Problem

- **Number of uninsured kids is high and growing**
  - 9.8 million uninsured children in 1995, up from 8.3 million in 1992
  - This compares to:

    7.0 million uninsured 45 to 64 year olds (including early retirees)

    7.5 million unemployed uninsured (not including dependents; not necessarily receiving UI)

- **Most uninsured kids come from working families**
  - 6.6 million of the 9.8 million uninsured children are in families above poverty

Uninsured ↑ 14.2% for children

- **Medicaid coverage of children is slowing**
  - No growth in enrollment of children between 1994 and 1995
  - Probably continued slow growth given welfare reform's effect on poverty-related covarege

Opportunity

Children in families 100-200% of poverty are losing most 2/3s above poverty

- Widespread support for kids
- Stronger safety net for kids in the wake of welfare reform
- Medicaid will be changed anyway next year

Constraints

- "New, entitlement" program
- Money
- Fear of employer dropping
- Conflict with Medicaid and state-initiated programs

Figure 2: The Percentage of Children and Adults With Private Insurance Declined Since 1987

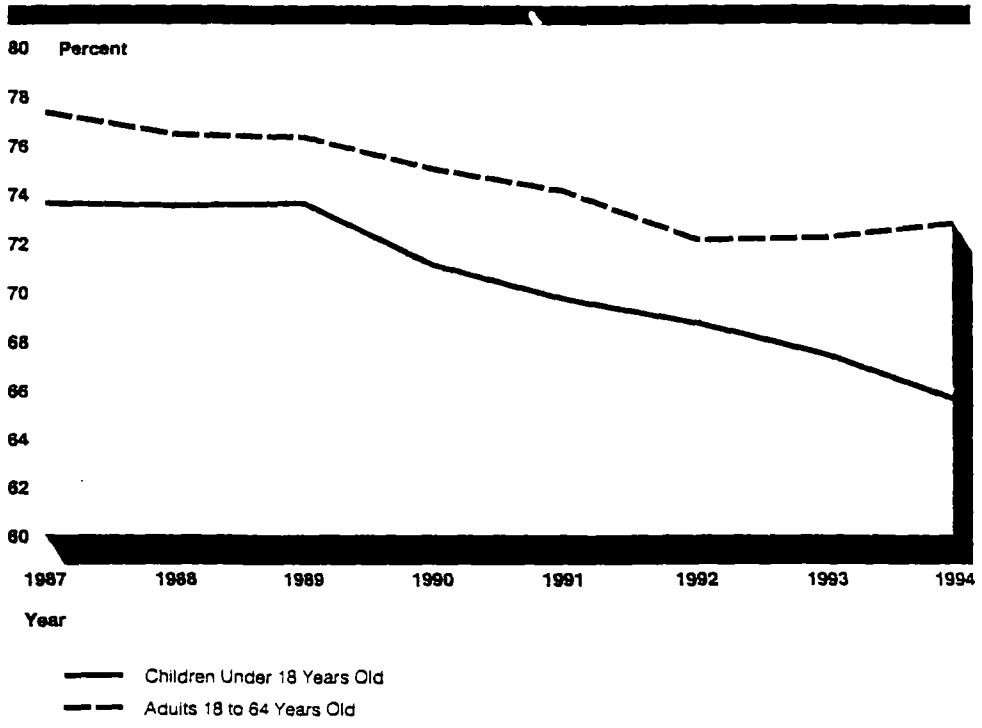
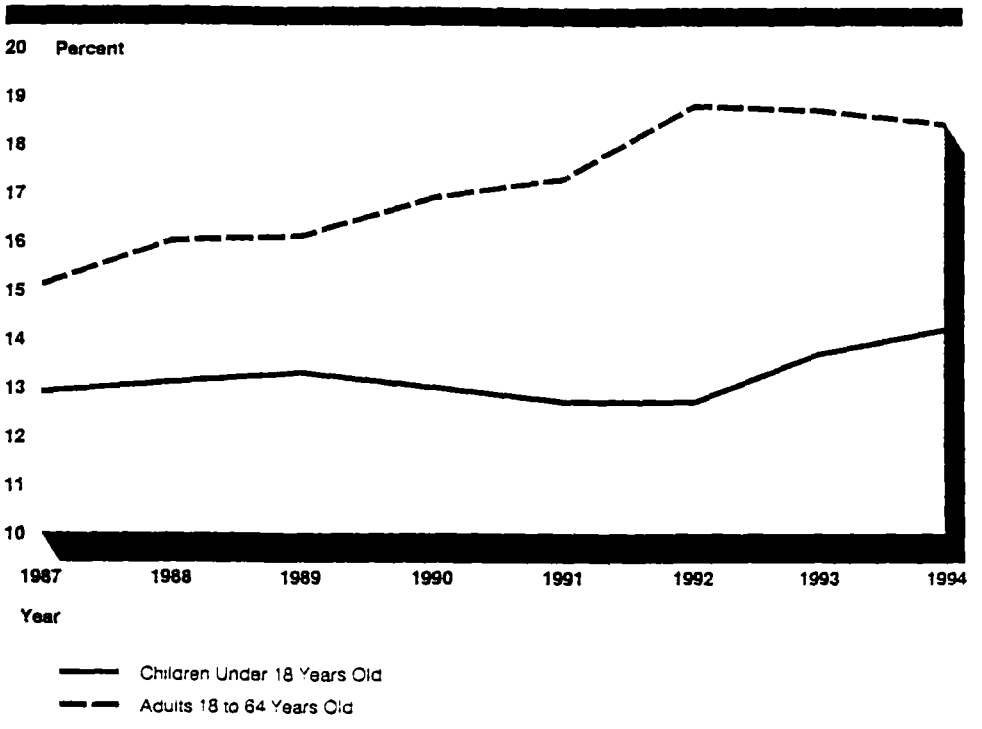


Figure 3: The Percentage of Uninsured Has Begun to Rise in the Last 2 Years for Children but Not Adults



Source: The Bureau of the Census.

Medicaid Recipients

Table I. Recipients by Category (in millions of people)

	1990	1991	1992	1993	1994	1995
Total	25.3	28.3	31.2	33.4	35.0	36.3
Aged	3.2	3.4	3.7	3.9	4.0	4.1
Blind and Disabled	3.7	4.1	4.5	5.0	5.5	5.9
Children	11.2	13.4	15.2	16.3	17.2	17.2
Adults	6.0	6.8	7.0	7.5	7.6	7.6
Others	1.1	.7	.7	.8	.8	1.5

Table I I. Growth

		1991	1992	1993	1994	1995
Total		12%	10%	7%	5%	4%
Aged		5%	12%	3%	5%	2%
Blind and Disabled		9%	10%	12%	8%	7%
Children		20%	12%	7%	6%	-.1%
Adults		13%	4%	7%	1%	.3%
Others		-41%	3%	13%	3%	96%

Parameters for options

- Incremental or demonstration
  - Phased in
  - Voluntary, not mandatory, for states and individuals
- Working family focus
  - Medicaid remains for sick and very poor children
- State-delivered
  - Builds on Medicaid and state-initiated programs
- Relatively inexpensive

Option 1: Medicaid-Based Program for Kids

- Create an option for states to participate in a kids' program in the per capita cap proposal
- National standards for eligibility, subsidies, and benefits
  - Only children in families with a worker are eligible
    - Medicaid continues for SSI or other Medicaid children with disabilities and for families without a worker / very low income
    - Excludes children who have had access to employer-sponsored insurance within the past 6 months
  - Uniform, national subsidy schedule
    - No premium for kids up to 133% of poverty (phased in at OBRA schedule for kids 13-18)
    - Sliding-scale premium for kids with incomes between 133% and 200% of poverty [upper limit depends on costs; could go to 250%]
  - Benefits equivalent of private plan [maybe FEHB BC BS] with preventive services and national cost sharing schedule for children above 133% [note: could work from Medicaid benefits; question about what to do with EPSDT]
  - Enrollment must be coordinated through schools
- States flexibility to:
  - Design delivery system with minimal Federal oversight
  - No explicit matching payments: must contribute as much as is needed to guarantee benefits to eligibles; may use private money and state money in current public-private partnerships
- Federal funding:
  - Same per capita payment per child as under per capita cap
  - For kids between 133 and 200 percent, the Federal per capita amount is scaled down at the same rate as the sliding-scale premium schedule.

Discussion of Option 1

- This option aims to ensure that, in the long run, a child may go from state to state and remain eligible for the same basic coverage.
- It trades national standards for state delivery.

Advantages:

- Avoids costs of state Medicaid buy-out; pays only Medicaid per capita (not 100% Federal subsidy)
- Moves toward a 100% Federal program if generous and states withdraw share
- Fixes Medicaid's instability for children (Chafee-Breaux welfare amendment) and simplifies eligibility
- May lessen the need for excessive Medicaid flexibility, since this program is flexible
- Not "Medicaid"; can be cast as not a welfare program

Disadvantages:

- If states that optionally cover children above 133% of poverty take the option, those children would face new cost sharing
- All states may not manage the program well, making the children coming from Medicaid worse off
- Benefits (EPSDT) limited

Option 2. State demonstrations

A. Mandatory program

- Direct HCFA Office of Research and Demonstrations to give preference to 1115 waivers that expand coverage to children
    - Allow states that agree to cover children at national eligibility and benefits standards to limit EPSDT and impose premium and cost sharing on new as well as old eligibles

B. Discretionary program

- Create discretionary program like the National Endowment for the Arts, with a budget at whatever can be afforded
- The endowment would take applications from states and fund private or public-private programs. They would approve only those programs that more toward the national eligibility and benefits standards.
- The endowment could also be responsible for long-term planning to more toward broader coverage of children

Medicaid: Why a per capita cap may be needed despite recent Medicaid spending slow-down

- May be last chance for a per capita cap
    - Increased flexibility means increased difficulty in implementing and enforcing a per capita cap
    - As more 1115s are approved, harder to override them with a per capita cap
    - Medicaid data problems are getting worse, and could make it impossible to do a per capita cap in a few years
- Not clear that slow growth will last
    - Flexibility could cost
    - If spending growth rises in the future and per capita cap is not viable, no alternative but a block grant
- Doing DSH alone may be impossible
- Only way to do a kids' expansion through Medicaid without block granting / "budget neutrality"

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: Jennifer Klein

FAX Number:

FROM: Jeanne

Pages:

Comments: (1) Why the old estimates of the Costs and coverage for kids need to be updated - IN MINNESOTA - WHICH IS MUCH MORE ANALOGOUS TO OUR OPTIONS THAN MEDICAID - ONLY 7% OF PARTICIPANTS PREVIOUSLY HAD INSURANCE, RELATIVE TO OUR ESTIMATE OF 50%

(2) KIDS + POVERTY, FYI

(3) SOMETIME, NOT URGENT, COULD YOU FAX OVER A COPY OF YESTERDAY'S SPEECH? I WANT TO SHARE IT W/ JUDY WHEN SHE GETS BACK - CONGRATULATIONS Again!

2233 Wisconsin Avenue, NW Suite 525 Washington DC 20007
202-687-0880 202-687-3110 *facsimile*

IS MINNESOTACARE HITTING ITS TARGET?

Nicole Lurie, MD, MSPH
Alfred Pheley, PhD
Michael Finch, PhD

Institute for Health Services Research
University of Minnesota School of Public Health
and
Hennepin County Medical Center

October 24, 1995

Executive Summary

This report was requested by the Minnesota Health Care Commission and the Minnesota Department of Health to determine:

1. Whether the state-subsidized MinnesotaCare program attracted the enrollees it intended to cover.
2. Whether enrollees had other options for getting health insurance.
3. Whether enrollees have adequate access to care through MinnesotaCare.
4. Whether MinnesotaCare has been of benefit to enrollees.
5. Whether the current premium subsidy structure is reasonable.

Findings

- When surveyed, 70% (n-546) were still on MinnesotaCare.
- Cost of the program was the major reason people applied (86%).
- Learning about the program was the major motivator for applying.
- Adverse selection of sick people into MinnesotaCare was not a major problem--82% enrolled when they were healthy and expected to remain so.
- Most people did not have other insurance options when they enrolled in MinnesotaCare. Over 88% reported no access to employment-based insurance. Most of those who had access to employment-based insurance couldn't afford it. Eight percent considered Medicaid to be their option.
- Most find MinnesotaCare affordable but say that other insurance options are not affordable. Most feel the premium is fair and the coverage meets their needs.

- Access to care through MinnesotaCare is excellent--91% report it is "very easy" or "somewhat easy" to receive care when they need it.
- Most are in better health because of MinnesotaCare and feel their health would suffer if the program were to end, and two-thirds of current enrollees would have to go without care they need. Many report they would spend down into Medicaid.
- A significant number of people make many transitions between Medicaid, MinnesotaCare, and being uninsured. Administrative solutions, such as locking people into enrollment for a fixed period of time, might save administrative costs.
- Most of those who would have difficulty affording other insurance if MinnesotaCare were to end have incomes less than 200% of the federal poverty limit.

Conclusions

MinnesotaCare seems to be hitting its target. There is little erosion from the private market, and the current premium structure is "reasonable." Most of those currently having difficulty affording the premium have incomes less than 200% of the poverty limit, so increasing the premium contribution for individuals below that level is probably unwise. Most people have benefitted from the program and their health would suffer if they no longer had access to it.

Table 5

EROSION FROM PRIVATE MARKET

% giving up "other insurance" to go on MinnesotaCare

(n = 781)

		OUR ESTIMATES
Private Market	**7.1%**	~ 50%
-- employment-based	**2.8%**	
-- self-insured	**4.2%**	
Public Programs	**5.7%**	~ 15%
-- medical assistance	**4.7%**	
-- other	**< 1%**	

UNITED STATES DEPARTMENT OF COMMERCE

NEWS

Economic & Statistics Administration

U.S. Census Bureau The Official Statistics

EMBARGOED UNTIL: 10 A.M. EDT, AUGUST 19, 1996 (MONDAY)
Please note our new policy:
NO BROADCAST OR PRINT BEFORE 10 A.M. EDT

Public Information Office
301-457-3030/301-457-3670 (fax)
301-457-4067 (TDD)
e-mail: pio@census.gov

T. J. Eller
Kathleen Short
301-763-8579

CB96-135

ALMOST ONE-HALF OF THE NATION'S CHRONICALLY POOR ARE CHILDREN, CENSUS BUREAU REPORTS

Children made up almost half (48 percent) of the chronically poor during 1992 and 1993, the Commerce Department's Census Bureau said today. Over the same period, the elderly accounted for 11 percent of the chronically poor. Chronic (or long-term) poverty refers to a situation in which families stayed below the poverty cutoff every month during 1992 and 1993.

