

Elements of State Health Reform: Covering Kids
Kaiser Family Foundation and
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LARRY LEVITT: This is Larry Levitt from KaiserNetwork.org. Welcome to Elements of State Health Reform, a partnership with the National Governors Association. These interactive web shows look at the growing momentum for health reform in the states and probe the key issues policy makers face as they develop approaches to cover the uninsured and make healthcare more affordable.

Today is the final show in our series, and we're looking at what is likely to be the biggest health issue Congress tackles this year, health coverage for kids. This year marks the tenth anniversary of SCHIP, a state/federal program designed to build on Medicaid to cover uninsured children. SCHIP now covers 6 million kids per year, on top of the 28 million covered by Medicaid. Since SCHIP began, the percentage of kids who are uninsured has fallen by more than a third, even in the face of declines in employer-sponsored insurance. Yet, over 8 million children are still uninsured. SCHIP is now up for reauthorization in Congress, and there are a number of proposals for restructuring the program going forward. President Bush has called for SCHIP to be refocused, limiting coverage of children to families with incomes under twice the poverty level and ending coverage for parents under the program. Bills in Congress

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would expand state options to cover additional kids and increase federal funding to keep up with the need. Though the future shape of SCHIP remains uncertain, states have not slowed their progress, and some have begun to put in place initiatives to move towards universal coverage for kids, building on a combination of Medicaid, SCHIP, and state-funded programs.

We're joined today by officials from three of these states. Jason Helgeson is the Medicaid Director for the State of Wisconsin. George Hoover is Deputy Commissioner for the CHIP and adultBasic Programs in the Pennsylvania Insurance Department. And Jacqui Ellinger is Deputy Administrator for Medical Programs in the Illinois Department of Healthcare and Family Services. You can ask questions of the panel at any time during the show by sending an e-mail to ask@kaisernetwork.org. Thanks to all of you for joining us.

Jacqui, let's begin with you. Illinois was, I'd say, the first state out of the block in aiming towards universal coverage for kids. Give a sense of what the impetus for that was, why the focus on kids?

JACQUI ELLINGER: Well, it was leadership from the governor really that started this. When Governor Blagojevich came into office in 2003, he pushed hard for us to raise the income levels of children in our SCHIP program at that time

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and to increase coverage for parents. And with his re-election to a second term, he is trying to launch universal coverage for all Illinoisans. In the last year of his first term, he launched coverage for all children, without regard to income level or whether the children are citizens or what status of immigrant or undocumented children. If they live in Illinois and they need health insurance, we can cover them. So, really, it was the governor's leadership that launched it for us.

LARRY LEVITT: And what are the building blocks of the expansion for kids? How did you use Medicaid, how did you use SCHIP, and what do parents have to pay of the coverage for their kids?

JACQUI ELLINGER: From the outset, when Illinois expanded its coverage for children, we really didn't expand coverage for children until SCHIP first became available. At that point, we were at the federal minimums under the Medicaid program. Until the governor launched the All Kids Expansion in 2005, the children were covered with Medicaid and then the SCHIP expansions. We have always had a very highly integrated program so that families didn't have to decide where to go to apply. We had a single application, and we continue to have a single application. We bear the burden of figuring out where we can get federal money for it

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and what income group the parents and children belong in. Our program has very modest premiums and co-payments at the lower income levels.

LARRY LEVITT: And that's the standard poverty, under 150-percent of poverty?

JACQUI ELLINGER: Well, no. Our premiums don't start until 150-percent of poverty. At that level, one child can be insured for \$15 per month for direct coverage under our program. From there, it does grow with income. At upper income levels, families are paying substantial premiums, but they are still, for those modest-income families, very affordable.

LARRY LEVITT: And how about how nationally three-quarters of the kids who remain uninsured are estimated to be eligible for public programs like SCHIP or Medicaid? What kinds of steps have you taken to try and get those kids enrolled?

JACQUI ELLINGER: Well, we've certainly seen that to be true in Illinois. The statewide expansion for all children was actually effective July 1, 2006. That's when coverage began. The program was announced and passed in the fall of 2005, so for that period of time we had a huge outreach campaign. Since we've been enrolling over this last year, we've seen growth in children enrolled at about

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150,000. Of those, only 50,000 kids are eligible under the expansion, so we picked up 100,000 kids who were not otherwise eligible. We think it's a combination of having a simple message – All Kids means All Kids, and it's a single program state wide – multiple ways to apply, but a single application, and actually as much media exposure as the state can afford, in the way of TV spots and radio. We really get a push that way. With the expansion to more children, the traditional methods of finding the poorest families through social service networks and healthcare providers don't work as well with higher income families. We need to find other avenues to reach them and get those kids enrolled.

LARRY LEVITT: George Hoover, Pennsylvania has been covering kids through a state-only program for quite a while, even before SCHIP existed, right?

GEORGE HOOVER: Right, we actually began to cover kids in 1993 in a state-only funded program and then, with the advent of Balanced Budget Act, provided some federal dollars so that we could expand the program. It's grown from around 60,000 when we had a state-only program to about 161,000 kids right now. Again, our governor sent a clear message that healthcare was really important to him, Governor Rendell, when his first executive order that he signed, upon becoming governor, was the establishment of the Office of

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Healthcare Reform. That office has led efforts in the commonwealth. We applied for a HRSA grant and used that HRSA grant to study the population. We also did a state-only survey to find out more about the uninsured. As a result of that survey, we found out that there were about 133,000 children that were uninsured. About 96-percent of the kids in Pennsylvania do have coverage, but with that's 133,000 too many. We set about trying to resolve that. Our expansion of healthcare coverage for kids was termed the Cover All Kids Initiative, but it was really an expansion to our successful CHIP program. We were not in it quite as early as Illinois was, but through state legislation and budgetary approval and then eventual federal approval of our state plan, we were able to begin to offer coverage to kids this March. We're seeing a pretty good uptake already.

