



Policy Matters

Setting and Measuring Benchmarks for State Policies

PROMOTING BETTER FAMILY HEALTH

A Discussion Paper for the Policy Matters Project

POLICY MATTERS: Setting and Measuring Benchmarks for State Policies

Promoting Better Family Health:
Recommendations for State Policy

A DISCUSSION PAPER FOR THE *POLICY MATTERS* PROJECT

Center
for the
Study
of
Social
Policy

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Dedication

This publication is dedicated to the memory of James (Jim) Allen Harrell, proud public servant, champion for the poor and disenfranchised, and faithful colleague.

Acknowledgements

The *Policy Matters* project is directed by Thabiti Anyabwile, Research Associate at the Center for the Study of Social Policy. Mr. Anyabwile also is the principal author of this report, along with **Phyllis E. Kaye** who authored earlier drafts and **James (Jim) Harrell** who contributed throughout.

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Preface

About the Policy Matters Project

Policy Matters is an initiative of the Center for the Study of Social Policy in collaboration with the National Center for Children in Poverty (NCCP) and Child Trends. The *Policy Matters* project is designed to develop and make available coherent, comprehensive information regarding the strength and adequacy of state policies affecting children, families, and communities. The project seeks to establish consensus among policy experts and state leaders regarding the mix of policies believed to offer the best opportunity for improving child and family well-being. A series of policy briefs, policy papers, guides for self-assessment, and 50-state comparative reports are envisioned. The project focuses on six core results: school readiness, educational success, family economic success, healthy families, youth development, and strong family relationships. These six core results comprise one composite family-strengthening policy agenda, emphasizing the importance of both individual results and the interaction of multiple results.

About This Paper

This paper presents a framework for health policies and health policy benchmarks to focus state-level strategic thinking about, and also contribute to, a national consensus on policy directions for promoting the physical and mental health of children and families.

Specifically, this paper examines issues affecting the health prospects of low- and moderate-income families (up to 250 percent of the federal poverty level) from three major vantage points: (1) the affordability, availability, and accessibility of appropriate health care services; (2) health related behaviors; and (3) health supporting environments. Section I of the paper presents a rationale for why these aspects of health and health care are so crucial for the well-being of children and families. Section II provides the conceptual framework for examining both health care services and public health issues that affect family health and a policy logic model connecting health policies and their intended outcomes. Section III provides a detailed set of policy options for improving health care services, health related behaviors, and health supporting environments. For each policy cluster, the paper presents a brief statement of the strategic policy objective, specific policy recommendations, and suggested benchmarks for each recommendation.

Taken together, the policies identified here present a powerful and compelling policy agenda for improving the health and well-being of families. Over time, recommendations and benchmarks will be improved, as more research and practice evidence is available. Future benchmarks may be modified to allow consistent tracking of state progress and to overcome data limitations. Thus, this paper presents a preliminary set of benchmarks. In the future, *Policy Matters* intends to assess states' progress toward meeting those benchmarks that more effectively and directly benefit low-income families and children. It is hoped that this framework will help states think strategically about policy decisions that improve the health and well-being of families.

This paper is offered as an invitation for further deliberation and action regarding policies leading to healthy families. It represents a beginning consensus among the experts involved in the healthy families workgroup and those who have given written and verbal feedback to the paper. In the future, through multiple and broadly inclusive discussions with state and national policymakers, administrators, practitioners, and advocates, the project hopes to expand this initial consensus to a national, bi-partisan consensus on policy directions for those interested in promoting positive health-related outcomes.

About the Partners

The Center for the Study of Social Policy is a non-profit, non-partisan policy organization located in Washington, D.C. The Center's mission is to promote policies and practices that improve the living conditions and opportunities of low-income and other disadvantaged persons. The Center works in partnership with federal, state, and local governments and communities to shape new ideas for public policy, to provide technical assistance to states and communities, and to develop and lead networks of innovators.

While CSSP developed and authored this report, work on the *Policy Matters* project has expanded to include two additional partners.

The National Center for Children in Poverty (NCCP) is a non-profit, non-partisan policy and social science research organization at Columbia University. NCCP identifies and promotes strategies that prevent child poverty in the United States and that improve the lives of low-income children and their families. The Center conducts and synthesizes research on the causes and consequences of poverty to develop policy solutions that will provide low-income families in the United States with the resources and tools they need to create better lives for themselves.

Child Trends is a non-profit, non-partisan research organization dedicated to improving the lives of children by conducting research and providing science-based information to improve the decisions, programs, and policies that affect children. In advancing

this mission, Child Trends collects and analyzes data; conducts, synthesizes, and disseminates research; designs and evaluates programs; and develops and tests promising approaches to research in the field. Child Trends has achieved a reputation as one of the nation's leading sources of credible data and high-quality research on children.

Promoting Better Family Health:

RECOMMENDATIONS FOR STATE POLICY

1 Family Health Matters: Background

The health status of low-income families is highly correlated with their prospects for better lives. The physical and mental well-being of family members is an important factor affecting a family's economic success, the readiness and success of children in school, and the engagement of youth in positive and productive roles. In addition, good health is crucial to a family's capacity to provide, nurture, and care for its members. Recognizing the extensive disparities between low-income families and other strata of society, *Healthy People 2010* – the nation's statement of health goals for the decade – has established the elimination of health disparities as one of its two overarching goals.¹

While state policies influence a number of health determinants, this paper focuses on those policies that can help low- to moderate-income families overcome a range of financial, structural (or systemic), and personal barriers to:²

- Receiving timely, appropriate, and coordinated diagnostic, preventive, and treatment services;
- Engaging in lifestyles that enhance their physical and mental well-being; and
- Living in health-supporting environments.

Special Challenges Facing Low-income Families

Low-income families face special challenges when it comes to health—whether trying to maintain or improve their overall physical and mental well-being, preventing future illnesses, recovering from illnesses, or living with disabilities or terminal illnesses. Specifically, three challenges—overall poor health status, high rates of being uninsured, and limited access to care—make it difficult for low-income families to maintain optimal health.

Poor Health Status

The health status of low-income families is frequently poorer than families with higher incomes. According to *Healthy People 2010*,

Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.³

In addition to disparities associated with income, health disparities among racial and ethnic minorities are well documented. For example, death rates from heart disease are more than 40 percent higher for African Americans than for whites, and Hispanics are nearly twice as likely as non-Hispanic whites to die from complications of diabetes.⁴ Deaths from cancer are 144 percent higher for African American males than white males, and 123 percent higher for African American females than white females.⁵ Some evidence suggests that these disparities emerge early in life. For instance, minority children ages 17 and younger more often report poorer health status than their non-minority counterparts, and less often report excellent health than white children. In addition, death rates for young African Americans, particularly males ages 15-24, are significantly higher than those of any other group.⁶ Health disparities between minority and non-minority populations are so significant that the National Institutes of Health (NIH) launched a strategic research effort to eliminate the incidence, prevalence, severity, and the social and economic burdens of disease in minority communities. Toward this goal, the NIH invested \$1.3 billion on research, research infrastructure, and public outreach in 2000.⁷

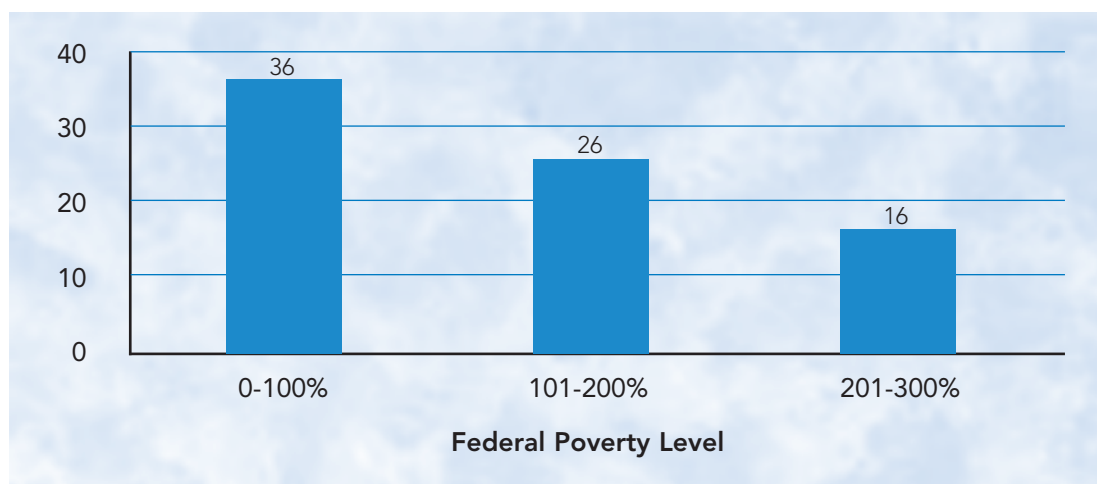
Low-income Families and Insurance Coverage

One of the most significant predictors of access to health services and treatment is health insurance coverage. However, many low-income families find it difficult to obtain coverage and appropriate services. While the health care safety net of public hospitals, community health centers, local clinics, and some primary physicians

plays an important role in many states and communities, health insurance coverage is critical to ensuring access and receipt of appropriate health services.⁸ Despite this fact, over 41.2 million Americans (15 percent) were without health insurance in 2002.⁹ Among states, uninsurance rates range from a state low of 10 percent in Minnesota to a high of 26 percent in Arizona, New Mexico, and Texas.¹⁰

Income level is significantly related to the likelihood of having health insurance coverage. Poor and near-poor families are at greatest risk for being uninsured and comprise 65 percent of all uninsured families. Assuming a 2000 federal poverty level (FPL) income of \$13,738 for a family of three, 36 percent of families below 100 percent of the FPL, 26 percent of families between 100 percent and 200 percent of the FPL, and 16 percent of families between 200 percent and 300 percent of the FPL had no insurance coverage in that year.¹¹ As can be seen from these data, the need for health insurance is significant even among moderate-income families.

Figure 1. Percentage of Uninsured Adults by Federal Poverty Level, 2000



Source: Hoffman and Pohl, Health Insurance Coverage in America: 2000 Data Update.

Most uninsured people live in low-income families where at least one member is working. The absence of employer-sponsored coverage seems particularly concentrated among near-poor working families¹² who generally find themselves ineligible for Medicaid and employed by small, low-paying employers offering no medical benefits.¹³ A full 40 percent of low-wage workers earning less than \$7 per hour have no access to employer-sponsored insurance at either their own or their spouses' place of employment. This is true for only four percent of workers earning \$15 or more per hour. In the 50 percent of cases where employer-sponsored insurance is offered, low-income working families find the cost of premiums, deductibles, and co-pays often too expensive to afford.¹⁴

In its report, *Coverage Matters*, the Institute of Medicine stresses the importance of health insurance to individuals and families:

Health insurance is a key factor affecting whether an individual or family obtains health care. Uninsured Americans are not able to realize the benefits of American health care because they cannot obtain certain services or the services they do receive are not timely, appropriate or well coordinated. The most apparent deficits in care experienced by those without insurance are for chronic conditions and in preventive and screening services.... Far too often key aspects of quality health care... are beyond the reach of uninsured persons.¹⁵

According to a Families USA study, uninsured persons with the most prevalent chronic health conditions (heart disease, hypertension, high cholesterol, arthritis, and chronic back pain) “receive half the number of lab tests; are much more likely to go without medicines essential to maintaining health; obtain far fewer screenings for high blood pressure or cholesterol; depending on the condition, make 19-28 percent fewer visits to physicians’ offices, clinics, and other outpatient settings; and are three to four and one-half times more likely, depending on condition, to have been unable to obtain care due to affordability problems.”¹⁶

Low-income families who are insured depend on a mix of public and private programs for their insurance coverage, including employer coverage, Medicaid, and the State Children’s Health Insurance Program (S-CHIP). Using data from the 1999-2000 Current Population Survey, the Urban Institute estimates that near-poor, non-elderly adults receive coverage primarily from employers (32.9 percent of covered persons) and Medicaid (15 percent of covered persons). Privately purchased coverage and other public programs comprise a relatively scant 7.9 percent and 4.4 percent, respectively. Regarding all children with insurance coverage, employer-sponsored plans and Medicaid cover 35.7 percent and 32.6 percent, respectively.¹⁷ Differences in Medicaid rates of coverage for adults (15 percent) and children (32.6 percent) result largely from states’ more stringent Medicaid eligibility requirements for adults.

