THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. The President's children's health initiative will extend coverage to up to 5 million uninsured children by 2000.

Strengthening Medicaid for Poor Children

- **12-Month Continuous Eligibility.** Currently, many children receive Medicaid protection for only part of the year. The President's budget gives States the option to provide one year of continuous Medicaid coverage to children. The budget invests $4.9 billion over five years for this health insurance.

- **Outreach.** The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

Building Innovative State Programs for Children in Working Families

- **State Partnership Grant Program.** The President's budget provides $3.8 billion between 1998 to 2002 ($750 million a year) in grants to States. States will use these grants to provide insurance for children, leveraging State and private investments in children's coverage through a matching system (as in Medicaid). States have flexibility in designing eligibility rules, benefits (subject to minimums set by the Secretary) and delivery systems.

- The Federal grants, in combination with State and private money, will cover children whose families earn too much to qualify for Medicaid but too little to afford private coverage. The grant program will also increase Medicaid enrollment since some families interested in the new program will learn that their children are in fact eligible for Medicaid.

Continuing Coverage for Children Whose Parents are Between Jobs

- **Workers Between Jobs Initiative.** Nearly half of all children who lose health insurance do so because their parents have lost or changed jobs. The President's budget will give States grants to cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window. The program, which is structured as a four-year demonstration, will offer temporary assistance (up to 6 months) to families. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for workers and their children.

ALLIANCE FOR HEALTH REFORM

WHAT WE ARE

Following three years of high-profile debate, comprehensive health reform aimed at covering the uninsured and containing costs looks as remote as ever. While cost increases for health care have moderated, spending continues to grow considerably faster than the economy, with implications for employers, governments and families alike. Medicare and Medicaid are targeted for substantial savings. Employer-based coverage continues to erode, swelling both the ranks of the uninsured and out-of-pocket payments by those with insurance. Even changes described as incremental -- insurance reform, malpractice reform and others -- evoke controversy.

In such uncertain times, it is critical for the public, and the opinion leaders to whom they look for guidance, to understand the roots of the nation's health problems and the trade-offs posed by various reform proposals. The Alliance for Health Reform meets this challenge by helping journalists, elected officials and other shapers of public opinion bridge the huge gaps in public awareness.

The Alliance began in 1991 as a non-partisan, not-for-profit group providing opinion leaders an objective source of information on the U.S. health system. The Alliance advocates no particular blueprint for reform, but pursues the goals of containing cost and extending coverage to all Americans. Senator Jay Rockefeller of West Virginia, a national leader in health policy, chairs the Alliance's diverse board of directors, which includes Senate Labor and Human Resources Committee Chairman Nancy Kassebaum of Kansas and distinguished leaders from the fields of medicine, labor, consumer advocacy and public interest. Ed Howard, former general counsel to the Pepper Commission, heads the Alliance's staff.

During four years of operation, the Alliance has organized scores of forums in Washington and across the country, presenting a diverse range of expert views to journalists, business leaders and legislative staff. The Alliance has published sourcebooks for journalists, including one focusing on Medicare & Medicaid, widely praised primers on primary care and medical education and much more. The Alliance's ongoing media resource service has assisted hundreds of journalists nationwide develop articles and broadcasts on health reform issues.

The Alliance is currently at work on a number of projects including a further update of the journalists' sourcebook, regional and national media seminars, Congressional staff briefings, and various publications and work on primary care.

March 1996

1900 L Street NW • Suite 512 • Washington, DC 20036
(202) 466-5626 • Fax (202) 466-6525

THE PRESIDENT IS FIGHTING TO EXPAND COVERAGE FOR CHILDREN

TEN MILLION AMERICAN CHILDREN TODAY LACK HEALTH CARE COVERAGE. THE 1995 REPUBLICAN BUDGET WOULD HAVE MADE THE PROBLEM WORSE. IT WOULD HAVE:

- **Increased the number of uninsured children.** The 1995 Republican budget even failed the "do no harm" test in the area of children's health. That budget eliminated the guarantee of a meaningful Medicaid package for poor children and attempted to replace Medicaid with an insufficiently funded block grant program:

  -- Would have forced states to decreased the number of insured children by as many as 3.8 million due to a lack of sufficient funds, according to a study by the Department of Health and Human Services.

