

RACE & HEALTH INITIATIVE

PHOTOCOPY
PRESERVATION

GOAL 2 - Eliminate disparities in cancer screening and management.

Cancer is the second leading cause of death in the United States, accounting for more than 544,000 deaths each year. About 1.4 million new cases of cancer are expected to be diagnosed in 1997, and approximately 7.4 million Americans have or have had cancer. The chances of developing cancer in a lifetime are nearly 50 percent for men and nearly 40 percent for women. About half of those who develop the disease will die from it.

Many minority groups suffer disproportionately from cancer. Disparities exist in both mortality and incidence rates. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites (171.6 vs. 127.0 per 100,000). The death rate for cancer for black men is about 50 percent higher than it is for white men (226.8 vs. 151.8 per 100,000). The death rate for lung cancer is about 27 percent higher for blacks than for whites (49.9 vs. 39.3 per 100,000). The prostate cancer mortality rate for black men is more than twice that of white men (55.5 vs 23.8 per 100,000).

Paralleling the death rate, the incidence rate for lung cancer in black men is about 50 percent higher than in white men (110.7 vs. 72.6 per 100,000). Native Hawaiian men also have elevated rates of lung cancer compared with white men. Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do whites. Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than white women (47.3 vs. 8.7 per 100,000). Hispanic women also suffer elevated rates of cervical cancer.

Much can be done to reduce the burden of cancer in the United States through prevention. Lifestyles can be modified to greatly reduce an individual's risk for cancer. Tobacco use is responsible for nearly one-third of all cancer deaths. Evidence suggests that diet and nutrition may be related to 30 to 40 percent of cancer deaths. Additionally, many of the estimated 900,000 skin cancer cases diagnosed each year could be prevented by reducing sun exposure.

For some cancers that we do not yet know how to prevent, early detection can dramatically reduce the risk of death. Regular mammography screening and appropriate follow-up can reduce deaths from breast cancer by about 30 percent for women 50 years of age and older. Screening by Pap test for cervical cancer along with appropriate follow-up care can virtually eliminate the risk of developing this disease.

The purpose of goal 2 is to improve screening and management of cancer. Although colorectal cancer screening is now recommended, few data on screening rates exist. Screening for prostate cancer remains controversial, and for this cancer as well, few data on screening rates exist. Indeed, there is a significant need for public education about what is known, what is not known, and what is believed about prostate cancer screening and treatment. Breast and cervical cancers, however, have proven screening modalities for which screening data, both baseline and continuing, are available. For this reason, the strategy for achieving goal 2 focuses on breast and cervical cancers.

Despite the considerable gains in screening in the black community, the mortality rate from breast cancer for black women is greater than for white women. Some of the reasons for this disparity include the fact that many women have not yet had a mammogram or a Pap smear, many more are not screened regularly, and still others are screened but have limited follow-up and treatment services available to them. Hispanic, American Indian and Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, culture, and negative provider attitudes, which negatively affect their health status. Eliminating these differences is critical and will be the focus of attention for the HHS initiative to help identify and understand approaches that have proven successful in some communities. Our focus on tracking breast and cervical cancer will serve as an indicator for assessing our overall efforts to reduce and eventually eliminate disparities in the prevention and management of all cancers.

Breast Cancer

Our goal for the year 2000 for breast cancer screening is to increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and a mammogram within the preceding 2 years.

Near-Term Goal

Increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and mammogram within the preceding two years.

Cervical Cancer

Our goal for the year 2000 for cervical cancer is to increase to at least 85 percent the proportion of all women aged 18 and older who have received a Pap test within the preceding 3 years.

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GOAL 5 - Eliminate disparities in HIV Infection/AIDS.

HIV infection/AIDS is a leading cause of death for all persons 25 to 44 years of age. Between 650,000 and 900,000 Americans are estimated to be living with HIV infection. Approximately 62 percent (375,000) of the 604,200 adults and adolescents reported with AIDS in the United States have died from the disease.

AIDS has disproportionately affected minority populations. Racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, yet they account for nearly 54 percent of all AIDS cases. While the epidemic is decreasing in some populations, the *number* of new AIDS cases among blacks is now greater than the number of new AIDS cases among whites.

There are several different HIV epidemics occurring simultaneously in the United States, each of which must address the specific population affected and their associated risk factors. For example, although the number of AIDS diagnoses among gay and bisexual men has decreased dramatically among white men since 1989, the number of AIDS diagnoses among black men who have sex with men have increased. In addition, AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 75 percent were among minority populations (56 percent black and 20 percent Hispanic). Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities.

During 1995 and 1996, AIDS death rates declined 23 percent for the total U.S. population while declining only 13 percent for blacks and 20 percent for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies. The cost of efficacious treatment, between \$10,000 and \$12,000 per patient per year, is a major hurdle in the effort to ensure equitable access to available drug therapies.

