ISSUE REVIEW

Iowa Legislative Fiscal Bureau

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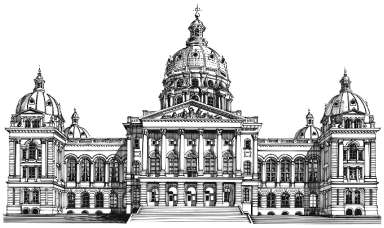


State Capitol
Des Moines, IA 50319
January 9, 1998

Children's Health Insurance Program

ISSUE

Implementation of a federal initiative to expand health care coverage to low-income uninsured children.

AFFECTED AGENCIES

Department of Human Services (DHS), Division of Medical Services
Department of Commerce, Insurance Division
Iowa Department of Public Health

CODE AUTHORITY

Chapter 249A, Code of Iowa

Public Law 105-33, Social Security Act, Title XXI, the State Children's Health Insurance Program (SCHIP)

CURRENT SITUATION

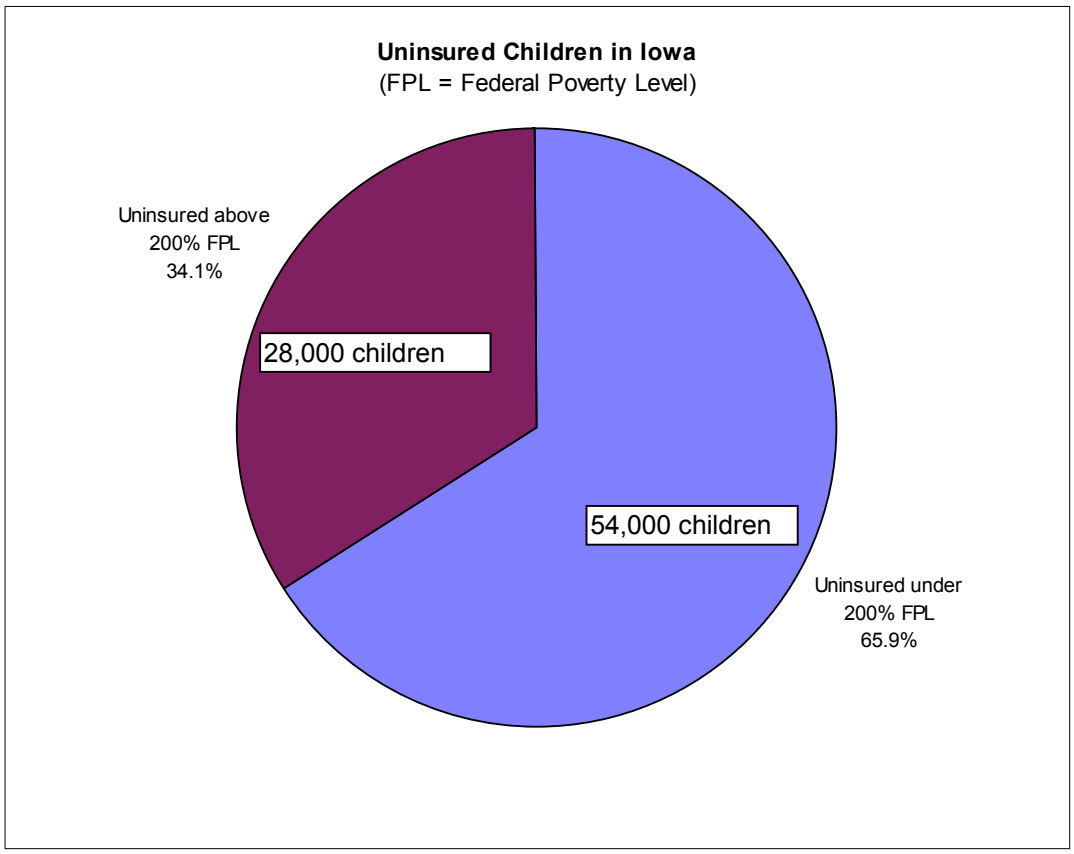
One significant provision of the federal Balanced Budget Act of 1997 (HR 2015) is the creation of the State Children's Health Insurance Program (SCHIP). The SCHIP is created under Title XXI of the Social Security Act. The stated purpose of the Program in the Balanced Budget Act is:

> *The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through—*
>
> 1. *obtaining coverage that meets the requirements of section 2103, or*
> 2. *providing benefits under the State's Medicaid plan under Title XIX, or*
> 3. *a combination of both.*

Uninsured Children In Iowa

There are many estimates of the number of uninsured children in Iowa and in other states. Iowa's allotment of federal funds is based on the Health Care Financing Administration (HCFA) estimate of 67,000 uninsured children in Iowa. Data estimates evaluated by the Iowa Healthy Kids Task Force were reported in the Iowa Healthy Kids Report to the Governor and the General Assembly in February 1997. The Report cited a range of 50,000 to 173,420 uninsured children in the State. A copy of the Iowa Statistics portion of the Report is included in **Appendix 1**. Additional estimates provided by the Bureau of Census and calculated by the Children's Defense Fund in October 1997 are detailed in **Appendix 2**. When comparing estimates of uninsured children, it is important to compare assumptions of the estimates as well, including the length of time the child is uninsured, if the estimate is applying the national average of uninsured children to a state's child population, or if it includes income groups eligible for Medical Assistance or above 200% of the federal poverty level (FPL), which are not included in the SCHIP population. The following pie chart indicates the numbers of uninsured children by poverty level, concluding that an estimated 54,000 children could receive primary and preventive health care through this Program while an additional 28,000 uninsured children would remain ineligible for the SCHIP because family incomes exceed 200.0% of the FPL.