  -- Eliminated the Medicaid phase-in for children between the ages of 13 and 18.

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE PROPOSES TO EXPAND HEALTH CARE COVERAGE FOR MILLIONS OF CHILDREN.

The President is fighting to ensure that any balanced budget agreement expands children's health coverage. His Children's Health Initiative would provide health coverage for as many as 5 million additional children by:

- **Covering Children Whose Parents Are In-between Jobs**. Nearly half of all children who lose health insurance do so because their parents lose or change jobs. The President's budget provides up to six months of premium assistance to families that would otherwise lose their coverage and will insure about 700,000 kids.

- **Creating State Partnerships to Cover Children**. When job-related insurance loss is put aside, the most important reason why children lose coverage is that it is too expensive for their family. The President's budget provides $750 million annually to states to help families who earn too much to qualify for Medicaid but too little to afford private coverage.

- **Expanding Access Through Medicaid Improvements.** The President's proposal would give states the option to guarantee Medicaid coverage for up to one year for all children who are eligible. This will increase access of kids to their doctors and reduce paperwork. Currently many children receive Medicaid coverage for only part of the year. The Administration will also work with governors and communities to reach out to the three million children who are eligible for Medicaid but are not currently enrolled.

THE PRESIDENT IS FIGHTING TO PROTECT AND IMPROVE THE MEDICAID PROGRAM

THE 1995 REPUBLICAN BUDGET PROPOSED A BLOCK GRANT WHICH WOULD HAVE DEVASTATED THE MEDICAID PROGRAM, HURTING MILLIONS OF CHILDREN, PREGNANT WOMEN, PEOPLE WITH DISABILITIES AND OLDER AMERICANS. IT WOULD HAVE:

- **Cut more than $163 billion from the Medicaid program.** More than ten times over anything ever enacted by *any* Republican or Democratic President. The $163 billion only reflected federal cuts. If states had only decided to contribute the amounts the federal government would have matched, the total reduction in federal and state Medicaid funding would have exceeded $400 billion over seven years compared to current law.

- **Repealed the Medicaid program and replaced it with a block grant**. The plan would have eliminated the Federal guarantee Medicaid provides to poor families. In 2002 alone, nearly 8 million people could have lost their Medicaid coverage, because of inadequate funding, including 3.8 million children, 1.3 million people with disabilities, and 850,000 elderly.

- **Denied as many as 330,000 people nursing home coverage in 2002.** The Republican budget would have repealed the guarantee of nursing home coverage for the approximately two-thirds of nursing home residents who rely on Medicaid.

THE PRESIDENT'S BUDGET PRESERVES THE MEDICAID GUARANTEE AND GIVES STATES INCREASED FLEXIBILITY TO MANAGE THEIR PROGRAMS.

- **Protects the Medicaid guarantee.** The President's proposal preserves Medicaid for the 37 million children, pregnant women, elderly, and people with disabilities who depend on it.

- **Controls Medicaid spending growth through a per capita cap policy.** In the early 1990s, Medicaid spending per beneficiary rose rapidly. While Medicaid spending is low today, it may rise again in the future. The President's per capita cap policy gives states an incentive to reduce cost growth without reducing coverage.

- **Offers unprecedented state flexibility.** The President's budget contains unprecedented flexibility in Medicaid so that states, not the Federal government, can determine how to best meet the needs of their populations. The proposal would repeal the Boren amendment; enable states to reform their program without the need for a waiver; and administer their programs with fewer and simpler requirements.

- **Improves Medicaid coverage of children.** The President is proposing to give states the option to guarantee Medicaid coverage for up to one year for all children who are eligible. He is also proposing to work with states and local communities to reach out to the three million children who are eligible for Medicaid but are not currently enrolled.

