

## NOTES

### Improving Health Care for Uninsured Children in the Wake of the State Children's Health Insurance Program (SCHIP)

#### I. INTRODUCTION

Following the 1997 revision of the Social Security Act that created the State Children's Health Insurance Program (SCHIP),<sup>1</sup> it is important to measure the federal and state progress toward providing low-income children with adequate health insurance coverage. The time is ripe for evaluation because federal funding has been available for over three years,<sup>2</sup> plans from all fifty states have been approved and implemented,<sup>3</sup> and the Secretary of Health and Human Services (Secretary) is due to submit a report to Congress evaluating the program by December 31, 2001.<sup>4</sup>

The lack of comprehensive health care for children is a serious concern for many reasons. First, children have unique developmental needs that require regular doctor's visits, diagnostic screening, and preventative services to ensure that they grow to be healthy adults.<sup>5</sup> Uninsured children are at a "significantly increased risk for preventable health problems"<sup>6</sup> because they are more likely to delay or forego needed medical care due to financial barriers.<sup>7</sup> Children without insurance visit the doctor fewer times each

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1. Balanced Budget Act of 1997 § 4901, 111 Stat. 552 (codified at 42 U.S.C. §§ 1397aa-1397jj (Supp. IV 1998)).

2. States were eligible for federal payments for coverage starting on October 1, 1997. *See* 42 U.S.C. § 1397aa(d) (Supp. IV 1998).

3. The last of the fifty states to implement its SCHIP plan was Hawaii on July 1, 2000. *See* Health Care Financing Administration, *State Children's Health Insurance Program: Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Year 2000* (visited Feb. 16, 2001) <<http://www.hcfa.gov/init/fy2000.pdf>> [hereinafter HCFA, *Enrollment Statistics for 2000*]. *See generally* Health Care Financing Administration, *The State Children's Health Insurance Program Annual Enrollment Report: October 1, 1998—September 30, 1999*, 3 (Jan. 11, 2000) <<http://www.hcfa.gov/init/enroll99.pdf>> [hereinafter HCFA, *Annual Enrollment Report*].

4. *See* 42 U.S.C. § 1397hh (Supp. IV 1998). The Secretary's report will be based on evaluations submitted by the states on March 31, 2000, and will also be available to the public. *See id.* *See generally* Health Care Financing Administration, *State Children's Health Insurance Program Approved Plan Files* (visited Feb. 16, 2001) <<http://www.hcfa.gov/init/chpa-map.htm>>.

5. *See* Families USA Foundation, *One Out of Three: Kids Without Health Insurance 1995-1996* (March 1997) <<http://www.familiesusa.org/kwohi.htm>> [hereinafter Families USA, *One out of Three*].

6. HCFA, *Annual Enrollment Report*, *supra* note 3, at 1.

7. *See* Families USA, *One Out of Three*, *supra* note 5 (citing Paul W. Newacheck et al., *Children's Access to Health Care: The Role of Social and Economic Factors*, in *HEALTH CARE FOR CHILDREN: WHAT'S RIGHT, WHAT'S WRONG, WHAT'S NEXT* (Ruth E. K. Stein, ed., 1997)).

year and are less likely to receive immunizations.<sup>8</sup> Uninsured children are also four times as likely to live without a needed medical service such as dental care, mental health care, prescription medications, or glasses.<sup>9</sup>

Second, uninsured children are less likely to see a doctor when they are sick.<sup>10</sup> They often fail to seek medical attention for conditions such as asthma or earaches, which require treatment and have the potential to cause long-term health problems.<sup>11</sup> Even when uninsured children do receive medical attention, they fare worse and are more likely to die than insured children hospitalized for similar health problems.<sup>12</sup> Because emergency medical treatments and procedures are more costly than preventative health services, children would suffer fewer long-term health problems and the community would incur less expense if children were provided with basic health care before their conditions escalated into emergencies.<sup>13</sup>

Finally, the lack of comprehensive health care has numerous ramifications for society. "Providing health care coverage to children impacts much more than their health—it impacts their ability to learn, their ability to thrive, and their ability to become productive members of society."<sup>14</sup> A lack of health insurance is correlated with higher infant mortality rates,<sup>15</sup> suggesting that fewer uninsured children survive their first year to

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8. See *id.* (citing Newacheck et al., *Children and Health Insurance: An Overview of Recent Trends*; Eugene Lewit and Linda Schuurmann Baker, *Health Insurance Coverage*, 5 THE FUTURE OF CHILDREN 1 (1995); Alan C. Monheit and Peter J. Cunningham, *Children Without Health Insurance*, 2 THE FUTURE OF CHILDREN, 154 (1992)).

9. See *id.* (citing Paul W. Newacheck et al., *Children's Access to Health Care: The Role of Social and Economic Factors*, in HEALTH CARE FOR CHILDREN: WHAT'S RIGHT, WHAT'S WRONG, WHAT'S NEXT (Ruth E. K. Stein, ed., 1997)).

10. See *id.* (citing Newacheck et al., *Children and Health Insurance: An Overview of Recent Trends*; Eugene Lewit and Linda Schuurmann Baker, *Health Insurance Coverage*, 5 THE FUTURE OF CHILDREN 1 (1995); Alan C. Monheit and Peter J. Cunningham, *Children Without Health Insurance*, 2 THE FUTURE OF CHILDREN, 154 (1992)).

11. See *id.* (citing Jeffrey J. Stoddard et al., *Health Insurance Status and Ambulatory Care for Children*, 330 NEW ENG. J. MED. 1421 (1994)). See also MediKids Health Insurance Act of 2000, H.R. 4390, 106th Cong. § 1(c)(2) (2000) (proposing that a comprehensive health insurance plan is needed because of lifetime individual health costs suffered by uninsured children and because of costs to the American economy).

12. See Families USA, *One Out of Three*, *supra* note 5 (citing Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome*, 265 JAMA 373 (1991)). Depending on race, the hospital death rate was 1.46 to 1.88 times higher for uninsured children as compared to privately insured children. See *id.*

13. See Rosa L. DeLauro, *Moral, Economic, and Social Issues in Children's Health Care: Helping American Parents Raise Healthy Kids: Congress' Efforts to Solve the Problem of Uninsured Children*, 2 QUINNIPIAC HEALTH L. J. 63, 65-66 (1998) available in LEXIS, Lexsee 2 QUINNIPIAC HEALTH L.J. 63 (1998).

14. Congressman Pete Stark, Extension of Remarks at the Introduction of the MediKids Health Insurance Act of 2000 (May 4, 2000) available in <<http://www.house.gov/stark/documents/106th/medikidssumm.html>> [hereinafter Stark, Remarks at MediKids].

15. See Jim Weill, *The Convention on the Rights of the Child and the Well-Being of America's Children*, 5 GEO J. FIGHTING POVERTY 257, 259 (1998) available in LEXIS, Lexsee 5 GEO J. FIGHTING POVERTY 257 ("The U.S. infant mortality rate...is the second worst among industrialized nations—eighteenth out of

grow into adults contributing to the community. Because health insurance has been found to contribute to academic success, children without health insurance may be educationally disadvantaged.<sup>16</sup> Children without health care miss more days of school and suffer from treatable conditions such as asthma, vision problems, and ear infections that interfere with classroom participation.<sup>17</sup> Furthermore, statistics suggest that the problem is widespread; approximately ten million children go without health insurance each year.<sup>18</sup> These "innocent children need and deserve [the] basic right to adequate health coverage, for someday our society will benefit from the contributions these children make."<sup>19</sup>

The child's right to health care has been recognized as a global concern. The United Nations Convention on the Rights of the Child (Convention) recognizes "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."<sup>20</sup> Ratifying nations agreed to take measures to reduce infant and child mortality and "[t]o ensure the provision of necessary medical assistance and health care to *all* children with emphasis on the development of primary health care."<sup>21</sup> The Convention was adopted in 1989 and has been ratified by 191 countries; the only two countries yet to sign the document are Somalia and the United States.<sup>22</sup> Although the United States has not ratified the Convention, the implementation of the State Children's Health Insurance Program (SCHIP) shows that children's health care has become a national priority. "The steady growth of the S-CHIP [sic] program is evidence of the success of this Federal-State partnership and the nation's commitment to ensuring that all children have health insurance coverage."<sup>23</sup>

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nineteen.").

16. See Health Care Financing Administration, *The State Children's Health Insurance Program: Preliminary Highlights of Implementation and Expansion*, 6 (July 2000) <<http://www.hcfa.gov/init/wh0700.pdf>> [hereinafter HCFA, *Highlights of Implementation and Expansion*].

17. See *id.*

18. See U.S. Census Bureau, *Health Insurance Historical Table 5: Health Insurance Coverage Status and Type of Coverage by State—Children Under 18: 1987 to 1999* (last modified Oct. 18, 2000) <<http://www.census.gov/hhes/hlthins/historic/hihist5.html>> [hereinafter U.S. Census Bureau, *Historical Table 5*] (indicating that about ten million children were uninsured as of March, 2000).

19. DeLauro, *supra* note 13, at 67.

20. U.N. Convention on the Rights of the Child, *adopted and opened for signature* Nov. 20, 1989, art. 24 reprinted in CHILDREN'S RIGHTS IN AMERICA: U.N. CONVENTION ON THE RIGHTS OF THE CHILD COMPARED WITH UNITED STATES LAW xi, at xxi (Cynthia Price Cohen & Howard A. Davidson eds., 1990).

21. *Id.* (emphasis added).

22. See Weill, *supra* note 15, at 257. Although the United States participated in the drafting of the document, Weill suggests that it has not ratified the Convention partially because of the nation's skepticism towards international treaties and partially because of American attitudes toward children. Children's political interests are only represented by their parents' votes. Cultural and demographical changes have eroded parents' "virtual representation" on behalf of their children; there are fewer guardians to vote for children's programs and a greater emphasis on programs that benefit aging Americans. *Id.* "Almost all wealthy industrial nations provide or assure the provision of health coverage to all of their citizens, or at least to all of their children. The United States stands alone in not doing so." *Id.* at 259.

23. HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 1.

This Note evaluates state use of the Children's Health Insurance Program to provide low-income children with health insurance and discusses ways through which more children could gain insurance coverage. Part II analyzes the current status of health care legislation by reviewing the Social Security Act, the problems leading to the 1997 amendment, and the State Children's Health Insurance Program. Part III summarizes and evaluates state progress in implementing SCHIP. Part IV focuses on ways to improve the current health care initiatives through increased outreach and enrollment efforts and Section 1115 demonstration proposals.<sup>24</sup> Part V discusses how future reforms such as legislative proposals and local initiatives can extend beyond existing Medicaid and SCHIP programs to provide comprehensive health care for *all* children. Although the State Children's Health Insurance Program is a significant step in the right direction, Part VI concludes that states must take action to enroll eligible children and aid those not covered by current programs in order to ensure that all children receive adequate health care.

## II. HEALTH CARE LEGISLATION

### A. The Social Security Act<sup>25</sup>

Under the Social Security Act, federal matching funds are available to states that offer certain basic services to mandatory Medicaid eligibility groups.<sup>26</sup> States maintain some discretion in deciding which groups the state program will cover, the financial eligibility requirements, and the amount and duration of services offered under the state program.<sup>27</sup> Every state program, however, must provide certain basic services to the categorically needy.<sup>28</sup> These services include inpatient and outpatient hospital services, physician and dental services, family planning, health clinic services, laboratory services, pediatrics, and early periodic screening, diagnosis, and treatment (EPSDT) services for people under twenty-one.<sup>29</sup> State Medicaid programs must provide eligible children with the health care services considered "medically necessary" by EPSDT,

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24. Demonstrations projects are authorized by 42 U.S.C. § 1315 (1994 & Supp. IV 1998).

25. 42 U.S.C. 1396 (1994 & Supp. IV 1998).

26. See *id.* §§ 1396, 1396a(10). See generally Health Care Financing Administration, *Medicaid Eligibility* (visited Feb. 21, 2001) <<http://www.hcfa.gov/medicaid/meligib.htm>>. The federal government will match the amount a state provides for its eligible Medicaid recipients. Unlike SCHIP, there is no funding cap. See also Health Care Financing Administration, *Medicaid Services*, ¶ 11 (visited Feb. 22, 2001) <<http://www.hcfa.gov/medicaid/mservice.htm>>.

27. See Health Care Financing Administration, *Medicaid Eligibility* (visited Feb. 22, 2001) <<http://www.hcfa.gov/medicaid/meligib.htm>>. See also Health Care Financing Administration, *Medicaid Services* (visited Feb. 22, 2001) <<http://www.hcfa.gov/medicaid/mservice.htm>>.

28. See Health Care Financing Administration, *Medicaid Services*, ¶ 7 (visited Feb. 22, 2001) <<http://www.hcfa.gov/medicaid/mservice.htm>>.

