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FROM POLICY TO PEOPLE:
THE IMPLEMENTATION MAZE
NEW JERSEY KIDCARE: A CASE IN PROCESS

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New Jersey Policy Forums on Health & Medical Care

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FROM POLICY TO PEOPLE: THE IMPLEMENTATION MAZE
NEW JERSEY KIDCARE: A CASE IN PROCESS

ISSUE: Over 200,000 New Jersey children lack health insurance or comprehensive health care. Does New Jersey have the will and can the state mobilize its collective ability to respond to this need, given the "much-lobbied-for" authority and funding it now has? Although the State Children's Health Insurance Program (CHIP) represents the largest expansion of health coverage for a single group since the passage of the Medicaid and Medicare programs, will enacting legislation and appropriating funds for health insurance result in healthier children?

INTRODUCTION

During the course of the 1990s, the path of health policy and insurance reform on the state level has "switch-backed" from status quo to comprehensive reform efforts and back again to incremental reforms aimed at benefiting smaller populations. The issue of uninsured children gained prominence in the public policy arena over the past two years, specifically through large-scale changes to the Medicaid program[1], along with the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and of the State Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act of 1997.

Under the precept of devolution, the federal government is continuing to shift authority to the individual states to administer major health and human services programs. Health policy analysts across the country contend that the states' implementation of CHIP is the first comprehensive litmus test for devolution; i.e., how well or how poorly the children's health insurance program fares at the state level will represent states' capacity to take the lead role as program designers, administrators and evaluators. As each state continues to explore the new "freedom" of expanded discretionary authority balanced with the administrative challenge of operating old (with variations) and new health and social welfare programs, the issues of governing capacity and implementation become even more prominent. What specific challenges does New Jersey face in its implementation of New Jersey KidCare, its new program to provide health insurance for its uninsured children?

[1]The Balanced Budget Act of 1997 (P.L. 105-33) significantly expands the authority of state Medicaid agencies to provide covered health services through managed care organizations (MCOs). Without obtaining waivers, states are enabled to require most Medicaid beneficiaries to enroll in MCOs that do business only with the Medicaid program; states are also allowed to limit the number of participating Medicaid MCOs. According to the Center for Budget and Policy Priorities, these provisions "are likely to have a major [as yet undetermined] effect on access to covered hospital and physician services by low-income women and children and other Medicaid populations" (Schneider, 1997; Congressional Budget Office, 1997).

IMPLEMENTATION: THE ROAD WELL-TRAVELED

Public policy analysts have long explored and debated the "gap" between the policies designed by legislators and decision makers and the implementation of those policies into actual programs and services. Too often the day-to-day operations of programs may look nothing like the original enabling legislation, having lost both intent and content along the path of implementation. Monitoring and follow-up are extremely difficult with scarce resources, and policies made based on crises and political exigencies are vulnerable to creating unintended consequences. A recent political cartoon featured in *Time* magazine expressed such a scenario about seemingly unrelated policy decisions: in the cartoonist's vision of the American future, the public policy decision to enforce the global warming agreement would result in the banning of sports utility vehicles, which would then create a reduction in air pollution, consequently resulting in Americans' living longer, and then creating a disaster for the Social Security program when "everyone's living to be 120 years old"!

In an essay discussing the challenges of public policy administration, Donald Van Meter and Carl Van Horn defined policy implementation as "those actions by public and private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions" (1975). During the same year, in a now-classic study of the complex issues surrounding the implementation process in social policy, social scientist Hargrove accurately labeled implementation "The Missing Link" (1975). Twenty years later, in this era of devolution and the rise of states' authority, policy implementation more

closely resembles the model presaged by theorists as "Implementation on Its Head":

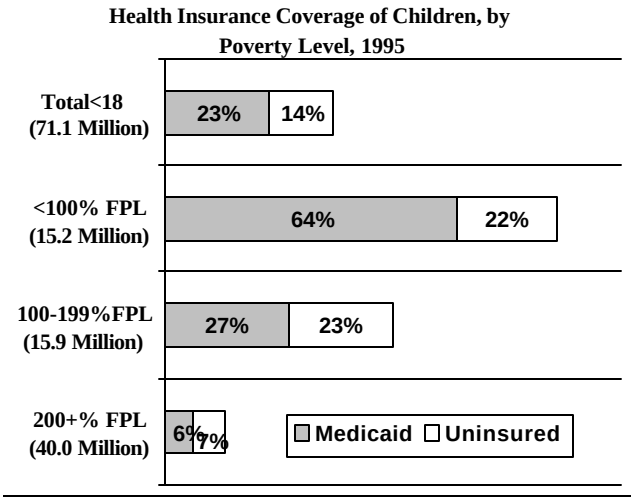
> There are many contexts in which the latitude of those charged with carrying out a policy is so substantial that studies of implementation should be turned on their heads. In these cases, policy is effectively "made" by the people who implement it.
> [Lipsky; emphasis added]

Historically, the "implementation gap" has been quite wide in the health and social welfare policymaking environment. For example, the reality that implementing new coverage programs does not guarantee that eligible individuals will actually get enrolled is most disturbingly illustrated in the statistic that close to 3 million children are eligible for Medicaid, yet they remain unenrolled (Center on Budget and Policy Priorities Report, 1997).[2] [3] What types of "checks and balances" must be put in place at the state and especially at local levels -- where most of the activities take place in the operation of health and social services programs for children -- to ensure that the implementation process is "in synch" with the prior policies that have effected its course?

