S. HRG. 105-459

INCREASING CHILDREN'S ACCESS TO HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

APRIL 30, 1997

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

47-966—CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-057647-4

S361-27

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INCREASING CHILDREN'S ACCESS TO HEALTH CARE

APRIL 30, 1997

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:52 a.m., in room SD-215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Hatch, D'Amato, Nickles, Gramm, Moynihan, Baucus, Rockefeller, Graham, Moseley-Braun, Bryan, and Kerrey.

The CHAIRMAN. The committee will please be in order.

We are going to change the process a little bit. I understand that, Senator Hatch, you have a very strict time requirement. So, what I would like to do is let you and Senator Kennedy, whom we are very pleased to have with us today, make your statements.

I would ask both of you to try to summarize, because we have a full schedule in trying to meet the requirements of any number of Senators, as well as the panel. But we are delighted to have both of you.

Senator Hatch.

STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. We thank you for this courtesy, for this hearing, and for your leadership role on an issue which I think clearly ranks at the top of our national agenda, and that is the lack of health insurance for many of our Nation's young people. These are people primarily from working families, 86 percent of whom live in families where at least one parent is working, but they do not make enough money to pay for health insurance.

My only regret this morning is that I cannot attend the entire hearing. The Judiciary Committee is currently meeting across the hall to hear testimony by Attorney General Reno on the independent prosecutor issue, and, as chairman, I have to preside.

There are many on this committee and in the Senate who have been working on child health legislation, some with differing perspectives, but all with the same objectives.

I do not have time to recognize each Senator, but I certainly must single out several major bills: Senator Gramm's legislation; the Chafee-Rockefeller-Jeffords-Breaux bill; Senator Daschle's proposal; and, of course, the Hatch-Kennedy Child Health Insurance

and Lower Deficit Act. I am naturally partial to the Child bill, of course, not only because I drafted it along with Senator Kennedy, but also because it is now co-sponsored by 24 Senators.

We are having a healthy dialog, one which I hope will be productive, because the bottom line is the kids, about 10 million of whom do not have health insurance. That is nearly 14 percent of all the children in the United States.

These numbers are obviously disturbing. If we do not get these kids off to a good start, then we will pay more as a society and as a government in the long run.

Senator Kennedy and I have put forth one proposal to address this abysmal situation. We are co-sponsors of the Chafee bill as well, both Senator Kennedy and I.

I see these two pieces of legislation as totally compatible; where Medicaid leaves off, our bill takes up. Senator Kennedy and I have worked very hard at fashioning a bill that is fully financed and provides needed flexibility to the States. We recognize that alternative proposals will be on the table, and we want to work within the Senate to develop a consensus approach. That is the only way to get the job done.

I also wanted to take a moment to welcome two old friends to the committee. First, Christine Ferguson, who will now sit before us as a witness. It is no secret that she has always told us what to do. Now, Christie, you can do that in public.

And also Rich Tarplin, whose nomination as Assistant Secretary for Legislation will be before the committee later today. Rich does a first-rate job. He is a real asset to HHS, and I predict will easily win confirmation. I recommend to all of my colleagues that we support him.

I regret that I need to excuse myself, but you can be sure that I will be reviewing this record carefully, Mr. Chairman. That is all I will say at this particular time, if I may be excused.

The CHAIRMAN. Yes. Thank you very much, Orrin. We appreciate your being here and we understand the conflict.

Senator Kennedy, it is a pleasure to have you.

Senator CHAFEE. Mr. Chairman, before Senator Hatch leaves, could I just briefly say that I want to salute him and Senator Kennedy for the long-time work they have done in connection with children's issues and children's health care. I know Senator Hatch has to rush off, but I think it is right to recognize not only what they both have done here, but on other health issues in the past. So, we want to thank both of you.

Senator HATCH. Well, I thank you, John. I appreciate those kind remarks. I have to say that it is a privilege to work with Senator Kennedy. He is an effective legislator. He works these issues; he is willing to compromise. He is willing to resolve conflicts between the two parties. This is not a party issue.

This is not a Democrat/Republican issue; this is a bi-partisan debate on an issue that literally needs to be solved. We differ widely, perhaps, throughout the Senate on this issue. From my perspective, sometimes you have to file a bill, take the withering criticism as well as the praise, and bring people together to mold the bill and get a compromise that people from both sides can support. Both of us intend to do that, and we intend to follow this through.

Nobody is going to back me off in doing the best I can to accomplish that goal.

The CHAIRMAN. Well, I think we are all in agreement that we want to ensure that children have access to good health care, and that is the reason we are here today.

Senator Kennedy.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman. I will put my statement in the record and I will be very brief.

I want to, first of all, express my very strong admiration for the work, as Senator Hatch has pointed out, of this committee in the area of health care. Senator Chafee, Senator Rockefeller, Senator Moynihan and others have been extremely vigilant on these issues over a long period of time, and I think that there is no question that the children in my State and other States have benefited significantly from their efforts.

Senator Gramm has come up with an imaginative approach to this issue, building on the Maternal and Child Health block grant program. As well, the Administration has made children's health a priority in terms of the budget negotiations. I think all of this reflects the Nation's belief that every child in this country ought to have a healthy start.

So, we have strong leadership from the President and strong leadership from this committee. Senator Hatch and I—he as former chairman of the Labor and Human Resource Committee—have had a particular interest in children and children's interests over a long period of time. We are grateful for the opportunity to work with the members of this committee, and we look forward to it.

We would be very hopeful, Mr. Chairman, that the members of this committee and all members of Congress would embrace three fundamental goals: No. 1, affordable insurance coverage for every American child must be included in this budget.

No. 2, we hope that we could combine improvement and expansion of Medicaid with grants to States for private insurance coverage for working families who make too much for Medicaid but not enough for private insurance.

No. 3, as Senator Hatch has pointed out, a significant, substantial increase in the cigarette tax should be made a major source of financing because it is the right thing to do to improve children's health by cutting smoking, and because it would be wrong to pay for this program by cutting Medicaid, Medicare, or other essential programs.

I would just say very briefly, Mr. Chairman, the largest growth in the uninsured in the country today are children. Their numbers are increasing. That is a recent phenomenon. What we have seen, is these are the sons and daughters of working families, 40 hours a week, 52 weeks of the year.

You have 1.5 million children a month who have high fever and strep throats who never see a doctor. You have 400,000 children every year that have medicines prescribed to them who cannot afford it and do not receive it. You have 600,000 asthmatic children,

half of whom never see a doctor. For too many children, the emergency room is the family physician.

I think most Americans believe that we ought to be able to provide our children with the kind of health coverage that is included in the Medicaid program. This is the only coverage which has been developed to meet the needs of children. It's been developed with the care, advice, and concern of pediatricians and those that have been the most interested and concerned about children.

We fund our program. We build on the States. Thirty-one different States have programs to expand health insurance coverage to children. We make it voluntary. We build on the private sector by expanding private insurance coverage and encourage competition in those States to hold down costs. We leave maximum flexibility to the States to decide whether to participate, to design the program, and to set eligibility levels.

Finally, we finance it by increasing tobacco taxes, which we think has very strong health implications because, as we have seen, price is one of the most important factors in determining whether young people, particularly children, are going to use cigarettes. Ninety percent of all of those that smoke start during their teens. The average addiction is 14 years of age. We know that price and cost—even with this proposal, the amount of tax from Federal, State, and local communities will be half of every other industrialized nation of the world.

If we had not repealed most of the tax in the 1960's, the tax, after this bill is implemented, would effectively be what it would have been if it had grown by inflation from that period of time. We think it is reasonable, and we appreciate the chance to appear before the committee today.

[The prepared statement of Senator Kennedy appears in the appendix.]

The CHAIRMAN. Well, thank you very much for coming here. I share your interest and your concern. I think we all are bothered by the fact that the number of children that have access has decreased rather than increased, and we look forward to working with you and Senator Hatch in developing a broad consensus on legislation.

Senator MOYNIHAN. Mr. Chairman, could I just say, I think the Senator's point about the reduction in the tax in the 1960's is an important one, and we might get the Joint Committee on Taxation to give us the calculations that he has just mentioned.

The CHAIRMAN. We will request that that be done.

Thank you very much, Senator Kennedy.

Senator KENNEDY. Thank you very much.

Can I add—just for Rich Tarplin—I have known Rich for a long period of time, and I know him to be a really outstanding public servant. And Christine Ferguson—we have appreciated the opportunity to work with her as well, with Senator Chafee, on other health care matters. Thank you.

The CHAIRMAN. Very good.

Let me proceed. I will make a brief opening statement, then we will yield to Senator Moynihan. He says he has no statement. Congratulations.

Senator Gramm, we will call on you next, at which time we expect Senator Daschle, who is also under a very serious time constraint and we are trying to meet that, after which we will call upon Senator Frist. Then there may be some other members of the panel who will want to make a statement.

Senator GRASSLEY. Mr. Chairman, could I also have 60 seconds to introduce an Iowan, because I will be in and out of the hearing?

The CHAIRMAN. Please proceed.

Senator GRASSLEY. Thank you very much.

We have the good fortune of having Mr. Don Herman, who is the Medicaid director for my State of Iowa, here with us today. He was very helpful to me and a lot of other members of this committee 2 years ago when we were also doing a lot of policymaking on Medicaid and welfare at the time. So, he is no stranger to some of the members of this committee.

But he is coming here today because Iowa has taken a very aggressive approach to examine the reasons millions of children are without health insurance, or who also may be under-insured.

Mr. Herman is going to present for our committee the Iowa Healthy Kids Program study, which serves as a tool for policymakers in my State of Iowa, and now with his attendance here will be valuable information, very useful to the Congress as we work on developing children health insurance initiatives.

I hope that my colleagues will pay close attention to his testimony and realize that he has worked with this committee over the last recent years.

Thank you very much, Mr. Chairman. As I indicated, I regret that I am going to be in and out today. Hopefully, I will not miss Mr. Herman's testimony, but I am also across the hall for the oversight hearing of Judiciary with Janet Reno, the Attorney General. Thank you.

The CHAIRMAN. Thank you, Senator Grassley.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Let me just point out that the issue of increasing access to health care for children is not a new issue for this committee. There is a long history of work in this area, stretching back over many past Congresses. The past does tell us this issue does not yield to one simple solution.

Of the 71 million children in the United States, more than 86 percent are already covered by private or public health insurance. Perhaps the greatest challenge facing the various child health proposals before us is to reach more children without eroding the present system which provides health care coverage for seven out of eight children.

Two-thirds of all children gain access to health care through the private sector. Thus, we need to proceed carefully to make certain that we do not displace the private sector role in providing health insurance for children. Nearly 20 percent rely on public programs to gain access to care.

Yet, the complex matter of who is insured, and why, is not simply a matter of eligibility for existing programs, nor family income.

For example, one-third of the uninsured children are, indeed, eligible for Medicaid, but are not enrolled for a number of reasons.

How then do we reach these children who, for whatever reason or circumstance, have not gained access to the health insurance they need? How do we ensure that all children have the opportunity to grow up healthy? The facts about children's access to health care suggests there is unlikely to be a single solution to the problem, we need a variety of approaches.

We should also recognize that the States are far ahead of the Federal Government in developing new and innovative programs. The proposal forwarded by Senator Gramm, Senator Frist, and myself will support the States in their efforts to expand health coverage to children, including through Medicaid, as they may choose.

A children's health initiative should also be an opportunity to help families make the important transition from welfare to work. Many families, especially those headed by a single parent, face the dilemma of earning too much to qualify for Medicaid and too little to afford private insurance.

The proposal that Senators Gramm, Frist, and myself have developed can become the stepping stone to freedom for many families with children who want to escape from welfare dependency.

Our proposal will support States in their efforts to reach children through other innovative programs, such as those we will hear about today.

Before we proceed further, I do want to thank all the members in this 105th Congress, especially members of the Finance Committee, for their work and contributions to this critically important subject of increasing children's access to health care.

Now, Senator Moynihan, would you care to make any comments?

Senator MOYNIHAN. Sir, we have a presentation, I believe, from Senator Gramm and I think we ought to move directly to that, if we can.

The CHAIRMAN. All right.

Senator Gramm.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS

Senator GRAMM. Thank you, Mr. Chairman. I have to go preside over a hearing at 10:30, and I appreciate you recognizing me early.

What I would like to do, is to go over some very important points that, first, apply to every bill that we are going to consider.

The first, is the problem that you mentioned, Mr. Chairman, and that is the problem of crowding out. In OBRA, in 1989, we legislated a substantial increase in Medicaid coverage. You can see, if you look at the blue line here, that actually the percentage of children in America covered by Medicaid, beginning in 1989, started to rise.

But, at the same time, and with turning points almost identical—in fact, if you did a regression analysis, Senator Moynihan, you would find that about 98 percent of the changes in private health coverage, reflected in green, could be explained statistically by the growth in Medicaid with a negative relationship.

In other words, statistically, the rise in Medicaid, which we funded with taxpayer funding, for all practical purposes on a one-to-one basis, statistically crowded out private health insurance.

If you look at the red line, the percentage of children in America who are uninsured, after spending tens of billions of dollars, did not change between 1988 and 1995.

I think the logical explanation for it is pretty simple. That is, low-income people tend to work in marginal jobs. So, if the Federal Government provides a major benefit—in this case private health insurance—it is no longer in the interest of the employer or the employee to provide that coverage.

The second chart I want to show you is almost impossible to read, and forgive me for it. But I can explain it to you.

What this shows is the percentage of children in the various income groups who have private health insurance. Between 100 and 149 percent of poverty, roughly one-half of all the children in America in that modest income group, are covered by private health insurance.

Between 150 and 200 percent of poverty, that number rises to roughly 68 percent of all children are covered by private health insurance. In the range from 200 to 300 percent of poverty, you are reaching the point where 82 percent of all children are covered by private health insurance.

It is imperative, as we try to deal with this problem, that we do not have a program that crowds out private health insurance, especially as income goes up, because, for example, in the income group 200 to 300 percent of poverty, for every one child you are covering you would be crowding out 4 children who have private health insurance.

That is why, when you look at some of these programs, like the President's program where he is providing funding for private health insurance for children where their parents are unemployed, he provides roughly 5 times the amount of money you would have to provide to simply buy private health insurance for all the children.

Senator ROCKEFELLER. Would the Senator yield?

Senator GRAMM. I would be happy to.

Senator ROCKEFELLER. I would hope that the Senator would take a look at Senator Chafee's and my bill, because nothing that the Senator has said has included anything that we cover. Everybody that we cover is below that 150 percent. You are talking about middle and upper income, he and I are talking about the 5 million that does not fit on your chart anywhere.

Senator GRAMM. But my point is, when you get especially into these higher income groups, part of your problem is, you are crowding out private health insurance. We are never going to have an effective program if, for every 5 people you are paying for, 4 of them would have either directly or indirectly bought coverage for themselves.

What we do in the bill put together by the Republican Health Task Force is try to focus on the 3.2 million children who do not qualify for Medicaid and who have incomes in their families below 200 percent of poverty. We try to do this through a very successful program, the Maternal and Child Health block grant. We create no

new program, no new bureaucracy. We transfer the money to the States. The States are very concerned about the crowding out problem.

We believe that they can work, if we give them the flexibility, in subsidizing private health insurance where that works for them, expanding Medicaid coverage where that works for them, other ranges of options.

We do two other things, Mr. Chairman, as you well know. One, we grant waivers to the States that they have requested which will strengthen their ability to reach out to children. Those waivers, we estimate, will save them $1.6 billion a year.

We also, for moderate-income families who would choose to use a medical savings account approach, allow them to do that. So, this is a simple program that does not create a new bureaucracy, does not create a new program, no new entitlement, the idea being to work with the States to try to find a mechanism to cover the children who do not have coverage who have moderate income, but in every way we can to try not to crowd out private health insurance. I think that is our challenge as we write the final bill which, obviously, will be a bipartisan effort on this committee.

We have to be very sensitive that anything we do—for example, a refundable tax credit is going to, dollar-for-dollar, crowd out private health insurance because no private employer who is hiring basically low-income people will continue to provide health benefits when they have got a refundable tax credit that will pay for it.

I mean, there is no doubt about the fact that that will terminate private health insurance. For every new person who gets health insurance, we are going to have a couple who would have had it through the private sector who are not going to have it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Gramm.

I see Senator Frist is sitting there. Senator Frist, I wonder if you would not mind coming up now and making your statement. I have assured the distinguished Democratic Leader, Senator Daschle, who has a very tight timeframe, that we would try to recognize him as promptly as possible when he comes, and I understand he is on his way.

Senator FRIST. I would be happy to get started. I am going to spend probably just 4 or 5 minutes. If he comes, I will be happy to recognize him.

The CHAIRMAN. Please proceed.

STATEMENT OF HON. BILL FRIST, M.D., A U.S. SENATOR FROM TENNESSEE

Senator FRIST. Mr. Chairman and members of the committee, thank you for allowing me to speak a few minutes before you on an issue that many people do not know very much about. It arises in the Gramm-Roth Republican Working Group proposal.

Let me say at the outset that I personally support the intent of all of these pieces of legislation. The broad array, which really come down to, I think, not so much just getting insurance policies out there, but what the real goal needs to be, and that is improving the health and health services for the children of our land.

I am going to concentrate in the next few minutes on that aspect, not so much on how to get insurance policies out there, but delivery of services to the children who, in my practice of medicine, I had the opportunity to see frequently.

I do need to make the distinction, because I think we all need to keep it in mind, that just having an insurance policy out there does not mean that the individual child in the mother's arms is going to actually get care.

Right now, that is illustrated by the fact that we have 2.8 to 3.2 million individuals who have access to a policy that is paid for, that is out there, that is waiting for them, yet those children never get their immunizations, preventive care, or go and get the services.

It is hard, because we have built this whole access thing up; if we just put policies out there people will be taken care of. That is not right, especially in the pediatric population, where preventive care makes a bigger difference, I think, than at any other age group.

The common goal is to improve the health status of these children, in my mind, in all of these pieces of legislation. Therefore, I am not going to talk about financing, but think more about the best structure to accomplish improving health care for children.

The proposal that Senator Gramm has mentioned and Senator Roth referred to builds on an existing structure called the Maternal and Child Health block grant program. It has several strengths that I think we need to recognize, put up front, and then have all of us go back and talk to our individual States and see how strong or how weak that program is. Overall, it is very strong.

The strengths are as follows: No. 1, it has an existing focus on children. It is already serving about 19 million people, serving segments of our population that we need to reach, specifically targeted to uninsured families and others who face limitations or barriers to care, and families with children with special health care needs.

No. 2, and I think very important, it is already community-based. It is already pulling together services in the private and public sector which are out there, which people are doing a great job with. States like it. It is very popular in the States. In fact, in the matching program that we have set up, nearly all States are contributing more than their specified match. In Tennessee, we are putting in $4 million more because the program is so positive.

It is an efficient program. Right now, less than 10 percent of the moneys go to administrative costs of the programs, 90 percent get out into the field in that interaction of where the child accesses health care, down to that level. It does not get lost in Washington, does not get lost in the States, does not get lost at the community level, but 90 percent is out there in the field.

No. 3, it is fascinating in that it requires coordination with Medicaid. We all know we have 10 million children we are addressing today, we have 3 million children who have Medicaid. We asked, why are these 3 million children who have insurance, who have Medicaid, not getting the services that are there? It is paid for, it is on the table.

The beauty about the MCH, Maternal and Child Health block grant, is that it requires coordination with Medicaid in order to

participate. So, if you identify a child, you immediately have to go register them with Medicaid.

The incentives today in an emergency room when a child comes in and has an earache is not to register them in Medicaid. There is no financial incentive for the hospital to do it. Therefore, the emergency room sees the child, sends them off, and probably will not see the child again.

It is very different than an adult, who comes in as a result of a motor vehicle accident, cancer, crushing chest pain—a huge expense over time, there is a real incentive for the hospital to enroll them in Medicaid. So, we have to address the problem of the 3 million children not enrolled in Medicaid.

By law, MCH addresses that issue of those 3 million by requiring coordination with Medicaid. It is very important, and all these other plans need to address those 3 million people. The President's budget talks about it, but they do not say exactly how they are going to do that.

No. 4, is scientific data. We have to do a better job in looking at outcomes data. If we throw these programs out there, whatever they are, and we do not know the right answer, we need to be able to track it with scientific outcomes over time.

The Maternal and Child Health block grant does just that, it uses what is called Healthy People 2000, which is Health and Human Services 10-year public health goals. The States have to meet those plans, have to meet those goals, those benchmarks along the way.

All of us know we do not do as good a job as we would like in tracking where this money goes and the outcome. Very specific indicators have been set up. The States have to comply with those. But measurable scientific outcomes data is the fourth advantage already built in to this Maternal and Child Health block grant.

There are many examples of how the program coordinates the services that are there. The broad themes that I would encourage you to address this morning and as you address the issue are, No. 1, State flexibility.

Just in the newspaper today as I was looking at my clips this morning, the headlines in the Commercial Appeal were "Tenn Care to Expand More Coverage to More Kids." We are all seeing that right now in our States, as our Governors are taking initiatives which are very, very positive. What happens in Texas, Delaware, or Tennessee may be very different. There are different demographics, different community needs. All of those are being addressed, so whatever we do we need to continue to give the States flexibility.

No. 2, the State initiatives. We cannot come in with something that takes away that initiative, again, because State officials are closer to the needs of the State. Tennessee, 29 days ago, began enrolling all children without access to insurance regardless of income. That is the sort of initiative we cannot destroy.

No. 3, I do not think we need to create new entitlements. No. 4, let us not crowd out—exactly what Senator Gramm says. Historically, what we have done is put more money in Medicaid. We still had 3 million of that population uninsured.

We put more money in; it has crowded out the private sector. Why? The small business person sees more money coming down. They say, that saves me money, therefore, I am going to cancel my private health insurance policies, and we never get to the uninsured. I think it is an important point that we have to address.

So, the beauty of the Gramm-Roth proposal, in closing, is that it has the flexibility, it coordinates what is out there, it allows for innovative health care programs including subsidies for private health insurance, it allows expansion of State initiatives, and access to group health insurance is encouraged.

Again, I will just close and say that the goal is not to just put more insurance policies out there; this population is too specific. It is really to make sure that we take the children that we have today and that they have access and are taking advantage of the health services that are available. A healthy child is the goal.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Frist appears in the appendix.]

The CHAIRMAN. I see the distinguished Democratic Leader is here.

Senator ROCKEFELLER. Am I allowed just a quick question, with deference to our Leader?

The CHAIRMAN. Yes.

Senator ROCKEFELLER. That is simply, to Senator Frist, in that you are referring to a block grant program which does not necessarily equate, under either your bill or under present law, as being turned into health insurance for kids. How do we know that the State will use that money for health insurance for kids?

Senator FRIST. I think what we do is tie it to the measurable scientific outcomes data. Right now, it does allow subsidies for either private health insurance or entrance into the Medicaid program. Those incentives have to be there.

Senator ROCKEFELLER. I agree.

Thank you.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator Daschle, we are pleased to have you here.

STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA, AND DEMOCRATIC LEADER OF THE U.S. SENATE

Senator DASCHLE. Thank you very much, Mr. Chairman.

It is a pleasure for me to follow one as knowledgeable as Senator Frist, and I thank you very much for giving me the chance to testify before you.

I have an extended statement that I would ask your consent to have made part of the record. I know you have a lot of witnesses today, and I will attempt to be brief.

The CHAIRMAN. Without objection.

[The prepared statement of Senator Daschle appears in the appendix.]

Senator DASCHLE. I think we all know the problem. The problem is, we are the only industrialized country in the world that does not provide health insurance for its children.

We know that, while there may be differences with regard to the assessment of the impact of the problem for children's health, approximately 10 million children have no health insurance on any given day.

About 20 million, or 1 in 3 kids in this country, have no health insurance at some point during the year. If you take all the uninsured children in South Dakota and put them in one city, it would be the third largest city in my State. These figures do not tell the whole story. There are millions more children who are under-insured; they are at risk because they do not have adequate coverage. So, it is not just a question of insurance itself, but what kind of insurance children have.

There is a misconception about who is affected by this problem. There is a sense that all uninsured are covered by Medicaid. The fact is, they are not. Only the poorest of the poor children are eligible for Medicaid.

What we are really talking about here are those working families with one, or in some cases even two, wage earners who have no insurance because their employers do not offer it.

The numbers of uninsured, working families are growing because each year more people take jobs in firms that don't offer coverage. Employers are not as able as they once were to provide insurance for their employees, and even fewer provide coverage for their workers' families.

But it is gratifying to see that there is a substantial degree of interest in this issue on this committee and in the Labor Committee. As I understand it, a majority of members of this committee have sponsored or co-sponsored legislation to address this problem.

From the response on the committees, there is reason to believe that we can address the problem in a satisfactory way. I am particularly grateful to those who have co-sponsored S. 13.

That is the bill which I introduced earlier this year that calls for a refundable tax credit to help low- and moderate-income people provide private insurance for their children. There are many other good ideas that have come along since I introduced that bill.

The bipartisan Medicaid expansion bill, introduced by Senators Jeffords, Chafee, Rockefeller, and Breaux, would cover millions of additional children. I think that is an approach we ought to pursue.

The Kennedy-Hatch bill obviously gives States much more flexibility and resources with which to deal with uninsured children in their own ways. South Dakota might be different than New York or Delaware, and this would give us an opportunity to look at various State approaches.

Another proposal by Chairman Roth and Senator Gramm to expand the Maternal and Child Health block grant merits, in my view, consideration.

I also applaud, Mr. Chairman, the charities and the organizations that have done an outstanding job in recent years in trying to address the problem in a myriad of innovative ways in the private sector. That, too, has made an impact.

While charitable efforts are commendable, frankly, I think we would all agree they are not enough. You could quadruple what these charities are doing and you would not be able to meet the

need across the country, and you certainly would not be able to do it in an equitable way.

We need a national response. It should be done, in my view, on the basis of three fundamental principles. First, is that it should not disrupt existing coverage. We should bolster, not replace, the employer-provided coverage that already exists.

Second, total out-of-pocket expenses—that is, premiums, co-payments, and deductibles—must be within the reach of working families or we really have not done them any good.

Third, coverage should meet the needs of children, especially preventative care, and basic and catastrophic care directed toward children.

These are the principles that I have embodied in S. 13. My bill recognizes that the private market can respond to these challenges if we empower it to do so; it places no mandates; it allows the market, not the Government, to set premiums; it includes incentives to create plans that meet the specific needs of children; and it targets working families who need the help.

It may be that this bill could work well in combination with some of the additional proposals sponsored and co-sponsored by the members of this distinguished committee, including expanded Medicaid and Maternal and Child Health block grants, maybe working with the Kennedy-Hatch proposal to provide more flexibility and resources to the States.

I would hope that, as we debate this issue, our efforts continue to be bipartisan, that we be responsive to the basic principles that I have just outlined, and that we successfully address this problem this year.

I do not know if you saw the story over the weekend about the couple in Pennsylvania that denied health care to their 16-year-old daughter, who ultimately died of complications from diabetes. That followed the denial of health care to her 8-year-old brother, who died of untreated ear infections a few years ago.

It is hard to imagine that a family would refuse care, but they did. It seems equally hard to imagine that we, as a Nation, with all of our success in so many ways, would refuse to provide meaningful health insurance in a much more systematic way to the kids who are our future. We cannot guarantee good health, but we ought to be able to guarantee good health insurance and that will help guarantee a healthy country for us all.

I thank you, Mr. Chairman, and members of the committee.

The CHAIRMAN. Well, thank you very much for being here today. We look forward to working on this issue in a bipartisan way. I think we have broad interest. The goals and objectives are very much alike, and we look forward to seeing something positive accomplished.

Senator BAUCUS. Mr. Chairman.

The CHAIRMAN. Yes.

Senator BAUCUS. Mr. Chairman, I would like to thank our Democratic Leader for such an aggressive and comprehensive effort he has undertaken in this area. He has worked so in many areas, and this is another one. I want to personally, particularly, compliment him for doing so.

I might add, Mr. Chairman, one of the ways a nation is judged is how it takes care of its children. On that basis, I think the United States is not doing very well. We are quite inadequate, certainly when compared with other countries that do provide health insurance for their children.

I am, on the other hand, very heartened by the very strong bipartisan interest I see in addressing this problem. I mean, there are many bills introduced by Senators from both sides of the aisle, and many committees.

I am hopeful that we are going to follow up on and actually pass something very significant here, just as we did in the last Congress in following the lead of Senator Kassebaum and Senator Kennedy, in another health care effort addressing portability, as well as pre-existing conditions.

It may well be this could be the major bill this Congress passes this year. That is, it has a significant effect on our country. I hope, at least, it does pass. I see good signs of bipartisanship and common effort so that we finally can address a grievous deficiency this country now faces, namely inadequate health care protection for our Nation's children.

Senator CHAFEE. Mr. Chairman, I just want to join in saying I think that was a powerful statement Senator Daschle gave.

Senator DASCHLE. Thank you very much.

The CHAIRMAN. Thank you very much, Senator Daschle.

Now, I know there are a number of members of the panel who want to make remarks. I would ask that each one who wants to speak at this time keep their remarks very brief, if possible, because we do have a distinguished panel that we want to hear from who are patiently waiting. Of course, we have a further confirmation process.