THE PRESIDENT IS WORKING TO IMPROVE THE MEDICARE PROGRAM FOR THE 21st CENTURY

THE 1995 REPUBLICAN BUDGET CONTAINED DANGEROUS MEDICARE STRUCTURAL REFORMS THAT WOULD HAVE UNDERMINED PROGRAM AND IMPOSED PREMIUMS AND BURDENS THAT WOULD HAVE HURT OLDER AND DISABLED AMERICANS. IT WOULD HAVE:

- **Created Medical Savings Accounts which would have encouraged "Cherry Picking" that would have harmed beneficiaries and damaged the Medicare program**. The Republican Medical Savings Accounts proposal would have established plans that only the healthy and wealthy could afford -- leaving the sickest and most costly beneficiaries in a weakened fee-for-service program.

- **Eliminated balanced billing protections,** allowing doctors in the new private fee-for-service plan options to overcharge above Medicare's approved amount leaving the elderly vulnerable to higher costs and giving doctors in the fee-for-service program an incentive to switch to private health care plans, reducing access for beneficiaries in the traditional plan.

- **Increased premiums from 25% of Part B program costs to 31.5%.** These higher costs would have placed a large financial burden on Medicare beneficiaries -- three-quarters of whom have incomes below $25,000. In 1996, this would have increased costs per elderly couple by $264.

- **Eliminated the guarantee of Medicaid coverage of Medicare deductibles, copayments, and premiums** for older Americans and people with disabilities near or below the poverty line known as "Qualified Medicare Beneficiaries (QMBs)". They set aside less than half the money needed to cover premiums for QMBs and set aside no funding for deductibles or copayments. More than 5 million elderly and disabled poor Americans would have lost their guarantee that Medicaid covers Medicare cost-sharing.

- **Permitted Medicare beneficiaries to enroll in risky "association" plans** that limit enrollment to beneficiaries affiliated with a union, association, or organization. These limited enrollment plans would only participate if they knew that their affiliated group was healthier than average, leading to risk selection and thereby increasing the costs of what would be a sicker and weaker traditional Medicare program.

- **Imposed an arbitrary hard budget cap on Medicare spending** regardless of changes in the economy. Under this proposal, if costs increase faster than projected, and spending could no longer keep up, beneficiaries, doctors, hospitals, and other providers would have to absorb these losses.

TO MODERNIZE THE MEDICARE PROGRAM AND BRING IT INTO THE 21ST CENTURY, THE PRESIDENT'S BUDGET:

- **Extends the life of the Medicare Trust Fund until at least 2006.**

- **Makes positive structural reforms.** The President's budget contains a series of structural reforms which modernize the program, bringing in line with the private sector and preparing it for the baby boom generation. It:

  -- *Increases the number of private health plan options* -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities.

  -- *Improves Medicare managed care payment methodology and informed beneficiary choice.* The President's budget addresses geographic disparities in payments; removes graduate medical education and disproportionate share hospital payments from managed care rates; and adjusts managed care rates for overpayments due to favorable selection.

  -- *Guarantees that beneficiaries can enroll in Medigap plans annually without being subject to preexisting condition exclusions,* enabling beneficiaries to enroll in Medicare without fearing that they would not be able to re-enroll in traditional Medicare.

  -- *Builds on the successful hospital prospective payment system model,* implementing prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments.

  -- *Adopts successful approaches to purchasing other types of services,* including: competitive pricing for durable medical equipment, laboratories, other items and supplies; expanded "centers of excellence"; and increased flexibility from program rules in negotiating rates.

- **Imposes no new out-of-pocket expenses on middle-class Medicare beneficiaries.** The President's budget rejects any new premiums for middle-class beneficiaries and imposes no new copayment requirements.

- **Expands preventive benefits.** The President's budget:

  -- Waives cost-sharing for mammography services and provides annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer;

  -- Establishes a diabetes self-management benefit;

  -- Covers colorectal screening (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure);

-- Increases reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.