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) - THE CATALYST FOR EXPANSION

The State Children's Health Insurance Program (codified as Title XXI of the Social Security Act) was enacted as part of the Balanced Budget Act of 1997. It is both the end result of various "policy and political compromises" and the starting point for complex policy, programmatic and implementation issues confronting states in the environment of devolution (Rosenbaum et al, 1998). CHIP was conceived in response to a series of complex policy issues which have at their locus the fact that in 1996, an estimated 10.1 million children were uninsured in America on any given day (Employee Benefit Research Institute, 1997; General Accounting Office Report, 1996).[4] [5] (See Appendix, Table 1, "Children Under Age 19 Uninsured, by State, 1993-95.") The intent of CHIP is to expand health insurance coverage to uninsured children under age 19 in families with incomes below 200 percent of poverty[6]. Based on Congressional Budget Office projections, CHIP is expected to cover 2.8 million previously uninsured children assisted with CHIP funds and another 600,000 enrolled in Medicaid through CHIP outreach and eligibility screening efforts (Rosenbaum et al, 1998).

Chart 1



A 1998 General Accounting Office Report analyzed several studies which found that health insurance coverage increased children's access to health care services. In general, insured children were more likely to have preventive and primary care than uninsured children; they were also more likely to have an established relationship with a primary care physician and to receive required preventive services. These differences in access between insured and uninsured children were evident even for children who had chronic conditions and special health care needs (U.S. General Accounting Office. "Coverage Leads to Increased Health Care Access for Children," GAO/HEHS-08-14, 1998).

The two major sources of health insurance coverage for children are employer-sponsored coverage through a parent and Medicaid (Weil, 1997). In 1995, private coverage for children (which is primarily employer-sponsored) reached approximately 65 percent of children, while Medicaid covered 23.2 percent (with some children having both) (Ibid.; U.S. Census Bureau Data). In the years prior to 1995, an erosion of employer-based coverage for children began: between 1987 and 1995, the share of children insured through a parent's workplace dropped from 66.7 percent to 58.6 percent (Employee Benefit Research Institute, 1997). During the same period, the amount deducted from a parent's

[2] In recognition of the significance of this problem, the Clinton Administration is requiring federal and state agencies to begin a major effort to locate and sign up those eligible, but as yet unenrolled, children into the Medicaid program. (*The New York Times*, December 29, 1997).

[3] Policy analyst Frank Thompson points out that "liberal and wealthier northern states [do] not fare appreciably better than their southern counterparts" when it comes to enrolling Medicaid-eligible children; consequently, there is not one state that can be viewed as exemplary in addressing this problem (1997).

[4] At present, estimates on the number of uninsured children in this country range from 8.5 million to 11.3 million (The Robert Wood Johnson Foundation, 1998).

[5] In New Jersey, estimates indicate that there are approximately 248,000 uninsured children (Current Population Survey Data, March 1996).

[6] The Federal poverty Level (FLP) is $13,330 for a family of three in 1997. For a family of three in 1997, 200 percent of the FPL was $26,660; for a family of four, it amounted to $32,000.

paycheck for health coverage tripled from an average of $37.00 to $107.00. Under CHIP mandates, children with private insurance or who are covered by or qualify for Medicaid are ineligible for CHIP. Also ineligible are those who are residents of public institutions or whose families are eligible for state employee health benefits (The Kaiser Commission on the Future of Medicaid, *Legislative Summary*, December 1997).

As a federal grant-in-aid program, CHIP entitles states to allotments to enable them to initiate and expand the provision of child health assistance to "targeted low-income children."[7] CHIP funds may be used by the states to implement programs for children's health care through one of three ways: (1) by the expansion of already existing Medicaid programs; (2) by creating or expanding a separate state program to purchase children's health insurance, or (3) by designing a combination of both programs. Allotments to states will be through an "enhanced" federal matching rate based on their Medicaid matching rate. Funds are available to states upon approval by HCFA of their child health plan.[8] The Health Care Financing Administration (HCFA) is responsible for administering CHIP, with joint oversight by the Health Resources and Services Administration (HRSA).

