STATE OF MAINE
118TH LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSION

Final Report
of the

MAINE COMMISSION
ON
CHILDREN'S HEALTH CARE

January 28, 1998

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Table of Contents

Executive Summary

The Maine Commission on Children's Health Care was established by Public Law 1997, chapter 560, Part B to consider the problem of uninsured children in Maine and options to increase the number who are insured. The commission worked through the fall and winter and is pleased to present this report to Governor King and the 118th Legislature with the recommendations of the commission. The commission endorses the submission of a plan to the federal Department of Health and Human Services that is a combination approach to reducing the number of uninsured children - an expanded Medicaid program and a separate state children's health coverage program.

The commission recommends a comprehensive approach to reducing the number of uninsured children, an approach that is two-fold:

- Expand the popular and effective Medicaid program. Currently children ages birth through 12 months are eligible for Medicaid if their family incomes are below 185% of the federal poverty level. Children ages 1 through 5 years old are eligible for the Medicaid program if their family incomes are below 133% of the federal poverty level. Children ages 6 through 18 are eligible up to 125% of the federal poverty level. The commission recommends simplifying the eligibility criteria by imposing one higher figure, 150% of the federal poverty level, for all children ages 1 to 18. This would make the comprehensive health benefit coverage of the Medicaid program available to children in families of 3 with incomes up to approximately $20,000.

- Create a new program, paid for in part by premium contributions, for children in families between 150% and 185% of the federal poverty level. This would make health insurance with comprehensive benefits available to families of 3 earning between $20,000 and $24,700. The commission proposes naming the new program the Cub Care program.

The commission recommends that the State of Maine provide health insurance to children through the following approaches:

- Submitting a plan to the Department of Health and Human Services that is a Title XXI combined expanded Medicaid program and a separate state children's health insurance program.

- Continuing to cover children ages birth through 12 months of age in families with incomes below 185% of the federal poverty level.

- Increasing the eligibility level for Medicaid to cover children 1 through 18 years of age in families with incomes below 150% of the federal poverty level.

- Establishing the Cub Care program to provide health insurance coverage to children 1 to 18 years of age in families with income from 150% to 185% of the federal poverty level. The income eligibility level will fluctuate depending on program expenditures, expanding upward if program expenditures are low in order to maximize the number of children covered and contracting downward if program expenditures are high in order to maintain expenses within the program budget.

- Allowing the purchase of Cub Care coverage for Cub Care enrollees and children on the Medicaid program whose family incomes rise above their program eligibility levels, at premium levels that cover the costs of providing coverage plus contributions for administrative costs.

- Granting continuous eligibility for 6-month enrollment periods in the Cub Care program.

- Imposing premiums, based on family income and the number of children covered, on all families in the Cub Care program.

- Spending up to 2% of program funds for outreach. After 6 months of operation if the program budget allows, spending an additional 3% on initiatives to increase access to health care, including the purchase of dental chairs for health clinics to improve access to dental services.

- Addressing crowd-out in the private insurance market through a number of provisions:
  (1) excluding children with group health coverage or who had employer-based coverage within the 3 months prior to application for which the employer paid at least 50% of premium cost, with exceptions for high cost coverage and when coverage is lost through change of employment, termination under COBRA or for a reason not in the control of the employee; and
  (2) charging premiums on a scale dependent on income for families above 150% of the federal poverty level.

- Adding at least one full-time position equivalent for health policy administration within the Bureau of Medical Services, adding 30 full-time positions within the Bureau of Family Independence, reauthorizing the Maine Commission on Children's Health Care for 1 year and requiring a quarterly determination by the Commissioner of Human Services of the fiscal status of the program and a report to the commission and the Appropriations and Financial Affairs and Health and Human Services Committees.

I. Introduction

Public Law 1997, chapter 560, Part B established the Maine Commission on Children's Health Care to study and report to the Governor and the Legislature on the following issues:

* Assess the best and latest available data regarding children's health insurance in the State, including the number of children under 18 years of age who lack health insurance;
* Examine the costs and benefits of Medicaid expansion with pending federal changes;
* Examine the benefits and detriments of accepting a block grant that would expand children's health access; and
* Examine the advantages and disadvantages of alternative health services and financing mechanisms of children's health services.

The report of the commission may include necessary implementing legislation. The Joint Standing Committee on Health and Human Services may report out legislation based on the report of the commission. A copy of Part B of Public Law 1997 chapter 560 is included in **Appendix A**. The membership of the Maine Commission on Children's Health Care is included as **Appendix B.**

A companion portion of the law, Public Law 1997, chapter 560, Part C established the Children's Health Reserve Account, a dedicated fund to receive income as specified in the law from the General Fund, the Abandoned Property Fund and Title IV-A funds available through the Department of Human Services. The funds in the Children's Health Reserve Account are dedicated to use as matching funds to match available state and federal funds for the purpose of meeting the recommendations of the commission. In addition the law requires the Governor to submit a request to the Joint Standing Committee on Appropriations and Financial Affairs for the additional funding required to fulfill the recommendations of the commission. The commission was informed that the Children's Health Reserve Account contained a balance of over $8,000,000 during December, 1997. Part C of Public Law 1997 chapter 560 is included in **Appendix A.**

While the 118th Legislature was in summer recess and appointments to the commission were pending, the United States Congress passed the Balanced Budget Act of 1997, Public Law 105-33 (1997). This law, in Subtitle J, establishes in Title XXI of the Social Security Act, 42 U.S. Code section 2101 et seq. (1997), the State Children's Health Insurance Program (CHIP). The State Children's Health Insurance Program enables each state to initiate and expand health care for low-income children through expanding the state Medicaid program, establishing a separate state sponsored health insurance program under Title XXI, or utilizing the two programs. Part J of the Balanced Budget Act of 1997 is

included as **Appendix C. Appendix D** contains an amendment to the Balanced Budget Act of 1997 which was enacted in November, 1997.

The Balanced Budget Act of 1997 allocates $20,000,000,000 over five federal fiscal years for state children's health insurance programs. The State of Maine has been informed that Maine's share of the federal funding is as follows:

* For federal fiscal year 1997-98	$12,724,728
* For federal fiscal year 1998-99	$12,724,728
* For federal fiscal year 1999-2000	$12,724,728
* For federal fiscal year 2000-2001	$13,233,956
* For federal fiscal year 2001-2002	$10,126,638
* Total for all 5 federal fiscal years	$61,534,777

The passage of the Balanced Budget Act of 1997 caused the focus of the work of the Maine Commission on Children's Health Care to change even before the commission had met. The federal law requires that a state match be appropriated, increases the federal matching rate for Medicaid funds for the Title XXI program 30% over the usual matching rate applicable to the state, allows the state to carry forward unexpended balances for 2 federal fiscal years and distributes any remaining federal surplus among states that have fully spent their federal funds.

II. The Commission Process

The Commission began its work on October 14, 1997 and completed its meetings on January 19, 1998. During the course of its work the Commission heard testimony and received information from school-based children's health programs, community and Indian health centers, the Maine Center for Economic Policy, the Maine Children's Alliance, the Department of Human Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Bureau of Insurance, the State Employees' Health Insurance Program, the Maine Medical Association, the Office of Fiscal and Program Review, Blue Cross Blue Shield of Maine, and other members of the public. Materials provided to the states by the Health Care Financing Administration of the federal Department of Health and Human Services assisted the commission in its work.

The Maine Department of Human Services contracted with the Muskie School of Public Service to conduct a survey of children's health insurance coverage in Maine. A preliminary report on the survey was provided to the commission. The report estimates the number of uninsured children in the state and their family income levels. From these estimates and the cost per child information provided by the Department of Human Services, the commission estimated program costs and considered the options for coverage presented to the commission.

Currently children in Maine are eligible for the Medicaid program at different income levels depending on the children's ages. Children birth to 12 months of age are eligible with family incomes up to 185% of the federal poverty level. Children ages 1 through 5 years are eligible with family incomes up to 133% of the federal poverty level. Children ages 6 through 18 years are eligible with family incomes up to 125% of the federal poverty level. The federal poverty levels applicable in 1997-98 are as follows:

Federal Poverty Levels, 1997-98

Size of family	100%	125%	133%	150%	185%
1	$7,890	$9,863	$10,494	$11,835	$14,597
2	10,610	13,263	14,111	15,915	19,629
3	13,330	16,663	17,729	19,995	24,661
4	16,050	20,063	21,347	24,075	29,693
5	18,770	23,463	24,964	28,155	34,725
6	21,490	26,863	28,582	32,235	39,757
7	24,210	30,263	32,199	36,315	44,789
8	26,930	33,663	35,817	40,395	49,821

III. Federal Balanced Budget Act of 1997

The State Children's Health Insurance Program provisions of the Balanced Budget Act of 1997 were enacted to enable states to initiate and expand health insurance coverage for uninsured children. Funding under Title XXI of the Social Security Act is provided to states submitting approved Title XXI plans to the Department of Health and Human Services. The total amount of federal funding available to the states for federal fiscal year 1997-98 is $4,275,000,000. The share for the State of Maine for that federal fiscal year is $12,724,728. To qualify for this amount the state must submit an approvable plan by July 1, 1998. Federal funds for each fiscal year may be carried forward from the year in which they are allocated for 2 succeeding years. Federal funds not spent by a state within the year of the allocation or the following 2 years will be pooled and redivided among the states that spent their entire allocations for the year of the initial allocation.

The Balanced Budget Act of 1997 contains a number of options and requirements for the states. Title XXI funding may be used to expand Medicaid beyond the eligibility levels in effect on April 15, 1997. Under this option Medicaid rules would apply to children acquiring coverage under the Title XXI expansion. The funding may be used to create or expand a separate state children's health insurance program to run in conjunction with the Medicaid program, which is required to cover all children who are Medicaid eligible. Because Maine does not have a separate children's health insurance program, this would mean establishing such a program. The third option is for the state to use Title XXI funding to expand the Medicaid program and create a separate children's health insurance program.

State Children's Health Insurance Program federal funding is available to the states at an enhanced federal matching rate that is equal to the current federal matching rate plus 30% of the difference between the state's regular match rate and 100%, subject to a limit of 85%. For Maine the enhanced match rate will provide $3.20 in federal funds for each $1.00 in state funds spent. Title XXI funding at the enhanced match rate is capped at the maximum amount allocated to the state under the State Children's Health Insurance Program. Once the cap is reached federal matching funds are available at the regular Medicaid match rate for an expanded Medicaid program, which provides $1.90 for each $1.00 in state funds spent.

The Balanced Budget Act of 1997 requires states implementing a children's health insurance program to apply Medicaid rules if using a Medicaid expansion. If a non-Medicaid program is chosen, coverage must include benefits that are the same as a benchmark package calculated according to the law, an actuarial equivalent to the benchmark package or a package approved by the Department of Health and Human Services. Cost-sharing may be required only of families above 150% of the federal poverty level but not for well-baby and well-child care or immunizations. Above 150% of the federal poverty level premiums may not exceed 5% of annual family income.

States may adopt continuous eligibility for children in Medicaid and in a Title XXI separate state program. State Medicaid programs may adopt application procedures that provide for periods of up to 2 months of presumptive eligibility from the date of application.

IV. Insured and uninsured children in Maine

The Maine Department of Human Services contracted with the Institute for Health Policy at the Muskie School of Public Service, University of Southern Maine, to conduct a survey of children's health insurance coverage in Maine. The survey was subcontracted to and conducted by the research organization Mathematica Policy Research, Inc. of Princeton, New Jersey. It was sponsored by Blue Cross Blue Shield of Maine, the Maine Children's Alliance, the Maine Community Foundation and MaineHealth.

The preliminary report was a valuable resource for the Commission. It estimates the number of uninsured children in the state and their family income levels. From these estimates the commission estimated the number of children anticipated to enroll in a children's health insurance program at different family income levels. Applying a per child per year cost based on the experience of the state in the Medicaid program and Maine Health Program, the commission estimated program costs, considered the options presented to it and chose an eligibility level designed to maximize coverage for children, avoid the forfeiture of federal funding for state children's health insurance programs available to the state under the Balanced Budget Act of 1997 and maintain state spending within the program budget.

Between October 20 and November 30, 1997, Mathematica called 13,291 Maine households and completed interviews with 2,449 households with children. Preliminary findings of the survey are that 10.0% of Maine children lack health insurance, totaling 34,440

children. The income levels of these children, as shown in the following chart, are low. 10,366 of the 34,440 children without health insurance coverage live in families with incomes below 125% of the federal poverty level, making them eligible for the Medicaid program under current eligibility levels. Another 11,449 live in families with incomes between 125% and 185% of the federal poverty level, making some of them eligible for Medicaid currently and all of the reminder eligible for an expanded Medicaid program or the new Cub Care program. See **Appendix E** for a copy of the survey instrument and **Appendix F** for a copy of the preliminary report prepared by Beth Kilbreth, Senior Research Associate at the Institute for Health Policy at the Muskie School of Public Service.

Estimated Uninsured Children in Maine, 1997

Income levels, based on federal poverty levels	Percent uninsured	Number of children
Less than 125% fpl	12.7%	10,366
125% - 133% fpl	24.7%	2,871
133% - 185% fpl	21.3%	8,578
185% - 200% fpl	15.2%	2,264
200% - 250% fpl	8.3%	3,526
Above 250% fpl	2.3%	2,862
No income information	13.0%	3,974

In addition to the information on uninsured children, Mathematica obtained information about health insurance coverage for children in the state that was helpful to the commission. 63.2% of all Maine children have employer-sponsored health insurance coverage. An additional 5.8% have private insurance coverage. Medicaid provides coverage for 18.0%, while 2.7% more are covered by other government insurance.

V. Commission Recommendations

The commission makes the following recommendations to the Governor and the 118th Legislature. These recommendations are also listed in **Appendix G** and are contained in the proposed legislation included as **Appendix H**. A bill entitled "An Act to Implement the Recommendations of the Maine Commission on Children's Health Care" will be printed and considered by the Joint Standing Committee on Health and Human Services. The commission recommends that the State of Maine provide health insurance to children by doing the following:

- Submitting a plan to the Department of Health and Human Services that is a Title XXI combined expanded Medicaid program and a separate state children's health insurance program.

- Continuing to cover children ages birth through 12 months of age in families with incomes below 185% of the federal poverty level.

- Increasing the eligibility level for Medicaid for children to cover children 1 through 18 years of age in families with incomes below 150% of the federal poverty level.

- Establishing the Cub Care program to provide health insurance coverage to children 1 to 18 years of age in families with income from 150% to 185% of the federal poverty level. The income eligibility level will fluctuate depending on program expenditures, expanding upward if program expenditures are low in order to maximize the number of children covered and contracting downward if program expenditures are high in order to maintain expenses within the program budget.

- Allowing the purchase of Cub Care coverage for Cub Care enrollees and children on the Medicaid program whose family incomes rise above their program eligibility levels, at premium levels that cover the costs of providing coverage plus contributions for administrative costs.

- Granting continuous eligibility for 6-month enrollment periods in the Cub Care program.

- Imposing premiums, based on family income and the number of children covered, on all families in the Cub Care program.

- Spending up to 2% of program funds for outreach. After 6 months of operation if the program budget allows, spending an additional 3% on initiatives to increase access to health care, including the purchase of dental chairs for health clinics to improve access to dental services.

