide Web. "Cyber-Stand For Children" will take place in conjunction with local Stand For Children Day events on the Stand For Children Website at www.stand.org.

More than 200,000 visitors are expected to visit the web site to learn about how they can help ensure all children are ready to learn in the classroom and ready to succeed in life. Visitors will be encouraged to sign the Stand For Children pledge and send Cyber-Postcards to their elected officials encouraging them to stand up for legislation to support children and families. Last year 150,000 people participated in Cyber-Stand For Children, 1,000 of whom sent emails to their Members of Congress.

In 1996, the first Stand For Children Day drew more than 300,000 people to the Lincoln Memorial in the largest demonstration of commitment to children in U.S. history. In 1997, more than 700 local Stand For Children Day events focused on the health issues of children, and encouraged legislators to pass the Child Health Insurance Program (CHIP) which will provide health insurance to more than 5 million children. In 1998, more than 1,200 events nationwide, focused national attention on issues related to child care, and helped pass the Kerry/Bond amendment, the strongest vote for child care in over a decade.

Volunteers interested in participating in or planning a Stand For Children Day '99 event should call 1-800-663-4032, visit the web site at www.stand.org, or via email at tellstand@stand.org. Stand For Children will provide technical support and assistance and link organizers and their events to millions of people nationwide.

Stand For Children is a nonprofit, nonpartisan national membership organization organizing a powerful citizen voice to give all children the opportunity to grow up healthy, educated, and safe. Stand For Children is an affiliate of the Children's Defense Fund with more than 100 Stand For Children Chapters which have completed or are undertaking hundreds of initiatives for children.

HEADLINE: Health-care reform far from completed

While Americans are generally happy with their health insurance coverage, four in 10 adults say insurers have a bigger say than doctors in the care they receive.

That's according to a new poll conducted for the Associated Press. "Generally," is right. U.S. health care is the most advanced in the world, for those who have it, but getting it is neither easy nor inexpensive.

The poll largely ignored the biggest problem, the number of uninsured - whose largest goal in life is to avoid getting sick or injured while they are without a safety net.

Forty million Americans cannot afford health insurance, recklessly choose not to buy it or have employers who do not provide it as a benefit. Yet, they are not poor enough to be on Medicaid or old enough to be on Medicare, and they do not have some other government option.

The Clinton administration has moved toward cutting those numbers by identifying uninsured children. Congress passed the Children's Health Insurance Program, or CHIP, which, with state aid, cares for uninsured children. Texas has an estimated 1.4 million such children, about 100,000 in Bexar County.

For those lucky enough to have insurance, though, insurers, not physicians, often call the shots nowadays, as 41 percent of poll respondents indicated. While that cuts costs, because expensive procedures can be denied to patients who need common-sense care, it also is risky.

That should tell Congress to reconsider the patients' bill of rights legislation that did not receive serious debate last year because of objections from the health insurance lobby.

If four of 10 Americans think doctors are secondary to insurance bureaucrats in the decision-making process, and when one in seven Americans cannot get decent medical care, health-care reform is far from complete.

FDCH Federal Department and Agency Documents
February 11, 1999; Thursday

AGENCY: DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEADLINE: THE CLINTON ADMINISTRATION'S INITIATIVE TO IMPROVE HEALTH CARE ACCESS FOR UNINSURED WORKERS

CONTACT: (202) 690-6343

Overview: The Clinton Administration has taken a number of important steps since 1993 to expand coverage and respond to rapid changes in the U.S. health care system. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed both making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. Many providers of free or low-cost health care services currently do not have the resources or technical capacity necessary to coordinate their efforts with other providers. This initiative, funded at \$1 billion over 5 years, will help fill that gap. The bulk of the funding would provide federal grants to help community health clinics, health departments, public hospitals, academic health centers, and other providers of free or low cost health services to create networks that strengthen comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into a "seamless" system of care for low-income working families.

A key emphasis in the early years of the program will be assisting communities and providers in the development of the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured, reaching approximately 100 communities over five years. Although need will vary by community, the focus will be on expanding access to primary health care and ensuring that it is coordinated with other health care needs, including mental health and substance abuse services.

Millions of Americans still lack health insurance. In 1997, the number of Americans without health insurance stood at over 43 million. While the Children's Health Insurance Program and increased Medicaid outreach can potentially provide insurance coverage for about half of the approximately 11 million uninsured children, roughly 32 million adults between the ages of 19 and 64 remain uninsured. Among these uninsured adults, about 17 million have incomes below 200 percent of the poverty level. Many of them receive their care at community health clinics and local hospitals.

Many of these Americans suffer from multiple health problems and require access to a coordinated set of health care services. Yet data show that these needs are not being met. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. They were only about half as likely to receive a routine check-up as insured adults. Among those who did have a regular source of care, uninsured adults were about five times more likely than insured adults to use the emergency room as their regular source of care.

Health care providers that help uninsured Americans face many pressures. These providers consist of institutions, facilities, and individual health professionals that provide a significant volume of health care services, either without payment or on a reduced fee basis, to those who are uninsured. They face a number of challenges, such as increases in the number of uninsured workers, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

The Clinton Administration proposes strengthening health services for uninsured workers. To respond to these needs, the President's fiscal year 2000 budget will propose a competitive grant program that would provide \$1 billion over five years to strengthen public and private entities in 100 communities, increasing the availability of comprehensive, coordinated health care for uninsured workers. The President will request \$25 million for the first year of this initiative in his fiscal year 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Those who provide health care to the uninsured will get help to create the infrastructure they need to provide quality care. A key emphasis in the early years of the program will be assisting communities and providers to develop the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development

of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. This support will improve the ability of providers to track patient care needs and receipt of service over time; permit more clients to be served; and strengthen the financial standing of providers by enhancing their ability to compete for business from Medicaid and commercial managed care organizations. Once a coordinated system has been established within a community, uninsured workers will gain entry into a coordinated health care system that meets their individual needs.

Once health services are coordinated in a community, gaps in service can be identified and filled. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the emphasis will be on expanding access to primary health care and insuring coordination with other health care needs, including mental health and substance abuse services.

There is a history of bipartisan support for coordinating health care for uninsured workers. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. Support for coordinating community health services has been bipartisan, and the Administration looks forward to building that kind of consensus around this new initiative.

The Clinton Administration builds on a strong record of extending health care services to more Americans. Since 1993, HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. In 1996, the President signed the Kassebaum-Kennedy act, which ensured that Americans could take their health care with them when they changed jobs. In 1997, under the Balanced Budget Act, the Administration successfully supported the Children's Health Insurance Program (CHIP). Since then, 49 states and territories have had their CHIP plan approved by the U.S. Department of Health and Human Services.