Figure 1



Source: Department of Human Services

SERVICES COVERED

Two types of coverage are provided in the Act, basic and optional services. Details of services covered by the two categories are included in the following table:

Figure 2

Basic Services	Optional Services
• Inpatient and outpatient hospital services.	• Prescription drugs coverage.
• Physicians' surgical and medical services.	• Mental health services.
• Laboratory and x-ray services.	• Vision and/or Hearing services.
• Well-baby and well-child care, including age-appropriate immunizations.	• Other services as determined by the individual states.

States have three primary options in determining the type of program to establish.

- A plan comparable to the Blue Cross/Blue Shield plan available to federal employees.
- A plan comparable to the plan which State employees receive.
- A plan approved by the Secretary of Health and Human Services.

States have significant flexibility in determining the type of program offered. Benefits do not have to be consistent statewide. Regional variation in services is permitted.

ADMINISTRATIVE FUNDING LIMIT

A maximum of 10.0% of the federal funds expended may be used for administration, outreach programs, and direct provision of service. Representatives from the National Conference of State Legislatures have communicated with the Health Care Financing Administration (HCFA) in an attempt to apply the 10.0% administrative limit to total funds expended rather than federal funds expended on the Program. The current legislation also requires the limit be applied quarterly, creating a potential burden due to start-up costs.

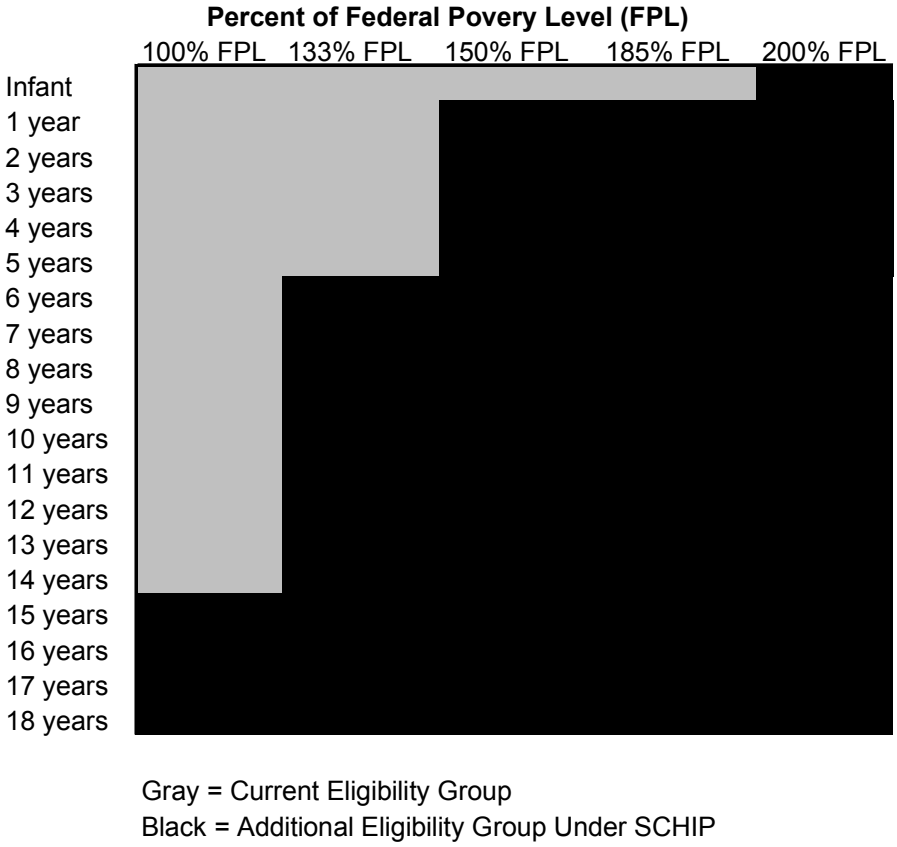
ELIGIBILITY AND COPAY

The Act provides eligibility for children with family incomes below 200.0% of the federal poverty level. States may impose deductibles for those individuals with income greater than 150.0% of the poverty level, but may not impose any cost sharing requirements for preventive services. Families with incomes above 150.0% of the poverty level may have nominal deductibles or cost sharing not to exceed 5.0% of gross family income. A schedule of allowable cost sharing under Medicaid is provided in **Appendix 3**.

The SCHIP is defined in the Act as a federal entitlement, which means funds are appropriated in advance of Congressional action for future budget years. The Act specifically prohibits an individual entitlement to services, meaning that states have the ability to restrict coverage within the funds available. However, if Iowa were to extend Medicaid eligibility to 200.0% of the federal poverty level (FPL), an individual entitlement to services would be created. The enhanced match rate of 74.6% would apply until the entire SCHIP allotment was exhausted, then the current federal match rate of 63.7% for Medicaid would apply to additional State expenditures. States may not cover existing Medical Assistance groups with the enhanced funding, but may choose to extend eligibility to non-covered groups.

Prior to the adoption of the SCHIP, states had the option of expanding Medicaid coverage for "SOBRA" (Sixth Omnibus Budget Reconciliation Act) eligibles. The SOBRA eligible individuals originally applied to children born prior to 1990. These individuals were covered up to 133.0% of the federal poverty level. Each year, the age category increases, so currently, the State of Iowa is covering those individuals ages 6 through 14 up to 100.0% of the federal poverty level. The SCHIP would permit coverage for all children up to 200.0% of the federal poverty level. The following graphic illustrates the additional potential eligibility groups added by the SCHIP.