Inadequate recognition of risk, detection of infection, and referral to follow-up care are major issues for high-risk populations. About one-third of persons who are at risk of HIV/AIDS have never been tested. Better prevention strategies are needed that are acceptable to the target community (i.e., they must be culturally and linguistically appropriate), and the capability of organizations serving at-risk populations to develop, implement, evaluate, and fund prevention and treatment programs must be improved. Efforts should include risk reduction counseling, street and community outreach, prevention case management services, and help for individuals at risk in gaining access to HIV testing, treatment, and related services.

At this moment, there are many causes for optimism in the fight against HIV/AIDS. HIV prevention efforts have contributed to slowing the spread of the disease. For the first 6 months of 1996, there was an overall decrease in deaths among persons with AIDS, attributed primarily to the effect of antiretroviral therapies on the survival of persons with HIV infection. The decrease in the growth of AIDS cases in minority populations, however, has not been so strong.

To enable HIV-infected persons to benefit from treatment advances, HIV counseling and testing programs in screening and health care settings must better facilitate early diagnosis of HIV infection and ensure that HIV-infected persons have access to care and treatment services. Continued emphasis on behavioral risk reduction and other prevention strategies targeted to these populations is still the most effective way to reduce HIV infections.

Although advances in prevention and treatment are improving the quality of life for individuals living with HIV/AIDS, not everyone is benefiting equally from this progress. Concerns regarding education about the benefits of knowing one's serostatus, access to counseling and testing, and referral and access to medical services, including efficacious therapies, will continue to guide the development and administration of Federal initiatives to prevent HIV transmission and improve access to care for individuals living with HIV/AIDS.

Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and ensuring access to appropriate health services for all and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE

Act will ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to promote the current standard of clinical care for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

Near-Term Goal

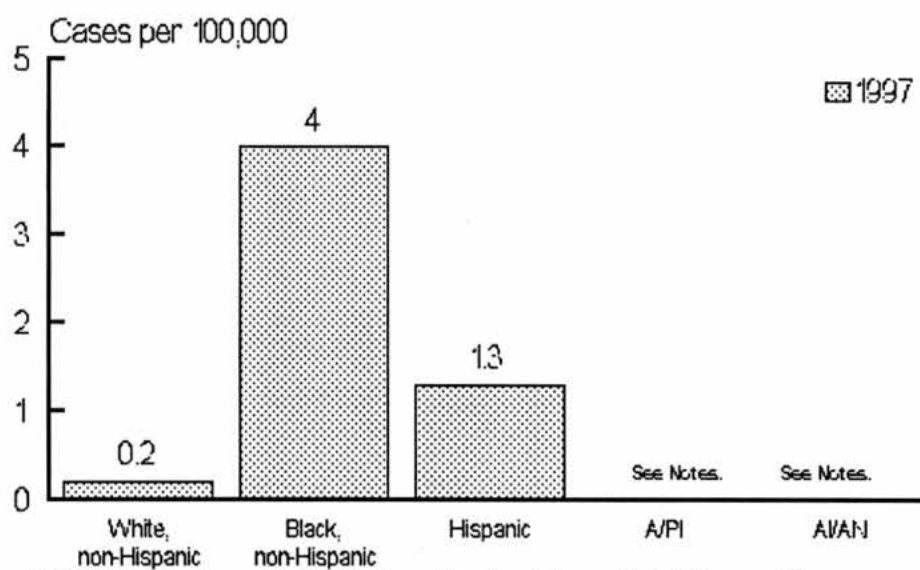
Ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS.

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[\[ASPE Home Page\]](#) [\[HHS Home Page\]](#) [\[Site Home Page\]](#) [\[Top of Page\]](#)