Model Programs:

Urban - Sunset Park is a large community health center providing services to over 82,000 residents of Southwest Brooklyn, New York every year. Sunset Park is a multi-site system, operating as a managed care network, that offers primary care facilities, a school health program, and a mental health center which includes mental health and substance abuse treatment along with HIV/AIDS services and primary care. The network offers

a full array of ancillary and diagnostic services, rehabilitation and early intervention programs, WIC nutrition programs, social services, comprehensive health promotion/disease prevention activities, and HIV counseling and testing.

Rural - Family Health Center of Marshfield, Inc. (FHC) serves eleven counties in rural north central Wisconsin. FHC offers an insurance-like package of benefits that encompass preventive, primary and secondary physician care, and prescription drugs. FHC also works with local rural hospitals to provide outpatient and emergency room services. FHC has a large grassroots referral network which includes existing and past members, clergy, providers, social service agencies, and many other private and public agencies. FHC has leveraged significant resources to assist Marshfield Clinic in the development of an immunization registry and is now seeking to link population-based registry outreach efforts with health benefits counseling in order to help identify children eligible but not enrolled in Medicaid.

Federal News Service
FEBRUARY 11, 1999, THURSDAY

HEADLINE: PREPARED STATEMENT OF
HONORABLE NANCY-ANN MIN DEPARLE
ADMINSTRATOR, HEALTH CARE FINANCING ADMINISTRATION
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
SUBJECT - MANAGEMENT OF THE MEDICARE PROGRAM

BODY:

Chairman Thomas, Congressman Stark, distinguished committee members, thank you for inviting me to discuss our progress in strengthening Health Care Financing Administration (HCFA) management of Medicare and our other programs and responsibilities. I would also like to thank the General Accounting Office (GAO) for its evaluation and advice on this and other subjects over the past year since I became Administrator.

beneficiaries. States also must be Year 2000 compliant for Medicaid and CHIP programs to continue uninterrupted service. Our monitoring indicates that some States and providers could well fail. We are providing assistance to the extent that we are able, ...

... beneficiaries in managed care, consumer protections in the private insurance market, and consumer protections in nursing homes.

Children's Health Insurance Program. We are implementing the new Children's Health Insurance Program, or CHIP. We have approved 50 State and Territory plans, which States expect to cover more than 2.5 million children, most of whom are in working ...

must be Year 2000 compliant for Medicaid and CHIP programs to continue uninterrupted service. Our monitoring indicates that some States and providers could well fail. We are providing assistance to the extent that we are able, but that likely will not be enough

Federal News Service
FEBRUARY 10, 1999, WEDNESDAY

HEADLINE: PREPARED TESTIMONY OF
THE HONORABLE DONNA SHALALA
U.S. SECRETARY OF HEALTH AND HUMAN SERVICES
BEFORE THE HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND
RELATED AGENCIES

... Department resources in the effort to provide health education, prevention, and treatment services targeted to minority populations. Medicare, Medicaid, and the Children's Health Insurance Program Our budget also includes a variety of legislative proposals to expand access to Medicare and Medicaid for groups that would otherwise be denied health ...

... disease management techniques, derived in large part from NIH-funded research, for children enrolled in Medicaid and CHIP. Participating States will measure success in reducing asthma related incidents such as emergency room visits and length of hospital ...

... steps to support families of all types, ranging from the Earned Income and Child Tax Credits to the Family and Medical Leave Act and the Children's Health Insurance Program. The next step we must take is to help all parents find child care that is safe, reliable, and affordable. This is not only ...

3/26
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Gannett News Service
February 10, 1999, Wednesday, FINAL EDITION

All but one state have federal approval to cover uninsured children
BYLINE: ELIZABETH NEUS; Gannett News Service

WASHINGTON - The 15-month-old federally sponsored program to help children of the working poor get medical care already has some success stories: teens seeing the dentist for the first time, a boy with a brain tumor getting insurance coverage, children eligible for Medicaid finding their way into that program.

At least 10 states already have permission to expand their original Children Health Insurance Programs (CHIP) , and Wyoming and Washington, which initially chose not to seek federal funding, may this year join the list of states that have asked for their share of the \$ 4.3 billion appropriated by Congress in 1998.

"We've seen a lot of activity, and from our perspective that's good," said Greg Haifley of the children's advocacy group, the Children's Defense Fund. "We're going to get a lot of Medicaid kids (into the program) and a lot of CHIP kids in."

Of the 48 states that requested permission to start a program since the more than \$ 24 billion program began Oct. 1, 1997, 47 have gotten approval. Tennessee is the only one outstanding. The Virgin Islands, Puerto Rico and the District of Columbia have also begun CHIP plans, and Guam and American Samoa are awaiting approval.

About 11 million children in America lack health insurance. Most are the children of poor working parents, who don't have health insurance on the job and cannot afford their own coverage, but who make too much to qualify for the Medicaid health program provided to those on welfare.

Federal officials think about 4 million of these children are eligible for Medicaid but are not enrolled. The states estimate that their programs will cover about 2.5 million of the 11 million once their plans are implemented.

States design their own programs to cover children, and match the federal money allocated to them. The yearly amounts per state vary from Vermont's \$ 3.9 million to California's \$ 855 million.

The children eligible for the coverage are those who do not already qualify for Medicaid, who don't have another source of health insurance, and whose family income is 200 percent of poverty or below (about \$ 33,000 a year for a family of four). In some states, children from families with higher incomes may be eligible.

The federal Health Care Financing Administration, which oversees the program, has not yet counted the number of children actually enrolled.

One of the federal government's goals is to use the program as a method of finding children who are eligible for Medicaid. Many parents do not apply because they are afraid of the stigma, don't realize their children are eligible or don't want to deal with the paperwork.

"Of all the unintended benefits of the program, the best is how much states are improving their Medicaid programs," Haifley said. "They're shortening application forms, letting them mail them in, eliminating the resource application tests."

Some states are using the same form to enroll a child in either program, for example.

The more hassle a family has to go through to enroll a child in Medicaid, he said, "represents a potential barrier to a family successfully enrolling in the program."

In Alabama, the first state to receive approval for a program, about half the children whose parents attempt to enroll them in "ALKids" turn out to be eligible for Medicaid instead, and are automatically enrolled there, said Fern Shinbaum, assistant director for that state's child health insurance program. Another 30 percent belong in ALKids, and the rest are not eligible for any program, she said.

Response to Alabama's various outreach programs has been so strong that the state will easily meet its goal of enrolling 15,000 children by the end of February, she said. "If we didn't get any more applications, we'll have 15,000 just from what we have on hand," she said.

Alabama is among those states planning to expand the program and wants to focus on children with special needs - particularly those who need treatment for mental illness or are otherwise disabled.

"Our mental health coverage is really limited now," she said.

Other states have had so much success finding uninsured children that Blue Cross has shut down at least two of its 25 Caring Programs, a charitable project that pays for health coverage for about 59,000 children across the nation. Children in Caring Programs in Missouri and North Carolina qualify for state-sponsored CHIP programs in those states.

