TAKE A STAND FOR CHILDREN AND CO-SPONSOR THE ALL HEALTHY CHILDREN ACT OF 2007

Dear Colleague:

More than 9 million children under the age of 19 in the United States have no health insurance. Every 46 seconds, another child is born uninsured in America. Almost 90% of these children live in households with working parents and more than half live in two-parent households. Many of these children are eligible for coverage under Medicaid and/or the State Children's Health Insurance Program (SCHIP) but are not enrolled due to eligibility requirements and enrollment barriers that make it difficult to obtain or keep coverage. Millions more children are underinsured or are at risk of losing coverage if their parents change jobs or more employers drop family coverage.

HR 1688, the "All Healthy Children Act of 2007" is a logical, smart and achievable incremental next step to close the child coverage gap and guarantee all children the health coverage they need to survive, thrive and learn. This proposal would blend and expand existing children's health insurance programs to make sure that all children, regardless of the state in which they live, have access to affordable, quality, comprehensive health coverage with simple enrollment rules.

Consolidation and Strengthening of Children's Health Coverage. Currently, two different programs cover uninsured children—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid guarantees comprehensive coverage to over 25 million children. SCHIP is a state block grant that provides coverage to 5 million children with benefits which vary by state and is not guaranteed. The "All Healthy Children Act of 2007" would consolidate the children's portion of Medicaid (Title XIX of the Social Security Act) and the SCHIP program (Title XXI of the Social Security Act) to create one new streamlined children's health insurance program building on the best successes and features of both. All eligible children would be guaranteed coverage and comprehensive benefits in the new program.

HR 1688 WOULD NOT ELIMINATE SCHIP AND MEDICAID. HR 1688 WOULD EXPAND THE COVERAGE OF BOTH PROGRAMS TO ENSURE THAT ALL CHILDREN ARE COVERED.

I have attached a section-by-section analysis of the bill as well as a two-page summary for your review. Should you have any questions or wish to sign-on as a co-sponsor, please contact Randi Estes-Petty at 202-225-8351 or by email at randi.estes-petty@mail.house.gov.

Very truly yours,

Robert C. "Bobby" Scott
Member of Congress

All Healthy Children Act of 2007
Section by Section
(March 26, 2007)

Section 1 – Short Title, Table of Contents, and Findings

Section 2 - Creation of New Title XXII of the Social Security Act as follows:

Section 2201. All Healthy Children Program.

Section 2201(a). In General. This section establishes a new State-operated program receiving Federal financial assistance to provide comprehensive health coverage for children and pregnant and post-partum women in place of benefits previously provided under Medicaid and SCHIP.

Section 2201(b). State All Healthy Children Plan Required. In order to receive funds, a State must have an approved state plan that meets the requirements of section 2202.

Section 2201(c). State and Individual Entitlement. This section provides that States are entitled to receive payments authorized under section 2204 and eligible individuals are entitled to the benefits authorized under the title.

Section 2201(d). Private Right of Action. This section provides that any person aggrieved by a violation of the title may bring a private right of action to protect their rights. "Aggrieved persons" are defined as individuals entitled to benefits under the program as well as providers or entities representing the interests of eligible individuals.

Section 2201(e). Effective Date. The effective date for the new program is October 1, 2008.

Section 2202. General Contents of State All Healthy Children Plan; Eligibility; Enrollment.

Section 2202(a). General Contents. The state plans are required to describe how the program will operate, including the methods of delivery of services, outreach and enrollment activities and methods of assuring the quality of care and access to all medically necessary health services.

Section 2202(b). Eligibility Standards and Methodology. All children under age 19 and pregnant and post-partum women whose family incomes do not exceed 300% of the federal poverty level, or FPL ($61,950 for a family of four in 2007) are eligible for benefits under the program along with other children currently eligible for Medicaid benefits, including former foster children through age 20 and certain children with special needs. In addition, individuals whose family income is over 300% FPL would be permitted to buy coverage under the program.

A three-month transitional eligibility is provided for families whose income rises above 300% of the FPL, with cost-sharing amounts to remain at the same levels as those prior to such transition.

Rules for determining income may not be more restrictive than those used in certain provisions of Title XIX. No asset or resource test for eligibility may be imposed.

Individuals are eligible for benefits if they are residents of the state, defined as present in the state with intent to remain and includes any individual who would be treated as such a resident under Medicaid. No citizenship or documentation requirements are permitted nor does receipt of coverage or services under this program constitute a public benefit within the meaning of the 1996 welfare law.