Limited Access to Care

Having health insurance, while critically important, is not sufficient to *guarantee* good health or quality health care. Resources and services must be available, accessible, and appropriate. For example, needed services, including those related to prevention and regular screening for undiagnosed diseases, dental, mental health, and substance abuse treatment might not be covered by a family’s insurance policy. Low-income, racial and ethnic minority families face particular challenges associated with an increased likelihood of receiving lower-quality health care, regardless of insurance status or income.¹⁸ Families with disabilities also seem plagued by limited

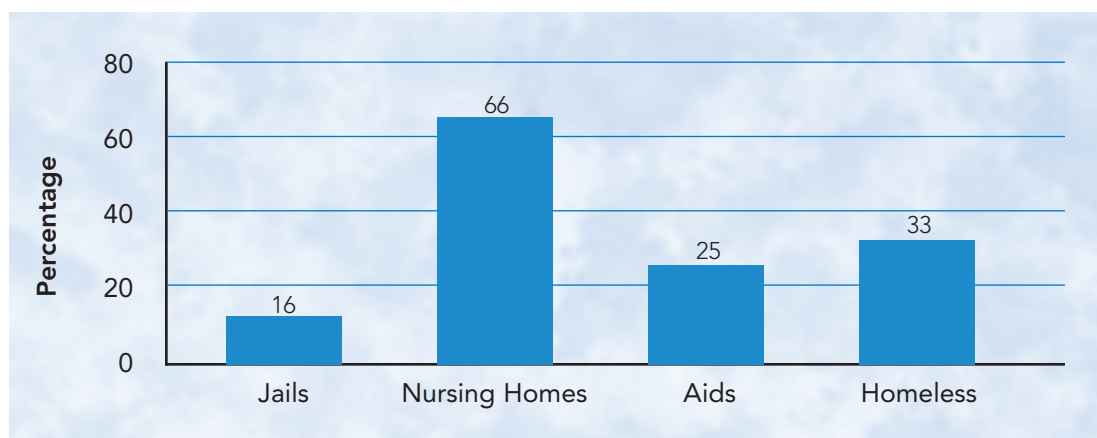
access to integrated and coordinated health care services. All too often, necessary mental health, special needs, and behavioral health treatment options are either unavailable, under-funded, or both.

Mental Health Needs among American Families

Approximately 43 million Americans have a mental illness, with 5.5 million having a severe illness.¹⁹ About one in five adults cope with a diagnosable mental disorder in a given year, and major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder rank among the ten leading causes of disability. Twenty percent of American families will be affected by severe mental illness in their lifetime.²⁰ Moreover, the effects of mental illness are seen in a variety of public institutions and social problems (see Figure 2).

Mental health illnesses affect children as well as adults. One in ten children and adolescents in the U.S. has a mental illness severe enough to cause impairment.²¹ The range of disorders is wide and particular disorders appear more prevalent for different age groups. Young people ages 15-24 are more likely than any other age group to experience a major depressive disorder.²² In addition, suicide is the third leading cause of death among this age group.²³ Attention Deficit Hyperactivity Disorder (ADHD) affects four percent of youth ages 9 to 17, usually becoming evident in preschool or early elementary school.²⁴ And yet, approximately one-half of all children with a diagnosable mental disorder do not receive any level of treatment in a given year.²⁵

Figure 2. Percentage of People in Jails, in Nursing Homes, with AIDS, and Homeless with Mental Illness



Source: National Institute of Mental Health, Mental Health Liaison Group, National Alliance for Mentally Ill.

The societal costs of untreated mental health disorders are significant. One research study calculated the total economic costs of mental illness at \$147.8 billion in 1990. Morbidity costs associated with mental disorders were \$63.1 billion dollars in 1990 and mortality costs were valued at \$11.8 billion.²⁶

The Influence of Federal Policy

Public investments in the health status of families are a joint venture between federal and state governments. Currently, there are hundreds of federal policies and programs addressing important health care services, health-related behavior, and health-supporting environment issues. Therefore, an analysis of state efforts to promote and ensure healthy families must be seen within the context of federal funding requirements, funding flexibility, and laws governing interstate health-related matters such as food and drug safety.

In some cases, federal policy carries very specific requirements for states. For example, the federal Substance Abuse Prevention and Treatment Performance Partnership block grant specifies that 20 percent of state allocations be set aside for substance abuse and tobacco smoking *prevention* activities. Similarly, federal environmental laws often take precedence in areas such as food or pharmaceutical safety. While in other areas, such as air quality, states may have greater latitude.

The federal government may be most influential through funding and related requirements for health services. For children and families, federal financial support for health services comes to the states through a variety of mechanisms including public insurance programs, block grants, and demonstration programs. These mechanisms differ substantially in the flexibility afforded to the states.

Public Insurance

Medicaid, authorized by Title XIX of the Social Security Act, is the country's largest public insurance program for children and families. Under this program, the federal government reimburses state expenditures for medical services at state-specific rates that may not be lower than 50 percent or higher than 83 percent of approved costs of care, with poorer states receiving higher rates. The federal law identifies some mandatory categorically needy eligibility groups, yet provides broad latitude to states to augment these requirements. In addition, the Medicaid program requires coverage of specific services for children and expands requirements through the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).

S-CHIP entitles participating states to allotments that finance health insurance for children of targeted low-income families who are ineligible for other insurance coverage, including Medicaid. In this program, states may choose to expand their Medicaid program, develop new freestanding programs, or use a combination of both approaches. States have much greater flexibility in freestanding programs, which need only provide coverage equivalent to that in certain “benchmark” programs.

Block Grants

Health-related federal block grants to states often combine a number of categorical programs into one federal funding stream that states may use to serve the uninsured or to complement services provided through public and private health insurance. Federal block grant programs include those for maternal and child health, mental health, and substance abuse prevention and treatment.

Policy Flexibility

While the devolution of policymaking to the states has provided greater latitude to state governments, federal policy still has significant effects on state-level child and family health policy. The systems are interdependent and complex. In some cases, such as EPSDT, existing federal policies may not be fully implemented or federal mandates may not be uniformly enforced by all the states. In other cases, federal policy may create obstacles to the development of a full continuum of care by states. Flexibility granted to the states, while providing opportunities to address specific health needs, can result in significant state-level disparities in the affordability, availability, and accessibility of appropriate health services. Striking a balance between flexible federal funds that provide for significant state-level control and the establishment of a consistent health care service system available to children and families nationwide is a significant challenge in the health sector.

Healthy Families:

A FRAMEWORK FOR STATE POLICY

2 Key Definitions

Definition of Healthy Families

This paper broadly defines “healthy families” as those families whose members: (1) engage in lifestyles that make a positive contribution to their physical and mental well-being; (2) are physically and mentally able to participate in activities of daily living and are self-sufficient to the extent their abilities allow; and (3) are actively engaged in their own and their family’s health care and treatment decisions. Equal concern for the emotional, behavioral, and physical health of families is assumed.

“Family” is defined as a unit consisting typically of one or more parents and one or more children. Family also refers to “child-only” families, as might be the case with emancipated youth or young people in the custody of state agencies. “Parent,” broadly defined, refers to an adult member of the household, including a grandparent, who has assumed responsibility for raising biological and adopted children in the household. The families of primary interest in this paper are those with incomes up to 200 percent of the federal poverty level. However, because 15 percent of moderate-income families lack health insurance coverage, states should consider focusing some eligibility policy on families with incomes up to 250 percent of the federal poverty level.

Definition of Policy

The term “policy” refers to formal decisions reflected in state statutes, executive orders, and judicial rulings. While many innovative policies exist at other levels of government (i.e. county or city) and health-related policies also may be promulgated by private corporations or businesses, our consideration is limited to those policies that emanate from public entities and extend statewide in scope or impact. Primary authority for ensuring the health and welfare of citizens resides with states. In some states, the authority to make and implement policy has been delegated to local county and municipal levels (such as policies related to lead-based paint abatement in housing and public facilities).

The policies recommended in this paper are the result of an interdisciplinary workgroup charged with reaching consensus on a select number of policies with the best potential for improving family health. The recommendations are not exhaustive; they represent a beginning set of state policies that will frame a “healthy families” policy agenda and establish the basis for both a self-assessment and a comparative report of state policy efforts. The recommendations meet a number of general criteria that guided the deliberations of the workgroup and include:

1. Demonstrated effectiveness in the research and evaluation literature;
2. Support by collective wisdom of practitioners from the field;
3. Address children and families with the poorest outcomes;
4. Possess sufficient scope and scale to address the outcome;
5. Are politically and administratively feasible; and
6. Are compatible with the values and assumptions of a family-strengthening perspective.

Definition of Benchmark

A “benchmark” is a point of reference from which measurements may be made, and serves as a standard for comparisons. Benchmarks convey not only the general idea of measurement but also are an explicit standard for performance. Where indicators measure a change in a result or condition over time, benchmarks measure such changes against an established standard. Consequently, benchmarks make possible certain judgments about success or failure that indicators alone do not. Here, the concept of “benchmarks” is applied to policies designed to achieve specific outcomes or results. For example, a state may raise income eligibility for parent coverage in its health insurance programs from 100 percent to 150 percent of the federal poverty level. Such a movement would be important progress. However, considering a significant number of adults with incomes up to 250 percent of the federal poverty level are uninsured, a benchmark for state health insurance eligibility might be best set at this level. A state eligibility policy of 150 percent would then be gauged against this benchmark or standard.

A Health Policy Framework

The health of individuals and families is determined by several factors including an individual's genetic makeup, health-related behavior and lifestyle, social and physical environment, and receipt of health or medical services.²⁷ While each of these factors may be considered separately, they often overlap, and no one factor is sufficient for ensuring a healthy life.

Health Care Services

Health care services pose the greatest challenge for policymakers because they drain public resources and have the clearest impact on national, state, and local economies. Health services, including medical, dental, mental health, and substance abuse treatment services, may involve preventive, treatment, palliative, and maintenance interventions to ensure, restore, and maintain physical and mental well-being. Health services provide:

- Immunizations,
- Pre- and post-natal care,
- Screening for chronic and infectious diseases,
- Treatment of chronic diseases,
- Treatment of acute infectious diseases and trauma,
- Care for those with long-term disabilities, and
- Care for the dying.

Health care requires receipt of expert services from highly trained people and generally involves many financial transactions. As medical science has become increasingly effective in preventing, diagnosing, treating, and caring for human illnesses, the web of financial transactions has become more complex. This complexity poses major public policy challenges—especially in the case of low-income families who either cannot afford these services, lack access to services even when they are able to pay, or receive inadequate and poor quality services.

Health Related Behaviors

Health-related behaviors include some of the leading contributors to premature death and disability in the United States.²⁸ They can be grouped together as follows:

- Tobacco, alcohol, and drug use,
- Nutrition and diet,
- Physical fitness and physical activity,
- Violence, and
- Sexual activity.

Healthy lifestyles and individual behaviors affect the levels of risk associated with chronic illnesses, traumas, and some transmittable infectious diseases. While healthy behaviors cannot always prevent the onset of specific illnesses, chronic conditions, or injuries, a person's health-related decisions and habits can make such conditions more manageable and reduce the risk of serious illness resulting from them. At their origins, heart disease, some forms of cancer, stroke, adult-onset diabetes, obesity, HIV/AIDS and other sexually transmitted diseases, and traumatic injury from both violent and unintentional causes have little to do with the existence of health care services. However, treatments for such diseases do consume large amounts of available resources, and failure to detect and treat health problems at an early stage can lead to higher costs, decreased productivity, and premature death.

Low-income and minority populations are disproportionately affected by diseases stemming from high-risk behaviors.²⁹ However, interventions intended to reduce these behavioral risks to health, such as tobacco and alcohol restrictions, gun control measures, and sex education, are often politically contentious.