States like Florida, New York and Pennsylvania, where there are existing state-funded children's health insurance programs, are seeking federal matching funds to enhance their programs. Under Federal provisions, these three states are required to maintain efforts in their state-only programs. Connecticut is one state that is combining a Medicaid expansion with a separate state program to cover insured children. At present, CHIP is a work in progress -- approximately 15 states have submitted their Title XXI plans to HCFA.[9] Each plan reflects its own state culture and is designed based on existing Medicaid and child health insurance activities. Of plans submitted, approximately one-third are based on Medicaid expansion, one-third are "new" programs, and one-third are combination initiatives. The flexibility for states as requested by the National Governor's Association is present in CHIP's enabling statute regarding state choices about program operations; e.g., a state may expand Medicaid and then move children into a separate state-funded program as it is developed, or conversely, states may develop separate programs but if they become unworkable, they can switch to a Medicaid expansion program (Weil, 1997).

STATE TRENDS IN COVERING UNINSURED CHILDREN

Under the Federal Medicaid program, states are mandated to cover certain specific categories of children, such as all children through age five in families with income below 133 percent of the Federal Poverty Level (FPL). Over the years of the Medicaid program, the majority of states (including New Jersey) have expanded health insurance coverage for children beyond Federal requirements, either through Medicaid expansions, separate state-funded programs, or smaller private programs (Weil, 1997). Most of these expansions are through the Medicaid program. For example, 27 states have expanded coverage for children (ages 1 through 18) beyond Federal requirements and 34 states have expanded coverage for pregnant women and infants under the age of 1 (Ibid). Eight states have separate state-administered programs targeting low-income families or children not eligible for Medicaid, but only four enroll more than 10,000 people (Gauthier and Schrodel, 1997). [10] States in the Northeast have been actively engaged in developing plans of action for children's health insurance and access to appropriate health care.[11] (See Appendix for a Summary of CHIP implementation actions in New Jersey's neighboring states.)

DEVOLUTION AND STATES' DISCRETION: MEDICAID EXPANSION, A SEPARATE PROGRAM, OR BOTH

[7] Congress set a 10-year appropriation for CHIP: the Balanced Budget Act authorizes $20.3 billion in funds from FY 1998 through FY 2002 and $19.4 billion over the second five years of the appropriation. The allocation of funds to each state is based on a formula that primarily uses the number of uninsured children below 200 percent of FPL in the state.

[8] According to January 1998 conversations with HCFA staff, 15 states have submitted their CHIP (Title XXI) plans to HCFA; New Jersey, which has an extensive draft plan for New Jersey KidCare, has not yet submitted its formal plan to HCFA.

[9] The CHIP environment is changing so rapidly that when this author attended a recent conference in Washington DC, HCFA was reporting that the number of plans submitted by states was changing on a daily basis.

[10] The states of Minnesota and Florida are two lead states in developing comprehensive initiatives for uninsured children.

[11] Massachusetts' Children's Medical Security Plan provides physician and outpatient care for children age 18 and under, at an average monthly cost of $52.50 per child; New York's Child Health Plus provides physician, outpatient and inpatient care for children under age 19 at an average monthly cost of $54.71 per child; and Pennsylvania's Children's Health Insurance Program provides comprehensive health care to children ages 0-5 with incomes below 235 percent of poverty, and children ages 6 to 15 with incomes below 185 percent of poverty at an average monthly cost of $63 per child. The Commonwealth of Pennsylvania also has a local/private initiative, the Western Pennsylvania Caring Program for Children (which supplements the state CHIP program) that provides physician, outpatient and inpatient care for children under age 19 with incomes under 185 percent of poverty, at an average monthly cost of $70.60 per child. The Caring Program (begun in 1985 by a group of clergyman in Pittsburgh) now has been replicated in 20 states, including Massachusetts and New York. Within Pennsylvania, the state CHIP and the Caring Program insure only 60,000 of the state's 300,000 (approximately) uninsured children (National Council of State Legislatures, 1997; HCFA, 1997).

As with every new policy or programmatic decision, each choice carries with it a set of potential benefits and challenges. Because Title XXI takes the form of a grant-in-aid from the Federal government, it is not an entitlement program and so there are enrollment limitations; both enrollment and expenditures must be closely monitored by states to allow fairness and equity in coverage. Further, because CHIP is a grant-in-aid program and is being viewed by many states as a "block grant" program, it is anticipated that HCFA will not promulgate specific rules governing the program, but will issue letter "guidelines" to states (Mann, 1997; Rosenbaum et al, 1998). For example, the federal Medicaid statute provides for federal rule-making by HCFA and for federal judicial interpretation of the statute and rules (Weil, 1997). The new Title XXI law, however, allows flexibility for how state-developed and state-administered programs are run and these programs may be subject initially to state rule-making and state administrative law and judicial interpretation. Consequently, the role of the states in making critical, independent decisions regarding health coverage and implementation decisions for the lives of their children will be significant.