The Secretary is authorized to adjust income eligibility levels for the territories of the United States, taking into account factors such as average income, costs of living, and availability of health coverage.

Section 2202 (c). Enrollment. The state plan must provide a streamlined enrollment system incorporating the best practices and lessons from Medicaid and SCHIP. This would include a simple, short application form allowing self-attestation of eligibility; no asset or resource test; options for submitting applications in person, on-line, by mail or as part of an application for other federally-funded, means-tested programs; 12-month continuous eligibility periods; presumptive eligibility; and application assistance that is culturally and linguistically competent and accessible to those with limited ability to communicate. Automatic enrollment (no separate applications) would occur for children who have already applied or qualified for other means-tested programs including the National School Lunch Program, food stamps, WIC, and subsidized child care, unless the parent or guardian declined such coverage. Parents would be provided the opportunity to enroll their children in the program at other critical junctures such as birth, issuance of a Social Security card, school enrollment, or discharge of a child from a public facility, and would have the right to decline coverage. States would be required to develop information technology infrastructures needed for automated transmission of data to expedite enrollment and to ensure, after enrollment, that parents or guardians receive confirmation of coverage and benefits. The state plan shall ensure individuals covered through auto-enrollment do not receive fewer services than those enrolled through other means.

Section 2202(d). Avoiding Crowd-Out and Coordination with Other Health Coverage Programs. The state plan would be required to include a description of procedures, similar to those used under the current SCHIP program, to ensure that benefits provided under this program do not substitute for coverage under group health plans, except that no individual can be denied enrollment as a result of such policies if they were eligible for Medicaid under the state law in effect on October 1, 2005 or have an income below 150% of the FPL. Further, the state plan could not exclude individuals who had been without coverage for more than four months or lost coverage because of the death of a parent, a job loss, or other circumstances. Coverage cannot be denied because of the failure of a parent or other individual to enroll in an available group health plan.

In order to coordinate benefits with other available health coverage, the state plan must provide supplemental coverage in the case of children with disabilities as defined under SSI, who are enrolled in group health plans or individuals who would have qualified for such supplemental coverage under Medicaid prior to October 1, 2005. The state plan may provide such supplemental coverage to other eligible children who have group health insurance. The supplemental coverage includes benefits covered by the state plan that are not included in the

group health plan and reimbursement of premium and out of pocket costs payments for such coverage.

Section 2202(e) and (f). Assistance for Children Who Age Out of Assistance and Emergency Coverage. The state plan must also provide assistance in obtaining health coverage to individuals who lose eligibility because of age. Further, the state plan must provide immediate and automatic presumptive eligibility when an eligible individual enrolled in one state moves to another state because of a natural disaster or for other reasons.

Section 2203. Benefits; Premiums, Cost-Sharing, Provider Payment Rates.

Section 2203(a). Benefits. The program would cover all medically necessary services, including the early and periodic screening, diagnostic, and treatment services (including dental, vision, and mental health services) now covered under Medicaid but not currently required under the SCHIP program. The legislation creates an entitlement to these benefits and services, enforceable by eligible individuals and/or their representatives.

Section 2203(b). Premiums. No premiums are imposed for those with family incomes at or below 300% of the FPL; families over 300% of the FPL would be charged premiums at levels to cover the full, average per capita cost of the coverage, provided that premiums can not exceed 7.5% of the family income (or 15% in the case of multiple eligible individuals in the same family). However, these limits on premiums would not apply if the family failed to enroll in an available employer provided group health plan (or other sponsored plan) for which at least 50% of the premium was paid. States would also be permitted to reduce the level of premiums for reasonable classifications of eligible individuals, such as those with special health needs or who would have been eligible under an optional Medicaid category.

States are required to develop systems for collection of premiums that promote continuity of coverage, such as allowing premium payments to be made by credit or debit card, electronic fund transfers, or payroll withholding, or payment locations in the community, and provide reasonable opportunities to correct any default in premium payments.

Section 2203(c). Cost-Sharing. No out-of-pocket cost-sharing payments for services may be imposed for families with incomes at or below 200% of the FPL. Families with incomes between 201% and 300% of the FPL may be charged nominal out-of-pocket cost-sharing, and for those families with incomes over 300% of the FPL, out-of-pocket cost-sharing may not exceed levels consistent with charges under employer-based health insurance nationally. However, in no case may a child in a family whose income is at or below 300% of the FPL be denied services because of a failure to pay out-of-pocket costs.

