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

November, 1997

BACKGROUND

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

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

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

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

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

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

PROGRAM GOALS

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

OVERVIEW OF THE FEDERAL LEGISLATION

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

[3] P.L. 105-33.

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

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

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

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

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

ESTIMATING THE UNINSURED

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

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

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

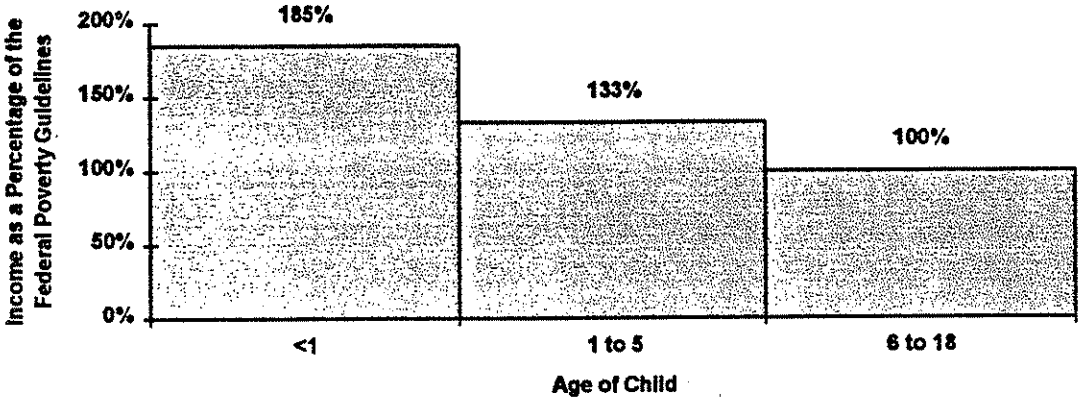
[7] In determining whether the child is eligible for Medicaid, states must use the Medicaid eligibility rules that were in effect in April 5, 1997.

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

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

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

Medicaid Income Guidelines Vary By Age of Child



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

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

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

Average Daily Health Insurance Coverage, by Poverty Status
North Carolina

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

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

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

PROBLEMS FACED BY UNINSURED CHILDREN

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

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

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

OVERVIEW OF THE CHOICES

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

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

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

1) Basic Program Options

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

a. Medicaid Expansion:

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

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

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

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

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

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

b. New Child Health Insurance Program

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

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

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

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

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

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

c. Combination of Medicaid Expansion and New Insurance Program:

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

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

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

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

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

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

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

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

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

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

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

3. Benefits Package

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

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

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

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

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

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

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

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

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

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

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

* Does not include administrative costs.

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

4. Cost-Sharing

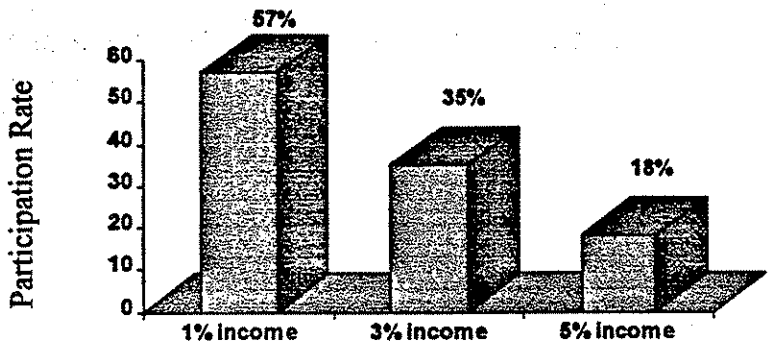
Federal law sets different cost-sharing requirements for families with incomes below 150% of the federal poverty guidelines versus those with incomes at or above 150%. For families below 150% of the federal poverty guidelines, states may impose nominal monthly premiums, but no cost-sharing (i.e., deductibles,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

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

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

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

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



Premiums as a Percentage of Family Income

(Ku and Coughlin, 1997).

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

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

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

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

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

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

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

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

Option a: No premium or cost-sharing.