LARRY LEVITT: Is your experience similar, in that many of the kids you see coming in were already eligible for existing programs?

GEORGE HOOVER: About half the kids that we've seen come in so far were eligible for existing programs. We've taken a look at what that data looks like. The majority of the kids who are uninsured in Pennsylvania are eligible or were eligible for the prior Medicaid and SCHIP program. Others, 133,000 kids – only about 25,000 were above the old

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populations. About half the kids that are coming in at this point in time appear to be kids newly have the opportunity for coverage under expanded CHIP program.

LARRY LEVITT: Jacqui, you talked about some of the advantages of a universal program, being able to send a very clear message that all kids are covered or can be covered. Are there some challenges as well, as you go up the income families, to families that have more resources that are more likely to have private insurance? What are some of the challenges in doing that?

GEORGE HOOVER: You're exactly right. Those families probably have had private insurance somewhere in the past and, like other state programs, once families are above 200-percent of poverty, we do require a 6-month period of no insurance or a 6-month go-bare period. Also, higher-income families tend to believe that they're just between insurance programs. Maybe somebody had a job and had insurance, but they lost the job. They believe another job is right around the corner with insurance, but we're finding that as employer-based insurance erodes, it doesn't necessarily mean that the next job will have insurance coverage with it.

LARRY LEVITT: There are a lot of proposals out there now on the presidential campaign trail for universal coverage involving an individual mandate. Massachusetts is poised to

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implement such a plan in just a couple of weeks. It would require people to purchase insurance. In a universal program for kids, do you think you can get to universal coverage of kids, truly covering all kids, without that kind of mandate?

GEORGE HOOVER: I think it become a little more difficult because even a lot of kids who receive Medicaid do go on and off the program. With requirements such as annual renewal and so forth, there are a lot of reasons why families might drop off, or somebody may become employed in the family and they do get private insurance, then once that employment is lost, there is again a gap. One of the things we are trying to do with our kids expansion is also to now look at covering all adults through our Cover All Pennsylvanians Initiative. We believe by broadly adding adults and kids into these programs, we're going to certainly decrease the number of uninsured people in Pennsylvania.

LARRY LEVITT: And Jason Helgeson, let me bring you in. Wisconsin has been aiming at universal coverage for kids as well through BadgerCare Plus. What's the status of that?

JASON HELGERSON: Right now it's a budget proposal to the [inaudible]. It's actually made it sort of halfway through the state budget process successfully. We're quite hopeful, based on the reaction we've gotten actually from members of the legislature of both parties, in terms of

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support of the idea, that in a state like Wisconsin, which has really very low uninsured rates, particularly for kids, we can make that final step forward and ensure that every child has access to affordable health insurance.

LARRY LEVITT: Federal approval is pending?

JASON HELGERSON: Federal approval is pending. We're actually in discussions right now. We're actually going to be one of those states that are going to try to use the Deficit Reduction Act, the flexibility that that relatively new legislation allows states. We're actually going to be requesting very little through actual 1115 waiver [misspelled?]. To be honest, what we're really asking for is flexibility to greatly streamline and simplify the program, which is a key part of what we think makes BadgerCare Plus unique.

LARRY LEVITT: Give us some examples of how that streamlining would work.

JASON HELGERSON: Sure. Right now, there are roughly 20 doors one can go through to become eligible for 1 of 3 programs that exists in Wisconsin for low-income families. There is the AFDC-related Medicaid, which is for very low-income individuals. There is what is called Health Start, which is another program that was an add-on to the basic Medicaid package a number of years back. And then there is

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what's called BadgerCare, which is our version of an SCHIP program. For each of these programs and even within those programs there is a whole bunch of different ways that income is tested and eligibility is determined. That's a lot of time, a lot of effort, a lot of information that a family needs to provide. Families, although they may bounce from one program to another during a year, it has no effect on their health coverage. Their health coverage is the same. What we're proposing to do is merge those three programs, significantly streamline them and go to one definition of income, not 20. And through that streamlining, we hope to actually get rid of a lot of the barriers that exist to low-income children getting access to healthcare.

LARRY LEVITT: Will that definition of income look most like one of the existing programs?

JASON HELGERSON: It's going to be a very close to gross income with a couple of minor adjustments, so basically what shows up on a person's check every week or every month will be basically what their income is. We think that by getting rid of all these adjustments – which, frankly, have very little impact on someone's eligibility when we're talking about this subset of the population – it will really be a major innovation that will help us get kids signed up for healthcare.

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LARRY LEVITT: Part of this expansion has been aimed at bringing more parents into the program as well. George talked a little bit about covering whole families and the advantage that has. Is that something that you've found as well?

JASON HELGERSON: Absolutely. We're one of those states where our SCHIP actually covered adults and we've made covering families a key part of our overall strategy for more than a decade. I think what BadgerCare Plus does and our experience with BadgerCare and other programs to date is that when you actually offer health insurance to the entire family, you actually are going to get a lot better uptake rates. Right now in Wisconsin, we estimate that roughly 50-percent of our uninsured kids appear to be eligible for our programs today, which is, obviously, less than the national average. I think that our approach to date has really helped us in getting more kids signed up.

LARRY LEVITT: I'm going to move onto some of our e-mail questions, since we've gotten many. The first concern is funding, which I'm sure is something you all think about quite a bit. The question is about cigarette taxes as a way to fund children's healthcare. This comes from Oregon. Let me start a little bit broadly, Jacqui, with you. There is state money in the expansions you undertook in Illinois.

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Where did that come from? Was that just in the normal part of the budget process? Was there some earmark funding?