29. See *id.* at ¶ 1.

even if the state's plan does not cover those services.<sup>30</sup> Although state Medicaid programs may impose co-payments, children under 18 are excluded from cost-sharing.<sup>31</sup>

The federal government requires that Medicaid services are provided according to the recipient's need, as determined by status or income. Income eligibility requirements are based on the Federal Poverty Level (FPL) for the year; in 2000 the FPL for a family of four living in the United States, excluding Alaska and Hawaii, was \$17,650.<sup>32</sup> State Medicaid plans must cover babies of Medicaid-eligible mothers for one year and children up to age six whose family income is at or below 133% of the FPL.<sup>33</sup> States have also been required to phase in coverage of all children born after September 30, 1983, with family incomes at or below the federal poverty level.<sup>34</sup> These children are eligible for Medicaid until they turn nineteen.<sup>35</sup> States can also choose to provide coverage for other categorically needy groups, like infants under age one whose family income is under 185% of the FPL and targeted low-income children.<sup>36</sup>

### B. The Problem

Prior to 1997, children's health care reformers focused on expanding the Medicaid program to help very poor families, who they thought most needed assistance with insuring their children.<sup>37</sup> Medicaid was designed "to furnish medical assistance on behalf of families . . . whose income and resources are insufficient to meet the costs of necessary medical services,"<sup>38</sup> as defined by the federal poverty level. Although Medicaid reform offered to help the very poorest of children, not all eligible children were enrolled. Millions of other children remained uninsured because their family income was above the federal poverty level, too high for them to be eligible for Medicaid.<sup>39</sup>

In 1995, two years prior to the enactment of the SCHIP legislation, 13.8% of chil-

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30. See *id.* at ¶ 6.

31. See *id.* at ¶ 10.

32. See Annual Update of the HHS Poverty Guidelines, 66 Fed. Reg. 10695 (2001), available in LEXIS 66 FR 10695. The FPL is \$14,630 for a family of three and \$20,670 for a family of five. For larger families, the FPL is determined by adding \$3,020 for each additional person. See *id.* The 2001 Poverty Guidelines reflect poverty thresholds for the year 2000. See U.S. Department of Health and Human Services, *The 2000 HHS Poverty Guidelines* (visited Nov. 27, 2000) <<http://aspe.hhs.gov/poverty/01poverty.htm>>.

33. See Health Care Financing Administration, *Medicaid Eligibility*, ¶ 1 (visited Feb. 22, 2001) <<http://www.hcfa.gov/medicaid/meligib.htm>>.

34. See *id.*

35. See *id.* By the year 2002, all children under 19 with family incomes at or below 100% FLP will be eligible for state Medicaid plans. See *id.*

36. See *id.* at ¶ 2.

37. See DeLauro, *supra* note 13, at 63.

38. Social Security Act, 42 U.S.C. § 1396 (1994).

39. See generally Ruth A. Almeida & Genevieve M. Kenney, *Gaps in Insurance Coverage for Children: A Pre-CHIP Baseline*, in URBAN INSTITUTE: ASSESSING THE NEW FEDERALISM, at 2 tbl.1 (New Federalism: National Survey of America's Families No. B-19, May 2000) available in <<http://newfederalism.urban.org/pdf/b19.pdf>> [hereinafter Almeida & Kenney].

dren under nineteen years old lacked health insurance for the entire year.<sup>40</sup> This meant that 9.8 million children were living without health insurance.<sup>41</sup> These figures would have been even higher if calculated to include children uninsured for part of the year. Statistics showed that about twenty-three million children had gone without insurance for part of the two-year period between 1995 and 1996.<sup>42</sup> Of the sixty-one million children (86.2%) insured for all or part of 1995 nationwide, forty-seven million (66.1%) were covered by private or employment-based health plans.<sup>43</sup> Medicaid insured the remaining 16.5 million (23.2%).<sup>44</sup>

The situation worsened in 1996. The percentage of uninsured children rose from 13.8% to 14.8% of all children, meaning that a total of 10.6 million children lacked health insurance for the entire year of 1996.<sup>45</sup> The states with the highest percentages of children uninsured for all or *part* of years 1995 and 1996 were Texas, New Mexico, Louisiana, Arkansas, Mississippi, the District of Columbia, Alabama, Arizona, Nevada, and California.<sup>46</sup> The state with the lowest percentage was Minnesota, with 22% of the children in the state living without insurance for part of the two year period.<sup>47</sup>

In 1996, 23.3% of poor children lacked health care, while only 12.7% of children above the FPL were uninsured.<sup>48</sup> Although poor children are more likely to be uninsured, most uninsured children come from families living above the FPL,<sup>49</sup> making them ineligible for Medicaid. Of the uninsured in 1997, it is estimated that (3.3 million) 36% of all uninsured children were eligible for Medicaid, with incomes at or below the FPL.<sup>50</sup> The remaining (5.8 million) 63% of uninsured children came from families with incomes above the FPL.<sup>51</sup> Of the uninsured children ineligible for Medicaid, 40% came from families with incomes between 100 and 200% of the FPL and 14% came from

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40. See U.S. Census Bureau, *Current Population Survey: Health Insurance Coverage Status of Children and Type of Coverage, 1995* (last modified Dec. 13, 2000) <<http://www.census.gov/hhes/hlthins/chldhins/chhitab1.html>>.

41. See *id.*

42. See Families USA, *One out of Three*, *supra* note 5. See also DeLauro, *supra* note 13, at 64.

43. See U.S. Census Bureau, *Current Population Survey, Table 1: Health Insurance Coverage, Status of Children and Type of Coverage, 1995*, (last modified Dec. 13, 2000) <<http://www.census.gov/hhes/hlthins/chldhins/chhitab1.html>>.

44. See *id.*

45. See U.S. Census Bureau, *Census Brief: Children Without Health Insurance* (March 1998) (visited Feb. 16, 2001) <<http://www.census.gov/prod/3/98pubs/cenbr981.pdf>>.

46. See Families USA, *One Out of Three*, *supra* note 5. The percentages are as follows: Texas, 46%; New Mexico, 43%; Louisiana, 43%; Arkansas, 42%; Mississippi, 41%; District of Columbia, 39%; Alabama, 38%; Arizona, 38%; Nevada, 37%; and California, 37%. See *id.*

47. See *id.* at 4.

48. See U.S. Census Bureau, *Census Brief: Children Without Health Insurance* (March 1998) (visited Feb. 16, 2001) <<http://www.census.gov/prod/3/98pubs/cenbr981.pdf>>.

49. See *id.*

50. See Almeida & Kenney, *supra* note 39, at 2 tbl.1.

51. See *id.*

families with incomes between 200 and 300% of the FPL.<sup>52</sup> These statistics suggest that the number of uninsured children can be reduced by 36% if outreach efforts can increase enrollment in state Medicaid programs. Another 40% of uninsured children would gain coverage if all programs expanded coverage to children at or below 200% of the FPL. Finally, a program that raised eligibility requirements to 300% of the FPL could insure an additional 14% of currently uninsured children. Therefore, increasing outreach efforts and offering coverage of children up to 300% of the FPL could provide approximately 90% of uninsured children with access to health care.

### C. The 1997 Amendment: The State Children's Health Insurance Program<sup>53</sup>

Because families above 100% of the FPL did not qualify for Medicaid, there were no programs in place to help children whose parents were ineligible for Medicaid, yet unable to afford private health insurance.<sup>54</sup> The State Children's Health Insurance Program, codified in Title 42 of the United States Code at Chapter 7, Subchapter XXI, was created to address this problem. Subchapter XXI provides states with federal funds "to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."<sup>55</sup> Designed to compliment other state programs such as Medicaid, state plans must include a description of procedures that will be used to ensure coordination with other programs for low-income children.<sup>56</sup> State programs also cooperate to identify and enroll children already eligible for state Medicaid plans.<sup>57</sup>

Under the plan, states can provide health coverage by implementing separate child health insurance programs, expanding coverage under the state's Medicaid plan,<sup>58</sup> or combining the two strategies.<sup>59</sup> States choosing Medicaid expansion programs can raise the income eligibility ceiling of their Medicaid plans to increase the number of children insured by the program.<sup>60</sup> States that implement child health programs that are separate from their state Medicaid program must meet certain coverage requirements. They may offer a benchmark benefit package, such as Blue Cross/Blue Shield, a health plan offered to state employees, or the HMO health plan that has the largest non-Medicaid

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52. *See id.*

53. 42 U.S.C. §§ 1397 (Supp. IV 1998).

54. *See generally* HCFA, *Annual Enrollment Report*, *supra* note 3, at 1.

55. 42 U.S.C. § 1397aa(a) (Supp. IV 1998).

56. *See id.* § 1397bb(b)(3).

57. *See id.* § 1397bb(b)(3)(B).

58. *See generally* 42 U.S.C. § 1396 (1994 & Supp. IV 1998).

59. *See* 42 U.S.C. § 1397aa(a)(1)-(2) (Supp. IV 1998).

60. *See* U.S. Department of Health and Human Services, *The State Children's Health Insurance Program: HHS Fact Sheet* (Feb. 2, 2001) <<http://www.hhs.gov/news/press/2001pres/01fsschip.html>> [hereinafter HHS, *Fact Sheet*]. States must offer the full state Medicaid benefit package under their expansion. *See id.*

enrollment in the state.<sup>61</sup> A state may also provide insurance under an "equivalent" plan, which is equal in value to the benchmark plans.<sup>62</sup> Equivalent plans must also include basic services: inpatient and outpatient hospital services, physician's medical and surgical services, laboratory and x-ray services, and baby and child care services, including immunizations.<sup>63</sup>

Under SCHIP, states may cover "targeted low-income children."<sup>64</sup> These are children not already covered by the state's Medicaid program whose family income is less than 200% of the FPL<sup>65</sup> or does not exceed 50 percentage points above the state Medicaid eligibility requirements.<sup>66</sup> The upper income eligibility for an individual state's child health program therefore depends upon the state Medicaid eligibility. Because states have flexibility in determining eligibility for state Medicaid programs, State Children's Health Insurance Programs also range in their coverage of children. Currently, the upper income eligibility of state plans ranges between 100% and 300% of the FPL.<sup>67</sup>

Limited cost-sharing is permitted under SCHIP.<sup>68</sup> Pre-existing Medicaid limits apply to children enrolled in state Medicaid expansion programs.<sup>69</sup> Separate child health programs cannot impose enrollment fees and premiums over \$19 per month per family, nor may they charge deductibles over 2.5% of family income for children below 150% of the FPL.<sup>70</sup> For children whose family incomes exceed 150% of the FPL, charges must be imposed on a sliding scale, not to exceed 5% of the family's yearly income.<sup>71</sup>

To be eligible for federal funding, a state must submit a state child health plan that indicates how the funds will be used in accordance with the requirements of Subchapter XXI to provide health insurance to needy children.<sup>72</sup> Once the Secretary approves the submitted plan,<sup>73</sup> states are eligible for payments for child health assistance coverage beginning in the quarter specified, after October 1, 1997.<sup>74</sup> A state may amend its state child health plan by submitting a plan amendment to the Secretary.<sup>75</sup> The Secretary will promptly review plans and plan amendments; a state may assume approval if not notified of disapproval within 90 days after the plan is received.<sup>76</sup> If the Secretary disap-

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61. See 42 U.S.C. § 1397cc(b) (Supp. IV 1998).

62. *Id.* § 1397cc(a)(2). See generally HHS, *Fact Sheet*, *supra* note 60.

63. See *id.* § 1397cc(c). For a full list of health benefits, see § 1397jj(a).

64. *Id.* § 1397bb(a)(1). "Targeted low-income children" is defined in § 1397jj(b).

65. See *id.* § 1397jj(c)(4).

66. See *id.* § 1397jj(b)(1)(B)(ii)(I).

67. See HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

68. See 42 U.S.C. § 1397cc(e) (Supp. IV 1998).

69. See *id.* § 1397cc(e)(4).

70. See *id.* § 1397cc(e)(3)(A). See also HHS, *Fact Sheet*, *supra* note 60.

71. See 42 U.S.C. § 1397cc(e)(3)(B) (Supp. IV 1998).

72. See *id.* §§ 1397aa(b), 1397ff(a)(1).

73. See *id.* § 1397aa(b)(2).

74. See *id.* § 1397aa(d).

75. See *id.* § 1397ff(b).

76. See *id.* § 1397ff(c).



proves an amendment or if a state is not conducting its program in accordance with its plan, the state has a "reasonable opportunity" to make corrections before financial sanctions are undertaken.<sup>77</sup>

Once a plan is approved, a state can receive enhanced federal matching up to a fixed state allotment.<sup>78</sup> The State Children's Health Insurance Program established federal funding totaling nearly \$40 billion over ten years.<sup>79</sup> Each fiscal year, the Secretary allots a proportion of the funding to each state with an approved plan.<sup>80</sup> For 2001, state allotments range from Vermont's \$4.6 million allotment to California's \$704.9 million allotment.<sup>81</sup> That proportion is determined by multiplying the number of low-income uninsured children whose family income does not exceed 200% of the federal poverty level and the state cost factor,<sup>82</sup> which adjusts for variations in health costs between states.<sup>83</sup> This figure is reduced by certain Medicaid expenditures counted against state allotments.<sup>84</sup> Furthermore, an allotment for one of the states or the District of Columbia will not be less than \$2 million<sup>85</sup> and cannot exceed the total federal allotment amount for the fiscal year already reduced by the allotments to the territories.<sup>86</sup> Amounts allotted to a state remain available for three years, through the second succeeding fiscal year.<sup>87</sup> The Secretary will redistribute allotments not used within this time period to states that have expended their allotment amounts.<sup>88</sup>

As the single largest expansion of children's health insurance since Medicaid, SCHIP presents states with "an historic opportunity" to reduce the number of American children lacking health insurance.<sup>89</sup> "With CHIP, states now have the potential to provide insurance coverage for almost all low-income uninsured children ages 18 and under. The challenge will be to translate that potential into coverage for all eligible but uninsured children."<sup>90</sup>

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77. *Id.* §§ 1397ff(c)(3), 1397ff(d)(2).