- Addressing crowd-out in the private insurance market through a number of provisions:
  (1) excluding children with group health coverage or who had employer-based coverage within the 3 months prior to application for which the employer paid at least 50% of premium cost, with exceptions for high cost coverage and when coverage is lost through change of employment, termination under COBRA or for a reason not in the control of the employee; and
  (2) charging premiums on a scale dependent on income for families above 150% of the federal poverty level.

- Adding at least one full-time position equivalent for health policy administration within the Bureau of Medical Services, adding 30 full-time positions within the Bureau of Family Independence, reauthorizing the Maine Commission on Children's Health Care for 1 year and requiring a quarterly determination by the Commissioner of Human Services of the fiscal status of the program and a report

to the commission and the Appropriations and Financial Affairs and Health and Human Services Committees.

APPENDIX A

AUTHORIZING LEGISLATION
PUBLIC LAW 1997
CHAPTER 560

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-SEVEN

H.P. 1357 - L.D. 1904

An Act to Discourage Smoking, Provide Tax Relief and Improve the Health of Maine Citizens

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 22 MRSA §1546 is enacted to read:

§1546. Tobacco Tax Relief Fund

1. Tobacco Tax Relief Fund established. The Tobacco Tax Relief Fund, referred to in this section as "the fund," is established as part of a program to address urgent tax relief needs of citizens of the State. Expenditures from the fund must be made as provided in this section.

2. Transfers to fund. Beginning November 1, 1997, the State Controller shall transfer to the fund money representing 37 mills per cigarette from the tax levied under Title 36, section 4365.

3. Payments from fund. After depositing funds under subsection 2, the State Controller shall make the following payments in the following order:

A. The State Controller shall transfer to the department for the Tobacco Prevention and Control Program established in section 272 funds sufficient for all allocations from the fund; and

B. No other funds may be expended without the recommendations of the joint standing committee of the Legislature having jurisdiction over tax matters and enacted by the full Legislature.

4. Nonlapsing fund. Any unexpended balance in the fund may not lapse, but must be carried forward to be used pursuant to subsection 3.

5. Transfer to General Fund. The State Controller shall transfer into the General Fund the revenues necessary to maintain the level of cigarette tax revenue at the level that was budgeted for the General Fund in fiscal years 1997-98 and 1998-99. Beginning in fiscal year 1999-2000, the State Controller shall transfer to the General Fund the revenues necessary to maintain the level of cigarette tax revenue in the previous year less 3%. The Treasurer of State shall annually review the recommendations of the Consensus Revenue Forecasting Committee to determine whether any change in the reduction rate is required and, if so, shall change the rate accordingly.

Sec. A-2. 36 MRSA §4365, as repealed and replaced by PL 1997, c. 458, §6, is amended by adding a new 2nd paragraph to read:

Beginning November 1, 1997, as a public health measure, the tax imposed under this section is 37 mills per cigarette. The tax imposed pursuant to this section is dedicated to the Tobacco Tax Relief Fund established in Title 22, section 1546.

Sec. A-3. 36 MRSA §4365-D is enacted to read:

§4365-D. Rate of tax beginning November 1, 1997

Beginning November 1, 1997, the following provisions apply to cigarettes held for resale on that date.

1. Stamped rate. Cigarettes stamped at the rate of 18.5 mills per cigarette and held for resale after October 31, 1997 are subject to tax at the rate of 37 mills per cigarette.

2. Liability. A person possessing cigarettes for resale is liable for the difference between the tax rate of 37 mills per cigarette and the tax rate of 18.5 mills per cigarette in effect before November 1, 1997. Stamps indicating payment of the tax imposed by this section must be affixed to all packages of cigarettes held for resale as of November 1, 1997, except that cigarettes held in vending machines as of that date do not require that stamp.

3. **Vending machines.** Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on November 1, 1997 and the tax imposed by this section must be reported on that basis. A credit against this inventory tax must be allowed for cigarettes stamped at the 37 mill rate placed in vending machines before November 1, 1997.

4. **Payment.** Payment of the tax imposed by this section must be made to the State Tax Assessor by February 1, 1998, accompanied by forms prescribed by the assessor and must be credited to the Tobacco Tax Relief Fund established in Title 22, section 1546.

Sec. A-4. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1997-98	1998-99
ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF		
Bureau of Taxation		
Positions - Legislative Count	(1.000)	(1.000)
Personal Services	$15,903	$32,904
All Other	38,920	53,440
Capital Expenditures	10,000	
Provides funds for one Revenue Agent position, effective January 1, 1998, one contract investigator and related administrative expenses to administer and enforce the cigarette tax laws.		
DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES TOTAL	$64,823	$86,344

Sec. A-5. Effective date. This Part takes effect October 1, 1997.

PART B

Sec. B-1. Maine Commission on Children's Health Care established. The Maine Commission on Children's Health Care, referred to in this Part as the "commission," is established.

Sec. B-2. Membership. The commission consists of 16 members as follows:

1. The following 2 commissioners:

A. The Commissioner of Human Services, or the commissioner's designee; and

B. The Commissioner of Professional and Financial Regulation, or the commissioner's designee;

2. Seven public members, 3 appointed by the Governor, 2 appointed by the President of the Senate and 2 appointed by the Speaker of the House of Representatives; and

3. Seven Legislators of whom 4 represent the majority party and 3 represent the minority party. Of the 7 Legislators, at least 2 may be members of the Joint Standing Committee on Health and Human Services, 2 may be members of the Joint Standing Committee on Banking and Insurance and 2 may be members of the Joint Standing Committee on Appropriations and Financial Affairs. The legislative members must be appointed jointly by the President of the Senate and the Speaker of the House of Representatives.

The chair of the commission must be selected jointly from among the members by the President of the Senate, the Speaker of the House of Representatives and the Governor.

Sec. B-3. Appointments. All appointments must be made no later than 15 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council upon making their appointments. When the appointment of all members is complete, the Executive Director of the Legislative Council shall call and convene the first meeting of the commission no later than October 10, 1997.

Sec. B-4. Duties. The commission shall assess the current health needs of the children of this State and develop a series of recommendations to maximize the fulfillment of those needs. The commission shall:

1. Assess the best and latest available data regarding children's health insurance in the State, including the number of children under 18 years of age who lack health insurance;

2. Examine the costs and benefits of Medicaid expansion with pending federal changes;

3. Examine the benefits and detriments of accepting a block grant that would expand children's health access; and

4. Examine the advantages and disadvantages of alternative health services and financing mechanisms of children's health services.

Sec. B-5. Staff assistance. The commission may request staffing and clerical assistance from the State Planning Office and the Legislative Council.

Sec. B-6. Compensation. Commission members who are Legislators are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses for each day's attendance at meetings of the commission. Other members of the commission are not entitled to compensation or reimbursement for expenses.

Sec. B-7. Report. The commission shall submit its recommendations, with any necessary implementing legislation, to the Governor and the Legislature by December 15, 1997. The Joint Standing Committee on Health and Human Services may report out legislation based on the report of the commission.

Sec. B-8. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1997-98
LEGISLATURE	
Maine Commission on Children's Health Care	
Personal Services	$1,540
All Other	1,900
Provides funds for the per diem and expenses of legislative members and miscellaneous costs, including printing of the Maine Commission on Children's Health Care.	

LEGISLATURE TOTAL	$3,440

PART C

Sec. C-1. Children's Health Reserve Account established. The Children's Health Reserve Account, referred to in this Part as the "account," is established as an Other Special Revenue account that may not lapse. The following funds must be transferred into the account.

1. Excess General Fund revenue; transfer of funds. Notwithstanding any other provision of law, the State Controller shall transfer an amount not to exceed $6,200,000 in excess of the base General Fund revenue estimates for fiscal year 1997-98 for inheritance and estate tax to the Children's Health Reserve Account as Other Special Revenue in the Department of Administrative and Financial Services no later than June 30, 1998. These funds may be transferred and made available by financial order, upon recommendation of the State Budget Officer and approval of the Governor, to be used for children's health services.

2. Abandoned Property Fund; transfer of funds. Notwithstanding any other provision of law, the State Controller is authorized to transfer $500,000 in fiscal year 1997-98 and $500,000 in fiscal year 1998-99 from the Abandoned Property Fund to the Children's Health Reserve Account as Other Special Revenue no later than June 30th of each fiscal year. These transfers are to be made after the Abandoned Property Fund transfers to the General Fund, as included in the last accepted revenue estimate for the 1998-1999 biennium, have been made.

3. Department of Human Services; transfer of funds. The Department of Human Services shall seek reimbursement of expenditures under Aid to Families with Dependent Children, Title IV-A of the Social Security Act in the amount of $800,000 in fiscal year 1997-98 to be credited to the Children's Health Reserve Account as Other Special Revenue no later than June 30, 1998.

Sec. C-2. Use of funds. Funds from the account must be used to match available state and federal funds for the purpose of meeting recommendations of the Maine Commission on Children's Health Care as enacted by the Legislature.

Sec. C-3. Additional funds. If the funds in the account are insufficient to meet the requirement of section 2 of this

Part, the Governor shall include in the Governor's recommendations to the Joint Standing Committee on Appropriations and Financial Affairs, in the budget submitted in the Second Regular Session of the 118th Legislature, any necessary additional funds to fulfill the recommendations of the Maine Commission on Children's Health Care.

PART D

Sec. D-1. 5 MRSA §12004-I, sub-§36-D is enacted to read:

36-D. Human Services	Tobacco Prevention and Control Advisory Council	Expenses/ Legislative Per Diem for Non-salaried Employee Members	22 MRSA §272

Sec. D-2. 22 MRSA c. 102 is enacted to read:

CHAPTER 102

TOBACCO TAX AND HEALTH PROTECTION

§271. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Bureau. "Bureau" means the Bureau of Health.

2. Advisory council. "Advisory council" means the Tobacco Prevention and Control Advisory Council.

3. Program. "Program" means the Tobacco Prevention and Control Program.

4. Tobacco products. "Tobacco products" means any form of tobacco and any material or device used in the smoking, chewing or other form of tobacco consumption, including cigarette papers and pipes.

§272. Tobacco Prevention and Control Program

1. Program established. The Tobacco Prevention and Control Program is established in the bureau. The purposes of the program are to prevent the State's youths from ever using tobacco

products and to assist youths and adults who currently smoke cigarettes and use other tobacco products to discontinue that use. The program includes the following components:

A. An ongoing, major media campaign to:

(1) Educate the public about the health hazards, costs and other relevant facts surrounding the use of tobacco products;

(2) Encourage young people not to begin using tobacco products;

(3) Motivate the users of tobacco products to discontinue smoking; and

(4) Encourage public acceptance of smoke-free environments;

B. Grants for funding community-based programs aimed at tobacco prevention and control, including funding of tobacco prevention and control education for those school administrative units that choose to offer such programs to primary, middle and high school students; for community-based enforcement of state tobacco control laws, including sales to minors and for cessation services;

C. Procedures for monitoring and evaluating the prevention and control program, including:

(1) Monitoring and maintaining the program's effectiveness through an evaluation of each component; and

(2) Assessing the prevalence of the use of tobacco products and knowledge about and attitudes towards such use on a statewide and community basis; and

D. In conjunction with law enforcement and other state and federal agencies, increased law enforcement efforts to increase compliance with laws regarding the transportation, distribution and sale of cigarettes and tobacco products.

The bureau shall administer the program with the review and advice provided by the council in subsection 2 and may contract for professional services to carry out the program.

2. Tobacco Prevention and Control Advisory Council. The Tobacco Prevention and Control Advisory Council is established

under Title 5, section 12004-I, subsection 36-D to review the program. The advisory council shall provide advice to the bureau in carrying out its duties under this section and ensure coordination of the program with relevant nonprofit and community agencies and the Department of Education, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Office of Substance Abuse and other relevant state agencies. The advisory council consists of 9 members, appointed as follows:

A. Two public health officials, appointed by the Governor;

B. Two representatives of nonprofit organizations involved in seeking to reduce the use of tobacco products in the State, with one representative appointed by the President of the Senate and one representative appointed by the Speaker of the House of Representatives;

C. A person who designs and implements issue-oriented public health media campaigns, appointed by the Governor;

D. Two persons involved in designing and implementing community-based education or cessation programs for the prevention of tobacco products use, one to focus on adults, appointed by the President of the Senate, and one to focus on youth, appointed by the Speaker of the House of Representatives; and

E. Two members of the public, appointed jointly by the President of the Senate and the Speaker of the House of Representatives in consultation with the leaders of the minority political party.

Appointments to the advisory council must be made by October 15, 1997. Members serve for 3-year terms and may be reappointed. When the appointment of all members is complete, the Governor or the Governor's designee shall convene the first meeting of the advisory council no later than November 15, 1997. The advisory council shall choose a chair from among its members and establish its procedure for reaching decisions. The bureau shall provide staff assistance to the advisory council. The advisory council shall report annually on the program to the Governor and the Legislature by December 1st and include any recommendations or proposed legislation to further the purposes of the program.

The appointing authority shall fill a vacancy on the advisory council for the remainder of the vacant term. Each member who is not a salaried employee is entitled to compensation as provided in Title 5, section 12004-I, subsection 36-D, following approval of expenses by the Director of the Bureau of Health.

Sec. D-3. Allocation. The following funds are allocated from Other Special Revenue to carry out the purposes of this Part.

	1997-98	1998-99
HUMAN SERVICES, DEPARTMENT OF		
Bureau of Health		
All Other	$3,500,000	$3,500,000
Provides funds from the Tobacco Tax Relief Fund to support the Tobacco Prevention and Control Program.		

PART E

Sec. E-1. Task Force on Improving Access to Prescription Drugs for the Elderly established. The Task Force on Improving Access to Prescription Drugs for the Elderly, referred to in this Part as the "task force," is established.

Sec. E-2. Membership. The task force consists of 9 members appointed as follows:

1. Three members, appointed by the President of the Senate;

2. Three members, appointed by the Speaker of the House of Representatives; and

3. Three members, appointed by the Governor.

The chair of the task force must be selected jointly from the members by the President of the Senate, the Speaker of the House of Representatives and the Governor.

Sec. E-3. Appointments. All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council upon making their appointments. When the appointment of all members is complete, the Executive Director of the Legislative Council shall call and convene the first meeting of the task force no later than October 10, 1997.

Sec. E-4. Duties. The task force shall determine and recommend methods on improving access to prescription drugs for the State's elderly citizens.

Sec. E-5. Staff assistance. The task force may request staffing and clerical assistance from the Legislative Council.

Sec. E-6. Compensation. Members of the task force who are Legislators are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses for each day's attendance at meetings of the task force. Other members of the task force are not entitled to compensation or reimbursement for expenses.

Sec. E-7. Report. The task force shall submit its recommendations, with any necessary implementing legislation, to the Governor and the Legislature by January 15, 1998. The Joint Standing Committee on Health and Human Services may report out legislation based on the report of the task force.