JACQUI ELLINGER: For the most part, our match comes from state general revenue funds and special taxes, cigarette taxes or other things, are always an option, but at the end of the day, there are many demands at the state level and it really depends on the political will to use what resources are available for coverage for children. When we started, when our waiver in Illinois, we did convince the federal Centers for Medicare and Medicaid Services, HICFA at that time, to allow us to match some state-only programs that brought us in some more federal money that we then turned around [interposing] and used to cover more parents.

LARRY LEVITT: These were pre-existing state programs?

JACQUI ELLINGER: They were pre-existing state programs and they represent the adults who aren't parents who we cover in Illinois. It's only 1,500 people. It's not very many. But by far and away, this is state general revenue money for us.

LARRY LEVITT: George, is it similar in Pennsylvania?

GEORGE HOOVER: We do use some cigarette tax money. It's basically general fund money and cigarette tax money. Those are the two primary sources.

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LARRY LEVITT: And what were the politics of using the cigarette tax money?

GEORGE HOOVER: Well, we actually got our state program started with cigarette tax money back in the early 1990s. Once we had that in place, we've been able to add just a bit more to the cigarette tax and use additional general funds.

LARRY LEVITT: And how about issues of sustainability? Is this a yearly struggle, or do you feel that the funding is stable now, at least at the state level?

GEORGE HOOVER: Yes, I think it's been fairly stable. There was some interest when we went to the expansion recently about where the funding was going to come from. We, of course, are always required to do five-year budget projections when we implement a new program so that we can be sure we can sustain the program. Just based upon the fact that we've been good spenders of our dollars over time, we've actually had an excess of SCHIP dollars, so we do have some money in reserve. By having that money in reserve, we could see ourselves through that five-year period without additional taxation.

LARRY LEVITT: Jason, you talked about being in the middle of the budget process now, the governor's initiative was as a budget proposal. How are the funding discussions

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playing? Are they paramount, or are they part of the discussion?

JASON HELGERSON: Oh, yes, absolutely. I think the thing is that, in terms of our expansion to cover more kids, since we are a state that covers the overwhelming majority of kids – over 96-percent – the cost implications of BadgerCare Plus are not that significant. But in terms of the cigarette tax, in particular, the governor has proposed \$1.25 increase in cigarette tax, which we believe is the largest, one-time increase in cigarette tax any state has ever tried. Obviously, we think the cigarette tax has two-fold benefits. One, it actually is a revenue source that the overwhelming majority of Wisconsin residents think, in polls that they've done, that's appropriate. The governor has proposed to use that funding source basically entirely for healthcare. Also, it has the added benefits of reducing smoking, particularly the youth smoking, which, in Wisconsin, is a problem. So we think that it's actually a very good policy choice.

LARRY LEVITT: And do you worry about people saying that if you're successful with the cigarette tax and reduce smoking as you said that you actually put yourself in a difficult position from a funding perspective?

JASON HELGERSON: Well, in a sense, the Medicaid budget in Wisconsin is about \$5 billion. About \$2 billion of

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that comes from general tax revenue and the increase specifically, which is what is being earmarked, is actually a fairly small percentage of the total, but absolutely right. If we're successful and smoking decreases, it will certainly not be a growing revenue source and potentially be a slightly declining revenue source, which we will have to deal with. But I think in Wisconsin healthcare has been a major priority and, despite some of the worst budgets in state history, we did not cut off a single individual from healthcare, which I think is a tribute to Governor Doyle's commitment to healthcare, particularly for kids.

LARRY LEVITT: Let me ask you something. Many states have suffered budget problems in the last few years. Were there cutbacks in any of your states during that period, either moving backwards in terms of simplifying the process and doing outreach?

JACQUI ELLINGER: I can say for Illinois that we've had no cutbacks in eligibility or the scope of benefits covered, but we've done a lot to reduce our spending in the area of drug prices particularly and also we are now launching a new primary care case management system, which some people may be well aware of. We have not been a heavily managed care state in Illinois, but our All Kids expansion was – you asked me about taxing for financing it – financed

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by finding the money within the existing budget, through both primary care case management a new disease management initiative, to improve service delivery and, at the same time, utilization of services and reducing the costs. That's the way we've been able to hold the line there.

LARRY LEVITT: Let me follow up. We had another question from your home state of Illinois. How much of what is spent for SCHIP goes to the insurance industry and how much to care providers? You talked about not being a heavily managed care state. Has that been controversial, moving to a primary care case management?

JACQUI ELLINGER: Actually, I don't think it has. Primary care case management actually doesn't involve insurance companies much. We have some managed care in Illinois. It's been voluntary under the Medicaid program. We haven't required people to use HMOs, but they've had that choice in about six of our counties where HMOs operate. Primary care case management is a system where individuals who participate have to enroll with a primary care provider, who then controls their care and refers them for other care.

LARRY LEVITT: And that's through the traditional program, not necessarily [interposing]?

JACQUI ELLINGER: That's through the traditional program. We're still paying those doctors directly or the

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clinics who participate directly. They don't take on any risk for services. The state is still bearing the risk for the services that are provided. It's actually going pretty well so far. We're implementing slowly, in stages and carefully, but we think it's going to work well.

LARRY LEVITT: How about in Pennsylvania, are you programs heavily managed care?

GEORGE HOOVER: Yes, Pennsylvania's programs are heavily managed care. In the Medicaid program, about two-thirds of the eligibles are enrolled in managed care. In the SCHIP program, everyone receives their services through a managed care program. We're pretty saturated with managed care in Pennsylvania.

JASON HELGERSON: For the BadgerCare Plus population, over 70-percent is in managed care. Our goal within the next couple of years is to get as close as you can get to 100-percent, obviously with a line with some people with complex conditions topped out, but it's a big part of our initiative.