78. *See id.* §§ 1397aa(b)(2), 1397ee.

79. *See id.* § 1397dd(a).

80. *See id.* § 1397dd(b)(1).

81. *See* State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2001; Correction, 66 Fed. Reg. 6630, 6631 (2001).

82. To calculate the State Cost Factor, first determine the ratio of annual wages for each health industry employee in the state to the annual wages for each health industry employee in the 50 states and the District of Columbia. Multiply this ratio by 0.85 and then add 0.15. State Cost Factors for the 2001 allotments ranged from 0.8415 for Montana to 1.296 for the District of Columbia. *See id.*

83. *See* 42 U.S.C. § 1397dd(b) (Supp. IV 1998). *See generally* 66 Fed. Reg. 6630 (2001).

84. *See* 42 U.S.C. § 1397dd(b)(1) (Supp. IV 1998).

85. *See id.* § 1397dd(b)(4).

86. *See id.* §§ 1397dd(a), 1397dd(d).

87. *See id.* § 1397ff(e).

88. *See id.* § 1397ff(f).

89. HCFA, *Annual Enrollment Report*, *supra* note 3, at 1.

90. Almeida & Kenney, *supra* note 39, at 1.

### III. STATE PROGRESS WITH CHILDREN'S HEALTH INSURANCE PROGRAMS

On January 30, 1998, Alabama's Medicaid expansion program became the first SCHIP plan to be approved.<sup>91</sup> By September 30, 1999, each of the 56 States and Territories and the District of Columbia had followed suit with approved SCHIP plans.<sup>92</sup> Once approved, states may begin using SCHIP funds to enroll children and provide health insurance coverage.<sup>93</sup> Unfortunately, not all states implemented the plans immediately following approval. For example, though the Secretary approved Hawaii's plan on January 19, 1999, its plan was not implemented until over a year later, on July 1, 2000.<sup>94</sup> Many of the initial plans submitted have since been amended; the Secretary has approved a total of 73 amendments and 12 more are currently being considered.<sup>95</sup>

During federal fiscal year 1999, six states changed their type of SCHIP program; Illinois, Indiana, Mississippi, North Dakota, South Dakota, and Texas replaced their Medicaid expansion programs with combination programs in 2000.<sup>96</sup> As of September 30, 2000, the states' SCHIP plans consisted of 17 Medicaid expansion plans, 15 separate child health care plans, and 19 combination programs.<sup>97</sup> Since then, two other changes have been approved. On October 1, 2000, West Virginia changed from a combination program to a separate child's health program by incorporating its Medicaid expansion into the separate program.<sup>98</sup> On July 1, 2001, Maryland plans to change its Medicaid expansion program into a separate child health program.<sup>99</sup>

Data reported by the states showed that almost two million children were enrolled in State Children's Health Insurance Programs for Federal Fiscal Year 1999.<sup>100</sup> Because

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91. See HCFA, *Annual Enrollment Report*, *supra* note 3, at 3.

92. See *id.* Statistics on the SCHIP plans for each of the 51 states are given in a subsequent table. The Territories' plans were approved as follows: American Samoa, April 13, 1999; Commonwealth of the Northern Mariana Islands, August 27, 1999; Guam, March 29, 1999; Puerto Rico, June 26, 1998; and United States Virgin Islands, September 17, 1998. See U.S. Department of Health and Human Services, *State Children's Health Insurance Program: Status Report* (last modified Oct. 27, 1999) <<http://www.hcfa.gov/init/chstatus.htm>> [hereinafter HHS, *Status Report*].

93. See *supra* note 78.

94. See HHS, *Status Report*, *supra* note 92. See also HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

95. See Health Care Financing Administration, *Children's Health Insurance Program: Status Report and State Contact Information* (visited Feb. 10, 2001) <<http://www.hcfa.gov/init/statepln.htm>> [hereinafter HCFA, *Status Report*]. See also Health Care Financing Administration, *Children's Health Insurance Program: SCHIP Plan Activity Map* (visited Feb. 16, 2001) <<http://www.hcfa.gov/init/children.htm>>.

96. See Health Care Financing Administration, *The State Children's Health Insurance Program (SCHIP): Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999* (visited Feb. 10, 2001) <<http://www.hcfa.gov/init/fy99-00.pdf>> [hereinafter HCFA, *Enrollment Statistics for 2000 and 1999*].

97. See *id.* These statistics account for Maryland's plan amendment, approved November 7, 2000, and West Virginia's plan amendment, effective October 1, 2000. The amendment in each state changed the prior SCHIP plan to a separate child health program. See *id.*

98. See HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

99. See HCFA, *Enrollment Statistics for 2000 and 1999*, *supra* note 96.

100. See HCFA, *Annual Enrollment Report*, *supra* note 3, at 2. See also HCFA, *Enrollment Statistics for*

not all state plans were operating for the entire year and because states have continued amending and improving their plans, the number of children insured under SCHIP plans increased dramatically in 2000. More than 3.3 million children were enrolled in State Children Health Insurance Programs for 2000.<sup>101</sup> One million of these children benefited from Medicaid expansion programs and 2.3 million benefited from separate child health programs.<sup>102</sup> States with Medicaid expansion programs enrolled 569,000 children, states with separate child health programs enrolled 604,000 children, and states with combination programs enrolled 2,161,000 children in 2000.<sup>103</sup> Although these statistics appear to indicate that combination programs are the most effective, it is important to note how many children were uninsured in states using each type of program.<sup>104</sup>

The income range of children covered by SCHIP varies among states because SCHIP funds may only be used to cover previously uninsured children, and states must accommodate children not already covered by the state's Medicaid program.<sup>105</sup> Of the SCHIP plans approved by September 30, 2000, plans in thirty-four states covered children from families whose incomes were 200% of the federal poverty level or higher.<sup>106</sup> Although initial SCHIP plans usually outlined "a modest expansion of coverage," several states have followed up their original plans with amendments that propose greater coverage.<sup>107</sup> Eight states increased their upper income eligibility standard between 1999 and 2000.<sup>108</sup> This is an important step towards insuring those children who received no state aid prior to SCHIP because their family incomes surpassed the federal poverty level, making them ineligible for Medicaid.

The following table summarizes some relevant statistics regarding Children's Health Insurance Programs in each state. The first column lists each state and the name of its SCHIP program.<sup>109</sup> The second column indicates the date the initial SCHIP plan

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2000 and 1999, *supra* note 96.

101. See HCFA, *Enrollment Statistics for 2000 and 1999*, *supra* note 96.

102. See HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

103. See *id.* For these statistics, Maryland was considered a Medicaid expansion program and West Virginia was considered a combination program, despite recent amendments altering the type of program. See *id.*

104. For 1999, the 17 states with Medicaid expansion programs had a total of approximately 1,896,000 uninsured children and 569,000 were enrolled in SCHIP for 2000. The 15 states with separate child health programs had a total of about 2,145,000 uninsured children in 1999; 604,000 children were enrolled in SCHIP in 2000. For 1999, the 19 states with combination programs had a total of approximately 5,982,000 uninsured children and 2,161,000 were enrolled in SCHIP for 2000. It is important to note that the number of children insured by each type of program is roughly proportional to the number of uninsured children living in states utilizing those programs. See U.S. Census Bureau, *Historical Table 5*, *supra* note 18. See also HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

105. See 42 U.S.C. § 1397jj(1) (Supp. IV 1998).

106. See HCFA, *Annual Enrollment Report*, *supra* note 3, at 4 & Table 1.

107. *Id.* at 15, n.1.

108. The eight states are: Illinois (133% to 185%), Indiana (150% to 200%), Iowa (185% to 200%), Mississippi (100% to 200%), North Dakota (100% to 140%), Ohio (150% to 200%), South Dakota (140% to 200%) and Texas (100% to 200%). See HCFA, *Enrollment Statistics for 2000 and 1999*, *supra* note 96.

109. See generally Health Care Financing Administration, *The State Children's Health Insurance Program: SCHIP Approved Plan Files* (visited Feb. 17, 2001) <<http://www.hcfa.gov/init/chpa-map.htm>>.

was approved<sup>110</sup> and the number of approved amendments.<sup>111</sup> The third column lists when the initial plan was implemented, as reported by the states.<sup>112</sup> The fourth column of the table indicates whether the state has implemented a Medicaid expansion program, a separate children's health program, or a combination (combo) plan.<sup>113</sup> The fifth column provides the eligibility requirements for each state program; children from families at or below the indicated percentage of the Federal Poverty Level (FPL) are eligible to receive SCHIP benefits from the state.<sup>114</sup> The sixth column lists the number of children in each state without health insurance in 1999. The percentage of children without insurance is listed in parentheses to facilitate comparison between states.<sup>115</sup> The seventh column shows the number of children enrolled in a state's CHIP program for the year 1999.<sup>116</sup> When compared with the total number of uninsured children in the state during 1999, these statistics help illustrate how many children remained uninsured in 1999 despite state programs. Finally, the last column illustrates the number of children enrolled in a state's program for the year 2000.<sup>117</sup> These statistics are helpful in comparing how a state's program has improved its coverage of uninsured children since the previous year.

State & Program	Date Approved & Approved Amendments	Date Implemented	Type of SCHIP Program	Upper Income Eligibility (% FPL)	Number of (and %) Uninsured Children in 1999	Number Children Enrolled in SCHIP in 1999	Number Children Enrolled in SCHIP in 2000
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110. See HHS, *Status Report*, *supra* note 92.

111. See Health Care Financing Administration, *Children's Health Insurance Program: Status Report and State Contact Information* (visited Feb. 10, 2001) <<http://www.hcfa.gov/init/statepln.htm>>. See also Health Care Financing Administration, *Children's Health Insurance Program: SCHIP Plan Activity Map* (visited Feb. 16, 2001) <<http://www.hcfa.gov/init/children.htm>>. The number of approved amendments is listed first. The number of amendments submitted, but yet to be approved, is listed in parentheses.

112. See HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

113. See *id.* Except as otherwise noted, statistics represent the program type as of September 30, 2000. See *id.*

114. See *id.* Unless otherwise noted, these statistics represent the upper income eligibility in effect beginning September 30, 2000. See *id.*

115. See U.S. Census Bureau, *Historical Table 5*, *supra* note 18. These statistics represent the number of uninsured children as of March 2000. *Id.*

116. See HCFA, *Enrollment Statistics for 2000 and 1999*, *supra* note 96. Statistics for "1999" include data collected between October 1, 1998 and September 30, 1999. For states with combination programs, the statistic reported was computed by adding the number of children enrolled in the Medicaid expansion program and the number of children enrolled in the separate child health program during any part of the year. The computation controlled for children who enrolled, lost coverage, and reenrolled; these children were not double counted. However, children in combination states would have been double counted if they were enrolled in both the Medicaid program and separate program during the year. See *id.*

117. See *id.* Statistics for "2000" include data collected between October 1, 1999 and September 30, 2000.

<b>Alabama</b> ALL Kids	01/30/98 2 (0)	02/01/98	Combo	200	122,000 (10.6%)	38,980	37,587
<b>Alaska</b> Denali KidCare	12/11/98 0 (0)	03/01/99	Medi- caid	200	33,000 (16.2%)	8,033	13,413
<b>Arizona</b> KidsCare	09/18/98 4 (0)	11/01/98	Separate	200	308,000 (22.0%)	26,807	60,803
<b>ARK</b> ARKids First	08/06/98 0 (1)	10/01/98	Medi- caid	100	81,000 (11.8%)	913	1,892
<b>CAL</b> Healthy Families	03/24/98 5 (0)	03/01/98	Combo	250	1,726,000 (18.3%)	222,351	477,615
<b>COL</b> Child Health Plan Plus	02/18/98 1 (2)	04/22/98	Separate	185	187,000 (16.0%)	24,116	34,889
<b>CT</b> HUSKY Plan	04/27/98 1 (0)	07/01/98	Combo	300	84,000 (9.2%)	9,912	18,804
<b>DEL</b> Delaware Healthy Children Program	09/01/98 1 (0)	02/01/99	Separate	200	14,000 (6.7%)	2,433	4,474
<b>D.C.</b> Healthy DC Kids	09/17/98 0 (0)	10/01/98	Medi- caid	200	19,000 (17.2%)	3,029	2,264 <sup>118</sup>
<b>Florida</b> KidCare Program	03/06/98 3 (0)	04/01/98	Combo	200	583,000 (16.5%)	154,594	227,463
<b>Georgia</b> Peach Care for Kids	09/03/98 1 (0)	11/01/98	Separate	200	262,000 (12.6%)	47,581	120,626
<b>Hawaii</b> Title XXI	01/19/99 1 (0)	07/01/00	Medi- caid	200	34,000 (10.6%)		2,256
<b>Idaho</b> Idaho	06/15/98 1 (1)	10/01/97	Medi- caid	150	72,000 (20.5%)	8,482	12,449

118. This is the number of children ever enrolled in the third quarter of FFY 2000 because the District of Columbia did not report annual enrollment. See HCFA, *Enrollment Statistics for 2000*, *supra* note 3.

