July 26, 1996

To: Jen Klein

From: Amy Nevel, ASPE/HP

Subject: Blue Cross/Blue Shield and the Caring Programs for Children

In response to your call to Christy Schmidt I'm sending you a draft summary of a National Governors Association report on *Innovative State Health Initiatives for Children* and two tables from that report which outline the costs of the programs described in the report. Please note that we would not base our premium estimates on those for the Caring Programs for Children because those premiums do not reflect the true costs of the program.

If you have any additional questions, please call me at 202/690-7795.

Call for more detail.

NGA--Innovative State Health Initiatives for Children

NGA outlined three types of initiatives which have been used to provide insurance coverage to children--public, private and public/private partnerships. What is remarkable about these programs is that they are fairly unremarkable. Programs differ primarily on the funding mechanisms, eligibility criteria and benefits covered.

Public initiatives. These programs are financed through federal, state or local government funds. Such programs provide insurance primarily through the state Medicaid program. States typically expand their Medicaid program beyond the federal mandate for eligibility. States have also sought waivers to increase coverage of children or have exclusively used state funds to pick up coverage for children where Medicaid ends. The NGA report provides examples of programs in Minnesota (MinnesotaCare), Pennsylvania (Children's health Insurance Program), and Washington (Basic Health Plan Plus.

Private initiatives. NGA reported that these programs are those administrated by Blue Cross and Blue Shield plans as the Caring Programs for Children. These are funded through private donations and by Blue Cross and Blue Shield and operate in about 20 states. The eligibility requirements and benefit packages vary by program. Children cannot be eligible for public assistance and the family cannot otherwise afford private insurance. The NGA report provides examples of programs in Alabama, Missouri, and Utah.

Public/Private partnerships. These programs are funded through public, private and philanthropic funds. NGA describes these as programs where the public and private sectors collaborate to provide and pay for health services for children. Some states have participated in the Caring Programs for Children to do this. Other have combined other resources to provide such services. For example, Colorado funds its programs through private donations, participant fees, and Medicaid funds (from a teaching allowance paid to a university hospital) as well as in-kind contributes. Other programs in Florida and New York are also described by NGA.

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

State	Type of Program	1996 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 Aecess 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.

MEMO

FROM: Cathi Callahan
Jim Mays

DATE: 7 August 1996

RE: Cost Estimates: Clarifications and Next Steps

Below are responses to the next steps noted in Laura's memo of 7 August 1996:

1. Modeling the premiums for groups of children.

   a. This involves converting the per child cost to a per unit cost based on the average number of children in families.
      i. We will be modeling the premium costs associated with covering child units, in addition to our current basis where we price each child individually. If a two-way basis is used (one price for a single child, a second price for two or more), then families with more than two children get something of a break, at the expense of families with only two children. This is a cross-subsidy from smaller families to larger families, rather than a "discount" in the normal sense. We will be developing estimates of the distributions of children by family size and by family income.

2. Providing an explanation of take-up assumptions for the various populations.

   As we refine our estimates and overall participation assumptions, the specific numbers mentioned below are also subject to revision.

   a. Case A is a 'high' participation rate case for each scenario. Rules for participation in Case A are as follows:
      i. Children with or eligible for Medicaid participate only under all of the following conditions:
         (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
         (2) Receive a 100% subsidy.
      ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.
      iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80%

available if reform legislation passes * marginal tax rate of 35%).

iv. Other children with employer sponsored insurance who are under 200% of poverty come in with an average of 10% participation. Participation is sloped by poverty group as follows:
   (1) under 100% of poverty: 16.0% participation
   (2) 100-124%: 13.7% participation
   (3) 125-132%: 11.3% participation
   (4) 133-149%: 9.0% participation
   (5) 150-174%: 6.7% participation
   (6) 175-184%: 4.3% participation
   (7) 185-199%: 2.0% participation

v. Children who are uninsured
   (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 50% participation for those who are partially subsidized (between 133% and 250% of poverty), scaled as follows:
      (a) 133-149%: 96.0% participation
      (b) 150-174%: 78.0% participation
      (c) 175-184%: 60.0% participation
      (d) 185-199%: 42.0% participation
      (e) 200-224%: 24.0% participation
      (f) 225-249%: 6.0% participation
   (2) Scenario 2: 20% participation for those under 250% of poverty, and 10% participation for those at or above 250% of poverty. These rates do not slope by poverty level.
   (3) Scenario 3: 30% participation for those under 250% of poverty, and 15% participation for those at or above 250% of poverty. These rates do not slope by poverty level.

b. Case B is a 'medium' participation rate case for each scenario. Rules for participation in Case B are as follows.

i. Children with or eligible for Medicaid participate only under all of the following conditions:
   (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
   (2) Receive a 100% subsidy.

ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.

iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).

iv. Other children with employer sponsored insurance who are under 200% of poverty come in at 5% participation. The rates used

above for the 10% participation for this class were halved to reach 5% participation.

v. Children who are uninsured
   (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 25% participation for those who are partially subsidized (between 133% and 250% of poverty),scaled as follows:
      (a) 133-149%: 50.0% participation
      (b) 150-174%: 40.5% participation
      (c) 175-184%: 31.0% participation
      (d) 185-199%: 21.5% participation
      (e) 200-224%: 12.0% participation
      (f) 225-249%: 2.5% participation
   (2) Scenario 2: 10% participation for those under 250% of poverty, and 5% participation for those at or above 250% of poverty.
   (3) Scenario 3: 15% participation for those under 250% of poverty, and 7.5% participation for those at or above 250% of poverty.

c. Case C is a 'low' participation rate case for each scenario. Rules for participation in Case C are as follows.
   i. Children with or eligible for Medicaid participate only under all of the following conditions:
      (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
      (2) Receive a 100% subsidy.
   ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.
   iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).
   iv. Other children with employer sponsored insurance who are under 200% of poverty come in at 2.5% participation. The participation rates used for the 5% participation (Case B) were halved to reach 2.5%..
   v. Children who are uninsured
      (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 10% participation for those who are partially subsidized (between 133% and 250% of poverty),scaled as follows:
         (a) 133-149%: 20.0% participation
         (b) 150-174%: 16.2% participation

(c) 175-184%: 12.4% participation
(d) 185-199%: 8.6% participation
(e) 200-224%: 4.8% participation
(f) 225-249%: 1.0% participation

(2) Scenario 2: 5% participation for those under 250% of poverty, and 2.5% participation for those at or above 250% of poverty.

(3) Scenario 3: 7.5% participation for those under 250% of poverty, and 3.75% participation for those at or above 250% of poverty.

3. Providing an explanation of how adverse selection for the uninsured population was determined.

a. Selection effect here is ONLY the effect of bringing in uninsured persons with partial subsidies. Additional effects for age and insurance mix have not been calculated yet.

(1) % of uninsured with partial subsidy calculated for each Scenario/Case.

(2) ARC Small Group Model (multi-year claims based model) used to determine relative cost of those participating.

(a) Model uses prior-use based premiums to model effects.

(b) it was assumed that half of the participants were at the top of the distribution (for X% participation, then X/2% were the most expensive persons), and the other half were randomly distributed from the rest of the distribution.

(3) Starting per capita premium adjusted to reflect contribution by the uninsured to the overall average premium.

(4) Deficit due to selection is calculated as (number of persons receiving partial subsidy) * (actual cost - adjusted uninsured cost).

(5) Selection Impact is defined to be the deficit divided by the gross cost of the program.

4. Modeling adverse selection for those with other private and ESI (self-employed).

a. We will be replicating the logic used with respect to selection in the uninsured population for a subset of these persons.

5. Providing an explanation of how this base premium ($1246) was derived, and then how it compares with numbers from the HSA era.

a. Derivation of the $1246 per child premium:
   i. NMES based covered expenses for the privately insured population calibrated to CBO projections of the National Health Accounts for CY 1996 and inflated to 1997.
      (1) This includes all channels of payment for the following services:
         (a) hospital
         (b) physician
         (c) prescription drugs
         (d) other professionals
         (e) dental
      (2) This is for the entire non-institutionalized population, with the following subgroups looked at specifically
         (a) under 65 (per capita covered expense of $2081)
         (b) under 18 (per capita covered expense of $1466)
   ii. Blue Cross/Blue Shield FEHBP Standard Option plan used to calculate medical and dental benefit rates (average fraction of benefits paid).
      (1) For under 65 (adults), the benefit rates used were as follows:
         (a) medical: 0.7812
         (b) dental: 0.1400
      (2) For under 18 (children), the benefit rates used were as follows:
         (a) medical: 0.7555
         (b) dental: 0.3000
   iii. Benefits adjusted for age and insurance composition of exposed population, as compared to total non-institutionalized.
      (1) Adjustments made for the under 18 population only. The composite factor of 1.0017 was broken down as follows:
         (a) age composition: 1.0374
         (b) insurance composition: 0.9656.
   iv. Benefits adjusted for expected induction by the uninsured. The induction assumption used was that the uninsured would have their expenses brought up to the levels of the privately insured ("Jim-Bob" assumption during HSA). This results in an overall factor of 1.0712.
   v. Benefits adjusted for expected discounts gotten by the federal government (5% reduction).
   vi. Premiums calculated based on an assumed 15% administrative loading charge.

vii. Resulting per child premium is $1246.

b. Comparison of the $1246 per child premium with HSA-era numbers.
   i. HSA starting per family premiums (HCFA) by type of family for 1994 are as follows:
      (1) Single: $1933
      (2) Couple: $3866
      (3) 1 Adult + Kid(s): $3894
      (4) 2 Adults + Kid(s): $4361
   ii. Using counts, per family, and per person costs from the ARC model used at the same time for ASPE, the above per family premiums were converted into per capita premiums for adults and children. Premiums are as follows (1994 terms):
      (1) Per Adult: $1704
      (2) Per Child: $927
   iii. Inflating the HSA per child premium to 1997 (using CBO based factors for private health insurance) results in $1173/child, which is approximately 6% lower than our current estimate.
   iv. Possible differences include:
      (1) HCFA estimates are for the 'alliance' population only (excluding large employer, medicare, medicaid).
      (2) Differences in assumptions for administrative load and discounts.
      (3) Possible differences in the baseline historical national health accounts being used (revisions have occurred since HSA).

6. Modeling changes in employer behavior for the ESI population with the 50% vs. 0% employer contribution requirements.
   a. Refine estimates of persons affected at 50% and 0% level by looking at March 94 CPS and NMES PUF 15 file (employer survey).