Section 2203(d). Limitation on Out-of-Pocket Costs. The combined premiums and out-of-pocket costs must be kept to affordable levels, both for individual and total family costs, and in no case can they exceed the levels that would have been charged under state Medicaid or SCHIP law as of October 1, 2005, updated based upon changes in average earnings for families at or below 200% of the FPL. States may also waive these out-of-pocket cost-sharing payments.

Section 2203(e). Choice of Plans. To the extent feasible where benefits are provided through enrollment in a health plan, a state plan must provide enrollees a choice of at least two health plan options.

Section 2203(f). Reimbursement Rates. Payments rates shall be established by the states, in consultation with appropriate child health providers and experts, so that payment rates for providers are not less than 80% of the average payment rates for similar services under private health plans, at levels sufficient to ensure that enrollees have adequate access to all services covered under the program. Payments to capitated plans must be actuarially sound, based on comprehensive encounter data.

Section 2204. Payment to the States.

Section 2204(a) and (b). Payments and Computation of Federal All Healthy Children Matching Rate. States will receive federal payments for benefits under this program based upon a federal matching rate designed to provide funds sufficient to cover all additional required services and mandatory eligibility categories, subject to a state's continuing to pay a base amount based upon its 2006 child health expenditures, adjusted to account for changes in state child population and the medical care component of the consumer price index. The projected matching rate would require states to contribute above current level of adjusted expenditures for any optional coverage provided under the program. The Secretary is required to establish a formula for providing, in addition to the base federal matching amounts, automatic supplemental assistance to states that experienced a sustained economic downturn.

Section 2204(c). Bonus for Meeting Enrollment Targets. The Secretary is authorized to provide bonuses to states that meet or exceed enrollment targets established for each state.

Section 2204(d). Advance Payment; Retrospective Adjustment. The Secretary is authorized to make payments for each quarter on the basis of advance estimates of expenditures submitted by the states and may reduce or increase the payment as necessary to adjust for any overpayment or underpayment for prior quarters.

Section 2204(e). Treatment of Territories. The Secretary is required to establish, by regulation, an equitable formula for allocating funds to provide benefits to all eligible individuals residing in the territories of the United States.

Section 2205. Application of SCHIP, Medicaid and Related SSA Provisions; Waivers; Administration.

Section 2205(a). SCHIP Provisions Relating to Plan Submission, Strategic Objectives and Performance Goals and Audits. Except to the extent inconsistent with the provisions of this title, various provisions of SCHIP relating to state plans and goals are applicable to the new program.

Section 2205(b). Medicaid Provisions. Except to the extent inconsistent with the provisions of this title, various provisions of Medicaid and title XI of the Social Security Act, including section 1115, are applicable to this title.

Section 2205(c). Limitation on Waivers. The Secretary may, pursuant to section 1115, grant waivers to states with respect to this title, but no waivers can be granted that increase health care or health premiums costs or reduce benefits, eligibility, guaranteed eligibility, health care access, or health care quality.

Section 2205(d). Annual Reports. The Secretary is required to present annual reports to Congress describing the implementation of this title, including optional coverage chosen by the states, and nation-wide and state-specific data showing the number and characteristics of enrollees, services provided, categories and amounts of expenditures.

Section 2206. Definitions. This section defines, for the purposes of this title, various terms.

Section 2207. Effective Dates: Transitions.

Section 2207(a). Effective Date. Benefits and payments to states are available for services on or after October 1, 2008.

Section 2207(b). Transition Provisions. Any child under 19 years of age, any pregnant woman or any independent foster care adolescent who is enrolled in SCHIP or Medicaid on the day before the effective date of this title shall be automatically qualified for and enrolled in the state plan under this title.

Any adults enrolled in the SCHIP program through an existing program waiver shall be eligible for enrollment in the state Medicaid plan for the duration of the period for such program waiver, with the enhanced SCHIP federal matching rate to continue for that time.

The Secretary is required to provide guidance to the states in carrying out these transitions.

Section 2207(c). Medicaid and SCHIP Transition. Any individual eligible for this program after the effective date shall not be eligible for coverage under Medicaid or SCHIP, and no federal matching payments shall be made available under either program with respect to such individual.

Section 3. Commission on Children's Health Insurance.