CHIP							
Illinois KidCare	04/01/98 1 (0)	01/05/98	Combo	185	404,000 (12.1%)	42,699	62,507
Indiana Indiana CHIP	06/26/98 1 (0)	10/01/97	Combo	200	135,000 (8.9%)	31,246	44,373
Iowa (HAWK- I)	09/01/98 4 (0)	07/01/98	Combo	200	46,000 (6.2%)	9,795	19,958
Kansas Health- Wave	09/01/98 1 (0)	01/01/99	Separate	200	84,000 (12.5%)	14,443	26,306
KY Kentucky CHIP	11/25/98 1 (1)	07/01/98	Combo	200	126,000 (13.7%)	18,579	55,593
LA LaCHIP	10/20/98 1 (1)	11/01/98	Medi- caid	150	280,000 (24.6%)	21,580	49,995
Maine Cub Care	08/07/98 0 (1)	07/01/98	Combo	185 <sup>119</sup>	21,000 (6.7%)	13,657	22,742
MD Maryland CHIP	07/29/98 2 (0)	07/01/98	Medi- caid <sup>120</sup>	200 <sup>121</sup>	114,000 (9.5%)	18,072	93,081
MASS Mass- Health	05/29/98 0 (0)	10/01/97	Combo	200	140,000 (9.1%)	67,852	113,034
MI MiChild	04/07/98 2 (0)	05/01/98	Combo	200	284,000 (9.7%)	26,652	37,148
MN Minne- sota's CHIP	07/17/98 0 (0)	10/01/98	Medi- caid	280	100,000 (7.4%)	21	24
MISS Health Benefits Program	10/26/98 3 (0)	07/01/98	Combo	200	117,000 (15.5%)	13,218	20,451

119. Maine expanded its coverage to 200% of the Federal Poverty Level, which is reflected in the enrollment counts for FFY 2000. Approval of the plan is pending. *See id.*

120. On November 7, 2000, Maryland's state plan amendment was approved. Maryland's amendment will implement a separate child health care program beginning July 1, 2001. *See id.*

121. The income eligibility standard will rise to 300% FPL when Maryland's separate child health program is implemented on July 1, 2001. *See id.*

<b>MO</b> Missouri CHIP	04/28/98 1 (0)	09/01/98	Medi- caid	300	78,000 (5.4%)	49,529	73,825
<b>Montana</b> Montana CHIP	09/11/98 1 (0)	01/01/99	Separate	150	45,000 (18.9%)	1,019	8,317
<b>NEB</b> Kids Connec- tion	08/07/98 1 (0)	05/01/98	Medi- caid	185	40,000 (8.9%)	9,713	11,400
<b>Nevada</b> CheckUp	08/13/98 1 (0)	10/01/98	Separate	200	131,000 (22.1%)	7,802	15,946
<b>NH</b> Healthy Kids	09/15/98 1 (0)	05/01/98	Combo	300	21,000 (5.9%)	4,554	4,272
<b>NJ</b> NJ Kid- Care	04/27/98 4 (0)	03/01/98	Combo	350	196,000 (9.8%)	75,652	89,034
<b>NM</b> New Mexico CHIP	01/11/99 2 (0)	03/31/99	Medi- caid	235	150,000 (27.7%)	4,500	6,106
<b>NY</b> Child Health Plus	04/01/98 1 (0)	04/15/98	Combo	192 <sup>122</sup>	551,000 (11.5%)	521,301	769,457
<b>NC</b> N. Caro- lina CHIP	07/14/98 4 (1)	10/01/98	Separate	200	234,000 (12.4%)	57,300	103,567
<b>ND</b> Healthy Steps	10/09/98 1 (0)	10/01/98	Combo	140	16,000 (10.4%)	266	2,573
<b>Ohio</b> Healthy Start	03/23/98 1 (0)	01/01/98	Medi- caid	200	267,000 (8.9%)	83,688	111,436
<b>OK</b> Sooner- Care	05/27/98 1 (0)	12/01/97	Medi- caid	185	137,000 (17.0%)	40,196	57,719
<b>Oregon</b> Oregon	06/12/98 1 (2)	07/01/98	Separate	170	117,000 (13.2%)	27,285	37,092

122. This statistic reflects the state net income standard. The gross income standard is 230% of the FPL.  
See *id.*

CHIP							
PA Pennsyl- vania CHIP	05/28/98 4 (0)	05/28/98	Separate	200	219,000 (7.6%)	81,758	119,710
RI Rhode Island CHIP	05/08/98 1 (0)	10/01/97	Medi- caid	250	18,000 (6.9%)	7,288	11,539
SC Partners for Healthy Children	02/18/98 0 (0)	10/01/97	Medi- caid	150	175,000 (19.4%)	45,737	59,853
SD S. Dakota CHIP	08/25/98 3 (0)	07/01/98	Combo	200	17,000 (9.1%)	3,191	5,888
TN TennCare	09/03/99 0 (1)	10/01/97	Medi- caid	100 <sup>123</sup>	131,000 (9.4%)	9,732	14,861
Texas Texas CHIP	06/15/98 1 (0)	07/01/98	Combo	200	1,343,000 (24.1%)	50,878	130,519
Utah Utah CHIP	07/10/98 0 (0)	08/03/98	Separate	200	82,000 (11.4%)	13,040	25,294
Vermont Dr. Dynasaur	12/15/98 3 (0)	10/01/98	Separate	300	12,000 (8.0%)	2,055	4,081
Virginia FAMIS	10/22/98 1 (0)	10/22/98	Separate	185	243,000 (14.1%)	16,895	37,681
WA Washing- ton CHIP	09/08/99 0 (1)	02/01/00	Separate	250	188,000 (13.3%)		2,616
W.VA W. Vir- ginia CHIP	09/15/98 3 (0)	07/01/98	Combo <sup>124</sup>	200 <sup>125</sup>	50,000 (13.8%)	7,957	21,659

123. Tennessee's Medicaid § 1115 demonstration has no upper income eligibility ceiling. Enrollees above 100% FPL pay monthly premiums; the state subsidizes premiums for recipients with incomes up to 400% of the FPL. *See id.*

124. Beginning October 1, 2000, West Virginia implemented a separate child health program. *See* HCFA, *Enrollment Statistics for 2000 and 1999*, *supra* note 96.

125. The income eligibility standard in West Virginia was raised from 150% to 200% of the FPL, effective November 1, 2000. *See* HCFA, *Enrollment Statistics for 2000*, *supra* note 3.



WIS Badger- Care	05/29/98 1 (0)	04/01/99	Medi- caid	185	167,000 (10.7%)	12,949	47,140
WY CHIP One	09/08/99 0 (0)	12/01/99	Separate	133	19,000 (14.5%)		2,547
NAT'L TOTALS	01/30/98 09/08/99 Amend: 73 (12)	10/01/97 07/01/00	Medi- caid: 17 Sep: 15 Com: 19	Range: 100 to 350	10,023,000 (13.9%)	1,959,330	3,333,879

State progress will be even easier to assess by the beginning of 2002. Each state with an approved child health plan was required to submit an evaluation by March 31, 2000, assessing the state plan's effectiveness in increasing the number of children with health insurance.<sup>126</sup> Based on the states' evaluations, the Secretary will submit a report to Congress by December 31, 2001.<sup>127</sup> This report will contain the Secretary's assessment of the state SCHIP plans as well as conclusions and recommendations.<sup>128</sup> States are also required to assess the operation of the state plan each fiscal year and report to the Secretary by the first of January.<sup>129</sup> Since all states will have implemented their SCHIP plans, state evaluations of the year 2001 will supplement the Secretary's report with more updated statistics and further improvements to the plans.

#### IV. MAKING THE MOST OF CURRENT HEALTH INSURANCE PROGRAMS

The success of the State Children's Health Insurance Program depends in great part on efforts to identify and reach eligible children.<sup>130</sup> Although most state SCHIP plans increased the income eligibility ceiling, making more children eligible for health insurance coverage, these children must actually be enrolled to benefit from this coverage. Outreach and enrollment is also an important concern because states that fail to enroll eligible children and spend their entire allotments risk losing the unused portion of their federal funding.<sup>131</sup> Recognizing the importance of reaching eligible children, SCHIP,

126. See 42 U.S.C. § 1397hh(b)(1) (Supp. IV 1998).

127. See *supra* note 4.

128. See 42 U.S.C. § 1397hh(b)(2) (Supp. IV 1998).

129. See *id.* § 1397hh(a).

130. See HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 6.

131. See 42 U.S.C. § 1397ff(f) (Supp. IV 1998). See generally Paul Van Slambrouck, *A County Offers Health Coverage For Every Kid*, THE CHRISTIAN SCI. MONITOR, Oct. 6, 2000, at 2 available in LEXIS, News Group File (describing how California is in danger of losing federal funding which has gone unused because of outreach and enrollment problems within the state).

requires state plans to include a description of procedures the state will use to inform families of their children's eligibility for health care programs—SCHIP, state Medicaid, and private plans—and help them enroll.<sup>132</sup> Up to ten percent of a state's total expenditures may be used for administration of the program and for outreach activities to increase awareness of SCHIP.<sup>133</sup>

Since states are required to screen all children and enroll all those eligible in Medicaid, outreach services funded by State Children's Health Insurance Programs also benefit many children not eligible for SCHIP.<sup>134</sup> Approximately one-third (32%) of uninsured children in 1995 were eligible for Medicaid but not enrolled.<sup>135</sup> The "screen and enroll" requirement ensures that all children eligible for Medicaid receive benefits from the program and prevents states from claiming more federal funds for children already eligible for Medicaid.<sup>136</sup> Although the amount of children enrolled in Medicaid specifically because of SCHIP outreach efforts cannot be measured, "[m]any States report that SCHIP-related outreach and simplified and coordinated eligibility processes have led to enrollment of a significant number of Medicaid-eligible children."<sup>137</sup>

Much like Medicaid, many children probably eligible for SCHIP have yet to enroll. In the twelve states with the largest number of uninsured children, Medicaid and SCHIP covered fewer children in 1999 than were covered by Medicaid alone in 1996.<sup>138</sup> Researchers estimated that only 48% of eligible children would be enrolled in state CHIP programs in 1999, unless outreach and enrollment efforts were strengthened.<sup>139</sup> Since roughly three-quarters of uninsured children would be covered by Medicaid and SCHIP plans,<sup>140</sup> the fact that only 3.3 million children were enrolled in 2000<sup>141</sup> suggests that a

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132. See 42 U.S.C. § 1397bb(c) (Supp. IV 1998).

133. See MICHELLE MICKY, AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION, CHIP OUTREACH AND ENROLLMENT: A VIEW FROM THE STATES 1 (1999), available in <http://www.hcfa.gov/init/outreach/examples.htm> [hereinafter MICKY].

134. See Vicky Pulos, Families USA, *Outreach Strategies in the State Children's Health Insurance Program*, 1 (June 1998) <<http://www.familiesusa.org/out2.htm>> [hereinafter Pulos] (on file with author) ("CHIP funds can be used to assist children in enrolling in any public or private health coverage program. This means outreach services reimbursed by CHIP can also benefit undocumented children not eligible for insurance coverage through CHIP.").

135. See U.S. Census Bureau, *Health Insurance Statistics—Children's Health Insurance* (visited Nov. 19, 2000) <<http://www.census.gov/hhes/hlthins/chldhins/chhitxt.html>>.

136. David Grant et al., Medi-Cal Community Assistance Project, *Healthy Families at Year One: Outreach, Application and Enrollment Issues*, 9 (July 1999) (visited Feb. 21, 2001) <<http://www.familiesusa.org/hfam799.pdf>>. See generally Pulos, *supra* note 134, at 10.