Figure 3



Gray = Current Eligibility Group
Black = Additional Eligibility Group Under SCHIP

ALLOCATION OF FEDERAL FUNDS

Federal funds in the amount of $23.9 billion are allocated in Federal Fiscal Years (FFY) 1998-2002. The Act specifies continuation of the funding stream through FY 2007. Of the entire allocation, the Congressional Budget Office (CBO) has estimated that $3.9 billion is needed to fund:

- $700.0 million for a new state option to provide one-year continuous Medicaid eligibility to children.
- $100.0 million for mandatory Medicaid coverage for certain disabled children previously eligible for Supplemental Security Income (SSI).
- $400.0 million for increased enrollment in the Medicaid program due to a new state option to provide presumptive eligibility for children.
- $2.4 billion for additional costs to Medicaid for children identified as eligible by SCHIP outreach.
- $300.0 million for two Diabetes Grant Programs.

The remaining $20.0 billion is available to states for the SCHIP, effective October 1, 1997, upon verification of State appropriation of matching funds and approval of a state plan detailing implementation of the Program.

Allocation Formula

Funds for FFY 1998-2000 will be allocated to states on the proportion of low-income children that an individual state bears in relation to the total number of low-income uninsured children nationwide. The specific formulas for allocation are detailed in **Appendix 4**.

Allocation to Iowa

The FY 1998 SCHIP allotment for Iowa is $32.5 million in federal funds. Federal funds would have to be matched at the enhanced matching rate, which is approximately 74.6%. The enhanced rate is 10.9% higher than the standard Medicaid matching rate the State currently receives. Using the enhanced federal match rate, the State would be required to expend an additional $11.0 million in General Fund moneys if the State desired to fully maximize federal funds. The FY 1998 SCHIP allotments, state matching funds, and matching rates are detailed by state in **Appendix 5**.

TIMEFRAME

States are eligible to receive federal funds beginning October 1, 1997. In order to receive the FFY 1998 allotment, a state must have an approved State Child Health Plan by September 30, 1998. The U.S. Department of Health and Human Services advises that states submit plans for approval no later than July 1, 1998, to receive FFY 1998 funding. Key factors influencing implementation include:

- Program Options: Determination of eligibility groups, covered benefits, and implementation design (for example, should the existing structure of eligibility determination be expanded, or should some other mechanism or combination of mechanisms be used for enrolling children in the Program?) The State Children's Health Insurance Program Task Force has considered needs of uninsured children, several implementation options, and eligibility groups. The final meeting of the Task Force was October 23, 1997, with recommendations to an interagency

work group and subsequent recommendations required to be reported to the Governor by December 1, 1997. The Task Force made the following recommendations:

Expand Medicaid to 133% of the federal poverty level for all children under the age of 19 and create a separate private health care coverage program for children up to the age of 19 who live in families with income up to 200% of the federal poverty level as allowed by the federal legislation.

A copy of the Iowa Kids Report of the State Children's Health Insurance Program (SCHIP) Task Force Executive Summary is attached as **Appendix 6**.

- Enacting legislation will be required, including an appropriation for the State share of expenses (up to $11.2 million will qualify for the enhanced federal match).
- Submission of a State Plan to the Health Care Financing Administration and approval by the federal authorities.
- A state may amend, in whole or in part, its State Child Health Plan at any time through the transmittal of a plan amendment. Approval of a Plan will reserve the entire allotment for an individual state, which may be expended over three years (amounts allotted to states for a fiscal year are available through the second succeeding fiscal year).

ALTERNATIVES

The General Assembly may wish to consider the following options:

- How should the Program be implemented? Should a stand-alone program be instituted by contracting for health insurance coverage for low-income children or should Medical Assistance eligibility be expanded. The primary benefit of expanding Medical Assistance eligibility is the potential of grouping both the existing eligibility groups with the SCHIP eligibility group to pool risk, which may result in reduced costs for the State. This will be of benefit as the Medical Assistance Program moves from a fee-for-service plan to some form of managed care. Alternatively, separating the SCHIP group from the Medical Assistance Program may prove less costly because of the enhanced services provided to Medical Assistance clients. The Task Force discussed the possibility of extending coverage to 133.0% of the FPL to simplify Medicaid eligibility determination and level the criteria for all children (excluding infants currently eligible up to 185.0% of the FPL). At this point, no estimate of the cost savings of either option is available.
- What services beyond the required services should be offered? The SCHIP allows changes in benefit packages that are an actuarial equivalent to one of the three primary coverage options discussed above (i.e., the federal Blue Cross/Blue Shield plan, a State employee plan, or a plan approved by the Secretary of Health and Human Services).
- What level of co-pay or deductible should be required (if any)?
- What mechanism of delivery should be utilized? Options include inclusion of SCHIP eligibility determination in the role of the DHS field offices, contact and outreach through local school districts, marketing by insurance companies offering an eligible benefits package, contact with a new mother in a hospital, or through doctors' offices and clinics.
- Should the State expand eligibility to cover a larger number of low-income uninsured children? If so, how much should the eligibility be expanded (up to 200.0% of federal

poverty level receives enhanced federal matching funds). Some states, such as Connecticut, have used income offsets to increase the number of families eligible up to 300.0% of the federal poverty level. States are given the discretion to define income level in the State Plan, as long as the definition is applied consistently to the Medicaid Program.

- Should parents of low-income children or families with incomes exceeding the eligibility criteria be allowed to buy into the Program at cost? (The SCHIP specifications allow parental coverage if proven to be cost effective.)
- What measures should be taken to prevent "crowd-out" or the shift of coverage from some other entity to the SCHIP? Various states have specified periods of time without insurance coverage, varying from three months to 18 months, prior to obtaining eligibility for the SCHIP. Several states have included specific exceptions to the required gap in coverage (such as a change in employment without an insurance benefit or an employer action which discontinues insurance coverage). California has included a discrimination clause, indicating that employers must offer dependent coverage for both high- and low-income employees or for neither group.

