State Initiatives to Cover Uninsured Children

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Issue Editor’s Note

Despite a dramatic expansion in the coverage of infants and young children under the Medicaid program since the mid-1980s, more than 9 million children had no health insurance coverage in 1992. Millions more lacked full coverage for primary care and preventive services. To address the problems faced by these uninsured and underinsured children, innovative programs to provide health care coverage to low-income children in families with incomes too high to qualify them for Medicaid have been developed in almost half of the states in this country.

In this article, Ian Hill and Larry Bartlett of Health Systems Research, Inc., and Molly Brostrom, formerly of Health Systems Research Inc., currently with the White House Health Care Reform Task Force, describe these innovative programs, including the privately financed Blue Cross/Blue Shield Caring Programs and promising public sector programs in 11 states. They analyze the major public and private programs using a matrix of key design features, including eligibility requirements, benefit packages, payment and delivery arrangements, and locus of control, which define each program.

The privately financed Blue Cross/Blue Shield Caring Programs and New York State’s Child Health Plus have a number of features in common. The programs offer subsidized coverage for primary and preventive services to low-income children ineligible for Medicaid. Although these programs have limited enrollments and a limited benefits package, they have scored some important successes in simplifying enrollment procedures and mainstreaming low-income children into a private system of primary care.

Other states (Maine, Vermont, Washington, and Wisconsin) have built on their Medicaid programs to provide coverage of comprehensive health services for children otherwise ineligible for Medicaid. As described in this paper, Florida offers comprehensive health care coverage in a pilot program which uses the school system in one county as a pooling mechanism to purchase private managed care coverage. Other states are also experimenting with small-scale programs to reach designated populations of uninsured children.

Perhaps the most exciting state program described by Hill, Bartlett, and Brostrom is Minnesota’s Children’s Health Plan. Implemented in 1988 with a limited benefit package of ambulatory preventive and primary care for children between the ages of one and eight in families with incomes below 185% of the federal poverty level, the program has been so successful that it has been steadily expanded. The benefit package has been enhanced to include inpatient hospital care and other previously excluded, high-cost health services and eligibility criteria expanded to include families with incomes up to 275% of poverty and adults without children by July 1994.
Another recent development which may provide direction for state child health insurance initiatives is the 1902(r)(2) option. This amendment to the federal Medicaid statute provides states with the opportunity to capture federal dollars to support expanded child health insurance initiatives under the Medicaid program. As detailed in this article, a number of states have already used this option to obtain federal matching funds to double or even triple state dollars going into expanded Medicaid programs.

While policymakers at the federal level are still contemplating various strategies for extending health insurance coverage to the country’s large uninsured populations, a large number of states seem to be providing coverage to thousands of children who previously lacked it. Although these state programs have not been well evaluated, there is reason to believe that they should be watched closely as they may be the stepping-stones to more comprehensive health care reform initiatives.

— E.L.

Created in 1965 as Title XIX of the Social Security Act, the Medicaid program today serves as the primary public program financing health care services for low-income American children. Indeed, a series of federal statutory changes begun in the mid-1980s has dramatically expanded this program’s coverage of infants and young children. As of January 1993, all states offer Medicaid coverage to children under age 6 in families with incomes below 133% of the federal poverty level, and to children under age 10 living in families with incomes below 100% of poverty. Coverage of children up to age 19 in families with incomes below 100% of poverty is being phased in on an annual basis.

In spite of these expansions, an estimated 9.5 million children in the United States remained without any form of health care coverage in 1991. Additionally, millions of other children had insurance that provided less than full coverage of primary and preventive services. In part, because private employer-based health insurance coverage of dependents declined significantly in the late 1980s, many of these children are members of “working poor” families whose incomes are too high for them to qualify for Medicaid coverage, even with the recent expansions.

To address the problems faced by these children, a number of states have established programs that seek to extend coverage to certain low-income children who are not eligible for Medicaid. A number of private insurers, sometimes in collaboration with state governments, have also established similar subsidized programs.

This article describes these innovative programs and is organized in the following manner. First, an effort is made to identify the key design decisions planners must make in developing programs of this kind. Next, the major programs established by individual states or private organizations which are currently directed at extending subsidized coverage to low-income children who are ineligible for Medicaid are described. Then, a description of new opportunities that exist for using federal Medicaid funds to support these new programs, as well as the potential role that these programs can play in states’ broader strategies to provide universal access to health care is provided. Finally, the article concludes with a summary of the lessons
Box 1

Medicaid

Because so many of the child health insurance programs described in this paper build upon the policies and structures of the Medicaid program, it is important to understand many of that program’s key components. Provided below is a brief description of Medicaid’s fundamental eligibility rules, services, and administrative practices.

Eligibility Rules

Medicaid’s eligibility rules are intimately linked to those of various public welfare programs. From its inception, Medicaid coverage was created as an additional benefit that persons eligible for welfare would receive along with their cash assistance payment. Specifically, Medicaid is currently provided to women and children eligible for the Aid to Families with Dependent Children (AFDC) program, and to aged, blind, or disabled individuals eligible for Supplemental Security Income (SSI) cash benefits. These so-called “categorical” links, therefore, create a program that is by no means available to any “poor” person. In fact, because states possess the flexibility to set income eligibility limits for the AFDC programs, Medicaid coverage may be available only to the “very poor.” For example, in Alabama, very strict eligibility criteria for AFDC have limited cash assistance to families possessing incomes below 15% of the federal poverty level.

As described in the introduction, federal statutory changes enacted in the late 1980s eliminated this link between eligibility for AFDC and Medicaid, allowing states to set the income eligibility threshold for children and pregnant women significantly higher than the threshold set for the AFDC program.

Services

State Medicaid programs are required to extend to program recipients a rich set of health care benefits, including inpatient and outpatient hospital services, physician services, rural health clinic services, laboratory and x-ray services, skilled nursing facility and home health services for persons over age 21, family planning services and supplies, and nurse-midwife services. All states are also required to provide early and periodic screening, diagnosis, and treatment services (EPSDT) to children under age 21. (These services must include, at a minimum, assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; vision, hearing, and laboratory tests; dental screenings; and treatment for vision, hearing, and dental problems.) States have the option of adding to this package a broad range of optional services, including prescription drugs, physical/occupational/speech therapies, case management, hospice care, dental care, respiratory care, and services rendered in intermediate care facilities for the mentally retarded. States also have the flexibility to define limits on the coverage of these services; therefore, considerable variation among the states in both the range of services covered and the amount of care covered under each category exists.

Administrative Practices

Medicaid is jointly administered by the federal and state governments, with the federal government dictating the overall structure and states retaining flexibility to establish income eligibility thresholds, determine optional service coverage, and set payment rates for providers. The federal government finances between 50% and 80% of program expenditures, based on a formula that reflects the relative wealth of states and their ability to pay for care. Providers, both institutional and individual, must enter into a formal contractual agreement with the state to receive reimbursement under Medicaid. Because state Medicaid reimbursement levels are often low in comparison to private-pay rates, many states experience very low rates of provider participation in the program.

Key Decisions in Designing Innovative Coverage Programs for Low-income Children

In designing children’s health insurance programs, states have been required to make important decisions in a number of key policy areas. These areas include the following:

- Eligibility. State children’s health insurance programs, by their nature, are designed to extend coverage to populations not covered under state Medicaid programs. However, when the funds available for such extensions are limited, states must decide how to allocate scarce resources. In the area of eligibility, states are faced with the question of whether to expand eligibility based upon age or income. For exam-
ple, given current Medicaid eligibility limits, a state establishing a supplemental program may decide to extend poverty-level coverage to older children who are ineligible for Medicaid because of their age. Conversely, the state may choose to raise income eligibility thresholds to allow coverage of younger children in families with incomes above Medicaid limits.

