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HEALTH INSURANCE FOR CHILDREN

State and Private Programs Create New Strategies to Insure Children

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The Honorable Christopher J. Dodd
Ranking Minority Member
Subcommittee on Children and Families
Committee on Labor and Human Resources
United States Senate

Dear Senator Dodd:

Since 1987, the number of children covered by employment-based health insurance has decreased, and, by 1993, more than 9.3 million children lacked health insurance. Studies have shown that uninsured children are less likely than insured children to get needed health and preventive care. Lack of such care can adversely affect their health status throughout their lives.

In the mid-1980s, several states began using state and other nonfederal funds to develop health insurance programs for children who were caught in the uninsured gap between private insurance and Medicaid, the federal/state program that insures some low-income people. In addition to state efforts, Blue Cross/Blue Shield organizations throughout the United States developed privately funded programs to insure children. At the same time, the federal government and many states expanded eligibility for Medicaid, the primary source of insurance for poor children.[1]

The 104th Congress is considering legislation making the Medicaid program into a block grant, limiting the growth of program expenditures, and removing most guarantees of eligibility for coverage and requirements for states to cover services. Such restructuring could give states significantly more flexibility in how they provide insurance to children.

In light of these developments, you asked us to examine emerging state and private efforts to insure children who are not eligible for Medicaid and whose families are not able to purchase private coverage. Specifically, you asked us to provide information on (1) enrollment, costs, funding sources, and annual budgets of these state and private programs; (2) the strategies these programs have used to manage costs while providing children access to health care; and (3) program design elements that have facilitated program implementation.

[1] Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995).

To answer these questions, we visited six programs in five states: two privately funded programs—the Alabama Caring Program for Children and the Western Pennsylvania Caring Program for Children—and four state-funded programs—the Florida Healthy Kids Program, MinnesotaCare,[2] New York's Child Health Plus Program, and Pennsylvania's Children's Health Insurance Program.[3] We selected programs that had at least 2 years' operational experience at the time of our visit and that represented a variety of approaches in diverse geographic areas. (See app. II for more detail on specific programs.)

For each program, we reviewed relevant program documents and interviewed program officials, participating insurers or managed care organizations, and physicians. We also interviewed officials from the Department of Health and Human Services' Health Care Financing Administration (HFCA), which administers the Medicaid program, and representatives from children's advocate organizations in program states. We analyzed other information, including information collected by the National Governor's Association, on programs to insure children. We performed our work between November 1994 and October 1995 in accordance with generally accepted government auditing standards.

Results in Brief

In the mid-1980s, states and private organizations began developing health insurance programs to increase health care access for children. By 1995, 14 states and at least 24 private-sector organizations had such programs. The number of children enrolled in the six programs we visited ranged from more than 5,000 to more than 100,000. Unlike state Medicaid programs, which operate as open-ended entitlements funded in part by the federal government, these programs operated within fixed and often limited budgets and were funded by various nonfederal sources, such as dedicated state taxes and private donations. To better target their resources, the state- and privately funded programs restricted eligibility for subsidized services to low-income, uninsured, or underinsured children. Regardless, limited budgets compelled five of the six programs to cap enrollment at times and to place eligible children on waiting lists.

[2]MinnesotaCare began as a state-funded program and is classified as such in this report. However, the children participating in the program were transferred to Medicaid on July 1, 1995, as part of Minnesota's Medicaid 1115 waiver.

[3]We also visited Maine's Medicaid program, which now covers children of similar ages and family incomes as did the Maine Health Program, a state-funded program that is no longer in existence. However, this report focuses solely on programs that were state- or privately funded at the time of our visit.

To manage their costs, the programs used several strategies. Some limited services covered, but all covered basic preventive and outpatient services. Some of the programs that did not provide inpatient care relied on Medicaid to provide this service. Other cost-management strategies included patient cost-sharing through premiums and copayments, enrolling children in managed care, and using competitive bidding to select insurers.

The six programs were designed to attract both providers and families. Most operated, at least partially, through nonprofit or private insurers, which enabled the programs to use existing provider payment systems and physician networks and to offer near-market reimbursement rates—features that appealed to insurers and providers. For patients, the programs guaranteed access to a provider network, had simple enrollment procedures, and took specific steps to avoid the appearance of a welfare program. Moreover, initial surveys suggested that children in these programs increased their access to and appropriate use of health care.

Background

Health insurance helps children obtain health care. Children without health insurance are less likely to have routine doctor visits, seek care for injuries, and have a regular source of medical care. Their families are more likely to take them to a clinic or emergency room (ER) rather than a private physician or health maintenance organization (HMO).[4,5,6] Children without health insurance are also less likely to be appropriately immunized—an important step in preventing childhood illnesses.[7,8]

During the 1980s, employment-based health insurance—the most common source of health coverage for Americans—decreased. By 1993, more than 39 million Americans lacked any type of health insurance. Almost

[4]Barbara Bloom, Health Insurance and Medical Care: Health of Our Nation's Children, United States (Hyattsville, Md.: Advance Data from Vital and Health Statistics, National Center for Health Statistics, No. 188, 1990).

[5]David L. Wood and others, "Access to Medical Care for Children and Adolescents in the U.S.," Pediatrics, Vol. 86, No. 5 (1990), pp. 666-673.

[6]Mary D. Overpeck and Jonathan B. Kotch, "The Effect of U.S. Children's Access to Care on Medical Attention for Injuries," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 402-404.

[7]Charles N. Oberg, "Medically Uninsured Children in the United States: A Challenge to Public Policy," Pediatrics, Vol. 85, No. 5 (1990), pp. 824-833.

[8]David U. Himmelstein and Steffie Woolhandler, "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 341-344.

one-quarter of these people were children, despite the relative affordability of providing insurance for children.[9]

Uninsured children are generally children of lower-income workers. Lower-income workers are less likely than higher-income workers to have health insurance for their families because they are less likely to work for a firm that offers insurance for their families. Even if such insurance is offered, it may be too costly for lower-income workers to purchase.[10] In 1993, 61 percent of uninsured children were in families with at least one parent who worked full time for the entire year the child was uninsured. About 57 percent of uninsured children had family income at or below 150 percent of the federal poverty level.

Recognizing the need to provide insurance for children, the federal government and the states expanded children's eligibility for Medicaid, a jointly funded federal/state entitlement program. Beginning in 1986, the Congress passed a series of Medicaid-expansion laws that required states to provide coverage to certain children and pregnant women and gave states the option to expand eligibility further.[11] Many states opted to use this approach instead of funding their own programs, because expanding Medicaid allowed them to get matching federal funds. As of April 1995, 37 states and the District of Columbia had expanded coverage for infants or children beyond federal requirements. In addition to these expansions, between 1991 and August 1995, five states implemented Medicaid demonstration waivers, some of which included coverage expansions to some uninsured children. Between 1989 and 1993, Medicaid expanded from covering 14 percent of U.S. children (8.9 million) to 20 percent (13.7 million). Nevertheless, many uninsured children remain ineligible for Medicaid.

[9]Personal health care expenditures per capita for children were $737 in 1987 (the most recent national data available)—one-sixth those of the elderly. VHI-Lewin, a health care consulting firm, estimated that the United States could implement a Medicare-type system of coverage for children using existing public and private coverage plus an increase of $5.7 billion—an increase of 0.4 percent over current national health spending. See Robert G. Hughes, Tania L. Davis, and Richard C. Reynolds, "Assuring Children's Health As the Basis for Health Care Reform," Health Affairs, Vol. 14, No. 2 (1995), pp. 158-167.

[10]GAO/HEHS-95-175, July 19, 1995.

[11]The Omnibus Budget Reconciliation Acts of 1986 (P.L. 99-509), 1987 (P.L. 100-203), 1989 (P.L. 101-239), and 1990 (P.L. 101-508) and the Medicare Catastrophic Care Amendments of 1988 (P.L. 100-360).

State- and Privately Funded Programs Improved Children's Coverage

Beginning in 1985, states and private entities began to fund programs that provided insurance for children who were ineligible for or not enrolled in Medicaid and did not have private or comparable insurance coverage.[12] The programs we visited varied in several respects, but all were limited in how many children they could cover by the size of their budgets, which depended on their funding sources. Every state had substantially more uninsured children than children enrolled in one of these programs. Almost all of these programs have had to restrict enrollment and develop waiting lists of children who could not enroll because of insufficient funding. To target their funding, most programs restricted enrollment to low-income, uninsured children not enrolled in Medicaid.

Programs Varied in Several Respects, but All Provided Coverage Through Set Budgets

In 1995, 31 states had either a publicly or privately funded program that provided health insurance coverage for children.[13] (See app. I for a list of these states.) Fourteen states had publicly funded programs that provided insurance for children, which generally relied heavily on state funding. In 1994, these programs enrolled from 39 to 98,538 children and had budgets ranging from about $240,000 to about $71.5 million.

In addition to state-level efforts, the private sector developed voluntary insurance programs supported through philanthropic funding. The best known of these are the Caring Programs, sponsored by 24 Blue Cross/Blue Shield organizations in 22 states. The Caring Programs, which served more than 41,000 children in 1994, ranged in size from 400 to almost 6,000 enrolled children and had budgets from $100,000 to $4.3 million.

The four state- and two privately funded programs that we visited varied in enrollments and funding sources. They provided insurance coverage to between 5,532 and 104,248 children under set yearly budgets. Much of the state programs' funding came from state general revenues, cigarette or tobacco taxes, or health care provider taxes; counties; and foundations and other private-sector entities. The private programs each received funding from Blue Cross/Blue Shield and from private individuals and organizations.

[12]For other discussions of these programs, see Ian T. Hill, Lawrence Bartlett, and Molly B. Brostrom, "State Initiatives to Cover Uninsured Children," The Future of Children, The Center for the Future of Children, Vol. 3, No. 2 (Los Altos, Calif: 1993); Patricia Butler, Robert L. Mollica, and Trish Riley, Children's Health Plans, National Academy for State Health Policy (Portland, Maine: 1993); Christopher DeGraw, M. Jane Park, and Julie A. Hudman, "State Initiatives to Provide Medical Coverage for Uninsured Children," The Future of Children, The Center for the Future of Children, Vol. 5, No. 1 (Los Altos, Calif: 1995).

[13]Much of this information comes from Deborah F. Perry, "Innovative State Health Initiatives for Children," Stateline, National Governor's Association (Washington, D.C.: 1995).

The programs' costs, covered services, and premium subsidies also varied. Moreover, four of the programs operated statewide, but Florida Healthy Kids and the Western Pennsylvania Caring Program for Children operated only in certain counties. (See table 1.)