Poverty in the U.S. is based on a familyþs income compared to the familyþs poverty threshold, that is determined by the size of the family, the number of children, and the age of the householder. For example, the average poverty threshold in 1993 for a family of four was $14,763.

These findings were published in Dynamics of Economic Well-Being: Poverty, 1992-1993, Who Stays Poor? Who Doesnþt?, P70-55, a report based on the Survey of Income and Program Participation (SIPP). The SIPP is a continuing monthly survey of approximately 20,000 households across the country. The survey makes it possible to measure movement into and out of poverty and to distinguish between short-term and long-term poverty. The SIPP also measures participation in government-assistance programs, as well as economic well-being.

The report shows that children (persons under 18) were more likely than non-elderly adults (persons 18 to 64) to remain poor over a two-year period. According to author T. J. Eller, The differences in chronic poverty are striking. Eight percent of

children versus 3 percent of non-elderly adults were poor in all 24 months of 1992 and 1993. About 5 percent of the elderly population (persons 65 and over) were chronically poor during the same period.

Other findings from the report include:

- About 5 percent of the nationps population, or 12 million people, were chronically poor in 1992 and 1993.

- Based on annual estimates, about 22 percent of people who were poor in 1992 were not poor in 1993. People in married-couple families were more likely to exit poverty (29 percent) than people in other types of families (12 percent).

- Half of poverty spells lasted 4.9 months or longer. (Poverty spells are defined as two or more consecutive months below the poverty line.)

- Half of poverty spells experienced by African Americans lasted 6.2 months or longer, compared to 4.6 months or longer for Whites.

The data presented here were collected in a sample survey, and are therefore subject to sampling variability as well as reporting and coverage errors.

-X-

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Jack

To: Chris
Cea

Phone: (202) 690- _____
(202) 690-6870
FAX: (202) 401-7321

Phone: _____

Fax: _____

Number of Pages (Including Cover): _____

Comments: These are the drafts we circulated. There is a conf. call today to clear so we can send something to Andi, I hope

Jack

DRAFT

Summary of Cost Estimates of Child Only Health Insurance Proposals - Revised

Fall '94 Proposal (Scenario 1)
- Full subsidy < 133% poverty
- Sliding subsidy from 133% - 250% poverty
- No subsidy for >= 250% poverty

Democratic Leadership Proposals:
Low subsidy (Scenario 2)
- 25% subsidy up to 250% poverty, 10% subsidy thereafter
- no maximum income level

High subsidy (Scenario 3)
- 50% subsidy up to 250% poverty, 25% subsidy thereafter
- no maximum income level

Preliminary estimates from ARC (8/14) for the Democratic Leadership Proposals show the following:
Total take-up is estimated to range from 2 million to 6 million children, with an average cost per child of $1800-$2700 including the effects of adverse selection. Total program costs range from $4-11 billion. *(GH: 7-17 million children; $1400-$1900 per child; total program costs $13-25 billion)*

The Federal share of the program cost is estimated to range from $1-5 billion. *(GH: $2-10 billion)*

The number of previously uninsured children estimated to be drawn into these programs ranges from 0.2 million to 2 million, resulting in 10-30% of the participant population being made up of the target group (those without insurance prior to the program). *(GH: 0.1-2 million previously uninsured children; 2-15% of participant population)*

The remaining 70-90% of the participant population are those which were insured previously (other private, ESI - self-employed, ESI, and Medicaid) but were drawn into the program either by the subsidy level or by changes in employer behavior (the substitution effect).

Those with Medicaid are assumed to substitute into this program if they are above the federal floor for Medicaid and if the subsidy is 100% (therefore occurs only in the Fall '94 proposal).

The effects of adverse selection, modeled for the uninsured receiving partial subsidies, were estimated to increase total program costs by 20-60%. The selection impact is greatest when the subsidies are lower making the total takeup smaller. *(GH: selection impact is 10% to 20%)*

Each of these proposals replaces current coverage more than newly covering the uninsured. This substitution effect varies slightly with the level of subsidy over the ranges given above.

Summary of Participation Assumptions for the Kids Coverage Cost Estimate Model

1. The Self-Employed

ARC: If subsidy >= 28%, then 90% participation (=.80*35%)

GH: If subsidy >= 6.75%, then 90% participation (=.45*15%) -- 100% participation was run to produce a conservative estimate

GH Reason: .45 is the deduction rate for years 1998-2002 (.80 is phased in later); 15% marginal tax rate is more applicable to the low-income population.

2. Other Private (non-employer sponsored)

ARC: If subsidy >=20%, then 80% participation

GH: If subsidy >10%, then 90% participation -- 100% participation was run to produce a conservative estimate

GH Reason: More people will take advantage of this offer if it is implemented through the tax system.

3. Uninsured

ARC: Scenario 2 (25/10) participation equals 2/3 of Scenario 3 (50/25) participation

	Scenario 2:	Scenario 3:
For Case A:	20%/10%	30%/15%
For Case B:	10%/5%	15%/7.5%
For Case C:	5%/2.5%	7.5%/3.75%

GH: Scenario 2 participation should equal 1/3 of Scenario 3 participation (across all cases).

GH Reason: Few uninsured people will be attracted by the low subsidy of Scenario 2 -- moving from Scenario 2 to 3 (low to high subsidy) should make a bigger difference.

4. Employer Insurance (ESI)

ARC: Scenario 2 or 3	50% (Cases A/B/C)	0% (Cases A/B/C)
% participation for those <200%	10%/5%/2.5%	5%/2.5%/1.25%
GH -- Scenario 2 (all cases)	14%	4%
Scenario 3 (all cases)	50%	14%
(up to 250% poverty; less thereafter)		

GH Reason: Employers are looking for ways to save money and will change their behavior more dramatically if they are given the "moral out" of knowing that their employees will be able to take advantage of this other program. ARC believes that employer behavior will not change as radically -- at least not as a result of this kids only program.

Democratic Leadership Proposals -- Summary Cost Estimates

Estimates Shown for Medium Participation Assumption (Case B)

					Participants - Coverage Prior to Program							Financing		
Low Subsidy Scenario 2		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
50% Emp Contrib	ARC Assump	$2400	2.4 m	23%	0.4 m	0.1 m	1.2 m	0.1 m	0.00	0.5 m	0.00	$5.7 B	$1.4 B	62%
	GH Assump	$1800	8.6 m	3%	0.2 m	0.04 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$15.0 B	$2.6 B	13%
0% Emp Contrib	ARC Assump	$2300	2.0 m	22%	0.4m	0.02 m	1.2 m	0.1 m	0.00	0.3 m	0.00	$4.7 B	$1.2 B	51%
	GH Assump	$1900	7.1 m	3%	0.2 m	0.009 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$13.4 B	$2.2 B	15%

					Participants - Coverage Prior to Program							Financing		
High Subsidy Scenario 3		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
50% Emp Contrib	ARC Assump	$2000	4.7 m	20%	0.7 m	0.2 m	2.6 m	0.1 m	0.00	0.5 m	0.6 m	$9.7 B	$4.1 B	28%
	GH Assump	$1500	16.3 m	6%	0.7 m	0.2 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$24.0 B	$9.7 B	10%
0% Emp Contrib	ARC Assump	$2200	4.3 m	18%	0.7 m	0.03 m	2.6 m	0.1 m	0.00	0.2 m	0.6 m	$9.4 B	$3.9 B	33%
	GH Assump	$1800	9.4 m	8%	0.7 m	0.03 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$16.7 B	$6.3 B	16%

Democratic Leadership Proposals -- Cost Estimates

Scenario 2 (Low Subsidy): 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above

50% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 2		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$2100	3.6 m	33%	0.9 m	0.3 m	1.2 m	0.1 m	0.00	1.1 m	0.00	$7.4 B	$1.8 B	50%
	B	$2400	2.4 m	23%	0.4 m	0.1 m	1.2 m	0.1 m	0.00	0.5 m	0.00	$5.7 B	$1.4 B	62%
	C	$2500	1.9 m	14%	0.2 m	0.04 m	1.2 m	0.1 m	0.00	0.3 m	0.00	$4.6 B	$1.1 B	59%
GH Assump	A	$1800	8.8 m	6%	0.4 m	0.1 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$15.8 B	$2.8 B	16%
	B	$1800	8.6 m	3%	0.2 m	0.04 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$15.0 B	$2.6 B	13%
	C	$1700	8.4 m	2%	0.1 m	0.03 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$14.5 B	$2.6 B	11%

Scenario 3 (High Subsidy): 50% Subsidy up to 250% Poverty, 25% Subsidy for 250% Poverty and Above

50% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 3		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$1800	6.2 m	30%	1.4 m	0.4 m	2.6 m	0.1 m	0.00	1.0 m	0.6 m	$11.2 B	$4.9 B	20%
	B	$2000	4.7 m	20%	0.7 m	0.2 m	2.6 m	0.1 m	0.00	0.5 m	0.6 m	$9.7 B	$4.1 B	28%
	C	$2100	4.0 m	13%	0.4 m	0.1 m	2.6 m	0.1 m	0.00	0.2 m	0.6 m	$8.5 B	$3.5 B	27%
GH Assump	A	$1400	17.2 m	11%	1.4 m	0.4 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$24.9 B	$10.2 B	8%
	B	$1500	16.3 m	6%	0.7 m	0.2 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$24.0 B	$9.7 B	10%
	C	$1400	15.5 m	3%	0.4 m	0.1 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$23.1 B	$9.3 B	8%

Scenario 2 (Low Subsidy): 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above

0% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 2		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$2200	2.8 m	33%	0.9 m	0.02 m	1.2 m	0.1 m	0.00	0.5 m	0.00	$6.2 B	$1.5 B	55%
	B	$2300	2.0 m	22%	0.4m	0.02 m	1.2 m	0.1 m	0.00	0.3 m	0.00	$4.7 B	$1.2 B	51%
	C	$2700	1.7 m	14%	0.2 m	0.008 m	1.2 m	0.1 m	0.00	0.1 m	0.00	$4.4 B	$1.1 B	65%
GH Assump	A	$1800	7.1 m	6%	0.4 m	0.02 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$13.4 B	$2.2 B	15%
	B	$1900	7.1 m	3%	0.2 m	0.009 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$13.4 B	$2.2 B	15%
	C	$1800	6.9 m	2%	0.1 m	0.005 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$12.9 B	$2.1 B	12%

Scenario 3 (High Subsidy): 50% Subsidy up to 250% Poverty, 25% Subsidy for 250% Poverty and Above

0% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 3		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$2000	5.3 m	29%	1.4 m	0.05 m	2.6 m	0.1 m	0.00	0.5 m	0.6 m	$10.5 B	$4.5 B	27%
	B	$2200	4.3 m	18%	0.7 m	0.03 m	2.6 m	0.1 m	0.00	0.2 m	0.6 m	$9.4 B	$3.9 B	33%
	C	$2200	3.8 m	11%	0.4 m	0.03 m	2.6 m	0.1 m	0.00	0.1 m	0.6 m	$8.4 B	$3.4 B	28%
GH Assump	A	$1700	10.1 m	55%	1.4 m	0.05 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$17.4 B	$6.7 B	15%
	B	$1800	9.4 m	38%	0.7 m	0.03 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$16.7 B	$6.3 B	16%
	C	$1700	9.0 m	35%	0.4 m	0.03 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$15.7 B	$5.9 B	13%

M E M O R A N D U M

DATE: August 17, 1996

TO: Jennifer Klein

C.C. Chris Jennings

FROM: Stan Dorn, Gregg Haifley

RE: Children's coverage

A few weeks ago, Gregg spoke with you about a possible children's health coverage initiative. Issues were raised about costs, and we thought you might find the attached piece helpful. It discusses possible approaches to certain key cost issues -- the possibility that, in response to new public subsidies for children's health coverage, states might drop optional Medicaid coverage of pregnant women and children, and employers might drop coverage for children.

One other thought we've had about cost is that new children's subsidies could be phased in to parallel the age-based expansion of guaranteed Medicaid coverage. In other words, subsidies could be limited to children born after September 30, 1983 who are ineligible for Medicaid. Medicaid, not the new subsidy system, would cover children in poverty. Not only could this lower the cost of a new subsidy program, it would allow the argument that the children who need help are not poor children thankfully covered by Medicaid, but rather are children of working, middle-class parents, increasingly left behind by changes in the global economy, who need some assistance to provide their own children with health care.

We've also attached some interesting polling data from Kaiser, on the off chance that you haven't had a chance to look at their recent report closely.

Appendix B

CONTROLLING COSTS BY PREVENTING COST-SHIFTS FROM CURRENT PURCHASERS OF CARE

Any system that increases health coverage for children should avoid excessive costs by discouraging current purchasers of care from dropping their coverage and shifting costs into the new system. Scarce public dollars should help additional children, not substitute for current spending on children.

Two groups of current purchasers of care are potentially at issue. The first group would matter only to a new federal system for helping children. The second group would be important in the design of either federal or state programs.

- **States should be discouraged from dropping Medicaid coverage for children and pregnant women.** Many states provide Medicaid coverage to optional groups of children and pregnant women--groups the states are not required by federal law to cover. If a new, federal system covers children and pregnant women, some states may cut back their optional Medicaid coverage, shifting costs onto the new, federal system.

  The simplest way to avoid this problem is a maintenance of effort requirement -- that is, states wishing to participate in the new system could be forbidden from cutting back their Medicaid coverage. Such a measure is far from unprecedented. For example, when Congress expanded guaranteed Medicaid coverage for pregnant women in 1989, states were forbidden from cutting back their previous, optional coverage. Similarly, when Congress extended cash assistance to the elderly, blind and disabled through SSI, states were forbidden from cutting back their previous efforts to provide cash assistance to those same populations.

  Although maintenance of effort requirements are familiar, some state officials may complain that they should not be held to a higher standard because they previously helped more children than was required. To some extent, better-off states have been providing more optional coverage, and can afford to be held to a higher standard. But one way to respond to such state concerns without opening the door to a large cost-shift from Medicaid to a new federal program for children would be to keep current law Medicaid coverage in place but provide an increased federal match for Medicaid coverage of children and pregnant women that exceeds minimum, federal standards. States that have treated children well would be rewarded with increased federal assistance, but federal costs could be kept at a level far lower than would result from states' wholesale abandonment of optional Medicaid coverage for children and pregnant women.