Aside from establishing age and income criteria, there are a number of other areas in which eligibility policy decisions must be made. For example, a state must decide whether it will offer coverage only to children who possess no other form of insurance, or allow the new program to cover underinsured children as well, that is, children who possess insurance that does not cover certain needed services or that has significant cost-sharing requirements that limit access to these services.

- **Covered Benefits.** States have several decisions to make regarding the benefits to be covered under these programs. A state may choose to provide comprehensive coverage similar to that available under its Medicaid program, or a state may opt to provide coverage only for ambulatory primary and preventive services. To the extent that the needs of older and younger children differ, the content and scope of covered benefits may need to be linked to the program’s eligibility policies.

- **Payment and Delivery Arrangements.** States must also make important decisions concerning both the method and the level of payment to be made to providers under these programs. As will be discussed, while a number of programs enroll children in capitated arrangements, fee-for-service arrangements are also quite common. Fee levels used can be the same as those paid under Medicaid, or a program may utilize private sector rates. Similarly, a new program may provide care to children through the same providers participating in the Medicaid program, or utilize a network of providers (including health maintenance organizations and/or preferred providers) established by private insurers.

- **Public versus Private Programs.** A number of the programs described in this article represent primarily private sector initiatives, although some of these have been developed with the cooperation and support of state governments. Others are primarily public sector programs, receiving the bulk of their support through state funds. However, even if programs are financed primarily with public sector dollars and their policies and procedures are made consistent with those of their counterpart state Medicaid programs, states must still decide the degree to which they wish to give these programs their own separate identity in an attempt to avoid the welfare stigma often associated with Medicaid. States must also decide whether they will directly administer a primarily public program, or contract with private insurers for certain services such as eligibility determination and/or claims processing.

- **Financing.** As noted above, funding for these programs may come from a variety of sources, both public and private. Private sector support may include in-kind administrative support, special provider discounts, and subsidies or premiums assessed on families. Public sector funds have been derived from a number of sources, including general revenue appropriations and increases in cigarette taxes or other dedicated revenue sources.

A description of how these design features have been combined in existing programs is presented in the following section.

### Children’s Health Insurance Initiatives

In roughly half the states in this country, innovative programs for providing health care coverage to low-income children have been developed. Described below are the design features and early experiences of many of these children’s health insurance initiatives, beginning with programs that originated in the private sector and continuing with promising public sector initiatives in 11 states. Table 1 provides a summary matrix of the characteristics and policies of these different programs, including those related to eligibility, benefits, and reimbursement.
<table>
<thead>
<tr>
<th>State Child Health Insurance Initiatives</th>
<th>Implementation Date</th>
<th>Age Limit (years)</th>
<th>Income Limit (FPL)</th>
<th>Other Criteria</th>
<th>Premium Contribution</th>
<th>Benefits</th>
<th>Basis for Reimbursement</th>
<th>Financing</th>
<th>Enrollment (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross/Blue Shield: Caring Programs (private programs in 17 states)</td>
<td>June 1985</td>
<td>&lt;19</td>
<td>---&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Ineligible for Medicaid</td>
<td>None</td>
<td>Preventive and primary outpatient care, including emergency services and outpatient surgery</td>
<td>None</td>
<td>Rates set by BC/BS</td>
<td>Primarily philanthropic donations</td>
</tr>
<tr>
<td>California: Access to Infants and Mothers (AIM) (s)</td>
<td>Jan, 1992</td>
<td>&lt;2&lt;sup&gt;c&lt;/sup&gt;</td>
<td>200%-250%</td>
<td>No comparable insurance</td>
<td>Up to 2% of family income</td>
<td>Similar to Medicaid</td>
<td>None</td>
<td>Rates set by private insurer</td>
<td>Cigarette and tobacco taxes</td>
</tr>
<tr>
<td>Colorado: Child Health Plan (p)</td>
<td>Oct, 1992</td>
<td>&lt;9</td>
<td>&lt;185%</td>
<td>Ineligible for Medicaid</td>
<td>$25 annual enrollment fee ($150 cap/family)</td>
<td>Any medical care provided in physician’s office</td>
<td>$2 per physician visit; $7,500 annual limit on services</td>
<td>Capitated rate for primary care; Medicaid rates for other services</td>
<td>Federal Medicaid dollars (waiver) and philanthropy</td>
</tr>
<tr>
<td>Connecticut: Healthy Steps (p)</td>
<td>Oct, 1992</td>
<td>&lt;14</td>
<td>&lt;200%</td>
<td>One child in family enrolled in school; ineligible for Medicaid; no other insurance</td>
<td>$60/child annually ($240 cap/family)</td>
<td>Inpatient hospital, physician, dental, outpatient mental health and substance abuse treatment, prescription drugs</td>
<td>Co-payment for prescription drugs</td>
<td>Rate set by BC/BS</td>
<td>State funds and family contribution</td>
</tr>
<tr>
<td>Delaware (s)</td>
<td>Oct, 1992</td>
<td>&lt;19</td>
<td>&lt;100%</td>
<td>None</td>
<td>None</td>
<td>Medicaid</td>
<td>None</td>
<td>Medicaid rates</td>
<td>State &amp; federal Medicaid funds</td>
</tr>
<tr>
<td>Florida: Healthy Kids (p)</td>
<td>Feb, 1992</td>
<td>&lt;19</td>
<td>None</td>
<td>Enrolled in Volusia County school district or older sibling enrolled; ineligible for Medicaid</td>
<td>100%-135% FPL: $3/child/month; 136%-185% FPL: $16/child/month; &gt;186% FPL: $57 (full premium)</td>
<td>Similar to Medicaid</td>
<td>$3 pharmacy; $25 non-emergency ER use; $10 mental health; $10 eyeglasses; $1 million lifetime limit</td>
<td>HMO capitated rate</td>
<td>Medicaid demonstration funds and state dollars</td>
</tr>
<tr>
<td>Maine: Maine Health Program (s)</td>
<td>Oct, 1990</td>
<td>&lt;20</td>
<td>&lt;125%</td>
<td>None</td>
<td>If 100%-185% FPL, contribute 1.5%-3% of income</td>
<td>Full Medicaid package</td>
<td>None</td>
<td>Medicaid rates</td>
<td>Medicaid demonstration funds and state dollars</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Enrollment Criteria</th>
<th>Medicaid Services</th>
<th>Enrollment Fees</th>
<th>Enrollment Tax or Other Requirement</th>
<th>Cigarette Tax or Other Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minnesota</strong></td>
<td>Children’s Health Plan (now part of MinnesotaCare) (s)</td>
<td>July 1988 &lt;18 15%</td>
<td>Ineligible for Medicaid</td>
<td>$25 annual enrolment fee per child ($100 cap/family)</td>
<td>Preventive and outpatient care, including dental and vision services, most prescription drugs, emergency care, o.p. surgery, o.p. mental health and substance abuse treatment</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>New York</td>
<td>Child Health Plus (s)</td>
<td>Sept. 1991 &lt;16 None</td>
<td>Ineligible for Medicaid; no other insurance</td>
<td>&lt;160% none; 160%–222%: $25/child/year; &gt;222% full premium</td>
<td>Ambulatory preventive and primary care services</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Dec. 1992</td>
<td>&lt;6 235%</td>
<td>N/A</td>
<td>&lt;185% none; 185%–235%: one-half of premium</td>
<td>Preventive and primary care; hospital services</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>Vermont</td>
<td>Dr. Dynasaur (s)</td>
<td>July 1989 &lt;18 225%</td>
<td>None</td>
<td>None</td>
<td>Full Medicaid package</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>Virginia</td>
<td>Governor’s Child Health Package (s)</td>
<td>July 1992 100%</td>
<td>None</td>
<td>None</td>
<td>Full Medicaid package</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>Washington</td>
<td>Children’s Health Program (p)</td>
<td>Jan. 1991 &lt;18 100%</td>
<td>None</td>
<td>None</td>
<td>Full Medicaid package</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>Washington</td>
<td>Basic Health Plan (BHP) (p)</td>
<td>Jan. 1989 None</td>
<td>Suggest that applicant apply for Medicaid if appears to be eligible</td>
<td>Premium based on income level</td>
<td>Hospital physician, and preventive services, emergency care (no vision, dental, prescription drugs, mental health)</td>
<td>Medicaid rates</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Healthy Start Program (s)</td>
<td>Aug. 1988 26 133%–155%</td>
<td>None</td>
<td>Medicaid</td>
<td>Medicaid rates</td>
<td>Medicaid rates</td>
</tr>
</tbody>
</table>