Sec. E-8. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1997-98
LEGISLATURE	
Task Force on Improving Access to Prescription Drugs for the Elderly	
Personal Services	$1,320
All Other	1,700
Provides funds for the per diem and expenses of legislative members and for miscellaneous costs, including printing of the Task Force on Improving Access to Prescription Drugs for the Elderly.	
LEGISLATURE TOTAL	$3,020

PART F

Sec. F-1. Health Care Fund for Maine Citizens established. The Health Care Fund for Maine Citizens, referred to in this Part

as the "fund," is established. Any unexpended balance in the fund may not lapse, but must be carried forward to be used pursuant to section 2 of this Part.

Sec. F-2. Tobacco suit award or settlement. Any award or settlement amount received by the State from a tobacco company pursuant to the action brought by the State against cigarette manufacturers or any other funds received as a result of any action involving the tobacco industry must be deposited into the Health Care Fund for Maine Citizens, an Other Special Revenue account that may not lapse. Notwithstanding any other provision of law to the contrary, the Attorney General's Office may recover the costs of bringing the action upon recommendation of the Legislature.

Sec. F-3. Contingent effective date. This Part does not take effect unless the State receives funds pursuant to section 2 of this Part.

APPENDIX B

MAINE COMMISSION ON CHILDREN'S HEALTH CARE MEMBERSHIP

MAINE COMMISSION ON CHILDREN'S HEALTH
Chapter 560, P.L. 1997, Part B

Membership

Appointments by the Governor:

Mr. Lee Urban, Esq.
75 Pearl Street, Suite 430
Portland, ME 04101

Mr. John Wipfler
93 Winding Way
Portland, ME 04102

Mr. David Howes, M.D.
287 Church Road
Brunswick, ME 04111

Joint Appointments by the President and Speaker

Senator Michael H. Michaud
111 Main Street
East Millinocket, ME 04430

Senator Susan W. Longley
RR1, Box 1108
Liberty, ME 04949

Senator S. Peter Mills
P.O. Box 9
Skowhegan, ME 04976

Representative J. Elizabeth Mitchell
28 Eastern Promenade #8
Portland, ME 04101

Representative Randall L. Berry
184 Robinson Road
Livermore, ME 04253

Representative Joseph Bruno
168 Egypt Road
Raymond, ME 04071

Representative Glenys Lovett
16 Cedarbrook Drive
Scarborough, ME 04074

Appointments by the Senate President

Mr. Neil Rolde
P.O. Box 304
York, ME 03909

Ms. Vicki Kelley
RR#4, Box 6225
Gardiner, ME 04345

Appointments by the Speaker of the House

Ms. Patricia Riley
National Academy for State Health Policy
50 Monument Square, Suite #502
Portland, ME 04101

Ms. Chris Hastedt
Maine Equal Justice Project
71 State Street
P.O. Box 5347
Augusta, ME 04332-5347

Ex Officio

Commissioner S. Catherine Longley
Department of Professional & Financial Regulation
35 State House Station
Augusta, ME 04333-0035

Commissioner Kevin W. Concannon
Department of Human Services
11 State House Station
Augusta, ME 04333-0011

Staff: Jane Orbeton, Office of Policy and Legal Analysis

APPENDIX C

PUBLIC LAW 105-33 (1997), THE BALANCED BUDGET ACT OF 1997, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, PART J

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

Subtitle J—State Children's Health Insurance Program

CHAPTER 1—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 4901. ESTABLISHMENT OF PROGRAM.

(a) ESTABLISHMENT.—The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

"SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.

"(a) PURPOSE.—The purpose of this title is to provide funds to States 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. Such assistance shall be provided primarily for obtaining health benefits coverage through—

"(1) obtaining coverage that meets the requirements of section 2103, or

"(2) providing benefits under the State's medicaid plan under title XIX,

or a combination of both.

"(b) STATE CHILD HEALTH PLAN REQUIRED.—A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that—

"(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

"(2) has been approved under section 2106.

"(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

"(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

"SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

"(a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

"(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

"(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

"(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

"(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

"(5) eligibility standards consistent with subsection (b);

"(6) outreach activities consistent with subsection (c); and

"(7) methods (including monitoring) used—

"(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and

"(B) to assure access to covered services, including emergency services.

"(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.—

"(1) ELIGIBILITY STANDARDS.—

"(A) IN GENERAL.—The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

"(B) LIMITATIONS ON ELIGIBILITY STANDARDS.—Such eligibility standards—

"(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

"(ii) may not deny eligibility based on a child having a preexisting medical condition.

"(2) METHODOLOGY.—The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

"(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS.—The plan shall include a description of procedures to be used to ensure—

"(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

"(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

"(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

"(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

"(E) coordination with other public and private programs providing creditable coverage for low-income children.

"(4) NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

"(c) OUTREACH AND COORDINATION.—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

"(1) OUTREACH.—Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

"(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS.—Coordination of the administration of the State program under this title with other public and private health insurance programs.

"SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.

"(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

"(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

"(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

"(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

"(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

"(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal

to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

"(3) EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

"(4) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

"(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

"(1) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

"(2) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

"(3) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

"(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

"(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

"(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—

"(1) CATEGORIES OF BASIC SERVICES.—For purposes of this section, the categories of basic services described in this paragraph are as follows:

"(A) Inpatient and outpatient hospital services.

"(B) Physicians' surgical and medical services.

"(C) Laboratory and x-ray services.

"(D) Well-baby and well-child care, including age-appropriate immunizations.

"(2) CATEGORIES OF ADDITIONAL SERVICES.—For purposes of this section, the categories of additional services described in this paragraph are as follows:

"(A) Coverage of prescription drugs.

"(B) Mental health services.

"(C) Vision services.

"(D) Hearing services.

"(3) TREATMENT OF OTHER CATEGORIES.—Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

"(4) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

"(A) by an individual who is a member of the American Academy of Actuaries;

"(B) using generally accepted actuarial principles and methodologies;

"(C) using a standardized set of utilization and price factors;

"(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

"(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

"(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

"(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

"(5) CONSTRUCTION ON PROHIBITED COVERAGE.—Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

"(d) DESCRIPTION OF EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—

"(1) IN GENERAL.—A program described in this paragraph is a child health coverage program that—

"(A) includes coverage of a range of benefits;

"(B) is administered or overseen by the State and receives funds from the State;

"(C) is offered in New York, Florida, or Pennsylvania; and

"(D) was offered as of the date of the enactment of this title.

"(2) MODIFICATIONS.—A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of—

"(A) the actuarial value of the coverage under the program as of the date of the enactment of this title, or

"(B) the actuarial value described in subsection (a)(2)(B),

evaluated as of the time of the modification.

"(e) COST-SHARING.—

"(1) DESCRIPTION; GENERAL CONDITIONS.—

"(A) DESCRIPTION.—A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance,

and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

"(B) PROTECTION FOR LOWER INCOME CHILDREN.—The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

"(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES.—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D).

"(3) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

"(A) CHILDREN IN FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

"(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

"(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

"(B) OTHER CHILDREN.—For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

"(4) RELATION TO MEDICAID REQUIREMENTS.—Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

"(f) APPLICATION OF CERTAIN REQUIREMENTS.—

"(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

"(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the

plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

"(2) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

"SEC. 2104. ALLOTMENTS.

"(a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

"(1) for fiscal year 1998, $4,275,000,000;
"(2) for fiscal year 1999, $4,275,000,000;
"(3) for fiscal year 2000, $4,275,000,000;
"(4) for fiscal year 2001, $4,275,000,000;
"(5) for fiscal year 2002, $3,150,000,000;
"(6) for fiscal year 2003, $3,150,000,000;
"(7) for fiscal year 2004, $3,150,000,000;
"(8) for fiscal year 2005, $4,050,000,000;
"(9) for fiscal year 2006, $4,050,000,000; and
"(10) for fiscal year 2007, $5,000,000,000.

"(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

"(1) IN GENERAL.—Subject to paragraph (4) and subsection (d), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

"(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

"(B) the sum of the products computed under subparagraph (A).

"(2) NUMBER OF CHILDREN.—

"(A) IN GENERAL.—The number of children described in this paragraph for a State for—

"(i) each of fiscal years 1998 through 2000 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year;

"(ii) fiscal year 2001 is equal to—

"(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

"(II) 25 percent of the number of low-income children in the State for the fiscal year; and

"(iii) each succeeding fiscal year is equal to—

"(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

"(II) 50 percent of the number of low-income children in the State for the fiscal year.

"(B) DETERMINATION OF NUMBER OF CHILDREN.—For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

"(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the 'State cost factor' for a State for a fiscal year equal to the sum of—

"(i) 0.15, and

"(ii) 0.85 multiplied by the ratio of—

"(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

"(II) the annual average wages per employee for the 50 States and the District of Columbia.

"(B) ANNUAL AVERAGE WAGES PER EMPLOYEE.—For purposes of subparagraph (A), the 'annual average wages per employee' for a State, or for all the States. for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

"(4) FLOOR FOR STATES.—Subject to paragraph (5), in no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than $2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below $2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

"(c) ALLOTMENTS TO TERRITORIES.—

"(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

"(2) PERCENTAGE.—The percentage specified in this paragraph for—

"(A) Puerto Rico is 91.6 percent,

"(B) Guam is 3.5 percent,

"(C) Virgin Islands is 2.6 percent,

"(D) American Samoa is 1.2 percent, and

"(E) the Northern Mariana Islands is 1.1 percent.

"(3) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

"(A) Puerto Rico.

"(B) Guam.

"(C) the Virgin Islands.

"(D) American Samoa.

"(E) the Northern Mariana Islands.

"(d) CERTAIN MEDICAID EXPENDITURES COUNTED AGAINST INDIVIDUAL STATE ALLOTMENTS.—The amount of the allotment otherwise provided to a State under subsection (b) or (c) for a fiscal year shall be reduced by the sum of—

"(1) the amount (if any) of the payments made to that State under section 1903(a) for calendar quarters during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1920A, and

"(2) the amount of payments under such section during such period that is attributable to the provision of medical assistance to a child for which payment is made under section 1903(a)(1) on the basis of an enhanced FMAP under section 1905(b).

"(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.

"(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS.—The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the amount of their allotments under this section.

"SEC. 2105. PAYMENTS TO STATES.

"(a) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104 (taking into account any adjustment under section 2104(d)), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter—

"(1) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103; and

"(2) only to the extent permitted consistent with subsection (c)—

"(A) for payment for other child health assistance for targeted low-income children;

"(B) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

"(C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

"(D) for other reasonable costs incurred by the State to administer the plan.

"(b) ENHANCED FMAP.—For purposes of subsection (a), the 'enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

"(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

"(1) GENERAL LIMITATIONS.—Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

"(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE.—

"(A) IN GENERAL.—Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a quarter in a fiscal year to the extent the total of such expenditures exceeds 10 percent of the sum of—

"(i) the total Federal payments made under subsection (a) for such quarter in the fiscal year, and

"(ii) the total Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 1905(u)(2) for such quarter.

"(B) WAIVER AUTHORIZED FOR COST-EFFECTIVE ALTERNATIVE.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(2) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

"(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;

"(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and

"(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

"(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE.—Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

"(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and

"(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

"(4) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

"(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST-SHARING.—For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

"(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

"(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

"(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

"(7) LIMITATION ON PAYMENT FOR ABORTIONS.—

"(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in

the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

"(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

"(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

"(d) MAINTENANCE OF EFFORT.—

"(1) IN MEDICAID ELIGIBILITY STANDARDS.—No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

"(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN.—

"(A) IN GENERAL.—The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which—

"(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

"(ii) the total of such expenditures in fiscal year 1996.

"(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES.—The term 'State children's health insurance expenditures' means the following:

"(i) The State share of expenditures under this title.

"(ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under section 1905(u).

"(iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described section 2103(d).

"(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

"SEC. 2106. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.

"(a) INITIAL PLAN.—

"(1) IN GENERAL.—As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

"(2) APPROVAL.—Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

"(A) shall be approved for purposes of this title, and

"(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

"(b) PLAN AMENDMENTS.—

"(1) IN GENERAL.—A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

"(2) APPROVAL.—Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)—

"(A) shall be approved for purposes of this title, and

"(B) shall be effective as provided in paragraph (3).

"(3) EFFECTIVE DATES FOR AMENDMENTS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

"(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—

"(i) NOTICE REQUIREMENT.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

"(ii) TIMELY TRANSMITTAL.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

"(C) OTHER AMENDMENTS.—Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

"(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

"(1) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

"(2) 90-DAY APPROVAL DEADLINES.—A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

"(3) CORRECTION.—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

"(d) PROGRAM OPERATION.—

"(1) IN GENERAL.—The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

"(2) VIOLATIONS.—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

"(e) CONTINUED APPROVAL.—An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

"SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

"(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

"(1) DESCRIPTION.—A State child health plan shall include a description of—

"(A) the strategic objectives,

"(B) the performance goals, and

"(C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

"(2) STRATEGIC OBJECTIVES.—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

"(3) PERFORMANCE GOALS.—Such plan shall specify one or more performance goals for each such strategic objective so identified.

"(4) PERFORMANCE MEASURES.—Such plan shall describe how performance under the plan will be—

"(A) measured through objective, independently verifiable means, and

"(B) compared against performance goals, in order to determine the State's performance under this title.

"(b) RECORDS, REPORTS, AUDITS, AND EVALUATION.—

"(1) DATA COLLECTION, RECORDS, AND REPORTS.—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

"(2) STATE ASSESSMENT AND STUDY.—A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

"(3) AUDITS.—A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

"(c) PROGRAM DEVELOPMENT PROCESS.—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

"(d) PROGRAM BUDGET.—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.

"(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

"(1) TITLE XIX PROVISIONS.—

"(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

"(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

"(C) Section 1903(w) (relating to limitations on provider taxes and donations).

"(2) TITLE XI PROVISIONS.—

"(A) Section 1115 (relating to waiver authority).

"(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

"(C) Section 1124 (relating to disclosure of ownership and related information).

"(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

"(E) Section 1128A (relating to civil monetary penalties).

"(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

"(G) Section 1132 (relating to periods within which claims must be filed).

"SEC. 2108. ANNUAL REPORTS; EVALUATIONS.

"(a) ANNUAL REPORT.—The State shall—

"(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

"(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

"(b) STATE EVALUATIONS.—

"(1) IN GENERAL.—By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

"(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

"(B) A description and analysis of the effectiveness of elements of the State plan, including—

"(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

"(ii) the quality of health coverage provided including the types of benefits provided,

"(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

"(iv) the service area of the State plan,

"(v) the time limits for coverage of a child under the State plan,

"(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

"(vii) the sources of non-Federal funding used in the State plan.

"(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

"(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

"(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

"(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

"(G) Recommendations for improving the program under this title.

"(H) Any other matters the State and the Secretary consider appropriate.

"(2) REPORT OF THE SECRETARY.—The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

"SEC. 2109. MISCELLANEOUS PROVISIONS.

"(a) RELATION TO OTHER LAWS.—

"(1) HIPAA.—Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

"(2) ERISA.—Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)).

"SEC. 2110. DEFINITIONS.

"(a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the

case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

"(1) Inpatient hospital services.

"(2) Outpatient hospital services.

"(3) Physician services.

"(4) Surgical services.

"(5) Clinic services (including health center services) and other ambulatory health care services.

"(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

"(7) Over-the-counter medications.

"(8) Laboratory and radiological services.

"(9) Prenatal care and prepregnancy family planning services and supplies.