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

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

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

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

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

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

5. Delivery System

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

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

Medicaid-administered, private plan participation:

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

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

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

Contracting with Lowest Cost Bidder(s):

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

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

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

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

Vouchers:

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

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

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

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

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

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

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

6) Access, Quality Assurance and Consumer Protections

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

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

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

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

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

7. Crowd-Out

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

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

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

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

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

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

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

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

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

ESTIMATED PROGRAM COSTS

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

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

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

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

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

Special Note

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

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

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APPENDIX A
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Association of County Commissioners
- Patrice Rossler

Medical Review of North Carolina
- Peg O'Connell
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State Center for Health Statistics
- Harry Herrick

NC Fair Share
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NC Child Advocacy Institute
- Paula Wolf

NC Pediatric Society
- David Tayloe
- Wallace Brown

William Mercer (Actuaries)
- Jeffrey Smith
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NC Primary Care Association
- Steven Shore

NC Academy of Family Physicians
- Jonathan Sheline
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NC Health Access Coalition
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Insurance Providers
- Sandra Greene (Blue Cross)
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APPENDIX B
Comparison of Benefits Covered by Medicaid and a Modified State Employees Health Plan

Services	Medicaid	Modified State Employees Health Plan
Mandatory Services		
Hospital Services (inpatient and outpatient)	Covers inpatient and outpatient hospital care, including specialty hospitals (pulmonary and chronic diseases).	Covers if precertified, no day limits. Covers room and board in semi-private accommodations (unless hospital has only private rooms), medically necessary supplies, medications, lab tests, radiological services, operating and recovery rooms, hospital staff. Outpatient surgery covered. The state uses a DRG reimbursement system.
Physician Services	Covers physician services and other professional services; 24 visit limits waived for children who require additional visits as result of EPSDT screenings.	Covers office visits, surgical services and anesthesia services.
Laboratory and x-ray services	Covered.	Covered.
Well-baby and well-child care	Health Check (EPSDT) includes periodic physicals, immunizations, and all the follow-up treatment identified by the provider. The Health Check periodicity schedule is 5 times in first year; 3 times in 2nd year, annually in the 3-6 years, and then one checkup every three years thereafter.	Covers well baby and well-child care. Allows all medically necessary care. No limits on well-child visits up to age 1; 3 visits ages 1-2, and 1 visit ages 2-7. Children older than seven can obtain a check-up once every three years.
Immunizations	Covered.	Covered.
Additional Services		
Prescription drugs	Covers prescription drugs and insulin.	Covers prescription legend drugs and insulin. (Legend drugs must have unrestricted market approval by FDA).
Mental health services	Covers, including treatment in state mental hospitals. 24 visit/year limit waived if care provided through Area Mental Health agency, or needed as result of EPSDT screening. No day or dollar limits, but case managed through Carolina Alternatives, which is a carved-out managed care program covering mental health and substance abuse services for children. Operates out of 10 area MHDDSAS program (32 counties).	Covered. No day/dollar limits. Can obtain 26 visits outpatient visits/year without preauthorization. Most other mental health services require preauthorization (including inpatient mental health, urgent admissions, 23-hour observation bed stays, partial hospitalization treatment, psychiatric residential treatment care, care in intensive outpatient program) More than 26 outpatient visits requires preauthorization.
Vision	Vision screening; corrective lenses, eyeglasses and other visual aids covered (prior approval required for visual aids).	One comprehensive eye exam covered every two years.

