1998

SENATE COMMITTEE OF THE WHOLE- SPECIAL SESSION ON CHILDREN'S HEALTH INSURANCE

MINUTES

State of North Carolina

JAMES B. HUNT JR.
GOVERNOR

PROCLAMATION

WHEREAS, there are more than 71,000 uninsured children in North Carolina whose parents make too much to qualify for Medicaid but cannot afford to purchase health insurance for their children; and

WHEREAS, children who do not receive proper medical care have more trouble staying healthy enough to attend school and often have trouble learning when they are in school; and

WHEREAS, under Title XXI of the Social Security Act, North Carolina now has the opportunity to receive $79.9 million in federal money in order to provide health care for children; and

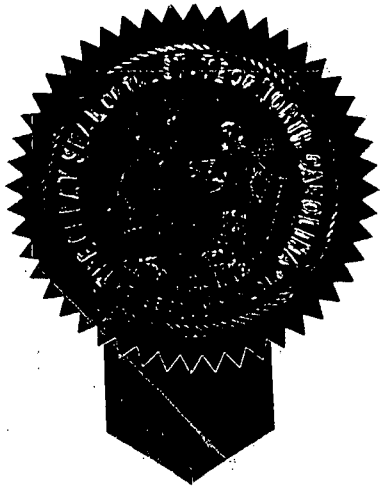
WHEREAS, to meet federal deadlines, North Carolina must adopt by legislation its state plan and needs to submit the plan to the Health Care Financing Agency; and

WHEREAS, the Children's Health Insurance Plan is designed to comply with federal requirements and provide the health insurance coverage described herein.

NOW, THEREFORE, I, James B. Hunt Jr., Governor of the State of North Carolina, pursuant to the authority granted to me by Article III, Sec. 5(7) of the Constitution of North Carolina, find that the circumstances stated above constitute an extraordinary occasion within the meaning of Article III, Sec. 5(7) of the Constitution of North Carolina and PROCLAIM that the General Assembly is hereby convened in an extra session for the purpose of considering the adoption of a state plan in accordance with the above.

This extra session shall begin the 24th day of March 1998 at 12:00 p.m. and shall continue as provided by law and the rules of each House until both Houses shall have adjourned sine die.

Done in Raleigh, North Carolina, this the 27th day of February, 1998.



James B. Hunt Jr.
Governor

MAR 2 1998

N C GENERAL ASSEMBLY - SENATE - 1998 SPECIAL SESSION
SENATOR - TELEPHONE - OFFICE

NAME	TELEPHONE	OFFICE
Charlie W. Albertson	733-5705	525 LOB
Austin M. Allran	733-5876	516 LOB
Frank W. Ballance, Jr.	715-3032	523 LOB
Patrick J. Ballantine	733-5856	519 LOB
Marc Basnight	733-6854	2007 LB
John Blust	733-7850	1117 LB
Robert C. Carpenter	733-5875	517 LOB
John H. Carrington	733-5653	515 LOB
R L Clark	733-5742	1118 LB
Betsy L. Cochrane	715-2525	1127 LB
Roy A. Cooper, III	733-5664	2117 LB
Walter H. Dalton	733-5880	2113 LB
Charlie S. Dannelly	733-5955	2106 LB
Don W. East	733-5655	521 LOB
James S. Forrester	733-5708	1121 LB
Virginia Foxx	733-5743	1120 LB
John A. Garwood	715-0706	1419 LB
Wib Gulley	715-3036	408 LOB
Fletcher L. Hartsell, Jr.	733-7223	518 LOB
Hamilton C, Horton, Jr.	733-3272	1406 LB
David W. Hoyle	733-5734	300A LOB
Thomas K. Jenkins	733-6275	622 LOB
Luther Henry Jordan, Jr.	735-3034	407 LOB
John H. Kerr, III	733-5621	526 LOB
Eleanor Kinnaird	733-5804	2115 LB
Jesse Ingram Ledbetter	733-5748	520 LOB
Howard N. Lee	715-3030	406 LOB
Jeanne Hopkins Lucas	733-4599	620 LOB
R. L. Martin	715-3040	410 LOB
William N. Martin	715-3042	411 LOB
J. Mark McDaniel, Jr.	733-5620	522 LOB
Brad Miller	733-9349	621 LOB
Kenneth R. Moore	733-5745	1119 LB
T. L. Odom	733-5707	300B LOB
Dan Page	733-7659	1414 LB
Beverly M. Perdue	733-2055	629 LOB
Jim W. Phillips, Sr.	733-5870	628 LOB
Aaron W. Plyler	733-5739	627 LOB
William R. Purcell	715-0690	2117 LB
Anthony E. Rand	733-9892	300C LOB
Eric Miller Reeves	733-3460	2111 LB
Robert A. Rucho	733-5650	1113 LB
Larry Shaw	733-4809	625 LOB
Robert G. Shaw	715-3050	1129 LB
R. C. Soles, Jr.	733-5963	2022 LB
Ed Warren	733-5953	623 LOB
Hugh Webster	733-5665	1101 LB
David F. Weinstein	733-5651	2108 LB
Allen H. Wellons	733-5850	1026 LB
Leslie Winner	715-3038	409 LOB

North Carolina Senate
Committee of the Whole

Agenda
March 24, 1998

I. Presentation of SB 2

-- Sen. Tony Rand

II. Staff Discussion of SB 2

-- Carol Shaw, Fiscal Research Division

-- Gann Watson, Bill Drafting

III. DHHS Discussion of SB 2

-- Secretary David Bruton

IV. Committee Discussion

V. Committee Vote on SB 2

VI. Adjournment of Committee of the Whole

MINUTES

COMMITTEE OF THE WHOLE
Tuesday, March 24, 1998, 12:30 p.m.
Senate Chamber

The Senate met as a Committee of the Whole on Tuesday, March 24, 1998, at 12:30 p.m. in the Senate Chamber to consider Senate Bill 2, introduced to establish and fund the State Children's Health Insurance Program. All Senators were present.

Senator Marc Basnight presided. He introduced Dr. David Bruton, Secretary of the Department of Health and Human Services, to explain the bill. Dr. Bruton provided a summary handout of the bill (see Attachment 1) and summarized the provisions for the Committee.

Senator Rand spoke in support of the bill. Several Senators asked questions about the provisions of the legislation. Dr. Bruton introduced Mr. Paul Perruzzi, Director of the Division of Medical Assistance, who answered technical questions about the proposed program, the Child Health Insurance Task Force Report (see Attachment 2) and Medicaid.

After all Senators' questions had been heard and answered, and all Senators had the opportunity to make comments on the bill, Senator Rand moved a favorable report of Senate Bill 2. The motion carried.

The meeting adjourned at 2:30 p.m.

Senator Marc Basnight
Chair

Dot Waugaman, Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

COMMITTEE OF THE WHOLE COMMITTEE REPORT
Senator Marc Basnight, Chairman

Tuesday, March 24, 1998

SENATOR RAND,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **2** State CHIP.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: Sen. Rand to sign.

GENERAL ASSEMBLY OF NORTH CAROLINA

EXTRA SESSION 1998

SENATE

MAR 2 4 1998

PRINCIPAL CLERK

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SENATE DRS7880*-LN169A1(3.6)

Short Title: State CHIP. (Public)

Sponsors: Senator Rand.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 108A of the General Statutes is amended by adding the following new Part to read:

"Part 8. Children's Health Insurance Program.

"**§ 108A-70.18. Short title; purpose; no entitlement.**

This Part may be cited as the Children's Health Insurance Program Act of 1998. The purpose of this Part is to provide comprehensive health insurance coverage to uninsured low-income children who are residents of this State. Coverage shall be provided from State and federal funds appropriated and other funds made available for this purpose. Nothing in this Part shall be construed as obligating the General Assembly to appropriate funds for the Program or as entitling any person to coverage under the Program.

"**§ 108A-70.19. Program established.**

There is established the Children's Health Insurance Program. The Program shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI, and related federal rules and regulations. Claims processing, benefits administration, and eligibility determination processes for the Program shall be as provided under the Medical Assistance Program. The Department may authorize coverage under the Program to be provided by private insurers so long as the private coverage meets the requirements for coverage under the Program and under Title XXI, and the cost of the private coverage is equal to or less than the cost of equivalent coverage under the Program.

"**§ 108A-70.20. Definitions.**

Unless the context clearly requires otherwise, the term:

(1) 'Comprehensive health coverage' means creditable health coverage as defined under Title XXI.

(2) 'Family income' has the same meaning as used in determining eligibility for the Medical Assistance Program.

(3) 'FPL' or 'federal poverty level' means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) 'Medical Assistance Program' means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

(5) 'Program' means the children's health insurance program established in this Part.

(6) 'State Plan' means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(7) 'Title XXI' means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C. (1997).

(8) 'Uninsured' means the applicant for Program benefits is not covered under any private or employer-sponsored comprehensive health insurance plan at the time of application.

"**§ 108A-70.21. Program eligibility; benefits; cost-sharing; appeals.**

(a) Eligibility. -- The Department may enroll eligible children based on availability of funds. In order to be eligible for benefits under the Program, children must:

(1) Be under the age of 19;

(2) Be ineligible for Medicaid, Medicare, or other government-sponsored health insurance;

(3) Be uninsured;

(4) Be in a family that meets the following family income requirements, without regard to assets:

a. Infants under the age of one year whose family income is from one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level;

b. Children age one year through five years whose family income is from one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal poverty level; and

c. Children age six years through eighteen years whose family income is from one hundred percent (100%) through two hundred percent (200%) of the federal poverty level; and

(5) Be a resident of this State or otherwise eligible under federal law.