"(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

"(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

"(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

"(13) Disposable medical supplies.

"(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

"(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

"(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

"(17) Dental services.

"(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

"(19) Outpatient substance abuse treatment services.

"(20) Case management services.

"(21) Care coordination services.

"(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

"(23) Hospice care.

"(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

"(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

"(B) performed under the general supervision or at the direction of a physician, or

"(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

"(25) Premiums for private health care insurance coverage.

"(26) Medical transportation.

"(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

"(28) Any other health care services or items specified by the Secretary and not excluded under this section.

"(b) TARGETED LOW-INCOME CHILD DEFINED.—For purposes of this title—

"(1) IN GENERAL.—Subject to paragraph (2), the term 'targeted low-income child' means a child—

"(A) who has been determined eligible by the State for child health assistance under the State plan;

"(B)(i) who is a low-income child, or

"(ii) is a child whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level; and

"(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

"(2) CHILDREN EXCLUDED.—Such term does not include—

"(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or

"(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

"(3) SPECIAL RULE.—A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

"(4) MEDICAID APPLICABLE INCOME LEVEL.—The term 'medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child.

"(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

"(1) CHILD.—The term 'child' means an individual under 19 years of age.

"(2) CREDITABLE HEALTH COVERAGE.—The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

"(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC.—The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in section 2191 of the Public Health Service Act.

"(4) LOW-INCOME.—The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

"(5) POVERTY LINE DEFINED.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"(6) PREEXISTING CONDITION EXCLUSION.—The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

"(7) STATE CHILD HEALTH PLAN; PLAN.—Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under section 2106.

"(8) UNCOVERED CHILD.—The term 'uncovered child' means a child that does not have creditable health coverage.".

(b) CONFORMING AMENDMENTS.—

(1) DEFINITION OF STATE.—Section 1101(a)(1) is amended—

(A) by striking "and XIX" and inserting "XIX, and XXI", and

(B) by striking "title XIX" and inserting "titles XIX and XXI".

(2) TREATMENT AS STATE HEALTH CARE PROGRAM.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(A) in paragraph (2), by striking "or" at the end;

(B) in paragraph (3), by striking the period and inserting ", or"; and

(C) by adding at the end the following:

"(4) a State child health plan approved under title XXI.".

CHAPTER 2—EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID

SEC. 4911. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.

(a) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME CHILDREN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4702(a)(2), is amended—

(1) in subsection (b), by adding at the end the following new sentence: "Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures

described in subsection (u)(2)(A) or subsection (u)(3) the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b)."; and

(2) by adding at the end the following new subsection:

"(u)(1) The conditions described in this paragraph for a State plan are as follows:

"(A) The State is complying with the requirement of section 2105(d)(1).

"(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out paragraph (2) and section 2104(d).

"(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year.

"(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year.

"(C) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 2110(b)(1) who would not qualify for medical assistance under the State plan under this title based on such plan as in effect on April 15, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(2)(D)).

"(3) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of April 15, 1997.".

(b) ESTABLISHMENT OF OPTIONAL ELIGIBILITY CATEGORY.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 4733, is amended—

(1) in subclause (XII), by striking "or" at the end;

(2) in subclause (XIII), by adding "or" at the end; and

(3) by adding at the end the following:

"(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

SEC. 4912. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

"PRESUMPTIVE ELIGIBILITY FOR CHILDREN

"SEC. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

"(b) For purposes of this section:

"(1) The term 'child' means an individual under 19 years of age.

"(2) The term 'presumptive eligibility period' means, with respect to a child, the period that—

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

"(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

"(3)(A) Subject to subparagraph (B), the term 'qualified entity' means any entity that—

"(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) or (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9821 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

"(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

"(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

"(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

"(c)(1) The State agency shall provide qualified entities with—

"(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

"(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

"(2) A qualified entity that determines under subsection (b)(1)(A) that a child is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

"(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

"(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

"(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that—

"(1) are furnished to a child—

"(A) during a presumptive eligibility period,

"(B) by a entity that is eligible for payments under the State plan; and

"(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: "and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section".

(2) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended by inserting before the period at the end the following: "or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4913. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting "(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section" after "title XVI".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

APPENDIX D

PUBLIC LAW 105-100 (1997), AMENDING THE BALANCED BUDGET ACT OF 1997

H.R. 2607 - Public Law 105-100
Signed 11/19/97 by President

One Hundred Fifth Congress of the United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the seventh day of January, one thousand nine hundred and ninety-seven

An Act

Making appropriations for the government of the District of Columbia and other activities chargeable in whole or in part against the revenues of said District for the fiscal year ending September 30, 1998, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the District of Columbia for the fiscal year ending September 30, 1998, and for other purposes, namely:

TITLE I—FISCAL YEAR 1998 APPROPRIATIONS

FEDERAL FUNDS

FEDERAL PAYMENT FOR MANAGEMENT REFORM

For payment to the District of Columbia, as authorized by section 11103(c) of the National Capital Revitalization and Self-Government Improvement Act of 1997, Public Law 105–33, $8,000,000, to remain available until September 30, 1999, which shall be deposited into an escrow account of the District of Columbia Financial Responsibility and Management Assistance Authority and shall be disbursed from such escrow account pursuant to the instructions of the Authority only for a program of management reform pursuant to sections 11101–11106 of the District of Columbia Management Reform Act of 1997, Public Law 105–33.

FEDERAL CONTRIBUTION TO THE OPERATIONS OF THE NATION'S CAPITAL

For a Federal contribution to the District of Columbia toward the costs of the operation of the government of the District of Columbia, $190,000,000, which shall be deposited into an escrow account held by the District of Columbia Financial Responsibility and Management Assistance Authority, which shall allocate the funds to the Mayor at such intervals and in accordance with such terms and conditions as it considers appropriate to implement the financial plan for the year: *Provided*, That these funds may be used by the District of Columbia for the costs of advances to the District government as authorized by section 11402 of the National Capital Revitalization and Self-Government Improvement Act of 1997, Public Law 105–33: *Provided further*, That not less than $30,000,000 shall be used by the District of Columbia to repay the accumulated general fund deficit.

Effective October 1, 1997, the Balanced Budget Act of 1997 (Public Law 105–33) is amended by striking section 11715.

SEC. 158. Notwithstanding any provision of any federally granted charter or any other provision of law, the real property of the National Education Association located in the District of Columbia shall be subject to taxation by the District of Columbia in the same manner as any similar organization.

SEC. 159. (a) Section 501(c)(4) of the District of Columbia Police and Firemen's Act of 1958 (D.C. Code, sec. 4–416(c)(4)) is amended by striking "locality pay" and inserting "longevity pay".

(b) The amendment made by subsection (a) is effective on the date of enactment of Public Law 105–61.

SEC. 160. In addition to amounts appropriated or otherwise made available, $3,000,000 is appropriated for the purpose of funding a Medicare Coordinated Care Demonstration Project in the District of Columbia as specified in section 4016(b)(2)(C) of the Balanced Budget Act of 1997.

SEC. 161. Nothing in this Act shall be construed to authorize any office, agency or entity to expend funds for programs or functions for which a reorganization plan is required but has not been approved by the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this section referred to as "Authority"). Appropriations made by this Act for such programs or functions are conditioned only on the approval by the Authority of the required reorganization plans.

SEC. 162. Effective as if included in the enactment of subtitle J of title IV of the Balanced Budget Act of 1997 (Public Law 105–33) the Social Security Act is amended as follows:

(1) The fourth sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by inserting "for the State for a fiscal year, and that do not exceed the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year," after "subsection (u)(3)".

(2) Section 1905(u) of such Act (42 U.S.C. 1396d(u)) is amended—

(A) in paragraph (1)(B), by striking "paragraph (2)" and inserting "the fourth sentence of subsection (b)";

(B) in paragraph (2)(A), by striking "(C), but not in excess" and all that follows up to the period at the end and inserting "(B)";

(C) by striking subparagraphs (B) and (C) of paragraph (2) and inserting the following:

"(B) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)).";

(D) in paragraph (3)—

(i) by striking "described in this subparagraph" and inserting "described in this paragraph"; and

(ii) by striking "April 15, 1997" and inserting "March 31, 1997"; and

(E) by adding at the end the following:

"(4) The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).".

(3) Section 2110(b) of such Act (42 U.S.C. 1397jj(b)) is amended—

(A) in paragraph (1)(B)(ii) to read as follows:

"(ii) is a child—

"(I) whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level;

"(II) whose family income (as so determined) does not exceed the medicaid applicable income level (as defined in paragraph (4) but determined as if 'June 1, 1997' were substituted for 'March 31, 1997'); or

"(III) who resides in a State that does not have a medicaid applicable income level (as defined in paragraph (4)); and"; and

(B) in paragraph (4)—

(i) by striking "June 1, 1997" and inserting "March 31, 1997"; and

(ii) by inserting "or 1905(n)(2) (as selected by a State)" after "1902(l)(2)".

(4) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by striking "or 1905(p)(1)" and inserting "1905(p)(1), or 1905(u)".

(5) Section 2105(c)(2)(A) of such Act (42 U.S.C. 1397ee(c)(2)(A)) is amended to read as follows—

"(A) IN GENERAL.—Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a fiscal year to the extent the total of such expenditures (for which payment is made under such subsection) exceeds 10 percent of the sum of—

"(i) the total of such expenditures for such fiscal year, and

"(ii) the total expenditures for medical assistance by the State under title XIX for which Federal payments made under section 1903(a)(1) are based on an enhanced FMAP described in section 2105(b) for such fiscal year.".

(6) Section 2104 of such Act (42 U.S.C. 1397dd) is amended—

(A) in subsection (d)(1), by striking "for calendar quarters" and inserting "for expenditures claimed by the State"; and

(B) by striking subsection (d)(2) and inserting the following:

"(2) the amount (if any) of the payments made to that State under section 1903(a) for expenditures claimed by the State during such fiscal year that is attributable to the provision of medical assistance to a child for which payment is

made under section 1903(a)(1) on the basis of an enhanced FMAP under the fourth sentence of section 1905(b).".

(7) Section 2105 of such Act (42 U.S.C. 1397ee) is amended by adding at the end the following:

"(f) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this section or subsections (e) and (f) of section 2104 shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.".

(8) Section 2104 of such Act (42 U.S.C. 1397dd) is amended—

(A) in subsection (a)(1), by striking "$4,275,000,000" and inserting "$4,295,000,000";

(B) in subsection (b)(4), by striking "Subject to paragraph (5), in" and inserting "In"; and

(C) in subsection (c)—

(i) in paragraph (2)(C), by inserting "the" before "Virgin Islands", and

(ii) in paragraphs (3)(C) and (3)(E), by striking "the" and inserting "The".

(9) Section 2110(c)(3) of such Act (42 U.S.C. 1397jj(c)(3)) is amended by striking "2191" and inserting "2791".

SEC. 163. The Administrator of General Services is authorized to amend the use restriction contained in the Administrator's 1956 conveyance of land to the City of Bonham, Texas, mandated by Public Law 586 of the 84th Congress. The amended use restriction will limit the property to State veterans, nursing homes and public safety communications purposes only.

SEC. 164. Notwithstanding any other provision of law, rule, or regulation, the evaluation process and instruments for evaluating District of Columbia public schools employees shall be a non-negotiable item for collective bargaining purposes.

SEC. 165. There are appropriated from such funds of the District of Columbia, as are deemed appropriate by the District of Columbia Financial Responsibility and Management Assistance Authority, $2,600,000, for the Fire and Emergency Medical Services Department for a 5 percent pay increase for uniformed firefighters.

SEC. 166. Notwithstanding any other provision of Federal or District of Columbia law applicable to a reemployed annuitant's entitlement to retirement or pension benefits, the Director of the Office of Personnel Management may waive the provisions of section 8344 of title 5 of the United States Code for any reemployed annuitants appointed heretofore or hereafter as a Trustee under section 11202 or 11232 of the National Capital Revitalization and Self-Government Improvement Act of 1997, or, at the request of such a Trustee, for any employee of such Trustee.

SEC. 167. Section 2203(i)(2)(A) of the District of Columbia School Reform Act of 1995 (Public Law 104–134; 110 Stat. 3009–504; D.C. Code 31–2853.13(i)(2)(A)) is amended to read as follows:

"(A) IN GENERAL.—

"(i) ANNUAL LIMIT.—Subject to subparagraph (B) and clause (ii), during calendar year 1997, and during each subsequent calendar year, each eligible chartering authority shall not approve more than 10 petitions to establish a public charter school under this subtitle.

"(ii) TIMETABLE.—Any petition approved under clause (i) shall be approved during an application approval period that terminates on April 1 of each year. Such an approval

APPENDIX E

MAINE CHILDREN'S HEALTH INSURANCE SURVEY INSTRUMENT

MAINE HEALTH INSURANCE SURVEY

INTRODUCTION.

Appendix E

>a0< Hello, my name is _____. I'm calling on behalf of Maine's Department of Human Services to find out about children's health care services and coverage. This is a survey being done to help the Department of Human Services and the state legislature plan health programs for children.

First, does anyone under the age of 19 live in your household now?

PROBE FOR HOUSEHOLD DEFINITION: We consider household members to be people who think of the household as their primary residence, that is, where they keep their belongings or receive their calls.

<1> YES [goto a0b]
<0> NO

===>

>a0a< **Is any member of your household a full-time high school or college student? Only include household members less than 24 years old.**

PROBE FOR COLLEGE STUDENTS: Please include household members less than 24 years old who are away at college, regardless of whether they live in a dorm or off-campus apartment.

<1> YES [goto a0b]
<0> NO

>clos< Those are all the questions I have. Thank you for your time.

[goto end]

>a0b< This information is needed to plan how to make health care in Maine more affordable and easier for children to obtain. We need only a few minutes of your time. We are not trying to sell anything or ask for money. Because this survey concerns health issues, I'd like to speak with a **parent or guardian** who is familiar with the health insurance coverage of the people who live in your household. Would you be that person?

PROBE IF NO: May I speak to that person?

IF MORE NEEDED: We are doing this study because so much has changed in recent years. Many people are concerned that they can't afford health insurance for their children, or that they might lose coverage, and that they won't be able to get the care their families need. Our goal is to get accurate information on children's health care needs. [You may be interested to know that SPONSOR of SPONSORING AGENCY urges residents of Maine to take part in this survey.]

<g> CONTINUE [PUT CODES ON NEXT PAGE]

===>

SCREEN FOR RESPONSE CODES [USE TRADITIONAL CODES]

>ai< ADDITIONAL QUESTIONS SCREEN

HOW LONG WILL THE INTERVIEW TAKE: For most people, the interview only takes a few minutes. (For others, it may take longer. Why don't we get started.)

HOW WAS MY HOUSEHOLD SELECTED: Your telephone number was randomly generated by a computer program. Your interview will count for a lot because your household represents many others in your community. [IF NEEDED]: For our results to be valid and useful, it is very important that we interview the people we select.

IS THE INFORMATION CONFIDENTIAL: All of the information you provide will be kept confidential. Your name will not be associated with the answers. Your answers will be combined with those of others and will be used to help evaluate Maine's health insurance system.

