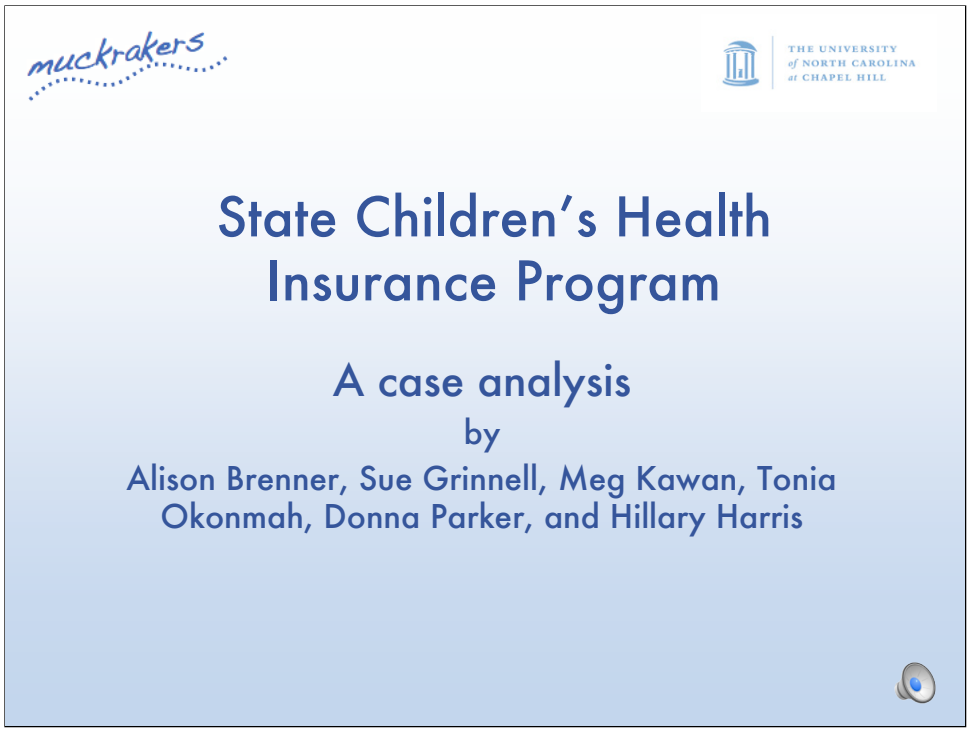

Hello, we are the Muckrakers Group, and today we will be presenting an analysis of the State Children's Health Insurance Program, also known as SCHIP.

We are representatives of different areas of the health sector who have come together as a government task force, appointed by North Carolina Governor Mike Easley. We have been asked to study health care coverage of children in North Carolina and examine the feasibility of expanding coverage for this group.

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Agenda

- Process
- Introduction to SCHIP
- Policy problem
- Goals
- Policy alternatives
- Policy recommendation
- Implementation plan
- Evaluation plan

We will first explain the process through which we researched the issue and introduce you to the MindMap we created to document it. We will then introduce you to the State Children's Health Insurance Program, providing you with its history, and the historical and current political and social climate. We will then present details of the policy problem, which we will follow with our goals in updating the policy. Next, we'll present several alternatives to the current implementation of the policy in North Carolina and provide our recommendation for the most viable of these alternatives. We will complete the presentation with plans for implementation and evaluation of our policy recommendation.

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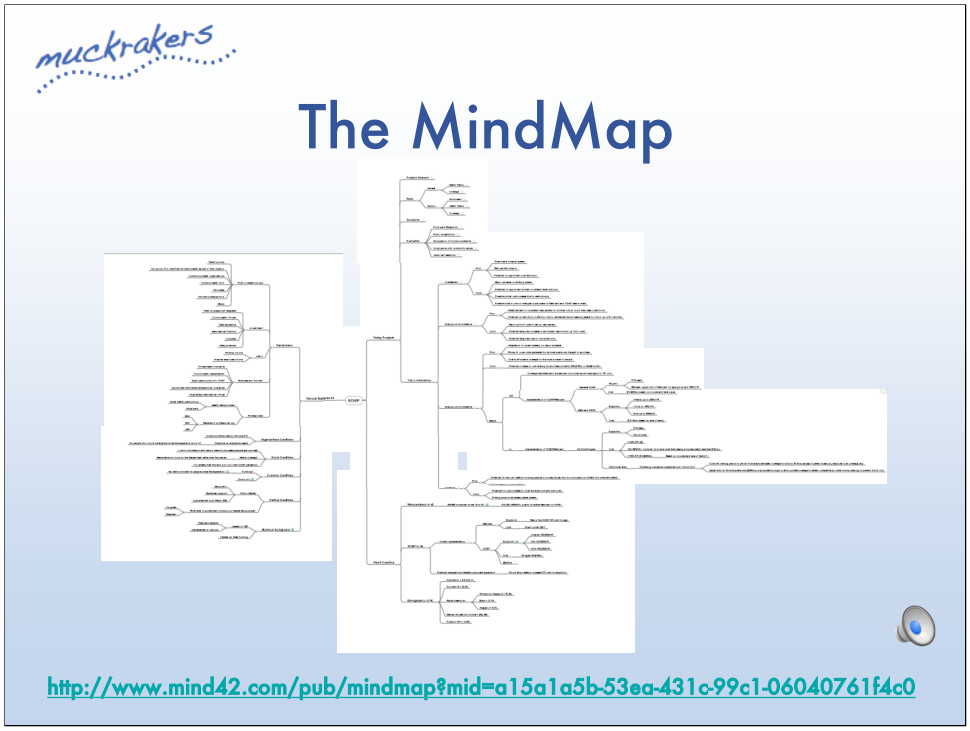
Process

- Research the issue
- Define the policy problem
- Determine goals in changing policy
- Assess the current political, social, and economic climate
- Identify and assess possible policy alternatives
- Determine the most viable alternative in terms of implementation and sustainability