- **Employers should be discouraged from dropping their coverage of children.** Some academics have claimed that increased coverage of children and pregnant women, through Medicaid or otherwise, "crowds out" health coverage offered by

employers. The contention is that, if Medicaid or other public coverage is available, workers ask their employers for pay hikes funded by eliminating employer-funded health coverage during pregnancy and health coverage for workers' children. The significance of this "crowd-out" or "employer substitution" effect is much dispute and has been the subject of several studies in recent years, with more forthcoming.

This issue arose during the health care reform debate in the 103rd Congress. The bill reported out by the Senate Finance Committee provided subsidies for families' health insurance. The bill reduced subsidies, dollar for dollar, based on employer contributions to health premiums. The bill also prohibited companies that do not self-insure from providing more generous health coverage to lower-wage workers, potentially eligible for subsidies, than to higher-income employees ineligible for subsidies. Current law already prohibits such discrimination by companies that self-insure.

The Congressional Budget Office ("CBO") found that the "crowd-out" costs would be very moderate. It analyzed this proposal as follows:

> "Some low-income workers could gain thousands of dollars in higher wages by moving to firms that did not contribute to employee health insurance... That process would occur gradually as employment expanded in some firms and contracted in others. In the CBO estimate, this reallocation of low-wage workers among firms accounts for $12.6 billion [i.e., would **increase total subsidy costs by 8.5%**] of the cost of the subsidies in 2004 [the ninth year of the program]."
>
> "In addition, some companies might stop paying for insurance, but the effect of that action on the government's costs would probably not be large, for several reasons. For one thing, the number of firms that would be likely to stop paying is limited because, if firms did so, high-wage workers in those firms would lose the tax benefits of excluding health insurance from the payroll tax. Moreover, the net additional subsidy cost to the government... would be largely offset by higher tax revenues from the workers because... wages would be higher."[1]

CBO took a similar view in its analysis of Majority Leader Mitchell's bill, finding that movement of employees to firms not paying for health coverage **could increase total premium subsidy costs by 8.8%** in 2004.[2] It is unknown why

---

[1] CBO, A Preliminary Analysis of the Health Security Act as Reported by the Senate Committee on Finance (July 28, 1994) pp. 11-12; Table 1.

[2] A Preliminary Analysis of Senator Mitchell's Health Proposal (Aug. 9, 1994) pp. 15, Table 1.

this figure was minimally higher for the Mitchell proposal than for the Finance Committee proposal.

Based on this analysis, a similar policy applied to children's health care -- an extension of the existing prohibition against discrimination on the basis of income, coupled with a reduction of government assistance based on the availability of help from the employer -- likely would increase total costs by less than 4.3%, or half the average of the CBO cost-estimates from the Finance Committee and Mitchell proposals. A children's health program would offer a much lower amount of assistance to a worker, hence a much reduced potential salary advantage from changing jobs.

In fact, this 4.3% figure overstates the likely costs, in several ways. First, actuaries estimate that children's health coverage averages 50% of the cost of coverage for a single, working adult. This is considerably less than 50% of the cost of family coverage, and family subsidies were a major part of the Mitchell and Finance Committee bills. Second, the analysis assumes that workers' willingness to change jobs decreases 50% as the potential salary benefit drops by 50% or more. In fact, such reduced willingness to change jobs probably would be greater, given the inconvenience and risk of changing employment. Finally, CBO assumed only a gradual cost effect, reaching a peak of roughly 8.5% after nine years.

The policy evaluated by CBO becomes particularly appealing when the alternatives are considered. On the one hand, employers could be required to cover children or to maintain current spending for children's health care. Such approaches could be difficult to enforce and likely would create enormous opposition. On the other hand, some have proposed that children without health coverage could be denied assistance and remain without health care for four months or more, thereby eliminating any supposed incentive for employees to request a reduction in their children's health coverage. Some have even proposed that if employers have ever offered health coverage for children, even if they did not offer to pay for it, children should be barred from health coverage under a new system. There is no need to go to such extremes that would deny children the health care they need. A far more moderate and reasonable policy has already received a favorable score from CBO.

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER-HARVARD PROGRAM ON
THE PUBLIC AND HEALTH/SOCIAL POLICY

Survey of Americans on Health Policy

Questionnaire and National Toplines
July 30, 1996

A JOINT PROGRAM OF THE HENRY J. KAISER FAMILY FOUNDATION AND HARVARD UNIVERSITY

KAISER FAMILY FOUNDATION: 2400 SAND HILL ROAD, MENLO PARK, CA 94025 415 854-9400 FAX 415 854-4800
HARVARD SCHOOL OF PUBLIC HEALTH: 677 HUNTINGTON AVENUE, BOSTON, MA 02115 617 432-4502 FAX 617 432-0092

26. For which ONE of the following groups, if any, do you think we should try to provide health insurance coverage first? (READ AND ROTATE ITEMS 1-4)

Total	Republicans	Democrats	Independents	
48%	53%	45%	46%	Children
22	21	22	23	Working people who are currently uninsured
15	13	16	15	All low-income people
10	9	10	11	People who need long-term care
4	2	6	4	Don't know
1	1	1	1	Other (VOL.)
*	1	*	*	None (VOL.)
*	*	*	*	Refused

27. Would you be willing to pay more--either in higher health insurance premiums or higher taxes--in order to guarantee health insurance coverage for all Americans, or not?

Total	Republicans	Democrats	Independents	
60%	46%	72%	63%	Yes, willing
36	49	26	35	No, not willing
3	5	2	1	Don't know
1	*	*	1	Refused

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: ....JENNIFER KLEIN.....

FAX Number: .....

FROM: ....Jeanne.....

Pages:

Comments: ATTACHED IS (1) LATEST THOUGHTS
(2) OLD ESTIMATES.

THE MAJOR DIFFERENCES B/W THIS OPTION + THE OLD PROGRAM ARE:

(1) MEDICAID INTERACTION - I THINK IT'S PROBABLY IMPOSIBLE TO TRULY WEAN OFF MEDICAID, ESPECIALLY BECAUSE STATES HAVE TO ADMINISTER THE PROGRAM. USING THE MCO PER CAPITA COULD HELP

(2) DIFFENTIATING KIDS IN WORKING FAMILIES. IT'S KIND OF UGLY, BUT MAY HELP W/ COSTS (ADVERSE SELECTION) AS WELL AS POLITICS.

WE'LL CATCH UP NEXT WEEK. AND, CONGRATULATIONS AGAIN ON YOUR HEALTH CARE SUCCESSES!

2233 Wisconsin Avenue, NW Suite 525 Washington DC 20007
202-687-0880 202-687-3110 *facsimile*

Parameters for Kids' Program

The following is a list of the assumptions that have a strong influence on how a kids' program is structured. Different assumptions would lead to different options.

1. **Goal is to extend health insurance coverage**

- While this may seem obvious, there are other, maybe more efficient ways to improve kids' health (e.g., increased state block grants for maternal and child health; increase community-health center funding; target DSH payments to hospitals serving high numbers of uninsured children). It also precludes policies like tax credits which would likely have a very small impact on the number of uninsured. ?

2. **Incremental:** Given recent experience, the proposal should be:

- Optional: No mandates for individuals or states
- Targeted toward the working poor
- Private, managed-care oriented
- Phased in

3. **Administered through States, in tandem with Medicaid** Why ?

- Uses system already in place: States' health and human services divisions are the only currently-running organizations that conduct income determination in all areas.
- Helps move toward a poverty-based eligibility determination for Medicaid.
- Minimizes financial and programmatic conflicts between Medicaid and the new program.
- Allows the use of Medicaid funding (for approximately one-third of Medicaid kids in working families being transferred to the new program).

Problems:

- Moves away from a fully Federal program. While this adds uniformity of eligibility and benefits, it allows variation in how kids are covered. Once the States are given a greater role, it will be even harder to replace them with a full Federal program.
- Difficult to monitor and enforce. The problems experienced in Medicaid will also be experienced in this program, maybe exaggerated given limited Title XIX-like protections.
- For some States, eligibility for full subsidies is lower than in current Medicaid.
- As for any kids' program, the targeting of the uninsured is not efficient. ?

Kids' Program: State Choice

How it would work

- States have the option to participate in a Federally-defined kids' program distinct from Medicaid.
  - The Federal government sets parameters for eligibility, benefits and enforcement, and contributes toward the cost of coverage.
  - States who opt to participate design the way that kids are covered. They may use their State employee system, private purchasing cooperatives, school-based programs, or any other vehicle that suits their circumstances.

Eligibility

- Low-income children in families with a worker:
  - No premium for kids up to 133% of poverty
  - Sliding-scale premium for kids with incomes between 133% and 200% [upper limit depending on costs]

- Phase-in:
  - For children currently 6 and 13 years up to 133% PL: Immediately [could phase in with the 6 year olds, one year at a time if too costly]
  - For children currently 13 to 18: OBRA schedule up to 133% PL
  - For buy in (sliding-scale premium): Immediately

- Exclusions (note: Medicaid eligibility is virtually unchanged):
  - Children eligible for Medicaid through SSI or institutionalization
  - Children eligible through OBRA '90 in families without a worker
  - Children who have had employer-sponsored insurance within the past 6 months

Benefits

- FEHBP Blue Cross / Blue Shield; Federal standards for cost sharing

Funding

- States get the child per capita limit (Federal spending per child in 1995, inflated by the per capita cap index) for enrolled kids below 133 percent of poverty. This means that there is the same Federal payment for kids in either Medicaid or the new program. For kids between 133 and 200 percent, the Federal per capita amount is scaled down at the same rate as the sliding-scale premium schedule.

- States would make whatever financial contribution is necessary to meet Federal guidelines for guaranteeing accessible, affordable coverage for the specified children.

- Federal costs: Somewhat less than the Fall 1994 option, given (a) Federal costs per child based on Federal Medicaid per capita, not premium; (b) Medicaid offset.

Supporting Facts

Nation

- Medicaid is a major source of coverage for poor children, but its coverage declines dramatically for children in families above the poverty threshold.

- Only about one-quarter of uninsured kids are poor; 30 percent have income between 100 and 185 percent of poverty. About 15 percent of kids with employer-sponsored insurance are in this income bracket.

Children's Health Coverage, 1993

Poverty Level	Employer-Based	Medicaid & Other	Uninsured	TOTAL
< 100%	1.0	13.5	2.4	**16.9**
100 to 133%	1.2	2.2	1.1	**4.6**
134 to 185%	3.5	1.8	1.7	**7.1**
185 to 299%	10.7	1.9	2.2	**14.8**
300% and over	21.5	1.9	1.9	**25.3**
TOTAL	**37.8**	**21.4**	**9.3**	**68.6**

Source: The Urban Institute, March 1994 CPS adjusted using TRIM2

- Children in working families are more likely to be uninsured than children with unemployed parents.

    - Nearly 90 percent of uninsured children lived in a family with at least one worker (GAO, 1995).

    - About 12 percent of children with a parent working full-time and 21.7 percent of children with a parent working part-time were uninsured in 1994. This compares to 14.6 percent of children in unemployed families (GAO, 1996).

States

- States have already demonstrated a commitment to children and have developed innovative approaches to expanding coverage.

    - Fully half of all States have used the Medicaid options to expand coverage to children beyond mandatory levels (GAO, 1996).

    - Over 30 states have either a supplemental public or a public / private partnership program for health coverage for children (NGA, 1995).

6/3/95

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1995-2000	Total 1995-2002	Total 1995-2005
OUTLAYS														
Kids' Program (1,2)														
Free to 133%, Phase-Out to 240%	0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	34.8	56.7
Temporarily Unemployed Program (2,3)	0.0	0.0	1.5	2.2	2.3	2.5	2.8	3.0	3.3	3.5	3.8	8.6	14.3	25.0
Limit to those who formerly had insurance														
Public Health/ FQHC	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	1.5	2.0
Long Term Care Program														
Expand Home & Community Based Services	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	9.7	15.4
REVENUES (4)														
Program Revenue Offsets (6)	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	1.2	2.0
Self-Employed Deduction														
100% Deduction Phased In (5)	-0.5	-0.5	-0.9	-1.4	-2.0	-2.2	-2.4	-2.7	-3.0	-3.2	-3.5	-7.5	-12.6	-22.3
Long Term Care														
Long-Term Care Insurance Tax Incentives	0.0	-0.2	-0.4	-0.5	-0.6	-0.8	-0.9	-1.0	-1.1	-1.2	-1.4	-2.5	-4.3	-8.0
Personal Assistance Services Tax Credit	0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4	-0.7	-1.2

Note: Administrative costs are not included in these estimates; ASSUME NO INTERACTION BETWEEN KIDS' AND TU PROGRAM (STAND-ALONE ESTIMATES)

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

(3) Assumes that unemployment compensation is included in income determinations.

(4) These estimates are effects on revenue, not outlays. Thus, the negative numbers indicate decreases in revenue. Prepared by Treasury.

(5) Phase in: 25% in 1994, 25% in 1995, 50% in 1996, and 75% in 1997 and 100% in 1998. Assumes the self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

(6) Does not include the revenue offsets from the temporarily unemployed program.

DRAFT

Coverage of Uninsured Children Under Medicaid Expansions and Proposed Children's Health Insurance Program

Millions of Children, 1997

Total Uninsured Children in 1997	**8.6**
Uninsured Children Over 240% of Poverty and Not Eligible for a Premium Subsidy	1.8
Uninsured Children Under 240% of Poverty and Eligible for a Premium Subsidy or Coverage Through Medicaid Expansions	6.8
Uninsured Children That Will Be Covered Through Current Law Expansions Of Medicaid	1.8
Remaining Uninsured Children Under 240% of Poverty Eligible for a Premium Subsidy	5.0
Uninsured Children Likely To Participate in New Kids' Program	1.9
Previously Uninsured Children Covered By Medicaid and New Kids' Program	3.7

NOTES:

Children in Families Under 133% of poverty receive full premium subsidy. Premium subsidy phases out at 240% of poverty.

Program is assumed to be a capped amount provided to states and not an individual entitlement.

RAF

Distribution of Federal Funds and Participants
By Income Quintile: 1997
(Persons in millions, dollars in billions)

PROGRAMS		Income Quintiles 1st	2nd	3rd	4th	5th	Total
Kids' Program (Full Coverage in 1997) Free to 133% PL; 240% PL Phase-Out	Participants	0.4	2.0	2.9	1.3	0.3	6.9
	Subsidies	11%	45%	37%	6%	1%	$5.6
Kids + Temporarily Unemployed Free to 133% PL; 240% PL Phase-Out	Participants	1.1	3.5	4.4	2.2	0.5	11.7
	Subsidies	15%	42%	33%	6%	2%	$9.1
Long Term Care Program High Option (1)	Participants	40%	33%	23%	3%	1%	0.5
	Subsidies	60%	26%	13%	2%	1%	$1.8

NOTE: The 1997 costs represent a full year of subsidies; in the "Uses Table", only 75% of these subsidies are displayed since the programs begin on January 1, 1997.