Proof of family income and residency and a declaration of uninsured status shall be provided by the applicant.

Enrollment shall become effective beginning in the month in which the application is received and shall be effective for one year. Applicants may reapply for enrollment at the end of each year. If during the period of enrollment an enrollee fails to meet the requirements of subdivision (1), (2), (3), (4), or (5) of this subsection due to a change in status, the enrollee shall be ineligible for further coverage and shall be disenrolled from the Program. The family member who is legally responsible for the children enrolled in the Program has a duty to report any change in an enrollee's status within 60 days of the change of status.

(b) Benefits. -- Health benefits coverage provided to children eligible under the Program shall be the same as authorized under the Medical Assistance Program in the Current Operations Appropriations Act. Except as otherwise provided in this Part, terms, conditions, and limitations on Program benefits shall be the same as apply under the Medical Assistance Program.

(c) Cost-sharing. -- There shall be no premiums charged to Program participants. There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is at or below one hundred fifty percent (150%) of the federal poverty level. Families covered under the Program whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Three dollars ($3.00) per child for each physician visit, clinic visit, dental visit, and optometry visit, except that no copayment shall be required for preventive services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) Three dollars ($3.00) for each brand name prescription filled;

(4) Twenty dollars ($20.00) for emergency room services for nonemergency care. As used in this subsection, 'nonemergency care' shall consist of diagnoses not meeting the definition of 'true emergency' under the Carolina Access Program.

The total annual aggregate cost-sharing with respect to all children in a family receiving Program benefits under this Part shall not exceed five percent (5%) of the family's income for the year involved.

(d) Appeals. -- Applicants for and participants in the Program who are dissatisfied with the actions of a county or State agency pertaining to eligibility for and benefits under the Program may appeal the action in accordance with procedures established for the Medical Assistance Program pursuant to G.S. 108A-79 and applicable federal regulations. To the extent the process for appeal under G.S. 108A-79 is inconsistent with appeals under Chapter 150B of the General Statutes, the process under G.S. 108A-79 shall control.

"**§ 108A-70.22. Application for enrollment; outreach.**

(a) The Department shall develop an application form and enrollment process that makes application for and enrollment in the Program as simple, accessible, and efficient as possible.

(b) The Department shall conduct outreach activities statewide that will effectively provide information about the Program and will encourage potential participants to inquire and apply for enrollment. The outreach activities shall be targeted toward families likely to be eligible for benefits under the Children's Health Insurance Program or other health coverage programs to explain the eligibility requirements and benefits available. The Department may seek private and federal grant funds to conduct outreach activities. The Department may work with the State Health Plan Purchasing Alliance Board to develop programs that utilize the expertise and resources of the Alliances in outreach activities to employees of small businesses.

"**§ 108A-70.23. State Plan for Children's Health Insurance Program.**

The Department shall develop and submit a State Plan to implement the Child Health Insurance Program authorized under this Part to the federal government as application for federal funds under Title XXI. The Department shall report to the Joint Legislative Health Care Oversight Committee amendments to the State Plan for the Committee's review.

"**§ 108A-70.24. Data collection; reporting.**

(a) The Department shall establish procedures for the collection and analysis of data pertinent to the implementation and continuing evaluation of the Program.

(b) The Department shall report on October 1 of each year, and more frequently if requested, to the Joint Legislative Health Care Oversight Committee on the implementation of the Program. The report shall include, but is not limited to, the following:

(1) Number of children enrolled in the Program;

(2) Program areas that are working well and those that need improvement;

(3) Recommendations on ways to improve the efficiency and effectiveness of the Program; and

(4) Any other items requested by the Joint Legislative Health Care Oversight Committee.

The Department shall provide a copy of the report to the Joint Appropriations Subcommittee on Health and Human Services.

"**§ 108A-70.25. Fraudulent misrepresentation.**

(a) It shall be unlawful for any person to knowingly and willfully, and with intent to defraud, make or cause to be made a false statement or representation of a material fact in an application for coverage under this Part or intended for use in determining eligibility for coverage.

(b) It shall be unlawful for any applicant, participant, or person acting on behalf of the applicant or participant to knowingly and willfully, and with intent to defraud, conceal or fail to disclose any condition, fact, or event affecting the applicant's or participant's initial or continued eligibility to receive coverage under this Part.

(c) It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a participant under this Part, or otherwise to deliberately

misuse a Program identification card. This misuse includes the sale, alteration, or lending of the Program identification card to others for services and the use of the card by someone other than the participant to receive or attempt to receive Program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

(d) A person who violates a provision of this section shall be guilty of a Class I felony if the value of the coverage wrongfully obtained is more than four hundred dollars ($400.00). A person who violates a provision of this section shall be guilty of a Class 1 misdemeanor if the value of the coverage wrongfully obtained is four hundred dollars ($400.00) or less.

(e) For purposes of this section, the word 'person' includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization."

Section 2. G.S. 120-70.111 reads as rewritten:

"**§ 120-70.111. Purpose and powers of Committee.**

(a) The Joint Legislative Health Care Oversight Committee shall review, on a continuing basis, the provision of health care and health care coverage to the citizens of this State, in order to make ongoing recommendations to the General Assembly on ways to improve health care for North ~~Carolinas~~ Carolinians. To this end, the Committee shall study the delivery, availability, and cost of health care in North Carolina. The Committee shall also review, on a continuing basis, the implementation of the State Children's Health Insurance Program established under Part 8 of Article 2 of Chapter 108A of the General Statutes. The Committee may also study other matters related to health care and health care coverage in this State.

(b) The Committee may make interim reports to the General Assembly on matters for which it may report to a regular session of the General Assembly. A report to the General Assembly may contain any legislation needed to implement a recommendation of the Committee."

Section 3. G.S. 143-626(2) reads as rewritten:

"(2) Accept applications by carriers to qualify as Accountable Health Carriers, determine the eligibility of carriers to become Accountable Health Carriers according to criteria described in G.S. 143-629, designate carriers as Accountable Health Carriers, ~~and~~ approve one additional qualified health care plan to be offered to small employers beyond the basic and standard health care ~~plans.~~ plans, and approve programs that provide options for the purchase of private insurance for dependent coverage that meets the requirements of the Children's Health Insurance Program established under Part 8 of Article 2 of Chapter 108A of the General Statutes and Title XXI of the Social Security Act."

Section 4. (a) There is appropriated from the General Fund to the Department of Health and Human Services the sum of fourteen million nine hundred eighty-four thousand four hundred forty-seven dollars ($14,984,447) in recurring

funds for the 1998-99 fiscal year to be used for the Children's Health Insurance Program established under this act and under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552. The Office of State Budget and Management shall establish a Contingency Reserve for fiscal year 1998-99 and shall deposit into the Reserve ten percent (10%) of the funds appropriated under this section. Funds in the Reserve shall be used for unanticipated start-up, enrollment, and services costs occurring during the first year of Program implementation. The Office of State Budget and Management shall include in the proposed continuation budget the amount of State funds necessary for Program implementation for the budgeted fiscal year but not more than the amount necessary to draw down the maximum amount of federal funds available to the State for the budgeted fiscal year for the Children's Health Insurance Program under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

(b) Of the funds appropriated under subsection (a) of this section, the Department may use up to two million dollars ($2,000,000) to cover unmatched start-up costs for the Children's Health Insurance Program established under this act.

(c) Funds appropriated under this section and not expended or obligated in the 1998-99 fiscal year shall revert to the General Fund on June 30, 1999.

(d) No State funds appropriated under this act may be expended for any purpose other than implementation of the State Children's Health Insurance Program established under this act and approved by the United States Secretary of Health and Human Services under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

Section 5. Section 4 of this act becomes effective July 1, 1998. Health insurance coverage provided to children under the Children's Health Insurance Program established in this act shall become effective no earlier than October 1, 1998. The remainder of this act is effective when it becomes law.

ATTACHMENT 1

BILL SUMMARY
98-LN-169A1(3.6)
STATE CHILDREN'S HEALTH INSURANCE PROGRAM
March 24,1998

Element		Bill pg.#
Short Title:	Children's Health Insurance Program Act of 1998	1
Purpose:	Provide comprehensive health insurance to low-income children who are residents of North Carolina	1
	No entitlement	1
Admin:	Program administered by DHHS. Benefits administered as under Medicaid	1
Eligibility:	Enrollment based on available funds	2
	Children under age 19	2
	Ineligible for Medicaid, Medicare	2
	Uninsured at time of application	2
	Family income 200% FPL	2
	Resident of NC or otherwise eligible under federal law	2
	Enrollment effective for 1 year; applicant may reapply	3
Benefits	Same level as authorized under Medicaid.	3
Premiums	None	3
Cost-share	None under 150% FPL.	3
	Above 150%FPL:	
	$3/per child/Physician, dentist, optometrist visit; no cost-share for preventive services.	3
	$5/per child/each outpatient hospital visit	3
	$3/each brand-name prescription drug	3
	$20 ER visit for non-emergency care	3
	Total annual aggregate cost sharing may not exceed 5% of family income.	3
Appeals	Same as under Medical Assistance Program	3
Application	DHHS develops simple application form/process.	3-4
Outreach	DHHS conducts outreach statewide	4
State Plan	DHHS develops and submits as provided by law.	4
	Proposed amendments reviewed by Joint Legislative Health Care Oversight	4

Item		Page/Line
Data Coll.	DHHS collects data and reports to Health Care Oversight	4
Fraud	Penalty for fraudulent misrepresentation same as for Medicaid/food stamp fraud	4-5
GA O'sight	Jt. Legislative Health Care Oversight Committee reviews Program implementation	5
SHPPA	Authorize plan participation by State Health Plan Purchasing Alliances	5
Funds	$14,984,447 in recurring funds for implementation and start-up. Use and budgeting of funds restricted. $2,000,000 for start-up $10% in 1-year Reserve for unanticipated expenses	5-6
	Unexpended funds revert on June 30, 1998.	6
	Dept. may not use funds for anything but CHIP.	6
Effective	Funds eff. 7/1/98. Insurance coverage begins 10/1/98. Act effective upon becoming law.	6

Dot Waugaman

North Carolina
Department of Health and Human Services
Division of Women's and Children's Health
1330 St. Mary's Street • Post Office Box 29597 • Raleigh, North Carolina 27626-0597
Courier 52-01-00

James B. Hunt Jr., Governor
H. David Bruton, M.D., Secretary

Ann F. Wolfe, M.D., M.P.H., Director

November 21, 1997

MEMORANDUM

To: Child Health Insurance Task Force Participants

From: Gordon DeFriese, Ph.D. Gordon
Tom Vitaglione Tom V

Re: Task Force Report

Enclosed is the final report of the Task Force that has been submitted to Secretary David Bruton for his consideration and decision-making. Despite news reports you may have seen, Secretary Bruton continues to revise and refine his recommendations based upon the report. Legislative review of his final recommendations will begin during December.