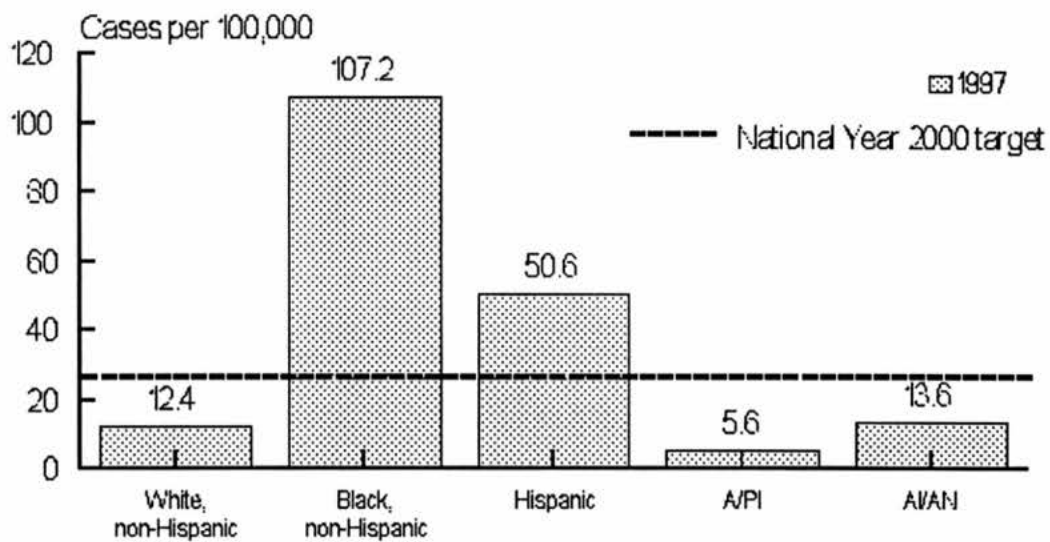
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AIDS Case Rates in Children under 13 years by Race and Hispanic Ethnicity, United States, 1997



NOTES: Asian American or Pacific Islander and American Indian or Alaska Native populations have fewer than 10 cases. SOURCE: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Pediatric AIDS Case Reporting System.

AIDS Case Rates in Persons 13 years and over by Race and Hispanic Ethnicity, United States, 1997



NOTES: A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.
SOURCE: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Adult/Adolescent AIDS Reporting System.

GOAL 4 - Eliminate disparities in diabetes.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly 16 million Americans. The estimated total direct and indirect costs of diabetes for the United States in 1993 was \$98 billion.

HISPANIC The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among American Indians and Alaska Natives is more than twice that for the total population and at least one tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world.

Cardiovascular disease is the leading cause of death among people with diabetes, accounting for over one-half of all deaths. Achieving mortality reduction among high-risk populations will require targeted efforts to reduce cardiovascular risk factors among these groups, which is a focus of our goal on eliminating disparities in cardiovascular disease. Individuals with diabetes, however, face not only a shortened life span, but also the probability of multiple acute and chronic complications, including end-stage renal disease (ESRD), blindness, and lower extremity amputations. All of these complications have the potential to be prevented.

- If uncontrolled hypertension among people with diabetes were reduced by half, about one-quarter of **ESRD** due to diabetes could be prevented.
- **Diabetic retinopathy** is the leading cause of new cases of blindness among people 20 to 44 years of age. Clinical trials have demonstrated that approximately 60 percent of diabetes-related blindness can be prevented with good blood glucose control or by early detection and laser photocoagulation treatment, which is widely available but underused.
- One half of all **lower extremity amputations** can be prevented through proper foot care and by reducing risk factors such as hyperglycemia (abnormally high blood sugar), cigarette smoking, and high blood pressure.

Preventive interventions should target high-risk groups. Rates for diabetes-related complications such as ESRD and amputations are higher among blacks and American Indians compared to the total population. Even among similarly insured populations, such as Medicare recipients, blacks are more likely than whites to be hospitalized for septicemia, debridement, and amputations -- signs of poor diabetic control. Scientists are concerned that a number of people in these minority groups develop type 2 (non-insulin-dependent) diabetes in adolescence, and therefore face a lifetime of diabetes and its potential complications. Undiagnosed and poorly controlled diabetes increases the likelihood of serious complications; for every two persons who are aware of their illness, there is one person who remains undiagnosed.

Although the increasing burden of diabetes is alarming, the good news is that much of this major public health problem can be prevented with early detection, improved care, and diabetes self-management education. Diabetes presents both a challenge and an opportunity for public policy makers, health care providers, community leaders, and individuals with diabetes to apply prevention strategies known to make a significant impact. Recent studies in diabetes have confirmed that careful control of blood glucose levels is a strategy that works for preventing the complications of diabetes. The challenge is to make proper diabetes management part of daily clinical and public health practice.

Therefore, our goal is to monitor progress in reducing diabetes by reducing the overall rate of diabetic complications among all individuals with diabetes and eventually to eliminate disparities among groups. As a major step toward that end, we have set two near-term goals: (1) reducing the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent from their 1995 levels by the year 2000, and (2) reducing lower extremity amputation rates from diabetes among blacks by 40 percent from their 1995 levels. Rates of diabetic complications among Hispanics are also high; however, current data do not permit us to monitor diabetic complications among this group. We will develop strategies to reduce diabetes-related complications among all minority groups and to improve data collection.

Near-Term Goals

- Reduce the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent.
- Reduce lower extremity amputation rates from diabetes among blacks by 40 percent.