(1) Assumes implementation in FY 1998

Income Quintiles are Annual Cash Income (1994$):

1st Quintile: $0 - 9,400
2nd Quintile: $9,400-20,400
3rd Quintile: $20,400 - 35,000
4th Quintile: $35,000 - 57,500
5th Quintile: $57,500

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: ..... JENNIFER KLEIN .....

FAX Number: .....

FROM: ..... JANE .....

Pages:

Comments:

I AM SORRY I MISSED YOU THE OTHER NIGHT. LAST NIGHT, CHRIS CALLED WITH QUESTIONS ABOUT THE OPTIONS + PROS + CONS. HE MAY NOT COMPLETELY UNDERSTAND THE KIDS STAY OPTION, SO I HAVE COLLAPSED ALL THE PREVIOUS PAGES I SENT YOU INTO A COUPLE OF PAGES. THIS IS MORE AN FYI, SINCE I WENT OVER THIS W/ YOU ALREADY.

2233 Wisconsin Avenue, NW Suite 525 Washington DC 20007
202-687-0880 202-687-3110 *facsimile*

State Program for Kids

Eligibility: Kids in working families with income below 200 percent of poverty without insurance (previous 6 months) or access to employer-based insurance (previous 18 months). This includes Medicaid children in working families, except for SSI and institutionalized children. Coverage would be phased in.

Benefits: FEHBP Blue-Cross, Blue-Shield like package

Delivery System: State designed. States may cover children through Medicaid, State employee health plans, private HMOs or any other program suited to the State's circumstances.

Funding:

Federal: Federal Medicaid per capita cap amount for kids in the State

- Full amount for kids below 133 percent of poverty
- Partial amount for kids between 133 and 200 percent of poverty (for States that currently optionally cover these kids, they would get the full per capita, as under the per capita cap).

Note: A significant proportion of the total program funding would be a transfer from Medicaid to the new program. New spending would be for increased participation and States that do not now cover children at higher levels.

Participant: No premiums or cost sharing for children below 133 percent of poverty

Sliding scale premium for children 133 to 200 percent of poverty; co-payments for some services (not for preventive or primary care)

State/Private: The residual funding needed to assure that all eligibles receive the nationally-defined benefits package.

Discussion of Kids' Options

Why Kids:

- One of four uninsured is a child. Children are one of the fastest growing groups of uninsured.
- Probably have greater coverage per dollar spent than TU program [although I am not sure yet]
- Given the problems with the Chafee-Breaux amendment, this offers a substitute. Creates a uniform, national safety net of benefits and eligibility — the intent but the not effect of the OBRA '90 expansion.
- Counterbalances State reductions in welfare coverage

Why State Program:

- Less expensive than a full subsidy program since (a) only Federal share of per capita; (b) indexed through per capita cap; and (c) State optional.
- Given limited availability of new funding, allows States to use some current Medicaid funding in a more flexible program to pool for greater purchasing power.
- Builds on State Medicaid programs and other initiatives to cover children. Over 30 States have either State-only or public / private partnerships for coverage of children. Both Republican and Democratic governors have supported these initiatives; this is one of Chiles' and Romer's top issues.
- May reduce pressure on Medicaid for greater flexibility. If States can have more program flexiblity for healthy kids, they may not feel the same need to change the Medicaid program which would remain the source of coverage for kids with special needs.

Disadvantages:

- Likely to have some employer dropping.
- Advocates might feel that it goes back on EPSDT and other Medicaid protections
- If it becomes too flexible, it could do more harm than good by putting current Medicaid kids at risk.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: Jennifer Klein

FAX NO.:

FROM: Jeanne

DATE:

PAGES INCLUDING THIS COVER SHEET:

COMMENTS:

2233 Wisconsin Avenue, NW Suite 525 Washington DC 20007
202-687-0880 202-687-3110 *facsimile*

TO: Jennifer Klein
FROM: Jeanne
RE: **Kids' program and costs**
DATE: August 10

I am tentatively attaching a spreadsheet to give you a sense of the costs of the options. **They are not right**: we have to update the underlying data and assumptions in the original model. What they do show is that we can probably, with some work, get these estimates down to $15 billion to $18 billion. I can't say what the coverage looks like; for that, we really need Urban Institute.

There are two ways that the costs of the state optional program could be lowered: changing the policy and refining the estimating.

Policy Changes

- **Phase in**: The attached assumed all kids are eligible day one. There could be two phase in schedules:
  - (a) Bring kids 6 to 13 (today covered at 100%) to 133% PL, and then use the OBRA schedule to phase in the program for older children;
  - (b) Phase the program in for the 6 year olds for whom Medicaid offers coverage now at 133% PL.

  Note that this does not preclude states from using their own money to cover kids at higher levels / ages or opting not to participate since they can get a full Medicaid payment for kids at the upper income levels in their current programs.

- **Drop upper eligibility threshold to 200% of poverty**: The 240% upper limit was more of an historical artifact than scientifically based.

- **Change from monthly eligibility determination:** If we move to maybe a 6 month eligibility determination, the costs and coverage would be lower. This is more consistent with what many states do for Medicaid.

Technical Changes

- **Adjustment for states that would not participate**: The current estimates include all states. To be conservative, it might be useful to keep it this way, but CBO could assume that some states won't participate, thus lowering costs.

- **Revisit dropping assumptions and participation rates**: I will continue working on this. Once I figure out a plan, I'll let you know.

- **Use updated Urban Institute model**: The underlying data have changed since 1991 (what we used in 1994). I am not sure if this will increase or decrease costs, given high numbers of uninsured kids, but slower inflation projections. I think costs may go down.

Other comments:

One of the cons for the state option — that kids who are currently state optional at higher income levels would now have to pay — is also a problem for the full federal subsidy program.

The GAO report does say that 62 percent of children on Medicaid have a parent who works.

Attached is a Minnesota fact sheet that I found interesting. I am looking closely at Washington and Minnesota to see what is going on; also New York's Child Plus program.

I am going to be at the Radisson St. Paul on Sunday and Monday morning. I can't quite find the phone number but I am sure it is in information. The room is in Judy's name (I also check my voice mail, so it might be easier to leave a message there if you need to). I originally planned to come back on Monday night, but the conference doesn't look that great, so I may be back on Monday afternoon with Judy. Please don't hesitate to call — it's not like I am going on vacation!

And thank you for listening to me. I have surprised myself at my inability to shake this feeling of responsibility for the quality of information you get. Its a terrible personality flaw, especially since I have so little recourse to suggest ideas or change estimates within the Department. That is why your taking the time yesterday meant a lot.

DRAFT PRELIMINARY Kids' Program Estimates

Fiscal Years, Billions of Dollars

	1997	1998	1999	2000	2001	2002	Total 1997-2002
Kids' Program: Using FEHB Full Premium							
Free to 133%, Phase-Out to 240% (1)		4.3	5.9	6.1	6.3	6.5	**29.1**
Excluding Costs of State Optional Medicaid Kids (1)		3.4	4.6	4.8	5.0	5.3	**23.2**
Kids' Program: Using Medicaid Per Capita							
Excluding Costs of State Optional Medicaid Kids (2)		2.9	3.9	4.1	4.3	4.5	**19.7**

Assumes October 1, 1997 implementation

Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

Note: Changing these estimates to an annual AGI saves approximately 20%.

These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

(1) Estimates from January 1995; they have only been changed to (a) eliminate 1997; (b) use current CPI.

(2) ROUGH APPROXIMATION: This is the full subsidy costs, without State Optional Medicaid kids, multiplied by the ratio of the CBO Medicaid spending per child by the FEHB premium for a single child. This does not take into account growth rate constraints.

10-Aug-96

State Programs

[redacted]

Region
Overall, 30% of the MinnesotaCare members we interviewed live in the 7-county Twin Cities metro area, and 70% live in Greater Minnesota.

Health
Ratings of their own health: 29% "excellent," 40% "very good," 24% "good," 5% "fair," and 2% "poor."

Adults/Children
During the survey interviews, 16% gave ratings of adults' care only, 69% gave ratings of both adults' and children's care, and 15% gave ratings of children's care only.

Age, Education, Gender
The average (mean) age of MinnesotaCare survey respondents is 37. Overall, 16% are less than 30, 48% are in their thirties, 29% are in their forties, and 7% are 50 or older. Overall, 47% have a high school education or less, 37% have had some college or other education or training after high school, and 16% are college graduates. Overall, 22% are men, and 78% are women.

Length of Enrollment
Overall, 69% have been enrolled in MinnesotaCare for 2 years or less, and 31% have been enrolled for more than 2 years.

Own Contribution to Premium
Overall, 64% pay all of their MinnesotaCare premium themselves, 32% pay part of it, and 4% pay none of it.

How to Use this Web Site

If you're using Netscape or a browser that supports tables, please use these links to find out more about Minnesota Care Members' ratings of:

Overall Satisfaction
Benefits and Coverage
Handling of Members' Questions and Problems by the Plan
Overall Rating - Able to Get Care When Needed
Getting Appointments When Sick
Getting Medical Help by Phone, Evenings and Weekends
Medical Care Received by Adults
Medical Care Received by Children

If you're using another browser, including non-graphical browsers, please use these links:

Overall Satisfaction
Benefits and Coverage
Handling of Members' Questions and Problems by the Plan

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date: 8-9-96

From: Cheryl Austein

To: Jen Klein

Phone: (202) 690-
(202) 690-6870
FAX: (202) 401-7321

Phone: 456-2599

Fax: 456-2878

Number of Pages (Including Cover):

Comments:

HHS Accomplishments for Children

- In FY 1996, HHS is spending approximately $50 billion, or about a sixth of its total budget, to sustain its investments in our nation's children and young people. HHS especially serves children and teens who are disadvantaged.

- HHS programs for children in need serve about one in every five children in America.

- Secretary Shalala established an HHS **Governing Council for Children and Youth,** bringing together all parts of the Department to better serve children, youth and families.

Medicaid

- President Clinton firmly upheld his commitment to preserving the Medicaid entitlement as a sine qua non in the welfare reform negotiations. Medicaid covers *over 18 million children,* or roughly one in every five children in the U.S.

- Under health care reform waivers in 12 states, many previously uninsured children are eligible for Medicaid. Massachusetts and Florida alone expect to to cover some 670,000 new children (121,000 and 550,000 respectively) under Medicaid expansions.

Immunization

We are extremely happy with the progress we have made since the Clinton Administration took office 3 years ago. The Childhood Immunization Initiative (CII) is one of several factors contributing to this success:

- In 1994, 75 percent of the nation's two-year-olds received the full recommended series of vaccines -- the highest levels ever recorded. In addition, childhood vaccine-preventable diseases are now at record lows.

- Despite this success, about 25% of our toddlers -- about 1 million children under age 2 -- lack one or more doses of the full series of vaccinations.

We now plan to reach our Year 2000 goals for children who are two years old in 1997--that is, 90% of all two year olds will be fully immunized in 1997. THIS WILL BE A GREAT ACCOMPLISHMENT!

Maternal and Child Health Block Grant

- HHS provides direct investment in State Health Departments through the Maternal and Child Health Block Grant. This funding is critical to ensuring that the most vulnerable children and their families receive needed health care and related services. In FY 1996 the Block Grant was funded for $678.2 million

Teenagers and Smoking

- In August 1995, the President announced the nation's first comprehensive campaign to limit both the access and the appeal of tobacco products to minors. Under proposed regulations by the FDA, children would not be able to buy cigarettes and smokeless tobacco products, and promotional and advertising gimmicks appealing to children would be limited.

Teenage Pregnancy Prevention

- The Administration's strategy to prevent teen pregnancy encourages abstinence and personal responsibility by young people, provides financial support to enhance access to health and family planning services, supports community efforts, and invests in research and evaluation to determine what approaches work.

  As part of this strategy, the President's FY 1997 budget request includes $30 million for HHS to launch a new Teen Pregnancy Prevention Initiative, to support prevention efforts in communities with high teen pregnancy rates.

Insurance Reform

- The limitations on pre-existing conditions exclusions are expected to protect many children who would otherwise lack access to needed coverage. There are an estimated 1 million children in families in which at least one individual faces an exclusion for a pre-existing condition.

Health Care for the Temporarily Uninsured

- The President's plan for the temporarily uninsured would extend transitional coverage to 3 million people, including 700,000 children.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
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Hope this helps!

NATIONAL GOVERNORS' ASSOCIATION

StateLine

Health Policy Studies Division
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July 21, 1995

Innovative State Health Initiatives for Children*

Summary

The health of the nation's children depends on many factors, including the provision of timely and high-quality preventive health services throughout childhood. Children who have health insurance are more likely to receive regular, preventive health care than are those who are uninsured. During the last decade, states have made significant changes to the eligibility criteria for Medicaid that have increased the number of infants, children, and pregnant women who have access to publicly funded health insurance. Concurrently, the percentage of children who are covered by private, employer-based health insurance has declined.

According to a recent report by the U.S. General Accounting Office (GAO), 13.5 percent of all children living in the United States in 1993, or 9.3 million children, lacked public or private health insurance for the entire year. Many more were covered for only a portion of that twelve-month period. In response to this problem, states have launched a variety of programs to ensure health care coverage of children. This *StateLine* summarizes the results of a recent survey conducted by the National Governors' Association (NGA) on state programs that provide health insurance to children not covered by Medicaid or employer-based insurance.

Background

The Nature of the Problem. A growing number of U.S. children are without health insurance. Compared with children with health care coverage, uninsured children are less likely to receive early, preventive health care services such as routine childhood immunizations and are more likely to require treatment in an emergency room after a health care problem has worsened. GAO recently issued an analysis of the U.S. Bureau of the Census March Supplement of the Current Population Surveys (CPS) for 1990 and 1994.[1] The number of children without public or private health insurance increased from 8.7 million children in 1989 to 9.3 million in 1993. During this same period, the percentage of children covered by employer-based health insurance decreased from 63.2 percent to 57.6 percent.