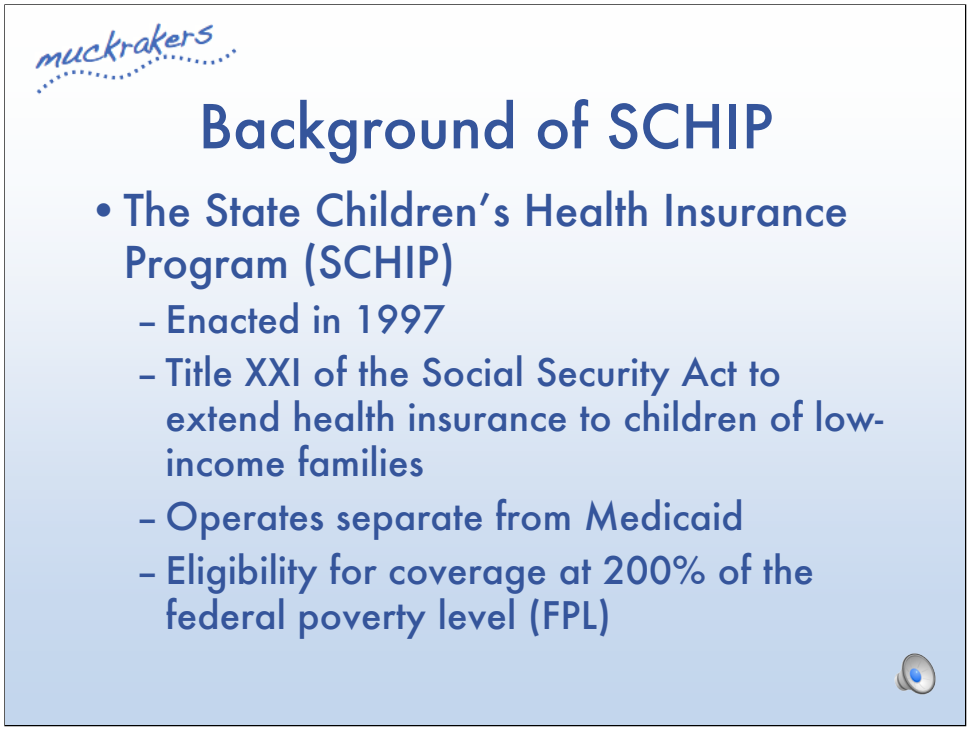
To ensure the legitimacy of our recommendation, we want to share with you the process we used in coming to our conclusions. We began the process by extensively researching the history of the issue We then defined the policy problem and determined what our goals were in making changes to the policy. In this context, we then assessed the current political, social, and economic climate and identified possible alternative policies. And finally, through a contextual assessment, we then came to a conclusion as to which of the alternative policies we identified would be the most viable in terms of successful implementation and of sustainability.



We are a virtual organization--peers collaborating from a distance. We created this flow chart on a website that allowed us to collectively track our process. What you see on this slide is a screenshot of that flow chart, called a MindMap. Keeping this chart has been a key component of our analysis; it allowed us to break the very complex issue down into smaller facets. We chose to share this tool with you for several reasons:

Number one, we believe that it helps to legitimize our recommendation because it comes from a strong knowledge base. But secondly, the map also contains a virtual library of information beyond the scope of our presentation today. We invite you to visit our MindMap online. Where ever possible, websites are linked to the arms regarding the topic it represents. If, in any area, you feel that more information is required, you may easily find the information we utilized in our analysis.

The link at the bottom of the slide will take you to our MindMap. Please feel free to visit the site at your convenience to peruse the sources we utilized in our analysis or to bolster your understanding of our topic.



The State Children's Health Insurance Program, or SCHIP, was originally enacted in 1997 as Title twenty-one of the Social Security Act to extend health insurance coverage to children of low-income families. As a result of this legislation, rates of uninsured children have fallen from 23% nationally in 1997 to 14.4% in 2004. **States were given three options for implementation of SCHIP: they could do it as an expansion of Medicaid, they could do it as a separate program, or they could use a combination of both.** North Carolina chose to implement an SCHIP program that is separate from Medicaid and has set the eligibility for coverage at up to 200% of the federal poverty level.

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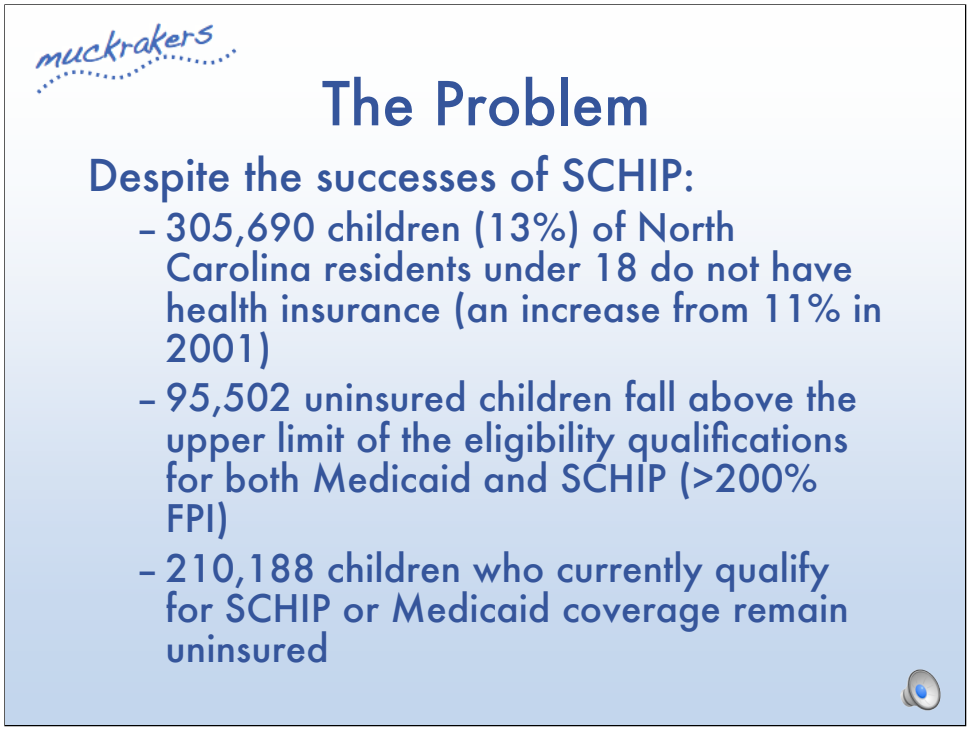
SCHIP eligibility in North Carolina