The rates of diabetes-related complications used as outcome measures are crude indicators of progress in eliminating disparities; however, they are the only outcome measures available consistently on a national basis. We also will monitor behavioral practices and health care access issues as indicators of success. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of blood glucose levels, clinic visits, diabetic foot care, and dilated-eye exams.

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GOAL 6 - Eliminate disparities in child and adult immunization rates.

The reduction in incidence of vaccine-preventable diseases is one of the most significant public health achievements of the past 100 years. This success is best illustrated by the global eradication of smallpox, achieved in 1977. The major factor in this success is the development and widespread use of vaccines, which are among the safest and most effective preventive measures. Billions of dollars are saved each year through the use of vaccines.

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. The 1996 immunization coverage targets for all five vaccines (measles, mumps, and rubella [MMR]; polio; diphtheria, tetanus, and pertussis [DTP]; *Haemophilus influenza* type B [Hib]; and hepatitis b [Hep B]) were exceeded. Although immunization rates have been lower in minority populations compared with the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. For example, four of the five 1996 coverage targets were met for blacks. Current efforts must be sustained in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations.

Although coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of underimmunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas with traditionally underserved populations, there is a potential for outbreaks of vaccine-preventable diseases.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90 percent of all influenza-associated deaths in the United States occur in people aged 65 and older, the fastest growing age group of the population. Reduction of deaths in this age group has been hindered in part by relatively low vaccine utilization. Immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. Each year, however, an estimated 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of safe and effective vaccines to prevent these conditions and their complications. In addition, the overall cost to society for vaccine-preventable diseases exceeds \$10 billion each year.

There is a disproportionate burden of these diseases in minority and underserved populations. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the general population and the year 2000 targets.

Childhood Immunization

Our goal is to enhance current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations and to eliminate remaining disparities among groups.

Near-Term Goal

Achieve and maintain at least 90 percent coverage for all recommended childhood vaccines in all populations

Adult Immunization

Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent and eventually to eliminate disparities among groups. To reach this goal by the year 2000, we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and

Asians and Pacific Islanders and *quadruple* the 1994 pneumococcal immunization rates among these groups.

Near-Term Goal

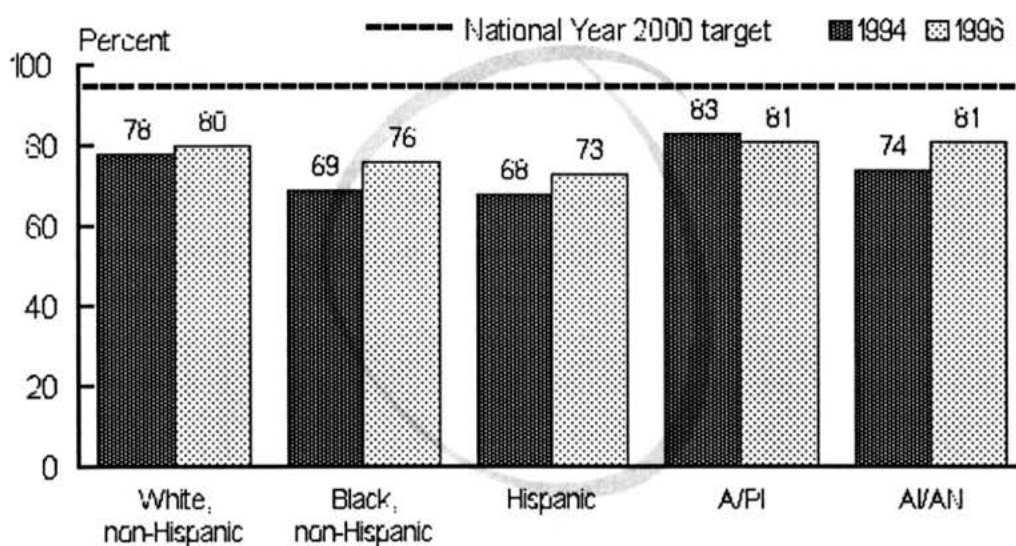
Increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent

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[\[ASPE Home Page\]](#) [\[HHS Home Page\]](#) [\[Site Home Page\]](#) [\[Top of Page\]](#)