MEMO

FROM: Cathi Callahan
Jim Mays

DATE: 8 August 1996

RE: Cost Estimates: Clarifications and Next Steps, Revised

Below are responses to the next steps noted in Laura's memo of 7 August 1996:

1. Modeling the premiums for groups of children.

   a. This involves converting the per child cost to a per unit cost based on the average number of children in families.

      i. We have modeled the premium costs associated with covering child units, in addition to our current basis where we price each child individually. (See table below)

One Way (Per Unit) Rate Base

		Case A	Case B	Case C
Scenario 1	Premium/Unit	$2,398	$2,404	$2,409
	Effect On:			
	<133%	98.8%	99.0%	99.2%
	133-200%	102.9%	103.2%	103.5%
	>=200%	103.0%	103.1%	103.2%
Scenario 2	Premium/Unit	$2,346	$2,345	$2,341
	Effect On:			
	<133%	96.5%	96.5%	96.3%
	133-200%	100.7%	100.7%	100.5%
	>=200%	106.6%	105.6%	105.1%
Scenario 3	Premium/Unit	$2,252	$2,226	$2,207
	Effect On:			
	<133%	92.6%	91.5%	90.7%
	133-200%	96.7%	95.6%	94.8%
	>=200%	107.7%	106.8%	106.1%

      ii. We still are working on the situation where a two-way basis is used (one price for a single child, a second price for two or more). In this situation, families with more than two children get something of a break, at the expense of families with only two children. This is a

cross-subsidy from smaller families to larger families, rather than a "discount" in the normal sense. We expect it to look similar to the above table, with a slightly steeper slope by income.

iii. For both the above cases, we will be developing estimates of the distributions of children by family size and by family income.

2. Providing an explanation of take-up assumptions for the various populations.

As we refine our estimates and overall participation assumptions, the specific numbers mentioned below are also subject to revision.

a. Case A is a 'high' participation rate case for each scenario. Rules for participation in Case A are as follows:
   i. Children with or eligible for Medicaid participate only under all of the following conditions:
      (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
      (2) Receive a 100% subsidy.
   ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.
   iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).
   iv. Other children with employer sponsored insurance who are under 200% of poverty come in with an average of 10% participation. Participation is sloped by poverty group as follows:
      (1) under 100% of poverty: 16.0% participation
      (2) 100-124%: 13.7% participation
      (3) 125-132%: 11.3% participation
      (4) 133-149%: 9.0% participation
      (5) 150-174%: 6.7% participation
      (6) 175-184%: 4.3% participation
      (7) 185-199%: 2.0% participation
   v. Children who are uninsured
      (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 50% participation for those who are partially subsidized (between 133% and 250% of poverty), scaled as follows:
         (a) 133-149%: 96.0% participation
         (b) 150-174%: 78.0% participation
         (c) 175-184%: 60.0% participation
         (d) 185-199%: 42.0% participation

(e) 200-224%: 24.0% participation
(f) 225-249%: 6.0% participation

(2) Scenario 2: 20% participation for those under 250% of poverty, and 10% participation for those at or above 250% of poverty. These rates do not slope by poverty level.

(3) Scenario 3: 30% participation for those under 250% of poverty, and 15% participation for those at or above 250% of poverty. These rates do not slope by poverty level.

b. Case B is a 'medium' participation rate case for each scenario. Rules for participation in Case B are as follows.

i. Children with or eligible for Medicaid participate only under all of the following conditions:
(1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
(2) Receive a 100% subsidy.

ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.

iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).

iv. Other children with employer sponsored insurance who are under 200% of poverty come in at 5% participation. The rates used above for the 10% participation for this class were halved to reach 5% participation.

v. Children who are uninsured
(1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 25% participation for those who are partially subsidized (between 133% and 250% of poverty),scaled as follows:
(a) 133-149%: 50.0% participation
(b) 150-174%: 40.5% participation
(c) 175-184%: 31.0% participation
(d) 185-199%: 21.5% participation
(e) 200-224%: 12.0% participation
(f) 225-249%: 2.5% participation

(2) Scenario 2: 10% participation for those under 250% of poverty, and 5% participation for those at or above 250% of poverty.

(3) Scenario 3: 15% participation for those under 250% of poverty, and 7.5% participation for those at or above 250% of poverty.

c. Case C is a 'low' participation rate case for each scenario. Rules for participation in Case C are as follows.

i. Children with or eligible for Medicaid participate only under all of the following conditions:

(1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and

(2) Receive a 100% subsidy.

ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.

iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).

iv. Other children with employer sponsored insurance who are under 200% of poverty come in at 2.5% participation. The participation rates used for the 5% participation (Case B) were halved to reach 2.5%..

v. Children who are uninsured

(1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 10% participation for those who are partially subsidized (between 133% and 250% of poverty),scaled as follows:

(a) 133-149%: 20.0% participation
(b) 150-174%: 16.2% participation
(c) 175-184%: 12.4% participation
(d) 185-199%: 8.6% participation
(e) 200-224%: 4.8% participation
(f) 225-249%: 1.0% participation

(2) Scenario 2: 5% participation for those under 250% of poverty, and 2.5% participation for those at or above 250% of poverty.

(3) Scenario 3: 7.5% participation for those under 250% of poverty, and 3.75% participation for those at or above 250% of poverty.

3. Providing an explanation of how adverse selection for the uninsured population was determined.

a. Selection effect here is ONLY the effect of bringing in uninsured persons with partial subsidies. Additional effects for age and insurance mix have not been calculated yet.

(1) % of uninsured with partial subsidy calculated for each Scenario/Case.

