REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

VIRGINIA CHILDREN'S MEDICAL SECURITY INSURANCE PLAN

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 24

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

Preface

Chapter 679 of the 1997 Virginia Acts of Assembly directs the Director of the Department of Medical Assistance Services to report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Virginia Children's Medical Security Insurance Plan Trust Fund, the number of children served by the Virginia Children's Medical Security Insurance Plan, and any issues related to the Virginia Children's Medical Security Insurance Plan that may need to be addressed. This first report shall consist of the proposal for implementation. The legislation is included as Appendix 1.

This report was prepared by a workgroup at the Department and in consultation with other agencies, particularly the Department of Social Services, the Department of Health and the Department of Planning and Budget. The Department also worked closely with the staff of the Joint Commission on Health Care.

The Department acknowledges the help of Barbara Scheil and Diane Boxley, consulting actuaries with Barbara Scheil and Associates, who compared options and estimated per member per month costs.

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EXECUTIVE SUMMARY

This report is in response to the legislative mandate for the Department of Medical Assistance Services to develop a proposal to implement the Virginia Children's Medical Security Insurance Plan to provide health insurance for uninsured and underinsured children in families with income under 200 percent of poverty. In order to leverage state funds, the Department has developed five options consistent with requirements in federal legislation passed this summer, which creates a new State Children's Health Insurance Program, using federal matching funds at a higher match rate than the current Medicaid program. The state has already earmarked $7.3 million annually for children's health insurance.

The Department estimates there are 154,000 uninsured children under 200 percent of poverty. Of those children, approximately 82,000 are eligible for Medicaid, but not enrolled, and 72,000 are eligible for the new health insurance initiative.

While the Department will continue to analyze other options, for this report the Department analyzed the following options

Option 1-Expand Medicaid to 125 Percent of Poverty
Option 2-Expand Medicaid to 150 Percent of Poverty
Option 3-Key Advantage to 200 Percent of Poverty (Gross Income)
Option 4-Bid Regional Contracts to 200 Percent of Poverty (Gross Income)
Option 5-Expand Medicaid to 200 Percent of Poverty

Option 1 is designed to cost no more than the state funds already committed to the trust fund. Options 1, 2, 3 and 4 would meet the goal of the Virginia Children's Medical Security Insurance Plan to provide insurance to children in families with income under 200 percent of poverty. Since some income is disregarded in determining Medicaid eligibility, gross income exceeds Medicaid countable income by as much as 50 percent of poverty. As a result, Option 5 would cover children up to 200 percent of poverty and above.

Only the options to expand Medicaid could be implemented by July 1, 1998. The Medicaid options would expand an entitlement but Medicaid also provides children the most comprehensive benefits package. Options 3 and 4 would be separate state programs. Both would use the State Employees Key Advantage benefit plan. Option 3 would also use the Key Advantage delivery system and benefits administration structure. Under Option 4, the state would bid regional contracts. Options to create a separate program could delay implementation from 6-18 months.

Under the various options, between 29,900 and 88,400 additional children would be expected to enroll in the new health insurance program over three years. An additional 41,000 uninsured children would be expected to enroll in the current Medicaid program as a result of outreach.

CHAPTER 1 - VIRGINIA CHILDREN'S MEDICAL SECURITY INSURANCE PLAN

Legislative Background

Chapter 679 of the 1997 Virginia Acts of Assembly (HB 2682) establishes the Virginia Children's Medical Security Insurance Plan (see Appendix 1) "to provide (health insurance) coverage for individuals, up to the age of eighteen, when such individuals (i) are in families with incomes at 200 percent of poverty or less and (ii) are not insured or are underinsured by any policy, plan or contract providing health benefits." The legislation passed the General Assembly 98-0 in the House and 40-0 in the Senate.

The legislation established a trust fund for this program. There are three sources of funds authorized by the legislation: the "premium differential,"[1] employer contributions and all grants, donations, gifts, and bequests. No employer contributions or gifts are anticipated at this time. The premium differential would provide an estimated $3.5 million in SFY 1998, $7.3 million in SFY 1999 and similar amounts in future years. The actual amount will be calculated by the State Corporation Commission on or before June 30 for the immediately preceding taxable year and transferred to the trust fund by the Controller of the Commonwealth. The first transfer would be made on or before June 30, 1998. Effectively the money would not be available until the following fiscal year. The Governor and the General Assembly may want to consider accelerating the transfer during the current fiscal year.

The General Assembly required the Department to develop a proposal for this program by December 1, 1997, and to consider (1) services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan (CHIRP); (2) the provision of services through a network of participating providers; (3) the development of public/private partnerships; (4) a schedule for providing universal coverage for uninsured and underinsured children in families with incomes at 200 percent of the poverty level or less, to be phased in over a period of five years; and (5) alternatives for soliciting or requiring contributions from employers.

Estimate of Uninsured and Underinsured Children Under 200 Percent of Poverty

The target population for the Virginia Children's Medical Security Insurance Plan is children in families with income under 200 percent of the federal poverty line. This standard is adjusted for family size and is increased annually to reflect inflation. Effective March 1997, the income limits representing 200 percent of the federal poverty line are described below.

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[1] The premium differential refers to an increase in the premium tax paid by Trigon Blue Cross and Blue Shield and Blue Cross and Blue Shield of the National Capital Area. Prior to 1996, the Commonwealth exempted these organizations from part of the premium tax in exchange for providing open enrollment for its individual and primary small group employer policies. As a result of the federal Health Insurance Portability and Accountability Act of 1996, all insurance policies now must include this feature. Subsequently, the General Assembly repealed the partial tax exemption and earmarked the revenue for the Virginia Children's Medical Security Insurance Plan Trust Fund.

200 Percent of Poverty by Family Size, 1997

Family Size	Income Limit
2	$21,220
3	$26,660
4	$32,100
5	$37,540
6	$42,980
7	$48,420
8	$53,860

DMAS estimates of the eligible population are derived from multiple sources. The most important is a Health Access Survey conducted by the Virginia Health Care Foundation for the Joint Commission on Health Care. The Foundation surveyed 1,861 households statewide by telephone in early 1997 about their health insurance access. Based on the survey, DMAS and the Joint Commission estimate there are 154,000 uninsured children under 200 percent of the poverty line. Of those children, approximately 82,000 are eligible for Medicaid, but not enrolled, and 72,000 are uninsured and ineligible for Medicaid. To estimate the number of insured children in families with income under 200 percent of poverty, DMAS used Census estimates of total children in families with income under 200 percent of poverty and subtracted Medicaid enrollees under age 19 and uninsured children. The estimates are summarized below.

Virginia Children (Under Age 19) in Families with Income under 200 Percent of Poverty, by Health Insurance Status

Total	533,000
Medicaid Enrollees	315,000
Eligible for Medicaid but not Enrolled	82,000
Uninsured but not Eligible for Medicaid	72,000
Privately Insured	64,000

HB 2682 requested the Department to include in its proposal criteria for determining "underinsured." While underinsurance clearly exists, it is difficult to measure. Some of the possible criteria that could be used to determine underinsured status are the insurance deductible, the kind of coverage or the cost of the plan. For example, insurance for hospitalization only could be considered underinsurance. Underinsurance is also related to family income or willingness to take risk. For example, high deductible catastrophic plans may be all an individual can afford or it may represent the desired level of insurance.

The Health Access Survey asked respondents who had insurance to indicate whether it was "comprehensive" or "non-comprehensive." DMAS considers those respondents who indicated they had non-comprehensive insurance as being underinsured. The survey indicated that approximately 7.5 percent of the insured children were underinsured. Using this percentage, DMAS estimates there are approximately 4,800 underinsured children in families under 200 percent of poverty.

Goals

The Virginia Children's Medical Insurance Plan hopes to achieve a number of objectives. The primary goal is to provide health insurance for low income uninsured and underinsured children, but the overall impact will have far reaching consequences for the citizens of Virginia. The Department has identified six additional goals. Increased access to health insurance does not guarantee the achievement of these goals, but in most cases it is a prerequisite to achieving these goals.

- Support welfare reform
- Help low income working families financially
- Reduce uncompensated care burden on health care providers
- Increase number of children with good primary health care
- Decrease unnecessary care
- Increase productivity of educational system

The Commonwealth's welfare reform initiative is moving recipients from welfare to work. For most recipients, welfare is limited to two years. Welfare reform, however, guarantees Medicaid eligibility for the family for an additional year. After a year, the former welfare recipient usually loses Medicaid eligibility, but the children may still be eligible if income does not exceed the eligibility thresholds (up to 133 percent of poverty for children 0-5 and up to 100 percent of poverty for children 6-18). If family income exceeds the income threshold, however, then the children lose Medicaid eligibility unless the child has very high medical expenses and can achieve temporary eligibility through spenddown. Health care costs frequently offset any financial gain a family experiences from moving from welfare to work.

The availability of Medicaid or other public insurance effectively supplements the income of low income working families.[2] Most working Virginians receive health insurance through work but many former welfare recipients and other low income Virginians have jobs that do not provide health insurance. According to the Census Bureau, nine out of ten uninsured children have parents who work.[3] Even if health insurance is offered by an employer, many decline it if substantial cost sharing is required. Most employers expect employees to bear a larger share of the cost for family coverage (for children) than they do for the employee.

Uncompensated care is a major burden on the health care industry in the Commonwealth.[4] Health care providers provide health care services free of charge or on a sliding scale to low

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[2] One study estimates that, on average, families that moved from private to public insurance received an implicit income transfer of $1,523, or 8 percent of family income. See David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," Health Affairs, Volume 16, Number 1, January February 1997, p. 184-200.

[3] Children's Defense Fund, "14 Things You Should Know About the New Child Health Program," September 4, 1997.

[4] Hospital uncompensated care costs, net of all related subsidies, totaled $407 million in 1996 or roughly 7 percent of total cost. See Virginia Hospital and Healthcare Association, "Virginia's Uninsured: A Profile of Virginia's Uninsured Population and Hospital and Health System Services Provided to Them," October 1997.

income uninsured and underinsured Virginians when they need care. While a certain amount of bad debt or uncompensated care is to be expected in any industry, it is a significant cost in the health care industry. The Commonwealth tries to equalize the burden between hospitals for uncompensated care provided to individuals with income below 100 percent of poverty through the Indigent Health Care Trust Fund. Medicaid also pays additional subsidies to hospitals that serve a disproportionate share of low income patients on the assumption that these hospitals have a high share of uncompensated care.

Increasing the number of children with health insurance would be expected to reduce the amount of uncompensated care. The connection between uncompensated care and new health insurance for children is implicit in the recent federal legislation. The increase in health insurance was used to justify the cuts in Medicaid payments for disproportionate share hospitals. Reducing the amount of uncompensated care indirectly helps the consumer. Many providers feel a social obligation to provide care to those who cannot afford it, but at some point providers will try to recover the costs of uncompensated care by charging paying consumers extra.

While most uninsured children receive health care when they need it even if they cannot pay for it, children without health insurance are less likely to receive good primary and preventive care. Only one-third of preschool children in families with income under 200 percent of poverty receive all the preventive care recommended by the American Academy of Pediatricians compared to half of preschool children in families with income over 200 percent of poverty.[5] Uninsured persons in Virginia are less likely than insured persons to have health problems or injuries treated, have a routine source of health care, receive necessary immunizations or receive necessary dental care.[6]

One of the benefits of good primary and preventive care is the reduction in unnecessary acute care. Proper utilization of primary and preventive care reduces the utilization of more costly acute care services, such as hospitalizations. Reductions in utilization are also a result of improvements in health status.

