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REMARKS: Child Summary

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Balanced Budget Act -- Summary of Medicaid Provisions**SUBTITLE J -- STATE CHILDREN'S HEALTH INSURANCE PROGRAM****Chapter I -- STATE CHILDREN'S HEALTH INSURANCE PROGRAM****Establishment of Program (Sec. 4901)****Provision**

- o The Social Security Act is amended to add a new title: Title XXI -- State Children's Health Insurance Program. The provisions described below list the section numbers of the new title XXI.

Purpose; State Child Health Plans (Section 2101)**Provision**

- o The purpose is to enable States to initiate and expand child health assistance to uninsured, low-income children. Assistance is provided primarily for obtaining health benefits coverage through: (1) meeting the requirements for child health coverage in section 2103; or (2) benefits under the State's Medicaid plan, or a combination of both. In order to be eligible for funds, States must submit to and obtain approval from the Secretary for a State Child Health Plan that describes how the State intends to use the funds provided under this title. This program is a capped entitlement for States.

Effective Date

- o No State is eligible for payments prior to October 1, 1997.

General Contents of State Child Health Plan; Eligibility; Outreach (Section 2102)**Provision**

- o A State Child Health Plan must include general background on the extent children currently have coverage, current State efforts to obtain coverage, how the plan will be coordinated with other efforts, proposed delivery methods and methods to assure quality and access to covered services.
- o A State Child Health Plan must describe standards used to determine eligibility for targeted low-income children. The standards must cover lower income children within a category of covered children before higher income children and may not deny eligibility based on a preexisting condition. It also must include a description of screening procedures to ensure that only targeted low-income children receive assistance; Medicaid

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eligible children are enrolled in Medicaid; this assistance does not substitute for group coverage; eligible Indians receive assistance; and coordination with other programs.

- o A State Child Health Plan must describe outreach procedures to families of children likely to be eligible for assistance under the plan or under other public or private coverage and inform them of availability of and assist in enrollment in these programs.
- o The Plan must describe coordination of the State program with other public and private insurance programs.

Coverage Requirements for Children's Health Insurance (Section 2103)**Provision**

- o Child Health Assistance (other than Medicaid) must consist of any of the following:
 - (1) Benchmark coverage: Benefit plans must be equivalent to: the standard Blue Cross Blue Shield preferred provider option offered under FEHBP; a health benefits plan that is offered and generally available to State employees; and the HMO benefit plan with the largest commercial enrollment in the State.
 - (2) Benchmark-equivalent coverage: The coverage must include benefits in the following categories of basic services: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations. The coverage must have an aggregate actuarial value that is at least equivalent to one of the benchmark packages. The coverage also must be at least 75 percent of the actuarial value of the benchmark packages for the following additional services: prescription drugs; mental health; vision; and hearing services.
 - (3) Existing comprehensive State-based coverage: Coverage is defined as a program that provides a range of benefits; is administered by the State and receives State funds; is offered in New York, Florida or Pennsylvania; and was offered on the date of enactment of this title.
 - (4) Secretary-approved coverage: Any other coverage that the Secretary determines provides appropriate coverage for targeted low-income children.
- o A State Child Health Plan must include a description of cost-sharing and must be pursuant to a public schedule. Cost-sharing only may be varied in a manner that does not favor higher income children over lower-income children. No cost-sharing is permitted for well-baby and well-child care, including age-appropriate immunizations. Cost-sharing for

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children in families below 150 percent of poverty must be consistent with Medicaid. Cost-sharing for children at 150 percent of poverty and above must be based on an income-related sliding scale and the annual aggregate for all children in a family cannot exceed 5 percent of the family's income.

- o The State Child Health Plan may not impose pre-existing condition exclusions for covered benefits. States that provide for benefits through a group health plan or group health insurance coverage may permit pre-existing condition exclusions as allowed under the applicable section of the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA).

Allotments (Section 2104)**Provision**

- o Total allotments are: \$4.275 billion for fiscal years 1998 - 2001; \$3.15 billion for fiscal years 2002 - 2004; \$4.05 billion for fiscal years 2005 -2006; and \$5 billion for fiscal year 2007. For each fiscal year, the allotment will be reduced by .25 percent for the territories.
- o In fiscal years 1998 - 2000, each State with an approved Child Health Plan will receive an allotment based on the State's proportion of the total number of low-income, uninsured children (multiplied by a geographic cost factor). For FY 2001, States receive their allotment based on their proportion of a blended number of children in the nation, adjusted by a geographic cost factor.

The number of children is equal to the sum of two factors: 1) 75 percent of the number of low-income, uninsured children in the State and 2) 25 percent of the number of low-income children in the State. For each succeeding year, States receive their allotment based on their proportion of a blended number of children in the nation, adjusted by a geographic cost factor. The number of children is equal to the sum of 75 percent of the number of low-income, uninsured children in the State and 25 percent of the number of low-income children in the State. The geographic cost factor is based on annual wages in the health care industry. The number of children is calculated from the three most recent Census Population Survey data sets.

- o The amount of a State's allotment will be reduced by the State's expenditures on presumptive eligibility and the expenditures for targeted low-income children under Medicaid.
- o Each State will receive a minimum floor of \$2 million. Amounts allotted to a State will be available for 3 years. Any unused amounts after 3 years will be redistributed to States that

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have fully spent their allotments.

- o The territories shall receive .25 percent of the total yearly allotments, to be divided among Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands in the following manner:
 - Puerto Rico receives 91.6 percent
 - Guam receives 3.5 percent
 - Virgin Islands receives 2.6 percent
 - American Samoa receives 1.2 percent, and
 - the Northern Mariana Islands receives 1.1 percent

Payment to States (Section 2105)

Provision

- o The Secretary will make payments to States with approved Child Health Plans for child health assistance for targeted low-income children that meet the coverage requirements in Section 2103 after reducing for expenditures for presumptive eligibility and for targeted low-income children under Medicaid. No more than 10 percent of a State's payment may be used for the total costs of: other child health assistance for targeted low-income children; health services initiatives; outreach; and administrative costs.
- o The enhanced Federal medical assistance percentage (FMAP) for child health assistance provided under this title is equal to the current FMAP increased by 30 percent of the difference between 100 and the current FMAP. The enhanced FMAP may not exceed 85 percent. Federal funds, premiums, other cost-sharing, provider taxes and donations cannot be used for the State matching requirements.
- o The Secretary may waive the 10 percent limitation for coverage that she deems is a cost effective alternative and is provided through 330 community health centers or disproportionate share hospitals. The Secretary also may allow payment to a State for the purchase of family coverage under a group health plan if the State establishes to her satisfaction that it is cost-effective and it would not substitute for existing coverage.
- o No payments can be made for expenditures that would have been made under private coverage or under any federally operated/financed program other than an IHS program.
- o Payments also cannot be used to pay for abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes abortion. Exceptions are provided for abortions that are necessary to save the life of the mother or if the pregnancy is the result

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of an act of rape or incest. This is not to be construed as preventing a State, locality or private person or private funds from purchasing coverage that includes abortion.

- o States will not receive any payments for child health assistance if they adopt income and resource standards and methodologies for Medicaid that are more restrictive than those in effect on June 1, 1997. A State's allotment will be reduced by the amount by which the total of the State children's health insurance expenditures in the preceding year is less than such expenditures in 1996. State children's health insurance expenditures are defined as the State share under this title, the State share under Medicaid, attributable to an enhanced FMAP and State expenditures for the existing comprehensive State-based programs in New York, Florida or Pennsylvania.

Process for Submission, Approval and Amendment of State Child Health Plans (Section 2106)

- o In order to receive funds under this title, a State must submit and obtain approval of its Child Health Plan from the Secretary. No funds are available prior to October 1, 1997. A State may submit an amendment to its Child Health Plan at any time. Any amendment that restricts or eliminates eligibility may not take effect unless the State certifies that it has provided prior public notice of the change and will not be effective for longer than 60 days unless it has been transmitted to the Secretary during the 60 day period. Other types of amendments will not remain in effect after the fiscal year (or, if later, the end of a 90 day period) unless the amendment has been transmitted to the Secretary.
- o A State Child Health Plan or plan amendment is deemed approved unless the Secretary notifies the State in writing within 90 days after receiving the plan or amendment that it is disapproved or that additional information is needed. The Secretary must provide a reasonable period for correction in the case of a disapproval.
- o States must conduct the program in accordance with the approved plan and plan amendments. The Secretary must establish a process for enforcing the requirements under this title, including withholding of funds in the case of substantial noncompliance. The Secretary must provide a reasonable period of correction before taking financial sanctions.

Strategic Objectives and Performance Goals; Plan Administration (Section 2107)

- o A State Child Health Plan must include a description of strategic objectives, performance goals and performance measures for providing child health assistance to targeted low-income children and for maximizing health benefits coverage for other low-income children and children generally in the State. The Plan must describe how performance measures will be assessed through objective, independently verifiable means and compared against performance goals.

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- o A State Child Health Plan must include an assurance that the State will collect data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. It also must describe the State's plan for annual assessments, reports, and evaluations and assure the Secretary access to records for audit purposes.
- o A State Child Health Plan must include a description of its process to involve the public in the design and implementation of the plan as well as ongoing involvement and its budget.
- o Medicaid provisions relating to conflict of interest, limitations on payment and limits on provider taxes and donations apply to this title. In addition, a number of fraud and abuse provisions of title XI apply to this title.

Annual Reports; Evaluations (Section 2108)**Provision**

- o The State must assess the operation of the State plan, including progress made in reducing the number of uncovered, low-income children and report annually to the Secretary by January 1.
- o By March 31, 2000, each State with an approved State Child Health Plan must submit to the Secretary an evaluation addressing: the State's effectiveness in increasing the number of children with creditable coverage; the effectiveness of other elements of the State's plan including characteristics of children served, quality, amount and level of assistance, service area, time limits, coverage and other sources of non-Federal funding; the effectiveness of other public and private programs in increasing the availability of affordable quality coverage; the State's coordination between other public and private programs for children; an analysis of the changes and trends that affect affordable, accessible coverage for children; the State's plans for improving the availability of children's coverage; recommendations for improving the State's program; and other matters the State and Secretary deem appropriate.
- o The Secretary must submit a report to Congress by December 31, 2001 based on the State evaluations.

Miscellaneous Provisions (Section 2109)**Provision**

- o Coverage other than Medicaid will be considered creditable coverage for purposes of HIPAA. ERISA will not be affected by this title.

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Definitions (Section 2110)

Provision

- o The following terms are defined: child health assistance; targeted low-income child; child; creditable health coverage; group health plan; health insurance coverage; low-income; poverty line; preexisting condition exclusion; State Child Health Plan; and uncovered child.
- o The term "targeted low income child" means a child who: meets the eligibility standards set by the State; resides in a family with income below the greater of the following: 200 percent of poverty or, if the Medicaid eligibility limit is higher, 50 percentage points above the Medicaid eligibility limit; and is not eligible for Medicaid or private coverage. Children excluded are those who: are inmates of public institutions; patients in an Institution for Mental Disease (IMD); and children whose families are eligible for the State employee benefits plan. The term may include children covered under a health insurance coverage program in operation since 7/1/97 that is offered by the State and receives no Federal funds.

Chapter 2 — EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID

Optional Use of State Child Health Assistance Funds for Enhanced Medicaid Match for Expanded Medicaid Eligibility (Section 4911)

Provision

- o States may elect to use child health assistance funds to expand Medicaid eligibility. In order to receive funds to expand Medicaid eligibility, States must meet two conditions: (1) they must maintain their Medicaid eligibility at levels that are not more restrictive than those applied as of June 1, 1997; and (2) they must provide for reporting of information about expenditures relating to presumptive eligibility and to child health assistance provided to "optional targeted low-income children" under the expanded Medicaid program.
- o States that elect to use the child health assistance funds to expand Medicaid eligibility and meet the two conditions described above will be eligible to receive an enhanced Medicaid match for "optional targeted low-income children." The enhanced Medicaid match is the State's current FMAP increased by 30 percent of the difference between 100 and the current FMAP.
- o The enhanced Medicaid match will apply to expenditures for "optional targeted low-income children." They are defined as targeted low-income children who would not

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qualify for Medicaid based on the plan that was in effect on April 15, 1997. It does not apply to expenditures for children below poverty born after 9/30/83 as they age onto Medicaid under current law. The amount of expenditures cannot exceed a State's allotment for the year reduced by any expenditures for child health assistance paid to the State under the grant program.