Table 1: Characteristics of the Six Programs

Program name, type, and implementation date	Enrollment, 7/95	Cost per child per month	Funding sources	Annual budget, 1994 (in millions)	Covered services	Premium, copayment, and deductible
Alabama Caring Program for Children (private, 1988)	5,922	$20.00	Private donations, Blue Cross/Blue Shield	$1.7	Outpatient only	No premium, some copayments, no deductibles
Western Pennsylvania Caring Program for Children (private, 1985)	5,532	70.60	Private donations, Blue Cross/Blue Shield	4.3	Outpatient; limited inpatient	No premium, some copayments, no deductibles
Pennsylvania's Children's Health Insurance Program (state, 1993)	49,634	62.60	State cigarette tax, premium payments, insurer donations	21	Outpatient; limited inpatient	Sliding scale premium, some copayments, no deductibles
New York's Child Health Plus Program (state, 1991)	104,248	54.71	State Bad Debt and Charity pool raised through hospital assessments and premium payments	55	Outpatient only	Sliding scale premium, some copayments, no deductibles
Florida Healthy Kids Program (state, 1992)	15,254	46.50[a]	State general revenue funds, several types of county funds, school board funds, premium payments	8.8	Outpatient and inpatient	Sliding scale premium, some copayments, no deductibles
MinnesotaCare (state, 1992)	44,689	53.00	State and federal Medicaid funds, premium payments	36.6[b]	Outpatient and inpatient	Sliding scale premium, no copayments, no deductibles

[a]For Volusia County.

[b]MinnesotaCare's budget included services for child and adult participants.

Unlike state Medicaid programs, which operate as open-ended federal/state entitlements, all the programs we reviewed operated within limited and fixed budgets. These budgets did not allow them to cover most of the uninsured children in their states. The private program budgets were limited by the amount that could be raised by corporate donors, such as Blue Cross/Blue Shield, and individual donors. The state-funded

programs had larger budgets, but they, too, were limited by the amount of funding states were willing to devote to insuring children.

All the states in which these programs operated had more uninsured children than children enrolled in the programs.[14] For example, New York's Child Health Plus Program represented a substantial investment for the state in children's health coverage—$55 million—and it had the largest enrollment: 104,248. But in 1993, New York State had almost half a million uninsured children. Other programs could only cover a small fraction of their uninsured. For example, Alabama had 156,000 uninsured children in 1993, and its Caring Program covered 5,922 in 1995—only about 3 percent. MinnesotaCare had the highest ratio of enrolled children in 1995 to uninsured children in 1993: 44,689 to 76,517, or 58 percent.

Lack of funding forced all the programs we visited (except Minnesota's) to restrict enrollment at times and to relegate children who applied for the program to waiting lists. According to child advocates and officials of these programs, restricting enrollment and developing waiting lists undermine program credibility. In addition, Florida has been unable to start its Healthy Kids Program in many interested counties because the program has lacked funding.

Some Programs Limited Eligibility to Target Resources to Children Most in Need

The programs we visited limited program eligibility to cover children most in need of insurance. Generally, they tried to cover low-income, uninsured children not enrolled in Medicaid in order not to duplicate existing public coverage.

Four programs limited eligibility to families on the basis of their income, although each program's income eligibility differed. All six were designed to complement Medicaid coverage for children, since none enrolled children who had Medicaid coverage and most tried to steer possibly eligible children to Medicaid first. Four programs required children to be uninsured, although two allowed children with limited and noncomparable coverage to enroll. (See fig. 1.)

[14]The numbers of uninsured children by state are 1993 numbers that we derived from the Bureau of the Census' March 1994 Current Population Survey, which was the most recent Census data on uninsured children available.

Figure 1: Program Eligibility Requirements

Program	Age	Family Income Limit	State Residence	In School	Not Enrolled In: Medicaid	Not Enrolled In: Private Insurance	Not Enrolled In: Other Requirements
Alabama Caring Program for Children	0-18	$9,500 Annually	■	■	■	■	■[a]
Florida Healthy Kids Program, Volusia County	5-19 and Siblings 3-4	None	■	■	■	■[b]	■[c]
MinnesotaCare	0-20	275% of FPL[d]	■		■	■	■[e]
New York's Child Health Plus Program	0-14	None	■		■	■[b]	
Pennsylvania's Children's Health Insurance Program	0-15[f] 0-5	185% of FPL 235% of FPL	■		■	■	
Western Pennsylvania Caring Program for Children	16-18	185% of FPL	■	■	■	■	

[a]All eligible children in a family must be enrolled.

[b]Enrollment in other health insurance is allowed as long as the coverage is not equivalent to the coverage offered under Florida Healthy Kids Program or New York's Child Health Plus Program.

[c]Children must also be enrolled in the National School Lunch Program.

[d]Federal poverty level.

[e]Children whose family incomes are between 150 and 275 percent of FPL cannot have had insurance for the 4 months before applying for MinnesotaCare and cannot have had access to employer-paid insurance for the 18 months before applying for MinnesotaCare.

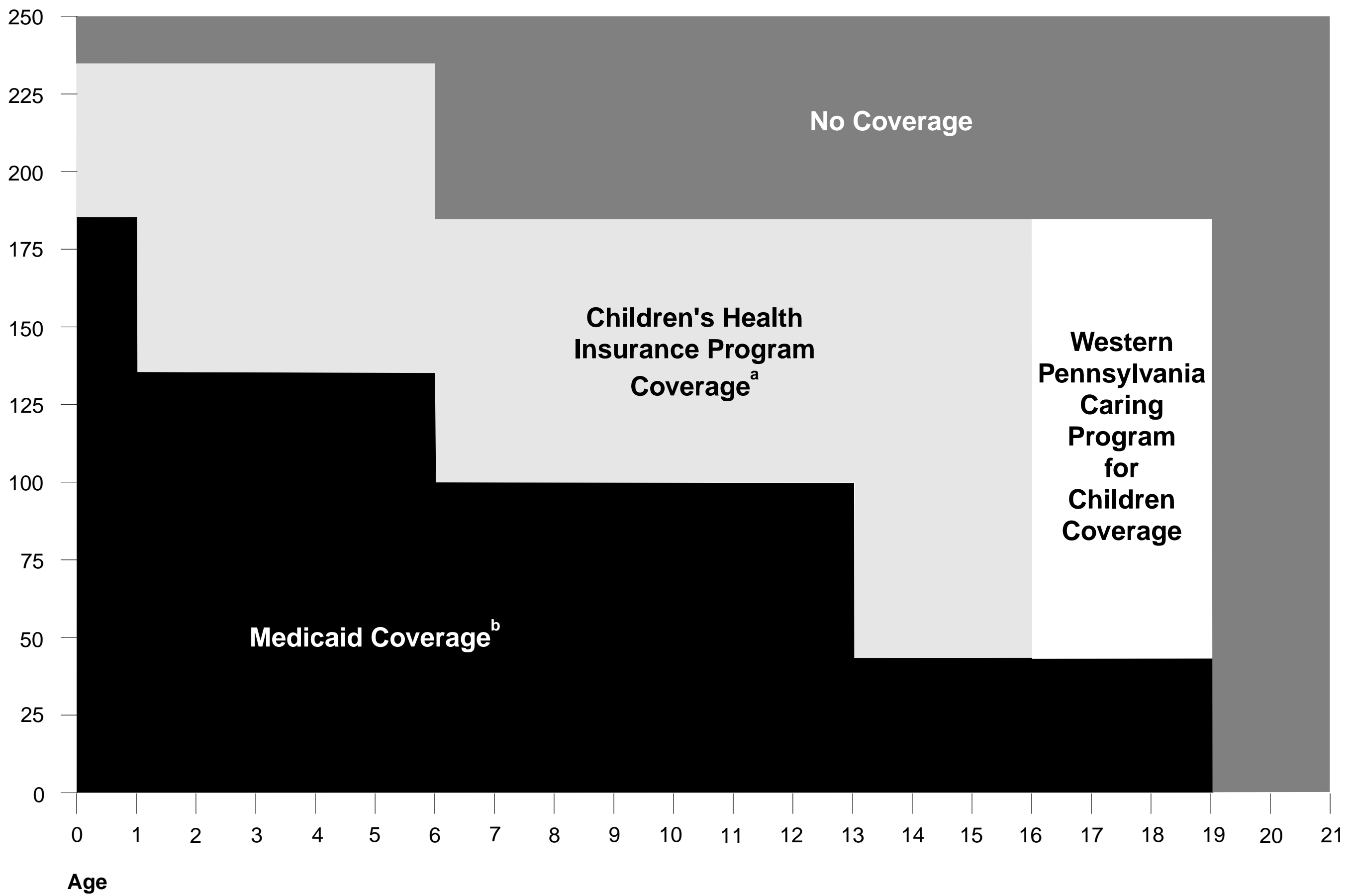
[f]The maximum eligible age will increase by 1 year each year on October 1, until the maximum age of 17 is reached in 1996.

Two programs—New York's Child Health Plus and Florida's Healthy Kids—covered uninsured children at any income level as long as their families paid the full premium costs. These two programs also extended coverage to insured children if their health insurance was not comparable to what the programs offered.[15] In western Pennsylvania, state- and privately funded programs developed eligibility criteria to minimize duplication of coverage. The three children's health insurance programs in western Pennsylvania—Medicaid, the state-funded Children's Health Insurance Program, and the privately funded Western Pennsylvania Caring Program for Children—in combination provided coverage to children under 6 with family income at or below 235 percent of FPL[16] and to children from 6 to 19 with family income below 185 percent of FPL. The Western Pennsylvania Caring Program for Children changed its eligibility criteria after the Children's Health Insurance Program was developed to complement its coverage and provide coverage for children that it did not cover. (See fig. 2.)

[15]Insurance with benefits consistent with New York's Child Health Plus benefit package and with payments and/or deductibles consistent with insurance industry standards is considered equivalent. However, policies that omit certain of the Child Health Plus benefits or that impose greater cost-sharing requirements on enrollees than does Child Health Plus can be deemed equivalent.

[16]The Caring Program, which predated the Children's Health Insurance Program, provided insurance to children up to age 19 who were at 150 percent of FPL and who were not covered by Medicaid. When the Children's Health Insurance Program was created, the Caring Program changed its eligibility criteria to insure children aged 6 to 19 at 185 percent of FPL. When the Children's Health Insurance Program eligibility expanded in 1994, the Caring Program changed eligibility criteria again, insuring children aged 15 to 19 at 185 percent of FPL who were not covered by the Children's Health Insurance Program or the Medicaid program.

Figure 2: Health Insurance Eligibility for Children in Western Pennsylvania



Note: To be eligible for any of these programs, other applicable program eligibility requirements, such as state residency, must be met.

[a]The law increases the eligible age for this program every year on October 1; the maximum eligible age of 17 will be reached in 1996.

[b]In this chart, Medicaid coverage includes expansions based on age, poverty level, and eligibility related to receipt of Aid to Families with Dependent Children (AFDC). Medicaid expansions require states to provide Medicaid coverage to children up to age 6 with family income at or below 133 percent of FPL and to poor children aged 6 or over born after September 30, 1983, until all children living in poverty up to age 19 are covered in October 2002. States could expand eligibility further, which Pennsylvania did for infants. For children older than 13, this figure shows Pennsylvania's Medicaid income eligibility for a family of three in 1994 who received AFDC, according to the Maternal and Child Health Update, National Governors' Association, March 1995. Eligibility for AFDC ends at age 18 or, at state option, at age 19 if the child is a full-time student. Other children, such as disabled children or children with very high medical expenses, may be eligible for Medicaid coverage but are not included in this simplified chart.