Finally, healthier individuals are more productive. For children, this translates into an increased ability to learn. According to the State of Florida, uninsured children are 25 percent more likely to miss school.[7]

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[5] P.F. Short, D.C. Lefkowitz, "Encouraging Preventive Services for Low-Income Children; the Effect of Expanding Medicaid," *Medical Care*, 1992, Vol. 30, No. 9, p. 766-780.

[6] Joint Commission on Health Care, "Indigent/Uninsured Study (SJR 298): Phase 1 Report," June 1997.

[7] Children's Defense Fund, "14 Things You Should Know About the New Child Health Program," September 4, 1997.

CHAPTER 2 - STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The President signed into law the Balanced Budget Act of 1997, which among other things creates a new Title XXI of the Social Security Act providing for a State Children's Health Insurance Program (S-CHIP). This new Title enables states to initiate and expand health insurance coverage for uninsured children (under age 19) with income up to 200 percent of the poverty line who are not eligible for Medicaid. The comparison in the box demonstrates that the target population for the Virginia Children's Medical Security Insurance Plan and the federal State Children's Health Insurance Program is nearly identical.

Criteria for Health Insurance Coverage Under State and Federal Initiatives

	Virginia Children's Medical Security Insurance Plan (Chapter 13 of Title 32.1 of the Code of Virginia)	State Children's Health Insurance Program (Title XXI of the Social Security Act)
Age	Up to age 18	Up to age 19
Income Level	In families with income up to 200 percent of poverty	In families with income up to 200 percent of poverty
Insurance Status	Uninsured or underinsured	Uninsured, not eligible for Medicaid

This program provides federal matching funds to leverage state funds. The match rate for Virginia for the new program is 66 percent compared to the regular Medicaid match rate of 51.5 percent.[8] In order to leverage state funds with enhanced federal matching funds, the Department has developed proposals that would be consistent with the requirements in the federal legislation.

The federal legislation appropriates $24 billion in matching funds over five years ($48 billion over ten years) and includes a formula for individual state allocations. Virginia's allocation for FFY 1998 will be $68.3 million with similar amounts in each of the three succeeding years.[9] In order to receive federal money, the Commonwealth must have a Title XXI state plan approved by the U. S. Secretary of Health and Human Services. She has 90 days to approve a plan but the clock can be interrupted for substantive questions.

Federal money is available as of October 1, 1997, but federal allocations can be carried forward for two additional years. To protect Virginia's entitlement to its 1998 federal allocation, however, it must have an approved plan before October 1, 1998. Therefore taking into account time to answer questions, the plan should be submitted by next May.

The Commonwealth has two broad options under Title XXI: to expand Medicaid or to create a separate health insurance program. The Commonwealth also can choose a combination of the two approaches. Whatever the initial decision, Virginia can change approaches or make additions in the future.

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[8] The S-CHIP match rate is derived from a formula using the regular Medicaid match rate. If the regular Medicaid match rate changes, the S-CHIP match rate will also change proportionately in the same direction.

[9] The federal allocation is based on a formula which could produce different allocations in future years.

An expansion of Medicaid would have to follow all the requirements under Title XIX related to Medicaid. If the Commonwealth creates a separate program, it has flexibility within broad parameters established in the legislation, including the capability of capping enrollment or targeting it to specific groups. The benefit package, however, must be similar or of equivalent value to one of three commercial "benchmarks."[10] The benchmark equivalent plan must cover inpatient and outpatient hospitalization, physician services, lab and x-ray services, and well-child and well-baby care, including immunizations. The benchmark equivalent plan must provide 75 percent of the actuarial value of vision, hearing, prescription drug and mental health benefits provided in the benchmark plan. Premiums and copays are limited.

All Title XXI state plans (even a Medicaid expansion) must also describe:

- outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs
- screening to ensure that those Medicaid eligible are enrolled in Medicaid
- coordination with other public and private health insurance programs
- a strategy to ensure that this new coverage does not substitute for coverage under private health insurance.

Other states are considering a wide variety of approaches. Preliminary information about activities in other states is summarized by the National Academy for State Health Policy in Appendix 2.

[10] Benchmark plans are the standard Blue Cross Blue Shield preferred provider option under the Federal Employees Health Benefits Plan (FEHBP), a health benefits coverage plan generally available to State employees and an HMO plan with the largest insured commercial, non-medicaid enrollment.

CHAPTER 3 - PROGRAM OPTIONS AND DISCUSSION OF ISSUES

Description of Plan Options

Many possible options could be described under the federal legislation for analysis. While the Department will continue to analyze other options for implementing S-CHIP, DMAS has analyzed the following five options for this report.

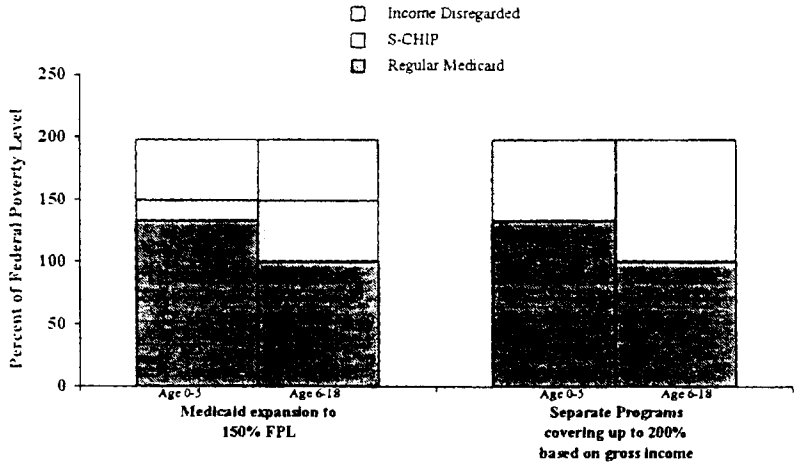
Option 1: Expand Medicaid to 125 Percent of Poverty
Option 2: Expand Medicaid to 150 Percent of Poverty
Option 3: Key Advantage to 200 Percent of Poverty (Gross Income)
Option 4: Bid Regional Contracts to 200 Percent of Poverty (Gross Income)
Option 5: Expand Medicaid to 200 Percent of Poverty

Under the Medicaid options (Options 1, 2 and 5), the Department assumes that the gross income equivalent is 50 percent higher than the nominal. This is because some income is disregarded in determining Medicaid "countable income" in Virginia's Medicaid program. As a result, the gross income may be substantially higher. Appendix 3 explains the assumptions used in determining a gross income equivalent for Medicaid countable income. Under Options 3 and 4, the Department proposes to use gross income to qualify children. The chart on the next page illustrates how Option 2 covers the same children as Options 3 and 4.

Options 1, 2, 3 and 4 provide health insurance for children in families with incomes at 200 percent of poverty or less. Option 1 to expand Medicaid to 125 percent of poverty was designed specifically to cost no more when fully mature than could be funded with the revenue already earmarked for the Virginia Children's Medical Security Insurance Plan. This option only affects children 6-18, since children 0-5 are already covered by Medicaid up to 133 percent of poverty. Option 5 to expand Medicaid to 200 percent was recommended by the Indigent/Uninsured Subcommittee of the Joint Commission on Health Care. With Medicaid income disregards, however, this option would provide health insurance to children with gross income above 200 percent of poverty. This option is permitted under Title XXI because states have latitude in determining how to measure income.

The Department considered two different program designs for a separate program. Option 3 would contract with Trigon using the same administrative structure as the state employee's Key Advantage health insurance program. Under Option 4, the Department would bid managed care/insurance contracts regionally, six regions for example. DMAS assumes one contract per region for economies of scale and administrative simplicity and that the contract would cover all benefits provided under the program.

Children Covered Under Program Options by Poverty Level



Estimated Enrollment in the Children's Health Insurance Plan

Actual enrollment in the new insurance option will depend to a great extent on the success of the outreach program discussed below. DMAS estimates that 70 percent of the eligible uninsured will eventually enroll in the new insurance program. Currently, about 80 percent of Medicaid eligible children enroll in Medicaid, but Medicaid enrollment for many children is linked at least partially to cash welfare benefits. DMAS uses a lower estimate than for the Medicaid program because there would be no automatic linkage to the new insurance program. The Department's estimate is higher than the estimate of the Congressional Budget Office (CBO), which assumes that 55 percent of the uninsured would enroll in the new insurance option nationwide.

While both the federal and state initiatives are targeted to providing health insurance to uninsured children, it is inevitable that some previously insured children will enroll in the new insurance option. Anyone who currently has health insurance at the time of application would not be eligible, but many insured children will eventually lose their health insurance and become eligible. CBO estimates that 20 percent of those who would have otherwise had insurance will participate in the new insurance option, which is what DMAS uses in its estimate. In general, CBO does not assume that employers or individuals will drop their current private insurance, but that the existence of a new public program will reduce the amount of private insurance that comes into being. States are required to take steps to prevent the substitution or "crowding out" of private insurance by public insurance, but it is difficult to predict how successful such an effort will be.

The table below estimates enrollment for each option.

Estimated Enrollment in S-CHIP

	Total Eligible	Percent Enrolling	Total Enrolling
Option 1			
Uninsured	37,000	70 percent	25,900
Previously Insured	20,000	20 percent	4,000
Total			29,900
Options 2, 3 and 4			
Uninsured	72,000	70 percent	50,400
Previously Insured	64,000	20 percent	12,800
Total			63,200
Option 5			
Uninsured	92,000	70 percent	64,400
Previously Insured	120,000	20 percent	24,000
Total			88,400

Based on past expansions, DMAS assumes that it will take three years to enroll the total new population. Approximately 50 percent of the total will enroll in the first year, 30 percent in the second year and the remaining 20 percent in the final year. The program will reach maturity, or a stable enrollment, only at the end of the third year. The following table shows how DMAS expects enrollment to grow for the new insurance program under each option. If outreach is successful, it is possible that more may enroll in the first or second year than estimated.

Estimated Enrollment at End of Year

	First Year	Second Year	Third Year
Option 1	14,950	23,920	29,900
Options 2, 3 and 4	31,600	50,560	63,200
Option 5	44,200	70,720	88,400

Benefit Comparisons

If Virginia chooses to expand Medicaid (Options 1, 2 and 5), children will receive the Medicaid benefit package. This is a comprehensive benefit package designed to serve low income children. It includes extensive preventive health screenings and treatment, comprehensive mental health benefits, vision and hearing care and non-emergency transportation that are frequently not included in commercial insurance which is designed primarily for working adults. Medicaid also gets high marks for serving children with special needs who are physically or developmentally disabled. It does not exclude children with preexisting conditions and provides full treatment.