Effective Date

- o Items and services furnished after October 1, 1997.

Medicaid Presumptive Eligibility for Low-Income Children (Section 4912)

Provision

- o States are permitted under their Medicaid program to make medical assistance available to children under 19 during a presumptive eligibility period. The period begins with a date that a qualified entity determines, using preliminary information, that the family income does not exceed the income eligibility level; and the period ends with the earlier of an eligibility determination or if an application for eligibility has not been filed on the last day of the month following the month the entity makes the preliminary determination.
- o The term a "qualified entity" means an eligible provider under Medicaid or any entity that is authorized to determine eligibility for the Head Start program, the Child Care and Development Block Grant Act, or WIC. The Secretary may issue regulations further limiting qualified entities.
- o A qualified entity must notify the State agency of the determination within 5 working days and inform the parent or custodian of the child that an application is required to be filed by the end of the following month.

Effective Date

- o On enactment.

Continuation of Medicaid Eligibility for Disabled Children Who Lose SSI Benefits (Section 4913)

Provision

- o States must continue Medicaid eligibility for disabled children who would have lost SSI benefits because of the change in the definition of childhood disability under the Personal

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Balanced Budget Act -- Summary of Medicaid Provisions**Responsibility and Work Opportunity Act of 1996.****Effective Date**

- o July 1, 1997

Chapter 3 — DIABETES GRANT PROGRAMS**Special Diabetes Programs for those with Type I Diabetes (Section 4921)****Provision**

- o The Secretary shall provide --directly or through grants-- for research into the prevention and cure of Type I diabetes. Grants will be made available to children's hospitals, grantees under section 330 of the Public Health Service Act, and other Federally qualified health centers (FQHCs), State and local health departments and other public or non-profit private entities. For each of fiscal years 1998 - 2002, \$30 million is transferred from title XXI for grants under this section.

Special Diabetes Programs for Indians (Section 4922)**Provision**

- o The Secretary must make grants for the prevention and treatment of diabetes (for individuals of all ages) for services provided through the Indian Health Service (IHS), through an Indian health program operated by a tribe or tribal organization funded by IHS, or through an urban Indian health program funded by IHS. For each of fiscal years 1998 - 2002, \$30 million must be transferred from title XXI for grants under this section.

Report on Diabetes Grant Programs (Section 4923)**Provision**

- o The Secretary must conduct an evaluation of the diabetes grant programs in sections 4921 and 4922 and submit an interim report to Congress by January 1, 2000 and a final report by January 1, 2002.

March of Dimes
Birth Defects Foundation
National Government Affairs Office
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March of
Dimes
Preventing
Birth Defects

August 28, 1997

MEMORANDUM

To: Chris Jennings

Fr: Marina L. Weiss

Re: California Children's Health Plan

FYI - Governor Wilson released his state plan yesterday.

Rec'd
9/29
LC

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THE PROBLEM

According to the March 1996 Current Population Survey (CPS), roughly 1.6 million California children - 17 percent of children ages 17 and under - have no health insurance. One in four California children (2.3 million) rely on Medi-Cal for insurance coverage, while just over half of the state's children (53 percent) have employment-based coverage through a parent.

Most uninsured California children come from low-income families, with nearly 75 percent of uninsured children (1.2 million) living in families with incomes below 200 percent of the federal poverty level (FPL). Children whose families earn incomes between 100-200 percent of the FPL - an estimated 580,000 children - are among the most vulnerable of populations. Their families make too much money to generally qualify for free Medi-Cal, are employed in working class jobs that typically do not offer insurance, and cannot afford private health insurance. In short, affordability remains a major barrier to obtaining coverage.

Notwithstanding the generally good health of children, health insurance coverage is important to ensure that they receive the well-child examinations that are necessary to promote good health and nutrition, and to address potential health problems early.

Lack of insurance coverage for children results in reduced access to medical services, resulting in restricted access to primary and preventive care and increased reliance on emergency rooms and hospitals for treatment.

GUIDING PRINCIPLES

- Children's health coverage expansion strategies should be designed and implemented with the goal of improving the health status of uninsured, low-income children.
- Uninsured children below age 19 with family incomes below 200 percent of the federal poverty level should be the top priority for expanding health care coverage.
- Programs must be structured to maximize the number of children covered; using existing, costly entitlement programs, such as Medi-Cal, to expand health care access to uninsured Californians limits the state's ability to serve the total eligible child population within available state resources.
- Private sector-based solutions offer California affordable, accessible, high quality solutions to meet children's health care needs while promoting consumer choice.
- Children's health coverage expansions should be implemented as quickly as possible in order to ensure the expeditious enrollment of currently uninsured, low-income children.
- Parental responsibility for child health and well-being should be supported and encouraged to promote child enrollment in and utilization of available programs and services.
- Families of enrolled children should share in the cost of their health care in order to make individuals sensitive to the cost of health care decisions, to promote personal responsibility and to help finance the program. Family contributions should be based on ability to pay and should be structured so as not to discourage appropriate use of primary and preventive care.
- Health care coverage is not an individual entitlement.
- Protections should be established to guard against a shift of privately insured individuals or employers to drop private coverage to receive publicly-sponsored benefits.

CALIFORNIA CHILDREN'S HEALTH PLAN (CCHP) HIGHLIGHTS

- **CHILD FOCUSED COMPREHENSIVE BENEFIT PACKAGE** - the proposed benefit package contains all the health, dental and vision care benefits necessary for a child to attend school healthy and ready to learn.
- **CHOICE** - families will have a choice of health plans and be able to select the plan which best meets the needs of their children.
- **POOLED PURCHASING POWER** - the pooled purchasing of coverage for the large number of children to be served will provide the state with marketplace clout to negotiate favorable rates and improvements in health plan performance/quality.
- **MODELED AFTER SUCCESSFUL EXISTING CALIFORNIA PURCHASING COOPERATIVES** - program model will be similar to successful employer sponsored purchasing cooperatives currently operating in California such as: the California Public Employees Retirement System (Cal PERS), the Health Insurance Plan of California (HIPC) and the Pacific Business Group on Health (PBGH).
- **BRIDGE TO EMPLOYER SPONSORED COVERAGE** - the program will provide transition coverage for families moving off of welfare programs (TANF and Medi-Cal) to employer sponsored health coverage. Benefit and copayment levels will be set at levels to help families make the transition from the full service no cost Medi-Cal program to the cost sharing levels commonly found in the employer based market.
- **AVOIDANCE OF WELFARE PROGRAM STIGMA** - participation in the program will be similar to the purchase of private coverage; a simple mail-in application process will be used with annual reevaluation of a family's eligibility.
- **FAMILY PARTICIPATION IN THE COST OF COVERAGE** - families will participate in the cost of coverage through nominal premiums and copayments. Family cost sharing makes families sensitive to the cost of health care decisions, promotes family responsibility, and helps to finance the program.
- **STATEWIDE AND COMMUNITY BASED OUTREACH** - a statewide outreach effort will inform parents about both Medi-Cal and the new program. In a focused effort to reach all eligible parents, a statewide media campaign and targeted multicultural linguistically appropriate local campaigns will be used.

- **SIGNIFICANT NUMBERS OF CHILDREN COULD BE ENROLLED IN A SHORT TIME FRAME.** The first child could be enrolled in the program within nine months of enactment of the authorizing legislation.
- **FLEXIBILITY** - the program benefits, eligibility, and rules of participation can be designed to respond to the California market.
- **PRIVATE SECTOR EMPHASIS** - The Managed Risk Medical Insurance Board (MRMIB) will provide policy oversight to the program, while all operational activities will be performed by the private sector.
- **NO NEW ENTITLEMENT TO SERVICES IS CREATED** - the program is authorized to operate with a fixed appropriation.
- **ABILITY TO OPERATE WITHIN A FIXED BUDGET** - the program benefits, eligibility, and rules of participation can be tailored to the available level of funding. If demand exceeds available funds, a waiting list of interested families can be maintained. The program design can be easily altered as funding levels change.
- **STREAMLINING MEDI-CAL TO SMOOTH THE TRANSITION TO THE NEW PROGRAM** - three changes to Medi-Cal will smooth the transition between the two programs.
 - one month "continued eligibility" for those Medi-Cal enrollees who lose eligibility for no cost Medi-Cal due to increases in family income. This will provide families with a grace period so that they will have time to apply and enroll in the new program to ensure continuity of care.
 - a "resources disregard" in the Medi-Cal program for children concurrent with the implementation of the new program. This will assure that all families with incomes below 200% FPL have access to coverage for their children.
 - accelerated coverage in Medi-Cal of all children under 19 below 100% FPL. This will assure that the children not currently served in Medi-Cal will not fall through the cracks between the new program and Medi-Cal.

CALIFORNIA CHILDREN'S HEALTH PLAN (CCHP)

The CCHP Program Description

1. General Approach

Coverage of children will be provided through subsidized private insurance policies. Families will be encouraged to take advantage of employer sponsored coverage when it is available. The type of coverage provided will be similar to that currently offered through employer sponsored plans.

The CCHP program will be built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (Cal PERS) and the Health Insurance Plan of California (HIPC) - price competition between health plans, family choice of health plans, performance based contracts with health plans, and reliance on existing private sector financing and delivery systems.

The approach's primary strengths are its flexible program design, ability to operate within a fixed funding level, and the use of pooled purchasing techniques to achieve cost savings.

2. Delivery System

Two approaches will be used to provide coverage to children in low income families; enrollment of children in a purchasing pool through which families could select a health plan for their children, or provision of an Insurance Purchasing Credit to families to assist them in paying for the costs of employer based dependent coverage. Both approaches will be administered under the oversight of the Managed Risk Medical Insurance Board (MRMIB) to provide ease of application for families.

The purchasing pool: For the majority of eligible families, MRMIB will offer access to health plans via a subsidized consumer choice purchasing program. In the purchasing program, many of the same health plans and networks available to the employer market will be used. This will provide for broad access to health care providers.

MRMIB will be authorized to contract with licensed health plans and health insurers, Local Initiatives approved by the Department of Health Services to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects (i.e., Santa Barbara's COHS).

To assure that health care providers currently serving low income families are given the opportunity to participate in the program, contractual language will be adopted to provide an incentive for health plans to include in their networks those providers practicing in safety net facilities, such as licensed community clinics or county facilities.

Families will select a health plan for their child from several plans offered in their communities.

Insurance Purchasing Credit For Families With Access To Employer Sponsored Coverage: Those families with access to employer sponsored coverage will be given an Insurance Purchasing Credit to subsidize the cost of the dependent portion of the coverage available through their employer's health plan. It is estimated that 15% of uninsured children reside in families where employer sponsored dependent coverage is available. The use of existing employer based plans is likely to be popular with families, employers, policy makers and health plans because it builds on the group coverage model and enables the child to enroll in the same health plan as the parents.

Insurance Purchasing Credits will have a value relative to the cost of enrolling the child in the purchasing pool. Families will be notified by the program administrator of their eligibility for an Insurance Purchasing Credit and its value. To the extent possible, transactions related to the Insurance Purchasing Credit will be automated to eliminate the administrative cost and complexity of a paper based system. The same simple mail-in application form will be used for the purchasing pool and Insurance Purchasing Credit programs.

3. Governance

The Managed Risk Medical Insurance Board (MRMIB) will be the state entity that administers the CCHP program. MRMIB is comprised of five volunteer members, three appointed by the Governor, one by the Assembly and one by the Senate.

The mission of MRMIB is to improve and increase the affordability and availability of quality health care coverage for Californians.

MRMIB has a proven track record of being able to start up and administer new and creative health benefits programs effectively and efficiently. MRMIB currently administers three health benefits programs:

- the Major Risk Medical Insurance Program (MRMIP) serves persons unable to obtain private health coverage due to pre-existing medical conditions,
- the Access For Infants and Mothers (AIM) program provides prenatal and infant care to low income pregnant women and their children, and
- the Health Insurance Plan of California (HIPC) provides a health care purchasing cooperative for small businesses.

4. Benefit Package

The design of the CCHP benefit package should be driven by the health care needs of children, with emphasis on those health care benefits necessary for children to be able to attend school healthy and ready to learn; able to read the chalkboard; and to hear the teacher.

