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HEALTH INSURANCE POLICY IN NEW YORK CITY & WESTCHESTER COUNTY

BY

COLIN STONE

SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR
THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION
DEPARTMENT OF PUBLIC ADMINISTRATION
DYSON COLLEGE OF ARTS AND SCIENCES
PACE UNIVERSITY

April 2008

APPROVED BY _____

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Chapter 1 – Introduction

Health insurance policy is an important and timely issue in the United States. According to many reports, the number of individuals who lack any type of health insurance in this country numbers approximately 47 million. This paper will focus on government sponsored health insurance programs in New York City and Westchester County, New York, including a discussion of the State Children's Health Insurance Program (SCHIP). In the fall of 2007, SCHIP was proposed for expansion by the U.S. Congress. This program provides funding for states to provide health insurance to children whose parents cannot afford health coverage. Members of Congress proposed to expand this legislation to cover more children; however, it was vetoed by President Bush and subsequently, Congress failed to override this veto. However, the President and Congress did finally agree to an 18 month extension that began on December 29, 2007 and will run until March 31, 2009.

The SCHIP legislation and its veto stirred heavy debate at the Federal level, with arguments over whether to cover only children, or parents as well. Policy makers argued that by covering more parents, more children would be covered in turn. In order to address the problem of the uninsured, especially uninsured children, some states are beginning to branch off and are attempting to address the issue on their own. This is due to the perceived lack of action by the Federal government.

A well known example of this is in Massachusetts. Under Governor Mitt Romney, the Massachusetts State Legislature passed a bill in 2006 that required each person in the state to sign up for some type of health coverage (Ward, 2007). If healthcare is not provided in their workplace, or an individual is not employed and does not qualify for Medicaid or Medicare, state run options are available (The Commonwealth Connector, 2008). The bill provides virtually free

health care for anyone earning below the Federal poverty line. It also subsidizes access to health care for those earning up to three times the poverty threshold. The law established the *Commonwealth Health Insurance Connector Authority*, which requires private insurance companies to create low-cost plans to be made available to the uninsured and helps residents buy coverage. The program includes incentives for residents to obtain coverage, including penalties imposed on those who fail to obtain a coverage plan (The Commonwealth Connector, 2007).

Legislation such as this represents the 'slippery slope' notion of policy making. When comparing the Massachusetts plan to a policy such as SCHIP, some have argued that providing coverage to children is acceptable, but a plan such as the Massachusetts law goes too far. It is interesting to note that during Mitt Romney's recent failed bid for the Republican nomination for President, he shied away from supporting this type of health care system (Ward, 2007). He commented that he did not necessarily agree with a universal system of health care. Romney's decision not to endorse this type of system was most likely based on his campaign's strategy to portray him as a conservative candidate (Ward, 2007). Putting Romney's campaign position aside, ideological divides are a major concern when discussing the possible implementation of a universal health care system. However, the SCHIP bill's bipartisan support showed that a universal health care system could become a reality for the United States in the future.

Similar to the Romney program, New York State Assemblyman Richard Gottfried released a proposal in December 2007 outlining a plan for universal health care in New York State (New York State Assembly, 2007). This proposal is called New York Health Plus and the basic premise of the proposal is to expand existing New York State plans to include all residents of the state. Individuals and employers are permitted to keep their current coverage and every New York resident would be eligible.

> Gottfried estimated the cost of the plan, if all New Yorkers signed up, at about $59 billion a year. This compares to the $63 billion a year employers and individuals now pay in premiums, deductibles and co-pays. This does not include the administrative savings to providers who would not have to spend as much time determining eligibility or going after payments from uninsured patients, or the amount the state would save on subsidies paid to health care providers who treat the uninsured (The Business Review, 2007).

This plan is a move toward universal coverage, but it is only a proposal at present. The program's funding and implementation remain unclear.

The purpose of this paper is to evaluate SCHIP in the context of New York City and the Westchester County region. The SCHIP program is one that has been in existence for roughly ten years and provides health insurance to children whose parents do not, or cannot, provide health care coverage. Although SCHIP is a Federal program, it is administered at the state and local level. In the fall of 2007, Federal legislators unsuccessfully proposed an increase to the number of children who would be eligible for benefits. The program's failure to expand will be examined, as well as the implications this failure has had on the health of the region's children.

Chapter 2 – Literature Review

Health care policy in the United States is one of the most important matters facing this country. Many factors contribute to the poor condition of the health care system currently. The rising cost of care, the aging population, the rising uninsured population, the increased costs associated with advancing technology, and other factors have all pushed the system to the breaking point. In an effort to insure more individuals, especially children, states have begun taking matters into their own hands and creating new policies that go beyond federal regulations.

There is a significant population in this country that cannot afford health care insurance. For those who can, the rising cost of care pushes many families away from being able to afford consistent health coverage. Premiums have increased significantly in recent years and out-of-pocket costs are extremely high as well. Employer sponsored health insurance is the traditional way that Americans have obtained health care coverage. This accounts for approximately 160 million Americans. However, due to rising health care costs, many employers are beginning to limit the amount of money they are willing to contribute to subsidize coverage for their workers. Some companies have stopped offering coverage altogether, while those that still do are cutting the amount they will fund. As a result, new workers and seasonal employees may not be offered benefit packages, a population that often cannot afford to pay for private insurance. Also, if the company will fund a small portion of insurance coverage, many still cannot afford their share and will opt to go without coverage. This population also runs into the problem of not being eligible for public assistance programs, such as Medicaid (Cook, Dubay & Holahan, 2007).

This current situation is particularly troublesome for workers with dependent children. Those without health insurance often go without routine care and this has a particularly negative impact on young children, as their future health and development is highly dependent on proper

health care at a young age. "The most dramatic impacts of both Medicaid and SCHIP are found in early childhood. Access to health care reduces infant mortality, childhood deaths, and the rate of babies born with low birth weight" (Shea, et al, 2007). The SCHIP legislation attempts to bridge this gap and provide coverage for those who cannot afford insurance for their families. This public assistance program seeks to provide coverage only for children whose families' income meets certain criteria (Shea, et al, 2007).

The overall number of individuals without health insurance has been steadily rising over the last ten years. Recent estimates from the 2006 census place these numbers at roughly 47 million Americans. Eighty percent of the uninsured are citizens of the United States and almost 70 percent have full-time jobs (U.S. Census Bureau, 2006). The reason that so many individuals *with* jobs do not have coverage is that many jobs are reducing or not offering health benefits to workers. In 2006, 1.3 million full-time workers lost health insurance as a benefit from employers, and one-third of companies in the United States did not offer their employees health coverage, leaving nearly nine million children without health insurance. This is close to twelve percent of all children in this country. The year 2006 saw the number of children without insurance increase by 610,000 children from the previous year. This was the second year in a row that this population grew substantially. As mentioned earlier, children who lack insurance are particularly vulnerable due to the fact that proper health care at a young age is necessary for continued health throughout a person's life (U.S. Census Bureau, 2006).

When a company or firm reduces or eliminates health insurance coverage as a benefit, this is usually due to the high cost of health care. Increasingly, companies cannot afford the costs. This elimination of benefits produces negative results not only for the employee, but also any dependents he or she may have. In 2006, 40 percent of the population that did not have

health insurance lived in a family unit that earned $50,000 or above in annual income (U.S. Census Bureau, 2006). This statistic shows the negative impact that the high cost of medical care has had on middle class populations in the United States.

The State Children's Health Insurance Program is administered by the Centers for Medicare and Medicaid Services, a Federal agency. Authorized under Title XXI of the Social Security Act, SCHIP offers health insurance coverage for many of the nation's uninsured children. The program started in 1997 and offers coverage to children from low-income families (Centers for Medicare and Medicaid Services, 2008). The outline of the program calls for it to be administered on the state level. States are given a choice of three ways to enact the plan: expand their present Medicaid Program; set up a new program separate from Medicaid; or combine Medicaid and a new program in some manner to accomplish the goal of covering more children (Sultz & Young, 2006). New York State uses the last option and runs a combination program – a Medicaid expansion plan along with a separate SCHIP plan (Hall, 2007).

The Federal program of Medicaid is authorized and funded under title XIX of the Social Security Act. In New York State, funding of Medicaid requires a local share. Responsibility is broken down to roughly 50 percent Federal, 25 percent State, and 25 percent Local in most cases. In New York State, SCHIP under Medicaid is known as Child Health Plus B. New York State also has a Child Health Plus A program, known as Children's Medicaid. Although both programs are dependent upon the income levels of the family units they reside in, the difference is that Child Health Plus A is designed for lower income children than Child Health Plus B. Child Health Plus B is a Federal-State joint venture and the Federal portion for this program is 65 percent in New York State. Local governments do not have to contribute to the program. It is designed primarily for children in households above the Medicaid level. Family income can

range up to 250 percent of the Federal poverty level, with premium payments above 160 percent of the Federal poverty level. Child Health Plus B provides coverage to 141,000 children in New York City and 361,740 children in the state (New York State Department of Health, 2008).