Whatever program design direction each state takes, it is confronted with detailed decisions regarding covered services, cost sharing, eligibility standards, quality evaluation and monitoring, and coordination among programs and delivery systems. While most states are still analyzing how to structure their Title XXI-funded programs, many are considering the position that using child health funds to expand coverage through the Medicaid program is the strongest one. Reasons for states' choosing the Medicaid expansion option include:

- avoiding the need for (and cost of) duplicative administrative systems;
- having access to open-ended federal matching payments and greater protection against rising health costs;
- allowing states a more consistent level of federal matching payments over time;
- permitting states to unify standards and methods used to determine eligibility (important because children must be screened and determined to be ineligible for Medicaid before they can receive CHIP benefits); and,
- helping to create a system of coverage that provides continuity of care and which reduces fragmentation of services.

Those advocating for a separate CHIP program focus on the "entitlement" argument raised by Medicaid expansion as the central policy issue to be addressed. Specifically, if a state decides on either whole or partial CHIP implementation through Medicaid expansion, the state is then obligated to offer assistance to all eligible children (Id). Program administrators may lose control of caseload growth; consequently, a Medicaid expansion may force states to spend funds they may not be prepared to commit. [12] Conversely, under the rubric of a separate state CHIP program, a state can set explicit enrollment caps: once a certain number of people who meet the eligibility standards are enrolled, the enrollment is closed.[13]

In states like New Jersey, in which the plan is to combine both a Medicaid expansion and a Title XXI CHIP program, there is a strategy to monitor enrollment and "gauge" uncontrolled costs, while limiting the administrative and access difficulties of operating two separate programs (Weil, 1997). According to a December 1997 HCFA report, New Jersey's maximum state matching requirement under CHIP is $48 million for FY 1998.

NEW JERSEY KIDCARE -- MOVING IN THE RIGHT DIRECTION?

New Jersey's 248,000 uninsured children may be defined by certain demographic attributes. Of this total, approximately 158,000, or 63 percent of uninsured children, are living in families with incomes at or below 200 percent of the Federal Poverty Level (March 1996, Current Population Survey Data). Within the larger context of the number of children in New Jersey living at or below 200 percent of poverty (approximately 591,000 insured and uninsured), there are various types of health insurance coverage. For example, 185,000 (or 31 percent) are in employer-related group coverage; 54,000 (or 9 percent) are with other non-group coverage (such as Medicare and Champus); 190,000 (32 percent) are Medicaid-enrolled children and 4,300 (or less than 1 percent) are enrolled in New Jersey's Health Access program (all figures are approximate and based on the Current Population Survey Data; see Appendix, Table 2, "New Jersey Profile of Child Health Coverage"). The children enrolled in Health Access with incomes below 200 percent of the FPL will be converted to the Title XXI coverage under NJ KidCare.

Historically, the state of New Jersey has been one of the lead states in moving "beyond" Federal requirements in providing health care coverage for children, as well as for mothers and pregnant women. Efforts have included Medicaid expansions, the

[12] Rosenbaum et al (1998) point out that "in the 'post-entitlement' world of welfare reform, one of the most politically difficult issues to overcome is the specter of uncontrolled caseload, particularly when coupled with fears of private insurance crowd-out."

[13] Weil (1997) points out that the states of Washington, Minnesota and Hawaii have done such enrollment caps through waivers for their Medicaid expansion programs; these state programs are designed not as entitlements, but are subject to annual appropriation.

implementation and operation of HealthStart,[14] and of the Healthy Mothers Healthy Babies program. However, the scope and persistence of the issues surrounding maternal and child health and vulnerable populations -- even in the presence of such programs -- are reflected in a recent New Jersey *Blue Ribbon Panel Report on Black Infant Mortality* Reduction which recognized that in the United States and in New Jersey, "a black infant is more than two times likely to die before his or her first birthday than a white infant" (State of New Jersey, Department of Health and Senior Services, September 1997).

In their state plan submission for Title XXI CHIP funds, New Jersey KidCare administrators discuss the state's involvement in facilitating health care for children and families on many fronts: through insurance reform efforts (individual and small group insurance to make commercial insurance more affordable), and through efforts to finance direct services and to finance coverage. For example, New Jersey's charity care program provides funding to hospitals for services provided to uninsured individuals (including children) with family incomes below 300 percent of the FPL.[15] Direct services are also provided through a network of 11 Federally Qualified Health Centers in the state and through public health programs, such as immunization, lead screening, programs for tuberculosis and sexually transmitted diseases.