137. HCFA, *Annual Enrollment Report*, *supra* note 3, at 2.

138. See BARENTS GROUP LLC, FINAL REPORT ON "REVIEW OF THE LITERATURE ON EVALUATIONS OF OUTREACH FOR PUBLIC HEALTH INSURANCE AND SELECTED OTHER PROGRAMS" 2 (March 31, 2000).

139. See *id.*

140. This estimate is based on 1997 statistic which found 36% of uninsured children had family incomes below 100% of the FPL (eligible for Medicaid) and 40% came from families with incomes between 100 and 200% of the FPL (with most State Children's Health Insurance Programs covering children at or below 200%

substantial number of the 10 million uninsured children are probably eligible for Medicaid or SCHIP but not receiving benefits.

### A. Increasing Outreach Efforts

Low-income working families previously ineligible for public assistance may now qualify for SCHIP or Medicaid, but fail to enroll because they do not know they are entitled to collect benefits.<sup>142</sup> Several states have implemented outreach and enrollment efforts tailored to their community to inform families about new programs and sign them up for benefits. "Every state is . . . engaged in some kind of outreach effort, and in many communities there are multiple, complementary strategies ongoing to inform families about the availability of SCHIP and Medicaid."<sup>143</sup> Other states can learn from and utilize techniques that prove successful to continue increasing children's participation in state Medicaid and SCHIP plans. In general, states need to identify the potentially eligible target population, let the public know that help is available, and educate individuals about SCHIP and eligibility requirements.<sup>144</sup>

Relying on demographic data and feedback from community groups, states determine which local populations to target with outreach campaigns.<sup>145</sup> Outreach efforts are usually aimed at reaching vulnerable populations that "face socioeconomic or linguistic issues, low literacy levels, geographic isolation, or other barriers that make it difficult for them to enroll in health insurance."<sup>146</sup> Many states have focused outreach activities on minority communities, such as Hispanics and Native Americans.<sup>147</sup> Other states have targeted their rural population; Georgia, for example, participates in local events and advertises through local businesses.<sup>148</sup> Other states have targeted homeless and migrant children.<sup>149</sup> The targeted population should always be considered when developing an outreach plan. Materials may need to be translated into another language, advertisements may need to account for cultural differences, and distribution plans should consider whether the targeted population would be reached.<sup>150</sup> Arizona's KidsCare, for ex-

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of the FPL). See Almeida & Kenney, *supra* note 39, at 2 tbl.1.

141. See HCFA, *Enrollment Statistics for 2000 and 1999*, *supra* note 96.

142. See HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 6. See also Pulos, *supra* note 134, at 4.

143. HCFA, *Annual Enrollment Report*, *supra* note 3, at 10.

144. See generally BARENTS GROUP LLC, FINAL REPORT ON "REVIEW OF THE LITERATURE ON EVALUATIONS OF OUTREACH FOR PUBLIC HEALTH INSURANCE AND SELECTED OTHER PROGRAMS" 5-6 (March 31, 2000).

145. See MICKEY, *supra* note 133, at 6.

146. HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 7.

147. See MICKEY, *supra* note 133, at 6. See generally U.S. Census Bureau, *Current Population Reports: Health Insurance Coverage: 1999* (Sept. 2000) <<http://www.census.gov/hhes/www/hlthin99.html>> (showing disparities in the percent of children insured by race).

148. See HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 7.

149. See Pulos, *supra* note 134, at 6.

150. See MICKEY, *supra* note 133, at 6.

ample, has attempted to reach the local Hispanic population by developing applications written in Spanish, advertising the program on Spanish television stations, targeting the Hispanic audience for media messages, and placing the program's logo on traditionally Hispanic-owned businesses.<sup>151</sup>

Collaborating with community-based organizations helps states address local needs and educate individuals about public health programs. States have used focus groups, committees, and local coalitions to review outreach materials and tailor outreach efforts to particular communities.<sup>152</sup> States can also form partnerships with organizations that are willing to help distribute outreach materials and applications. Placing "outstation workers" throughout the community to discuss public health programs and help families complete applications encourages enrollment by eliminating the need for families to visit welfare offices.<sup>153</sup>

Many states place outstation workers or distribute informational materials at organizations eligible families may already use, like Women's Infant and Children (WIC) programs, Head Start Programs, subsidized day care centers, health clinics, and schools.<sup>154</sup> School-based outreach activities, for example, take advantage of the extensive contact schools have with children and parents. Educating school staff members about SCHIP, displaying brochures, adding check-boxes to school lunch program applications, making enrollment part of the school registration process and including applications with report cards are all effective ways to make sure parents hear about state health insurance programs.<sup>155</sup>

A number of national agencies, such as the National Governor's Association (NGA) and the Department of Health and Human Services (HHS), have helped the states in their outreach efforts.<sup>156</sup> The Federal Interagency Task Force on Children's Health Insurance Outreach, which is comprised of many federal agencies and private organizations that serve potentially eligible populations, produced training kits that were distributed to federal workers.<sup>157</sup> These agencies also worked together to launch the Insure

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151. See HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 7.

152. See MICKEY, *supra* note 133, at 6.

153. HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 7 (noting that the stigma attached to welfare offices may discourage families from inquiring about or enrolling in programs). See also Victoria Wegener, *Issue Notes: Children's Health Insurance Program—Outreach and Enrollment*, 3 WELFARE INFORMATION NETWORK, 2 (May 1999) <<http://www.welfareinfo.org/chipissuenotes.htm>> [hereinafter, Wegener] (on file with author).

154. See MICKEY, *supra* note 133, at 7. See also Pulos, *supra* note 134, at 5-6.

155. See Insure Kids Now, *Insure Kids Now! Through School District Outreach and Enrollment Activities* (visited Mar. 4, 2001) <<http://www.ed.gov/chip/activities.html>>. For more specific information on school-based outreach activities, see Secretary of Health and Human Services, *Report to the President on School-Based Outreach for Children's Health Insurance* (July 2000) <<http://www.hcfa.gov/childhealth/school/sbrpt700.pdf>>.

156. See HHS, *Fact Sheet*, *supra* note 60. See generally, Wegener, *supra* note 153, at 6.

157. See HHS, *Fact Sheet*, *supra* note 60. See also HCFA, *Annual Enrollment Report*, *supra* note 3, at 11.

Kids Now campaign, which maintains a national toll-free number that forwards calls to state hotlines.<sup>158</sup> Effective state hotlines should provide callers with multi-lingual information on SCHIP and Medicaid, assist callers with applications, and offer to send callers a mail-in application.<sup>159</sup> Eligibility and contact information for each state is also available through the Insure Kids Now website.<sup>160</sup>

By considering the targeted population and utilizing outreach partnerships, states have developed a variety of techniques to inform families of state Medicaid and SCHIP plans. Mailing informational materials directly to target populations is a highly effective and inexpensive way to inform potentially eligible families of child health programs.<sup>161</sup> Information may be sent to families receiving Medicaid redeterminations, Women's Infant and Children program benefits, or food stamps.<sup>162</sup> Many states distribute flyers and SCHIP applications by including them in other mailings, such as utility bills, church bulletins, and school materials.<sup>163</sup> Pamphlets, posters, and fact sheets placed in areas where targeted populations will see them—such as government agencies, fast food restaurants, and child care centers—has also proven to be an effective way to let families know about state child health plans.<sup>164</sup> Besides pamphlets and posters, a variety of other creative materials may be distributed; New Mexico gives out rulers, coloring books, and growth charts as a way to advertise their health program.<sup>165</sup>

States also employ media campaigns to educate potentially eligible families about the availability of state programs. Though costly, radio and television advertisements are considered moderately to highly effective.<sup>166</sup> Radio announcements may be particularly useful in reaching large, rural populations; advertising on foreign-speaking radio and television stations may help inform minority individuals of their Medicaid and SCHIP eligibility.<sup>167</sup> A less expensive way to use the media is to place articles and advertisements in local newspapers.<sup>168</sup> Other states use more innovative advertising techniques by displaying information about programs on billboards and in public transportation. Significant activities such as television advertisements can significantly increase calls to hotlines. Arkansas, for example, reported that half of all applicants said a television

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158. See HHS, *Fact Sheet*, *supra* note 60 (noting that as of December of 2000, about 500,000 calls had been placed to 1-877-KIDS-NOW, the national toll-free line).

159. See Wegener, *supra* note 153, at 2.

160. See Insure Kids Now at <<http://www.insurekidsnow.gov>>. See also HHS, *Fact Sheet*, *supra* note 60.

161. See MICKEY, *supra* note 133, at 3 (indicating that direct mailings are the most effective form of outreach materials).

162. Some states also send materials to participating providers and pediatricians, who can distribute or post the information. See *id.*

163. See *id.*

164. See *id.* at 2.

165. See Wegener, *supra* note 153, at 2.

166. See MICKEY, *supra* note 133, at 3.

167. See *id.*

168. See *id.*

advertisement first notified them of the program.<sup>169</sup> Armed with materials tailored to reach targeted populations and the cooperation of community organizations, states will hopefully be able to inform more eligible families of the state Medicaid and SCHIP plans.<sup>170</sup>

### B. Establishing Procedures to Encourage and Facilitate Enrollment

Even if families know about public health programs like Medicaid and SCHIP, they may be discouraged from applying because of high premiums, difficult applications, and complex eligibility requirements. "The simpler the application process, the lower the risk of denying coverage to eligible children for procedural reasons."<sup>171</sup> Many states have encouraged enrollment by keeping costs low and shortening application forms. Some states have also simplified eligibility requirements by coordinating Medicaid and SCHIP plans, eliminating asset tests, minimizing the number of verifying documents that must be supplied by the applicant, and granting presumptive eligibility or twelve-month continuous coverage.

Since families seeking health coverage under Medicaid or SCHIP presumably cannot afford private insurance, it is important that states keep premiums affordable.<sup>172</sup> Studies show that as the price of premiums increased the percentage of uninsured families enrolled declined.<sup>173</sup> States should make an effort to eliminate premiums for lower-income families.<sup>174</sup> If families must be charged, small one-time or annual enrollment fees are preferable to monthly premiums.<sup>175</sup>

States can also promote enrollment by shortening applications, offering to help families complete the forms, and making applications more accessible.<sup>176</sup> Although the application must elicit enough information to determine a child's eligibility, states can eliminate unnecessary questions to make the application shorter and easier to complete.<sup>177</sup> Though states generally avoided lengthy forms when developing their SCHIP applications, many have also taken steps to simplify their state Medicaid application.<sup>178</sup>

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169. See Pulos, *supra* note 134, at 5.

170. See MICKEY, *supra* note 133, at 5.

171. Pulos, *supra* note 134, at 7.

172. See *id.* at 19.

173. See *id.*

174. See *id.*

175. See *id.* ("[S]tates may want to consider a modest one-time enrollment fee that gives parents an investment in the program but is not a financial barrier to coverage and does not require the complicated administrative structure needed to collect monthly premiums.").

176. See generally HCFA, *Annual Enrollment Report*, *supra* note 3, at 11 ("While there are no data correlating the ease of the application process with enrollment numbers, it is generally agreed that simplified, streamlined and non-stigmatizing procedures promote enrollment among eligible children.").

177. See generally Wegener, *supra* note 153, at 3. Unfortunately, in an effort to shorten applications, questions that could be used to evaluate outreach efforts may be eliminated. See Pulos, *supra* note 134, at 10.

178. See HCFA, *Annual Enrollment Report*, *supra* note 3, at 11. In a 1998 letter to officials, the Health

If families are unable to complete the forms due to the length of the paperwork, the documentation requested, or language barriers,<sup>179</sup> outstation workers in the community can help families fill out applications.<sup>180</sup> Even families who may have difficulty reaching a particular site to fill out an application can apply in other ways.<sup>181</sup> Accepting mail-in applications, taking application information over the phone,<sup>182</sup> and making applications available over the Internet<sup>183</sup> make applications more accessible to potentially eligible families.

States may also want to consider using a joint application for the state Medicaid and SCHIP plans. Joint applications tend to be shorter and also help ensure that children receive the best benefit package for which they are eligible.<sup>184</sup> Joint forms also "create seamless insurance coverage" so that kids can move between Medicaid and SCHIP as family circumstances or incomes change.<sup>185</sup> If both programs have the same eligibility requirements, states can use a short joint application to enroll children in the program that will benefit them the most.<sup>186</sup> However, "[t]here is a trade-off between the goals of facilitating enrollment by shortening the application form and maximizing the availability of all benefits for which a family may be eligible."<sup>187</sup> If the Medicaid and SCHIP programs have different eligibility requirements, the joint application will probably be longer than an application for only one program.<sup>188</sup> States that choose shorter SCHIP applications should be sure to inform parents of the benefits available through Medicaid.<sup>189</sup>

Aside from coordinating eligibility requirements of state programs, states can encourage enrollment by simplifying eligibility rules in a variety of other ways. Asset tests, which require families to report the value of their personal property, can be confusing to families and can significantly lengthen applications.<sup>190</sup> To further simplify the application process, states can eliminate asset tests altogether.<sup>191</sup> States can also minimize verification requirements, which force applicants to produce official documents

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Care Financing Administration encouraged states to simplify their applications, including copies of one-page application forms from Georgia and South Carolina. *See* Pulos, *supra* note 134, at 9.