LARRY LEVITT: And have you used, for the sake of a better term, mainstream insurance plans, plans that are generally available to the commercial population or more targeted Medicaid-only or SCHIP-only –

JASON HELGERSON: We actually have a good mix. It's interesting because we've moving into pay-for-performance

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within managed care, which is going to be interesting to see as we actually put portions of the capitated rate at risk based on their actual ability to achieve specific performance measures, how the various plans compete and do. But, yes, we have commercial plans as well as Medicaid only.

GEORGE HOOVER: In Pennsylvania, we have the same, too, especially in the SCHIP program. We have eight contractors that serve individuals in the state. About five of those are just commercial plans and three are also Medicaid plans.

LARRY LEVITT: I just got a question from North Carolina about the relative merits of enrolling children in Medicaid or SCHIP versus providing premium assistance to get them enrolled in private insurance. We talked earlier about some of the challenges as you move up the income scale, in terms of families having more resources and being more likely to have private insurance. Have any of you built in any premium assistance for private insurance into your plans?

JACQUI ELLINGER: Illinois has. Because of the artifact of the way the federal law is structured, we do it in a curious way. I think it's curious. It's only available to families between 134-percent and 200-percent of poverty. To offer it to families at the Medicaid level, the federal requirements – Jason talked about trying to get away from

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some of the incredible requirements embedded in Medicaid law – are just too difficult administratively to do it at that level. We've handled that by letting families choose what they want to do. Under our SCHIP program and with our SCHIP waiver, families can move in and out of direct coverage. They can keep their private insurance and take direct coverage. They can not take direct coverage, but choose our premium assistance instead. We called it All Kids Rebate. We found that it has been very effective for families to choose what works best for them.

LARRY LEVITT: What percentage of kids end up being covered under the premium assistance?

JACQUI ELLINGER: I don't know that number off the top of my head, but it is relatively small. It is really not a whole lot, but it does allow families to take advantage of that employer-sponsored plan.

JASON HELGERSON: Along those lines, I think that we are actually proposing some significant changes to basically allow us to do it. Right now, we have a program that's fairly small, but we actually think that through some administrative changes we can open it up to a whole new set of people. One example is right now we have to basically be able to be buy people in the family coverage, which tends to be lower employer subsidy to those types of plans, but we

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think that we just might buy and adult, the parent, into the insurance through the employer and then cover the kids through the regular plan. That might be a way to get more adults into private insurance.

LARRY LEVITT: So you would just sort of take that mixed approach where you would actually do the premium assistance for the parent, but keep the kids in the state program?

JASON HELGERSON: Absolutely. We think that change, in and of itself, will help us significantly increase the number of people. We definitely want to keep the employer-sponsored insurance system up and running. I think whenever you expand to higher incomes, that's one concern you always have to take into account.

LARRY LEVITT: When SCHIP was first passed 10 years ago, there was a lot of concern about crowd out, about the expansion in public coverage crowding out private insurance. What has the experience been? Is that something you've actually noticed happening a lot in your states?

GEORGE HOOVER: We've tried to measure crowd out effectively each year since our program has been in place. We've never really seen any evidence of real crowd out, but there was a real concern about that when we did our expansion program because now we were going to cover children in higher

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income levels. Two of the parameters that we've worked with in Pennsylvania to try and minimize crowd out is, one, for children in families with incomes above 200-percent of poverty, there is a 6-month go-bare period, except for kids under the age of 2. There is no go-bare period, regardless of what income is. But we also do a match. Prior to authorizing anyone above 200-percent of poverty, we do a match with a third party source that can tell us whether or not any of those children have had insurance any time within the last six months. It's working out quite well. There was a concern that maybe families would come to us and not have met that go-bare period, so we instituted a match and it's working out quite well.

LARRY LEVITT: We have another e-mail question about undocumented immigrants. This came up a little earlier as well. Jacqui, you said Illinois does cover undocumented immigrants. You can't use federal money for that, right?

JACQUI ELLINGER: That's right. We can't unless it's an unborn child, a pregnant woman. We are using federal money to buy prenatal care services for undocumented pregnant women.

LARRY LEVITT: And are these kids or women in the same program as everyone else? It's just you're segregating the financing, not the coverage?

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JACQUI ELLINGER: Yes, that's right. But we also cover children who are undocumented if they are residents of Illinois. We've dropped the requirement that they show us that they have either a citizenship or alien registration status here.

LARRY LEVITT: And has it been an issue in Wisconsin or Pennsylvania?

JASON HELGERSON: We are not proposing our BadgerCare Plus to cover the undocumented population because it is a Medicaid expansion. Actually, we're doing it through SCHIP, the coverage of the undocumented pregnant women and it's been a highly successful program because it's good that the federal government at least recognizes that when that child is born and we are then, therefore, bearing the financial cost of that, it makes sense to make sure that the mother gets prenatal care because it's so essential. But that part has been a successful program already.

LARRY LEVITT: I want to come back to this idea of enrollment outreach and simplification. Jacqui talked about some of the steps that they took in Illinois. We had a question about enrollment to reach the lowest income of the group, people under poverty. George, talk a little bit about what you've done in Pennsylvania to bring kids in, particularly the lowest-income kids.

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GEORGE HOOVER: Well, we believe the Cover All Kids message is certainly going to resonate. One of the things we had done is through the Gallop Survey Group [misspelled?]. We had tried to study to see whether or not people were well aware of the CHIP program and what their impression was. We found out that, yes, 90-percent of people are aware of CHIP and most of those folks have a favorable impression, but also we found out that families thought, even some of the lower-income families, that we considered them "no me's." They thought that because somebody was working in the family that they probably weren't eligible. We believe the Cover All Kids message now makes families realize that they will be eligible, despite the fact that there is income. It would just mean a difference in terms of the premium that they would pay.