At this time, I think, Senator Baucus, you already made your statement.

Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. I will ask that my statement go in the record.

I do want to welcome Christine Ferguson, whom many of us know from the years she was here, and Barbara DeBuono, who was commissioner of Health in my home State of Rhode Island before she moved to New York.

I believe the Medicaid program is the best avenue to reach these uninsured children, and expansions in the Medicaid program over the years have done wonders in increasing coverage for children and pregnant women. We will hear testimony to that effect.

I believe that the legislation that Senator Rockefeller and I are submitting today offers the States additional matching funds, if they choose—if they choose, they are not mandated—to provide Medicaid coverage to all children up to 150 percent of the poverty level.

So, I join in the efforts here. I also strongly believe we should come up with a bipartisan piece of legislation. That is the kind we traditionally have done in this committee, and hopefully will be

able to do again. It is encouraging that so many bills have been submitted because it shows there is determination to wrestle with this effort.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Senator Chafee appears in the appendix.]

The CHAIRMAN. Senator D'Amato.

OPENING STATEMENT OF HON. ALFONSE M. D'AMATO, A U.S. SENATOR FROM NEW YORK

Senator D'AMATO. Mr. Chairman, I have to tell you, we have to be very concerned that we do not create the kind of problem that I think Senator Gramm expressed best in our zeal to cover the uninsured—the unintended consequences of having a situation where employers then begin to drop insurance, particularly for those at the lower-level working families, that they might otherwise be providing for their children.

I have joined with Senator Chafee in his legislation, but I would like to at this time acknowledge the fact that we have been great recipients of a wonderful leader in the health care area, Dr. DeBuono, who is our commissioner of Health in New York.

I am looking forward to her sharing with this committee the very imaginative program that has been undertaken in New York and that has been meeting with remarkable, remarkable success.

It is a quiet success. It is a program that has gone almost unmentioned. It has actually reduced hospital rates for children who are covered by it, it has improved the health care status of hundreds of thousands of children.

There is still a lot more that we can do because we find that many of the people who do qualify for Medicaid for whatever reason do not want—even though it would be available—to participate. The program is means tested. There is a small co-payment process.

It seems to me that we have to give to States the ability to tailor their own programs and that a meaningful block grant program which gives them the kind of flexibility to develop programs like Child Plus really are the answer. It has been a quiet success. It goes back to 1991.

I am looking forward to Dr. DeBuono sharing with us what she believes would best enhance not only this particular plan, but plans of that type. We should be very careful that, in our zeal to deal with this problem of the uninsured, we do not foster a huge growth in the expansion of the Federal obligations, push people from the private sector, and encourage employers to drop insurance so that the Government will pick them up.

That is just a fact. It is going to happen. If you are a corporation, a business, and you see there is a program out there that is going to pick up these children, there will be many, many who will begin to not make those programs available to new hires.

I would hope that we would be very cognizant of that, notwithstanding our desire to see to it that the children of America do have adequate health care made available to all of them, regardless

of their financial circumstances or the circumstances of their family.

I commend the Chairman for his leadership in holding this hearing.

The CHAIRMAN. I know of the strong bipartisan interest in this matter and I do not want to cut anybody off. We will give everyone an opportunity who wants to speak, but I would hope that we could keep those limited in number and brief in duration because I am anxious to move on to the panel.

Is there anybody else who desires to receive recognition?

Senator Graham.

OPENING STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. I would like to recognize one of our participants this morning, Ms. Rose Naff, who is the executive director of the Florida Healthy Kids Corporation.

This was a corporation established in our State to encourage a partnership among local school districts, the State, and the families of children who did not have health insurance. This provides private health insurance through a collective mechanism utilizing the schools as the principal point of contact with the children.

Today, there are some 36,000 Florida children being covered under this program. It is one of the initiatives which I hope, by whatever program we finally adopt, will continue to encourage States to show this kind of partnership innovation.

I believe it is a good example of the confidence that we can place in States in their commitment to children and their ability to fashion appropriate programs to meet their health needs.

Thank you.

Senator NICKLES. Mr. Chairman.

The CHAIRMAN. Senator Nickles.

STATEMENT OF HON. DON NICKLES, A U.S. SENATOR FROM OKLAHOMA

Senator NICKLES. Mr. Chairman, I want to thank you for having this hearing.

I want to just make a couple of comments that are a little different in vein than some of the others. I think a lot of this is having a very interesting impact. We want to do something to help kids, and who is going to object to that? Some of us also want to balance the budget.

Ten years ago, in Medicaid, the Federal Government spent $27 billion, this year we are going to spend $99 billion, about 4 times what we spent 10 years ago. It has exploded.

If you ask any Governor—and we have a couple of Governors on this committee—they will say that their biggest financial problem in their State budgets has been Medicaid.

Medicaid, amongst the States 10 years ago, was about 10 percent of their budget. Today it is 20 percent of their budget. That means it is crowding out education, it is crowding out highways, and it is crowding out a lot of other things for their States, so they have problems. I would just mention that.

Then, just a couple of other things about the scope of the problem. We have heard people repeatedly say, "Well, there are 9.8 million children that are uninsured," and maybe that figure has kind of taken on a life of its own.

I have seen another statistic that says there are 23 million. If you want to look at any one period of time during a year, if you said a child being without insurance for 1 month, I think that number would go up to 23 million, according to *USA Today*.

Likewise, if you said the number of children that are uninsured for 4 months or longer, that 9.8 million, I think, is cut in half. In other words, about only half of that 9.8 million kids without insurance actually are without insurance for greater than 4 months. Again, I think we ought to look at the scope of the problem.

Also, of that 9.8 million children, about 3.2 million are already currently eligible for Medicaid, and for whatever reason they have not signed up. Is that the end of the world? I do not think so.

My guess is, if you have an uninsured child who is eligible for Medicaid who is in an accident, they would soon be enrolled in Medicaid. My guess is, they would not be denied care. I would hope they would not be denied care; I would think that they would not be denied care.

I think Senator Frist mentioned as well, someone can have an insurance policy and it does not mean they get coverage. Someone might be eligible for insurance, but it does not make sure that they get coverage. We have seen that in some of the programs that we have for inoculations and so on. Some people just do not sign up, even if you pay for it, even if you make it available.

I think the scope of the problem is maybe not quite as draconian as what some people have advocated, and I think we have to be careful in trying to find the solution that we do not explode entitlements even further, and certainly crowd out private insurance.

I think the proposal that Chairman Roth and Senator Gramm had, where they talk about giving the States some money through a block grant where they can utilize that to help fill the gap, makes some sense.

I might also mention that 31 States now have programs to provide coverage for children above Medicaid eligibility, so a lot of States are doing a very good job. We want to encourage that. We want to compliment it. We certainly do not want to override.

Also, we want to be careful, in our zest or zeal, to cover this group that is not the group that is Medicaid-eligible today. I would hope that we would not come up with an entitlement for people that are 200–300 percent above poverty, as some proposals would include.

So, if we target it for this middle group that may be between the cracks if the States have not done it, I would hope that we would do it not in a way that is more generous to that group than we do to Medicaid, is one of the proposals.

Actually, I think Senator Kennedy's proposal has the Federal Government, on the match to encourage participation, paying 80–90 percent, a more generous subsidy for people in that 100–200 percent of poverty than even for the lower group. I really do not think that makes sense.

I look forward to working with my colleagues to try to see if we cannot come up with a fiscally responsible proposal that will, indeed, help children and also at the same time allow us to meet some of our fiscal responsibilities as well.

Senator ROCKEFELLER. Mr. Chairman, I sense your displeasure, but in view of what was just said and what Senator Graham said, Senator Nickles referred to, "any former Governor would know."

Well, when I took office as a Governor, and then over the next 10 years, the percentage of people covered by their employers went down by 5 percent. The pretext of this is, do not always blame Medicaid. This went down anyway. Employers just started to cover less.

In fact, between 1987 and 1995, the percentage of children covered under health insurance from employers went down by 8 percent. So, all the trends are down anyway.

Employers are doing this less anyway, regardless of Medicaid. In fact, some part of me says, "Thank heavens that we did do some expansions of Medicaid, or else the number of uninsured children would be a lot higher."

I thank the Chairman.

The CHAIRMAN. If we have no further comments—and I hope we do not—I would like to proceed to our very distinguished panel. Today, we will hear from Barbara DeBuono, commissioner of the Department of Public Health for the State of New York; to Christine Ferguson, who we are happy to welcome back, who is director of the Department of Human Services for the State of Rhode Island; Don Herman, administrator of the Division of Medical Services for Iowa; Michael Koch, executive director of CaliforniaKids Healthcare Foundation; and, finally, Rose Naff, executive director of Florida Healthy Kids Corporation.

Please come forward. We are, indeed, delighted to have you here today. We are going to hear from the experts rather than from ourselves now.

Senator CHAFEE. Mr. Chairman, while the panel is getting situated, I just would point out to Senator Nickles that the Medicaid baseline for May 1996, projected forward, is down by $90 billion. So, I think that we are making progress on what the Medicaid expenditures would have been.

The CHAIRMAN. Ladies and gentlemen, it is a great pleasure to have you here. Ms. Ferguson and others, you can see nothing has ever changed.

Barbara, we would look forward to having you start with your testimony.

STATEMENT OF BARBARA A. DEBUONO, COMMISSIONER, DEPARTMENT OF PUBLIC HEALTH, STATE OF NEW YORK, ALBANY, NY

Dr. DEBUONO. Good morning. I am Dr. Barbara DeBuono, commissioner of Health for the State of New York.

Chairman Roth, Senators Moynihan, D'Amato, and Chafee, it is delightful to see you again. Distinguished members of the Senate Finance Committee, thank you very much for inviting me to speak to you today. I am really honored and delighted to be here.

I am also delighted to see Congress focusing so much attention on the issue of health care coverage for our Nation's children.

New York State has already, very proudly, stepped up to the plate. As Senator D'Amato and Senator Moynihan are very, very well aware, New York is proud of the leadership role that it has taken by designing one of the earliest and most successful programs for child health insurance coverage.

That program covers health care for 124,000 children of low income families in New York and, starting this June, will expand to include both inpatient and outpatient care.

The program has been operating for 7 years, and, with its recent expansion under Governor George Pataki, can serve as a model for the Nation. Child Health Plus is the name of the program.

It was created as a partnership between the State and private insurers. Together, we developed an insurance package to provide primary and preventive care for children through the age of 12. Drawing on revenue from a State hospital surcharge, we provided subsidies to low income families, those with incomes below 222 percent of the Federal poverty level.

As of 1996, 15 participating insurers offer the Child Health Plus insurance product, and more than 100,000 children were enrolled. Based on the success of that program, Governor George Pataki included in his Health Care Reform Act of 1996 a major expansion of Child Health Plus.

What he did, was raise the age limit to children through the age of 18. He also included inpatient coverage. That was added to the benefit package, inpatient hospital coverage. Goals were set to increase enrollment from 124,000 in 1996 to 251,000 in 1999.

In order to achieve this major expansion, Governor Pataki increased funding for this program from $73 million in 1996 to $109 million in 1997, and up to $207 million by 1999.

It is important to note that all of these figures are solely New York State dollars. This revenue is generated through a surcharge on hospital and ambulatory care services charged to health payors. We will also be dedicating a portion of these funds to an intensive effort to expand community outreach and marketing.

In doing so, we will be very cognizant of actions taken by business in moving employees out of private insurance. In the expanded program, premium costs continue to be subsidized according to a sliding scale, based on family household income.

Coverage is fully subsidized for families earning under 120 percent of the Federal poverty level which, for New York, comes out to $19,300 for a family of four.

There are small family contributions for families earning between 120 percent and 222 percent of the poverty level. Again, small family contributions for families where the earning is up to $35,600 for a family of four.

These families pay a monthly fee of $9–13 per child, per month, with a cap so that families with more than 4 children have no additional costs. All other families in the State, regardless of income, can purchase the product at the full price of $60–100 per child per month, considerably more affordable than purchasing it privately.

Another important feature of the expanded program is the way it interfaces with our States's Medicaid program. We sought to cre-

ate a seamless interface between Child Health Plus and Medicaid, so the children who move from one program to the other will face no disruption in their care.

Children who apply for or drop out of one program are automatically screened for eligibility for the next. Many of the same insurers who are participating in our State's Medicaid managed care program have submitted proposals to participate in our expanded Child Health Plus program as well.

Seven years of the Child Health Plus program in New York have provided us with valuable experience in the area of child health insurance. We know that parents have overwhelmingly reported high levels of satisfaction with the program.

Children with chronic illnesses, like asthma, diabetes, and attention deficit disorder report better access to primary care, better health care, and better health status as a result of the program. Children in the program make more visits to primary care doctors, more visits even to specialty care physicians, and visit the hospital less. Hospitalizations are reduced by 4 percent in this program.

I hope that this program will receive the consideration it deserves in developing a national program, and I would like to commend the Senate for taking this issue up at a national level.

We in New York would like to see fairness and flexibility as we move forward with our expansion. There are three very brief concerns I want to articulate abut the Federal programs that have been introduced to date.

First, President Clinton's proposal is funded through a per capita cap on Medicaid payments and a cap on disproportionate share payments—essentially, Medicaid cuts. That will hurt New York State. In effect, we would be taking money from one needy group—those with AIDS, those who are uninsured—in order to pay for another.

Second, several of the current proposals require a State maintenance of effort without a Federal match. That means that all of the work we have done in New York to develop and expand Child Health Plus and to enroll 250,000 children by 1999 will go unrecognized.

I would question the fairness of a policy that ends up penalizing the States that have been leaders in expanding coverage for children. Again, States that have already expanded coverage would get no reward, they would, in fact, be punished.

Third, is the proposed Federal requirement that the benefit package for a child health insurance program be identical to that for Medicaid. This is not consistent with the widely held belief that the Medicaid program is too costly—we know it is in New York—and more generous than many commercial products.

Our goal, in fact, in New York is to create a seamless system of care and to mainstream our Medicaid population and the private insurance sector together. We made a decision not to turn to Medicaid because we know it would be too limiting and restrictive.

Through Child Health Plus we have created a program that is, instead, comparable to a typical private benefit plan, a typical employer-based health benefit. By keeping costs down, we have been able to reach a greater number of children while avoiding the incentive for employers to drop coverage.

In conclusion, I believe it is possible for us to develop a program that expands access to insurance coverage for children, while allowing enough flexibility for States to meet the unique needs of their population, and without unfairly penalizing States that have already been leaders in meeting the needs of their children.

I believe that we can, and should, do nationally what New York has done locally, develop a fair and flexible program to ensure access to care for our most vulnerable children.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. DeBuono appears in the appendix.]

The CHAIRMAN. Ms. Ferguson.

STATEMENT OF CHRISTINE FERGUSON, DIRECTOR, DEPARTMENT OF HUMAN SERVICES, STATE OF RHODE ISLAND, CRANSTON, RI

Ms. FERGUSON. Thank you, Mr. Chairman. It is wonderful to be here, although it is somewhat disconcerting to see the front of your heads as opposed to the back. So, I apologize if I am a little bit nervous.

The CHAIRMAN. Which way do we look better? [Laughter.]

Ms. FERGUSON. I am not going to touch that one.

I understand that my purpose on the panel is to talk about using Medicaid as a vehicle for children's health care. You have my prepared testimony, as well as the outcomes research that has been done to evaluate the Right Care program in Rhode Island. I am going to highlight pieces of what you have before you.

First of all, coverage of children under the age of 18. In 1994, when we began our 1115 waiver under the Medicaid program, which Dr. DeBuono, in fact, was present for the conception of and worked to develop, we had roughly 8 percent of our children under the age of 18 who were uninsured.

Today, we have about 5.5 percent uninsured. Starting tomorrow, Governor Almon has put through an increase in eligibility for the Right Care program to all children under the age of 18, up to 250 percent of poverty.

We anticipate that over the next year, between 0 and 1 percent of the children in Rhode Island under the age of 18 will remain uninsured. We will be close to 0 percent who do not have access to insurance. They may choose not to get into the program, but they will have access.

How good is it? It is a Medicaid package of benefits. That is a very comprehensive package of benefits. We focused on it because we believe that kids, in general, can get catastrophic care. If there is an asthma problem or a crisis with diabetes regulation, they can get into the hospital, get hospital care, get emergency room care. What they do not get, is management and prevention in advance.

So, we took on the Medicaid package. We believe that healthy babies lead to healthy students, lead to healthy workers. We purchased our insurance coverage from four private insurers: Blue Cross, Harvard Community Health Plan, Neighborhood Health Plan of Rhode Island, and United Health Plan.

Our first member satisfaction survey, which is in the material in front of you, indicates 95 percent satisfied or very satisfied with the services that they are receiving.

We pay, on average, $75 per month for children. You can compare this to a small group purchasing cooperative which has a similar population, but half the size that we do. They pay, on average, $80 a month for a less comprehensive benefits package.

Our outcomes in the delivery system. We have doubled the number of physicians participating in Right Care. Now, 90 percent of the physicians in the State accept Medicaid patients. We have more than doubled the number of physician's visits for our beneficiaries. Our emergency room use has decreased by a third, our hospital use has decreased by a third.

How are our health outcomes? Also, the outcome studies are in front of you. In the first 2 years of the program alone, smoking rates among pregnant women were reduced by 14 percent. Alcohol use is on a downward trend.

There is a 10 percent increase in the number of women entering prenatal care in the first 3 months, a 20 percent increase in the number of women receiving comprehensive prenatal care.

There has been a dramatic increase in the number of women waiting longer than 18 months between children. It has gone from 58 percent of our population waiting for more than 18 months to 72 percent, in a year and a half. That is equivalent to the birth interval in the private sector commercial employer-based health insurance.

One-third of the births in the State are covered by the Right Care program. In 1996, our preliminary infant mortality rates are the lowest ever. We have 5.5 out of 1,000 births, lower than our goal for the year 2000 of 6.0 out of 1,000 births.

We have had a decrease in low birth weight babies, a decrease in premature children, and a decrease in very sick newborns who are in the neonatal intensive care unit for more than 30 days.

How did we achieve the outcomes? We changed the thrust of how we run the Medicaid program. I remember in the late 1980's having a discussion at 2 a.m. at a budget reconciliation conference over on the House side with a member of the Energy and Commerce staff who said to me after some exchanges in exasperation, "Look, Christie, Medicaid is just insurance. It has nothing to do with the delivery system." I was flabbergasted.

Now, I can tell you, running this program, I cannot imagine anyone who would spend so much of their State budget—between one-quarter and one-third—without being concerned about outcomes.

We have a constant feedback loop with our providers and our plans. We have clearly helped the commercial plans improve their quality of service to both our population and the commercial population. One person buying insurance coverage with cash or a voucher does not have the ability to negotiate as well as a group.

We are very lucky in Rhode Island that we do not have poverty like large urban centers. We still have a chance to affect the health and development of our children and young people. Our small investment is going a long way toward ensuring that this next generation of children has a healthy start.

I urge you not to get tied up in theory. We know very little for certain. If you look at the outcomes that we have, and other States that are working on this have, I think you can probably come up with a good proposal that will actually expand coverage for kids.

Finally, I would just finish with an invitation from Governor Almon. We are a State that is small in size. We are easy to get your arms around, but we are very large in beauty, especially in the summer.

We would be delighted to host a field trip for the committee members to see how Medicaid really works, warts and all, in a State and to learn firsthand the problems of moving from a payor of claims to a purchaser of service. Computer systems, consumers, providers, plans and workers all have to change.

Thank you very much.

The CHAIRMAN. Thank you very much. We appreciate the invitation.

[The prepared statement of Ms. Ferguson appears in the appendix.]

The CHAIRMAN. Mr. Herman, please.

STATEMENT OF DONALD W. HERMAN, ADMINISTRATOR, DIVISION OF MEDICAL SERVICES, STATE OF IOWA, DES MOINES, IA

Mr. HERMAN. Thank you, Mr. Chairman and members of the committee.

If Senator Grassley were here at this time, I would tell him that it is good to see him—unfortunately not as our Governor to be, but fortunately continuing as our Senator here in Washington.

My name is Don Herman. I am the Medicaid director for the State of Iowa, and have been since 1984. I appreciate the opportunity to speak to you today. My written testimony has been submitted for the record. I would like to use this time to share with you some highlights from that testimony.

The message that is coming through loud and clear is that the Congress is serious about increasing access to health care for children. I want to reinforce for you what a positive message that is to hear. I have no doubt that you, upon making the commitment to do so, will begin making progress. So, I start with applauding your efforts and, in the spirit of cooperation and collaboration, I want to give you some advice on how to do it.

Virtually all of the proposals that have surfaced would have the States as the administrative entity. That is appropriate. I can think of no better form of government to carry out an expansion of health care to children than States, with the possible exception of more local forms of government.

Use Medicaid as an example of the ability of States to administer health care programs. We are serving some 36 million persons nationwide, with 25 million of those being families and children in a program that has more complexity, more rules and regulations than you can imagine.

Yet, while in a steady state with no expansion of eligibility, we have brought average annual growth and the cost of the program down to the 6 percent range. We have aggressively pursued and controlled abuse in the program, and we have kept administrative

costs at a minimum, all the while increasing access to care and, we believe, improving quality.

But we can do better, which brings me to the message that I want to deliver today. That is, do not tie our hands. Give the States the ability, the authority, to design eligibility criteria, benefit packages, and delivery systems that meet the unique needs and desires of States and localities.

Flexibility. You have heard that before, but it truly is the operative word. The number of low income elderly and disabled in this country who have access to good health care as the measure, Medicaid deserves high marks.

If you look at the number of children with access to health care, it deserves, perhaps, only mediocre marks, at best. I believe that is, in part, related to historical, almost exclusive, focus on treating illness rather than prevention.

If we had greater ability to focus on well-being and could be less concerned about offering every conceivable treatment that medical science can develop, we could cover more children more appropriately and avoid greater costs in the future, and it would be the right thing to do.

I want to again say that all proposals for expanding access for children are laudable. We support the end goal. Those proposals, however, that expand Medicaid as we know it today will not achieve the greatest possible result.

We suggest a combined approach of adopting Medicaid reforms that have been recommended by the National Governors Association, setting a single eligibility threshold for Medicaid, and then providing additional funding above that threshold, perhaps providing it outside the Medicaid statute. Above that threshold, avoid the entitlement and provide maximum discretion to the States.

Such a package would dovetail nicely with the Iowa Healthy Kids initiative that I speak to in my written testimony. This program, patterned somewhat after the Florida Healthy Kids program that you will shortly hear Ms. Naff speak to, involves providers, both public and private, payors, both public and commercial, education, State government, and others, coming together and designing a program that emphasizes outreach, prevention, and personal responsibility.

This program is in the planning stage, having received development funds from the Iowa General Assembly. Additionally, we are seeking support from interested philanthropic organizations with a goal of reaching consistency within the State early next year.

This is a first work product out of that Healthy Kids initiative task force, and I would be happy to share that entire report with the committee.

Nothing better could happen for our children than joint State and Federal initiatives coming together in a combined approach. I know that is the goal that we all have.

Thank you again, Mr. Chairman, for this opportunity. I will end my remarks at this time.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Herman appears in the appendix.]

The CHAIRMAN. Mr. Koch.

STATEMENT OF MICHAEL J. KOCH, EXECUTIVE DIRECTOR, CALIFORNIAKIDS HEALTHCARE FOUNDATION, WOODLAND HILLS, CA

Mr. KOCH. Mr. Chairman and members of the committee, I am Michael Koch, executive director of the CaliforniaKids Healthcare Foundation, and I appreciate the opportunity to testify before you today.

CaliforniaKids is a broad-based community program, providing access to primary and preventive health care services to children whose families are not eligible for Medicaid and cannot afford to purchase health insurance. This program has provided services to over 14,000 children through a capitated managed care network.

CaliforniaKids was founded by Blue Cross of California in 1992 and was originally supported by Merck Pharmaceuticals, Proctor & Gamble, and the California Community Foundation.

CaliforniaKids is a model that we believe policymakers can learn from when designing programs for children. I want to stress that CaliforniaKids is not the answer to financing health care for children. There are over 1.3 million children in California who fall through the cracks because they lack health care insurance.

CaliforniaKids can only go so far with private contributions, and philanthropic support is not a long-term solution. In order for us to reach our fullest potential, other funding sources and partnerships are needed to provide coverage to these children.

Who is eligible for CaliforniaKids? To qualify for enrollment, a child's family must have income between 100 to 200 percent of the Federal poverty level, be ineligible for Medicaid, and be uninsured. The family is asked to complete a one-page application. All eligible children ages 2 through 18 in the family are enrolled at the same time and receive 1 year of coverage.

Once enrolled, each child receives a plastic ID card that looks like every othen private insurance card in the doctor's office. The child can be re-enrolled each year, as long as the family's income level continues to meet the criteria.

What benefits are covered? The benefit package is designed to meet the typical needs of children, including office visits, immunizations, outpatient surgery, emergency care, prescription drugs, preventive vision and dental services, and a 24-hour Ask-A-Nurse program. Next quarter, CaliforniaKids will expand its benefit package to include behavioral health services as well.

Inpatient care is not a covered benefit. CaliforniaKids assists families when inpatient care is needed by serving as liaison between the family and the hospital social worker to enroll the child into an appropriate State program.

CaliforniaKids is designed to keep kids healthy and avoid expensive hospital care, and has proven to be very successful. By providing children with a primary care physician, we have experienced only 7 inpatient cases out of 14,000 children.

What is the cost? The cost for the program is $33 per child, per month, or $400 per year, under a capitated, managed care arrangement.

Families do not pay a premium, however, these hardworking parents do take personal responsibility in the program by paying a nominal co-payment for services, thereby retaining their dignity.

Contributions to underwrite the $33 program are donated by corporations, foundations, and individuals.

Who provides the services? The CaliforniaKids network includes over 20,000 health care providers and 80 percent of the pharmacies throughout the State. The network has been developed to provide choices in order to meet the needs of the family and child. For example, we encourage partnerships with providers who are sensitive to the parents' language and cultural needs, and who offer extended access, such as transportation and longer office hours.

Since the program's inception, one of our major challenges has been shaping the parents' behavior for health care services for their children out of the emergency room and into a medical home.

Parents and children should know the name of their primary care physician and not be familiar with their emergency room doctor. To reduce ER visits and provide education to our members, CaliforniaKids added a 24-hour nurse hotline. We have redirected over 80 percent of the members who called and would have used the ER to an appropriate alternative.

How do we find eligible children? A key component to all programs targeting low income children is effective outreach. Local school systems, particularly school nurses, Head Start, and Healthy Start coordinators, have been our primary resources for identifying eligible children. We also partner with county, child care councils, boys and girls clubs, Big Brothers/Big Sisters groups, and other community organizations and appropriate State programs.

What are the lessons learned over the 4 years? Personal responsibility is essential. While no premium payments are required, we believe it is critical that affordable co-payments are required for all services. Our experience has shown that these families do not want hand-outs. These are hardworking parents and they want to be able to contribute to the cost of care. These co-payments provide responsibility and ownership for the services delivered.

Maintaining the respect and dignity of each family is important. CaliforniaKids reinforces these values by issuing a classic ID card, providing a one-page application, and offering enrollment in established plans such as Blue Cross of California, Delta Dental, Vision Service plan, and Aetna, to deliver quality care.

Inpatient hospitalization does not need to be a covered benefit. Inpatient hospitalization is very expensive and is generally covered by Medicaid. We have shown that by providing comprehensive primary and preventive services, we can reduce hospitalizations. This has allowed us to be cost-effective and to provide services to more children.

Flexibility to foster private and public partnerships must be a component of any plan. We have continually refined our program over the last 4 years. The paramount lesson we have learned is that flexibility is absolutely critical.

While all States are different, we have become keenly aware that each county in California is also unique. We have had to fashion different provider networks and outreach efforts for each community.

Successes of the program include cost effectiveness. It does not cost much to keep a child healthy, about $1 a day. Other successes include peace of mind for the parents, enhanced self-esteem for the

child, decreased school absentee rates for children enrolled in the CaliforniaKids program, and increased productivity rates for the parents, and keeping the parents in the work force rather than on welfare.

CaliforniaKids' next steps are to continue its creative, innovative model and fill the gaps of the uninsured children. In keeping with this goal, we are developing a sliding fee subsidy product for families between 200 and 300 percent of the Federal poverty level.

Thank you again for the opportunity to testify. I would like to conclude with one of my favorite sayings. "If you always do what you have always done, you always get what you always got."

Clearly, changes are needed in order to ensure that all children have access to basic health coverage, which is a right, and not a privilege. Fostering programs like CaliforniaKids and those of my colleagues here today which have demonstrated success is an opportunity to enact beneficial change. More importantly, health care for children is an obvious and essential investment in our country's future.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Koch.

[The prepared statement of Mr. Koch appears in the appendix.]

The CHAIRMAN. Ms. Naff.

STATEMENT OF ROSE M. NAFF, EXECUTIVE DIRECTOR, FLORIDA HEALTHY KIDS CORPORATION, TALLAHASSEE, FL

Ms. NAFF. Thank you for the opportunity to bring this issue back to this committee.

I will mention that in 1988 an article was written, introduced, and published in the *New England Journal of Medicine,* which first described the concept that Healthy Kids is built on.