179. *See* HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 6.

180. *See* Pulos, *supra* note 134, at 8.

181. *See id.* at 7. *See also* Wegener, *supra* note 153, at 3.

182. *See* MICKEY, *supra* note 133, at 8. Applications filled in through phone conversations are then sent to the families to sign and return. *See id.*

183. *See* Wegener, *supra* note 153, at 3.

184. *See* HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 3. *See also* MICKEY, *supra* note 133, at 8 (noting that a joint application is the easiest way to fulfill the screen and enroll requirement).

185. Pulos, *supra* note 134, at 9.

186. *See id.* at 10.

187. *Id.*

188. *See id.*

189. *See id.*

190. *See id.* at 16. *See also* Wegener, *supra* note 153, at 3.

191. *See* MICKEY, *supra* note 133, at 10.

verifying information given on applications before they can receive benefits.<sup>192</sup> Instead of requiring documents, states could rely on an applicant's self-declaration or on computer matching information.<sup>193</sup>

States could also offer children presumptive eligibility while parents gather the necessary verification documents. Some states allow "qualified entities," such as assistance programs like Head Start and WIC, to enroll children into SCHIP or state Medicaid programs on a temporary basis without requiring applicants to produce any documentation.<sup>194</sup> "States that allow presumptive eligibility not only increase a child's access to health insurance, but also expedite access to health care."<sup>195</sup> If families seeking coverage are turned away because they do not have the required documentation, they may not return.<sup>196</sup> To implement presumptive eligibility, states enroll children in SCHIP or Medicaid programs based on a parent's representation of eligibility requirements until a more formal evaluation of eligibility can be conducted.<sup>197</sup> This provides children with immediate access to health care by awarding them coverage on a temporary basis. Within the next month, families must submit an official SCHIP or Medicaid application, with the help of assistance programs.<sup>198</sup> Once the application is filed, presumptively eligible children can stay enrolled until the state reaches a decision on an individual's eligibility for the program.<sup>199</sup>

Finally, states help facilitate enrollment by offering continuous eligibility. Some states permit children to enroll in SCHIP for up to twelve months, independent of changes in family income, before re-certification is required.<sup>200</sup> By offering continuous eligibility, states could minimize the chance that a child's insurance would be disrupted by a minor fluctuation in monthly income or migrant status.<sup>201</sup> Ideally, states will use all available methods to create a user-friendly application procedure that will encourage and

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192. See Wegener, *supra* note 153, at 3.

193. See *id.*

194. *Id.* at 4. Nebraska Kids Connection is an example of such a program; Nebraska allows certain providers and agencies to determine presumptive eligibility for Medicaid. See HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 4.

195. Wegener, *supra* note 153, at 4.

196. See Pulos, *supra* note 153, at 18 (discussing how requiring children to be uninsured for a period of several months before enrolling in SCHIP may discourage families from returning to try enrolling again). Applicants may be unable to return because of difficulty finding transportation to the site, scheduling an appointment around the parent's work, or making child care arrangements. See *id.* at 7.

197. See HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 4.

198. See Wegener, *supra* note 153, at 4. See also Pulos, *supra* note 153, at 22 ("Presumptive eligibility lasts for however many days are left in the month in which the children are found presumptively eligible, *plus* the next full month.").

199. See Pulos, *supra* note 153, at 22.

200. See Wegener, *supra* note 153, at 3.

201. HCFA, *Highlights of Implementation and Expansion*, *supra* note 16, at 4. Thirty-two states enroll children for twelve months. See *id.*



facilitate enrollment.<sup>202</sup>

### C. Continuing Testing: Section 1115 Demonstration Proposals<sup>203</sup>

The State Children's Health Insurance Program gave states the flexibility to implement a variety of outreach and enrollment initiatives; successful efforts provide other states with examples of effective ways to reach and insure children. Similarly, Section 1115 of the Social Security Act allows states the flexibility to experiment with specific provisions of their Medicaid or SCHIP programs.<sup>204</sup> The Secretary of Health and Human Services may waive compliance with certain requirements of SCHIP and provide funding for an experimental, pilot or demonstration program that "is likely to assist in promoting the objectives" of the program.<sup>205</sup>

States may conduct up to three demonstration projects "to achieve more efficient and effective use of funds for public assistance, to reduce dependency, and to improve the living conditions and increase the incomes of individuals who are recipients of public assistance."<sup>206</sup> States generally submit a formal proposal of the demonstration they wish to undertake. Projects usually must be conducted using experimental methodology, provide for independent evaluation, and run for a limited period of time.<sup>207</sup> After discussing and negotiating the terms of the proposal with the state, the Health Care Financing Administration may develop conditions for the operation of the waiver.<sup>208</sup> For example, the Department of Health and Human Services approved Wisconsin's SCHIP waiver dependant on several conditions.<sup>209</sup> Wisconsin agreed to use a simplified joint application rather than face-to-face interviews and eliminate asset limit requirements. The State also acknowledged that closing enrollment, creating waiting lists, or decreasing eligibility standards would result in a loss of funding for adults.<sup>210</sup>

As of January, 2001, seven states had submitted Section 1115 demonstration pro-

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202. See generally Wegener, *supra* note 153, at 6. States could use short, mail-in applications that require no assets test and provide presumptive and twelve-month continuous eligibility. See *id.*

203. Social Security Act, 42 U.S.C. § 1315 (1994 & Supp. IV 1998).

204. See *id.* See also State Coverage Initiatives, *SCHIP Section 1115 Waiver* (visited Feb. 22, 2001) <<http://www.statecoverage.net/schip-1115.htm>> [hereinafter SCI, *1115 Waiver*]. See also Health Care Financing Administration, *State Children's Health Insurance Program: Pending Section 1115 Demonstration Proposals* (Jan. 5, 2001) <<http://www.hcfa.gov/init/chpwvrsd.htm>>. For information on Section 1115 demonstrations including Medicaid, see generally Health Care Financing Administration, *Comprehensive State Health Reform Demonstrations* (visited Mar. 4, 2001) <<http://www.hcfa.gov/medicaid/1115/default.htm>>.

205. Social Security Act, 42 U.S.C. § 1315(a) (1994 & Supp. IV 1998). See also SCI, *1115 Waiver*, *supra* note 204.

206. Social Security Act, 42 U.S.C. § 1315(b) (1994 & Supp. IV 1998).

207. See SCI, *1115 Waiver*, *supra* note 204.

208. See Health Care Financing Administration, *Steps in the 1115 Demonstration Proposal Process* (visited Mar. 6, 2001) <<http://www.hcfa.gov/medicaid/hpg6.htm>>.

209. See Letter from Bob Lang, Director, to Members of Joint Committee on Finance (Jan. 23, 2001) (available at [http://www.legis.state.wi.us/lfb/01-03Bills/012301\\_AB36\\_SB18.pdf](http://www.legis.state.wi.us/lfb/01-03Bills/012301_AB36_SB18.pdf)).

210. See *id.*

posals regarding their State Children's Health Insurance Program: California, Minnesota, New Jersey, New Mexico, Ohio, Rhode Island, and Wisconsin.<sup>211</sup> States use Section 1115 demonstrations to implement a variety of experimental services.<sup>212</sup> Because family-based approaches are believed to increase the enrollment of eligible children as compared to exclusively child-based programs,<sup>213</sup> California, New Jersey, Rhode Island and Wisconsin have each proposed to use SCHIP funding to insure parents with incomes above the federal poverty level.<sup>214</sup>

If implemented, California's proposal would extend coverage under SCHIP to parents of eligible children with incomes between 100% and 200% of the FPL.<sup>215</sup> The program would also cover parents below 100% of the FPL who do not qualify for state Medicaid because of excess assets.<sup>216</sup> Most parents would be enrolled in their child's program and would pay premiums of twenty to twenty-five dollars per month.<sup>217</sup> California would address concerns about outreach and enrollment by modifying current outreach materials to include information on coverage for parents.<sup>218</sup> Adding the demonstration application to the existing joint Medicaid and SCHIP application would make parental enrollment easy.<sup>219</sup> If approved, California hopes to implement the Healthy Families Demonstration on July 1, 2001.<sup>220</sup>

By extending coverage to parents, California hopes to increase the number of eligible children enrolled in the state Medicaid and SCHIP programs.<sup>221</sup> Studies cited in California's proposal suggest that family-based programs would enroll 75% of eligible children as compared to children-only programs, which would enroll 45% of eligible kids.<sup>222</sup> California's demonstration also hopes to show that family-based insurance pro-

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211. See Health Care Financing Administration, *State Children's Health Insurance Program: Pending Section 1115 Demonstration Proposals* (Jan. 5, 2001) <<http://www.hcfa.gov/init/chpwvrsd.htm>>.

212. Minnesota proposes to provide additional coverage for children through a variety of activities, New Mexico wants to implement "supplement wraparound services," and Ohio wishes to implement annual enrollment fees as a cost-sharing device. See *id.*

213. See State of California Health and Human Services Agency, *California's Healthy Families SCHIP 1115 Demonstration Project*, 3 (Dec. 19, 2000) <<http://www.dhs.cahwnet.gov>> [hereinafter California HHS, *Healthy Families 1115 Demonstration*].

214. See Health Care Financing Administration, *State Children's Health Insurance Program: Pending Section 1115 Demonstration Proposals* (Jan. 5, 2001) <<http://www.hcfa.gov/init/chpwvrsd.htm>>.

215. See California HHS, *Healthy Families 1115 Demonstration*, *supra* note 213, at 3. California officials are particularly concerned with health care for working parents because fewer California businesses offer health insurance to their employees and California has more small businesses, which have the lowest rates of health insurance. See *id.*

216. See *id.*

217. See *id.* at 4.

218. See *id.* at 8.

219. See *id.* at 5.

220. See *id.*

221. See California HHS, *Healthy Families 1115 Demonstration*, *supra* note 213 at 1. The SCHIP allotment would first be used to cover children, with the excess dedicated to the waiver demonstration. See *id.* at 7.

222. See *id.* at 3 (discussing a study conducted by Tulane University).

grams promote continuity of coverage and increased access to care.<sup>223</sup> However, California views the demonstration waiver as a "temporary solution" and encourages the federal government to continue pursuing initiatives that would help insure low-income working families.<sup>224</sup>

Section 1115 demonstration proposals from New Jersey, Rhode Island, and Wisconsin proposals were approved on January 18, 2001.<sup>225</sup> Like California, these states proposed to use federal SCHIP matching payments to expand coverage to parents. New Jersey will cover parents with incomes up to 200% of the FPL,<sup>226</sup> Rhode Island will cover parents between 100% and 185% of the FPL,<sup>227</sup> and Wisconsin will cover parents up to 185% of the FPL.<sup>228</sup> The New Jersey and Rhode Island demonstrations also have provisions to cover pregnant women within specified income brackets.<sup>229</sup> These demonstrations are expected to show that providing parents with insurance will increase enrollment of children in SCHIP, encourage the use of child health services, and help manage health care costs.<sup>230</sup> With the SCHIP demonstration, Rhode Island hopes to increase enrollment from 106,000 to 130,000 people in the next three years.<sup>231</sup> New Jersey hopes to cover 81,000 parents and children by 2002.<sup>232</sup> Section 1115 demonstration proposals may show how states can use SCHIP funds in innovative ways to insure more eligible children and needy individuals.

## V. FUTURE REFORMS

In addition to legislative proposals that may stem from successful SCHIP Section 1115 demonstration waivers, ambitious congressional or local action must be taken if all American children are to have health insurance. As the largest expansion of public health insurance for low-income children since Medicaid in 1965, the State Children's Health Insurance Program was a "great victory for uninsured children."<sup>233</sup> Outreach and enrollment efforts are crucial to ensure that all low-income children that are eligible for public programs receive benefits. However, even if Medicaid and SCHIP were perfectly

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223. See *id.* at 7.

224. *Id.*

225. See SCI, *1115 Waiver*, *supra* note 204.

226. See Health Care Financing Administration, *New Jersey Title XXI Demonstration* (visited Mar. 6, 2001) <<http://www.hcfa.gov/init/1115nj.htm>>.

227. See Health Care Financing Administration, *Rhode Island Title XXI State Plan and Section 1115 Demonstration Fact Sheet* (visited Mar. 6, 2001) <<http://www.hcfa.gov/init/1115ri.htm>>.

228. See Health Care Financing Administration, *Wisconsin Title XXI State Plan and Section 1115 Demonstration Fact Sheet* (visited Mar. 6, 2001) <<http://www.hcfa.gov/init/1115wi.htm>>.

229. New Jersey will cover pregnant women between 185 and 200% FPL. See *supra* note 226. Rhode Island will cover pregnant women between 185 and 250% FPL. See *supra* note 227.