Program Type by Age	Eligibility as % of FPL	Premium requirement per year
Separate SCHIP		
Infants	185%-200%	$50-$100
0-5 years	133%-200%	$50-$100
6-18 years	100%-200%	$50-$100

Eligibility for SCHIP is determined in North Carolina by the family income in terms of the Federal Poverty Level and by the age of the child or children involved. In all three age groups, children whose families have an income of up to 200% of the Federal Poverty Level, which is $44,400 for a family of 4, qualify for SCHIP or Medicaid coverage. For families on the upper borderline, certain deductions can be made in gross income to allow the children to qualify for coverage. The yearly premium, paid by the enrollees, is $50 for one child, and $100 for two or more children.



SCHIP has, largely, been extremely successfully. But despite the successes of this legislation, many children remain uninsured. In North Carolina, 305,690 children, or 13% of North Carolina residents age 18 or younger, do not have health coverage, an increase from 11% in 2001. Of these children, 95,502 fall above the upper limit of eligibility for both Medicaid and SCHIP. The remaining 210,188 children do qualify for either Medicaid or SCHIP but, likely due to the confusing eligibility requirements and complex enrollment process, remain uninsured.

Uninsured people tend to have poorer health outcomes than those with insurance, and cost the state money both in health care and in lost productivity.

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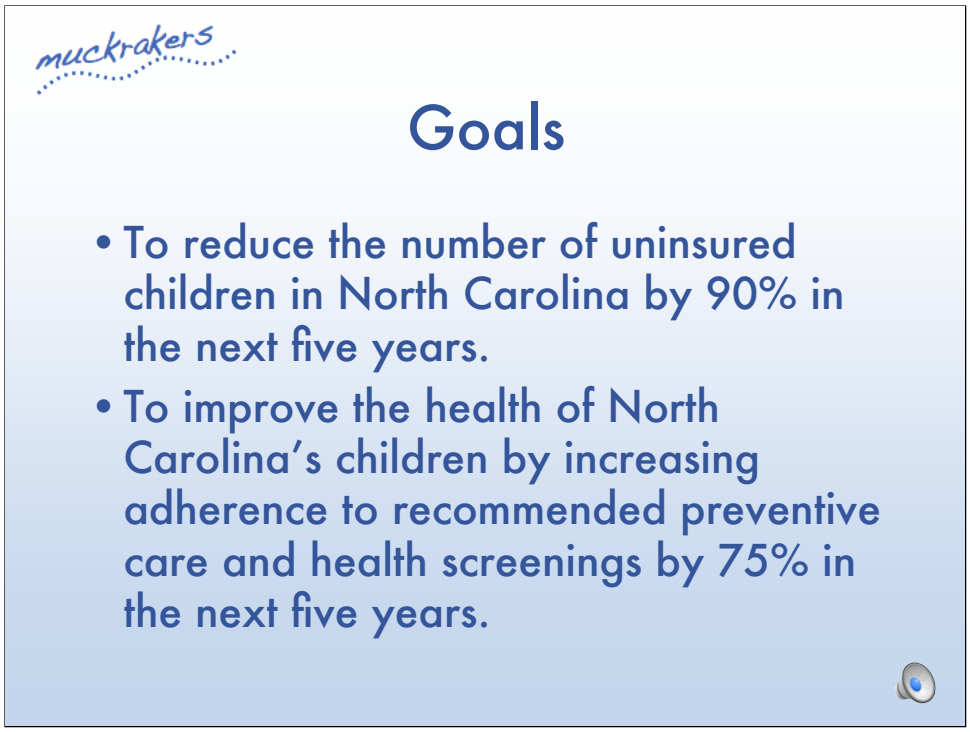
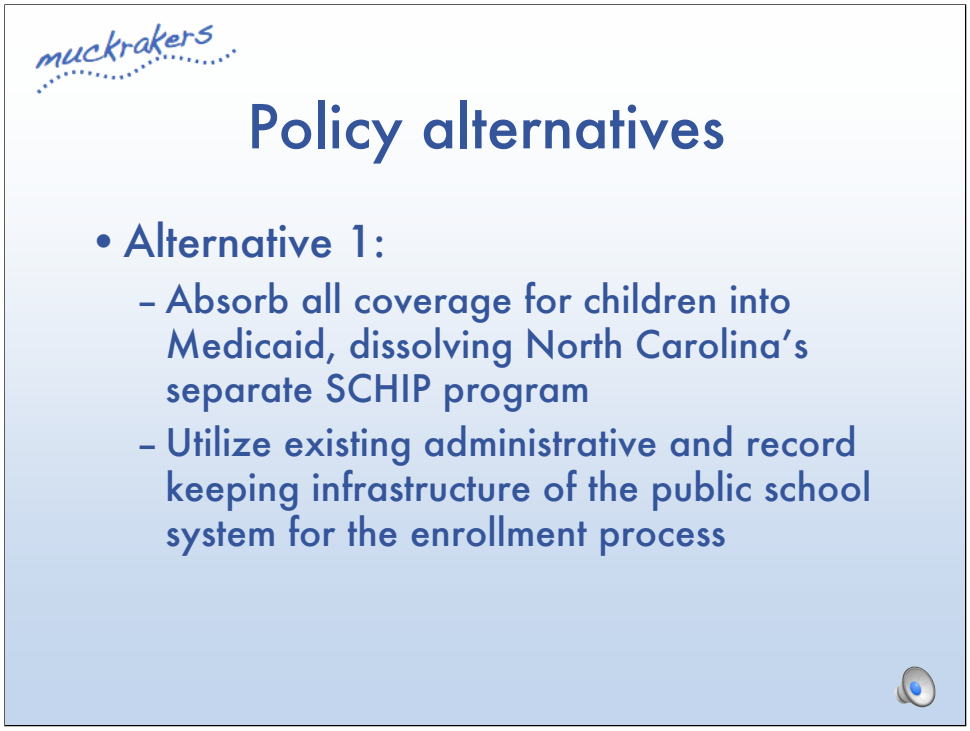
Goals

- To make good, affordable health coverage available to all children in North Carolina through changes to the current SCHIP program that will simplify eligibility and enrollment procedures.