The Urban Institute also conducted an analysis of the CPS data, but this model merges three years of data in order to examine differences among states for the period 1990 to 1992.[2] These data are the most current state-by-state figures available. Nationally, 15.8 percent of the total number of nonelderly residents living in the United States were uninsured. Among all uninsured, nonelderly residents, 22 percent were children. Data on the percentages of children covered by employer-based health insurance, Medicaid, and other programs, as well as those in the residual uninsured category, are presented in Table 1, found at the end of this *StateLine*.

According to GAO, nearly 90 percent of uninsured children in 1993 lived in a family where at least one parent worked; in 61 percent of the families with uninsured children, one parent worked full time for the entire year. One third of the children who were without insurance in 1993 lived in families with incomes between 100 percent and 200 percent of the federal poverty level. Medicaid continues to provide health care coverage for more children in working poor families through a combination of state-initiated expansions and increased federal mandates. From 1989 to 1993, the number of children enrolled in Medicaid increased by 54 percent, from 8.9 million to 13.8 million.

Beyond Medicaid Coverage. Medicaid, the state and federally funded health insurance program for the poor authorized under Title XIX of the Social Security Act, was never intended to provide coverage for all uninsured citizens. By expanding eligibility criteria for Medicaid, states have exercised considerable leadership to significantly increase the number of poor children who have health care coverage.[3] Despite state efforts, declining employer-based coverage is resulting in a loss of health insurance for children. To increase the number of children who have health care coverage, particularly those in working poor families, many states have created new programs to cover children who are not eligible for Medicaid. Some of these programs are completely financed and operated by the state, while other models partner state efforts with those of nonprofit entities.

Recent Studies of Programs for Uninsured Children. In 1993 the National Academy for State Health Policy released a report describing state efforts to provide health insurance for uninsured children. Based upon fifteen state examples, *Children's Health Plans* included detailed information on eligibility, administration, benefits, financing, and premiums and cost-sharing arrangements.[4] The report concluded with a section on some of the next steps that policymakers should consider in addressing the needs of uninsured children as well as the questions that should be answered as these programs are evaluated.

In its *1994 State Legislation Report*, the American Academy of Pediatric, included state-by-state information on activities related to children's health insurance programs.[5] A majority of states considered proposals to increase access to health insurance for children. Seven states expanded Medicaid coverage of children through Section 1902(r)(2) of the Social Security Act—Connecticut, New Hampshire, New Mexico, North Carolina, Utah, West Virginia, and Wisconsin. In addition, Pennsylvania expanded eligibility for its state-funded health insurance program through an executive order effective July 1, 1994; the executive order also added mental health services to the benefits package.

An article published in the spring 1995 issue of the *The Future of Children* presents an overview of Medicaid expansions to increase coverage for pregnant women and children, including a brief description of the impact of Section 1115 waivers on these populations.[6] The article also examines the increased use of schools to expand health care coverage and services for children. State-funded programs and the Blue Cross and Blue Shield Caring Programs are explored briefly.

Finally, GAO is conducting a study of children's health insurance programs based on site visits to six states. Its work will provide information on the financing and costs of these programs; implementation issues, such as the process for determining eligibility for the programs, the types of providers, and provider reimbursement rates; benefits, including how the benefits packages were developed; and the impacts of these programs in terms of service utilization and the extent of coverage of uninsured children. The report should be available in the fall of 1995.

NGA Survey on Children's Health Insurance Programs

This *StateLine* provides updated information on many of the programs and initiatives examined in the reports cited above. However, with a few exceptions, it does not address Medicaid expansions because this is the subject of the regularly produced NGA newsletter *MCH Update*. The focus of this *StateLine* is state programs—public, private, and public/private partnerships—that provide health care coverage to children who are traditionally not eligible for Medicaid and who do not have access to employer-based health insurance through their parents.

Methodology. In consultation with GAO staff, NGA staff developed a survey instrument to req information from states on their children's health insurance programs related to eligibility criteria, administration and financing, enrollment, the type of health plans in which children can enroll, program costs, premiums and cost-sharing arrangements, and benefits offered. The questionnaire was sent to state maternal and child health contacts, usually in the Medicaid agency, in January 1995. These contacts were asked to forward the children's health insurance program survey to the appropriate respondent for the state. Responses were received from all states, and programs in twenty-nine states are highlighted in this *StateLine*.

Results. Many of the survey results are summarized in Tables 2 through 5, found at the end of this *StateLine*. When comparing the data on different state programs, it is important to recognize that each program reflects a unique constellation of policy decisions concerning eligibility, funding, benefits offered, and service delivery models. The number of enrollees has a direct impact on the budget, and both the comprehensiveness of the benefits package and the service delivery arrangements affect the cost per child. Caution must be exercised in drawing conclusions from the data included in the summary tables.

The programs states reported were categorized into three types: public programs, financed entirely by federal, state, or local government funds; public/private partnerships, programs funded through a mix of public, private, or philanthropic funding; and Caring Programs for Children, private programs administered by regional Blue Cross and Blue Shield plans.[7]

Enrollment and Budget. Table 2 presents data on the number of enrollees, the total budget for the program, and the sources of funds. The number of children enrolled in the program is related to the size of the population of children living in the state, the eligibility criteria used by the program, and the outreach efforts made by program staff. The enrollment data also reflect how long the program has been in operation. For example, the Healthy Kids program in New Hampshire, which reports the smallest number of enrollees, just began enrolling children in January 1995. New York's program, which has been in operation since 1991, has the largest number of children enrolled, reflecting both the broad eligibility criteria and the size of the state's population of children. Variations in the budgets for these programs reflect both the size of the population enrolled as well as the comprehensiveness of the benefits package.

Costs and Premiums. Table 3 provides data on the average cost per child per month, the average premium per month, and the cost-sharing arrangements with families. The cost per child is a result of many factors, including the cost of living in the state and the medical price index, and reflects the comprehensiveness of the benefits package offered to program participants. Programs also vary as to whether parents are asked to contribute to the cost of the premium. In none of the reported Caring Programs for Children are parents asked to pay any portion of the premium. In nearly all of the

public/private partnerships, parents pay a portion of the premium. In Florida and New York, families with incomes above a certain level pay the whole premium amount. In public programs, more than half of the states require parents to contribute to the cost of the premium on a sliding-fee scale.

Eligibility Criteria. Table 4 describes the eligibility criteria for enrollment in the program. The majority of the programs target only children. The exceptions are California, which includes pregnant women; and Georgia, which extends eligibility to the parents of enrolled children. In Minnesota, Nebraska, Rhode Island, Tennessee, and Utah, children's health insurance coverage is part of a larger health care program. Nearly all of the children's health insurance programs target low-income families; the lowest levels of financial eligibility tend to be at or below 100 percent of the federal poverty level. The highest levels of financial eligibility are set in Minnesota and Rhode Island, at 275 percent and 250 percent of the federal poverty level, respectively. Florida and New York operate two of the three programs in which all families can participate regardless of income; upper-income families pay the full premium costs in order to enroll their children in these programs. In Wisconsin's Youth Med program, all families are eligible regardless of their income.

Covered Services. Table 5 provides information on which services are covered by the programs. Any copayments that are required, and any caps or limitations on the services are described in detail in the state profiles found in the appendix. All programs cover physician visits, with all but two specifically covering well-child visits. Nearly all programs provide coverage for immunizations, and none of these programs requires a copayment for this service. Other services that are covered by nearly all of the programs include diagnostic tests, emergency care, and outpatient surgery. Prescription drugs, offered by approximately two thirds of the programs, is the service for which a nominal copayment is most often required. Mental health services, offered by more than half of the programs, are most often subject to caps or limitations placed on the number and type of covered visits. Transportation and dental services are the least common services to be reimbursed under these programs.

Of the fifteen services listed on the survey instrument, five state programs cover all of the services, three of which are state Medicaid programs operating under Section 1115 waivers (Arizona, Tennessee, and Rhode Island). The programs in Minnesota and Washington also cover all of the services. Several other state programs offer very comprehensive benefits packages, including California (fourteen services); Florida, Georgia, and Pennsylvania (thirteen services); and Maryland and New Hampshire (twelve services). In general, the reported Caring Programs for Children tend to offer a more limited benefits package, perhaps reflecting their limited funding.

Service Delivery Models. Finally, the figure found at the end of this *StateLine* provides information on the type of plans in which children can enroll: managed care, fee for service, both, or other.[8] Fifteen states are offering children coverage for health services through managed care arrangements, with nine of these providing coverage solely through a managed care system. An additional eight states are operating their systems on a fee-for-service basis. Seven states have some other service delivery arrangement, commonly a form of a preferred provider organization; these arrangements are all reflected in Caring Programs for Children.

State Profiles. Several state profiles of each type of program are presented to provide policymakers with information that could be helpful in designing a new program or modifying an existing program to improve health care coverage for children.

Public Programs. The predominant way that states provide public funding for children's health insurance is through the Medicaid program. The component of Medicaid that is exclusively for children, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, provides eligible children with a comprehensive array of health care benefits. In fact, as a result of federal expansions to EPSDT authorized by the 1989 Omnibus Budget and Reconciliation Act, states are required to provide any medically necessary service a child may need to correct or ameliorate a health problem identified in a screen, whether or not that service is included in the state's Medicaid plan.[9]

As of February 1995, thirty-four states had exceeded the federal mandate for eligibility for pregnant women and infants, and eighteen had exceeded the income eligibility requirement for some additional groups of children. These expansions have been accomplished primarily by disregarding income and other resources, an option available to states without requesting a waiver, under Section 1902(r)(2) of the Social Security Act. The primary advantage of expanding eligibility for Medicaid is that federal matching funds are available to the state for the newly eligible children. The disadvantage of expanding Medicaid eligibility is that the state must comply with all federal regulations concerning the benefits package, reimbursement rates, providers, and other features of the program.

Seeking greater flexibility, some states have applied for waivers from the federal program requirements.[10] Other states have initiated programs to provide children with health insurance funded entirely with state dollars. Typically, these programs have age and income eligibility criteria that begin where the state's eligibility criteria for Medicaid end. Three profiles of state-initiated, publicly funded programs to provide health insurance for children follow.

Minnesota—MinnesotaCare is a state-funded program that provides health coverage to children and adults statewide. Administered by the department of human services, which is also the state Medicaid agency, the program serves children between the ages of one and eighteen living in families with incomes at or below 275 percent of the federal poverty level who are state residents, who do not have access to employer-subsidized health insurance, and who are not eligible for Medicaid. At the end of 1994, 42,891 children were enrolled in fee-for-service plans across the state. Recently, the state published a managed care request for proposals. MinnesotaCare is funded through health care provider taxes and enrollment premiums, and the total budget for the state fiscal year ending June 30, 1994, was $34.2 million.

The average monthly cost per child is $53, including administrative costs of $5.30 per child. Parents pay a portion of the monthly premium based upon family size and income. Children at or below 150 percent of the federal poverty level pay $4 per month. The maximum premium is $24 per month for a single person and $32 per month for a married couple without children. No copayments are required for any of the health care benefits offered to children under this program.

The comprehensive benefits package includes primary and preventive care (e.g., physician visits, immunizations, well-child visits, prescription drugs, and vision, dental, and hearing care) as well as specialty services (e.g., mental health, substance abuse treatment, and physical therapy services). Nonemergency transportation services are not available, nor is coverage of special education health-related services provided by school districts. Outreach is conducted through public service announcements on radio and television. Families applying for MinnesotaCare are referred to Medicaid, as appropriate, but they are provided sixty days of health coverage to give them time to apply for Medicaid. Applications are made available in a variety of locations, including state offices,

schools, Head Start and Special Supplemental Feeding Program for Women, Infants, and Children (WIC) sites, and community health and social services agencies.

Pennsylvania—The Children's Health Insurance Program (CHIP) provides comprehensive benefits to 40,563 children across the state. CHIP was authorized by the Children's Health Care Act of 1992 and was implemented the following spring. To quality for the program, children must be a resident of the state for at least thirty days and be uninsured.

Children between the ages of one and fifteen living in families with incomes below 185 percent of the federal poverty level who are uninsured and do not qualify for Medical Assistance are provided free health insurance, while children below age six living in families with incomes between 185 percent and 235 percent of the federal poverty level are provided subsidies for their insurance. The program is administered by a management team consisting of the secretaries of health and budget and the insurance commissioner and is financed through a tax on cigarettes of two cents per pack. Children receive health care services through a statewide system of managed care and indemnity plans provided by five regional grantees. The program budget was $21 million in 1994. The average monthly premium the program pays health plans to cover a single child is $64.13 in the unsubsidized program and $84.48 in the subsidized program. CHIP pays 50 percent of the cost of the premiums for the subsidized group.

A broad array of primary and preventive care services are included in the benefits package. These are supplemented by dental care, emergency care, hearing care, hospitalization, outpatient surgery, physical therapy, and vision care. Prescription drugs is the only service requiring a copayment from the family. Transportation and substance abuse services are not offered to children under CHIP.

When a child is being considered for enrollment in the program, CHIP staff will refer families to Medicaid and help them by providing instructions and/or mailing completed Medicaid applications. A family may be required to apply for Medicaid prior to enrolling in CHIP if family income is very close to Medicaid eligibility limits. Outreach efforts are funded through a requirement that grantees match state dollars with in-kind contributions equal to 2.5 percent of their allotment. Required semiannual and quarterly reports submitted by grantees indicate that a broad array of community-based and other resources are mobilized to conduct outreach, including religious organizations/churches, day care facilities, union and labor groups, county assistance offices, and hospitals and other health care providers.

Washington—Children below age nineteen living in families with income below 200 percent of the federal poverty level are eligible for Basic Health Plan (BHP) Plus. The program, which serves only children, is jointly administered by the Medicaid agency and the Washington Health Care Authority. Medicaid and BHP Plus have a joint application process to help ensure that families eligible for Medicaid have the opportunity to enroll. At the end of 1994, 16,944 children were enrolled in BHP Plus. The budget for fiscal 1995 was $20.78 million. Both federal Medicaid funding and state funds are used to finance the program.

Children receive services in managed care settings, and the program pays the plans an average of $61.31 per month for each child covered. The average administrative cost per child of $1.65 is included as part of this premium. Parents are not required to pay any portion of their child's premium, and copayments are not required for any BHP Plus services.

Children are eligible for a comprehensive array of services. Preventive services such as well-child care and immunizations are covered, as are acute care and specialty services. Public service announcements are supplemented with mailings and presentations to inform eligible families about the program.

Public/Private Partnerships. Increasingly, the public and private health sectors have found mutual benefits in collaborating to provide and pay for health services. This trend is also reflected in programs to provide children with health insurance coverage. For example, Iowa, Kansas, Michigan, and North Carolina have made a financial investment in several of the Caring Programs for Children. Michigan's Caring Program is actually a demonstration project approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services and is financed through a combination of federal and state dollars and foundation funds. Three state models of public/private partnerships are profiled below.