New Jersey KidCare will be comprised of both a Medicaid expansion (NJ KidCare A) and Title XXI only components (NJ KidCare B&C). The Medicaid expansion component will cover children up to 133 percent of the FPL; the new state program is targeted to children living in families with incomes up to 200 percent of the FPL. A comprehensive package of health care services will be provided through the use of HMOs. The services will include well child and other preventive services, hospitalization, physician care, lab and x-ray services, prescription drugs, mental health services, as well as dental, vision and hearing services.

Depending upon the component, premiums and copayments will have to be paid by some families. The premium will be $15.00 per month for each family no matter how many children are in the program. These households that must pay the monthly premium will also have to pay small copayments for certain services. For example, under NJ KidCare A, outpatient hospital services are mandatory services; in comparison, under NJ KidCare B & C, there is a $5.00 copay for each outpatient hospital visit. Total yearly premiums and copayments will never exceed 5 percent of the family's income. (Premiums are based on income levels; for example, a family of three with a yearly income above $19,995 is required to pay a premium; for a family of four, the yearly income level that triggers a premium is $24,075).

Any state that operates a separately administered CHIP program must provide coverage that meets one of several benchmarks.[16] The benchmark for the NJ KidCare program is the standard Blue Cross-Blue Shield PPO option of the Federal Employees Health Benefit Program. As a means to discourage employers from dropping existing coverage for their employees and dependents, NJ KidCare is available only to children who have been uninsured for at least 12 months.

The question of premiums and cost-sharing raises complex policy-making issues for states. Recent research studies of state health insurance programs in Minnesota, Hawaii and Washington found that higher premiums (measured as share of income) significantly reduced the likelihood of participation by families (The Kaiser Commission on the Future of Medicaid, *Policy Brief*, January 1998). In general, the higher the share of income required to pay the premium, the lower the participation for people eligible for coverage. Specifically, while just over half (57 percent) of the eligible uninsured participated with premiums at 1 percent of income, only 18 percent participated with premiums requiring 5 percent of income (Ibid.). These research findings carry great weight as states, including New Jersey, monitor access to care and contemplate "next steps" in broadening coverage beyond children to other uninsured population groups, such as early retirees.

BUILD IT AND MAYBE THEY WILL COME: THE CRITICAL ROLE OF OUTREACH

In the complex world of decisions regarding health policies and the design and implementation of health programs and services, the role of outreach has been one of long-standing importance. Just as the act of passing a law does not mean its intent will be fulfilled, implementing a program does not directly

[14] HealthStart offers enhanced services such as nutrition counseling and social services to ensure continuity of care to women during pregnancy.

[15] At present, New Jersey has pending a Section 1115 waiver request that would allow the state to "experiment" with using Disproportionate Share Hospital dollars for funding a better coordinated, network-based system of charity care (NJ KidCare, *Draft Title XXI State Plan*, 1997).

[16] For their benchmarks, states may select from the following: (1) the standard Blue Cross/Blue Shield preferred provider option offered to federal employees; (2) the state employee health benefit plan; or (3) the plan offered by the HMO with the largest non-Medicaid commercial health enrollment in the state. Basic services are inpatient and outpatient hospital care; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations.

correlate with enrollment of appropriate eligibles, nor is the fact of insurance coverage equivalent to access to quality and appropriate health care and to improved health status.

During the past two years, the federal government has made available to states two significant sources of funding that promote outreach activities to enroll children (DeChiara and Wolf, 1998). In 1996, Congress passed the Personal Responsibility and Work Opportunity Act (PRWORA) as part of its welfare reform initiative.[17] Under this Act, Congress allowed states to be provided up to $500 million in enhanced administrative matching funds to be used to ensure that children and parents do not lose Medicaid coverage as a result of changes related to welfare reform. The second source of funding is CHIP, under which states choosing to expand their existing Medicaid program can maximize funding for outreach and enrollment, within the limitation that all states are allowed up to 10 percent of total federal and state expenditures for such activities (Ibid).

Research has shown that barriers to access fall into two broad categories: (1) those associated with the health care system and the insurance system and (2) those related to individuals and households. Advocates for strong outreach efforts have been stymied by the absence of fiscal and staff resources, the fragmentation of the service delivery systems, the lack of coordination among service providers and the complex administrative procedures for program implementation, especially documentation requirements and follow-through. Another factor that has curbed aggressive outreach efforts in the past is the historical fear of the "woodwork" effect, under which program administrators fear that to offer new or expanded services would open up enrollment to too many people, ostensibly overwhelming program resources. As a consequence, many program administrators limited information sharing and knowledge about available resources.

In addition, all of these limiting factors are in place against the backdrop that many "eligibles" are not likely to seek out either social service or medical assistance programs, because of certain stigmas attached to them. Other individual and/or household factors which have acted as barriers to access include: inability to handle extensive paperwork required for enrollment; discouragement that eligibility is ever-changing and may not be long-lasting; materials about health insurance programs are not written in a user-friendly, easily understandable way; and various communication and transportation problems (DeCiara and Wolff, 1998).