The goal of this task force is to determine a viable, sustainable way to make good, affordable health coverage available to all children in North Carolina through changes to the current SCHIP implementation that will simplify eligibility and enrollment procedures. Through procedural simplifications, program costs will be reduced, allowing cost-sharing by the enrollees to be as minimal as possible.



More specifically, we aim to reduce the number of uninsured children in North Carolina by 90% in the next five years. That would reduce the number of uninsured children from 305,690 to less than 35,000. Additionally, we hope, through this increased insurance coverage, to improve adherence to preventive care and regular screenings by 75% in the next five years. We believe these measures will dramatically improve the overall health of North Carolina's children.

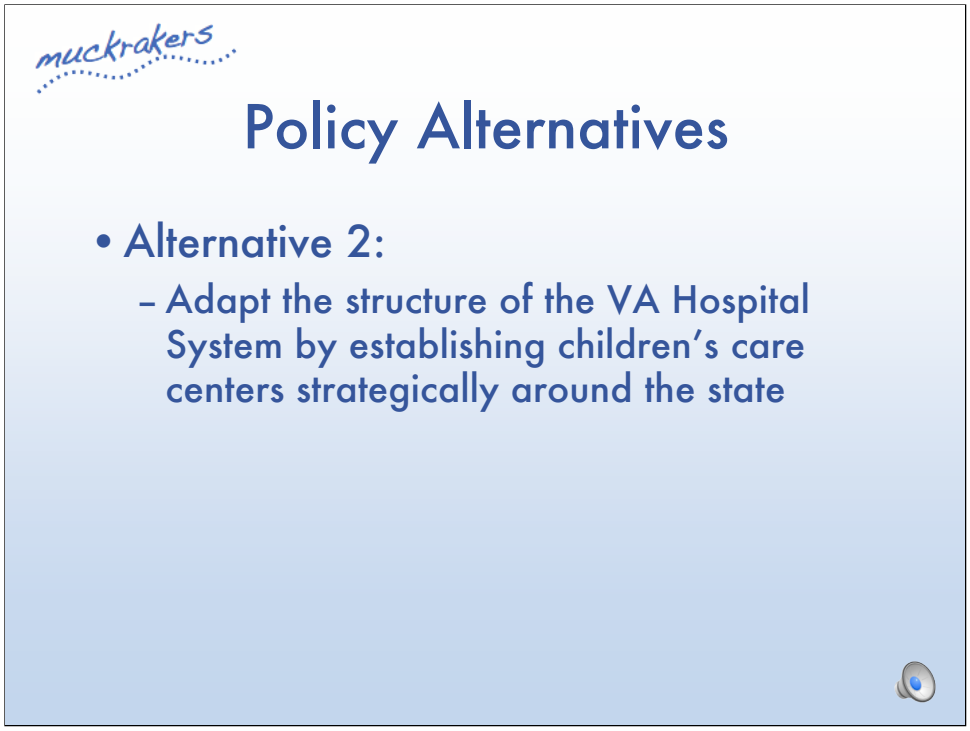


With the context we have just presented in mind, we will now present four policy alternatives with pros and cons of each.

Our first alternative is to absorb all coverage for children into Medicaid, dissolving North Carolina's separate SCHIP program. To maximize the efficacy of this legislation, we would propose that existing administrative and record keeping infrastructure, such as that of the public school systems, be utilized to track and maintain enrollment.

The major pro of this alternative policy is that it simplifies a complex system by taking two programs and combining them into one, which would reduce redundant efforts, both across SCHIP and Medicaid and, with the utilization of the public school records, across different social programs. Both of these reductions in redundancy introduce the potential for significant cost reduction.

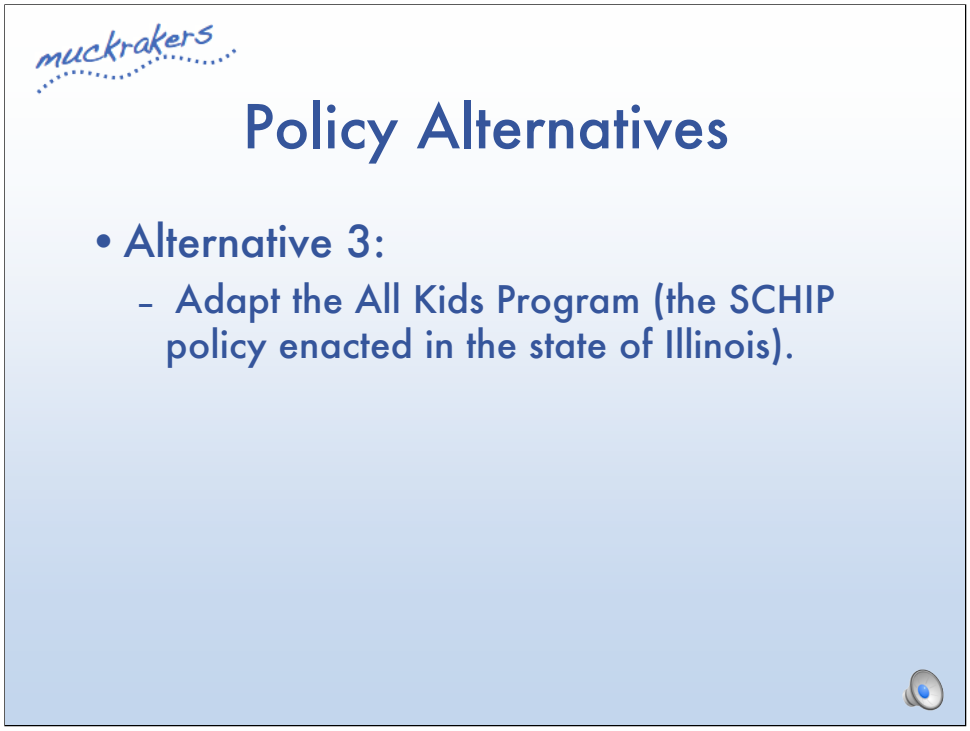
However, this alternative has some major cons as well. First, it would require a major upheaval of existing systems, SCHIP, Medicaid, and the public schools. Secondly, it has the potential to put significant burden on the already over-taxed school system. Thirdly, there would quite possibly be significant initial cost increases due to the major restructuring. And finally, there would be a likely possibility for major job loss or pay cuts for Medicaid and SCHIP case workers.