The CCHP benefit package will meet the requirements of the new federal law and will generally mirror benefits currently provided to working families through entities such as Cal PERS and the HIPC. These packages are very similar, have been accepted by the employer community, and are comprehensive in scope. They include coverage for medically necessary hospitalization, physician services, diagnostic and x-ray, prescription drugs, durable medical equipment, ambulance, emergency care, home health services, hospice, and blood products. Further, mental health and substance abuse services, occupational, physical and speech therapy, and skilled nursing care will be provided, though with some limitations. In addition, dental benefits will cover services appropriate to good oral hygiene and health, including preventive and diagnostic services such as teeth cleaning, x-ray, topical fluoride treatments, space maintainers, and sealants; and restorative services such as fillings, crowns and bridges. Vision related coverage offering annual exams and eyeglasses will be provided.

Family Cost Sharing Requirements: Consistent with the principle of personal responsibility, families eligible for the CCHP program will pay a monthly premium and nominal copayments for services. Premiums will be based on a sliding scale with the lower income families paying less than those of higher income. If premiums are established at 2% of a family's annual income, a family of four earning 101% of the fpl (\$16,210) would pay \$27.00 per month in premiums and a family of four earning 200% of the fpl (\$32,100) would pay \$53.50 per month in premiums. The average premium payment is estimated to be \$8 per child per month. CCHP program copayments of \$5 per office visit and \$5 per prescription for health benefits parallel those charged by most employer health plans. No copayments will be charged for inpatient care or for preventive services such as well child visits, health screenings, and immunizations.

Premium and copayments add value to the program design because they involve families in managing their health care resources and emphasize personal responsibility. Further, the inclusion of premiums and copayments in the program design reinforces the similarity of this approach to the coverage provided through employer based coverage as opposed to that provided through the Medi-Cal program. This distinction addresses subscriber concerns regarding the stigma of being on a "welfare based" program. The use of copayments will help control inappropriate utilization and should result in better negotiated rates from health plans.

5. Eligibility Process

To qualify for participation, families will be required to meet basic eligibility requirements, such as:

- Family income equal to or below 200% of the federal poverty level,
- Not eligible for no cost Medi-Cal or Medicare coverage, and
- Not covered by a private or employer sponsored insurance policy at the time of application or for the prior six months.

The CCHP program will be privately administered under the oversight of MRMIB. A mail-in process as used in the HIPC, AIM and MRMIP will be used. It is anticipated that no more than a 10 working day time frame for eligibility determination will be required.

The application will be designed to verify the income eligibility of families and to screen them for access to employer sponsored coverage. As is done in the AIM program, income eligibility would be verified using copies of last year's federal income tax forms, or current year wage stubs. A random sample of applications would be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to assure the fiscal integrity of the program.

The administrative contractor will be responsible for eligibility determination, premium collection, transmission of premium and enrollment information to health plans, administration of the Insurance Purchasing Credits, and printing and mailing of application materials.

In addition, an application assistance payment will be made to entities able to refer large numbers of children to the program. These include school districts, Healthy Start sites, hospitals, medical doctors, nurses, county health departments, county welfare offices, licensed day care operators, primary care community clinics, state maternal and child health contractors, participating health plans, and insurance agents or brokers. A flat fee of \$50 would be paid to the referring entity for every family that is determined to be eligible for and enrolled in the program.

6. Quality Oversight

The MRMIB will look to the state regulatory entities to assure the basic quality of health plans with regard to financial stability, adequacy of network, and appropriateness of medical policy. In addition, the best practices available in the employer market for quality improvement and monitoring will be adopted. Such performance standards could include assuring the accessibility of services (such as wait time for appointments) and the delivery of preventive treatments (such as improvements in the percentage of children that are fully immunized by age two).

7. Estimated Number of Children Covered and Estimated Overall Cost

The UCLA Center for Health Policy Research estimates there are 580,000 uninsured California children living in households with family incomes between 100% to 200% FPL. These 580,000 children are potentially eligible for the CCHP program.

If 580,000 children per year were enrolled in the CCHP program the annual cost is estimated at \$478.7 million of which \$167.5 million would be required state matching funds.

8. Timing of Implementation

Implementation of the CCHP program will take six to nine months, with appropriate exemptions from state contracting law and emergency regulatory authority. MRMIB's existing three programs have broad statutory flexibility to negotiate contracts with vendors outside of the usual state contracting processes.

The statutory authority for the three programs operated by MRMIB delegate most design features to the Board. These include eligibility determination, the extent of coverage, subscriber contribution amounts, and benefit design. The MRMIP was implemented seven months after creation of the MRMIB, AIM was implemented six months after legislation was signed, and the HIPC was operational nine months after legislation was signed.

Questions and Answers Regarding The California Children's Health Plan (CCHP)

Approach

1. How will CCHP work?

- CCHP will cover children through subsidized private insurance policies, similar to employer sponsored plans.
- Families will have a choice of health plans.
- There will be a simple mail-in application.
- When a parent has access to coverage through his or her employer, CCHP funds will be used to keep the child enrolled in the same health plan as the parent.
- CCHP can be implemented quickly, and enrollment of the first child can occur six to nine months following enactment of the enabling legislation.
- CCHP is modeled after organized health purchasers such as the California Public Employees Retirement System (Cal PERS) and the Health Insurance Plan of California (HIPC), which rely on private sector delivery systems.

2. Why is CCHP being created to expand coverage to children?

- Flexibility - the program benefits, eligibility, and rules of participation can be designed to respond to the California market.
- Ability to operate within a fixed budget - the program benefits, eligibility, and rules of participation can be tailored to the available level of funding. If demand exceeds available funds, a waiting list of interested families can be maintained. The program design can be easily altered as funding levels change.
- No new entitlement to services is created - the program is authorized to operate with a fixed appropriation.
- Use of purchasing clout to increase value - the pooled purchasing of coverage for the large number of children able to be served will provide the state with marketplace clout to negotiate favorable rates and improvements in health plan performance/quality.
- Family participation in the cost of coverage - families will participate in the cost of coverage through nominal premiums and copayments. Family cost sharing

makes families sensitive to the cost of health care decisions, promotes family responsibility, and helps to finance the program.

- Avoidance of welfare program stigma - participation in the program will be similar to the purchase of private coverage; a simple mail-in application process would be used with annual reevaluation of a families eligibility.
- Bridge to employer sponsored coverage - the program will provide transition coverage for families moving off of welfare programs (TANF and Medi-Cal) and to employer sponsored health coverage. Benefit and copayment levels will be set at levels to help families make the transition from the full service no cost Medi-Cal program to the significant cost sharing levels commonly found in the employer based market.
- Significant numbers of children could be enrolled in a short time frame. The first child could be enrolled in the program within nine months of enactment of the authorizing legislation.
- Private sector emphasis - The Managed Risk Medical Insurance Board (MRMIB) will provide policy oversight to the program, while all operational activities would be performed by the private sector.

3. Why isn't the Medi-Cal program being used to expand coverage to children?

- A Medi-Cal expansion is undesirable for a number of reasons. First, Medi-Cal does not require most enrollees to contribute to the cost of their coverage, thereby discouraging individuals to take greater responsibility for their health or the financial implications of their health care decisions. Simply expanding Medi-Cal to cover children in low wage working households would promote dependence on a welfare based system.
- Many low income Californians who are eligible for Medi-Cal avoid enrolling because of the welfare stigma associated with the program. Working low wage families with children eligible for CCHP are likely to share this concern, and experience with the AIM program suggests such families will prefer coverage similar to the employer based market.
- Medi-Cal is a fiscally open-ended entitlement program. Expanding Medi-Cal would limit policy makers' ability to set meaningful budget limits for CCHP.
- Medi-Cal is complex and difficult to administer. It is also susceptible to litigation. Medi-Cal operates under a patchwork of federal mandates, most of which are subject to varying interpretation by the courts and policy makers.

4. Wouldn't it be cheaper, easier and quicker for the state to use the existing Medi-Cal infrastructure to expand coverage?

CCHP will rely on private sector entities. Administration will be provided through a contract with a private sector vendor. Health benefits will be provided through health plans and insurers. Use of these private sector partners will enable CCHP to offer services at a price to the state comparable to, if not lower than, that available through the Medi-Cal program. The first child can be enrolled within 6 to 9 months after the passage of the enabling legislation. The proposed mail-in application process will ensure ease of enrollment.

Delivery System

1. How would CCHP be operated?

The program will be built around the concepts used successfully by organized purchasers such as Cal PERS and the HIPC - price competition between health plans, family choice of health plans, performance based contracts with health plans, and reliance on existing private sector financing and delivery systems.

The Managed Risk Medical Insurance Board (MRMIB) will contract with health plans for coverage of children. Families will select a plan from several available in their community. This model has been used successfully to assist small employers to increase the value of their health care coverage through the HIPC. Health plans will compete on price, service and quality for the enrollment of members.

Families purchasing coverage for their children through the program will fill out a simple mail-in application. Coverage will be similar to that offered to workers with employer based coverage. Once a year families will be requalified for the program and could choose to change health plans.

2. How would the Insurance Purchasing Credit work?

Families with access to employer sponsored coverage will be given an Insurance Purchasing Credit to subsidize the cost of the dependent portion of the coverage available through their employer's health plan. A UCLA study estimates that 15% of uninsured children reside in families where employer sponsored dependent coverage is available.

Insurance Purchasing Credits will have a dollar value similar to the cost of enrolling the child in CCHP. Families will be notified by the program administrator of their eligibility for an Insurance Purchasing Credit and its value.

To the extent possible, transactions related to the Insurance Purchasing Credit program will be automated to eliminate the administrative cost and complexity of a paper based system.

The same simple mail-in application form will be used for the purchasing pool and Insurance Purchasing Credit programs.

3. How will CCHP build upon and enhance existing employer based coverage?

Families with a working parent eligible for employer based coverage will be provided with financial assistance, in the form of an Insurance Purchasing Credit, to enable them to take advantage of dependent coverage available through their employer's group health plan. The Insurance Purchasing Credit mechanism will enable parents currently covered under their employer's plan to afford coverage for their children.

4. How can the state assure that the majority of funds are being used to purchase health services for children?

We recognize that funds for CCHP need to be spent on health care services for children, not on non-medical services. In its review of selecting health plans for participation in CCHP, MRMIB will look at the proportion of dollars each plan estimates will be spent on health care services as opposed to administrative costs.

State administrative costs will be held to a minimum. A simplified mail-in application for CCHP will reduce funds spent on administration of the program.

5. Will families be able to see their traditional providers to promote continuity of care?

What consumers value most in selecting a health plan is the ability to see their own physician. CCHP will allow families to select a health plan for their child from several plans offered in their communities.

To assure that a broad selection of health plans and physicians are available to families enrolled in CCHP, MRMIB will be authorized to contract with the following entities:

- Licensed health plans and health insurers,
- Local Initiatives approved by the Departments of Corporations and Health Services to provide service to Medi-Cal beneficiaries,
- County Organized Health Systems such as Solano, San Mateo, Santa Cruz and Orange, and
- Federal Health Insuring Organization demonstration projects, such as the Santa Barbara Health Authority.

6. How will CCHP promote the inclusion of safety net providers?

CCHP will infuse a significant amount of money into the health care delivery system to provide coverage and additional payment for a significant portion of the uninsured. While this program does not resolve the problem of providing services to uninsured adults, it is a major step forward in providing funding for services that were provided with minimal or no reimbursement. In that respect, it should help the safety net.

MRMIB will be authorized to contract with licensed health plans, health insurers, and Medi-Cal managed care plans such as Local Initiatives and County Organized Health Systems. Further, participation requirements for insurers and health plans will be designed to encourage subcontracting with safety net and traditional providers.

Eligibility

1. Who will be eligible for CCHP?

Uninsured children residing in households with an annual family income above the levels eligible for no cost Medi-Cal and equal to or below 200% of the federal poverty level. 580,000 California children may be eligible for the program.

2. How will a family document their income eligibility?

Families will be asked to document their income eligibility using copies of federal tax returns or current wage stubs. A similar process has successfully been used in the AIM program.

3. How will a family document their access to employer sponsored coverage?

Families will be asked to document if they have access to employer sponsored coverage, and if so what health plan provides the coverage. Families will self certify that their responses are true and accurate. A similar self certification process has successfully been used in the AIM and MRMIP programs.