Programs Managed Their Costs by Limiting Benefits and Using Other Strategies

Health insurance costs for individuals were partially dependent on the costs of covered medical services, but other factors influenced costs as well.[17] Some programs covered inpatient care and other expensive services, while others chose to limit or exclude expensive services. Moreover, the premium costs per child were similar in some of the programs that covered inpatient care and other expensive services and in some that limited such services or did not cover them.

In addition to limiting services, state and private programs used other strategies to manage costs, such as sharing costs with patients and using competitive bidding and managed care. One factor that did not significantly increase costs as had been expected by program administrators was excessive use of health services. On the contrary, program children's use of services was similar to that of privately insured children.

Program Costs Per Child Varied Based Partially on Services Covered

The state and private programs' benefit packages varied from providing only primary and preventive care and emergency and accident services to providing a comprehensive range of benefits, including inpatient services. Costs to provide coverage for children varied from $20 to $70.60 per month, partly because of the kinds of services covered and the limitations on those services.

All programs provided a core set of services that program officials cited as most important for most children. These services included primary and preventive services—such as well-child visits, immunization, outpatient surgery, outpatient physician services, and diagnostic testing—and

[17]Variations in cost may reflect factors other than the services covered, which could include the regional cost of care, amount of provider payment, competition among providers, age of children covered, and the use of managed versus fee-for-service care. In addition, reported average costs per child were not always the full cost per child, since some programs did not include all of their administrative costs.

outpatient emergency services. In addition, most programs offered other benefits, such as mental health services, vision and hearing care, and prescription drugs. Three of the state- and privately financed programs also provided some dental services. Officials from several state and private programs noted that they would like to provide more benefits—such as dental care, which some cited as a critical preventive service—but did not want to increase the cost of their program. (See fig. 3.)

Figure 3: Average Cost Per Child Per Month for Services Covered by Programs

Costs/Services	Alabama Caring Program for Children	Florida Healthy Kids Program (Volusia County)	MinnesotaCare	New York's Child Health Plus Program	Pennsylvania's Children's Health Insurance Program	Western Pennsylvania Caring Program for Children
Average Cost Per Child Per Month[a]	$20.00	$46.50	$53.00	$54.71	$62.60	$70.60
Primary and Preventive Care[b]	■	■	■	■	■	■
Emergency and Accident Care	■	■	■	■	■	■
Speech Therapy		■[c]	■		■	■
Physical and Occupational Therapy		■[c]	■	■	■	■
Prescription Drugs		■	■	■	■	■
Hospitalization and Inpatient Physician Services		■	■		■[c]	■[c]
Mental Health		■[c]	■		■[c]	■[c]
Substance Abuse		■[c]	■	■[c]		
Vision Care		■[c]	■		■[c]	■[c]
Hearing Care		■	■		■	■
Dental Care			■		■	■
Home Health Care		■	■		■	■
Ambulance Services		■	■			
Durable Medical Equipment and Prosthetic Devices		■	■			
Podiatry		■[c]	■			
Chiropractic Services		■[c]	■			
Family Planning		■	■			
Other Services	■[d]	■[d]	■[d]	■[d]	■[d]	■[d]

[a]Average cost reflects the total premium cost, regardless of the funding source, but excludes program administrative costs.

[b]Primary and preventive care services include well-child visits, immunizations, diagnostic testing, outpatient physician services, and outpatient surgery.

[c]These services have specific limitations. See app. II.

[d]These programs cover other services. See app. II.

The Alabama Caring Program for Children, which covered outpatient care only, provided the fewest services and was the least expensive per child—$20 per month. The other programs reported average per-child costs ranging from $46.50 to $70.60 per month, and some provided more benefits than others. Florida ($46.50) and Minnesota ($53) covered many services, including inpatient and outpatient treatment, prescription drugs, and physical therapy. Minnesota also covered dental care and inpatient and outpatient substance abuse treatment. In contrast, New York's Child Health Plus Program ($54.71), Pennsylvania's Children's Health Insurance Program ($62.60), and the Western Pennsylvania Caring Program ($70.60) were more expensive, yet they provided either limited or no inpatient care.

The programs that did not provide inpatient services or provided only limited inpatient services often relied on Medicaid to meet enrolled children's needs. According to officials from two of these programs, the families of children who needed hospitalization could qualify for Medicaid services through medically needy spenddown provisions because of the cost of the care. Under spenddown, the cost of expensive services, such as hospitalization, is deducted from family income to determine the child's Medicaid eligibility.[18] Pennsylvania's Children's Health Insurance Program was planned to shift the costs of inpatient care to Medicaid when possible. The program covers 3 days of hospitalization, after which families are required to apply for Medicaid. For families whose children cannot qualify for Medicaid through spenddown, the Children's Health Insurance Program covers up to 90 inpatient days per year.

Patient Cost-Sharing Added to Most Programs

In addition to limiting benefits, most programs added some patient cost-sharing provisions. However, they generally kept premiums and copayments minimal, especially for families in the lowest income ranges. None of the programs required deductibles. Because most children

[18]In 1994, the District of Columbia and 31 states, including Florida, Maine, Minnesota, New York, and Pennsylvania, provided coverage to some medically needy persons. Alabama did not.

enrolled were from the lowest income brackets, families did not generally have to contribute much for their children's care. (See table 2.)

Table 2: Comparison of Family Cost-Sharing Provisions

Program	Income range, as a percentage of FPL	Family premium contribution per month per child by income range	Percent enrolled by income range	Copayments	Service and amount of copayment
Alabama Caring Program for Children	$0-9,500[a]	$0	100	Yes[b]	Outpatient services-$5
Florida Healthy Kids Program	0-130 131-185 over 185	5-20[c] 13-27[c] 43-49[c]	73 14 13	Yes	Prescription drugs-$3, eyeglass lenses-$10, refractions-$3, nonauthorized emergency room visits-$10
MinnesotaCare	0-150 151-275	4 4-138[d]	66[e] 34[e]	No	None
New York's Child Health Plus Program	0-159 160-222 over 222	0 2.08 54.71	87 13 <1	Yes	Prescription drugs-$1-3, inappropriate emergency room use-$35
Pennsylvania's Children's Health Insurance Program	0-184 185-235	0 39.75-52.64[c]	95 5	Yes	Prescription drugs-$5
Western Pennsylvania's Caring Program for Children	0-185	0	100	Yes	Prescription drugs-$5

[a]Alabama uses absolute dollar amounts for income eligibility determination.

[b]Preferred doctors may require a $5 copayment for some services; however, most doctors waive the copayment.

[c]Premium contribution varies by locale or insurer.

[d]Premium contribution varies by income level within specified range.

[e]Estimated by program officials.

Cost-sharing provisions varied by program. Family premium payments priced on a sliding scale based on family income as a percent of FPL were required by the four state-funded programs. Copayments for some services were required by three of the four state-funded programs and the two Caring programs. However, two state-funded programs did not require families in the lowest income range to pay any portion of the premium.

All of the state-funded programs expected families with income that exceeded the lowest income level to pay a portion of their child's premium. However, the size of the premium varied for families with similar incomes. For example, a family with an income at 200 percent of FPL would pay at least $43 per month in Florida to enroll one child and at least $39.75 in Pennsylvania, but only $2.08 in New York.

Some advocates expressed concern that premium contributions were too high for lower-income families in Pennsylvania and Minnesota and that high premium contributions discouraged these families from enrolling their children. Florida's Healthy Kids executive director also commented that the price of insurance affects enrollment. When the Healthy Kids premium dropped below $50, she reported, the number of enrollees who paid the full premium increased.

Two state-funded programs, those in Florida and New York, covered children at any income level as long as families with income over a specified level paid the full premium cost. Although this approach enabled those programs to help any uninsured child, relatively few children were enrolled when families had to pay all of the premium. New York targeted its outreach to lower-income families, which might explain why so few full-premium children enrolled, according to one New York program official. Florida marketed its program to all children attending public schools and still had low enrollment of children paying the full premium.

Copayments Added for Some Services

Most programs did not require program participants to contribute a copayment for most services. When programs did require copayments, they were generally $10 or less and applied to those services listed in table 2, such as prescription drugs and vision care. None of the programs allowed providers to charge copayments for primary and preventive services, except Alabama's Caring Program for Children, which asked, but could not require, physicians to waive the copayments they normally charged Blue Cross/Blue Shield patients.

Managed Care Strategies Becoming More Commonly Used

Most of the state and privately funded programs we visited were increasing their use of managed care, which is a strategy widely followed by private companies to constrain health care costs.[19] Many of the

[19]Whether managed care actually reduces payer cost is unclear. Managed care is a continuum of different types of care arrangements, from least to most restrictive. HMOs, the most restrictive type of care, seem to have the greatest potential to actually reduce costs, since they can reduce utilization of expensive services. But whether HMOs reduce costs for those paying the premiums depends not only on reducing use of expensive services but also on passing these savings on to payers. See Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

programs enrolled some of their children in HMOs, and most were trying to increase their use of HMOs. In addition, three of the state-funded programs paid insurers fixed, lump-sum payments to cover needed health services, which placed risk with the insurer rather than the program. Of these three state-funded programs, two used competitive bidding to choose their insurers. (See fig. 4.)

Figure 4: Programs' Use of Managed Care Strategies

Program	Medicaid Fee-for-Service Providers	Managed Care		
		Private Provider Networks	HMOs	Gatekeeper/ Case Manager
Alabama Caring Program for Children		■		
Florida Healthy Kids Program			■	
MinnesotaCare	■			
New York's Child Health Plus Program		■	■	■
Pennsylvania's Children's Health Insurance Program		■	■	
Western Pennsylvania Caring Program for Children		■	■	

Minnesota paid Medicaid-certified providers on a fee-for-service basis, but the program plans to transition to managed care in 1996. The other programs covered children using private provider networks,[20] HMOs, gatekeeper/case managers, or some combination of these. Alabama's Caring Program for Children was the only program using network providers exclusively, and Florida's program was the only one using HMOs exclusively. Pennsylvania's Children's Health Insurance Program and the Western Pennsylvania Caring Program for Children enrolled children in HMOs whenever available. At least 80 percent of the enrollees in New York's Child Health Plus Program, Pennsylvania's Children's Health

[20]Families with children enrolled in provider networks are either prohibited from using nonnetwork providers or required to pay more for care if they use them.

Insurance Program, and the Western Pennsylvania Caring Program for Children were in HMOs. These three programs expect to increase their use of HMOs for program children's care.

All of the state programs except Minnesota paid insurers a fixed, per child, per month payment, which shifted risk from the public payers to the insurers. The insurers or managed care organizations were then responsible for providing or contracting for all covered health services. Florida and Pennsylvania used a competitive process to select insurers and set rates; New York had a selection process that was not competitive. In Florida, Healthy Kids contracted with one HMO organization selected through competitive bidding for each county or group of counties. In Pennsylvania's Children's Health Insurance Program, if more than one insurer bid, the contract was awarded to the lowest qualified bidder, but other qualified bidders could provide services in the same area at the lowest bidder's price. In New York, all insurers who met specified program qualifications during the selection process were permitted to participate, but the state had approval rights over the premiums they charged.