We appreciate the comments that several of you submitted regarding the prior draft. Most comments have been incorporated into the enclosed report. (You will note, however, that there are no changes of substance between the draft and the report.) As promised, any separate letters of support or concern that we receive are also being submitted to the Secretary.

As this process comes to a close, we want to thank you sincerely for your participation on the Task Force. Your hard work and prayerful thought are reflected in the report. Your reward is the thousands of children who will have access to health insurance based on your efforts.

TV/nl

$65.88/mo

$72.80

FINAL REPORT
OF THE
TASK FORCE ON CHILD HEALTH INSURANCE
TO THE
SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

November, 1997

BACKGROUND

In June, 1997, the Secretary of the North Carolina Department of Health and Human Services, the Honorable H. David Bruton, charged the North Carolina Institute of Medicine and the Division of Women's and Children's Health to form a Task Force on Child Health Insurance.[1] The Task Force, chaired by Dr. Gordon H. DeFriese, President of the Institute of Medicine, included representatives of organizations and constituencies around the state having an interest in child health issues (See Appendix A for Task Force listing).[2] The Task Force met six times between the middle of June and the end of October, while subcommittees held additional meetings to deliberate on specific issues.

The work of the Task Force took on more urgency with the passage of the Child Health Insurance Program as part of the Balanced Budget Act of 1997. The number of constituencies represented on the Task Force increased substantially over the course of the meetings, and included representatives of state and local governmental agencies, private health care providers,

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[1] Prior to the Secretary's charge to the N.C. Institute of Medicine, there were two private initiatives to expand health insurance coverage to uninsured children. The N.C. Caring Program, a private-public partnership with Blue Cross Blue Shield, has been operational for ten years. The Caring Program receives approximately $1.0 million each year from the N.C. General Assembly along with private contributions which enables the program to cover approximately 7,000 children with a low-cost limited primary care benefits package. Healthy Kids of North Carolina, Inc. was a separate non-profit initiative aimed at providing low -cost health insurance coverage to children eligible for the free or reduced lunch programs. Healthy Kids, a coalition of consumers, providers and managed care organizations, approached the N.C. Division of Women's and Children's Health to encourage them to apply for a Robert Wood Johnson Foundation grant to replicate the Florida Healthy Kids demonstration program in North Carolina. The group pulled together for the Robert Wood Johnson proposal grew into the Secretary's Task Force.

[2] The Task Force on Child Health Insurance wishes to express its gratitude to Pam Silberman, J.D., Dr.P.H. of the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, and to Tom Vitaglione, MPH, Chief, Children and Youth Section, Division of Women's and Children's Health, North Carolina Department of Health and Human Services, for their staff assistance during the process through which this report was prepared. The Task Force is also grateful to Thomas C. Ricketts, III, Ph.D., Deputy Director for Policy Analysis, and Ms. Ann Howard, Systems Analyst, of the Sheps Center at UNC-Chapel Hill and to Christopher Conover, Ph.D., of the Center for Health Policy, Law and Management at Duke University for their expert and timely analysis of state and federal data pertinent to the number of uninsured children in this state. The Task Force also wishes to thank Aimee Briggs, J.D., Jean Hetherington, J.D., MPH, and Gus Papas, M.D., students at the School of Public Health at UNC-Chapel Hill, for their assistance in providing some of the research used for the Task Force deliberations.

health insurers, managed care organizations, academic health centers, and child advocacy organizations. Although no formal "votes" were cast, genuine efforts were made to ascertain all points of view, to hear about the child health care activities of all public and private agencies and organizations, and to debate the relative merits of all alternative pathways to provide health insurance coverage for North Carolina's uninsured children.

This report presents the major policy choices facing the state in enacting child health insurance coverage. The information provided in this report will enable policy makers to make expeditious and educated decisions on how to implement the provisions of the new Child Health Insurance Program. The Task Force believes that this is the most opportune time in the past 30 years to take such a bold initiative in the interest of North Carolina's children.

PROGRAM GOALS

The Task Force members agreed that the ultimate goal for the new program is to provide children in North Carolina with access to quality, affordable health care. Therefore, the state should define eligible children broadly to reach as many uninsured children as possible. The program should help increase the utilization of preventive health services in order to improve the general health status of children and reduce program costs over the long term. The program should be "seamless" and allow families to participate easily. Adequate information and counseling should be provided so that families understand all their program options, and how to utilize services appropriately. Families should be allowed to enroll all of their children as members of a family unit—therefore, to the extent possible, eligibility and benefits should be consistent for all children in a family and not vary by the age of the child. The program should be built upon the existing state and local infrastructure, so as not to create duplicative administrative structures and higher costs. The new Child Health Insurance Program must include accountability and oversight structures, as well as an evaluation mechanism to assess the effectiveness of the system. Adequate resources should be made available to ensure the success of the program.

OVERVIEW OF THE FEDERAL LEGISLATION

Congress created a new child health insurance block-grant program as part of the Balanced Budget Act of 1997.[3] The program was enacted as Title XXI of the Social Security Act. The federal legislation appropriates $39.6 billion over the next ten years to expand health insurance coverage for uninsured children under age 19 in families with incomes up to 200% of the federal poverty guidelines ($26,600 for a family of three in 1997; this is the equivalent of two workers each earning $6.50/hr.).[4] States are basically given three options: 1) they can

[3] P.L. 105-33.

[4] The legislation authorizes states to cover children up to 200% of the federal poverty guidelines, or 50 percentage points above its current Medicaid income guidelines, whichever is higher. This means that North Carolina could choose to cover infants under age one up to 235% of the federal poverty guidelines (as the state already covers all infants with family incomes up to 185% of the federal poverty guidelines).

expand Medicaid; 2) they can create a new state child health insurance program; or 3) they can implement a combination of both.

Title XXI, like Medicaid, is funded jointly by the federal and state governments. However, states are entitled to an enhanced matching rate under Title XXI to pay for the expanded coverage for children. In North Carolina, the federal government will pay for 74.1% of program costs up to a federal maximum allotment of $79.5 million in FY 1998 (compared to the regular Medicaid matching rate of 63.0%).[5] The state is expected to match the new federal monies.[6] As much as 10% of the federal funds may be used for program administration, outreach efforts, and payment for direct provision of services. If the state chooses to establish a new child health insurance program, it will be limited to the Title XXI federal allotment. However, if the state chooses to expand Medicaid, it may continue to draw down federal monies at the regular Medicaid matching rate if Title XXI enhanced funds are exhausted.

Certain children are ineligible for coverage under the new Title XXI program. States may not use the new money to cover children who presently have private health insurance coverage. Further, states may not use the enhanced federal funds to cover children who are already eligible for Medicaid.[7] In fact, states must screen potential eligibles to determine if they are eligible for Medicaid coverage, and if so, must enroll them in Medicaid. States that choose to establish a new child health insurance program may not use the funds to cover children who are members of a family that is eligible for health benefits coverage under a state health benefits plan, although such limitation does not apply if the state chooses to expand Medicaid coverage.[8]

In order to receive FY 98 federal monies, a state must submit a child health plan to the Secretary of Health and Human Services describing how it will implement the new child health block grant. The plan must describe the state's eligibility standards, the method for delivering services, the benefits package, the outreach plan, and the state's mechanism for monitoring quality and ensuring access. The plan must be approved before September 30, 1998 for the state to receive its 1998 allotment. The state has up to three years to expend each annual allotment of federal funds.

ESTIMATING THE UNINSURED

Low income children, defined as those with family incomes below 200% of the federal poverty guidelines, obtain health insurance coverage through a variety of methods. Some children in North Carolina obtain group health insurance coverage as dependents of working

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[5] The amount of the state's allotment is based on the state's numbers of uninsured children as reported in the Current Population Survey (CPS).

[6] States are expected to match federal Child Health Insurance funds. If the program spent the full $79.5 million in FY 1998, then North Carolina would be expected to provide $27.6 million as the state match. However, the expected expenditures for the first year should be considerably less (see p. 23).