A Commission on Children's Health Insurance is established, with members appointed by the majority and minority leaders of the House of Representatives and the Senate, the Secretary of Health and Human Services, the American Academy of Pediatrics, Institute of Medicine of the National Academies of Science, and two members appointed by the Secretary, one of whom shall be a representative of parents of children with special needs, and the other a representative of a children's advocacy group. Two non-voting members shall be appointed by the National Governors Association. Members shall be appointed for terms of two years, with vacancies filled in the same manner as the original appointment, and, with the exception of Federal officers or employees, shall be eligible for compensation at a per diem rate, including travel expense reimbursement.

The Secretary shall designate a Commission member as chair, and a supermajority (approval of at least six members) shall be required for commission actions. The commission shall have the power to hold hearings, acquire information from federal agencies, and hire staff. Funds for the operation of

the Commission shall be allocated by the Secretary from general operating funds of the Department of Health and Human Services.

The Commission shall be responsible for an annual report evaluating the status of children's health coverage in the United States, including evaluation of this program and recommendations for improvements at the state and national levels, and in the private sector to improve such coverage. Not later than three years after the date of enactment, the Commission shall submit a report to Congress containing a legislative proposal that would assure health benefits coverage for all children in the United States, that may include a requirement that parents obtain coverage for their children or that employers fund coverage for the children of their workers. The recommendations of the Commission shall receive expedited Congressional consideration, and the President may submit an alternative proposal that will receive expedited consideration.

SUMMARY OF *ALL* HEALTHY CHILDREN ACT
March 2007

Background and Purpose. **Nine million children under age 19 in the United States have no health insurance. Every 46 seconds, another child is born uninsured in America**. Almost 90% of these children live in households with working parents and more than half live in two-parent households. Many of these children are eligible for coverage under Medicaid and the State Children's Health Insurance Program (SCHIP) but are not enrolled in existing programs in large part because of different eligibility and enrollment barriers that make it difficult to obtain or keep coverage. Millions more children are underinsured or at risk of losing coverage if their parents change jobs or more employers drop family coverage.

The "*All* Healthy Children Act" is a logical, smart and achievable incremental next step to close the child health insurance gap and guarantee all children the health coverage they need to survive, thrive and learn. This bill would blend and expand existing children's health insurance programs to ensure that all children, regardless of the state in which they live, have quality comprehensive coverage with simple enrollment rules and retention processes.

Consolidation and Strengthening of Children's Health Coverage. Currently, two different programs cover uninsured children—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid guarantees comprehensive coverage to over 25 million children. SCHIP is a state block grant, which provides coverage to some 5 to 6 million children with benefits that vary by state and are not guaranteed. The "*All* Healthy Children Act" would consolidate the children's portion of Medicaid (Title XIX of the Social Security Act) and the SCHIP program (Title XXI of the Social Security Act) to create one new streamlined children's health insurance program building on the best successes and features of both existing programs. All eligible children would be guaranteed coverage and comprehensive benefits in the new program.

- **Administration.** This new program would be administered by the states with enhanced federal financial support for expansions and improvements to cover all children and ensure all an equal benefit package.

- **Eligibility**. The Act would establish national eligibility criteria to ensure all low- and moderate-income children access to coverage regardless of state of residence. Currently, wide differences in eligibility and benefits between states result in major inequities in access to care. **All children and pregnant women living in families with incomes at or below 300% of the federal poverty level ($61,950 for a family of four in 2007) would qualify for the new program**. Other children currently eligible for Medicaid under current law would also be eligible, including former foster children through age 20 and certain children with special needs.

  Families with incomes over 300% of the federal poverty level could buy coverage for their children through the program. States would have the option to subsidize some children who have particularly high health care costs or who live in areas with a high cost of living.

  Families who have employer-sponsored insurance could receive supplemental coverage under the program if their existing insurance does not provide full benefits for all the health and mental health services a child needs. As under current SCHIP law, states would be required to adopt policies to prevent the program from replacing employer-sponsored coverage.

- **Benefits.** The program would cover **all medically necessary health services**, including early periodic screening, diagnosis and treatment services now covered under Medicaid. Currently, not all SCHIP programs cover all necessary care. States would be required to offer a choice of health plan options where feasible.