The General Assembly may also wish to consider a phased approach of implementation, by first extending Medicaid eligibility to a specified level of poverty, including this in a State Plan filed with the federal authorities, and then adding the privatization component through a subsequent amendment to the Plan. The original approval of a State Plan will reserve Iowa's allotment for the subsequent two fiscal years. Under this method, it would not be required that the State appropriate the entire $11.0 million State match in the first year of the SCHIP's operation. A phased approach would likewise limit the number of eligible children receiving health care coverage corresponding to the level of State funds appropriated.

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Appendix 1

RESEARCH

IOWA STATISTICS

The first step in determining the scope of the program parameters was to obtain reliable Iowa statistics. The use of data from the Iowa State Access Plan, Iowa Kids Count Data Book, General Accounting Office, the Federal Bureau of Statistics, Health Systems Research Incorporated, as well as other data was utilized to obtain current and accurate Iowa statistics.

The data sources and estimates obtained all fell within the range of 50,000 to 173,420 uninsured children in the state of Iowa. The majority of the indicators fell within the range of 50,000 to 75,000 uninsured Iowa children. Carl Harris, the independent actuary retained to conduct the actuarial analysis, used the number of 82,447 uninsured children for his projections. The Task Force used this information, as well as national statistics provided by the actuary, to determine projected numbers and costs.

Listed below are Iowa and national statistics acquired for use by the Task Force.

- In September, 1996 there were 533,784 students enrolled in public schools in Iowa. Of those, 142,795, or 26 percent, were eligible for the *Free and Reduced Price Meals Program* through the Iowa Department of Education. 108,787 students were eligible to receive free meals and 34,008 qualified for reduced price meals. Of the 1,763 school units reporting, 136, or seven percent, do not have any students in this Section 11 Program. 80 percent of the program participants are located in the southern two tiers of Iowa counties.

- The *Iowa Legislative Service Bureau* in October 1995 estimated that between 51,000 to 75,000 children were uninsured.

- A July 1995 *General Accounting Office* report estimated that the number of Iowa children without health insurance in 1993 was 61,389 or eight percent of the general population. The same report recorded 65,398 on Medicaid (8.5%) and 534,200 (69.3%) with employer-based insurance.

- *The 1995 State-Level Data Book on Health Care Access and Financing* estimated the following:

There were 754,000 Iowans under the age of eighteen:

Type of Insurance	*Number*	*Percent*
Employer-based insurance	527,046	69.9%
Medicaid	99,528	13.2%
Other	76,154	10.0%
None	51,272	6.8%

There were 323,000 Iowans at or below 100 percent of poverty:

Type of Insurance	*Number*	*Percent*
Employer-based insurance	47,804	14.8%
Medicaid	138,890	43.0%
Other	60,724	18.8%
None	75,582	23.4%

There were 503,000 Iowans between 100 percent -199 percent of poverty:

Type of Insurance	*Number*	*Percent*
Employer-based insurance	265,584	52.8%
Medicaid	31,689	6.3%
Other	104,121	20.7%
None	101,606	20.2%

- The Federal Bureau of Statistics reported that in 1994 there were 82,000 Iowa children without health insurance, or 10.9 percent of all children. This is an increase of 22,000 children since 1987. Statistics for the years 1987 to 1994 are listed below:

Year	*Total Children Under 18*	*Medicaid Coverage*	*No Insurance*
1994	754,000	113,000 (15.0%)	82,000 (10.9%)
1993	777,000	108,000 (13.9%)	65,000 (8.3%)
1992	797,000	124,000 (15.6%)	70,000 (8.8%)
1991	754,000	113,000 (14.9%)	47,000 (6.2%)
1990	716,000	89,000 (12.5%)	39,000 (5.5%)
1989	767,000	79,000 (10.2%)	40,000 (5.2%)
1988	751,000	62,000 (8.3%)	50,000 (6.6%)
1987	853,000	113,000 (13.3%)	60,000 (7.1%)

- The American Hospital Association Health Statistics Group provided the following statistics for the State of Iowa for 1994:

Total Children	*Private Coverage*	*Employer - Other*	
753,871	604,564	473,542	131,021

Public Coverage		
Total	*Medicaid*	*No Health Insurance*
121,619	113,031	87,447

- *The 1995 Primary Care Access Plan* prepared by the Iowa Department of Public Health determined the medically indigent population in the state. The State of Iowa population was 2,776,755. Of the total, 20.6 percent or 572,012 were indigent or estimated to be without health insurance.

- *The 1993 Current Population Survey* estimated the number of uninsured persons in Iowa to be 259,559. The estimated number of children without health insurance is 65,000 children, or 25 percent.

- *Iowa Kids Count Data Book (1992 Urban Institute Survey)* found that 6.8 percent or 50,000 of Iowa children did not have health insurance in 1995.

- *Employee Benefits Research Institute* indicated that in 1992 the percentage of uninsured Iowans was 11.7 percent of the population or about 300,000 people. If 35 percent of the population are children, then in 1992 the estimate of uninsured children would be 75,000.

- The *Urban Institute* analysis merged *CPS* data for the three year period of 1990-1992. The report estimated that 20 percent, or 51,600, of Iowa's 258,000 uninsured were children.

- *Division of Health Policy Research and the American Academy of Pediatrics* offered the following statistics:

  Number of Children Without Insurance by Income Level:
  1990-1992:
  All children in Iowa - 72,600 (8.0%)

100% of poverty	18,200 (17.0%)
185% of poverty	45,600 (13.7%)
More than 185%	27,100 (4.7%)

  **source current population surveys 1991, 1992, and 1993*

  This is an increase over 1989 data. Iowa was one of 21 states that saw the number of children without health insurance increase.