230. See *supra* note 227.

231. See *id.*

232. See *supra* note 226.

233. DeLauro, *supra* note 13, at 70.

implemented and every eligible child were enrolled, there would still be many American children without health insurance<sup>234</sup> because neither Medicaid nor the State Children's Health Insurance Program was designed to cover *all* children.<sup>235</sup>

#### A. Legislative Proposals: The Title XXII MediKids Program<sup>236</sup>

On May 4, 2000, legislators introduced the MediKids Health Insurance Act "to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2001."<sup>237</sup> In introducing the bill, Congress recognized that although SCHIP and Medicaid "are successfully extending a health coverage safety net to a growing portion of the vulnerable low-income population of uninsured children," these two programs alone "cannot achieve 100 percent health insurance coverage for our nation's children due to inevitable gaps during outreach and enrollment, fluctuations in eligibility, and variations in access to private insurance at all income levels."<sup>238</sup> By attempting to insure 100 percent of American children, drafters of MediKids hope to produce a healthier, more productive, and more equitable society.<sup>239</sup>

All children born in the United States after December 31, 2001 would automatically be enrolled in MediKids and issued an insurance card.<sup>240</sup> Children born outside the country would be automatically enrolled on the date of immigration into the United

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234. See Almeida & Kenney, *supra* note 39, at 2 tbl.1 (describing how approximately 10% of uninsured children in 1997 were from families with incomes above 300% of the FPL).

235. See 42 U.S.C. § 1397jj (Supp. IV 1998) (indicating that states are restricted to covering children whose family income is less than 200% of the FPL or a percentage not higher than 50 points above the state Medicaid eligibility requirements); Health Care Financing Administration, *Medicaid Eligibility* (visited Feb. 22, 2001) <<http://www.hcfa.gov/medicaid/meligib.htm>> (indicating that children under 19 from families with incomes at or below the FPL are covered by Medicaid). See also Don R. McCanne, *Commentary: Perspective on Health: "MediKids" Would Insure More Children: Two Federal Legislators Have A Proposal To Ensure Medical Coverage For All Children*, L. A. TIMES, June 1, 2000, at B11 available in LEXIS, News Group File (noting that enrolling every eligible child in SCHIP is "an administrative impossibility under the current program"); Alexandra Starr, *Children First: Kids are the easiest group to insure universally. But the system that covers them is a patchwork mess*, THE AM. PROSPECT, Jan. 1, 2001—Jan. 15, 2001, at 40 available in LEXIS, News Group File ("The failure of Medicaid and CHIP [sic] to provide health coverage to all needy children can be traced to the fact that these programs were never conceived to be available to every American under the age of 18.").

236. MediKids Health Insurance Act of 2000, H.R. 4390, 106th Cong. (2000).

237. *Id.*

238. *Id.* § 1(c)(3).

239. See *id.* § 1(c)(12). See also Letter from Pete Stark, U.S. Congressman, to Colleagues (Aug. 15, 2000) available in <<http://www.house.gov/stark/documents/106th/medikidsdc2.html>> ("In a nation that values equality and ethnic diversity, [the] disparities in health care access are unacceptable." MediKids "would eliminate disparities in health insurance coverage by providing automatic enrollment for all children and by providing access to similar services and benefits."). See generally U.S. Census Bureau, *Current Population Reports: Health Insurance Coverage: 1999* (Sept. 2000) <<http://www.census.gov/hhes/www/hlthin99.html>>.

240. See H.R. 4390 § 2(a), proposed §§ 2201(b)(1), 2201(b)(4). Parents are also allowed to pre-enroll their children one month prior to the expected birth. See *id.* § 2(a), proposed § 2201(b)(1).

States.<sup>241</sup> Coverage would continue until the child reaches the age of twenty-three<sup>242</sup> as long as the child continues to meet the immigration requirement.<sup>243</sup> Since MediKids proposes automatic enrollment without regard to family income, the program represents a significant departure from existing public health programs. Currently, a great deal of effort is spent on determining a child's eligibility for Medicaid or SCHIP. In order to insure children, states must identify which families may be eligible, conduct outreach activities to persuade families to inquire about the program, determine eligibility, aid in enrollment, and periodically reevaluate family incomes to determine whether children still meet the eligibility requirements.<sup>244</sup> The easy enrollment process proposed by MediKids is especially important since statistics show that many children eligible for Medicaid and SCHIP do not benefit from the programs simply because their families fail to enroll.<sup>245</sup> "The MediKids Health Insurance Act would offer guaranteed, automatic health coverage for every child with the simplest of enrollment procedures and no challenging outreach, paperwork, or re-determination hoops to jump through."<sup>246</sup>

Designed to supplement existing programs, individuals enrolled in MediKids would not be prevented from seeking health coverage from state Medicaid plans or SCHIP plans.<sup>247</sup> During periods of equivalent coverage by other sources, such as Medicaid, SCHIP or private insurance, no premium would be charged for MediKids.<sup>248</sup> If insurance coverage from an alternative source were to lapse, MediKids would automatically cover children's health insurance needs and a premium would be owed for the months covered by MediKids.<sup>249</sup> Because MediKids proposes to insure children during times when they are ineligible for other public programs, it promises to span the gaps in coverage that typically leave children vulnerable and uninsured. Children often lose insurance when they move to a different state, when parents are between jobs or unemployed, during family crises like the divorce or death of a parent, and when families are making the transition from welfare to employment.<sup>250</sup> More than one out of five children become uninsured after leaving welfare, and family incomes often fluctuate between being

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241. *See id.* § 2(a), proposed § 2201(b)(2).

242. *See id.* § 2(a), proposed § 2201(a)(1).

243. *See id.* § 2(a), proposed § 2201(d). *See also* Letter from Pete Stark, U.S. Congressman, to Colleagues (July 12, 2000) available in <<http://www.house.gov/stark/documents/106th/medikidsdc1.html>> (discussing the importance of covering young adults, who are still at risk for asthma, infections, and injuries).

244. *See generally* Starr, *supra* note 235.

245. *See* discussion *supra* Part IV.

246. Stark, Remarks at MediKids, *supra* note 14.

247. *See* H.R. 4390, § 2(a), proposed §§ 2201(g), 2207(b).

248. *See id.* § 2(a), proposed § 2203(a)(2).

249. *See id.* § 2(a), proposed § 2203. *See also* *Health Care for These [sic] Moving Off Welfare, 2000: Testimony Before the House Ways and Means Comm. on Human Resources*, 106th Cong. (May 16, 2000) (testimony of Pete Stark, Representative) available in LEXIS, News Group File ("For those months when other sources of health coverage fall through, MediKids would automatically pick [children] up, and their parents would be charged a small premium on their income tax returns.").

250. *See* Stark, Remarks at MediKids, *supra* note 14.

eligible and ineligible for need-based programs like Medicaid and SCHIP.<sup>251</sup> Even with perfect enrollment in SCHIP and Medicaid, gaps in coverage because of need-based eligibility requirements would deny children consistent and regular access to health care.<sup>252</sup> "The key to [the] program is that whenever other sources of health insurance fail, MediKids would stand ready to cover the health needs of our next generation."<sup>253</sup>

When enrolled in MediKids, families would be responsible for a premium of one-quarter the annual cost of MediKids per child, which would be collected from a family's income taxes; each family's financial obligation would not exceed five percent of total income.<sup>254</sup> In order to encourage parents to seek regular medical attention for their kids, early and periodic screening and diagnostic services would be exempt from cost-sharing.<sup>255</sup> MediKids would also reduce financial obligations for needy families; those with incomes under 150% of the FPL would owe no premiums or deductibles.<sup>256</sup> Families between 150% and 300% of the FPL would receive a graduated discount in the premium and a graduated refundable credit for cost-sharing payments.<sup>257</sup> Children enrolled in MediKids would be entitled to at least the same benefits offered under Medicaid and Medicare, as well as prescription drugs.<sup>258</sup> The Secretary is given discretion to update benefits offered under MediKids in order to meet the age-appropriate needs of the enrollee population.<sup>259</sup>

Drafters suggest that money from the settlement of the United States' civil suit against tobacco producers should be deposited in the MediKids Trust Fund<sup>260</sup> to help cover the costs of the program.<sup>261</sup> Within one year of enactment of the program, the Secretary of Treasury would impose a schedule of progressive taxes to fund the program as the number of children enrolled in MediKids grows.<sup>262</sup> Critics are skeptical about the affordability of the program, and point out that money from the tobacco settlement

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251. See *Health Care for These [sic] Moving Off Welfare, 2000: Testimony Before the House Ways and Means Comm. on Human Resources*, 106th Cong. (May 16, 2000) (testimony of Pete Stark, Representative) available in LEXIS, News Group File.

252. See Stark, Remarks at MediKids, *supra* note 14.

253. *Id.*

254. See H.R. 4390, § 2(a), proposed § 2203 (2000). See also Stark, Remarks at MediKids, *supra* note 14.

255. See H.R. 4390, § 2(a), proposed § 2202(b)(4)(A).

256. See *id.* § 2(a), proposed §§ 2203(d), 2202(b)(4)(B). See also Stark, Remarks at MediKids, *supra* note 14.

257. See H.R. 4390, §2(a), proposed §§ 2203(d), 2202(b)(4)(C). See also Stark, Remarks at MediKids, *supra* note 14.

258. See H.R. 4390, §2(a), proposed § 2202(b). Medicaid benefits available to MediKids enrollees would include the Early and Periodic Screening, Diagnosis and Treatment benefits (EPSDT) for children. See *id.* §2202(b)(2). See also Stark, Remarks at MediKids, *supra* note 14.

259. See H.R. 4390, § 2(a), proposed § 2202(a).

260. The Trust Fund is established under H.R. 4390, § 2(a), proposed § 2204(a).

261. See *id.* § 5.

262. See *id.* § 6.

would be used only for the first few years until the progressive tax could be established.<sup>263</sup> Since MediKids would be a “breathtaking step toward federalizing health coverage” and only requires higher-income beneficiaries to pay a fraction of the cost, “[i]t seems obvious that the ‘tax changes’ would have to be as breathtaking in scope as the [MediKids] coverage.”<sup>264</sup>

MediKids has also been described as “overly bureaucratic,” since the program reverses the need-based premise of most public programs like Medicaid and SCHIP.<sup>265</sup> Proponents defend the program, however, by likening MediKids to Medicare, a universal program in which Americans over 65 are automatically enrolled.<sup>266</sup> “Like Medicare, MediKids would be independently financed, would cover benefits tailored to the needs of its target population, and would have the goal of achieving nearly 100% health insurance coverage for the children of this country—just as Medicare has done for our nation’s seniors and disabled population.”<sup>267</sup> Children, the segment of our population that is the least expensive to insure and the least able to control factors determining eligibility for public programs,<sup>268</sup> need comprehensive health insurance. Similar to Medicare and Social Security, a national health program like MediKids would entitle children to the quality health care they deserve.<sup>269</sup>

#### **B. Local Initiatives: Santa Clara County’s Children’s Health Initiative<sup>270</sup>**

Since the MediKids program has yet to be approved, some counties have begun to use local initiatives to ensure that all uninsured children receive health coverage. “Unwilling to wait for national and state officials to respond to the problem,”<sup>271</sup> a grassroots

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263. See Michael Pretzer, *Pete Stark Thinks Big Brother Ought To Take Care Of The Kids*, 77 MED. ECON. 34 (2000) available in LEXIS, News Group File.

264. *MediKids Subsidized Coverage To Age 23 And After 65, And Taxes In Between*, CHARLESTON DAILY MAIL, May 9, 2000, at P4A available in LEXIS, News Group File.

265. Pretzer, *supra* note 263 (“MediKids reverses the premise of most government assistance programs. Typically, they’re need-based, and one must apply to get in. With MediKids, one is automatically in, and must maneuver to get out.”).

266. See Starr, *supra* note 235 (“If we are really serious about ensuring that all American children have health coverage, we should create a program for them that is roughly analogous to Medicare.”). See also Letter from Pete Stark, U.S. Congressman, to Colleagues (July 22, 2000) available in <<http://www.house.gov/stark/documents/106th/medikidsdc3.html>>.

267. Stark, Remarks at MediKids, *supra* note 14.

268. See *id.*

269. See Starr, *supra* note 235. See also McCanne, *supra* note 235 (“When fully implemented, MediKids would assure every children of having health care coverage. Participation would be an entitlement, as are Medicare and Social Security.”).

270. See *Summary of Proceedings: Board of Supervisors: Santa Clara County*, 4 (Dec. 5, 2000) <<http://claraweb.co.santa-clara.ca.us/bosminutes/120500.pdf>>. See also *New Program to Insure Children in Santa Clara County* (Dec. 4, 2000) <<http://www.scvmed.org/newsroom.htm>>. Note that sometimes the Children’s Health Initiative is also called “Healthy Kids.”