Then Committee Chairman, Senator Lloyd Bentsen, invited the author, Dr. Steve Freedman from the University of Florida, to this committee to testify and present his idea.

The results of his testimony led to your including some Medicaid demonstration grants in the Omnibus Reconciliation Act of the same year, 1989. Florida was a recipient of one of those grants, and I hope I am here to bear the fruits of your financing.

What we do, is we use school districts as a grouping mechanism to provide affordable insurance. Children do not have to rely upon their parents' employment for their access to health care coverage.

As a benefit package, I will simplify it by just saying we cover check-ups through transplants. It is a very comprehensive product, and it often includes dental services. There are some nominal copayments applied, and there are some benefit limitations.

By excluding services that are not typically utilized by children and competitively bidding a product by geographic region, we are able to offer this comprehensive product at an average monthly premium of $51 per child, per month.

To be eligible, a child must be enrolled in school, uninsured, and not on the Medicaid program. Preschool-aged siblings of children can also be covered. To avoid duplication of coverages and to ensure we are serving our targeted population, we routinely verify a child's eligibility for Medicaid before accepting them. If they are on the Medicaid program, their application is rejected or canceled.

We provide subsidies based on a sliding scale, according to the guidelines of the National School Lunch Program. This is a program that parents know and understand.

Today, regardless of income, all families contribute to the cost of their coverage. Families in the free lunch program will pay $5 or $10 a month for their care, families in the reduced lunch program will pay $10 to $20 a month, and families who are not in the lunch program pay the full cost of their coverage.

Senator Frist hit on an important point that I wanted to speak to also. I will not spend a lot of time on it, because I thought he covered it very well. That is, providing a child with an insurance card does not necessarily give him access to health care.

We require, before any program is implemented in Florida, that a qualified, adequate network of physicians and other providers, are available to serve the children and provide the benefits that are covered.

We require a great degree of local involvement in our program before any program is implemented. Interested school districts and communities have to make application. They are required to contribute financially, and it is voluntary on the school district's part.

Specifically, local governments contribute a percentage share of the insurance cost. They have their own sliding scale that is applied to them. In exchange for local financial participation, they participate in many elements of the program.

They participate in the bidding process and they assist in the selection of an insuring partner. They have input into the sliding scale that will be used in their area, and they can enhance the benefits if they wish. They also determine the number of children they wish to serve, and participate in the marketing of the program. The local financial requirement, though, has proven to be a barrier for some communities. There may be some merit to reducing the maximum level of local funding that is required.

Today, local governments contribute about 18 percent of the cost of the program. Families, based on the sliding scale I mentioned earlier, are contributing abut 35 percent of the cost of the program, and Florida State government is contributing the balance. There are no Federal funds in the program today. That demonstration grant expired in 1995.

Current enrollment, as of tomorrow, is 36,000 school-aged children and their younger siblings. They will be receiving services in 16 counties in Florida. They are served by 8 accredited health plans.

There are 8 participating counties who now have waiting lists, and there are 4,000 additional applications that are being processed.

The 17th county, Hillsborough, will begin enrolling children this summer during the summer school session, and 13 additional counties have expressed their interest in getting started. Eighty-five percent of the covered children are subsidized to some degree, the other 15 percent pay 100 percent for their care.

I want to mention a significant departure from our original demonstration grant. The 1989 language that authorized the Medicaid demonstration required us to give the insurance away for free to certain families, and that was families up to 100 percent of pov-

erty. That was not in our original program design, but the awareness of that requirement came very late in the process and we did go with it.

I mention it because, when Federal grant money expired, we went back to our original plan and started charging families what we thought was a reasonable monthly fee for their coverage. We anticipated some attrition from the program, but we did not anticipate the degree to which it would affect their utilization.

What we have found is that, when a family is required to pay a reasonable monthly fee, they are more likely to actually access the services and receive preventive care. I think that is an important element for you to consider.

I will mention emergency room use. Hospitals in Florida report a 30 percent decline in pediatric charity care in their emergency rooms where this program exists.

The health plans report a 70 percent decline in emergency room claims once this program is implemented.

Uninsured children are 8 times more likely to seek care in the emergency room than children enrolled in Healthy Kids. This year alone, we estimate the cost savings to Florida is over $13 million.

The average child enrolled in Healthy Kids is 10 years old. They live in a family of four, that is two married adults, and one or both are working. The adults have high school diplomas and some college education. The most common illness diagnosed among the children is asthma and other respiratory illnesses.

The average duration of a child's enrollment in the program is about a year. The reason families leave——

Senator MOYNIHAN. Ms. Naff, we will ask you to sort of wrap up so we can get in some questions.

Ms. NAFF. I will wrap it up.

The reasons that families leave is because they obtained other insurance. I cannot imagine a better reason for people to leave this program. The other reason they leave is because they have enrolled in the Medicaid program. They have become eligible. So families are using this as a bridge, a transitional program between those two important insurance mechanisms.

I guess I will skip to the last page. In closing, I wish Senator Gramm from Texas was still here. I was invited to speak to the Texas legislature this past summer about Healthy Kids, and I used this as my closing remark and they seemed to enjoy it, and I hope you will too.

That was, the concept of Healthy Kids was a Democratic idea that was implemented in a very Republican way. There is a place in the middle for this kind of initiative. I thank you for your work together on the issue of insuring children.

Senator MOYNIHAN. Well, we thank you. We will have to ponder that last proposition.

[The prepared statement of Ms. Naff appears in the appendix.]

Senator MOYNIHAN. May I just say to our distinguished panel, which has given us superb testimony, there is a vote in progress. Senator Roth has dashed off to vote, if he can dash back. I think our other committee members will want to be moving as well. But those who wish to stay may do so.

Dr. DeBuono, you have to leave shortly, do you not?

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Dr. DEBUONO. Yes.

Senator MOYNIHAN. Well, can I ask just a general question, and ask just how much it has been on your minds. Last year, August 22, the U.S. Government did a most extraordinary act of social policy in 60 years—it repealed the provision for dependent children in the Social Security Act. I mean, nothing like it was imaginable 5 years ago. A provision we put in place in the middle of the Depression, we ripped out of the Social Security Act, which provides Medicaid and other titles.

In about 4 years from now, we expect to see about 3.5 million children dropped from the AFDC rolls, the provision of minimum income. Are you thinking about what that implies for child health care, even though there is some Medicaid carry-on?

Dr. DeBuono, I know you have to leave soon.

Dr. DEBUONO. Yes. Thank you very much, Senator, for your graciousness.

I cannot tell you how much this is on the mind of Governor Pataki. He is very concerned about the implications of welfare reform on the health of children.

Senator MOYNIHAN. But he supported the measure.

Dr. DEBUONO. Well, he is very fortunate, though, to have the Child Health Plus program operational in New York, because those children will become eligible for the Child Health Plus program at what will likely be a full subsidy for those families. Again, if they are within the poverty limits that we have set and, in fact, therefore, would be eligible for what would be a full subsidy.

Senator MOYNIHAN. Full subsidy for medical?

Dr. DEBUONO. For their medical care. They would not have to pay a co-pay.

Senator MOYNIHAN. What are the implications of having no outside income?

Dr. DEBUONO. Again, that is certainly a serious concern, that link between income, housing, job, as well as health care. The children will be covered by the State through the Child Health Plus program as they move off Medicaid because of the changes in welfare reform.

Senator MOYNIHAN. I am not asserting this, I am asking, is there a proposition of massive social disorganization? It is not as if we do not have the equivalent already in New York.

Dr. DEBUONO. We do not believe that for children, particularly young children, that will occur in New York because of the fact that, as I mentioned in my testimony, we have a single eligibility form for both programs. As children move out of Medicaid for reasons that you state and welfare reform, they will automatically be moved into Child Health Plus. The health plans will be identical, so a child will not be disrupted from care.

Senator MOYNIHAN. But you assume a continuity in social circumstance.

Dr. DEBUONO. Well, that will occur, but there will not be——

Senator MOYNIHAN. It will occur?

Dr. DEBUONO. If it does occur, it will not occur on the health side because they will be covered. Their primary care provider will be identical, the plan that they belong to will also be the same plan that they will move into with Child Health Plus.

Senator MOYNIHAN. You are a graduate of the Harvard School of Public Health. Plan for an epidemic, will you?

Dr. DEBUONO. Well, I do not think we are going to have one in New York, particularly as it relates to health care for children.

Senator MOYNIHAN. I hope you are right.

Ms. Ferguson.

Ms. FERGUSON. Thank you. Senator, one person accused me of having spent too much time with you in the Rhode Island legislature when we did our welfare reform.

Senator CHAFEE. By you, you mean the Senate as a whole.

Ms. FERGUSON. No; Senator Moynihan. Because one of the things that we did——

Senator MOYNIHAN. No need to talk about that here. [Laughter.]

Ms. FERGUSON. One of the things that the Governor of the State of Rhode Island did was to require, under threat of a veto of the welfare reform bill in the State legislature, that all children under 18, under 250 percent of poverty, would have health care and all children under 185 percent of poverty would have child care guaranteed.

We believe that, over the next 4 years, we are going to see a movement away from cash and into work because those two supports are there. We do not envision that as a problem in Rhode Island.

Senator MOYNIHAN. Mr. Herman, Iowa.

Mr. HERMAN. Yes, I would like to respond to that, Senator.

Senator MOYNIHAN. Senator Chafee, did you want to say something?

Senator CHAFEE. Mr. Chairman, I suppose we have all got to go over and vote. I would hope this panel would stay here.

Senator MOYNIHAN. Mr. Roth is coming right back and we will keep it in session.

Senator CHAFEE. All right. If that could be done, because I would like to go over and vote and then come back, because I do have a couple of questions and it is getting pretty close right now.

Could I ask one question? I just want to get this in, if I might.

Senator MOYNIHAN. Yes.

Senator CHAFEE. Ms. Ferguson, you heard the testimony of Senator Gramm, and I think he raises a serious concern, namely the crowding out. If you look at the Rhode Island situation where, as I understand it, it is 250 percent of poverty, you go up that high, it seemed to me that would generate the crowding out. What about that?

Ms. FERGUSON. Two points. First of all, we have a provision for non-discrimination, so an employer cannot drop coverage for one portion of the work force, the lower income portion of the work force, and not the rest.

He has to drop his own coverage as well.

Senator CHAFEE. So the boss loses his own coverage.

Ms. FERGUSON. Exactly.

Second, we are purchasing——

Senator CHAFEE. But your law would not, obviously, apply to a multinational company because of ERISA.

Ms. FERGUSON. In Rhode Island, we would not make eligible for Right Care a family that chose not to accept insurance or whose

employer dropped insurance. So, there is a penalty. We do not see that happening extensively yet. We are watching it very closely, and if it ends up being a problem we are going to address it.

The other piece of what we are doing in Rhode Island, is we purchase from the private sector. We use insurance companies. A lot of the folks that are in this income bracket move from job to job—they are taking entry level jobs. Some of them have insurance, some of them do not, but most everyone in Rhode Island uses one of the four health plans that we contract with, in terms of employers. So what we are able to do, is to keep a person consistently in a plan, whether they are employer-based or not.

Senator CHAFEE. There are only 3 minutes left, Mr. Chairman, so I would ask that whoever is going to be left in charge—it is not going to be either of us—if the panel would be good enough to stay, please.

Senator MOYNIHAN. Yes. We shall surely do that.

Mr. Herman, my general question was, what are you thinking about in Iowa in terms of the 2001 cutoff of the AFDC program.

Mr. HERMAN. Senator, the Congress did provide a control mechanism when the delinking of health care from welfare occurred, and what the Congress said is that Medicaid eligibility criteria should remain as it existed on August 22, 1996.

So, you did provide a short-term fail-safe. The concern—and we are concerned—is the point at which those persons who are moved from assistance into the work force exhaust their Medicaid transition. At that point, yes, we are concerned. We become concerned about whether or not they would have coverage.

Senator MOYNIHAN. May I say that the trains are not working down below, or whatever, and Senator Roth is not back. On advice of his counsel, we are going to recess just for a moment. We hope that the panel will stay right where it is, because there are questions to be resumed. Thank you.

[Whereupon, at 11:31 a.m., the hearing was recessed.]

AFTER RECESS

The CHAIRMAN. The committee will please be in order.

I would like to ask the panel one question, and I would ask each of you to make any comments you may care to make on it.

Should we concentrate solely on expanding Medicaid or provide the States with additional options, flexibility, to target resources for children?

Ms. Naff, do you want to start with that?

Ms. NAFF. Sure, I would love to. I believe that there is a need for an intermediate program between Medicaid programs and commercial insurance. Programs which provide a somewhat reduced benefit to Medicaid, but more comprehensive, perhaps, than some commercial plans and that provide a financial transition for families.

The CHAIRMAN. Mr. Koch.

Mr. KOCH. I think that Medicaid has been a successful program. However, to expand it over to this population might be a little rich in benefits. We have identified, I think, what 90 percent of the children need in our benefit package, without the inpatient component.

When you are looking at the balance between, should the package be one-size-fits-all and comprehensive versus how many kids could we provide what we think is 90 percent of the services that they will need, I think we have identified those services and have been successful in wrapping around Medicaid, having Medicaid as a safety net and not having to factor in the inpatient component.

I think that, with a Medicaid piece, it does not allow for the flexibility that we have identified in the State of California, that you need that flexibility, county to county, city to city. Without that flexibility, programs like CaliforniaKids would not be able to foster and continue.

Last, I think it is the administrative component that one would have to look at. We work with the managed care, capitated environment. There is very little claims processing, since we pay a per member, per month. With the Medicaid as it is currently structured, the administrative costs would also have to be factored in and would be a tremendous expense and our $33 per member, per month would be probably in the $37 to $38 range.

The CHAIRMAN. Thank you.

Mr. Herman.

Mr. HERMAN. Mr. Chairman, my thinking has evolved on this over the last several years. I am as proud as anyone of what Medicaid has done and is doing today with regard to serving children. I think, however, in order for Medicaid to be the vehicle to continue to provide coverage for children, there are significant reforms that would have to occur.

When we were working with this committee back in 1995 on the Medicaid reform proposal, we felt very good about what that bill would have done in the way of easing the administrative burdens and taking the complexity out of the Medicaid program. That did not happen.

I think that today my thinking has evolved to where there is a need for a combination, a joint approach. As I testified earlier this morning, some flexibility is still needed in the Medicaid program.

But I think that a program above and beyond that Medicaid threshold, bringing Medicaid up to a consistent threshold for all persons, and then another program with maximum flexibility, absent the entitlement, above and beyond that, a mainstream approach for kids.

The CHAIRMAN. And Ms. Ferguson.

Ms. FERGUSON. I think allowing States to have some flexibility on how they want to do it, whether it is through vouchers, private insurance, Medicaid managed care, or the traditional fee-for-service system—I would urge you to look at three things, however, in whatever you do.

First of all, do not underestimate the importance of health insurance in welfare reform. For welfare reform to be successful, a lot of the women who have been in the program for a long time have no job experience. They have to start out at entry-level wages. Entry-level wages in most places do not offer health insurance as an option. That link is critical.

As you look at this, it is not just an issue of children's health, it is also an issue of successful transitioning off of assistance. The three things that I would urge you to include in any proposal that

you adopt is, first, to invest in the States to help them become purchasers of care as opposed to payors of bills. That shift is absolutely essential if you are going to get good bang for the buck.

Second, make sure that we do independent evaluations of the delivery system outcomes and the health outcomes, because otherwise you will not know whether or not the efforts have been successful, other than to say there are more people who are eligible for care.

Last, make sure that there is some flexibility built into the administration of the program, particularly around the computer systems. We went from 400 payment codes to 12,000 in order to comply with regulations about the Medicaid information system. That is a tremendous amount of money that perhaps could be retooled in different ways, and it is an outdated system.

The CHAIRMAN. Thank you, Ms. Ferguson.

Senator Chafee, do you have any questions?

Senator CHAFEE. Thank you, Mr. Chairman.

Just briefly, I noted in the outcomes report that you had, Ms. Ferguson, where you talk about the number of premature infants born to Medicaid-enrolled mothers decreased from 7.8 percent to 7.2 percent, and then you say that is a positive trend.

I would like you to just touch on that briefly, and the number of low-birth-weight infants, and the number of very sick newborns, as measured by the percentage of Medicaid newborns who stay in the neonatal intensive care unit longer than 30 days went from 13 percent to 8 percent. I would think the savings just in those statistics alone must be extraordinary. I mean, the cost of keeping an infant in a neonatal situation must be very, very expensive.

Ms. FERGUSON. Absolutely. That is how we have been able to shift the focus in the program from hospitalization to prevention. That money that we save in hospitalization has been translated into increased coverage at higher income levels, and increased preventive services.

So, we have shifted where we are spending our money and our focus from emergency rooms and hospitals, which has been the traditional place that people got coverage or care, to prevention and people having a relationship with a doctor so that they have their asthma under control, so they have their diabetes under control, and you do not have consistent crises occurring that causes them to go into very expensive care.

Senator CHAFEE. Could you just briefly amplify on one of your points, that the States should be purchasers of care, not payors?

Ms. FERGUSON. The best way to do it, is to give you an example. When I walked in the door of the Rhode Island Department of Human Services, the Medicaid director at the time came to me with a letter to sign. The letter was to deny a claim that had been submitted for a young woman who was in Rhode Island Hospital who wanted to go to a rehab facility in Massachusetts. I asked him why he was denying the claim, and the answer was, "We do not pay for out-of-State placements unless there are not any rehab facilities in the State, and there are rehab facilities in the State." I said, "Are there any empty beds?" " No." "All right. Where are we going to put this woman? She is going to stay in Rhode Island Hospital." Rhode Island Hospital, as you know, might be as high as $500 a day. A rehab facility is $250, $200. It was at least half the

cost. I said, "Well, is this the best kind of service to be providing this person and does it make sense?" The answer to me was, "Look, we are an insurance company; we just determine whether or not the claims are payable or not payable under our rules."

That is the way that the system was set up in the 1930's with the Blue Cross/Blue Shield program, claims payment. That is what Medicaid is all about. The revolution that is occurring now in the States, is we are moving from claims payment to paying someone else to provide the health care services for this individual and manage their care.

We are going to pay them a capitated rate. We are going to make sure that we get value for that $75 a month that we pay them, or $120 a month that we pay them, depending on who it is.

We are going to make sure that the services that they provide are appropriate and adequate. We monitor their activities on a monthly basis and we work in partnership with those plans to provide better care in a more full and complete delivery system. That is about purchasing services, developing contracts between providers and the State and holding everybody to those contracts, and then evaluating them. It is a constant feedback loop.

The Medicaid program traditionally has not had that kind of feedback loop, it really is a claims processing program. If we are going to use our Medicaid dollars effectively, we have to become purchasers of services.

Senator CHAFEE. All right. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Moynihan, do you have any further questions?

Senator MOYNIHAN. Yes. I would just like to say that I think Ms. Ferguson has done us a great service in making this point, that so long as Medicaid remained a claims processing system, the claims went up. They were growing and doubling every 7 years. Bringing some management into the process is not only good for the health care of the people involved, but good for the finances of the program. Thank you.

How come they always do things so well in Rhode Island?

Ms. FERGUSON. We are small, but we are great.

The CHAIRMAN. Not as small as Delaware. [Laughter.]

It seems to me that there are two basic points that the panel has made. First, is that the States are changing the way they do business, including the Medicaid program. We cannot stand still or remain locked into the current system.

Second, States that choose to expand need flexibility to design programs as they choose. We have models of success which should be encouraged, but not overtaken by Federal rules and regulations. Is that a fair statement, would you all agree?

Ms. NAFF. Yes.

The CHAIRMAN. Thank you for your affirmative answer. Let me thank each of you for being here today. I congratulate you on the progress and contributions you are making in this area as we proceed to try to develop a broad bipartisan consensus, and, undoubtedly, we will want to further consult with you.

Senator MOYNIHAN. Mr. Chairman, can we not also thank them for their example?

The CHAIRMAN. Exactly.

Senator MOYNIHAN. We see some very impressive things going on.

The CHAIRMAN. Very much so. Very encouraging.

Thank you very much.

Mr. HERMAN. Thank you, Mr. Chairman.

Ms. FERGUSON. Thank you.

Ms. NAFF. Thank you.

[Whereupon, at 11:52 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. JOHN H. CHAFEE

Thank you, Mr. Chairman. I want to congratulate the Chairman for holding this hearing today. There are few subjects which have garnered as much attention as this issue of finding some way to provide health insurance to the ten million children in this country who are without. This is a very serious problem for millions of working families and now is the time to try to find a solution.

I also want to welcome the distinguished panelists who are here today to tell us about what is happening in their states. I am especially pleased that Christine Ferguson is with us this morning. Christy runs the Medicaid program in Rhode Island and, as you may know, she was a member of my staff for many years. She has unparalleled expertise in the area of health care and Medicaid and I am very grateful that she could take the time to be here today. Also, I want to welcome Barbara DeBuono who spent several years running the Rhode Island Health Department prior to becoming the Commissioner of Public Health in New York.

The bad news is that ten million children are without insurance. The good news is that there are several members of this committee, and indeed more in the Senate as a whole, who have come up with different solutions to this problem. We have the Hatch-Kennedy bill to provide grants to states to assist low-income families in purchasing health insurance for their children, we have the Daschle proposal to provide tax credits to low income families for health insurance and we have the Gramm bill to provide additional funds through the Maternal and Child Health Block Grant. This afternoon, I will be introducing legislation along with Senator Rockefeller to give states the option to expand access to Medicaid. The Chafee-Rockefeller bill has 22 bipartisan sponsors, eleven of whom sit on this committee. So, I think there is real momentum for a solution and I am very optimistic about the prospects for legislation this year.

Senator Rockefeller and I have chosen to go the Medicaid route but we believe our proposal could be complemented by any of the others that have been introduced. Indeed, I think it is highly likely that we will end up with a combination of proposals.

Let me just say quickly why we believe that the Medicaid program is the best avenue to reach these uninsured children. Expansions in the Medicaid program over the years have done wonders in increasing coverage for children and pregnant women. We also have to keep an eye on cost, and Medicaid is an inexpensive way to cover children—While half of Medicaid beneficiaries are children, children only account for 15-cent of overall Medicaid spending. And Medicaid is a program that already exists, so we don't have to create a new entitlement program. In short, Medicaid works and works well.

The Chafee-Rockefeller proposal offers the states additional federal matching funds if they choose to provide Medicaid coverage to all children up to 150% of the federal poverty level. It is incompletely voluntary program—we hope that all states will participate, but we leave that decision to the Governors. States, like Rhode Island, that are already providing coverage at these levels will immediately begin to get additional federal matching funds. Our bill also provides grant funds for states to use for outreach to the three million children who are eligible for Medicaid but not enrolled.

So, again, I want to thank the Chairman for holding this hearing. I look forward to hearing from the witnesses.

PREPARED STATEMENT OF HON. TOM DASCHLE

Thank you, Mr. Chairman, Senator Moynihan, other members of the committee. I appreciate this opportunity to testify before you today.

Coming before this committee to advocate for better health coverage for America's children really is like "preaching to the choir." Many of you have been deeply committed to this issue for years, in some cases decades.

Your persistence, your commitment, is part of the reason that a solution to the problem of uninsured children is finally, I believe, within reach. I look forward to working with you to craft that solution.

We all know the facts. We've all heard the statistics:

The United States is the only industrialized nation that does not guarantee health care for its children.

Ten million children in this country are without health insurance.

Twenty million children—one out of every three children—goes without health insurance for at least part of the year.

To put those figures in perspective:

- If all the uninsured children in South Dakota lived in one place, they would create the third-largest city in my state.
- All the uninsured children in Mississippi would create a city of 134,000 people—the second-largest city in that state.
- And the 1.6 million uninsured children in California would make up a city larger than San Francisco.

If not for the recent expansions in Medicaid, millions more children would be without coverage.

These figures do not include the millions of children who are underinsured.

The children we are talking about are not the poorest of the poor; those children have Medicaid. Most uninsured children live in homes where at least one parent works full-time. Often both parents work.

Their numbers are growing because more and more people work in jobs that don't provide family health coverage, and don't pay enough for parents to purchase private health insurance for their children.

Some defenders of the status quo note that the percentage of American children without health insurance has remained fairly stable, at about 15 percent for a few years. That is true.

But we should not allow that relative stability to lull us into complacency. Fifteen percent is still unacceptably high.

While some uninsured children are treated in emergency rooms or public health clinics, we know that far too many of them delay treatment until it is too late to avoid needless suffering—and sometimes permanent damage.

Congress has struggled with this issue of uninsured children before, most notably at the end of the 103rd Congress.

There are signs that this time is different. This time we can succeed.

One hopeful sign is that a majority of the members of this committee has introduced or cosponsored child coverage bills. The same is true in the Labor Committee. I commend each of you for your leadership in this regard.

I am particularly grateful to those of you who are cosponsors of the bill I introduced on the first day of the session. That bill, S. 13, calls for refundable tax credits to help low- and moderate-income families purchase private coverage.

Many other good ideas have been advanced since that bill was introduced:

- A bipartisan Medicaid expansion and improvement plan will be introduced this week by Senators Chafee, Jeffords, Rockefeller, and Breaux. This solution could cover millions more uninsured children. It's not creating a new program, it's building on a successful one. I am a cosponsor of this bill because I believe it is a sensible proposal that advances the debate.
- The Kennedy-Hatch bill is another very good proposal. It would give states the resources and flexibility to tailor their own solutions to the problem of uninsured children. In the absence of a national solution, states have taken the lead in developing innovative coverage strategies; several of them will be featured later in this hearing. We should learn from their experiences and build on them.
- Another proposal, by Chairman Roth, Senator Gramm and others, would expand the Maternal and Child Health block grant.

We need to explore and debate the merits of all these proposals.

In the absence of a national plan, as I said, states have stepped in to fill the void. So have local governments, charities, and the business community.

Their efforts are more than commendable. Given the scope of the problem, they are heroic.

But they are not enough. Even if the local and charitable efforts were quadrupled, they wouldn't reach all of America's 10 million uninsured children. That's the practical reality.

From a philosophical perspective, I believe it is simply wrong to ask a small segment of our society to shoulder the burden of what is truly a national problem.

When President Truman created the school lunch program 50 years ago, he didn't call it a national nutrition program; he called it a national security program. He proposed the idea after shocking numbers of World War II recruits failed their physicals because of preventable childhood illnesses.

Truman understood, and Congress agreed, that giving children a healthy start in life was a matter of national security.

It still is.

Only a coordinated national response can close the gaps through which those 10 million children are falling.

So, what should such a program look like?

Any effort to expand health coverage for children should be based on three basic principles:

- First, it should not disrupt existing coverage. It should bolster—not replace—employer-provided health insurance. And, it should build on—not supplant—the successful programs that states, the private sector and charitable organizations have pioneered. This Is possible; many innovative programs to expand health coverage to children include features, that minimize so-called "employer crowd out."
- The second basic principle is this: Total out-of-pocket expenses—premiums, co-payments, deductibles—must be within reach of working families.
- Finally, coverage must meet the special health care needs of children: It must include preventive, basic, and catastrophic services. Evidence suggests that plans that don't cover primary care or do include large deductibles or copayments for these services discourage cost-saving preventive care.

These principles form the foundation of S. 13, the bill I introduced. The Child Health Coverage Act recognizes the private market can do much of the work to cover uninsured children—if we empower it to do so.

It specifically targets working families who are ineligible for Medicaid but unable to afford a private policy.

It contains incentives for the insurance industry to offer "children only" policies.

It also includes provisions to prevent employers from dropping their family policies for those who qualify for the credit.

In short, it places no mandates on employers or parents. And it allows the market, not government regulators, to set the premiums.

The alternatives proposed by many of my colleagues also have much to commend them. Rather than confuse the debate, they contribute to it.

In fact, I believe it will take a combined approach to solve this problem, since children lose their coverage for a variety of reasons.

It may be that a successful children's health initiative would include a combination of approaches. For example:

- Medicaid expansions for the lowest-income children;
- increased funding for the Maternal and Child Health block grant to get needed services to hard-to-reach populations; and
- a limited, non-bureaucratic program, like the one outlined in my bill or the Kennedy-Hatch proposal, to pick up the remaining uninsured children from working families.

The one thing we must not do is enact a meaningless program and claim victory. Such a response would set back our efforts.

While I was disappointed that the Republican leadership omitted expanded children's health coverage from its list of priorities at the start of this Congress and refused to include it among the topics for the first round of budget talks, I am heartened by recent developments.

Senator Hatch, in particular, has shown real leadership on this issue—and taken some heat for it. It's a sad commentary on this Congress that supporting a modest children's health bill can get you denounced in your own caucus.

This should not be a partisan battle. Almost every health care bill introduced in the 103rd Congress—by Republicans and Democrats alike—provided assistance to help low-income families purchase private children's health insurance.

That said, there are some approaches that could do more harm than good.

Some members of this Congress have suggested that we should require families who qualify for the Earned Income Tax Credit to prove that they have insurance for their children before they can receive this much-needed tax relief.

This would force the poorest working families to purchase health insurance, without giving them an additional dime, when they may need every dollar they now make to put food on the table for their kids. No other families in this country are required to purchase health insurance for their children—much less with money they simply don't have.