New York State's Child Health Plus B program provides coverage to children under the age of 19 who meet certain income requirements, usually applied to the child's family. Children in families whose income exceed Medicaid eligibility levels and are below 250 percent of the Federal poverty level can enroll in Child Health Plus B. Families with incomes above 250 percent of the Federal poverty level can pay the full premium of the health plan and buy into Child Health Plus B. Income requirements for Child Health Plus B are based on gross family income and vary by the age of the children: families with children less than one year of age are eligible between the levels of 200 and 250 percent of the Federal poverty level; families with children ages one to five are eligible between 133 and 250 percent of the Federal poverty level; families with children ages six to eighteen are eligible between 100 and 250 percent of the Federal poverty level. Additionally, children cannot currently have health insurance or be eligible for another type of coverage plan. In New York State, children are eligible for Child Health Plus B no matter their immigration status or the amount of time they have lived in the United States (New York State Department of Health, 2008).

In 2007, the New York State legislature passed an expansion of Child Health Plus B, that raised the limit to 400 percent of the federal poverty level. This expansion plan, however, was denied by the Centers for Medicare and Medicaid Services (Centers for Medicare and Medicaid Services, 2007). New York State is appealing the rejection of the expansion plan. Other states are planning similar actions in order to expand SCHIP income levels in their own states (New York State Governor, 2007).

The coverage benefits under this program are comprehensive and cover a variety of health care needs. In New York, Child Health Plus B provides coverage to beneficiaries through managed care plans. Covered services include child care, physical exams, immunizations, diagnosis and treatment of illness and injury, x-ray and lab tests, outpatient surgery, emergency care prescription medications, inpatient hospital care, chemotherapy, mental health and alcohol and substance abuse treatment, dental care, vision care, speech and hearing care, and a variety of other services (New York State Department of Health, 2008). Child Health Plus B has no monthly premium for families whose income is less than 1.6 times the Federal poverty level. Families with higher incomes pay a monthly premium of $9 or $15 a month per child, depending on income and family size. For larger families, the monthly fee is capped at three children. If the family's income is more than 2.5 times the poverty level, families pay the full monthly premium charged by the health plan (New York State Department of Health, 2008).

President Bush vetoed bipartisan SCHIP reauthorization legislation on two occasions in 2007, forcing Congress to pass a short-term extension of the program through March 31, 2009. This continuing resolution signed by the President will continue the current funding of $5 billion for 2008 and 2009 (Apolskis, 2007). According to the Congressional Budget Office, Congress would need to provide an additional $1.2 billion to maintain SCHIP at current levels for 2008 (Congressional Budget Office, 2007). In an effort to help states that are facing funding problems Congress included an additional $1.6 billion, and a similar amount for 2009. New York State is not expected to have a funding problem for either year (Families USA, 2008).

The primary goal of SCHIP was to reduce the number of uninsured children. The original funding level was between three and five billion dollars per year for ten years. States were to apply for the federal money after designing a plan for their state. The state would then have

three years to spend the money, after which any unspent money would be returned to the federal government (Barr, 2007). Unfortunately, the SCHIP program has not been as successful as hoped. "About 16 percent of children from families with incomes below 200 percent of the federal poverty level were without insurance in 2005, down from 23 percent in 1997, according to federal government analysis" (Stolberg & Hulse, 2007). This is an improvement, but approximately eight million children still lack any form of health insurance (Barr, 2007).

One problem with many government programs (and SCHIP is no different) is successfully marketing the program to the desired target group. Despite being in existence for ten years, SCHIP has enjoyed limited success, as thirty percent of eligible children are not signed up for the program (Stolberg & Hulse, 2007). Additionally, New York State's plan to cover children who fall under the 400 percent of the poverty level caused additional problems. In 2007, 200 percent of the Federal poverty level for a family of four was an annual income of approximately $43,300. An annual income of 400 percent would be roughly double that amount, or $86,600 (Hall, 2007). Offering the program to families with income as high as $80,000 does not match the program's initial goals according to some policy and law makers. The goal of the program was to cover low-income children, not those who border on the middle and even upper middle class. President Bush reaffirmed the original goal in defense of his veto. States such as New York attempted to make this expansion to higher percentages of the Federal poverty level and have been asked to return a portion of their federal funding as a form of perceived punishment (Barr, 2007).

The SCHIP program was set to expire on September 30, 2007. The proposed expansion bill passed by Congress was vetoed by the President on October 3, 2007 ((Stolberg & Hulse, 2007). George W. Bush made it clear early in the process that he planned to veto the bill if it

ever reached his desk. The debate between the President and lawmakers involves the financial strain of expanding the program, as well as the "philosophical debate over the role of government in health care" (Pear & Hulse, 2007). Prior to the Presidential veto, the House and Senate agreed to increase funding for this program by $35 billion, thus brining the total expenditure to $60 billion over the next five years. The primary debate over this program was its proposed expansion. President Bush felt that would have been a move toward national healthcare and he does not favor that policy. "The president says the measure, which would renew and expand the State Children's Health Insurance Program, costs too much and would be 'an incremental step toward the goal of government-run health care for every American'" (Pear & Hulse, 2007). On October 18, 2007, the House of Representatives missed overriding the Presidential veto by 13 votes. However, 44 Republicans joined 229 Democrats in support of the bill. A compromise bill prepared by both parties again caused conflict. Much of this conflict regarded "state flexibility to cover parents" (Pear, 2007). Many lawmakers and health officials agree that if more parents are covered by insurance, more children will be covered. However, President Bush and other Republicans believe this violates the original purpose of the program (Pear, 2007). After the veto override failed, the House of Representatives introduced and passed a second, very similar bill, which was subsequently passed by the Senate and again vetoed by President Bush on December 12th, 2007. Although the SCHIP program will continue, it will not include children whose parents are in the higher income ranges sought by those in favor of the expansion.

The goal of SCHIP is to improve access to health care for uninsured children. The program primarily targets families at or below 200 percent of the Federal poverty level. The original plan was for SCHIP to cut the number of uninsured children in the U.S. by half (Barr,

2007). However, this has not been the outcome. "The U.S. Census Bureau reported that, in 2004, 8.3 million children in the United States were uninsured – a number only slightly smaller than the 10 million children who were uninsured at the time SCHIP was passed by Congress" (Barr, 2007, p. 162). Unfortunately, the program has not been able to live up to its original promise.

The primary reason SCHIP was not expanded and was vetoed by President Bush are ideological. President Bush viewed SCHIP expansion as a step toward national health care. He believes the establishment of a national health system counters the American ideal of individualism and would set a precedent of too much government involvement. Mr. Bush believes in private health coverage, not coverage provided by the federal government. This philosophical divide is the primary reason why the expansion bill was vetoed and not overridden (Stolberg & Hulse, 2007).

The SCHIP program received unprecedented bipartisan support, and the political reality is that few issues in government ever receive such support (Stolberg & Hulse, 2007). The SCHIP bill is an example of a measure that received the support of the majority of Republicans and Democrats. However, the President's ideological objections prevented it from passing. The rising cost of health insurance is squeezing many low and middle income Americans. Children who are eligible for SCHIP often live in families who are not offered health coverage at work, and for whom buying an individual plan is simply too expensive. In many cases those who are eligible for the plan do not realize they are, or have simply not signed up (Barr, 2007).

Chapter 3 – Methodology

This paper focuses on the health insurance policies of New York City and Westchester County, New York. Conducted over a period of roughly eight weeks, it includes an analysis of health policy in New York City and Westchester County. This analysis includes academic journal review along with other sources. It also includes material gathered during face-to-face interviews with policy experts regarding child health insurance policy in New York City and Westchester County, New York. The following are the basic research questions that will attempt to be answered in this study.

Research Questions:

1) What is the State Children's Health Insurance Program (SCHIP)? What is the result of its lack of its lack of expansion on New York City and Westchester County, New York?

2) What are the alternatives and risks to not covering children? Will it cost more to insure children, or more not to insure them in the future?

3) How many children are enrolled in each program and are there common barriers to access to insurance?