(s) = statewide  (p) = pilot project

a. Federal Poverty Level

b. Varies from state to state—about half of the states set upper limits between 100% and 150% of the federal poverty level. The highest income limit is in the state of New York (222% of the federal poverty threshold) while the lowest limits are in Alabama and Mississippi (80% of the federal poverty threshold).

c. AIM covers infants under age two as well as pregnant women.

d. In October 1, 1992, Minnesota also began covering the parents and dependent siblings of Children’s Health Plan enrollees in MinnesotaCare, a new state health insurance plan. To be eligible, enrollees must be Minnesota residents and must have had no access to employer-paid health insurance within the previous 18 months.

e. Beginning July 1, 1993, state-only funds will be used to provide a package of primary and preventive services to infants under one year and in families with incomes between 133% and 200% of the federal poverty level.
The Blue Cross/Blue Shield Caring Programs

One of the earliest efforts to address the needs of uninsured children was initiated through community and private sector cooperation. In 1984, two ministers living and working in the city of Pittsburgh were becoming increasingly frustrated by the growing numbers of low-income uninsured children they saw who lacked access to even the most basic health services. At the time, the Pennsylvania Medicaid program covered only children in families with incomes up to 50% of the federal poverty level. These ministers wondered whether something could be done to assist poor children not eligible for Medicaid in obtaining health care coverage by combining the resources of the community and the private sector. They approached Blue Cross/Blue Shield of Western Pennsylvania with their idea and, from this initial encounter, the Caring Programs were born.

By pooling philanthropic and other community donations with administrative services from Blue Cross/Blue Shield, the program provides subsidized coverage of ambulatory preventive and primary care to uninsured children.

In 1985, the Caring Program of Western Pennsylvania was created as a nonprofit corporation. By pooling philanthropic and other community donations with administrative services in the form of marketing, eligibility determination, and claims processing support from Blue Cross/Blue Shield, the program provides subsidized coverage of ambulatory preventive and primary care to uninsured children living below the federal poverty level. Civic groups, churches, businesses, foundations, and individuals are approached by the Caring Program and invited to sponsor children by donating the cost of a year’s premium. Children are then given access to Blue Cross/Blue Shield’s network of providers.

Following the example of Western Pennsylvania, Caring Programs have been developed in 17 states, and programs are ready to begin in 5 additional states. While their specific designs vary slightly, Caring Programs generally serve uninsured children under age 19 who do not qualify for Medicaid but who live in families with incomes near the federal poverty level. Caring Programs across the country also share the following characteristics:

- Most programs cover outpatient care, well-child visits, immunizations, primary care for illness and accident, emergency services, laboratory and x-ray services, and outpatient surgery. Plans in six states offer prescription drugs, but only three states offer coverage for inpatient hospital care.

- Eligibility determination processes are typically quite simple: applications are never more than one page; no assets restrictions are imposed; no income verification is required; and families pay no enrollment fee. To reduce adverse selection and discourage families from enrolling only sick children, some programs require that all eligible children in a family enroll. In addition, because Caring Programs are designed to supplement Medicaid, their plans require potentially eligible children first to apply for Medicaid. Indeed, through outreach, public education, and enrollment efforts, some Caring Programs have identified large numbers of children who are eligible for but not enrolled in Medicaid.

Across all programs, the cost of sponsoring a child (i.e., the annual per-child premium) averages $270 per year. Annual premiums range from a low of $156 in Western Pennsylvania to a high of $528 in the New York Caring Program, reflecting variations in program policies and in health care costs in different regions. While the majority of financing support for the programs is derived from philanthropic donations, some Blue Cross/Blue Shield organizations also directly match private donations. In addition, public funds also support the provision of care in some Caring Programs. For example,

- A $335,000 grant, awarded in the late 1980s by the federal Maternal and Child Health Bureau, was used as seed money by several states to replicate the original Western Pennsylvania program;

- A federal Health Care Financing Administration (HCFA) demonstration grant underwrites a portion of Michigan’s Caring Program; and

- In Alabama, Iowa, and Western Pennsylvania, public funds are used to support
directly a portion of the cost of covering children in these states.

Enrollment in Caring Programs has increased steadily over time. In the most recent year for which data are available, total enrollment in the 17 Caring Programs nearly doubled, rising from 21,695 in September 1991, to 39,070 children in September 1992. In 1993, total enrollment is expected to double again as several of the more recently implemented programs mature and as five new programs begin operation. In addition to expanded enrollment, Caring Programs have enjoyed other important successes. Namely, program administrators report that the simple eligibility determination process enables families to maintain their sense of dignity while receiving publicly subsidized medical assistance. Mainstreaming low-income children into a private system of primary care is also facilitated by providing families with a Blue Cross/Blue Shield card which is virtually indistinguishable from standard insurance cards.

**State-sponsored Child Health Insurance Programs**

While Caring Programs represent an important step toward providing health care coverage to uninsured children and also provide an example of the potential of community and private sector collaborative efforts, their limitations must also be acknowledged. Despite their continued growth, for example, Caring Programs remain relatively small. The Western Pennsylvania Caring Program, which has the largest enrollment of all the plans at approximately 6,500 children, is reaching only 11% of the current estimated eligible child population in the service area. The dependence of the Caring Programs on philanthropy also limits their possibilities for expansion—waiting lists for coverage exist in 13 programs—and adds an element of uncertainty about their future operations.

Thus, as the numbers of low-income uninsured children continued to increase in the late 1980s, state governments began efforts to expand health care coverage for this population. Some states, such as Minnesota and New York, focused resources on providing coverage of preventive and primary care services. Other states, such as Vermont, Maine, Washington, and Wisconsin, developed programs which build upon the Medicaid program to provide coverage of comprehensive health services for children. Florida also provides comprehensive health care coverage in a pilot program in one county, but uses the school system as a pooling mechanism to purchase private coverage. Each of these programs is discussed in detail below.

**The Minnesota Children’s Health Plan**

Minnesota was one of the first states to establish a special health insurance program to subsidize coverage of low-income children ineligible for Medicaid. In response to the rapidly growing number of uninsured children in the state, in 1987 the Minnesota Legislature dedicated a one-penny increase in the cigarette tax to the creation of the Children’s Health Plan (CHP). Implemented in July 1988, the plan was designed to conserve scarce state resources in two important ways:

- First, program eligibility initially was limited to children between the ages of one and eight in families with incomes below 185% of the federal poverty level.
- Second, to provide at least basic coverage to the greatest possible number of children, program benefits were limited to a package of ambulatory preventive and primary care services.

In response to the rapidly growing number of uninsured children in the state, in 1987 the Minnesota Legislature dedicated a one-penny increase in the cigarette tax to the creation of the Children’s Health Plan.