I am also concerned about talk of eliminating the EITC for some workers in order to expand the Maternal and Child Health block grant. This would be robbing Peter to pay Paul. Its likely effect would be to increase the number of working Americans without health coverage.

The perfect should not be the enemy of the good. But we should not let opponents of children's health coverage dictate the outcome of this debate by proposing plans that are ineffective at best and counterproductive at worst. Whatever we do should make working families more secure, not less.

There was a sad story in the paper over the weekend about a family in Pennsylvania whose 16-year-old daughter died from complications of untreated diabetes. A few years ago, her 8-year-old brother died from an untreated ear infection. The family had refused medical treatment for either child because they believed God would cure them. The parents now face possible criminal action.

Our hearts go out to that family. But most of us, hearing that story, have a difficult time imagining how any parent could withhold potentially lifesaving medical treatment from a child.

I have just as difficult a time imagining how we as a nation can sit back and watch as 10 million children go without health coverage.

How many more tragedies will it take before we are willing do what every other industrialized nation in the world does?

We can't guarantee that our children will always be healthy. But we can guarantee that every child in America has basic health insurance. It's time for the Congress to meet that responsibility with a strategy that truly helps families help themselves.

**Testimony Submitted to
The Committee on Finance
United States Senate
April 30, 1997**

**Statement of
Barbara A. DeBuono, M.D., M.P.H.
New York State Commissioner of Health**

Ensuring Fairness and Flexibility in National Child Health Coverage

Introduction

I am pleased to have this opportunity to submit testimony on the subject of child health insurance coverage. The Senate Finance Committee and Congress should be commended for focusing on the need to provide health insurance coverage for our children. Ensuring that New York's children grow up healthy is one of the highest priorities of Governor George Pataki and the New York State Department of Health. We must ensure that every child has access to regular medical check-ups, immunizations, and early diagnosis and treatment of illness and developmental disabilities.

I come before you today to offer New York's child health insurance program as a national model and to offer our assistance in the development of federal legislation. I ask that you help the states expand coverage for children, without eroding support to the states for other needy populations.

Research has documented the strong link between health status, educational attainment, and self-sufficiency. The key to improving health status for children is early and continuous primary and preventive care that prevents most disease and disability from occurring and provides early identification and treatment of health problems when they do occur. Low-income children are currently at particular risk for disease and disability due to their lack of access to regular health care.

New York Provides a National Model

New York has taken a leadership role in designing a state-subsidized health insurance program to cover children of the working poor. Recognizing that many hard-working, low-income parents frequently do not receive health benefits through their employment, and often can't afford the high cost of private insurance, New York State in 1990 authorized the creation of the Child Health Plus program. The program is based on a partnership between government and private insurers, and is supported entirely through State funds and payments by policy-holders.

Through Governor Pataki's Health Care Reform Act of 1996 (HCRA), New York recently made a major commitment to expanding this program by increasing eligibility to children through age 18 and adding inpatient coverage. In expanding the program, Governor Pataki stated, "It is very important that parents facing a major hospital expense for a child will not have to worry about their ability to handle the costs."

With more than 124,000 children currently enrolled in Child Health Plus, we plan to increase enrollment to 251,000 by 1999. HCRA provides a stable method of financing the program through a surcharge on outpatient and inpatient services paid by both private payers and Medicaid.

The expanded Child Health Plus program provides comprehensive primary and preventive care and inpatient care for children through the age of 18. Child Health Plus provides fully subsidized insurance for children whose family incomes are below 120 percent of the federal poverty level -- the equivalent of an annual gross income of $19,260 for a family of four. It provides partially subsidized insurance for children whose family income falls within 120 percent and 222 percent of the poverty level -- which is equivalent to an annual gross income of $35,631 for a family of four. Families with incomes above 222 percent of poverty can also purchase the insurance but must pay the full premium, which will range from $60 to $100 per member per month. However, they benefit from lower group rates, which on average are about half the cost of individual policies.

New York's expanded Child Health Plus program, which will be in place by June, will use a managed care product to deliver cost-effective health care with an emphasis on prevention. The State Department of Health has received 33 proposals from managed care organizations in response to a Request for Proposals issued by the department in December.

New York's Program Works

New York's Child Health Plus program is showing results. An extensive statewide evaluation of the program conducted by the University of Rochester Child Studies Program in 1995-96 found that children enrolled in Child Health Plus experience improved health status and their parents report better quality care.

The study also showed that Child Health Plus:

- Reduces hospitalizations by 4 percent and reduces the potential for hospitalization by nearly 2 percent.
- Provides insurance to a large number of children from working poor families, most of which were previously uninsured and could otherwise not afford insurance.
- Results in increases in all types of primary care visits and specialty care.
- Provides easy access to primary care for children with chronic illnesses.
- Has a high level of parent satisfaction with the quality and ease of using the program.

Effective Marketing and Enrollment are Critical

Effective marketing, outreach, and ease of enrollment are necessary to a successful child health insurance program. Under New York's expanded program, community outreach and marketing will occur through four avenues: (1) a community outreach contractor selected through a competitive RFP process; (2) participating insurers; (3) local social services agencies; and (4) an extensive statewide media campaign.

The marketing program also includes the establishment of telephone hotlines that can refer children to Medicaid or Child Health Plus and linkages with schools and community-based organizations.

Eligibility and enrollment are coordinated by Child Health Plus insurers and local social services agencies so that children applying for Child Health Plus who qualify for Medicaid are referred to the Medicaid program, and children who don't qualify for Medicaid are referred to the Child Health Plus program. The State Department of Health is currently developing a joint application process for Medicaid, Child Health Plus, and the Special Supplemental Food Program for Women, Infants and Children (WIC) to streamline and simplify eligibility determination and enrollment in these three programs.

Mechanisms are in place to guard against dual enrollment in Child Health Plus and Medicaid. Computerized information on enrollees in Child Health Plus and Medicaid are compared monthly to identify any dually enrolled children.

<u>Concerns about Federal Proposals</u>

We are looking to Congress for assistance to increase access to health insurance for more children. While we are pleased and excited with the proposals now being discussed at the federal level, we have a number of concems with some of them. The intent of all of the proposals is to be commended. However, some of the funding constraints could hinder our efforts in New York. What we are seeking in any new law are fairness and flexibility as we move forward in expanding coverage.

I have three main concerns about the federal proposals. First, President Clinton's proposal, as you are aware, is funded through cuts to the Medicaid program. These proposed cuts would severely affect New York State. President Clinton proposes a per capita cap on Medicaid payments and a cap on disproportionate share payments. We oppose an arbitrary, unilateral cap on Medicaid. We will continue our efforts at the state level to rein in program costs.

Federal approval of New York's application for a 1115 waiver, which we are still awaiting after 25 months, would help us tremendously in that regard. But a cap on Medicaid Disproportionate Share payments would be hurtful to New York. Since New York has a large percentage of vulnerable populations, including the poor elderly, low-income children, persons living with AIDS and uninsured, any cuts in DSH payments would severely impact our state and our providers' ability to serve these populations.

I am sure you would agree that it makes no sense for the federal government, on the one hand, to expand coverage to children, and on the other hand, penalize a state that does so much for the health care needs of so many other low-income and uninsured persons.

Second, any proposal that requires state maintenance of effort, a provision contained in most of the recent proposals, hurts those states that have been leaders in expanding Medicaid coverage for children and providing health insurance for otherwise uninsured children. Such a requirement would penalize New York. We would hope that our efforts would be recognized and rewarded, not penalized. We believe that states that have already expanded coverage should get the same new federal support as contained in any new legislation to encourage expanded coverage.

My third concem is the proposed federal requirement that the benefit package offered under a child health insurance program match those provided under the Medicaid program. This seems inconsistent with the general consensus on both the state and national level that the Medicaid program has proven too costly. New York has a very generous Medicaid benefit package, and we aren't the only state with a Medicaid program that is much more comprehensive than most private sector plans.

Our goal is to mainstream the Medicaid population into the private sector health care market. Our plan to enroll Medicaid beneficiaries in HMOs is helping us to do that. While we are working toward a seamless system of coverage for children, it is not the Medicaid program that should be considered "mainstream" coverage, but the private sector.

Thus, we designed our Child Health Plus program based on the benefits most people receive through private insurance. In order to provide access to care for greater numbers of children, and to avoid creating an incentive for employers to drop coverage, we have developed a benefit package that is comparable to a typical employer-based benefit plan. If our goal is to provide a medical home for as many children as possible, we must focus on the most essential services.

Another area in which the federal government can be of great assistance to the states is in support for marketing and outreach. New York's experience has shown us that effective marketing and outreach are critical to a successful child health insurance program. We have learned that in order to reach as many of the low-income, uninsured children in New York who are eligible for the Child Health Plus program, we must conduct very targeted outreach efforts. Any assistance you can provide us in this regard would be greatly appreciated.

Conclusion

Thank you for this opportunity to discuss New York's efforts to expand access to health care for the children of the working poor. Just as it has been possible for us in New York to develop a program that efficiently and effectively extends coverage to our state's children, so I believe it is possible for Congress to develop such a program for our nation's children. However, such an effort must provide the fairness and flexibility necessary for a successful program. I stand ready to assist you in any way possible.

Child Health Plus Insurance Program

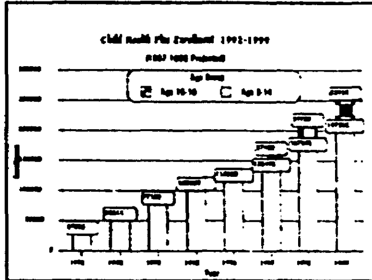
Purpose: Improving the health status of New York State's children is one of DOH's highest priorities. An important way to improve child health is by increasing access to primary and preventive care. Through the Child Health Plus program, the State is subsidizing health insurance for children of low-income families.

Background

- Chapters 922 and 923 of the Laws of 1990 authorized the creation of a subsidized outpatient health care coverage program for children under 13 at an annual appropriation of $20 million. The appropriation and age eligibility have been subsequently expanded.
- The Health Care Reform Act of 1996 (HCRA of 1996) significantly expanded the program.
  - → the age eligibility has been increased through age 18;
  - → an inpatient benefit has been added; and
  - → funding will be incrementally increased up to $207 million in 1999.
- An RFP was issued in December, 1996, requesting insurers to participate in the expanded program.

Enrollment

- Over 231,000 children have been provided health coverage through the program since it's inception in 1990.
- Enrollment in the program is anticipated to continue at a strong and steady rate.
- As of February, 1997, over 115,000 children under the age of 19 were enrolled in the program.
- There are approximately 1,500 new enrollees per month.



Funding

The expanded program is financed through a surcharge on hospital and ambulatory care services paid by both Medicaid and private payers. As established through HCRA of 1996, statewide allocations available for the program are:

- 1997: $109 Million
- 1998: $150 Million
- 1999: $207 Million

Benefits

- Inpatient care (excluding inpatient mental health, substance abuse or alcohol treatment)
- Outpatient care including preventive care, well-child exams, immunizations, diagnosis of illness or injury, x-rays and lab tests and treatment for alcohol or substance abuse
- Outpatient or ambulatory surgery
- Emergency care
- Prescription drugs
- Therapy services including physical and occupational therapy, chemotherapy and dialysis.

Eligibility

- Children under the age of 19
- Not enrolled in Medicaid
- Not having equivalent health insurance coverage
- New York State resident

Family Contributions

Gross Family Income (% of FPL)	Required Family Contribution
<120%	No Contribution
120% - 159%	$9/month/child up to a family max. of $36/month
160% - 222%	$13/month/child up to a family max. of $52/month
>222%	Full Premium

Co-Pays

- With the addition of inpatient coverage, there will be a $2 co-pay required for all physician visits, except those provided on an inpatient basis, for well-child care or otherwise prohibited by Insurance Law.
- A plan may impose a $35 co-pay for inappropriate ER use and/or failure to notify within 24 hours of an ER visit.
- A maximum co-pay of $3 per prescription drug

Interaction with the Medicaid Program

- If a child is enrolled in Medicaid, he or she is not eligible for the Child Health Plus program.
- All Child Health Plus applicants will be screened for Medicaid eligibility. If a child appears to be Medicaid eligible, he or she will be referred to the Medicaid program.
- There are mechanisms in place to guard against dual enrollment.

TESTIMONY BY CHRISTINE FERGUSON
DIRECTOR OF RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
TO THE
UNITED STATES SENATE COMMITTEE ON FINANCE

Hearing on Increasing Children's Access to Health Care
Wednesday, April 30, 1997

Mr. Chairman and members of the Committee, my name is Christine Ferguson, Director, Rhode Island Department of Human Services. I am here to talk to you today about our efforts to ensure that virtually every child in Rhode Island has access to comprehensive health care coverage.

Rhode Island has done this through, first, improving and, then, expanding the State's Medicaid Program.

In 1993, Rhode Island's Medicaid Program was a traditional fee-for-service program. Rhode Island was first among all 50 States in per capita hospital expenditures and 49th in per capita physician expenditures. More than 50 percent of inner-city residents under Medicaid received their primary care in the local, hospital emergency room. Although a strong network of community health centers provided primary care to 60,000 people each year, serving as a safety net to some of the State's 115,000 Medicaid participants and our 100,000 uninsured, there was still limited access or no access at all to primary and preventive care, for the majority of families on Medicaid.

In 1994, with HCFA's approval, Rhode Island began to operate the portion of its Medicaid program that covers AFDC families under a 1115 Research and Demonstration waiver called RIte Care. The goals were very clear. For our State's existing Medicaid families we wanted to: improve access, quality, and health outcomes, while controlling the annual rate of growth in Medicaid expenditures. This would bring it more in-line with regional, medical inflation rates. A second, and very ambitious goal, was to begin to extend coverage to Rhode Island's low income women and children, beginning with pregnant women and children under the age of six, with incomes of up to 250 percent of the Federal Poverty Level (FPL).

Beginning in August 1994, Rhode Island began enrolling its 60,000 AFDC recipients and 10,000 uninsured pregnant women and children into their choice of five Health Plans. Upon enrollment in a RIte Care Health Plan, family members choose their own primary care physician, who coordinates all of their health care.

In three and half years since implementing RIte Care, the State has evolved from the role of a fee-for-service payor to that of purchaser of health care for 7 percent of Rhode Island's population. As a purchaser, the State defines in contracts with Health Plans the coordinated, comprehensive health

care delivery system it purchases on behalf of RIte Care participants. The contracts specify access and quality standards for the delivery system. Standards include 24 hour, 7 day a week access: geographical access for specialty and pharmacy services, and numbers of members per primary care physician. Specific provider network standards include language designation for participating providers.

Rhode Island has established performance objectives to measure the effectiveness of the Health Plans in delivering the services we are purchasing. The State has moved into the role of assuring access and monitoring the quality of the delivery system including Health Plan compliance with financial, operational, and medical management requirements. The Office of Managed Care uses consumer focus groups, client/physician surveys, comprehensive site visits, complaints and grievance monitoring, analysis of utilization data, and focused clinical studies to monitor Health Plans.

The most important measures of the effectiveness of the new delivery system are the health status, health outcomes, and RIte Care member satisfaction.

I would like to talk today about the successes and results we have achieved in Rhode Island. We have succeeded in expanding health care for uninsured children by building upon the solid base of a quality, accessible Medicaid program for families, with the State assuming the role of purchaser.

RIte Care enrolled all of the eligible 70,000 members into one of five Health Plans over a one-year period, with 93 percent of the families choosing their preferred Health Plan. Having this choice was important, to ensure the continuity of care for members who had existing relationships with primary care physicians.

Prior to RIte Care's inception, only 350 of the State's 900 primary care physicians participated in Medicaid, resulting in poor access to primary care. **One immediate result of RIte Care's implementation, was more than a two-fold increase of physicians from 350 to more than 800 participating primary care physicians. This represents more than 90 percent of the available primary care physicians.**

In one year alone, trends showed a marked increase in primary care physician visits - more than doubling from two-per-year to five-per-year for the average enrollee. At the same time, emergency room visits and hospital use decreased by more than one-third. Emergency room visits dropped from 752 per-1,000 enrollees per year pre-RIte Care to 488 per-1,000 per year; hospital use decreased from 760 days per-1,000 enrollees per year to 441 days per-1,000 members per year after RIte Care was implemented.

Equally as important is the fact that RIte Care has been successful in improving health outcomes. Our emphasis on improved access to family planning services is demonstrated by a dramatic increase

in the number of RIte Care mothers who are waiting longer before having another baby. Before RIte Care, 58 percent of Medicaid women waited longer than 18 months between babies, while 69 percent of women in Rhode Island covered by commercial health insurance waited 18 months or more. By December 1995, just 17 months into RIte Care's implementation, there was only a 2 percent difference between women who were covered by Medicaid compared to those covered by commercial health insurance. (The differences were 72 percent, 74 percent respectively.)

The RIte Care Program also saw smoking rates among pregnant women drop significantly -- 14 percent -- from 1993 (pre-RIte Care) to 1995. Although still higher than smoking rates among commercially-insured pregnant women, there was no change in smoking rates in pregnancy among women with commercial insurance during this same period.

Alcohol consumption during pregnancy is showing a downward trend for women enrolled in RIte Care and the program is significantly affecting overall prenatal care.

Women participating in RIte Care entered prenatal care earlier and received improved prenatal care overall compared to pre RIte Care Medicaid participants. RIte Care has also significantly closed the gap between Medicaid and commercially insured women in both these indicators. In 1993, a total of 76 percent of women with Medicaid coverage entered prenatal care in the first trimester, while 96 percent of commercially-insured women entered prenatal care in the first trimester, a disparity of 20 percentage points. In 1995, a total of 82 percent of women enrolled in RIte Care received prenatal care in the first trimester, a growth of 9 percent, while 94 percent of commercially-insured women entered prenatal care in the first trimester. RIte Care closed this gap from 20 percentage points to just 12 percentage points.

Similarly, in 1993, a total of 55 percent of women with Medicaid coverage received adequate prenatal care, while 71 percent of commercially-insured women reported receiving adequate care, a disparity of 16 percentage points. Under RIte Care in 1995, a total of 65 percent of women received adequate prenatal care, an improvement of 20 percent while the number of commercially-insured women increased to 74 percent. RIte Care closed the Medicaid/Commercial gap from 16 percentage points to 9 percentage points.

It is widely recognized that early and adequate prenatal care as well as improvements in maternal health factors, such as inter-birth intervals, reduced smoking, and alcohol consumption, all contribute to the health of newborns. RIte Care has had positive impacts on both prenatal care and maternal health, and we are seeing positive trends in newborn health outcomes as a result.

The percentage of low birth weight infants born to mothers enrolled in Medicaid decreased from 9 percent in 1993 pre-RIte Care to 8.5 percent in 1995 with RIte Care. This trend is encouraging. Last week, the Rhode Island Department of Health released provisional 1996 infant mortality statistics for all Rhode Island births. The 1996 provisional infant mortality rate was 5.5 per 1,000 births, the

lowest ever in Rhode Island, surpassing even the State's own goal of 6.0 by the Year 2000. As RIte Care covers a third of the births in the State, we can assume that RIte Care's improvements in prenatal care and maternal health contributed to this successful milestone.

One of the most important determinants of a program's success is customer satisfaction. RIte Care conducted a member satisfaction survey in December 1996. Overall, 95 percent of the respondents reported that they were "very satisfied" or "satisfied" with RIte Care. Satisfaction was high with the members Health Plan, and particularly high with physicians. Of the members who had contacted their Health Plan's customer service department, 88 percent reported that they were "satisfied" or "very satisfied" with their plan's helpfulness. Ninety-six percent of respondents were "satisfied" or "very satisfied" with their regular physician and with the physician's staff. Ninety-seven percent were satisfied or very satisfied with the amount of time their physicians spent with them.

Even beyond these wonderful statistics, the most telling statements for me, were member comments on the survey:

"The program has been a godsend, my daughter is frequently ill and there is no way I could pay for needed care for the plan. My self-employment barely makes ends meet, but we are determined to persevere".

"Our Pediatrician is very dedicated and caring, and her staff are as well. They do not treat us as "second class" citizens. RIte Care has enabled us to get a better quality of care for our children and to erase the Medicaid stigma".

"Thank you for being responsible for my child's medical expenses. I do not know what I would do without your help in this very crucial matter in a child's life. God bless you".

These statements represent and validate my firm belief that we have a responsibility to assure that all children have access to excellent quality health care. This can be achieved by building on the Medicaid program. This is exactly what we are achieving in Rhode Island.

On May 1st, we will fulfill our objective of assuring access to excellent quality health care coverage to all Rhode Island children, when we expand eligibility for RIte Care under our 1115 waiver, to all uninsured children under 250 percent FPL. **We believe that with this expansion, virtually all pregnant women and children in Rhode Island will have access to health care.** Separating Medicaid eligibility from welfare eligibility, as this expansion does, gives welfare recipients the ability to obtain an entry level job without worrying about losing health coverage for their children. Combined with the child care benefits Rhode Island will be offering women on welfare who enter the workforce, this will provide support for working families who are struggling to become or remain independent.

We have already offered RIte Care benefits to the AFDC population, to pregnant women and children in low income working families, and most recently, to family day care providers who take care of at least one child of a low-income family.

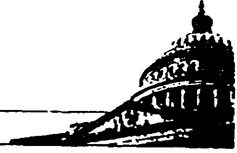
It has been argued in some places that expanding Medicaid to working families may result in employees dropping families from employer-sponsored health coverage. As a matter of RIte Care policy, we will not enroll families who voluntarily drop coverage, nor under Rhode Island law do we allow employers to drop coverage to only a segment of their workforce.

I am here, today, to tell you that it makes sense to build children's health care coverage on an existing successful delivery system. With Medicaid, we can use the strength of a large purchaser to define and assure a quality, accessible delivery system for children and families at the best price. We have accomplished this in Rhode Island in a very short time. We can accomplish the same for our country by the Year 2000.

Such a strategy would enable all States to build on a program that has a comprehensive health benefit package that emphasizes ambulatory preventive care. The Medicaid program has a national focus on early and periodic diagnostic services for children that has been developed with input from the health care community. Medicaid has in many States like Rhode Island begun the transition from payor to purchaser; a transition that includes the ability to establish performance objectives, monitor Health Plan performance and assure that children receive quality health care services. The role of Medicaid has moved from paying claims to assessing the process and the outcomes of the health care delivery system. Medicaid agencies are now advocates for enrolled members through monitoring of complaints and grievances, and designing contracts.

Options that do not use the experience of the Medicaid agencies will result in the new consumer having to face a market with little or no guidance except for the glitter of the Health Plan marketing literature. Who will advocate for translation and language capabilities in the primary care physician's office? Require that screening services be provided on a timely basis? Monitor for access to all health providers in the delivery system. Medicaid agencies now know that simply paying for health care is not sufficient. We must look creatively at purchasing coverage, developing a delivery system, and monitoring health outcomes to ensure that our money is appropriately spent.

Bill Frist



UNITED STATES SENATOR • TENNESSEE

TESTIMONY BY SENATOR BILL FRIST
BEFORE THE SENATE COMMITTEE ON FINANCE
WEDNESDAY, APRIL 30, 1997

Mr. Chairman and Members of the Committee, thank you for inviting me to appear before you today to discuss the issue of pediatric health care. Indeed, this issue transcends both party and idealogy. While I am not currently a cosponsor of any specific legislation, I support the intent of the broad array of legislation -- to improve health for our children.

Therefore, I'd like to concentrate in my testimony on the key issue of this debate -- finding the most appropriate delivery mechanism. As a physician, I know that ultimately, access to health insurance does not always translate into care being delivered. The Medicaid program is an example. Three million kids are eligible, but for whatever reason, are not enrolled. Even those that are enrolled do not always access the most appropriate care or take advantage of preventive care.

We agree on the problem. There are currently 10 million children in this country who are uninsured, roughly 1 child in 7.

And, we share a common goal -- to improve the health status of these children.

So for the moment, let's put the financing of this program to the side. There will be room in the budget for adjustments to fund this objective. Instead, we must ensure that the policy to be funded is sound and desirable. This morning, I urge you to put aside all other agenda items, narrow the discussion, magnify the policy and discuss the best structure to improve access to healthcare for children.

After studying the various proposals, I believe the plan being crafted by Senators Gramm and Roth which builds on the existing structure of the Maternal and Child Health Block Grant has several important strengths:

First, the MCH program has an inherent focus on children. Clearly, it is already serving segments of the population we need to reach, and is specifically

targeted to almost 16 million people -- those who face other limitations in access to care, and families with children with special health care needs.

Second, MCH is community-based. It is popular with the states. In fact, nearly all states contribute over and above the required federal/state match. In my own state of Tennessee, we contribute $4 million over and above our required match. And the money is reaching children, not funding bureaucracy, as less than 10% of MCH funds currently go to support Administrative functions.

Third, MCH is required to coordinate with the Medicaid program. We have heard a great deal in recent weeks about the three million children who are eligible for Medicaid, but remain unenrolled. The MCH approach provides a natural incentive to encourage enrollment in Medicaid when appropriate.

Fourth, to insure real progress in the pediatric population, we need scientific outcomes data. Unlike Medicaid, MCH is required to meet Healthy People 2000, HHS' ten year public health goals. This yardstick has enabled and encouraged states to make real strides in measuring and improving the health of children.

The Maternal and Child Health Program changes lives for the better. In my own state, the MCH program has had many successes in identifying and facilitating care for health needs. For example, an infant in the West Tennessee area, was legally blind and suffering from nystagmus. This went undetected until a home health worker, coordinated through MCH, discovered his disability. MCH helped the family hook up with a pediatric specialist for vision programs, and coordinated with the Department of Education to enroll the infant in an early intervention program. This assisted the family with paying for rehabilitation services for the infant. He's about two years old now, and catching up developmentally. The baby's mother was a teen mother who had dropped out of school. She is now back in vocational school, and getting her G.E.D. This baby is up on his well-child visits and immunizations. He has received a more healthy start on life. Building on this multi-faceted program with the addition of a dedicated funding stream to assist states in developing and operating innovative children's health programs is worthy of this committee's attention.

As we approach consideration of a reasoned policy for children's health, I'd like to suggest some broad themes.

First, we must consider state flexibility. Medicine is an art and so is

policymaking. As a physician, I can't depend on cookbook medicine to treat an individual patient and their unique needs. Similarly, as a United States Senator, I must not assume that all states can or need to approach this problem in the same manner. For example, Delaware, New York and Tennessee all have tailored programs to address health care for their children. They need different solutions, because the problems that lead to uninsured children differ from state to state. Even within my own State of Tennessee, the needs vary depending on the community's employment base, the demographics, provider population and maturity of the health care market.

Second, we must respect the state's initiatives in the area of children's health. As I previously stated, I am very concerned that the federal government refrain from treading on the state's worthy initiatives with a one-size fits all plan. Even more, we must be careful not to penalize states, and ultimately the children, for showing initiative in providing coverage.

Twenty-nine days ago, Tennessee starting enrolling all children without access to insurance, regardless of income. The state has committed $20 million to this aggressive outreach and hopes to enroll 57,000 children. Federal assistance must not ignore this effort and lock the state into a new and untested program. Some legislative proposals require a maintenance of effort by the state -- requiring that they continue with current efforts and limiting new federal assistance only to supplement the existing effort. However, should Tennessee be unable to maintain the financial commitment of its new program, it could lose the option of federal matching dollars. As a result, the children in Tennessee would lose and Tennesseans tax dollars would go to assist other states that did not step forward earlier to meet the needs of uninsured children.

Third, we must avoid the temptation to create a new federal entitlement. As we've seen with our other entitlements, this mechanism does not change or flex easily with time. We don't have the best answer to insuring children yet, and we shouldn't lock ourselves in to a solution before we fully understand the problem.

Finally, we must be cautious not to crowd out private sector efforts simply to have them replaced by public efforts. This has been demonstrated over the years. The goal is to reach the children without current access to health care. Despite various expansions of state Medicaid programs over the years, the proportion of uninsured children has remained basically the same. Regrettably, we've simply given employers a reason not to cover dependents. This will remain our greatest

challenge in crafting a successful policy.

The beauty of the Gramm-Roth proposal is that it would allow a wide menu of options for innovative health programs, including subsidies for purchase of private health insurance, vouchers, expansions of state initiatives, coverage through community based organizations and access to group health insurance that provides coverage for children.

In closing, I believe the key issue for debate is not the funding mechanism. No, it is the appropriate structure, the real policy decisions that we face. Regrettably, more people can tell you how the policies will be funded rather than how the services will actually get to the kids. I'm eager to dig in to the real issue and pursue the answers with my colleagues from both sides of the aisle.

Testimony of Donald W. Herman
Before the United States Senate Finance Committee
April 30, 1997

Chairman Roth and members of the committee, thank you for giving me the opportunity to share with you what Iowa is doing to extend health care coverage to uninsured children. Additionally, I appreciate the opportunity to share with you my concerns, which I believe are shared by many of my fellow State Medicaid Directors, about federal health care proposals that simply expand Medicaid as we know it today.

In response to skyrocketing health care costs, new technologies, an aging population, and various other factors, the private-sector health care market has changed dramatically in the past fifteen years while Medicaid has virtually remained unchanged. There have been expansions in eligibility and we have witnessed the emergence of managed care, but the cookie cutter approach of giving everyone the same set of benefits remains unchanged. States need the flexibility to tailor the benefits, delivery system, and scope of their Medicaid programs to best meet the needs of their citizens while, at the same time, control the cost.