4. Will children who are qualified aliens be eligible for the program?

Under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), only qualified alien children with entry into the United States before August 22, 1996, are eligible for federally funded public benefit programs, including this program.

In addition, new entrant qualified aliens in the "protected class" are eligible for this program. Generally, aliens in the protected class include persons who are lawfully

admitted for permanent residence and who have 40 qualifying quarters of work (with no public assistance); various categories of refugees and asylees for the first five years after entry; and aliens who are on active duty with the U.S., military forces, veterans, and spouses and children of such persons.

Children of legal immigrants who entered the United States on or after August 22, 1996, will not be eligible for CCHP. Consistent with federal law, no federal funding is available for children of legal immigrants who entered the United States on or after August 22, 1996. Rather, sponsors of such children and their families will be responsible for their medical needs.

5. Which aliens are qualified aliens?

Qualified aliens include aliens who are lawfully admitted for permanent residence, specified classes of refugees, parolees, and asylees, aliens with some types of conditional entry status, and battered women and children who meet the requirements in the federal law.

6. Which alien children are not qualified aliens?

Generally, this group would include aliens who are not lawfully present in the United States (largely undocumented aliens), nonimmigrant aliens who are lawfully present in the United States (e.g. visa holders), and some refugees, and a variety of other alien categories.

Benefit Package/Family Cost Sharing

1. What benefits will be provided?

The design of the benefit package should be driven by the health care needs of children, with emphasis on those health care benefits necessary for children to be able to attend school healthy and ready to learn; able to read the chalkboard; and to hear the teacher.

CCHP's benefit package will meet the requirements of the new federal law and will mirror benefits currently provided to working families through the California Public Employees Retirement System (Cal PERS). This package has been accepted by the employer community and is comprehensive in scope. CalPERS benefits include coverage for medically necessary hospitalization, physician services, diagnostic and x-ray, prescription drugs, durable medical equipment, ambulance, emergency care, home health services, hospice, and blood products. Further, mental health and substance abuse services, occupational, physical and speech therapy, and skilled nursing care will be provided, though with some limitations.

In addition dental benefits will cover services appropriate to good oral hygiene and health, including preventive and diagnostic services such as teeth cleaning, x-ray, topical fluoride treatments, space maintainers, and sealants; and restorative services such as fillings, crowns and bridges. Vision related coverage providing annual exams and eyeglasses will be provided.

Children with special health care needs that are eligible for services through the California Children's Services (CCS) program will continue to receive specialized services through CCS.

2. How will the benefit package differ from what is offered under Medi-Cal?

The primary objective in designing a benefit package is to assure that the health care needs of children are met in an efficient and cost effective manner. Design of the benefit package should be driven by the health care needs of children, with emphasis on those health care benefits necessary for children to be able to attend school healthy and ready to learn; to be able to read the chalkboard; and to hear the teacher.

The proposed CCHP program benefit package is the same benefit package available to State and local government employees through the California Public Employees Retirement System (Cal PERS). The Cal PERS package represents one of the most comprehensive employer sponsored health benefit packages in the market today.

The primary differences between a Medi-Cal package and that provided by Cal PERS are the restrictions on the number of in and outpatient mental health and substance abuse treatments (30 inpatient days per year and 20 outpatient visits per year), the

requirement that outpatient physical, speech and occupational therapy be pre-approved (limited to short term therapy for a period not to exceed 60 consecutive calendar days following the date of the first therapy session), and prohibitions on the coverage of non-emergency transportation.

3. What happens when a child needs more of one of the limited services offered by CCHP, such as mental health or speech therapy?

The benefits offered by CCHP are similar to or better than the benefits offered to working parents through their employer's health benefits. Those children with special health care needs will have access to the CCS program. We anticipate that this benefit design will provide for the health care needs of the virtually all children. In those rare cases where a child needs more of a particular service than is covered by CCHP, the family will still have the option to enroll the child in the Medi-Cal program after they have spent down their financial resources to the Medi-Cal eligibility level.

4. Will EPSDT services be provided?

The Early and Periodic Screening Diagnosis and Treatment (EPSDT) program is a federally mandated benefit for Medi-Cal eligible children under age 21. Under EPSDT children are entitled to routine medical screenings, preventive services and immunizations as well as all follow up diagnosis and treatment services to correct or ameliorate any medical conditions detected by the provider. These services include benefits generally not covered under the Medi-Cal State Plan.

Under CCHP all screenings, preventive services and immunizations will be provided with no copay. All medically necessary services required to resolve the condition will also be covered. However, the plan is limited to those treatment services in the plan's overall benefit design.

5. Is it reasonable to expect low income families to contribute toward the cost of coverage?

Yes. Premiums and copayments improve the program design because they involve families in managing their health care resources and emphasize personal responsibility. Inclusion of cost-sharing will reinforce CCHP's similarity to employer-based coverage. Experience in the AIM program suggests that low income working families prefer modest cost-sharing for private insurance coverage versus no cost Medi-Cal.

Copayments also help control inappropriate utilization, such as the use of the emergency room for non emergency health conditions. Copayments will also allow the program to negotiate better rates from health plans. *No copayments will be charged for health screening or preventive services.*

Cost sharing under CCHP will be based on a family's ability to pay. Premiums will be established at no greater than 2 percent of a family's annual income. A family of four earning 101 percent (\$16,210) of the federal poverty level (FPL) would pay a maximum of \$27.00 per month in premiums. A family of four earning 200 percent FPL (\$32,100) would pay a maximum \$53.50 per month in premiums. All children in the family will be covered for these premium amounts. Nominal copayments will be set within the amounts permitted in federal law. There will be no deductibles charged in CCHP.

6. Won't copayments keep families from seeking necessary preventive services?

No copayments will be charged for health screening or preventive services such as immunizations and well child visits.

7. Will children with special medical needs have easy access to specialty providers?

Children with special health care needs will continue to be served by the California Children's Services (CCS) program. CCS coordinates services for children with the managed care plan and the CCS specialty network to assure that children with special health care needs are met. Children enrolled in CCHP will have access to specialty providers through their health plan or the CCS program.

Outreach Efforts

1. **What kind of outreach will be used to make families aware of their children's eligibility for the program?**

A multifaceted statewide outreach effort will be launched to inform parents about the child health services offered through both Medi-Cal and CCHP. The outreach program will use mass media, toll free phone lines, community based organizations, and coordination with other state and local programs to deliver messages that are culturally and linguistically relevant. The goals of the campaign are to increase public awareness of the importance of preventive and other health care services and the availability of public programs to address children's health care needs.

2. **What role will community based organizations play in the outreach campaign?**

Community based organizations are important partners in the effort to conduct an aggressive outreach and education program about the importance of health care services for children and the availability of state-sponsored programs to help. Community based organizations are well positioned to promote locally designed outreach and education services that are culturally and linguistically appropriate. Such community based activities are important complements to broader statewide public awareness strategies.

3. **Why is a public awareness campaign necessary?**

Inherent in the creation of a CCHP program for uninsured children is the challenge to educate families about the program's availability, eligibility and application process. In addition, Medi-Cal eligible families need to be made aware of changes made to Medi-Cal to promote coordination between the two programs. Families not only need to be educated about these developments, but motivated to quickly take the steps necessary to insure their children. State experience supports our belief that multi-faceted public awareness campaigns that deliver their messages in a linguistically and culturally relevant manner can educate and motivate target populations.

4. **How will parents obtain application materials?**

CCHP will work closely with the myriad of community and state organizations that provide services or information to children. Organizations such as schools, medical offices, county health service sites, and day care centers all provide an excellent opportunity to reach families.

An application assistance payment will be paid to entities that assist families in completing the application form. These include insurance agents or brokers, school districts, Healthy Start sites, hospitals, medical doctors, nurses, county health departments, county welfare offices, licensed day care operators, primary care

community clinics, state maternal and child health contractors, and participating health plans. A flat fee of \$50 will be paid to the referring entity for every family that is deemed eligible for and enrolled in the program.

The use of an application assistance fee as opposed to on-going commissions has been successfully used in the MRMIP and AIM programs. On-going commissions would add to the administrative costs of the program, which would be problematic given the high percentage of state and federal funds used in the program.

5. What efforts will be made to assure that families not able to read or speak English are able to enroll in the program?

Program materials will be available in the threshold languages identified by the Department of Health Services as necessary to reach eligible persons in the Medi-Cal program. These threshold languages are English, Spanish, Vietnamese, Chinese, Farsi, Lao, Hmong, Cambodian, Armenian, and Russian.

The entity selected to provide eligibility and enrollment services for CCHP will be required to have the capability to provide phone service to families in the language spoken by the family.

In addition, health plans participating in the purchasing pool component of the program will be required to have interpreter services available at all initial points of contact. An innovative service provided by the Managed Risk Medical Insurance Board in the HIPC is the physician Super Directory. This directory lists all physicians participating in the program, their major field of practice and the language capabilities of the staff in the physician's office. A similar service summarizing the pediatricians and family practice physicians available to families through CCHP is planned. The Super Directory helps families select a health plan that has a provider network most appropriate to the needs of the family.

CCHP Program/Medi-Cal Coordination

1. Is anything being done to promote the compatibility between Medi-Cal and CCHP?

Several changes to the existing Medi-Cal program are included in the proposal to assure that families can move easily between the two programs as their family income fluctuates.

These changes to the Medi-Cal program include:

- One month "continued eligibility" for those Medi-Cal enrollees who would otherwise lose no cost Medi-Cal eligibility due to increases in family income. The one month grace period will give the family time to apply and enroll in CCHP to ensure continuity of care.
- A "resources disregard" in the Medi-Cal program for children concurrent with the implementation of CCHP. This will assure that all families with incomes below 200% FPL have access to coverage for their children.
- Coverage in Medi-Cal of all children under 19 below 100% FPL. Teens between 15 and 18 with family incomes between 84 -100% FPL will all be Medi-Cal eligible by 2002. We are proposing to accelerate their coverage in Medi-Cal.

2. Won't the program be confusing to families with one child eligible for Medi-Cal and another eligible for CCHP?

Today families are faced with a situation where one child is eligible for Medi-Cal and other children in the family have no coverage at all. The changes listed above will minimize this phenomenon. In the worst case scenario all children in the family will still have access to coverage, but through either Medi-Cal or CCHP.

Family continuity of care can be managed, to the extent possible, through the inclusion of Medi-Cal health plans in CCHP. Also, many doctors belong to multiple plans and this should help families to select health plans in which all children can be seen by the same providers.

3. Many low wage families' income moves up and down throughout the year. Won't the creation of a new program force families to move between Medi-Cal and CCHP as their family income fluctuates?

Eligibility for CCHP will be determined once a year. If a family continues to make their premium payments they can remain enrolled in CCHP until the next annual

requalification period. If a family's income decreases during the year and they would qualify for Medi-Cal, they can choose to disenroll from CCHP.

Eligibility for the Medi-Cal program is determined quarterly. If a family's income increases and they are no longer eligible for Medi-Cal, they will be given information about CCHP.

4. How will CCHP and Medi-Cal assure a smooth transition for subscribers moving between programs?

To assure that there is a smooth transition for Medi-Cal enrollees who are being disenrolled from Medi-Cal due to an increase in income, we will implement one month "continued eligibility" for these Medi-Cal enrollees so that they will have time to apply and enroll in CCHP to ensure continuity of care.

5. Will assets be used to review the eligibility of families?

CCHP will base eligibility on the income of a family. This will streamline the eligibility determination process and assure that children receive coverage as quickly as possible.

To assure a smooth interface between CCHP and the Medi-Cal program, we are proposing to waive the asset eligibility criteria in the Medi-Cal program for children concurrent with the implementation of CCHP. This will assure that all families with incomes below 200% FPL have access to coverage for their children.

Implementation of an asset waiver for children otherwise eligible for Medi-Cal will provide some administrative efficiencies to the Medi-Cal program by streamlining the eligibility process.

6. How will CCHP affect people leaving welfare (Cal-Work) and gaining employment?

Medi-Cal and CCHP provide additional support to families who leave welfare to obtain employment. This program structure assists families to obtain employment without the fear that their children would lose their health coverage.

Adults and children who leave welfare to obtain work are currently eligible for six months of transitional Medi-Cal. Those with earned income under 185% of the federal poverty level (FPL) are currently eligible for an additional six months of transitional Medi-Cal. Under the transitional Medi-Cal program, both the adult member of the family and all children receive full scope Medi-Cal for up to one year.