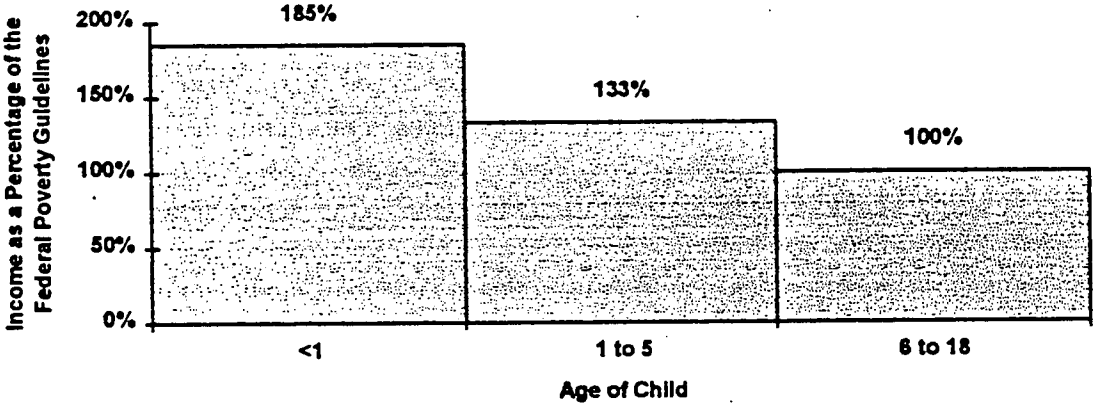
[7] In determining whether the child is eligible for Medicaid, states must use the Medicaid eligibility rules that were in effect in April 5, 1997.

[8] Sec. 2110(b)(2)(B). Children who are inmates of public institutions or patients in mental institutions are also ineligible for coverage.

parents. Some families purchase individual health insurance policies to cover themselves and their children. Other children qualify for publicly-funded programs, like Medicaid or CHAMPUS/VA.

North Carolina's Medicaid program currently covers all infants with family incomes up to 185% of the federal poverty guidelines, children ages one through five with family incomes up to 133% of the federal poverty guidelines, and children ages six through eighteen with family incomes up to 100% of the federal poverty guidelines. (See chart below). This still leaves a large number of uninsured children in families with incomes below 200% of the federal poverty guidelines.

Medicaid Income Guidelines Vary By Age of Child



In North Carolina, there are an estimated 138,743 uninsured children below 200% of the federal poverty guidelines. Of these, 67,401 are estimated to be eligible currently for the Medicaid program and 71,342 would be eligible for the new coverage under Title XXI. There are an estimated 7,800 uninsured children with family incomes below 200% of the federal poverty guidelines who are dependents of state employees.[9]

The basic data source to estimate the numbers of uninsured children in North Carolina is the Current Population Survey (CPS), an annual survey conducted by the U.S. Bureau of the Census. (See next page.) The CPS was chosen as the basic data source because it is the source used by the federal government in determining state allocations under Title XXI. This is the only readily available source of data to estimate the numbers of uninsured children in North Carolina.

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[9] The State Health Benefits Office does not collect data on the numbers of uninsured children who are dependents of state employees or teachers, nor does it collect data on total family income (to determine which state employees or teachers have family incomes below 200% of the federal poverty guidelines). Therefore, the Sheps Center for Health Services Research at UNC-CH used 1996 CPS data for the U.S. South to get an estimate of the numbers of state or local employees with family incomes below 200% of the federal poverty guidelines with uninsured children. The Sheps Center applied this percentage to the total number of N.C. state employees and teachers eligible for the state health benefits plan.

Average Daily Health Insurance Coverage, by Poverty Status
North Carolina

(based on 1995-96 Current Population Survey data, adjusted to 1997 NC Population Projections)[10]

Age Category/ Type of Coverage	Total Children	Family Poverty Status (as percent of Federal Poverty Guidelines) <100%	100-124%	125-149%	150-174%	175-199%	200-399%	400%+
				Average Daily Number				
Under 1	98,439	26,303	12,136	5,948	7,740	4,657	23,664	17,992
Group Coverage	38,861	1,509	2,162	662	5,555	1,902	15,347	11,725
Medicare	-	-	-	-	-	-	-	-
Medicaid	43,144	21,627	9,974	4,660	1,559	1,283	*4,041*	-
CHAMPUS/VA	7,683	678	-	626	626	632	4,275	845
Individual Coverage	1,429	-	-	-	-	-	-	1,429
Uninsured	7,321	2,489	-	-	-	840	-	3,992
1 to 5	510,676	139,311	27,174	33,602	28,291	28,584	154,870	98,843
Group Coverage	257,758	9,196	8,960	15,651	12,661	13,275	112,905	85,110
Medicare	-	-	-	-	-	-	-	-
Medicaid	153,381	106,086	10,958	10,365	5,905	7,566	10,874	1,627
CHAMPUSVA	29,648	2,016	1,749	1,784	6,727	4,613	12,139	619
Individual Coverage	12,293	1,275	1,803	-	2,100	-	2,221	4,894
Uninsured	57,595	20,738	3,704	5,803	898	3,129	16,730	6,593
6 to 18	1,290,676	268,871	52,875	67,351	73,853	62,323	479,429	285,975
Group Coverage	766,376	25,896	30,194	22,675	23,523	40,941	368,446	254,701
Medicare	3,863	-	2,630	-	-	1,233	-	-
Medicaid	239,431	185,007	3,623	15,933	13,679	6,638	14,551	-
CHAMPUS/VA	43,676	2,566	2,920	-	8,854	3,274	20,354	5,708
Individual Coverage	79,333	14,932	1,766	9,920	5,425	2,499	31,651	13,139
Uninsured	157,997	40,470	11,742	18,822	22,372	7,736	44,428	12,427
TOTAL CHILDREN	1,899,791	434,485	92,184	106,901	109,884	95,564	657,963	402,810
Group Coverage	1,062,996	36,601	41,316	38,988	41,738	56,118	496,698	351,536
Medicare	3,863	-	2,630	-	-	1,233	-	-
Medicaid	435,957	312,720	24,555	30,958	21,143	15,487	29,467	1,627
CHAMPUS/VA	81,006	5,260	4,669	2,410	16,207	8,520	36,769	7,172
Individual Coverage	93,054	16,207	3,569	9,920	7,525	2,499	33,871	19,462
Uninsured	222,913	63,697	15,446	24,625	23,270	11,705	61,158	23,012

[10] CPS data have some limitations. First, they are based on relatively small sample sizes in each state. Thus, experts at the Sheps Center for Health Services Research (UNC-CH), the Duke Center for Health Policy, Law and Management, and the State Center for Health Statistics combined 1995 and 1996 CPS numbers to gather more reliable estimates. Second, the CPS data were adjusted to reflect the actual number of children in North Carolina in 1997 (as estimated by the North Carolina Office of State Planning). Finally, CPS historically undercounts the number of children receiving Medicaid (thereby overestimating the numbers of uninsured). The Division of Medical Assistance adjusted the CPS numbers to reflect the true numbers of Medicaid enrollees.

PROBLEMS FACED BY UNINSURED CHILDREN

The lack of health insurance is a substantial barrier for low-income families in obtaining timely and appropriate health care. Children with health insurance are more likely to receive regular and preventive health care (GAO, 1996). Children without health insurance have difficulties in obtaining routine services and are less likely to receive childhood immunizations, one of the key preventive measures (Wood, 1990; Oberg,1990; Himmelstein, 1995). These children are more likely to be seen in an emergency room with more severe illnesses and are less likely to get care for injuries (Overpeck, 1995), to see a physician if chronically ill, or to obtain regular dental care (Monheit, 1992).

The lack of appropriate care can affect a child's health status throughout life. The 1987 National Medical Care Expenditure Survey showed that one-third of the uninsured children with recurring ear infections and half of the uninsured children with asthma never saw a doctor (Agency for Health Care Policy and Research, 1987). Children with recurring ear infections may suffer permanent hearing loss, and children with untreated asthma may endure avoidable hospitalizations. Children with undiagnosed vision problems may be unable to see the blackboard, and children in pain or discomfort may have trouble concentrating in school. The lack of health insurance coverage for children has adversely affected North Carolina's children, as is evidenced by these "real-life" examples below:

> Three-year-old Jane developed an earache one night. Since she was not covered by her parents' insurance, the family chose not to take Jane for medical care. After 3 days the earache subsided. Jane experienced five such episodes over the next 18 months. She was diagnosed with a mild hearing loss when she received her kindergarten health assessment.
>
> Paul was diagnosed with mild cerebral palsy soon after discharge from the newborn nursery. His parents' insurance covered basic medical care, but did not cover special therapies or equipment (such as wheelchairs). Because of their limited income, Paul's parents were unable to pay for these services and equipment out-of-pocket. Five years later, Paul entered school in a stroller. He had a curvature of the spine and joint contractures. The school arranged for special therapies and a wheelchair (to be used only at school). The therapists reported that Paul's disability had progressed too far for therapies to have their maximum positive effect.
>
> Mary was thirteen and having trouble adjusting to high school. Her grades began to slip and she seemed depressed. The school counselor recommended that Mary receive mental health services. Mary's parents had no insurance coverage. They were reluctant to seek "free" services in their community, and decided to seek second jobs to save money to get services for Mary. In the meantime, Mary attempted suicide.

OVERVIEW OF THE CHOICES

Each state faces a number of choices in designing its child health insurance program. These choices include:

- •Basic Program Options
  - •Medicaid Expansion
  - •New Insurance Program
  - •Combination of the Two
- •Administration
  - •Eligibility Determination/Enrollment
  - •Outreach
  - •Benefits Education and Advocacy
- •Benefits Package
- •Cost-Sharing
- •Delivery System
- •Access, Quality Assurance, and Consumer Protections
- •Crowd-Out

The Child Health Insurance Task Force considered these choices over a course of six meetings. Task Force members were generally in agreement on a number of these issues (including outreach and enrollment, administration and eligibility determination, benefits education and advocacy, and support services to promote utilization of preventive health services), but reached less consensus on other topics (including delivery system design). Where consensus was reached, only one set of recommendations is presented. Where consensus was not evident, a number of different options are presented along with the advantages and disadvantage of each.