The second alternative we composed was to adapt the structure and policy that define the Veteran's Administration Hospital System to a care system for children by establishing children's care centers strategically around the state.

There are some major advantages to this policy alternative: first and foremost would be the establishment of consistent care centers for children, which would lead to other advantages, such as potential cost reduction due to standardized practice and the potential for reduction in attrition due to centralized record keeping.

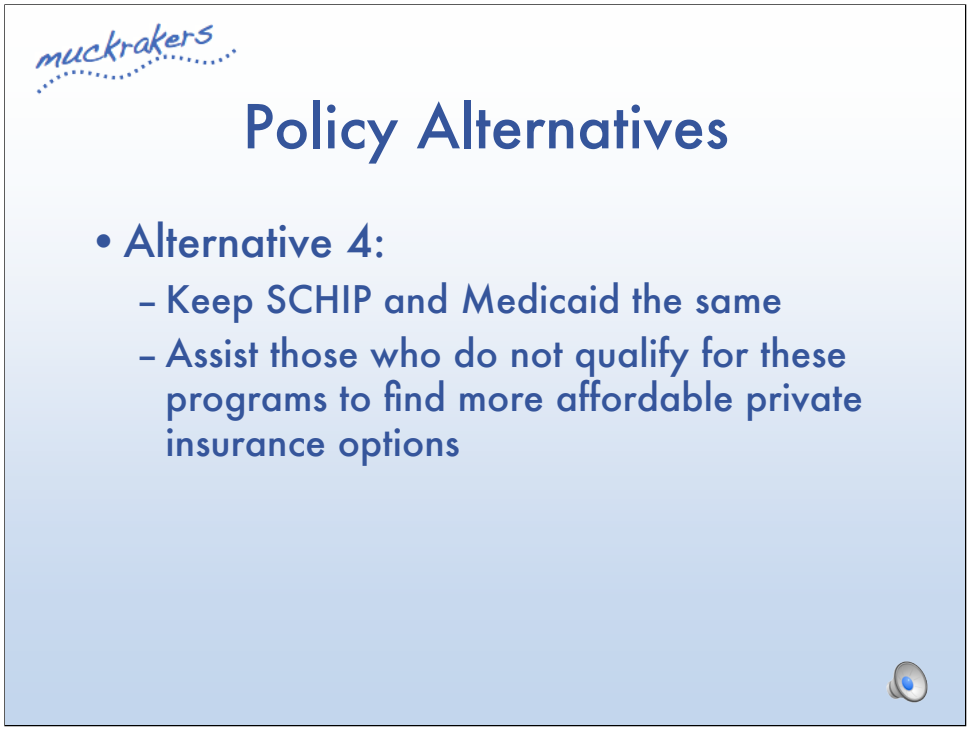
But, this policy alternative, too, has major cons. First, there would be major up front costs to set up the care centers, from construction to establishment, which would probably mean that, at least on a temporary basis, enrollment costs might have to be increased. Because of these increased costs, there might be a temporary rise in uninsured children. There is also the concern that a government provided health care system would lead to significant bureaucracy and poor patient satisfaction due to lack of choice and variety of care centers, analogous to the current military healthcare system. The Walter Reed crisis is one unfortunate example of potential pitfalls of such a system.



Our third alternative also involves adapting a similar policy to fit ours. A number of states have SCHIP policies for which all children are eligible. We found the Illinois All Kids program to be the most likely candidate for adaptation in North Carolina. The All Kids program uses an insurance buy-in approach supported by the existing Medicaid infrastructure. All families in the state of Illinois have the option of purchasing this plan, regardless of income. In their research on privately versus publicly administered plans, they found that a publicly funded plan using Medicaid as the base would be most cost-effective. We liked it because the cost sharing model is fairly simple. Families below 133% FPL pay no co-pay for services and have no premiums. Families between 133% and 150% pay nominal co-pays for services and have no premiums. Families above 150% FPL pay co-pays for services and pay a sliding scale premium based on income. But one of the details we found most appealing is that, regardless of income, there are no co-pays for preventive care. The plan also directly addresses the concern of "crowd out," which is the term appropriated to mean publicly subsidized insurance programs attracting people currently covered under private insurance away from their private coverage and into the public program. In the All Kids Program, premiums for children of higher income families are sufficiently high to be competitive with private plans and therefore prevent All Kids from "crowding out" private coverage.

In developing this alternative, we considered plans from three states that extend coverage to all children age 18 or younger: Illinois, Massachusetts, and Tennessee. We compared demographics and details of the plans with the current climate in North Carolina in considering which would be most viable in the state. We chose to focus on the Illinois program for many reasons. More information on the plans in Massachusetts and Tennessee can be accessed on the MindMap. Adapting the IL All Kids program has many pros, including, most importantly, the extension of quality, affordable coverage for the highest number of children. Additionally, it is an adaptation of a currently existing system, and, therefore, implementation would require no major upheaval. Finally, the program is partially funded by money generated from the minimal premiums paid by enrollees.