Health Supporting Environments

Physical and social environments are a second major contributor to family health status. Interventions to affect environmental health usually come in the form of legislative and regulatory protections. The list of health-related elements of a broad environmental health agenda include: traffic, highway, workplace, food, pharmaceutical and housing safety; clean air and water; climate; and violence-related law enforcement.

Policies that address these environmental issues do not tend to focus on the specific populations at highest risk. Laws governing highway safety, drug safety, food safety, clean air, and safe water supplies, for example, are designed to protect all people. On the other hand, some environmental concerns bear most heavily on the poor or are concentrated on certain types of employment. For instance:

- Many of the working poor depend heavily on migrant farm work and work in industrial plants for their income. These environments expose workers to greater risk of injury or disease when compared to work in offices or service industries.
- Young children of low-income families are more likely to be exposed to serious life-long health risks because of lead-based paint in old, usually inner-city housing stock.
- Poverty-stricken communities often lack adequate police protection to meet threats of violence.
- Extreme hot and cold weather has inordinate effects on the well-being of poor families, who cannot always afford proper heating or air-conditioning.

Interrelationships

The three bases of health status previously outlined are closely related. Consider the example of a healthy baby's birth. A baby's health status is strongly influenced by actions of the baby's mother, especially behaviors regarding nutrition, smoking, substance abuse, and exposure to sexually transmitted diseases. Likewise, the baby's health prospects depend on the health care services received by the mother in the prenatal period—screening for high blood pressure and gestational diabetes, identification and treatment related to alcohol, tobacco, and drug addictions, monitoring of fetal growth, and coaching through the crucial prenatal months. In addition, the mother's environmental exposures at her workplace, in her neighborhood, and in her home can influence her baby's chances for a healthy life. Though each health-contributing factor is necessary, no factor alone is sufficient to ensure the desired outcome. Even the most positive behavior, environment, or set of clinical services can be undermined by destructive or unhealthy aspects of one of the other factors. Consequently, state policy approaches should balance attempts to address health care services, behavior, and environment. The creation of “medical homes” is one way of balancing these factors and promoting continuity of care for children and families.

The “medical home” concept suggests a relationship in which health care professionals know the families they treat, provide regular clinical, counseling and support services over time rather than episodically, and refer patients to needed specialty care when appropriate. Public policy has a significant role in establishing and financing health care systems that provide families with continuity and consistency in the services received.

Healthy Families: A Policy Logic Model

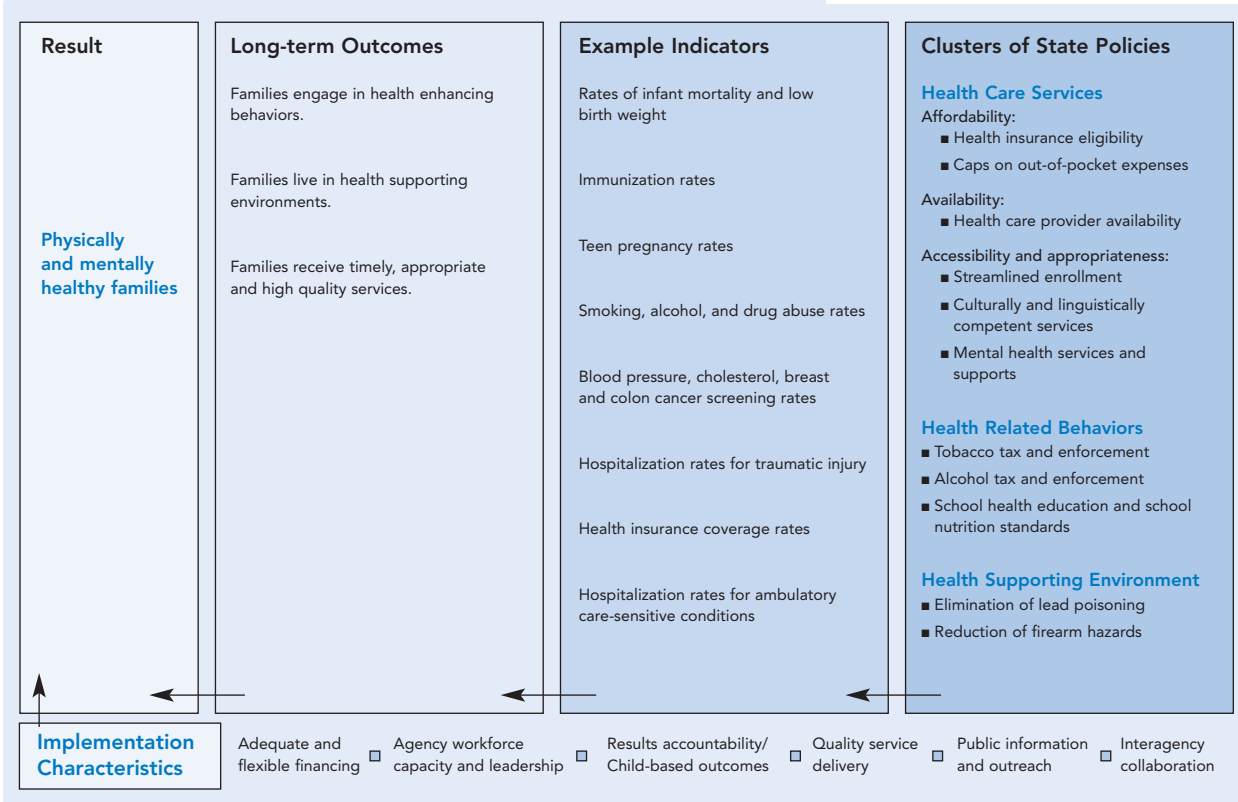
Figure 3 on page 14 presents a logic model illustrating the relationship between the core result, selected outcomes, and the mix of policies whose cumulative effects are likely to help improve the health status of families. The model identifies indicators that can be used to measure the outcomes, as well as implementation issues that must be addressed to achieve the outcomes. Although the logic model is linear for ease of representation, the relationships are far more complex, iterative, and interactive.

Core Result and Long-term Outcomes

Three long-term outcomes operationally define the healthy families result:

1. Families and children receive timely, appropriate diagnostic, preventive, and treatment services;
2. Family members engage in healthy behaviors and focus on long-term wellness; and
3. Families live in healthy physical and social environments.

Figure 3. Policy Logic Model for Healthy Families



Indicators or Measures

Indicators point to one or more of the three major elements contributing to a family’s health—health care services, health-related behaviors, and environmental health. They can serve as proxy measures for aspects of health status that are difficult to quantify. Examples of indicators and their relationship to healthy families include:

- **Rates of infant mortality and low birth weight** are indicators of health behaviors, maternal health, clinical services, environmental health factors, and socioeconomic conditions.³⁰ Low birth weight infants are at greater risk of premature death, long-term illness, and disability than are normal birth weight infants.³¹ In addition, as low birth weight babies grow, they face a greater risk for behavioral and some school problems.³² Caring for low birth weight infants may put added burdens on other family members.
- **Immunization rates** indicate the extensiveness and quality of clinical services, including access to primary care.
- **Teenage pregnancy rates** are indicators of health education, onset of sexual activity, and access to reproductive health services. Teen pregnancy is associated with long-term difficulties for mothers and their children. For mothers, giving

birth as an adolescent is associated with limited educational attainment, which can reduce future employment and earning potential. Children born to adolescents are at higher risk for low birth weight and infant mortality.³³

- **Smoking, alcohol and drug use rates** are measures of risk taking behaviors and the effectiveness of risk reduction strategies and clinical services (e.g., smoking cessation programs and substance abuse treatment). People who smoke risk premature death and smoking-related diseases. Alcohol and drug abuse are associated with a range of health disorders as well as with problems in driving, school, and the workplace. Parental substance abuse has been shown to affect the cognitive, physical, and social development of young children and to contribute to domestic violence and the maltreatment of children.³⁴ Substance abuse also interferes with the ability to work and/or progress in school and the ability to be self-sufficient.³⁵
- **Screening and treatment rates for early detection of chronic diseases** (e.g., blood pressure, cholesterol, breast and colon cancer) are indicators of clinical services and public health education. Left undiagnosed and untreated, chronic health conditions (e.g., asthma, diabetes, hypertension, and obesity) can result in premature death, lost time from school and/or work, and the need for more help and services from other family members, which in turn can affect the health of these caregivers.
- **Rates of hospitalization due to traumatic injury** are indicators of the effectiveness of environmental health protections, such as highway, workplace, recreation/sports, and community safety regulations.
- **Rates of health insurance coverage** are indicators of access to and use of medical services, and also indicate potential spillover effects for poor community-level health outcomes.³⁶
- **Rates of hospitalization for ambulatory care sensitive conditions** are indicators of availability and appropriateness of primary care services.

Areas of State Policy

Achieving long-term health outcomes involves addressing a number of specific issues related to the financing, delivery, and education systems that support families in their efforts to engage in healthy behaviors, live in healthy physical and social environments, and access and utilize appropriate services.

1. Health Care Services

Health care services - including services that address behavioral health (mental illness and substance addictions) - involve three elements: affordability, availability, and access to appropriate services. Each of these elements is amenable to policy intervention and supports families in their effort to be healthy.

RECOMMENDED POLICIES BY CATEGORY

Health Care Services

Affordability

- Health insurance eligibility
- Caps on out-of-pocket expenses

Availability

- Health care provider availability

Accessibility to Appropriate Care

- Streamlined enrollment
- Culturally and linguistically competent services
- Mental health services and supports

Health Related Behaviors

- Tobacco tax and enforcement
- Alcohol tax and enforcement
- School health education and school nutrition standards

Health Supporting Environments

- Lead poison abatement
- Reduction of firearm hazards

The American health care system is an extremely complex system of financing, federal and state regulation, and service delivery. In recommending benchmarks for state-level policy, these issues are not addressed comprehensively. Rather, the paper focuses on policies that appear most salient for improving the lives of low- and moderate-income families whose access to quality care may be limited or lacking entirely.

2. Health Related Behaviors

Public health, like public education, is a service for the entire population and is not specifically targeted to any one socioeconomic group. For that reason, many of the most basic public health policies contribute to the well-being of low-income families and their children as they serve to promote health among people of all income levels.³⁷ Though state public health laws intend these services to be distributed to all citizens, low-income families may receive inequitable distributions of the resources states authorize.

3. Health Supporting Environments

Some public health measures, however, target health issues more prevalent among families in low-income communities. High rates of alcohol and drug abuse may call for policies that specifically address educational preventive interventions, clinical services for addiction treatment, and more traditional public health interventions. Examples of strategic interventions to change the social environment include

regulation of access to alcohol products and restriction of advertisement and promotional tactics that target highly vulnerable population groups. High crime rates may suggest the need for community safety and police interventions in some, but not all, communities. Food security issues experienced by very poor families may suggest the need for special efforts to ensure the quality of menus in free breakfast and lunch programs at public schools and in child care programs, as well as enrollment of income-eligible young families in the Women-Infant-Children (WIC) food program. High prevalence of childhood obesity may require targeted efforts to improve access to healthy diets and regular physical exercise.

Implementation

While the logic model outlines the conceptual relationship between desired results and state-level policies, the relationship is by no means linear. Several factors either enhance or inhibit the likelihood of an enacted policy's success at producing intended outcomes. Implementation capacity and activities, as well as characteristics of state policy, are major factors contributing to success. The principal implementation categories necessary for the success of state policies are:

- Financing,
- Agency and professional workforce capacity and leadership,
- Quality service delivery (including program flexibility and local decision making),
- Public information and outreach,
- Accountability, monitoring, and data systems, and
- Interagency collaboration.

The kinds of performance measures that might be included in such a tracking menu for “healthy families” include: per-capita state funding for Medicaid, S-CHIP supplementation, and state-sponsored health care services; Medicaid and S-CHIP enrollment levels; professional workforce to low-income population ratios; distribution of professionals in “hard-to-serve” areas; regularity and timeliness of reports on health data, including service delivery data; and existence of interagency agreements and evidence of ongoing collaboration among agencies with roles related to public health and health care services. Appropriate measures of state implementation efforts will be developed in future project activities.