1) Basic Program Options

The state has three options under the Child Health Insurance Program—it can expand Medicaid, create a new child health insurance program, or design a system that combines the two.

a. Medicaid Expansion:

Under this option, the state would expand Medicaid to cover as many uninsured children under 200% of the federal poverty guidelines as funds would permit. Uninsured children who qualify for the program would be guaranteed coverage (i.e., the program would remain an entitlement program).

One of the chief advantages of using the Title XXI funds to expand Medicaid is that the state can build on an existing infrastructure (Weil, 1997). The state already covers approximately 435,000 low income children through the Medicaid program. The state has a network of providers, systems for handling client and provider issues such as enrollment,

education, outreach, appeals, and mechanisms for rate setting, claims payments, and fraud prevention. In addition, the state's administrative costs for Medicaid are quite low—averaging approximately 4 percent. The system is in place and operational, so it would be the easiest option to implement. Due to the size of the program, Medicaid has significant purchasing power. The addition of the newly-covered children would increase its leverage to the benefit of both the new and current eligibles.

Another advantage is that states can use enhanced Title XXI funds through the Medicaid program to cover the dependents of state employees and teachers. This is the only way currently that North Carolina can cover uninsured dependents of state employees and teachers.[11] This is an exception from the general provisions which prohibit states from using Title XXI funds to cover dependents of state employees. In addition, because Medicaid is an entitlement, the state can continue to draw down federal funds at regular Medicaid matching rates to support health insurance coverage for children if Title XXI funds are exhausted.

Expanding Medicaid eligibility would also be easier for many families. Under current Medicaid rules, some children in a family may be eligible for Medicaid and other siblings not, because of the difference in the state's Medicaid income guidelines for children of different ages. If the state expanded Medicaid to cover all children in the family, all the children in a single family would be eligible for the same benefits package and could obtain care from the same set of providers.

One concern raised by some is that, because Medicaid is an entitlement program, the state may be required to appropriate additional funds if the numbers of uninsured exceed the initial budget estimates. However, the General Assembly always has the option of modifying eligibility rules, payment rates, or services covered to decrease program costs. In addition, the current Medicaid eligibility determination process apparently creates barriers for some families, for many eligible families are not enrolled. (Note: The Task Force recommended that a simplified eligibility determination process be used in both the Medicaid and new Title XXI program.)

b. New Child Health Insurance Program

Another option is a separate child health insurance program. The federal law gives the state flexibility in designing this new program, as long as it creates a benefits package that is actuarially equivalent to one of three benchmarked plans (See Section 3 below).

The chief advantage of this approach is that the fiscal liability of the state is limited The state could set eligibility caps and establish waiting lists if the numbers of eligible uninsured children were higher than initial estimates.

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[11] The October 10, 1997 HCFA Question and Answer communication clarifies that states can use enhanced Medicaid funds to cover dependents of state employees if the state chooses to expand Medicaid (Question 34). However, states are still prohibited from using Title XXI funds to cover dependents of state employees if the state chooses to establish a new child health insurance program.

Disadvantages to this option would include higher administrative costs, the possibility that fewer services might be offered, and difficulties in coordination with the Medicaid Program (both in eligibility determination and in service delivery).

Another disadvantage is that the state cannot cover dependents of state employees if it enacts a separate child health insurance program. Also, under a separate insurance program, federal funds available to cover the uninsured are limited. Therefore, if the state does not want to put a limit on the number of children it covers, a separate program will provide less federal assistance than an entitlement program. See chart below:

	For Each $100 in Coverage Until the Allotment is Used Up		For Each $100 in Coverage After the Allotment is Used Up	
	Medicaid Option	Separate State Program	Medicaid Option	Separate State Program
Federal Share	$74.10	$74.10	$63.00	$0
State Share	$25.90	$25.90	$37.00	$100

c. *Combination of Medicaid Expansion and New Insurance Program:*

The state can expand Medicaid eligibility and create a new block grant program to cover the children above the state's new Medicaid income guidelines. For example, the state can expand Medicaid to 150% of the federal poverty guidelines, and create a new state child health program for children with family incomes between 150%-200% of the FPG. This limits the state's potential fiscal liability while still providing assurances that the lowest income children in the state will be covered. Also, dependents of state employees with family incomes below 150% of the federal poverty guidelines would be covered.

The program may not be as "seamless" for families if the state creates two programs with two delivery systems or benefit packages. However, this problem can be overcome if the state chooses to create a "Medicaid look-alike" program (which would be a non-entitlement program that offers children the Medicaid benefits package and operates through the Medicaid system).[12] Also, if the state does not want to put a limit on the number of children it covers, a block grant program will provide less federal assistance than an entitlement program.

[12] It is important to note that the state cannot cover uninsured dependents of state employees or teachers as part of a Medicaid look-alike program.

2. *Administration (Including Eligibility Determination/Enrollment, Outreach and Marketing, Benefits Education and Advocacy)*

There was a general consensus among members of the Child Health Insurance Task Force that the state should administer the new Child Health Insurance Program (whether it is a Medicaid expansion or a new block grant program). The state should have primary responsibility for the eligibility determination process, outreach and marketing, benefits education and advocacy, data collection and analysis, quality assurance, planning, and evaluation. The state should also be responsible for monitoring the performance of private managed care organizations (MCOs) if the state chooses to contract with private MCOs. The state can use up to 10% of the federal allocation for administration, outreach and marketing costs and direct provision of health services.

The Task Force recommended that the state simplify the application form (for both Medicaid and any new program), decentralize places where applications can be taken through outstationed staff, and allow mail-in applications. The Task Force also recommended that the state explore the role that others (e.g., public health, private providers, schools, Smart Start, day care, etc.) can play in the eligibility determination process. The same application should be used for the Medicaid program and the new child health block grant program, and ideally, should also allow the state to determine the family's eligibility for other public programs through the same process and portals of entry. In addition, the state should utilize the existing eligibility information system to prevent children from being inadvertently enrolled in two programs, provide a consistent source of enrollment data, and avoid the substantive investment required in creating a new computerized information system.

The state should also implement federal options for simplifying the Medicaid enrollment and re-enrollment process, and use these same strategies if the state implements a new child health insurance program. These strategies include presumptive eligibility for children, and 12 month guaranteed eligibility. Reports indicate that presumptive eligibility, simplified application forms, and outreach activities have been successful in enrolling eligible Medicaid recipients (GAO, 1991; Center on Budget and Policy Priorities, 1997).

The Task Force recommended that the state conduct an extensive outreach and marketing campaign in order to reach as many eligible children as possible. There are three possible sources of money for this effort: 1) a portion of the 10% federal Child Health Insurance Program funds spent in the state; 2) the federal funds available to the state for Medicaid outreach as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (90% federal matching rate);[13] or 3) Medicaid funds that are generally available for outreach activities (50% federal matching rate).

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[13] Congress appropriated $500 million to be made available to the states at an enhanced match rate to help pay for administrative activities to ensure that children and families do not lose Medicaid coverage as a result of welfare reform changes. Section 1931(h) of Title XIX of the Social Security Act (Medicaid). North Carolina's share of the allotment is $11,550,703. Federal Register. May 14, 1997. Vol. 62, No. 93.

The Task Force recommended that the state use a single name for both Medicaid and the new child health insurance program to support a simple, seamless marketing approach. (The Task Force recognized that it would be difficult to have a single name if the two programs operated substantially differently). The state should develop a marketing approach that includes the program name, logo, and slogans, through social marketing research with the targeted population. This would be similar to the process used in designing the "Baby Love" campaign, which has been heralded as one of the most successful efforts in the country in reaching out to uninsured pregnant women. The outreach and marketing plan should involve health care providers, consumers and local voluntary organizations with interests in children. Existing resources should be built upon and expanded to support the program, including the First Step Campaign Office, the Health Check Hotline and the system of Health Check Coordinators. The existing telephone hotlines can be used to provide families with program information and referral to community resources.

In addition, the Task Force recommended that the program include health benefits advisors and an Ombuds office. The health benefits advisors would help to educate families about the covered benefits, choice of plans (if any) and provider options. The program should also include a centralized Ombuds office. This office can help advocate on the child's behalf if problems arise in accessing services, can assist in the appeal process and ensure that the program is functioning as intended.

3. Benefits Package

The Medicaid benefits package is the most comprehensive health insurance package currently available for children in North Carolina. Unlike most commercial health insurance plans which are largely designed to meet the needs of commercially-insured adults, the Medicaid benefits package has been fashioned specifically to meet the needs of children, including children with special health care needs. Approximately 10% of the children in this country have special needs.[14] While Task Force members were generally supportive of using the Medicaid benefits package, they recommended that dental reimbursement rates be enhanced (for current Medicaid beneficiaries and for any children covered under Title XXI) to attract sufficient numbers of dentists to participate in the program.