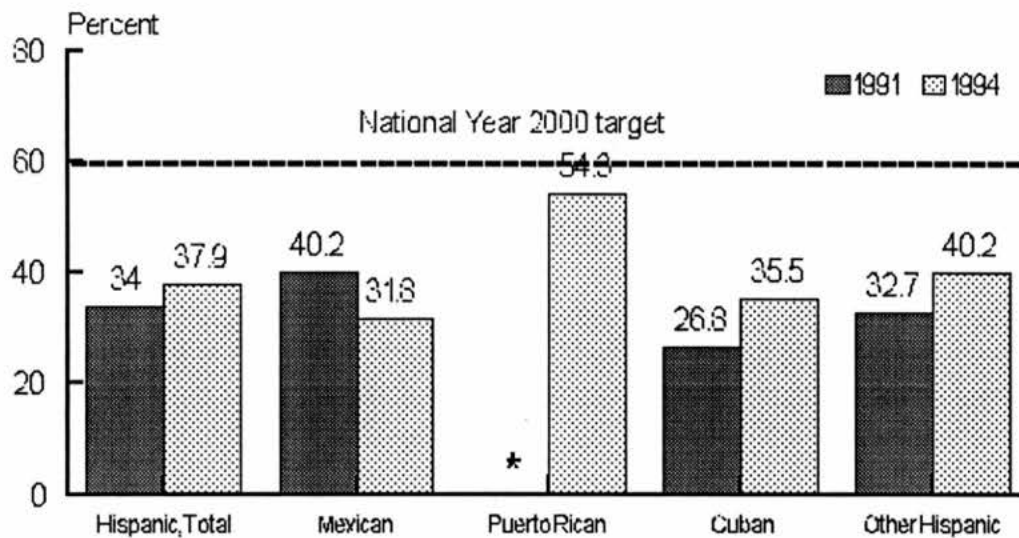
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Childhood Immunization Rates* by Race and Hispanic Ethnicity, United States, 1994 and 1996



*Immunization rates reflect those children ages 19-35 months who have received 4 doses of DTP (diphtheria, tetanus, pertussis), 3 polio, and 1 MMR (measles, mumps, rubella).
NOTE: A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.
SOURCES: Centers for Disease Control and Prevention, National Immunization Survey (1994-1996), and National Health Interview Survey (1992-1993).

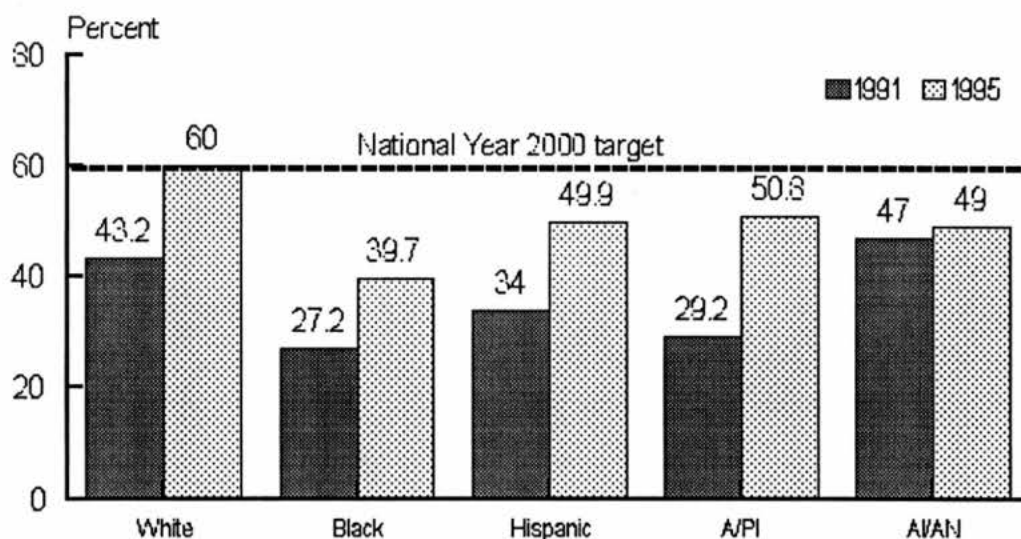
Influenza Immunization Rates for Persons 65 Years and Over by Hispanic Origin, United States, 1991 and 1994



* Relative standard error greater than 30 percent.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Influenza Immunization Rates for Persons 65 Years and Over by Race and Hispanic Ethnicity, United States, 1991 and 1995



NOTES: A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

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HHS FACT SHEET**February 23, 1999**