- **Enrollment.** The bill would require the Secretary of Health and Human Services (HHS) to establish a streamlined enrollment system incorporating the best practices and lessons from Medicaid and SCHIP. This must include a simple, short application form allowing self-attestation of eligibility; no asset or resource test; options for submitting applications in person, on-line, by mail or as part of an application for other federally-funded, means-tested programs; 12-month continuous eligibility periods; presumptive eligibility; and application assistance that is culturally and linguistically competent and accessible to those with limited ability to communicate. No citizenship or legal residency documentation or test would be permitted. Automatic enrollment (without separate application and with the right of parents or guardian to decline coverage) would occur for children who have already applied or qualified for other means-tested programs including the National School Lunch Program, food stamps, WIC, and subsidized child care, as well as at other critical junctures in life such as birth, enrollment in school, and issuance of a Social Security card.

- **Cost-Sharing**. No premiums or co-payments could be charged to families with incomes at or below 200% of the federal poverty level (FPL), and no premiums would be charged for families between 201% and 300% of FPL. Nominal co-payments could be charged for families with incomes between 201% and 300% of the FPL. Families with incomes above 300% of FPL who buy-in to the program would pay both co-payments and premiums.

- **Federal Financial Contribution**. The federal government would establish matching payment rates at levels between current Medicaid and SCHIP payment rates sufficient to ensure coverage of all eligible children without imposing new costs on any state. States may receive additional federal payments if they exceed state-specific targets for covering uninsured children or if they encounter economic downturns.

- **Guaranteed Coverage.** Like Medicaid, the new program would guarantee coverage and matching federal dollars for all eligible children. In contrast, the current SCHIP program allows states to deny coverage to fully eligible children and places artificial caps on each state's federal funding based on complex statutory formulas rather than children's needs.

- **Provider Reimbursement Rates.** Inadequate provider reimbursement rates often make it difficult for parents to find health care providers willing to accept children with Medicaid or SCHIP coverage. Payment rates for providers will be not less than 80% of the average payment rates for similar services under private health plans, at levels sufficient to ensure that enrollees have adequate access to all services covered under the program.

- **Transition.** All children currently enrolled in Medicaid or SCHIP would automatically qualify for and be enrolled in the new program**.**

- **Commission on Children's Health Coverage.** A Commission on Children's Health Coverage would be established and directed to issue annual reports to Congress evaluating the status of children's health coverage and to make recommendations to Congress for policy improvements at the state and national levels and in the private sector. No later than three years after passage of this Act, the Commission would present Congress with proposed statutory changes that would result in comprehensive health coverage of all children based on gaps experienced under this proposal. These recommendations would receive rapid and privileged consideration in the U.S. House and Senate.

True Stories of Uninsured Children in America

Our children are dying because they cannot get the health coverage and medical services they critically need.

Devante Johnson. died at the age of 14.
Houston, Texas

Every day mattered for Devante Johnson. The 13-year-old from Houston had advanced cancer of the kidneys and until last year depended on Medicaid to cover the chemotherapy, radiation and constant monitoring he needed to survive. His mother knew she had a chronically ill chld, and so submitted his renewal two months before the deadline. When she did not hear anything back, she submitted two more complete renewal applications – one through the financial counselor at Texas Children's Hospital – and called and faxed information dozens of times to keep her son covered. But due to the bureaucracy of the renewal process, her paperwork was never processed and her son went without coverage for four full months last year. During this time, he depended on clinical trials for care and his tumors continued to grow. A state representative intervened to restore coverage but it was too late. On March 1, 2007, Devante Johnson died from complications of cancer. He was 14 years old.

Deamonte Driver, died at the age of 12.
Prince Georges County, Maryland

Deamonte Driver, a seventh grader in Prince George's County, Maryland, just outside of Washington, D.C., died because he did not have health insurance to cover an $80 tooth extraction. The inexcusable loss of this 12-year-old's life started when he complained of a toothache. His mother, Alyce Driver, who works at low-paying jobs, did not have employer health insurance and had been focused on finding a dentist not only for Deamonte but for her 10-year-old son as well, who was also having serious dental problems from six rotting teeth. At the same time, Ms. Driver was struggling with getting and maintaining health coverage for her two older sons, whose coverage was constantly being denied or dropped without notice. Ms. Driver took Deamonte to a hospital emergency room where he was given medicine for a headache, sinusitis and dental abscess and then sent home. But his condition soon took a turn for the worse, and he was back at the hospital being rushed to surgery where it was discovered that the bacteria from his abscessed tooth had spread to his brain. Heroic efforts were made to save him, including two operations and eight weeks of addiitonal care and therapy, totaling over $250,000. Unfortunately, it was all too late. Deamonte Driver died on February 25, 2007.