Preliminary Health Policy Benchmarks

3

The preceding discussion of the policy logic model outlines the conceptual relationships between the core result (“healthy families”) and a mix of policies designed to have an impact on that result. The logic model also presents, in general terms, the specific implementation characteristics believed to contribute to more effective enforcement of policies and to desired health outcomes for families. If, however, the project is to translate the general list of policies and policy implementation characteristics into a system usable for comparing state efforts, these general listings must be transformed into specific, scaled criteria. These criteria then become the basis for measuring state policies against specific benchmarks.

The remainder of this section outlines the key criteria for policies recommended in each of five policy clusters. Tables 1-5 summarize the five policy clusters and their recommended policies. The first column in each table lists the recommended policies. Column two lists key policy features or decisions that should be present for the policy to have the greatest likelihood of success. Column three lists, for each key policy feature, one or more measurable criteria that can be used to evaluate states. In some cases, a simple “yes” or “no” is used to describe whether a policy feature exists in state policy. In other places, a greater level of detail is possible, and hence, a range of specific options is listed. Bold items propose a desired or acceptable benchmark against which to assess state policies.

Health Care Services

The following policies focus on improving the lives of families with incomes up to 250 percent of the federal poverty level. In 2000, 16 percent of persons with incomes between 200 and 300 percent of the federal poverty level were without health insurance coverage.³⁸ To most effectively serve the range of needs among the diverse families up to 250 percent of the federal poverty level, state policies should aim to provide consistent access to a system of quality health care services. In addition, state policies should seek to improve the affordability, availability and accessibility of the health care services system.

Affordability

Affordability in the American system means insurance coverage. Insurance is the key to whether families receive health care in this country.³⁹ The proportion of low- and moderate-income families who lack either publicly or privately financed insurance remains very high. Consequently, general health status and vulnerability to chronic diseases and disabilities often reflects an inability to purchase care. State policy can significantly enhance the ability of families to purchase health care through a range of policies designed to make health services more affordable.

Policy 1: Health Insurance Eligibility

Whatever the mix of federal, state, and private programs, families up to approximately 250 percent of the FPL need coverage. Good insurance coverage provides enrolled individuals or families with financial access to a comprehensive range of preventive and treatment services, including: primary and specialty care, dental health, mental health, and substance abuse services. The objective of state health insurance eligibility policies should be to secure continuous health insurance coverage for children and families facing financial hardship and disparate access to quality health care. To meet this aim, states should consider the following health insurance eligibility options.

1.1 Child Age Eligibility. Older children are more likely than younger children to be uninsured. With most adolescents becoming ineligible for public health insurance coverage around age 19, public programs tend to be more inclusive of younger children, even when their family's income is higher. Moreover, it is around age 19 that young people are least likely to earn enough to purchase private coverage or attain a job that includes health benefits, but most likely to face higher risks of serious injuries, need screening and treatment services for mental and reproductive health, and the onset of risky behaviors.⁴⁰ This results in insurance coverage and health service gaps at precisely the time

young people need these supports to successfully transition into adulthood. Given this, state health insurance policy should extend eligibility to all children and youth up to age 23.

1.2 Child Income Eligibility. As of January 2002, ten states expanded their Medicaid or S-CHIP income eligibility levels for children to 250 percent or more of FPL.⁴¹ States should ensure that children in families with incomes up to at least 250 percent of the federal poverty level should be eligible for health insurance coverage.

1.3 Parent Income Eligibility. Research indicates that parental insurance coverage and use of health services are strong predictors of a child's use of health services. When a parent is not covered by health insurance, children are less likely to get timely health care services, and their health and development is compromised.⁴² While some states meet or exceed child income eligibility levels at 250 percent of the federal poverty level, very few do so for either single or two-parent families. For example, the median state Medicaid eligibility policy for single-parent families with children was 66 percent of the 2001 FPL. While eighteen states made these families eligible at 100 percent or more of the FPL, only the District of Columbia, Minnesota, New Jersey, and Washington included single-parent families at 200 percent or more of the FPL. Thirty-six states passed laws covering two-parent families at the same level as single-parent families.⁴³ Given that adult participation in health care coverage and services often affects rates of child participation and well-being, state policy should make parents or guardians and pregnant women with family incomes up to 250 percent of the federal poverty level eligible for health insurance coverage.

1.4 State Financed Health Insurance Coverage for Legal Immigrants. Immigrants who are not eligible for federal assistance with health insurance lack access to quality health care services. Immigrant children and parents account for only about six percent of the entire population of uninsured persons. However, recent immigrants are nearly three times more likely to be uninsured than the general population, and poor immigrants have uninsured rates of 53 percent.⁴⁴ The impact of increasingly large immigrant populations, some immigrating with pressing health care needs, warrants attention to ensuring health care coverage for immigrant families. Despite the fact that the 1996 welfare reform law made many legal immigrants ineligible for federal sources of insurance coverage, states can enact state funded programs to cover legal immigrants who would otherwise be uninsured and ineligible for health care coverage. State policy should make immigrant families eligible for health insurance coverage up to 250 percent of the FPL.

Policy 2: Caps on Out-of-pocket Expenses

The financial protection of an insurance plan can be negated by high deductibles or catastrophic circumstances that leave even middle-income families facing bankruptcy because of extensive treatment expenses. Over one-quarter of families with incomes below 200 percent of the poverty level and with serious health problems face out-of-pocket expenses of over five percent of family income, not including premium costs. In addition, research reveals that families facing high out-of-pocket expenses will forgo necessary health care.⁴⁵ Out-of-pocket caps in employer-sponsored health insurance plans range from less than \$500 per year to no limit. However, the largest number of employer-sponsored plans had caps that fell between \$1,000 and \$1,500. With the exception of Medicare, public insurance programs (including Medicaid and S-CHIP) already limit co-payments and deductibles. State insurance commissions can greatly support the need for extending the affordability of health care coverage to families living near the poverty level by regulating family deductibles and co-pays required by private health care plans. Similarly, research confirms the need for parity in insurance coverage for mental/behavioral health treatment,⁴⁶ for which even federally funded insurance such as S-CHIP may limit coverage and place greater burdens on low-income families seeking treatment.⁴⁷

2.1 Caps on Out-of-pocket Expenses. Studies indicate that even low co-pays and deductibles have the effect of keeping low-income families from getting necessary care.⁴⁸ States should limit out-of-pocket expenses as co-pays, deductibles, and other patient-borne costs to a range of \$500-\$1,000 per year. Out-of-pocket expenses totaling \$1,000 is one full month's salary or approximately eight percent of a family's yearly salary at the poverty level. Limiting these costs to less than \$1,000 helps to protect low-income families from financial devastation.

Table 1. Affordability of Health Care Services

| POLICY | KEY FEATURE | POLICY OPTIONS |
|--|---|---|
| 1 Health Insurance Coverage | 1.1 Children and youth are covered to age: | <ul style="list-style-type: none"> • Below age 17 • Ages 17 to 20 • Ages 21 to 23 • Ages 24 and over |
| | 1.2 Child coverage up to: | <ul style="list-style-type: none"> • 100-149% FPL • 150-199% • 200-249% • 250-299% • 300% + |

Continued on page 23

Table 1. Affordability of Health Care Services

| POLICY | KEY FEATURE | POLICY OPTIONS |
|--|--|--|
| | 1.3 Parents or guardians are covered up to: | <ul style="list-style-type: none"> • 100-149% FPL • 150-199% • 200-249% • 250-299% • 300% + |
| | 1.4 Legal immigrants not eligible for federal assistance are covered under state program(s) up to: | <ul style="list-style-type: none"> • 100-149% FPL • 150-199% • 200-249% • 250-299% • 300% + |
| 2 Caps on Out-of-pocket Expenses | 2.1 State limits out-of-pocket expenses for low-income families to | <ul style="list-style-type: none"> • \$1,501+ • \$1,001-1,500 • \$501-1,000 • \$1-500 • None |

NOTE: Bold Policy Options represent the proposed benchmark for each policy decision

Availability

Insurance coverage has little utility without the actual availability of health care services. Availability refers to both the presence of individual providers and the overall service capacity of the health care system. In addition, the range of benefits covered in a health insurance plan also affects availability (See Appendix A for a recommended set of covered benefits).

Policy 3: Health Care Provider Availability for Lower-income Families

While having a broad range of benefits is ideal for families with diverse needs, simply including a benefit in a health plan does not ensure that a professional actually exists to provide such services. In 2002, the federal government designated 3,216 geographic areas as “shortage areas” for primary care health providers; 1,953 are so designated for dental health providers; and 963 are designated as having mental health provider shortages. The need to recruit and place health care professionals for direct-care positions and under-served areas is especially acute for rural communities.⁴⁹ To improve the availability of health care providers, states should consider a number of policy options designed to train, recruit, and compensate professionals for working in underserved areas and professions.

3.1 Loan Forgiveness and Scholarships. States should provide loan forgiveness and scholarships for professionals willing to serve in medically under-served areas or in professional specialties experiencing workforce shortages. Targeting incentives to areas of greatest need is important for making health care services available where they are needed most.

3.2 Minority Recruitment and Training. The percentage of minority enrollees in medical schools remained essentially unchanged between 1970 and 1996, and continued at a rate lower than minority representation in the general population.⁵⁰ Addressing this trend is important because minority physicians most often serve in minority communities and underserved areas.⁵¹ State policy should establish goals to encourage the recruitment and training of health care providers whose race, ethnicity, and language reflect the composition of the state and communities of need.

3.3 Telemedicine for Remote Areas. An approach with growing support is the use of telemedicine technology for linking underserved areas to remote sources of medical expertise.⁵² Telemedicine approaches enable the transfer of medical information - including medical images, two-way audio and videoconferences, patient records, and data from medical devices - for diagnosis, therapy and education. Extensive telemedicine operations have been deployed in many countries, including Norway, France, the United Kingdom, Japan, Australia, and Canada.⁵³ In the United States, health providers in a number of medical specialties use telemedicine practices.⁵⁴ The Kansas University Center for Telemedicine and Telehealth, in its brief summary of the small body of telemedicine research, reports that telemedicine practices appear to be at least comparable in cost to services offered using traditional methods, and may be substantially less expensive if telemedicine networks are more fully developed and utilized.⁵⁵ As of 2001, 19 states used Medicaid options to cover telemedicine services, and in some states private providers also provide limited telemedicine coverage.⁵⁶ In addition, 21 states require full licensure of medical practitioners providing telemedicine services across state borders and five states use a variety of approaches including registrations or permits for out-of-state physicians. Rather than taking a restrictive approach to licensing, 12 states have adopted the Interstate Nurses Licensing Compact, an agreement that provides mutual recognition between states and is administered by each state's head of nursing licensing board.⁵⁷ Given the early but promising research on telemedicine practices, states should make use of currently available technology to develop and support telemedicine systems that provide medical expertise to underserved geographic areas of the state. Specifically, states should exercise Medicaid options for reimbursing telemedicine services and protect patients by requiring out-of-state physicians to be licensed to provide telemedicine services.

3.4 Provider Reimbursement Rates. Medicaid reimbursement rates have been associated with child and family access to services as diverse as dental treatment, cochlear implants, and nursing home quality.⁵⁸ Between 1993 and 1998, Medicaid reimbursement rates grew slower than inflation and fell 14.3 percent when compared to Medicare rates. During that same period, only 11 states maintained Medicaid rates of 75 percent or more of Medicare rates for primary care, obstetric care, and other services.⁵⁹ Medicaid reimbursement rates vary widely among the states.⁶⁰ To improve the availability of quality care, states should set provider reimbursement rates for Medicaid and other state-funded health care services at 75 percent or more of current Medicare reimbursement rates.