The state can use the Medicaid benefits package in implementing the new child health insurance program (whether or not it chooses to expand Medicaid as an entitlement), or it can design a new benefits package. If the state chooses the latter, the state must create a comprehensive benefits package that is equal to or actuarially equivalent to one of three

[14] National estimates suggest that between 5-10% of children experience some developmental problems sometime during their lives, between 12-15% of children experience behavioral and emotional disorders, and between 3-5% of children have complex physical conditions (such as spina bifida, sickle cell anemia, AIDS, cancer or cystic fibrosis). Fox H, McManus P. Preliminary Analysis of Issues and Options in Serving Children with Chronic Conditions Through Medicaid Managed Care Plans. Maternal and Child Health Policy Research Center, Washington D.C. 1994 Aug.

benchmarked plans listed in the federal legislation: the State Employees Health Plan, the Federal Employees Health Benefit Plan (Blue Cross Blue Shield PPO option), or the most commonly commercially purchased HMO plan in the state. The Child Health Insurance Task Force analyzed the different benefits available under each of the benchmark plans (Medicaid, State Employees Health Plan, BCBS Federal Employees Health Benefits Plan, Healthsource Advantage,[15] and Blue Cross Blue Shield PCP Option 1).[16] Based on this analysis, it chose two plans (with some modifications) for William M. Mercer, Inc. to cost-out: 1) Medicaid; and 2) the State Employees Health Benefits Plan (See Appendix B).

The Task Force considered using the benefits package available to state employees and teachers, because it is one of the three allowable benchmarked plans and is well understood by the general public. Since this plan was largely designed for an adult population, the Task Force recommended the addition of preventive dental services and a biennial comprehensive vision exam to better meet the needs of children. In addition, the State Employees Health Plan also excludes certain services needed by children with special needs. For example, the State Employees Health Plan will pay for special therapies when a child is showing significant progress, but not to help a child maintain functional status. These services are critical to certain children with developmental disabilities and severe chronic illnesses who may need continuing therapies to ensure that the condition does not deteriorate. Therefore, if the state chooses to use the State Employees Health Benefits package, the Task Force would recommend the creation of a "wrap-around" reinsurance pool. This would enable families to obtain the specialized services that their children with special needs require.[17]

The William M. Mercer, Inc. actuarial data showed that the cost of the Medicaid expansion option (using current N.C. Medicaid reimbursement rates) was actually less expensive than a private option (based on the provider reimbursement rates currently paid under the State Employees Health Plan). The costs are described below:

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[15] According to data obtained from Healthsource, Healthsource Advantage is the most commonly purchased commercial HMO plan sold in North Carolina.

[16] According to data obtained from Blue Cross Blue Shield of North Carolina, PCP Option 1 is the most commonly purchased commercial POS plan sold in North Carolina.

[17] The North Carolina Pediatric Society has created a task force to explore the idea of creating a reinsurance pool to address the health care needs of special needs children who have commercial insurance or are uninsured.

Comparative Costs of the State Employees Health Plan and Medicaid Benefits Packages[18]
(common utilization assumptions with no cost-sharing)

Age/Gender Bands	Modified State** Employees Health Plan (per member per month)	Medicaid Benefits Package (per member per month)	Variance
<1	$318	$281	13%
1-5	95	85	12%
6-18	74	70	6%
14-18 female	159	154	3%
14-18 males	172	175	2%
Total*	108	104	4%

* Does not include administrative costs.

** Services for children with special needs are somewhat limited. Eyeglasses and hearing aids are excluded. Special therapies and medical equipment are not covered when a child's condition is not improving.

4. Cost-Sharing

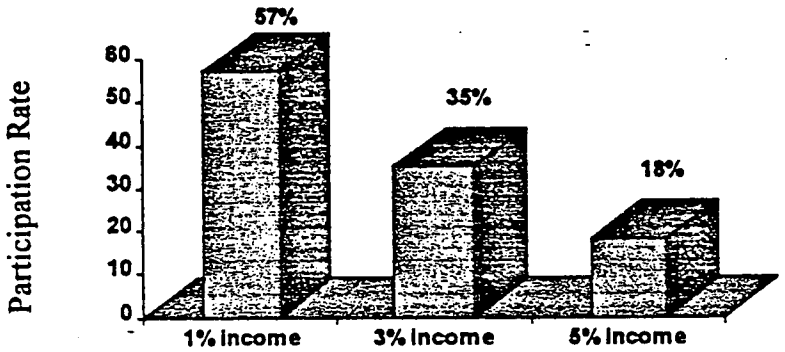
Federal law sets different cost-sharing requirements for families with incomes below 150% of the federal poverty guidelines versus those with incomes at or above 150%. For families below 150% of the federal poverty guidelines, states may impose nominal monthly premiums, but no cost-sharing (i.e., deductibles, copayments, or coinsurance). For families at or above 150% of the federal poverty guidelines, states may impose a premium and/or other cost-sharing, as long as the total out-of-pocket costs do not exceed 5% of the family's income. States may not impose any cost-sharing on preventive services (e.g., well-baby, well-child, or immunizations). Further, states may not use any cost-sharing amounts to finance the state share of the new Title XXI program.

Cost-sharing serves several purposes, such as deterring unnecessary utilization, reducing any potential welfare stigma associated with public programs, and potentially decreasing the possible "crowd-out" effect. However, cost-sharing may deter enrollment and utilization of

[18] William M. Mercer Inc. presentation to the Child Health Insurance Task Force, October 23, 1997. Mercer, Inc. provided actuarial estimates for both the Medicaid benefits package and that of the modified State Employee Health Plan (with dental and vision benefits included). The estimates are based on the reimbursement profiles of each program. Common utilization assumptions were used. The children that will receive coverage under Title XXI, taken as a whole, will be more indigent than the current SEHP child population, and less indigent than the current Medicaid Program child population.

possible "crowd-out" effect. However, cost-sharing may deter enrollment and utilization of medically necessary services. For example, a recent study from the Urban Institute showed that families are highly sensitive to the cost of health insurance premiums, and that even moderately priced premiums tend to deter significant numbers of low and moderate income families from participating in the publicly subsidized programs. In addition, collecting monthly premiums would be expensive and administratively burdensome.

Participation in Children's Health Programs In Relation To Premium Increases



Premiums as a Percentage of Family Income

(Ku and Coughlin, 1997).

For these reasons, the Task Force identified two policy options for the two income groups defined as targets in the statute: (a) no cost sharing of any kind, or (b) nominal cost sharing (including a one-time annual enrollment fee, and copayments for the higher income families). These options were presented to William M. Mercer, Inc. actuaries to determine the impact of these policies on actuarial costs. In general, the annual enrollment fee reduced the monthly costs by $1 per member. The copayments reduced the monthly costs by approximately $8 per member.

Families with incomes below 150% of the federal poverty guidelines:

Option a: No cost-sharing or premiums of any kind.

A policy of no cost-sharing or premiums would be the easiest to administer, and would eliminate any potential financial barriers which low income families may experience in obtaining needed health services or in participating in the program. However, free programs may carry a "welfare" stigma, and may reduce a family's perceived ownership of the insurance coverage.

Option b: $10 (one child)/$19 (two or more children) annual enrollment fee to be paid one time each year.

The Task Force chose not to recommend a monthly premium since the costs of collecting the premium would exceed any programmatic savings. The experience of some states that imposed monthly premiums in their child health insurance program showed that the premiums were hard to collect, and caused some beneficiaries to drop coverage. For example, approximately 40% of the children enrolled in the Florida Healthy Kids program dropped coverage when premium rates were increased about $15 per month (Shenkman, 1996). Those with the lowest family income were the most likely to drop coverage. Children with the greatest health care needs were the most likely to remain insured, thereby raising the premium costs for the covered children. Initially, Tennessee had great difficulty collecting premiums, and about 40% of the individuals who were required to pay premiums dropped their coverage (Wooldridge, 1996).[19] Because of the difficulties experienced in other states, the Task Force recommended a modest annual enrollment fee instead of a monthly premium.

An enrollment fee helps to reduce program costs and may create more investment in the program by families. However, even this modest annual enrollment fee may reduce program participation, and may be administratively complex to manage. Several members of the Task Force were reluctant to impose any enrollment fee, because of the concerns that this fee might deter program participation.

Families with incomes at or above 150% of the federal poverty guidelines:

Option a: No premium or cost-sharing.

Members of the Child Health Insurance Task Force thought that the same policy reasons for not imposing cost-sharing on the lower-income families also applied to the families with slightly higher incomes. In general, it is easier to design and implement a program without cost-sharing requirements. Without cost-sharing requirements, the state would have no need to monitor a family's out-of-pocket payments to ensure that the cost-sharing did not exceed 5% of the family's income.

Option b: $10/$19 annual enrollment fee. $0/$3 prescription drug copayment (generic/brand name drugs, $3 copayment would be waived if medical reason for brand-name); $3 acute care outpatient visits; $20 for non-"emergency" use of emergency department services.[20]

The combined enrollment fee and copayments reduce the monthly member costs by approximately $9. This would help reduce overall program costs. In addition, the copayments may help deter unnecessary utilization, and may create an investment in the program on the part of program participants and may remove the welfare stigma. However, some of the Task Force members expressed concerns with several aspects of this proposal. First, copayments are

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[19] Tennessee's premiums were based on the families' income, and ranged from 20% of the capitation rates for families with incomes between 100-199% of the Federal Poverty Guidelines to 100% of the capitation rate for families with incomes at 400% of the Federal Poverty Guidelines.

[20] The state would use the new definition of emergency contained in SB 455, enacted as part of the 1997 Session.

effectively "taxes" on *providers*. If the recipient is unable to pay the required copayment, the provider is in the position of having to refuse care or to have their reimbursement effectively cut by the cost of the copayment. This may deter provider participation in the program. Second, studies in the past have shown that cost-sharing helps deter both necessary and unnecessary care (Lohr, 1986). Poor children, those with incomes below 200% of the federal poverty guidelines, were most likely to be adversely affected by the imposition of cost-sharing, particularly for acute conditions where highly effective therapies were available. Third, 86% of the parents of uninsured children are also uninsured (National Association of Children's Hospitals, 1997). These families are already likely to be incurring significant out-of-pocket costs to meet the health care needs of the adult family members, and may have few resources available to pay additional health care costs.