NATIONAL STATISTICS

- *1990 Health Systems Research Incorporated (HSRI)* reported that the 1989 Current Population Survey indicated that nine percent of the state's population under age 65, or 220,000 Iowans lacked health care coverage. *HSRI* indicated that 25 percent of the uninsured population are children; which showed that in 1989 the number of uninsured children would have been 55,000.

- *Employee Benefits Research Institute (EBRI)* found that between 1988-1993 the percentage of children 18 and under with employment-based coverage fell seven percent - from 60.6 percent to 53.6 percent.

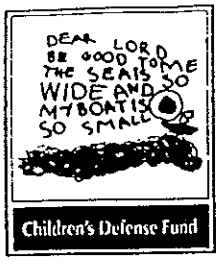
- *1994 General Accounting Office* analysis showed that there were:
  68.8 million children under 18 in the U.S.
  10.0 million (14.2%) had no health insurance.
  15.5 million (22.5%) were covered by Medicaid.
  43.3 million (65.6%) had some private insurance.

  - The percentage of children with private health insurance coverage reached the lowest level in eight years - 65.6 percent .
  - Among children with a parent working full-time during the entire year, 25 percent lacked private health insurance and nearly 12 percent were uninsured.
  - 62 percent of children covered by Medicaid had a working parent.
  - 50 percent of the children covered by Medicaid did not receive AFDC or other public assistance.

- *Institute for Child Health Policy* predicts that uninsured children nationwide will increase from 8.4 million to 11.2 million between 1990 and 1999.

- *U.S. Bureau of Census* found that in *1989*, 8.7 million children had no public or private health insurance and in *1993*, there were 9.3 million children without public or private health insurance. Nationally *from 1989 to 1993*, the percentage of children covered by employer-based health insurance decreased from 63.2 percent to 57.6 percent and from *1989 to 1993*, the number of children enrolled in Medicaid increased by 54 percent, from 8.9 million to 13.8 million.

Iowa data listed by county is included in the appendices.



Appendix 2

September 30, 1997

Census Bureau Releases Data on the Uninsured

On September 29, the Census Bureau released the results of the March 1997 Current Population Survey providing 1996 data on persons lacking health insurance coverage throughout the year. The data reveal that despite a booming economy, both the number and percentage of uninsured children rose to their highest levels ever reported by the Census. Please note: The following includes information both on children below age 18 and through age 18 (i.e., under age 19).

More Than Two-Thirds Of All 1996 Aggregate Losses In Health Coverage Were Experienced By Children.

- Altogether, the number of uninsured Americans in all age groups rose by 1.1 million from 1995 to 1996. The number of uninsured children through age 18 rose by 797,000.

The Number & Percentage Of Uninsured Children Rose Dramatically In 1996.

- Fully 11.3 million children through age 18 were uninsured in 1996, compared to 10.5 million in 1995.
- 15.1% of all children through age 18 were uninsured in 1996, compared to 14.0% in 1995.
- 10.6 million children under age 18 were uninsured year round in 1996, compared to 9.8 million in 1995.
- 14.8% of all children under age 18 were uninsured in 1996, compared to 13.8% in 1995.

Children With Family Incomes Above Poverty Were Hit Hardest.

- The Census Bureau reported that poor children experienced no statistically significant increase from 1995 to 1996 -- the increase in children under age 18 without insurance was experienced entirely among children with family incomes **above** poverty.

Uninsured Children in the United States

Year	Total population (through age 18)	Number Uninsured	Percent Uninsured
1996	74,898,553	11,300,022	15.1%
1995	74,766,124	10,502,977	14.0%

Year	Total population (under age 18)	Number Uninsured	Percent Uninsured
1996	71,224,235	10,554,054	14.8%
1995	71,147,733	9,795,045	13.8%

SOURCES: The above statistics describing children under age 18 were included in the Census Bureau's public statements. For the statistics describing children through age 18, calculations were performed by the Children's Defense Fund based on data available from the Census Bureau.

Uninsured Children Under Age 19 in the States, 1996

	Percent	Estimated number of uninsured children
United States (1996)	15.1 %	11.3 million
Alabama	15.1	179,000
Alaska	10.8	22,000
Arizona	22.4	281,000
Arkansas	19.3	139,000
California	18.7	1,804,000
Colorado	14.9	161,000
Connecticut	10.6	90,000
Delaware	12.7	24,000
District Of Columbia	15.7	19,000
Florida	17.5	652,000
Georgia	15.4	329,000
Hawaii	6.7	22,000
Idaho	13.4	51,000
Illinois	9.8	332,000
Indiana	11.2	180,000
Iowa	11.4	88,000
Kansas	10.3	76,000
Kentucky	15.0	160,000
Louisiana	20.3	277,000
Maine	14.0	45,000
Maryland	11.3	158,000
Massachusetts	9.3	141,000
Michigan	8.1	220,000
Minnesota	7.1	94,000
Mississippi	18.6	156,000
Missouri	12.3	184,000
Montana	10.7	27,000
Nebraska	9.4	45,000
Nevada	19.1	86,000
New Hampshire	10.2	32,000
New Jersey	13.9	295,000
New Mexico	22.9	126,000
New York	13.9	680,000
North Carolina	14.2	284,000
North Dakota	7.9	14,000
Ohio	10.1	309,000
Oklahoma	20.8	201,000
Oregon	14.0	123,000
Pennsylvania	9.3	288,000
Rhode Island	9.7	24,000
South Carolina	16.8	174,000
South Dakota	8.5	19,000
Tennessee	15.1	219,000
Texas	24.1	1,440,000
Utah	10.2	75,000
Vermont	7.0	11,000
Virginia	11.0	197,000
Washington	11.0	171,000
West Virginia	10.2	47,000
Wisconsin	6.4	92,000
Wyoming	13.4	20,000

NOTES: Children include 18 year olds. The U.S. percentage & number of uninsured are from the March 1997 Current Population Survey (CPS), released September 1997. The estimated percentage of uninsured children in each state is the average of the percentage of uninsured children during 1994-96. Three-year averages are used because of the small sample sizes in many states. The estimated number of uninsured children in each state is calculated by applying the average percentage of uninsured children to the most recent Census estimate of the number of children under age 19 in each state.