"Some of our plans have declared victory and are changing the mission of their programs," said Blue Cross spokesman Bill Pierce. "Some have pulled down the tent. What we see this as is victory."

But not everything is moving smoothly everywhere.

California, home to the single-largest plan with a potential 1 million children to cover, has run into problems attracting parents who don't speak English well. It also must simplify its application process more, according to The 100 percent Campaign, a non-profit research organization focusing on children's issues.

But at the same time, according to a December report by the campaign, parents are telling officials in California's Healthy Families (the name of the California CHIP plan) that because they have enrolled, they are able to take their children to the dentist and optometrist for the first time in years.

One father mentioned to a school nurse that his son needed an operation for a brain tumor but that they had no insurance; she told him that Healthy Families was having a sign-up event that night. "He was there before the doors opened, and enrolled his son ... that night," the report said.

"There are a lot of good activities taking place in terms of reaching families," said Dawn Horner, associate director of the Children's Partnership. "But we have a huge number of kids to reach, an unbelievable amount of kids."

The state of California has made an extra \$ 1 million available to local agencies for outreach programs this year, she said, and she's hoping the state's new Democratic governor will be interested in making a bigger push to get children enrolled.

National Public Radio (NPR)
SHOW: MORNING EDITION (10:00 AM on ET)
January 27, 1999, Wednesday

**HEADLINE: CHILDREN'S HEALTH INSURANCE PROGRAM FACES PROBLEMS
ENROLLING CHILDREN IN THE PLAN BECAUSE THEY LACK THE MONETARY MEANS
TO GET THE WORD OUT**

ANCHORS: BOB EDWARDS REPORTERS: VICKI QUE

BOB EDWARDS, host:

It's been more than a year since Congress appropriated \$ 24 billion to create the Children's Health Insurance Program. The program known by the acronym CHIP gives money to states so they can provide health insurance for low-income children. Most states have set up their CHIP programs and received a share of the federal funds, but others are having trouble signing up qualified children. When the program was created, health-care experts said they anticipated problems with enrollment, because Medicaid had experienced similar difficulties. NPR's Vicki Que reports.

VICKI QUE reporting:

It's estimated that nearly 11 million children in America have no health insurance, even though a third of them qualify for Medicaid, the government's health insurance program for the poor. Medicaid officials say the children are not enrolled because parents have not come forward to sign them up. Now the new health insurance program for low-income children seems to be running into some of the same problems. Federal officials say enrollment in some states--South Carolina, for example--is on target, but others have run into difficulty. Among them is California, which has nearly three million uninsured children. State officials hope to enroll 200,000 children into their new program by the end of its first year. But after six months, only about 55,000 children are signed up. Wendy Lazarus, the director of the Santa Monica-based Children's Partnership, says there were a number of problems with the state's enrollment system.

Ms. WENDY LAZARUS (Children's Partnership): The most serious was this really long application form, which would have put off even the most conscientious parent. It was a 28-page packet. Some of it was the application form; some of it was the instruction, but it was daunting.

QUE: California officials worked with Lazarus and other children's advocates to simplify the language on their application form and shorten it to four pages. The state hopes to begin using the new form by early spring. Two other problems, according to Lazarus, affect California, New York and other states with large immigrant populations. Many families don't realize that their children are eligible for assistance. The program covers children born in the US to immigrant families. Children born here are citizens themselves. And it covers legal immigrants who have been in the US since August of 1996. But even when immigrant families know about their eligibility, they sometimes think that signing up could be bad for the family.

Ms. LAZARUS: What needs to be done is the Immigration and Naturalization Service needs to write a very clear policy in very simple language that says it will not be used against the family when the parents apply for citizenship.

QUE: But the enrollment problems go well beyond immigrants. Trish Riley, who heads the National

Academy for State Health Policy based in Portland, Maine, has been tracking state efforts to insure children. Riley says it's become clear that getting the word out, doing what's called outreach, is crucial to making these programs successful. But outreach is expensive, and CHIP rules say states can only spend 10 percent of the funds on outreach.

Ms. TRISH RILEY (National Academy for State Health Policy): So it's a catch-22. Until you get children enrolled in the program, you can't draw down the federal funds, so you're not eligible for the 10 percent to pay for the outreach to enroll them until you actually get the kids in it.

QUE: To help states find eligible families, the Clinton administration is working to set up a national toll-free hot line which families could call to get information about the Children's Health Insurance Program where they live. And the Robert Wood Johnson Foundation, a private health-care philanthropy, has created a \$ 47 million program which awards grants to help states and community coalitions sign up uninsured children for health benefits. Vicki Que, NPR News.

Health Line
January 22, 1999

CHILDREN'S HEALTH: AHCPR ISSUES RFA FOR RESEARCH

The Agency for Health Care Policy and Research (AHCPR) and the David and Lucile Packard Foundation this week announced a request for applications for funding for projects to study health care delivery for low-income children. "We have an historic opportunity to learn about the impact of public insurance programs on the access to and quality of care for low-income children," said AHCPR Deputy Administrator Lisa Simpson. "This solicitation especially encourages research on how managed care and other recent changes in the financing and delivery of health care affect minority children and those with special health care needs -- two understudied populations." Applicants should focus on how the features of insurance programs and the organization of health care delivery systems associated with these programs affect access to services and the quality of care received by low-income children. Studies will fall into one or both of two categories: enrollee studies that examine the impact on low-income children enrolled in insurance programs; and community studies that examine the impact in a low-income community's health care delivery system and all children that it serves. Dr. Gene Lewit, senior program manager in the Children, Families and Communities Program of the Packard Foundation, said, "The Children's Health Insurance Program provides an important opportunity to engage in these community studies. In addition, studies to be funded under this (request for applications) should provide information that will be useful in designing and modifying CHIP and other health care programs for low-income children." AHCPR and the Packard Foundation will award \$2 million for the research next year for five to eight projects, and \$6 million over three years. Applications are due by April 22, 1999. for more information contact AHCPR's contractor, Equals Three Communications, Inc. at (301) 656-3100 (release, 1/20).

RURAL PROGRAMS TARGETING CHILDREN DEMAND CULTURAL SENSITIVITY

To reach uninsured children in the nation's rural and frontier areas, aggressive outreach that addresses cultural issues is critical. While there are no one-size-fits-all approaches to increasing access to healthcare services in rural communities, outreach efforts that address key misperceptions about CHIP (Children's Health Insurance Program) will have a higher rate of success, says Linda Rouse, government affairs special assistant for the National Rural Health Association in Washington, D.C.

One of the primary obstacles is the absence of rural mandates for states in administering the \$4.8 billion that they receive annually to provide healthcare outreach. Other social barriers include:

- * CHIP being perceived as a "welfare handout," particularly in states where CHIP is administered through its Medicaid program.

- * Immigrant families being fearful that their residency will be questioned if they pursue insurance for their children.