5. Delivery System

The Task Force members generally agreed that private managed care organizations (MCOs), including health maintenance organizations, provider sponsored networks or other forms of managed care, should be allowed to participate in the program. However, there was considerable divergence of opinion on how this could best be accomplished. There were generally three proposals discussed during the Task Force meetings: 1) operate the program through the Medicaid system, with the state setting an established premium price, allowing any MCO to participate as long as it met the state's quality, access and benefits standards; 2) contract out the program to the lowest cost bidder or bidders (with the assumption that bids must be less than Medicaid's cost to care for this population); or 3) create a voucher program and allow recipients to choose from competing health care plans

Because there was such diversity of opinion on these issues, the Task Force created a list of criteria for judging these different approaches, including: a) existence of an operational administrative structure; b) choice of plans; c) choice of providers; d) ease of implementation; e) ability to interface with Medicaid; f) cost-effectiveness; g) seamlessness for families; h) ability to track utilization and monitor quality; i) ability to operate the system statewide; j) simplicity of understanding for families.

Medicaid-administered, private plan participation:

The N.C. Division of Medical Assistance (DMA) would administer the program, but would allow any managed care organization to offer coverage as long as the MCO can deliver services for the same cost, quality and access as the state now provides to Medicaid-eligible children. This is similar to the system offered state employees and teachers, who are given a choice of a traditional fee-for-service indemnity plan or can pick from competing HMOs. Under this option, recipients would be given the option to choose any plan operating in their service area (including the Medicaid delivery system), at no additional cost to the family. Plans could compete on the basis of quality and extra services. This program could be operated even if the state chose not to expand Medicaid, by establishing a Medicaid look-alike program (basically a non-entitlement program that operates like a Medicaid program).

In assessing the Medicaid-administered, private plan participation option, the Task Force found the following:

a) *Existing administrative structure:* The Medicaid system is already operational statewide, and includes mechanisms for accountability, oversight and evaluation. The state would not need to create a new administrative structure, although an additional investment would be required to modify and expand existing systems to meet the broader needs and requirements of the Child Health Insurance Program.
b) *Choice of plans:* This system permits any willing MCO that meets the state's price and quality criteria to participate. This also would enable recipients to have a choice of plans.
c) *Choice of providers:* The lack of providers available to treat children is a concern in the Medicaid program. This problem might be ameliorated if more MCOs offer coverage, as MCOs may have a broader network of providers.
d) *Ease of implementation:* This option would be the easiest to implement, as Medicaid is already operational and has had experience with prior program expansions.
e) *Ability to interface with Medicaid:* Since this option would be implemented by the Division of Medical Assistance, it has the best ability to meet the federal requirements of coordination with the Medicaid program.
f) *Cost-effectiveness:* The program is cost-effective, as the Medicaid benefits costs are actually lower than benefits offered under the State Employees Health Plan, and the Medicaid administrative costs are only 4% of the total costs of the system. Further, the actuarial costs of the Medicaid benefits package, using the Medicaid reimbursement rates, are actually lower than other less comprehensive commercially available plans.
g) *Seamlessness for families:* Another advantage is that having the two programs operate in concert would make it easier to meet the federal requirements that the state coordinate coverage for Medicaid and the Children's Health Insurance Program. Also, as family incomes (and eligibility) fluctuate, eligibility for regular Medicaid or the look-alike plan may vary, but benefits and enrollment would be continuous and seamless.
h) *Ability to track utilization and monitor quality:* The state is enhancing its current computer system to be able to analyze managed care organization utilization data to assure access and quality.
i) *Statewide operation:* The Medicaid program is operational statewide, and allows for flexibility in the design of the delivery system to accommodate regional variations in the private market (for example, the Medicaid agency can operate a fee-for-service system, a primary care case management program, and a capitated program, depending on the availability of managed care organizations).
j) *Simplicity of understanding for families:* The Medicaid system already has experience educating low-income families and children about multiple plan options, which it can draw upon in implementing a further expansion.

Contracting with Lowest Cost Bidder(s):

Under this plan, the state would open the program for competitive bids from managed care organizations. The lowest bidder(s) who meets the state quality, access and benefits

requirements can participate in the program, provided the qualifying bids are less than Medicaid costs for serving the same population.

In assessing the lowest cost bidder option, the Task Force found the following:

a) *Existing administrative structure:* The Department of Health and Human Services would have to establish contracting rules to assure cost, access and quality standards are met.
b) *Choice of plans:* This system potentially offers the recipients the fewest choice of plans.
c) *Choice of providers:* Depending on the MCOs participating, plans may offer recipients an extensive or a more limited choice of providers.
d) *Ease of implementation:* Once basic contracting rules are established, the program would be relatively easy for the state to administer as the program would be contracted out to private organizations to deliver services.
e) *Ability to interface with Medicaid:* It would be more difficult to coordinate with Medicaid.
f) *Cost-effectiveness:* The state could save money if a MCO bid at a lower price than the Medicaid costs. However, it is probable that the overall administrative costs associated with developing efficient and effective linkages with Medicaid would be significant.
g) *Seamlessness for families:* This program would be harder to interface with Medicaid. If a family had one child in the Medicaid program, and another child who was receiving services through the private MCO, the family may have to take their children to different providers. Further, continuity of care might be impeded if family circumstances change so that they move from Medicaid to the separate child health insurance program (or the reverse).
h) *Ability to track utilization and monitor quality:* Most of the larger HMOs have experience tracking utilization data for HEDIS-type performance measures, although it is unclear that other MCOs have similar capacity. The state agency would still be charged with collecting and analyzing the data.
i) *Statewide operation:* Although several of the HMOs are licensed statewide, only about 90 of the counties have an HMO option available to them through the State Employees Health Plan.
j) *Simplicity of understanding for families:* A program with a limited choice of MCOs may be easier for families to understand. However, as noted previously, this program would be more difficult for families with other children covered by Medicaid as the family would need to understand two different program rules.

Vouchers:

Under this option, eligible families would be given a voucher to purchase a private health insurance plan that meets mandated cost, quality, access, and benefits requirements. Because there is an insufficient track record with this type of system operating successfully anywhere in the country, the Task Force was reluctant to recommend this option. However, as there were some Task Force members who expressed an interest in this type of approach, an analysis of this

option is reported below. Given the lack of experience with this type of approach, any suggestions on the impact of this program are largely speculative.

In assessing the voucher option, the Task Force found the following:

a) *Existing administrative structure:* The state would need to establish a new structure to administer the program. This would delay program implementation.
b) *Choice of plans:* Theoretically, this system would afford recipients the greatest freedom of choice among plans, assuming that plans were willing to participate at the state's fixed premium level.
c) *Choice of providers:* Depending on the MCOs or insurers chosen, the plan may offer recipients an extensive or a more limited choice of providers.
d) *Ease of implementation:* There is little existing structure in place to administer the program.
e) *Ability to interface with Medicaid:* As with the private contracting option, this program would be more difficult to coordinate with Medicaid.
f) *Cost-effectiveness:* The program would be relatively cost-effective if the state used the Medicaid actuarial costs as the voucher value.
g) *Seamlessness for families:* This program would be harder to interface with Medicaid. If a family had one child in the Medicaid program, and another child who was receiving services through a private MCO, the family may have to take their children to different providers. Further, continuity of care might be impeded if family circumstances change so that they move from Medicaid to the separate child health block grant program (or the reverse).
h) *Ability to track utilization and monitor quality:* With a multiplicity of participating plans, it would be more difficult to adequately track utilization and monitor quality. The state would need to build in strong marketing and consumer protections to prevent the dissemination of misleading information.
i) *Statewide operation:* It is unclear whether this program could successfully operate on a statewide basis, as it has largely been untested.
j) *Simplicity of understanding for families:* Because of the lack of experience with this approach, its understanding for families is difficult to assess. It seems likely, however, that this approach would require an enormous amount of health benefits advisement.

Based on this analysis, the Task Force developed the following chart comparing the three delivery system approaches:

Evaluation Criteria	**Medicaid administration and other plans participating**	**Contracting out to lowest cost bidder(s)**	**Vouchers**
Administrative structure in place	★★★★★	★★★★	★
Choice of plans	★★★	★★	★★★★★
Choice of providers	★★★	★★★★	★★★★
Ease and quickness of implementation	★★★★★	★★★★	★
Ability to interface with Medicaid	★★★★★	★★★	★★★
Cost-effective system of care	★★★★★	★★★★	★★★★
Seamlessness for families	★★★★★	★★★	★★★
Ability to track utilization	★★★	★★★	★
Statewide delivery system	★★★★★	★★★★	★★★
Simplicity of understanding	★★★★★	★★★★★	★
Average ranking:	4.4★	3.6★	2.6★

(Ranking: 1-5★, with 5★ indicating that the delivery option was most likely to meet the criteria established by the Task Force.)

6) Access, Quality Assurance and Consumer Protections

The Task Force believed that the new Child Health Insurance Program should include mechanisms to assist families in accessing health care services on behalf of their children. Families, particularly of low and moderate income, often experience barriers which make it difficult for them to access needed care. For example, some families lack transportation, have difficulty taking time off work to take their children to the doctor, need translation services, or help understanding how to obtain care within a managed care environment. North Carolina,

through Medicaid's Health Check program, has already had success in helping families obtain needed services. The program has coordinators in 53 counties which helps families access care and coordinates available community resources. This can serve as a model for the state's Child Health Insurance Program.