The eligibility policies of the Children’s Health Plan did not, however, remain static. After various Medicaid eligibility expansions rendered federally subsidized coverage available to more and more children, CHP raised its upper age limit. Beginning in January 1991, the program began covering all children under age 18 in families with incomes below 185% of poverty.

Access to the Children’s Health Plan was designed to be relatively simple: the program utilized a one-page application form which could be completed by mail. Families enrolled in CHP paid an annual
fee of $25 per child (with a per-family cap of $100 per year), and no additional family cost sharing was required for covered services.

From the outset, CHP allowed both uninsured and underinsured children to enroll. Program planners believed that out-of-pocket costs (in the form of high deductibles and co-insurance) and gaps in coverage effectively created barriers to care even for children with private insurance. In fact, program experience has supported this belief: each year, almost one-third of CHP enrollees were children who possessed some other form of health care coverage. The other two-thirds of CHP children had no health care coverage, although almost half of all CHP parents were insured through their employment.\textsuperscript{14,15}

By covering only ambulatory primary and preventive care, CHP’s benefit policies departed significantly from those of the Minnesota Medicaid program (which covered comprehensive inpatient and ambulatory services). The Children’s Health Plan initially covered medical and dental checkups, clinic and physician visits to treat illnesses, laboratory tests, prescription drugs, vision and hearing care, and emergency room care. In January 1991, when the upper age limit for coverage was raised to 18, CHP also began covering certain outpatient mental health services in order to be more responsive to older children’s needs. In contrast to Medicaid, CHP never provided coverage for inpatient hospital care. The Children’s Health Plan was, however, patterned after the Medicaid program for two of its policies related to services: children covered by CHP were required to receive care from providers enrolled in Minnesota Medicaid, and reimbursement rates under the program were identical to those paid by Medicaid.

During its first three years, CHP succeeded in reaching almost 50% of the state’s target population of low-income children. The state estimates that just under 30,000 children were enrolled in the program by the end of 1992. The state spent an average of $388 per child per year and, consistently, 80% to 90% of program expenditures were for physician, outpatient hospital, and dental services, and for prescription medications.\textsuperscript{15,16}

The Children’s Health Plan has received national recognition for its innovation and service to children, and evaluative studies of the program suggest a strong basis for this support. A formal unpublished evaluation of the program found that children covered by CHP utilized health services at significantly higher rates than their uninsured counterparts. The researchers also found that parents of enrolled children perceived that their children were experiencing developmental problems at lower rates than parents of uninsured children.\textsuperscript{17} Annual reports described provider participation in the program as generally high and families as very happy with the Children’s Health Plan. According to surveys of enrolled families, parents were pleased to find affordable health care for their children and appreciated the streamlined application system because it allowed them to maintain a sense of privacy and dignity while using a government program. Program officials also state that families seemed to be supportive of the requirement to pay a nominal $25 enrollment fee, because doing so creates a sense that they are contributing to the cost of their coverage and are not simply receiving a “handout.”\textsuperscript{14,15}

Indeed, the popularity and generally recognized success of the Children’s Health Plan recently inspired the Minnesota legislature to build upon the program to move toward universal health insurance coverage across the state. In April 1992, Minnesota’s Gov. Arne H. Carlson signed a law creating MinnesotaCare, a health insurance plan that will, over several years, extend state-subsidized health insurance coverage to all uninsured Minnesotans who are not eligible for Medicaid and who have incomes below 275% of the federal poverty level.\textsuperscript{18} The Children’s Health Plan has been incorporated as part of MinnesotaCare. This new initiative is discussed in detail in the FutureDirections section of this article.
New York’s Child Health Plus

In September 1991, the state of New York initiated a program which, like Minnesota’s CHP, subsidizes ambulatory preventive and primary care services for low-income children. However, New York’s Child Health Plus (formerly the Child Health Insurance Plan) differs significantly from Minnesota’s plan in that it uses state funds to purchase private health insurance for qualifying low-income children. In addition, Child Health Plus is available only to children with no other health care coverage.

Under Child Health Plus, New York purchases insurance from Empire State Blue Cross/Blue Shield plans and seven other private insurers throughout the state. These insurers were required to meet detailed specifications in order to be awarded the contracts from the state. Each plan is responsible for marketing Child Health Plus in its region. In a complementary effort, the state has also contracted with several community organizations in various regions of the state to develop regional outreach campaigns. Finally, an advertising agency has received a contract to develop a statewide, multimedia marketing effort.

Child Health Plus makes subsidized coverage available to all children under age 13 who are ineligible for Medicaid, possess no other health insurance, and live in families whose gross income falls below 222% of the federal poverty level. Families with incomes under 160% of poverty pay nothing to enroll their children, while those with incomes between 160% and 222% of poverty pay a $25 annual enrollment fee per child (with a per-family cap of $100 for families with four or more children). Families with incomes above 222% of poverty may purchase Child Health Plus coverage at the full cost of the premiums established under the program. These premiums range from $477 to $656 per year, varying with the region and specific health plan.

The program is funded by an annual appropriation of $20 million from the Statewide Bad Debt and Charity Care Pool, unused funds from other health programs, and enrollment fees and premium payments. Because the Statewide Bad Debt and Charity Care Pool is scheduled to sunset after December 1993, alternative sources of funding for the program are currently being investigated.

In its first six months, the program enrolled 14,000 children. By December 1992, enrollment had risen to approximately 32,000 children. (The program’s enrollment target is 55,000 children.) Only 150 of these children have family incomes which make them ineligible for a state subsidy.

Because of the minimal barriers to enrollment, insurers have encountered little difficulty in attracting families to the program: low fees make the plan affordable, and the simple application streamlines the eligibility process. Since providers are reimbursed at private insurance rates established by the plans, CHP children do not face the same provider participation problems as faced by children in the Medicaid program. Program administrators believe that Child Health Plus provides a successful model for how public dollars can be used to encourage private insurers to cover the uninsured.
Programs Built upon State Medicaid Programs

Unlike the states discussed above, which focused resources on providing coverage of ambulatory preventive and primary care, the states of Vermont, Maine, Washington, and Wisconsin, have developed child health insurance programs that provide comprehensive health care coverage. These initiatives build directly on the states’ Medicaid programs by employing many of the same benefit, payment, and administrative policies. Specifically, the programs

- Provide children with access to a comprehensive benefit package that is identical to that covered by Medicaid;
- Rely on Medicaid-participating providers to render services;
- Reimburse providers at Medicaid rates; and
- Use the state Medicaid program’s administrative systems for both eligibility determination and claims processing.

The unique features of each of these programs are described below.

Vermont’s Dr. Dynasaur Program

The state of Vermont began a program in 1989 to provide comprehensive Medicaid-like health care coverage for young, low-income children. Called Dr. Dynasaur, the program initially covered low-income children under age seven with family incomes under 225% of poverty.

In July 1992, additional state funds were authorized to raise to 18 the upper age limit for coverage under Dr. Dynasaur. This age expansion has fueled a dramatic increase in the size of the program: in June 1992, some 1,516 children participated in Dr. Dynasaur; by November 1992, about 4,960 children were enrolled in the program. Data available through July 1992 indicate that each child covered by Dr. Dynasaur costs the state roughly $600 per year.

It is important to note that, also in July 1992, the state legislature established the Health Care Authority to develop a plan to provide universally accessible health care to all Vermonter by 1994. That same month, the state took advantage of a new Medicaid option to incorporate a large portion of the Dr. Dynasaur program in the state’s Medicaid program, thus transforming what had been an entirely state-funded program into one funded by federal and state Medicaid dollars. (This option is discussed in detail in the last section of this article.)