While the family remains on transitional Medi-Cal, they would receive their health coverage under Medi-Cal. Once the time limit for transitional Medi-Cal expires, the

family's children could continue to be eligible for health coverage under either full scope Medi-Cal or CCHP depending on their family income.

Adults who lose welfare due to exceeding welfare time limits would not lose their full scope Medi-Cal coverage, nor would their children. This is because the welfare time limits do not apply to Medi-Cal.

Quality Oversight

1. How can we be certain children will receive necessary services?

All medically necessary health services will be covered benefits through CCHP.

We will rely on the state's regulatory entities to assure that the program is contracting with health plans and insurers in good standing with the state.

2. What standards will health plans be required to adhere to in assuring quality care is provided to children?

All contracts with health plans participating in CCHP will contain performance standards regarding the provision of necessary health promoting services, such as immunizations. These performance standards will help the state to assure that health plans are complying with best practice guidelines in providing care to children.

Also, we will encourage participating plans to seek certification from the National Committee For Quality Assurance (NCQA), and to participate in the California Cooperative HEDIS Reporting Initiative (CCHRI). These are well accepted quality improvement efforts in the health plan community which provide a third party review of health plan operations and performance data.

Examples of the child specific measures which are included in the 1996 HEDIS data set include the immunization of children and adolescents, and the treatment of children with ear infections.

For those plans that do not currently have the ability to comply with these state of the art performance standards, MRMIB will provide a transition period after which they will be required to operate in accordance with the standards.

Another tool used in the commercial market which could be used in CCHP is the Health Plan Value Check. The Health Plan Value Check is an independently administered patient satisfaction survey which looks at issues important to quality of care such as waiting time for appointments and how much the subscriber feels they were helped by the physician visit.

Timing of Implementation

1. When will the first child be enrolled?

The first child can be enrolled within 6-9 months of passage of the enabling legislation.

MRMIB has implemented all three of its current programs between six to nine months after the legislation was signed.

2. Wouldn't a Medi-Cal expansion be quicker?

We estimate that an expansion of Medi-Cal to serve all children under 200% FPL would require 10 - 15 months to implement given the program and administrative preparations that would be required at the state and county levels.

Estimated Number of Children to be Covered

1. How many California children will be eligible for the program?

The UCLA Center for Health Policy Research estimates there are 580,000 uninsured California children living in households with family incomes between 100% to 200% FPL. These 580,000 children are potentially eligible for CCHP.

Cost/Financing

1. How do the costs of CCHP compare to the cost of expanding coverage through Medi-Cal?

The estimated total cost of the benefit package and administrative expenses for CCHP are estimated to be \$74.75 per child per month. An average of \$8 of this amount will be paid by parents in the form of premiums, resulting in total cost to the state of \$66.75.

The estimated total cost of the benefit package and administrative expenses for expanding the Medi-Cal program are estimated to be \$76.60 per child per month.

2. How much federal money is available for the program?

The final federal budget reconciliation bill provides a total of \$39.65 billion over a ten year period in increasing federal funding to the states to expand health care for low income children.

California's allocation of these funds is estimated to be \$855.2 million annually for at least three years, beginning in FFY 1998 (10/1/97), declining thereafter.

3. Must the state's entire federal allocation be spent in one year?

No, the federal law allows the amount allotted each year to be carried over and spent over the following two years.

4. What would the state match requirement be and what programs qualify?

The federal law requires states to match the increased federal funding which would require a state/federal funding ratio for California of about 35% to 65%. Qualifying matching funds would be those funds spent on state and local programs providing health care to children.

For example, spending the full federal funding of \$855 million would require a state match of \$460 million.

Premiums or other cost-sharing (copayments) may not be used to meet the state match requirement. Neither may other federal funds be used as matching funds.

5. When are the federal dollars available for expenditure by the state?

Federal funding becomes available October 1, 1997. To access the federal funds the state must submit a plan outlining its approach to providing expanded coverage for eligible children.

6. What is the Maintenance of Effort (MOE) requirement and how does it work?

The federal law requires states to maintain Medicaid eligibility criteria at the June 1, 1997 level, i.e., California may not remove eligibility for any population now served by Medi-Cal.

“Crowd Out“

Substitution of Existing Employer Coverage For CCHP’s Coverage

1. What will prevent employers and families from dropping existing children’s coverage in order to qualify for CCHP?

Any expansion of public coverage for children could attract a number of children who already have insurance either through privately purchased policies or through their parent’s employment based coverage. We are sensitive to the concern that CCHP not become a substitute for private funds currently being used to provide coverage to children. We are also sensitive to inequities which may exist if we only provide help to families of children who are currently uninsured.

The following mechanisms will mitigate the effects of crowd out in CCHP:

CCHP will be open to those children who are currently uninsured. Children who have had coverage within the prior six months will not be eligible to enroll. This provision would not apply to families losing Medi-Cal due to increases in income. While this approach raises equity concerns regarding the treatment of similarly situated families, an equally strong counter-argument is that CCHP is a limited initiative designed to address the needs of uninsured children.

Children eligible for “qualified” employer-sponsored dependent insurance will not be eligible for the purchasing pool portion of CCHP unless the family can demonstrate that the employer contribution for dependent coverage and the value of the Insurance Purchasing Credit are insufficient to make the employer’s policy affordable. This policy is consistent with our interest in strengthening the employer based insurance market.

Governance

1. What is MRMIB and to whom is the Board accountable?

MRMIB is a department of State government. MRMIB is comprised of five volunteer members, three appointed by the Governor, one by the Assembly and one by the Senate.

MRMIB currently administers three health benefits programs:

- the Major Risk Medical Insurance Program (MRMIP) serves persons unable to obtain private health coverage due to pre-existing medical conditions,
- the Access For Infants and Mothers (AIM) program provides prenatal and infant care to low income pregnant women and their children, and
- the Health Insurance Plan of California (HIPC) provides a health care purchasing cooperative for small businesses.

Each of these programs were started up in a short time (between six to nine months) with great success.

2. Why was MRMIB chosen to administer CCHP?

MRMIB has a proven track record of being able to administer health benefits programs effectively and efficiently. CCHP is consistent with the mission of the MRMIB which is to improve and increase the affordability and availability of quality health care coverage.

3. Could CCHP be administered by a private sector entity?

Privatization of CCHP may be possible after several years of program operation. For example, the HIPC is likely to be transitioned to private administration after its fifth year of operation (a Request for Proposal process is underway). A barrier to privatization is the significant level of state and federal dollars that will be spent through the program. If funds for the new children's health program are administered on a private basis, state staff will be required to award the contract to a private sector entity and to provide oversight of the expenditures. Given the small size of the MRMIB staff it is unlikely that significantly fewer staff would be required under this model. Alternatively, direct contracting with a private sector entity without a competitive process could be viewed as a gift of state funds.

Side-By-Side of Medi-Cal and the California Children's Health Plan (CCHP)

	CCHP	Current Medi-Cal Program
Approach	Capped block grant -- promotes policy-makers' ability to operate the program within a fixed budget.	Open-ended entitlement program that limits policy-makers' ability to set meaningful budget limits.
Eligibility	<p>Uninsured children age 1-18 living in households with family incomes below 201% FPL and above the income eligibility level for no cost Medi-Cal (children 1 through 5 with incomes up to 133% remain in the Medi-Cal program).</p> <p>Eligibility for full scope benefits restricted to citizen/qualified legal alien children</p>	<p>A patchwork of eligibility standards that vary according to age and family income -- children under age one with family incomes to 200% FPL; ages 1 through 5 up to 133% FPL; ages 6 through 15 up to 100% FPL; ages 15 to 19 up to 84% FPL. Additional children are eligible under other Medi-Cal programs with a share of cost.</p> <p>Eligibility for full scope benefits restricted to citizen/qualified legal alien children.</p>
Benefits	<p>Comprehensive benefit package that is comparable to employer-based coverage, including prescription drug, mental health and substance abuse, vision, hearing and dental services.</p> <p>Provides coverage of the full-range of services children require, including primary, preventive, and specialty care services, with emphasis placed on primary and preventive services.</p>	Comprehensive package of benefits to citizen/qualified alien children that offers more extensive benefits than virtually any private insurance plan offered through employers in California. The Medi-Cal package imposes few if any limits on amount, duration, and scope of benefits and requires the provision of benefits not generally covered under the Medi-Cal State Plan.
Delivery System	Services provided by health plans that would contract with the Managed Risk Medical Insurance Board for coverage of children. A broad selection of health plans and providers will be available to enrolled families through commercial HMOs, Local Initiatives, and County Organized Health Systems. Families will select a plan from several offered in their community.	Services are delivered through a variety of mechanisms, depending on geographic location. For most children, care is provided through organized systems of care such as commercial HMO's, Local Initiatives and County Organized Health Systems.

	CCHP	Current Medi-Cal Program
<u>Delivery System (cont.)</u>	Families with access to employer sponsored dependent coverage will be eligible for insurance purchasing credits. The credit mechanism will permit families to enroll in one plan.	
<u>Beneficiary Cost-Sharing</u>	Eligible families will be asked to contribute toward the cost of coverage. Premium-sharing and copayments promote family responsibility, help control inappropriate utilization of services, reinforce the new program's similarity to employer-based coverage and help finance the program. Cost-sharing will be nominal and will not be imposed on primary and preventive services.	Most enrollees are not required to contribute to the cost of their coverage, thereby discouraging individuals from taking greater responsibility for their health or appreciating the financial implications of their health care decisions.
<u>Administration</u>	Privately administered with oversight by the State. Administratively less costly and cumbersome, both for program administrators and enrollees, through the utilization of private contractors, a mail-in application process, and less government red tape.	Administered via county welfare offices with oversight by State and Federal government. Federally dictated mandates and program priorities have resulted in a stupefyingly complex program to administer. Medi-Cal uses 83 individual "aid codes" which correspond to specific eligibility, benefit level and cost liability for every individual approved for Medi-Cal. Over 275 individual forms are used to process the various Medi-Cal programs.
<u>Speed of Implementation of Program Expansion</u>	Six to nine months from the day legislation is signed.	Ten to fifteen months would be required to expand Medi-Cal to cover uninsured children up to 200% FPL, given the complex systems, program and administrative preparations that would be required at the state and county levels of government.
<u>Welfare Stigma</u>	None. Participation in the program will be similar to the purchase of private coverage; a simple mail-in	Carries a stigma associated with welfare, a stigma that is seen by many to represent a barrier to accessing

	CCHP	Current Medi-Cal Program
<u>Welfare Stigma (cont.)</u>	application process will be used with annual reevaluation of a family's eligibility.	coverage -- even for families eligible for the program.
<u>Safety Net Considerations</u>	Safety net participation in CCHP will be encouraged by including Local Initiatives and COHS as plan choices and incentivizing commercial plans to subcontract with safety net providers.	Safety Net and Traditional providers' contribution to the provision of services for the Medi-Cal and uninsured populations is recognized through Medi-Cal managed care's efforts to promote their inclusion in organized delivery systems through subcontracting.
<u>Cost</u>		
Monthly State Benefit Cost Per Child	\$66.75	\$76.60
Fixed Costs	\$14.1 million	\$14.4 million
Total Annual costs	\$479 million	\$548 million*
General Fund Share	\$168 million	\$192 million
		* Based on current cost of Medi-Cal program.

COMPARATIVE FISCAL ANALYSIS
California Children's Health Plan (CCHP) vs. Medi-Cal Expansion

Assumptions:

580,000 average monthly eligibles

35% state match required to draw down federal funds

No copays on Medi-Cal services; Some copays on CCHP Services (except preventive and screening)

Benefit package conforms to federal law: medical, dental and vision services provided

	CCHP	Medi-Cal Expansion
Variable Costs		
Average Monthly Benefit Costs per Child	\$70.25	\$66.90
Average Monthly Administrative Cost per Child	\$4.50	\$9.70
Average Family Contribution (premium) per Child	(\$8.00)	\$0
Total per Child Variable Costs	\$66.75	\$76.60
Total Annual Variable Costs	\$464,580,000	\$533,136,000
Fixed Costs		
Statewide Outreach Campaign	\$12,000,000	\$12,000,000
State Administrative Costs	\$2,100,000	\$2,400,000
Total Fixed Costs	\$14,100,000	\$14,400,000
Total Annual Program Costs	\$478,680,000	\$547,536,000¹
Required State Match at 35%	\$167,538,000	\$191,637,600
Medi-Cal Conforming Costs²		
Accelerate coverage of children under 100% FPL	\$19,100,000	\$19,100,000
Asset waiver for children	\$24,100,000	\$24,100,000
One month extended eligibility when income increases	\$0	\$0
Total Medi-Cal Conforming Costs	\$43,200,000	\$43,200,000

¹ Based on current cost of Medi-Cal Program

² No new net costs since cost of coverage for these children are reflected under variable costs above.