Programs Did Not Attract High-Risk, High-Cost Children

The insurers and developers of most of the programs we visited had expected that children enrolling would be less healthy than children with private insurance and would, therefore, use services more frequently. In addition, since all the programs covered preexisting health conditions, the programs were expected to attract families with ill children who could not get other insurance coverage. Programs like Pennsylvania's Children's Health Insurance Program and the Florida Healthy Kids Program negotiated prices for their premiums assuming that the programs would attract children who would be more costly to serve than privately insured children. In addition, Alabama required families to enroll all of their eligible children in its program, which kept families from enrolling only sick children and assisted in health promotion.

However, according to managers from all the programs, the children served were not significantly sicker and did not use services more than privately insured children. New York's Child Health Plus Program officials found through a survey that most of the children enrolled in the program did so after they lost private insurance coverage. Alabama and Florida reported a slight increase in the use of services due to initial demand, but that soon stabilized. The lower-than-anticipated use of services led to cost-savings for Pennsylvania's Children's Health Insurance Program and the Florida Healthy Kids Program: a rebate of $1.3 million for the

Pennsylvania program and a 21-percent decrease in premiums for Healthy Kids in Volusia County.[21]

Program Designs Simplified Administration and Facilitated Participation of Providers and Patients

All the programs were designed to facilitate implementation and provider and patient participation. Most state- and privately funded programs relied on private insurers or nonprofits for many administrative functions and used their physician networks. The programs used existing billing systems and generally had reimbursement levels that approximated market rates—factors that were attractive to providers. The programs guaranteed access to a provider network, used simple enrollment procedures, and in many ways appeared similar to private insurance, which helped the programs avoid the stigma of welfare. Families surveyed by their programs were satisfied with the programs and with the health care their children received.

Programs Used Existing Administrative Systems

To some degree, all the programs we visited used administrative systems already in place when designing and implementing their programs. While Minnesota employed state Medicaid structures for administrative functions, the other programs employed nonprofit corporations or private insurers to perform key administrative functions. (For more detail on specific programs, see app. II.)

For example, in both the state-funded New York Child Health Plus and the Pennsylvania Children's Health Insurance programs, the state agencies exercised general program oversight, but most administrative functions were performed by private insurance plans under contract to the state. In addition to assuming responsibility for paying providers (and assuming risk for the costs involved), the insurers processed applications and determined eligibility. Each enrollee signed up with one of the insurers, which used its existing network of providers or HMOs to serve program patients.

[21]Pennsylvania's Children's Health Insurance Program included a "rate margin" provision in some of its insurers' contracts to protect them if the program attracted too many sick children. It guaranteed the insurers that if their actual costs exceeded the costs on which they based their premiums, the program would make up the difference, up to a limit of 5 percent of the anticipated costs. But the rate margin provision also guaranteed that if the insurers' costs were below expectations, they would have to return the excess (again, subject to the 5-percent limit). Since the insurers' costs were below expectations, the state became entitled to a $1.3-million rebate. In the second year, because the state and insurers had information from the program's first year to help price the premiums, the rate margin provision was dropped. Similarly, the Florida Healthy Kids Program renegotiated premium rates with the Volusia County HMO several times during the program's first year because service utilization and costs were lower than expected. Overall, the HMO cut the premium rate 21 percent—from $58.98 to $46.50 per month.

The nonprofit Florida Healthy Kids Corporation (FHKC) managed the Healthy Kids program using schools, HMOs, and contractors to provide some administrative services. It contracted with an HMO in each county to provide program services to enrollees in that county and with other entities to provide application processing, eligibility determination, premium billing and collection, technical assistance, and program evaluation. The schools also provided some administrative services, such as distributing enrollment applications and forwarding computerized data for eligibility determination.

In-Place Billing Systems and Provider Networks Encouraged Physician Participation

All the programs we visited used existing billing systems and provider networks, generally through private or nonprofit insurers. Contracting with an existing network of providers facilitated program implementation, since enrollees could be served as soon as a contract was signed. New York's Child Health Plus Program required contracted insurers to have an existing network of providers in place to enable them to reach program children in every part of the state. Program officials said that this requirement made the program "just another line of business" for the insurers.

In addition, physicians did not have to adapt to new, or to significantly change existing, operating processes to serve program children, which increased their willingness to participate in these programs. In Alabama, for example, all Caring Program providers filed claims electronically through Blue Cross/Blue Shield's existing claims system. According to a program official, most providers will accept lower payment rates and new patients if their routine billing and payment processes are not disrupted. One Alabama physician noted that quick reimbursement and lack of "red tape" contributed to her willingness to serve program children. Similarly, two providers cited use of Minnesota's Medical Assistance program billing structure as contributing to MinnesotaCare's success, because the physicians did not have to adjust to new operating procedures and hospitals could more easily participate in the program.

State and Private Programs Generally Set Acceptable Rates and Used Other Means to Ensure Provider Coverage

State and private programs have developed various methods for ensuring provider and insurer participation. Most of the programs chose to reimburse providers at close to market rates to ensure provider participation. In addition, some of the programs required physicians to accept the set rates as a condition of caring for other, more lucrative patients.

The state and private programs we visited, with the exception of MinnesotaCare, chose a strategy other than Medicaid for paying providers' rates. Because many state Medicaid programs have paid below market rates for services, these programs have had difficulty maintaining an adequate provider network. Some studies have indicated that Medicaid patients have more difficulty accessing health care than non-Medicaid patients. MinnesotaCare paid Medicaid rates, and some providers complained that MinnesotaCare's reimbursement was about 50 to 60 percent of their normal billing rates.

The other programs paid premiums intended to approximate market rates. The Alabama and Western Pennsylvania Caring Programs reimbursed physicians according to the rate schedules used by their respective Blue Cross/Blue Shield organizations, although for Alabama the rates paid for treating program participants were some of Blue Cross/Blue Shield's lowest.

As an additional incentive, physicians in several programs were required to treat program patients if they wished to treat other, sometimes more lucrative patients. For example, physicians participating in the Blue Cross/Blue Shield provider networks of Alabama and Western Pennsylvania could not refuse to serve Caring Program patients unless they withdrew from the Blue Cross/Blue Shield provider network entirely. Similarly, insurers in New York's Child Health Plus Program required their participating physicians to treat program patients as a condition of treating the insurers' private patients. And in Minnesota, physicians could not participate in the more lucrative state and local government employee health benefit program unless they also participated in the state's health assistance programs, which included MinnesotaCare.

Using Existing Provider Networks Gave Program Patients Guaranteed Access to Care

All six programs gave children access to a network of providers. In two programs, more than one insurer covered some parts of the state, so families had a choice of networks. Patients in Minnesota's program had access to providers that participated in Medicaid. Through state mandate, MinnesotaCare is ensured a large network; in 1995, the program had 24,000 primary care providers for 48,000 enrolled children.

Patients enrolled in all the programs except Minnesota's had guaranteed access to at least one and sometimes two established provider networks or HMOs through private insurers. New York's Child Health Plus Program had 15 insurers that together covered the entire state. A few areas in the

state were covered by more than one insurer, and patients were allowed to select between insurers. Three of the four regions covered by Pennsylvania's Children's Health Insurance Program were served by at least two insurers, which increased families' choices. The Alabama Caring Program for Children used the existing Blue Cross/Blue Shield network, which covered most physicians in the state. The Western Pennsylvania Caring Program for Children used either the Blue Cross/Blue Shield HMO or the Blue Cross/Blue Shield network, which included more than 12,000 physicians. Florida's Healthy Kids Program enrollees were limited to providers in a single HMO per county, but the program required that children be no more than a 20-minute car ride from a provider, except in the most rural areas.

Simple Enrollment Procedures Facilitated Access to Programs

The enrollment procedures for the state- and privately funded programs were relatively simple. Some programs were flexible about documenting information for eligibility and proceeding on the basis of trust. Simplified enrollment procedures and flexible eligibility documentation requirements minimized enrollment barriers and thus encouraged program participation.

All the state and private programs used a simple mail-in enrollment form (often one page long) and did not require face-to-face interviews. In addition, New York's Child Health Plus Program directed applicants to program insurers who provided telephone assistance in completing the forms. MinnesotaCare, which also used a mail-in application, asked follow-up questions by phone. Florida's Healthy Kids Program allowed parents to obtain and submit one-page applications through the schools.

Some programs were more flexible than others about documenting enrollment information, such as income. For example, the Alabama Caring Program for Children allowed an "honor system," on the theory that applicants were truthful about their incomes, and New York's Child Health Plus Program allowed a self-declaration of income if applicants were unable to produce any other verification. Pennsylvania's two programs required applicants to verify income, and the Florida Healthy Kids Program relied on the National School Lunch Program to verify applicants' income. Most of the programs did not apply resource tests, which also simplified eligibility determination. Minnesota and Alabama staff reported finding that families generally reported information honestly and accurately when applying for their programs.

Programs Offered an Identity Separate From Medicaid to Avoid Welfare Stigma

Program officials generally agreed that for families to use the program, they must not feel stigmatized, a problem that often exists with welfare recipients. Program staff stressed that it was important to preserve the families' dignity at all times.

To avoid the stigma of welfare, the state and private programs tried to resemble private insurance as much as possible. In addition to generally using private insurers' networks and simplified administrative processes that did not require face-to-face interviews at welfare offices for eligibility determinations, the programs used other strategies to preserve families' dignity. Some of these were modest. For example, all programs using private insurers issued enrollees insurance membership cards that were similar to cards issued for the insurers' commercial programs.

Families Satisfied With Care

Families generally reported being very satisfied in the five programs that assessed patient satisfaction.[22] For example, 97 percent of respondents in a 1993-94 survey of Florida's Healthy Kids families were either "very satisfied" or "satisfied" with the care provided for their children. More families with children in the Healthy Kids Program were satisfied with their care than families of children in any of the four comparison groups—Medicaid, private insurance, other insurance, or uninsured. A separate study of Healthy Kids families found that higher percentages of program families than of nonprogram families were "very satisfied" with the benefits available to their children, their doctor's availability, waiting times in the doctor's office, and the amount they had to pay at the time of an office visit. As another example, a 1989 survey of participants in Minnesota's Children's Health Plan, predecessor to MinnesotaCare, found that over 80 percent rated the program either a 9 or a 10 on a scale of 1 to 10, with 10 being excellent.

Programs Improved Children's Use of Health Care Services

All the programs we visited sought to reduce unmet medical needs and to encourage the appropriate use of primary and preventive care services. Several of the programs have begun to evaluate whether their programs are achieving these goals. Although some programs are finding that access and appropriate use of medical services have increased, several have found that use of preventive services is still below desired levels. Program staff have increased their efforts to educate parents about the importance of preventive care for children. (See app. III.)

[22]Pennsylvania's Children's Health Insurance Program was the only program that had not assessed patient satisfaction. The Western Pennsylvania Caring Program for Children included its Children's Health Insurance Program families in its satisfaction survey.

Conclusions

If enacted, legislation to change the Medicaid program to a block grant would give states greater flexibility to redesign their Medicaid programs, but it would also limit federal funding. To accommodate these changes, states would need to make difficult choices when structuring their Medicaid programs. While the programs we visited differed from Medicaid, they exemplified the choices states and private-sector organizations have made when using their own resources to provide health coverage to uninsured children.