(2) ARC Small Group Model (multi-year claims based model) used to determine relative cost of those participating.
   (a) Model uses prior-use based premiums to model effects.
   (b) it was assumed that half of the participants were at the top of the distribution (for X% participation, then X/2% were the most expensive persons), and the other half were randomly distributed from the rest of the distribution.

(3) Starting per capita premium adjusted to reflect contribution by the uninsured to the overall average premium.

(4) Deficit due to selection is calculated as (number of persons receiving partial subsidy) * (actual cost - adjusted uninsured cost).

(5) Selection Impact is defined to be the deficit divided by the gross cost of the program.

4. Modeling adverse selection for those with other private and ESI (self-employed).

As Parashar pointed out, transfers from other private and self-employed ESI will not just be those for whom the subsidies result in a lower price compared to average premiums. For some families, the ability to get coverage for a currently high expenditure child may allow the rest of the family to get lower cost coverage, which is not available currently because the sick child would not pass new underwriting.

The selection bias curves used for the uninsured should be suggestive of the bias as a function of enrollment. In modeling bias among the currently uninsured, we assumed 50% of the new enrollees were selecting against the plan, consistent with their ability to predict their medical spending based on the prior year's costs. We assumed the other 50% of the new enrollees came randomly from the rest of the group. To estimate bias for this new group of currently insured persons, it may be more appropriate to use the selection bias curve directly, since the logic of these people enrolling at all is to exploit the lack of underwriting. If 5% of the not-otherwise-enrolling other private and self-employed ESI kids take advantage of this, we would expect an average morbidity of 5 times average.

Note - this only applies because we have assumed guaranteed issue and modified community-rating. If state regulation does not force insurers to rate these products in this manner, than overall participation should be even lower, but selection bias in general would cease to be a major concern.

5. Providing an explanation of how this base premium ($1246) was derived, and then how it compares with numbers from the HSA era.

   a. Derivation of the $1246 per child premium:
      i. NMES based covered expenses for the privately insured population calibrated to CBO projections of the National Health Accounts for CY 1996 and inflated to 1997.
         (1) This includes all channels of payment for the following services:
            (a) hospital
            (b) physician
            (c) prescription drugs
            (d) other professionals
            (e) dental
         (2) This is for the entire non-institutionalized population, with the following subgroups looked at specifically
            (a) under 65 (per capita covered expense of $2081)
            (b) under 18 (per capita covered expense of $1466)
      ii. Blue Cross/Blue Shield FEHBP Standard Option plan used to calculate medical and dental benefit rates (average fraction of benefits paid).
         (1) For under 65 (adults), the benefit rates used were as follows:
            (a) medical: 0.7812
            (b) dental: 0.1400
         (2) For under 18 (children), the benefit rates used were as follows:
            (a) medical: 0.7555
            (b) dental: 0.3000
      iii. Benefits adjusted for age and insurance composition of exposed population, as compared to total non-institutionalized.
         (1) Adjustments made for the under 18 population only. The composite factor of 1.0017 was broken down as follows:
            (a) age composition: 1.0374
            (b) insurance composition: 0.9656.
      iv. Benefits adjusted for expected induction by the uninsured. The induction assumption used was that the uninsured would have their expenses brought up to the levels of the privately insured ("Jim-Bob" assumption during HSA). This results in an overall factor of 1.0712.
      v. Benefits adjusted for expected discounts gotten by the federal government (5% reduction).
      vi. Premiums calculated based on an assumed 15% administrative loading charge.

vii. Resulting per child premium is $1246.

b. Comparison of the $1246 per child premium with HSA-era numbers.
   i. HSA starting per family premiums (HCFA) by type of family for 1994 are as follows:
      (1) Single: $1933
      (2) Couple: $3866
      (3) 1 Adult + Kid(s): $3894
      (4) 2 Adults + Kid(s): $4361
   ii. Using counts, per family, and per person costs from the ARC model used at the same time for ASPE, the above per family premiums were converted into per capita premiums for adults and children. Premiums are as follows (1994 terms):
      (1) Per Adult: $1704
      (2) Per Child: $927
   iii. Inflating the HSA per child premium to 1997 (using CBO based factors for private health insurance) results in $1173/child, which is approximately 6% lower than our current estimate.
   iv. Possible differences include:
      (1) HCFA estimates are for the 'alliance' population only (excluding large employer, medicare, medicaid).
      (2) Differences in assumptions for administrative load and discounts.
      (3) Possible differences in the baseline historical national health accounts being used (revisions have occurred since HSA).

6. Modeling changes in employer behavior for the ESI population with the 50% vs. 0% employer contribution requirements.

The ESI substitution assumptions we discussed were predicated on a 50% employer contribution test, with any employer contribution less than that being considered inadequate, and thus the employees would be eligible for the program being offered. If the test is set at 0%, so any employer contribution makes the employees ineligible, then less substitution should be expected - the employer would have to make a bigger change to qualify. How much less substitution is of course as speculative a question as how much substitution should be expected in the base case. Using 3/4 as much seems plausible. NMES shows only 15% of employers had employer contributions under 50% for family coverage in 1987. Even if this is higher now, it shows the fraction of plans that bother to have an employer contribution without it being at least half is small (quite understandably). Thus, the fraction of employers who would be willing to cut their contributions to a low level (less than half) but who would not cut them to zero is arguably small.

GEORGETOWN UNIVERSITY MEDICAL CENTER → Colorado program?

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: Jennifer Klein

FAX Number: .....