Colorado—The Colorado Child Health Plan (CCHP) targets children below the age of thirteen who live in rural counties.[11] To be eligible, the child must be ineligible for Medicaid and live in a family with income below 185 percent of the federal poverty level. Other family assets cannot not exceed the following limits: $4,500 for a vehicle; $60,000 for an owner-occupied home; $50,000 for a business; and $2,000 in personal liquid assets. In 1994, 1,712 children were enrolled in the program. In June 1994, CCHP completed its second year of operation.

The program was authorized by the Children's Health Plan Act in 1990 and amended by additional legislative action. It is funded through a combination of private donations, modest participant fees, and a portion of the teaching allowance paid annually by Medicaid to the University of Colorado Hospital. The program is administered by the Health Sciences Center, which in turn has entered into an agreement with Blue Cross and Blue Shield of Colorado; Blue Cross and Blue Shield is donating administrative services as well as claims processing services to the program. Other in-kind contributions have been made by a variety of corporate partners, pharmaceutical companies, and community pharmacies.

Health care services provided to children under CCHP are delivered through a managed care system built upon capitated payment to a network of primary care physicians. Specialty services are reimbursed through a traditional fee-for-service system, under the direction of the network. The monthly fee paid to the network covers the provision of well-child care, acute care, chronic care, and nonacute trauma care. The network can also bill on a fee-for-service basis for services provided beyond the core primary benefits package. Specialists are paid at the Medicaid reimbursement rate plus 20 percent, with the exception of laboratory work and radiology, which are reimbursed at the Medicaid rates.

Cost studies were conducted for the 808 children enrolled in CCHP during fiscal 1994. Overall, the average monthly capitation fee paid to primary care physicians was $15.05. An additional $8.67 in claims reimbursement per child was paid monthly, bringing the total average cost per child to nearly $24. Approximately half of the enrolled children accounted for the additional claims-based costs. An annual cap on program costs of $7,500 has been instituted.

An extensive outreach campaign includes activities targeted to increasing the number of participating providers in counties where the program is operational as well as increased enrollment of eligible

families. A wide variety of outreach materials have been developed and distributed, employing user-friendly language and graphics. Public service announcements are supplemented with newsletters and collaborative outreach efforts by local human services agencies. Automatic enrollment campaigns have also been arranged with WIC nutrition programs and the Health Care Program for Children with Special Health Care Needs by virtue of similar income eligibility and enrollment criteria.

Florida—The Healthy Kids Corporation Act, passed by the legislature in July 1990, authorized the creation of a nonprofit corporation responsible for administering the Healthy Kids program. Initial funding, provided by a grant from the Robert Wood Johnson Foundation, was later supplemented by a four-year cooperative agreement from the federal Health Care Financing Administration as a result of a proposal submitted by the Medicaid agency, the Healthy Kids Corporation, and the Florida Institute for Child Heath Policy. The current budget for the program includes $1.7 million in federal Medicaid funds, $3.9 million in state general revenue, $1.1 million in local government funds, and $2.1 million in family contributions. Local program sites must contribute a minimum of 5 percent of the cost as a base, though some have contributed as much as 55 percent.

Using utilization data from similar children served in managed care settings, the Healthy Kids program was able to negotiate contracts that reflected the associated risk for providers and health maintenance organizations; the risk financiers include Florida Health Care Plan, Inc., HIP Health Plan of Florida, Humana Health Care Plans, and PCA Family Health Plan, Inc. Unlike most employer-based groups, the resulting premium costs negotiated through this process reflect the reduced cost of providing health services to a healthy—and therefore relatively inexpensive—group, school-age children. According to the *Healthy Kids 1995 Annual Report*, the cost of providing comprehensive health insurance to children under the model is less than the cost to provide them with school lunches.[12] The average monthly cost per child served in Healthy Kids is $50.

Eligibility for the health insurance coverage provided to children is based upon their enrollment in school. This unique model has several important advantages. By using school systems as a way to create a group of participants, the cost benefits that large employers enjoy can be realized. By limiting coverage to school-age children, the benefits package can be tailored to meet this population's unique health needs. Coverage can be offered to all families; in those families with incomes that are high enough, parents can contribute to the cost of their child's coverage. Some additional benefits may be realized by including health-related services for children with disabilities or special health care needs in the benefits package. Because these services must be provided by the school for those children who are eligible for special education, the local tax burden may be lessened. Finally, offering health coverage through the school may serve as an incentive for children not to drop out.[13]

The Healthy Kids benefits package is very comprehensive. It includes a broad array of primary, preventive, and specialty health care services; substance abuse treatment services are limited to pregnant teenagers and dental care is optional. Some modest copayments are required, for example, for emergency room care ($10), mental health services ($10), and prescription drugs ($3). The coverage has a lifetime cap of $1 million.

Efforts are underway to evaluate the impact of the program. Expansion to additional counties is also planned. New Hampshire has adopted this model for its state-initiated child health insurance program, also called Healthy Kids.

New York—Administered by the commissioner of health, Child Health Plus provides health coverage to New York State children who are below age fifteen, born on or after June 1, 1980, not eligible for Medicaid, and without equivalent health insurance coverage. Effective June 1995, children enrolled in the program prior to age fifteen may remain in Child Health Plus until age sixteen.

Children from households with a gross household income below 222 percent of the federal poverty level are eligible for subsidization of the premium. Children who are above this income and who meet other eligibility criteria may enroll in Child Health Plus but without a subsidy. Enrollment began in August 1991, and by May 1995, more than 100,000 children were enrolled in Child Health Plus.

Each insurer provides the same benefits package, which emphasizes preventive and primary health care services. Inpatient hospital care is not covered. A small copayment for each prescription and one for inappropriate emergency room use may be charged.

To better coordinate the Child Health Plus program with Medicaid, the department of health has been working with the department of social services to develop a joint enrollment form for Medicaid, WIC, and Child Health Plus. Additionally, legislation enacted in 1993 allocated funds for a comprehensive, independent evaluation of the program, which is expected to be completed in January 1996.

Caring Programs for Children. The nation's first Blue Cross and Blue Shield Caring Program for Children was initiated in 1984 by two ministers working in western Pennsylvania. The idea was to create a program that would provide health coverage to the thousands of unemployed steel workers, following the collapse of that industry in Pittsburgh in the early 1980s. To address these workers' concerns that they had lost not only their jobs but also health benefits for their children, the ministers approached the Western Pennsylvania Blue Cross and Blue Shield plan. The result was the formation of the Western Pennsylvania Caring Foundation, which sponsors the Caring Program for Children and serves as the administrator for the state's CHIP program in that region. (The Pennsylvania CHIP program was modeled after the Western Pennsylvania Caring Program for Children.)

As of the beginning of 1995, Caring Programs are operating in more than twenty states and are serving more than 120,000 children.[14] One of the unique features of these programs is that children are issued a standard Blue Cross and Blue Shield Plan identification card, which enables the family to avoid the possible stigma associated with being poor. Although specific eligibility criteria vary from plan to plan, all children who are enrolled in Caring Programs share certain characteristics: they live at home with their families and attend school, if school-age; they are not eligible for public assistance; and they live in families that cannot afford private health insurance. Because each Caring Program has its own eligibility requirements and benefits package, several state examples are provided below. At times, children must be put on waiting lists once they are determined eligible for a Caring Program; often the regional plan will increase fundraising efforts in order to provide coverage as soon as possible.

Alabama—The Alabama Caring Program for Children began late in 1987, with benefits being provided to children in March 1988. To be eligible for the program, the child must be age eighteen or younger; a resident of Alabama; in school, if school-age; not be eligible for Medicaid and have no private health insurance; and live in a family with an annual income below $9,500. The program is administered by the Alabama Child Caring Foundation. All administrative costs are donated by Blue Cross and Blue Shield of Alabama, enabling all of the donations and matching funds to be used to cover health services for eligible children. The administration of the program costs an average of

$2.80 per child per month, while the average cost to provide health insurance for a child for a year is $240. The program served 5,400 children in 1994.

The total amount of donations—from churches, civic organizations, businesses, foundations, individuals, and an endowment—are matched by Blue Cross and Blue Shield; the 1994 budget exceeded $1.2 million. In addition, Blue Cross and Blue Shield has contracted with a network of more than 6,000 doctors and health facilities, and the preferred providers agree to accept the Caring Program's payment as payment in full. The benefits package includes physician visits, including well-child care, immunizations, diagnostic testing, and hearing care. Emergency room care and outpatient surgeries are also covered.

An evaluation of the impact of the Caring Program on Alabama families was recently conducted.[15] Eighty-one percent of the 207 families that sent back survey responses reported that they now have an ongoing relationship with a primary care physician that they selected. Prior to enrolling in the program, one third of these families received their medical care in an emergency room and 40 percent received health services from a public health clinic. When the program began, some providers were concerned that this population might overutilize the services because of pent-up demand. With one exception, this fear did not materialize when utilization rates were examined. Compared with children enrolled in the regular Blue Cross program, there was increased utilization among children enrolled in the Caring Program in the treatment for chronic conditions during the first year of enrollment; specifically, the data showed a higher level of adenoidectomies, tonsillectomies, and insertion of ear tubes. The executive director attributed this higher utilization to the impact of postponing treatment for childhood ailments as a result of lack of health insurance and financial barriers to care. The evaluation study reported a variety of positive side-effects of insurance coverage, including better school attendance, improvements in academic performance, and increases in children's self-esteem.

Missouri—There are two Caring programs in Missouri, both administered by the Caring Foundation for Children. One program provides coverage in the thirty-five-county area that is served by Blue Cross and Blue Shield of Kansas City, and a Caring Program for Children administered by Blue Cross and Blue Shield in St. Louis serves the rest of the state.

The income eligibility criteria are somewhat higher for the Caring Program that serves families in Kansas City: to be eligible outside of the Kansas City program area, the income for a family of four cannot exceed $19,000 per year, compared with $22,212 for the Kansas City program. Another difference between the programs is the type of provider arrangement. In the Kansas City-based program, children enroll in managed care plans, while in counties served by the Caring Program administered by Blue Cross and Blue Shield of St. Louis there is a network of Caring Foundation participating providers. The average cost per child per year also differs—$200 per year for the St. Louis-based program, compared with $300 per year for the Kansas City-based program. Similar to Alabama, the Blue Cross and Blue Shield plans cover the administrative costs of the program, enabling all private and corporate donations and matching funds provided by Blue Cross and Blue Shield to be used to pay for health services for children.

In 1994, 775 children below the age of nineteen living in families with incomes at or below 150 percent of the federal poverty level were enrolled in the Kansas City-based program. The total budget for 1994 was $232,500. The benefits package includes a broad array of services for children, including well-child visits, physician visits, immunization, prescription drugs, dental care, outpatient surgery, and diagnostic testing. In the Caring Program affiliated with the St. Louis Blue Cross and

Blue Shield, 1,500 children were enrolled in 1994 and the budget was $600,000. Well-child care and other physician visits are covered, as are immunizations, diagnostic testing, outpatient surgery, emergency care, and substance abuse services. In both programs, parents do not have to pay any portion of the premium and no copayments for covered services are required. Outreach is conducted through presentations to community groups, hospitals, and schools. No children are on waiting lists.

Utah—Two programs provide health insurance for children in Utah: the Caring Program for Children and a high-risk insurance pool for uninsurable children and adults in Utah. Like the Caring Program, the latter is administered by Blue Cross and Blue Shield of Utah.

The Caring Program, with a 1994 budget of $612,000, provided health insurance coverage to 1,615 children as of December 3, 1994. Sources of funds included individual and corporate donations. Children across the state are eligible if they live in a family with an income below 150 percent of the federal poverty level. Children also must be unmarried; in school, if school-age; not eligible for public or private health plans; and legal residents of the state.

Children are provided health care service through a fee-for-service system. The average monthly program cost is $32 per child. Parents are not required to pay any portion of the child's premium, nor are copayments required for any covered services. Physician visits, including well-child visits, are covered, along with immunizations, hearing care, and outpatient surgery. Emergency care is also a covered service.

Outreach is conducted through coordination with the schools, focusing on kindergarten through grade three, and through the use of public health nurses and other community groups. In addition, radio public service announcements are used to inform eligible families about the Caring Program. Families that have not applied but may be eligible are referred to Medicaid, as appropriate.

Lessons for State Policymakers

Uninsured children have been provided with health insurance through a number of strategies. These include expanding eligibility for existing programs such as Medicaid, creating new public and private programs, and establishing public/private partnerships. Some lessons learned from the NGA survey may assist state policymakers as they make decisions on improving health care coverage for children.

- Children are generally very healthy, and therefore they are not a costly population to provide health insurance coverage.
- Most programs include low-cost preventive health services, such as well-child visits and immunizations, in their benefits package. In addition to promoting a proactive approach to health in young children, these services may save additional dollars in acute care services later in their lives.
- Decisions on which strategy to adopt to expand coverage must reflect hard choices concerning what services to offer and to whom. These decisions are likely to be influenced by the financing available for the program.
    - Although waiting lists are prohibited in Medicaid, they may exist in some of the other program models. Additional fundraising can be conducted on behalf of children on waiting lists in order to expand coverage to those children. Enrollment can be capped in a program funded with state revenues.

- The comprehensiveness of the benefits package offered to children may also reflect available financing. The most generous benefits package is that mandated by federal statute under the EPSDT program. As part of the current Medicaid program, this program is jointly funded by federal and state dollars and is an unlimited federal entitlement. All other program models operate under a fixed budget, so that decisions have to be made on which services to offer enrolled children.

- Creating a new public or Caring Program for Children or establishing a public/private partnership are strategies that maximize a state's flexibility in program design. Federal matching dollars are currently available for expansions to state Medicaid programs, though state flexibility and innovation are more limited. An increasing number of states are receiving waivers to increase their opportunities for program innovation and cost-savings, while maintaining federal financial participation.

States continue to take the initiative in providing vulnerable populations such as children with needed health care coverage. This *StateLine* has highlighted the innovative efforts of states that have sought to increase coverage of children by creating new public programs, collaborating with the private sector to create private programs, and establishing public/private partnerships. Through a mix of public, private, and collaborative efforts, a significant number of children have gained access to health care coverage—an important ingredient in producing the next generation of healthy, productive Americans.