Most notably, the state- and privately funded programs we visited

- covered some children who would not otherwise have been covered;
- complemented existing Medicaid coverage;
- kept per child costs to a minimum;
- provided preventive and primary care services—the services children are most likely to need;
- offered a wide network of providers;
- required families to share part of the cost;
- used HMOs frequently to manage children's health care; and
- used existing administrative systems of state, nonprofit, and private organizations.

Despite these state and private efforts, many children remained uninsured. In addition, eligible children sometimes had to wait to enroll. Further, programs did not always cover services routinely available to children insured through private insurance or Medicaid.

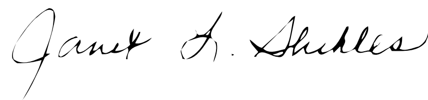
In the future, the responsibility for ensuring health care coverage for children may fall more directly on the states; their local communities, including private-sector providers and nonprofit organizations; and children's families. The programs we visited appear to have succeeded in bringing together these groups and individuals to expand children's access to health care. Their program experience could prove instructive for other states and the Congress.

Although this report does not focus on agency activities, we discussed its contents with responsible officials at HCFA, who had no comments. We also discussed its contents with officials in the programs we visited. Program officials' comments were generally limited to specific technical corrections, which we incorporated in this report.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to interested parties and make copies available to others on request.

Please contact me at (202) 512-6806 if you or your staff have any questions. This report was prepared under the direction of Sally Jaggar, Mark Nadel, and Rose Marie Martinez by Sheila Avruch and others. Other staff who contributed to this report are named in appendix IV.

Sincerely yours,



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Abbreviations

AFDC	Aid to Families With Dependent Children
ER	emergency room
FPL	federal poverty level
FHKC	Florida Healthy Kids Corporation
HCFA	Health Care Financing Administration
HMO	health maintenance organization

Most States Have Expanded Medicaid or Developed Other Health Insurance Programs for Children

Forty-five states and the District of Columbia have expanded Medicaid beyond federal requirements to cover infants or children, have implemented a Medicaid waiver, or have developed privately funded or state programs to insure children. Some states have more than one type of program to add coverage for children. (See fig. I.1.)

Figure I.1: States' Health Insurance Programs for Children

State	Medicaid Expansion Beyond Federal Requirements[a]					State	Medicaid Expansion Beyond Federal Requirements[a]				
	Infants (Birth to 1)	Children (1-18; Range Varies by Program)	Implemented Medicaid 1115 Waiver	Privately Funded Progam	State-Funded Program[b]		Infants (Birth to 1)	Children (1-18; Range Varies by Program)	Implemented Medicaid 1115 Waiver	Privately Funded Progam	State-Funded Program[b]
Alabama				■		Montana				■	
Alaska						Nebraska					■
Arizona	■	■			■	Nevada					
Arkansas						New Hampshire	■	■			■
California	■			■	■	New Jersey	■				
Colorado					■	New Mexico	■	■			
Connecticut	■	■				New York	■				■
Delaware	■	■			■	North Carolina	■			■	
District of Columbia	■					North Dakota				■	
Florida	■				■	Ohio				■	
Georgia	■	■		■		Oklahoma	■			■	
Hawaii	■	■	■			Oregon		■	■		
Idaho				■		Pennsylvania	■			■	■
Illinois						Rhode Island	■	■	■		
Indiana	■					South Carolina	■				
Iowa	■			■		South Dakota		■		■	
Kansas	■	■		■		Tennessee	■		■		
Kentucky	■	■				Texas	■			■	
Louisiana				■		Utah		■		■	■
Maine	■	■				Vermont	■	■			
Maryland	■			■	■	Virginia		■			
Massachusetts	■			■	■	Washington	■	■[d]			
Michigan	■	■			■	West Virginia	■	■			
Minnesota	■		■		■[c]	Wisconsin	■	■		■	
Mississippi	■			■		Wyoming				■	
Missouri	■	■		■		**Total**	**34**	**21**	**5**	**22**	**14**

(Figure notes on next page)

Note: Some of these programs insure adults and children.

[a]State Medicaid expansions as of April 1995.

[b]State funded programs include those classified by the National Governors' Association as both public and public/private, except Rhode Island and Tennessee, which have Medicaid 1115 waivers. The primary source of funding for most of these programs was state financing.

[c]The 1115 Medicaid waiver transferred children up to age 21 and pregnant women from MinnesotaCare to Medicaid. The other adult MinnesotaCare participants remained in the state-funded MinnesotaCare program.

[d]Medicaid funds the children's services for Washington's Basic Health Plan.

Sources: "Innovative State Health Initiatives for Children," Stateline, July 21, 1995, National Governors' Association, Washington, D.C., Center on Budget and Policy Priorities; Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995); Western Pennsylvania Caring Program for Children, personal communication with executive director; MinnesotaCare Program, personal communication with director; and Washington Basic Health Plan Plus, personal communication with program manager.

State- and privately funded programs vary in size: some cover fewer than 100 children, and others cover up to 99,000. (See table I.1.)

Table I.1: 1994 Enrollments and Budgets of State- and Privately Funded Programs to Insure Children

State	Enrollment	Budget (in millions)
State-funded[a]		
Arizona	2,300	$7.3
California	13,784	71.5
Colorado	1,712	.7
Delaware	8,473	NA[b]
Florida	15,500	8.8
Maryland	3,500	.9
Massachusetts	22,021	12.0
Michigan	3,105	1.4
Minnesota	42,891	36.6
Nebraska	245	5.0
New Hampshire	39	.2
New York	98,538	55.0
Pennsylvania	28,923	21.0
Utah	99	2.0
Washington	16,944	20.0
Privately funded		
Alabama	5,400	1.3
California	5,000	1.2

(continued)

State	Enrollment	Budget (in millions)
Georgia	409	NA[b]
Idaho	400	NA[b]
Iowa	2,117	.4
Kansas	3,474	.7
Louisiana	412	.1
Mississippi	1,027	.2
Missouri (2 programs)	2,275	.9
North Carolina	3,498	1.4
Ohio	5,717	1.6
Pennsylvania (western)	5,877	4.3
Pennsylvania (southeastern)	3,434	2.2
South Dakota	385	.2
Utah	1,615	.6
Wisconsin	800	NA[b]

Note: Budget and enrollment data were not identified for Caring Programs in Maryland, Massachusetts, Montana, North Dakota, Oklahoma, Texas, and Wyoming.

[a]State-funded programs include programs classified by the National Governors' Association as both public and public/private, except for Rhode Island and Tennessee, which have Medicaid 1115 waivers.

[b]Did not provide budget information.

Sources: "Innovative State Health Initiatives for Children," Stateline, July 21, 1995, National Governors' Association, Washington, D.C., and Western and Southeastern Pennsylvania Caring Programs for Children, personal communication with executive directors.

Descriptions of the Six State- and Privately Funded Programs

This appendix provides programmatic and administrative details about the six programs we visited, presented alphabetically by state. Each description includes

- a background section, which highlights the history of the program and its goals, and
- a section on program structure and operations, which includes information on administration; funding; eligibility; enrollment; covered services and costs; insurer payment and provider networks used; and publicity, outreach, and marketing.

The Alabama Caring Program for Children

Background

The Alabama Caring Program for Children is a statewide, privately funded program that was created in 1988 by Blue Cross/Blue Shield of Alabama. It provides primary care services to enrolled children using Blue Cross/Blue Shield providers. Enrollees are children from low-income, working families who do not have insurance through an employer, yet whose income is not low enough to qualify them for Medicaid.

Program Structure and Operations

The nonprofit Alabama Child Caring Foundation administers the program, including determining eligibility, enrolling children, publicizing the program, collecting donations, and fundraising. Blue Cross/Blue Shield staff process claims and pay providers. All administrative services, including Foundation staff salaries, are donated by Blue Cross/Blue Shield. The program does not underwrite insurance—instead it contracts with Blue Cross/Blue Shield for claims and payment services. The program also uses Blue Cross/Blue Shield's provider network to deliver health care services.

Funding

The Caring Program is funded entirely through the philanthropic donations of businesses, churches, foundations, civic/service organizations, and individuals. Blue Cross/Blue Shield matches all contributions dollar for dollar. The program's budget for 1994 was approximately $1.7 million, and the estimated budget for 1995 is approximately $2 million.

Eligibility

Children may enroll if they (1) are under age 19, unmarried, and have an annual family income under $9,500; (2) are full-time students (unless they are under school age or have completed grade 12); (3) are Alabama residents, and (4) are ineligible for Medicaid or other insurance. Additionally, families must enroll all of their eligible children in the program. Foundation staff refer children potentially eligible for Medicaid to the Medicaid bureau before they can enroll in the Caring Program.

Enrollment

As of July 31, 1995, 5,922 children were enrolled in the program. Since the available funding was not sufficient to provide coverage for all eligible applicants, 1,766 eligible children were on a waiting list. The Foundation generally responds to an application within one day of receipt, but the average waiting time for enrollment is 18 to 24 months, because the program does not have the funding to enroll children as soon as they are determined eligible. While the program is statewide, donors can designate their funding for particular counties, so children in some counties spend less time waiting to enroll.

The Alabama Child Caring Foundation determines eligibility and enrolls children using a simple, one-page, 12-question form that can be mailed to the Foundation. There are no income verification requirements. Once a child is admitted, the Foundation staff send the child a benefits handbook, a Blue Cross/Blue Shield identification card, and a list of participating providers.

Covered Services, Costs, and Cost-Sharing

The program covers primary and preventive outpatient services (well-child visits, immunizations, outpatient physician services, outpatient surgery, and diagnostic tests). It also covers emergency and accident care. It does not cover prescription drugs or inpatient, vision, hearing, or dental care (except in one county, which has a specially funded pilot program for dental care). Program officials told us that benefits have not been expanded further because funding is limited and many children are currently waiting to join the program. The program does not have any pre-existing condition exclusions.

The average monthly cost per child is $20, which does not include any administrative expenses. Program participants pay no premiums or deductibles. They may be required to pay a $5 copayment for some outpatient services. However, program and Blue Cross/Blue Shield officials have asked providers to waive the copayment in order not to discourage program participants from obtaining care, and most providers have complied.

Insurer Payment and Provider Networks

The Foundation pays for covered services provided by physicians in the Blue Cross/Blue Shield of Alabama provider network, to which most physicians in the state belong, according to the program's executive director. Physicians cannot refuse to treat Alabama Caring Program patients without dropping out of the network. Providers are reimbursed based on the existing Blue Cross/Blue Shield fee-for-service rate schedule, and claims are processed through the Blue Cross/Blue Shield billing system. Claims are paid within 5 days.

Publicity, Outreach, and Marketing

Program officials use a variety of methods for publicizing the program, including public service announcements on TV and radio, free advertising in newspapers, distribution of brochures and flyers, and contacts with providers, advocacy organizations, churches, schools, and corporate donors. Blue Cross/Blue Shield developed radio and TV public service announcements using some of Alabama's college football coaches. These announcements have been very successful at publicizing the program. Since the program is currently wait-listing applicants because it lacks the resources to enroll them, it has focused the past year's efforts principally on fund-raising rather than on outreach.