Services	Medicaid	Modified State Employees Health Plan
Hearing	Covered.	Surgery/services to correct hearing problems are covered; appliances are not covered.
Other Allowable Services		
Eyeglasses	Covers corrective lenses, eyeglasses and other visual aids covered (prior approval required for visual aids).	Excluded.
Dental services	Most general dental services covered, such as exams, cleanings, fillings, x-rays and dentures, and some additional services (prior approval required for certain services).	Covers preventive, oral evaluations, radiographs, tests and lab exams, palliative treatment, space maintenance, amalgam restorations, silicate restorations, filled or unfilled resin restorations, inlay restorations, extractions, surgical extractions, anesthesia, oral and maxillofacial surgery and dental care related to accidental injury. Not more than once every 6 months.
Dental devices	See below.	Excluded (unless due to accidental injury).
Hearing aids	Covered.	Excluded.
Therapy (physical, occupational, and services for individuals with speech, hearing, and language disorders)	Covers audiologists, occupational therapists, physical therapists, and respiratory therapists. Also covers speech and language pathologists. No day or dollar limits; provided for habilitative as well as rehabilitative care.	Physical, limited occupational, inhalation and speech therapy covered when approved in advance. Requirement that condition expected to show significant improvement.[1]
Inpatient substance abuse	Covered. Substance abuse services part of capitated managed care system for children in 32 counties through Carolina Alternatives. No day or dollar limits, but case managed through Carolina Alternatives.	Covered. No day or dollar limits.
Outpatient substance abuse	Covered. Substance abuse services part of capitated managed care system for children in 32 counties through Carolina Alternatives. No day or dollar limits, but case managed through Carolina Alternatives.	See above.
Clinic services and other ambulatory health care services	Covers services at community health centers, rural health centers, migrant health clinics, county health departments, 24 visit limit waived if additional services needed as result of EPSDT screening.	Covered.

[1] If doctor or therapists thinks the patient will get some benefit, then the state will cover services. The state looks for short-term and long-term objectives; if progress is being made then the state will continue to cover the services. For speech therapy, must be able to show potential for cognitive understanding. (Kyle Howard, Medical Review for State Health Plan, Aug. 29, 1997).

Services	Medicaid	Modified State Employees Health Plan
Prenatal care	Covers.	Covered. Prenatal care for child dependents excluded.
Family planning	Covered. Covers Norplant, IUDs, prescription contraceptives, Depo-Provera.	Covers birth control pills, Norplant and Depo-Provera.
Abortion (limited to when necessary to save the life of the mother or if pregnancy result of act of rape or incest)	Limited to when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	Limited to when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
Durable medical equipment and prosthetic devices, implants, adaptive devices	Prosthetics and orthotics covered.	Covers if reasonable and medically necessary (prior approval required if above $250). Prosthetics and orthotics are covered. Excludes: lifts, blood pressure cuffs and kits, wheelchair accessories, van lifts, ramps, and structural modifications, shoe inserts.
Disposable medical supplies	Under home health, Medicaid pays for medical supplies.	Covers medical supplies designed to serve only a medical purpose.
Over-the-counter medications	Not covered.	Not covered.
Home and community-based services (such as home health nursing, home health aide, personal care, assistance with activities of daily living, chore services, day care services, respite care, training for family members, and minor modification to home)	Covers personal care services such as assistance with dressing, feeding, household tasks, transportation and monitoring self-administered medication. Also covers home health services.	Home care includes private duty nursing, home care aides, skilled nursing visits, hospice care, home IV therapy. Prior approval required. Limited to 60 days, additional day available when approved in advance. To receive services, patient must be homebound, must require skilled services that cannot be provided by or taught to a person with no medical training. Excludes: care provided by family member, care provided by non-skilled or unlicensed caregiver, when patient no longer requires skilled level of care.
Nursing services (nurse practitioner services, nurse midwife services, advanced practice nurses, private duty nursing, pediatric nurse services, and respiratory care services in home, school or other setting	Covers nurse practitioner services, nurse midwifery, private duty nursing in certain instances. Covers home infusion therapy.	Private duty nursing covered when approved in advance.