The first step in the research process was to focus on a policy analysis of children's health care in the U.S. In order to perform this policy review several types of material were researched. First, the websites of policy implementation centers such as the United States

Centers for Medicare and Medicaid and the United States Department of Health and Human Services were reviewed for information pertaining to SCHIP. The New York State Department of Health, the New York City Department of Health and Mental Hygiene, and the Westchester County Department of Health also served as research tools for this paper. Additionally, the websites of the National Academy for State Health Policy and the National Conference of State Legislatures were consulted for pertinent information. These websites served as the initial resources for gathering data regarding health care policies, especially SCHIP. Second, news sources were reviewed to analyze current trends and topics in child health policy. These sources include the New York Times, Boston Globe, Washington Post, Financial Times and the Wall Street Journal. The final sources were academic journals such as *Healthcare Financial Management*, *The New England Journal of Medicine*, *Policy and Practice*, *Health Services Research*, and *Health Affairs*. The review of these academic journals completed the policy review and analysis portion of the research. Additionally, charts, graphs and tables were reviewed regarding SCHIP data. These materials outline the impact of SCHIP, its funding levels, its year-to-year enrollment, and other related information. This information was gathered from the implementation and policy centers and academic journals. These materials are listed in the appendix section of the paper. The academic journal review completed the policy research and analysis portion of the paper.

The next step was to conduct interviews with policy experts, individuals directly involved with health policy in New York City and Westchester County. The first interview was conducted with a member of the Human Resources Administration in New York City. This branch of city government is involved with the administration of government health plans at the city level. This individual oversees the "Medical Insurance and Community Services

Administration" within the department and is heavily involved with health care policy and implementation in New York City. The second interview was conducted with an official from the New York City Department of Health and Mental Hygiene. The New York City Department of Health and Mental Hygiene is involved with promoting and analyzing health care policy. This department official specializes in Federal health care policy. The final interview was conducted with the Deputy Director of the Westchester Children's Association. This association is involved with evaluating health care policy in Westchester County, New York. The Westchester Children's Association also works with community based agencies in order to increase advocacy efforts for re-enrollment in state sponsored health plans and to increase funding and income eligibility level for child health care enrollment.

The following page contains the questions that were asked to each interviewee. The questions focus on child health policy, policies that are developing and changing, and how SCHIP's failure to expand affected their region. Each interviewee was asked the same questions, in the same order, to gauge responses. Also, the interviewees were sent the questions in advance in order to better prepare and become familiar with the paper's purpose.

Capstone Interview Questions Template

Background

The paper will identify the options available to low income individuals who do not have health insurance. The research will focus specifically on options available to children, and will compare programs in New York City and Westchester County, NY.

Questions

1) What programs are available to those who do not have health insurance, especially children? Are there any programs specifically for children that do not include adults?

2) What is the most popular or most used program?

3) Which populations are primarily the "users" of these services?

4) How are these programs managed and funded?

5) What options are available to children whose parents do not have health insurance?

6) What impacts do you foresee, positive or negative, due to the failure of SCHIP to pass, regarding those without health insurance, especially children?

LIMITATIONS

The primary limitation of this study was time. This study was approximately eight weeks long, which is not enough time to perform certain types of in-depth research. In addition, the health insurance policies of every state and territory in the United States were not evaluated. This is beyond the scope of time and resources available. An analysis of the health care polices of foreign countries was also not performed. The reality of this study was that access to high ranking officials at Local, State, or Federal levels was not achieved. These issues limited the type of analysis performed as well as the scope of the research provided in the paper.

Chapter 4 – Research Findings

The research for this paper consisted of a review of relevant literature and face-to-face interviews. The following is a list of the individuals interviewed, their titles and affiliations, and a review of the discussions.

Interviewees:

1) **Mary Harper** – February 22, 2008
   Executive Deputy Commissioner, Medical Insurance and Community Services Administration
   New York City Human Resources Administration/Department of Social Services

   Mary Harper discussed the resources and options available to New York City residents who do not have and cannot afford health insurance.

2) **Frances J. Paris** – February 25, 2008
   Senior Policy Advisor, Bureau of Intergovernmental Affairs
   New York City Department of Health and Mental Hygiene

   Fran Paris discussed the policy implications regarding health insurance policy in NYC, especially the impact of the failure of the SCHIP expansions.

3) **Allison Lake** – February 28, 2008
   Deputy Director, Westchester Children's Association

   Allison Lake discussed the options available to Westchester County residents who do not have health insurance. She discussed SCHIP's relevance and impact on health insurance access for children in Westchester County, New York.

The following pages outline the discussions of the three interview sessions. These are not transcripts of the interview sessions, but summaries of the discussions and major topics covered in each of the three interviews.

Mary Harper Interview:

The interview with Mary Harper took place by telephone on February 22, 2008. Mary Harper is the Executive Deputy Commissioner of the Medical Insurance and Community Services Administration within the Human Resources Administration of New York City. The Human Resources Administration of New York City administers social welfare programs throughout New York City, which include temporary public assistance (commonly referred to as welfare), food stamps, health benefits, childcare, adult protective services (available to those who are physically and mentally handicapped) and prevention services that guard against eviction. Public health insurance in the United States is dictated at the Federal level by the Centers for Medicare and Medicaid Services. The New York State Department of Health then issues guidelines regarding public health insurance, and at the local level groups such as the Human Resources Administration of New York City are responsible for the administration of the actual health benefit plan to citizens who qualify.

During the course of this interview, Mary Harper was asked six questions regarding health insurance policies in Westchester County and New York City. Health insurance policies in New York State overall as well as Federal health care policy issues were discussed. Below are Mary Harper's responses to the interview questions.

Question 1:

CS: What programs are available to those who do not have health insurance, especially children? Are there any programs specifically for children that do not include adults?

MH: Medicaid and Family Health Plus are available to New Yorkers who meet certain qualifications. Child Health Plus is available to children in New York State and City. Child Health Plus contains Part A and Part B. Part B is New York State's "version" of SCHIP. Part A used to be called Children's Medicaid. Eligibility for these plans depends on the family's income level. Part A for lower income levels and Part B for higher income levels.

Question 2:

CS: What is the most popular or most used program?

MH: 2.5 million individuals are enrolled in Medicaid in New York City. Of those individuals, 141,000 are children. There are 370,000 children enrolled statewide. Medicaid programs are the most popular and most densely used. Each of the plans offers a variety of benefits in a managed care environment. These plans use managed care programs to carry out the benefits programs.

Question 3:

CS: Which populations are primarily the "users" of these services?

MH: There are a variety of New York City residents enrolled in Medicaid. As of October 2007 the Medicaid environment in New York City breaks down to approximately 1.8 million residents enrolled in Medicaid. Of those individuals the numbers break down by age as follows:

39,000 are unborn, meaning that a woman is pregnant
66,000 are less than one year old
215,000 are 1-5 years old
240,000 are 6-13 years old
122,000 are 18-31 years old
902,000 are 21-64 years older
And 135,000 are 65 years older and up

In New York City there are between 123,000-193,000 uninsured children.
The Bronx has the highest amount of eligible but not enrolled children in the five boroughs.
There are also 212,000-305,000 eligible but not enrolled adults in New York City.

Another note regarding CHP-B is that in New York State the children of undocumented aliens ***are*** eligible under CHP-B.

Question 4:

CS: How are these programs managed and funded?

MH: Medicaid is funded through Title XIX of the Social Security Act at the Federal Level. Medicaid is administered through individual states. New York State administers the program in our state's case through the State Department of Health, and the funding breaks down to roughly the following levels:

50% Fed
25% State
25% Local

However, the medical expenditures of each state are capped and not allowed to go over a certain amount. In New York State, CHP-B uses a managed care system. CHP-B, or Child Health Plus is the New York State "version" of SCHIP. New York State acts through managed care programs to deliver these services.

Question 5:

CS: What options are available to children whose parents do not have health insurance?

MH: The programs available are Medicaid, Child Health Plus A, which used to be known as Children's Medicaid), and Child Health Plus B – Funded by SCHIP. These programs all depend on the income levels of the family to determine eligibility of the child.

Question 6:

CS: What impacts do you foresee, positive or negative, due to the failure of SCHIP to pass, regarding those without health insurance, especially children?

MH: New York State is not expected to have a funding shortfall in the near future regarding the SCHIP Program. In New York City 141,000 children are currently covered by CHP-B, the program funded through SCHIP. All states will receive $5 Billion of funding through 3/31/09. Combining this fact, with no anticipated funding shortfall for New York State, SCHIP failure to be expanded by the Federal government means that New York City will not see a drastically negative reaction.

Several facts could pose a problem for New York State, though. President Bush wants a hard cap on funding of 250 percent of the Federal poverty level. New York State wanted it raised to 400 percent of the Federal poverty level. New York State could face a drop in matching funds if all those eligible are not enrolled, which is difficult to do. This means New York State could be penalized if they don't meet their numbers.

Fran Paris Interview:

The interview with Fran Paris took place in person on February 25, 2008. Fran Paris is a Senior Policy Advisor in the Bureau of Intergovernmental Affairs at the New York City Department of Health and Mental Hygiene. The New York City Department of Health and Mental Hygiene's primary role is to protect the health of all New York City residents. This involves many different areas of expertise and knowledge. The Bureau of Intergovernmental Affairs serves as the legislative liaison to other government agencies for the New York City Department of Health and Mental Hygiene. This Bureau crafts the Department's legislative agenda, tracks health related legislation at all levels of government, assists in developing and crafting testimony for Department of Health staff, and responds to constituent requests. Fran Paris' primary responsibilities are to advise the Department of Health on Federal health care policy and legislation, and the potential impact on New York City.