In the fall of 1995 when we believed a Medicaid reform block grant was imminent, our state put together a task force whose objective was to design a new Medicaid program. The task force was to assume they had total flexibility to establish eligibility guidelines and design the amount, duration, and scope of benefits within a given budget. The proposed product was called "MediVision." While the MediVision plan was never fully developed, some very strong themes came through. Our vision was to eliminate the "stigma of welfare" by mainstreaming the Medicaid population into the private sector health care market, to develop packages of benefits specifically designed to provide health care to those persons with special needs, to expand eligibility, and to expect those persons at the expanded eligibility levels to share in some of the cost of their health care.

In 1996, the Iowa General Assembly enacted, and Governor Terry Branstad signed, legislation which authorized the Insurance Division of the Iowa Department of Commerce to study all aspects of developing an Iowa Healthy Kids Program. Using the Florida and New Hampshire Healthy Kids Programs as models, the Iowa Healthy Kids Program conceptually would create risk pools of school-age children, based on school districts, in order to offer a comprehensive, low-cost health care plan to the families of uninsured children who are not Medicaid eligible. While the task force study identified basic principles under which such a program could be developed, much additional work needs to be done to fully develop the plan. To this end, Iowa has submitted a Healthy Kids Replication Program planning grant application to the Robert Wood Johnson Foundation in order to obtain additional funding for further planning and development. The goal is to design a Healthy Kids Program that includes a Medicaid outreach component, coordinates with existing Medicaid programs, and provides a seamless delivery of services.

I want to speak to three proposals being considered by all of you and your colleagues. They are the Child Health Insurance and Lower Deficit Act, the Children's Health Insurance Provides Security (CHIPS) Act, and the American Child Health Assurance Act of 1997. From the number of proposals being considered, it is clear there is general agreement that Congress desires to move forward on the issue of addressing the needs of this country's uninsured and underinsured children. It is equally clear however, that there are several schools of thought as to how to best accomplish this important goal. I applaud the efforts of everyone who has endeavored to find viable solutions and I am here today to offer the unique perspective of a State Medicaid Director on each of the three proposals.

The Child Health Insurance and Lower Deficit Act places new mandatory burdens on states and requires the private sector market to create a subsidized health care product that mirrors the state's Medicaid program. States are prohibited from making changes in

any manner to their Medicaid eligibility criteria if the change would reduce eligibility for some children unless the changes are made as the result of an 1115 waiver that was submitted prior to January 1, 1997. Since Medicaid is almost always more comprehensive in amount, duration, and scope of benefits than even the most comprehensive private sector health care plans, a new insurance product will have to be developed. It is believed this type of product would be very expensive. Especially in light of the 1989 EPSDT (early periodic screening diagnosis and treatment) mandate under the Medicaid program which requires that all medically necessary services, that could be provided under any state's Medicaid plan, must be provided to children. For example, Iowa Medicaid does not cover small bowel or pancreas transplants but under the EPSDT mandate Medicaid is required to cover them for children.

In establishing the subsidy level, states must give priority to families with the lowest income levels and establish higher income criteria for families with a disabled child. It is not clear how "disabled child" will be defined nor are there any guidelines as to how much higher the income criteria must be for these families. The modified adjusted gross income process used to determine eligibility is completely different than the process currently established in the Medicaid program, thus resulting in more administrative complexity.

This bill requires access to "traditional providers," which as of yet, is also undefined, and under the direct services benefit option, requires direct contracting with providers receiving grants under Section 330 of the Public Health Service Act. This limits a state's flexibility for service delivery. Furthermore, Section 1905(a) of the Social Security Act provides that Medicaid is obligated to pay cost-based reimbursements to any entity that meets the standards of the Public Health Service Act. Since we must contract with these providers under the provisions of this bill, they would be in a position to insist on cost-based reimbursement. We believe cost-based reimbursement should be phased out and that public health providers must learn to participate in today's competitive markets.

I also believe that the creation of a new subsidized insurance product that covers the same services as the State's Medicaid program would encourage families to either not enroll in or to drop coverage from employment-based plans that are already available to them and the so-called "crowd out" phenomenon that encourages employers not to offer dependent health care coverage because of expanding social programs would likely become more prevalent.

The Children's Health Insurance Provides Security (CHIPS) Act makes important changes in the Medicaid program to guarantee coverage for children. These changes would prevent a child from losing eligibility, as they do today, when there has been no change in the income of the family but eligibility is lost simply because the child had a birthday and now no longer qualifies for coverage. This bill offers financial incentives to states to expand Medicaid eligibility to children and proposes to "level the playing field" by allowing states to apply the same income threshold to all children under the age of 18. This would ensure that all children in the family are treated similarly. Today, some children may be eligible for Medicaid while their siblings are not, even though they live in the same household.

However, this bill also places additional mandates on states without granting any flexibility that would allow states to design their own Medicaid program. Even though eligibility thresholds can be expanded, states must still provide services in the same amount and scope that we do today.

The American Child Health Assurance Act of 1997, offers the most flexibility of any of the proposals and appears to be the most closely aligned with our vision of how Medicaid should deliver health care services in the future. This proposal increases the amount of funding for the Maternal and Child Health Block Grant and allows states to decide how to best use the additional funds to meet the health care needs of uninsured children.

Under this proposal, block grant funds could be used to fund a Healthy Kids initiative, such as we discussed earlier, or a variety of other programs that provide health care services to children. This proposal provides flexibility to the Medicaid program by adopting the Medicaid reforms recommended by the National Governor's Association (NGA), permits states to enroll Medicaid recipients in managed care plans without an 1115 waiver request, and repeals the Boren amendment.

As we enter the next century, I envision a new Medicaid program that looks quite different from the program we know today. In my vision, the new Medicaid program will be flexible enough to be modified to meet the changing health care needs of the State's citizens. The new Medicaid program will look like private sector health care coverage so that needy people will come forward to receive benefits without the stigma of being on "welfare." The new Medicaid program will contain a "disease management" component which ensures that those persons with chronic and disabling health care conditions receive the best care available to meet their special needs. The new Medicaid program will utilize regional "centers of excellence" to ensure that the best specialty care is available to those persons with major illnesses such as heart disease or cancer. And the new Medicaid program will provide quality accessible health care at a fair and reasonable cost.

My vision of the a new Medicaid program is ambitious. But by working together I know we can find viable solutions to best meet the health care needs of all our citizens in the next century. Thank you.

STATEMENT OF SENATOR EDWARD M. KENNEDY
ON THE CHILDREN'S HEALTH INSURANCE AND LOWER DEFICIT ACT
BEFORE THE SENATE FINANCE COMMITTEE

For Immediate Release: Contact: Jim Manley
April 30, 1997 (202) 224-2633

I thank the Chairman and Senator Moynihan for holding this hearing and for inviting me to testify on behalf of the Hatch-Kennedy Child Health Insurance and Lower Deficit Act.

I know that Senator Chafee, Senator Rockefeller and other members of this committee have also introduced legislation on children's health, and some have co-sponsored our bill. I look forward to working with all of you to improve the lives of children who lack health insurance.

Ten million children in this country have no health insurance. They fail to get the health care they need and deserve for a healthy start in life.

This can be the Congress where we guarantee every child the healthy start in life that should be the birthright of every American child. I commend the Administration for giving coverage for children a priority in this budget negotiation.

The legislation proposed by Senator Rockefeller, Senator Chaffee, Senator Jeffords, Senator Breaux and others addresses part of the need by improving and expanding the Medicaid program that serves the poor and near poor. The legislation Senator Hatch and I have proposed reaches children in millions of working families that earn too much for Medicaid but not enough to buy the private insurance coverage their children need. The combination of these two programs makes sense.

I urge the members of this committee and all the members of the Congress to embrace three fundamental goals:

--Affordable insurance coverage for every American child must be included in this budget;

--The program should combine improvement and expansion of the Medicaid program with a program of grants to states to provide private insurance coverage for working families who make too much for Medicaid and but not enough for private insurance;

--And a substantial increase in the cigarette tax should be a major source of financing, because it is the right thing to do to improve the health of our children, and because it would be wrong to pay for this program by cutting Medicaid, Medicare, or other essential social programs.

-MORE-

SENATOR KENNEDY TESTIMONY TO FINANCE COMMITTEE ON CHILD ACT 2-2-2

Three million uninsured children are eligible for Medicaid, but are not enrolled in it. Obviously, we should do a better job of reaching these families.

Ninety percent of the uninsured children are members of working families. The majority of these families have incomes above the Medicaid eligibility line, but below the income level it takes to afford private health insurance today.

The legislation that Senator Hatch and I have introduced takes provisions that were common to bills introduced two Congresses ago by Republicans and Democrats alike. It will make health insurance coverage more affordable for every working family with uninsured children. It does so without creating any new government mandates -- on the states, on the insurance industry, or on individuals. The program is purely voluntary.

The bill does not create new bureaucracies -- either Federal or State. The federal government already collects tobacco taxes, and all states have agencies that run their Medicaid, public health, and children's health insurance programs.

Our legislation thus builds on what the states are already doing. Fourteen states have their own public programs on which our program is modelled. Another 17 states have private programs to subsidize the cost of child-only coverage for low-income families.

Our legislation creates no entitlement. Instead, it encourages family responsibility, by offering parents the help they need to purchase affordable health insurance for their children.

Finally, it builds on the private insurance industry. States choosing to participate will contract with private insurers to provide child-only private coverage. Subsidies will be available to help many families purchase the coverage for their children, or to participate in employment-based health plans.

Coverage will be available for every child, including children in families not eligible for financial assistance. The program also allows states to use up to five percent of total program costs for preventive and primary care services for pregnant women through the maternal and child health block grant. Participating states must contribute to the cost of the program, and must maintain their current levels of Medicaid coverage for children.

By using the Medicaid benefit package, we build on what is already in place in every state. This benefit package guarantees that every child will get the preventive and acute care services they need. It guarantees that children with serious illnesses, including those with special needs, receive treatment for their specific illness. Unlike Medicaid, our bill allows co-payments and deductibles, which can reduce the cost of the benefits.

Under our plan, $20 billion over the next five years will be available to expand health insurance for children, and $10 billion will be available for deficit reduction. I share Senator Hatch's commitment to balancing the federal budget by the year 2002. As our plan today suggests, we believe we can do it, and do it fairly, and our legislation can contribute significantly to that goal.

-MORE-

SENATOR KENNEDY TESTIMONY TO FINANCE COMMITTEE ON CHILD ACT 3-3-3

Senator Hatch and I pay for the program with an increase of 43 cents a pack in the federal cigarette tax, from its current level of 24 cents. This aspect of our proposal is both logical and practical. The link between smoking and childrens' health is obvious. If we do nothing, five million of today's children will die from smoking-caused illness. Tobacco is a key gateway drug to cocaine and heroin. In fact, children who smoke are twelve times more likely to use heroin and nineteen times more likely to use cocaine.

Ninety percent of smokers become addicted while they are still children. Increased cigarette taxes are one of the most effective single steps we can take to reduce tobacco addiction.

For years, tobacco companies have cynically targeted our nation's children. It is appropriate to ask them to make a contribution to the cost of health insurance for uninsured children. By providing a specific financing source to cover the cost of the program and reduce the deficit as well, we are doing the fiscally responsible thing.

Smoking is the leading preventable cause of death in the United States. It kills more than 400,000 Americans a year. It costs the nation $50 billion a year in direct health costs, and another $50 billion in lost productivity. A cigarette pack sold for $1.80 costs the nation $3.90 cents in smoking-related expenses.

Increasing the cigarette tax is more a user fee than a tax. It is a modest reimbursement for the heavy costs that the cigarette companies and smokers inflict on all taxpayers.

Even with this increase, taxes on cigarettes in the United States as a proportion of the price of cigarettes will be lower than they are in almost every other industrial country in the world. Adjusted for inflation, the taxes after the increase will still be lower as a proportion of the price in the United States than they were in 1965.

Some argue that it is unacceptable to raise any tax. Yet, raising tobacco taxes to finance health insurance for children has overwhelming public support -- 76 percent of the public supports raising tobacco taxes to finance children's health care. If the tobacco tax is raised, over 80 percent of the public favor spending the additional revenue on children's health.

Combined with efforts to enroll more eligible children in Medicaid, we can take a giant step toward the day when every American child has health insurance. I look forward to working with the members on this committee. Every day we delay means more children suffer. Children are the country's future. When we fail our children, we also fail our country and its future.

MICHAEL J. KOCH
Executive Director
CALIFORNIAKIDS HEALTHCARE FOUNDATION

Mr. Chairman and Members of the Committee, I am Michael Koch, Executive Director of CaliforniaKids Healthcare Foundation. I appreciate the opportunity to testify before you today to describe the CaliforniaKids model and to discuss other ways to increase children's access to health care.

The CaliforniaKids program is a broad-based community program that provides access to primary and preventive health care services for children from uninsured, low-income families through partnerships with private industry, health care providers and community organizations. This program has provided health care services to over 14,000 California children through a managed care, capitated network. It is the only program of its kind providing private health care coverage to uninsured children in the state of California.

CaliforniaKids was founded by Blue Cross of California in July, 1992. The program was originally supported by Merck Pharmaceuticals, Procter & Gamble and the California Community Foundation.

In my testimony today, I will cover three areas:

- A description of the key features of the CaliforniaKids program;
- Our plans for expanding the program;
- The major lessons we learned from our program: the need for flexibility in program design; personal responsibility in the form of nominal copayments; and the ability to keep costs low (which allows more children to be covered) by excluding coverage for inpatient hospital services.

The CaliforniaKids Model – Key Features:

CaliforniaKids is a model from which we believe Federal and state policymakers can learn when designing programs to increase access to health care for children. From the outset, I want to stress that CaliforniaKids is not the answer. There are over 1.3 million children in California that "fall through the cracks" because they lack health insurance. These children are from families who do not earn enough money to purchase insurance, yet their income level is not low enough to qualify for Medi-Cal (California's Medicaid program).

CaliforniaKids can only go so far with private contributions and philanthropic support. Other funding sources and partnerships are necessary to provide coverage to these children.

A description of the key features of the program follows:

- **Eligibility:**

  To qualify for enrollment, a child's family must have income at or below 200 percent of the Federal poverty level, be ineligible for Medi-Cal, and be uninsured. Eligibility begins at age 2 and lasts through age 18. We begin at age 2 because the state provides coverage to all infants in families with incomes under 200 percent of poverty under the Medi-Cal, Child Health, Disability, and Prevention (CHDP), Aid for Infants and Mothers (AIM), or California Children Services (CCS) programs.

  The family is asked to complete a short, one-page application. Our program worked hard to keep the application as short as possible, in order to encourage participation. Parents are asked to return this application, along with a recent copy of their tax return and two current pay stubs to verify income.

  All eligible children in the family are enrolled at the same time. We do not just want to enroll the sick child. The goal of the program is to keep children healthy, rather than to simply respond to health problems after they have developed.

  Once eligible, the children will be covered for one year. The family can reenroll after the first year, as long as their family income level continues to meet the program's criteria. However, CaliforniaKids has experienced a 40 percent lapse/turnover rate, principally because the families' income either exceeds our threshold or declines, and therefore, the family becomes eligible for Medi-Cal.

- **Benefits:**

  CaliforniaKids provides eligible children with comprehensive preventive and primary health care coverage through a managed care network. Each child receives a plastic identification card that looks like every other private health insurance card in the doctor's office.

  The benefit package is designed to meet the typical needs of children. Covered benefits include: office visits, immunizations, physical exams, lab tests, outpatient surgery, emergency care, prescription drugs, vision exams and eyeglasses, preventive dental exams, and a 24-hour "ask-a-nurse" program. This year, we will also be adding a behavioral health benefit.

  Services are administered by Blue Cross of California, Delta Dental, Vision Service Plan, WellPoint Pharmacy and Access Health.

  Inpatient care is not a covered benefit. CaliforniaKids assists families if and when inpatient care is needed by acting as a liaison between the family and the hospital social worker to enroll the child into state programs that provide these services, such as Medi-Cal or California Children Services (CCS). The families of children who need hospitalization, in almost all cases, can qualify for Medi-Cal services through the medically needy spenddown provisions, because of the cost of care. Under "spenddown," the cost of expensive services is deducted from the families' monthly income to determine the child's Medicaid eligibility.

The purpose of the program design is to keep kids healthy and avoid expensive hospital admissions. This is working well. In the last four years, only seven inpatient hospital admissions have been reported, out of 14,000 children.

By excluding coverage for expensive hospital admissions, CaliforniaKids is able to keep monthly costs low. This has allowed us to offer coverage to more children.

- **Costs:**

The cost for the program in 1997, including the medical, dental, vision, prescription drugs, and behavior health benefits is $33 per child per month ($400/year).

Families do not pay a premium. However, they do participate in the ownership/personal responsibility of the program by paying a nominal copayment for services. including $5 for physician visits and prescription drugs (higher copayments are required for brand name drugs). We have found that the copayments maintain the dignity and respect of these hard-working families. They can generally afford these nominal copayments, and want to contribute to the cost of the care.

Funding to support the program comes from private contributions, including:

- Corporations: Blue Cross of California, Merck, Microsoft, Bank of America, Sprint, Procter & Gamble, Great Western Bank, AMC Theatres, Southern California Dodge and others.
- Foundations: California Community Foundation, Peninsula Foundation, Barlow Foundation, Amgen Foundation, David and Lucile Packard Foundation.
- Individuals.

All contributions go directly to providing medical services to children, as our Plan partners (Blue Cross of California, Delta Dental, Vision Service Plan) donate direct administrative expenses.

- **Managed Care Network:**

The CaliforniaKids program is unique, as it is one of the only children's programs to use a capitated, managed care model to deliver benefits to uninsured children.

The program is cost effective, minimizes risk and unnecessary administrative expense due to claims processing, and provides a "medical home" for the child. By using a managed care model, care is coordinated to assure that children receive the appropriate immunizations and follow-up care to keep them healthy.

CaliforniaKids has contracted with over 20,000 health care providers and 80 percent of the pharmacies throughout the state. The network is specially developed to provide choice of doctors and to include providers that meet the patients' language and cultural needs, and to offer "after hours" appointments, as most parents are working.

After the third year, we added a 24-hour nurse hotline to provide health care information and re-direct care from the emergency room to lower cost, more appropriate settings. We have found that this nurse counselor service helps guide the family to the appropriate provider, and serves as an educator on insurance issues.

Our network also includes partnerships with Child Health, Disability, and Prevention (CHDP) practitioners (this is the California name for the Early Periodic, Screening and Diagnostic Testing (EPSDT) program). These partnerships are critical to reduce claims costs for CaliforniaKids, since the program provides the child with a health care assessment, immunizations and follow-up. CaliforniaKids picks up the services not provided by CHDP. Once a child receives a CHDP exam, parents are encouraged to enroll the child in the CaliforniaKids program for ongoing medical care.

- **Outreach:**

A key component of all programs targeting the low income is effective outreach.

The local school systems have been our primary resource for identifying eligible children: school nurses, Head Start, and Healthy Start. Just in the past year, we have begun to partner with county Child Care Councils which serve as umbrella organizations to hundreds of day care centers. We also work closely with Boys and Girls Clubs and Big Brothers, Big Sisters.

CaliforniaKids also partners with state programs such as Access for Infants and Mothers (AIM) which provides care for children under 2 years old. This partnership allows us to continue covering the child after AIM coverage ends.

It is important that each organization with which we partner is familiar with the program so they can assist the family in understanding insurance concepts and to properly use the program once the child is enrolled. Since these outreach partners are the ones to enroll the child, it is most likely that the family will contact them for questions and further assistance. It is also important that each community embrace and endorse the program to ensure trust and effective communication. We spend considerable amount of time keeping our partners up-to-date so they can respond effectively to these situations.

- **Evaluation:**

The David and Lucile Packard Foundation has funded an 18-month evaluation being conducted by the University of San Francisco's Institute for Health Policy Studies to evaluate member satisfaction, and to compare CaliforniaKids with both the commercial and Medi-Cal programs in terms of health outcomes, the lapse/turnover rate and utilization.

Of special concern to our program is what happens to the children that do not reenroll after one year. The evaluation will provide information about how many children leave CaliforniaKids because their family's income has fallen below or has exceeded our threshold. If these children were to become uninsured again, it would be especially tragic. Our goal is to provide coverage so children stay healthy not just for one or two years, but for their entire

childhood. The evaluation will reveal how many of those families who disenrolled from the program because their income levels changed have enrolled in Medi-Cal, have purchased private coverage, or have become uninsured again.

We look forward to the results of this evaluation, portions of which will be available this December. This information will help us to continue to refine our program to make it as effective and efficient as possible, and provide guidance to others in structuring similar programs.

- **Plans for Expanding the Program:**

In addition to continual refinement of CaliforniaKids, we are now developing plans for an expanded program that would raise the income threshold to 300 percent of the federal poverty level. This increased threshold would be combined with a requirement for modest, premium payments for families with income over 200 percent of the poverty level. We are now exploring the appropriate premium sharing arrangements for specific income levels to determine what is affordable.

We believe that by implementing such a program, we will obtain useful information for Federal and state lawmakers in designing programs to increase children's access to health care coverage.

- **Major Lessons Learned:**

We have learned a lot over the last four years in structuring benefit packages, designing outreach initiatives, and in developing effective capitated, managed care networks.

CaliforniaKids is a model, not a solution. There are more than 1.3 million children in California that have no health care protection. Parents of these children often face heart-wrenching decisions. Because their incomes are low, there are times when there is not any money left after food and shelter to pay for medical bills, drugs for asthma, etc. Some parents are afraid to let their children play sports because of concerns about the lack of insurance. Minor illnesses may go untreated and lead to major health problems.

CaliforniaKids offers help to these parents. By keeping children healthy, children can stay in school and parents can go to work. Children's self-esteem is enhanced and the parents have peace of mind.

The key lessons learned that we believe will be helpful to your Committee as you structure programs to provide access for children are:

⇒ **Personal responsibility is important.** While no premium payments are required of the family, we believe it is critical that affordable copayments are required for all services. We believe these requirements provide dignity to the family. Our experience has shown that these families do not want hand-outs. These are working parents and they want to be able to contribute to the cost of care. These copayments provide responsibility and help offset cost of care. Since parents are contributing to the cost, just like all other parents with private coverage, there is no stigma associated with the program.

⇒ **Inpatient hospitalization does not need to be a covered benefit.** Inpatient hospitalization is very expensive, and is generally covered by Medicaid programs in most states. We have shown that by providing comprehensive outpatient primary and preventive services, we can reduce inpatient hospitalizations. In the four years of the program's operations, **only seven** inpatient hospital admissions have been reported out of 14,000 children. We will have more information available when the independent evaluation is completed. By acting as a liaison, our program is able to case manage children who need inpatient coverage and work with Medi-Cal or other appropriate state programs to finance the care. This has allowed us to keep the premiums low and provide services to more children.

⇒ **Flexibility to foster private and public partnerships must be a component of any plan.** We have continually refined our program over the last four years to foster effective partnerships with corporations, foundations, providers and the community. The paramount lesson we have learned is that flexibility is absolutely critical. While all states are different, we have become keenly aware that each county in California is also unique. We have had to fashion different provider networks and outreach efforts for each community. For example, in communities with public health delivery systems, CaliforniaKids has partnered with the county hospitals and community clinics to maximize CHDP exams and enroll children in an on-going health care program. Meanwhile, through the CaliforniaKids/AIM partnership, parents are notified about the opportunity to enroll their child in the CaliforniaKids program upon reaching their second birthday, allowing otherwise uninsured children to receive continuous care.

Thank you again for the opportunity to share our experience with the Committee. Providing access to health care services to uninsured children is an issue that is close and dear to my heart. We have a great deal of data and other information that may be useful in crafting legislation. We are eager to provide the Committee any technical assistance that we can.

CaliforniaKids Guiding Principles

Benefits

- provide uninsured children with comprehensive preventive and primary health care coverage
- available to all children
- benefit package should include preventive vision, dental and behavioral health coverage
- safety net for inpatient care

Network

- financing to providers utilizing a capitated model for cost-effectiveness
- model must provide a "medical home"
- provider network sensitive

Ownership

- personal responsibility for the delivery of services
- choice
- mirror private market insurance respecting the dignity of the member
- affordable

Outreach

- maximize Medi-Cal levels/support by increase outreach
- collaborative effort with the community

Legislation must

- be realistic
- encourage private-public partnerships/others to provide solutions/programs to decrease the 'gap'

CaliforniaKids Enrollment Form

Please print or type ALL information.
THIS IS NOT A TEMPORARY IDENTIFICATION CARD.

[illegible] LIST ALL CHILDREN IN THE FAMILY. If selected in the CaliforniaKids Program, each person listed below must receive all medical care through the Medical Group or Independent Practice Association (IPA) selected. [illegible] between the ages of 2 through 18, and must live within 30 miles of the group selected. Please see your CaliforniaKids Directory when selecting a Medical Group or IPA. IF YOU SELECT AN IPA, YOU MUST SELECT A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA and indicate the physician code below. If you need assistance, contact 1 (800) 374-4100

Children	Last Name	First Name	M.I.	Age	Date of Birth	Name of school enrolled in	Social Security No.	[illegible]	Primary Care Physician Code
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0

[illegible] ARE ANY OF THE ABOVE CHILDREN ELIGIBLE FOR ANY STATE OR FEDERAL HEALTH CARE BENEFIT PROGRAMS? IF YES, PLEASE LIST ELIGIBLE CHILD(REN) AND PROGRAM(S):

Name ______________________ Program ☐ Medi-Cal ☐ CHDP ☐ CCS ☐ Explain ______________

Name ______________________ Program ☐ Medi-Cal ☐ CHDP ☐ CCS ☐ Explain ______________

Name ______________________ Program ☐ Medi-Cal ☐ CHDP ☐ CCS ☐ Explain ______________

[illegible] Have any of the above children been enrolled in the Access for Infants and Mothers program (AIM)? ☐ YES ☐ NO

[illegible] DO THE CHILDREN IN SECTION 1 RESIDE WITH YOU FULL TIME? ☐ YES ☐ NO

[illegible] ARE ANY OF THE ABOVE CHILDREN COVERED BY ANY HEALTH INSURANCE COMPANY? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION.

FIRST NAME	INSURANCE NAME ID #	PHONE NUMBER
FIRST NAME	INSURANCE NAME ID #	PHONE NUMBER

70

PARENT / GUARDIAN / STEPPARENT / OR OTHER / LIVING WITH CHILD(REN) INFORMATION

MOTHER LAST NAME	FIRST NAME	EMPLOYER NAME	FATHER LAST NAME	FIRST NAME	EMPLOYER NAME
SOCIAL SECURITY NO	HOME TELEPHONE NO ( )	WORK TELEPHONE NO ( )	SOCIAL SECURITY NO	HOME TELEPHONE NO ( )	WORK TELEPHONE NO ( )

CHILDREN HOME ADDRESS	CITY	STATE	ZIP	CHECK ONE.	SINGLE / MARRIED	WIDOWED / DIVORCED	SEPARATED

Total yearly income of household before taxes

Total yearly income $ ______________ + $ __ ______________

+ other income $ ______________ = $ __ ______________ total yearly income.

Total # of people living in household as of this date: ______________

III. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION EXPLANATION

Blue Cross is authorized to obtain and release medical information in compliance with the Insurance and Privacy Protection Act, Section 791 et. seq. of the California Insurance Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Blue Cross of California any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.

I also authorize Blue Cross of California, or its agents, [illegible] or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If any coverage is under a Group Master Agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of [illegible] review or [illegible] audit.

The effective date of coverage is subject to Blue Cross of California approval.

This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Blue Cross of California to process claims. A photocopy of this authorization shall be as valid as the original.

IV. ARBITRATION AGREEMENT: I understand that any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and Blue Cross of California, or any participating medical office must be submitted to binding arbitration in lieu of a jury or court trial if the amount in dispute exceeds the jurisdictional limits of small claims court. If any such dispute is within the jurisdictional limits of small claims court, the matter will be resolved in small claims court.

V. I (we) certify that all information listed above on this application form is truthful, accurate and complete. I (we) understand that any false statements or any misrepresentation of facts is grounds for termination from this Program.

YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR FILES IF REQUESTED

[illegible]	EFFECTIVE DATE MO DAY YR	SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE SIGNED

CC 40 37 [illegible]

detach here

HealthyKids

Rose M. Naff
Executive Director, Florida Healthy Kids Corporation
Director, National Program Office

Introduction

In 1988, an article was published in the New England Journal of Medicine which first described the concept of School Enrollment-Based Health Insurance. Then Chairman of the Senate Finance Committee, Senator Lloyd Bentsen, invited the author to address the committee on June 12, 1989. The presentation by Dr. Steve Freedman of the University of Florida, Institute for Child Health Policy, contributed to Congress' decision to establish Medicaid demonstration grants under the Omnibus Reconciliation Act the same year. Florida was an eventual recipient of one of these grants and began enrolling children of Volusia County into a pilot program in 1992. Federal financial involvement in the demonstration ended after three years as directed by Congress in its original authorizing legislation.