LARRY LEVITT: The truth is that not all kids are eligible for a subsidy in Pennsylvania. The highest-income families can buy into the program, but pay full cost. But just the mere fact of this universal or All Kids message you're finding is able to- [interposing]

GEORGE HOOVER: Right, it provides an opportunity and as you said - you're correct - below 200-percent of poverty, there are no premiums. Between 200-percent and 300-percent of poverty, the premiums range from about \$38 a month to

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about \$60 a month per child. Then above 300-percent of poverty, as long as insurance is either inaccessible or unavailable to the child, the family can buy coverage. That average about \$150 per month, per child, but there is no federal or state subsidization involved with that.

JASON HELGERSON: One other thing that I think that we're at least trying in Wisconsin, which we hope will actually help us get some of those really low-income kids, is presumptive eligibility, which is really a way to open the door to a whole new range of options for getting kids signed up. Presumptive eligibility basically allows you to go through a much more streamlined process for signing a child up and it basically allows paperwork, things like identity and citizenship requirements to basically catch up and get a child access to care that might have otherwise taken a month or so to get access. It might have been the initial thing that stopped the parent and had them thinking, oh, boy, this is just something I'm not going to be able to deal with to be able to access. We think that through that we will be able to have community centers, YMCAs, WIC clinics, public health departments and a whole wide range of actors now become part of the process of getting kids signed up for healthcare, which we think would be a very powerful force. You don't have to go down to the county Welfare office to get access to

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healthcare. You can go to your school on the first day of school by having somebody with limited training and access to the internet. We think that will be major improvement in access to healthcare for kids.

LARRY LEVITT: You mentioned the documentation requirements that were put in place recently in Medicaid. What's been your experience with those?

JASON HELGERSON: We've been told we have the best statistics on this, and we have seen a significant negative affect of over 10,000 individuals losing access to the programs because of the new requirements. The overall bulk of those individuals lost it because of the identity requirement, actually having a picture ID. Interestingly enough, we were able, through data matching, to determine that basically 90-percent of our current program participants actually are citizens, which actually shouldn't be any surprise to anybody who's actually looked at this issue seriously. Yet, we still have this ID requirement, which is really problematic. What we hope to do is that through presumptive eligibility does is allow some of these things to catch up. It doesn't mean that if you show up on day one you will get automatically rejected and told to go home and find a picture ID for your 12-year-old child or get one made. This way, at least you can get determined eligibility and

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therefore find the ID and it gives you a number of weeks to get that accomplished.

LARRY LEVITT: So even the families that were lost in the shuffle through the identify requirement, not all of them were actually ineligible, it was simple the requirement itself?

JASON HELGERSON: Yes, and that's what we strongly suspect. Considering we were able to prove their citizenship, chances are it's just a question of making sure they have the picture ID. We think that over time, as people have adjusted to procedures, we've caught a lot of those people back, but it's kind of hard to determine exactly who we haven't gotten back. But, yes, it was a major problem when it was first implemented. It was just one of those things that it was not a well thought out policy at the federal level. It caused a lot of angst and a lot of cost at the state level, in terms of trying to deal with it.

LARRY LEVITT: Jacqui, Illinois has been doing the outreach efforts for quite a while now. Is this a one-time thing, or is it something that has to be sustained?

JACQUI ELLINGER: Outreach is something that I think has to be sustained because there are new children all the time and there are families coming and going and because employment status changes. I do think it does need to keep

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going, although having an All Kids program – All Kids is still relatively new to us, that branding is relatively new. I think that the longer we stick with that name, the more it will become routine. Every time we have a media push, we do see a bump in applications and we do see a bump in enrollment that tends to flow out of that. I think it's part and parcel of every strategy you can use. Jason mentioned presumptive eligibility, which we've been doing for a long time. About two years ago, we eased up on the re-determination process in Illinois to make it easier. If families don't have changes, we just allow the children to continue enrollment. We have 12 months of eligibility. That who array of things that takes families who really have very little means, at the lowest levels, very little income, no discretionary income and probably very little energy to deal with things they don't have to deal with. So, if you child isn't sick, getting that message across that it's important to have preventive healthcare and preventive dental care is really tough. I think that, to the extent that you can, you should maintain a presence with the general media so that everybody knows this is available and children should get healthcare. We're trying to make it right. We've made it available. Come and make use of it now.

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LARRY LEVITT: George also talked about some of these families being between jobs and coverage, or at least believing they're between coverage. The kind of steps you're talking about – let's say 12 months guaranteed coverage, raising income eligibility levels – presumably stabilizes the program to some extent as well. It minimizes the turnover.

JACQUI ELLINGER: That's one thing we certainly hope. We still, though, demand premium payments. Even at those levels, it's sometimes tough for parents to keep up the premiums. I think that would be the one thing that most frequently disrupts coverage, that they stop paying their premium. And then we do have some barriers in place for getting back in because when we established our program, there was a goal to make it look like private or employer-based insurance. To get that insurance, you have to pay for it, whether you use it or not. That's a message that is still a philosophy that underpins the program, but it does cause some disruptions.

LARRY LEVITT: George, you talked about putting in place premiums for, let's say, the higher lower-income families and then asking families above three times poverty to pay the full cost. What's been your experience with that as a deterrent to enrollment?

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GEORGE HOOVER: I can speak to this. Prior to our expansion, we did have a component of our program that went from 200-percent of poverty to [inaudible] percent of poverty where a family paid half the premium. That averaged about \$65 or \$67 a month. Families told us at that time that at that income level it was a tough premium to sustain. So when we developed the premiums for Cover All Kids, actually, that same group that had to pay \$67 or \$65 a month now only has to pay about \$38. We were sensitive to the ability for families to pay, and we tried to develop our premiums with that in mind, while still having an upper-level cap of above 300-percent of poverty paying the full cost.