Under CHIP allotments, states will have great discretion in designing and operating their child health insurance programs. However, one of the fiscal requirements is that no more than 10 percent of federal and state spending can be used for outreach, administrative costs or direct service payments to clinics or hospitals.

Both public and private health policymakers view the implementation of the CHIP as a vehicle for bringing to the forefront the issue of outreach. In light of their concerns, current activities at the Federal level include the Health Care Financing Administration (HCFA)'s and Health Resources Services Administration (HRSA)'s active role in providing technical assistance to the states for program implementation and outreach coordination. The Robert Wood Johnson Foundation has launched a new $13 million initiative, "Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children," to support state and local activities that will identify and enroll low-income children into existing coverage programs.

Under New Jersey's plan, its KidCare program will have an extensive and coordinated outreach component designed through a committee comprised of staff from the Departments of Human Services and Health and Senior Services, along with representatives from the WIC program, various public health programs and the Department of Education. A professional media campaign will be one component of its public awareness efforts. Targeted outreach, for example, will focus on schools with a high number of children eligible for the school lunch program (Id). Viable resources which are already in existence, such as the database of former Medicaid eligibles, the electronic birth certificate and immunization registry, and the charity care data base, will also be utilized. Two other components of the outreach plan include community education and consumer education.

The application process will be greatly simplified, and a single, mail-in application will be used for both the Medicaid (Title XIX) and the KidCare (Title XXI) programs. Because children eligible for Medicaid will not be allowed to enroll in KidCare, applications for children with family income below 133 percent of poverty level will be directly referred for evaluation of Medicaid Title XIX eligibility. In time, the One Ease-E Link network (a new social service computer network currently being

[17] PRWORA fundamentally changes federal child care assistance programs. It eliminates federal child care entitlements and consolidates the major sources of federal child care subsidies for low-income children into a single block grant to states. This Child Care and Development Fund (CCDF) provided up to $2.97 billion in federal funding in FY 1997, an increase of $600 million, or 27 percent, over prior law.

implemented by several state agencies) will be used in evaluating and making such eligibility referrals.

WHAT'S NEXT? - BEYOND UNINSURED CHILDREN

During the past two years, Congress has made a strong commitment to resolving the social problem of the country's uninsured children. At the same time, other vulnerable members of society, such as the elderly and the "pre-retirement" age group of those between the ages of 55 and 64, are being affected by changes in the rapidly evolving health policy and health care environment. Changes under the Balanced Budget Act of 1997 are re-structuring the Medicare program in ways which are expected to have significant impact on low-income elderly; at the same time, the Clinton administration is proposing Medicare "buy-in" plans for the 55-64 age group, who comprise a group with one of the highest rates of being uninsured. In the era of devolution, is there a "next step" for New Jersey (and other states) in enrolling families and/or other individuals currently living without health insurance?

Health policy analysts concur that the next focal point for health care reform could be early retirees and unemployed individuals who are uninsured. However, most agree with policy implementation analyst Frank Thompson's views that at present, there are many unknowns regarding the "implementation" of devolution, and it is not a time for states to move too quickly into uncharted territories. He suggests that the most appropriate image which represents devolution activities is a flashing red light that translates and signals to states: "Stop, look, listen; then proceed with caution."

END NOTES: POLICY IMPLICATIONS

The implementation of CHIP at the federal level and New Jersey KidCare at the state level represents the first concrete step in the environment of devolution in health and social welfare policy-making and program design. As with any new introductions, there are various policy, program and implementation implications inherent in the process. The following questions focus on some of the major issues that are arising out of federal and state decisions regarding health insurance coverage for children.

<u>Monitoring/Evaluation</u>

How will New Jersey design and establish a data collection/information system in order to standardize measures and track performance outcomes to assess the efficacy of its children's health care initiatives? Coordination of the implementation of its Medicaid expansion and NJ KidCare program involves many state and local players. What entity will be in charge of data coordination, analysis and ongoing evaluation?

What methods of ongoing evaluation will take place to ensure that the health care delivery systems to which New Jersey's children have access are actually improving their health status? What type of entity should oversee these evaluation activities: public sector? private sector with a strong consumer presence? or a partnership of both?

<u>Administration/Outreach</u>

Under welfare reform and Title XXI, there is funding for focused outreach efforts. How will service coordination be facilitated among social service agencies, Medicaid offices, county welfare agencies, community safety net providers, schools and communities in a system that has long been challenged by fragmentation?

How will the Title XXI child health initiatives coordinate with national public health initiatives already in existence, such as the Centers for Disease Control and Prevention's National Immunization Program (CDC/NIP)? Although the NIP program has experienced significant success, according to a recent program survey, in 1995 approximately 25 percent of preschool-age children had not received at least one dose of the recommended series of vaccines. Both initiatives require continued commitment through administration and stable funding sources.