**FEDERAL BUDGET
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

<u>Goal</u>	<ul style="list-style-type: none"> To provide states with resources to expand access to health care for low-income uninsured children under 19 years of age.
<u>Approach</u>	<ul style="list-style-type: none"> States may choose to spend allotments through Medicaid expansion, payment of insurance premiums, direct purchase of services, or a combination of all three.
<u>Eligibility/Coverage</u>	<ul style="list-style-type: none"> Children up to 200 percent of poverty. Lower income children must be served first. Children must not be Medi-Cal eligible or be privately insured. State may establish eligibility standards based on geography, age, income and resources, residency, disability status, access to health insurance, and duration of eligibility. No individual entitlement to benefits (unless Medicaid expansion chosen). No pre-existing health condition exclusions, except in a group health plan or insurance plan as permitted by ERISA. No inmates in public institutions or patients in mental institutions.
<u>Benefits</u>	<p><u>Options for Minimum Benefit Standards Under Private Insurance Option</u></p> <ul style="list-style-type: none"> Coverage must be equivalent to one of three benchmarks: <ol style="list-style-type: none"> The standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to federal employees, A health benefits plan available to state employees, or Coverage offered thru the largest commercial HMO in the state; <i>OR</i> Coverage must be actuarially equivalent to one of the benchmarks. Must include basic benefits: <ol style="list-style-type: none"> Inpatient and outpatient services, Physicians' surgical and medical services, Laboratory and x-ray services Well-baby and well-child care, including immunizations. <p>Must also offer 75% of the actuarial value of prescription drugs, mental health, visions and hearing benefits in the benchmark plan; <i>OR</i></p>

<u>Benefits (cont.)</u>	<ul style="list-style-type: none"> Existing comprehensive state-based coverage (applies to Florida, New York, and Pennsylvania); <i>OR</i> Other health benefit coverage as approved by the Secretary of Health and Human Services. For example: <ol style="list-style-type: none"> States may seek a waiver for a cost-effective alternative, including coverage through a community-based health delivery system. States may also seek a waiver for family coverage under a group health plan if such coverage is cost-effective and would not substitute for other coverage. <p><u>Medicaid Expansion</u></p> <ul style="list-style-type: none"> No change from current law (EPSDT).
<u>Maintenance of Effort (MOE) Requirements</u>	<ul style="list-style-type: none"> States must maintain Medicaid eligibility criteria at June 1, 1997 level (i.e., may not remove eligibility for any population now served by Medi-Cal). Only three states which already have an expanded state-only program (Florida, Pennsylvania and New York) must maintain state children's health insurance expenditures at the 1996 level.
<u>Spending Restrictions</u>	<ul style="list-style-type: none"> No more than 10 percent of total program spending can be used for other child health initiatives (including direct services), outreach, and administration. Funds may not be used for abortions except in cases of rape or incest or to save the woman's life.
<u>Cost Sharing</u>	<ul style="list-style-type: none"> States may impose premiums, deductibles, coinsurance, and other cost-sharing based on family income as long as they do not favor children from families with higher incomes over lower ones. A state may impose premiums or cost sharing requirements on low-income children with family incomes over 150 percent of FPL on a sliding scale as long as it does not exceed 5 percent of family income. Below 150 percent of FPL, premiums or copays must be nominal as defined under Medicaid law or as approved by the Secretary. No cost sharing for preventive services. Family cost-sharing contributions can not be counted toward the state match.
<u>Financing</u>	<p><u>Total Program \$40 billion over 10 years</u></p> <p><u>Formula</u></p> <p><i>FYs 1998, 1999, 2000</i></p> <ul style="list-style-type: none"> Percentage of the nation's uninsured low income children multiplied by a State cost factor, based on average wages, relative to other states (<u>20 percent in California</u>).

<p><u>Financing (cont.)</u></p>	<p>For the first three years, national allotment is \$4.275 b/yr.</p> <p>Preliminary estimate of California's share is <u>\$855 m/yr.</u>¹</p> <p><i>FY 2001</i></p> <ul style="list-style-type: none"> • [75%(CA's percentage of the nation's low income uninsured children)] plus [25%(CA's percentage of the nation's children under 200% FPL)] multiplied by a State cost factor relative to other states (<u>19 percent in California</u>). <p>Preliminary estimate of California's share is <u>\$822 m/yr.</u></p> <p><i>FYs 2002-2007</i></p> <ul style="list-style-type: none"> • [50%(CA's percentage of the nation's low income uninsured children)] plus [50%(CA's percentage of the nation's children under 200% FPL)] multiplied by a State cost factor relative to other states (<u>18.5 percent in California</u>). <p>Preliminary estimate of California's share is <u>\$581 m/yr</u> thru 2004, increasing gradually in 2005-07.</p>
<p><u>Federal Match Rate</u></p>	<p><u>Private Insurance Option or Medicaid Expansion</u></p> <ul style="list-style-type: none"> • Regular FMAP increased by a number of percentage points equal to 30 percent of the difference between 100 percent and the FMAP percent for the state (65 percent in California). • <u>Example:</u> To receive \$855 million in federal funds, California's state share would be \$460 million.
<p><u>State Match Flexibility</u></p>	<ul style="list-style-type: none"> • Federally operated or financed health care insurance programs may not be counted toward the state match. • Family cost-sharing contributions can not be counted toward the state match.
<p><u>State Plan</u></p>	<ul style="list-style-type: none"> • To receive payment, states must submit a plan no earlier than October 1, 1997. The plan must describe strategic objectives, performance goals, and performance measures for maximizing health benefit coverage for targeted low-income children and children generally. Plan must have other components, including data collection, state assessment and study, audits, program development process, and program budget. • A state must annually assess the operation of the state plan. By March 31, 2000, states must submit to the Secretary an evaluation (with specified components), including an assessment of the state's effectiveness in increasing the number of kids with health coverage.

¹The legislation calls for updating state counts of low income uninsured children based on a 3 year average. Allocations after 1998 assume state proportions of children do not change compared to 1998 allocations.

GOVERNOR PETE WILSON'S RECORD ON CHILDREN'S HEALTH

In Pete Wilson's first State of the State address, he outlined a new approach to children's services called Preventive Government, which shifted resources to the prevention of problems before they resulted in both human and fiscal costs.

By increasing children's resources - nutrition, mental health, day care, and substance abuse programs - the Governor affirmed his commitment to preventing problems before they occur. By investing in our children's health, the Governor is protecting California's future.

HEALTHY START

In 1991, the Wilson Administration sponsored legislation creating the Healthy Start Program, which provides funding for school districts to bring existing local health and social services to the school site in a coordinated fashion to better serve children and their parents. Healthy Start addresses the needs of California school children who are struggling with multiple problems - poor physical or mental health, inadequate nutrition, substance abuse, family dysfunction or insufficient community support.

ACCESS FOR INFANTS AND MOTHERS (AIM)

Working toward the goal of providing every expectant mother in California with access to prenatal care, the Wilson Administration sponsored legislation creating the Access for Infants and Mothers Program (AIM). The program is designed for low-income (up to 300 percent of the federal poverty level) women and infants up to age 2 who cannot afford pregnancy care but make too much money to qualify for Medi-Cal, California's Medicaid program. AIM provides comprehensive care during pregnancy, 60 days of post-partum care and two years of comprehensive infant health care, including preventive care and immunizations. Since 1992, AIM has served over 25,000 mothers and their children.

BABYCAL OUTREACH CAMPAIGN

Launched in 1991, the BabyCal multi-media campaign works to combat low birthweight and infant mortality. BabyCal's message reaches 80 percent of women surveyed in California and generates approximately 6,000 calls per month to its toll-free information line. The campaign combines research, advertising and community outreach to inform high-risk pregnant women statewide about the importance of prenatal care and a healthy lifestyle during pregnancy, as well as the availability of state programs, such as Medi-Cal and AIM, that can help.

EARLY INTERVENTION

With the passage of the 1996-97 budget, California nearly doubled the funding for early intervention services for children under three years of age who are at risk of developmental delays or who have existing disabilities. Since the program's inception in 1993, over 17,000 children have received early intervention services. Children who enter this program receive services ranging from medical and nutritional assistance to transportation and family training programs.

CHILDHOOD IMMUNIZATIONS

California has consistently worked to increase immunizations for infants and young children, including the Governor's proposal in his 1997-98 budget to increase vaccine spending by an additional \$15.3 million, expanding the number of children receiving these immunizations from 1.4 million to 1.8 million in 1997-98.

EARLY MENTAL HEALTH INITIATIVE

To prevent mild school problems from becoming major barriers to later successes in both school and adult life, the Wilson Administration proposed an initiative in 1991 to assist schools in bringing early mental health counseling to children. The Early Mental Health Initiative seeks to detect and treat mental health problems in children in grades as early as kindergarten.

HEALTH INSURANCE PLAN OF CALIFORNIA

To expand health care insurance for working families and their dependents, the Health Insurance Plan of California (HIPC) was created in 1992, the nation's first statewide small business health insurance purchasing pool. Since its inception, over 7,000 businesses have signed up with HIPC, reducing their health care costs by as much as 40 percent. HIPC provides insurance to more than 127,000 participating families and their dependents, many of whom were previously uninsured.

SIGNED LEGISLATION

Since 1991, Governor Wilson has signed countless bills into law to promote the health and well-being of California's children in all areas of health -- from prenatal care to case management of medically fragile children and beyond -- and has provided easier access to early and comprehensive health care.

PRENATAL CARE

Ensuring a healthy start for the children of California has remained a top priority for the Governor. In an effort to continue and expand prenatal care for low-income women and teenagers, the Governor has signed several pregnancy-related bills, including legislation involving eligibility requirements for pregnant women covered by the Medi-Cal program, statewide genetic testing, and foster care pregnancy prevention information.

CHILD SAFETY

To avoid future health problems, the Governor has signed laws requiring warning labels on food and toxic containers. Also, he signed legislation to help prevent accidental drownings and to make child safety restraint laws stronger. In addition, the Governor signed legislation requiring minors to wear bicycle helmets and mandating safety features around swimming pools.

HIV/AIDS

The Governor has signed legislation to combat the deadly HIV/AIDS virus, including laws which required AIDS education in schools, allowed up to three grants to be made to vaccine manufacturers for FDA-approved pediatric clinical trials, and required health care providers to offer HIV counseling and testing to every pregnant woman during prenatal care.

TOBACCO

The Governor has signed several laws to help reduce youth access to tobacco and to protect children's health, including the Stop Tobacco Access to Kids Enforcement (STAKE) Act, workplace smoking bans, laws prohibiting the sale of tobacco products from vending machines, and laws which punish minors who purchase, receive, or possess any tobacco product.

DATE:

COVER PLUS 15 PAGES

FAX FROM: Ginni Hain
Special Assistant
Center for Medicaid and
State Operations/HCFA
410-786-6036 (phone)
410-786-0025 (fax)

Note to: Debbie Chang
John Klemm
Jean Lambrew
Chris Jennings
Martha Walker

Subject: Estimated Cost of a Child Health Program in
California.

Sally Richardson asked that I provide you the attached copy of the Kaiser Family Foundation's recent report, "Estimated Cost of a Child Health Program in California."



September 10, 1997

DREW E. ALTMAN, Ph.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER

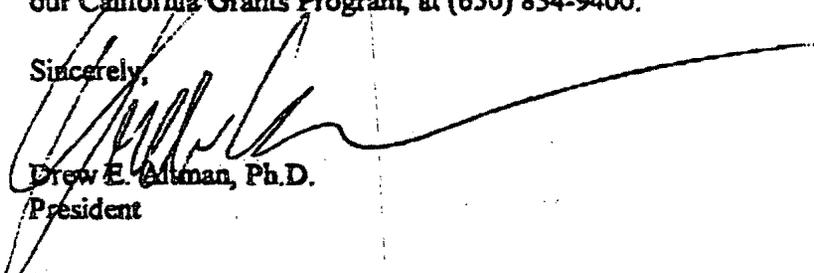
The Balanced Budget Act of 1997 recently enacted by Congress and signed into law by the President created a new federal/state program to cover uninsured children. The new Children's Health Insurance Program — funded through federal payments matched by states — gives states substantial flexibility in designing approaches to expand coverage. In assessing how best to provide coverage to uninsured children, it is important for states to consider various factors, including: ease of administration, the estimated cost per child, the estimated number of children likely to be covered, and whether coverage should be provided under a Medicaid entitlement or under a capped private health insurance program.