FROM: Jason

Pages:

Comments: (1) I HAVE ATTACHED MORE MUSINGS ABOUT AN EITHON — Since these days Rhetoric ≠ Reality, it might help. ALSO, CHECK OUT THE QUOTES FROM OUR FAVORITE GOVERNORS

(2) COSTS: THIS COULD, IF I SPEND MORE TIME, BE $15-20b between 97-02 [actually 98]. I am working to reduce the CSI dropping assumptions, which we did 2 years ago and I think were too conservative

(3) Discussion - we could do it over the phone or next week if it's more convenient.

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

Summary of the Children's Program

- **The Problem: Children in working families are losing coverage.** A startling trend in recent years is the decline in health coverage for children in working families. As insurance costs rise, workers in low-wage jobs or small businesses often find dependent coverage inaccessible or unaffordable. The General Accounting Office reports that the percentage of children with private coverage reached the lowest level in the last eight years — paralleled by an increase in the percentage of children with no insurance. Ten million children, or nearly one in every seven children, lack health coverage. It is not the poorest children who are at risk; they are eligible for Medicaid. The concern is for those children above poverty but below an income level that allows families to afford private health insurance.

- **The Program: Voluntary, public-private partnership.** In simple terms the program offers the following swap:

  The Federal government asks States to cover all eligible children, using uniform, national eligibility and benefits standards.

  The State government designs its own delivery system for this coverage in return for participation in this national "safety net".

  - ***Benefits working families***: This is a program for the families who work at low-wage jobs or in small firms that cannot afford to cover health insurance for dependents.

  - ***Builds on State experience:*** All elements of the program have been tested in Medicaid waivers, State programs, or public-private partnerships.

  - ***Encourages innovation:*** In 1995, over 30 States implemented or sustained either state-sponsored or public-private partnerships to cover children. Each program is unique in its funding and delivery system. The Federal government will offer to participate in these partnerships. It will contribute a limited amount of funding to supplement state, private and participant contributions.

  - ***Limits Federal costs***: Federal costs are limited because the program: (a) contributes a Federal payment based on Federal Medicaid spending, with States and participants filling in the rest of the costs; (b) allows States to use their current Medicaid funding for non-disabled children in working families; and (c) limits eligibility to children who have not had access to insurance recently and are in families with workers with incomes below [200 percent] of poverty.

Other Reasons:

1. It captures some of the money that we are withdrawing from the health system through Medicaid and Medicare proposals and reinvests in kids. It also leverages current-law Medicaid funding by allowing states to shift money for OBRA and optional kids in working families into the program.

2. Given recent trends, the Medicaid baseline will continue to decline. While it is high (which it hopefully will be in the Spring), we should get savings so we can have money to reinvest.

3. States will likely hate the Welfare Reform Chafee-Breaux amendment. For children, this could replace it.

4. Most governors could support such a policy, which could lessen the pressure on general Medicaid program flexibility demands.

5. The uninsured problem is greater for kids than for the temporarily unemployed, especially now, when unemployment is low and the number of uninsured kids is growing.

6. In the wake of welfare reform, it might be good to have something for kids. This would be national, uniform eligibility, so it maintains a national standard for coverage but gives states great discretion in how that coverage is implemented.

enrollees. Other proposals that became legislative bills include an expansion of Maine's small group insurance reforms to cover groups of up to 99 (the previous cut-off was at 25) and the continuation of phased-in community rating, which was authorized in 1994.

Senate Human Resources Committee Chair Joan Pendexter (R) supports modest changes, but sees major reform as too expensive for the state. "It's difficult to think a small state like Maine can effect major change without a national policy to support it. I do not feel tax [increases] are an effective way to deal with health care," she says. "The problem is affording premiums, and the purchasing alliance could be a solution."

Senate Banking and Insurance Committee Chair Joel Abromson (R) agrees that a purchasing alliance could become a reality along with a task force to monitor hospital de-regulation and collect data. Ellen Jane Schneiter, executive director of the Maine Health Care Commission, also expects little more than the health alliance to become law although she sees value in more extensive reforms. "For now I'd like to see us get incremental reforms that we can build on." she says.

Also in its health care reform proposal, Maine has a provision to expand Medicaid to cover all children through age 18 living at or below 250 percent of the poverty line. But because of budget restrictions, the prospect for such an expansion is unlikely.

In Colorado, where incremental approaches have tended to dominate, the legislature considered a bill early in the session that encouraged a public-private solution to the uninsured problem. Produced by a governor-appointed task force, the bill would have encouraged partnerships between businesses, health providers, health insurers, health maintenance organizations and local governments to develop pilot projects, which would have subsidized direct services or coverage for uninsured pregnant women and children to age 18 with incomes under 185 percent of poverty. Limited to $14 million and considered a good first step by reform supporters, the bill also enjoyed extensive support from the business and health provider communities. Initially it had good momentum and won unanimous passage by the House Education, Welfare and Institutions Committee, but it ultimately fell victim to partisan politics and was defeated in the House Finance Committee.

Supporters take some heart from the media attention and support the bill was able to gain its first time out, and they think next year could produce a better outcome for similar legislation. "I think there's definitely hope for the future of this type of legislation because of the broad community support it received," says Annie Van Dusen, senior policy analyst for the Office of Public and Private Initiatives in the Department of Health Care Policy and Financing. From: 1996 State Legislative Sessions, Alpha Center, March/April 1996

Expansion of Programs for Children

One constituency whose coverage remains a priority is children. Governors across the country are supporting expanded programs for their youngest citizens in the name of "protecting the state's most precious resource," as Florida Gov. Lawton Chiles (D) put it. Or as Colorado Gov. Roy Romer (D) argues, "Can't we at least agree that in Colorado we have a moral obligation to hold our children harmless and to provide each and every one of them with basic health care in the early years?"