SOURCES: Bureau of the Census: March CPS 1995-1997 & July 1, 1996 state population estimates.

Calculations by the Children's Defense Fund 10/1/97

Appendix 3

ALLOWABLE COST SHARING UNDER MEDICAID

Enrollment Fee, Premium or Similar Cost-Sharing Charge

Minimum charge- At least $1 per month is imposed on each:

1) One- or two-person family with monthly gross income of $150 or less;
2) Three- or four-person family with monthly gross income of $300 or less; and
3) Five- or more-person family with monthly gross income of $350 or less.

Maximum charge- May not exceed the standards in the table below.

Maximum Monthly Charge

Gross family income (per month)	Family size		
	1 or 2	3 or 4	5 or more
$150 or less	$1	$1	$1
$151 or $200	2	1	1
$201 to $250	3	1	1
$251 to $300	4	1	1
$301 to $350	5	2	1
$351 to $400	6	3	2
$401 to $450	7	4	3
$451 to $500	8	5	4
$501 to $550	9	6	5
$551 to $600	10	7	6
$601 to $650	11	8	7
$651 to $700	12	9	8
$701 to $750	13	10	9
$751 to $800	14	11	10
$801 to $850	15	12	11
$851 to $900	16	13	12
$901 to $950	17	14	13
$951 to $1,000	18	15	14
More than $1000	19	16	15

Deductible, Coinsurance, Co-payment or Similar Cost-Sharing Charge

Maximum charge- Any deductible must not exceed $2 per month per family for each period of Medicaid eligibility. Any co-insurance rate imposed must not exceed 5 percent of the payment an agency makes for the service. Any co-payment may not exceed the amounts in the table below.

States payment for service	Maximum co-payment chargeable to recipient
$10 or less	$.50
$10.01 to $25	$1
$25.21 to $50	$2
$50.01 or more	$3

Source: 42 CFR § 447.51- 447.59.

Appendix 4

DETERMINATION OF FY 1998 STATE ALLOTMENTS

STATE	NUMBER OF LOW-INCOME CHILDREN (000)	STATE COST FACTOR	PRODUCT	PERCENT SHARE OF TOTAL[2]	ALLOTMENT[1]
ALABAMA	154	0.951	146.46	2.05%	$85,997,312
ALASKA	9	1.0669	9.60	0.13%	$5,638,146
ARIZONA	184	1.0472	192.69	2.69%	$113,138,521
ARKANSAS	90	0.8871	79.84	1.12%	$46,878,527
CALIFORNIA	1,281	1.1365	1,455.92	20.33%	$854,864,484
COLORADO	72	0.9888	71.19	0.99%	$41,801,288
CONNECTICUT	53	1.1237	59.55	0.83%	$34,968,061
DELAWARE	13	1.0553	13.72	0.19%	$8,055,533
DISTRICT OF COLUMBIA	16	1.2857	20.57	0.29%	$12,079,106
FLORIDA	444	1.0368	460.32	6.43%	$270,284,180
GEORGIA	214	0.9923	212.36	2.97%	$124,692,179
HAWAII	13	1.1722	15.24	0.21%	$8,947,603
IDAHO	31	0.8726	27.05	0.38%	$15,883,789
ILLINOIS	211	0.9892	208.73	2.92%	$122,560,067
INDIANA	131	0.9169	120.12	1.68%	$70,530,557
IOWA	67	0.8253	55.30	0.77%	$32,468,807
KANSAS	60	0.8704	52.22	0.73%	$30,644,400
KENTUCKY	93	0.9146	85.06	1.19%	$49,945,361
LOUISIANA	194	0.8934	173.31	2.42%	$101,762,991
MAINE	24	0.8863	21.27	0.30%	$12,490,186
MARYLAND	100	1.0498	104.98	1.47%	$61,643,199
MASSACHUSETTS	69	1.0576	72.97	1.02%	$42,847,242
MICHIGAN	156	1.0001	156.02	2.18%	$91,609,050
MINNESOTA	50	0.9675	48.37	0.68%	$28,403,279
MISSISSIPPI	110	0.8675	95.43	1.33%	$56,031,502
MISSOURI	97	0.9075	88.03	1.23%	$51,686,405
MONTANA	20	0.8333	16.67	0.23%	$9,786,177
NORTH CAROLINA	138	0.9815	135.45	1.89%	$79,528,899

[1] Total amount available for allotment to the 50 states and the District of Columbia is $4,204,312,500; determined as the FY 1998 appropriation ($4,275,000,000) reduced by the total amount available for allotment to the Commonwealths and Territories ($10,687,500) and amounts for Special Diabetes Grants ($60,000,000) under sections 4921 and 4922 of P.L. 105-33.

[2] Percent share of total amount available for allotment to the Commonwealths and Territories is as specified in section 2104 of the Social Security Act.