To provide an independent source of information about the cost of covering uninsured children in California, the Henry J. Kaiser Family Foundation commissioned an analysis by the Actuarial Research Corporation (ARC), which provides actuarial assistance to a variety of public and private clients. We are pleased to provide you with a copy of the technical report prepared by ARC, under the direction of its President, Gordon Trapnell, F.S.A., M.A.A.A.

ARC's analysis suggests that expanding California's Medicaid program (which is called Medi-Cal) would be substantially less expensive than developing a new private insurance program as proposed. However, there are many factors in addition to cost which will be weighed by both the legislature and the Wilson Administration in deciding on how best to expand insurance coverage for children, including their preferences for an entitlement versus a non-entitlement approach. ARC's analysis of the cost of the private insurance option is essentially in agreement with the Wilson Administration's estimate of their private insurance proposal.

We hope you find this analysis informative. As other states move to implement children's health insurance programs, we expect to sponsor similar analyses. Other Kaiser Family Foundation publications are available by calling our request line at (800) 656-4533. Many are also accessible on our website at www.kff.org. For more information, please contact Larry Levitt, Director of our California Grants Program, at (650) 854-9400.

Sincerely,



Drew E. Altman, Ph.D.
President

enc.

**Estimated Cost of
a Child Health Program in California**

prepared by

**Gordon R. Trapnell, F.S.A.
Actuarial Research Corporation**

for the Kaiser Family Foundation

September 10, 1997



Summary

The Balanced Budget Act of 1997 created a new federal/state program to cover uninsured children. The new federal legislation provides states with a substantial amount of flexibility in designing their child health insurance programs by expanding their existing Medicaid programs, creating new state child health insurance programs, or a combination of both. This report provides an analysis of the cost of covering California children through the options available under the federal program.

The analysis is based on an August 27th plan presented by the Wilson Administration for covering uninsured children in California -- the California Children's Health Plan (CCHP). A key element of the proposed CCHP is to expand coverage to uninsured children using a private insurance mechanism, which the Wilson Administration has said would be slightly less expensive on a per child basis than using the Medicaid program (which is called Medi-Cal in California). The Wilson Administration estimates that the proposed CCHP would cost \$74.75 per child per month, while expanding Medi-Cal would cost \$76.60 per child. These figures do not include premium contributions made by families or various state administrative costs that might be required under either approach. If families made an average \$8 monthly premium contribution per child as suggested in the CCHP proposal, then the government's cost per child under the CCHP would drop to \$66.75 per month. The table on page 33 of the Administration's published August 27th plan shows that the estimated total program costs assuming full participation at 580,000 children under Medi-Cal would be more costly than under their proposed private insurance approach.

Our analysis follows the same basic approach used in the comparative fiscal analysis in the August 27th description of the CCHP. Our analysis finds that while the per month enrollee premium estimate for a private insurance plan is only slightly less than the premium estimated by the Administration for its private insurance proposal, the per enrollee cost of a Medi-Cal approach is significantly less than the Administration's Medi-Cal estimate. The primary reason our cost estimates for the Medi-Cal option are less expensive than the Wilson Administration's Medi-Cal estimates is that we have assumed that children who will enroll in the new program will be less expensive than children currently enrolled in Medi-Cal. In a full-participation scenario, we find that a Medi-Cal expansion would be significantly less costly than a private insurance approach. (See Exhibit 1)

In sum, in our analysis:

- the cost of a private insurance option would be \$74.39 per child per month, slightly less (-0.5%) than the Wilson Administration's estimates for its CCHP proposal;
- the cost of a Medi-Cal approach would be \$60.65 per child per month, substantially less (-21%) than the Wilson Administration's Medi-Cal estimates.

As a result, we estimate that a Medi-Cal approach would cost 18 percent less than the Wilson Administration's CCHP private insurance option. If the average \$8 per month enrollee premium contribution per child is used to offset government expenditures under the private option, the private insurance option premium would be \$66.39, making the Medi-Cal estimated cost 9 percent less than the private insurance option amount.

The Wilson Administration estimates that 580,000 uninsured children would be eligible for a new program. Our analysis suggests that if all of these children enrolled (and no currently insured children dropped private coverage and became eligible), then using our estimate of per child costs would yield a Medi-Cal option cost for 1998 that would be approximately \$96 million per year less than a private insurance option. If a family average premium contribution of \$8 per enrollee per month is used to offset government expenditures under the private option, government spending for the Medi-Cal expansion option would be approximately \$40 million per year less than for the private insurance option.

One reason why using Medi-Cal might be less expensive than providing coverage through a private insurance mechanism is that Medi-Cal has historically paid providers at lower rates than private health plans. However, the benefits provided by Medi-Cal are more comprehensive -- and therefore more expensive -- than those provided by most private health plans (and than those provided in the proposed CCHP).

Exhibit 1

ARC PREMIUM CALCULATIONS FOR CHILD HEALTH INSURANCE IN CALIFORNIA
CY 1998PER CHILD PER MONTH COSTS

Medi-Cal Option

Base Monthly Per Capita	\$50.32
Adjusted Benefit Package	\$50.22
Projected to 1998	\$54.86
Adjusted to HMO rates	\$54.31
Adjusted for Additional Administrative Functions	\$60.65

HIPC-Based Consortia Plan (Private Insurance Option)

Base Monthly Per Capita	\$60.03
Adjusted Benefit Package	\$67.28
Projected to 1998	\$70.84
Adjusted to HMO rates	\$70.84
Adjusted for Additional Administrative Functions	\$74.39 ¹

ESTIMATED 1998 AGGREGATE COSTS

(Maximum-Enrollment-Based Calculations, Assuming Total Enrollment of 580,000)

Medi-Cal Plan	\$422.1 million
Consortia Plan - gross	\$517.8 million
minus \$8/month enrollee charge	\$55.7 million
Net Consortia Plan	\$462.1 million
Difference	\$40.0 million

SOURCE: Estimates based on analysis by Actuarial Research Corporation.

¹If an average \$8 per month enrollee premium is taken into account, the government cost per child per month would be \$66.39.

Objective

Our objective is to estimate the cost per child covered of implementing a Child Health Program in California (CCHP) in one of two modes:

- Through an expansion of Medi-Cal income limits and liberalizing asset restrictions
- Through an independent program as suggested by Governor Wilson, modeled on the California HIPC structure, but with plans limited to HMOs (and EPOs) in order to keep cost sharing at levels suitable for a low income population.

In both cases we project the incurred cost of the first year of an expansion or new program that begins in July 1998.

Medi-Cal Expansion

1. Base

We do not have a comprehensive set of premium rates for Medi-Cal, but rather:

- A DHS tabulation of the Medi-Cal FFS claims for children other than infants and foster children, for the period July 1995 through June 1996.
- A somewhat detailed description of the derivation of the original premium rates proposed for Local Initiatives and Commercial Plans under the two plan model county rates from the experience of the Santa Barbara County Operated Health Plan, together with supporting data and information provided in the report "Two Plan Model; Capitation Rates for July 1, 1995 - May 31, 1996 and June 1, 1996 - September 30, 1997."
- DHS estimates of the average incurred FFS cost per capita for (i) members of families and (ii) foster children for the periods July '95 through June '96 and July '96 through June '97. In both cases the estimates exclude the costs of those institutionalized and specialized services for such children, and any other services not capitated with the "local initiative" prepaid plans.
- A comprehensive set of HMO payment rates from several years ago.

In addition, we have a copy of the Capitation Rate Manual for Fiscal Year 1990-91, compiled by the California Medi-Cal actuaries, which provides a number of factors concerning key financial relationships.

Of these data sets the most relevant are (i) the rate structure derived from the Santa Barbara plan and calibrated with the estimated average FFS claims incurred per capita for July 1996 through June 1997 and (ii) the tabulation, apparently on an incurred basis, of a sample of children ages 1-18. The average incurred FFS cost per child per month of eligibility from the DHS tabulation for the period July 1995 through June 1996 was \$50.32 per eligible per month (PEPM).

This rate is somewhat lower than the average FFS cost per eligible month in that period for foster children in the eight counties in which the two plan model will be implemented, \$58.20 (which was actually higher than the estimated cost a year later of \$57.47). This cost PEPM for foster children appears to be higher than found in the tabulation of all children for some combination of area differentials (most of the two plan counties are in the areas with higher average Medi-Cal costs) and a higher average cost for foster children than for children in families (which apparently are somewhat older on average and may include more children with special Medi-Cal needs). Both the estimate for foster children and that for all eligible children exclude the cost of expensive conditions found in infants.

Given the methodology followed by California in setting rates to be paid to health plans, the estimated FFS cost PEPM in July '95 through June '96 appears to provide the most reliable basis for an estimate of what the State would offer HMOs to cover an expanded child population. (It also necessarily provides the basis for an estimate of the average that would be paid if the services are not provided through prepaid plans, i.e. on a FFS basis.) The California methodology, well documented by the Medi-Cal actuaries in various reports, has been to:

- Project the average FFS cost by category of eligibility, age-sex group and county of residence
- Adjust for difference in the average cost of those eligible for enrollment in an HMO in each category of eligibility
- Adjust for differences in the benefits for which HMOs are responsible and those retained by Medi-Cal
- Increase the per capitas by an allowance for those state administrative expenses that will be replaced by contracting with managed care plans
- Decrease the results for the state's share of managed cost savings.

Prepaid plans are offered the resulting rates on a take it or leave it basis.

In addition, the total paid to prepaid plans can not exceed estimates of what would have been paid in a FFS system, according to Federal laws and regulations. Thus the estimated FFS cost PEPM controls what can be paid to prepaid plans under Medicaid, and is by definition what

a FFS program would cost.

The rate structure derived by the Medi-Cal actuaries produces numbers that appear to be reasonable in relationship to those from the FFS tabulation, but require adjustments for:

- Deriving a rate for children between 1st and 18th birthdays from the average family member rates
- Area differences between payments in the twelve two plan counties and the entire state
- Differences in the benefit package offered through the prepaid plans and all Medi-Cal benefits (to the extent that benefits were limited in the prepaid benefit packages).

Since each of these steps may involve error, we rely here on the rate (\$50.23) derived from FFS data for a population most like what is to be enrolled under CCHP. However, we note that to the extent that the new program will enroll some age groups in larger numbers than others (especially if distinctions are introduced), this provides a promising base for estimates of the relative cost of different age groups.

2. Adjustments to benefit package and eligibility

By definition, the benefit package would be the same as the full Medicaid program. Thus the tabulations of FFS data cited above exclude services not currently capitated with HMOs. The value for the average experience of all eligible children during the twelve months ending in June 1996 appears to include all categories of benefits, including some related to institutional services. These should probably be excluded from the estimate, on the grounds that most needing institutional services are already eligible for Medi-Cal, and would not be included in the expansion population. The adjustment appears to be a decrease of the order of \$.10 PEPM.

It is not clear whether the services provided to crippled children are included in the base data. If they were, the cost PEPM should be further reduced by around 5% to allow for the relatively high cost per capita of this group, compared to what may be expected to be found in the expansion program.

(3) Projection to First Program Year

The period for which the base rates were tabulated was from July 1995 through June 1996. The estimates from DHS estimates for the average incurred FFS cost per capita for (i) members of families and (ii) foster children for the periods July 1995 through June 1996 and July 1996 through June 1997 can be used to update this base for another year. The average increase is 2.1%.

The resulting rate represents the average cost of FFS Medi-Cal during the period from July 1996 through June 1997. We wish to project the cost to the period July 1998 through June 1999, which occurs two years later. We project the increase to be 3.5% per year. After incorporating these two trend factors, the estimated average FFS claims incurred for non-infant non-foster-child Medi-Cal children is \$54.86.