WHO IS SPONSORING THE STUDY: The study is being sponsored by a group of public and private organizations that are interested in trying to meet the needs of Maine's children. The group includes Maine's Bureau of Medical Services, Maine's Children's Alliance, and Blue Cross and Blue Shield of Maine.

CONTACT: If you would like to find out more about our study, you can call SPONSOR (1-800-___-____) at the SPONSORING AGENCY.

LETTER: I can read you a letter from SPONSOR, SPONSORING AGENCY, or I can send you copy. [INTERVIEWER: RECORD ADDRESS AND GIVE TO SUPERVISOR IMMEDIATELY.]

WHO ARE YOU: I work for Mathematica; we are part of the research team assembled by Maine's Department of Human Services.

HOUSEHOLD COMPOSITION

>thh< How many people are living or staying in your household now? Please include yourself.

PROBE FOR COLLEGE STUDENTS: Please include household members **less than** 24 years old who are away at college, regardless of whether they live in a dorm or off-campus apartment.

PROBE FOR HOUSEHOLD DEFINITION: We consider household members to be people who think of the household as their primary residence, that is, where they keep their belongings or receive their calls.

<1-25>

<98> DON'T KNOW
<99> REFUSED

===>

>hhld< What are the first names of the people who are living or staying here. Begin with one of the people who owns or rents this home, and then other people in the household. Be sure to include yourself.

PROBE: IF R. **IS RELUCTANT TO GIVE FIRST NAMES**: WE ARE ASKING FOR FIRST NAMES BECAUSE THE SURVEY INCLUDES QUESTIONS ABOUT THE HEALTH CARE OF FAMILY MEMBERS. IF YOU'D RATHER NOT GIVE NAMES, WE CAN USE RELATIONSHIPS OR SOME OTHER WAY TO TELL FAMILY MEMBERS APART.

INTERVIEWER: **IF MORE THAN 8 PEOPLE LIVE IN HOUSEHOLD**: LIST ALL ADULTS FIRST AND THEN CHILDREN.

INELIGIBLE RESIDENCES: IF VACATION RESIDENCE, THAT IS NOT USUAL RESIDENCE, INSTITUTION (SEE MANUAL), OR OTHER GROUP QUARTERS (10 OR MORE UNRELATED PERSONS LIVING TOGETHER), SKIP TO CALLBACK (:SKCB) AND CODE AS INELIGIBLE.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]

===>

>more< Have I missed any babies or small children, anyone who usually lives here but is away at present traveling, in school, or in a hospital, or any foster children, lodgers, boarders, and roommates?

IF YES: What are their first names?
IF NO: CODE "n"

PROBE IF R ASKS ABOUT STUDENTS: Include household members **less than** 24 years old who are away at college, regardless of whether they live in a dorm or off-campus apartment.

ENTER ADDITIONAL PERSONS, WITH A MAXIMUM OF 8 PER HOUSEHOLD

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NO OTHER HOUSEHOLD MEMBERS
<x> DELETE A HOUSEHOLD MEMBER

===>

>age1< Beginning with [fill you/HOUSEHOLDER'S NAME], what is (his/her/your) age?

INTERVIEWER: (1) IF R. IS UNCERTAIN, PROBE FOR BEST ESTIMATE.
(2) **REMEMBER THAT THIS IS THE HOUSEHOLDER.**

PROBE IF R IS RELUCTANT: This information is used to understand differences in health care for people in different age groups.

<16-96>

===>

>sex1< . . . and sex?

INTERVIEWER: CODE WITHOUT ASKING IF KNOWN

<1> MALE
<2> FEMALE

===>

test: [If age1 ge 13 and le 23, goto col1; else goto age2]

>col1< (Is/Are) [fill you/HOUSEHOLDER'S NAME] a full-time high school or college student?

PROBE IF YES: (Is/Are) [fill you/NAME] in high school or college?

PROBE: The definition of a full-time student should be based on [fill your/NAME]'s school.

<1> YES, HIGH SCHOOL STUDENT
<2> YES, COLLEGE STUDENT
<0> NO/NEITHER/PART-TIME

<8> DON'T KNOW
<9> REFUSED

===>

>age2< What is [fill SECOND PERSON'S NAME] age?

INTERVIEWER: (1) CODE "0" IF LESS THAN ONE YEAR.
(2) IF R. IS UNCERTAIN PROBE FOR BEST ESTIMATE. KEY AGE BREAKS ARE 18 AND 65. PLEASE TRY TO GET THE RESPONDENT TO ESTIMATE AROUND THESE BREAKS.

PROBE IF R. IS RELUCTANT: This information is needed only to understand differences in health care for people in different age groups.

<0-96>

===>

>sex2< . . . and sex?

INTERVIEWER: CODE WITHOUT ASKING IF KNOWN

<1> MALE
<2> FEMALE

===>

test: [if age2 ge 13 and le 23, goto col2; else goto rel1]

>col2< (Is/Are) [fill you/NAME] a full-time high school or college student?

PROBE IF YES: (Is/Are) [fill you/NAME] in high school or college?

PROBE: The definition of a full-time student should be based on [fill your/NAME]'s school.

<1> YES, HIGH SCHOOL STUDENT
<2> YES, COLLEGE STUDENT
<0> NO/NEITHER/PART-TIME

<8> DON'T KNOW
<9> REFUSED

===>

>rel1< What is [fill your/NAME]'s relationship to [fill HOUSEHOLDER]?

<1> HUSBAND
<2> WIFE
<3> OWN CHILD
<13> ADOPTED CHILD
<4> STEPCHILD
<5> GRANDCHILD
<6> PARENT
<7> BROTHER/SISTER
<8> SON/DAUGHTER-IN-LAW
<9> MOTHER/FATHER-IN-LAW
<10> OTHER RELATIVE
<11> FOSTER CHILD
<12> NON RELATIVE/UNMARRIED PARTNER

===>

Repeat age2-rel1 for each person.

test: [if any person is ge 16 and relationship to householder is <8>, <9>, <10> or <12> and at least one person, other than householder or spouse, is ge 16 and different sex from (this/these) persons; goto mar1; else goto test after sps1.]

>mar1< (Is/Are) [fill you/NAME] married to anyone who currently lives here?

INTERVIEWER: CODE "NO" FOR COHABITEE

<1> YES
<0> NO [goto next person or next test]

<8> DON'T KNOW
<9> REFUSED

===>

>sps1< To whom (Is/Are) [fill you/NAME] married?

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]

===>

tests: (1) Verify that spouses are opposite sexes and at least 16 years of age.

(2) Repeat for each person ge 16 and relationship to householder is <8>, <9>, <10> or <12>.

(3) If any person lt 18 and relationship to householder is not equal to <3>, <4>, <11>, or <13> then goto par1; else goto family formation.

===>

>par1< Is anyone who lives here the parent or guardian of [fill NAME]?

<1> YES
<0> NO [goto next child or next test]

===>

>who1< Who is [fill NAME]'s parent or guardian?

CODE ONLY ONE

INTERVIEWER: If child has two parents/guardians code mother or female guardian.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]

===>

Repeat for others meeting test before par1.

Form insurance units using the following rules:

(1) If no one in the household other than the householder and spouse and their own adopted or stepchildren under age 18, this consists of one unit.

(2) Assign persons whose relationship to householder is parent, and any children linked to them, to a separate family.

(3) Assign persons whose relationship to householder is mother/father-in-law, and any children linked to them, to a separate family.

(4) Assign additional married persons, and any children linked to them, to a separate family.

(5) If any remaining (unmarried) person's relationship to householder is child or step-child, he or she is 18 to 23, and a full time student , assign that person, and any children linked to that person, to householder's family.

(6) Assign any remaining, unmarried persons 18 and older who are not full time students (and any children linked to them) to separate family units.

(7) If householder or householder's spouse is under 18 and not a student, then he or she and his or her spouse and/or children are eligible. The householder and spouse (if under 18) should be treated as adult(s) during the interview.

(8) Exclude a person as ineligible if:

(1) Person is unmarried full-time student, 16-23 years of age, and is not a child of household member.

(2) Person is under 18, not a householder, relationship to householder is not equal to spouse or child, and no one in household is parent or guardian.

>b1< Now, I will list several types of health insurance or health coverage obtained through jobs, purchased directly, or from government programs. For each one, please tell me if (you/either of you/any of you) are currently covered by that type of plan.

TYPE <g> TO CONTINUE

===>

>b1a< (Are you/either of you/any of you) covered by a health insurance plan from (your/any of your/either of your) current or past employers or unions?

IF YES: Who is covered?

INTERVIEWER: INCLUDE MEDIGAP COVERAGE AS OBTAINED THROUGH AN EMPLOYER OR FORMER EMPLOYER HERE. DO NOT INCLUDE MILITARY COVERAGE.

PROBES: (1) Include insurance plans purchased through a professional association or trade group.

(2) Do not include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as dental care, vision care, nursing home care, or accidents.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>b1b< (Are you/either of you/any of you) covered by a health insurance plan bought on your own and not through an employer or union?

IF YES: Who is covered?

INTERVIEWER: INCLUDE MEDIGAP COVERAGE IF PURCHASED INDIVIDUALLY. DO NOT INCLUDE MILITARY COVERAGE.

PROBES: (1) Include health insurance plans provided by colleges and universities to students.

(2) Do not include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as dental care, vision care, nursing home care or accident.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>b1c< (Are you/either of you/any of you) covered by a health insurance plan held in the name of someone who does not live in this household?

IF YES: Who is covered?

INTERVIEWER: INCLUDE MEDIGAP COVERAGE IF IT IS HELD IN THE NAME OF SOMEONE OUTSIDE THE HOUSEHOLD. DO NOT INCLUDE MILITARY COVERAGE.

PROBE: Do not include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as dental care, vision care, nursing home care or accidents.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>b1d< (Are you/any of you/either of you) covered by Medicare, the health insurance plan for people 65 years old and older or persons with certain disabilities?

IF YES: Who is covered?

INTERVIEWER: INCLUDE IF COVERED BY PART A OR PART B.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>test b1d<
[IF PERSON IS GE 65 AND NOT COVERED BY MEDICARE GOTO b1d1; ELSE GOTO b1e]

>b1d1< IF PERSON AT LEAST AGE 65 AND **NOT** COVERED BY MEDICARE ASK: I noted that [fill NAME] is [fill AGE], but is not covered by Medicare. Is that correct or did I make a mistake?

<1> YES
<0> NO, ADD TO MEDICARE
<3> NO, NEED TO CORRECT AGE

===>

>ble< **(Are you/Any of you/Either of you) covered by Medicaid, NYLCare Choice, or PrimeCare?**

IF YES: Who is covered?

PROBES: (1) Medicaid is a government assistance program for people in need.

(2) NYLCare Choice is an HMO offered through Maine's Medicaid program.

(3) PrimeCare is a managed care health plan offered through Maine's Medicaid program.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

test be1 [IF ANY HOUSEHOLD MEMBER IS COVERED BY MEDICAID, NYLCARE CHOICE, or PRIMECARE goto be1; ELSE goto b1f]

>be1< (Is/Are) (READ NAMES WITH *) covered by Medicaid, NYLCare Choice, or PrimeCare also receiving benefits from SSI, a program for the blind and disabled.

IF YES: Who is receiving SSI?

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>b1f< (Are you/any of you/either of you) covered by CHAMPUS, CHAMP-VA, TRICARE, VA, or some other military health care?

IF YES: Who is covered?

INTERVIEWER: CHAMPUS, CHAMP-VA, TRICARE AND VA ARE HEALTH CARE PLANS AVAILABLE TO ACTIVE DUTY MILITARY PERSONNEL AND THEIR DEPENDENTS.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>b1g< (Are you/Any of you/Either of you) covered by the Indian Health Service?

IF YES: Who is covered?

INTERVIEWER: The Indian Health Service provides health insurance coverage for Native Americans in tribal settings.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>b1i1< (Are you/Any of you/Either of you), covered by a state-sponsored or public program that I have not mentioned?

IF YES: What is the name of the program?

INTERVIEWER: OBTAIN COMPLETE PLAN NAME.

<1> YES (TO ENTER PLAN NAME) [specify] END WITH ///
<0> NO [goto test b1j]

<8> DON'T KNOW [goto test b1j]
<9> REFUSED [goto test b1j]

===>

>bli2< Who is covered by [fill NAME SPECIFIED]?

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

test blj
[IF A HOUSEHOLD MEMBER WAS NOT COVERED UNDER SOME PLAN, goto blj;
ELSE goto nbl]

>blj< INTERVIEWER READ FOR FIRST PERSON ONLY: (According to the information we have, [fill you/NAME] (do/does) not have health care coverage of any kind.) (Do/Does) [fill you/NAME] have health insurance or coverage through a plan I might have missed?

INTERVIEWER: REVIEW PLANS IF INFORMANT IS UNSURE.

<0> NO/NOT COVERED BY ANY PLAN
<1> HEALTH INSURANCE PLAN FROM A CURRENT OR PAST EMPLOYER/UNION/SCHOOL
<2> A HEALTH INSURANCE PLAN BOUGHT ON HIS/HER OWN/PROF. ASS.
<3> A PLAN BOUGHT BY SOMEONE WHO DOES NOT LIVE IN THIS HOUSEHOLD
<4> MEDICARE
<5> MEDICAID, NYLCARE CHOICE, OR PRIMECARE
<6> CHAMPUS/CHAMP-VA, TRICARE, VA, OTHER MILITARY
<7> INDIAN HEALTH SERVICE

<10> OTHER PLAN [fill STATE PLAN]

<98> DON'T KNOW
<99> REFUSED

===> [goto NEXT UNINSURED PERSON OR GOTO nb1]

>nb1< **(Are you/Any of you/Either of you) covered by a dental insurance plan?**

IF YES: Who is covered?

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES [goto test b1k]
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW [goto test b1k]
<99> REFUSED [goto test b1k]

===>

>nb2< **Is [fill your/NAME's] dental plan through an employer, purchased privately, or through Medicaid, NYLCare Choice or PrimeCare, or some other program?**

<1> THROUGH AN EMPLOYER
<2> PURCHASED ON OWN
<3> MEDICAID, NYLCARE CHOICE, OR PRIMCARE
<4> OTHER [SPECIFY]
<8> DON'T KNOW [goto test b1k]
<9> REFUSED [goto test b1k]

===>

test b1k

[PROGRAM WILL DISPLAY A TABLE SHOWING TYPES OF PLANS AND PERSONS ASSIGNED TO THEM. FOR ALL INSURANCE UNITS, INTERVIEWER WILL VERIFY WITH INFORMANT TO REDUCE ERROR AND CORRECTIONS IN SUBSEQUENT QUESTIONS.]

>test< [if ge 19 (or parent/guardian or spouse of parent/guardian), goto i2; else goto itro]

>i2< Did [fill you/NAME] work at a paid job last week?

INTERVIEWER: IF ON VACATION, SICK, OR TEMPORARILY ABSENT LAST WEEK, CODE "0".

<1> YES [goto k6]
<0> NO

<8> DON'T KNOW
<9> REFUSED

===> [goto i3]

>i3< Did [fill you/NAME] have a job or business from which (you/he/she) (was/were) temporarily absent or on layoff last week?

INTERVIEWER: If on vacation or sick, code "1".