The Maine Health Program

In October 1990, the state of Maine established the Maine Health Program, an initiative to extend comprehensive health care coverage to low-income uninsured individuals in the state. The Maine Health Program was originally designed to subsidize coverage of children through age 19 in families with incomes at or below 125% of poverty and of adults with incomes under 95% of poverty. Because of budget shortfalls, however, enrollment in the adult component was terminated in February 1991 (although adults who were already enrolled continue to be covered). Beginning in June 1991, Maine was one of three states to receive a HCFA demonstration grant to support and test the cost-effectiveness of innovative coverage initiatives. Therefore, since that time, federal Medicaid funds have matched state expenditures incurred under the Maine Health Program.

As noted above, the Maine Health Program builds directly on the state Medicaid program; however, in a significant departure from Medicaid’s policies, the Maine Health Program imposes a sliding scale premium upon some of its enrollees. Specifically, families with incomes between 100% and 125% of poverty are asked to pay a premium equal to roughly 1.5% of family income ($9.55 for the first person in the family and $3.35 for each additional person). Children in families whose income rises above 125% of poverty are permitted to remain on the program for up to two years, with premiums adjusted to reflect the families’ increased earnings. At 185% of poverty, the per-child premium is roughly 3% of income.

Maine’s demonstration project also features a buy-out provision that permits the state to determine whether it is more cost-effective to enroll eligible individuals...
in Medicaid or to pay the premiums and cost sharing associated with available private employer-based coverage. The state may also decide to provide wrap-around coverage for Medicaid benefits not included in an employer’s benefit package. To date, the state has purchased employment-based coverage for only about 5% of plan enrollees.

As of January 1993, researchers were just beginning to evaluate the Maine Health Program. Available program data indicate that, as of November 1992, there were 6,026 children and 2,415 adults enrolled in the program. The majority of enrolled children are between the ages of 10 and 19 because the state Medicaid program already covers children under age 10 in families with incomes below the poverty level. The annual cost of covering children under the Maine Health Program has averaged $736 per child.26,27

Currently, there is enough funding to operate the children’s component of the Maine Health Program through June 1993. At that time, HCFA demonstration monies for this component of the program will run out; therefore, Maine officials are in the process of exploring alternative financing arrangements.

**Washington’s Children’s Health Program**

The state of Washington began its children’s health insurance program in January 1991 to provide poor children with access to comprehensive health care coverage. The Washington Children’s Health Program (CHP) provided fully state-funded, Medicaid-like coverage of children up to age 18 living in families with incomes below the federal poverty level and not eligible for Medicaid.

By the end of 1991, the program had enrolled more than 13,000 children, exceeding initial projections. At that time, because Medicaid covered all children up to age 9 living below poverty, the majority of children enrolled in CHP were between the ages of 9 and 18. Interestingly, more than half of all enrollees (53%)—and virtually every enrollee under age 9—were undocumented aliens who were ineligible for Medicaid because of citizenship requirements.28,29

Data available through March 1992 indicate that Washington’s cost experience was similar to that of Maine. For example, expenditures for inpatient hospital services accounted for approximately 30% of total program spending, and physician, outpatient hospital, and dental services consume all but 15% of remaining expenditures. The average annual cost per child under CHP was roughly $640.

*More than half of all enrollees (53%) were undocumented aliens who were ineligible for Medicaid because of citizenship requirements.*

As is discussed in detail in the final section of this article, a new Medicaid option permitted Washington to finance the bulk of its Children’s Health Program with federal and state Medicaid dollars beginning in January 1992. Since that time, therefore, the remaining portion of the Children’s Health Program supported by state funds alone has covered only children who do not meet federal Medicaid eligibility criteria (that is, primarily noncitizens). As of December 1992, there were approximately 8,000 children remaining in the state-funded Children’s Health Program.30

**Wisconsin’s Healthy Start Program**

Since August 1988, the state of Wisconsin has provided Medicaid-like health insurance to children between the ages of 2 and 6 in families with incomes between 133% and 155% of poverty through the Healthy Start Program. This program, while covering a narrower population than the initiatives described above, does provide comprehensive health benefits. The program is financed by state and federal Medicaid dollars under a federal waiver from the U.S. Health Care Financing Administration, and the state is in the process of negotiating a renewal of this waiver with HCFA. Currently, 2,500 children are enrolled in Wisconsin’s Healthy Start.31

**Providing Health Insurance Through the Schools**

**Florida’s Healthy Kids Program**

In early 1992, Florida initiated a children’s health insurance program which differs markedly from the programs described above in that it uses a school system as a grouping mechanism for the purposes of marketing and purchasing health insurance coverage for children. The original concept and the design for this model were developed by the Florida-based Insti-
When, in 1990, state data indicated continued declines in child health and school performance as well as continued growth in the number of uninsured children in the state, the Florida legislature created the Healthy Kids Corporation to implement this model. Aided by a demonstration grant from HCFA to finance the plan, the Healthy Kids Program officially began enrolling children from the Volusia County school district in February 1992.

Initially, all uninsured children ages 5 to 19 who were actively attending school and ineligible for Medicaid were eligible to enroll in the Healthy Kids Program. Beginning in November 1992, the younger siblings of school-age children (those not yet attending school) were also made eligible for enrollment in the plan. Enrollment is voluntary, and there are no exclusions for preexisting conditions.

Through a competitive bidding process, the Healthy Kids Corporation chose a local staff-model health maintenance organization (HMO)—Florida Health Care Plan, Inc.—to administer, underwrite, and provide services to children in the program. To meet expected demand and the Healthy Kids Corporation requirement that clients should not have to travel more than 20 minutes to receive care, the HMO has since contracted with five additional pediatricians and four family practice physicians located in Volusia County to serve Healthy Kids enrollees.

Through the plan, children have access to a benefit package that is comparable to that of the state Medicaid program. Healthy Kids covers primary and specialty physician visits, inpatient and outpatient hospital care, vision and hearing care, pharmacy, rehabilitation, organ transplants, and certain mental health services. Unlike the Medicaid program, some copayments are required—$3 for pharmacy, $25 for nonemergency use of an emergency room, $10 for mental health services, and $10 for eyeglasses. There is also a $1 million lifetime cap on services.

In another departure from existing state Medicaid policies, Healthy Kids imposes premium-sharing obligations on families enrolling their children. The program uses an income-based sliding scale, and the state subsidizes the $57 monthly HMO premium in the following manner: families with incomes under the federal poverty level pay nothing toward the cost of coverage; families with incomes between 101% and 135% of poverty pay $3 per child per month; families with incomes between 136% and 185% of poverty pay $16 per child per month; and families with incomes above 185% of poverty can purchase coverage for the full $57 per child monthly premium. Annualized, the program’s full premium currently stands at $684. At this time, only 2% of program enrollees receive no subsidy while almost two-thirds of enrollees’ families pay no premium.
Contrary to speculation among insurers when the program was being marketed, the Healthy Kids Program has not attracted a high proportion of especially sick or costly children. Early utilization data show that almost 70% of services used are primary care physician visits. In the first three months of the program, the Healthy Kids office visit rate was 10% higher than that of other children covered in the HMO, but now their rates are comparable. Few pregnant teens or children with special health care needs have enrolled in the program. One reason may be the fact that the Florida Medicaid program already covers all pregnant women—including adolescents—and infants in families with incomes below 185% of poverty. In addition, Florida is considered to have a broad and effective state Title V program serving chronically ill children.  

Through December 1992, the Healthy Kids Program had enrolled more than 5,700 children, almost half of the 12,000 uninsured children targeted by the plan. As of December 1, 1992, total expenditures under the program were $321,000. Of this, $19,000 was paid by participants and the rest, by federal and state Medicaid dollars.