New Jersey KidCare's outreach plan includes the operation of assistance sites at the local Medicaid District Offices. What type of training will be used to "re-orient" staff in these settings, who have been so used to working in an environment in which the prevailing culture was based on fear of the woodwork effect and often discouraged aggressive outreach?

Healthy Connections is a statewide program working in 26 rural communities of Massachusetts that seeks to enroll eligible children, families and adults in health insurance programs and to address health insurance gaps in the community. The program uses a community-based approach to doing outreach, emphasizing local infrastructure and one-to-one contact. Is such a program viable for New Jersey's rural communities? How will outreach efforts be targeted to the varied population centers throughout the state?

<u>Crowd-Out</u>

A January 1998 Families USA Report addressing the issue of crowd-out identifies how several national studies disagree on the extent of the

crowd-out problem. A significant problem facing researchers is that the erosion of employer-based coverage is taking place at the same time that there is expansion of the Medicaid program to cover those children who have been disproportionately affected by this erosion.[18] As a result, it is difficult to tease out the effect of Medicaid expansion from the underlying trend in employer coverage. States are using specific techniques to discourage crowd-out, such as eligibility restrictions and employer regulations and incentives. How will New Jersey continue to monitor this issue? Are more employer regulations and incentives an option?

Vulnerable Populations

As one of its primary recommendations, the New Jersey Blue Ribbon Panel on Black Infant Mortality Reduction called for a public-private-community partnership to address the challenge of reducing black infant mortality. How will New Jersey's KidCare initiative target aggressive outreach to this population in order to achieve access to appropriate health care services for prenatal care and the care of neonates?

As envisioned, NJ KidCare will provide health services through a managed care system of HMOs in the state. How will the most medically fragile children, especially those with chronic health problems -- which research has shown to have difficulty in securing comprehensive health services -- fit into this system of care?

An estimated 20 percent of American children and adolescents -- close to 11 million -- have serious diagnosable emotional or behavioral health disorders, which range from attention deficit disorder and depression to bipolar disorder and schizophrenia. How broad or how narrow will New Jersey KidCare's mental health benefits be operationalized for children enrolled in the program? Will some form of mental health parity be established?

[18]Merlis (1997) points to children's health insurance initiatives in the states of Florida, Minnesota, New Jersey, Pennsylvania, Tennessee and Washington and cites examples of "firewalls" that these states have built into their programs to avoid the crowd-out issue.

APPENDIX
Table 1

Children Under Age 19 Uninsured, By State, 1993

	Number of Children Uninsured (in thousands)		Percent of Children Uninsured	
	Total	**<200% FPL**	**Total**	**<200% FPL**
Alabama	193	154	15.9 %	25.8 %
Alaska	19	9	10.0	15.0
Arizona	245	184	20.3	29.6
Arkansas	128	90	18.9	25.2
California	1,757	1,281	18.4	26.7
Colorado	120	72	11.9	20.9
Connecticut	82	53	9.6	18.7
Delaware	22	13	12.4	18.8
District of Columbia	23	16	16.1	18.0
Florida	636	444	17.1	24.4
Georgia	312	214	15.5	24.3
Hawaii	23	13	7.8	12.5
Idaho	49	31	13.7	17.9
Illinois	341	211	10.3	18.2
Indiana	182	131	10.9	21.5
Iowa	90	67	10.9	21.5
Kansas	80	60	10.8	18.4
Kentucky	136	93	13.1	18.1
Louisiana	261	194	20.1	26.0
Maine	40	24	12.2	18.8
Maryland	158	100	12.0	20.5
Massachusetts	136	69	9.0	14.6
Michigan	235	156	8.5	14.3
Minnesota	85	50	6.6	12.3
Mississippi	143	110	18.5	24.0
Missouri	150	97	11.3	16.8
Montana	28	20	11.7	19.2
Nebraska	46	30	9.1	16.1
Nevada	74	43	18.4	27.9
New Hampshire	31	20	10.2	23.3
New Jersey	239	134	11.4	22.2
New Mexico	137	107	24.9	35.0
New York	613	399	12.5	18.0
North Carolina	218	138	13.1	19.2
North Dakota	15	10	8.1	14.9
Ohio	315	205	9.7	16.0
Oklahoma	215	161	22.7	33.5
Oregon	105	67	12.2	18.5
Pennsylvania	320	200	10.1	16.7
Rhode Island	28	19	11.4	20.4
South Carolina	152	110	14.7	19.3
South Dakota	21	15	9.3	14.7
Tennessee	177	115	12.2	16.5
Texas	1,333	1,031	23.2	34.9
Utah	71	46	9.9	16.0
Vermont	12	7	7.2	11.1
Virginia	200	118	11.7	18.8
Washington	138	85	9.7	18.5
West Virginia	60	45	14.1	19.9
Wisconsin	97	71	6.6	14.2
Wyoming	21	15	14.4	26.8
United States	**10,315**	**7,147**	**14.0 %**	**22.2 %**

Bureau of the Census, based on arithmetic averages of uninsured children calculated from the three most recent March supplements to the Current Population Survey. FPL = federal poverty level.