For perspective, there are 22 million Americans living in the 802 counties designated as Health Professional Shortage Areas, according to NRHA. While there are no statistics available on the number of uninsured children in rural areas, 22.4 percent of rural children are in poverty and at high risk for being uninsured.

To put a dint in the problem in one state, California earlier this month awarded Blue Cross of California a \$1.5 million grant to increase access to healthcare coverage for children in rural areas. The grant will target children of seasonal and migrant farm workers and Native Americans. California has 600,000 uninsured children - 50% are in the Los Angeles area with the rest spread throughout the state.

The funds were awarded by the Managed Risk Medical Insurance Board, the state agency that administers the Healthy Families Program, which provides low-cost healthcare coverage to children of medium- income working families. The grant will fund 20 rural projects.

Here, BCC relies on at least 45 outreach specialists to be the eyes and ears of the state's rural communities and to do "whatever it takes to get the job done," says Christopher Champlin, BCC's director of health education and sales promotion. These specialists do "county sweeps" in 28 rural areas, educating small business owners, community centers, health officials and schools about BCC's Healthy Families program. What works best is comparing the cost of the health coverage to the cost of a McDonald's extra value meal - about \$4 a month, says Champlin.

The "handout" issue and illegal immigrant concerns are prevalent for rural families in California, particularly in farming communities where being self-sufficient is a strong value. This is why the McDonald's analogy is so important in addition to positioning Healthy Families as a non-Medi-Cal healthcare service, says Champlin. Medi-Cal is the state's Medicaid program.

(NRHA, Linda Rouse, 202/232-6200; BCC, Chris Champlin, 805/384- 3614)

FDCH Federal Department and Agency Documents

January 11, 1999; Monday

HEADLINE: THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CONTACT: (202) 690-6145

Overview: Proposed by President Clinton and passed as part of the historic, bipartisan Balanced Budget Act of 1997, the Children's Health Insurance Program (CHIP). CHIP is the largest single expansion of health insurance coverage for children in more than 30 years. Today, nearly 11 million American children -- one in seven -- are uninsured. To reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, this new initiative set aside \$24 billion over five years for states to provide new health coverage for millions of children -- the largest children's health care investment since the creation of Medicaid in 1965. States will be able to use part of their federal funds to expand outreach and ensure that all children eligible for Medicaid and the new CHIP program are enrolled. More than 4 million uninsured children are eligible but not signed up for Medicaid.

To improve the health of our nation's children, the President has challenged the public and private sectors to work together to educate families and help them enroll their children in Medicaid or CHIP. The initiative is a partnership between the federal and state governments that will help provide children with the health coverage they need to grow up healthy and strong. At President Clinton's insistence, the CHIP program requires that states use this new money to cover uninsured children -- and not replace existing health coverage. The program also includes important cost-sharing protections so that families will not be burdened with heavy out-of-pocket expenses.

Funds for the program became available to the states on October 1, 1997, and HHS is working closely with states as they design plans in accordance with the new law. During January and February 1998, HHS sponsored nine regional conferences to help inform states of all the options available to cover children under CHIP.

Majority of state CHIP plans have been approved. In the 15 months since the program was created on October 1, 1997, 52 states and territories have submitted CHIP plans for approval by the Department of Health and Human Services. CHIP plans have been approved for 49 states and territories: Alabama, Colorado, South Carolina, Florida, Ohio, California, New York, Illinois, Michigan, Connecticut, New Jersey, Missouri, Rhode Island, Oklahoma, Massachusetts, Pennsylvania, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, the Virgin Islands, the District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky, Alaska, Vermont, and New Mexico. In addition, the following state plans have been submitted: Tennessee, Hawaii, and Guam. According to states' estimates, more than 2.8 million children will be covered when these CHIP plans are fully implemented.

EXPANDING CHILDREN'S ACCESS TO HEALTH COVERAGE

The federal-state Children's Health Insurance Program (CHIP), created under the new Title XXI of the Social Security Act, will expand health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. It builds on Medicaid, the federal-state health insurance program that covers approximately 36 million low-income individuals, including 18 million children. Because Medicaid allows states flexibility in determining eligibility, states currently

cover children whose family incomes range generally from below the federal poverty level to as high as 300 percent of poverty. (Note: One State, Tennessee, has no upper income cap.) The majority of states cover children in families between 100 and 150 percent of the federal poverty level (FPL). In the new CHIP program, states may either cover children in families whose incomes are above the Medicaid eligibility threshold but less than 200 percent of poverty, or within 50 percentage points over the state's current Medicaid income limit for children.

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

Limiting Patient Costs. Patient out-of-pocket costs for this program are allowed but are limited. If a state expands its Medicaid program, then existing Medicaid limits apply to the newly enrolled children. If a new health plan is developed, premiums for families whose income is under 150 percent of the poverty level cannot exceed \$19 per family per month and copayments must be nominal. Cost sharing is not permitted for well-child, well-baby visits.

For families with incomes above 150 percent of poverty, cost-sharing must be based on an income-related sliding scale with an annual total for all children not to exceed five percent of the family's income.

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

ACCESSING FEDERAL FUNDING

Under the new law, states are eligible to receive an enhanced federal matching rate drawn from an "allotment" for state programs approved by the Secretary of Health and Human Services that expand access to targeted, low-income children under the new CHIP program. Funds will be allocated to each participating state according to their number of uninsured low-income children, accounting for regional cost differences. Available state allocations for FY 1998, which were published in the Federal Register in September 1997, range from \$3.5 million for Vermont's relatively small population to a high of \$855 million for California. States may use up to 10 percent of the CHIP benefit expenditures for outreach, services other than the standard benefit package for eligible children, and administrative costs. To access the FY 1998 allocation, states must have their CHIP

plans approved by the Secretary of Health and Human Services by Sept. 30, 1999. The FY 1999 budget includes \$4.275 billion for FY 1999 state allotments. Funds will be allocated in the same proportion as they were in FY 1998.

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

EXPANDING OUTREACH

The Clinton Administration has made significant efforts to reach out to families whose children qualify for CHIP. These efforts include: New Presidential Directive to Launch a Government-Wide Effort to Enroll Uninsured Children. On February 18, 1998, in an executive memorandum to all federal agencies with jurisdiction over children's programs, President Clinton directed the establishment of a multi-agency effort to enroll uninsured children. The Departments of Agriculture, Interior, Education, Health and Human Services, Housing and Urban Development, Interior, Labor, and Treasury and the Social Security Administration, run programs such as WIC, Head Start, food stamps and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. The memorandum instructed these agencies: to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and to report back in 90 days on their plan to help enroll uninsured children. The Announcement of an Historic Private Sector Commitment to Provide Outreach. On February 18, 1998, the President announced unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

A new toll-free number that directs families around the nation to their state enrollment centers. The President announced that the National Governors' Association with a grant from Bell Atlantic will establish and operate a toll-free number to help states reach uninsured children and will automatically direct millions of families around the nation to their local state enrollment agency. The toll-free number and a radio advertising campaign to raise awareness were launched preliminarily in eight states - Colorado, South Carolina, Utah, Indiana, Idaho, Massachusetts, Pennsylvania, and Delaware -- on November 9, 1998. The toll-free hotline will be expanded nationwide in early 1999.