- **Improves long-term care options.**

-- Creates a Medicare respite benefit for families with Alzheimers disease or other irreversible dementia, covering up to 32 hours per beneficiary per year, taking the first steps to providing long-term care services.

Children's Coverage: State Partnership File

Children's Health Initiative: Grants To States

Q. How is the new state partnership program different than the 1115 waiver process? Aren't they both cases of states having to negotiate extensively with HCFA to meet unspecified and ever-changing criteria for approval?

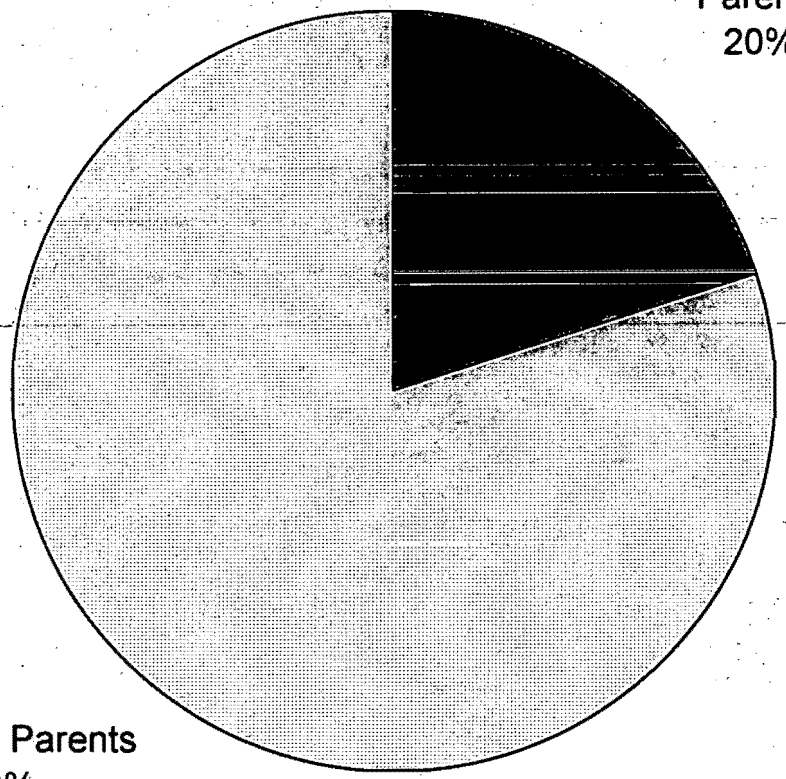
A. **Simpler and easier to access.** The new grant program for children's coverage is different than the 1115 waiver programs since (a) the application and approval process is simpler; and (b) the use of the funds is much less constrained.

No budget neutrality negotiation. Negotiating Federal funding or "budget neutrality" is the most time-consuming part of the 1115 waiver approval process. Under the new program, it is not needed. Federal funding is fixed and determined by a simple formula. The only negotiations will be to ensure agreement on the uses of the funds.

Much more rapid review process. The new program's application approval is subject to a 90 day deadline (with some exceptions). In contrast, it is rare that an 1115 is submitted and approved within a year.

Much greater flexibility in benefits, eligibility and delivery systems. Under the new grant program, states have almost complete latitude in program design and operation. This is very different than under 1115 waivers, which work within the confines of Medicaid rules.