A Unique Solution to a Common Problem

From our own experiences we know that we are much more motivated and productive when we are feeling well. The same is true for children. Children who attend school sick are not mentally or physically prepared to meet the challenges of learning. This becomes much worse for a child who cannot afford to see a doctor and suffers through the disease until it gets better on its own, or until the illness becomes too serious for home-treatments. All of this results in less productivity in the classroom and more days absent from school for the child.

The Florida Healthy Kids Corporation (FHKC), created by the Florida Legislature in July, 1990, was the first program in the country to use school districts as grouping mechanisms for the provision of health care coverage. By basing eligibility on school-enrollment, children did not have to rely on their parents employment to have access to health benefits. At the time, it was estimated that one-third of Florida's children lacked health insurance, translating to 700,000 children who do not have access to basic health care services.

Program Design

While the original concept of School Enrollment-Based Health Insurance provided for the extension of coverage to all family members of uninsured school students, the State of Florida has chosen to limit enrollment in the Healthy Kids program to children only.

Benefits

Florida recognized the importance of creating a 'kids-only' product, ensuring that children would receive care that is appropriate to their needs. Stressing the necessity for comprehensive care, a benefit package specifically designed to enhance learning was developed and includes: Well Child Visits, Immunizations, Primary and Specialty Physician Office Visits, Prescriptions, Inpatient and Outpatient Hospital Care, Vision and Hearing Screenings, Glasses and Hearing Aids, Mental Health, Home Health Services, Emergency Services and Transplants. Dental services may also be included. Some nominal co-payments and benefit limitations apply.

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Premium

By excluding services that are not typically utilized by children and competitively bidding the product by geographic region, Healthy Kids is able to offer comprehensive care for an average monthly premium of $51.

Eligibility

To be eligible, a child must be enrolled in school, uninsured and not a Medicaid recipient. Preschool age siblings of eligible children can also be covered.

To avoid duplication of coverages and to ensure we are serving our targeted population we routinely verify a child's eligibility for Medicaid before accepting a child in the program. When a child is found to be eligible for Medicaid their application is rejected or their coverage is canceled.

Subsidy

Because the monthly premium is still beyond the reach of some families, premiums are subsidized for qualified families. Family contributions are based upon a sliding scale according to the income guidelines of the National School Lunch program.

Today, regardless of income, all families contribute to the cost of their child's insurance.

SAMPLE SLIDING SCALES				
FAMILY INCOME	VOLUSIA	DADE	SANTA ROSA	HARDEE
Free Lunch 0-130% of Federal Poverty	$10.00	$10.00	$5.00	$5.00
Reduced Lunch 131-185% of Federal Poverty	$25.00	$20.00	$15.00	$13.00
Not On Lunch Program 186% of Federal Poverty and up	$48.00	$51.00	$53.00	$49.00

Physician Access

Cost is not the only barrier to health care. Healthy Kids knows that providing a child with an insurance card does not necessarily give him access to health care. In recognition of this, insurance networks that wish to participate in the program must meet stringent geographic, credentialling and access standards. Children must have 24 hour access to a physician and access to a primary care physician within a 20-mile drive from their home. The establishment of a medical home is believed to be the most effective deterent to emergency room use.

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Local Involvement

Healthy Kids pilot projects are strictly voluntary. Interested school districts and communities make application to the corporation and are required to contribute financially in order for a program to be implemented. Specifically, local governments contribute a percentage share of the insurance costs.

In exchange for local financial participation, communities participate in the bidding process and assist in the selection of an insuring partner, have input into the sliding scale that will be used in their geographic area, can enhance the benefits if desired (primarily through the addition of preventive dental services), determine the number of children they wish to serve, and participate in the marketing of the program.

Financing

Healthy Kids finances medical care through a unique approach. Resources, including local and state funds, are mingled with family contributions to purchase coverage. Families contribute according to the sliding scales discussed above and provide 35% of current funding.

Pilot sites also contribute varying percentages of local funding in each project. With a 5% minimum set as the base, each project increases its local contribution until it reaches a maximum of 40%. This allows local communities to implement the program with minimal start-up funding and provides an opportunity to increase local financial responsibility over time. Currently, local funds make up 16% of total funding for medical premiums. It is believed that the level of local funding required in the fifth year (40%) is a significant deterrent for some, especially rural, areas. There may be some merit to reducing the maximum level of local funding in order to encourage the participation of additional school districts in the future.

The balance of funding is provided by Florida State Government.

As described earlier, the first pilot project was launched with the assistance of a demonstration grant authorized by Congress in 1989 and administered by the U.S. Health Care Financing Administration. The three-year grant provided funding at the federal participation rate designated for the State of Florida. It tested the feasibility of alternative systems of determining financial eligibility, enhancing access to health care, and a unique system of care. Perhaps more importantly for Florida, it gave us credibility for this, as yet, untried experiment - an experiment that may never have moved from the drawing board without federal interest and assistance. The demonstration was completed in 1995 and the federal government currently does not provide any funding for this program.

Current Enrollment

As of May 1, over 36,000 school age children and their younger siblings will be receiving services delivered by eight accredited health plans in 16 Florida counties. Eight of the participating

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counties currently have waiting lists and four thousand additional applications are now being processed.

The seventeenth county, Hillsborough, will begin enrolling children during the summer school session. Thirteen additional counties have expressed their interest in getting started during the next two years.

Eighty-five percent of the covered children are subsidized to some degree. Another 15% are paying the full cost of their coverage.

No Stigma

In a significant departure from other programs providing health care services to children, Healthy Kids providers are blind to the child's income status; to the provider's knowledge, a uniform premium has been paid for each child (by FHKC) and modest co-payments are uniform for all participating families. Thus, any stigma of a "welfare" or "entitlement" program is avoided.

What We Know...

...about subsidy levels

Over the past five years, the Florida Healthy Kids Corporation, in offering this program, has introduced programmatic variations as a way to continue experimentation. Many lessons have been learned and we have continued to refine the program.

Most significant was a departure from the program originally implemented with federal assistance. Under the Medicaid demonstration grants authorized by Congress in 1989, the Florida program was mandated to provide coverage to families with incomes up to 100% of the federal poverty level (FPL) for free although this was not in our original program design. The first pilot site, Volusia County, was implemented in compliance with this federal requirement. The second income tier (101-130% FPL) was charged a monthly fee of $2.50 per child per month.

In 1993, a second pilot site was implemented in Okeechobee County without federal funds. Here, the original proposal to charge all families a portion of their coverage was tested. In this project families with eligible children and with incomes up to 130% FPL were charged a monthly fee of $5.00 per child per month. The resulting enrollment mirrored the participation levels of the Volusia pilot project and the monthly premium was determined not to be an unreasonable barrier to coverage for this population.

In 1994, three additional pilot sites were implemented without federal funds. Our first urban site, Broward County, began by charging $10.00 per child per month for families enrolled in the free lunch program (0-130% FPL) and, again, the resulting participation by income level was not affected.

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Therefore, coinciding with the scheduled cessation of federal funds in the original pilot site, Volusia County, Healthy Kids returned to its original plan to charge every family a portion of their health care coverage and the impact of this action was immediately apparent.

While we correctly anticipated attrition from the program when those families who had been receiving it for free were suddenly required to pay a small monthly premium, we did not anticipate the degree to which this would affect the utilization of health care services. In short, families who are required to make a monthly contribution toward their child's health care coverage are more likely to access services and receive preventive care. In fact, the percentage of non-use in the Volusia program dropped from 37% to about 20% - a 46% decline in non-use. Not only does the family contribution promote individual responsibility, it influences a family's utilization of the offered services in a positive way.

To take this experiment one step further, families in the lowest income categories in Volusia County were charged $15.00 per child per month for a brief period of time. And a significant increase in health care use was clearly evident. A new insurance term of "adverse retention" was coined to describe the effect of raising the family share of cost to a level which caused families with the healthiest children to drop their coverage, while the families with less healthy children continued to obtain services.

...about emergency room use

Independent studies of the Healthy Kids program have shown that Healthy Kids is not only beneficial to the children, but to the community as well. Hospitals report a 30% decrease in pediatric charity care when Healthy Kids becomes available in a community. In sites where a program has been active, emergency room claims have been shown to decline by 70% during the first year of operation. The reduction in emergency room use is attributed to two factors: children with a health care home are more likely to seek treatment before an illness becomes serious and they are more likely to seek and receive preventive services. In fact, families with uninsured children are eight times more likely to seek care in an emergency room than families with children enrolled in Healthy Kids. The decrease is emergency room use is estimated to have saved Florida $13,125,000 in health care costs this year alone.

...about the families

While the children enrolled in Healthy Kids represent a variety of backgrounds and characteristics, there are some qualities that are common among them. The average child enrolled in Healthy Kids is 10 years old and lives in a household where one or both of the adults are working. The average family of four is headed by a married couple with some college education. The most common illnesses diagnosed among the children are asthma and other respiratory infections. Through the program, these children are able to get the health care they need to stay active and healthy, improving their school performance and decreasing the utilization of emergency rooms.

Healthy Kids

Transitions

The average duration of a child's enrollment in the program is 12.25 months. The primary reason families disenroll from the program is because they have obtained other insurance, usually through an employer group; but the second most common reason is that they have become eligible for coverage through the Florida Medicaid Program. Because of this, we often describe Healthy Kids as a "bridge" program. Families are using the Healthy Kids program to transition between the two most widely accepted types of coverage available in the United States.

As we make progress in Welfare Reform, the bridge that programs like Healthy Kids can provide may become more important.

Please be reminded that when a child is found to be eligible for Medicaid their application is rejected or their coverage is canceled. In just the last six months, over 2,500 Florida Medicaid recipients applied for coverage in Healthy Kids and were denied entry into the program.

Imagine this: A family reviews enrollment materials for Healthy Kids and makes a decision to apply for a somewhat reduced benefit, that costs less than Medicaid. They have enclosed the first month's premium indicating they are willing to pay part of the costs (Which, by the way, increases the chances that they may actually access preventive services.) and we say NO, you can't have it. What kind of message does this send anyway?

Looking Toward the Future

While Healthy Kids is working to reduce the number of uninsured children in Florida, there are an estimated 10 million children throughout the nation without health insurance or access to affordable health care. In recognition of the necessity for programs like Healthy Kids, the Robert Wood Johnson Foundation has awarded a grant to fund a Healthy Kids National Program Office to aid other states in replicating the school enrollment-based health insurance program.

The Florida Healthy Kids Corporation was named a winner of the Innovations in American Government Award by the Ford Foundation and the John F. Kennedy School of Government at Harvard University. Healthy Kids was selected from over 1,560 applicants and received a $100,000 grant to support the replication of the program.

This week, the Florida Legislature will vote on a budget that will expand the Healthy Kids program through enhanced general revenue appropriations and provides authorization for us to again seek federal matching funds. Specific proviso language allows for expansion of the program to a maximum of 104,000 children during the next fiscal year.

Closing

It is my hope that in your review of the issue of increasing children's access to health care, you will consider the following:

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- Renewing federal participation in the Florida Healthy Kids program through a block grant or some other mechanism that provides a state with flexibility in designing their programs for uninsured children; and
- Providing a reasonable bridge of coverage between our Medicaid programs and commercial insurance plans, perhaps by allowing Medicaid eligibles to participate on a voluntary basis in programs like Healthy Kids.

Also, please see:

1997 Annual Report of the Florida Healthy Kids Corporation

Our website at www.healthykids.org

Florida Healthy Kids Demonstration: Final Report, Coulam, R.F., Ph.D., Levinson, J. Abt Associates, Inc. May 1, 1995

COMMUNICATIONS

STATEMENT OF THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

[SUBMITTED BY STANLEY B. PECK]

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services that support total health through the promotion of optimal oral health.

ADHA is pleased to share its views with regard to children's access to health coverage. In particular, we urge that any children's health legislation include measures to improve access to oral health care services. This is important because the Institute of Medicine estimates that fifty percent of Americans do not receive regular dental care. This figure is likely far higher for the population that children's health initiatives seek to cover.

ANY CHILDREN'S HEALTH INITIATIVE SHOULD INCLUDE MEASURES TO PREVENT ORAL DISEASE

Because ADHA feels strongly that all Americans should have access to affordable quality health care services, including oral health care services, ADHA is pleased with the significant level of interest and commitment in the 105th Congress to increase health insurance coverage among our nation's 10 million uninsured children. We are committed to participating in this process to ensure improved access to cost-effective quality health care coverage, including, at a minimum, preventive oral health services. Oral health is a part of total health; therefore oral health must be included in any children's health care initiative.

THE NATION'S ORAL HEALTH

Oral health is fundamental to total health. As former Surgeon General C. Everett Koop noted, "if you don't have oral health, you're not healthy." Despite recent advances in preventing oral disease and maintaining oral health, oral diseases still afflict 95% of all Americans. Oral Health America/America's Fund for Dental Health reports that 9 million school days are lost annually because of oral health problems.

COST-SAVINGS ASSOCIATED WITH PREVENTIVE ORAL HEALTH CARE

In contrast to most medical conditions, the three most common oral diseases—dental caries (tooth decay), gingivitis and periodontitis (gum and bone disease)—are proven to be preventable with the provision of regular oral health care. This proven ability translates into huge cost savings. Each $1 spent on preventive oral health care yields $8—$50 in savings. Because of this, increased access to preventive oral health services will likely result in decreased oral health care costs per capita and, more importantly, improvements in children's oral and total health.

Preventable oral diseases currently afflict the majority of our nation's children. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two-thirds experience gingivitis. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. Each of these oral health disorders—dental caries, gingivitis and periodontitis—can be prevented through regular preventive care.

All American children should have access to oral health coverage as one way to support total health. Ideally, every child should have access to diagnostic, preven-

tive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Additionally, any effort to revamp the present Medicaid and Medicare health care delivery systems or to advance incremental health care reform legislation should embody as one of its goals increased access to preventive oral health care services.

A 1996 U.S. Department of Health and Human Services (HHS) report on Children's Dental Services Under Medicaid indicated that, despite the provision for oral health benefits under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid children actually received preventive oral health services in 1993.[1] This represents a slight decrease from 1992 data. The 1996 HHS report attributes the low utilization rate for preventive oral health services to "the shortage of dentists who are willing to accept Medicaid patients."[2] Clearly, this trendline must be reversed. Dental hygienists can, and should, play a larger role in the delivery of oral health services to underserved populations, including Medicaid-eligible children. The nation's health care system must be reoriented to focus on preventive and primary care services including those provided by dental hygienists.

CHILDHOOD IMMUNIZATIONS SHOULD INCLUDE MEASURES TO PREVENT DENTAL DISEASE

ADHA urges that any children's health initiative improve access to the known benefits of preventive oral health care services. The increased access to oral health care for children that ADHA advocates can be achieved through the inclusion of dental sealants and fluoride in any definition of childhood immunizations. While research to develop a vaccine against dental caries (tooth decay) continues, we can today effectively guard against tooth decay—which is an infectious, transmissible disease—with the combined use of dental sealants and fluoride[3]. These services protect children against tooth decay just as vaccines immunize against certain medical diseases.

Dental Sealants

Pit and fissure adhesive sealant protection for the eight permanent molars (6-year and 12-year molars) is needed when the crevices in these teeth are deep. Sealants are thin plastic coatings that seal crevices in the teeth and act as a physical barrier to prevent oral bacteria from collecting and creating the acid environment essential to the initiation of oral disease. No discomfort is involved in sealant applications, which cost approximately $20-35 in private settings, and even less in public health settings. When properly applied, sealants are virtually 100 percent effective in preventing tooth decay in the pits and fissures of molars.

The National Institutes of Health (NIH) and former Surgeon General C. Everett Koop endorse the use of sealants. One of the objectives in Health People 2000, the national health promotion and prevention agenda, is to increase to at least 50 percent the proportion of children who have received protective sealants.

Fluoride

Appropriate use of fluoride can reduce smooth surface tooth decay in children. Optimal availability of fluoride from multiple sources, such as community water fluoridation, self-applied fluorides, and professionally applied fluorides, are effective in preventing dental decay.

Effectiveness

Together, dental sealants and fluoride are virtually 100 percent effective in protecting children against tooth decay and its physical, financial, academic, emotional, and social consequences. Accordingly, ADHA urges that any definition of immunization include dental sealants and fluoride.

CONCLUSION

Preventable oral diseases still afflict most of our nation's children, compromising their health and unnecessarily adding to health care costs. ADHA urges this Subcommittee—and all Members of Congress—to ensure that any children's health initiative promote access to quality, cost-effective preventive oral health care services. Ideally, all American children should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, children need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays.

ADHA stands ready to work with the nation's policymakers to improve children's access to preventive oral health services, which will achieve savings of billions of

health care dollars and improve children's oral health, a fundamental part of total health.

*** * * ***

ADHA appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander of McDermott, Will & Emery (202-778-8024).

ENDNOTES

[1]: *Children's Dental Services Under Medicaid: Access and Utilization*, U.S. Department of Health and Human Services, Office of the Inspector General, April 1996, (OEI-09-93-00240) at page 6.
[2]: Id. at page 7.
[3]: Research shows that the presence of bacteria known as mutans streptococci leads to dental caries in children. This decay causing bacteria is typically transferred from primary caregivers to young children between 22-26 months of age.

Publisher of Consumer Reports

Written Testimony of

Gail Shearer

Director, Health Policy Analysis
Washington Office
CONSUMERS UNION

before the

COMMITTEE ON FINANCE

UNITED STATES SENATE

HEARING ON:

INCREASING CHILDREN'S ACCESS TO HEALTH CARE

April 30, 1997

Washington Office
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Summary of Consumers Union Testimony

Congress should enact legislation that makes health insurance for children more affordable and more accessible, without fragmenting the market through anti-consumer provisions such as expanded medical savings accounts or multiple employer welfare associations.

Children's health reform legislation should be built on the following principles:

- universal coverage of children;
- adequate safety net (Medicaid's guarantee of a comprehensive benefits package);
- seamless coverage that provides continuous care;
- expeditious phase-in;
- incentives for employers to provide dependent's coverage;
- broad risk sharing;
- fair financing (with costs shared among employers, families and taxpayers);
- adequate benefit package (including prenatal care, preventive care, hospital care, and doctor care);
- family-friendly (with consumer choice of plan and provider, and access to providers who specialize in children); and
- no financial barriers to care.

Congress should reject options that would fragment the health care system by separating high risks from low risks. Congress should reject expansion of medical savings accounts for children for the following reasons:

- many children will not get preventive care;
- most families with uninsured children will face financial barriers to care if the children are enrolled in a high deductible health insurance policy;
- MSAs for children will separate the healthy from the sick, appealing to the healthy, and leaving the sick with higher out-of-pocket costs;
- families of all income levels will face higher premiums for low deductible health insurance;
- in the long-run, MSAs would drive low-deductible policies out of the market;
- families with a child with a chronic illness will face sizeable out-of-pocket costs if they have an MSA plan; and
- children's MSA accounts are likely to be empty.

Consumers Union[1] appreciates the opportunity to submit written testimony on the subject of increasing children's access to health care.

The failure of the U.S. health care system to provide coverage to ten million children is one of its most embarrassing shortcomings. Too often, children with serious illness are victims of their parents' changing circumstance (such as job change), and find their access to consistent, quality care is denied. To be sure, we need health care reform that provides access to health care coverage for all Americans, regardless of age. Ideally, health legislation should establish a blueprint for meeting this goal. We also need to build protections into the system which assure that all health plans -- whether they be traditional fee-for-service or managed care -- provide high quality care.

We are pleased that Congress is considering various options of expanding health insurance coverage for children. We believe it is crucial that Congress adopt steps that make health insurance for children more affordable and more accessible, without fragmenting the market through anti-consumer provisions such as expanded medical savings accounts or multiple employer welfare associations.

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[1]Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

We believe that sound children's health care reform measures should adopt the following principles:

- *Universal coverage: All* children who live in the United States should have high quality health care coverage.
- *Adequate safety net:* Medicaid's guarantee to health care -- and its comprehensive benefits package -- should be preserved as a safety net for the poor until such time that a universal, comprehensive program exists for all consumers.
- *Seamless coverage:* Children should have seamless health care coverage that provides consistent care regardless of their parents' employment status or income.
- *Expeditious phase-in:* The transition to full coverage to health coverage for children should be carefully planned, and should culminate in universal coverage for children as quickly as possible.
- *Employers' incentives:* Employers should be encouraged to provide health care coverage for their employees' children.
- *Broad risk sharing:* Risks should be pooled broadly to reduce individual costs, with less fragmentation of the population into low risk and high risk pools.
- *Fair financing:* Health care coverage for children should be financed fairly, with the cost shared among employers, families with children, and taxpayers.
- *Adequate benefits package:* Congress should establish a benefits package for

children's coverage that includes prenatal care for mothers, preventive care, hospital care, and doctor care, including benefits that meet the special needs of disabled children.

- *Family-friendly:* To the extent possible, families should be able to have health care coverage through one health plan -- rather than different plans for different members of the family. Consumer choice of health plan and choice of providers should be facilitated, and should include access to providers who specialize in children. The needs of disabled children for family-centered care should be met.
- *No financial barriers to care:* Cost-sharing (such as deductibles and coinsurance) should not be so high that it presents a financial barrier to receiving medically appropriate health care.

There are a variety of ways to meet these principles, for example through expansion of Medicaid or subsidization of private insurance by the working poor. It is clear, however, that some public policy options under consideration would be inconsistent with these principles. For example, the expansion of medical savings accounts (MSAs) and expansion of multiple employer welfare associations (MEWAs) could fragment the health insurance market and make traditional low-deductible health insurance *more* expensive for families with sick children. We urge you to *reject* expansions of MSAs and MEWAs.

Below, we outline several of the reasons why we believe that expanded MSAs would work to the detriment of children.

- *Many children will not get preventive care.*

MSAs for children are likely to be packaged with health insurance policies with high deductibles of $1,500 to $4,500. Even if the health insurance policies covered preventive benefits, insurance will actually pay the preventive care costs for a small percent of children, since few have costs high enough to meet the deductible. Families with unfunded MSAs will have to pay the full cost of preventive care (e.g., check-ups and immunizations) out-of-pocket. Many will be unable to afford to do this.

- *70 percent of children who are presently uninsured come from families that earn $31,000 or less, and therefore will face financial barriers to care if they enroll in a high deductible health insurance policy.*

Few of these families will be able to pay $1,000 or more per child to fund an MSA. Most of these families will be hard pressed to pay medical bills before a $1,500 (or higher) deductible is met. What this means is that their children will be denied medical care because of the financial barrier faced by their parents.

- *MSAs for children will separate the healthy from the sick, appealing to the healthy, and leaving the sick with higher out-of-pocket costs.*

Health costs are not spread evenly across the children's population. They are spread very unevenly, with 5 percent of children accounting for more than 59 percent of expenditures.[2] MSAs will appeal to the healthy 95 percent more than the

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[2] "Children Without Health Insurance: Use of Health Services in 1977 and 1987, Intramural Research Highlights NMES: National Medical Expenditure Survey, Agency for Health Care Policy and Research, February 1994, No. 30.

unhealthiest 5 percent. They will also appeal to relatively wealthy families who can afford high deductibles. If introduced as an option for all, the migration of the healthy children to MSA plans will severely erode the premium dollars in the risk pool to pay the costs of health care for the unfortunate 5 percent of relatively unhealthy children. This is a double whammy for these families who must then deal not only with a very sick child, but also with the unwillingness of society to help share the cost of medical care.

- ***Families of all income levels will face higher premiums for low deductible (e.g., $250 deductible) health insurance.***

It is important to look beyond the impact on the families who have MSAs. Analysts who have studied the total under-65 health insurance market have demonstrated that MSAs have a greater appeal to the healthy than they do to the sick. They have estimated that premiums for traditional health insurance (e.g., with deductibles of $250) will increase as much as 300 percent if MSAs are introduced on a large scale in the health insurance market.[3] The same will be true for children's MSAs; premiums for traditional (low-deductible) health insurance will skyrocket if MSAs are an option.

- ***In the long-run, MSAs would drive low-deductible policies out of the market.***

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[3]See, for example, "Medical Savings Accounts -- Cost Implications and Design Issues," American Academy of Actuaries, Washington DC, May 1995, p. 6; and Len M. Nichols, Marilyn Moon, & Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," The Urban Institute, Washington DC, April 1996, p. 12.

If premiums for health insurance with low deductibles (e.g., $250) increased between 60 percent and 300 percent (as predicted), these policies will be unaffordable for many. It is only a matter of time before insurers would decide to leave the traditional market in order to market high-deductible only policies. This means *less* choice of policies for families.

- ***Families with a child with a chronic illness will face sizeable out-of-pocket costs if they have an MSA plan.***

Consider the case of a child with a serious disability such as cerebral palsy. While the average annual health care cost for an infant (under 1 year old) receiving Medicaid was $2,284 (in 1992), the average annual health care cost for a *disabled* child of this age was $16,227, seven times as much.[4] If health care costs for a disabled child (who is not eligible for Medicaid) were $16,227, then this child's family would face sizeable out-of-pocket costs if they have a high-deductible health insurance policy: The deductible could be $2,000; coinsurance (at 20 percent) after meeting the deductible could be $2,845. The family's total out-of-pocket health care costs for this child (alone) would be $4,485. It is extremely unlikely that this family would have any balance in an MSA, since the baby is so young.

- ***Children's MSA accounts are likely to be empty.***

The 1996 Kassebaum-Kennedy health bill did not require employers to put

[4]Marsha Regenstein and Jack A. Meyer, "Low Income Children with Disabilities: How Will They Fare Under Health Care Reform?" The Economic and Social Research Institute, National Academy for State Health Policy, August 1994.

money into employees' MSAs. Since children don't have employers, it is even less likely that there would be any funding for MSAs outside the family. This is the case especially since fewer employers are providing health insurance coverage for employees' dependents, with the percent of children covered by their parents' employer-based plans decreasing from 67 percent in 1987 to 59 percent in 1995. Since most uninsured children live in families with modest incomes, it is very unlikely that their families could contribute money to a savings account for health care. Even if they could, they would find that tax benefits would be modest because of their low tax bracket.

In conclusion, we urge you to enact legislation that will expand health care coverage for children, without creating side effects that will make some families and their children worse off.

THE COUNCIL OF
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Written Statement on Behalf of the

COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS

(CWISH)

Senate Committee on Finance

Hearing on Increasing Children's Access to Health Care

April 30, 1997

Submitted by Susan Erickson

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Written Statement on Behalf of the
COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS
(CWISH)

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Hearing on Increasing Children's Access to Health Care
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Submitted by Susan Erickson
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Clinical Services Administrator, Women's Services; and
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The Council of Women's and Infants' Specialty Hospitals (CWISH) is a group of eight of the largest freestanding subspecialty perinatal hospitals dedicated to the delivery of high risk obstetrical and neonatal care to mothers and their infants.[1] CWISH is pleased to present its views with regard to children's access to health coverage.

Because access to risk-appropriate prenatal care is known to improve the outcome of pregnancy, inclusion of health insurance coverage for pregnant women in any children's health initiative will contribute to the goal of improved health for the nation's children. Accordingly, CWISH urges that **health insurance coverage for pregnant women be included in any children's health initiative.**

Further, children's health legislation must specifically assure access to quality, cost-effective high risk obstetrical and neonatal care for both pregnant women and infants. Access to high risk obstetrical and neonatal services is critical because studies show that **premature and low-birthweight infants born in large Level III subspecialty hospitals -- such as CWISH hospitals -- fare better than high risk deliveries in other settings without increased cost.**[2] Moreover, a healthy pregnancy and delivery bolsters the chances for a healthy childhood and can avert expensive acute and/or long-term care.

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[1] Perinatal services include maternal and infant care beginning before conception and continuing through the first year of an infant's life.

[2] The Effects of Patient Volume and Level of Care at the Hospital of Birth on Neonatal Mortality, Journal of the American Medical Association, Volume 276, No. 13, October 2, 1996, p. 1054.

CWISH SUPPORTS EXPANDED MEDICAID OUTREACH

CWISH is pleased with the significant level of interest and commitment in this Congress to increase health insurance coverage among our nation's ten million uninsured children, including the three million children eligible for, but not receiving, Medicaid benefits. CWISH is well aware of Medicaid's importance to the health of pregnant women and infants. Indeed, CWISH is a significant participant in the federal Medicaid program, with Medicaid payments constituting up to sixty-five percent of the care provided by our hospitals.

As Congress undertakes to reform the Medicaid program, we urge this Subcommittee -- and all Members of Congress -- to facilitate outreach and other programs to ensure health care coverage of all Medicaid eligible pregnant women and infants and to ensure that CWISH and other subspecialty perinatal hospitals will be able to provide quality cost-effective high risk obstetrical and neonatal services to pregnant women and infants in their communities, regardless of economic need.

IMPORTANCE OF RISK-APPROPRIATE CARE FOR PREGNANT MOTHERS AND INFANTS

Lack of health insurance often results in lack of timely care, which too often results in costly acute and/or long-term care. U.S. Census Bureau data reveals that one of three children lacked health insurance for one or more months during 1995-1996.[1] Many of these uninsured children are members of families where one or both parents are working, but simply cannot afford insurance. Clearly, we must do better.