If Virginia creates a separate program, it will have to design a benefit package similar or of equivalent value to one of three commercial "benchmarks." See the table below for comparison of the relative value between the benchmark plans and Medicaid.[11]

Actuarial Comparison of the Value of Benchmark Plans with Medicaid
(Medicaid prices and utilization were used to compare all plans)

Medicaid	100%
Sentara Optima (HMO plan with the largest enrollment)	85%
Key Advantage (state employees)	78%
Key Advantage (without copays)	89%
Standard Blue Cross Blue Shield Preferred Provider Option (FEHBP)	72%
Cost Alliance (state employees)	62%

For purposes of analysis of a separate program under Options 3 and 4, DMAS assumes that the benefit plan would be equivalent to the state employees' Key Advantage plan with one modification. None of the benchmark plans could be adopted as is without virtually eliminating cost sharing.[12] When DMAS eliminates cost sharing, the value of Key Advantage relative to Medicaid increases from 78 percent to 89 percent. Medicaid, of course, has no cost sharing.

The above actuarial comparisons of benefit packages are based on all plans using the same prices for services and utilization rates. In reality, each plan would pay different prices and control utilization differently. The actual cost of Key Advantage for children for state employees is actually higher than the cost of Medicaid even though benefits are lower. DMAS estimates the per member per month cost for Key Advantage children in FY 1998 as $97.67 compared to the Medicaid per member per month cost of $75.92.

Most commercial insurance does not cover the same benefits as Medicaid or fully meet the standards of the American Academy of Pediatricians for primary and preventive care. For an example, see below for a comparison of major coverage differences between Medicaid and the state employee's Key Advantage plan.

[11] Either one of the state employee plans, Key Advantage or Cost Alliance, could be a benchmark plan.
[12] The federal legislation does permit cost sharing but for lower income groups (under 150 percent of poverty) it is so minor as to be an administrative nuisance and for higher income groups it is too administratively complicated (capped at five percent of income).

Benefit Coverage Comparisons of Medicaid and Key Advantage

	Medicaid	Key Advantage
Well-Child Care	Comprehensive	To age 6.
Dental	Comprehensive, including orthodontics	Diagnostic, preventive and primary care services (annual cap of $1,000 per person)
Mental Health	Inpatient; 26 outpatient visits initially with an additional 26 visits per year; a variety of community mental health and substance abuse services provided by Community Service Boards	30 days of inpatient care or 50 outpatient visits per benefit period. 90 day maximum for inpatient substance abuse rehabilitation
Vision Care	Routine exams and eyeglasses	None.
Hearing Care	Routine exams and treatment	None.

Implementation

Internal planning at the Department has examined both the administrative and practical issues of a Medicaid expansion and the creation of a separate program. The Department projects that it can implement a Medicaid expansion (Options 1, 2 and 5) on July 1, 1998. While the Department will have to review HMO capacity and provider network adequacy, the delivery system is in place for a Medicaid expansion. In addition, DMAS will develop and implement an outreach program and modify its Medicaid Management Information System. DMAS will also work closely with the Department of Social Services on the determination of eligibility, on the enrollment process and on hiring and training eligibility workers. Other agencies will also be involved.

Creating a separate program would raise additional administrative and practical issues that could delay implementation. Crucial decisions about program design might not be known until the end of the legislative session and possibly the veto session. Additional changes to the Medicaid Management Information System over and above those necessary to expand Medicaid would probably be needed.

Contracting with Trigon (Option 3) could be implemented relatively quickly because Trigon already has an established network statewide and an administrative system in place for the state employee's Key Advantage plan. Trigon would need some start up time to make administrative adjustments. Ideally this contract should be bid, but in order to implement this option by January 1, 1999, it could initially be awarded on a sole source basis and subsequently bid.

Under Option 4, DMAS would have to go through the state procurement process to bid regional contracts. This could take six months or more and the successful bidders would need additional time for start-up. DMAS analysis of HMO penetration also shows it may be difficult to find potential bidders in some areas of the state, such as Southwest Virginia, Southside and the Blue Ridge (north of Charlottesville), though the experience of other states indicates it is possible. A well planned implementation of Option 4 could take two years until January 1, 2000.

Outreach

As part of the federal initiative, each state is required to implement a program of outreach to families of children likely to be eligible for child health insurance informing them of the availability of, and to assist them in enrolling their children in, such a program.

DMAS has convened an Outreach Committee with representatives from DMAS, other state agencies and private, non-profit and advocacy organizations to design an effective and aggressive outreach program. DMAS plans a multi-faceted campaign similar to outreach campaigns in Rhode Island, Georgia and Massachusetts to include:

- a statewide and regional media campaign (similar to the "kick off" for Virginia's welfare reform)
- advertising on radio, television, billboards
- notices to parents through the schools, preschools and day care centers
- regional outreach coordinators
- an increase in outstationed workers at hospitals, health clinics and other non-traditional, non-health sites
- distribution of information and applications to pediatricians and other providers
- coordination with local community organizations

One of the barriers to health insurance for low income families in Virginia is the negative stigma associated with welfare programs. Even though Medicaid and welfare have been delinked, many people still associate Medicaid with a negative image. An integral part of the media campaign and outreach program will be an attractive image and slogan for the program. For example, the program in Florida is called "Healthy Kids," in Arkansas it is called "ARKids First" and in Rhode Island it is called "RIte Care." This new image has been extended to include the current Medicaid program in some states.

Another aspect of the outreach effort will be simplifying the application process. Virginia plans to use a two page application form, which can be mailed in. This is similar to the current Medicaid "short form" which is used for pregnant women and indigent children. It is intended to make applying more convenient by having applications and assistance available at non-traditional sites and during non-traditional hours. Traditional application sites at local Social Service agencies are often hard to reach or open only during hours the parent must work.

To the extent feasible, the publicity campaign will incorporate education about the value of health insurance. If uninsured parents see the value of primary and preventive care, they will take the trouble to enroll their child in health insurance early rather than wait until there is a medical problem.

To do a successful outreach campaign requires resources. The Department believes that this campaign would need in excess of $1 million in each of the next two years and lower amounts

in future years. Outreach should be an ongoing effort and could be carried out through local DSS staff or contracted through private organizations.

The outreach program would be very similar under each of the options, with the possible exception of Option 1. Option 1 would provide health insurance for children in families up to 125 percent of the poverty level. In Virginia, children 0-5 are already covered by Medicaid up to 133 percent of poverty. As a result, the outreach program could be more targeted to older children.

Coordination with Other Private and Public Programs

Most working Americans receive health insurance through their employer. Employers do not have to provide health insurance, but those that do receive tax breaks. Congress envisioned that the new child health insurance would be coordinated with private insurance. In addition, states have many other public programs, especially for low income, at-risk children. The Department has identified three issues related to this coordination: the prevention of crowd out, the utilization of available health insurance to minimize costs and coordination with public programs.

Prevention of Crowd Out

In order to prevent the new insurance program from substituting for or "crowding out" private insurance, Congress placed three conditions on state programs.

- no one currently receiving health insurance is eligible for the new program,
- states must include in their Title XXI state plans procedures to be used to ensure "that the insurance provided under the State child health plan does not substitute for coverage under group health plans" and
- payments cannot be made if a child was excluded from eligibility under a private insurance plan because he or she is eligible for this new public insurance.

The legislation makes an important distinction between coverage and access. An employer may offer his employees health insurance, but they do not have to accept it especially if it requires employees to pay a share of the premiums. Employees also may have the choice of purchasing employee coverage only or family coverage. Employers frequently require employees to pay a larger share of the premium for family coverage than for employee coverage only. If a family has access to health insurance, but chooses not to purchase it, they are not excluded from coverage for the new insurance. This distinction, however, can create an inequity. Consider two families employed by the same firm with the same number of children and income. The family that sacrifices to purchase health insurance is excluded from coverage while the family that does not choose health insurance is eligible.

As a result, there is an incentive for the employee to drop health insurance and states are required to have a strategy to prevent crowd out. There is also some empirical evidence that crowd out exists but little agreement about the magnitude. The lower the income level the less the problem because fewer families have employer-provided insurance. Programs covering

children are also less problematic, because many employers who provide insurance to employees, do not provide family coverage or require employees to pay the full cost.[13]

The most common direct measure to prevent employees from dropping family coverage is a waiting period, a minimum time period without insurance. A waiting period could even be applied to access to insurance. States have experimented with waiting periods as short as three months and as long as 18 months. A strict policy to prevent employees from dropping health insurance would prevent low income families from taking advantage of the new program, even if their children are underinsured. Short waiting periods pose less of a hardship on the underinsured. Exceptions could be made for those who involuntarily lose insurance coverage, who have individual coverage or who must pay more than a minimum percent of the cost. The Department recommends a three month waiting period with exceptions for those who involuntarily lose insurance coverage or who have individual coverage.

Some policymakers argue that cost sharing and commercial benefit plans, which are typically less generous than Medicaid, also minimize crowd out indirectly. This may apply to a separate program (Options 3 and 4). While this would not be true of a Medicaid expansion (Options 1, 2 and 5), the Medicaid stigma discussed above may discourage some from dropping private insurance.

Equally important is to discourage employers from dropping health insurance for families. Employers who have many higher income employees will be reluctant to drop family health insurance for all employees, but those with mostly lower income employees might consider it. Employers would also have an incentive to "educate" low income employees about the advantages to them of dropping the family coverage in favor of enrolling in the new public insurance. The Governor and the General Assembly could build in an oversight role for the State Corporation Commission in monitoring insurance companies and employers, developing appropriate prohibitions and enforcing these prohibitions. California adopted employer and insurance company restrictions in its legislation.

Crowd out cannot be completely prevented. Over time, low income employees are less likely to choose family coverage when they change jobs and new employers are less likely to offer family coverage. This is already the trend in the employer market independent of the incentives implicit in the new public health insurance program.

One additional restriction applies only to a separate program (Options 3 and 4). A child who is a member of a family that is eligible for subsidized health insurance under a state health benefits plan is excluded from coverage under this new public insurance.

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[13] See Deborah Chollet, Michael L. Birnbaum and Michael J. Sherman, "Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience," Alpha Center, October 1997 (Pre-Publication Copy)

Utilization of Available Health Insurance

To the extent that eligible children have access to employer provided health insurance, it may be cost effective for the state to pay the employee's premium. Under Medicaid (Options 1, 2 and 5), DMAS has a program to do exactly this, the Health Insurance Premium Payment program. If Medicaid determines that paying the employee premium is cost effective compared to the cost of providing Medicaid services, Medicaid pays the premium and also provides "wrap around" Medicaid services if they are not covered by the private insurance. This can also have the indirect impact of paying for the health insurance for the entire family. The only drawback to such a program is that it is resource intensive to evaluate the cost effectiveness of each plan and to coordinate the payment of services.

A similar program could be incorporated into a separate program (Options 3 and 4) with or without wrap around coverage. Some states propose to provide insurance purchasing credits or vouchers to help employees pay for health insurance for their children. States would have to certify that the private insurance is equivalent to a benchmark plan under Title XXI. Title XXI also envisions states requesting waivers for purchase of family coverage if it is cost effective. The Department is continuing to investigate how to implement a program of vouchers.

Coordination with Public Programs

The Virginia Department of Health has identified 13 programs providing direct health and enabling services for children and families. In addition, the Virginia Department of Health identified eight other population based or infrastructure building programs. See Appendix 4. Public programs in both categories provide an infrastructure for serving children that is frequently not filled by the private sector. Some programs serve children with special needs or at higher risk. Funds for these programs are targeted to lower income individuals. Uninsured individuals usually pay on a sliding scale with 200 percent of poverty frequently being the upper income limit either for eligibility or for subsidized services. Other programs meet the high priority public health needs of the total population.