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

New initiatives from corporate and advocacy organizations to reach out to uninsured children. Procter

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

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

Since 1993, HHS has approved Medicaid waivers for 18 states for comprehensive health care reform projects that have allowed states to control costs and expand coverage. In addition, HHS has approved requests from 19 states for Medicaid waivers as part of larger welfare reform projects, as well as 25 local Medicaid demonstration projects. When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured. President Clinton also signed into law the Health Insurance Portability and Accountability Act of 1996, creating important new protections for an estimated 25 million Americans (approximately 1 in 10) who move from one job to another, who are self-employed, or who have pre-existing medical conditions.

CHIP also builds on the Clinton Administration's long standing commitment to improving health care for children. The President has issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. He also recently announced that in 1996, over 90 percent of America's toddlers received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal he set in 1993. And, the FDA recently released a rule that requires manufacturers to do studies on pediatric populations for new prescription drugs as well as those currently on the market. Combined, this administration's efforts will help assure that children get the healthy start they need to live long and productive lives.

STATE CHIP PROGRAMS

Descriptions of approved state CHIP programs follow:

Alabama

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

Alaska

Alaska could receive as much as \$5.66 million in FY 1998 funds for its CHIP plan. Alaska will use its CHIP allocation to expand its Medicaid program. Currently, the state covers children to age 1 in families with incomes up to 185 percent of the FPL, children 1-6 in families with incomes up to 133 percent of poverty, and children ages 6-19 in families with incomes up to 100 percent of poverty.

The state will use its Title XXI funds to expand Medicaid coverage to children in families with incomes up to 200 percent of the FPL. Eligible children will receive the full Medicaid benefit package and there are no cost sharing requirements. To reach eligible children, the state will work with local governments, schools, health care providers, tribal entities, and non-profit corporations serving children. The state plans to implement expanded eligibility on March 1, 1999 and it expects to enroll 4,900 children by October 2000. Alaska's plan was approved December 11, 1998.

Arizona

Arizona could receive as much as \$113 million in FY 1998 funds for its CHIP plan. Arizona will use its CHIP allocation to create, KidsCare, a new health insurance program which will cover children from birth through age 15. Income eligibility will increase over time, beginning at 150 percent of the FPL and rising to 175 percent on July 1, 1999, then to 200 percent from 2000 through 2007. The state expects to insure nearly 50,000 children by September 2000. Enrollees will receive coverage through established Arizona Health Care Cost Containment System plans and state employee health maintenance organizations that elect to participate in the program.

American Indians may choose to receive services through the Indian Health Service as well. Participants will pay a \$5 copayment for non-emergency use of the emergency room. To assist with outreach, the state has created an Outreach Coordinator position and has sent applications to organizations that serve low-income children. Arizona was approved on September 18, 1998.

Arkansas

Arkansas could receive as much as \$47 million in FY 1998 funds for its CHIP program. The state will use its CHIP allocation to expand Medicaid coverage to nearly 3,600 children who would otherwise not have health insurance. It will cover children born after September 30, 1982 and prior to October 1, 1983 whose family income is at or below 100 percent of the FPL. Arkansas is currently considering how to structure the second phase of its Title XXI program to cover even more children. The state currently has a Medicaid section 1115 waiver, ARKids First, that serves children through age 18 with family incomes up to 200 percent of poverty. Outreach activities will include radio and TV ads, a direct mail campaign, a toll-free number, and print advertising. Arkansas was approved on August 6, 1998.

California

California could receive as much as \$855 million in new funds for FY 1998. The state will expand its Medicaid program, known as Medi-Cal, by implementing an income disregard and by making children under age 19 eligible if they have family incomes at or below 100 percent of the federal poverty level. The state will also expand its current state program, known as Access for Infants and Mothers (AIM), which will cover infants up to age 1 from 200 percent to 250 percent of poverty. Through CHIP, California will also expand its Healthy Families program, which will provide coverage for children age 1-19 with family incomes from 100 percent to 200 percent of the federal poverty level. California insuring 500,000 children by the end of FY 1998. As part of its outreach efforts, California will subcontract for a media campaign with private and community based organizations, health brokers and insurance agents to directly identify and assist potential enrollees in filling out the joint application form for the Medi-Cal and Healthy Families program. In addition, California will conduct a provider education campaign to support its outreach effort. California was approved on March 24, 1998.

Colorado

Colorado could receive up to \$42 million in federal CHIP funds for FY 1998. The state will expand children's access to health coverage by building on its own Colorado Child Health Plan. The state expects to cover a total of 23,000 children under this non-Medicaid managed care plan by the third year.

The benefit package will include services such as hospital and emergency room transport, inpatient services, medical office visits, and prescription drugs. Coverage will be provided to children from birth through age 17 for families whose income is at or below 185 percent of the federal poverty level. The state will publicize the program through press releases, public service announcements, schools, employers, county agencies and regional and social agencies. Colorado was approved on February 18, 1998.

Connecticut

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

Delaware

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

District of Columbia

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

Florida

Florida could receive as much as \$270 million in fiscal 1998 funds for its CHIP plan. Phase One of Florida's new CHIP plan expanded Medicaid eligibility to children in families earning up to 100 percent of the FPL and expanded Florida's Healthy Kids program, a comprehensive program that was piloted in 20 counties, to additional counties. Phase Two will create the Florida KidCare Program which consists of:

expanding the Healthy Kids program on a state- wide basis and expanding eligibility for the program to children through age 18 in families with incomes up to 200 percent of FPL; creating the MediKids program to provide coverage for children up to age 5; creating the Children's Medical Services Network for children up to 18 with special needs; and expanding Medicaid to cover children ages 15 - 19 to 100 percent of FPL. The state plans to simplify its enrollment form and enrollment process and is developing an outreach strategy. State officials hope to enroll 175,000 children in the combined Florida Kidcare program by July 1, 1999. Florida received its plan approval on March 5, 1998, and its amendment approval on September 8, 1998.

Georgia

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

Idaho

Idaho could receive as much as \$15.8 million in new funds for FY 1998, which state officials will use to insure nearly 5,000 children. Idaho will use its new CHIP allocation to expand Medicaid eligibility to children up to age 19 in families with incomes up to 160 percent of the federal poverty level. Due to state legislation, the income threshold will be 150 percent of the federal poverty level effective, July 1, 1998. The state has formed a task force to study ways of further expanding Idaho's CHIP program. Children in the Medicaid expansion will receive the state's standard Medicaid benefit package, which includes inpatient and outpatient hospital services, inpatient psychiatric care, physician services, dental services, home health services, lab services, and prescription drugs. Outreach activities include mailing postcards to potential enrollees describing Title XXI. The mailing list is comprised of families who have lost cash assistance between April and December 1997. Idaho was approved on June 15, 1998.