Appropriate prenatal care for expectant mothers is a major determinant of good pregnancy outcome. In fact, prenatal care, especially among poor, minority and other high-risk women, reduces the risk of low-birthweight threefold and results in lower infant mortality rates and healthier infants. Numerous studies have also shown that women who receive no prenatal care are far more likely to have babies with health problems that could have been prevented or reduced had they received the appropriate perinatal care.[2] According to the American Hospital Association, leading the list of barriers to this important care is inadequate or total lack of health insurance.

Identification of high risk pregnancies and subsequent referral and appropriate treatment by specialists is critical. As cited earlier, the recent study reported in the *Journal of the American Medical Association* confirms that high risk deliveries in large level III neonatal intensive care units (NICUs) -- such as those in CWISH hospitals -- fare better than high risk deliveries in other settings *without* increased cost. Because the major decline in

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[1] One Out of Three: Kids Without Health Insurance 1995-1996, Families USA Foundation, Washington, D.C. 1997, p. 1.

[2] Infants At Risk: Solutions Within Our Reach, Greater New York March of Dimes/United Hospital Fund of New York, 1991, p. 28.

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infant mortality over the past 25 years is largely attributable to better access to the subspecialty services provided at hospitals such as ours, access to these high risk obstetrical and neonatal services must be included in any children's health initiative. Indeed, the Finance Committee expressly recognized the importance of access to specialty perinatal care in its fiscal year 1997 reconciliation recommendations (attached in pertinent part).

In conclusion, CWISH strongly advocates access for *all* pregnant women and infants to cost-effective quality risk-appropriate health care. Such care should specifically include high risk obstetrical and neonatal services provided in Level III regional specialty hospitals.

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CWISH appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander of McDermott, Will & Emery (202-778-8024).

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104TH CONGRESS
2d Session

COMMITTEE PRINT

S. PRT.
104-58

BUDGET RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON FINANCE

AS SUBMITTED TO THE COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 178

COMMITTEE ON FINANCE
UNITED STATES SENATE

WILLIAM V. ROTH, JR., *Chairman*

JULY 1996

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
25-736
WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052887-9

Effective Date

October 1, 1996.

E. Pre-existing conditions exclusions

Present Law

No provision.

Explanation of Provision

A State is prohibited from denying or excluding coverage on the basis of a preexisting condition. If a State contracts with a capitated organization or other entity and allowed the organization to impose preexisting condition exclusions, the State must provide alternate coverage for any covered services denied as a result.

F. Access

Present Law

State plans must meet the general requirements of comparability (the services available to any categorically needy beneficiary in a State must generally be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State) and Statewideness (generally, the amount, duration, and scope of coverage must be the same Statewide).

Explanation of Provision

The State plan must include a description of the State's goals related to access of care for children with special health care needs (as defined by the State). The State plan must assure that beneficiaries have access to nursing facilities and primary care services (within 50 and 30 miles of their residence, respectively, or within a "reasonable" distance in rural areas). States are encouraged to assure pregnant women and children access to appropriate levels of basic, specialty and subspecialty care.

The Committee has included a provision requiring that the State Medicaid plan include a description of the goals and objectives related to standards of care and access to services for children with special health care needs in that State. Children with special health care needs, those with serious chronic conditions or disabilities such as cerebral palsy, cystic fibrosis, cancer, or heart conditions represent approximately 2 percent of all children, but need special attention to make sure their needs are met. While managed care can offer all children and their families better access to care and better coordination of services, managed care plans often have not developed the expertise to treat children with special health care needs. Accordingly, the Committee intends that States outline in their plans how they will provide care to children with special health care needs.

Studies show that the high risk obstetrical and neonatal services provided at Level III regional specialty hospitals have contributed to the decline in U.S. infant mortality over the last 25 years. The Committee encourages the States to put in place protections so that pregnant women and babies receive the basic, specialty, and sub-

specialty care they need in the facility appropriate to their level of risk, including Level III regional specialty care, in keeping with *The Guidelines for Perinatal Care*, American Academy of Pediatrics/American College of Obstetricians and Gynecologists.

5. Delivery Systems

Present Law

Currently, the majority of Medicaid services are provided on a fee-for-service basis.

Under current law State plans must meet three general requirements: comparability (the services available to any categorically needy beneficiary in a State must generally be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State); Statewideness (generally, the amount, duration, and scope of coverage must be the same Statewide); and freedom of choice (beneficiaries must be free to obtain services from any institution, agency, pharmacy, person, or organization that undertakes to provide the services and is qualified to perform the services).

States wishing to use Medicaid funds to target otherwise ineligible populations, or to use innovative methods for delivering or paying for Medicaid services may apply to the Secretary for waivers of Medicaid requirements. States wishing to require Medicaid beneficiaries to enroll in managed care plans must obtain one of two types of waivers from the HCFA. Section 1115(a) of the Social Security Act offers States the greatest flexibility, allowing HCFA to waive a broad range of Medicaid requirements. These waivers allow States to expand coverage to those not traditionally eligible, to impose premiums and copayments on those new eligibles, and to modify the Medicaid benefit package. A second kind of waiver, known as a "Freedom-of-Choice" waiver, is permitted by section 1915(b) of the Social Security Act. Section 1915(b) waivers allow States to waive specific requirements for a specific population or geographical area. States do not need waivers to contract with managed care companies; without a waiver, however, States must operate a voluntary system, allowing beneficiaries to choose between an HMO and traditional fee-for-service care.

States are permitted, under the 1915(c) and 1915(d) waiver authority of current law, to offer home and community-based care services to persons who would otherwise require nursing home or institutional care that would be covered by Medicaid.

Explanation of Provision

The State is required to include in its plan a description of the delivery method, such as use of vouchers, fee-for-service, or managed care arrangements. To the extent that medical assistance is furnished on a fee-for-service basis, the plan must describe how the State determines the qualifications of providers eligible to provide such assistance and the method used to determine reimbursement rates for such assistance. The State plan must also describe the extent to which eligible individuals have freedom of choice of providers. States have the option of submitting the State plans that they used under Title XIX (including a plan provided under 1115 waiv-

NATIONAL CONFERENCE OF STATE LEGISLATURES

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April 28, 1997

The Honorable William Roth Jr.
Chairman, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

On behalf of the National Conference of State Legislatures (NCSL), I thank you for highlighting the issue of how to improve health insurance for children during the Senate Finance Committee briefing on April 30, 1997. NCSL is a bipartisan organization created to serve the legislators and staffs of the nation's 50 states, its commonwealths and territories, and the District of Columbia. States have considerable experience addressing this issue. Enclosed, please find a summary of children's health insurance initiatives in the states as well as a brief prepared by the Health Policy Tracking Service at NCSL on legislative initiatives currently being debated in state legislatures. I am respectfully requesting that you accept into the record these two documents.

At present 46 states have expanded health insurance coverage for children beyond that which is required under Medicaid. This number represents years of state legislative action to remedy the situation of uninsured children. This year is no exception with 25 states introducing over 40 bills designed to improve children's access to health insurance coverage. Some of the methods states employ to decrease the number of uninsured children include expanding Medicaid, establishing creative state only funded programs, and entering into public/private partnerships. States' differing approaches to address this issue take into account local problems and needs.

I am pleased that the Committee is addressing this issue and hope you will find states' experiences useful in your discussions. Please feel free to contact me at (502) 564-8100 or Margie Shofer at NCSL at (202) 624-3581 if you would like to discuss this issue further. I look forward to working with you on this critical issue.

Sincerely,

Thomas J. Burch
Kentucky House of Representatives
Chair, NCSL Health Committee

Enclosures

Health Policy Tracking Service

Subject:	Medicaid	Date: 04/01/97
Title:	Uninsured Children	

Extending health coverage to children of poor working families--families who make too much money to qualify for Medicaid but not enough to afford health insurance--is possibly the next big step in incremental health reform, following last year's passage of the Health Insurance Portability and Accountability Act, otherwise known as the Kennedy/Kassebaum law. Legislatures in almost half the states have proposed children's health initiatives this year that aim to ultimately cover the 9.8 million American children who are currently uninsured.

1997 FEDERAL INITIATIVES

On the federal level, President Clinton has proposed a plan for FY 1998 that aims to insure half the nation's 9.8 million uninsured children. The plan provides for the following: (1) annual grants to states to cover health insurance premiums for up to 6 months for unemployed parents (previously covered by employer-based insurance) and for their children ($1.7 billion in '98 and $9.8 billion from '98 to 2002); and (2) annual grants to states to develop insurance programs like those in Florida, Pennsylvania and Vermont for children whose parents earn too much for Medicaid but too little for private coverage ($750 million per year and $3.8 billion total from 1998-2002).

The initiative will also call for the Department of Health and Human Services to actively work with the states, communities, advocacy groups, providers and businesses to identify and enroll the estimated 3 million children who are eligible for Medicaid but not enrolled. In addition, the initiative will allow states to extend one year of continuous Medicaid coverage to children who are eligible for Medicaid but who will lose this coverage as their parents change jobs, move from welfare to work, or remarry (2).

Five bills have also been introduced in Congress. On January 21, Senate Minority Leader Thomas Daschle (D-SD) introduced a refundable tax credit bill (S 13). Also on January 21, Sen. Arlen Specter (R-PA) introduced legislation to allow states to provide vouchers with federal funds so families can choose their own health plans (S 24). Specter introduced another bill (S 435) on March 13 that is a more limited version of S 24. On February 4, Rep. Pete Stark (D-CA) introduced two bills, one that amends the Social Security Act to provide for a program of health insurance for children under age 18 and for pregnant women (HR 560) and another that amends the Internal Revenue Code of 1986 to require that group health plans and insurers offer access to coverage for children and assist families in the purchase of such coverage (HR 561).

1997 STATE INITIATIVES

Realizing that inadequate health care for children causes poor health outcomes later in life, which only translates into higher health care costs for states in the long run, states on the whole are beginning to put uninsured children higher on their list of priorities.

During this 1997 legislative session, 24 states -- **Alaska, Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Maine, Maryland, Massachusetts, Mississippi, Missouri,**

Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, Texas, Virginia and **Vermont** -- have introduced legislation on the topic of uninsured children. The two main approaches these states have taken include expanding Medicaid eligibility and creating or expanding state programs that provide uninsured children with basic health care. So far, **Arkansas** and **Vermont** are the only two states to enact legislation. AR S 348, signed into law on March 10, establishes ARKids First, a two-year pilot program beginning in the 1997-98 biennium, to expand Medicaid eligibility to children ages 18 and younger whose families have incomes up to 200% of the federal poverty level (FPL). VT H 105, signed on February 12, imposes a $3.00 dental copayment and a $10.00 per family monthly premium to the state's Dr. Dynasaur program, a comprehensive health coverage program for all uninsured children up to age 18 from families earning up to 300% FPL.

Two bills in **Virginia** have not been signed into law, but have passed out of both houses of the legislature. H 2682 expands Medicaid for children up to age 18 whose family incomes are at or below 200% FPL. To pay for the expansion, the bill establishes a trust fund that shall consist of premiums, any employer contributions, and any public or private donations. Governor George Allen (R) has until March 24, 1997 to sign the bill into law. SJR 298 directs the Joint Commission on Health Care to conduct an analysis of accessibility of child health preventive services and, as part of the study, directs the Joint Commission to develop a program to provide basic coverage for low-income, uninsured residents. The program will be presented to the 1998 Session of the General Assembly and, if approved, implemented by April 1, 1998.

Five bills that deal with providing health insurance for uninsured children have passed out of their house of origin. **Indiana** S 440 establishes a healthy kids program to provide for the payment and provision of health services to children enrolled in school. **New Hampshire** H 723 seeks to expand preventive health services by repealing the rule that the New Hampshire healthy kids corporation operate at no more than five geographic pilot sites. The corporation is a private nonprofit created to facilitate the provision of such services and provide children with comprehensive health insurance coverage. **New Mexico** H 354 requires that the Department of Human Services expand Medicaid to children and pregnant women in families at or below 185% FPL. **Oklahoma** S 478 directs the Oklahoma Health Care Authority to include a Medicaid option for children under 18 who do not receive cash assistance and whose family incomes do not exceed 250% FPL. **Oklahoma** S 639 specifies that in designing the state Medicaid plan, the Oklahoma Health Care Authority shall cover children under the age of 6 whose family incomes do not exceed 185% FPL. The Authority shall further cover all children 6 or older whose family incomes do not exceed 185% FPL and who are required to be covered at 100% FPL pursuant to federal requirements.

Several governors have also proposed their own initiatives. **Arkansas** Governor Mike Huckabee (R), for example, proposed the ARKids First program in his January 14 state-of-the-state address. Over the past two months, governors in **Colorado, Florida, Iowa, Maryland, Massachusetts, Missouri, New Jersey, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Washington, Wisconsin** and **Vermont** have also recommended, mostly in their pending budget bills, new children's health programs, expansions of existing programs, or more flexible eligibility requirements for Medicaid. The proposals are outlined below:

CO - Eliminate the assets test for children applying for Medicaid. Expand the Colorado Child Health Plan (CHP).

FL - Provide $15.5 million to expand the Healthy Kids program to cover an additional 60,000 kids.

IA - Provide funding to increase the percentage of children eligible for Medicaid who receive health screening and immunizations.

MD - Establish a program to provide pregnant women and children through age 3 whose family

incomes are between 185% and 250% FPL with primary and preventive health care services.

MA - Offer the Children's Medical Security Plan to an additional 13,000 uninsured children and adolescents. Expand Medicaid coverage to cover approximately 55,000 children and adults.

MO - Offer insurance coverage out of a statewide pool to the approximately 175,000 children currently uninsured in the state.

NJ - Appropriate $5 million in seed money for public/private insurance programs for uninsured kids with family incomes up to 250% FPL. Funding to come from insurers and corporations.

OH - Expand Medicaid eligibility to cover children under 18 whose family incomes are at or below 150% FPL -- approximately 96,000 children.

OR - Expand Medicaid coverage under the Oregon Health Plan to include children under age 6 and pregnant women whose family incomes are under 185% FPL.

PA - Expand the Children's Health Insurance Program by 3,000 children by dedicating an additional one cent of the state's existing cigarette tax to the program.

SC - Expand Medicaid eligibility to cover children ages 6-18 whose family incomes are under 133% FPL -- approximately 50,000 children. Funding to come from the South Carolina Hospital Association, state matching dollars and federal Medicaid matching dollars.

TN - Open TennCare enrollment to residents under 18. Coverage will be free to those whose family incomes are at or below FPL, and offered on a sliding scale to those above FPL.

WA - Provide $114 million to cover 20,000 more families under the Basic Health Plan.

WI - Develop a plan to cover the state's 90,000 uninsured children. Possible ideas for plan include subsidized health insurance policies, a new program run by a managed care company, or a program based on insurance policies sold through public schools, similar to the Florida Healthy Kids Program.

VT - Expand the state's Dr. Dynasaur Program nationwide.

CURRENT STATE INITIATIVES

State efforts to cover uninsured children are not new. At present, at least 37 states have expanded Medicaid eligibility beyond the federally-mandated levels, which are as follows: Medicaid coverage to children under age 6 up to 133% FPL and coverage to children up to 100% FPL who were born after September 30, 1983. Each year, one more group of children becomes eligible until the year 2002 when all children under 19 in families with incomes up to 100% FPL will be covered (3).

Several states have also created their own children's insurance programs. At present, approximately 13 states have some type of state program for uninsured children. Some of these programs are coordinated by the state, but include private involvement usually in the form of donations or administrative support. A number of other states also have private initiatives, which are funded solely with private donations.

As of March 18, 1997, 12 states had introduced Medicaid expansion measures, 17 states had created or expanded state programs, and 11 states had taken other approaches.

MEDICAID EXPANSIONS

There are a few benefits for states in choosing to expand their Medicaid programs rather than creating or expanding state programs. First, through Medicaid, states can receive federal funding to help them in their efforts. Second, states already have an administrative structure set up for Medicaid. One disadvantage to this approach, however, is that because Medicaid is a joint state and federal program, states must get permission from the federal government before expanding Medicaid for more children or before making other changes in their programs.

In order to expand Medicaid eligibility beyond federal requirements, states generally use either the Section 1902(r)(2) option of the Social Security Act or Section 1115 waivers. Section 1902(r)(2) allows states to use more liberal income and assets standards than the current law allows in expanding Medicaid eligibility to pregnant women and children. Although no federal approval is needed for the 1902(r)(2) option, programs created under the waiver cannot deviate from most Medicaid laws and regulations.

Under 1115 waivers, states have more flexibility, but also more oversight. States must first submit waiver requests to the Health Care Financing Administration and receive approvals before implementing any changes. In addition, 1115 waivers are time-limited and subject to evaluation. States have most commonly used 1115 waivers to move populations into managed care, expand eligibility, and modify benefit packages (3).

The following tables include all introduced legislation relating to uninsured children. The status of each bill is listed following the summary.

Table 1: Medicaid Expansions

Arkansas	S 348 establishes ARKids First, a two-year pilot program beginning in the 1997-1998 biennium to expand Medicaid eligibility to children ages 18 and younger whose families have incomes up to 200% FPL. States that the Department of Human Services will prepare and submit a waiver request to the Health Care Financing Administration to create and administer the program. Funding for the program will be derived from funds as may be provided by the General Assembly, copayments (as permitted by Medicaid waiver and determined through promulgated rules), and any federal matching funds available to the program. It is further the intent of this act that funds appropriated by the General Assembly for the purpose of funding the uninsured children's program be used where appropriate and practical to match federal funding sources to enhance the total available funding for the operation of the uninsured children's program. -- Enacted.
California	A 1126 revises the eligibility criteria for benefits under the Medi-Cal program to include residents of the state who are under 18 and whose family income does not exceed 200% FPL. Under existing law, counties are responsible for the determination of eligibility for benefits under the Medi-Cal program, and by revising eligibility criteria, this bill would increase the responsibilities of counties in making those eligibility determinations, thereby resulting in a state-mandated local program. -- Introduced.

Connecticut	H 5451 amends current law to expand Medicaid coverage to all children under 19 whose family incomes are less than 185% FPL. Also requires the Commissioner of Social Services to seek a waiver from federal law to provide Medicaid premium payments on a sliding scale for children from birth to 18 whose family income levels range from 185% to 250% FPL. -- Introduced. Drafted by Joint Select Committee on Children.
Maryland	S 233 expands Medicaid to children ages 0-3. Also expands Medicaid to pregnant women whose family income falls below 250% FPL and for children from age 4 up through and including age 18 whose family income falls below 185% FPL. -- Introduced. Amendment from Senate Committee on Finance adopted on Senate floor.
Maine	H 385 extends Medicaid coverage to children under 19 whose family income is below 133% of the nonfarm income poverty line. Establishes the Healthy Children's Trust Fund within the Department of Human Services to fund the expansion. The Fund does not lapse, but carries forward from one fiscal year to the next. Provides that interim funding for the Healthy Children's Trust Fund come from the General Fund in fiscal year 1998-99. For subsequent fiscal years, the Commissioner of Human Services is required to seek funding from outside sources, including nonprofit hospital or medical service organizations such as Maine Blue Cross/Blue Shield, which has agreed to participate in the funding of the trust fund. If sufficient funding is unavailable, the funds must be provided from the General Fund. -- Introduced. To Joint Committee on Health and Human Services.
Maine	H 422 extends Medicaid coverage to pregnant women and children under 19 years of age whose family income is below 185% of the nonfarm income poverty level. -- Introduced. To Joint Committee on Health and Human Services.
Maine	H 599 extends Medicaid coverage to children under 19 years of age whose family income is below 150% of the nonfarm income poverty line. Provides a system of copayments and a sliding scale for services if the family income is between 150% and 100% FPL. Provides that all Medicaid to children is through managed care and that the expansion is funded through a .5 mill increase in the cigarette tax. This would increase the tobacco tax to 19 mills for each cigarette beginning October 1, 1997. -- Introduced. To Joint Committee on Health and Human Services and to Joint Committee on Taxation.

Montana	S 317 states that medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% FPL. Medical assistance must also be provided, subject to appropriations and any necessary waivers, to all children ages 14 to 18 whose family incomes do not exceed 100% FPL. Any person described herein must be provided continuous eligibility for medical assistance. If the federal government offers the state an option either to expand Medicaid eligibility or buy health insurance, the department may by rule establish eligibility requirements and a range of monthly fees to be paid. The rules adopted by the department must provide for a sliding scale of payments to be made to the department by each recipient as required by this subsection and as permitted by federal waiver based upon the number of Medicaid recipients per family and the family's income. The department shall work with local health departments to control the cost of benefits provided. Subject to appropriations, the department may cooperate with and make grants to a corporation that uses donated funds to provide basic preventive medical benefits to children (1) whose families are ineligible for the Montana Medicaid program and any other health care coverage, (2) are under age 19, and (3) are enrolled in school if of school age. -- Introduced. Failed to pass Senate.
New Mexico	H 354 specifies that consistent with the eligibility criteria under the federal act and subject to available appropriations, the human services department must provide medical assistance through the Medicaid program to children and pregnant women in families at or below 185% FPL. -- Passed House. To Senate Committee on Public Affairs.
Oklahoma	S 478 states that the Oklahoma Health Care Authority shall include an option for covering children under the age of 18 years who do not receive cash assistance and whose family incomes do not exceed 250% FPL. The option will be a buy-in option that incorporates purchase of premiums on a sliding fee scale, provided that the amount of such premium does not exceed 30% of the actual cost of the premium. Requires the Authority to submit a waiver application to the federal Health Care Financing Administration no later than November 1, 1997 to amend the state Medicaid plan. -- Passed Senate. To House Committee on Appropriations and Budget.
Oklahoma	S 639 amends existing law to specify that in designing the state Medicaid plan, the Oklahoma Health Care Authority shall cover children under age 6 whose family incomes do not exceed 185% FPL. The Authority shall further cover all children 6 or older whose family incomes do not exceed 185% FPL and who are required to be covered at 100% FPL pursuant to federal requirements. -- Passed Senate. To House Committee on Appropriations and Budget.

Virginia	H 2682 amends medical assistance plan to expand, by July 1, 1998, coverage for individuals up to age 18 when such individuals are in families with incomes at 200% FPL or less and are not insured or are underinsured by any policy, plan or contract providing health benefits. Establishes the Virginia Children's Medical Security Insurance Plan Trust Fund to be administered by the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any employer contributions which may be solicited or received by the Department of Medical Assistance Services, and all grants, donations, gifts, and bequests from any source, public or private. -- Governor has until March 24, 1997 to sign into law.

STATE PROGRAMS

An alternative to the Medicaid expansion option for states is funding their own children's health programs. The most important benefit to this option is states' ability to change their programs however they wish without approval from the federal government. A downside to this approach, however, is that sometimes, due to the lack of federal funding, states are not able to make their programs as broad or as comprehensive as they would like.

In general, state program funding sources include state general revenues, private donations, and sin taxes. Many programs also use cost-management strategies such as patient cost-sharing through modest copayments and premiums. State efforts to attract providers include using insurers' existing payment systems and physician networks and paying near-market reimbursement rates. Their efforts to attract families include guaranteeing patient access to providers, having simple enrollment procedures and avoiding the appearance of a welfare program (1).

Table 2: State Programs

California	A 112 amends existing law to require the State Department of Health Services to provide preventive health services coverage for any child under age 18 who is not eligible for the Medi-Cal program or does not have coverage under any other public program or through any private insurance. Eligibility is subject to a premium determined on a sliding scale basis and by an asset eligibility requirement. Existing law provides for various preventive health care services and for the Medi-Cal program. Redefines "medically needy family person" to mean one whose family income exceeds 200% FPL but not 300%. This person shall be subject to an asset eligibility requirement as well as a sliding scale share of cost requirement. In the case of a medically needy family person whose family income does not exceed 200% FPL, eligibility shall not be subject to either a share of cost requirement or an asset eligibility requirement. -- Introduced. Referred to Assembly Committee on Health.

Colorado	H 1304 consolidates the state's existing child health programs and funding streams and creates a new children's basic health plan to provide comprehensive insurance coverage to children under 19 whose gross family income does not exceed 185% FPL. This would replace the state's current Child Health Plan, administered by the Colorado Health Sciences Center, which pays for outpatient pediatric services for children under 13 who are ineligible for Medicaid. With regards to funding the health plan, the bill creates a trust in the state treasury and requires school districts that enroll as Medicaid providers, after September 1, 1997, to deposit 30% of any Medicaid funds that become available to them into the trust. Appropriations to the trust from the state will be made by the general assembly based on the amount of savings achieved through reforms, consolidations, and streamlining of health care programs. The plan will be primarily funded through savings and efficiencies achieved in other health care programs; it is not the intent of the general assembly to create an entitlement for health insurance coverage. Premiums based on a sliding fee scale will also be collected from enrollees. A competitive bidding process will take place to select managed care organizations to provide services. The bill authorizes and requires the department of health care policy and financing to apply for any federal waiver necessary to implement the plan. If enacted, the effective date for the plan is September 1, 1997. -- Introduced. Reported favorably from House Committee on Appropriations.
Connecticut	H 5619 establishes a state-funded children's health insurance program for children age 6 and under to ensure that they receive basic health care. -- Introduced. To Joint Committee on Public Health.
Connecticut	H 6408 provides subsidized health insurance with benefits for prenatal and maternal care for any single resident whose personal income is 185% FPL or less and for any family whose income is 250% FPL or less. Also expands the pilot program that provides a subsidized nongroup health insurance product to pregnant women and children statewide. -- Introduced. To Joint Committee on Public Health.
Illinois	H 1302 provides comprehensive insurance coverage for children 18 or younger who are ineligible for medical assistance and whose families have net incomes equal to or less than 250% FPL. Annual premiums shall not exceed 5% of family net income. A board shall submit a report to the General Assembly no later than April 1, 1998 containing a plan for implementation beginning July 1, 1998 and specifying the amounts necessary to be appropriated by the General Assembly in order to subsidize the premiums. The board shall work with the appropriate state agencies to apply for any federal waivers necessary, including those to allow enrollees in state health care programs to assign the federal health insurance credit component of the earned income tax credit to the state of Illinois. -- Introduced. Passed out of House Committee on Children and Youth. Placed on short debate calendar, second reading.

Illinois	S 514 establishes a plan to promote access to comprehensive care for children 9 and younger who are ineligible for Medicaid, have net family income equal to or less than 250% FPL and are not otherwise insured for a particular covered health service. Families pay an annual enrollment fee based on their income. The director of the state Department of Public Aid shall apply for all federal waivers necessary to implement the plan, including those to allow enrollees in state health care programs to assign the federal health insurance credit component of the earned income tax credit to the state of Illinois. -- Introduced. In Senate Committee on Public Health and Welfare.
Indiana	S 440 establishes a program to provide for the payment and provision of health services to a child enrolled in school, or to a younger sibling not enrolled in school. The state department shall: (1) identify counties with the greatest need for services provided through the program; (2) determine which counties will be able to participate in the program based on need and available funds; and (3) determine the eligibility requirements for a child to participate in the program. The requirements established may be based on the same requirements to receive free lunches under the national school lunch program. The state department shall also annually adjust the eligibility requirements to reflect the amount of money available to provide health insurance to low income children. In addition, the state department shall adopt a sliding scale formula that specifies the premiums paid by parents or guardians based on their annual incomes. Premiums collected shall be deposited in the healthy Hoosiers fund. For each risk based service area, the state department shall appropriate money from the healthy hoosier fund for children residing in the area who are enrollees of the program. Funds appropriated shall be used to reimburse a qualified managed care organization that provides health services and items under the risk based contract. The office shall apply for a Section 1115 waiver to implement this chapter. -- Passed Senate. To House Committee on Public Health. H 1831 also establishes a healthy kids program and a healthy workforce program to provide health care to certain low income individuals who do not qualify for Medicaid. -- Introduced. To House Committee on Public Health.
Maryland	H 952 establishes a program under which health insurance would be free to children under 6 whose family income is no greater than 185% FPL. Insurance would also be free to children age 6 through the maximum program age whose family income is no greater than 100% FPL. The maximum program age would be 13 for the period ending 9/30/98; 14 until 9/30/99; 15 until 9/30/00; 16 until 9/30/01; and 17 thereafter. The provision of health insurance for an eligible child who is under 6 and whose family income is greater than 185% but not greater than 235% FPL may be subsidized by the fund at a rate not exceeding 50% of the premium. Establishes a fund that consists of a portion of tobacco tax revenues. -- Introduced. Reported unfavorably from the House Committee on Economic Matters.