Many programs providing direct health services are reimbursed by Medicaid or private insurance. These programs will receive additional reimbursement through the new insurance initiative. These programs also provide extensive "wrap around" services not provided by Medicaid and private insurance and would continue to do so. Population based or infrastructure programs are not typically reimbursed by public or private insurance programs.

In addition to programs at the Virginia Department of Health, the new program needs to be coordinated with health programs at other government agencies such as the Department of Mental Health, Mental Retardation and Substance Abuse Services.

States can use state funds already committed to public health programs as part of the state match. There is no maintenance of effort provision that applies. Many state funds are already used to obtain federal matching funds, however, and cannot be used to obtain two different federal matching moneys.

As a result of this new insurance, there could also be some marginal increase in enrollment for other programs like TANF, food stamps and WIC. The outreach campaign will be focused only on enrollment in the health insurance initiative. Anyone wanting to apply for other benefits will have to use the current eligibility process rather than the streamlined, more convenient process DMAS and DSS intend to use for the new health insurance. For the most part the increased enrollment would be of those already eligible. Increased enrollment in some programs would not affect the state budget, since some of the programs such as WIC and food stamps are funded 100 percent by the federal government.

Entitlement

Medicaid extends an individual entitlement to benefits to eligible individuals. Expanding Medicaid (Options 1, 2 and 5) would expand the entitlement to Medicaid benefits and all the rules associated with Medicaid. By contrast, a separate program under Title XXI (Options 3 and 4) would not be an individual entitlement to benefits but a state capped entitlement.

Most states have resisted the expansion of the Medicaid entitlement and advocate for more flexibility similar to the block grant proposal to replace Medicaid advanced in the previous Congress. Title XXI gives states some of the flexibility envisioned in the block grant proposal, but only for the new initiative. The current Medicaid program is not reformed significantly and the new program is an additional layer on top of Medicaid. The total picture, especially if a separate program is created, is potentially more complicated and burdensome for the states. The need for coordination with Medicaid required by the federal legislation has an impact on both policy choices and operational implementation that reduces some of the perceived flexibility of a separate program. There would also be particular discontinuities for families with income between 100 and 133 percent of the poverty line, because children 0-5 are covered up to 133 percent by Medicaid and children 6-18 are not.

If a separate program is statewide and covers all eligible children, the separate program is not much different than Medicaid. Supplemental programs targeted to children based on geography or special needs could still be implemented using Title XXI funds without having to meet all the requirements of Medicaid or without having to seek HCFA waiver approval.

Title XXI gives states the flexibility to limit costs that is not available if the state chooses to expand Medicaid. One way of limiting the cost is to offer a modified benefit package. It is only less costly than Medicaid, however, if the state can get the same prices for services as it gets with Medicaid. Private insurance can be more expensive than Medicaid even though benefits are less.

The state can also establish a waiting list. A State could set its financial commitment at the point it would exhaust available federal matching funds, which are capped, or at a lower level. The point at which federal matching funds would be exhausted is important, because under Title XXI states could be completely responsible for all costs in excess of this amount. If total costs or administrative costs exceed the federal allocation for the enhanced match, the Commonwealth

would still receive the regular Medicaid match for excess costs for a Medicaid expansion that it would not receive for a separate program. As a result, the Medicaid entitlement limits the state's financial risk.

Based on DMAS estimates of the costs in the next chapter, Virginia will not exceed the federal allocation for any of the options providing health insurance to the target population. Only Option 5 to expand Medicaid to 200 percent of poverty comes close to exceeding the federal allocation. By the fourth year, the federal share for Option 5 could exceed the annual allocation for that year, even though lower costs during the transition phase give a cushion.

While it is unlikely that total costs will exceed the federal allocation (except under Option 5), administrative costs are very likely to exceed the limit for reimbursement by SCHIP for all the options during the start up. Virginia would still receive the regular Medicaid match for excess administrative expenses under a Medicaid expansion, but would have to cover the excess completely from state funds if it was a separate program.

CHAPTER 4 - ESTIMATED COST OF PLAN OPTIONS AND FINANCING

Per member per month costs will vary for the five options. The reason that the per member per month cost differs between the three Medicaid options (Options 1, 2 and 5) is because of differences in the population and the cost to serve the population. Option 1 is the lowest because it would only cover children 6-18, which are less expensive to serve than children 0-5. Option 5 is the most expensive because the population would include proportionately more children 0-5 than Option 2.

Per Member Per Month Costs by Program Option

Program	Per Member Per Month Cost (PMPM)
Option 1-Expand Medicaid 125%	$58.55
Option 2-Expand Medicaid 150%	$75.92
Option 3-Key Advantage 200% (Gross)	$97.67
Option 4-Regional Contracts 200% (Gross)	$67.11
Option 5-Expand Medicaid 200%	$85.80

Even though Options 2, 3 and 4 serve the same population, the per member per month cost differs because of the delivery system and benefits package. The Department assumes under a separate program (Options 3 and 4) that the benefits would be equivalent to Key Advantage without copays. But under Option 3, DMAS assumes the cost would be higher than Medicaid even though the benefits are lower because Trigon pays much higher fees than Medicaid even assuming the "final discount" usually given the state by Trigon. Under the state employee's contract with Trigon, the managed care component is small with the state bearing all the risk. The administrative costs are also high.

Under Option 4, DMAS assumes the per member per month cost would be lower than Medicaid. Not only is the benefit package less generous, but DMAS would get a price more competitive with Medicaid by bidding contracts to HMOs.

Over the next five fiscal years, the total cost of the State Children's Health Insurance program in Virginia would vary substantially depending on the option chosen. Fiscal year costs differ because of differences in per member per month costs and the implementation schedule. Options 3 and 4 would implement later than Options 1, 2 and 5. DMAS assumes that under each option the program will not reach maturity until after the third full fiscal year of operation.

Total Cost of Options by State Fiscal Year in Millions

	1999	2000	2001	2002	2003
Option 1-Expand Medicaid 125%	$5.8	$15.6	$22.3	**$25.5**	**$26.3**
Option 2-Expand Medicaid 150%	$16.0	$42.8	$61.1	**$69.9**	**$72.0**
Option 3-Key Advantage 200% (Gross)	$7.2	$42.4	$69.8	$87.6	**$92.6**
Option 4-Regional Contracts 200% (Gross)		$4.9	$29.1	$48.0	$60.3
Option 5-Expand Medicaid 200%	$25.3	$67.7	$96.6	**$110.6**	**$113.9**

Administrative costs are calculated up to the limit permitted for enhanced matching.
Bold indicates a mature program. Future growth reflects an assumption of 3 percent growth in benefit costs.

All options would be fully phased in by the end of the fifth fiscal year with the exception of Option 4 which would be 95 percent phased in.

Under all but Option 5, Virginia would eventually lose substantial portions of the federal allocation despite the ability to carry forward any unspent allocation for two additional years (see table below). Option 5 comes close to exceeding the federal allocation. By the fourth year, the federal share for Option 5 could exceed the annual allocation for that year, even though lower costs during the transition phase give a cushion.

Federal Matching Funds Forfeited in Millions by Federal Fiscal Year Allocation

	FFY 1998	FFY 1999	FFY 2000
Option 1-Expand Medicaid 125%	$50.5	$53.0	$51.3
Option 2-Expand Medicaid 150%	$19.4	$26.6	$21.8
Option 3-Key Advantage 200% (Gross)	$24.1	$19.3	$9.6
Option 4-Regional Contracts 200% (Gross)	$60.2	$46.0	$34.6
Option 5-Expand Medicaid 200%			

Assumes federal allocation of $68.3 million in each of the first four years and $50.3 million in FFY 2002

The table below shows the state share of the cost by fiscal year for the five options. HB 2682 has already earmarked $3.5 million in FY 1998 and $7.3 million in FY 1999 for the Virginia Children's Medical Security Insurance Plan Trust Fund, which the Department envisions would be used as part of the state match. Because moneys are not transferred to the trust fund until the end of the fiscal year, the Governor and the General Assembly may want to consider accelerating the transfer of funds.

State Share (GF) of Cost by State Fiscal Year in Millions

	1999	2000	2001	2002	2003
Option 1-Expand Medicaid 125%	$2.0	$5.3	$7.6	**$8.7**	**$8.9**
Option 2-Expand Medicaid 150%	$5.4	$14.5	$20.7	**$23.7**	**$24.4**
Option 3-Key Advantage 200% (Gross)	$2.4	$14.4	$23.7	$29.7	**$31.4**
Option 4-Regional Contracts 200% (Gross)		$1.7	$9.9	$16.3	$20.4
Option 5-Expand Medicaid 200%	$8.6	$23.0	$32.8	**$37.5**	**$38.6**

Administrative costs are calculated up to the limit permitted for enhanced matching.
Bold indicates a mature program. Future growth reflects an assumption of 3 percent growth in benefit costs.

The federal legislation limits the amount of spending on administration, outreach and direct services that can receive the enhanced S-CHIP match to ten percent of total expenditures in the year.[14] [15] DMAS proposes to do similar outreach regardless of the option. Differences in spending by fiscal year would vary depending on the implementation date. All expenses associated with outreach, including those efforts reaching children already eligible for Medicaid,

[14] Initially the legislation limited administrative, outreach and direct services spending to 10 percent of federal expenditures in a quarter. A technical correction changed the limit to 10 percent of total expenditures in the federal fiscal year.

[15] In addition, the legislation authorizing the Virginia Children's Medical Security Insurance Plan limits administrative expenses to five percent of the fund.

are allocated to S-CHIP. Outreach expenses would be highest in the first year and decline, especially after the program phased in, but some expenses would continue.

Proposed Outreach Expenses in Millions

First Year	Second Year	Third Year	Fourth Year	Fifth Year
$1.4	$1.3	$1.3	$1.3	$0.9

Administration expenses include primarily eligibility determination (a DSS responsibility) and claims processing (a DMAS responsibility). Based on preliminary estimates, about four-fifths of administration expenses are for DSS and eligibility determination. For this new insurance program, DMAS and DSS propose that the state general fund bear the full cost of the state share rather than require localities to put up matching funds as they do for eligibility determination currently.