Table 2. Availability of Health Care Services

| POLICY | KEY FEATURE | POLICY OPTIONS |
|---|---|--|
| 3 Health Care Provider Availability | 3.1 State provides loan forgiveness and scholarships for entering health fields and serving medically underserved populations or areas | Yes • No |
| | 3.2 State provides incentives for the recruitment and training of health providers who are representative of the racial/ethnic groups in the state | Yes • No |
| | 3.3a State uses Medicaid or other public options to reimburse telemedicine services provided in underserved areas | Yes • No |
| | 3.3b State adopts telemedicine licensing laws that protect patients from unqualified physicians | <ul style="list-style-type: none"> • No laws adopted • Requires registration or permits • Adopts interstate compact • Requires full licensure |
| | 3.4 Medicaid or other state-funded provider reimbursement rates for primary, obstetric, and other care services (as % of Medicare rates) | <ul style="list-style-type: none"> • 0-25% • 26-50% • 51-74% • 75-85% • 86%+ |

NOTE: Bold Policy Options represent the proposed benchmark for each policy decision

Accessibility

Accessibility of appropriate health care services is defined as the ability of families and children to reach or secure needed health care services. Accessibility involves the relative difficulty or ease of enrollment in public health care insurance programs, culturally and linguistically responsive service delivery, and use of alternative delivery strategies.

Policy 4: Enrollment in Publicly Funded Insurance Programs

Complex and difficult enrollment procedures tend to stand as barriers to insurance coverage and, therefore, as barriers to receipt of health care services. While states have made strides in expanding coverage for children during the 1990s, protecting those gains and making enrollment more “user-friendly” are important policy issues.

4.1 Streamlined Procedures for Enrollment in Medicaid and S-CHIP. States should adopt enrollment procedures that reduce complexity and increase the ease of enrollment by low-income families. Several enrollment procedure policies have proven effective at improving access. They include use of joint application forms for Medicaid and S-CHIP (28 states), dropping asset tests for eligibility determination (42 states), eliminating face-to-face interviews (40 states), and extending re-determination intervals to 12 months (39 states). Less frequently used are adoption of temporary presumptive eligibility determination (8 states), self-declaration of income (10 states), and 12-month continuous eligibility regardless of income changes (13 states).⁶¹ Based on state experience with these options, states should adopt a mix of at least four of the above procedures.

Policy 5: Culturally and Linguistically Appropriate Services

The increase in immigrant groups in most states, coupled with higher incidence of chronic health conditions needing regular health care monitoring, argues strongly for health care services that can adequately serve linguistically and ethnically diverse families. A federally sponsored survey in 1996 found that 15 percent of American Indian and Hispanic families and 14 percent of Asian and Pacific Islander families experienced difficulty or delays in receiving health care or received no health care when needed.⁶² To improve the cultural and linguistic responsiveness of the health care system, states should adopt the following policy features:

5.1 Cultural and Linguistic Competence. Concern for the cultural and linguistic appropriateness of health services prompted the federal Office of Minority Health to lead a national effort to produce consensus-backed standards for cultural and linguistic competence in health care.⁶³ These standards are endorsed by more than 20 national health-related organizations.⁶⁴ Other research indicates that some states were unprepared for significant growth

in Hispanic and Asian populations and the health care access challenges such growth created.⁶⁵ To better serve the health needs of their diverse communities, states should require and fund training for health care providers to ensure culturally and linguistically competent health care services, as defined by federal Cultural and Linguistic Appropriate Services (CLAS) standards.

5.2 Translation and Outreach Materials. Several studies indicate that patients for whom English is a second language experience a range of serious difficulties when attempting to access medical care. For instance, one national survey of Hispanic adults found that those who primarily speak Spanish reported significantly greater communication problems than those who primarily speak English.⁶⁶ Other studies reveal that patients with language barriers are more often less satisfied with their care, often do not understand medical instructions, are less willing to return to hospital emergency rooms, less likely to receive a follow-up appointment, and less likely to have a medical home or receive preventive care.⁶⁷ To provide better access to health care and prevent unnecessary complications due to language and cultural barriers, states should provide translation and outreach and educational materials in the languages of patient populations.

Policy 6: Mental Health Services

The need for mental health supports and treatments is pervasive. Prior to 1996, however, it was commonplace for health insurance providers and plans to either refuse coverage of mental illness and substance abuse treatment or provide significantly lower levels of coverage for such services. This policy approach left many families without necessary mental health care or resulted in extraordinary out-of-pocket costs when compared to physical health care and surgery costs. In addition, other mental health policies, often in an effort to make mental health treatment accessible and affordable, actually do harm to families needing help. To better meet the pervasive mental health needs of significant numbers of Americans, states should adopt policies that make mental health care affordable, accessible, and more family-friendly.

6.1 Parity for Mental Health and Substance Abuse Treatment. The practice of limiting mental health benefits in private insurance plans is widespread. Some research indicates that 94 percent of health maintenance plans and 96 percent of other plans significantly limit mental health benefits, such as the number of outpatient sessions and inpatient days covered.⁶⁸ This state of affairs prompted the federal Mental Health Parity Act of 1996 (MHPA), which requires that annual or lifetime dollar limits on mental health benefits be no lower than such limits for medical and surgical benefits offered by a group health plan.

The Act gives employers discretion over the extent and scope of mental health benefits covered in the plan and does not apply to substance abuse or chemical dependency.⁶⁹ As of 2002, 34 states enacted mental health parity laws. The statutes varied in terms of benefits covered and eligible participants.⁷⁰ States should enact parity laws requiring insurers to cover treatment costs for both biological and non-biological disorders and for substance abuse or chemical dependency. In addition, states should require eligibility for all employees at businesses (public and private) with 51 or more employees, which is the federal standard set in MHPA.

6.2 Parental Custody and Treatment Rights. In a survey of child welfare directors in 19 states and juvenile justice officials in 30 counties, the General Accounting Office (GAO) found that the parents of over 12,700 children relinquished custody to either the child welfare or the juvenile justice system so that their children could receive necessary mental health services. The report estimates that the actual number of children and families in such situations is likely higher. Officials responding to the survey indicated that limitations in public and private health insurance coverage, limited service availability, and difficult eligibility rules all contribute to the practice of relinquishing custody to child welfare and juvenile justice agencies as a prerequisite to state payment for such treatment.⁷¹ Nearly half of the states now require that families of children in need of mental health treatment relinquish custody to child welfare or juvenile justice systems.⁷² This policy is clearly harmful to the maintenance and stability of long-term family bonds. Consequently, states should enact voluntary placement statutes that allow parents to place their children in child welfare or juvenile justice residential treatment settings for emotional and mental health treatment without relinquishing parental rights. Eleven states have adopted such laws and three others have empowered courts to order treatment from an appropriate agency without terminating parental rights.⁷³

6.3 Range of Mental Health Services and Supports. In order to meet the various mental health needs of its citizens, states must fund a range of services and supports to eligible children. Typically, the range of needed services covered by Medicaid include: day treatment (42 states), case management for serious emotional illness (43 states), intensive home-based services (35 states), independent living skills training (30 states), therapeutic foster care (20 states), and child respite care (11 states). States also provide summer camps and programs (5 states), after school activities (8 states), family support and wraparound services (19 states), therapeutic nurseries (7 states), therapeutic preschools (3 states), and other psychosocial rehabilitation programs (14

states).⁷⁴ In addition to these supports, more aggressive use of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are another way for states to provide necessary mental health supports to children and youth up to age 21. State Medicaid programs and qualified Medicaid providers must provide mental health treatment services to children screened through EPSDT and found to have a diagnosed disease or condition. In states where SCHIP is not an expansion of Medicaid or a Medicaid look-alike programs, state policy should ensure that children eligible for SCHIP have access to the same range of services as Medicaid-eligible children. In most states, separate SCHIP programs are more restrictive than its Medicaid counterpart. And in order to ensure a sufficient range of services, state policy should make available 6-8 of the recommended community-based services for children with mental health needs. Sixteen states meet this benchmark, and another 6 offer between 9 and 11 of the recommended services.⁷⁵

6.4 Community-based Mental Health Options. The widespread demand for mental health supports and treatment services creates a strain on already thin mental health resources. To meet the need for community-based treatment options, state lawmakers should consider two Medicaid options for making mental health services available to children - the Tax Equity and Financial Responsibility Act of 1998 (TEFRA) option and the Home- and Community-based Services Waiver (HCBW). The Medicaid TEFRA option - more commonly known as Katie Beckett waivers - permits states to enroll children with a federally defined disability needing extensive medical care, which could appropriately be provided at home less expensively than institutional care. While 20 states have enacted a TEFRA option for children with disabilities, only 10 of these states include children with mental and emotional health needs.⁷⁶

The HCBW option provides states flexibility to furnish children or adults, without regard to family income and as an alternative to more costly institutional care, an expanded range of community-based services. Services include: family respite care, family support services, skill building and independent living services, home supports, adaptive equipment and environmental modification, individualized care coordination, crisis-response, and one-time start up expenses for the child's transition from an institution to home. To date, 49 states have elected the HCBW option to support people with disabilities, but only Kansas, Vermont, and New York use this waiver to cover home- and community-based treatments for mental or emotional health disorders.⁷⁷

Both the TEFRA and HCBW options require the state to utilize treatment options that are less expensive than institutions, creating cost savings. In

2001, Kansas, Vermont, and New York reported that average annual per child costs using the HCBW were less than half the projected institutional costs. In addition, both the TEFRA and HCBW options are effective at reducing the likelihood that parents will relinquish custody to secure care for their children.⁷⁸ Given this evidence, states should seek TEFRA and HCBW options that include both children and adults with developmental disabilities and those with mental or emotional disorders.

Table 3. Accessibility to Appropriate Health Care Services Index

| POLICY | KEY FEATURE | POLICY OPTIONS |
|---|---|---|
| <p>4</p> <p>Health Insurance Enrollment</p> | <p>4.1 Streamlined procedures for enrollment in Medicaid and S-CHIP: (a) temporary presumptive eligibility, (b) joint applications, (c) extended re-determination intervals, (d) self-declaration of income, (e) eliminates asset tests, (f) eliminates interviews, and (g) provides 12 months of eligibility regardless of income changes</p> | <ul style="list-style-type: none"> • No streamlined procedures • 1 recommended procedure • 2 recommended procedures • 3 recommended procedures • 4 recommended procedures • 5 recommended procedures • 6 recommended procedures • 7 recommended procedures |
| <p>5</p> <p>Culturally and Linguistically Appropriate Services</p> | <p>5.1 State requires and funds cultural/linguistic competence training in publicly funded health care services</p> | <p>Yes • No</p> |
| | <p>5.2 State funds translation, outreach and materials in language of patient population</p> | <p>Yes • No</p> |
| <p>6</p> <p>Mental Health Services</p> | <p>6.1a State has a parity law requiring insurers to pay for mental health/substance abuse treatment to the same extent they pay for physical health care</p> | <ul style="list-style-type: none"> • No law enacted; • For mental health illness with biological causes only • For mental health illnesses with biological and non-biological causes • For mental health illnesses and substance abuse treatment |

Continued on page 31

Table 3. Accessibility to Appropriate Health Care Services Index

| POLICY | KEY FEATURE | POLICY OPTIONS |
|---|--|--|
| <p>6</p> <p>Mental Health Services</p> | <p>6.1b State parity law requires insurers cover:</p> | <ul style="list-style-type: none"> • Either public or private employees only • All employees with employers of 51 or more employees • All employees with employers of 25 or more employees |
| | <p>6.2 State statute does not require parents to relinquish custody in order to obtain mental health and substance abuse treatment for their children</p> | <p>Yes • No</p> |
| | <p>6.3a State provides a comprehensive range of mental health treatment options, including use of EPSDT options (see page 36)</p> | <ul style="list-style-type: none"> • 0-2 recommended services • 3-5 recommended services • 6-8 recommended services • 9-11 recommended services • 12-14 recommended services |
| | <p>6.3b State policy makes available comparable mental health and substance abuse treatment services in both Medicaid and SCHIP programs</p> | <p>Yes • No</p> |
| | <p>6.4a State uses TEFRA option and/or HCBW waiver to provide community-based care options to children and adults</p> | <ul style="list-style-type: none"> • Exercises neither option • Exercises TEFRA only • Exercises TEFRA and HCBW |
| | <p>6.4b Eligibility for state TEFRA and/or HCBW options include:</p> | <ul style="list-style-type: none"> • Exercises neither option • Only people with developmental disabilities • People with developmental disabilities and mental health needs |

NOTE: Bold Policy Options represent the proposed benchmark for each policy decision

Health-related Behaviors

Health-related behaviors include some of the leading contributors to premature death and disability in the United States.⁷⁹ Healthy lifestyles and individual behaviors affect the levels of risk associated with chronic illnesses, traumas, and some transmittable infectious diseases. While healthy behaviors cannot always prevent the onset of specific illnesses, chronic conditions, or injuries, a person's health-related decisions and habits can make such conditions more manageable and reduce the risk of serious illness resulting from them. Moreover, state policy is a useful tool for encouraging healthier and discouraging risky behaviors.