Table 2
Enrollment and Funding of Children's Health Insurance Programs

State	Type of Program	1994 Enrollment	1994 Total Budget (in millions)	Sources of Funds
Alabama	Caring	5,400	$ 1.25	Corporations, churches, community-based organizations, foundations, gifts
Arizona	Public	2,300	7.30	State only
California[1]	Public	13,784	71.50	Tobacco tax, subscriber contributions
California[2]	Caring	5,000[3]	1.2	Businesses, foundations, individuals
Colorado	Public/Private	1,712	0.66	Medicaid teaching allowance, Blue Cross and Blue Shield
Delaware	Public/Private	8,473	NA	NA
Florida	Public/Private	15,500	8.80	Federal, state, and local funds, family premium payments
Georgia	Caring	409	NA	Blue Cross and Blue Shield, businesses, corporations, foundations
Idaho	Caring	400	NA	NA
Iowa	Caring	2,117	0.36	NA
Kansas	Caring	3,474	0.71	State and private
Louisiana	Caring	412	0.07	Individual/corporate donations, matching funds
Maryland[4]	Public	3,500	0.85	State general revenue, federal Medicaid
Massachusetts	Public	22,021[5]	12.00	State general revenue (23 percent), Health Care Access Fund
Michigan	Public/Private	3,105	1.40	State general revenue, federal Medicaid, foundations
Minnesota	Public	42,891	34.20	State only
Mississippi	Caring	1,027[6]	0.21	Private and matching funds, Blue Cross and Blue Shield
Missouri[7]	Caring	1,500	0.60	Blue Cross and Blue Shield, donations
Missouri[8]	Caring	775	0.23	Blue Cross and Blue Shield, donations
Nebraska	Public/Private	245	5.00	Assessments from insurance companies: high-risk pool
New Hampshire	Public/Private	39	0.24	State funds
New York[9]	Public/Private	98,538	76.50	Bad Debt and Charity Pool
North Carolina	Caring	3,498	1.42	State general revenue, local government, private
Ohio	Caring	5,717	1.55	Fundraising, matching funds, Blue Cross and Blue Shield
Pennsylvania	Public	28,923	21.00	Cigarette tax of two cents per pack
Rhode Island	Public	NA	NA	Federal and state Medicaid funds (Section 1115 waiver)
South Dakota	Caring	385	0.18	Maternal and Child Health block grant, foundations, donations
Tennessee	Public	58,172[10]	NA	Federal Medicaid, state, premium payments, (Section 1115 waiver)
Utah[11]	Public/Private	99	2.00	State funds, premium contributions
Utah[12]	Caring	1,615	0.61	Donations, individual and corporate
Virginia	Caring	2,700	NA	NA
Washington	Public	16,944	20.00	Medicaid and Health Services Act (tax on alcohol, tobacco, and providers)
Wisconsin	Private[13]	800[14]	NA	Family premium payments

Note: NA indicates data are not available.
See Notes to Table 2.

Notes to Table 2

Notes:
1 California Access for Infants and Mothers program.
2 CaliforniaKids program.
3 CaliforniaKids program enrollment figures current as of July 1, 1995.
4 Maryland figures as of June 1995.
5 Massachusetts enrollment figures as of March 31, 1995.
6 Mississippi enrollment figures as of May 8, 1995.
7 Caring Foundation for Children, St. Louis, Missouri.
8 Caring Foundation for Children, Kansas City, Missouri.
9 New York enrollment figures as of April 1995; budget for 1995.
10 Tennessee enrollment figures are for children ages one to thirteen.
11 Utah Health Insurance Pool.
12 Utah Caring Program for Children.
13 The Youth Med program, administered by Blue Cross and Blue Shield United of Wisconsin, is not considered a Caring Program for Children.
14 Wisconsin enrollment figures current as of June 30, 1995.

Source: National Governors' Association, July 1995.

Table 3
Costs, Premiums, and Cost Sharing in Children's Health Insurance Programs

State	*Average Cost per Child per Month*	*Average Premium per Month*	*Family Contributes to Premium*
Alabama	$20	0	No
Arizona		$91; capitated	No
California[1]	[2]		Yes[3]
California[4]	$28	$33	No
Colorado	$23	$2	Yes
Delaware	$71		Yes[5]
Florida	$50	$43	Yes[6]
Georgia			
Idaho			No
Iowa	$26	0	No
Kansas	$17	$17	No
Louisiana	$20	0	No
Maryland	20		No
Massachusetts	$70	$70	Yes[7]
Michigan		$35	No
Minnesota	$53	0	Yes[8]
Mississippi	$20	0	No
Missouri[9]	$17	0	No
Missouri[10]	$25	0	No
Nebraska	$50-$180	$50-$180	Yes
New Hampshire	$52	$52	Yes
New York	$55	$55	Yes[11]
North Carolina	$22	$22	No
Ohio	$19	$19	No
Pennsylvania		$79	Yes[12]
Rhode Island[13]	$130	$112	Yes[14]
South Dakota		0	No
Tennessee			Yes[15]
Utah[16]	$171-$192	0	Yes
Utah[17]	$32	0	No
Virginia	$29	0	No
Washington		$61.31	No
Wisconsin	$60	$60	Yes

Note: Cost figures include administrative costs.
See Notes to Table 3.

Notes to Table 3

Notes:
1 California Access for Infants and Mothers program.
2 In the California Access for Infants and Mothers program, $10,000 is the average cost per child and mother; coverage is for pregnant women plus sixty days of postpartum care and for children up to age two.
3 In the California Access for Infants and Mothers program, families contribute 2 percent of their gross annual income.
4 CaliforniaKids program.
5 In Delaware only non-Medicaid-eligible families contribute.
6 In Florida families contribute on a sliding-fee scale.
7 In Massachusetts families contribute on a sliding-fee scale: families with incomes between 200 percent and 400 percent of the federal poverty level pay $15 per child per month up to $45 per family per month.
8 In Minnesota families contribute on a sliding-fee scale based upon income and family size.
9 Caring Foundation for Children, St. Louis, Missouri.
10 Caring Foundation for Children, Kansas City, Missouri.
11 In New York families contribute if their income is above 160 percent of the federal poverty level.
12 In Pennsylvania children below age five are subsidized by the state.
13 Cost and premium figures for Rhode Island figures reflect the entire population served under the state's Section 1115 waiver.
14 In Rhode Island families contribute 3 percent of the premium if their income is between 185 percent and 250 percent of the federal poverty level.
15 In Tennessee non-Medicaid-eligible families contribute if their income is at or above 100 percent of the federal poverty level.
16 Utah Health Insurance Pool.
17 Utah Caring Program for Children.

Source: National Governors' Association, July 1995.

Table 4
Eligibility Criteria for Children's Health Insurance Programs

State	Children only	Ages	Income Below	Resident	In School	Unmarried	Not Eligible for: Medicaid	Not Eligible for: Private Insurance
Alabama	Yes	18 and below	$9,500	•	•		•	•
Arizona	Yes	below 13	[1]				•	
California[1]	No[3]	below 2	200%-250% of FPL[4]	•			•	•
California[5]	Yes	2-18	100%-200% of FPL					
Colorado	Yes	0-13	185% of FPL[6]					
Delaware	Yes	0-1/1-5/ 6-19	185% of FPL/133% of FPL 100% of FPL					
Florida	Yes	5-19	Sliding scale		•		•	•
Georgia[7]	No	none	100% of FPL					
Georgia[8]	Yes	1-18	150% of FPL					
Idaho	Yes	0-18	150% of FPL				•	•
Iowa	Yes	0-19	133% of FPL				•	
Kansas	Yes	0-18	133% of FPL	•	•	•	•	•
Louisiana	Yes	0-18	100% of FPL	•			•	•
Maryland	Yes	1-6/6-11[9]	133%-185% of FPL/ 100%-185% of FPL					
Massachusetts	Yes	0-12	Not applicable	•				Primary/preventive only
Michigan	Yes	up to 19	185% of FPL	•			•	•
Minnesota	No	1 to 18	275% of FPL	•			•	
Mississippi	Yes	up to 19	100% of FPL	•	•	•	•	
Missouri[10]	Yes	below 19	$13,000 for family of two					
Missouri[11]	Yes	below 19	150% of FPL					
Nebraska	No	none					Uninsurable	
New Hampshire	Yes	3-18		•			•	Uninsured for three months
New York	Yes	below 15	[12]	•				
North Carolina	Yes	0-19	185% of FPL	•	•	•	•	•
Ohio	Yes	6-18	133% of FPL		•	Living with parent	•	•
Pennsylvania	Yes	1-15	185% of FPL	•			•	
Rhode Island	No	0-6	250% of FPL					
South Dakota	Yes	6-19	133% of FPL	•	•	Living at home	•	•
Tennessee	No	0-21					[13]	
Utah[14]	No	none						High-risk uninsurable
Utah[15]	Yes	01-19	150% of FPL	•	•	•	•	
Virginia	Yes	1-19	200% of FPL	•		•	•	•
Washington	Yes	0-19	200% of FPL					
Wisconsin	Yes	0-23[16]	Not applicable					

Note: FPL means federal poverty level.

See Notes to Table 4.

Notes to Table 4

Notes:
1 In Arizona children ages thirteen and younger are eligible if they have received food stamps or exceed state medically needy/medically indigent levels but do not exceed federal poverty guidelines.
2 California Access for Infants and Mothers program.
3 In California's Access for Infants and Mothers program, women who are less than thirty weeks pregnant are also covered.
4 In California's Access for Infants and Mothers program, family income must be above 200 percent of the federal poverty level and at or below 250 percent of the federal poverty level.
5 CaliforniaKids program.
6 In Colorado assets are limited for automobile, business, home, and personal costs.
7 Georgia Caring Program for Children.
8 Georgia Partnership for Caring Foundation.
9 In Maryland children ages six through eleven must have been born before September 30, 1983.
10 Caring Foundation for Children, St. Louis, Missiouri.
11 Caring Foundation for Children, Kansas City, Missouri.
12 In New York premiums for children in families with incomes below 160 percent of the federal poverty level are fully subsidized; premiums for children in families with incomes between 161 percent and 222 percent of the federal poverty level are subsidized 50 percent; and premiums for children in families with incomes above 222 percent of the federal poverty level are paid in full by the parents.
13 In Tennessee eligible participants must be uninsured or uninsurable.
14 Utah Health Insurance Pool.
15 Utah Caring Program for children.
16 In Wisconsin children are eligible up to age twenty-three if they are students and are enrolled in the program prior to age nineteen.

Source: National Governors' Association, July 1995.

Table 5
Services Covered by Children's Health Insurance Programs

State	Dental Care	Diagnostic Testing	Emergency Care	Hearing Care	Hospitalization	Immunizations	Mental Health	Outpatient Surgery	Physical Therapy	Physician Visits	Prescription Drugs	Substance Abuse	Transportation	Vision Care	Well-Child Visits
Alabama		•	•	•		•		•		•					•
Arizona	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
California[1]		•	•	•	•	•	•	•	•	•	•	•	•	•	•
California[2]		•	•	•		•	•	•	•	•	•			•	•
Colorado		•	•	•		•		•	•	•	•			•	•
Florida	[3]	•	•	•	•	•	•	•	•	•	•	[4]		•	•
Georgia[5]	•	•		•	•	•	•	•	•	•	•		•	•	•
Georgia[6]		•	•	•		•		•		•	•			•	•
Idaho			•							•	•				
Iowa		•	•			•		•		•					•
Kansas		•	•	•	•	•	•	•		•		•		•	•
Louisiana		•	•			•		•		•					•
Maryland		•	•	•		•	•	•	•	•	•	•		•	•
Massachusetts		•	•	•		•	•	[7]		•	•			•	•
Michigan		•	•			•		•		•	•	•	•		•
Minnesota	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Mississippi		•	•			•		•		•					•
Missouri[8]		•	•			•		•		•		•			•
Missouri[9]	•	•	•			•		•		•	•				•
Nebraska	•		•	•			•	•	•	•	•	•			
New Hampshire		•	•	•	•	•	•	•	•	•	•			•	•
New York		•	•			•		•	•	•	•	•			•
North Carolina		•	•	•		•		•		•					•
Ohio		•		•		•		•		•	•				•
Pennsylvania	•	•	•	•	•	•	•	•	•	•	•			•	•
Rhode Island	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
South Dakota		•	•		•	•		•		•					•
Tennessee	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Utah[10]		•	•		•	•	•	•	•	•	•	•			•
Utah[11]		•	•	•		•		•		•			•	•	•
Virginia	•	•	•			•	•	•		•	•				•
Washington	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Wisconsin		•	•	•	•	•		•	•	•	•				•

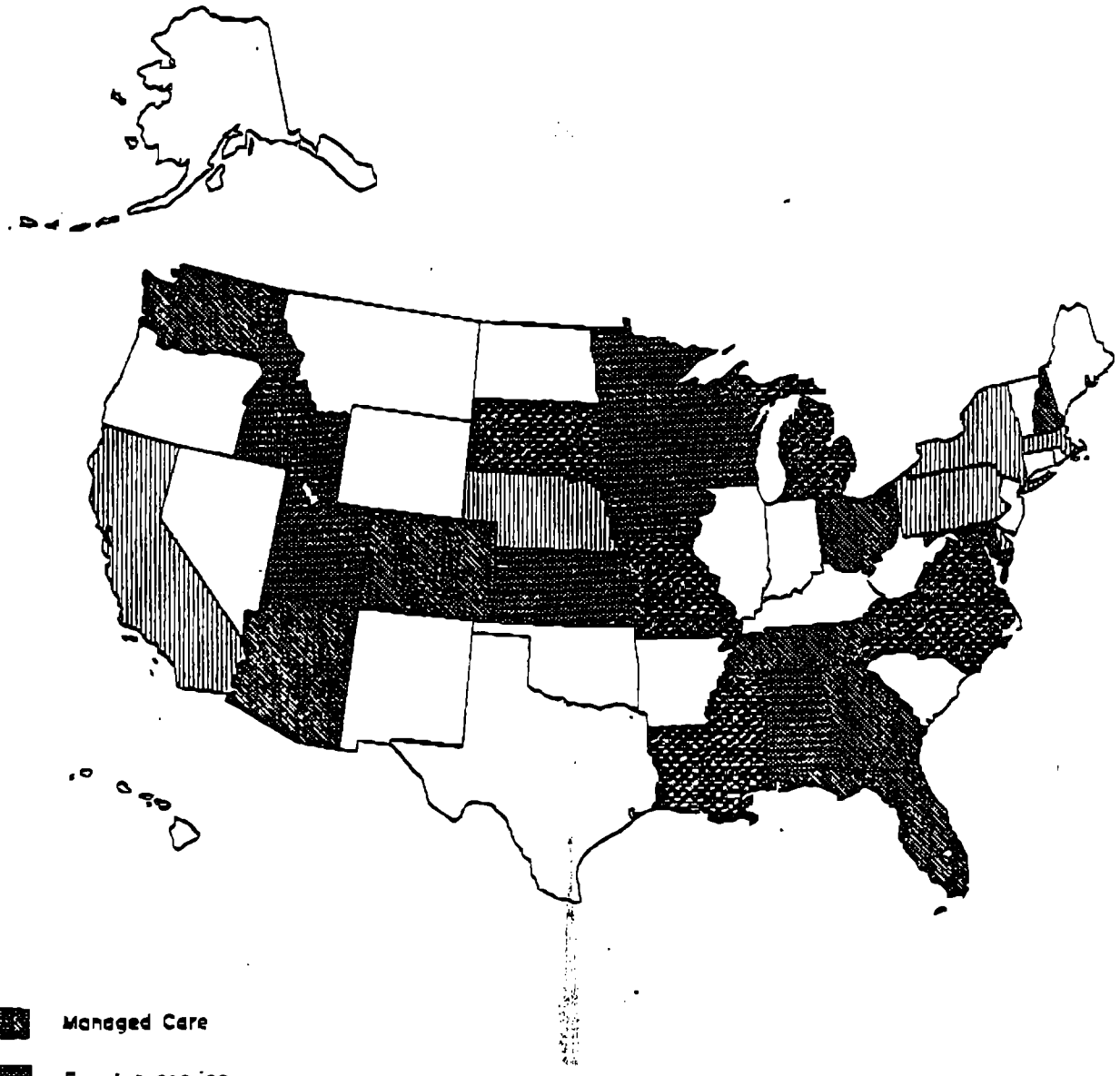
See Notes to Table 5.