Proposed Administration and Outreach Expenses in Millions

	1999	2000	2001	2002	2003
Option 1-Expand Medicaid to 125%					
Total Administration and Outreach	$3.7	$4.5	$5.2	$5.1	$4.8
S-CHIP Limit	$0.6	$1.6	$2.2	$2.6	$2.6
Administration and Outreach Above Limit	$3.1	$2.9	$3.0	$2.6	$2.2
State Share (GF)	$1.6	$1.4	$1.5	$1.3	$1.1
Option 2-Expand Medicaid to 150%					
Total Administration and Outreach	$6.1	$7.9	$9.5	$9.4	$9.3
S-CHIP Limit	$1.6	$4.3	$6.1	$7.0	$7.2
Administration and Outreach Above Limit	$4.5	$3.6	$3.4	$2.4	$2.1
State Share (GF)	$2.2	$1.8	$1.7	$1.2	$1.0
Option 3-Key Advantage 200% (Gross)					
Total Administration and Outreach	$3.0	$7.0	$8.7	$9.4	$9.4
S-CHIP Limit	$0.7	$4.2	$7.0	$8.8	$9.3
Administration and Outreach Above Limit	$2.3	$2.7	$1.7	$0.6	$0.1
State Share (GF)	$2.3	$2.7	$1.7	$0.6	$0.1
Option 4-Regional Contracts 200% (Gross)					
Total Administration and Outreach		$3.0	$7.0	$8.7	$9.4
S-CHIP Limit		$0.5	$2.9	$4.8	$6.0
Administration and Outreach Above Limit		$2.5	$4.1	$3.9	$3.4
State Share (GF)		$2.5	$4.1	$3.9	$3.4
Option 5-Expand Medicaid to 200%					
Total Administration and Outreach	$7.9	$10.5	$12.7	$12.6	$12.6
S-CHIP Limit	$2.5	$6.8	$9.7	$11.1	$11.4
Administration and Outreach Above Limit	$5.4	$3.7	$3.0	$1.6	$1.2
State Share (GF)	$2.7	$1.9	$1.5	$0.8	$0.6

Totals do not add due to rounding.

Only administration and outreach expenses up to the S-CHIP limit can receive the enhanced match under Title XXI. Under a Medicaid expansion, non S-CHIP administrative expenses for the new program would not be reimbursed at the enhanced rate, but would still be reimbursed by Medicaid based on the regular Medicaid match. If it is a separate Title XXI program, any non S-CHIP expenses would be totally a state expense.

DMAS expects administration and outreach costs in the first few years to exceed the federal limitation when benefit expenditures are low relative to administrative costs. These expenditures, however, are a necessary investment in implementing a successful program. Initial estimates for administration and outreach costs, however, indicate that spending on administration and outreach will exceed the S-CHIP limit not only during the start-up years, but also in future years. These costs also exceed the five percent limit on administrative expenses for use of funds from the Virginia Children's Medical Security Insurance Plan Trust Fund. DMAS recognizes that these costs must be trimmed, but did not have the time to thoroughly review the administrative cost estimates.

CHAPTER 5 - IMPACT ON CURRENT MEDICAID PROGRAM

As a result of the outreach program, DMAS expects to identify half of the 82,000 children who are eligible for the current Medicaid program but not enrolled.[16] The enrollment estimate is higher than that assumed nationally by the Congressional Budget Office, but Virginia has done very little outreach compared to other states. These children are already eligible but not receiving benefits for whatever reason, but many in this group will be targeted by the planned outreach effort. While these children are not part of the new federal program, providing health insurance for these children is part of the goal of the Virginia Children's Medical Security Insurance plan. Virginia can only receive the regular Medicaid match rate for this group.

The table below estimates the total cost and the state share over the next five fiscal years (see Appendix 5 for a detailed estimate). The state share for regular Medicaid expenses is 51.5 percent. These estimates assume that outreach will begin in time to implement the new insurance initiative on July 1, 1998. If the new insurance initiative is implemented later (Options 3 and 4) and the outreach initiative is delayed, the projected costs would also be delayed. DMAS assumes that the impact on Medicaid will not be fully felt until the FY 2002.

Cost to Current Medicaid Program of Outreach in Millions

	1999	2000	2001	2002	2003
Benefit Cost	$9.3	$25.0	$35.6	$40.8	$42.0
Administration Cost	$2.7	$3.8	$5.0	$5.0	$5.1
Total	$12.0	$28.8	$40.6	$45.7	$47.1
State Share (GF)	$5.7	$13.9	$19.6	$22.1	$22.7

Totals do not add due to rounding.

[16] Outreach efforts under Option 1 potentially could be more limited since Option 1 would only target children 6-18, but DMAS proposes to do the same outreach for all options.

CHAPTER 6 - CONCLUSION

The Virginia Children's Medical Security Insurance Plan may have to be modified or repealed to implement a program under the new Title XXI of the Social Security Act, but the goals of the legislation are very similar to the federal legislation. Following the federal legislation allows Virginia to leverage state funds to provide health insurance to children in families with income under 200 percent of poverty.

The Department estimates there are 154,000 uninsured children in families with income below 200 percent of poverty in Virginia. If Virginia were to develop a program consistent with the new federal legislation to provide health insurance for these children, DMAS estimates that over three years approximately 63,200 children would enroll in the new health insurance program and an additional 41,000 children would enroll in the current Medicaid program. The total number of children with public insurance would be 104,200, or one-third as many children already enrolled in Medicaid.

The Department analyzed five options (see summary table). Options 1-4 comply with the legislative request to develop a schedule for providing health insurance for uninsured and underinsured children in families with incomes at 200 percent of poverty or less, to be phased in over five years. Option 5 would provide health insurance to children in families with income up to 200 percent of poverty and above.

Options for Virginia's State Children's Health Insurance Program

Program Description	Entitle-ment	Cost Per Member Per Month	Number of Children Enrolling	Imple-mentation Schedule	Advantages	Disadvantages
Option 1-Expand Medicaid to 125% of Poverty	yes	$58.55	29,900	July 1, 1998	Implement soon. Comprehensive benefits. Delivery system in place. Cost no more than money currently earmarked.	Medicaid "stigma." Only covers children 6-19.
Option 2-Expand Medicaid to 150% of Poverty	yes	$75.92	63,200	July 1, 1998	Implement soon. Comprehensive benefits. Delivery system in place.	Medicaid "stigma."
Option 3-Key Advantage to 200% of Poverty (Gross Income)	no	$97.63	63,200	Jan. 1, 1999	Delivery system in place.	More costly per person than Medicaid. Less comprehensive benefits. Implement later. Children of State employees ineligible.
Option 4-Bid Regional Contracts to 200% of Poverty (Gross Income)	no	$67.11	63,200	Jan. 1, 2000	Least costly per person.	Less comprehensive benefits. Implement latest. Children of state employees ineligible.
Option 5-Expand Medicaid to 200% of Poverty	yes	$85.80	88,400	July 1, 1998	Implement soon. Comprehensive benefits. Delivery system in place. Provides insurance to children above target population.	Medicaid "stigma." Benefits unnecessarily generous. Exacerbate substitution of private insurance.

APPENDIX 1

HB 2682

CHAPTER 679

An Act to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 13, consisting of sections numbered 32.1-351, 32.1-352 and 32.1-353, relating to establishing the Virginia Children's Medical Security Insurance Plan; trust fund.

[H 2682]

Approved March 21, 1997

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 13, consisting of sections numbered 32.1-351, 32.1-352 and 32.1-353, as follows:

CHAPTER 13.
VIRGINIA CHILDREN'S MEDICAL SECURITY INSURANCE PLAN.

§32.1-351. Virginia Children's Medical Security Insurance Plan established.

A. The Department of Medical Assistance Services shall develop the Virginia Children's Medical Security Insurance Plan to provide coverage for individuals, up to the age of eighteen, when such individuals (i) are in families with incomes at 200 percent of the poverty level or less and (ii) are not insured or are underinsured by any policy, plan or contract providing health benefits.

B. The Department of Medical Assistance Services shall develop a proposal for this program by December 1, 1997. In developing this proposal, the Department shall consider, but need not limit its proposal to: (i) the services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan (CHIRP); (ii) the provision of services through a network of participating providers; (iii) the development of public/private partnerships; (iv) a schedule for providing universal coverage for uninsured and underinsured children in families with incomes at 200 percent of the poverty level or less, to be phased in over a period of five years; and (v) alternatives for soliciting or requiring contributions from employers. The Department shall also include in its proposal criteria for determining "underinsured."

C. Funding for this program shall be provided through the Virginia Children's Medical Security Insurance Plan Trust Fund.

D. The Board of Medical Assistance Services may promulgate such regulations pursuant to the Administrative Process Act (§9-6.14:1 et seq.) as may be necessary for the implementation of the program consistent with this chapter.

§32.1-352. Virginia Children's Medical Security Insurance Plan Trust Fund.

A. For the purpose of providing primary and preventive care to certain individuals up to the age of eighteen, there is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Children's Medical Security Insurance Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall

consist of the premium differential, any employer contributions which may be solicited or received by the Department of Medical Assistance Services, and all grants, donations, gifts, and bequests from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to subdivision A 4 of §58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in §38.2-4201 or §38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to subdivision D of §38.2-4229.1. The State Corporation Commission shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Children's Medical Security Insurance Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Children's Medical Security Insurance Plan, developed by the Department of Medical Assistance Services pursuant to §32.1-351. No more than five percent of such Fund may be used for administration.

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served, the costs of such services, and any issues related to the Virginia Children's Medical Security Insurance Plan that may need to be addressed. The first such report shall, however, consist of the proposal for implementation of the Virginia Children's Medical Security Insurance Plan as required by this chapter.

§32.1-353. Rights and Responsibilities.

This chapter shall not be construed as creating any legally enforceable right or entitlement to payment for medical services on the part of any medically indigent person or any right or entitlement to participation.

APPENDIX 2

SURVEY OF INITIATIVES IN OTHER STATES
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Children's Health Insurance Program:

A Status Report

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October 1997

Background

States are busy considering options and developing recommendations to implement CHIP

In September, 1997 NASHP conducted a brief one page survey of states to gauge the status of plans to implement the Children's Health Insurance Program (CHIP) and the approaches being considered on key variables:

- The agency or agencies responsible for designing and implementing the state's plan;
- Approaches being considered;
- Strategies to prevent "crowd out;"
- Eligibility level; and
- Benefit package.

This report represents a snapshot of planning activity in 47 states between the end of September and the middle of October. States are moving quickly to examine options, make recommendations and develop implementation plans and the information may have changed since this report was completed.

Lead agencies

Governor's offices and Medicaid agencies are taking lead

Planning is being coordinated by the governor's office in ten states (Connecticut, Delaware, Florida, Illinois, Indiana, Maryland, New York, South Carolina, Texas and Washington). Medicaid agencies have been designated as the sole lead agency in eighteen states and are involved with other agencies in five states.

Commissions, Task Forces and interagency work groups have been formed to develop recommendations in eight states

Task forces have been formed in nine states -Alabama, Iowa, Louisiana, Maine, Mississippi, Montana, Nebraska, North Carolina and West Virginia.

In Alabama, the state Medicaid agency formed a task force when the federal law passed. The state legislature passed a bill creating a commission chaired by the State Health Officer (Department of Health). The Commission began meeting in October and will review the Medicaid agency's recommendations before submitting its report to the legislature in January.

Iowa has appointed a task force and an interagency work group. The task force which includes consumers, providers,

educational associations and insurance companies is holding 18 public forums around the state. It was charged with developing options for implementing the program. The interagency work group is chaired by the Medicaid agency and will make recommendations to the governor using the work done by the task group.

Louisiana's task force was created September 16th by the Governor within the Department of Health and Hospitals. The task force will explore expanding Medicaid and developing a pilot project providing private or school-based insurance with full or sliding scale premiums and minimal co-payments. The 15 member task force consists of legislators and state officials.

In Maine, a Commission on Children's Health Care created by the state legislature began meeting on October to develop recommendations. The 16 member commission includes two state agencies, seven legislators and seven public members appointed by the Governor, Speaker of the House and the President of the Senate. A report is due by December 15th.