Contact: HCFA Press Office (202) 690-6145

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Overview: Proposed by President Clinton and passed as part of the historic, bipartisan Balanced Budget Act of 1997, the Children's Health Insurance Program (CHIP) is the largest single expansion of health insurance coverage for children in more than 30 years. Today, nearly 11 million American children -- one in seven -- are uninsured. To reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, this new initiative set aside \$24 billion over five years for states to provide new health coverage for approximately 3 million children. To improve the health of our nation's children, the President has challenged the public and private sectors to work together to educate families and help them enroll their children in CHIP or in Medicaid. CHIP is a partnership between the federal and state governments that will help provide children with the health coverage they need to grow up healthy and strong. Each state has an allotment of funds based on the number of uninsured children in the state, and the states can draw on a single year's allotment for up to three years. To help states find the parents of eligible children, states are able to use a percentage of their federal funds to expand outreach and ensure that all children eligible for CHIP, as well as Medicaid, are enrolled. The program also includes important cost-sharing protections so that families will not be burdened with heavy out-of-pocket expenses. At President Clinton's insistence, the CHIP program requires that states use this new money to cover uninsured children -- and not replace existing health coverage. Funds for the program became available to the states on October 1, 1997, and HHS is working closely with states to approve plans in accordance with the new law. States can receive federal matching funds only for actual expenditures to insure children. Most state CHIP plans have been approved. Since CHIP implementation began on October 1, 1997, 53 states and U.S. territories have submitted CHIP plans for approval by the Department of Health and Human Services. CHIP plans have been approved for 50 states and U.S. territories. In order of approval they are: Alabama, Colorado, South Carolina, Florida, Ohio, California, New York, Illinois, Michigan, Connecticut, New Jersey, Missouri, Rhode Island, Oklahoma, Massachusetts, Pennsylvania, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, the Virgin Islands, the District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky, Alaska, Vermont, New Mexico, and Hawaii. The following state plans have been submitted and are under review: Tennessee, Guam, and American Samoa. In addition, 11 states have submitted and had amendments approved to expand their CHIP plans. According to states' estimates, 2.5 million children will be covered by October 2000.

EXPANDING CHILDREN'S ACCESS TO HEALTH COVERAGE

The federal-state Children's Health Insurance Program (CHIP), created under the new Title XXI of the Social Security Act, expands health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. It builds on Medicaid, the federal-state health insurance program that covers approximately 36 million low-income individuals, including 18 million children. Under Medicaid, states currently cover children whose family incomes range generally from below the FPL to as high as 300 percent of poverty. The majority of states cover children in families between 100 and 150 percent of the FPL. In the CHIP program, states may either cover children in families whose incomes are above the Medicaid eligibility threshold but less than 200 percent of

poverty, or within 50 percentage points over the state's current Medicaid income limit for children.

Ensuring Meaningful Health Benefits. CHIP gives states flexibility in targeting eligible uninsured children. States may choose to design new child health insurance programs, expand their Medicaid programs, or create a combination of both. States choosing a new children's health insurance program may offer one of the following benchmark plans: the standard Blue Cross/Blue Shield Preferred Provider Option offered by the Federal Employees Health Benefit Program; a health benefit plan offered by the state to its employees; or the HMO benefit plan with the largest commercial enrollment in the state. A state may also choose to offer the "equivalent" of one of the benchmark plans. If a state chooses this option, its plan's total actuarial value must be at least equal to the benchmark plan's and it must include: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and X-ray services; and, well baby/child care services, including immunizations. In addition, if the plan a state chooses as its benchmark includes coverage for prescription drugs, mental health services, vision care, and hearing-related expenses, the state's "equivalent" plan must include similar benefits. Under the law, New York, Pennsylvania and Florida can continue to offer their current benefit packages (with some modifications to comply with the law's cost-sharing protections). States choosing the Medicaid option must offer the full Medicaid benefit package for children.

Limiting Patient Costs. Patient out-of-pocket costs for this program are allowed but are limited. If a state expands its Medicaid program, then existing Medicaid limits apply to the newly enrolled children. If a new health plan is developed, premiums for families whose income is under 150 percent of the poverty level cannot exceed \$19 per family per month and copayments must be nominal. Cost sharing is not permitted for well-child, well-baby visits. For families with incomes above 150 percent of poverty, cost-sharing must be based on an income-related sliding scale with an annual total for all children not to exceed five percent of the family's income.

Preventing Cost Shifting. To prevent states from shifting children from the traditional Medicaid program to CHIP, states may not restrict the Medicaid eligibility standards for children that were in place on March 31, 1997. In addition, states must enroll all children who meet Medicaid eligibility rules in the Medicaid program rather than in the new CHIP plan. All states must design their programs to prevent private cost shifting as well. In their child health plans, states must describe methods they will use to prevent "crowd out" or the shifting of children from private insurance to CHIP.

ACCESSING FEDERAL FUNDING

States are eligible to receive an enhanced federal matching rate for CHIP. The funds are drawn from an "allotment" for state programs that expand access to targeted, low-income children under the CHIP program. To access the allotment, plans must be approved by the Secretary of Health and Human Services. Funds will be allocated to each participating state according to their number of uninsured low-income children, accounting for regional cost differences. Available final state allotments for fiscal year 1998 and reserved allotments for fiscal year 1999, which were published in the Federal Register, range from \$3.5 million to \$855 million. States may draw on a single year's allotment for up to three years, and they may use up to 10 percent of the CHIP benefit expenditures for outreach and certain administrative costs. To access the fiscal year 1998 allotment, states must have their CHIP plans approved by the Secretary of Health and Human Services by Sept. 30, 1999. The fiscal year 1999 budget includes \$4.275 billion for fiscal year 1999 state allotments.