I did want to add one other point, too, that I think is really important to understand about keeping the families connect, and that is the importance of community partners and community agencies. An awful lot of folks may or may not respond to a TV ad that we do or a piece of literature that they find, but if they have someone that they trust in the community that is willing to explain the program to them, or maybe can even lead them to the program, that can be quite helpful. Probably the collective three of us have spent many, many years trying to make forms simple. At the end of the day, you just have to ask for a lot of information and some forms can never be totally simple. We've added over-

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the-phone enrollment where folks can call a 800 number and the enrollment can take place over the phone, an application can be submitted for them, as well as a re-application. I think some folks are just always going to struggle, whether it's a literacy level or whether it's the terminology that we maintain. It has to be simple, but it just isn't quite simple. I think that presents a struggle. I think by having our arms out to the community and by having the community helping us enroll, as well as re-enroll children, we will be more successful.

LARRY LEVITT: In working through community partners, does the state provide funding to these organizations to help out with this?

GEORGE HOOVER: Well, we really don't. We had, at one point in time, funded 20 mini-grants. Those were small grants that generated a lot of activity. I do have to tell you that when we started that, we weren't sure how many organizations would be interested. We got about 180 applications from organizations around the state. We funded those 20, but, with many of the other we had to deny, it actually generated some interesting and built up some momentum and they went out and found funding through other sources. Some of that funding still continues today, so there are an awful lot of folks that, when you plant the

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idea, really want to do a good job to try and help you enroll kids.

JACQUI ELLINGER: I'd like to talk about what Illinois does in the way of community partners, because it's really an important part of our plan. We do pay, but we pay for a particular kind of performance, so we have established all-case application agents. They sign a little agreement with us and we train them. Their job is to take applications and assist families in completing applications. They only get paid if the application they send us is for a family that has not already been enrolled. They have to check so we don't get duplicate applications. It has to be a new enrollment, not just adding a child to a case. The application has to be complete. I think George made a great point about how we really struggle to make these simple, but the laws just aren't simple and the information we need to decide how to pay a medical bill isn't simple either. These application agents have been very productive for us. The applications that we get from these folks we pay, over time, have resulted in 80 to 90-percent payment, which means 80 to 90-percent of the time they're finding families who are not already attached to us and who give us complete information to make that decision. That's been very productive. It was a little tough to get off the ground and to put the payment

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system in place, but in the long run it's been very productive and they've been great partners.

LARRY LEVITT: And how about collecting premiums? It's actually not a common function for a Medicaid agency or a public Welfare department. Have there been logistical and administrative challenges in making that work?

GEORGE HOOVER: So far it's working well for us. All of the premiums are collected by our contractors, and those are contractors that are used to having premium assistance for their private insurance. We put the responsibility on the contractor. That's who the premiums are paid through. I think that's one of the reasons why our program works so well. In the CHIP world, families identify with their healthcare contractor. They never really have to work with the insurance department, since their relationship for application, renewal and premium payment is always through their healthcare contractor.

LARRY LEVITT: You're in the insurance department. Is that historically how this program has been run, out of the insurance department?

GEORGE HOOVER: Absolutely, yes. When the program first started with one person back in 1993, it was decided that it would be started in the insurance department. I think that does help families decide that what they're

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applying for is insurance, but it's remained in the insurance department. We actually think that that helps make our program successful because the CHIP is a form of health insurance. It certainly resonates with families, in terms of they respond. When we do advertisements, quite often about 40-percent of the applications we receive we actually send over to the Medicaid Agency, because people respond to ads about insurance and about healthcare. I think we probably are the best outreach effort for the Department of Public Welfare, which manages the Medicaid program in Pennsylvania.

LARRY LEVITT: Jason talked about the idea of streamlining. Have you all thought about this?

JASON HELGERSON: Yes, what we're actually in the process of doing is actually turning it into a one-page application form. That is literally what we're seeking to do in the Deficit Reduction Act, to get enough flexibility [interposing] a front-back application. In Wisconsin, we actually run a program called SeniorCare, which is the last pharmacy-plus waiver program that exists in the country. Our experience with that is that seniors signed up for this program all across the state, love it, would stand up and cheer and say, "I'm part of this program." And most of those seniors have no idea that they're on Medicaid. What we're trying to do with our low-income family population, through

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BadgerCare Plus, is go to a program and try to, to the greatest degree possible, eliminate the stigma associated with signing up for a "public welfare program." We want to do many more applications via the internet, for which we have a very good tool that we can already utilize, plus over the phone, which we've been doing for years. So through this mechanism, we hope to make it so that people will just get their little card that says BadgerCare Plus on it and, like the SeniorCare population today that serves over 100,000 people, have them not even think about the fact that they're on Medicaid. That's not going to happen tomorrow, but I think in order to really get people - particularly those folks who are a little hesitant to sign up, because they think, well, I have a job and I'm not on public assistance, therefore I'm not eligible. We need to get those people to start thinking about how healthcare is an essential thing and everybody has a right to have access to in our state. I think that's going to be a major initiative that's really going to take years to really try to hone if we're going to be successful.

LARRY LEVITT: This idea of using the internet for application, are you finding that that may be an effective strategy for families directly, or for application assisters?

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JASON HELGERSON: It's both. We couldn't believe when we actually put it up. We've been expanding its use ever since for the existing population. I can't even remember the number of hits we got in the first month we had it up and running, but it was incredible, over 10,000 hits or something like that. We think that it's actually a growing tool that, yes, individual families can access or that individuals or organizations or churches can access. I think that's one of the other organizations we're particularly excited to work with. Parts of our plans are mini-grants to try to give out to individuals because a lot of times the best messenger is not somebody who works for the state or works for a county Welfare office. It's somebody in the church or in the community who understands and knows that person, who can convince them that this is a good program for them. It's not just about getting access services that day. It's about buying an insurance policy or getting into a program to get you that preventative care. That's a lot more one-on-one communication that is necessary to really convince people why that that's important.