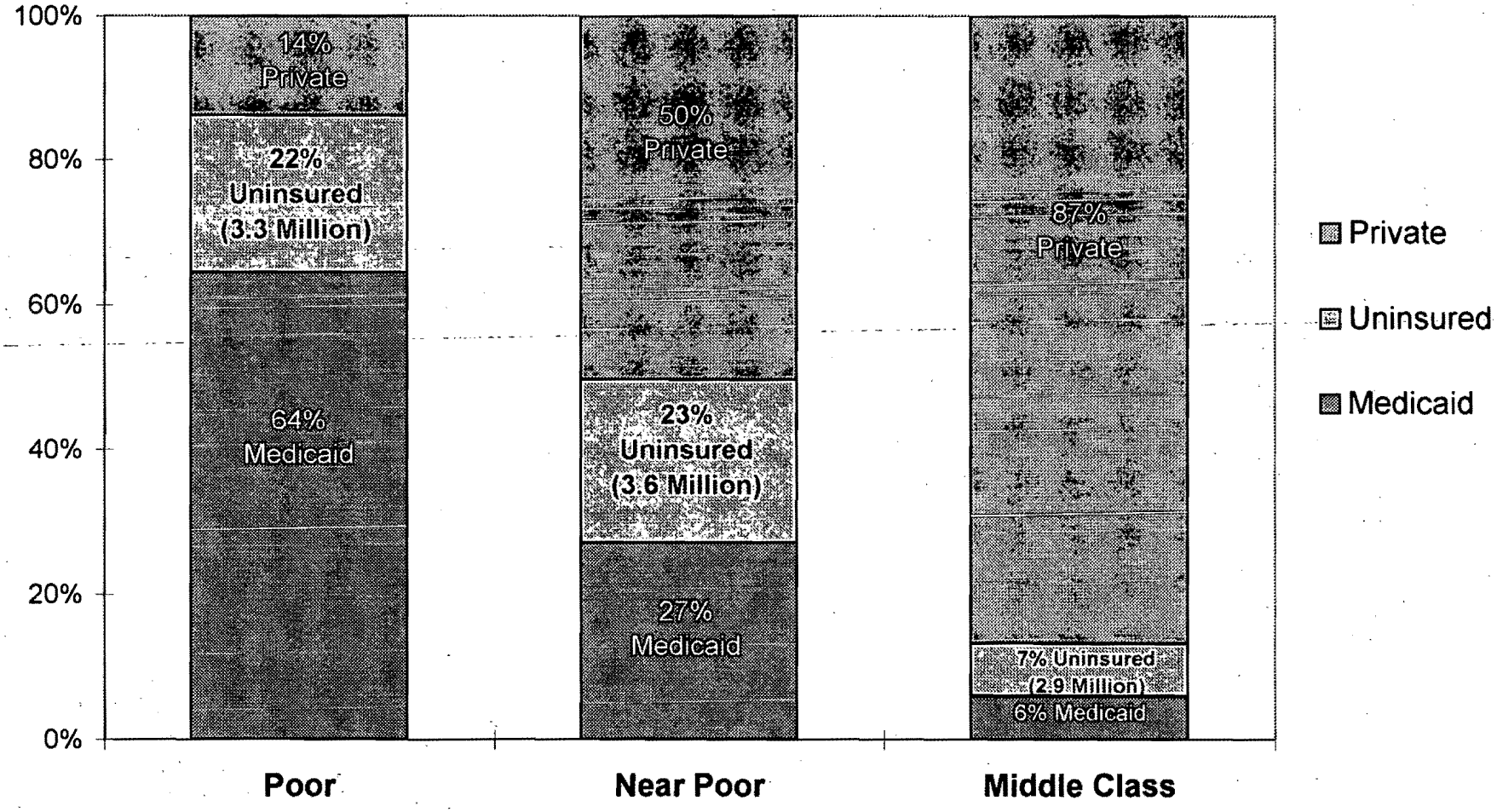
Most Uninsured Children Have a Parent Who Works



Note: 56% of children (two-thirds of working children) have parents who work full year, full time
Source: EBRI, 1996