The Department of Health and Human Services (HHS) is working closely with states as they design CHIP plans that meet the requirements of the new law. HHS has written to each state outlining the program, and has published a preliminary check-list of information states must submit to HHS when applying for their allotments; and answers to the most commonly asked questions from states about how to develop their children's health insurance programs. The department works with states to expedite the development and implementation of state CHIP plans.

EXPANDING OUTREACH

The Clinton Administration has made significant efforts to reach out to families whose children qualify

for CHIP. These efforts include:

The Announcement of an Historic Public and Private Commitment to Provide Outreach. On February 23, 1999, the President announced unprecedented new contributions from the private and public sector to help ensure that all children who are eligible for health insurance receive it, including:

- **A new toll-free number, 877-KIDS-NOW, that directs families around the nation to their state enrollment centers.** The President announced that the National Governors' Association, with a grant from Bell Atlantic, has established a national toll-free number to help states reach working parents of uninsured children. The number, 877-KIDS-NOW, will automatically direct callers to their state's enrollment agency.
- **A national radio advertising campaign to promote the Insure Kids Now Campaign.** HHS is sponsoring a \$1 million national radio advertising campaign to promote the 877-KIDS-NOW toll-free number and to complement states' outreach efforts. The campaign includes a four-week paid radio campaign and public service announcements to be distributed throughout each state.

A pilot program of the radio advertising campaign was implemented last fall. The nationwide campaign began February 23, 1999, and will run through mid-March in 11 states. The radio campaign will air in other states in April and May.

- **The www.insurekidsnow.gov Web site links parents to eligibility and enrollment information.** HCFA launched a Web site, www.insurekidsnow.gov, which offers parents a phone number to call for information on children's health insurance coverage in their state, information on how to apply for coverage, and guidelines for whether they might qualify for their state's plan. In addition, visitors can see and hear messages from First Lady Hillary Rodham Clinton, the nation's governors and other messages about the importance of health insurance for children.
- **Mobilizing Federal Agencies and Federal Employees.** The Federal Interagency Task Force on Children's Health Insurance Outreach released an outreach training kit for use by workers from all federal departments that will participate in the Insure Kids Now campaign. The task force was charged by President Clinton in February 1998, to support CHIP and Medicaid outreach and enrollment. The kit contains a presentation outline, posters, and materials that can be used as handouts. In addition, federal departments have promised to distribute more than 140,000 outreach posters to their grantees, field offices, and human services agencies.

Ongoing Outreach Activities

Presidential Directive to Launch a Government-Wide Effort to Enroll Uninsured Children. As the first step in his public-private children's health outreach campaign, the President directed relevant federal departments in February 1998, to commit to outreach activities aimed at enrolling uninsured children in state health insurance programs. In June of 1998, this Federal Interagency Task Force on Children's Health Insurance Outreach prepared a report to the President, outlining activities that federal agencies would undertake to identify and help to enroll in children in Medicaid or other health insurance programs prior to June 1999. The President charged the HHS Secretary with oversight of the implementation of this outreach initiative.

Since then, each of the 10 departments has been actively engaged in outreach activities focused in three areas: educating their workforce; educating families about state health insurance programs; and coordinating cross-agency and public-private efforts to identify and enroll children in these programs. For example, the Department of Agriculture has distributed CHIP information to WIC programs in states. HUD- sponsored Neighborhood Networks centers, which provide computer training at no cost to residents of more than 400 HUD-assisted multifamily housing developments, have started serving as an access point to download Federal and State information about Medicaid and CHIP.

\$45 million in commitments from private foundations across the country. The Robert Wood Johnson Foundation will spend \$45 million over the next 3 years to fund innovative state-local

coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to \$10 million over the next 5 years on studies to help understand why eligible children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and in collaboration with the American Academy of Pediatrics, will mobilize corporations such as SmithKline Beecham and Schering Plough, as well as local communities nationwide, in children's health outreach efforts.

Corporate and advocacy organizations reach out to uninsured children. Procter and Gamble, the manufacturer of Pampers diapers, has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, providing information about available health insurance options. Grocery stores and chain drug stores across the country will provide information about the new toll-free number to their customers. The National Education Association will launch an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

CHIP builds on the Clinton Administration's long standing commitment to improving health care for children. The President has issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. In addition, the President recently announced that in 1996, over 90 percent of America's toddlers received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal the Administration set in 1993. And the FDA recently released a rule that requires manufacturers to do studies on pediatric populations for new prescription drugs as well as those currently on the market.