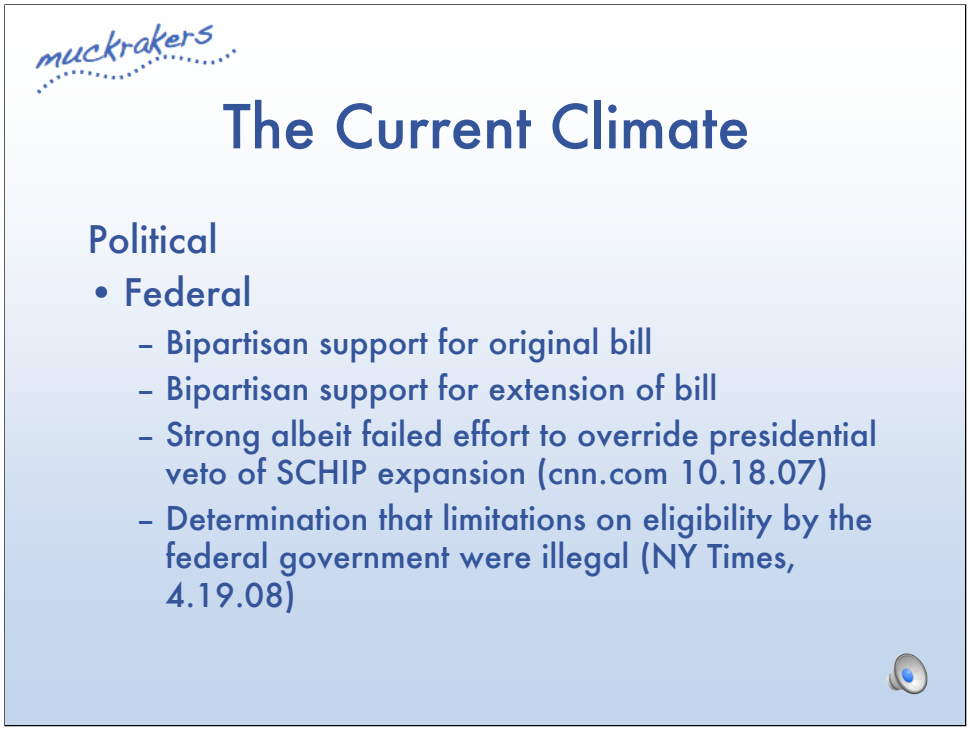
Like our other alternatives, there are always cons. The cons here include a potential increase in cost sharing by enrollees in order to cover more children. Also, this would require the dissolution of the current SCHIP program which would create some temporary upheaval in the system.



Our final alternative is to keep SCHIP and Medicaid the same, and find other ways to assist those who do not qualify for these programs to find more affordable private insurance options.

The major pro for this policy alternative is simplicity: no changes would be made to the current system. There is also the potential that new jobs would be created to bring in people to help those who do not qualify for SCHIP or Medicaid find other affordable coverage.

The major con to this alternative is that it would, of course, put more work on an already taxed social service system. There would also be a potential need for a higher cost for health coverage than would be feasible for the people this policy would be attempting to serve to cover the extra work and new jobs. It is unlikely that this alternative would have a significant impact in reducing the number of uninsured children in the state.

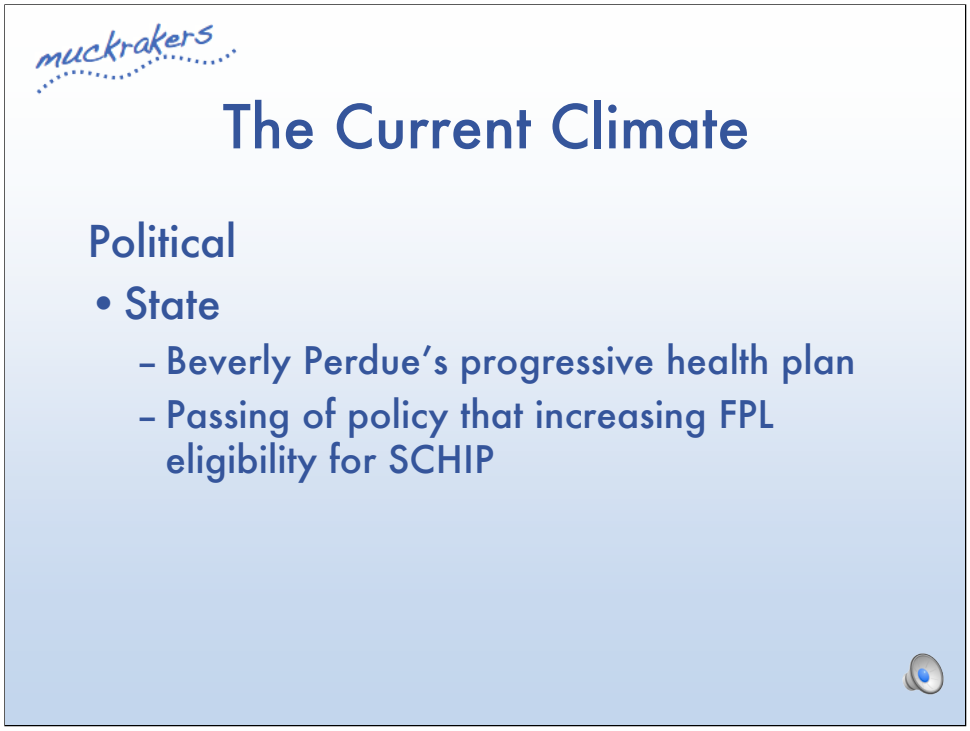


In analyzing the viability of the policy alternatives we laid out we had to determine what kind of policy window we were working with., if any We started by assessing the current climate.