Two evaluations of Healthy Kids are currently under way. HCFA has funded an evaluation to study whether the school-based program is an effective model for providing affordable health insurance for children. An evaluation by the Florida-based Institute for Child Health Policy will also examine both the implementation and impact of the program.  

Emerging State Initiatives

In addition to the programs described above, a number of states have either passed or recently implemented legislation authorizing the enactment of other children’s health insurance initiatives. Brief descriptions of these new efforts are provided below.

California's Access to Infants and Mothers

In January 1992, California began an initiative to provide comprehensive health coverage primarily to low- and moderate-income pregnant women, as well as to their very young children. Under the Access for Infants and Mothers (AIM) Program, pregnant women with no comparable private insurance benefits who are not more than 30 weeks pregnant when they apply can obtain comprehensive health services for themselves and their children under age two if their family income is between 200% and 250% of poverty. Participants pay a $50 annual enrollment fee and contribute monthly premiums (which cannot exceed 2% of gross family income) toward the cost of their care. The program, funded by cigarette and tobacco tax revenues, currently has enrolled approximately 4,000 women and 1,000 children.

Colorado’s Child Health Plan

Colorado has recently begun pilot programs in two counties to provide health care coverage for up to 2,000 low-income children (1,000 in each site) through selected managed care systems. Begun in October 1992, the Child Health Plan subsidizes coverage for children under age nine in families with incomes below 185% of the federal poverty level who are not eligible for Medicaid coverage. Families pay a $25 annual enrollment fee per child (capped at $150 per family). Any medical care provided in a physician’s office is covered under the plan (that is, services such as eyeglasses, prescription drugs, and inpatient hospital care are not covered). Enrollees are subject to a $2 co-payment for office visits and a $7,500-per-year limit on services.
federal Medicaid dollars authorized under special waiver authority.\textsuperscript{43,41}

**Pennsylvania**

In December 1992, Gov. Robert Casey signed into law a new children’s health initiative that is scheduled for implementation in April 1993. The program is designed to cover children who are not eligible for Medicaid and whose families lack access to employment-based coverage. The program will provide

- Fully subsidized coverage of children under age six in families with incomes below 185\% of poverty;
- A 50\% subsidy for children under age six with family incomes between 185\% and 235\% of poverty; and
- Fully subsidized coverage of children ages 10 through 12 in families with incomes below 100\% of poverty. (The upper age limit of this poverty-level coverage will be expanded by one year each year until all children under age 19 are covered.)

The Pennsylvania program will be modeled closely after the Caring Program in Western Pennsylvania. The state will contract with Blue Cross/Blue Shield organizations to administer the plan, and the program will provide coverage of both ambulatory preventive and primary care services, as well as inpatient hospital care. State officials estimate that the program will eventually serve 40,000 of a potentially eligible population of 90,000 children, and that the per-child cost will be roughly $900 per year.

**Connecticut’s Healthy Steps**

Connecticut has also recently launched Healthy Steps, a public-private partnership with Blue Cross/Blue Shield to improve health care coverage for up to 1,000 low-income uninsured children in the city of New Haven. To be eligible, one child in the family must be enrolled in school, children must be under the age of 14, must live in families with incomes below 200\% of poverty, must be ineligible for Medicaid, and may not possess any other form of health insurance. Open enrollment extended from October 15 to December 15, 1992, and coverage will last for one year beginning January 1, 1993.

Under the Healthy Steps program, which is marketed through New Haven schools, families pay $15 per child every three months (capped at $240 a year per family). One million dollars of state funds subsidizes the remaining program costs. The total premium paid to Blue Cross/Blue Shield is $1,000 per child, and Blue Cross/Blue Shield absorbs any remaining risk. In contrast to the Caring Program model, Connecticut’s program will provide comprehensive benefits, including inpatient hospital visits, basic dental care, outpatient mental health and substance abuse treatment, and prescription drugs through a preferred provider organization developed by Blue Cross/Blue Shield. The state is currently hiring a contractor to evaluate the program.\textsuperscript{43}

**Future Directions**

To date, initiatives designed to expand low-income children’s access to health care coverage have been established in just over one-half of the states. However, the questions of whether more states will follow suit by starting additional child health insurance programs and how existing programs may evolve given the intensifying national debate on health care reform remain unanswered. Recent developments do provide some insight into two possible directions for the future of child health insurance initiatives.

- First, an amendment to the federal Medicaid statute, cited at Section 1902(r)(2) of the Social Security Act, provides states with a unique opportunity to capture federal dollars either to support new or to expand existing child health insurance initiatives.
- Second, given the growing interest among policymakers in expanding health insurance coverage to broader populations of the uninsured, child health programs may increasingly be viewed as starting points for more comprehensive health reform initiatives. As demonstrated recently in the state of Minnesota, child health insurance programs can be steppingstones to universal access.
These recent developments are described below.

**The 1902(r)(2) Option**

Cost is one of the most significant barriers currently preventing additional states from enacting programs that increase access to health care coverage. With health care costs continuing to rise more rapidly than general inflation and with Medicaid expenditures consuming ever-increasing proportions of state budgets, policymakers in many states have been reluctant to consider taking on the additional financial burden of expanded health care programs. However, Section 1902(r)(2) of the Social Security Act may provide the means for additional states to acquire the resources needed to undertake special programs for mothers and children while also allowing those states already operating such programs to broaden the scope of existing state programs even further.

Section 1902(r)(2) was added to the Medicaid statute by the Medicare Catastrophic Coverage Act of 1988, but states have only recently begun to capitalize on its potential. Essentially, 1902(r)(2) allows states to expand dramatically the population of children and pregnant women eligible for Medicaid coverage by permitting states to use more liberal income and resource methodologies when determining eligibility. Under Medicaid rules, states have always subtracted certain costs—such as those related to child care and work expenses—from a family’s gross earnings when calculating whether “countable” income falls below a given income eligibility threshold. By allowing states to disregard more types and greater amounts of income for pregnant woman and child applicants, Section 1902(r)(2) may enable states to restructure their Medicaid programs to allow more of these populations to qualify and, in so doing, to capture federal matching dollars toward the cost of their coverage.

Already, three of the states discussed in this article have utilized the authority contained within Section 1902(r)(2) to obtain federal Medicaid matching funds for their existing, previously state-funded child health programs.

- Beginning January 1992, Washington State made Medicaid coverage available to all children between the ages of 9 and 19 with incomes below the federal poverty level, thus financing much of its formerly state-funded Children’s Health Program with state and federal Medicaid dollars. To accomplish this, the state now disregards all income between the state’s Medicaid eligibility standard and 100% of poverty for children below age 19. (Under existing authority granted by Section 1902(1)(3), the state also disregards all assets when determining eligibility.)
- Vermont’s Dr. Dynasaur program became fully Medicaid-financed in July 1992. To make Dr. Dynasaur children eligible for Medicaid coverage, Vermont now disregards all assets and all income between the state’s current Medicaid eligibility standard and 185% of poverty for children under age 18.
- Finally, effective July 1, 1993, Minnesota received federal approval of a state Medicaid plan amendment to provide Medicaid coverage to all infants and pregnant women with family income below 275% of poverty. The state is using 1902(r)(2) authority to disregard all income between the current Medicaid eligibility standard and 275% of poverty, while also disregarding all assets.

In addition, two states that were planning to begin state-funded child health plans have recently opted to expand Medicaid instead, using 1902(r)(2) to maximize the impact of their state expenditures.