Chart 1

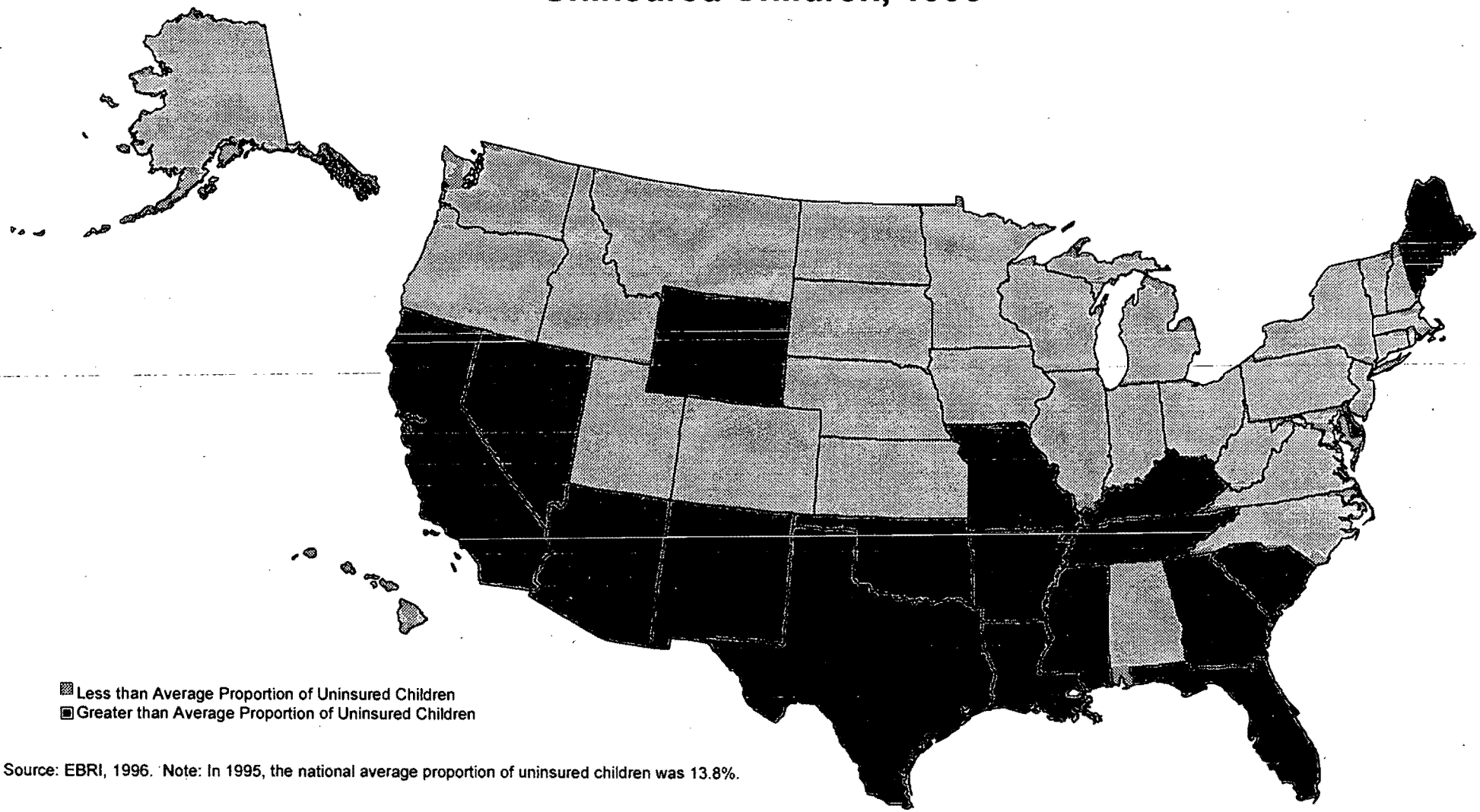
Children's Health Coverage, 1995
Proportion of Children Covered by Different Sources