An informal work group is meeting in Mississippi to examine the issues and options for implementation. The group includes the governor's office, state agencies and key legislators.

A task force of 30 members, led by the Medicaid Department, has been appointed in Nebraska. Weekly meetings are being held.

North Carolina's 50 member task force was appointed by Governor Hunt in July. The group includes state agencies, the NC Institute of Medicine, insurers, family advocates, and providers. The group is considering Medicaid expansion, a state subsidized program and a voucher program. Recommendations are expected by mid-November.

In Utah, implementation options are being reviewed by the Health Policy Commission, a standing commission created to develop health reform initiatives. The Commission will make recommendations to the governor and the legislature.

Lead agencies	
Agency	Number of states*
Governor's office	10
Medicaid Department	23
Health Department	7
Maternal and Child Health Division	0
Task Force	9
Other	10

Approaches

Medicaid expansions and subsidized insurance plans are the most prevalent approaches being considered.

Most states are considering Medicaid and/or subsidized insurance strategies. Medicaid is sole strategy in Missouri, Vermont and Wisconsin. Subsidized insurance programs are the sole strategy in Arkansas, Colorado, Connecticut, New York, Pennsylvania and Utah. Massachusetts is considering tax credits for individuals and employers while Idaho, Minnesota and Montana were considering tax credits/deductions for individuals. Texas was also considering the use of tax credit/deductions.

Some states were considering dual approaches, typically using Medicaid up to 100% (California) or 150% (Oregon, South Carolina) of poverty and a subsidized insurance plan for children in families with incomes between the Medicaid threshold and 200% of poverty.

California will use a purchasing pool created by the Managed Risk Medical Insurance Board. It will also create a purchasing credit option for employees to pay for employer-sponsored coverage for dependents. Contracting plans will be required to have contracts with traditional and safety net providers.

Nevada's governor has announced plans to use Family Resource Centers, school based clinics and Early Children programs to deliver services.

Program approaches	
Approaches being considered	Number of States*
Medicaid expansion	21
Subsidized insurance plan	23
Tax credits/deductions	8
New system of care	9
Not determined	2

* Many states are considering more than one approach.

1115 waiver implications

Unique circumstances have emerged in several states which expanded eligibility for families and children through 1115 waivers. Hawaii's HealthQuest program expanded Medicaid eligibility to 300% of poverty for adults and families. Advocates successfully filed a suit on behalf of aged, blind and disabled beneficiaries whose eligibility was not increased. Since equalization would have considerable budgetary implications, the state imposed an assets test and will propose to reduce the income eligibility level to comply with the court's decision. However, this action to equalize eligibility is contrary to CHIP which denies Title XXI reimbursement to any state which reduces its Medicaid eligibility standards for children after June 1997.

Rhode Island, which recently increased eligibility for women and children to 250% of poverty, is also exploring innovative approaches to expanding coverage and creating incentives for employers to cover employees and their families.

Tennessee re-opened enrollment in TennCare to uninsured children in April 1997. To participate, children must not have had access to other coverage. Since the program expansion took place prior to April 15th, the state may not be eligible for the enhanced matching rate.

Oklahoma is implementing its SoonerCare program under an 1115 waiver which is similar to Title XXI. Part of the expansion planned under SoonerCare, eg., phased eligibility to 200% beginning 12/97 and to 250% 12/98 may be covered through Title XXI.

Eligibility levels

Under CHIP, states may serve uninsured children in families with incomes below 200% of the federal poverty or 50% above the state's Medicaid eligibility level in effect in June 1997. Nineteen states had not determined the likely eligibility level and ten states indicated that 200% is the likely criteria. Eligibility thresholds ranged from 100% in Alabama to 300% in Missouri. States that are considering other thresholds include Colorado (185%), Connecticut (285%), New Mexico and Pennsylvania (235%), South Carolina (150% initially), Vermont (275-300%) and Washington (250%). Massachusetts will increase its threshold to 133% threshold immediately, with a further increase to 200% when its Title XXI state plan is approved.

Hawaii faces a court decision which found that higher eligibility levels for adults and children than for aged, blind and disabled beneficiaries violated the Americans with Disabilities Act. Since it cannot afford to raise eligibility for all categories, it may reduce eligibility to comply with the court decision. However, this may violate the provisions of Title XXI which do not allow states to reduce Medicaid eligibility afer June 1997.

Nebraska is conducting an analysis of how many children can be covered with available funds at various levels of poverty. The state is interested in eliminating eligibility differences based on age.

Nevada will stagger eligibility levels by age. Children under 5, who are now eligible for Medicaid if their income is below 133%, will be eligible up to 150%; children 6-12 at 133% and children 13-18 at 100%. Current Medicaid eligibility is 100% and 35% of poverty respectively.

Pennsylvania will retain the 235% level under its state funded CHIP program but may propose increasing the zero

premium level from 185% to 200% of poverty.

Rhode Island expanded eligibility for children to 250% of poverty under its 1115 program, RiteCare, and its exploring implications and options under Title XXI.

Wisconsin's "Family Health Insurance Program" will cover all children in uninsured families up to 185% of poverty. However, children will remain eligible if their income rises to 200% of poverty as long as they were previously eligible. Premiums will be charged to children in newly eligible families.

Approach to "crowd out"

The law requires that states submit, as part of their state plan, a description of how the program will deal with children who have access to or are covered by other health plans. The law also does not allow CHIP to be the primary payer for children who have other coverage. States are interested in ensuring that families do not drop private coverage for their children and that employers that provide health insurance benefits do not discontinue dependents coverage. Fifteen states are planning to require that children eligible for the state CHIP plan were uninsured prior to coverage through CHIP. Two states are considering penalties on employers who drop dependent coverage and eight states are considering requiring families to enroll in an employer's plan if dependent coverage is offered. Three states may conduct studies of "crowd out" to determine if and to what extent it occurs and the appropriate steps to address the issue. Twenty one states had not

"Crowd out" strategy	
Approaches	Number of states
Uninsured prior to coverage	17
Penalties on employers	2
Require enrollment in employer plan	8
Conduct a study	3
Not Determined	26

determined what approaches they may take to this issue. Eleven states indicated that multiple strategies were being considered.

California will exclude children who have been covered by an employer plan within three months of application, however, children with prior individual coverage will be eligible.

Governor Thompson of Wisconsin proposed to exclude children of workers whose employer offer coverage and pays 80% of the premium cost.

Benefit package

Most states have not determined their benefit design although Medicaid leads among respondents stating a preference

The law gives states several options for developing benefit packages for CHIP. States may enroll eligible children using one of the following benefit plans:

- Enroll in the state's Medicaid program;
- Provide benefits using a benchmark plan;
- Develop a benefit package that is actuarially equivalent to a benchmark plan;
- Enroll in an existing comprehensive state-based program (New York, Florida, Pennsylvania only); or
- A package approved by the Secretary.

Only Nevada plans to use a commercial HMO plan as the benchmark plan

The benchmark plans include:

- FEHBP equivalent children's coverage using the standard Blue Cross/Blue Shield preferred provider option;
- State employee coverage;
- Coverage offered through an HMO which has the largest insured commercial enrollment.

States may develop a package that is actuarially equivalent to a plan providing basic services (inpatient and outpatient, physicians' surgical and medical services, lab and x-ray services, well-baby and well-child care including age appropriate immunizations) and 75% of the actuarial value of supplemental services. The supplemental services include prescription drugs, mental health services, vision services and dental services.

The survey indicated that 23 states had not determined which approach will be taken to provide benefits and ten states were likely to enroll eligible children in their Medicaid program. Three states planned to develop an actuarially equivalent plan and four states were considering using the state employee benefit package. Utah may add additional preventive benefits to the sate employee package. Nevada was the only state to indicate that they would design a benefit plan based on the commercial HMO option. No state indicated that would use the FEHBP.

Benefit package	
Option	Number of states
State employees plan	4
Commercial HMO	1
Actuarial equivalent	3
Medicaid	10
FEHBP	0
Not determined	18

Note: Several states will use Medicaid and a second package for subsidized insurance coverage.

State action

Arkansas passed a bill in 1997 prior to passage of the federal bill, creating the ARKids program to serve children under age 19 in families with income below 200% of the federal poverty level for whom health coverage is unavailable. Regulations and policies implementing the program are being prepared by the Department of Human Services.

In California, legislation implementing a new program was signed by Governor Wilson on October 2nd. The Health Families program will cover a projected 580,000 uninsured children with incomes between 100% and 200% of the federal poverty level. Monthly premiums from $7 to $27 will be charged depending on income and the plan selected. The program will be administered by the Major Risk Medical Insurance Board which developed the

state's regional purchasing alliances for small group policies. In addition to the subsidized program, Medicaid eligibility will be expanded for uninsured children age 13-18 in families with income below 100% of the federal poverty level. Benefits will be based on the state employee insurance program plus dental and vision coverage.

Conclusion

A majority of states were continuing to examine the multiple options available under Title XXI. Task forces established in many states will be forwarding recommendations to state agencies and governors from the end of October to the end of November. Legislative initiatives, which were not included in this review, can also be expected as proposals from governors are reviewed during the 1998 legislative session.

Prior to Title XXI, several states had already expanded Medicaid eligibility to uninsured families and children at varying levels of poverty under 1115 waivers. These states, eg., Minnesota, Rhode Island, are now exploring options to cover uninsured parents of children now covered by the Medicaid expansion.

Because many states had not completed their review and developed specific proposals, the findings summarized in this survey will change quickly.

APPENDIX 3

EXPLANATION OF MEDICAID COUNTABLE INCOME

EXPLANATION OF MEDICAID COUNTABLE INCOME

For purposes of estimation and program design, the Department considers Medicaid "countable income" to be equivalent to a gross income 50 percentage points of poverty higher. Medicaid countable income is similar to the concept of "adjusted gross income" used for taxation. Medicaid disregards some income in determining eligibility. The eligibility policy manual used by DMAS and the Department of Social Services takes 15 pages to explain income, but the most common income disregards are:

- standard work exclusion (first $90 per month of gross earned income for each employed member of family)
- child care/incapacitated adult care expenses ($175 per month per child older than 1 and $200 per month per child up to age 1)
- child support (first $50 each month)

The following table shows examples of calculations of Medicaid countable income at 150 percent of poverty for different family sizes. Gross income can exceed the countable amount by 50 percentage points though the actual amount depends on individual circumstances.

By using income disregards, Virginia could actually cover children in families with gross income in excess of 200 percent of poverty. If Virginia expands Medicaid to 200 percent of poverty as recommended by the Joint Commission Subcommittee, gross income could exceed 200 percent of poverty. If a state wanted to cover children at even higher levels of gross income, it could do so by using very liberal income disregards. HCFA apparently intends to permit states such flexibility.