Note: The Current Population Survey (CPS) most likely overstates the number of uninsured children because it does not adjust for the underreporting of children who have Medicaid coverage. The number of children reported to have Medicaid coverage on the CPS is substantially below the number of enrollees that states themselves report to HCFA (16.5 million versus 21.4 million in 1995). The Urban Institute's TRIM2microsimulation model attempts to adjust for this undercount by imputing Medicaid enrollment to individuals to align to HCFA enrollment counts. The result is to increase the number of children on Medicaid and reduce the number of uninsured children. The Urban Institute estimates that 4.6 million children below 200 percent of poverty are uninsured as opposed to 7.2 million on the CPS. However, since the s-CHIP statute allocates funds to states on the basis of CPS estimates, those estimates are used in this brief.
Source: Weil, A. "The New Children's Health Insurance Program: Should States Expand Medicaid?" Series A, no. A-13. New Federalism. Issues and Options for States. The Urban Institute. October 1997.

NEIGHBORING STATES - CHIP IMPLEMENTATION ACTIONS

A summary of New Jersey's neighboring state CHIP implementation actions regarding Title XXI follows:

- Connecticut — Legislation adopted (October 30, 1997) to expand Medicaid to 185 percent of poverty through age 18 and to create a new program to 300 percent of poverty. Scheduled to begin April 1998.
  [161,000 uninsured children]

- Massachusetts — Legislature unanimously approved a bill (November 1997) to expand Medicaid to cover children under age 19 under 200 percent of poverty. Scheduled to begin March 1998.
  [141,000 uninsured children]

- New Jersey — Legislature passed and Governor signed (December 1997) legislation creating a Medicaid expansion for children through age 18 up to 133 percent of poverty, and a new state program providing private coverage up to 200 percent of poverty. The Medicaid expansion is to begin February 1, 1998; private coverage is to begin March 1, 1998.
  [295,000 uninsured children]

- New York — Plan submitted to HCFA (November 1997) which would expand enrollment and increase premium subsidies in the state's current child health insurance program.
  [680,000 uninsured children]

- Pennsylvania — Plan submitted to HCFA (November 1997) that also expands the state's current child health insurance program. State has covered children formerly on the program's waiting list in anticipation of federal grant funds. Governor signed legislation enabling state to access federal funds.
  [288,000 uninsured children]

- Maryland — Governor proposed a Medicaid expansion (December 1997) to 200 percent of poverty through age 18. Legislative leadership proposes Medicaid expansion to 185 percent of poverty and a separate state program to 250 percent of poverty.
  [158,000 uninsured children]

[National Council of State Legislatures, December 1997]

APPENDIX

Table 2

NEW JERSEY PROFILE OF CHILD HEALTH COVERAGE

Attributes of Population	Children in Employer-related group Coverage	Children with other/ non-group coverage*	Medicaid enrolled children	Health Access enrolled children	Uninsured children
Income Level					
<100%	29,987	23,537	143,357	1,755	67,749
≤ 133%	48,876	3,804	22,974	1,094	37,989
≤ 185%	82,882	19,773	23,890	1,265	43,692
≤ 200%	22,885	7,228	0	194	8,562
> 200%	1,301,132	48,539	32,348	303	90,630
Age					
0 – 1	80,606	5,433	7,311	146	19,160
1 – 5	451,865	13,808	53,041	1,081	88,418
6 – 12	555,381	31,905	77,599	1,856	72,982
13 – 18	397,910	51,736	84,618	1,528	68,062
Race and Ethnicity					
American Indian or Alaskan Native	6,390	0	0	15	0
Asian or Pacific Islander	117,218	2,491	13,239	258	5,706
Black, not of Hispanic origin	127,197	7,268	67,293	241	16,804
Hispanic	148,701	8,330	84,896	315	63,167
White, not of Hispanic origin	1,086,257	84,792	57,140	3,117	162,945

* Includes Champus and Medicare

Source: State of New Jersey. Draft Title XXI Plan. November 1997.

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Another informative resource regarding emerging initiatives for children is the Center for Health Care Strategies (CHCS), a policy resource center in Princeton, New Jersey. An ongoing focus of the center is the public policy issue of uninsured children. A CHCS-sponsored meeting in June 1997 brought together several Foundations which reported on plans to promote, demonstrate and/or evaluate the enrollment of eligible children in Medicaid and in other health insurance vehicles." Reference is made to: www.chcs.org.