LARRY LEVITT: I want to come back to some of our E-mail questions. We've gotten a number of questions about the benefits in these programs, the actual coverage services, whether it is substance abuse services, EPSDT under Medicaid

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or prevention services, which you mentioned. Jason, you've talked about simplifying these multiple programs, these multiple routes in. Does that also involve simplifying the coverage and making uniform coverage [interposing]?

JASON HELGERSON: Sure. Under the BadgerCare Plus, basically for the existing population of currently eligible [inaudible] programs, they will continue to have the same rich Medicaid benefit that have today. For the higher-income individuals, we designed a benchmark plan, consistent with what the Deficit Reduction Act calls for, which gives states flexibility in benefit design. It's much more closely routed to – in fact, it's based on the most subscribed to HMO plan in the State of Wisconsin. Our idea is that we will offer these two different benefit packages. The idea there is to help minimize crowd out at the higher ends, but try at the same time to keep it pretty simple so that people understand what it is that they're eligible for.

LARRY LEVITT: George, what was your experience when you originally the state-only program and the SCHIP program? Was this a program that had different benefits from Medicaid?

GEORGE HOOVER: Yes, it actually had lighter benefits than Medicaid. We have added some benefits since that point in time, but it doesn't have the early-screening kind of coverage that you receive under Medicaid. We came up with a

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plan, not unlike what Jason talked about, where the Medicaid program provides the extensive coverage with wraparound services, but our CHIP benefit is more like the private, commercial, HMO-type coverage. It's a good program with pharmacy and mental health services. Maybe not as extensive as under Medicaid, but still families tell us that they're pleased with the benefits that they receive under the CHIP program.

LARRY LEVITT: And Jacqui, you had talked about not primarily making use of private managed care, but how about the benefits, are there still different benefits between Medicaid and –

JACQUI ELLINGER: They're very minor differences. We have a very broad coverage and I think we want to keep it that way. We deal with the upper-income families by having much more aggressive co-payments and much higher premiums for them. In reality, those children who need higher, more expensive services can bankrupt a middle class family faster than anything else. One of the hottest issues in our state is children with autism. Many of those families at least look like they're well-off, but the costs of services are overwhelming. We've dealt with it by asking those higher-income families to contribute more on the front end, but not curtail a benefit package.

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LARRY LEVITT: We're approaching the end of the hour and I want to talk a little bit about the SCHIP reauthorization process, which I'm sure is front and center for all of you in running these programs. Jacqui, there are a number of issues in this reauthorization process. There is the overall funding level and the allocations to states. There are some proposals, as I mentioned earlier, by the President to refocus the program to limit enrollment to kids under 200-percent of poverty and to limit coverage of parents.

Going into this process, what are your biggest worries and/or your biggest hopes?

JACQUI ELLINGER: Well, we rely very heavily on SCHIP funding to finance our parent coverage. There aren't a lot of states that have done that. That's been a controversial issue, but it's really important to us. When Governor Blagojevich came into office, we covered parents at 50-percent of poverty. That's as far as we had gone.

LARRY LEVITT: Give us a sense of what the income level of that is. It's under \$10,000- [interposing]

JACQUI ELLINGER: For about a family of four, yes. It would be very low. I don't even like to think about it. Going back to that, it's inconceivable in some respects, but I think it will have a really detrimental effect on

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enrollment of children. As we have looked at enrollment, our threshold of eligibility for children last changed in the year 2003. Parent income eligibility continued to rise after that time in Illinois. Even though the children's income threshold didn't change, as the parents' threshold changed, so did the enrollment of children, so they track really closely. It looks like, on paper at least, that treating a family as a family is a powerful effect in getting everybody covered and getting kids covered. Often it will be the parent who needs the healthcare and the whole family comes along and the children get covered at the same time. That parent coverage is very important. The overall funding amount is key. We've, across the states and in various ways, made tremendous progress here. It would be a terrible thing to cut that cut that back in the name of some sort of equalization to keep everybody at, what, the lowest common denominator? That hardly seems like a productive way to use the money. Then I think that state flexibility is important. If the state has the money within its allocation to raise the income threshold to 300-percent of poverty, why not, why not cover more families? These are still working families without a lot of discretionary income and their children definitely need that healthcare. There are many other things. Not imposing that citizenship documentation

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requirement under SCHIP would be key. Basing the funding allocation formula on what states actually spend, rather than trying to base it on the uninsured child population in the state, because I think one thing we've proven is we do not have good measures of that. Illinois, at one time, paid for a study. We spend \$0.5 million to do our own study of how many uninsured children we have in this state. What we've mostly seen is that the current population surveyed just doesn't do a very good job on a state-by-state, year-by-year basis. It's just not a good enough tool. It's a very crude measure and it doesn't [interposing] well.

LARRY LEVITT: And where has Illinois been with its allocation? Have you used the full allocation previously?

JACQUI ELLINGER: [Laughter] We've used more than our allocation. Early on, we failed to use more of our allocation and recommitted ourselves to make certain that we didn't. If you look at redistributed funds that other states have not used, you will see in recent years that Illinois got a very substantial portion of those. So we've been very aggressive at using SCHIP money.

LARRY LEVITT: George, you talked about not using the full allocation in Pennsylvania, right?

GEORGE HOOVER: Right. That really helped us quite a bit, Larry. When we went to CMS, it was very helpful to us

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in the process. It was right about the same point in time that the President was saying he wanted to focus on 200-percent of poverty that our state plan was in front of CMS and there we were wanting 300-percent of poverty, but because we had money in reserve – at the beginning of the year, we had about \$165 million in reserve – that was not a big issue. CMS told us that we were wise spenders in the past, so they didn't have that concern. The biggest discussion with CMS with the state plan in Pennsylvania was to have the no go-bare period for kids under the age of 2. That actually was not part of the original discussions, but we had the Pennsylvania Academy of Pediatrics working very closely with us, as well as a number of organizations around the state that convinced us, including our secretary of health, that we didn't want to have any child under the age of 2 missing any of those very important immunization and well-baby visits. Actually, when we had our state plan discussion with CMS, there was much more of a discussion on how we were going to measure crowd out for that population under the age of 2. We agreed to help them study that issue by looking at individuals between the ages of birth and 2 and comparing that with any kind of crowd out numbers that we could find for individuals in the 2 to 5-year-old age group. Jacqui did a great job covering the issues that relate to SCHIP.