Policy 7: Tobacco Tax and Enforcement

Tobacco leads the list of behavioral contributors to preventable death and chronic disease in the United States.⁸⁰ However, studies indicate that state taxes levied on tobacco products significantly lower product use, especially among youth, pregnant women, and low-income people.⁸¹ To reduce health risks associated with tobacco use, state tobacco tax policy should include:

7.1 Cigarette Tax. A state excise tax of \$1.00 per pack of cigarettes or more appears to be an effective rate for influencing harmful tobacco consumption, and this is recommended as the policy benchmark. Two states - New York and California - have raised cigarette taxes to over \$1.00 per pack with resulting reductions in consumption for teenagers.⁸² The average state tax per pack of cigarettes is set to increase from 42 cents in 2001 to over 62 cents in July 2003.⁸³ Research indicates that higher cigarette prices are an effective tool for lowering consumption for all young smokers, with highest reductions seen among those young smokers previously smoking as much as one-half a pack of cigarettes per day.⁸⁴ In addition to curbing unhealthy smoking behaviors, cigarette taxes are a revenue source for state governments.

7.2 Enforcement of Tobacco-related Age Restrictions. Provisions of the Substance Abuse Prevention and Treatment Partnership Block Grant (the Synar Amendment) require that states take action to enforce age restrictions on access to tobacco products. The most recent report indicates that sales to minors have dropped from 40.1 percent of cigarette sales in 1996 to 16.3 percent in 2001.⁸⁵ Educating cigarette retailers, aggressive compliance checks, along with fines and other punitive measures are among the approaches used to reduce youth access to tobacco products.⁸⁶ According to one survey of experts administering youth access enforcement programs, implementing these measures at high levels is needed and effective where present.⁸⁷ The Synar Amendment also requires states to achieve an overall 20 percent violation rate goal. In 2001, 38 states achieved this goal and 13 others achieved negotiated target rates for 2001.⁸⁸

Policy 8: Alcohol Tax and Enforcement

Alcohol competes with tobacco as a major risk to the health of Americans. Its threat extends beyond the health of the user and is a principal contributor to injuries from drunk driving, community and domestic violence, and other preventable tragedies.⁸⁹ However, state tax policy can influence alcohol consumption levels, again particularly among youth and low-income people.⁹⁰ And, like cigarette taxes, taxes on alcoholic beverages are a revenue source for state governments. To curb unhealthy alcohol consumption, state alcohol taxation policy should include:

8.1 Alcohol Taxes. Since 1951, only the increase in federal wine tax rates has kept pace with inflation. To offset inflation over this period, taxes on beer and distilled spirits would have required a fourfold and eightfold increase, respectively. In other words, the real value of taxes on most forms of alcohol is well below the real value of these taxes in 1951.⁹¹ Earlier recommendations from the Bush Administration suggested a tax rate of 25 cents per ounce of pure alcohol in any beverage, a rate substantially above the existing tax rate of the time.⁹² In short, most states have significant room to raise alcohol taxes both as a strategy for reducing negative child and family outcomes and increasing state revenue. States should establish an excise tax of more than \$.30 per gallon to control beer consumption. Fifteen states now have rates exceeding \$.30, the U.S. median tax rate on beer is 18.5 cents and the average is .26 cents.⁹³ States should establish an excise tax of more than \$4.00 per gallon to control liquor consumption. Twelve states now have rates exceeding \$4.00.⁹⁴ To control wine consumption, state policy should set an excise tax of more than \$.75 per gallon. Nineteen states now have rates exceeding \$.75, with eleven of those states enacting wine taxes exceeding \$1.00 per gallon.⁹⁵

8.2 Enforcement of Alcohol-related Age Restrictions. States should establish procedures to ensure that the prohibition of alcohol sales to minors is enforced. Some states have adopted use of improved technology for on-site verification of drivers' licenses, use of "cop-in-shop" approaches to monitoring sales, and employment of youth to perform compliance checks of retail establishments.⁹⁶ Several studies have found that programs monitoring retailer compliance with age restrictions lowered sales to minors from a range of 60 to 80 percent to a range of 25 to 30 percent.⁹⁷

Policy 9: School Health Education and School Nutrition Standards

Rising obesity among children and youth make diet and physical exercise important policy concerns for state governments. For example, in 2000 and 2001, the Centers for Disease Control (CDC) provided funding to twelve states to initiate social marketing strategies to prevent obesity and other chronic diseases.⁹⁸ Specifically, state policies affecting health education, school breakfast, lunch and nutrition programs, and physical exercise are important.

Schools in over 80 percent of states and 85 percent of school districts require classes in health education. However, requirements do not extend throughout all grade levels. Full, statewide provision of comprehensive health education ranges from a high of 44 percent of schools at the 5th grade level to a low of two percent at the 12th grade level.

In addition to health education, school breakfast and lunch programs are especially crucial services for children of low-income families. The nutritional content of these meals is a significant aspect of preventive health. Similarly important is the availability of regular physical exercise and physical education for establishment of life-long patterns of physical activity.⁹⁹ Both diet and physical activity are especially significant for children and youth, given the increasing prevalence of obesity.

9.1 Comprehensive School Health Education. Comprehensive school health education generally includes the prevention of accidents and injury, alcohol and other drug use, HIV/AIDS, pregnancy, sexually transmitted diseases, suicide, tobacco use, and violence. It also includes a focus on nutrition, diet, and physical fitness.¹⁰⁰ Evaluations indicate that children and teenagers who received comprehensive school health education were both more knowledgeable about the consequences of health risks and less likely to be engaged in them.¹⁰¹ Given this evidence, states should fund age-appropriate comprehensive school health education for grades kindergarten through 12. Moreover, as an effort to keep parents informed and involved in their children's health education, states should require parental consent for children participating in such programs.

9.2 Physical Education. Obesity among young people is estimated at 14 percent of children ages 6 to 11 years and 12 percent of all adolescents. In addition, the trends appear to be worsening as young people move into adulthood. Obesity rates among adults were nearly 21 percent in 2001, increasing more than 60 percent since 1991.¹⁰² Nationally, an estimated 300,000 deaths annually are attributable to obesity.¹⁰³ Given the growing concern for the physical fitness of young people, states should require and fund school-based physical education as part of elementary and secondary school curricula.

9.3 Nutrition Standards for School Meals. The most recent School Health Policies and Programs Study conducted by the Centers for Disease Control and Prevention found that 28.6 percent of schools and 20.5 percent of school districts required use of the Nutrient Standard Menu Planning Guidelines for planning school meals.¹⁰⁴ States should adopt and enforce national standards (or equivalent standards) for the nutritional content of meals served as part of school food service programs. Such standards help ensure that students receive a nutritionally balanced diet, and consequently, reduce the risk of diet related problems like obesity.

Table 4. Health Related Behaviors

| POLICY | KEY FEATURE | POLICY OPTIONS |
|--|---|--|
| <p>7</p> <p>Tobacco Tax and Enforcement</p> | <p>7.1 Per pack excise tax on cigarettes to reduce consumption</p> | <ul style="list-style-type: none"> • 0 - \$.50 • \$.51-\$1 • \$1.01+ |
| | <p>7.2 State has enacted and funds effective enforcement procedures (e.g., retailer education, compliance checks, fines and penalties) to reduce cigarette sales to minors</p> | <p>Yes • No</p> |
| <p>8</p> <p>Alcohol Tax and Enforcement</p> | <p>8.1a Excise tax rates set to control beer consumption rates (per gallon)</p> | <ul style="list-style-type: none"> • 0 - \$.15 • \$.16 - .29 • \$.30 - .45 • \$.46 - .70 • \$.71+ |
| | <p>8.1b Excise tax rates set to control liquor consumption rates (per gallon)</p> | <ul style="list-style-type: none"> • 0 - \$2.00 • \$2.01 - 4.00 • \$4.01 - 6.00 • \$6.00+ |
| | <p>8.1c Excise tax rates set to control wine consumption rates (per gallon)</p> | <ul style="list-style-type: none"> • 0 - \$.50 • \$.51 - \$.75 • \$.75 - .99 • \$1.00 - 2.00 • \$2.00+ |
| | <p>8.2 Established procedures (e.g., on-site driver's license verification, "cop-in-shop" approaches, compliance checks, fines and license revocation) for enforcement of prohibition of alcohol sales to minors</p> | <p>Yes • No</p> |

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Table 4. Health Related Behaviors

| POLICY | KEY FEATURE | POLICY OPTIONS |
|---|--|---|
| 9 School Health Education and Nutrition Standards | 9.1 Funds comprehensive health education in K-12 schools and requires parental consent for participation | <ul style="list-style-type: none"> • No • Funds but does not require consent • Funds and requires consent |
| | 9.2 Required school-based physical education | Yes • No |
| | 9.3 Adopts national food service program standards for nutritional content, quality, and quantity of foods served in school cafeterias (e.g. prohibits “junk” food) | Yes • No |

NOTE: **Bold Policy Options** represent the proposed benchmark for each policy decision

Health Supporting Environments

Policies of particular relevance to low-income families that help shape health-supporting environments include addressing clean indoor air, lead poisoning, and prevention of firearm hazards.

Policy 10: Lead Poison Abatement

Ingested lead paint particles are linked to serious physical and mental impairments in young children. Exposure to lead-based paint is almost exclusively a danger experienced by children living in old, usually inner-city housing. An early 1990s study found that 22 percent of non-Hispanic African American children living in homes built before 1946 had elevated blood lead levels.¹⁰⁵ To address risks of lead poisoning, states should adopt:

- 10.1 Lead-based Paint Inspection and Abatement.** State policy that requires inspections and abatement is a significant environmental health intervention. Such policies should be coupled with measures to ensure that housing stock is not taken off the market rather than undergoing the relatively expensive process of abatement. States should fully fund lead-based paint inspections and subsidize abatement in housing found to have lead-based paint.

Policy 11: Firearm Hazards

Violence continues to be a disproportionately greater threat to the health of low-income individuals than to the general population. However, the costs of gun violence affect the entire country at the rate of approximately \$100 billion per year - \$15 billion of which is attributable to gun violence against youth.¹⁰⁶ Another \$4 - 5 billion is spent annually on strengthening law enforcement, prosecution, and incarceration associated with gun crime.¹⁰⁷

Using education as a proxy for income status, the rate of firearm-related deaths in 1998 was 21 percent higher for people ages 25 to 64 with less than a high school diploma than for those with a high school diploma, and over three times higher than for people with some college education.¹⁰⁸ The rate of firearm-related deaths among African Americans in 2000 was three times the rate for the general population in the same year.¹⁰⁹

Annually, more than 20,000 children and youth under age 20 are killed or injured by firearms in the United States, making firearms second only to motor vehicle accidents as the leading cause of death among 10 to 19 year olds. In 1998, for example, 3,792 young people below age 20 died as a result of firearm-related injuries - down from the 1994 peak of 5,833 deaths and representing 7 percent of all deaths in this age group.¹¹⁰

Conventional wisdom holds that states enacting firearm safety measures, including laws governing procedures for safe storage, ownership, and purchasing, have better chances of preventing gun-related deaths and injuries than those with no or less comprehensive measures. For example, 68 percent of Americans—and 64 percent of gun owners—support government safety regulations for the design of guns. Seventy-one percent (71%) of Americans polled—and 59 percent of gun owners—support legislation requiring manufacturers to personalize all handguns sold in the U.S.¹¹¹ Some research evidence, briefly reviewed below, support these widely held positions.