During the course of this interview, Fran Paris was asked six questions regarding health insurance polices in Westchester County and New York City. Health insurance policies in New York State as well as Federal health care policy issues were discussed. However, this interview consisted primarily of a discussion of the policy implications for New York State and City regarding the lack of expansion of SCHIP. Only questions one and six were discussed in great detail, because those questions related most directly to the interviewee's area of expertise. Below are Fran Paris' responses to the question one and six of the interview questions.

Question 1:

CS: What programs are available to those who do not have health insurance, especially children? Are there any programs specifically for children that do not include adults?

FP: Medicaid is offered for those below certain income levels. SCHIP in New York State is known as CHP-B.

Also, hospitals are required to give medical attention to those who need it who do not have coverage. Hospitals receive money for this type of charitable care in an effort to give children a "medical home," which is something the New York City Department of Health and Mental Hygiene stresses.

Questions 2-5 were not discussed in detail, as mentioned above.

Question 6:

CS: What impacts do you foresee, positive or negative, due to the failure of SCHIP to pass, regarding those without health insurance, especially children?

FP: New York State wanted to enhance the matching rate of SCHIP, but it was not achieved. The Federal government is now paying a higher share for higher income children, but this varies by different regions.

The debate over the SCHIP bill is highly political and centers on two main arguments:
1) Conservative vs. Liberal Politicians
2) Single Payer vs. Multiple Payer Health Care Systems

SCHIP is dictated by the Centers for Medicare and Medicaid Services at the Federal Level.
At the State level private health insurance is bought/subsidized by the State to provide coverage for beneficiaries

Cost "containment" is a goal of this program, or keeping costs low.

The Two Primary Pitfalls to the SCHIP Expansion Proposal were:
1) Republicans were concerned about SCHIP becoming a form of national health care
2) Republicans were also concerned about the extension of "entitlements" (essentially, the guaranteeing of benefits)

New York City uses managed care in an effort to get kids into a "medical home," and a provided with a regular source of care. This provides better care than private plans and helps to track patients.

New York City's system of 20 public hospitals and other medical facilities helps to treat the uninsured. These resources help to limit the negative impact of SCHIP not being expanded. However, this system does not usually provide primary care.

The SCHIP legislation is a "political hot potato."

Allison Lake Interview:

The interview with Allison Lake took place by telephone on February 28, 2008. Allison Lake is the Deputy Director at the Westchester Children's Association. The Westchester Children's Association attempts to improve the lives of children in Westchester County, New York through outreach and advocacy work. The Association also produce a variety of research on relevant policy issues regarding children in the region. The Westchester Children's Association is a non-partisan group that is not tied to any political groups or organizations. The Westchester Children's Association was founded in 1914.

During the course of this interview, Allison Lake was asked six questions regarding health insurance policies in Westchester County and New York City. Health insurance policies in New York State as well as Federal health care policy issues were discussed. Below are Allison Lake's responses to the interview questions.

Question 1:

CS: What programs are available to those who do not have health insurance, especially children? Are there any programs specifically for children that do not include adults?

AL: The programs available through Medicaid are:
Family Health Plus and Child Health Plus

There are seven private health plans available in Westchester County through which public health benefits are managed.

Westchester County has seven community health centers:
Greenburgh Neighborhood Health Center in White Plains
Hudson Valley Health Center in Peekskill
Mount Vernon Neighborhood Health Center in Mount Vernon
Ossining Open Door in Ossining
Rye Brook Open Door in Rye Brook
Sleepy Hollow Open Door in Sleepy Hollow
Yonkers Neighborhood Health Center in Yonkers

Westchester County also has several County Hospitals:
Sound Shore Medical Center
Northern Westchester Hospital Center
Westchester Medical Center

Question 2:

CS: What is the most popular or most used program?

AL: State sponsored programs are the most popular, meaning Medicaid and Child Health Plus are the most popular.

Outreach efforts for Medicaid in Westchester County are difficult. It is hard to remove the "stigma" of public assistance programs and enroll all eligible people.

Question 3:

CS: Which populations are primarily the "users" of these services?

AL: The primary users of these services in Westchester County concentrate around the urban centers of the county. These include Yonkers, New Rochelle, White Plains, and Peekskill. Minority and Latino populations make up the majority of the users of these services as well.

Employment in Westchester is shifting to smaller companies that often do not offer health insurance. This results in new populations being encouraged to enroll through the use of "Facilitator Enrollers, or "FE's".

These are workers who help to enroll potential users of the program and simplify the process. This program was started with Governor Pataki.

Outreach and advocacy efforts are tough. Beneficiaries have to recertify each year, and FE's help in this process.
Beneficiaries have to prove income, housing, citizenship, etc, in order to re-certify each year.

4% of Westchester's children are uninsured equaling 15,000 children and that is a target population for these programs.

Question 4:

CS: How are these programs managed and funded?

AL: In New York State Medicaid is funded:
50% Fed
25% State
25% County
But not all states are like this. Income levels and each state's individual plan administration depend on funding levels

Question 5:

CS: What options are available to children whose parents do not have health insurance?

AL: The answer to question five was discussed in detail in question one. It was agreed to move forward to the final question of the interview.

Question 6:

CS: What impacts do you foresee, positive or negative, due to the failure of SCHIP to pass, regarding those without health insurance, especially children?

AL: Nine years ago Child Health Plus funding was given to states to use as they saw fit, but what was actually accomplished?

If each state does not enroll 95% of eligible kids, then the program cannot be expanded. This is very hard to accomplish.

Regarding SCHIP's failure to be expanded in December 2007, New York Sate would have been able to provide coverage for an additional 40,000 children.
In the population group:
75% are from Working Families
82% are Citizens
63% are Non-White

SCHIP's failure to expand produced a negative impact for Westchester County, NY.

Regarding overall enrollment in these plans, outreach is always a problem. Reducing the stigma of public assistance programs and providing children with a "medical home" are two primary goals.

The New York State Budget for the current fiscal year (2008-2009) includes income expansion and a simplified re-enrollment process. This helps due to the fact that many beneficiaries do not realize they are required to re-enroll every year and some also forgot about this requirement. The Westchester Children's Association is encouraging efforts to expand the income level and simplify enrollment. New York State has funding through 2008, but most states do not.

The data gathered during the literature review consisted of a combination of data review from relevant policy implementation websites, scholarly journals, and relevant newspaper articles. Information and data from the websites of the United States Centers for Medicare and Medicaid, the New York State Department of Health, the New York City Department of Health and Mental Hygiene, and several other policy analysis groups provided relevant information regarding SCHIP. Even though this topic is relatively new, the SCHIP program began in 1997 and much has been written about it. All levels of government and several different policy group websites provided analysis and factual information regarding this program.

The information gathered during the interview portion of data gathering was a combination of factual information and policy analysis of Federal, New York State and regional health insurance policies. The three interviewees represented individuals from different areas of health care policy. Mary Harper works for the City of New York and is involved with the administration of public health insurance programs. Fran Paris is a policy advisor at the New York City Department of Health and Mental Hygiene and concentrates on Federal policy issues for the department. Allison Lake is involved with advocacy and outreach regarding access to health insurance and other services for children in Westchester County, New York.

In New York City, Medicaid and Family Health Plus are available to individuals who meet certain qualifications, totaling approximately two and a half million residents. Of this population, roughly 141,000 are children. Statewide, there are roughly 370,000 children

receiving Medicaid benefits. Medicaid programs in New York City are the most popular and most participated in, due to the variety of benefits offered. In the next several years New York State is not expected to have a funding shortfall. President Bush is lobbying to place a cap of 250 percent of the Federal poverty eligibility level on families in order to receive SCHIP benefits. New York State is fighting to extend this level in order to cover more children.

According to Allison Lake, an additional 40,000 children in New York State would have been eligible for benefits if the expansion program had been enacted. Of these children 75% are from working families, 82% are legal citizens and 63% are non-white (personal communication, February 28, 2008). In addition to the vast number of children not being covered, other problems persist in Westchester County. Outreach efforts have not been fruitful. Many who are eligible for existing benefit packages have not enrolled. The New York State budget includes income expansion for this program. Ms. Lake would encourage the development of a simplified re-enrollment program and enhanced outreach efforts. New York State has adequate funding for SCHIP through 2008, but most states do not.

It should be noted that several unsuccessful attempts were made to interview individuals at the Westchester County Department of Health and the Westchester County Department of Social Services. These attempts were made through Pace University's Department of Public Administration and repeated attempts to find interview participants were not successful.