Notes to Table 5

Notes:
1 California Access for Infants and Mothers program.
2 CaliforniaKids program.
3 In Florida dental care is an optional service.
4 In Florida substance abuse treatment is available only to pregnant teenagers.
5 Georgia Partnership for Caring Foundation.
6 Georgia Caring Program for Children.
7 In Massachusetts the only surgical procedures covered are those for inguinal hernia and ear tubes.
8 Caring Foundation for Children, St. Louis, Missouri.
9 Caring Foundation for Children, Kansas City, Missouri.
10 Utah Health Insurance Pool.
11 Utah Caring Program for Children.

Source: National Governors' Association, July 1995.

Types of Health Plans Offered for Children



Note: * Other indicates that a different type of arrangement is in place, for example, a preferred provider organization.

Source: National Governors' Association, July 1995.

ALABAMA

Caring Program for Children

Covered Services Diagnostic testing, emergency care, hearing care, immunizations, outpatient surgery, physician visits, and well-child visits.

Copayments None.

Caps or Limitations None.

ARIZONA

Children's Care Program

Covered Services Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, transportation, vision care, and well-child visits.

Copayments None.

Caps or Limitations None.

CALIFORNIA

Access for Infants and Mothers

Covered Services Diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, and substance abuse.

Copayments None.

Caps or Limitations Mental health services are limited to ten inpatient days and twenty outpatient visits per year. Physical therapy is available only for acute conditions on a short-term basis. Substance abuse services are limited to detoxification. Transporation is provided only on an emergency basis.

CaliforniaKids

Covered Services Diagnostic testing, emergency care, hearing care, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, vision care, and well-child visits.

Copayments A $5.00 copayment is required per office visit. This copayment covers all services performed during the office visit, including laboratory and diagnostic tests, hearing screenings, and immunizations. A $25.00 copayment is required if emergency room care is not an emergency. A $5.00 copayment may also be required for outpatient surgery and physical therapy. The copayment for prescription drugs is either $5.00 or $10.00. Vision care requires a $10.00 copayment.

Caps or Limitations Vision care is limited to one office visit per year.

COLORADO

Child Health Plan

	Diagnostic testing, emergency care, hearing care, immunizations, outpatient surgery, physical therapy, physician visits, prescription drugs, vision care, and well-child visits.
Copayments	A $2.00 copayment is required for emergency care, physician visits, prescription drugs, vision care, and well-child visits.
Caps or Limitations	Overall, coverage is limited by an annual cap of $7,500.

FLORIDA

Healthy Kids

Covered Services	Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, vision care, and well-child visits. Other covered services include home health care and transplants.
Copayments	Dental care, which is an optional service, requires a $3.00 copayment. For emergency care and mental health services, a $10.00 copayment is charged. Copayments for physician visits and vision care can vary, from none to $3.00, and from $3.00 to $10.00, respectively. A $3.00 copayment is collected for prescription drugs.
Caps or Limitations	Mental health services are limited to fifteen inpatient days and twenty-one outpatient visits per year. Substance abuse treatment is available only to pregnant teenagers. There is a lifetime cap of $1 million in coverage per child.

GEORGIA

Partnership for Caring Foundation

Covered Services	Dental care, diagnostic testing, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, transportation, vision care, and well-child visits.
Copayments	None.
Caps or Limitations	None.

Caring Program for Children

Covered Services	Diagnostic testing, emergency care, hearing care, immunizations, outpatient surgery, physician visits, prescription drugs, vision care, and well-child visits.
Copayments	A $3.00 copayment is required for prescription drugs.
Caps or Limitations	Coverage of diagnostic testing, hearing care, and well-child visits is limited to preventive care services.

IDAHO

Caring Program for Children

Covered Services Emergency care, physician visits, and prescription drugs.

Copayments None.

Caps or Limitations None.

IOWA

Caring Program for Children

Covered Services Diagnostic testing, emergency care, immunizations, outpatient surgery, physician visits, and well-child visits.

Copayments None.

Caps or Limitations None.

KANSAS

Caring Program for Children

Covered Services Diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physician visits, substance abuse, vision care, and well-child visits.

Copayments None.

Caps or Limitations There is a limit of four visits to the emergency room and four inpatient days of hospitalization. Physician visits, including well-child visits, are limited to twelve per year. Mental health services include coverage for substance abuse treatment but only on an outpatient basis.

LOUISIANA

Caring Program for Children

Covered Services Diagnostic testing, emergency care, immunizations, outpatient surgery, physician visits, and well-child visits.

Copayments None.

Caps or Limitations Emergency care is covered up to four times per year. Outpatient surgery is covered on an emergency basis, and it is also provided for up to six elective episodes. One well-child visit per year is covered, up to $150.

MARYLAND

Kids Count

Covered Services Diagnostic testing, emergency care, hearing care, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, vision care, and well-child visits.

Copayments A $5.00 copayment is required for prescription drugs.

Caps or Limitations Diagnostic testing, emergency care, and outpatient surgery are provided in hospitals. Substance abuse is covered only as part of the mental health benefit. Vision care is limited to one pair of eyeglasses per year.

MASSACHUSETTS

Children's Medical Security Plan

Covered Services Diagnostic testing, emergency care, hearing care, immunizations, mental health, outpatient surgery, physician visits, prescription drugs, vision care, and well-child visits.

Copayments Copayments vary from $1.00 to $5.00 for diagnostic testing, emergency care, hearing care, mental health, outpatient surgery, physician visits, and vision care. Prescription drugs are subject to a copayment that ranges from $3.00 to $4.00.

Caps or Limitations Coverage for emergency care is limited to $1,000 per year. Mental health benefits are limited to thirteen outpatient visits per year. A maximum of $100 in coverage for prescription drugs is provided. Vision care is available only if medically necessary.

MICHIGAN

Caring Program for Children

Covered Services Diagnostic testing, emergency care, immunizations, outpatient surgery, physician visits, prescription drugs, substance abuse, transportation, and well-child visits.

Copayments A copayment of fifty cents is charged for prescription drugs.

Caps or Limitations Coverage for substance abuse treatment is limited.

MINNESOTA

Minnesota Care

Covered Services — Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, transportation, vision care, and well-child visits.

Copayments — None.

Caps or Limitations — Hospitalization is covered up to $10,000 per year. Mental health services and prescription drugs are subject to the same coverage provisions as in the Medicaid program. Transportation services are covered only in an emergency. Vision care is provided through a state contract.

MISSISSIPPI

Caring Program for Children

Covered Services — Diagnostic testing, emergency care, immunizations, outpatient surgery, and physician visits.

Copayments — None.

Caps or Limitations — None.

MISSOURI

Caring Foundation for Children—St. Louis

Covered Services — Diagnostic testing, emergency care, immunizations, outpatient surgery, physician visits, substance abuse, and well-child visits.

Copayments — None.

Caps or Limitations — None.

Caring Foundation for Children—Kansas City

Covered Services — Dental care, diagnostic testing, emergency care, immunizations, outpatient surgery, physician visits, prescription drugs, and well-child visits.

Copayments — None.

Caps or Limitations — None.

NEBRASKA

Comprehensive Health Insurance Pool

Covered Services — Dental care, emergency care, hearing care, hospitalization, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs and substance abuse.

Copayments — An annual deductible must be met, and then coinsurance of 20 percent is the responsibility of the family for emergency care, outpatient surgery, physical therapy, and physician visits. For mental health and substance abuse services, the coinsurance is 50 percent. No copayment is required for generic prescription drugs.

Caps or Limitations — The lifetime benefits are capped at $500,000. For mental health and substance abuse services, benefits are capped at $25,000. Coverage for dental care is limited to treatment of temporal mandibular joint disorder.

NEW HAMPSHIRE

Healthy Kids

Covered Services — Diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, vision care, and well-child visits.

Copayments — A $10.00 copayment is required for hearing and vision care and mental health services. A $25.00 copayment is required for emergency care if the primary care physician did not make a referral. A $5.00 copayment is required for physical therapy, physician visits, and prescription drugs.

Caps or Limitations — None.

NEW YORK

Child Health Plus

Covered Services — Diagnostic testing, emergency care, immunizations, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, and well-child visits.

Copayments — A $35.00 copayment is charged for inappropriate use of the emergency room. Prescription drugs require a copayment ranging from $1.00 to $3.00.

Caps or Limitations — Substance abuse treatment services are limited to sixty visits per year, and family therapy is limited to twenty visits per year.

NORTH CAROLINA

Caring Program for Children

Covered Services	Diagnostic testing, emergency care, hearing care, immunizations, outpatient surgery, physician visits, and well-child visits.
Copayments	None.
Caps or Limitations	None.

OHIO

Caring Program for Children

Covered Services	Diagnostic testing, hearing care, immunizations, outpatient surgery, physician visits, prescription drugs, and well-child visits.
Copayments	A $3.00 copayment is required for prescription drugs.
Caps or Limitations	Only routine hearing care is covered.

PENNSYLVANIA

Children's Health Insurance Program

Covered Services	Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, vision care, and well-child visits.
Copayments	Prescription drugs require a $5.00 copayment.
Caps or Limitations	None.

RHODE ISLAND

RIteCare

Covered Services	Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, transportation, vision care, and well-child visits.
Copayments	Hospitalization requires a $25.00 copayment. A $15.00 copayment is required for outpatient surgery. A $5.00 copayment is charged for physician visits, except for prenatal or preventive care. Prescription drugs are subject to a $2.00 copayment.
Caps or Limitations	Hospitalization is limited to fifteen days for mental health and substance abuse treatment. Outpatient mental health and substance abuse services are limited to twenty visits per year.

SOUTH DAKOTA

Caring Program for Children

Covered Services	Diagnostic testing, emergency care, hospitalization, immunizations, outpatient surgery, physician visits, and well-child visits.
Copayments	None.
Caps or Limitations	Diagnostic testing is limited to specific procedures, such as radiology services and laboratory tests.

TENNESSEE

TennCare

Covered Services	Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, transportation, vision care, and well-child visits.
Copayments	No copayments are required for families with incomes below 100 percent of the federal poverty level, for Medicaid-eligible families, or for preventive services. For families between 101 percent and 199 percent of the federal poverty level, there is a graduated scale for copayments. For families above 200 percent of the federal poverty level, a copayment of 10 percent of the cost of the service is required.
Caps or Limitations	In general, coverage is provided for services deemed medically necessary. Coverage for inpatient substance abuse treatment is subject to a lifetime limitation of two treatment programs no longer than twenty-eight days each plus two five-day detoxifications. A forty-five visit annual limit on outpatient mental health services is imposed on all participants except those who are chronically mentally ill. Nonemergency transportation services are provided only as necessary for enrollees lacking accessible transportation to covered services.

UTAH

Health Insurance Pool

Covered Services	Diagnostic testing, emergency care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, and well-child visits.
Copayments	A 20 percent copayment is required for all covered services.
Caps or Limitations	Coverage for mental health and substance abuse services is limited.

: Children

Diagnostic testing, emergency care, hearing care, immunizations, outpatient surgery, physician visits, substance abuse, transportation, vision care, and well-child visits.

None.

...ions In lieu of coverage for prescription drugs, a 10 percent discount is offered to enrolled families through a designated pharmacy. Some ambulance care is covered as part of the transportation benefit, and some vision care is donated by providers.

...GINIA

Caring Program for Children

Covered Services Dental care, diagnostic testing, emergency care, immunizations, mental health, outpatient surgery, physician visits, prescription drugs, and well-child visits.

Copayments Prescription drugs require a $3.00 copayment per prescription.

Caps or Limitations Dental care is limited to preventive and diagnostic services. Use of the emergency room is limited to twice per year. Mental health services are limited to six counseling visits per year. Outpatient surgical procedures that are covered include the removal of tonsils and adenoids, repair of hernias, insertion of ear tubes, and repair of broken bones. Coverage for prescription drugs is limited to $500 per year.

WASHINGTON

Basic Health Plan Plus

Covered Services Dental care, diagnostic testing, emergency care, hearing care, hospitalization, immunizations, mental health, outpatient surgery, physical therapy, physician visits, prescription drugs, substance abuse, transportation, vision care, and well-child visits.

Copayments None.

Caps or Limitations None.

WISCONSIN

Youth Med

Covered Services	Diagnostic testing, emergency care, hearing care, hospitalization, immunizations, outpatient surgery, physical therapy, physician visits, prescription drugs, and well-child visits.
Copayments	After a $250 deductible, a 20 percent copayment is required for all covered services except immunizations and well-child visits and except for preventive care offered as part of diagnostic testing and physician visits. A copayment of $5.00 is required for generic prescription drugs and $10.00 for brand-name prescriptions.
Caps or Limitations	Coverage of preventive physician visits is limited to $125 per year.