Florida Healthy Kids Program

Background

The Florida Healthy Kids Program is a school enrollment-based program created through the July 1990 Healthy Kids Corporation Act. Its goal is to provide every child access to quality health care by uniting children with accessible, local, comprehensive health care providers. The program was initially funded in Volusia County as a HCFA demonstration project that also received state, county, and private funds. It is currently available in seven Florida counties, with 13 other counties waiting to join. Uninsured children of any income level attending school in a participating county can join, but only children with family income at or below 185 percent of FPL will have their premiums partially subsidized.

Program Structure and Operations

The nonprofit Florida Healthy Kids Corporation (FHKC) has overall administrative responsibility for the program. FHKC contracts with others for processing applications, determining eligibility, billing and collecting premiums, providing technical assistance, and evaluating the program.

County schools and their boards help inform parents about the program, disseminate enrollment applications, and provide monthly computerized data, which are used for eligibility redeterminations. In addition to the board that oversees FHKC, each county has its own board to direct Healthy Kids activities.

Funding

The program was initially funded by federal and state funding, including a HCFA demonstration grant, which ended in February 1995, and family premium payments. The program is currently funded by state general revenue funds, a county ad valorem tax for children's services, other county funds, health district tax funds, county school board funds, and premium payments by parents. The program's total funding for 1994 was approximately $8.8 million, and the amount budgeted for 1995 was $13.1 million.

Eligibility

A child may enroll in Healthy Kids if he or she is (1) 5 through 19 years of age or a 3- to 4-year-old sibling of an enrollee, (2) actively attending school, (3) uninsured, and (4) not enrolled in the Medicaid program. In some counties, children must prove they are not eligible for Medicaid before being enrolled in Healthy Kids; in others, not being enrolled in Medicaid is enough. Children must participate in the National School Lunch Program to get their premiums subsidized, since income eligibility for subsidized premiums is determined through the School Lunch Program eligibility process. FHKC redetermines eligibility monthly by having a contractor compare computerized records for the Healthy Kids, School Lunch, and Medicaid programs.

Enrollment

The Healthy Kids Program provides school enrollment-based health insurance. The children obtain health coverage in the form of group insurance policies provided through the school districts, rather than through employers. By using school districts, the program can tap into existing communication systems with parents to market the program and enroll children. School officials distribute and collect applications during the open enrollment period at the beginning of the school year. Additional enrollment periods are available to children who transfer to other schools. An FHKC contractor determines eligibility and then FHKC sends a list of eligible children to the responsible HMO. The HMO sends the family new member information and a membership card and requests that the family select a primary care provider. If the family does not respond within 90 days, the HMO will send a follow-up letter and call the family to encourage them to use well-child services.

As of July 1, 1995, 6,602 children were enrolled in Volusia County, and 15,254 children were enrolled in the Healthy Kids Program statewide. Statewide, 87 percent of enrolled children had family income at or below 185 percent FPL and thus had their premiums partially or fully subsidized; in Volusia County, 93 percent were in that category.

Covered Services, Costs, and Cost-Sharing

The Volusia County program offers a wide range of services including primary and preventive outpatient services (well-child visits, immunizations, outpatient physician services, outpatient surgery, and diagnostic tests), emergency and accident care, hospitalization, and related inpatient physician services. It also includes physical, speech, and occupational therapy (limited to 15 inpatient days per contract year and 24 outpatient treatment sessions within a 60-day period per episode of illness or injury). In addition, it covers prescription drugs, vision care (corrective lenses limited to one pair every 2 years unless prescription or head size changes), hearing care, home health care, ambulance services, durable medical equipment and prosthetic devices, family planning, chiropractic care (limited to six visits in 6 months), and podiatric care (limited to 2 visits per month). Mental health services are included, but limited to 15 inpatient days per contract year and 20 outpatient visits per contract year, with a lifetime maximum expenditure of $20,000. Substance abuse services are provided for pregnant teens only. Healthy Kids covers newborn care, skilled nursing facility services limited to 100 days per contract year, and transplant services. Covered services and limitations may vary by county. For example, dental care is available in some counties. There are no preexisting condition exclusions.

The average cost per month to provide health services to children in Volusia County was $46.50, which reflects the total premium payment to the HMO. Program officials estimated that, in addition, the program averages administrative costs of about $1.50 per month per child.

The amount that parents pay toward premiums differs by county and income category. Since September 1, 1995, all counties have required parents to pay some share of their children's premium. Before that time, Volusia County did not require poor parents to pay any share of their children's premiums, while other counties required parents to pay $5 per month for children in the lowest income group (at or below 130 percent of FPL.) Starting in September 1995 in Volusia County, families with income at or below 100 percent of FPL paid $15 per child per month; those with income between 101 and 130 percent of FPL paid $20; those with income

between 131 and 185 percent of FPL paid $27; and those with income above 185 percent of FPL paid $48. Families pay no deductibles.

Some services require a small copayment. Prescription drugs and optometrist refractions both have $3 copayments, mental health outpatient visits have a $5 copayment, and prescription eyeglass lenses and nonauthorized ER visits have $10 copayments.

Insurer Payment and Provider Networks

The program pays a capitated monthly fee to HMOs to cover enrolled children's health care services. To choose HMOs, FHKC sends out requests for proposals and then contracts with one HMO per county. The HMOs are required to provide hospitalization and specialist services as needed and ensure that children live no more than 20 minutes by car from a provider except in the most rural areas. To meet these requirements, the HMO in Volusia County contracted with some private doctors in the western, more rural, part of the county. The HMO contracts with FHKC allow FHKC to pay for services that patients need and then bill the HMO for the services if the HMO is not providing adequate service. FHKC monitors waiting time and patient complaints to measure access.

Publicity, Outreach, and Marketing

The Florida Healthy Kids Program uses numerous methods to reach its target audience, including paid and public service radio and television ads, brochures and flyers, a video, and presentations by FHKC and HMO staff. In 1994, FHKC spent less than $5,000 on advertising. However, most advertising is donated by HMOs, school districts, county boards, and others. For example, in Volusia County, one large fast-food restaurant used tray liners publicizing the program. According to program officials, the school district and the county board have been creative and effective at developing advertising strategies tailored to their community.

The program has specifically targeted teens, and African-American and migrant children, who were not joining the program at expected rates. The program used high school coaches and shop teachers to speak for the program and school dial-up message systems and direct mail to reach teens' parents. The program has also worked through churches to reach African Americans and through migrant crew chiefs to reach migrant families.

Minnesota's MinnesotaCare Program

Background

MinnesotaCare was established by the state legislature in 1992 to both expand and replace Minnesota's Children's Health Plan. The Children's Health Plan, the first statewide, state-funded program providing health insurance coverage for uninsured children of low-income families, began in July 1988. When MinnesotaCare was implemented in October 1992, it broadened the Children's Health Plan's eligibility criteria by allowing parents and siblings living in the same households as qualifying children to enroll, and it subsequently expanded to include adults without children. In April 1995, Minnesota received HCFA approval of a Section 1115 Medicaid waiver that integrated a segment of the MinnesotaCare population—children and pregnant women—into the state's Medicaid program effective July 1, 1995. The waiver allows the state to receive federal Medicaid funding for children and pregnant women in MinnesotaCare, but leaves children and pregnant women subject to MinnesotaCare rules regarding eligibility, enrollment, and cost-sharing. The state hopes to develop uniform eligibility, enrollment, and other criteria for MinnesotaCare, Medicaid, and the state's General Assistance Medical Care program.

Program Structure and Operations

The program is administered by the state's Department of Human Services, the same agency that administers the state's Medicaid program. However, MinnesotaCare has a separate office within that agency, as well as its own director and 89 dedicated staff. Other Department of Human Services staff perform some duties related to the program as well.

Funding

The portion of MinnesotaCare that covers children and pregnant women is financed by a combination of federal Medicaid funding, state funds, and enrollee premium contributions. The remainder of MinnesotaCare is financed entirely by state funds and enrollee premiums, which is how the whole program was financed before the waiver. The state finances its share of the program through a 2-percent provider tax. Previous state funding sources have included the state's general funds and a 1-percent cigarette tax. Program costs (including administrative costs and program expenditures) were $36.6 million in fiscal year 1994, and are budgeted at $93.9 million for fiscal year 1995.

Eligibility

Children under age 21, as well as their parents and dependent siblings if they reside in the same household, may enroll in MinnesotaCare if (1) their family income does not exceed 275 percent of the FPL, (2) they are permanent Minnesota residents, (3) they have had no other health insurance for the preceding 4 months, and (4) they could not get employer-subsidized insurance for the preceding 18 months. (The last two requirements do not apply to children in families with incomes that do not exceed 150 percent of FPL.) Single adults and families without children may enroll if their household incomes do not exceed 125 percent of FPL and they satisfy the other requirements. If funding is available, the state may increase the upper income limit for single adults and families without children to 135 percent of FPL in October 1995 and to 150 percent of FPL in October 1996.

The current eligibility criteria for MinnesotaCare are much broader than the criteria used when the program that preceded it, the Children's Health Program, was first implemented in 1988. At that time, the only eligible group was children aged 1 through 8 with family incomes up to 185 percent of FPL.

Enrollment

As of July 1995, MinnesotaCare had 88,123 enrollees. Of this total, 50.7 percent were children, 43.2 percent were adults in households with children, and 6.1 percent were adults in households without children. MinnesotaCare has a mail-in enrollment and recertification process. A staff of 44 eligibility representatives reviews the applications and follows up with applicants by telephone or mail on an as-needed basis to verify residency status, income, and availability of other health insurance. Since May 1994, enrollees have received a generic identification card that the state uses for all its state-supported health care programs.[23]

Covered Services, Costs, and Cost-Sharing

MinnesotaCare provides children with a comprehensive benefit package that includes primary and preventive outpatient care (including well-child visits, immunizations, diagnostic testing, outpatient physician services, and outpatient surgery); emergency and accident care; physical, occupational, and speech therapy; prescription drugs; inpatient hospital and psychiatric care; mental health and chemical dependency services; vision, hearing, and dental care; home health care; durable medical equipment and prosthetic devices; podiatry; chiropractic services; family planning; case management; Christian Science sanitoriums; daycare/school examinations; day treatment; hospice care; intermediate

[23]Previously, MinnesotaCare participants received an identification card that specifically indicated that they were MinnesotaCare enrollees.

care facilities for the mentally retarded; nurse anesthetists, private duty nursing, nursing facility services, and in-home nursing services; orthodontia; personal care; public health clinic visits; speech, hearing, and language disorders treatment; and medical transportation. Adults receive a similar benefit package, but a few services (such as nonpreventive dental care) are not covered, and some others are subject to service limitations or copayments. The benefit package has expanded considerably since the inception of the Children's Health Program in 1988, when only children's outpatient services were covered.

The average monthly cost per child for MinnesotaCare is $53, excluding administrative costs. Enrollees pay a monthly premium that is determined using a sliding scale linked to income level and household size and that ranges from 1.5 to 8.8 percent of gross family income. However, a reduced premium of $48 per year is payable for children in families with incomes that do not exceed 150 percent of FPL. According to state officials, about two-thirds of all children in the program fall into this category. The program has no deductibles or copayments for children's services, but adults are required to contribute copayments for certain services.