11.1 Safety Devices on Handguns. Safety devices, including trigger locks, gun safes, grip safety, and magazine disconnect devices, are generally thought to reduce accidental injury involving firearms and gun theft. For instance, nearly three-quarters of Americans support a requirement that trigger locks be used for all handguns.¹¹² While some safety products are not tamper proof, even with children, products meeting more exacting standards show promise. For example, California adopted a law, effective January 2002, requiring locks that meet exacting standards on guns sold in the state.¹¹³ Massachusetts' law requires childproofing features on all commercially sold handguns. New Jersey also requires new handguns sold in the state to be childproof and Maryland law requires all handguns sold after December 31,

2002 to have an “integrated mechanical safety device that disables or locks the gun.”¹¹⁴ States should require trigger locks or other safety devices on all handguns manufactured or sold in their jurisdictions.

11.2 Gun Storage. To help protect children from accidental injury and death, states should enact laws that require firearms be locked when stored and laws that hold gun owners liable for failure to comply. Four states - California, Connecticut, Hawaii, and Massachusetts - have adopted such laws.¹¹⁵ Some research indicates that the eighteen states with safe storage laws have firearm thefts 26 percent lower than states that do not, and these states show a sharper decline in overall theft rates over the last ten years.¹¹⁶ This is an important finding, given that firearm theft is a major supplier to the illegal firearm market.

11.3 Licensing of Gun Owners. With over 4,000 gun shows in the U. S. each year, averaging 2,000 to 5,000 attendees, firearms are easily accessible to young people and high-risk buyers. However, in 1999, only Maryland and California had statutes regulating purchases at gun shows.¹¹⁷ In one national study involving male high school sophomores, 50 percent of participants reported that obtaining a gun would be “little” or “no” trouble.¹¹⁸ This same ease of accessibility is also true for would-be gun purchasers who would be prohibited from purchasing weapons under the Gun Control Act of 1968 and the Brady Act of 1994. States should require licenses for purchasing guns from retailers, individuals and gun shows. Fifteen states have such licensing or registration laws.¹¹⁹

11.4 Waiting Periods. States should require waiting periods for the purchase of firearms. Proponents of this policy argue that waiting periods provide a “cooling off” period and potentially reduce impulsive crimes and suicide. In some public opinion research, 81 percent of respondents say they want both a five-day waiting period and background checks.¹²⁰ Twenty-two states have waiting periods for handguns and six states require waiting periods for rifles and shotguns. States should require waiting periods be enforced for purchasing handguns, rifles and shotguns from both retailers and private sellers.

11.5 Background Checks. Six years following passage of the Brady Act of 1994 requiring background checks, approximately 700,000 illegal purchases were prevented.¹²¹ Even more illegal purchases could be prevented if the 40 percent of all firearm sales made through non-retail outlets (individual sale, gun shows, classified ads, internet) also were subject to background checks.¹²² Twenty-three states require only federal background checks when

handguns are bought from a dealer; the other 27 states require state police record checks as well. Thirty-two states require no background checks when handguns are purchased privately.¹²³ Given the benefits of keeping firearms out of the hands of illegal purchasers and the effectiveness of background check policies, states should require federal and state background checks for both the retail and private purchase of firearms. In 95 percent of cases, these checks can be completed within two hours, with most completed in a couple of minutes.¹²⁴

Table 5. Health Supporting Environments

| POLICY | KEY FEATURE | POLICY OPTIONS |
|--|--|--|
| 10 Lead Poison Abatement | 10.1 Lead-based paint inspections and abatement | <ul style="list-style-type: none"> • Not funded • Partially funded • Fully funded |
| | 11.1 Requires trigger locks or other safety devices on handguns | Yes • No |
| 11 Firearm Hazards Reduction | 11.2 Requires locked storage of firearms to protect children | <ul style="list-style-type: none"> • Not required • Yes, but no liability for noncompliance • Yes, with liability for noncompliance |
| | 11.3 Licensing for gun ownership required for: | <ul style="list-style-type: none"> • Retail purchases only; • None • Retail and private purchases; |
| | 11.4 Waiting periods required for purchase of: | <ul style="list-style-type: none"> • None • Handguns only • Handguns, rifles, and shotguns |
| | 11.5 Background checks | <ul style="list-style-type: none"> • No checks for private purchases • Fed'l checks for retail only; • Fed'l and state for retail purchases only • Fed'l checks for retail and private purchases • Federal and state checks for retail and private purchases |

NOTE: Bold Policy Options represent the proposed benchmark for each policy decision

Conclusion

4

Health care services to meet the preventive, diagnostic, treatment, and medical management needs of low-income families claim a large and growing portion of public resources. Acute and chronic illnesses and diseases create major burdens not only on individuals and families but also on communities and society at large. For this reason, policymakers at the federal and state levels are constantly challenged to craft laws and to appropriate sufficient funds to maintain or reform complicated health care delivery systems that meet the needs of vulnerable children and their families.

This paper provides an outcome-focused framework for assessing the adequacy of state policies that address health issues. Health care services, health-related behaviors, and health-supporting environments are the three major components of this framework. Because of their significant impact on public resources, health care services receive the most attention here, with emphasis on policies aimed at affecting the affordability, availability, and accessibility of appropriate services.

This framework and the policy options presented are not exhaustive. Their focus is on poor and near-poor families whose circumstances make them most vulnerable to the crises and burdens of traumatic injury and acute or chronic illness. The policies are limited to a selection holding the most promise for achieving the outcomes that support health for these families.

Appendix A

RECOMMENDED SERVICES FOR COVERAGE IN PUBLIC HEALTH INSURANCE PROGRAMS

Appendix A. Recommended Services for Coverage in Public Health Insurance Programs

| SERVICE AREA | SERVICES | OPTIONS* | | |
|----------------------------|--------------------------------|----------|----------|---------------|
| | | MEDICAID | S-CHIP | STATE PROGRAM |
| Primary and specialty care | Physician's office visits | Yes • No | Yes • No | Yes • No |
| | Laboratory tests | Yes • No | Yes • No | Yes • No |
| | Referral to specialists | Yes • No | Yes • No | Yes • No |
| | Hospital care | Yes • No | Yes • No | Yes • No |
| | Emergency care | Yes • No | Yes • No | Yes • No |
| | Home health care | Yes • No | Yes • No | Yes • No |
| | Skilled nursing | Yes • No | Yes • No | Yes • No |
| | Personal care | Yes • No | Yes • No | Yes • No |
| | Vision care | Yes • No | Yes • No | Yes • No |
| | Prescription drugs and devices | Yes • No | Yes • No | Yes • No |
| | Dental care | Yes • No | Yes • No | Yes • No |
| | TB-related treatment | Yes • No | Yes • No | Yes • No |
| | HIV/AIDS-related treatment | Yes • No | Yes • No | Yes • No |

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Appendix A. Recommended Services for Coverage in Public Health Insurance Programs

| SERVICE AREA | SERVICES | OPTIONS* | | |
|--------------------------|--|---|----------|---------------|
| | | MEDICAID | S-CHIP | STATE PROGRAM |
| Behavioral health | Screening for mental health and substance abuse in primary care for all children | Yes • No | Yes • No | Yes • No |
| | Definition of mental health includes both biologically-based conditions and behavioral disorders (all DSM-IV diagnoses) | Yes • No | Yes • No | Yes • No |
| | Early intervention services to screen, assess, and treat emotional and behavioral needs of young children and their families: | <ul style="list-style-type: none"> • Child and parent • Child only • Parent only | | |
| | <ul style="list-style-type: none"> • Exercises option to serve “at risk” children for emotional problems under Part C of IDEA | Yes • No | | |
| | <ul style="list-style-type: none"> • Assures transition and continuation of services for emotional and behavior problems of preschool-age children by using same criteria for Medicaid Part C and Part B services | Yes • No | | |
| | Intensive 24-hour outpatient care for substance abuse treatment services | <ul style="list-style-type: none"> • Child and Parent • Child only • Parent only | | |
| Family-focused services | Family planning | Yes • No | | |
| | Prenatal care | Yes • No | | |
| | Childbirth education | Yes • No | | |
| | Parenting education | Yes • No | | |
| | Respite care | Yes • No | | |
| | Family counseling | Yes • No | | |
| Prevention and education | Child immunizations | Yes • No | | |
| | Adult immunizations | Yes • No | | |
| | Nutrition counseling | Yes • No | | |
| | Smoking cessation programs | Yes • No | | |
| | Worksite health promotion programs | Yes • No | | |

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Appendix A. Recommended Services for Coverage in Public Health Insurance Programs

| SERVICE AREA | SERVICES | OPTIONS* |
|-------------------|-----------------|----------|
| Enabling services | Interpreters | Yes • No |
| | Transportation | Yes • No |
| | Child care | Yes • No |
| | Case management | Yes • No |

* Covered services in SCHIP and other state programs that are not an expansion of Medicaid or Medicaid look-alike programs should be comparable to coverage and eligibility levels for Medicaid.

Appendix B

FEE ANALYSIS GROUPS USED IN MEDICAID TO MEDICARE FEE RATIOS

FEE ANALYSIS GROUPS USED IN MEDICAID TO MEDICARE FEE RATIOS

Primary Care Fees Include

- 99203 Office Visit, New Patient, *30 Minutes*
- 99213 Office Visit, Established Patient, *15 Minutes*
- 99214 Office Visit, Established Patient, *25 Minutes*
- 99244 Office Visit, New Patient, *60 Minutes*
- 93000 Electrocardiogram

Obstetric Care Fees Include

- 59410 Vaginal Delivery Only
- 59515 Cesarean Delivery and Postpartum Care

Other Fees Include

- 99222 Initial Hospital Care, New or Established Patient, *50 Minutes*
- 99254 Initial Inpatient Consultation, *80 Minutes*
- 43235 Upper Gastrointestinal Endoscopy
- 58120 Dilation and Curettage
- 58150 Total Hysterectomy
- 66984 Cataract Removal with Lens Implant
- 70450 Computerized Axial Tomography Scan, Head or Brain
- 71020 X-Ray, Chest, Two Views
- 76805 Echography, Pregnant Uterus
- 81000 Urinalysis, Routine
- 87081 Culture, Bacterial, Screening Only
- 88035 Surgical Pathology

Source: Stephen Norton, "Recent Trends in Medicaid Physician Fees, 1993 - 1998" (Washington, D.C.: The Urban Institute, July 1999).

Appendix C

POLICY MATTERS PROJECT OVERVIEW

State policymakers, whether they are governors, state legislators, executive agency managers or policy advocates, are concerned about the effectiveness of the policies and programs they develop. However, the ability to assess the success of existing and new policy initiatives to produce positive and lasting results for families and children is frequently elusive. Currently, there is no commonly accepted way to assess the degree to which state policies advance or detract from the goal of improving child, family, and community well-being.

While policies are often developed to address or produce a certain set of outcomes, the relationship between policy and outcomes is not well understood. Little investigation of the impact of policy on system improvement and on outcomes for children and families has occurred, leaving policymakers and administrators without the needed information to guide the development and implementation of policy that will produce results.

In such an environment, how can state legislators and leaders know whether policies they implement are supportive of families? How can they discern whether the mix of policy improvements and legislative changes bring them closer to achieving better outcomes? How can policymakers and leaders make informed decisions about an array of policy choices for families? To answer these questions, the Center for the Study of Social Policy, with support from The Annie E. Casey Foundation, has begun a project to develop a results-based framework that proposes benchmarks for state policies.

Policy Matters attempts to offer comprehensive information regarding the strength and adequacy of state policies affecting children and families. This is done by establishing consensus among policy experts and state leaders regarding the cluster of policies believed to offer the best opportunity for improving key child and family results. Further, the project puts forth benchmarks for gauging the strength of existing state policies aimed at these results.

How the Policies Are Organized

Policy Matters examines six related results: school readiness; educational success; youth engaged in positive, productive roles; family economic success; healthy families; and strong family relationships. When viewed collectively, these six results form one possible composite of family-strengthening policy. Included are results that focus on the entire family (family economic success, healthy families, and strong family relationships) as well as results that focus more narrowly on young children (school readiness), youth (educational success and youth engaged in positive, productive roles), and particular issue areas (education, health, and economic success). The mix of results and policies focuses on a broad life span, from birth to retirement (see Figure 1), and a broad range of potential policy categories (see Tables C.1 - C.6).