Chapter 5 – Analysis of Findings

There were several results from this research effort. The failed expansion effort of the SCHIP legislation resulted in a relatively minor impact on the health care coverage of children in New York City (Mary Harper & Fran Paris, personal communications, February 22 & 28, 2008). However, Westchester County was impacted in a negative manner (Allison Lake, personal communication, February 28, 2008). According to figures on the New York State Department of Health Website, New York City accounts for a higher percentage of Medicaid eligible individuals, while Westchester County does not account for a significant percentage state-wide (New York State Health Department, 2008).

The New York State proposed budget for the 2008-2009 fiscal year includes a proposal to expand Child Health Plus B to 400 percent of the Federal poverty level. An estimated 40,000 uninsured children in New York State would be eligible for Child Health Plus B if this expansion were to take place (New York City Human Resources Administration Estimates, 2008). Financed with state funding, the estimated total increase in Child Health Plus B costs for the 2008-2009 fiscal year is $55 million (New York City Human Resources Administration Estimates, 2008). Specifically, the cost to families enrolled in Child Health Plus B would increase from $108 to $180 per child, per year in families at 160 to 222 percent of the Federal poverty level and from $180 to $300 per child per year for families at 223 to 250 percent of the Federal poverty level.

The research shows that the effect on Westchester County and New York City is different. New York City has a network of 20 public hospitals, medical centers, treatment facilities, and nursing facilities throughout the five boroughs of the city. These institutions and various other programs help to serve the low-income populations of the city (New York City

Health and Hospitals Corporation, 2008). New York City also has a significantly larger budget than Westchester County. In 2008, the New York City operating budget was $59 billion, while the Westchester County operating budget was approximately $1.7 billion, a substantially large difference (The New York City Office of Management and Budget; Westchester County Budget Department, 2008). Specifically, Westchester County does not have the budget capacity of New York City or the system of public hospitals. The lack of SCHIP expansion means that many children still do not have access to health insurance coverage, primarily within minority populations. Westchester County was susceptible to more of this than New York City (Allison Lake, personal communication, February 28, 2008). In many areas of Westchester County, outreach efforts have not been successful. The urban areas of Westchester County account for the majority of the population who are eligible for assistance. This includes areas such as White Plains, Yonkers and New Rochelle. Outreach and enrollment efforts in these areas have not enrolled high numbers, and many who are eligible are not using the services available to them. In New York City, enrollment efforts have attracted more children and families (Mary Harper & Allison Lake, personal communication, February 22 & 28, 2008).

Worth noting was that during both the Fran Paris and Allison Lake interviews the term "political hot potato" was used in reference to SCHIP, alluding to the fact that the issue will come up again (Fran Paris & Allison Lake, personal communications, February 25 & 28, 2008). Providing health coverage to individuals who cannot afford coverage on their own is a problem many politicians want to solve. However, there are many different ideas and sets of values surrounding the issue. These differing values and ideas resulted in the back and forth negotiations during the time that the SCHIP expansion bill was debated. It was not expanded due to ideological differences within the U.S. Congress and the Bush Administration. This bill

represented a move toward socialized medicine to some, and our country is not in agreement that health care should be a service available to all citizens. Improving the health care system is at the top of many political agendas, but it is proving to be a very difficult system to change. This is due to political realities and the implementation problems surrounding this issue. Designing a system that will improve quality care and expand access is a very difficult problem to solve.

Research surrounding the Federal implications for this program show that the proposed Federal budget for the 2009 fiscal year proposes to reauthorize SCHIP with additional funding of $l9.7 billion over the next five years from 2009 to 2013. However, the President's proposal may not be sufficient to protect states from funding shortfalls in the coming years (Park, 2008). The President's proposal would require states to cover at least 95 percent of eligible children at 200 percent of the federal poverty level before expanding beyond 200 percent. States that already cover children above 200 percent and do not meet the 95 percent target could face a one percent drop in their Federal SCHIP matching rate. This results in a penalty for each year a state is not in compliance with the regulations. The penalty could present a possible five percent drop in funding (Families USA, 2008). Adhering to this type of requirement would cause a problem for almost all states, including New York, where children are already eligible for coverage above 200 percent of the Federal poverty level (New York City Human Resources Administration, 2008).

It has also been shown that New York State on the whole is better off than other states. On a chart developed by the Center on Budget and Policy Priorities, New York State is not listed among the states that are expected to experience a funding shortfall in 2008, or by the year 2012 (Park, 2007). This shows that many other states are worse off than New York State on this issue. The projected funding shortfalls in many states are dramatic and are not expected in New York

State by the year 2012. New York City is better off than Westchester, but both are better off than many other parts of the country (Park, 2007).

The data show that overall SCHIP has still only had moderate success. Many of those who are eligible to receive benefits from the program have not signed up. This is due in part to outreach problems as well as the "stigma" of public assistance (Allison Lake, personal communication, February 28, 2008). There is no easy way to tell how many people do not seek services because they are embarrassed about needing help or simply do not know that they may qualify for such assistance. These problems are common ones for any assistance program. Getting the word to those that are eligible can prove to be a very difficult task. Administrative barriers also lower the number of those enrolled in SCHIP. It can be difficult to sign up for certain programs and remain enrolled. New York State has developed a program of "facilitated enrollers" (Allison Lake, personal communication, February 28, 2008). These are individuals who assist with the enrollment process. Facilitated Enrollers help individuals needing public health insurance enroll in the services and stay enrolled. As beneficiaries are required to re-enroll every year, this can cause a problem for many people who are not aware of this step or simply forget to re-enroll. These Facilitated Enrollers serve to help bridge this coverage gap and enroll more individuals who are eligible (Mary Harper & Allison Lake, personal communications, February 22 & 28, 2008).

Overall, New York State is better off regarding the funding of SCHIP than most other states. New York State has funding that will continue longer than most states. However, the problem remains primarily financial. Financial realities are a major burden on the health care system. The Center on Budget and Policy Priorities explains that the rising cost of health care is

causing problems with the SCHIP program overall and many states will feel this burden soon, if not already:

> The fundamental factor driving the shortfalls is not some deep flaw in SCHIP's financing structure; rather, it is health care cost inflation. With health care costs rising significantly throughout the U.S. health care system — in the private and public sectors alike — it costs more each year just to keep insuring the same number of SCHIP beneficiaries (Broaddus & Park, 2007).

The cost of medical care is rising at unsustainable rates. The rising cost of care, as well as the cost of insurance makes health care too expensive for many to seek on a regular basis. This contributes to a cycle whereby individuals do not receive regular care, then require costly emergency care. This can result in relatively minor conditions becoming emergency or even chronic conditions. Emergency and chronic care can be very expensive. Hence, those who are not enrolled in an insurance plan tend to be expensive users of health care in the long term. This is especially true with children. Children that receive quality, regular care early in their lives will usually live healthier lives and help keep costs down. High costs are the primary reason for the severe problems that our medical system is currently experiencing (Kenney, 2008).

Chapter 6 – Conclusions and Recommendations

The non-expansion of SCHIP was a political decision. The movement toward a socialized system of medicine in this country runs contrary to Republican values. In a broad sense, the Medicare and Medicaid programs are as far as the current President's administration is willing to go regarding socialized medicine. Our country does not want to join other industrialized nations and implement a national system of health care. However, this paper is not an attack on the Bush Administration or the Republican Party. The financial reality is that the United States cannot continue its current levels of health care spending. Total health care spending accounts for an approximately 15% share of the gross national product (Kaiser Family Foundation, 2007). This level of spending is not sustainable in the long term. More must be done to promote and encourage "front-end" programs. Human beings will always encounter health problems and as the world and health care evolves, so should our system. The problems associated with our health care system are primarily linked to the costs associated with the lack of health coverage for such a large proportion of the United States population. In the "Analysis of Findings" section of this paper a quote from the Center on Budget and Policy Priorities referenced the increased cost of health care due to inflation. Health care spending must be controlled in some manner. The quote goes on the mention that "it costs more each year just to keep insuring the same number of SCHIP beneficiaries." It is necessary to find a way to maintain our country's health and control costs (Broaddus & Park, 2007).

Funds must be set aside for "front-end" programs to ensure good health. Leading a healthy life and having health insurance coverage go hand-in-hand. Simple economic principle shows that if one has access to an item or service, that item or service will be used or consumed. This is true with health care. Those with health insurance seek out care and are often healthier than those

without health insurance. Those who do not have coverage usually cannot and do not seek out health care, unless they are in dire need. Individuals with health coverage usually see a regular doctor, receive pre-natal care and receive other preventative health services. Therefore, why not offer health care coverage to more people, especially children? Covering more people, especially children, will help make a healthier population and keep costs down over the long term.

This paper is not advocating a universal program, only one that includes more children. If children grow up healthier, they will be healthier adults and they will be cheaper in the long run. This may be viewed as an insensitive argument, but the fiscal realities must be addressed. Healthier people cost less than those who are sick. An overall healthier population will be cheaper in the long run, and this could be accomplished by covering more young people and encouraging more programs that promote healthier lifestyles.