Comparison of Gross and Medicaid Countable Income Based on the Most Common Income Disregards									
Family Size	Medicaid Countable Income 150% of Poverty	Working Exclusion ($90 per month per worker)	% of Poverty	Max. Child Care ($175 per month per child >1)	% of Poverty	Child Support ($50 per month per child)	% of Poverty	Total	Gross Income % of Poverty
	Single Parent Working								
2	$15,915	$1,080	10%	$2,100	20%	$600	6%	$19,695	186%
3	$19,995	$1,080	8%	$4,200	32%	$1,200	9%	$26,475	199%
4	$24,075	$1,080	7%	$6,300	39%	$1,800	11%	$33,255	207%
	Two Parents Working								
3	$19,995	$2,160	16%	$2,100	16%			$24,255	182%
4	$24,075	$2,160	13%	$4,200	26%			$30,435	190%
5	$28,155	$2,160	12%	$6,300	34%			$36,615	195%

APPENDIX 4

VIRGINIA DEPARTMENT OF HEALTH PROGRAMS SERVING CHILDREN AND FAMILIES

RELATIONSHIP OF VIRGINIA DEPARTMENT OF HEALTH PROGRAMS TO THE NEW STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Direct Health and Enabling Services for Children and Families

Program or Service	Eligibility	Funding Source	Medicaid Billable Services (many, but not all are billable to private insurance)	Non-billable Services
Child Development Services	0 - 21 yrs. with developmental or behavioral problems	Medicaid and private insurance, sliding fee scale, federal MCH block grant and state match	physician psychologist care coordination 0 - 2 yrs (limited) interdisciplinary medical conference	care coordination >2 yrs interpreter (deaf and foreign language) clinic network multidisciplinary teams of pediatric specialists (physician, nurse, social worker, psychologist)
Children's Specialty Services	0 - 21 yrs. with selected handicapping conditions; <200% poverty for most conditions, some higher with sliding scale	Medicaid and private insurance, sliding fee scale, federal MCH block grant and state match	inpatient and outpatient hospital care and physician services rehabilitative services (limited) durable medical equipment and supplies (limited) care coordination 0-2 yrs (limited) psychology (limited)	rehabilitative therapies beyond Medicaid limit durable medical equipment and supplies beyond Medicaid limit care coordination >2 yrs interpreter (deaf and foreign language) clinic network multidisciplinary teams of pediatric specialists psychological testing education consultant nutrition counseling linkages to Part H and other community services
Metabolic Treatment Program	All children with a metabolic diseased screened through the Newborn Screening Program	Federal MCH block grant and state match	physician	clinic network nutrition counseling

Resource Mothers Program	Pregnant and parenting teens to infant's first birthday; additional target populations in some localities	Medicaid administrative funds, federal MCH block grant and state match, federal Healthy Start grant, local public and private	transportation to medical appointments	outreach home visiting family support health education parenting education transportation to apply for Medicaid and other services child care for medical appointments
Comprehensive Health Investment Project (CHIP)	Low income families with preschool children; varies by locality	General fund, federal MCH block grant and state match, Kellogg Foundation, other public and private	care coordination for medically high-risk infants 0-2 yrs. (limited) transportation to medical appointments	care coordination for >2 yrs. and for medically low risk family support services transportation to social services health education
Immunizations	All	Federal Vaccines for Children, state/local cooperative budget	vaccine administration	
Primary care for children and adolescents	Services and eligibility vary by locality	Medicaid and private insurance, sliding fee scale, federal MCH block grant and state match, state/local cooperative budget, other public and private	EPSDT physician care coordination 0 - 2 yrs .for medically high risk (limited	health education care coordination for > 2 yrs. and for medically low risk interpreter (foreign language) nutrition counseling social work information and referral outreach home visiting
Sexually Transmitted Diseases	All	Medicaid and private insurance, federal grants for HIV; state/local cooperative budget	testing medical treatment	outreach case management
Lead Poisoning Prevention	0 - 6 yrs	Medicaid and private insurance, federal grant, state/local cooperative budget	screening medical treatment environmental investigation	health education nutrition counseling case management

Prenatal care	Pregnant females	Medicaid and private insurance, sliding fee scale, federal MCH block grant and state match, state/local cooperative budget	medical care care coordination for medically high risk (limited) nutrition counseling (limited) homemaker service (limited) health education (limited)	social work health education information and referral interpreter (foreign language) home visiting
Family Planning	Child-bearing age	Medicaid and private insurance, federal Title X and state match, state/local cooperative budget	comprehensive family planning services	community education outreach
Dental Health	Varies by locality	Medicaid and private insurance, sliding fee scale, state/local cooperative budget	preventive and restorative dental care 1 oral hygiene visit	oral hygiene education beyond 1 visit
School Health	Public school children in selected localities	Federal MCH block grant and state match, state/local cooperative budget, other public and private	skilled nursing sessions for special education students, e.g. medications, specialized health care procedures	case finding nursing care procedures for non-special education students care coordination Medicaid outreach health counseling and instruction first aid and emergency care

Population Based and Infrastructure Building Programs

Program	Target Population	Funding	Strategies
Newborn Screening Program	All infants born in Virginia through 6 mo.	Federal MCH block grant and state match	parent hotline tracking and follow-up public education consultation
Hearing Impairment Identification and Monitoring System	All births with or at high risk for hearing impairment	Federal MCH block grant and state match	monitoring for hearing impairment parent education referral for evaluation and treatment
High Priority Infant Tracking Program	0 - 3 yrs with or at risk of developmental or chronic health problems	Federal Part H grant to DMHMRSAS	hospital discharge planning referral tracking
Healthy Start	Pregnant women and infants in Richmond City (5 different communities in FY 97)	Federal grant	community coalitions fetal/infant mortality review public education support services
Regional Perinatal Coordinating Councils	Pregnant women and infants	Federal MCH block grant and state match	community coalitions professional education parent education fetal/infant mortality review
Teen Pregnancy Prevention Program	Adolescents	Medicaid administrative funds, federal MCH block grant and state match	health education social support community coalitions
Fatherhood Initiative	Fathers	Federal MCH block grant and state match, federal grant to DSS, general fund	public education community projects resource center
Childhood Injury Prevention	Children and adolescents	Federal PHHS block grant, federal MCH block grant and state match	community coalitions public education community projects

APPENDIX 5

DETAILED COST ESTIMATES

Option 1: Expand Medicaid Up to 125% of Poverty

Uninsured Children	
Uninsured Kids Becoming Eligible for Medicaid	37,000
Estimated Cost Per Full Year Eligible	$702.60
Potential Full Year Cost	$25,996,200
Currently Insured Children	
Number of Currently Insured Children Potentially Eligible	20,000
Estimated Cost Per Full Year Eligible	$702.60
Potential Full Year Cost	$14,052,000
Expected Enrollment in Mature Program (Maximum)	
Assume 70% of Uninsured Children will Enroll in the New Program	25,900
Assume 20% of Insured Children will Enroll in the New Program	4,000
Total Enrollment in Mature Program	29,900
Estimated Cost Per Full Year Eligible	$702.60
Potential Full Year Cost	$21,007,740

Assume Program will Require 3 Years to Reach Maturity

FY 1999 Enrollment	14,950
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	351.3
FY 1999 Medical Cost	$5,251,935
Allotment Allowed for Administrative, Outreach, & Direct Services	$583,548
Total Funds	$5,835,483
GF	$1,979,000
NGF	$3,856,000
FY 2000 - Enrollees at the Beginning of the Year	14,950
Full Year Cost (Increase FY 1999 Figure By 3%)	$724
Cost for Full Year Enrollees	$10,823,800
FY 2000 - Enrollees Phasing In During the Year	8,970
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$362.00
Cost for New Enrollees	$3,247,140
Total FY 2000 Cost	$14,070,940
Allotment Allowed for Administrative, Outreach, & Direct Services	$1,563,438
Total Funds	$15,634,378
GF	$5,302,000
NGF	$10,332,000
FY 2001 - Enrollees at the Beginning of the Year	23,920
Full Year Cost (Increase FY 2000 Figure By 3%)	$746
Cost for Full Year Enrollees	$17,844,320
FY 2001 - Enrollees Phasing In During the Year	5,980
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$373.00
Cost for New Enrollees	$2,230,540
Total FY 2001 Cost	$20,074,860
Allotment Allowed for Administrative, Outreach, & Direct Services	$2,230,540
Total Funds	$22,305,400
GF	$7,565,000
NGF	$14,741,000
FY 2002 - Enrollees at the Beginning of the Year	29,900
Full Year Cost (Increase FY 2001 Figure By 3%)	$768
Total FY 2002 Cost	$22,974,562
Allotment Allowed for Administrative, Outreach, & Direct Services	$2,552,729
Total Funds	$25,527,291
GF	$8,658,000
NGF	$16,870,000
FY 2003 - Enrollees at the Beginning of the Year	29,900
Full Year Cost (Increase FY 2002 Figure By 3%)	$791
Total FY 2003 Cost	$23,663,799
Allotment Allowed for Administrative, Outreach, & Direct Services	$2,629,311
Total Funds	$26,293,110
GF	$8,917,000
NGF	$17,376,000

Option 2: Expand Medicaid Up to 150% of Poverty

Uninsured Children	
Uninsured Kids Becoming Eligible for Medicaid	72,000
Estimated Cost Per Full Year Eligible	$911.00
Potential Full Year Cost	$65,592,000
Currently Insured Children	
Number of Currently Insured Children Potentially Eligible	64,000
Estimated Cost Per Full Year Eligible	$911.00
Potential Full Year Cost	$58,304,000
Expected Enrollment in Mature Program (Maximum)	
Assume 70% of Uninsured Children will Enroll in the New Program	50,400
Assume 20% of Insured Children will Enroll in the New Program	12,800
Total Enrollment in Mature Program	63,200
Estimated Cost Per Full Year Eligible	$911.00
Potential Full Year Cost	$57,575,200

Assume Program will Require 3 Years to Reach Maturity

FY 1999 Enrollment	31,600
On the Average Enrolled For a Half (Divide Full Year Per Person Cost By two)	455.5
FY 1999 Medical Cost	$14,393,800
Allotment Allowed for Administrative, Outreach, & Direct Services	$1,599,311
Total Funds	$15,993,111
GF	$5,424,000
NGF	$10,569,000
FY 2000 - Enrollees at the Beginning of the Year	31,600
Full Year Cost (Increase FY 1999 Figure By 3%)	$938
Cost for Full Year Enrollees	$29,640,800
FY 2000 - Enrollees Phasing In During the Year	18,960
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$469.00
Cost for New Enrollees	$8,892,240
Total FY 2000 Cost	$38,533,040
Allotment Allowed for Administrative, Outreach, & Direct Services	$4,281,449
Total Funds	$42,814,489
GF	$14,521,000
NGF	$28,294,000
FY 2001 - Enrollees at the Beginning of the Year	50,560
Full Year Cost (Increase FY 2000 Figure By 3%)	$966
Cost for Full Year Enrollees	$48,840,960
FY 2001 - Enrollees Phasing In During the Year	12,640
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$483.00
Cost for New Enrollees	$6,105,120
Total FY 2001 Cost	$54,946,080
Allotment Allowed for Administrative, Outreach, & Direct Services	$6,105,120
Total Funds	$61,051,200
GF	$20,706,000
NGF	$40,346,000
FY 2002 - Enrollees at the Beginning of the Year	63,200
Full Year Cost (Increase FY 2001 Figure By 3%)	$995
Total FY 2002 Cost	$62,882,736
Allotment Allowed for Administrative, Outreach, & Direct Services	$6,986,971
Total Funds	$69,869,707
GF	$23,696,000
NGF	$46,173,000
FY 2003 - Enrollees at the Beginning of the Year	63,200
Full Year Cost (Increase FY 2001 Figure By 3%)	$1,025
Total FY 2003 Cost	$64,769,218
Allotment Allowed for Administrative, Outreach, & Direct Services	$7,196,580
Total Funds	$71,965,798
GF	$24,407,000
NGF	$47,559,000