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage.
Source: EBRI, 1996

Chart 2

Uninsured Children, 1995

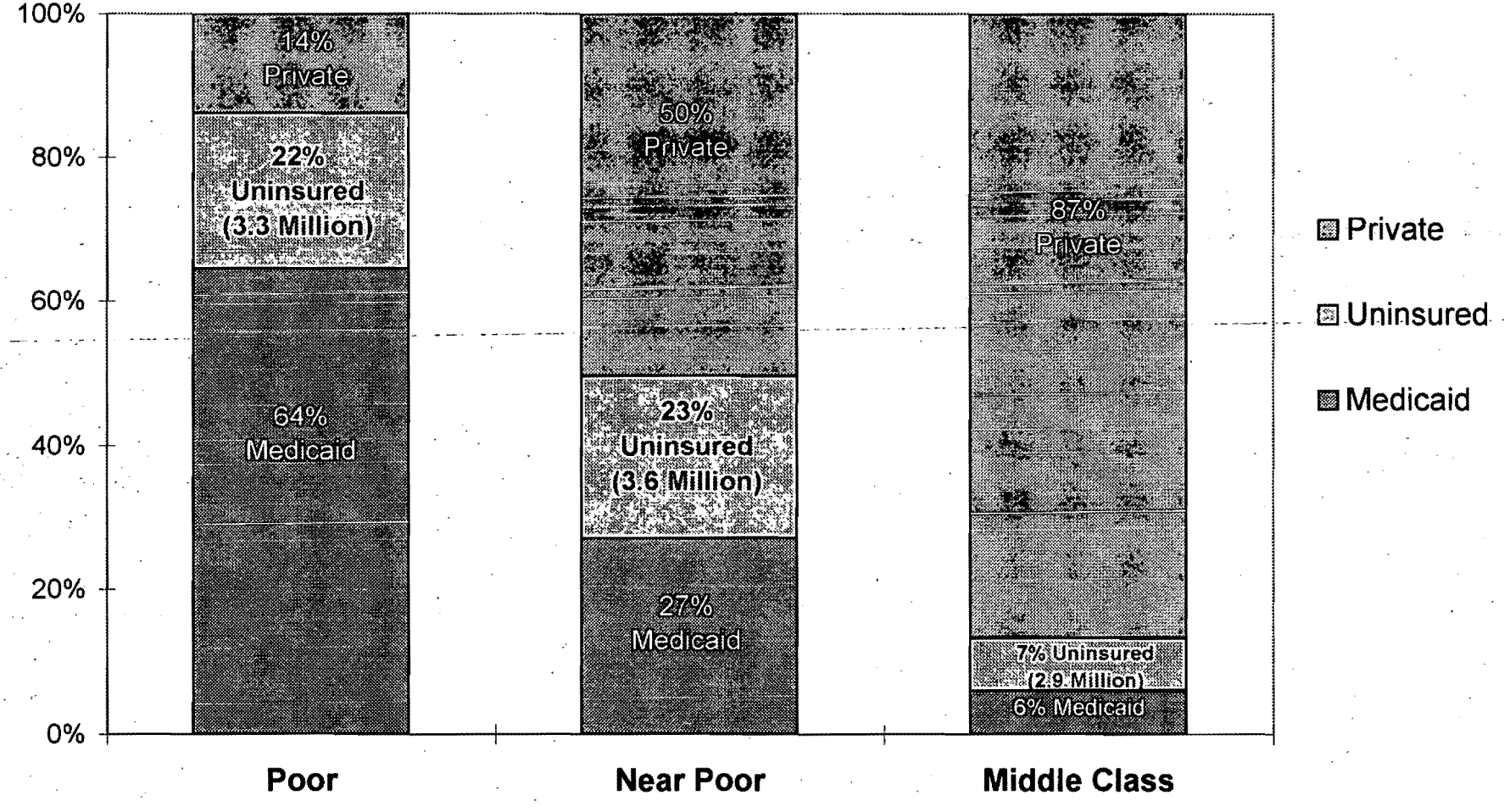


Less than Average Proportion of Uninsured Children
Greater than Average Proportion of Uninsured Children

Source: EBRI, 1996. Note: In 1995, the national average proportion of uninsured children was 13.8%.