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===>

>k6< (Is/Are) [fill you/NAME] of Spanish or Hispanic origin or descent?

PROBE FOR REFUSALS: I understand that these questions may be sensitive. We are asking these questions to help understand differences in health care problems and needs.

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===>

>k7< What race (do/does) [fill you/NAME] consider (himself/herself/yourself) to be?

PROBE FOR REFUSALS: I understand that these questions may be sensitive. We are asking these questions to help understand differences in health care problems and needs.

INTERVIEWER: (1) READ CATEGORIES IF NECESSARY.
(2) CODE RESPONDENT OFFERED CATEGORIES IN "OTHER".
(3) CODE BI-RACIAL/MULTI-RACIAL IN "OTHER".

<1> WHITE
<2> AFRICAN-AMERICAN OR BLACK
<3> NATIVE AMERICAN (AMERICAN INDIAN)
<4> ALASKA NATIVE
<5> ASIAN OR PACIFIC ISLANDER
<6> OTHER (SPECIFY AND END WITH ///) [specify]

<8> DON'T KNOW
<9> REFUSED

===>

INCOME: ASK FOR ALL INSURANCE UNITS IN HOUSEHOLD

>Itro< **The next questions are about income in 1997 for [fill NUMBER OF INSURANCE UNITS] different groups of people who live here. I would like to ask you about income that (READ NAMES WITH * IN FRONT) will receive during 1997. To do this, I will ask you about ranges of income so you won't have to reveal your exact income.**

>inc1< Will (READ NAMES WITH * FRONT) 1997 estimated income before taxes be more than [fill 200% POVERTY]?

PROBES:

(1) We are asking these questions to find out whether people can afford the health care they need.

(2) Total income includes wages and salaries from jobs, net income from farms or businesses, interest or dividends, pensions or social security, income from rental property, estates, or trusts, public assistance or welfare, child support, and other sources. Include the amount before taxes and other deductions.

(3) Your best estimate would be fine. If respondent does not know, probe for total income over past 12 months.

(4) Include the 1997 income of all current family members even if you weren't living together then.

<1> YES [goto inc2]
<0> NO [goto inc3]

<8> DON'T KNOW
<9> REFUSED

===> [goto Xi1]

>inc2< Will (READ NAMES WITH * FRONT) 1997 estimated income before taxes be more than [fill 250% POVERTY]?

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===> [goto Xi1]

>inc3< Will (READ NAMES WITH * FRONT) 1997 estimated income before taxes be more than [fill 133% POVERTY]?

<1> YES [goto inc4]
<0> NO [goto inc5]

<8> DON'T KNOW
<9> REFUSED

===> [goto Xi1]

>inc4< Will (READ NAMES WITH * FRONT) 1997 estimated income before taxes be more than [fill 185% POVERTY]?

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===> [goto Xi1]

>inc5< Will (READ NAMES WITH * FRONT) 1997 estimated income before taxes be more than [fill 125% POVERTY]?

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===> [goto Xi1]

REPEAT inc1 TO inc5 FOR ADDITIONAL INSURANCE UNITS

>Xi1< Now, I have a few background questions.

>nres< What city or town do you live in?

PROBE: We need this information to help determine whether health care coverage varies in different parts of the state. Please keep in mind that all of the information you provide will be kept confidential.

PROBE IF NECESSARY: Could you spell that for me?

<1> TO ENTER NAME [SPECIFY]

<8> DON'T KNOW
<9> REFUSED

===>

>nzip< What is your zipcode?

PROBE: We need this information to help determine whether health care coverage varies in different parts of the state. Please keep in mind that all of the information you provide will be kept confidential.

PROGRAMMER: SET UP CHECK FOR MAINE SPECIFIC ZIPCODES.

<03901-04996>

<99998> DON'T KNOW
<99999> REFUSED

===>

>h30< Are there any other telephone numbers in this household besides [fill PHONE NUMBER] that people receive calls on?
IF YES: How many?

PROBE: We need this information so that households are correctly represented in our sample.

<0> NO OTHER PHONES [goto insurance unit selection]
<1-4> OTHER TELEPHONE NUMBERS

<9> REFUSED [goto insurance unit selection]

===>

test [if h30 eq 1 goto h31; else goto H31]

>h31< Is this line used for business purposes only?

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===> [goto h32]

>H31< How many of these lines are used for business purposes only?

<0> NONE
<1-4> USED FOR BUSINESS ONLY

<8> DON'T KNOW
<9> REFUSED

===>

>h32< During the past 12 months, was there any time when you did not have a working telephone in your household for two weeks or more?

<1> YES [goto h33]
<0> NO

<8> DON'T KNOW
<9> REFUSED

===> [goto insurance unit selection]

>h33< For how many of the past 12 months did you not have a working telephone for two weeks or more?

<0-12> MONTHS

<98> DON'T KNOW
<99> REFUSED

===>

END OF PART I

INSURANCE UNIT SELECTION

ELIGIBLE

Uninsured:

At least one non-parent member of insurance unit between the ages of 0 and 18 years uninsured.

Low Income Privately Insured (Includes insurance through employer, union, professional association, or individually purchased):

No uninsured non-parent members of IU between the ages of 0 and 18.
IU income <250% poverty as defined by INC1 and INC2.
At least one non-parent member of insurance unit between the ages of 0 and 18 with private insurance.

INELIGIBLE

Insurance unit does not meet either of the above criteria.

PART II: FOR PARENTS/GUARDIANS, SPOUSES OF PARENTS/GUARDIANS AND CHILDREN BETWEEN THE AGES OF 0 AND 18 ONLY

>d1< The rest of the interview is about the health care experiences of (FILL NAMES OF PARENTS/CHILDREN). (FILL IF ANY NON-PARENT INSURANCE UNIT MEMBER OVER 18: We will no longer be asking about some adult members of the household.)

test d2 [if anyone in the selected unit is covered by private insurance goto d2; else goto test e11]

PRIVATELY INSURED ONLY

>d2< At this time, in how many health insurance plans from employers, HMOs, or insurance companies are (* READ ASTERISKED NAMES BELOW *) enrolled?

INTERVIEWER: IF RESPONDENT DOESN'T KNOW, GET BEST ESTIMATE.

<1-10>

===>

>d3< In whose name is the [fill NUMBER] policy?

INTERVIEWER: LIMIT LIST TO PERSONS 18 OR OLDER. CODE ONLY ONE.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<0> NOT LISTED AS A HOUSEHOLD MEMBER

===>

test [if screener indicates selected unit members only have individually purchased plans goto d6]

>d4a< Is this policy through a current employer or union, through COBRA, through a retirement plan, or was it purchased directly from an insurance company or HMO?

PROBES: (1) COBRA provides continuation of benefits for former employees or their dependents for some period of time, usually 18 or 36 months, after termination of employment.

(2) CODE "1" FOR PURCHASES THROUGH A SCHOOL-BASED PLAN.

<1> CURRENT EMPLOYER OR UNION
<2> COBRA
<3> RETIREMENT
<4> INSURANCE COMPANY OR HMO

<8> DON'T KNOW
<9> REFUSED

===>

>d6< Who is covered by [fill your/NAME]'s health insurance plan?

INTERVIEWER: ONLY PEOPLE WHO REPORTED PRIVATE INSURANCE IN (bla-blc) ARE VALID. THESE PEOPLE HAVE A * IN FRONT OF THEIR NAMES.

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

test [if additional policy goto d3; else goto test e11]

testell [if anyone in the selected unit is currently insured, goto ell; else goto test e5]

CURRENTLY INSURED ONLY

>ell< During the past 12 months, [fill was/were] (* READ ASTERISKED NAMES BELOW *) **continuously** covered by health insurance?

PROBE: Include Medicare, Medicaid, NYLCare Choice, or PrimeCare, CHAMPUS, CHAMP-VA, other military care, and any other type of health insurance from an employer, HMO, insurance company, or other sources.

<1> YES [goto test e5]
<0> NO

<8> DON'T KNOW [goto test e5]
<9> REFUSED [goto test e5]

===>

>e12< Who was not covered by health insurance at some time during the past 12 months?

<1> [fill NAME]
<2> [fill NAME]
<3> [fill NAME]
<4> [fill NAME]
<5> [fill NAME]
<6> [fill NAME]
<7> [fill NAME]
<8> [fill NAME]
<n> NONE/NO ONE/NO OTHER RESPONSES [goto test e5]
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>e13< For how many of the past 12 months (was/were) [fill you/NAME] not covered by some type of health insurance plan?

<1-11> MONTHS

<98> DON'T KNOW
<99> REFUSED

===> [REPEAT FOR EACH CURRENTLY COVERED PERSON CODED IN e12]

test e5 [if anyone in the selected unit is uninsured, goto e5; else goto F1]

CURRENTLY UNINSURED ONLY

>e5< At any time during the past 12 months (was/were) [fill you/NAME] covered by Medicaid, NYLCare Choice or PrimeCare or any public or private health insurance plan?

PROBES: (1) Medicaid is a government assistance program for people in need.

(2) NYLCare Choice is an HMO offered through Maine's Medicaid program.

(3) PrimeCare is a managed care health plan offered through Maine's Medicaid program.

<1> YES
<0> NO [goto next test]

<8> DON'T KNOW [goto next test]
<9> REFUSED [goto next test]

===>

>e6< What type of health insurance coverage did [fill you/NAME] have?

INTERVIEWER: (1) CODE ALL THAT APPLY; READ IF NECESSARY.

(2) CODE WITHOUT ASKING IF KNOWN FROM PRIOR QUESTION.

(3) IF ANSWER IS "NONE": jb to PREVIOUS QUESTION AND CHANGE ANSWER.

<1> PRIVATE
<2> MEDICARE
<3> MEDICAID, NYLCARE CHOICE or PRIMECARE
<4> CHAMPUS/CHAMP-VA, TRICARE-VA, OTHER MILITARY
<5> INDIAN HEALTH SERVICE

<8> OTHER (SPECIFY) [specify]
<n> NONE/NO ONE/NO OTHER RESPONSES
<x> NEED TO DELETE A RESPONSE

<98> DON'T KNOW
<99> REFUSED

===>

>e7< For how many of the past 12 months (was/were) [fill you/NAME] covered by (this/these) plan(s)?

<1-11> MONTHS COVERED

<98> DON'T KNOW
<99> REFUSED

===>

REPEAT e5-e7 FOR OTHER UNCOVERED PERSONS.

test [if at least one non-parent insurance unit member between the ages of 0 and 18 is uninsured and income le 250% poverty, goto test ne8; else goto F1]

test ne8[if e6 ne 3, goto ne8; else goto ne9]

ASK ne8 FOR UNINSURED CHILDREN ONLY

>ne8< Was [fill NAME OF UNINSURED CHILD] ever covered by Medicaid, NYLCare Choice, or PrimeCare, or the Maine Health Program?

PROBES: (1) Medicaid is a government assistance program for people in need.

(2) NYLCare Choice is an HMO offered through Maine's Medicaid program.

(3) PrimeCare is a managed care health plan offered through Maine's Medicaid program.

(4) The Maine Health Program was an insurance program administered by the State for people who could not afford traditional insurance. The program ended in 1995.

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===>

>ne9< Did you know that Medicaid offers health coverage to *all* children and pregnant women who meet certain income guidelines, even if one or both parents are working?

PROBE: You would need to talk to your local regional office of the Department of Human Services to find out if your family qualifies.

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===>

HEALTH UTILIZATION (CHILDREN BETWEEN THE AGES OF 0 AND 18)

>F1< Now I have some questions about [fill NAME]'s health?

TYPE <g> TO CONTINUE

===>

>h2< Would you say [fill NAME]'s health in general is excellent, very good, good, fair, or poor?

<1> Excellent
<2> Very good
<3> Good
<4> Fair
<5> Poor

<8> DON'T KNOW
<9> REFUSED

===>

>f1< Is there a particular doctor's office, health maintenance organization, hospital or some other place that [fill NAME] **usually** goes to if [fill NAME] is sick or needs advice about (his/her) health?

<1> YES
<0> NO, THERE IS NO PLACE [goto ng7]
<3> NO, THERE IS MORE THAN ONE PLACE

<8> DON'T KNOW [goto ng7]
<9> REFUSED [goto ng7]

===>

>f2< IF (f1=1) THEN READ:
What kind of place is it--a doctor's office, an HMO, a hospital outpatient clinic, some other clinic or health center, an emergency room, or some other place?

IF (f1=3) THEN READ:
IF MORE THAN ONE PLACE: What kind of place (do/does) [fill NAME] go to most often--a doctor's office, an HMO, a hospital or outpatient clinic, some other clinic or health center, an emergency room, or some other place?

PROBES:

IF CLINIC, ASK: Is it a hospital outpatient clinic, company clinic, school clinic, or some other kind of clinic?

IF HOSPITAL, ASK: Is it a hospital outpatient clinic or a hospital emergency room?

IF SOME OTHER PLACE, ASK: Where was that?

INTERVIEWER: CODE WITHOUT ASKING IF KNOWN.

<1> DOCTOR'S OFFICE OR GROUP PRACTICE
<2> HEALTH MAINTENANCE ORGANIZATION (HMO)
<3> HOSPITAL OUTPATIENT CLINIC
<4> HOSPITAL EMERGENCY ROOM
<5> COMMUNITY OR MIGRANT HEALTH CENTER
<6> INDIAN HEALTH SERVICE
<7> PUBLIC HEALTH DEPARTMENT
<8> COMPANY INDUSTRIAL CLINIC
<9> SCHOOL CLINIC
<10> WALK-IN CENTER
<0> OTHER (SPECIFY AND END WITH ///) [specify]

<98> DON'T KNOW
<99> REFUSED

===>

>f3< Do(es) [fill NAME] usually see the same doctor or other health professional each time (you/he/she) go(es) there?

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===>

>nf1< Is there a particular dentist's office, clinic, health maintenance organization, or other place that [fill NAME] usually goes to if [fill NAME] needs dental care?

<1> YES
<0> NO, THERE IS NO PLACE [goto nf2a]
<3> NO, THERE IS MORE THAN ONE PLACE

<8> DON'T KNOW [goto nf2a]
<9> REFUSED [goto nf2a]

===>

>nf2< IF (nf1=1) THEN READ:
What kind of place is it--a dentist's office, a clinic, an HMO or some other place?

IF (nf1=3) THEN READ:
IF MORE THAN ONE PLACE: What kind of place (do/does) [fill NAME] go to most often--a dentist's office, a clinic, an HMO or some other place?

<1> DENTIST'S OFFICE
<2> CLINIC
<3> HEALTH MAINTENANCE ORGANIZATION (HMO)
<4> OTHER (SPECIFY AND END WITH ///) [SPECIFY]

<8> DON'T KNOW
<9> REFUSED

===>

>nf2a< In the past 12 months, how many times has [fill NAME] received dental care?

PROBE: Please include routine check-ups. Do not include visits to specialists such as oral surgeons, orthodontists, and periodontists.

PROBE: Your best estimate is fine.

<0> NONE
<1-365> NUMBER OF DENTIST VISITS

<998> DON'T KNOW
<999> REFUSED

===>

>ng7< In the past 12 months, has [fill NAME] gone to a hospital emergency room for care?