Services	Medicaid	Modified State Employees Health Plan
Case management services	Covers case management services for pregnant women, children under age of 5 with special needs, mentally ill, chronic substance abusers, and people with HIV. Also provides case management services as part of Carolina Alternatives, Mecklenburg Co. managed care project, and Health Check.	None currently provided.
Care coordination	See above.	None currently provided.
Hospice care	Covered.	Covers.
Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative services (whether in facility, home, school or other setting) if prescribed by physician or other licensed provider, performed under supervision of physician, or furnished by licensed health care facility.	See therapy services above.	Covers up to $650/year in cardiac rehabilitation.
Premiums for private health care coverage	Not covered.	Not covered.
Medical transportation	Covers ambulance services (when other means of transportation would endanger the patient's health).	Covers ambulance services up to 50 miles.
Enabling services (such as transportation, translation, and outreach services) designed to increase accessibility of primary and preventive health services	Covers translation (paid as part of administrative costs or as part of cost-based reimbursement for federally qualified health centers), case management, medically necessary transportation.	None.
Any other health care services allowed by law (see below for examples)	Covers services of podiatrists, osteopaths, chiropractors, and optometrists; 24 visit limitation waived if need identified as part of EPSDT screening.	Covers up to $2000/year chiropractic services, podiatry services.
Other Covered Services by Plan		
Transplants and Dialysis	Covers.	Covers bone marrow for specified diagnoses, corneal, heart, kidney, liver, lung, pancreas and pancreas/ kidney. Requires prior approval. Excludes transplants determined to be experimental or investigational.
Alternative Therapy		Covers acupuncture by American MDs.

Services	Medicaid	Modified State Employees Health Plan
Wellness	Covered under Health Check described above, also covers parenting, childbirth education and other health education services provided as part of an office visit. Smoking cessation not covered (except in Mecklenburg Co. HMO project).	Covers $150 of eligible wellness charges each fiscal year (then covers additional amounts with deductibles/coinsurance). Services include general health check-ups, routine diagnostic exams and tests, x-rays, mammograms, prostate and rectal exams, blood pressure checks, urine tests and tuberculosis tests. There is a periodicity schedule which may be waived if medically necessary.
Other Excluded Services		
Learning disorders	Exclude special education services, but covers health related services.	
Reconstructive Surgery	Not covered if exclusively cosmetic.	Covered, including breast reconstruction following mastectomy. Excluded if purely cosmetic.
Experimental or Investigational Therapies excluded	Excluded if part of a protocol for investigation, not authorized by FDA. (Similar to other plans exclusions).	G.S. 35-40.1(7.1). Similar to other plans' exclusions.
Other exclusions		Cosmetic surgery, radial keratotomy, services to reverse surgical sterilization.
Other unusual provisions		Excludes maternity benefits for dependent children; newborn nursery care when mother not eligible for maternity benefits.
General Provisions		
Medical Necessity defined	Services which are, in the opinion of the treating physician or the DMA consulting physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration and scope to reasonably achieve its purposes; and the amount, duration or scope may not be arbitrarily denied or reduced solely because of the diagnosis, type of illness or condition.	Acceptable medical diagnoses and treatment of disease, injury or illness.
Emergency room or urgent care (coverage and definition; would be included as part of mandatory hospital care)	Covers care in emergency room. Must be pre-authorized if patient enrolled in Carolina Access or Mecklenburg County HMO project.	Covers with copayment (waived if admitted to hospital or no other care reasonably available).

Services	Medicaid	Modified State Employees Health Plan
Primary Care Providers	To participate as a primary care provider in Carolina Access, the provider must be enrolled as a Medicaid primary care provider for the service area; provide patient care coordination (provide or arrange for care), operate the office a minimum of 30 hours/week, provide essential preventive services, provide after hour coverage that does not automatically refer to the ER, establish and maintain hospital admitting privileges or establish formal arrangements with another practice to manage inpatient care, participate with Carolina ACCESS utilization management and quality assessment programs, and refer potentially eligible enrollees to WIC.	NA
Statewide Coverage		
Currently offered	100 counties	100 counties (HMOs offered in 92 counties). Out-of-state and out-of-country also covered.
Sources of Information	Division of Medical Assistance.	Its Your Choice (1997); Your Health Benefits (1996).