Option 3: Expand Up to 200% of Poverty (Gross Income) - Key ADVANTAGE

Uninsured Children	
Uninsured Kids Becoming Eligible for Program	72,000
Estimated Cost Per Full Year Eligible	$1,172.04
Potential Full Year Cost	$84,386,880
Currently Insured Children	
Number of Currently Insured Children Potentially Eligible	64,000
Estimated Cost Per Full Year Eligible	$1,172.04
Potential Full Year Cost	$75,010,560
Expected Enrollment in Mature Program (Maximum)	
Assume 70% of Uninsured Children will Enroll in the New Program	50,400
Assume 20% of Insured Children will Enroll in the New Program	12,800
Total Enrollment in Mature Program	63,200
Estimated Cost Per Full Year Eligible	$1,172.04
Potential Full Year Cost	$74,072,928
Assume Program will Require 3 Years to Reach Maturity	
(PROGRAM WILL NOT START TILL JANUARY 1999)	
FY 1999 Enrollment	22,120
On the Average Enrolled For Quarter a Year (Divide Full Year Per Person Cost By Quarter)	293.01
FY 1999 Medical Cost	$6,481,381
Allotment Allowed for Administrative, Outreach, & Direct Services	$720,153
Total Funds	$7,201,535
GF	$2,442,000
NGF	$4,759,000
FY 2000 - Enrollees at the Beginning of the Year	22,120
Full Year Cost (Increase FY 1999 Figure By 3%)	$1,207
Cost for Full Year Enrollees	$26,698,840
FY 2000 - Enrollees Phasing In During the Year	18,960
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$603.50
Cost for New Enrollees	$11,442,360
Total FY 2000 Cost	$38,141,200
Allotment Allowed for Administrative, Outreach, & Direct Services	$4,237,911
Total Funds	$42,379,111
GF	$14,373,000
NGF	$28,006,000
FY 2001 - Enrollees at the Beginning of the Year	41,080
Full Year Cost (Increase FY 2000 Figure By 3%)	$1,243
Cost for Full Year Enrollees	$51,062,440
FY 2001 - Enrollees Phasing In During the Year	18,960
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$621.50
Cost for New Enrollees	$11,783,640
Total FY 2001 Cost	$62,846,080
Allotment Allowed for Administrative, Outreach, & Direct Services	$6,982,898
Total Funds	$69,828,978
GF	$23,682,000
NGF	$46,146,000
FY 2002 - Enrollees at the Beginning of the Year	60,040
Full Year Cost (Increase FY 2001 Figure By 3%)	$1,280
Cost for Full Year Enrollees	$76,851,200
FY 2002 - Enrollees Phasing In During the Year	3,160
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$640.00
Cost for New Enrollees	$2,022,400
Total FY 2002 Cost	$78,873,600
Allotment Allowed for Administrative, Outreach, & Direct Services	$8,763,733
Total Funds	$87,637,333
GF	$29,722,000
NGF	$57,915,000
FY 2003 - Enrollees at the Beginning of the Year	63,200
Full Year Cost (Increase FY 2002 Figure By 3%)	$1,318.40
Total FY 2003 Cost	$83,322,880
Allotment Allowed for Administrative, Outreach, & Direct Services	$9,258,098
Total Funds	$92,580,978
GF	$31,399,000
NGF	$61,182,000

Option 4: Expand Up to 200% of Poverty (Gross Income) - Regional Contracts

Uninsured Children	
Uninsured Kids Becoming Eligible for Program	72,000
Estimated Cost Per Full Year Eligible (for FY 1999)	$805.32
Potential Full Year Cost	$57,983,040
Currently Insured Children	
Number of Currently Insured Children Potentially Eligible	64,000
Estimated Cost Per Full Year Eligible	$805.32
Potential Full Year Cost	$51,540,480
Expected Enrollment in Mature Program (Maximum)	
Assume 70% of Uninsured Children will Enroll in the New Program	50,400
Assume 20% of Insured Children will Enroll in the New Program	12,800
Total Enrollment in Mature Program	63,200
Estimated Cost Per Full Year Eligible	$805.32
Potential Full Year Cost	$50,896,224
Assume Program will Require 3 Years to Reach Maturity	
(PROGRAM WILL NOT START TILL JANUARY 2000)	
FY 2000 Enrollment	22,120
On the Average Enrolled For Quarter a Year (Divide Full Year Per Person Cost By Quarter)	201.33
FY 2000 Medical Cost	$4,453,420
Allotment Allowed for Administrative, Outreach, & Direct Services	$494,824
Total Funds	$4,948,244
GF	$1,678,000
NGF	$3,270,000
FY 2001 - Enrollees at the Beginning of the Year	22,120
Full Year Cost (Increase FY 2001 Figure By 3%)	$829
Cost for Full Year Enrollees	$18,337,480
FY 2001 - Enrollees Phasing In During the Year	18,960
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$414.50
Cost for New Enrollees	$7,858,920
Total FY 2001 Cost	$26,196,400
Allotment Allowed for Administrative, Outreach, & Direct Services	$2,910,711
Total Funds	$29,107,111
GF	$9,872,000
NGF	$19,235,000
FY 2002 - Enrollees at the Beginning of the Year	41,080
Full Year Cost (Increase FY 2002 Figure By 3%)	$854
Cost for Full Year Enrollees	$35,082,320
FY 2002 - Enrollees Phasing In During the Year	18,960
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$427.00
Cost for New Enrollees	$8,095,920
Total FY 2002 Cost	$43,178,240
Allotment Allowed for Administrative, Outreach, & Direct Services	$4,797,582
Total Funds	$47,975,822
GF	$16,271,000
NGF	$31,705,000
FY 2003 - Enrollees at the Beginning of the Year	60,040
Full Year Cost (Increase FY 2002 Figure By 3%)	$880
Cost for Full Year Enrollees	$52,835,200
FY 2003 - Enrollees Phasing In During the Year	3,160
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$440.00
Cost for New Enrollees	$1,390,400
Total FY 2003 Cost	$54,225,600
Allotment Allowed for Administrative, Outreach, & Direct Services	$6,025,067
Total Funds	$60,250,667
GF	$20,434,000
NGF	$39,817,000

Option 5: Expand Medicaid Up to 200% of Poverty

Uninsured Children	
Uninsured Kids Becoming Eligible for Medicaid	92,000
Estimated Cost Per Full Year Eligible	$1,030
Potential Full Year Cost	$94,760,000
Currently Insured Children	
Number of Currently Insured Children Potentially Eligible	120,000
Estimated Cost Per Full Year Eligible	$1,030.00
Potential Full Year Cost	$123,600,000
Expected Enrollment in Mature Program (Maximum)	
Assume 70% of Uninsured Children will Enroll in the New Program	64,400
Assume 20% of Insured Children will Enroll in the New Program	24,000
Total Enrollment in Mature Program	88,400
Estimated Cost Per Full Year Eligible	$1,030.00
Potential Full Year Cost	$91,052,000
Assume Program will Require 3 Years to Reach Maturity	
FY 1999 Enrollment	44,200
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$515
FY 1999 Medical Cost	$22,763,000
Allotment Allowed for Administrative, Outreach, & Direct Services	$2,529,222
Total Funds	$25,292,222
GF	$8,578,000
NGF	$16,714,000
FY 2000 - Enrollees at the Beginning of the Year	44,200
Full Year Cost (Increase FY 1999 Figure By 3%)	$1,061
Cost for Full Year Enrollees	$46,896,200
FY 2000 - Enrollees Phasing In During the Year	26,520
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$530.50
Cost for New Enrollees	$14,068,860
Total FY 2000 Cost	$60,965,060
Allotment Allowed for Administrative, Outreach, & Direct Services	$6,773,896
Total Funds	$67,738,956
GF	$22,974,000
NGF	$44,765,000
FY 2001 - Enrollees at the Beginning of the Year	70,720
Full Year Cost (Increase FY 2000 Figure By 3%)	$1,093
Cost for Full Year Enrollees	$77,296,960
FY 2001 - Enrollees Phasing In During the Year	17,680
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$546.50
Cost for New Enrollees	$9,662,120
Total FY 2001 Cost	$86,959,080
Allotment Allowed for Administrative, Outreach, & Direct Services	$9,662,120
Total Funds	$96,621,200
GF	$32,769,000
NGF	$63,852,000
FY 2002 - Enrollees at the Beginning of the Year	88,400
Full Year Cost (Increase FY 2001 Figure By 3%)	$1,126
Total FY 2002 Cost	$99,519,836
Allotment Allowed for Administrative, Outreach, & Direct Services	$11,057,760
Total Funds	$110,577,596
GF	$37,502,000
NGF	$73,075,000
FY 2003 - Enrollees at the Beginning of the Year	88,400
Full Year Cost (Increase FY 2002 Figure By 3%)	$1,160
Total FY 2003 Cost	$102,505,431
Allotment Allowed for Administrative, Outreach, & Direct Services	$11,389,492
Total Funds	$113,894,923
GF	$38,627,000
NGF	$75,267,000

Potential Cost for New Medicaid Enrollees
Currently Eligible But Not Enrolled

Maximum Potential Cost	
Maximum Number of New Enrollees	82,000
Medicaid Cost Per Full Year Eligible	$911
Total Per Year Cost if All Potential Eligibles Enrolled in Medicaid	$74,705,000
Estimated Cost if All Estimated Enrollees were Immediately Enrolled	
If it is assumed half of these children would eventually enroll	41,000
Medicaid Cost Per Full Year Eligible	$911
Total Per Year Cost if 41,000 Children Enrolled	$37,353,000
Assume Phased in Enrollment	
FY 1999 Enrollment (20,500)	20,500
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$455.50
FY 1999 Cost	$9,338,000
GF	$4,524,000
NGF	$4,814,000
FY 2000 - Enrollees at the Beginning of the Year	20,500
Full Year Cost (Increase FY 1999 Figure By 3%)	$938
Cost for Full Year Enrollees	$19,229,000
FY 2000 - Enrollees Phasing In During the Year	12,300
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$469.00
Cost for New Enrollees	$5,768,700
Total FY 2000 Cost	$24,997,700
GF	$12,111,000
NGF	$12,886,700
FY 2001 - Enrollees at the Beginning of the Year	32,800
Full Year Cost (Increase FY 2000 Figure By 3%)	$966
Cost for Full Year Enrollees	$31,684,800
FY 2001 - Enrollees Phasing In During the Year	8,200
On the Average Enrolled For Half a Year (Divide Full Year Per Person Cost By two)	$483.00
Cost for New Enrollees	$3,960,600
Total FY 2001 Cost	$35,645,400
GF	$17,270,000
NGF	$18,375,400
FY 2002 - Enrollees at the Beginning of the Year	41,000
Full Year Cost (Increase FY 2002 Figure By 3%)	$995
Cost for Full Year Enrollees	$40,795,000
Total FY 2001 Cost	$40,795,000
GF	$19,765,000
NGF	$21,030,000