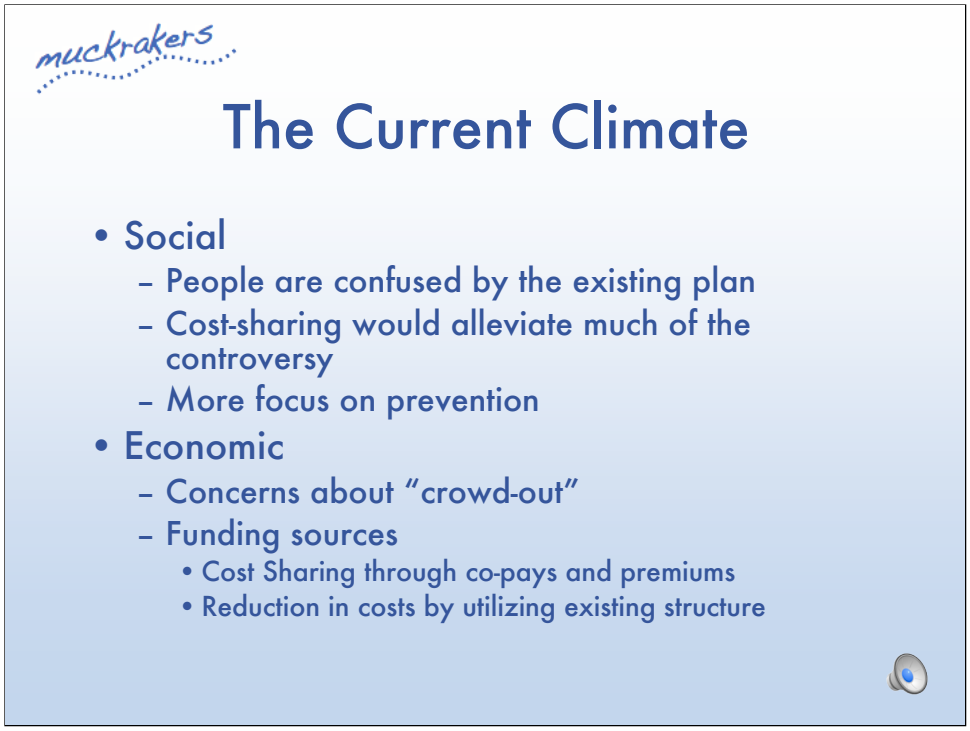
In our assessment, we found that the current political climate is quite definitely ripe for change to this policy;

This policy has had bipartisan support from the beginning, and the extension of the program recently passed in congress continued to attract bipartisan support.

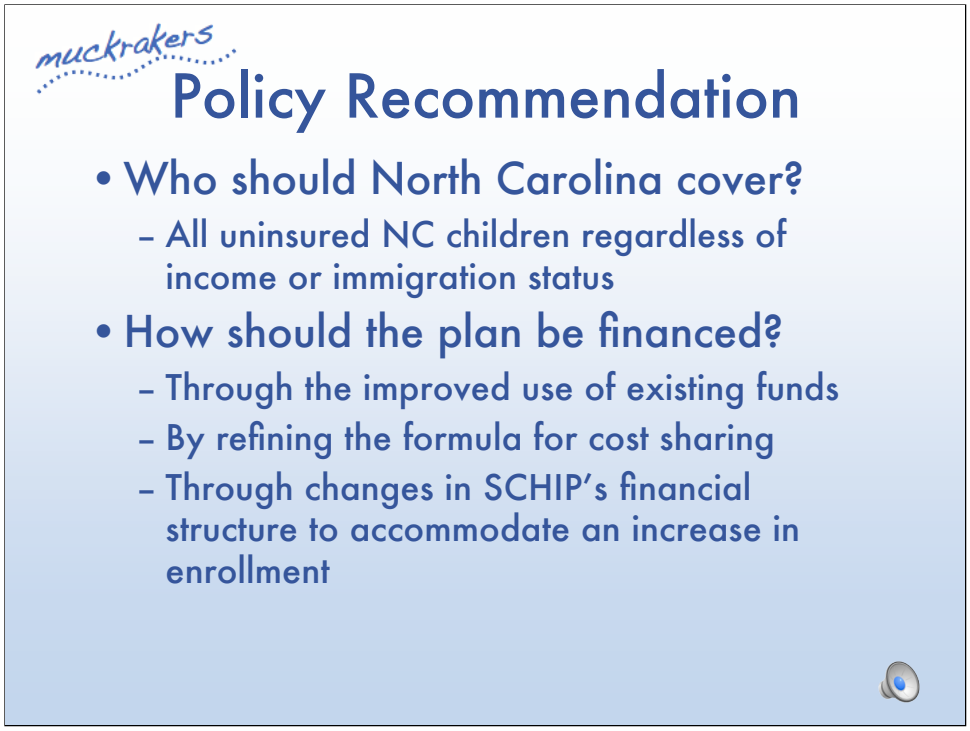
The president recently vetoed an expansion of the SCHIP program, which created an uproar, bringing the problem to the forefront. Even more recently, the limitations that the federal government chose to put on states ability to increase the FPL eligibility cap for SCHIP was found to be against federal law. Finally, it is a presidential election year, and several candidates have progressive health policies. The two contenders for democratic nomination for president , Senators Hillary Clinton and Barack Obama, have progressive health policies.



At the state level, the democratic gubernatorial contender in North Carolina has an extremely progressive health policy. Additionally, the state of North Carolina recently passed policy that increases the FPL eligibility limit for SCHIP, leaving the window open for further policy improvement.



In terms of the current social climate, research suggests that people are very confused by the existing plan. After George Bush's controversial veto of the SCHIP expansion, it became clear that the majority of the public has little understanding about the current SCHIP legislation and benefits. Additionally, in light of the current obesity epidemic and increase in chronic disease, there is an increasing interest in preventive care, particularly with children. Our plan emphasizes preventive care by having no co-pays for well visits, regardless of income. Economically, the majority of the public does believe that people should take some financial responsibility toward healthcare, but that it should be more affordable. Our plan addresses that concern with the cost-sharing structure. But the co-pays and premiums are significant enough at higher income levels to address the concern of private insurance "crowd-out", while still leaving the option open for any family who doesn't have access to affordable employer-based health plans to obtain insurance for their children.



As was stated in our goals, we believe that affordable health coverage should be made available to all children in North Carolina, regardless of income or immigration status. The basis of the field of public health, and of the public's health, is that one man's, or one child's, illness is the community's illness. This can be interpreted literally--a person's communicable disease must be contained or else it could trigger an outbreak--or figuratively--the cost of one persons illness is, ultimately, borne by the community, whether it be in cost of care or in lost productivity. Healthy children tend to grow up to be healthy adults, and health coverage is strongly linked with better health outcomes. Healthy children grow into adults with less chronic disease which will have a dramatic impact on reducing health care costs in the future. Thus, health coverage for all children is vital, and will create dramatic health savings in the future.