<1> YES
<0> NO [goto ng8]

<8> DON'T KNOW [goto ng8]
<9> REFUSED [goto ng8]

===>

>ng7a< How many times has [fill NAME] gone to a hospital emergency room for care in the past 12 months?

PROBE: Your best estimate is fine.

<1-365> NUMBER OF VISITS
<998> DON'T KNOW
<999> REFUSED

===>

>ng8< In the past 12 months, about how many days of [day-care or normal play activities/ preschool or normal play activities/ school/ school or work] did [fill NAME] miss because of illness or injury?

PROGRAMMER: FILL DAY-CARE OR NORMAL PLAY ACTIVITIES FOR 0-2 YEARS, PRESCHOOL OR NORMAL PLAY ACTIVITIES FOR 3-4 YEARS, SCHOOL FOR 5-17 YEARS, AND SCHOOL OR WORK FOR 18 YEAR OLDS.

PROBE: Your best estimate is fine.

PROBE: Do not count half-days.

<0> NONE
<1-365> NUMBER OF VISITS
<998> DON'T KNOW
<999> REFUSED

===>

EMPLOYMENT (PARENTS/GUARDIANS AND SPOUSES OF PARENTS/GUARDIANS ONLY)

>i0< The next series of questions is about jobs. Answers to these questions are particularly important to our survey because they help explain whether people can afford the health care they need. Also, I want to emphasize that the information you provide will be kept confidential and will be used only in statistical summaries.

TYPE <g> TO CONTINUE

===>

>i1< First, what (was/were) [fill you/NAME] doing most of last week--
working for pay, keeping house, going to school, or something else?

INTERVIEWER: CODE <2> (WITH A JOB BUT NOT AT WORK) SHOULD BE USED IF THE PERSON HAS A DEFINITE JOB TO WHICH HE/SHE CAN RETURN AFTER A TEMPORARY ABSENCE DUE TO ILLNESS, VACATION, LABOR DISPUTE, ETC.

<1> WORKING [goto i7]
<2> WITH A JOB BUT NOT AT WORK [goto i7]
<3> LOOKING FOR WORK
<4> KEEPING HOUSE
<5> GOING TO SCHOOL
<6> UNABLE TO WORK
<7> RETIRED
<0> OTHER (SPECIFY AND END WITH ///) [specify]

<8> DON'T KNOW
<9> REFUSED

===>

>test<[if i2 eq <1> or i3 eq <1>, goto i7; else goto k5]

>i7< IF i1 EQ 1 OR 2 ASK: What kind of business or industry (do/does) [fill you/NAME] work for?

IF i2 EQ 1 OR i3 EQ 1 ASK: Earlier you said that [fill you/NAME] worked at a paid job. What kind of business or industry did [fill you/NAME] work for last week?

PROBE: What does the company do or make?

INSTRUCTIONS: If this person worked for two or more employers last week, enter the one for whom he or she worked the most during the past week.

<1> (SPECIFY AND END WITH ///) [specify]

<8> DON'T KNOW
<9> REFUSED

===>

>i7a< Is this job a seasonal job?

PROBE: Is this a job that only gets filled during certain parts of the year?

<1> YES
<0> NO

<8> DON'T KNOW
<9> REFUSED

===>

>i8< On this job, (is/are) [fill you/NAME] employed by a private company, (is/are) (you/he/she) a federal, state, or local government employee, self-employed, or working without pay in a family business or farm?

INTERVIEWER: (1) CODE WITHOUT ASKING IF KNOWN FROM PREVIOUS QUESTION.

(2) CODE NOT-FOR-PROFIT ORGANIZATION AS PRIVATE COMPANY.

<1> PRIVATE COMPANY
<2> FEDERAL GOVERNMENT
<3> STATE GOVERNMENT
<4> LOCAL GOVERNMENT
<5> SELF-EMPLOYED
<6> FAMILY BUSINESS OR FARM

<8> DON'T KNOW
<9> REFUSED

===>

>i11< About how many people are employed by (this employer/[fill NAME]/you) at all locations?

PROGRAMMER: USE "YOU" IF SELF-EMPLOYED.

<1> 1
<2> 2-25
<3> 26-100
<4> 101-500
<5> MORE THAN 500

<8> DON'T KNOW
<9> REFUSED

===>

>i12< How many hours per week (do/does) [fill you/NAME] USUALLY work at this job?

PROBE: If [fill you/NAME] usually worked overtime hours include those hours.

<1-80>

<98> DON'T KNOW
<99> REFUSED

===>

test [if i8 eq 5 or 6 and i11 eq 1, goto k5; else goto test i19]

testi19 [if at least one parent employed and no parent has employer-sponsored health coverage goto i19; else goto test i21]

Create alternative fills for i19 or i21 based on response to i8.

>i19< If i8 ≥ 4 or ≤ 8; does [fill your/NAME]'s employer or union offer a health insurance plan to any of its employees?

If i8 > 4 and < 8; (do/does) [fill you/NAME] offer or have a health insurance plan through (his/her) business or farm?

<1> YES
<0> NO [goto k5]

<8> DON'T KNOW [goto k5]
<9> REFUSED [goto k5]

===>

>i20a< (Is/Are) [fill you/NAME] eligible to enroll in this (employer's) insurance plan?

<1> YES [goto i20c]
<0> NO

<8> DON'T KNOW [goto k5]
<9> REFUSED [goto k5]

===>

>i20b< What is the main reason [fill you/NAME] (is/are) not eligible to enroll in this (employer's) insurance plan?

<1> HAVEN'T WORKED LONG ENOUGH
<2> DON'T WORK ENOUGH HOURS (PART-TIME)
<3> ON-CALL EMPLOYEE
<4> MEDICAL PROBLEMS / PRE-EXISTING CONDITION
<5> AGE CONSTRAINTS
<6> OTHER [SPECIFY]

<8> DON'T KNOW
<9> REFUSED

===> [goto k5]

>i20c< What is the main reason [fill you/NAME] (is/are) not participating in (your/his/her) (employer's/this) insurance plan?

<1> TOO EXPENSIVE / CAN'T AFFORD IT/ PREMIUMS TOO HIGH
<2> DON'T BELIEVE IN INSURANCE
<3> DON'T NEED INSURANCE / USUALLY HEALTHY
<4> COVERED BY SOME OTHER PLAN
<5> FREE/INEXPENSIVE SOURCE OF CARE READILY AVAILABLE
<6> OTHER [SPECIFY]

<8> DON'T KNOW
<9> REFUSED

===> [goto k5]

testi21 [if at least one parent employed and parent(s) has employer-sponsored coverage but at least one child is uninsured goto i21; else goto k5]

>i21< If i8 ≤ 4 or ≥ 8; Does [fill your/NAME]'s employer or union offer family coverage through their health plan to any of its employees?

If i8 > 4 and < 8; (Do/Does) [fill you/NAME] offer or have family coverage through (his/her) family business or farm?

<1> YES
<0> NO [goto k5]

<8> DON'T KNOW [goto k5]
<9> REFUSED [goto k5]

===>

>i21a< Is [fill NAME OF UNINSURED CHILD] eligible to enroll in this (employer's) family coverage plan?

<1> YES [goto i21c]
<0> NO

<8> DON'T KNOW [goto k5]
<9> REFUSED [goto k5]

===>

>i21b< What is the main reason [fill NAME OF UNINSURED CHILD] is not eligible to enroll in this (employer's) family coverage plan?

<1> HAVEN'T WORKED LONG ENOUGH
<2> DON'T WORK ENOUGH HOURS (PART-TIME)
<3> ON-CALL EMPLOYEE
<4> MEDICAL PROBLEMS / PRE-EXISTING CONDITION
<5> AGE CONSTRAINTS
<6> OTHER [SPECIFY]

<8> DON'T KNOW
<9> REFUSED

===> [goto k5]

>i21c< What is the main reason [fill NAME OF UNINSURED CHILD] is not participating in (your/his/her) (employer's/this) family coverage plan?

<1> TOO EXPENSIVE / CAN'T AFFORD IT/ PREMIUMS TOO HIGH
<2> DON'T BELIEVE IN INSURANCE
<3> DON'T NEED INSURANCE / USUALLY HEALTHY
<5> FREE/INEXPENSIVE SOURCE OF CARE READILY AVAILABLE
<6> OTHER [SPECIFY]

<8> DON'T KNOW
<9> REFUSED

===>

>k5< Finally, what is the highest level of school [fill NAME] ever completed or the highest degree [fill NAME] received?

PROBE FOR REFUSALS: I understand that this question may be sensitive. We are asking this question to help understand differences in health care problems and needs.

<1> LESS THAN HIGH SCHOOL
<2> HIGH SCHOOL GRADUATE OR GED
<3> SOME COLLEGE OR ASSOCIATE'S DEGREE
<4> BACHELOR'S DEGREE
<5> MASTER'S DEGREE
<6> LAW DEGREE (JD)
<7> MD/DOCTORATE (PhD)

<8> DON'T KNOW
<9> REFUSED

===>

>END< This concludes the interview. Thank you so much for your time and patience.

===>

APPENDIX F

MAINE CHILDREN'S HEALTH INSURANCE PRELIMINARY RESULTS

UNIVERSITY OF SOUTHERN MAINE
Edmund S. Muskie School of Public Service

Preliminary Results

Health Insurance Coverage Among Maine Children

Findings from a Household Survey Conducted by
Mathematica Policy Research Inc.
1997

Elizabeth Kilbreth, Ph.D
The Institute for Health Policy
Edmund Muskie School of Public Service
University of Southern Maine

Interim Findings

1. Percent of Maine Children, who lack health coverage: 10.0%

2. Estimated number of Maine children without health coverage: 34,440

3. Children without health coverage by family income

	Percent Uninsured	Estimated Number of Children	Cumulative Number of Children
Less than 125% of FPL	12.7	10,366	10,366
125-133% FPL	24.7	2,871	13,237
133-185% FPL	21.3	8,578	21,815
185-200% FPL	15.2	2,264	24,079
200-250% FPL	8.3	3,526	27,605
Above 250% FPL	2.3	2,862	30,467
No income information	13.0	3,974	

4. Age Distribution of Uninsured and Insured Children

	Uninsured Children Percent Distribution by Age	Insured Children Percent Distribution by Age	Percent in Each Age group Who are Uninsured	Number of Uninsured Children by Age Group
Age 0-5	24.4	27.2	9.0	8,427
Age 6-12	38.2	38.0	10.0	13,177
Age 13-17	29.8	30.0	10.0	10,296
Age 18-24	7.6	4.8	15.0	2,634

5. Estimated Distribution of Maine Children by Type of Insurance Coverage

Type of Coverage	Percent Coverage Among Maine Children
Employer-sponsored benefits	63.2
Other Private Insurance	5.8
Medicaid	18.0
Other Government	2.7
None	10.0
Unknown	0.3

Household Survey Background Information

In September, 1997, Maine's Department of Human Services contracted with the Institute for Health Policy at the Muskie School of Public Service, University of Southern Maine, to conduct a study to determine the extent of lack of health insurance or health benefits among children in Maine. This study was co-sponsored and financially supported by a number of organizations with an interest in the welfare of Maine's children. The sponsoring organizations include: Blue Cross and Blue Shield of Maine; Maine Children's Alliance; The Maine Community Foundation; and MaineHealth.

The Muskie School sub-contracted with Mathematica Policy Research, Inc., of Princeton New Jersey, to assist in the development of the survey instrument and to conduct the survey field operations. Mathematica has extensive experience in household surveys and in the collection of health coverage and health status information. Under contract to the Robert Wood Johnson Foundation, Mathematica conducted household surveys in 10 states between 1993 and 1994. Telephone interviews were completed with 27,137 families, compiling information on health coverage status and access to care, among other things. Mathematica uses a computer-assisted telephone interview technology (CATI) for interviewing.

The Maine survey was conducted between October 20 and November 30, 1997. Mathematica called 13,291 Maine phone numbers to locate and complete interviews with 2,449 households with children. Among eligible households, the response rate was 75 percent – a high response rate for telephone surveys, and one that allows estimates to the general population. From the completed interviews, Mathematica will produce weighted data files and statewide estimates, with estimates of design effect. The final survey report will include a detailed description of sampling and survey methodology.

The preliminary datafile from the Maine survey was delivered to the Institute for Health Policy of the Muskie School on December 15. Analysis of the data is currently underway. A final report of survey findings is scheduled for release in January, 1998.

Please note: The attached preliminary findings are derived from survey data that has not been weighted to ensure that the survey findings appropriately represent Maine's total population. Final weights, which are currently under development at Mathematica, will benchmark the survey results to Maine census figures. Although

these adjustments will make only minor changes to the numbers, it is likely that the final survey report will differ slightly from these preliminary findings.

For more information or to request a copy of the final report, please contact:

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APPENDIX G

MAINE COMMISSION ON CHILDREN'S HEALTH CARE, MEDICAID EXPANSION AND CUB CARE PROGRAM

MAINE COMMISSION ON CHILDREN'S HEALTH CARE
MEDICAID EXPANSION AND CUB CARE PROGRAM

Program Design:	Expand Medicaid to 150% of the federal poverty level for children 1 to 18. Establish the Cub Care program for children 1 to 18 whose family income is 150% to 185% of the federal poverty level. DHS directed to monitor the program and expenditures, to expand or contract the % eligibility levels to ensure (1) that the maximum number of children are covered within the program budget and (2) that federal State Children's Health Insurance Program funds are not forfeited. DHS may change the % level only after 30 days prior notice to the AFA and HHS Committees. The program will be integrated and administered by DHS with the Medicaid program, sharing administrative structure, simplified enrollment and eligibility process, benefit package and procedures, with the exceptions noted below in premiums, eligibility, terminations for nonpayment of premium. No co-pays or deductibles of any type will be charged. Services for both the Cub Care program and Medicaid will be provided by the same health plans through one RFP and contracting process.
Premiums:	Families will pay premiums for Cub Care coverage for children based on a sliding scale applied to gross family income: below 150% fpl - no premium. 150% to 160% - premiums of 5% of benefit cost per child, limit 10% per family. 160% to 170% - premiums of 10% of benefit cost per child, limit 20% per family. 170% to 185% - premiums of 15% of benefit cost per child, limit 30% per family. Monthly premiums, with notice and grace period. Good cause exceptions for non-payment of premium may be granted by DHS. Re-enrollment after termination for nonpayment of premium only after a waiting period equal to the number of months of unpaid premium for which the child was provided coverage, up to a maximum of 3 months. Good cause exception to the consequences may be granted by DHS.
Continuous Enrollment;	6 month continuous enrollment when a child is determined to be eligible. Termination of enrollment for nonpayment of premium, at expiration of 6-month enrollment period, as above. Allow buy-in for 18 months for children enrolled in Cub Care or Medicaid whose family income rises above the program maximum at a premium level that covers cost plus an amount consistent with COBRA for administrative costs. DHS rulemaking to administer the buy-in.