Families must continually re-apply for health coverage for which they are eligible, causing significant periods of time where children are forced to live without health coverage and services.

The Uhr Family – Robert, 10
Houston, Texas

Richard Uhr fought for a full year to get his grandson's SCHIP coverage renewed. Because his own son, his grandson's father, is deaf, he took on what he thought would be a relatively routine task. But it turned into a nightmare of lost information and frequent and conflicting requests for more information. Mr. Uhr received eighteen letters with incorrect names and case numbers requesting information he had already provided. He even went to Austin to testify about the difficulties he was having trying to renew his grandson's health coverage. Only after CDF intervened for him, did he finally receive an approval letter. He calls his SCHIP ordeal, "the worst fight I've ever been in."

Working families are unable to afford health coverage because eligibility levels for Medicaid and SCHIP in many states are simply too low and employer-provided or private insurance are too expensive.

The Cusic Family – Keyonna, 9, and Tracy, 3
Fayette, Mississippi

Mekeal Cusic, a recently divorced mother, said her two children were dropped from SCHIP in January because her annual salary exceeds the income eligibility level by $2,000. She applied for private coverage through Blue Cross Blue Shield (BCBS) and was approved for her 3-year-old but not for her 9-year-old. She suspects it is because her daughter suffered from irritable bowel syndrome over three years ago. When she asked why BCBS refused coverage for her older daughter, they told her it was because of "strict underwriting." So now the family is trying to get by with no health insurance, praying every day the children do not get sick.

The Harvey Family – Kyle, 9
Missouri City, Texas

Kyle has chronic asthma, migraine headaches and attention-deficit hyperactivity disorder (ADHD), but his mother, who is a small business owner, cannot afford to pay for private health coverage. She learned about SCHIP three years ago and enrolled Kyle, who was eligible. But before SCHIP, Kyle had no pediatrician and had to go to the emergency room when his asthma or migraines got bad. If a child with an asthma attack can see a doctor when the attack is still mild, he or she can be treated for about $100. But if he or she cannot get early treatment and has to go to the emergency room for treatment of full-blown symptoms, the child faces a three-day hospital stay that costs more the $7,300, according to the Harris County Hospital District.

Many children in the same family are not guaranteed the same medical services, forcing many children to go without the care they really need.

The Blackmon Family – Jeffrey, 12 and Vontirous, 3
Jackson, Mississippi

Ethel Blackmon is a single mother caring for her two boys, ages 12 and 3. Her older son, Jeffrey, suffers from major depression and Attention Deficit Hyperactivity Disorder (ADHD). Because he has been labeled disabled, he qualified for Medicaid. Her younger son suffers from severe asthma and is covered by SCHIP. Jeffrey's condition requires that he attend school in a controlled environment where there are doctors and counselors who can work with his aggression and constantly monitor his medication, but Medicaid recently cut him from this program.

Although Ethel works full-time, she earns only slightly more than $1,000 a month, and Jeffrey's situation has made it difficult for her to find constant supervision for him so she can continue to

go to work. She said that she is working with her SSI caseworker to get his coverage back but admits she has lost all hope in the Medicaid system.

Medical providers are far too often unwilling to take "Medicaid children" because reimbursement rates to the providers are so low.

The Bostic Family - Marihelen, 1; Elizabeth, 5; Michael, 10; Steffy, 17
Dublin, Ohio

Marc and Patti Bostic work hard to take care of their four children on their very limited income. The family had been seeing a physician they trusted and with whom they felt comfortable. But when they showed up one day for an appointment for routine shots for Elizabeth, they were told the doctor no longer provided medical services to those covered by Medicaid. It was explained to them that the reimbursement rates paid to the doctor for his services were meager compared to the rates he received from other insurers and programs.

Mr. and Mrs. Bostic also have had tremendous difficulty in getting prescriptions for their children. Elizabeth, who requires medication for her allergies; Michael, who needs medicine for ADHD and Tourette Syndrome; and Steffy, who requires medication to regulate her periods, all have had to go without the prescriptions that could significantly help or mitigate their conditions. This situation causes considerable frustration and stress for the Bostics who want to give their children the medical care they need but are unable to do so because of extremely limited access to qualified physicians who accept Medicaid patients.