Each of the six results is guided by a working definition and focus:

- **School Readiness** is defined broadly as the preparedness of young children, ages 0-8 years, to enter school and the preparedness of schools to receive young children into public educational settings. The cluster focuses on young children and the major policies that support their social, cognitive, and emotional development and on child-serving systems and their capacities to deliver high-quality, developmentally appropriate care and education. The school readiness policy cluster includes: child care quality, affordability, and accessibility; Head Start, public preschool, and kindergarten quality and standards.
- **Educational Success** focuses on the public school and post-secondary educational achievement of students and the provision of quality public and education services. The educational success policy cluster includes policies governing class size and school enrollment, school accountability systems, teacher quality and retention, alternative education, curriculum standards, testing, and post-secondary financial aid.
- **Youth Engaged in Positive, Productive Roles** is defined as the availability of healthy personal, civic, peer, family, and community options for young people ages 8-24. This area focuses on the developmental needs of pre-adolescents, adolescents, and young adults and the crucial transitions between each of these periods of increasing maturity. Policies in this cluster include those that

encourage and support youth in meaningful civic roles, prepare young people for work and other adult roles, and make available quality child welfare, juvenile justice, after-school, school-to-work, and health promotion services.

- **Family Economic Success** refers to the ability of working age (18-65) adults and families (up to 200 percent of the federal poverty level) to earn enough pay and benefits to provide for their basic needs and to accrue long-term assets like homes and retirement benefits. This policy cluster includes policies that support the acquisition and retention of quality jobs (e.g., WIA and TANF), improve income and earnings (e.g., state-enhanced minimum wage, personal income tax thresholds, earned income tax credit, health insurance and affordable housing), encourage and protect the development of assets (e.g., Individual Development Accounts, anti-predatory lending), and create an economic safety net for families (e.g., unemployment insurance).
- **Healthy Families** refers to the physical and mental well-being of families and examines the availability, quality, and accessibility of appropriate health care services for low-income families. This policy cluster includes policies related to health insurance coverage and benefits, health safety nets, health support services like transportation and translation, and policies promoting healthy behaviors and environments.
- **Strong Family Relationships** is defined as the relational well-being of families. While the successful promotion of “strong family relationships” is clearly tied to ensuring family economic success and family health, this result focuses primarily on strengthening the formation of families, the interaction of parents and children, the connection of families to social networks, and the adequacy and quality of necessary family resources. This policy cluster includes food security (e.g., food stamps and WIC), child welfare, domestic violence, family formation, homelessness, affordable housing, father involvement, and family support (e.g., home visiting, family and medical leave, and parent education) policies.

The categorization of policy according to desired results is imprecise. For the purposes of this project, specific policies were assigned to a category either because the category offered the “best fit” for the policy or because the workgroup tasked with developing benchmarks for that result area was best suited to discuss the policy in question. Many policies appropriately apply to many of the desired results and will “show up” in each place where it is applicable. For example, health insurance coverage plays a role in achieving all six of the results. In addition, some policies appear in multiple categories with a shifted focus depending on the category. For instance, housing policy appears in both the family economic sufficiency and the strong family relationships results. However, housing policy included in the family

economic success result focuses on home ownership while reduction in homelessness and affordable rental housing is emphasized in the strong family relationships result. Policies appearing in multiple result areas are likely to be “high leverage” policies because of their potential impact on multiple outcomes.

How the Project Is Organized

Given the breadth and complexity of state policy, it is important to clarify what the *Policy Matters* project intends to produce. Specifically, *Policy Matters* is an attempt to meet the information needs of policymakers, advocates, administrators, and local leaders with four products. These products, while distinct from one another, are developed sequentially and build upon the successful completion of the previous product.

First, six policy papers will be developed and published during this project. Each paper, one for each of the six result areas, will offer a strategic policy framework for achieving a specific result and set of outcomes. The policy papers will include a short list of policies that collectively have: (1) evidence supporting their effectiveness at effecting the desired result, (2) the best chance of being supported by multiple constituencies, and (3) sufficient scale and scope for impacting the desired result. For each recommended policy, the papers also will posit the key attributes and interactions between policies that are thought to enhance the policy’s effectiveness. Teams of state and national policy experts will review drafts of the papers and meet to reach consensus on specific policy recommendations. The papers could be a positive contribution to the strategic understanding of the link between policy and results for children and families.

Second, *Policy Matters* examines the strength and adequacy of state policies affecting children, families, and communities. This is done by establishing benchmarks for a cluster of policies aimed at specific child and family results, and disseminating the benchmarks will be published for consideration and use to state and local leaders.

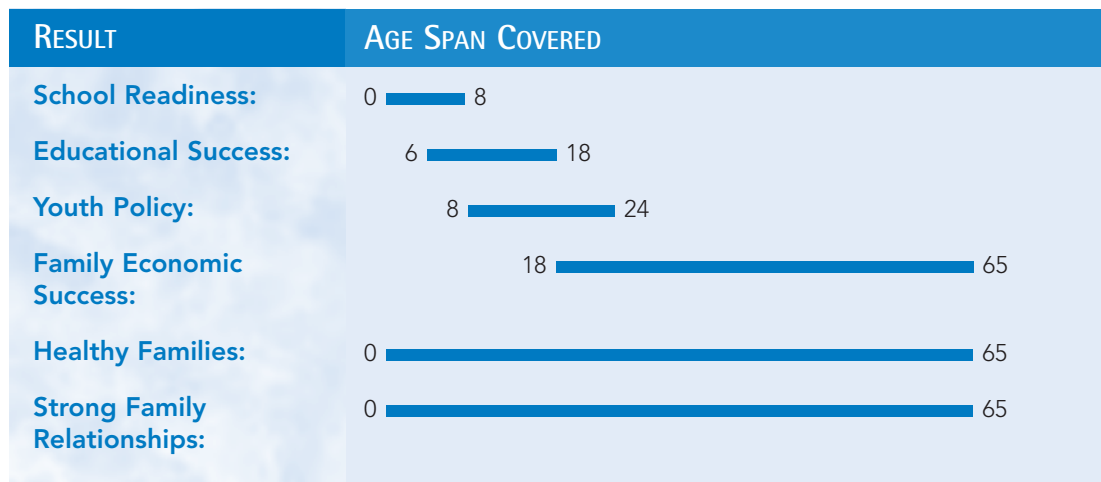
Third, the project will develop the policy papers and policy benchmarks into a *self-assessment tool* useful for those involved in policy planning and advocacy. The self-assessment tool might include a range of policy options beyond the “core” policies recommended in the policy papers and benchmarks product. The tool is envisioned to be an easy-to-use tool that identifies strengths and weaknesses in a state’s policy agenda that would have import for strategic efforts. The tool will be widely available to state and local leaders.

Fourth, this effort could lead to a Kids Count-like product that compares state policy efforts. However, where Kids Count is concerned with *child* well-being, this effort is concerned with assessing *policy*. The effort to set benchmarks for state policy might be

thought of as a *policy well-being* project that measures an individual state’s policy against agreed upon benchmarks in critical areas. By measuring the strength of state policies against established benchmarks, the project hopes to provide further insight on the policy context of state success at achieving positive outcomes for children and families.

While the collection of products described previously could be useful to the field of policy analysis, this current project is not an attempt to track a wide range of possible policies related to a given topic. Nor is the project intended to be a policy clearinghouse or program “best practices” guide. Lastly, the project is not a well-being indicator, evaluation, or measurement project, though information from these activities helps to shape our policy focus. All of these activities are valuable contributions and services, and many organizations do an excellent job at one or more of them. However, these activities are beyond the scope of the current project.

Figure C.1. Overlapping Age Spans for Policy Matters Results



Scale: Ages 0 – 65 years

Table C.1. Preliminary List of “School Readiness” Policies

| CLUSTER | POLICIES |
|--|---|
| Ready Systems of Early Care and Education (ECE) | <ul style="list-style-type: none"> • State-funded ECE Programs • Child Care Subsidy Programs • Child Care Tax Provisions • Licensing and Accreditation • Professional Development and Compensation • ECE Systems Development • ECE Standards and Assessments • Facilities/Capital Investments |
| Ready Schools | <ul style="list-style-type: none"> • Kindergarten Quality • ECE Systems Development |

Table C.2. Preliminary List of “Healthy Families” Policies

| CLUSTER | POLICIES |
|--|---|
| Health Care Services | |
| <ul style="list-style-type: none"> • Affordability • Availability • Accessibility and Appropriateness | <ul style="list-style-type: none"> • Health Insurance Coverage Caps on Out-of-pocket Expenses • Provider Incentives • Streamlined Enrollment Procedures • Culturally and Linguistically Appropriate Services • Mental Health Services and Supports |
| Health-related Behaviors | <ul style="list-style-type: none"> • Tobacco Tax and Enforcement • Alcohol Tax and Enforcement • School Health Education and Food Services |
| Health-supporting Environments | <ul style="list-style-type: none"> • Lead-based Paint Abatement • Firearm Safety |

Table C.3. Preliminary List of “Strong Family Relationships” Policies

| CLUSTER | POLICIES |
|---|---|
| Family Formation and Maintenance | <ul style="list-style-type: none"> • Marriage Promotion • Birth Supports • Out-of-Wedlock Pregnancy Prevention |
| Support for Participation and Nurturance | <ul style="list-style-type: none"> • Father Involvement • Child Support Enforcement • Family and Medical Leave • Respite Care |
| Lasting Stability and Safety | <ul style="list-style-type: none"> • Child Welfare • Domestic Violence |

Table C.4. Preliminary List of “Youth Engaged in Positive, Productive Roles” Policies

| CLUSTER | POLICIES |
|----------------------------------|--|
| Universal Policies | <ul style="list-style-type: none"> • Education • Preventive Health and Health Education • Health Care Services • Civic Participation |
| Vulnerable Youth Policies | <ul style="list-style-type: none"> • Child Welfare and Transition to Independence • Juvenile Justice • Career and Work Preparation • Runaway and Homeless Youth Services |
| Youth-focused Policies | <ul style="list-style-type: none"> • Youth Programming • Coordination of Youth Programs • Youth Representation on Boards and Committees |

Table C.5. Preliminary List of “Family Economic Success” Policies

| CLUSTER | POLICIES |
|---|---|
| Work Preparation | <ul style="list-style-type: none"> • Temporary Assistance for Needy Families (TANF) • Workforce Investment Act (WIA) |
| Work Attachment | <ul style="list-style-type: none"> • Health Insurance Coverage • Child Care Subsidies • Housing Location |
| Income Support Policy | <ul style="list-style-type: none"> • Income Tax Thresholds • Sales Tax • State Earned Income Tax Credits (EITC) • Housing Subsidies • Child Support • State-Enhanced Minimum Wage Policy • Food Security |
| Asset Development and Protection | <ul style="list-style-type: none"> • Homeownership • Asset Promotion • Anti-predatory Lending • Unemployment Insurance |
| Job Creation | <ul style="list-style-type: none"> • Public Sector Employment • Employer-based Wage Subsidies |

Table C.6. Preliminary List of “Educational Success” Policies

| CLUSTER | POLICIES |
|---------------------------------|--|
| Student Achievement | <ul style="list-style-type: none"> • Student Achievement Standards • Testing in Core Academic Subjects • School Choice • Graduation Requirements |
| Quality Schools | <ul style="list-style-type: none"> • Curriculum • Inclusion • Class and School Size • Results Accountability • Community Connections |
| Teacher Quality | <ul style="list-style-type: none"> • Teacher Education and Qualifications • Hiring Incentives and Compensation |
| Education Finance | <ul style="list-style-type: none"> • Elementary and Secondary Funding • Financial Aid for Post-secondary Education |
| Post-secondary Education | <ul style="list-style-type: none"> • Academic Supports • Diversity • Community College Offering Relevant Courses |

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