Outreach/10% Funds:	Establish outreach expenses at 2% of program budget. After the first 6 months of operation and to the extent that the program budget allows, DHS may spend an extra 3% to increase access to health care. Access initiatives may be continued by DHS if funding is available. In its contracting process, DHS will create incentives to reward plans that contract with school-based clinics and federally qualified community health centers and other community-based programs.
Anti-Crowd Out:	The following children are not eligible for enrollment in the Cub Care program (ineligibility under paragraphs 1 thru 3 is required by federal law): 1. a child who is eligible for Medicaid, 2. a child who is covered under a group insurance plan or is eligible for the State Employee Health Program, 3. a child who is an inmate of a public institution or a patient in an institution for mental diseases, 4. a child who had coverage within the last 3 months under an employer-based plan for which the employer paid at least 50% of the premium cost, provided that this exclusion does not apply when: (a) the cost of the employee's share of family coverage exceeds 10% of family income, (b) the loss of coverage for the child is not the result of a voluntary act by the child or family, or (c) a determination of good cause exception is made by DHS.
Administration and Budgetary Control:	Administrative costs will include at least one line position within the Bureau of Medical Services for health policy administration and 30 other staff positions within the Bureau of Family Independence. The Maine Commission on Children's Health Care will be reauthorized for 1 year, as it is currently composed, to meet 2 times during 1998, to receive quarterly reports from the Commissioner of DHS, and to report to AFA and HHS Committees of the 119th Legislature by December 15, 1998. Similar budget for expenses and reimbursement as during 1997. OPLA staffing. AFA and HHS to notify Commission members prior to meeting with the Commission. Commissioner of DHS reports quarterly to Commission on Children's Health Care for one year and also to AFA and HHS Committees. Commissioner to report on enrollment approvals, denials, levels, and projections, terminations and re-enrollments, buy-in to the Cub Care program from over-income enrollees of Cub Care and Medicaid, program expenditures and projections, proposals for increasing or decreasing enrollment, proposals for enhancing the program, information on employer health coverage and insurance coverage for low-income children and administrative costs of the program.

APPENDIX H

PROPOSED LEGISLATION

Appendix H

Sponsor: Commission on Children's Health Care
Drafted by: Jane Orbeton
Date: 1/28/98

DRAFT

Title: An Act to Implement the Recommendations of the Maine Commission on Children's Health Care

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, approximately 34,440 children in Maine are without health coverage and periodically require health care treatment for preventative, diagnostic, therapeutic, rehabilitative and acute care purposes; and

Whereas, the State is committed to finding a way to make health coverage available to uninsured Maine children and expressed that commitment by establishing the Maine Commission on Children's Health Care in Public Law 1997, chapter 560, and setting aside approximately $8,000,000 to fund health coverage; and

Whereas, the federal government has made funding available to the State of approximately $61,500,000 over the next five years for a children's health program under the Balanced Budget Act of 1997; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 22 MRSA §3174-G, sub-§1 is amended to read:

1. Delivery of services. The department shall provide for the delivery of federally approved Medicaid services to qualified pregnant women up to 60 days following delivery and infants up to one year of age when the woman's or child's family income is below 185% of the nonfarm income official poverty line ~~and children under 5 years of age and~~ , qualified elderly and disabled persons ~~,~~ when the ~~child's or~~ person's family income is below 100% of the nonfarm income official poverty line and children ages 1 year old through 18 years old when the child's family income is below 150% of the nonfarm income official poverty line. The official poverty line shall be that applicable to a family of the size involved, as defined by the Federal Office of Management and Budget and revised annually in accordance with the United States Omnibus Budget Reconciliation Act of 1981, Section 673, Subsection 2. ~~These services shall be effective October 1, 1988.~~

Sec. A-2. 22 MRSA §3174-R is enacted to read:

§3174-R. Cub Care program

1. Program established. The Cub Care program is established to provide health coverage for low-income children who are ineligible for benefits under the Medicaid program and who meet the requirements of subsection 2. The purpose of the Cub Care program is to provide health coverage to as many children as possible within the fiscal constraints of the program budget and without forfeiting any federal funding that is available to the State for the State Children's Health Insurance Program through the Balanced Budget Act of 1997, Public Law 105-100 (November 19, 1997), as amended, hereinafter referred to as the Balanced Budget Act of 1997.

2. Eligibility; enrollment. Health coverage under the Cub Care program is available to children ages 1 through 18 years old whose family income is above the eligibility level for Medicaid under section 3174-G and below the maximum eligibility level established under paragraphs A and B, who meet the requirements set forth in paragraph C and for whom premiums are paid under subsection 5.

A. The maximum eligibility level, subject to adjustment by the commissioner under paragraph B, is 185% of the nonfarm income official poverty line.

B. If the commissioner has determined the fiscal status of the Cub Care program under subsection 8 and has determined that an adjustment in the maximum eligibility level is required under this paragraph, the commissioner shall adjust the maximum eligibility level in accordance with the requirements of this paragraph.

(1) The adjustment must accomplish the purposes of the Cub Care program set forth in subsection 1.

(2) If program expenditures are reasonably anticipated to exceed the program budget, the commissioner shall adjust the maximum eligibility level set in paragraph A downward to the extent necessary to bring the program within the program budget.

(3) If program expenditures are reasonably anticipated to fall below the program budget, the commissioner shall adjust the maximum eligibility level set in paragraph A upward to the extent necessary to provide coverage to as many children as possible within the fiscal constraints of the program budget.

(4) The commissioner must give at least 30 days notice of the proposed change in maximum eligibility level to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services matters.

C. All children resident in the State are eligible except a child who:

(1) Is eligible for coverage under the Medicaid program;

(2) Is covered under a group health insurance plan or under health insurance, as defined in section 2791 of the federal Public Health Service Act;

(3) Is a member of a family that is eligible for health coverage under the State Employee Health Program under Title 5, section 285;

(4) Is an inmate in a public institution or a patient in an institution for mental diseases; or

(5) Within the 3 months prior to application for coverage under the Cub Care program, was insured or otherwise provided coverage under an employer-based health plan for which the employer paid 50% or more of the cost for the child's coverage, except that this subparagraph does not apply if:

(i) The cost to the employee of coverage for the family exceeds 10% of the family's income;

(ii) The parent lost coverage for the child because of a change in employment, termination of coverage under COBRA or termination for a reason not in the control of the employee; or

(iii) The department has determined that grounds exist for a good cause exception.

D. Coverage under the Cub Care program may be purchased for an additional period of 18 months as provided in this paragraph at a premium level that is revenue neutral and that covers the cost of the benefit and a contribution toward administrative costs no greater than the maximum level allowable under COBRA. The department shall adopt rules to implement this paragraph. The following children are eligible to enroll under this paragraph:

(1) Children who are enrolled under paragraph A or B and whose family income, at the end of the child's 6-month enrollment term, exceeds the maximum allowable income set in that paragraph; and

(2) Children who are enrolled in the Medicaid program and whose family income exceeds the limits of that program. The department shall terminate Medicaid coverage for a child who enrolls in the Cub Care program under this subparagraph.

E. Notwithstanding changes in maximum eligibility level determined under paragraph B, the following requirements apply to enrollment and eligibility:

(1) Children must be enrolled for 6-month enrollment periods. Prior to the end of each 6-month enrollment period the department shall redetermine eligibility for continuing coverage; and

(2) Children of higher family income may not be covered unless children of lower family income are also covered. This subparagraph may not be applied to disqualify a child during the 6-month enrollment period. Children of higher income may be disqualified at the end of the 6-month enrollment period if the commissioner has adjusted the maximum eligibility level downward under subsection 2, paragraph B.

3. Program administration; benefit design. With the exception of premium payments under subsection 5 and any other requirements imposed under this section, the Cub Care program must be integrated with the Medicaid program and administered with it in one administrative structure within the department, with the same enrollment and eligibility process, outreach and benefit package and in compliance with the same laws and policies as the Medicaid program, except when those laws and policies are inconsistent with this section and the Balanced Budget Act of 1997. The department shall adopt and promote a simplified eligibility form and eligibility process.

4. Benefit delivery. The Cub Care program must use, but is not limited to, the same benefit delivery system as the Medicaid program, providing benefits through the same health plans, contracting process and providers. Co-payments and deductibles may not be charged for benefits provided under the program.

5. Premium payments. Premiums must be paid in accordance with this subsection.

A. Premiums must be paid at the beginning of each month for coverage for that month according to the following scale:

(1) Families with incomes between 150% and 160% of the nonfarm income official poverty line must pay premiums of 5% of the benefit cost per child, not exceeding 5% of the cost for 2 children;

(2) Families with incomes between 160% and 170% of the nonfarm income official poverty line must pay premiums of 10% of the benefit cost per child, not exceeding 10% of the cost for 2 children; and

(3) Families with incomes between 170% and 185% of the nonfarm income official poverty line must pay premiums of 15% of the benefit cost per child, not exceeding 15% of the cost for 2 children.

B. When a premium is not paid at the beginning of the month, the department shall provide notice at the beginning of that month and month 6 of the 6-month enrollment period if the premium is unpaid at that time, an opportunity for a hearing and a grace period in which the premium may be paid and no penalty will apply for the late payment. If a premium is not paid by the end of the grace period, coverage must be terminated unless the department has determined that waiver of premium is appropriate under paragraph D. The grace period must be determined according to this paragraph.

(1) If non-payment is for month 1, 2, 3, 4, or 5 of the 6-month enrollment period, the grace period is equal to the remainder of the 6-month enrollment period.

(2) If non-payment is for month 6 of the 6-month enrollment period, the grace period is equal to 6 weeks.

C. A child whose coverage under the Cub Care program has been terminated for non-payment of premium and who has received coverage for a month or longer without premium payment may not re-enroll until after a waiting period that equals the number of

months of coverage under the Cub Care program without premium payment, not to exceed 3 months.

D. The department shall adopt rules allowing waiver of premiums for good cause.

6. Incentives. In the contracting process for the Cub Care program and the Medicaid program the department shall create incentives to reward health plans that contract with school-based clinics, community health centers and other community-based programs.

7. Administrative costs. The department shall budget 2% of the costs of the Cub Care program for outreach activities. After the first 6 months of the program and to the extent that the program budget allows, the department may expend up to 3% of the program budget on activities to increase access to health care. Administrative costs must include the cost of staff with experience in health policy administration equal to one full-time equivalent position.

8. Quarterly determination of fiscal status; reports. On a quarterly basis the commissioner shall determine the fiscal status of the Cub Care program, determine whether an adjustment in maximum eligibility level is required under subsection 2, paragraph B and report to the joint standing committees having jurisdiction over appropriations and financial affairs and health and human services on the following matters:

A. Enrollment approvals, denials, terminations, re-enrollments, levels and projections. With regard to denials, the department shall gather data from a statistically significant sample and provide information on the income levels of children who are denied eligibility due to family income level;

B. Program expenditures, expenditure projections and fiscal status;

C. Proposals for increasing or decreasing enrollment consistent with subsection 2, paragraph B;

D. Proposals for enhancing the program;

E. Any information the department has from the program or from the Bureau of Insurance or the Department of Labor on employer health coverage and insurance coverage for low-income children;

F. The use of and experience with the purchase option under subsection 2, paragraph D; and

G. Program administrative costs.

9. Rulemaking. The department shall adopt rules in accordance with Title 5, chapter 375 as required to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter II-A.

Sec. 3. Reauthorization of the Maine Commission on Children's Health Care. The Maine Commission on Children's Health Care, established in Public Law 1997, chapter 560, Part B, is reauthorized for 1998 for the purpose of overseeing the expansion of the Medicaid program

under 22 MRSA section 3174-G and the establishment of the Cub Care program under 22 MRSA section 3174-R. The commission shall receive quarterly reports from the Commissioner of Human Services. The commission is authorized to meet up to 2 times during 1998 and shall submit a report and recommendations to the Joint Standing Committees on Appropriations and Financial Affairs and Health and Human Services of the 119th Legislature by December 15, 1998 on the operation of the Cub Care program.

Sec. A-4. Application clause. Section 3 of this Act applies retroactively to December 15, 1997.

Sec. A-5. Appropriation.
(To be written by the Office of Fiscal and Program Review)

Provide appropriations from the General Fund sufficient for 1 administratorFTE position in the Bureau of Medical Services and 30 full-time employees in the Bureau of Family Independence.

Sec. A-6. Allocation.
(To be written by the Office of Fiscal and Program Review)

Provide allocations from federal funds sufficient for 1 administrator FTE position in the Bureau of Medical Services and 30 full-time employees in the Bureau of Family Independence.

PART B

Sec. B-1. 24 MRSA §2332-A, sub-§2 is amended to read:

2. Medicaid and Cub Care programs. Nonprofit service organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3174-R, referred to as "the Cub Care program," when considering coverage eligibility or benefit calculations for subscribers and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid or Cub Care program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the covered subscriber or family member to payment by the nonprofit service organization for those health care items or services. Upon presentation of proof that the Medicaid or Cub Care program has paid for covered items or services, the nonprofit service organization shall make payment to the Medicaid or Cub Care program according to the coverage provided in the contract or certificate.

B. A nonprofit service organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Cub Care coverage and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual.

Sec. B-2. 24-A MRSA §2808-B, sub-§1, paragraph E is amended to read:

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A B, ~~C,~~ C-1 or D.

Sec. B-3. 24-A MRSA §2844, sub-§2 is amended to read:

24A § 2844. Coordination of benefits

2. Medicaid and Cub Care programs. Insurers may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3174-R, referred to as the "Cub Care program," when considering coverage eligibility or benefit calculations for insureds and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid or Cub Care program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the insured or family member to payment by the insurer for those health care items or services. Upon presentation of proof that the Medicaid or Cub Care program has paid for covered items or services, the insurer shall make payment to the Medicaid or Cub Care program according to the coverage provided in the contract or certificate.

B. An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Cub Care coverage and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual.

Sec. B-4. 24-A MRSA §2848, sub§1-B, paragraph A is amended to read:

§1-B. Creditable coverage. "Creditable coverage" means:

A. Health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier; or

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act, or a state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e).

Sec. B-5. 24-A MRSA §2849-B, sub-§3 is amended to read:

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. A late enrollee may be excluded from coverage for not more than 12 months based on medical underwriting or preexisting conditions. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy or terminated coverage under the succeeding contract because that individual was covered under a prior contract or policy and:

(1) Coverage under that contract or policy ceased because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce; or

(2) Employer contributions toward that coverage were terminated;

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order;

C. ~~That person was covered by the Maine High Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage; or~~

C-1. That person was covered by the Cub Care program under Title 22, section 3174-R, and the request for replacement coverage is made while coverage is in effect or within 30 days after the termination of coverage; or

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect July 1, 1998.

SUMMARY

This bill contains the recommendations of the Maine Commission on Children's Health Care. It does the following:

(1) Expands coverage under the Medicaid program for children 1 through 18 years of age whose family incomes are below 150% of the federal poverty level.

(2) Establishes the Cub Care program to provide health insurance coverage to children whose families are between 150% and 185% of the federal poverty level and who pay a monthly premium and for 18 months at premium levels that equal the benefit cost plus an administrative fee to children who are enrolled and who become ineligible because of increasing family income.

(3) Reauthorizes the Maine Commission on Children's Health Care for a period of 1 year.

(4) Appropriates and allocates the necessary funding to support the expansion of the Medicaid program and the creation of the Cub Care program.

(5) Amends provisions in Titles 24 and 24-A related to insurance coordination of benefits, late enrollee status and continuity of coverage.