(4) Adjustments for prepaid plan payment rates

Medi-Cal has increased payment rates to HMOs by 1% to reflect the estimated savings in Medi-Cal administrative expenses, and decreased rates by a small percentage to obtain a state share of managed care savings, e.g. a projected 2% in the calculation of two plan county rates. The rates are also reduced by around 0.5% to reflect a loss of interest when capitations are paid in advance rather than claims paid some time after the date on which services are performed.

After these adjustments, the average payment rates to prepaid plans for Medi-Cal children ages 1 - 18 would be \$54.31 PEPM.

(5) Medi-Cal administrative expense

The primary categories of expense that will be expanded would be expenses relating to eligibility determination and enrollment in prepaid plans. There would also be a modest increase in the workloads of the central staff and auditors. All additional expenses would be marginal expenses, since the same basic systems and procedures in place for Medi-Cal would be extended to the new eligible groups.

The most important new expense would be determining eligibility for a large new population. There would also be increased cost to calculate a new category of rates and to integrate the new beneficiary class into the current system of contracting with prepaid plans. The new categories would also produce an increase in auditing expense and the cost to analyze encounter data from the prepaid plans. Even relatively large such increases in the work loads of central staff, however, would not produce more than nominal increases in administrative outlays.

We have been provided the following information from the operation of the Medi-Cal program and plans for an expansion through Medi-Cal to cover new eligible children:

- Medi-Cal reimburses the counties \$119.51 per intake per case (family) and \$20.46 per month for "ongoing costs".
- Planning for an expansion of Medi-Cal under the Child Health Program is based on payment to the counties of \$119.51 per case "at least once per case" per year for "intake" and "redetermination" after any year of continuous eligibility and an allowance of \$10.23 per month per active case.

The latter amounts appear excessive for the marginal costs of administering an expansion population under Medi-Cal, but would produce the \$116.02 projected per case (and something more than the \$9.67 projected in the August 27 description, as a monthly cost per eligible since some children would not be eligible for multiples of full years). In addition, although eligibility determination is the largest expense of an expansion of Medi-Cal, it is not the only additional expense. There would also be increases in Medi-Cal expenditures for a number of other functional expenses, including hearings and appeals, auditing of payments to health plans, central office staff time, etc.

The level of reimbursement to counties, however, appears to be excessive for the marginal cost of determining eligibility for an expansion population in which incomes should be more stable, and for which income verification will not have to be performed for all eligibles (since many with relatively low health needs will never apply). We also note that past expansions of eligibility of children do not appear to have produced significant increases in Medi-Cal administrative costs as a percentage of benefits. Consequently, we will base our estimate on an average administrative expense for eligibility of 60% of that projected, and increase the result by 1% of the average benefits per capita (including payments to health plans) to allow for other functions.

This produces an average administrative cost of \$6.34 in addition to the basis of payment to health plans, bringing the total estimate to \$60.65 PEPM.

(5) Payment of bad debts

An important effect of the expansion should be some relief to major providers from the burden of bad debts. The primary beneficiaries would be the "essential providers", i.e. institutions that now receive Disproportionate Share payments and cross subsidies to Federally Qualified Health Centers. To the extent that the state's share of differential payments (including the extent to which a higher payment rate has been built into the two plan county rates) will be reduced by the new benefits, the state's cost for the program will be reduced.

(6) Coverage of children now covered by employer plans

A strong incentive is created by the new coverage for families that now pay for coverage of their children through employer plans to drop this coverage. Their children would become eligible for Medicaid immediately.

Medicaid, however, can consider such coverage in determining eligibility. Further, the Medicaid eligibility is designed to detect employment and ask about such coverage, and the questions would be repeated quarterly. Medicaid has the option (and, if cost-effective, is required by HCFA) to pay the employee contribution rates to obtain coverage for persons eligible for Medicaid. It should be noted, however, that this affects aggregate outlays, but not necessarily the PEPM).

(7) Selection

The average rate PEPM derived above is determined for coverage of the full population eligible for the expansion, estimated to be some 580,000 children. In practice, only some fraction of these children would actually become enrolled, issued health cards and enrolled in prepaid plans. Thus there would continue to be a FFS program paying some claims for eligibles before they are enrolled in prepaid plans. The method of estimation implicitly averages such claim payments and the cost of processing with the premium rates paid to the prepaid plans.

Further, although those who are enrolled will include most with major health expenses, some of the expenses of the potential expansion population will not be paid under the expansion because the providers do not find obtaining eligibility worth the effort and because some care will not be provided to those who do not obtain eligibility. On the other hand, the average cost per person found eligible will be significantly higher than the average expenditure per potential eligible derived above.

(8) Other considerations

One possible shortcoming of the estimates derived above is that the plans may balk at the level of rates being offered. Since we assume the newly covered group will be offered as part of the overall package, however, a decision to withdraw would necessarily involve losing the rest of the Medi-Cal enrollment. For this reason, we only mention the possibility that the increased size of the contract at what appear to be below market rates may result in some loss of potential contractors.

Consortia Plan

(1) Base

The most important consideration in the choice of a base is to emulate the procedures that will be followed to determine the premium rates that will be paid for the coverage. A fundamental difference between the procedures used to determine rates for the consortia plans offered in California and the managed Medicaid plans is that the plans are free to bid rates that they believe constitute prudent business decisions, without the implicit threat of loss of existing market share.

In contrast, in the managed Medi-Cal program, the prepaid plans must accept the rates offered, or not participate. Many have participated despite the apparently low level of payment rates offered. Further, if additional volume is not accepted, the plans would lose their present share of this market. It is much more difficult for a HMO management to decide to drop an existing product line than to decide not to bid on a new class of business.

The most appropriate base for which we have adequate publicly available information

from which to estimate the premium rates that would be bid by health plans in a new program offered by MRMIB would be the average of the HMO "Preferred" plans being offered through the HIPC, averaged over the areas in which the uninsured children live. This base is most appropriate for the CCHP plan because:

- The mechanism is more like that to be used for CCHP than CalPERS, since there will be needs to maintain eligibility roll by individual/family, eligibility depends on payment of premiums (complete with grace periods), there are enrollments taking place throughout the year, etc.
- In addition, enrollment is open to biased selection through dumping of sick employees by very small employers (who constitute a large proportion of the actual enrollment).
- The average is less biased toward urban areas where there are proportionately more civil servants than the near poverty population.

Since we do not have the enrollment by plan in HIPC, nor any rates specifically for children living alone, we determine an adjusted premium rate for those plans offered widely throughout each of the six HIPC areas from that charged for single adults using (i) standard demographic relationships relating to the average cost of covering children and single adults through HMOs and (ii) the average Medi-Cal costs of children over age one to that for all children under age 19.

The next step is based on an assumption concerning how the premium rates would be charged, namely that payments by CCHP would be based on the lowest rate of prepaid plans widely available throughout each county (less \$8.00) and families would be responsible for the additional premium charged by the health plan chosen. This would mean that the CCHP expenditure would in effect be based on the premium rates of the lowest cost plan in each county. To simulate this basis, we based the estimate on the average of the lowest cost among plans widely available in each area. (We believe that this method (i) overweights areas 1 and 2, which have the highest of the lowest premium rates for widely available plans to offset (ii) a bias in projecting the lowest cost plans (usually Kaiser Permanente) to be fully available in all counties in areas 3 through 6. The result was an average child premium of \$60.03.

(2) Adjustments to benefit package

We estimate the benefits included in the August 27 descriptive proposal. (These benefits may have to be increased to meet the "actuarial equivalence tests" required by federal law.) Accordingly, adjustments must be made for including vision care (including eyeglasses) and a full benefit package for preventive and restorative services for dental care. We estimate the cost of these additional benefits to be \$7.25.

(3) Projection to first program year

The present HIPC rates are for calendar year 1997. We are estimating the average cost during the first operating year of a program that would be in effect during 1999, and perhaps begin as early as July 1998. We project the cost for July 1998 through June 1999. Thus the general level of rates needs to be projected for 1.5 years. The projection was made at 3.5% annually.

(4) Administrative expenses

The average administrative expenses will be significantly higher than currently experienced in the HIPC for:

- Enrollment, eligibility determination and premium processing for individual family units rather than employers, meaning smaller numbers of persons per contract.
- Premium collection costs will be higher, with more late payments and grace period notices and processing. (Dealing with inexperienced family heads rather than the administrators of small employers.)
- More rapid turnover, with higher finders fees and enrollment expenses as a proportion of total expenses.
- Units are limited to one or more children, without any adults, meaning both smaller families and much lower premium per family unit, than found in individual insurance.

Administrative expenses as a percentage of the average benefits will be increased for two primary reasons: (i) the additional cost to deal with individual families, especially low income families and (ii) the cost of administrative functions will be divided by a much lower average premium per unit.

Unlike the situation with an expansion of Medi-Cal, a new operation is to be brought into existence under MRMIB, requiring the hiring a completely new staff, renting new facilities and purchase or lease of equipment, software, etc. The cost to set up and run the organization will be a higher percentage of the relatively low premium rates for children compared to those of the HIPC. Thus there should be no savings compared to the level of functional costs of the HIPC, but these will constitute a much higher percentage of benefits.

The primary functional area in which the unit expenses will be greater is in dealing with individual enrollments and all the attendant problems. The complications will affect both the umbrella organization and the health plans, although primarily the former. (It is also not clear

that the HMOs will build the additional cost of dealing with individuals into their bids, since many HMOs cross subsidize individual product administrative expenses.)

Typical administrative expenses of health insuring organizations that deal primarily with individuals run 15% to 20% or more of benefits (although much of this is marketing expenses). Further, although the average duration of individual health insurance policies tends to be relatively short, e.g. an average of three to four years, turnover in the population to be covered is likely to be much higher, perhaps one third to one half of the enrollment each year. Further, by limiting coverage to children in the families, there is less premium over which to spread the cost of administration. Consequently, the average administrative expenses are likely to run an order of magnitude higher than for the current mix of small employer groups. The \$50 finder's fees, which are payable for nearly all new enrollments, with one-third turnover each year, by themselves increase premiums by nearly 2%.

The most suitable starting point would be the total administrative costs of the HIPC divided by the number of employment groups. This would be biased upward, since the cost to deal with employment groups of many individuals will be higher than for a family. But the calculation is likely to be more instructive than beginning with the percentage allowance in the current HIPC rates.

In comparison to the administrative costs found in Medi-Cal, allowances must be made for the additional functions associated with coverage dependent not only on eligibility determination but on the collection of monthly premium rates, especially given the targeted income group and the creation of a completely separate organization to handle all staff functions. The latter include:

- Maintaining enrollment files
- Premium collection (including pursuit of unpaid premiums due)
- Margins to fund uncollectible premiums due and interest on grace periods
- Commissions and finders' fees
- Accounting, audit, etc.
- Actuarial
- Investment of surplus
- Employee services and benefits management
- Insurances (e.g. E&O)
- Provider/plan relations
- Compliance with regulations and other staff functions (e.g. legal, actuarial, etc.).
- Corporate overhead
- Risk/profit charges to fund increasing needs for working capital.

Although this is a highly uncertain estimate, it is difficult to see how administrative expenses could be less than 10% to 15% of benefits. This compares to a present level of administrative expenses of a few percent of premium built into the rates charged by the HIPC.

i.e. an increase of the order of 5% beyond the percentage included in HIPC rates. Compounding these factors from the base rate yields a final cost per child of \$74.39.

(5) Anti-selection

The average cost per child under the proposed CCHP program would be increased by limiting eligibility to those willing to pay the premium. This is not reflected in these estimates. As with the August 27 proposal's support material, for purposes of discussing the relative merits of alternative implementations, the estimates are based on a "high cost" scenario reflecting enrollment at the total number of uninsured eligible children implied by Census data.

(6) Coverage of children now covered by employer plans

A strong incentive is created by the new coverage for families that now pay for coverage of their children through employer plans to drop this coverage. Their children would become eligible for the new program after six months.

There would appear to be few barriers to such conversion of child coverage from employer plans to CCHP. First, eligibility is only determined on an annual basis, and without the kind of investigation that is likely to find all existing insurance coverage. Further, some families would decide that a six month waiting period was well worth having the new program pick up a much higher proportion of the cost. Thus a substantial coverage of children now covered by employer sponsored insurance must be anticipated under this program. However, as noted previously, this primarily affects the aggregate program costs, rather than the PEPM.