Illinois

Illinois could receive as much as \$123 million in new funds for FY 1998, which state officials will use to insure 40,000 additional children within the next three years. With its CHIP allotment, Illinois will expand Medicaid eligibility for children up to age 19 whose families have incomes at or below 133 percent of the federal poverty level. Prior to the CHIP expansion, the income level for Medicaid eligibility varied based on the age of the child. Under the new program, income thresholds have been equalized. State outreach efforts will include reviewing automated records to identify eligible participants followed by the notification of those individuals. In addition, the Illinois Department of Public Aid will send a notice to all non-assistance Child Support families informing them of the program and of locations where families can go to enroll their children. Illinois was approved on April 1, 1998.

Indiana

Under the CHIP program, Indiana could receive as much as \$70.5 million in new funds for FY 1998. Indiana will use its new allocation to expand its Medicaid program and estimate that they will insure as many as 58,000 more children by the year 2000. The program will expand eligibility to children up to age 19 in families with incomes up to 150 percent of the federal poverty level, and the state has formed a task force to study ways to further expand its CHIP program. Children in the Medicaid expansion population will receive the state's standard Medicaid benefit package, which includes inpatient and outpatient hospital services, inpatient psychiatric care, physician services, dental services, home health care, lab services and prescription drugs. To raise awareness about the program, the state will launch a media

campaign and conduct outreach through state and local government agencies and community organizations. Indiana's CHIP plan was approved on June 26, 1998.

Iowa

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

Kansas

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

Kentucky

Kentucky could receive as much as \$49.9 million in federal FY 1998 funds for its CHIP plan. Kentucky will use its allotment to both expand its Medicaid program and launch a separate insurance program called K-CHIP. Children ages 14-18 who are in families with incomes up to 100 percent of the FPL will be enrolled in CHIP as a Medicaid expansion. Children through age-18 in families with incomes up to 200 percent of the FPL, and who are not eligible for Medicaid, will be enrolled in K-CHIP. The K-CHIP benefit plan will be a benchmark equivalent to the Standard High Option HMO plan for state employees. Benefits will also include all basic services such as inpatient and outpatient hospital services, physicians' surgical and medical services; laboratory and x-ray services, and well-baby and well-child care. There is some cost sharing, but costs will not exclude 5 percent of family income. Families with incomes between 100 and 133 percent of the FPL will pay a \$10 premium for a six-month period. Families with incomes between 134 and 149 percent of the FPL will pay a maximum premium of \$20 for a six-month period. Families with incomes between 150 and 200 percent of the FPL will pay a maximum of \$120 for a six-month period, and payments can be made at \$20 each month or \$60 per quarter. To reach eligible children, the state will conduct a media campaign and outreach activities at schools, clinics, community centers, health fairs, health departments, and housing projects. Kentucky expects to enroll nearly 50,000 children by June 2000. Kentucky's plan was approved November 25, 1998.

Louisiana

Louisiana could receive as much as \$102 million in federal FY 1998 CHIP funds for its CHIP plan. The state will use its allotment to expand Medicaid to children ages 6 through 18 whose family income is at or below 100 percent of the Federal poverty level. The benefit package will be the regular state Medicaid program and there will be no cost sharing for families. The state plans to launch a large

outreach campaign to educate potential CHIP enrollees. The campaign will include media advertising and mailing to specific target audience groups, including low income working parents, current and former recipients of Families Independence-Temporary Assistance Program, children with special needs, Native Americans, and migrant children. Louisiana estimates it will enroll more than 28,000 children by the end of September 2000. Louisiana's plan was approved October 20, 1998.

Maine

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

Maryland

Maryland could receive as much as \$62 million in federal FY 1998 funds. Maryland will expand its Medicaid program with its new CHIP allotment to an estimated 15,500 uninsured children. Under the CHIP plan, children between birth and age 19 whose family incomes are below 200 percent of poverty will receive coverage. Children covered by CHIP will receive the Medicaid benefits package. To reach families who might be eligible for CHIP, the state will launch a grassroots information dissemination campaign involving state agencies, advocacy and community groups and provider organizations. In addition, the state will launch a public media and advertising campaign to include television, radio, mass transit, and newspaper advertising. Maryland was approved July 31, 1998.

Massachusetts

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

Michigan

Michigan could receive as much as \$92 million in federal FY 1998 funds, which state officials will use to insure as many as 133,000 new children by September 2000. The state will use its new allocation to implement MICHild. The program will provide comprehensive health care coverage to all children under age 19 whose families have incomes at or below 200 percent of the federal poverty level. The benefit package will mirror the state employees' plan and will be administered by multiple managed care providers. MICHild will not impose co-payments on families with incomes at or below 150 percent of

poverty. Some co-payments will apply for families between 151-200 percent of poverty. The state's outreach efforts will include demographically-targeted media campaigns and coordination with relevant community programs and agencies. Michigan's plan was approved on April 7, 1998.

Minnesota

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

Mississippi

Mississippi could receive as much as \$56 million in federal FY 1998 funds for its children's health insurance plan. Mississippi will expand Medicaid to cover children ages 15 through 18 in families with incomes up to 100 percent of the federal poverty level. The state estimates it will enroll 7,500 children by the end of FY 1999 and 12,000 children by the end of FY 2000. Recipients will receive the regular Medicaid benefit package and there are no cost sharing requirements. As part of an outreach plan, Mississippi will develop a broad based media campaign that will include television, radio and print advertisements. In addition, it will provide information to community health care providers, hospitals, health clinics, Indian reservations and schools. Mississippi's plan was approved October 26, 1998.

Missouri

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

Montana

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

Nebraska

Nebraska could receive approximately \$15 million in federal CHIP funds for FY 1998. The first phase, Kids Connection Phase I, expanded Medicaid coverage to children age 15 through 18 whose family income is at or below 100 percent of the federal poverty level. Enrollees in Phase I received the state's regular Medicaid benefit package. Kids Connection Phase I was expected to enroll about 1,000 children. The amendment, Kids Connection Phase II, expanded Medicaid eligibility to children under age 19 whose family incomes are up to 185 percent of the Federal poverty level. Kids Connection II is expected to reach 16,000 children by October 2000. To encourage enrollment, the state will work with advocacy agencies in disseminating information as well as distribute pamphlets and brochures. Neither phase has cost-sharing for enrollees. The state's original plan was approved August 7, 1998, and an amendment was approved October 13, 1998.