Provider Network and Reimbursement

MinnesotaCare gives enrollees access to the same providers who participate in the state's Medicaid program. It pays providers on a fee-for-service basis using the Medicaid fee structure. Minnesota requires providers to either take part in the state's health assistance programs or forgo participating in the more lucrative state and local government employee health benefit programs.

Under the terms of the Medicaid waiver, most of the children in Medicaid, including those transferred into Medicaid from MinnesotaCare, will eventually be enrolled in HMOs. Program participants who live in areas where there is a scarcity of HMOs will continue to be served by fee-for-service providers. The state plans to award the first HMO contracts in 1996.

Publicity, Outreach, and Marketing

Program officials use a variety of methods to publicize the program, including paid radio advertisements, radio and television public service announcements, listings in community-based service agency publications, and brochures and flyers. Officials also rely on contacts with hospitals, doctors' offices, advocacy organizations, public clinics, and schools, among others.

New York's Child Health Plus Program

Background

Child Health Plus is a statewide, state-funded program created by the New York State legislature in 1990 to insure children. The program's goals are to provide low-income children with comprehensive outpatient health care services, increase children's access to primary and preventive health care, and improve participating children's health status. The program is open to children at all income levels, but only children in families with gross income below 222 percent of FPL receive a subsidy.

Program Structure and Operations

The New York State Department of Health has overall responsibility for administering the program, while the State Insurance Department approves participating insurance companies' premiums and reviews subscriber contracts. The State Insurance Department works with the Department of Health to define "equivalent health insurance" to determine which children can join the program. The program uses private insurers to perform many administrative functions, including processing applications, determining eligibility, collecting premiums, paying providers, engaging in marketing and outreach, and monitoring quality assurance. The program also contracts out marketing and outreach activities to two nonprofit organizations.

Funding

The program is funded by enrollee premiums and New York's Bad Debt and Charity Care pool, which is raised by an assessment on hospitals. The amount appropriated to Child Health Plus limits the number of children who may be enrolled. Child Health Plus received $55 million from the Bad Debt and Charity Care pool during 1994 and has been budgeted $76.5 million for 1995.

Eligibility

Children may enroll in Child Health Plus if they (1) are under age 15 and born on or after June 1, 1980; (2) do not have "equivalent insurance";[24] (3) are New York State residents (even if they are not legally in the United States); and (4) are not enrolled in Medicaid. The maximum eligible age has been increased since the start of the program from under 13 to under 15.

[24]The "equivalent insurance" provision is intended to exclude children with insurance coverage "consistent with the Child Health Plus benefit package" and whose copayments and/or deductibles are consistent with insurance industry standards.

Enrollment

Child Health Plus is targeted primarily at low-income children. According to a survey of program applicants completed in 1993, most children joined after losing private insurance coverage or Medicaid. Their average family income was $16,000. As of July 1995, the program had 104,248 enrollees, of whom 99.6 percent were subsidized (under 222 percent of FPL).

Insurers process enrollment using a simple one-page application, which can be submitted by mail, without a face-to-face interview. The program is flexible about the documents needed to prove eligibility. For example, income can be proved by means of employer attestations or, as a last resort, a self-declaration form. Under the "presumptive eligibility" procedure, families lacking needed documentation but whose children appear eligible can have their children covered for up to 60 days while they complete the application process. Unlike Medicaid, which counts net income and also uses a resource test, the Child Health Plus Program counts gross income and omits a resource test, which expedites eligibility determination.

Covered Services, Costs, and Cost-Sharing

The program covers primary and preventive care (including well-child care, in accordance with American Academy of Pediatrics guidelines, immunizations, outpatient treatment of illness and injury, diagnostic tests, and outpatient surgery); emergency care; prescription drugs; outpatient treatment for alcoholism and substance abuse; short-term physical and occupational therapy; radiation therapy; chemotherapy; and dialysis. It does not cover inpatient care, including inpatient mental health care; dental care (except when necessary to treat a medical condition); or speech therapy.

In 1994, the average monthly per patient cost was $54.71. The monthly per child premiums paid to insurers ranged from $36 to $66.50, reflecting geographical and other differences among the insurers. In addition, the Department of Health incurred $0.80 per patient per month in administrative costs.

Most children's families pay little for coverage and services. Families with gross incomes below 160 percent of FPL pay no premium (almost 87 percent of enrolled children). Families with incomes between 160 and 222 percent of FPL pay $25 per child per year up to a maximum of $100 for the entire family (13 percent of enrolled children) toward the premium cost. Families with incomes above 222 percent of FPL pay the entire premium (0.4 percent of enrolled children). Families pay no deductibles. Families may have copayments of $35 for inappropriate ER use (or may

have these claims denied) and may have copayments of up to $3 for each pharmacy prescription, depending on the insurer.

Insurer Payment and Provider Networks

The program pays a capitated monthly fee per child to insurers to cover enrolled children's health care services. The participating 15 nonprofit insurers joined by submitting bids in response to a 1990 request for proposal. To join the program, insurers had to have an existing network of providers in place, with a sufficient number of board-certified physicians. Child Health Plus Program enrollees are given access to the same physicians as plan members with private insurance.

The 15 insurers together cover the entire state. Children must enroll with an insurer responsible for the area in which they live. Certain areas fall within more than one insurer's service area, so enrollees residing in those areas have a choice of insurer. Of the 15 insurers, 12 are managed care plans and 3 are indemnity plans. As of December 1993, 80 percent of the enrollees were enrolled in managed care plans.

Publicity, Outreach, and Marketing

The state contracted with two nonprofit organizations to provide marketing and outreach services to the program; insurers also provide such services.[25] Both the contractors and insurers work through community-based organizations that serve low-income populations, such as churches, clinics, and schools. Both make presentations and distribute brochures and posters. One of the contractors also arranges "enrollment events" and operates a hotline for New York City. The other contractor operates a statewide hotline for the program. In addition, the Department of Health supports outreach. For example, the staff worked with the State Education Department to send an informational letter about the Child Health Plus Program to every school district superintendent. The Department of Health also provides a toll-free referral hotline that is used to publicize the program and refer callers to participating insurers.

[25]The state's total estimated expenditures to the two contractors from the program's inception through the end of 1995 are approximately $1,602,000, including $815,420 for January 1, 1994, through December 31, 1995. The amount paid to the insurers for marketing and outreach is included in their premiums.

Pennsylvania's Children's Health Insurance Program

Background

Pennsylvania's Children's Health Insurance Program is a statewide, state-funded program established by the Children's Health Care Act of 1992 to provide free or subsidized health care coverage to uninsured, nonMedicaid-eligible children. It is modeled on Western Pennsylvania's Caring Program for Children.

Program Structure and Operations

The Children's Health Insurance Management Team[26] has overall responsibility for the program. They prepare budgets, execute contracts with insurers, approve rates, and coordinate enrollment outreach activities. They contract with insurers or their designates to handle many other administrative functions, including processing applications, determining eligibility, collecting premiums, paying providers, and engaging in outreach.

Funding

The state funds the Children's Health Insurance Program through a 2-cent per pack cigarette tax, and through parental premium contributions. Some insurers pay the parents' portion of the premium. The state expended approximately $9.4 million on the program during the fiscal year July 1993 through June 1994, and approximately $28 million is budgeted for fiscal year 1995.

Eligibility

Children may enroll in the Children's Health Insurance Program if they are (1) under age 6 with family income at or below 235 percent of FPL, or age 6 through 15 with family income at or below 185 percent of FPL;
(2) Pennsylvania residents for at least 30 days (except for newborns); and (3) not eligible for Medicaid or other insurance. Children who might be eligible for Medicaid must apply to Medicaid before they can be enrolled in the Children's Health Insurance Program. Children's Health Insurance Program participants are annually reassessed for eligibility. If during annual eligibility reassessment an enrolled child appears Medicaid-eligible, the Children's Health Insurance Program will continue to cover the child for up to 60 days while the Medicaid bureau determines the child's eligibility.

[26]The team consists of Pennsylvania's Secretary of the Budget, Secretary of Health, and Insurance Commissioner.

Enrollment

As of July 1, 1995, 49,634 children were enrolled in the Children's Health Insurance Program. Ninety-seven percent of these children have income at or below 185 percent of FPL and have their premium fully subsidized. In May 1995, approximately 1,504 children were on waiting lists across the state. Children on the waiting lists may participate in the program by paying an at-cost premium.

Insurers determine eligibility and process enrollment, which can be completed entirely by mail. Enrollment procedures vary somewhat among insurers. Families who pay part of the premium must remit the first payment before enrollment.

Covered Services, Costs, and Cost-Sharing

The Children's Health Insurance Program covers primary and preventive health care (including well-child visits, immunizations, diagnostic testing, outpatient physician services, and outpatient surgery); emergency and accident care; physical, speech, and occupational therapy; vision care (limited to one pair of corrective lenses every 6 months and one pair of frames every 12 months); and hearing, dental, home health,and prescription drug services. An enrolled child who cannot qualify for benefits under the Medical Assistance spenddown provisions is eligible for a maximum of 90 days of inpatient services for each calendar year, which includes inpatient mental health services. Also covered are transplant services, ultrasound and nuclear medicine, and allergy testing.

The original benefit package was established legislatively, but some benefits have been added, such as inpatient and outpatient mental health services in 1994. The program does not exclude coverage for any preexisting condition.

The average monthly cost per child is approximately $63, which includes both premiums and some administrative costs. The program limits insurers' administrative cost reimbursement to no more than 7.5 percent of submitted invoices. Premium rates vary by insurer and region—from $57.77 to $64.25 per child per month for fully subsidized children, and from $67.30 to $83.52 per child per month for partially subsidized children.

Most children's families pay nothing for coverage, and the remainder are partially subsidized. Families with income at or below 185 percent of FPL (97 percent of enrolled children in July 1995) do not pay any share of their children's premiums. The state pays half the premium for children with family income between 185 percent and 235 percent of FPL. Some insurers subsidize the remaining half; otherwise parents must pay that share of the

premium. The program requires no deductibles, and the only copayment ($5) is for prescription drugs.

Insurer Payment and Provider Network

The Children's Health Insurance Program pays a capitated monthly fee per child to insurers to cover enrolled children's health care services. Insurers were selected through a competitive bid process, but the nonprofit insurers were legislatively required to bid. Insurers who did not have the lowest winning bid for a premium rate could participate if they were willing to match that rate. Currently, four nonprofit insurers and one for-profit insurer give families a choice of insurers in three of the four regions.

About 80 percent of program children are enrolled in HMOs, and the rest are in preferred provider networks.[27] Children are automatically enrolled in HMOs, where available. If a county changes to HMO service, children may remain in the preferred provider network plan until their recertification, but then they are automatically transferred to the HMO.

Publicity, Outreach, and Marketing

Each of the insurers is responsible for program publicity and outreach. The insurers use a variety of publicity and outreach approaches, including paid radio, TV, and newspaper ads; distribution of brochures and flyers; and contacts with hospitals, doctors, advocacy organizations, churches, and schools. Insurers must develop an outreach plan and are required to contribute at least 2.5 percent of the total amount they bill the program as an in-kind outreach contribution. The Department of Health and the Insurance Department also conduct some outreach.