These proposed solutions are not a panacea. If a child has had health care insurance coverage their whole life, when they are on their own they might be more likely to seek it out and have coverage, instead of going uncovered. In this context the price factor must be addressed as well. Coverage must be affordable and accessible in order for this to happen. Certainly many young people go without insurance, but if more are aware of their options, and given more options, this could reduce health care spending. One of the problems encountered throughout the study was getting those who are eligible for services, signed up for them. Outreach for these programs continues to be a problem. The problem persists that all individuals who are eligible are not signing up. In both New York City and Westchester County, this remains a problem. During both the Mary Harper and Allison Lake interviews this issue was mentioned. A significant portion of individuals in both New York City and Westchester County,

who are eligible have not signed up. Increased efforts must be made to enroll, and maintain enrollment.

The use of Facilitated Enrollment has helped this process, but more must be done. The enrollment process in Westchester County has been simplified in order to increase access and ease of enrollment. Forms may be filled out electronically and sent to both the New York State and Westchester County Department of Health (Westchester County Department of Health, 2008). This speeds up the enrollment time and reduces paperwork. However, the number of those not enrolled, but eligible, remains too high. The enrollment process for Child Health Plus must be completed on an annually basis, by those who want to access the services. Due to this annual renewal process a significant number of individuals drop out of the program each year who either do not know they have to re-enroll, or simply forget. The use of facilitated enrollers and an easier paperwork process has helped this situation, but these efforts must be increased in order to lower the numbers of eligible but not enrolled in Westchester County, New York City, and in the country overall.

Access to care begins with having an insurance plan, and the marketing efforts of Child Health Plus need to be increased. Outreach efforts in schools and other community outlets have not been enough. Advertisements for Child Health Plus are performed over television and other media, but again, increased efforts are needed. During the Allison Lake interview, the "stigma" attached to public assistance programs was also mentioned. This is an unavoidable issue, but hopefully the programs will be more accepted as the numbers of enrolled increase.

At present there is not a simple recommendation or conclusion to draw from this data, or for that matter, one regarding the overall state of health care in this country. The election for the next President of the United States is also taking place. Each candidate has their own policies

and beliefs regarding the health care system and how to improve it. An analysis of those plans would prove to be another project all together. However, as mentioned before, the primary issue involved with health care today is cost. The current spending levels are not able to be sustained, and average citizens cannot afford their health care bills, even some who have insurance. A way to temper these costs and keep the system intact would be to attempt to grow a healthier population from a younger age. That would mean covering children at a younger age and trying to contain costs across all income and health levels.

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New York City Health and Hospitals Corporation:

http://www.nyc.gov/html/hhc/html/home/home.shtml

Westchester County Department of Health

http://www.westchestergov.com/health/

Appendix A

2008 NYS Income and Resource Standards and Federal Poverty Levels

Human Resources Administration
Medical Assistance Program
MAPDR-01 (face).....Rev.01/07/08

Source: GIS 07 MA/025; 08 MA/001

1. CHPlus A, PCAP and Medicaid Monthly Income Levels (Pregnant Women and Children Under 19)

Family Size	1	2	3	4	5	6	Each Add'l Person
Children under 1 yr; Pregnant Women Perinatal Coverage Only **(200% FPL)**	$1734	$2334	$2934	$3534	$4134	$4734	$600
Children 1-5 **(133% FPL)**	$1153	$1552	$1951	$2350	$2749	$3148	$399
Children 6-18 **(100% FPL)**	$867	$1167	$1467	$1767	$2067	$2367	$300
Children 19-20 yrs; Parents/Disabled Individuals	$725	$1067	$1100	$1109	$1117	$1134	$142
Pregnant Women **(count as 2 people)** Full Coverage **(100% FPL)**		$1167	$1467	$1767	$2067	$2367	$300

2. Child Health Plus B Premium Levels – Monthly Income by Family Size (Children Under 19 NOT Medicaid-Eligible)

Premium Categories	1	2	3	4	5	6	Each Add'l Person
Free Insurance **(160% FPL)**	$1368	$1866	$2346	$2826	$3306	$3786	$480
$9 per child per month (Max. $27 per family) **(222% FPL)**	$1924	$2590	$3256	$3922	$4588	$5254	$666
$15 per child per month (Max $45/Family) **(250% FPL)**	$2167	$2917	$3667	$4417	$5167	$5917	$750
Full Premium per child/month if **over** 250% FPL	$2167	$2917	$3667	$4417	$5167	$5917	$750

3. Regular Medicaid Levels (Parents, 19 and 20 year olds, 21-64 disabled, 65 and over.)

Family Size	1	2	3	4	5	6	Each Add'l Person
Monthly Income	$725	$1067	$1100	$1109	$1117	$1134	$142
Resource Level	$4350	$6400	$6600	$6650	$6700	$6800	$850

4. Family Health Plus Income/Resource Levels

a) Parents Living with Children Under 21 in their Household; 19-20 year olds living with their parents

Family Size	1	2	3	4	5	6	Each Add'l Person
FHP Limit 150% FPL	$1300	$1750	$2200	$2650	$3100	$3550	$450
Resource Level	$13050	$19200	$19800	$19950	$20100	$20400	$2550

b) Adults Without Children Under 21 in Household, and 19-20 Year Olds Living Alone

Family Size	1	2
FHP Limit 100% FPL	$867	$1167
Resource Level	$13050	$19200

5. Family Planning Benefit Program Income Levels (No Resource Test)

Family Size	1	2	3	4	5	6	Each Add'l Person
FPBP 200% FPL (Child Bearing Age)	$1734	$2334	$2934	$3534	$4134	$4734	$600

6. Medicaid Buy-In for Working People with Disabilities

Family Size	1	2	**Resources**
MBI-WPD (16-64) 250% FPL	$2167	$2917	$10,000

If consumer (other than a single or childless couple) is ineligible because of excess income and or resources, consider Spenddown.

Source: New York City Human Resources Administration

Appendix B

MAPDR-01 (reverse)
Rev. 01/07/08

2008 NYS Income and Resource Standards and Federal Poverty Levels

Human Resources Administration
Medical Assistance Program

7. Monthly Standards
(Non-Disabled Adults ages 21-64 Without Children under 21 in the Household)

(a) Public Assistance Monthly Standards		Family Size 1	Family Size 2
Maximum Gross Income Test (Initial **Screening**) (185%)		$651.39	$866.73
Std. PA Allowance	+	$112.00	$179.00
Home Energy Allowance	+	$ 25.10	$39.50
Actual Rent or Max. Rent Allowance	+	$215.00	$250.00
Maximum Net PA Income Allowed	=	**$352.10**	**$468.50**

(b) Resource Levels		
No. of persons in S/CC household	1	2
Resource Allowance: (Ages 21-59)	$2000	$2000
Resource Allowance: (Ages 60-64)	$3000	$3000

8. Medicare Savings Program (Buy-In)

		Income Family of 1	Income Family of 2
QMB 100% FPL **(Excludes $20 Disregard)**	Annual	$10400	$14000
	Monthly	$867	$1167
SLIMB 120% FPL	Annual	$12480	$16800
	Monthly	$1040	$1400
QI-1 135% FPL	Annual	$14040	$18900
	Monthly	$1170	$1575
RESOURCES		$4000	$6000

NOTE: No resource test for QI-1

9. Other Important Figures

Medicare Part A Premium: $423.00
Medicare Part B Premium: $96.40 for most recipients
Standard Allocation: From non-SSI-related parent to non-SSI-related child $342
PASS-THROUGH FACTORS: .893 .188

Family Size	1	2
COBRA (100% FPL)	$867	$1167
AIDS Health Ins. Program (AHIP) (185% FPL)	$1604	$2159
QWDI (200% FPL)	$1734	$2334
COBRA, QWDI No Resource Test for AHIP	$4000	$6000

10. Spousal Support And Resource Level

INCOME (MMMNA) - $2610	**RESOURCES** – (Minimum) - $74,820 (Maximum) - $104,400	**FAMILY MEMBER ALLOWANCE USE** - $1750.00 (Estimated) $584 is the maximum family member allowance allowed.

11. Monthly Regional Nursing Home Rates (2008)

NEW YORK CITY (All boroughs) - **$9636**	**LONG ISLAND - $10,555** Nassau, Suffolk
NORTHEASTERN - $7,431 Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**NORTHERN METROPOLITAN - $9,316** Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
WESTERN (Buffalo) - $7,066 Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**ROCHESTER - $8,089** Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
CENTRAL (Syracuse) - **$6,696** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	

In determining the community resource allowance on and after January 1, 2008, the community spouse is permitted to retain resources in an amount equal to the greater of the following: $74,820 or the amount of the spousal share up to $104,400. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the date of the first continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989. Look-back period anchored in month A/R is both institutionalized and applying for MA.