Massachusetts	H 1897 states that the department of public health shall establish a program of medical assistance for pregnant women and minors who do not receive public or private insurance coverage or whose coverage does not cover all medically necessary care. Assistance would cover (1) all medically necessary care to maintain health during the course of the pregnancy and delivery, including care required for complications; (2) all necessary post-partum obstetric and gynecological care; (3) nutritional counseling, social work and special laboratory tests; (4) newborn care including at least one postpartum pediatric ambulatory visit, as indicated for newborns in unstable conditions; (5) case management to ensure that all women who appear to be eligible for medical assistance are assisted in enrolling for such coverage. The cost of the program shall be funded by affordable premiums contributed by enrollees according to a sliding scale based on family income and size, provided however that enrollees whose income exceeds 250% of the US non-farm poverty guidelines pay 100% of premium contributions. -- Introduced. To Joint Committee on Health Care.
Massachusetts	H 1898 provides for comprehensive child health and maternity care services as well as for supplemental services and certain home and community-based care services. Eligible participants include children who have not yet turned 2, every pregnant woman as defined in Section 8, and every mother of an eligible child. Any child born to a woman during the period of coverage under a qualified health plan shall, as of the date of birth, be automatically enrolled and covered for benefits under the plan. Any child born in the US to a woman who is not, at the time of birth, enrolled under a qualified health plan shall be automatically enrolled and covered for benefits as of the date of birth if an application for such enrollment is made no later than 60 days after the date of birth or, if later, at the end of the year in which the child is born. Establishes a trust fund to receive funds and other revenues appropriate to the program, including gifts and bequests, and to disburse funds in accordance with rules and regulations established by the Bureau. Discusses other revenue sources, such as private donations, federal cost-sharing and foundation grants, funds from health insurance companies and medical and hospital service corporations that receive premiums for coverage of benefits included in this bill, tobacco supplemental taxes, and federal funds authorized under the Public Health Service Act for achieving the Year 2000 National Health Objectives. If, despite the foregoing provisions, insufficient revenues have been collected to carry out the purposes of this chapter, funds shall be generated from general revenues and temporary surcharges on the alcohol excise tax. -- Introduced. To Joint Committee on Health Care.

Missouri	H 811 creates the Healthy Missouri Children Corporation, a not-for-profit corporation that will operate on sites to be designated by the corporation. Requires the corporation to phase in a program that incorporates such activities as the following: (1) organize school children groups to facilitate the provision of preventive health care services and provide comprehensive health insurance coverage to children; (2) arrange for the collection of any family or employer payment or premium, in an amount to be determined by the board of directors according to a sliding scale based upon need; and (3) establish eligibility criteria including, but not limited to, the rule that a child who is Medicaid eligible or receiving Medicaid benefits shall not be eligible to participate. -- Introduced.
Nebraska	L 675 establishes a fund to provide grant funds for a pilot project(s) administered by a qualifying private foundation(s) that provides health insurance or assists in paying health care costs for Medicaid ineligible children under 19 in families with annual incomes below 200% of the federal OMB poverty guidelines. -- Introduced. Indefinitely postponed from Legislative Committee on Banking, Commerce and Insurance.
New Jersey	A 2559 amends current law to increase the yearly allocations to the Health Access New Jersey subsidy account. In 1997, the account shall be allocated $45 million instead of the originally allocated $25 million. In 1998, the account shall be allocated $20 million. Of these amounts, $20 million in 1997 and $20 million in 1998 shall be used to provide subsidies to purchase health care coverage specifically for low income, uninsured children based on a sliding income scale with modest copayments. -- Introduced. To Assembly Committee on Health.
New York	A 5887 expands eligibility and benefits under the child health insurance plan and provides for additional funding. Expands eligibility to cover children in households having a net income at or below 300% of the non-farm FPL or the gross equivalent of such net income. Specifies that to the extent permitted under federal law and pursuant to receipt of a waiver submitted by the Commissioner, children eligible for care and services under the child health insurance plan shall be deemed eligible for medical assistance care and services under this title to the extent that such care and services are a benefit covered under and provided through the child health insurance program. Expands benefit package to include dental, vision, speech and hearing services that were formerly optional. Institutes a premium of $17.00 per month for each eligible child whose family net household income is between 185% and 300% of the non-farm FPL or the gross equivalent of such net income, but no more than $68 per month per family. Institutes a tax of cigarettes to help finance the program and to be deposited in the child health insurance account. -- Introduced. Referred to the Health Committee.

Rhode Island	H 6276/S 451 amends a section of the General Laws to read that for children who lack health insurance and do not qualify for federal medical assistance, but whose family available income is less than 250% FPL, the department shall provide services in the same amount, duration and scope as provided to children who qualify for coverage under the federal medical assistance program. At present, the state has a payor of last resort program called "Rite track" that provides comprehensive health care for children whose family income levels are up to 250% FPL until they reach age 18. -- Introduced. To House/Senate Committee on Finance.
Texas	H 3 establishes a non-profit corporation to provide health benefits for eligible children who are not covered by insurance or another type of health benefit plan, or are not covered by insurance that, in the opinion of the board, provides adequate coverage. The guardian of a child is responsible for premiums and applicable copayments, coinsurance or deductibles. The corporation may develop a premium structure that varies according to ability to pay and may require that the guardian, in accordance with the premium structure, pay the full cost of the child's coverage, especially if the child is Medicaid-eligible. The health benefit coverage provided under the corporation's program is secondary to any other available private coverage covering a child or a family member, and the corporation shall ensure that benefits provided by the program are the payor of last resort. -- Introduced. Reported favorably from House Committee on Public Health.

OTHER APPROACHES

Other approaches include school-based primary health care, universal health care for children, and countywide or multi-county health plans.

Table 3: Other Approaches

Alaska	H 99/S 72 establishes a program to provide Medicaid coverage for targeted case management services for pregnant women and eligible children under age 5. -- Introduced. To House/Senate Committee on State Affairs.

Hawaii	H 516 explores the feasibility of a universal health care program for children, which shall include but not be limited to mental health care for all children in Hawaii from birth to age 17. Program benefits will be the same as those offered under Medicaid. Children with family incomes up to 200% FPL will be eligible, and children with family incomes greater than 200% FPL will be eligible, provided that fees or premiums shall be on a sliding scale based on income and provided that these children shall not be eligible if their parents are currently covered under chapter 393, Hawaii Revised Statutes. Involves the transfer of all children from birth to 17 currently covered under the health QUEST program to the new program. Requires mandatory screening and testing for all children covered under the new program before the age of 3 by the EPSDT Medicaid program. The departments of human services and health shall submit a workable plan to implement the new program 20 days prior to the convening of the regular 1998 session. The department of human services shall also report to the legislature regarding the status of its efforts to provide universal access by means of Medicaid waivers, such as a waiver for children qualifying for services under the state health QUEST program, Aid to Families with Dependent Children, or other public assistance programs. -- Introduced. To House Committee on Health.
Mississippi	H 1097 directs the Division of Medicaid to conduct a study on the feasibility and cost of establishing a program to provide state-funded Medicaid coverage for children of unemployed parents for up to one year after the parents become unemployed. Directs the Division to submit the study to the Legislature before the 1998 session. Also, provides that such children shall be eligible for Medicaid beginning July 1, 1998. -- Died in House Committee.
New Hampshire	H 723 repeals the rule that the New Hampshire healthy kids corporation shall operate at no more than five geographic pilot sites. The corporation is a private nonprofit created to facilitate the provision of preventive health services and provide children with comprehensive health insurance coverage. -- Passed House. To Senate.
New Jersey	AR 20 (resolution) recognizes and encourages the expansion of corporate efforts in the state to develop health information programs and expand public-private partnerships to increase the availability of primary care services for children in the state. -- Introduced. To Assembly Committee on Health.
New Mexico	H 356 encourages the development of countywide or multi-county comprehensive health plans to promote better allocation of health care resources and better delivery of health services to underserved populations. $1 million is appropriated from the general fund to the department of health for expenditure in FY 1998 for grants to counties for development of county comprehensive health plans and for administrative costs of the department of health in assisting counties. Any unexpended or unencumbered balance remaining at the end of FY 1998 shall revert to the general fund. -- Introduced. Referred to House Committee on Government and Urban Affairs and to House Committee on Appropriations and Finance.

New Mexico	HJM 19 instructs the New Mexico health policy commission to establish a task force in cooperation with the association of counties and the departments of health and insurance to make recommendations to expand health care access to indigent and working poor populations. Recommendations are to be presented to the appropriate interim legislative committee no later than September 1, 1997. -- Passed House. To Senate Committee on Public Affairs.
New York	A 5085 promotes school-based primary health services for pre-school and school-age children by requiring the Commissioner of Public Health, in consultation with the Commissioner of Education, to provide technical assistance to local school districts and boards of cooperative educational services in the development of school health services. Such assistance shall include, but not be limited to, the provision of information directed at increasing community and parental involvement. The trustees or board of education of any school district and any board of cooperative educational services may provide a program of primary, preventative and other health services for school-age children and preschool children pursuant to this section for the purposes of providing access to such services and improving the health of children. Boards of education and boards of cooperative educational services may accept federal, state or local funds and contributions made available for the purposes of services authorized by this section, but any additional expenses or costs to be paid by the school district or component districts of the board of cooperative educational services shall be subject to the approval by the voters or board in the same manner as the budget of the district or board of cooperative educational services. -- Introduced. Referred to the Health Committee.
New York	S 392 promotes school-based primary health services for pre-school and school-age children in a similar way as noted in first paragraph of NY A 5085. States that during the periods 7/1/97 through 3/31/98 and 4/1/98 through 3/31/99 and for each fiscal year commencing on April 1 thereafter, general hospital outpatient and diagnostic and treatment centers that provide school health services and can demonstrate on forms provided by the Commissioner that such facilities serve a disproportionate number of charity care patients may include an allowance to reflect the needs of such centers. The facilities applying for disproportionate share (DSH) allowances shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources available for school health services. The total amount of funds to be allocated and distributed for DSH allowances to eligible centers for a rate period shall be limited to an annual aggregate amount of $10 million. -- Introduced. To Senate Committee on Health.
Vermont	H 105 makes appropriations to the Medicaid program and includes the following general fund reduction: $525,000 due to revised EPSDT personal care caseload and adding $39,600 from the implementation of a $3.00 dental co-pay and $200,000 from implementing a $10.00 per family monthly premium in the Dr. Dynasaur program, a comprehensive health coverage program for all uninsured children up to age 18 from families earning up to 300% FPL. -- Enacted.

Virginia	SJR 298 resolves that the Joint Commission on Health Care, in cooperation with the Board of Health, the Department of Health, the Board of Medical Assistance Services, the Department of Medical Assistance Services, the Commonwealth's academic health centers and various governmental entities, shall study the provision of health care for the indigent and uninsured. The study shall include an analysis of accessibility of child health preventive services. As part of the study, the Joint Commission shall develop a program to provide basic health insurance coverage for low-income, uninsured Virginians. The program will be presented to the 1998 Session of the General Assembly and, if approved, implemented by April 1, 1998. -- Passed both House and Senate.

References

(1) GAO Letter Report, "Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children," January 16, 1996.

(2) Health and Human Services, press release, February 6, 1997. Preliminary Report on the President's Budget Proposal, National Conference of State Legislatures, February 6, 1997.

(3) National Governors' Association, MCH Update, September 10, 1996.

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CHILDREN'S HEALTH INSURANCE: STATE INITIATIVES

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April, 1997

States with Children's Health Insurance Initiatives: Funding Sources and Enrollment

STATE	FEDERAL/STATE (Medicaid expansions, waivers)[1]	STATE ONLY	PUBLIC/PRIVATE[2]	PRIVATE	PROPOSALS/ENACTMENTS
AL				Caring Program covers ages 0-18 up to 80% FPL. Approximate enrollment-5,926.	
AR					Enacted Act 407 (ARKids First) expands Medicaid coverage up to age 18 up to 200% FPL as part of a two year pilot program. HCFA waiver needed. Funded with $11 billion in surplus funds (with a $33 million federal match). It is expected to insure an additional 80,000 to 90,000 children.
AZ	Currently ages 0-1 up to 140% FPL[3] and 13-14 up to 100% FPL get Medicaid benefits. Ballot initiative in 1996 expands Medicaid services to kids of all ages for families up to 100% FPL.	1996 law establishes the basic children's medical services program to provide grants to hospitals exclusively serving the needs of kids, esp. those who are indigent, uninsured or underinsured. Program will have sliding scale fees. Funding is from tobacco tax, to extent funding is available (many other programs rely on tobacco tax). Up to $5 million may be allocated a year.			
CA	Ages 0-1 up to 200% FPL and 13-19 up to 100% FPL get Medicaid benefits.	Access for Infants and Mothers-ages 0-2 between 200-300% of FPL get comprehensive benefits. Recipient cost share imposed. Funded by tobacco tax, subscriber contributions. Approximate enrollment-23,500 infants, 26,447 pregnant moms.		CaliforniaKids covers ages 2-18 between 100-200% FPL. Approximate enrollment- 1,102.	

[1] Under OBRA 1989 states required to cover ages 0-6 up to 133% FPL. OBRA 1990 requires states to phase in coverage for kids up to 100% FPL born on or after October 1983 up to age 19. As of October 1996, states are required to cover children ages 13 and younger.

[2] Blue Cross and Blue Shield (BC/BS) Association Foundations administer Caring Programs. Benefits include diagnostic testing, emergency care, immunizations, outpatient surgery, physician visits and well-child visits. Some also include dental, vision and drug benefits. Recipients must not be eligible for Medicaid or private insurance. Many programs provide benefits at no cost, while others require modest co-pays, such as $3 for drugs. Average amount of time in the program is 18 months. These states (CO, IA, KS, MI, MT and PA) have formed a partnership with BC/BS. In other states (private column), the programs receive no state funding and are funded by private donations. In some of these programs, BC/BS matches private donations.

[3] Federal Poverty Level

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
CO			Children's Health Plan is a capitated primary care plan. It provides limited services (immunizations, well-child check ups, labs tests, physician visits for illness/injury) in certain counties to kids ages 0-12 up to 185% of FPL who are uninsured and not eligible for Medicaid. Cost share of $25/child/yr. Co-pay $2/office visit. BC/BS provides administrative support at no cost. Program received $1 million in state funding to expand for the first time last year (in existence 5 yrs). Approximate enrollment - 5,000. Anticipated to be 12,280 by Dec. 1998.		Expand the Child Health Plan.
CT	Ages 0-13 up to 185% of FPL get Medicaid benefits.	Healthy Steps provides limited services (preventive care, emergency care, outpatient mental health care, dental care and lab tests) to kids ages 0-18 below 200% of FPL who have no health insurance. It is a pilot program that only operates in New Haven. The program allocation is $455,000.			
DE	Ages 0-1 up to 185% of FPL and 13-19 up to 100% FPL get Medicaid benefits.			Nemours Foundation, through a partnership with DuPont Pediatric Practices of Dupont Hospital, subsidizes comprehensive benefits for kids not eligible for Medicaid up to 250% FPL. Above 250% cost share is imposed. The pediatric practices have 10 offices through out the state. Benefits include those provided at the offices and at the DuPont Hospital for Children. Approximate enrollment- 3,000 uninsured kids (program also serves Medicaid population and those with insurance).	

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
FL	Ages 0-1 up to 185% FPL and ages 13-20 up to 100% FPL get Medicaid benefits.	Healthy Kids Corporation provides comprehensive care for kids 1-19 by offering insurance to children and families through schools. Funded by state, local funds. Recipient cost share imposed. Sample sliding scale premiums: up to 130% FPL- either $5 or $10; between 131%-185% - either $15 or $25; over 185% - either $45 or $50. Premiums lower in rural areas. Approximate enrollment 26,000. [4]			Provide $15.5 million to expand the Healthy Kids program by covering an additional 60,000 kids.
GA	Ages 0-1 up to 185% FPL and ages 13-19 up to 100% FPL get Medicaid benefits. Pending 1115 waiver will provide primary and preventive care to kids 1-6 between 133-185% FPL.			Caring Program covers ages 1-18 up to 150% of FPL. Approximate enrollment - 1,065.	
HI	Quest (Waiver) Ages 0-19 up to 300% FPL get Medicaid benefits through managed care. Benefits are at no cost for ages 0-1 up to 185% FPL, 1-6 up to 133% and 6-13 up to 100%. Those above these income levels must pay full premium.				
ID				Caring Program covers ages 0-18 up to 150% of FPL. Approximate enrollment- 470.	
IN	Ages 0-1 up to 150% FPL get Medicaid benefits.				
IA	Ages 0-1 up to 185% FPL get Medicaid benefits.		Caring Program covers ages 0-18 up to 133% of FPL. State appropriates $75,000/yr. Approximate enrollment- 1,784.		

[4] Robert Wood Johnson is funding an expansion of the Florida model to 7 other states. The RFP was sent out in May, recipients will be notified in November 1997.

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
KS	Ages 0-1 up to 150% FPL and 13-17 up to 100% of FPL get Medicaid benefits.		Caring Program- 0-18 up to 133% of FPL get limited benefits. Only program with co-sponsors, the Kansas Medical Society and the Kansas Hospital Association. State appropriates $250,000/yr. Approximate enrollment- 2,584.		
KY	Ages 0-1 up to 185% FPL, and 13-19 up to 100% FPL get Medicaid benefits. Amended waiver approved and soon to be implemented will provide benefits through managed care (any savings may be used for further expansion).				
LA				Caring Program covers ages 0-18 up to 100% of FPL. Approximate enrollment - 375.	
ME	Ages 0-1 up to 185% FPL and 6-19 up to 125% FPL get Medicaid benefits.				
MD	Ages 0-1 up to 185% FPL get Medicaid benefits. Ages 1-6 between 133%-185% FPL and 6-13 between 100%-185% get prescriptions, vision, primary and preventive care.			Caring Program covers ages 1-18 up to 135% FPL. Approximate enrollment - 1,400.	
MA	Current benefits- Ages 0-1 up to 185% FPL get Medicaid benefits. In July 97 MassHealth will expand Medicaid benefits to ages 0-18 up to 133% FPL. (1996 bill authorizing this allows the state to further expand Medicaid benefits to ages 0-12 up to 200% FPL. Ages 13-18 between 133-200% get partial benefits.)	The Children's Medical Security Plan, (CMSP) covers kids not eligible for Medicaid - ages 0-18 get preventive and primary care benefits - no hospitalization. Up to 200% FPL no cost share; between 201%-400% pay $10.50/mo per child capped at $31.50/mo and above 400% FPL pay full cost of $52.50/mo. Funded by tobacco tax. Approximate enrollment- 27,000.		Caring Program was covering ages 0-18 up to 200% FPL. Now that the state is covering this population- program in the process of revision. Plan is to cover benefits beyond that offered under the CMSP, namely vision and dental benefits. These will be offered in 6-8 communities most in need. Number of children covered will depend on available private funding.	Expand coverage under the Children's Medical Security Plan to an additional 13,000 uninsured children and adolescents. Expand Medicaid coverage to an additional 50,000 children and adults.
MI	Ages 0-1 up to 185% FPL and 1-16 up to 150% of FPL get Medicaid services.		Caring Program covers ages 1-18 up to 185% FPL. State appropriates $1 million. Approximate enrollment- 4,654.		

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
MN	MinnesotaCare (1115 waiver) ages 0-21 get Medicaid benefits through managed care. Premium paid on sliding scale fee, those between 150-275% FPL. Up to 150% FPL pay $4/person/mo.				
MO	Ages 0-1 up to 185% FPL and 13-19 up to 100% FPL get Medicaid benefits.			Caring Program covers ages 0-18 up to 150% of FPL. Approximate enrollment - 5,045.	Establish a nonprofit corporation to subsidize health insurance premiums for uninsured children. Premiums based on a sliding scale fee according to a family's income level. The corporation will seek bids from insurers or HMOs to provide benefits on a statewide or regional basis. State will appropriate funding for initial start-up; thereafter to rely on funding from any public or private source.
MS				Caring Program covers ages 13-19 up to 133% FPL. Approximate enrollment - 860.	
MT			Caring Program covers ages 0-18 up to 150% FPL. State appropriates $100,000. Approximate enrollment - 1,438.		
NE	Ages 0-1 up to 150% FPL get Medicaid benefits				
NH	Ages 0-19 up to 185% FPL get Medicaid benefits.			Healthy Kids Program- 3mos- high school graduation between 185-250% FPL get preventive and primary care benefits including dental, vision, hearing and mental health care. Premiums paid by parents- $77/mo for kids below 2; $67/mo for kids 2 and over. BC/BS administers the plan at no cost. Pilot program in 6 counties to provide benefits at half the premium cost. Approximate enrollment- 1,600.[5]	

[5] While the program initially received a state appropriation of $240,000 in 1994 for start-up costs, it is expected to be self-supporting.

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
NJ	Ages 0-1 up to 185% FPL get Medicaid benefits.	Health Access New Jersey provides comprehensive benefits for ages 0-64 up to 250% FPL. Cost sharing is imposed. Ind. must not have had access to employer based insurance for the past 12 months. The 1997 General Fund allocation is $25 million. Approximate enrollment-17,559.			Appropriate $5 million in seed money for Children First Program. Kids in families up to 250% FPL who are not eligible for Medicaid or other health insurance would get comprehensive coverage at reduced premiums. Insurers and corporations to contribute funding.
NM	Ages 0-19 up to 185% FPL get Medicaid benefits.				
NY	Ages 0-1 up to 185% FPL get Medicaid benefits.	Child Health Plus Program - Ages 0-19 up to 120% FPL get comprehensive benefits through managed care. Between 120-159% FPL pay $9/child/mo capped at $36/mo, and between 160-222% pay $13/child/mo capped at $52/mo. Above 222% recipients pay full cost. Approximate enrollment - 110,500. Expected to be 160,000 by Dec. 1997. FY 97 funding- $109 million.; FY 98- $150M; FY 99- $207 M.[6]			
NC	Ages 0-1 up to 185% FPL and 13-19 up to 100% FPL get Medicaid benefits.			Caring Program covers ages 1-19 up to 185% of FPL. Approximate enrollment - 5,500.	
ND	Ages 13-18 up to 100% FPL get Medicaid benefits.			Caring Program covers ages 0-18 up to 150% of FPL. Approximate enrollment - 480.	
OH	OhioCare (1115 waiver)-All ages below 100% FPL get basic benefits, drug treatment and mental health coverage under managed care (program currently delayed).			Caring Program covers ages 16-18 up to 133% FPL. Approximate enrollment - 3,493.	Expand Medicaid eligibility for children up to age 18 at or below 150% FPL. Part of the funding is from savings from moving Medicaid recipients into managed care. An additional 96,000 children are expected to be covered.

[6] 1996 law expands the program by adding inpatient benefits (previously only primary care benefits) and expanding eligibility to up to age 19. The state is now seeking RFPs to provide insurance coverage through a managed care product. Hope to have the program in place by May 1997. Previously funded through Bad Debt and Charity Pool, 1996 law provides funding through the Health Care Initiatives Pool. Funding for the pool is from a variety of sources including private payor and Medicaid surcharges on net patient revenues, insurer assessments on covered lives, and hospital taxes.

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
OR	Ages 13-19 up to 100% FPL get benefits according to prioritized list.				Expand Medicaid coverage to kids up to age 6 and pregnant women up to 185% FPL.
PA	Ages 0-1 up to 185% FPL get Medicaid benefits.		Children's Health Insurance Program (CHIP) operates in 3 different regions. All 3 provide comprehensive benefits for ages 1-17 up to 185% FPL. Cost sharing for ages 0-5 from 186-235% FPL. Funded with tobacco tax. BC/BS Foundation subsidizes administrative and outreach costs. Approximate enrollment - 50,879.	Caring Programs expands on CHIP programs in 2 of the 3 regions: Ages 17-19 up to 185% FPL- fully subsidized, ages 6-19 up to 235%FPL- cost sharing required. Approximate enrollment - 7,437. [7]	Expand CHIP program to an additional 3,000 kids by dedicating an additional one cent of the cigarette tax.
RI	RiteCare (1115 waiver) currently 0-8 up to 185% FPL get primary and preventive care, dental care and mental health under managed care. Between 185-250% cost sharing imposed. 1996 law increases eligibility to 18 pending approval of amendment to waiver.				
SC	Currently ages 0-1 up to 185% FPL get Medicaid benefits. Under waiver still not implemented 0-18 up to 133% FPL get Medicaid benefits under managed care.				Expand Medicaid to ages 6-18 up to 133% FPL. Funding sources are the state's public teaching hospitals ($3 million), Dept. of Health and Human Services ($1 million) appropriations from the legislature ($2.4 million) and federal matching funds to provide $21.6 million for an additional 50,000 kids.
SD	Ages 13-19 up to 100% FPL get Medicaid benefits.			Caring Program covers ages 6-18 up to 133% FPL. Approximate enrollment - 348.	
TN	TennCare (1115 waiver) Ages 0-1 up to 185% FPL, get Medicaid benefits through managed care. Cost sharing imposed for those not Medicaid eligible up to 400% FPL. Kids up to 100% FPL get Medicaid benefits under managed care. Above 100% cost share is imposed.				Effective April 1, 1997 TennCare enrollment open to residents under age 18 (enrollment had been limited since 1995 to the uninsurable and those who would have qualified under standard Medicaid rules). Coverage free to those up to the FPL and offered on a sliding scale to those above.

[7] The Western program is being expanded to allow those above 250% of FPL to get benefits at cost (about $95/child/mo).

STATE	FEDERAL/STATE	STATE ONLY	PUBLIC/PRIVATE	PRIVATE	PROPOSALS/ENACTMENTS
UT	Ages 13-17 up to 100% FPL get Medicaid benefits.			Caring Program covers ages 0-18 up to 150% FPL. Approximate enrollment - 1,102.	
VT	Ages 0-18 up to 225% FPL get Medicaid benefits. 1996 law imposes a $10 premium between 185-225% FPL.				
VA	Ages 13-19 up to 100% FPL get Medicaid benefits. Waiver sought kids 1-5 between 133-200% FPL to get Medicaid benefits.				Enacted Chapter 679 expands Medicaid coverage for children up to age 18 up to 200% FPL. Funding consist of revenues generated by any increased license taxes assessed against direct gross subscriber fee income derived from subscription contracts issued to primary small group insurers in compliance. The Fund may also receive any employer contributions which may be solicited or required by the Department of Medical Assistance Services, and grants, donations, and bequests from public and private sources. Effective date is July 1, 1998. By Dec. 1, 1997 the Department of Medical Assistance must develop a proposal for implementation to include: 1) the services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan; 2) the provision of services through a network of providers; 3) development of public/private partnerships; 4) how to phase in coverage over a period of five years for those between 200-300% FPL; and 5) alternatives for obtaining employer contributions.
WA	Ages 0-19 up to 200% FPL get Medicaid benefits.				Appropriates $114 million to cover an additional 20,000 families under the Basic Health Plan by 1999.
WV	Ages 0-1 up to 150% and 13-19 up to 100% FPL get Medicaid benefits.				
WY				Caring Program covers ages 0-19 up to 120% FPL. Approximate enrollment - 432.	

Sources: Alpha Center, *State Subsidized Insurance for Low-Income People;* American Academy of Pediatrics, *Access- State Health Insurance Programs*; Caring For Children Foundation of Texas, *Caring Program Summary - Third Quarter,1996*; National Governor's Association, *State Medicaid Coverage of Pregnant Women and Children- Summer 1996*; Health Policy Tracking Service at the National Conference of State Legislatures and conversations with state agencies and private programs.

Note - Since this charts details enacted laws, some of the programs listed may not be fully implemented, or may have limited enrollment.

Testimony Submitted by the Pipe Tobacco Council, Inc.

The Pipe Tobacco Council appreciates the opportunity to submit testimony for this hearing. The Council consists of 12 manufacturers and importers of pipe tobacco, who represent 98% of the pipe tobacco sold in the United States, and 5 associate members who are suppliers to the industry. Our members have facilities in Illinois, Virginia, Kentucky, Pennsylvania, North Carolina, and Georgia, and purchase tobacco leaf grown in 10 states. Many of our members run primarily family-owned businesses which have manufactured smoking tobacco for generations.

Pipe tobacco sales in the United States have been declining in unit volume for many years. In 1970, an estimated 52 million pounds of pipe tobacco were sold. In 1990, 12.4 million pounds were sold. In 1996, sales were expected to reach only 7.5 million pounds. Sales have declined 85.6 % since 1970.

Nearly 90% of all pipe smokers are white males, and almost half are over the age of 46. Our best data indicates that the 3 million pipe smokers in the United States account for a mere 3.3% of the total male population over age 21. Sixty percent of them are currently married, and almost half attended college or received a college degree. In terms of occupation, most pipe smokers are employed in the clerical, sales, and repair fields. Seventy percent of pipe smokers earned less than $50,000 in 1994; 40% earned less than $30,000.

We want to emphasize that we are not commenting on legislative initiatives intended to expand health care opportunities for our 10 million uninsured children. We note that the recently announced budget agreement covers 5 million children and does not include an

excise tax. The Pipe Tobacco Council is, however, opposed to funding any expansion through an increased excise tax on pipe tobacco. Indeed, the child health provisions in the budget agreement between the White House and the House and Senate leadership shows that this can be done without an excise tax driving the pipe tobacco companies out of business.

Many supporters of the Kennedy-Hatch legislation support a tobacco tax in hopes that it might reduce the number of teenagers who use tobacco products. The irony is that children don't smoke pipes. The typical pipe smoker is a white male over the age of 50. Many pipe smokers are elderly, retired, and on a fixed income. We believe that it is unfair and misguided to make our consumers, who can least afford it, pay to deter children from using cigarettes.

It also makes no sense to rely on a declining revenue source to fund a new entitlement program for children's health care. The use of tobacco products, including pipe tobacco, has dwindled steadily over the past several decades, and will probably decline even further if large excise taxes are added to their cost. Frequently, when Congress establishes a new entitlement program, it underestimates the number of people who will qualify for benefits. It is critical that the children's health initiative be funded by a stable and predictable revenue source.

We appreciate having this opportunity to contribute to the discussion regarding children's health proposals. If you need any additional information, please contact Norm Sharp,

ISBN 0-16-057647-4