Western Pennsylvania Caring Program for Children

Background

The Western Pennsylvania Caring Program for Children was the nation's first private-sector initiative to provide primary care health coverage to

[27]We have previously described preferred provider networks as arrangements that retain many elements of indemnity plans but provide enrollees a financial incentive to receive care from providers selected by the insurer (Managed Health Care: Effect on Employers' Costs Difficult to Measure, GAO/HRD-94-3, Oct. 19, 1993, pp.7-8). Although Children's Health Insurance Program officials did not characterize its non-HMO plans as preferred provider networks, we believe they are, because children in those plans who visit providers who are outside the insurer's provider network may be required to pay the difference between what the insurer pays its network providers and what the nonnetwork providers charge.

uninsured, low-income children who could not qualify for Medicaid. In 1984, a group of Presbyterian ministers from a local Pittsburgh church became concerned that many children were losing employment-based health care coverage as the local steel mills closed. The group approached Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield, which agreed to help provide health coverage for the children. Together they developed the Caring Program, which enrolled its first child in June 1985. The Caring Program has changed its eligibility standards and its benefits since then to complement changes in Medicaid eligibility and the introduction of the Pennsylvania Children's Health Insurance Program, a state-financed children's health insurance program that was partially modeled on the Caring Program and introduced in 1993.

Program Structure and Operations

The Western Pennsylvania Caring Foundation, Inc., a nonprofit organization set up by Blue Cross/Blue Shield, administers the Caring Program. The Foundation conducts enrollment and eligibility determination, care coordination for children with special health care needs, and outreach. Blue Cross/Blue Shield provides claims processing, retrieval, and legal services to the program.

Funding

The Caring Program is financed by tax-deductible donations made by local foundations, religious organizations, civic groups, labor unions, corporations, schools, and individuals. Community contributions provide significant financial support for the program—for example, for fiscal year 1994, Pittsburgh area communities donated $870,000. However, the Caring Program's major donor is Blue Cross/Blue Shield, which donates $2 for every $1 contributed by other donors as well as all administrative costs, including Foundation staffs' salaries. In fiscal year 1994, Blue Cross/Blue Shield contributed about $4 million.

Eligibility

When the program began, it enrolled uninsured children not eligible for Medicaid from birth to 19 years of age with total family income no greater than 100 percent of FPL. But as more public coverage options became available for some of the younger children through Medicaid and the Children's Health Insurance Program, the Caring Program changed its eligibility rules to provide services to older children and to complement rather than compete with the Children's Health Insurance Program and Medicaid coverage.

Children may enroll in the Caring Program if they (1) are age 16 to 19 with total family income no greater than 185 percent of FPL, (2) are attending

school, (3) have resided in Pennsylvania for the past 30 days, and (4) are uninsured and ineligible for Medicaid. Applicants who appear eligible for but are not receiving Medicaid must apply for Medicaid and be denied before being enrolled in the Caring Program. On average, the Caring Foundation refers about 300 to 400 applicants each month to Medicaid. The Foundation recertifies eligibility annually on the family's enrollment date. At that time, if a child appears to have become Medicaid-eligible, the Caring Program provides temporary coverage while the child's Medicaid eligibility is determined.

Enrollment

As of July 1, 1995, 5,532 children were enrolled in the program. To enroll, families fill out a simple, one-page application, which is processed by the Foundation. If approved, the family is mailed an acceptance letter and a provider directory. Children covered by a fee-for-service system get active coverage as of the beginning of the month, but those covered by an HMO must choose a provider to activate their coverage. All participants receive an enrollment card that is practically identical to that used by any other Blue Cross/Blue Shield plan member. Enrollees must enroll in HMOs if Blue Cross/Blue Shield is operating an HMO in their county.

Covered Services, Costs, and Cost-Sharing

The Caring Program's initial benefit package was very limited, including only doctor office visits, immunizations, diagnostic testing, emergency care, and outpatient surgery. The program developers would have preferred to provide a more comprehensive package at that time, but since the program's funding depended entirely on charitable donations, limiting benefits allowed the program to serve more children.

When the Children's Health Insurance Program began, the Caring Program wanted to provide the same set of covered services. In 1993 and again in 1994, the Caring Program expanded its services, adding dental, hearing, and vision care; prescription drugs; limited hospitalization; and mental health services. As under the Children's Health Insurance Program, families of children who are hospitalized must apply for Medicaid coverage after 3 days. For families who do not qualify for Medicaid, the Caring Program will pay for up to 90 days per year.

Currently, the program covers primary and preventive health care (including well-child visits, immunizations, diagnostic testing, outpatient physician services, and outpatient surgery); emergency and accident care; physical, speech, and occupational therapy; vision care (limited to one pair of corrective lenses every 6 months and one pair of frames every 12 months); hearing, dental, and home health care; and prescription drug

services. An enrolled child who cannot qualify for benefits under the Medical Assistance spenddown provisions is eligible for a maximum of 90 days of inpatient services for each calendar year, which includes inpatient mental health services. Also covered are transplant services, ultrasound and nuclear medicine, and allergy testing. The program does not exclude coverage for any preexisting medical conditions.

The average cost for services is now $70.60 per child per month. This does not include any administrative expenses, which are donated by Blue Cross/Blue Shield. In 1985, the more limited benefit package cost about $13 per child. The program requires little cost-sharing from families: Families do not have to pay any share of their children's premiums. The program requires no deductibles, but does have a $5 copayment for prescription drugs.

Insurer Payment and Provider Networks

The Foundation pays providers through Blue Cross/Blue Shield. Children are enrolled in HMOs in 16 counties and in indemnity plans in 13 counties. HMOs are paid on a capitated basis, while network and other physicians are paid on a fee-for-service basis. Children may go to doctors outside the Blue Cross/Blue Shield network, but if they do the families are responsible for any charges beyond the rate Blue Cross/Blue Shield would normally pay for services. Few children use doctors who are not Blue Cross/Blue Shield providers.

Publicity, Outreach, and Marketing

The Caring Program publicizes itself in various ways, from Mister Rogers television spots to bus billboards to grassroots efforts in every county. In addition, its fundraising efforts help make it known to churches and other community groups who can help outreach to families. Three outreach specialists work in 29 counties to locate sponsors for the children, make presentations, distribute applications, and help families enroll. In 1993, more than 100 schools and several major corporations helped the program raise funds and publicize its services. Currently, several chain stores have distributed flyers and hung posters to inform shoppers about the Caring Program. In addition, members of the Pittsburgh Steelers football team have made speeches to community groups, donated prizes to fundraisers, and hosted kick-off luncheons and victory parties as incentives for schools raising funds for the program. The Western Pennsylvania Caring Foundation spent about $370,000 in fiscal year 1994 for outreach and publicity for both the Caring Program and the Children's Health Insurance Program.

Limited Evaluations Show Programs Improved Children's Use of Health Care Services

Limited available evaluations show that the six programs we visited have improved children's access to and use of health care. The programs increased the likelihood that children would get the care that they needed, reduced inappropriate ER use in some cases, and increased children's use of preventive services. Some evaluations suggest children enrolled in the programs may still not be getting as many preventive services as recommended by health authorities.

Incidence of Unmet Medical Needs Has Been Reduced

Three programs' evaluations have found evidence that they have reduced their enrollees' level of unmet need for medical treatment. A 1991 survey of participants in the Western Pennsylvania Caring Program for Children found that, before enrolling their children in the program, 33 percent of parents postponed taking them to a physician when they thought it was necessary, but after enrollment only 2 percent did so. HCFA's evaluation of the Florida Healthy Kids Program found that more enrolled children had their medical needs met than did uninsured children in those states. A separate study of the Florida program found that only 1 percent of Healthy Kids respondents, compared with 17 percent of non-Healthy Kids respondents, failed to seek medical care for their children because the cost of a doctor's visit deterred them.

Inappropriate Use of Emergency Room Was Reduced in Certain Programs

Low-income families sometimes use hospital ERs when treatment by a primary care provider would be more appropriate and less costly. The programs' effect on ER use was mixed: ER use by program children declined in one program, but not in two others. In fact, the two programs that used copayments to discourage inappropriate ER use had different results.

Evaluation of the Healthy Kids Program found that participating children were significantly less likely to use the ER than a comparison group of nonparticipants. In addition, a hospital used by program children in Volusia County studied its ER usage and found that uninsured pediatric ER visits declined by about 15 percent during the 2-year period after the program began, without an increase in ER visits by children enrolled in the HMO used by the program. Florida uses a copayment to discourage inappropriate ER use.

However, ER use by program families in the Western Pennsylvania Caring Program and New York's Child Health Plus Program did not decrease. According to a 1991 University of Pittsburgh survey, participants in the

Western Pennsylvania Caring Program used the ER slightly more often following enrollment in the program. Preliminary results of the University of Rochester's survey of participants in a limited geographic area in New York's Child Health Plus Program showed no significant changes in ER use following enrollment in the program, even though Child Health Plus authorizes a copayment for inappropriate ER use. Statewide data are not yet available to fully evaluate the program's impact on ER use.

Preventive Services Used but Perhaps Not Enough

A number of programs have been successful at encouraging use of primary and preventive care services. However, evidence from three programs suggests that preventive services may still be underused by program participants.

Four programs found that enrolled children were more likely than uninsured children to get preventive and primary care. For example, a 1991 survey of participants in the Western Pennsylvania Caring Program found that the likelihood of a child's having had at least one well-child visit during the year and being up-to-date with immunizations increased after the child enrolled in the program. Evaluations of the Florida program found that enrolled children were more likely to have had a doctor's visit or a preventive checkup in the previous 3 months than a comparison group of uninsured children. An Alabama Caring Program evaluation found that 81 percent of the enrolled children had developed an ongoing relationship with a pediatrician or family doctor, whereas before enrolling in the program only 17 percent of these children had ever visited a private doctor.

Despite these increases in children's use of primary and preventive care, some children may still not be using preventive services at recommended levels. Several programs evaluated their enrolled children's care use and found that many children were not using their insurance to get an initial checkup or to get immunized. For example, the Institute for Child Health Policy in Florida analyzed Healthy Kids children's use of health care services. They found that 32 percent of program children studied had never had a doctor's examination, and that the poorest enrolled children and African-American and Hispanic enrollees were more likely to have never used program services—results similar to those found from evaluating another health program serving a similar population. The Institute for Child Health Policy concluded that various sociopolitical and cultural factors may discourage African-American and Hispanic families from getting preventive services for their children.

New York and Minnesota also found that children were not using preventive services sufficiently. An early quality assurance study of New York's Child Health Plus Program found that enrolled children averaged 2.5 immunizations by their first birthday, even though American Academy of Pediatrics guidelines call for a minimum of 8 immunizations. The University of Minnesota found in a study of Minnesota's Children's Health Program (the precursor to MinnesotaCare) that more than 30 percent of enrolled children did not receive well-child care in 1990. According to several program officials or analysts, many families thought they were supposed to use their children's coverage only when their children were sick. Program officials or insurers in Florida, Minnesota, and New York attempted to increase the use of preventive care through sending newsletters and other written materials to families.

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Related GAO Products

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Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995.)

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