Source: New York City Human Resources Administration

Appendix C

The following charts represent the number of individuals enrolled in Child Health Plus in New York City (Each Borough is considered its own county) and Westchester County, NY. Child Health Plus is offered through Private Insurers and the key identifying each insurer is included on each page.

County	Total	AFFINITY	BCBSCNY	BCBSUW	CDPHP	CENTER	COMMBLUE	CPLUS	EBCBS	FIDELIS	FLBCBS	GHI_HMO
Bronx	22,383	4,616	0	0	0	621	0	438	927	1,692	0	286
Kings	48,808	1,888	0	0	0	576	0	3,491	11,732	1,485	0	95
New York	10,816	830	0	0	0	946	0	394	1,432	690	0	94
Queens	53,046	1,987	0	0	0	938	0	7,577	9,519	2,221	0	148
Richmond	7,299	144	0	0	0	43	0	470	1,809	510	0	41
Westchester	21,158	2,260	0	0	0	0	0	0	3,438	1,902	0	169
Total State Wide	364,543	24,109	12,184	13,116	17,867	3,124	10,469	12,370	61,562	39,564	17,882	3,045

AFFINITY	AFFINITY HEALTH PLAN
BCBSCNY	EXCELLUS HEALTH PLAN, INC. D/B/A BCBSCNY
BCBSUW	EXCELLUS HEALTH PLAN, INC.D/B/A BCBSUW
CDPHP	CDPHP
CENTER	CENTERCARE
COMMBLUE	HEALTHNOW NY, INC. D/B/A BCBSWNY
CPLUS	CAREPLUS
EBCBS	EMPIRE HEALTHCHOICE
FIDELIS	NEW YORK STATE CATHOLIC HEALTH PLAN, INC.
FLBCBS	EXCELLUS HEALTH PLAN D/B/A BCBS OF ROCHESTER
GHI_HMO	GHI HMO

Source: New York State Department of Health

(Continued)

County	HFPHSP	HIP	HPLUS	HUDSON	METRO	MVP	NHP	NYHCH	SCHC	SUFFOLK	UHC	UNIVERA	WELLCARE
Bronx	5,147	640	1,949	0	4,078	0	374	456	0	0	30	0	1,129
Kings	4,501	1,720	12,188	0	4,741	0	2,171	901	0	0	1,506	0	1,813
New York	1,590	494	932	0	1,381	0	190	1,040	0	0	34	0	769
Queens	5,473	3,503	6,889	0	7,214	0	3,657	1,338	0	0	525	0	2,057
Richmond	290	427	3,432	0	0	0	28	0	0	0	105	0	0
Westchester	0	616	0	12,773	0	0	0	0	0	0	0	0	0
Total State Wide	28,531	12,543	26,566	19,796	17,414	1,486	6,420	3,735	3,270	3,698	10,566	6,314	8,912

HFPHSP	HEALTHFIRST PHSP
HIP	HEALTH INSURANCE PLAN OF GREATER NY
HPLUS	HEALTHPLUS PHSP INC.
HUDSON	HUDSON HEALTH PLAN
METRO	METROPLUS HEALTH PLAN
MVP	MVP HEALTH PLAN
NHP	NEIGHBORHOOD HEALTH PROVIDERS
NYHCH	NEW YORK HOSPITAL COMMUNITY HEALTH
SCHC	SCHC TOTAL CARE
SUFFOLK	SUFFOLK HEALTH PLAN
UHC	UHC OF NY
UNIVERA	UNIVERA COMMUNITY HEALTH
WELLCARE	WELLCARE

Appendix D

The below charts represent the number of Medicaid eligible individuals by category of eligibility, in New York City and Westchester County, NY.

Rev. 6/25/07

Social Services District	TOTAL MEDICAID ELIGIBLES	Medicaid and Subsistence					
		TANF CHILDREN	TANF ADULTS	SAFETY NET CHILDREN	SAFETY NET ADULTS	SSI AGED	SSI BLIND & DISABLED
New York State	4,127,816	244,667	81,188	133,464	150,051	155,805	527,229
New York City	2,719,730	167,564	51,972	107,783	114,050	123,509	307,497
Rest of State	1,408,086	77,103	29,216	25,681	36,001	32,296	219,732
Westchester	100,865	5,157	2,153	2,724	3,030	3,526	15,121

Social Services District	TOTAL MEDICAID ELIGIBLES	Medicaid Only							
		TANF CHILDREN	TANF ADULTS	SAFETY NET CHILDREN	SAFETY NET ADULTS	AGED	BLIND & DISABLED	FAMILY HEALTH PLUS	OTHER
New York State	4,127,816	1,182,047	353,191	59,117	316,528	210,053	141,877	543,029	29,570
New York City	2,719,730	735,560	193,885	52,865	270,493	109,473	58,842	400,954	25,283
Rest of State	1,408,086	446,487	159,306	6,252	46,035	100,580	83,035	142,075	4,287
Westchester	100,865	32,159	9,416	501	4,509	7,831	5,057	8,632	1,049

*TANF = Temporary Assistance for Needy Families

Source: New York State Department of Health

Appendix E

States Projected to Face Federal Funding Shortfalls in Select Years: 2008 and 2012
(assumes moderate expenditure growth and current rules for allocating and redistributing funds across states)

2008		2012	
State	**Estimated Shortfall**	**State**	**Estimated Shortfall**
Alaska	$18,037,000	Alabama	$73,741,000
California	$203,611,000	Alaska	$27,969,000
Georgia	$154,444,000	Arizona	$36,981,000
Illinois	$291,823,000	Arkansas	$35,156,000
Iowa	$30,779,000	California	$778,379,000
Kansas	$247,000	Georgia	$271,454,000
Maine	$11,438,000	Hawaii	$12,593,000
Maryland	$93,093,000	Illinois	$474,552,000
Massachusetts	$170,863,000	Iowa	$55,837,000
Minnesota	$42,797,000	Kansas	$31,095,000
Mississippi	$54,301,000	Kentucky	$40,117,000
Missouri	$42,097,000	Louisiana	$53,476,000
Nebraska	$12,865,000	Maine	$20,294,000
New Jersey	$214,102,000	Maryland	$146,770,000
North Carolina	$44,017,000	Massachusetts	$282,675,000
North Dakota	$1,000	Michigan	$99,597,000
Ohio	$8,108,000	Minnesota	$73,277,000
Rhode Island	$54,478,000	Mississippi	$92,588,000
South Dakota	$2,240,000	Missouri	$79,994,000
Wisconsin	$33,402,000	Montana	$5,762,000
		Nebraska	$24,396,000
		New Jersey	$330,732,000
		New Mexico	$67,132,000
		North Carolina	$120,150,000
		North Dakota	$3,770,000
		Ohio	$123,022,000
		Oklahoma	$36,942,000
		Oregon	$55,794,000
		Pennsylvania	$92,694,000
		Rhode Island	$77,688,000
		South Dakota	$8,604,000
		Texas	$82,620,000
		Virginia	$66,319,000
		West Virginia	$26,158,000
		Wisconsin	$67,482,000
		Wyoming	$6,230,000
Total States:	**Total Shortfall:**	**Total States:**	**Total Shortfall:**
20	**$1,482,745,000**	**36**	**$3,882,040,000**

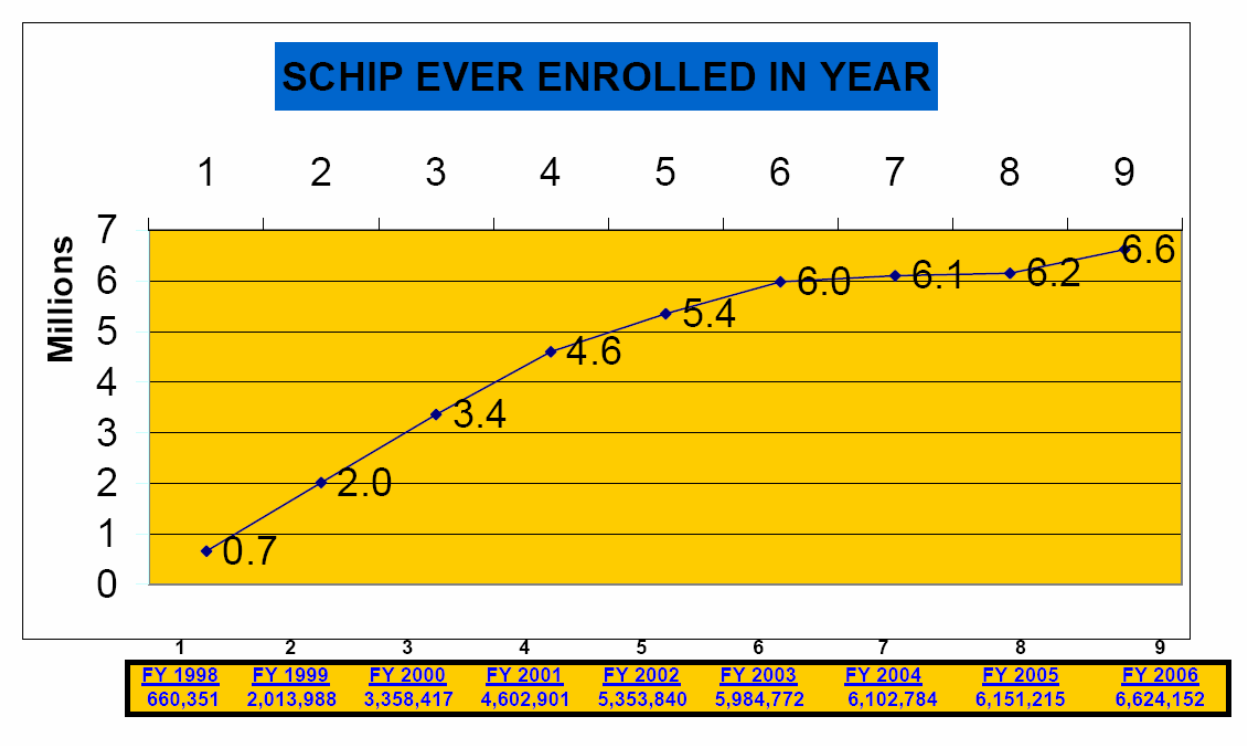
Source: Center on Budget and Policy Priorities