In Florida, Chiles' 1996-97 budget includes $33 million to expand the state's Healthy Kids Program. Started as a pilot program in 1990, Healthy Kids currently covers 26,500 children in seven of the state's 67 counties. The additional funding would be used to cover 12,000 children ages 5 to 18, and 98,000 children under the age of six. The legislature convenes this month with leaders emphasizing that this will be a tight year for any new spending although the governor's support will ensure that the proposed expansion receives full consideration.

In Colorado, Romer set aside $14 million to increase the number of children who have health coverage in the state. In his state of the state address in January, Romer asserted that the state could afford the expenditure this year, and he urged the General Assembly to use the funds creatively to reach as many as possible of the 150,000 who don't

have health coverage because their families cannot afford it.

In New York as well, Governor Palatki (R) has included in his budget the funds to double from 100,000 to 200,000 the number of low-income covered by the state's Children's HealthPlus insurance program.

Hot Issues for 1996: Maternity Stays and Any Willing Provider

Two types of bills that fall under the "consumer protection" or "anti-managed care" labels, depending on one's perspective, are high on the agenda of a number of states this year. Minimum maternity stay bills are making their way onto legislative agendas in most states this year with proposals varying from insurer benefit mandates to codifying prevailing medical practice to state requirements that further studies take place before anything can be passed. Despite various hesitations, Iowa, Kentucky, Maine, Minnesota, Washington, Maryland, Missouri and New York all expect that some measure will pass to protect new mothers against having to leave the hospital before it is medically safe for both mother and child.

Meanwhile, any willing provider and any willing pharmacy provisions also continue to rise to the top of the legislative agendas in Vermont, Missouri, Colorado and Washington. As in previous years, however, little action is anticipated.

In a new twist, however, Iowa legislators are debating an "any-willing-rural-provider" bill. It would require managed care plans with limited provider networks to accept providers and hospitals in rural areas for their point of service plans.

Outlook

After years of ambitious reform efforts at the state and national levels, 1996 is proving to be a year for legislative review and recovery. Clearly conservative shifts nationwide have slowed the push toward major health policy change, and health issues are significantly less audible on the 1996 presidential campaign trail than they were in 1992.

Regardless of how the politics play in the next four years, many state policy makers expect to see a renewed commitment to health care reform early next century because they see substantial coverage problems remaining unsolved. They also project that by then, middle class voters will make up a larger percentage of those needing help to secure and maintain health insurance. Many of those willing to make a long-term prediction view this year as more of a lull in the activity than the end of the story.

SUMMARY -- COST ESTIMATES OF KIDS ONLY HEALTH INSURANCE PROPOSALS

Given these options, if such a program were implemented, at most 37% of program participants would be members of the target population (the presently uninsured). -- Scenario 1

Given these subsidies, keeping out children who currently have Medicaid or employer-sponsored insurance will be non-trivial.

Keeping out children who currently have coverage through non-employment based private insurance will be difficult (consider requirement of 6-month uninsured period). While data from the March 1995 CPS shows fewer such children than the earlier surveys had suggested, the number is still large relative to the number of uninsured children who can plausibly be expected to take advantage of a limited subsidy.

- There are close to 1 million children with other private health insurance with incomes less than 133% of poverty.

These child coverage initiatives based on subsidizing purchase of insurance face two major problems:

- **limited effectiveness** in terms of getting currently uninsured children to enroll, and
- **limited efficiency** in terms of spending new dollars only on the uninsured, and only on services which would not otherwise be received

Scenario 1
Draws in the greatest number of those who are presently uninsured -- both in absolute numbers and in terms of the percentage of the subsidized population which is made up of the target (uninsured now) population. A major reason is that a full subsidy is available to those with incomes less than 133% of poverty, a cohort with a relatively high concentration of uninsured individuals.

Those with Medicaid (and above the Federal floor) come in *only* under this scenario, which offers a full subsidy to those with incomes below 133% of poverty.

Scenario 2
Draws in fewer of the presently uninsured than Scenario 1, because a smaller subsidy (25%) is available to those with incomes less than 133% of poverty. This results in a subsidized population which is smaller overall and consists of a larger percentage of those who had some form of insurance prior to the subsidy.

Scenario 3
Also draws in fewer of the presently uninsured than Scenario 1 (but slightly more than Scenario 2), again due to the less generous subsidy (50%) available to those with incomes less than 133% of poverty.

Draws in more of those who currently have insurance, both other private and ESI, self-insured, than Scenario 2, due largely to its more generous subsidy provisions to those above 250% of poverty.