The federal Balanced Budget Act requires the state's Child Health Insurance Program to include performance measures and report on these measures to the U.S. Secretary of Health and Human Services. Performance measures will assist the state with assuring that the program provides accessible, high-quality health care services to North Carolina's children. Both quality assurance and quality improvement measures will be used. The quality assurance measures will focus on structural issues, such as accreditation and credentialing of providers, provider capacity, and geographic accessibility. These measures also will assess processes, for example the percentage of children and adolescents receiving check-ups and immunizations as called for by the American Academy of Pediatrics. By contrast, the quality improvement measures will focus on outcomes; for example, a quality improvement intervention could look at whether the rates of sexually-transmitted diseases in adolescents decreased over time.

While the "science" of performance measurement is still evolving, there are a number of quality assessment tools that already are available or are under development, including measures from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS), the Health Care Financing Administration's Quality Assurance Reform Initiative (QARI), and Quality Improvement System for Managed Care (QISMC, which will replace QARI and unify Medicare and Medicaid performance measures), and Foundation for Accountability (FACCT), a set of performance measures developed by a nonprofit coalition of public and private purchaser and consumer organizations. These various measures should be explored in depth for potential use by the state Child Health Insurance Program because: (1) they are already in existence through the efforts of public-private development partnerships; (2) many providers, nationwide, already are familiar with them; (3) they tend to be comprehensive, addressing clinical and non-clinical areas, such as effectiveness of care, access to/availability of care, consumer satisfaction with care, health plan stability, utilization of services, cost of care, and consumer services. In addition, whatever measures are designed for use in the new state Child Health Insurance Program should also be used to measure the performance of the Medicaid program.

The Task Force was also concerned that the state build in adequate due process measures, including written notice of any decision to deny or reduce requested services (or to deny eligibility), expedited review of certain medical decisions, and review by an independent hearing officer. The Medicaid program already has a model grievance process in place for the recipients enrolled in MCOs, which could be used as a model for this new program.

7. *Crowd-Out*

When Congress passed the Child Health Insurance Program, it took steps to ensure that the new federal monies would be used to cover uninsured children rather than to substitute for, or "crowd-out," private coverage. For example, the state cannot create a new child health insurance program which uses Title XXI funds to cover children who already have private health insurance coverage or who are eligible for Medicaid. However, this provision does not prohibit coverage of children who are eligible for, but not actually covered under, an employer plan at the time they apply for child health assistance (with the exception of children eligible for coverage under the State Employees Health Plan). The state plan must describe the procedures the state will use to ensure that the insurance provided under the plan does not substitute for existing coverage (Sec. 2102(b)(3)(c)).

It is impossible to accurately predict how many employees and employers would actually drop dependent coverage in order to enroll dependents in the new public program. Policy experts strongly disagree regarding the amount of crowd-out that states have experienced as a result of the Medicaid expansions for pregnant women and children in the last ten years. Estimates range from virtually no crowd-out effect (Yazici, 1996) to over 50% (Dubay, 1997). Most of the studies were derived from cross-sectional data of different individuals gathered at various points in time.. One study tracked the same poor and near-poor children to monitor the impact of the previous Medicaid expansions on their private insurance coverage and concluded that minimal or no-crowd-out occurred (Yazici, 1996).

It is difficult to ascertain what portion of the drop in private health insurance coverage is directly attributable to the availability of publicly-subsidized health insurance coverage, and what portion of the decline is due to external factors, such as changes in the economy (i.e., recession), the rising cost of health insurance coverage, and/or "changes in the nature of employment and employers' views about the benefits they need to offer to attract workers" (Cutler, 1997; Cutler, 1996; Holahan, 1997). For example, an increasing number of individuals are employed by small businesses which are less likely to offer health insurance coverage (National Association of Children's Hospitals, 1997). The percentage of workers in firms with less than 25 employees increased from 28.8% in 1988 to 31% by 1994. Further, there has been a shift to part-time and temporary employment which are less likely to offer the benefit of insurance coverage. Moreover, there has been a disproportionate increase in premium costs for family coverage as opposed to individual employee coverage. Between 1989 and 1996, cost increases for family premiums were 13-23% higher than for employee-only premiums. (GAO, 1997). Not surprisingly then, the percentage of children with employment-based health insurance coverage nationally declined steadily from 66.7 percent in 1987 to 58.6 percent in 1995 (EBRI, 1997). In North Carolina, there was a 5.2% drop in employer-based health insurance coverage for children between 1990-92 relative to 1988-90 (Holahan, 1995).

In Minnesota, researchers surveyed individual participants in the publicly-subsidized health insurance program to determine the extent of prior health insurance coverage. The study determined that only 7% of the newly eligibles had been previously insured with private

coverage (Call, 1997). "Importantly, there is little evidence that the MinnesotaCare program has resulted in significant erosion from the private market. In fact, most of the uninsured in 1995 reported having no access to insurance through their employer or family members, and those that technically had such access simply found it to be unaffordable" (Call, 1997). The minimal coverage-shifting experienced in Minnesota suggests that extensive precautions against crowd-out may be unjustified.

According to some experts, there are several possible political disadvantages to erecting strict crowd-out policies. First, by restricting the coverage for those children whose parents have had some access to employer-based coverage, the program is penalizing parents for past decisions to obtain coverage. In addition, overly strict policies may ultimately defeat the primary objective of the legislation by preventing coverage of many poor and near-poor uninsured children (Merlis, 1997). In addition to these negative policy implications, severe restrictions would create another serious administrative burden and expense for the new program. Florida's Healthy Kids program dropped its verification of children's previous insurance status largely because of the administrative difficulties in obtaining verification from employers and insurance companies (Gauthier, 1997).

Based on the lack of clear evidence that significant crowd-out will occur, and awareness of the potentially harmful effects that ill-conceived restrictions might have, the Task Force recommends that the state avoid imposing harsh restrictions immediately. As the state plan progresses, the shifts in enrollment should be closely monitored to determine whether any crowd-out is occurring as a result of the expanded coverage. If it appears that a significant percentage of new enrollees have recently dropped private insurance coverage, then the state can design future "firewalls" to avoid this coverage shifting.[21]

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[21] California has completed its proposed state plan and adopted a similar approach. If the federal government requires more restrictive firewalls, it affords the administering agency the discretion to exclude children if they were covered by employer-sponsored insurance within the previous three months. After a "reasonable period" of monitoring or if required by the federal government, the program could extend the exclusion up to six months. California also provides that exceptions will be made for "cases where prior coverage ended [within the previous three or, if applicable, six months] due to reasons unrelated to the availability of the program," and at least under the following conditions: the loss of a job other than as the result of quitting; the unavailability of employer-sponsored coverage; the discontinuation of health benefits for all employees; and the termination of the 18 month COBRA coverage period.

In addition to the construction of firewalls, the California legislation addresses other means of preventing unwanted coverage shifting. It provides for monitoring to ensure that private coverage is not being improperly dropped (sec. 12693.71; 12693.80). Insurance industry personnel who encourage people to terminate their employment-based dependent coverage by referring them to the state plan or arranging for them to apply may be guilty of "unfair competition" for which an employee has a personal cause of action (sec. 12693.81). It is also an unfair labor practice for either insurers or employers to improperly influence enrollment in the state program (sec. 12693.82; 12693.83).

ESTIMATED PROGRAM COSTS

The state's annual allocation of $79.5 million in federal funds, plus the $27.6 million in required state match, appears adequate to cover the entire estimated target of 71,342 uninsured children in families below 200% of the poverty guidelines, using the actuarial estimates presented on p. 13, and assuming 100% participation. The pragmatics of budget estimation for operation of the program for the first several years have been left to the experienced professionals of the Department of Health and Human Services.

In the first year of program operation, it is reasonable to expect less than full participation as the word of the new program and the eligibility requirements are made public. Even in subsequent years, it is unlikely that all eligibles will participate. Experience from the prior Medicaid expansions around the country for children suggest that on average 32-38% of eligible children fail to enroll, and even in the states with the highest penetration between 7-27% of eligibles remain uninsured (Summer, 1997). Therefore, based on past experience, it is reasonable to assume no more than 80% of the program eligibles will participate.

The issue of crowd-out must also be addressed in budget estimates. Given the uncertainty of the level of crowd-out as noted on pages 22 and 23, it seems reasonable to assume (at least initially) a mid-level range of crowd-out between 10% and 30%. Thus, for planning and budgeting purposes, a crowd-out level of 20% is proposed. Since the estimated enrollment of the uninsured is 80%, and the enrollment due to crowd-out is 20%, it seems reasonable to use the original figure of 71,342 uninsured children as the long-term enrollment figure for budget planning purposes.

The Task Force recommends that the outreach, marketing, and health benefits functions be funded as fully as possible. States may use up to 10% of the federal allotment for administration, outreach and direct services.

During the course of its meetings, the Task Force received suggestions regarding the use of the "10 percent money" for direct services. Among those suggestions were: support services for children with special needs; support for school-based health services to enhance access to care by school-age children; support for centers to provide services to traditionally hard-to-reach populations, such as migrants and farmworkers. While the Task Force did not rank these suggestions above the outreach, etc. functions noted above, it seems reasonable to review these suggestions after the initial year of the new program's operation.

Special Note

As noted earlier, an estimated 67,000 children are currently eligible, but not enrolled in the Medicaid Program. As the new program is implemented, its outreach activities will surely lead to the Medicaid enrollment of many of these children. The Task Force did not make specific budget projections in this regard. It was noted that these children are probably relatively

healthier than the children enrolled in Medicaid, and their enrollment will be slow and incremental. DHHS budget planners should use these assumptions in developing budget estimates in this regard.

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APPENDIX A
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Committee of the Whole — **Name of Committee**

March 24, 1998 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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VISITOR REGISTRATION SHEET

Committee of the Whole — **Name of Committee**

March 24, 1998 — **Date**

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