Nevada

Nevada could receive as much as \$30 million in new funds for FY 1998. With its new CHIP allotment, the state will create, Nevada Check Up, a statewide health insurance program which will provide coverage to children up to age 18 in families with incomes at or below 200 percent of poverty. The Nevada Check Up program is estimated to cover 43,500 children in its first year. To encourage enrollment, the state has simplified the CHIP eligibility application, which will be available statewide through schools, child care facilities, family resource centers, social service agencies, and other locations where eligible children and/or their parents frequent. The state has also established a toll-free information number, which is listed on posters, marketing brochures, and the application form. Public service announcements are also planned. Nevada's plan was approved on August 13, 1998.

New Hampshire

New Hampshire could receive as much as \$11 million in new funds for the FY 1998 allocation of its CHIP funds. The state will use its CHIP allocation to expand its Medicaid program and create a separate statewide children's health insurance program. Healthy Kids-Gold, or Phase I, will expand Medicaid eligibility for newborns and infants up to age one in families with incomes up to 300 percent of the FPL. Healthy Kids-Silver, or Phase II, will be a separate statewide health insurance plan that will mirror the benefit package offered to federal employees in the state. Healthy Kids-Silver is aimed at children ages 1 to 19 in families with incomes up to 300 percent of poverty. In order to expand its coverage to this level of family income, the state will apply an income disregard-setting aside certain types of income the family may have. The state expects to insure 4,000 children by September 2000. New Hampshire's plan was approved September 16, 1998.

New Jersey

New Jersey could receive approximately \$89 million in new funds for FY 1998, which state officials will use to insure as many as 102,000 new children by the end of the program's first year. The state will use its new allocation to create NJKidCare which will include a Medicaid expansion and a new state CHIP plan. The Medicaid expansion will provide comprehensive health care coverage to all children under age 19 whose families have incomes at or below 133 percent of the federal poverty level. The new CHIP insurance program will be targeted to children in families with incomes above 133 percent to 200 percent of poverty. The new program will charge families a \$15 per month premium. The state will have a fourfold outreach effort which will include: public awareness, targeted outreach, community education, and consumer education. The state is also committed to targeting outreach to special populations such as HIV and homeless populations. New Jersey's plan was approved on April 27, 1998.

New Mexico

New Mexico could receive as much as \$57 million in federal FY 1998 funds for its CHIP plan. The state will use its allotment to expand its Medicaid program for children from birth to age 18 in families with incomes up to 235 percent of the FPL. Enrollees will receive the state's Medicaid benefit package. Families with incomes between 186 and 235 percent of the FPL will pay copayments of \$5 for most services, but cost sharing cannot exceed five percent of a family's income. In accordance with the CHIP law, preventive services and prenatal care are exempt from cost sharing. Working with a private contractor, the state will conduct a public awareness campaign to inform potential enrollees. In addition, New Mexico will work with the Indian Health Service to assure CHIP access to American Indians. New Mexico expects to insure 5,000 children by September 30, 2000. Its CHIP plan was approved January 11, 1999.

New York

New York was one of three states for which existing children's health coverage benefit packages were "grandfathered" into the CHIP legislation. The state could receive as much as \$256 million in new funds for FY 1998, which state officials will use to insure as many as 360,000 additional children within the next three years. New York will use its new allocation to expand its existing CHPlus program, which currently provides insurance to children up to age 19 whose families have incomes at or below 185 percent of the federal poverty level. CHPlus is a partnership between the state and private insurers with the state subsidizing private coverage for enrollees. The benefit package includes a full range of inpatient and outpatient services. The state's outreach activities will include a statewide media campaign that will be conducted by the New York State Department of Health. New York's plan was approved on April 1, 1998.

North Carolina

North Carolina could receive as much as \$79 million in new funds for FY 1998. North Carolina will use its CHIP allocation to create a separate state health insurance program to provide coverage to uninsured children whose family income does not exceed 200 percent of the federal poverty level. The state expects to insure 35,000 children. Families whose incomes rise above 200 percent of poverty up to a maximum of 225 percent will be able to buy into the program for one year. The benefit package is equivalent to that offered to state employees, plus Medicaid-equivalent benefits for children with special health care needs. North Carolina plans to improve outreach efforts by simplifying the application forms for both Medicaid and CHIP and by using existing public/private partnerships between local departments of health and social services. North Carolina's plan was approved on July 14, 1998.

North Dakota

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

Ohio

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

Oklahoma

Oklahoma could receive as much as \$81 million in new funds for FY 1998, which state officials will use to expand its Medicaid program. With its federal allotment, the state hopes to expand coverage to 71,000 children by the end of the program's first year. Oklahoma will provide the state's regular Medicaid benefit package to the newly-enrolled children. Oklahoma plans to use its CHIP allotment to provide Medicaid coverage to children born on or after October 1, 1983, with family incomes up to 185 percent of the federal poverty level. The Oklahoma Health Care Authority is collaborating with other interested agencies in the state to develop a marketing and outreach plan. The plan will consist of posters, public service announcements, fact sheets, press releases and outdoor advertising. Oklahoma's plan was approved on May 26, 1998.

Oregon

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

Pennsylvania

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

Puerto Rico

Puerto Rico could receive as much as \$9.8 million in new funds for FY 1998 under the CHIP program. Puerto Rico will use its allotment to expand Medicaid eligibility. Medicaid coverage will be expanded to cover children through age 18 in families with incomes below 200 percent of the

commonwealth poverty level (\$8,220 for a family of four). Federal CHIP funding will allow Puerto Rico to cover approximately 20,000 children. Puerto Rico's program will also include children currently under its public health system, which receives no federal funding. Puerto Rico is also unique in that it has elected to contribute more money than the standard federal- state matching funds. Officials in Puerto Rico estimate that there will be 165,000 children in their CHIP plan by the end of FY 1998. Puerto Rico will develop a number of outreach efforts, including disseminating brochures, leaflets, and posters with information on the CHIP program; launching a broad-based media campaign; and appealing directly to eligible children and families. Puerto Rico's plan was approved June 26, 1998.

Rhode Island

Rhode Island could receive as much as \$10.6 million for FY 1998, which state officials will use to insure as many as 3,000 children by the end of FY 2000. Rhode Island will use its allocation to expand its Medicaid program. The program will provide comprehensive health care coverage to children between the ages of 8 and 15 whose family income is between 100 and 250 percent of the federal poverty level. The program will also cover children 15 to 18 whose families have incomes up to 250 percent of poverty. Beginning at 185 percent of the federal poverty level, or about \$30,432 for a family of four, families will begin paying modest premiums or co- payments. In order to effectively reach the target population, various outreach methods will take place. The first phase of Rhode Island's outreach efforts, a public information campaign, will last four months. The second phase of outreach will include follow-up and evaluation activities which will last approximately six months. Rhode Island's plan was approved on May 8, 1998.