Fall '94 Proposal (Scenario 1) -- Summary Cost Estimates

50% Emp Contribution (top) and 0% Emp Contribution (Bottom) Requirements

				Participants - Coverage Prior to Program					
Scenario 1 (50% Req)	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1300	9.1 m	36%	2.8 m	0.4 m	1.1 m	3.2 m	1.1 m	0.4 m
B	$1300	7.9 m	33%	2.3 m	0.3 m	1.1 m	3.2 m	0.5 m	0.4 m
C	$1300	7.2 m	30%	1.9 m	0.2 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$11.7 B	$10.5 B	68%	$1100	$400 m	3.5%
B	$10.4 B	$9.4 B	68%	$1200	$540 m	5.5%
C	$9.4 B	$8.7 B	68%	$1200	$460 m	5.2%

				Participants - Coverage Prior to Program					
Scenario 1 (0% Req)	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1300	9.3 m	37%	2.8 m	0.6 m	1.1 m	3.2 m	1.1 m	0.4 m
B	$1300	8.0 m	34%	2.3 m	0.4 m	1.1 m	3.2 m	0.5 m	0.4 m
C	$1300	7.2 m	31%	1.9 m	0.3 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$12.0 B	$10.6 B	68%	$1100	$400 m	3.7%
B	$10.5 B	$9.4 B	68%	$1200	$600 m	5.8%
C	$9.5 B	$8.7 B	68%	$1200	$500 m	5.5%

ARC Estimates of Kids-Only Health Insurance Proposals

50% Employer Contribution Requirement

Scenario 1: Full Subsidy<133% Poverty, Partial Subsidy to 250% Poverty (Fall '94 Proposal)

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 50% participation for those from 133% to 250% poverty
Case B had 25% participation for those from 133% to 250% poverty
Case C had 10% participation for those from 133% to 250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 1	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
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C	$1300	7.2 m	30%	1.9 m	0.2 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
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ARC Estimates of Kids-Only Health Insurance Proposals

0% Employer Contribution Requirement

Scenario 1: Full Subsidy<133% Poverty, Partial Subsidy to 250% Poverty (Fall '94 Proposal)

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 50% participation for those from 133% to 250% poverty
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	Financing					
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B	$10.5 B	$9.4 B	68%	$1200	$600 m	5.8%
C	$9.5 B	$8.7 B	68%	$1200	$500 m	5.5%

NOTE TO: Jim Mays, ARC
Cathi Callahan, ARC

FROM: Laura Brice, ASPE

SUBJECT: Next Steps in Cost Estimates for Kids Health Insurance Proposals

DATE: August 7, 1996

Regarding yesterday's conference call with Treasury, OMB, and Labor, the following is a list of next steps which were suggested:

- Modeling the premium for groups of children -- could there be a discount for families with multiple children? What would be the demographics (such as income distribution) of such a discount? Cob tomorrow
- Providing a written explanation of take-up assumptions (including poverty slope, elasticities used -- is that correct?) for the various populations - today
- Providing a written explanation of how adverse selection for the uninsured population was determined today
- Modeling adverse selection for those with other private and ESI (I'm assuming self-employed here, is that correct?) -- if health status affects their premiums in the private market but not this new program, how many of the sickest people will switch to the new program? Cob tomorrow
- Providing a written explanation of how this $1246 premium compares with numbers from the HSA era -- how is the increase accounted for? - Cob tomorrow
- Modeling changes in employer behavior (the ESI population) with the 50% versus the 0% employer contribution requirements -- will employers change their rate of contribution in response to different eligibility requirements for this program? Cob tomorrow (?)

I think this covers the concerns that were raised. Let me know if you think I have left something out. Jack is very interested to know the timeline for completing these next steps. What information might it be possible to obtain today and how long might the additional modeling take? Jack needs to let Andie King know when we would be able to brief her on the outcome of these analyses.

Thank you.

Improving Children's Access to Health Care

Issue:

Today, 10 million out of 70 million children - or 14% - are uninsured. Many more children are underinsured, with limited access to critical preventive and primary care services. Children may be especially vulnerable because of their particular need for early preventive and primary care services and because of the lack of dependent coverage offered by employers.

Executive Summary of Options:

There are several possible approaches to help improve access to health care for American children. The options range from encouragement of private sector and state initiatives to federal participation in funding either health care services or health insurance coverage. Government efforts can encompass a variety of approaches, including advocating the development of child-only health insurance policies, utilizing existing program authorities to their full extent, expanding the direct financing of services and enhancing entitlement programs. These options are not mutually exclusive and could be "packaged" to address a range of populations.

I. Create a Bully Pulpit

A. Campaign for Children's Health Insurance

- Campaign to employers to emphasize how inexpensive insurance for children really is.
- Campaign to the Insurance Industry to encourage the offering of products for primary and preventive care for children.

B. Develop a Model Law for State Mandate for Children's Health Insurance Coverage

- Develop a model law, to be used by states, that would mandate that health insurance companies which sell policies in that state must include child-only policies among their options.
- Work with the American Academy of Pediatrics to develop a model benefit package for children and adolescents.

II. Create A Children's Health Network through a Public-Private Network

- Support a new program for creating Children's Health Networks: A Public-Private Partnership which would assist local communities in enhancing existing networks or creating new partnerships of providers. Grant funds would be awarded to states in partnership with targeted local communities, including EZ/EC areas (e.g., states could work in partnership with local health departments, health care organizations, or local philanthropic health care foundations).

III. Enhance Support for Existing Programs that Serve Children

A. Work with states to improve methods for enrolling eligible children into Medicaid by

identifying and promoting more effective ways of enrolling eligible children and assuring that they receive appropriate primary and preventive care services.

B. Encourage states to use existing Medicaid authority for a "buy-in" option for child-only coverage to make available an affordable benefit package. How many states ?
How much administrative costs ?

C. Expand funding for Community Health Centers (CHC) targeting geographic areas and population groups where levels of uninsurance among children are particularly high and/or growing.