Appendix F

Projected Federal SCHIP Funds Available in States as a Percentage of States' Projected Need for Such Funds (assumes moderate expenditure growth and current rules for allocating and redistributing funds across states)					
	2008	**2009**	**2010**	**2011**	**2012**
# States Under 100%	**20**	**23**	**30**	**34**	**36**
Alabama		66%	59%	55%	51%
Alaska	40%	38%	36%	33%	31%
Arizona				94%	78%
Arkansas				78%	59%
California	83%	63%	59%	55%	51%
Georgia	53%	48%	46%	42%	39%
Hawaii			66%	60%	55%
Illinois	43%	40%	38%	35%	32%
Iowa	55%	50%	47%	44%	40%
Kansas	100%	68%	63%	59%	55%
Kentucky				72%	64%
Louisiana			83%	68%	63%
Maine	58%	54%	51%	47%	44%
Maryland	43%	41%	39%	36%	33%
Massachusetts	32%	28%	27%	25%	22%
Michigan		75%	70%	65%	60%
Minnesota	54%	51%	48%	44%	41%
Mississippi	53%	50%	48%	44%	41%
Missouri	64%	60%	56%	52%	48%
Montana					75%
Nebraska	63%	60%	56%	52%	46%
New Jersey	35%	32%	31%	28%	26%
New Mexico			77%	48%	45%
North Carolina	77%	66%	62%	58%	54%
North Dakota	100%	83%	78%	73%	68%
Ohio	96%	70%	66%	61%	57%
Oklahoma			97%	71%	66%
Oregon			67%	55%	51%
Pennsylvania				83%	66%
Rhode Island	23%	22%	21%	19%	17%
South Dakota	84%	68%	64%	60%	55%
Texas					91%
Virginia			72%	64%	59%
West Virginia		83%	60%	56%	52%
Wisconsin	68%	64%	60%	56%	51%
Wyoming			86%	58%	53%

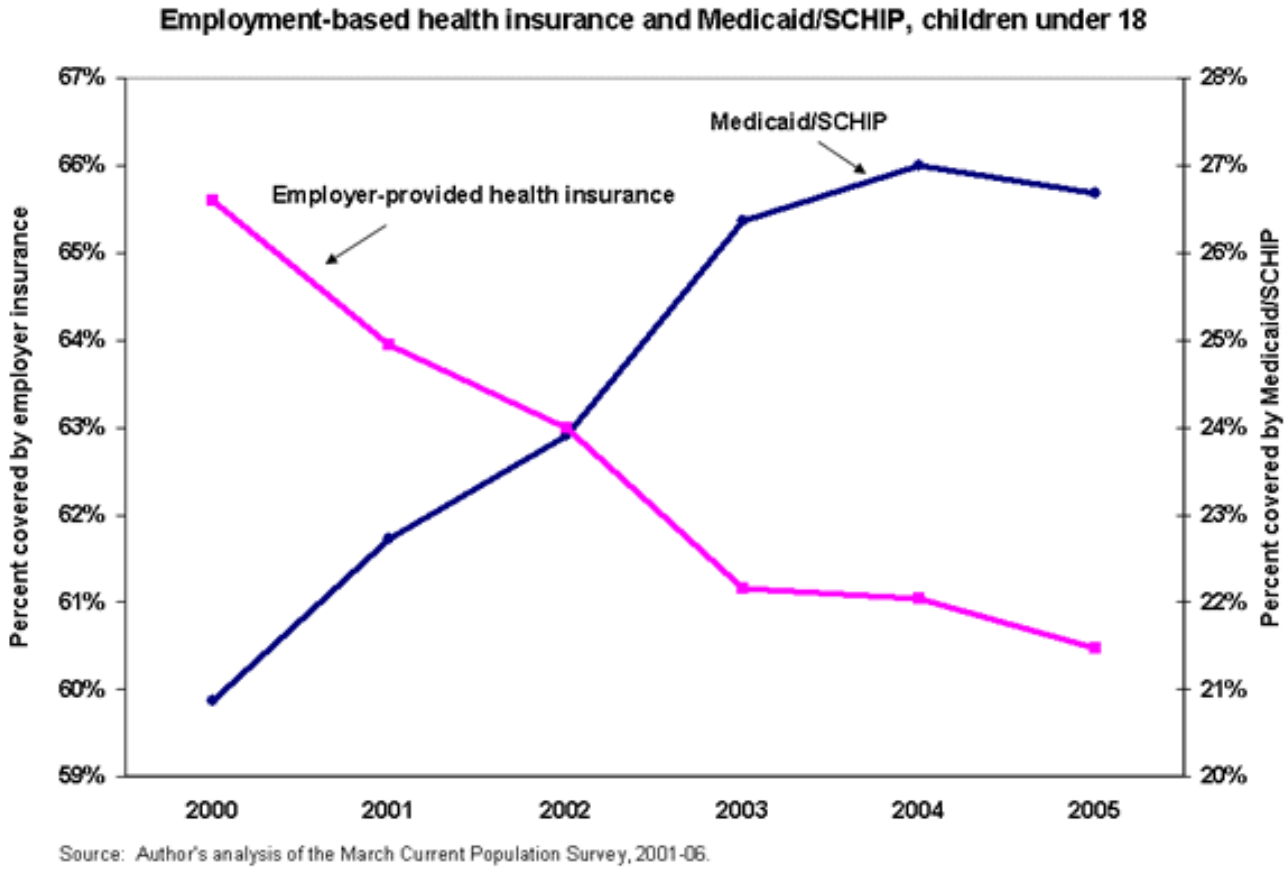
Source: Center on Budget and Policy Priorities' moderate expenditure growth SCHIP financing model

Appendix G



Source: Centers for Medicaid and Medicare Services

Appendix H



Source: Economic Policy Institute

Appendix I

TABLE 1: SCHIP Reauthorization Timeline

2007	
February	
5	President releases FY 2008 budget, which includes $4.8 billion in new SCHIP funding over five years
May	
25	President signs H.R. 2206, approving an additional $650 million for SCHIP funding in FY 2007 to prevent shortfalls
August	
1	House passes H.R. 3162, The Child Health and Medicare Protection Act of 2007 (225-204)
2	Senate passes S.1893/H.R. 976, The Children's Health Insurance Program Reauthorization Act of 2007 (68-31)
17	CMS Directive released
September	
21	House and Senate leaders announce agreement on conference bill (H.R. 976)
25	House passes the conference bill, H.R. 976 (265-159-1)
27	Senate passes the conference bill, H.R. 976 with House amendments (67-29)
October	
3	President vetoes H.R. 976
18	House fails to override veto of H.R. 976 (273-156)
25	House passes H.R. 3963, The Children's Health Insurance Program Reauthorization Act of 2007 (265-142)
November	
1	Senate passes H.R. 3963 (64-30)
December	
12	President vetoes H.R. 3963
18	Senate passes S. 2499, The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Unanimous Consent)
19	House passes S. 2499 (411-3)
29	President signs S.2499 into law (PL 110-173)
2008	
January	
23	Veto override vote of H.R. 3963 fails in House (260-152)
February	
4	President releases FY 2009 budget, which includes $19.7 billion in new SCHIP funding over five years

Sources: Roll call votes, www.whitehouse.gov

Note: SCHIP is the State Children's Health Insurance Program. Roll call votes for bills are in parentheses after the bill name and in the format (Yays-Nays-Present)

Source: Urban Institute