The important question is how to pay for this. We believe that through the improved use of existing funds, by refining the formula for cost sharing, and through changes in SCHIP's financial structure to accommodate increased enrollment, a viable and sustainable policy can be developed and implemented.

The Muckrakers Policy Consulting Group therefore recommends an adaptation of the All Kids program in Illinois for implementation in North Carolina. This recommendation is based on a fourfold reasoning structure.

First, this option makes it possible to achieve our major goals; the most important of our goals is to extend affordable coverage to all children in the state of North Carolina, which the All Kids plan does. Additionally, it makes the eligibility process absolutely clear—everyone is eligible—thus simplifying enrollment.

Secondly, preventive care is highly emphasized—no co-pay is required for preventive care—which will save money for the state in prevented illness.

Thirdly, because cost sharing is utilized, the structure of the program simultaneously helps fund itself and quells debate. It also utilizes existing infrastructure from the Medicaid program, which the Office of the State Auditor showed recently could save nearly 16 million dollars.

Finally, the plan addresses concerns regarding crowd out. The sliding-scale monthly premiums are competitive with private premiums, with the high end being sufficiently high to make private plans competitive for those who can afford them, but maintaining affordability for those who cannot. Additionally, a 12 month mandatory waiting period after dropping employer-based insurance is part of the plan--with exceptions for job loss. These features coupled together significantly reduce concerns about crowd out.

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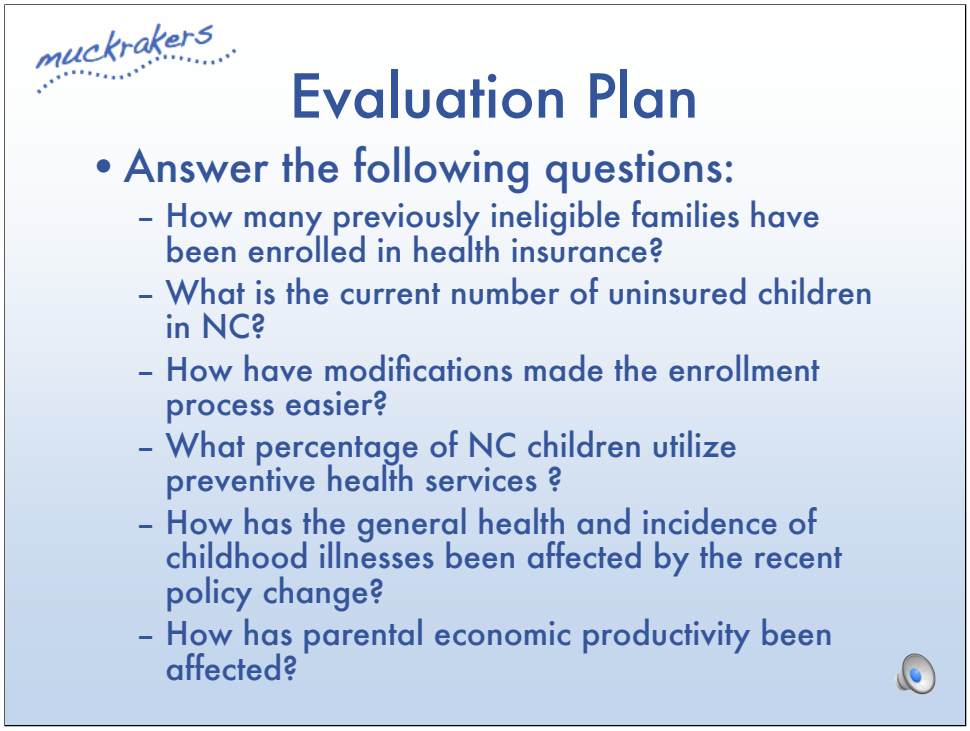
Implementation Plan

Community Needs	Goals	Inputs	Activities	Outcomes
305,690 (13%) children in NC are uninsured.	The goal of the Muckrakers policy consulting group is to advise the Governor on how to implement changes to the current SCHIP program that will: 1.Simplify intake process and expand SCHIP eligibility to include all NC children 2.Decrease the number of uninsured children in North Carolina by 90% in the next 5 years. 3.Increase the general health of NC children by increasing utilization of preventive services by 75% within the next 5 years	1.Six Muckrakers members 2.Program staff 3.Stakeholders (inside and outside government) 4.Key community volunteers 5.Advisory committee 6.Financial and material resources	1.Stakeholder meeting with NC legislature to push for policy changes 2.Develop new staff SCHIP manual working with program staff at NC DHHS 3. Develop, coordinate and establish outreach into rural and suburban communities in NC 4. Training of key community volunteers by program staff 5.Develop and pilot data base specifications on the number of insured versus uninsured children in NC 6. Distribute applications for SCHIP sign up at the start of the school year in schools and other strategic community locations.	1.NC legislature approve policy change to increase funding allocation to SCHIP to cover all children in NC 2. Increased financial resources to fund SCHIP program 3. Key community volunteers increase awareness of parent stakeholders on expanded eligibility guidelines 4. Staff effectively utilize insured/uninsured children data base for program evaluation 5. Increased number of uninsured children served across the state as shown by data base information 6. Increased number of healthy children with a medical home in NC 7.Increased economic productivity of NC parents

This slide shows our implementation plan. It is available in the appendix to the briefing summary, so we will not read it to you. Please read over it at your convenience and contact us with questions or comments.

Our evaluation plan at this stage includes individual self report from enrollees taking several measures including satisfaction with enrollment process, with care received, and with cost-sharing amounts. Also included in our plan is observational data collected from case workers enrolling new members and working with existing members, and secondary data analysis, including claims data from the SCHIP and Medicaid offices to determine utilization of certain markers of care--particularly preventive care.

We propose that the evaluations be conducted at baseline, program implementation, and then annually for the five years following.



In our evaluation, we hope to answer the questions listed on this slide. This list is also included in the appendices of the briefing paper, so we will not read them aloud to you. Please read over them at your convenience and contact us with questions or comments.

We'd like to thank you for your time today. Please contact us with questions or suggestions . We can be reached at muckrakers@muckrakersconsulting.org.