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Flexibility, I think, is extremely important. States have really just been able to grow their programs to what they think works best for them. The population may not be the same in every state. I think as long as a state can live within its allocation, they should be permitted to be able to have the flexibility to have that work best in the state.

LARRY LEVITT: Are you looking for additional flexibility, or just avoiding- [interposing]

GEORGE HOOVER: No, I would say avoiding any strings that are attached. We think we've got good flexibility at this point. We would, of course, like others states, like the opportunity to be able to have children of government employees - those kids can be enrolled in Medicaid, but they can't be enrolled in an SCHIP program, so that's a disparity. We would like a little bit more flexibility in that area.

LARRY LEVITT: And you have government employees in Pennsylvania who would qualify?

GEORGE HOOVER: Yes, unfortunately we do. We have some folks that would fall within the income levels. And now, especially since we've expanded the program, folks could buy in at almost any level. Again, we'd like that flexibility. I think what I've also seen in the SCHIP legislation, or at least in the Snowe-Rockefeller Bill, was the possible even repeal of the citizenship and identify

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requirements for Medicaid, at least making it a state option. I think a lot of states would like to have that option to be able to make that decision themselves, so again, probably more flexibility in just those couple areas.

LARRY LEVITT: Jason, I'm going to give you the last word here. You're in the middle of this process of developing a program going forward. First, talk about what it is in SCHIP that allows you to do this. What are the pieces of SCHIP that you're using?

JASON HELGERSON: Right, basically SCHIP right now for us, and it will be under the new program, is just a funding source. We don't run it as a separate program. Our goal is to have basically one program that serves all the low-income families and kids in the state. Really, for us, we want to make sure that SCHIP is actually a funding source we can access because, like Illinois, we cover adults and, frankly, we were a state that had coverage pretty high up into the income levels under Medicaid before SCHIP even existed. What we're concerned about is that we could get into a situation where we're basically ensuring that every child has access to health insurance, covering 96 or 97 or 98-percent of all kids, but that we're going to be potentially leaving \$20, \$30 or \$40 million on the table at the federal level in unused SCHIP money. That's kind of what

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we're looking at and it's sort of hard to explain that to the legislators, to reports, to advocates that say, how is it that you can't do this? Well, it's somewhat of an accident in history. We were more aggressive in the past. We were sort of covering kids because covering kids was cool. SCHIP was created 10 years ago. I think those are the things. We're very hopeful that we will be able to continue to see SCHIP as a valuable revenue source to help us with our goal of ensuring that every kid in Wisconsin has access to healthcare.

LARRY LEVITT: And could you do it without re-authorization at the kinds of levels that are being talked about?

JASON HELGERSON: Well, as long as we can cover adults under Medicaid, which is somewhat of an issue we're hearing about lately - we may not be able to do that, which would be devastating not just for Wisconsin, but for lots of states - but it basically becomes a differential between the two rates that [interposing]. Yes, exactly. Obviously, it will make it more difficult, but we don't see it as sort of catastrophic. I think what's more disconcerting is we're in an environment that people want to cover more people and they want to allocate more federal dollars to do it. The thought

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of leaving \$30 to \$40 million on the table just seems very disconcerting to us.

LARRY LEVITT: In talking about where you go from kids, [chuckles] I'm sure you don't feel like you've succeeded quite yet, but at least all three of you states are on the way to at least universal access and possibly close to universal coverage of kids. Is this a platform to build on for covering everyone? Certainly your governors have talked about it. It's on it's way. Is that the next step?

JACQUI ELLINGER: Well, we're trying to do it in Illinois. Our governor has proposed Illinois Covered, which is universal access to healthcare for all Illinoisans. It's a much more blended kind of model than what we've had with children, but it definitely builds on what we've done with kids. Right now, it's in the middle of a legislative fight over doing it and financing it. I think financing it has been the bigger issue. There is tremendous support in the states, at least in our state, for making healthcare available to people. There is just this expectation now that we should be able to make this happen. This is the first year of my governor's second term. He has, so far, never flagged in his interest in [chuckles] healthcare expansion. I think we will continue moving in that direction and building on the successes that we've had so far.

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LARRY LEVITT: George, you talked earlier about Pennsylvania actually expanding coverage to kids before SCHIP. It seems like you might be in a similar position for adults as well.

GEORGE HOOVER: Right, Governor Rendell's proposal for Cover All Pennsylvanians is really just a piece of the overall prescription for Pennsylvania. We believe coverage for adults is important, but we also believe that if we only go to coverage for adults and costs continue to increase, it's going to continue to be unaffordable, so, really, the Cover All Pennsylvanians component of the prescription for Pennsylvania is just one piece. We're trying to reduce hospital-acquired infections and deal with chronic care better. We think that if we can somehow decrease the cost of care, or at least minimize any kind of additional growth in the cost of care, it means covering adults will be more sustainable for us in the long term. It's really just part of a much larger picture to try and turn around the delivery of healthcare in an effective and efficient manner in Pennsylvania.

LARRY LEVITT: As wise-spending Pennsylvanians, right?

GEORGE HOOVER: Absolutely.

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LARRY LEVITT: I want to thank all of you for joining us. I want to thank all of you for joining us for Elements of State Health Reform. I'm Larry Levitt and you've been watching Kaisernetwork.org.

[END RECORDING]

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