271. 146 CONG. REC. E 2144 (daily ed. Dec. 7, 2000) (statement of Hon. Fortney Pete Stark).

campaign led by Working Partnerships USA and People Acting in Community Together developed the Children's Health Initiative, an aggressive plan to insure all children in Santa Clara County.<sup>272</sup> Santa Clara obtained funding from a variety of sources and on December 5, 2000, became the first county to approve a comprehensive plan to provide health coverage for all children.<sup>273</sup> Santa Clara expects to begin enrolling families on January 2, 2001 and begin coverage in February.<sup>274</sup>

The Initiative was necessary because many children in Santa Clara County remain uninsured despite the state Medicaid program (Medi-Cal) and the California SCHIP plan (Healthy Families). In the city of San Jose alone, one out of seven children—a total of 37,000 kids—lacks health insurance.<sup>275</sup> In Santa Clara County there are still an estimated 71,000 uninsured children.<sup>276</sup> Some of these children are uninsured because public programs failed to reach and enroll eligible kids. Fifty-one thousand (72%) of the uninsured children in Santa Clara County qualify for Medi-Cal or Healthy Families but are not enrolled.<sup>277</sup> The remaining 20,000 (28%) of uninsured kids are not eligible for public programs. About 10,000 children do not qualify because their family's income exceeds California's SCHIP income eligibility ceiling of 250% of the FPL.<sup>278</sup> Although the State's income eligibility requirement is typical of SCHIP plans, some residents of Santa Clara County earn more than this amount, yet still cannot afford health insurance due to the county's high cost of living.<sup>279</sup> Another 10,000 children are ineligible for Medi-Cal or Healthy Families because they are undocumented immigrants.<sup>280</sup>

Santa Clara County's Children's Health Initiative created a "third insurance option

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272. See Liane Wong, Institute for Health Policy Solutions, *Background Data and Models for Expanding Health Insurance Coverage to Uninsured Children in Santa Clara County*, 1 (Oct., 2000) <<http://www.ihps.org>> [hereinafter Wong]. See also Michelle Guido, *Santa Clara wants \$14 million from tobacco to insure poor children*, SAN JOSE MERCURY NEWS, Oct. 20, 2000 available in LEXIS, News Group File [hereinafter Guido, Oct. 20] (indicating how a report studying proposals throughout the country concluded that Santa Clara's plan "is among the most promising and far-reaching models being developed.").

273. See 146 CONG. REC. E. 2144 (daily ed. Dec. 7, 2000) (statement of Hon. Fortney Pete Stark). See also Maya Suryaraman, *Santa Clara County ensures all children to get health coverage*, SAN JOSE MERCURY NEWS, Dec. 6, 2000 available in LEXIS, News Group File.

274. See Suryaraman, *supra* note 273.

275. See Eric Bailey, *San Jose Considers Health Care for Uninsured Kids*, THE COM. APPEAL (Memphis, TN), June 4, 2000, at A6 available in LEXIS, News Group File. See also Eric Bailey, *California and the West, San Jose Rejects Universal Child Health Care*, L. A. TIMES, June 14, 2000, at A1-3 available in LEXIS, News Group File [hereinafter Bailey, June 14].

276. See Wong, *supra* note 272, at 1. See also Guido, Oct. 20, *supra* note 272.

277. See Wong, *supra* note 272, at 1. See also Michelle Guido, *Santa Clara County, Calif., Plan Guarantees Health Coverage to Uninsured Youth*, SAN JOSE MERCURY NEWS, Oct. 4, 2000 [hereinafter Guido, Oct. 4].

278. See Guido, Oct. 20, *supra* note 272. See also Guido, Oct. 4, *supra* note 277.

279. See *Tobacco Money Used to Insure Children*, TELEGRAPH HERALD (Dubuque, IA), Dec. 6, 2000 at c8, available in LEXIS, News Group File (noting that the median house price is over \$550,000 and the market for apartments is tight).

280. See Guido, Oct. 20, *supra* note 272. See also Guido, Oct. 4, *supra* note 277.



for families who 'fall through the cracks'.<sup>281</sup> The Initiative plans to cover all children in the county through three steps, starting by reaching children eligible for existing state Medicaid and SCHIP plans through aggressive outreach and enrollment activities.<sup>282</sup> The county has already invested another \$1.9 million into its existing outreach program and increased its staff from ten to thirty people.<sup>283</sup> Although Medi-Cal and Healthy Families have had problems reaching eligible children, the Children's Health Initiative is optimistic that partnerships with churches, schools, and day care centers will help inform parents about the program.<sup>284</sup> "We're going to be out there on every door step, just like the census takers."<sup>285</sup> A simple two-page application form will also help encourage enrollment.<sup>286</sup>

The second part of the Children's Health Initiative uses funding to help needy families pay co-payments and premiums.<sup>287</sup> Although there are no premiums under Medi-Cal, children enrolled in Healthy Families must pay between four and nine dollars per child per month.<sup>288</sup> Even this modest amount can be problematic for working families with several children.<sup>289</sup> The Children's Health Initiative will pay most insurance premiums; families may be required to contribute a maximum of eighteen dollars per month.<sup>290</sup> Finally, children who do not qualify for Medi-Cal or Healthy Families will be enrolled in private insurance.<sup>291</sup> This step will provide insurance to the 10,000 uninsured children whose family's income exceeds 300% of the FPL and the 10,000 children ineligible for public programs because they are undocumented immigrants.

Monies received from the tobacco litigation settlement will fund a large part of the Santa Clara County Children's Health Initiative. In November of 1999, the tobacco industry and 46 states reached a \$206 billion settlement.<sup>292</sup> California will get about \$1 billion per year until 2025, with half of the settlement money going to the counties.<sup>293</sup> Santa Clara will receive approximately \$18.5 million per year and the city of San Jose

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281. *California: County Plan Would Cover Uninsured Children*, AM. HEALTH LINE, Oct. 6, 2000 available in LEXIS, News Group File.

282. See Guido, Oct. 4, *supra* note 278. The Children's Health Initiative will extend coverage to children from families with incomes up to 300% of the FPL and attempt to enroll all eligible children. See *id.* See generally 146 CONG. REC. E 2144 (daily ed. Dec. 7, 2000) (statement of Hon. Fortney Pete Stark).

283. See Guido, Oct. 4, *supra* note 277.

284. See Suryaraman, *supra* note 273.

285. Slambrouck, *supra* note 131 (quoting Jim Beall, County Supervisor).

286. See Suryaraman, *supra* note 273.

287. See Guido, Oct. 4, *supra* note 277.

288. See *id.*

289. See *id.*

290. See Suryaraman, *supra* note 273.

291. See Guido, Oct. 4, *supra* note 277.

292. See Julie N. Lynem, *State Urged To Use Money To Help Poor*, S. F. CHRON., May 3, 2000, at A17 available at LEXIS, News Group File.

293. See *id.*

will get about \$10 million.<sup>294</sup> Some suggested that the entire tobacco settlement received by the county should be spent on health care, because the state and federal government may be reluctant to increase funding for health care if the county uses the money on any other initiatives.<sup>295</sup> However, many other worthy causes were vying for the funding.<sup>296</sup> The City of San Jose initially rejected a proposal to give \$2 million per year to the Children's Health Initiative because City Council believed more study needed to be done before funds could be dedicated.<sup>297</sup>

San Jose's rejection of the plan was a set-back, but "[p]ublicity about the plan brought an avalanche of public support . . . including calls from a half-dozen of California's largest private foundations eager to participate."<sup>298</sup> The County of Santa Clara contributed \$3 million per year from the tobacco settlement and \$2 million per year from Proposition 10 tobacco taxes.<sup>299</sup> The Santa Clara Family Health Foundation, a county HMO, also pledged to contribute \$1 million for the first year. On December 12, 2000, the San Jose City Council finally approved funding, adding three million dollars to the Children's Health Initiative over three years.<sup>300</sup> In addition, private foundations have been asked to contribute to the remaining cost of the program, estimated to be between eight to twelve million dollars per year.<sup>301</sup>

Although critics remain concerned about the costs of the program and the ability to reach and enroll eligible children,<sup>302</sup> those involved in the Santa Clara County Children's Health Initiative hope to spur other counties in California and across the nation into taking similar action.<sup>303</sup> "The model we will put forward sets the stage for other

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294. See Maria Alicia Gaura, *San Jose's Children May Get Insurance From Tobacco Cash; Proposal Would Set National Precedent*, S. F. CHRON., May 31, 2000, at A17 available in LEXIS, News Group File.

295. See Tracey Kaplan, *Official Backs Off His Plan For Tobacco Settlement Funds*, SAN JOSE MERCURY NEWS, Nov. 30, 1999, available in LEXIS, News Group File.

296. The settlement money could have been used to discourage smoking or help people quit, provide insurance for uninsured county workers, increase gang intervention programs, feed senior citizens, or implement educational programs. See Janice Rombeck, *San Jose, Calif., Council Seeks Suggestions to Spend Tobacco Settlement Funds*, SAN JOSE MERCURY NEWS, Aug. 18, 2000, available in LEXIS, News Group File. See also Kaplan, *supra* note 295.

297. See Bailey, June 14, *supra* note 275.

298. Maria Alicia Gaura, *Pioneering Plan For Uninsured Kids to Get Health Care: Santa Clara County Ahead Of Curve*, S. F. CHRON., Oct. 4, 2000, at A15 available in LEXIS, News Group File.

299. See Wong, *supra* note 272, at 1. See also *Universal Coverage: Calif. Cities Move To Cover Kids*, AM. HEALTH LINE, Dec. 14, 2000 available in LEXIS, News Group File; Gaura, *supra* note 298.

300. See Michelle Guido, *San Jose, Calif., Puts \$3 Million from Tobacco Funds Into Childrens [sic] Insurance*, SAN JOSE MERCURY NEWS, Dec. 13, 2000 available in LEXIS, News Group File.

301. See generally Gaura, *supra* note 298.

302. See *Universal Coverage: Calif. Cities Move To Cover Kids*, AM. HEALTH LINE, Dec. 14, 2000 available in LEXIS, News Group File.

303. See Maria Alicia Gaura, *San Jose's Children May Get Insurance From Tobacco Cash; Proposal would set national precedent*, S. F. CHRON., May 31, 2000, at A17 (quoting Councilwoman Margie Matthews: "The benefits of this would be enormous, and if we do it, there's a good chance others will follow suit."); Slambrouck, *supra* note 131 (quoting County Supervisor Jim Beall: "We think this is a national model, using local initiative to respond to the healthcare needs of kids."); Guido, *supra* note 300 (quoting Amy Dean,

counties in California to do the same. That will advance the national discussion about universal health care. It's going to have that kind of a ripple effect."<sup>304</sup> With other local initiatives already emerging,<sup>305</sup> local communities may be drawing closer to the goal of insuring all children one county at a time.

## VI. CONCLUSION

With over three million children enrolled in child health programs in 2000, the State Children's Health Insurance Program has helped provide a significant number of children with health insurance coverage. Since many more children are eligible for existing Medicaid and SCHIP plans, states need to focus on strengthening their outreach and enrollment efforts. By learning from each other and experimenting through demonstration waivers, states can begin implementing techniques that really work to enroll children and families in available public programs. Unfortunately, the best efforts at outreach and enrollment will not be enough; even if states can enroll every child eligible for SCHIP, there will still be children left without the financial means or public assistance necessary to purchase health care. Legislative and local initiatives like MediKids and Santa Clara County's Children's Health Initiative aspire to give *all* children access to comprehensive health care. Just as it was considered unacceptable to leave ten million children without health insurance when the State Children's Health Insurance Program was implemented in 1997, it remains unacceptable to now overlook the children SCHIP has left behind. If Santa Clara's efforts are successful in extending coverage to all county children, we will gain significant insight into how to provide one of our neediest populations with the health care they deserve.

Lisa J. Andeen \*

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Chairwoman of the South Bay Labor Council: "I hope that today's victory will spread throughout the state and the nation like seeds being carried by the wind."); 146 CONG. REC. E. 2144 (daily ed. Dec. 7, 2000) (statement of Hon. Fortney Pete Stark: "I hope that other counties, states, and the federal government will follow Santa Clara County's lead. MediKids . . . is one approach to ensuring coverage for all children in the nation. There are alternative approaches that build on other existing programs, similar to the new effort being undertaken by Santa Clara County.").

304. Guido, Oct. 4, *supra* note 277 (statement of Supervisor Blanca Alvarado after the Children's Health Initiative plan was unveiled).

305. As of November 30, 1999, five other counties in California had agreed to use the tobacco settlement money exclusively on health care. See Kaplan, *supra* note 295. The five counties were Alameda, Los Angeles, Monterey, Santa Barbara and San Mateo. See *id.* Preliminary meetings to develop a similar initiative in San Francisco may result in a plan by early 2002. See *Universal Coverage: Calif. Cities Move To Cover Kids*, AM. HEALTH LINE, Dec. 14, 2000, available in LEXIS, News Group File.

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