- In October 1992, Delaware expanded its Medicaid eligibility standards to include children through age 18 living in families with incomes below the federal poverty level.
- Beginning July 1, 1992, Virginia made Medicaid coverage available for children through age 12 living below the federal poverty level. In July 1993 this coverage was extended to children through age 18. (Also beginning July 1993, state-only funds...
are used to provide a comprehensive package of primary and preventive services to infants under one year and between 133% to 200% of poverty.)

Minnesota, however, provides one example of how a children's health insurance program can become a stepping-stone to broader health care reform initiatives.

And finally, the state of Rhode Island has developed RItc Track, a program that has not yet been enacted by the state legislature which would use 1902(r)(2) authority to provide Medicaid coverage to all children under age six in families with incomes below 250% of poverty.

Perhaps because the potential of the 1902(r)(2) option has only recently been appreciated, there remain numerous child health programs that are being supported without the benefit of federal Medicaid support. However, other reasons exist which may explain why some states would choose not to take advantage of 1902(r)(2). First, to receive Medicaid funds, states must offer full Medicaid benefits. States whose programs currently offer only preventive and primary care benefits might balk at the prospect of expanding the scope of services that children would be eligible to receive. In addition, some state officials attribute the success and popularity of their programs to the fact that they are distinct from the Medicaid program. Thus, while 1902(r)(2) might allow a state to double or even triple its investment of state dollars, policymakers might be reluctant to risk patient and provider support by incorporating their programs into Medicaid.

The MinnesotaCare Program

It is evident that Section 1902(r)(2) creates the potential for even more states to implement child health insurance initiatives. Yet, while these programs represent a step toward increasing access for one important segment of the estimated 36.3 million uninsured Americans, they fall short of fulfilling the widely held goal of universal access to health care. The nearly 10 million uninsured children targeted by these programs represent less than one-third of the nation’s uninsured population. Clearly, further efforts are needed if access to health care coverage for both uninsured children and adults is to improve.

Minnesota, however, provides one example of how a children’s health insurance program can become a stepping-stone to broader health care reform initiatives. After several years of focusing on expanding access to health care for the priority populations of pregnant women and children, the state of Minnesota enacted legislation in 1992 that will phase in health care coverage for uninsured low- and moderate-income adults.

Building on the success and popularity of the Children’s Health Plan and utilizing revenues generated by a new five-cent-per-pack cigarette tax, the MinnesotaCare program began covering, on October 1, 1992, not only children under age 18 in families with incomes below 185% of the federal poverty level, but also their parents and dependent siblings (unmarried children under age 25 who are full-time students and financially dependent upon their parents). In January 1993, MinnesotaCare will extend coverage even further, to families with incomes up to 275% of poverty. The final stage of the phase-in will occur in July 1994 when adults without children (again, with incomes below 275% of poverty) will be eligible for coverage. In addition to meeting the income and age guidelines presented above, persons must not be eligible for Medicaid, must have had no access to employer-subsidized coverage for 18 months, must have been uninsured for 4 months, and must be permanent Minnesota residents to qualify for coverage.

Services covered under MinnesotaCare will also expand upon the current Children’s Health Plan benefit package. Starting in October 1992 and continuing through 1993, the basic CHP package will be broadened to include inpatient hospital and mental health services, outpatient treatment for chemical dependency, and emergency medical transportation services. Starting in July 1993, adults and children began paying a premium for coverage rather than the $25 per child enrollment fee currently assessed. The premium is based on a sliding scale, ranging from 1.5% to 8.8% of gross family income. Additional cost sharing doesn’t apply to services for children, but does apply to selected services for adults, including a $3 co-payment for prescription
drugs, a $25 co-payment for eyeglasses, 50% co-insurance for nonpreventive dental services, and 10% co-insurance for inpatient hospital services (subject to an annual cap). Care will continue to be received from any provider enrolled in the Minnesota Medicaid program, and reimbursement rates will still be the same as those paid by Medicaid.

Approximately 30,000 individuals are currently enrolled in MinnesotaCare. At this time, only 1,000 of these are adults. While service utilization rates for children are expected to remain relatively constant, annual per-enrollee costs under MinnesotaCare are expected to increase in fiscal year 1993 to $1,188 (from the current $388 annual cost of covering children for ambulatory preventive and primary care) because of the inclusion of more costly services (such as inpatient hospital) and the coverage of traditionally more costly adults.16

Conclusion

As this article has described, state programs designed to extend health care coverage to uninsured children vary dramatically in their scope and design. Unfortunately, given the relative newness of most of these efforts, few researchers have had the opportunity to formally evaluate their relative impacts and effects. As a result, analysts must rely on state program data, annual reports, and the anecdotal insights of program administrators to begin forming initial impressions about how and how well these programs are achieving their objectives. Because of its relative maturity, the Minnesota Children’s Health Plan has provided us with the greatest amount of information regarding how a children’s health insurance program may interact with existing public and private health care financing and delivery systems. Some of the early lessons that have been learned from state initiatives are described below.

Many policymakers argue that both patients and providers will respond more favorably to programs that involve private insurers because such programs avoid the stigma often associated with public assistance programs. (The popularity of the Caring Foundation programs and New York’s Child Health Plus support this contention.) However, the Minnesota Children’s Health Plan and Vermont’s Dr. Dynasaur—two completely public programs that employ many of the same policies and administrative systems used by their respective Medicaid programs—have also been extremely well received by clients and providers alike. These experiences suggest that, if a program can, through effective marketing and outreach, create an attractive and appealing image, then it can be popular regardless of whether it is financed and/or administered by a public or private entity.47

It appears that there may be some positive aspects to requiring families to share in the cost of program premiums. Early state experiences indicate that many families are both willing and able to pay something toward the cost of their coverage. (Indeed, as was discussed above, Minnesota families report that the annual $25-per-child enrollment fee creates a sense that they are not simply being provided a “handout” by the state.)

However, despite such anecdotal evidence, we still do not know the degree to which premium-sharing requirements act as a barrier to enrollment by discouraging families from applying for coverage. Further, we do not have a clear sense of when premium contributions become unaffordable for families with different incomes.

If a program can create an attractive and appealing image, then it can be popular regardless of whether it is financed and/or administered by a public or private entity.

Despite sometimes slow enrollment, most children’s health insurance programs have experienced substantial demand, and some have made significant inroads in providing coverage to the target populations of uninsured children. However, the experiences of some states have made it clear that the demand for coverage does not come only from families with uninsured children. Rather, many children who possess insurance with inadequate coverage of certain services (such as well-child care) or with extensive cost-sharing requirements also seek coverage under these new programs.

Indeed, looking again at the Minnesota experience, the Children’s Health
Plan consistently found that roughly one-third of its enrollees had been already-insured children. Further, many children who obtained coverage under CHP came from families in which the parents possess insurance, suggesting that parents were either not offered or did not purchase employer-based coverage of their dependents.

- Private physicians seem to be satisfied with their participation in state children's health insurance programs, especially in states that have succeeded in creating a distinctly non-Medicaid image for their programs. Ironically, Minnesota officials report that private physicians have, on occasion, stated publicly that they believe the Children’s Health Plan not only pays better than the state Medicaid program but also is administratively simpler and more efficient in its claims processing. In fact, CHP reimburses physicians according to the same fee schedule as Minnesota Medicaid and processes claims through the same system.

- In states such as Florida and New York, private insurers were initially reluctant to become involved in initiatives to expand coverage of low-income children. Fearing high levels of adverse selection, these payers were nervous about the financial exposure they might face if they were to underwrite coverage of this group. In fact, children enrolling in these special insurance programs do not appear to be inordinately expensive. Rather, per-child cost data indicate that the types and amounts of services consumed by enrolled children are similar to those of insurers' regular membership children. No programs, to date, seem to have experienced significant adverse selection.