STATE	NUMBER OF LOW-INCOME CHILDREN (000)	STATE COST FACTOR	PRODUCT	PERCENT SHARE OF TOTAL	ALLOTMENT
NEBRASKA	30	0.844	25.32	0.35%	$14,866,746
NEVADA	43	1.2046	51.80	0.72%	$30,414,882
NEW HAMPSHIRE	20	0.976	19.52	0.27%	$11,461,349
NEW JERSEY	134	1.1241	150.62	2.10%	$88,440,626
NEW MEXIC0	107	0.9169	98.11	1.37%	$57,605,226
NEW YORK	399	1.0914	435.47	6.08%	$255,692,115
NORTH DAKOTA	10	0.8587	8.59	0.12%	$5,042,037
OHIO	205	0.9617	197.16	2.75%	$115,764,112
OKLAHOMA	161	0.8588	138.26	1.93%	$81,182,913
OREGON	67	0.9947	66.65	0.93%	$39,131,718
PENNSYLVANIA	200	1.0005	200.09	2.79%	$117,486,712
RHODE ISLAND	19	0.958	18.20	0.25%	$10,687,168
SOUTH CAROLINA	110	0.9843	108.27	1.51%	$63,574,155
SOUTH DAKOTA	15	0.8559	12.84	0.18%	$7,538,311
TENNESSEE	115	0.9799	112.69	1.57%	$66,170,086
TEXAS	1,031	0.9275	956.25	13.35%	$561,475,805
UTAH	46	0.8977	41.30	0.58%	$24,247,390
VERMONT	7	0.8604	6.02	0.08%	$3,536,354
VIRGINIA	118	0.9862	116.38	1.63%	$68,332,474
WASHINGTON	85	0.9352	79.49	1.11%	$46,673,207
WEST VIRGINIA	45	0.8937	40.21	0.56%	$23,612,812
WISCONSIN	71	0.9229	65.53	0.92%	$38,475,831
WYOMING	15	0.8758	13.14	0.18%	$7,713,620
TOTAL STATES ONLY			7,160.35	100.00%	$4,204,312,500
ALLOTMENTS FOR COMMONWEALTHS AND TERRITORIES[3]					
PUERTO RICO				91.60%	$9,789,750
GUAM				3.50%	$374,063
VIRGIN ISLAND				2.60%	$277,875
AMERICAN SOMOA				1.20%	$128,250
N. MARIANA ISLANDS				1.10%	$117,563
TOTAL COMMONWEALTHS AND TERRITORIES				100.00%	$10,687,500
TOTAL STATES AND COMMONWEALTHS AND TERRITORIES					$4,215,000,000

Source: State Children's Health Insurance Program; Reserved Allotments to States for Fiscal Year 1998; Enhanced Federal Medical Assistance Percentages. *Federal Register,* September 12, 1997, pages 48101-48102.

[3] The total amount available for allotment to the Commonwealths and Territories is $10,687,500; determined as .25 percent of the FY 1998 appropriation ($4,275,000).

Appendix 5

FY 1998 SCHIP ALLOTMENTS, MATCH AMOUNT AND STATE MATCH REQUIREMENT

State/Territory	Federal $'s	State $'s	FY '98 FMAP	Child Health FMAP
Alabama	85,997,312	23,525,500	69.32	78.52
Alaska[1]	5,638,146	2,207868	59.8	71.86
Arizona	113,138,521	36,258,707	65.33	75.73
Arkansas	46,878,527	11,003,345	72.84	80.99
American Samoa	128,250	69,058	50	65
California	854,864,484	443,138,072	51.23	65.86
Colorado	41,801,288	21,171,427	51.97	66.38
Connecticut	34,968,061	18,828,956	50	65
Delaware	8,055,533	4,337,595	50	65
District of Columbia[2]	12,079,106	3,210,902	70	79
Florida	270,284,180	121,659,237	55.65	68.96
Georgia	124,692,179	47,083,794	60.84	72.59
Guam	374,063	201,418	50	65
Hawaii	8,947,603	4,817,940	50	65
Idaho	15,883,789	4,296,352	69.59	78.71
Illinois	122,560,067	65,993,882	50	65
Indiana	70,530,557	26,099,881	61.41	72.99
Iowa	32,468,807	11,037,567	63.75	74.63
Kansas	30,664,400	12,043,678	59.71	71.8
Kentucky	49,945,361	13,069,225	70.37	79.26
Louisiana	101,762,991	27,018,319	70.03	79.02
Maine	12,490,186	3,894,683	66.04	76.23
Maryland	61,643,199	33,192,492	50	65
Massachusetts	42,847,242	23,071,592	50	65
Michigan	91,609,050	44,087,958	53.58	67.51
Minnesota	28,403,279	14,308,419	52.14	66.5
Mississippi	56,031,502	10,704,446	77.09	83.96
Missouri	51,686,405	19,624,860	60.68	72.48
Montana	9,786,177	2,540,535	70.56	79.39
Nebraska	14,866,746	5,549,000	61.17	72.82
Nevada	30,414,882	16,377,244	50	65
New Hampshire	11,461,349	6,171,496	50	65
New Jersey	88,440,626	47,621,876	50	65
New Mexico	57,605,226	13,661,910	72.61	80.83
New York	255,692,115	137,680,370	50	65
North Carolina	79,528,899	27,710,717	63.09	74.16
North Dakota	5,042,037	1,316,143	70.43	79.3
Northern Mariana Islands	117,563	63,303	50	65
Ohio	115,764,112	47,975,792	58.14	70.7
Oklahoma	81,182,913	21,114,104	70.51	79.36
Oregon	39,131,718	14,458,693	61.46	73.02
Pennsylvania	117,486,712	56,903,539	53.39	67.37
Puerto Rico	9,789,750	5,271,404	50	65
Rhode Island	10,687,168	5,211,624	53.17	67.22

[1] The 1998 Budget Act increased the Alaska FMAP from 50% to 59.8% through FY 2000.

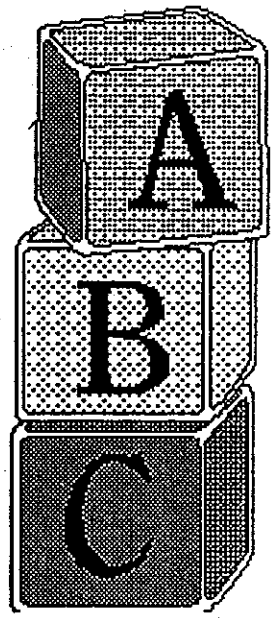
[2] The 1998 Budget Act increased the District of Columbia FMAP from 50% to 70% with no sunset date.