South Carolina

South Carolina had already begun to expand its Medicaid program when the new CHIP law was enacted, and could receive over \$63 million in new funds for FY 1998. The state will use its share of CHIP funds to expand its Medicaid program, and hopes to enroll an additional estimated 75,000 children. Regular cost-sharing rules apply and eligibility will be extended to children under age 19 whose family incomes are at or under 150 percent of the federal poverty level. The state has placed eligibility workers in public schools, hospitals, clinics, pharmacies and other places frequented by families with potentially eligible children. South Carolina's plan was approved on February 18, 1998.

South Dakota

South Dakota could receive as much as \$7.5 million for FY 1998. The state will use its CHIP allocation to expand its Medicaid program to insure 7,400 children in its first year. The state will increase eligibility limits for children ages 6 to 18 from the current limit of 100 percent of FPL to 133 percent of FPL. The benefit package for children enrolled in CHIP will be the same as that offered to other children in the state's Medicaid program. Families will not be charged for medical care under this CHIP program. The state will identify eligible children and mail their families applications. South Dakota's plan was approved on August 25, 1998.

Texas

Texas could receive as much as \$561 million in new funds for FY 1998, which state officials estimate that they will use to enroll nearly 58,000 children in their CHIP program by October 1, 1999. Texas will use its allotment to expand Medicaid eligibility to children up to age 19 in families with incomes below 100 percent of the federal poverty level. Texas currently covers children from birth to one in families with incomes up to 185 percent of poverty, ages 1- 5 up to 133 percent of poverty, ages 6-14 up to 100 percent of poverty, and ages 15-19 up to 47 percent of poverty. The state also plans to expand coverage to additional low-income children and families by submitting an amendment to their CHIP program in 1999. Outreach activities will include working the entire network of public health providers to

disseminate outreach materials to providers so that they may supply information to families with potentially eligible children. Texas' plan was approved on June 15, 1998.

Utah

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

Vermont

Vermont could receive as much as \$3.5 million in FY 1998 funds for its CHIP plan. The state will use its allotment to create a separate health insurance program to cover children up to age 18 in families with incomes between 225 and 300 percent of the FPL. Health services to children will be delivered by the managed care organizations that currently provide services under the Vermont Health Access Plan, a Medicaid section 1115 waiver. An amendment to the Medicaid waiver was approved November 6, 1998, allowing the state to expand coverage to underinsured children up to 300 percent of the FPL. The benefits package for the Vermont CHIP program is the same as provided through the state's Medicaid program. The state will charge beneficiaries a premium of \$10 per month per household. Beginning July 1, 1999, providers will be allowed to charge a \$10 copayment for office visits. No copayments will be charged for well-baby and well-child visits. Maximum cost sharing will not be allowed to exceed 5 percent of a family's income. The state will integrate its outreach activities with the current outreach campaign for Medicaid, which includes advertising, brochures, flyers, and outreach through community health and social service providers. Vermont also offers a toll-free telephone line with information on Medicaid and CHIP. Vermont expects to insure 1,088 children by October 2000. Its CHIP plan was approved December 15, 1998.

Virginia

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

Virgin Islands

The Virgin Islands could receive nearly \$280,000 in new funds for FY 1998. The territory will use its CHIP allocation to expand its Medicaid program to children receiving services through a

territory-funded program. CHIP funds will help strengthen federal support for children's health in the Virgin Islands. The local government will not expand eligibility, but the current income level for a family of four is \$8,500 - or about half the level of states. The Virgin Islands' plan was approved September 17, 1998.

West Virginia

West Virginia could receive as much as \$23 million in new funds for FY 1998. The state will use its CHIP allotment to expand Medicaid eligibility to children between the ages of one and five in families with incomes up to 150 percent of FPL. The state currently has an income cutoff for that group of 133 percent of FPL. The newly covered children will receive the regular Medicaid benefit package at no cost to their families. As part of their outreach efforts, the state will include Medicaid information in all free or reduced lunch and textbook applications and the state's toll-free 24 hour hotline will include information on the CHIP program. The state is currently planning a second expansion stage. West Virginia's plan was approved on September 15, 1998.

Wisconsin

Wisconsin could receive as much as \$38 million in new funds for FY 1998, which state officials will use to expand its Medicaid program. The state will initially cover an additional 2,000 children under its Phase One plan for the new federal CHIP program, and will amend its program with a more comprehensive plan in the near future. Wisconsin plans to expand Medicaid eligibility to children ages 15-18 in families with incomes below 100 percent of the federal poverty level. Presently, the state's Medicaid program covers children under age 6 in families with incomes less than 185 percent of poverty, and children ages six to 14 in families with incomes less than 100 percent of poverty. All eligible children will receive the full Medicaid benefit package with no out-of-pocket costs for families. Wisconsin's outreach efforts will include: public health agencies coordinated efforts with schools; the expansion of school-based clinics in 12 Milwaukee public schools; and inclusion of schools as potential outstation sites for Medicaid eligibility workers. Wisconsin's plan was approved May 29, 1998.

**HEADLINE: STATE LEGISLATURES: SURVEY HIGHLIGHTS
PRIORITIES FOR '99**

Managed care reform, long-term care and children's health care are likely to be the hottest health care issues in statehouses next year, according to the National Conference of State Legislatures. The NCSL's Health Policy Tracking Service found that those three issues were named most often in a poll of state legislatures, governor's offices and executive agencies. The annual poll showed that 31 states expect to consider HMO liability, 22 states expect to consider legislation establishing an independent appeal process for denials of care, and 15 states expect to consider "any willing provider" legislation. Other issues likely to receive attention include medical records confidentiality, drug formulary regulation, mental health parity and insuring indigent and high-risk populations.

LONG-TERM ISSUES

Driven by aging populations and highlighted by several prominent elder-care scandals (see AHL 7/27), almost every state expects to consider some aspect of long-term care for the elderly and disabled. Of the 45 states where long-term care services are expected to be on the agenda, 32 are expected to consider legislation on assisted living and nursing facilities and 26 states expect to address the availability of prescription drugs for the elderly. A significant percentage of states expect to consider bills that would extend prescription-writing rights or otherwise expand the scope of practice of non-physicians: 24 states to nurse practitioners, 14 states to pharmacists, 13 states to midwives, 12 states to psychologists and 11 states to physician assistants.

WHAT ABOUT THE KIDS?

Now that almost every state has submitted a children's health plan under the federal CHIP program, many expect to undertake further efforts in that direction -- 40 states plan to consider CHIP enhancements or changes. Many states rushed to enact "placeholder" plans while they took the time to design more far-reaching programs. Twenty-three states are planning to take up school-based health service legislation, 19 expect to consider bills on teenage pregnancy and 11 expect to consider mandatory coverage of hearing screenings for newborns. Also, following the lead of Wisconsin's BadgerCare, more states may attempt to bundle family health plans along with CHIP programs in an attempt to insure more of those who earn too much to qualify for Medicaid but too little to afford private health insurance.