D. Expand investment in School Health Programs to develop school-based/linked programs that would directly benefit many of the children who lack adequate health insurance coverage or access to health care services. Communities design programs
How successful ?

E. Encourage state experimentation through the Maternal and Child Health (MCH) Block Grant. States could be encouraged to use block grant funds for health insurance experiments directed at uninsured children and/or the federal government could continue/expand its investment in SPRANS projects (special projects of regional and national significance), a number of which improve children's access to health care.

Caring for Kids

Proposal Outlines

Fall '94 Proposal (Scenario 1)

- Full subsidy < 133% poverty
- Sliding subsidy from 133% - 250% poverty
- No subsidy for >= 250% poverty
- Medicaid Substitution -- if subsidy is 100%, those above Federal floor are assumed to come in

Andie King 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

Conditions Examined

- Substitution Effects
- Adverse Selection
- 0%/50% Employer Contribution Requirements

What Can You Do?

You can help support the Caring Program for Children by referring needy children or by sponsoring someone enrolled in a program. For more information about the program and its eligibility requirements or to contribute to one of the Caring Programs, call 1.800.543.7105.

The Caring Program for Children is currently available in conjunction with the following 25 independent Plans.

Blue Cross and Blue Shield of Alabama
Blue Cross of California
Blue Cross and Blue Shield of Georgia
Blue Cross of Idaho Health Service Inc.
Blue Shield of Idaho
Blue Cross and Blue Shield of Iowa
Blue Cross and Blue Shield of Kansas
Blue Cross and Blue Shield of Louisiana
Blue Cross and Blue Shield of Maryland
Blue Cross and Blue Shield of Massachusetts
Blue Cross and Blue Shield of Michigan
Blue Cross and Blue Shield of Mississippi
Blue Cross and Blue Shield of Missouri (St. Louis)
Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Montana
Blue Cross and Blue Shield of Central New York
Blue Cross and Blue Shield of North Carolina
Blue Cross and Blue Shield of North Dakota
Community Mutual Blue Cross and Blue Shield (Cincinnati)
Independence Blue Cross (Philadelphia)/ Pennsylvania Blue Shield
Blue Cross of Western Pennsylvania (Pittsburgh)/ Pennsylvania Blue Shield
Blue Cross of South Dakota and South Dakota Blue Shield
Blue Cross and Blue Shield of Texas
Blue Cross and Blue Shield of Utah
Blue Cross and Blue Shield of Virginia
Blue Cross and Blue Shield of Wyoming

Jud Gordon 6207

For further information about the Caring Program, contact:
Charles P. LaVallee, Vice Chairman
National Coordinating Council of Caring Programs for Children
Western Pennsylvania Caring Foundation
P.O. Box Caring
Pittsburgh, PA 15230
412.645.6200

6202 CHIP Program

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Building For A Stronger Future

Caring Program for Children℠

Our Goal

- A healthier future for children

Our Commitment

- Primary and preventive care for children

Our Solution

- The Caring Program for Children℠

What Is the Caring Program for Children?

The Caring Program for Children is an exceptional community outreach effort the Blue Cross and Blue Shield System of independent Plans supports as a commitment to health care access and wellness. The program provides primary health care coverage to uninsured children at no cost to their families.

The first Caring Program for Children began in 1985 at Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield (independent licensees of the Blue Cross and Blue Shield Association). A totally original concept, the program was conceived out of desperate need. Pittsburgh's steel industry collapse in 1984 created massive layoffs and dislocations. Newly unemployed workers found themselves not only without jobs but without health care coverage as well. The children of these workers became suddenly vulnerable: an unforeseen accident or sickness could push these families over the financial edge.

For the thousands of workers who were devastated by these circumstances, the Caring Program for Children became a much needed safety net. It provided a primary health care package to children whose families could not afford health insurance for them. Since then, Blue Cross of Western Pennsylvania's Caring Program has enrolled more than 30,000 children.

The success of the program and its need in these uncertain economic times have fostered the replication of the Caring Program across the nation. Currently, 25 Caring Programs have been established by independent Blue Cross and Blue Shield Plans, and more than 120,000 children have benefited.

How Does It Work?

Although each program varies Plan by Plan, they all offer the same assurance of quality health care coverage and personal dignity. The standard Blue Cross and Blue Shield Plan identification card furnishes Caring Program children with a benefit package that commonly includes immunizations, well-child care, sick-child care, diagnostic tests, emergency accident and medical care, and outpatient surgery.

Eligibility guidelines vary among programs, but all children who qualify live at home and are from families who are ineligible for public assistance and who cannot afford private health insurance for their children.

Who Supports the Program?

Support for the Caring Programs is a true grass-roots effort. Local businesses, foundations, religious organizations, civic groups, schools, unions and individuals sponsor children in the program. In some regions, community contributions are matched by the participating Blue Cross and Blue Shield Plans, which cover all administrative costs. Every dollar contributed is, therefore, used to pay for the children's health coverage. The Caring Programs represent a powerful example of the private sector working to solve community and national problems.

Where Is It Going?

State legislators have begun to recognize the value of Caring Programs as they search for ways to address the needs of uninsured children. In New York and Pennsylvania, Caring Programs have served as models for statewide programs. In addition, the local independent Blue Cross and Blue Shield Plans fulfill a major role in the administration of these programs.

Even though legislation is imminent, national health care reform may not take effect immediately. In the meantime, tens of thousands of children are without health care coverage now. We need ongoing solutions such as the Caring Programs to take our children into the future.