Since 1993, HHS has approved Medicaid waivers for 18 states for comprehensive health care reform projects that have allowed states to control costs and expand coverage. In addition, HHS has approved requests from 19 states for Medicaid waivers as part of larger welfare reform projects, as well as 25 local Medicaid demonstration projects. When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured.

Combined, this administration's efforts will help assure that children get the healthy start they need to live long and productive lives.

STATE CHIP PROGRAMS

Descriptions of approved state CHIP programs follow:

Alabama

Alabama could receive as much as \$86 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is implementing its CHIP plan in two phases. The first phase expanded Medicaid eligibility to uninsured children under 19 years of age whose family incomes do not exceed 100 percent of the FPL. The AL-Kids program, the second phase, is a separate state children's health insurance program that expands coverage to children up to age 19 whose family income is between 100 and 200 percent of the FPL. AL-KIDS offers coverage comparable to the HMO with the largest insured commercial, non-Medicaid enrollment in the state. With both phases, Alabama expects to insure 36,000 children by September 1999. Alabama is hiring extra outreach workers to increase the number of children located and enrolled in Medicaid. Information on the new program is being advertised through newspapers, public service announcements and through the school system. Alabama was the first state approved on January 30, 1998 and its amendment was approved August 18, 1998.

Alaska

Alaska could receive as much as \$7 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Alaska is expanding its Medicaid program for its CHIP plan. Previously, the state covered children up to age 1 in families with incomes up to 185 percent of the FPL, children 1-6 in families with incomes up to 133 percent of poverty, and children ages 6-19 in families with incomes up to 100 percent of poverty. The state is using its Title XXI funds to expand Medicaid coverage to children in families with incomes up to 200 percent of the FPL. Eligible children receive the full Medicaid benefit package and there are no cost sharing requirements. To reach eligible children, the state is working with local governments, schools, health care providers, tribal entities, and non-profit corporations serving children. The state plans to implement expanded eligibility on March 1, 1999 and it expects to enroll 4,900 children by October 2000. Alaska's plan was approved December 11, 1998.

Arizona

Arizona could receive as much as \$117 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. Arizona is using its CHIP allotment to create, KidsCare, a new health insurance program that covers children from birth through age 15. Income eligibility will increase over time, beginning at 150 percent of the FPL and rising to 175 percent on July 1, 1999, then to 200 percent from 2000 through 2007. The state expects to insure nearly 50,000 children by September 2000. Enrollees receive coverage through established Arizona Health Care Cost Containment System plans and state employee health maintenance organizations that elect to participate in the program. American Indians may choose to receive services through the Indian Health Service as well. Participants pay a \$5 copayment for non-emergency use of the emergency room. To assist with outreach, the state has created an Outreach Coordinator position and has sent applications to organizations that serve low-income children. Arizona's CHIP plan was approved on September 18, 1998.

Arkansas

Arkansas could receive as much as \$48 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is using its CHIP allotment to expand Medicaid coverage to nearly 3,600 children who would otherwise not have health insurance. It covers children born after September 30, 1982 and prior to October 1, 1983, whose family income is at or below 100 percent of the FPL. Arkansas is currently considering how to structure the second phase of its Title XXI program to cover even more children. The state currently has a Medicaid section 1115 waiver, ARKids First, that serves children through age 18 with family incomes up to 200 percent of the FPL. Outreach activities include radio and TV ads, a direct mail campaign, a toll-free number and print advertising. Arkansas was approved on August 6, 1998.

California

California could receive as much as \$855 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is expanding its Medicaid program, known as Medi-Cal, by implementing an income disregard and by making children under age 19 eligible if they have family incomes at or below 10 percent of the FPL. The state is also expanding its current state program, known as Access for Infants and Mothers (AIM), which covers infants up to age 1 from 200 percent to 250 percent of poverty. Through CHIP, California is also expanding its Healthy Families program, which provides coverage for children age 1-19 with family incomes from 100 percent to 200 percent of the FPL. California estimated it will insure 500,000 children by the end of fiscal year 1998. As part of its outreach efforts, California is subcontracting for a media campaign with private and community-based organizations, health brokers and insurance agents to directly identify and assist potential enrollees in filling out the joint application form for the Medi-Cal and Healthy Families program. In addition, California is conducting a provider education campaign to support its outreach effort. California's plan was approved on March 24, 1998.

Colorado

Colorado could receive up to \$42 million for both fiscal year 1998 and fiscal year 1999 for its CHIP plan. The state is expanding children's access to health coverage by building on its own Colorado Child Health Plan. The state expects to cover a total of 23,000 children under this non-Medicaid managed care