- Annual per-child cost data from the states indicate that coverage of comprehensive inpatient and outpatient care costs roughly twice as much as coverage of ambulatory preventive and primary care alone.

- New opportunities exist for financing children’s health insurance programs through the Medicaid program. Using optional authority granted under Section 1902(r)(2) of the Social Security Act, three states have already transformed what had been solely state-funded initiatives into programs that provide comprehensive coverage to children under Medicaid. Two other states that had been planning implementation of state-funded programs recently took advantage of 1902(r)(2) to finance these programs under Medicaid instead.

The unique opportunity offered by 1902(r)(2) cannot be overemphasized. By expanding children’s health care coverage through its Medicaid program, even the “richest” state would be able to capture roughly one federal dollar for every state dollar invested. Therefore, given the cost data reported above, a state that was planning to extend only preventive and primary care services to children under a state-only program could instead use these same state dollars to leverage federal funds under 1902(r)(2) to extend comprehensive care to the same child population at the same cost to the state.

- In the broader context of health care reform, children’s health insurance programs represent an important strategy for extending coverage to one high-priority segment of the uninsured population. However, as has been seen in Minnesota, these programs can also be used effectively as stepping-stones to comprehensive health reform initiatives.

While policymakers at the federal level have contemplated various possible strategies for expanding health insurance coverage to this country’s 35.7 million uninsured individuals, a large number of states have moved aggressively forward with initiatives that target coverage to at least one high-priority group among the uninsured: children. As this article has described, these programs are differently designed with regard to eligibility, benefit, reimbursement, and administrative policies. However, they all share the same objective of extending financial access to care to greater numbers of needy children. While policymakers must wait for the results of various evaluation efforts before they can fully under-
stand the impact of these programs, early evidence suggests that these programs have succeeded in providing valuable coverage to thousands of children who previously lacked it.

We would like to thank the various state officials who so generously contributed their time toward the preparation of this article and Eugene M. Lewit for his helpful guidance and comments throughout the editorial process.

1. The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) permitted states to raise the Medicaid income eligibility threshold for children under age five and pregnant women to 100% of the federal poverty level. (OBRA-86 also allowed states to drop the assets test entirely when determining Medicaid eligibility for children and pregnant women.) The following year, the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) allowed states to extend this optional poverty-level coverage to children up to eight years of age and to raise the income eligibility threshold for infants and pregnant women up to 185% of poverty. The Omnibus Budget Reconciliation Acts of 1989 and 1990 (OBRA-89 and OBRA-90) subsequently mandated certain coverage that had been optional up to that time. Specifically, OBRA-89 required all states to cover children up to age six with incomes below 133% of poverty. And OBRA-90, as described in the text, required states to phase in coverage for all children up to age 19 in families with incomes below 100% of poverty (reaching full coverage of children by October 2001).


6. Five states set upper income eligibility limits at 100% of poverty or lower; the upper limits of nine states are established at a level between 100% and 150% of poverty; two states set upper limits above 150% of poverty; and one state varies its income limit based on the age of the child. The highest income limit is in the state of New York (222%), while the lowest eligibility levels are in Alabama and Mississippi (80%). See note no. 5, Caring Program Data.

7. See note no. 5, Caring Program Data.


10. Alabama Caring Program. Personal communication with Al Rohling, executive director, January 1993.

11. Caring Program of Western Pennsylvania. Personal communication with Mary Emery, program coordinator, January 1993.


13. Underinsurance refers to health care coverage that does not adequately cover the services needed by the beneficiary or requires high out-of-pocket payments which serve to limit the beneficiary’s access to care.


18. MinnesotaCare is one piece of the state’s comprehensive health care reform initiative called HealthRight.


20. For example, Blue Cross/Blue Shield Rochester, New York, offers insurance for inpatient hospital care through its ValueMed program at a premium of $10 per month for families with incomes below 222% of poverty. See note no. 19, New York Child Health Insurance Plan.


23. Dr. Dynasaur also provided state-funded insurance to pregnant women in families with incomes between 185% and 200% of poverty. Similar state-funded maternity programs exist in the states of California, Massachusetts, and Rhode Island.


27. Funds through a new HCFA demonstration grant will allow Maine to reinstate the adult component of its program beginning in February 1993. Under the demonstration, the state expects to be able to extend coverage to an additional 2,500 individuals. Maine Bureau of Medical Services. Maine Health Program data, 1990, 1991, 1992.


30. Under a separate pilot project begun in January 1989, the Washington Basic Health Plan (BHP) has subsidized comprehensive health care coverage for families with incomes under 200% of poverty. While the program is not designed exclusively for children, almost half of enrollees (44%) are families with children, and 2% of enrollees are families that enroll children only. Currently, BHP enrolls families in managed care programs in 17 of the state’s 39 counties. BHP enrollees contribute to the cost of coverage by paying a monthly premium and paying co-insurance on certain services. The average individual contribution per month is $17.29, and the average state subsidy per month is $68.74, for an average annual total cost of just over $1,000. The benefit package provided under BHP is less expansive than the Medicaid package provided under CHP. For example, vision, mental health, dental services, and prescription drugs are not covered. In December 1992, enrollment stood at almost 22,000; but, because of budget constraints, a sizable waiting list exists. Washington Department of Social and Health Services, Medical Assistance Administration. Personal communication with Steve Wish, December 1992; Washington Legislative Budget Committee. Washington Basic Health Plan Sunset Review (Report 91-5). October 16, 1991; Washington Basic Health Plan. Status report. December 1, 1992; Washington Basic Health Plan. Annual Report to the 1992 Legislature. January 1992.


34. Early utilization under the program has been less costly than predicted, allowing officials to reduce the initial $60 monthly premium by 5%. Further reductions are anticipated in the future.

35. To minimize administrative costs and avoid the need for a separate and potentially time-consuming income eligibility determination, Healthy Kids utilizes the records of the National School Lunch Program to establish family income and to determine enrollees’
eligibility for state subsidies. The program is authorized to use these records in lieu of a formal Medicaid application as part of its HCFA demonstration grant.


44. Minnesota's experience provides an example of why this concern may be warranted. After passage of OBRA-89, which mandated that states provide Medicaid coverage to all children under age six in families with incomes below 133% of poverty, Minnesota found that nearly 4,500 children enrolled in CHP were eligible for coverage under the newly expanded Medicaid program. However, when the state attempted to encourage families to apply for Medicaid coverage, only half of referred children enrolled in Medicaid over the subsequent nine months. When surveyed, families who did not apply for Medicaid said that they were too embarrassed to visit county agencies, that the Medicaid eligibility process was too much of a hassle, and that they felt like Medicaid was a welfare program. See Nicholson, E. Two become one: Combining the best of the Children's Health Plan and medical assistance into a united plan in Minnesota. Children's Defense Fund–Minnesota, June 1, 1992.

45. It should be noted that a small number of states have already implemented state programs to provide “universal” access to care. Since 1974, Hawaii has extended health insurance to 98% of its citizens through a combination of employer-mandated coverage, a state-subsidized “gap group” insurance program, and existing public aid programs (such as Medicaid). Similarly, Massachusetts also passed health care reform legislation in 1988 that would have provided universal access to health insurance for its citizens based on a pay-or-play employer health insurance mandate model. However, an economic slowdown and changes in the state government have delayed the implementation of the program.

46. Permanent residency is demonstrated by maintaining a residence at a verified address within the state for 180 days prior to application and signing an affidavit relating to permanent residency.

47. It may also be, of course, that states such as Minnesota and Vermont, which have successfully built expanded coverage on their existing Medicaid programs, have more popular, less troubled Medicaid programs to begin with than states that have not tried this approach.