State/Territory	Fy '98 Federal $'s	Child Health State $'s	FMAP	FMAP
South Carolina	63,574,155	16,736,804	70.23	79.16
South Dakota	7,538,311	2,197,335	67.75	77.43
Tennessee	66,170,086	22,828,012	63.36	74.35
Texas	561,475,805	202,125,181	62.28	73.53
Utah	24,247,390	5,758,042	72.58	80.81
Vermont	3,536,354	1,273,049	62.18	73.53
Virgin Islands	277,875	149,625	50	65
Virginia	68,332,474	35,138,868	51.49	66.04
Washington	46,673,207	23,501,514	52.15	66.51
West Virginia	23,612,812	5,335,100	73.67	81.57
Wisconsin	38,475,831	15,570,848	58.84	71.19
Wyoming	7,713,620	2,694,719	63.02	74.11
Total	**$4,215,000,000**	**$1,788,894,018**	**61**	**74**

Source: State Children's Health Insurance Program; Reserved Allotments to States for Fiscal Year 1998; Enhanced Federal Medical Assistance Percentages. *Federal Register*, September 12, 1997, pages 48101-48102 and 48104. State share calculations prepared by the National Conference of State Legislatures.

Appendix 6

Iowa Kids



Report of the State Children's Health Insurance Program (SCHIP) Task Force

November 1997

New Options for Providing Health Care Coverage to Uninsured Children in Families with Modest Incomes

Executive Summary

As part of the Balanced Budget Act of 1997, Congress created the State Children's Health Insurance Program (SCHIP) by adding a new Title XXI to the federal Social Security Act. Congress also appropriated $39.6 billion dollars over the next 10 years to fund the program.

This legislation provides states with the opportunity to create programs to provide health care coverage to targeted low-income children under the age of 19. In Iowa, the State Health Care Reform Strategy Group gave the Division of Medical Services, within the Department of Human Services, the task of developing options as to how the SCHIP legislation could be developed. A State Interagency Work Group was convened to begin the planning process. It was determined that a task force should be appointed in order to gather input from a wide array of interested parties and to develop program options. It was further determined that the Task Force membership should include the members of the Healthy Kids Program Study Task Force that was convened in 1996, as well as legislators, and other representatives from the business, education, medical, and advocacy communities.

The Work Group determined that gathering input from Iowa citizens was critical in developing program options. Eighteen public forums were scheduled in nine communities throughout the state. The media, direct mailings, and the distribution of over 70,000 flyers statewide were used to notify citizens and interest groups of the forums. Additionally, a toll-free telephone number, a fax line, and an e-mail site were established to gather input from persons who could not attend the forums.

The public forums and other methods established to garner input provided an opportunity for citizens to help shape the program options and gave the Task Force and Interagency Work Group additional information and insight as to how best structure a program in Iowa to provide health care coverage to uninsured children. Forum participants strongly supported the creation of a program to provide health care coverage to uninsured children. Participants most often cited the new welfare reform policies, the belief that an increasing number of two-parent

families are working for wages under 200% of the federal poverty level, and a declining number of employers providing family health plans as reasons to support the creation of a children's health care coverage program. It was noted that schools and other public and private agencies should be involved in assisting in the creation and implementation of this program. It was also felt that employers and providers should play a critical role in ensuring that any new program works effectively and efficiently.

There was strong sentiment to make sure that the Title XXI program coordinates with the Title XIX program. Public forum participants also strongly felt that state policy makers should learn from previous experiences with Medicaid, make necessary and important corrections, and ensure a seamless children's health care coverage program. There was also clear recognition of the value of Title XIX and the belief that it could provide the structure upon which to build a health care program for uninsured children.

Preventive services for children were identified as the key health benefit Iowans want for their children. In addition to medical benefits required under the federal legislation, mental health services, vision, dental, and prescription drugs were cited as very important services. Citizens also endorsed the concept of cost-sharing for those participating in the program. Sliding fee scales, co-payments at the provider level, or premiums and/or deductibles were noted to be important as "buy-in" by families, as well as to help in managing utilization.

The Task Force created two subgroups to address specific issues. The "Who/What" group was given the charge of developing options around the program structure, benefit design, eligibility criteria, "crowd-out," and private sector issues. The group identified and prioritized five general options for the structure of the program:

1. A public/private partnership (i.e., Medicaid expansion along with a separate child health program);
2. A private program only;
3. A voucher system;
4. A Medicaid-only expansion; and

5. Tax treatment.

The "How" group was charged with addressing administrative issues, and marketing and outreach. Building upon the "Who/What" group's deliberation, the "How" group recommended the option to expand Medicaid to 133% of the federal poverty level in conjunction with the implementation of a separate program for children living in families with incomes between 133% and 200% of the federal poverty level. The program design should be flexible in order to accommodate future modifications.

Although the Task Force was unable to develop options on all of the issues, as a result of the community forums, citizen input, and the deliberations and recommendations of the two subgroups, the Task Force developed guiding principles and values on which options developed by the Interagency Work Group should be based. The principles and values address:

1. Eliminating barriers to coverage;
2. Access;
3. Outreach and education (for Title XIX and Title XXI);
4. Benefits;
5. Participation in the program; and
6. Cost sharing.

The Task Force made the following recommendation and strongly endorses it as a program option:

Expand Medicaid to 133% of the federal poverty level for all children under the age of 19 and create a separate private health care coverage program for children up to the age of 19 who live in families with income up to 200% of the federal poverty level as allowed by the federal legislation.