Chart 3

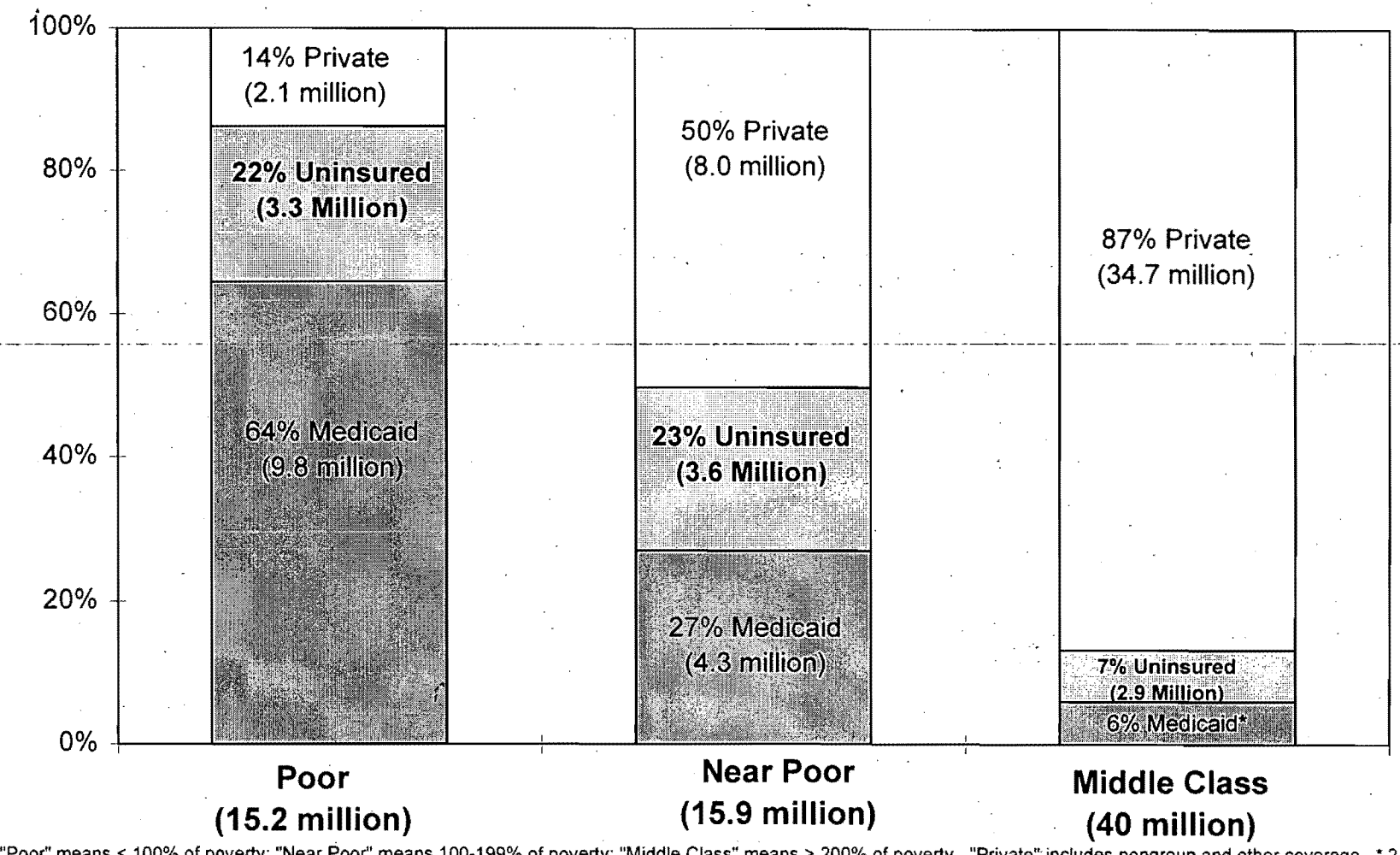
Children's Health Coverage, 1995
Proportion of Children Covered by Different Sources



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage.
Source: EBRI, 1996

Chart 4

What Is the Distribution of Uninsured Children By Income



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage. * 2.4 million.
Note: The number of children covered by Medicaid is less than 18 million due to under-reporting on this survey. Source: March 1996 Current Population Survey.

WESTERN PENNSYLVANIA
CARING FOUNDATION, INC.

P.O. BOX CARING
PITTSBURGH, PA 15230

A MOTHER'S PERSPECTIVE

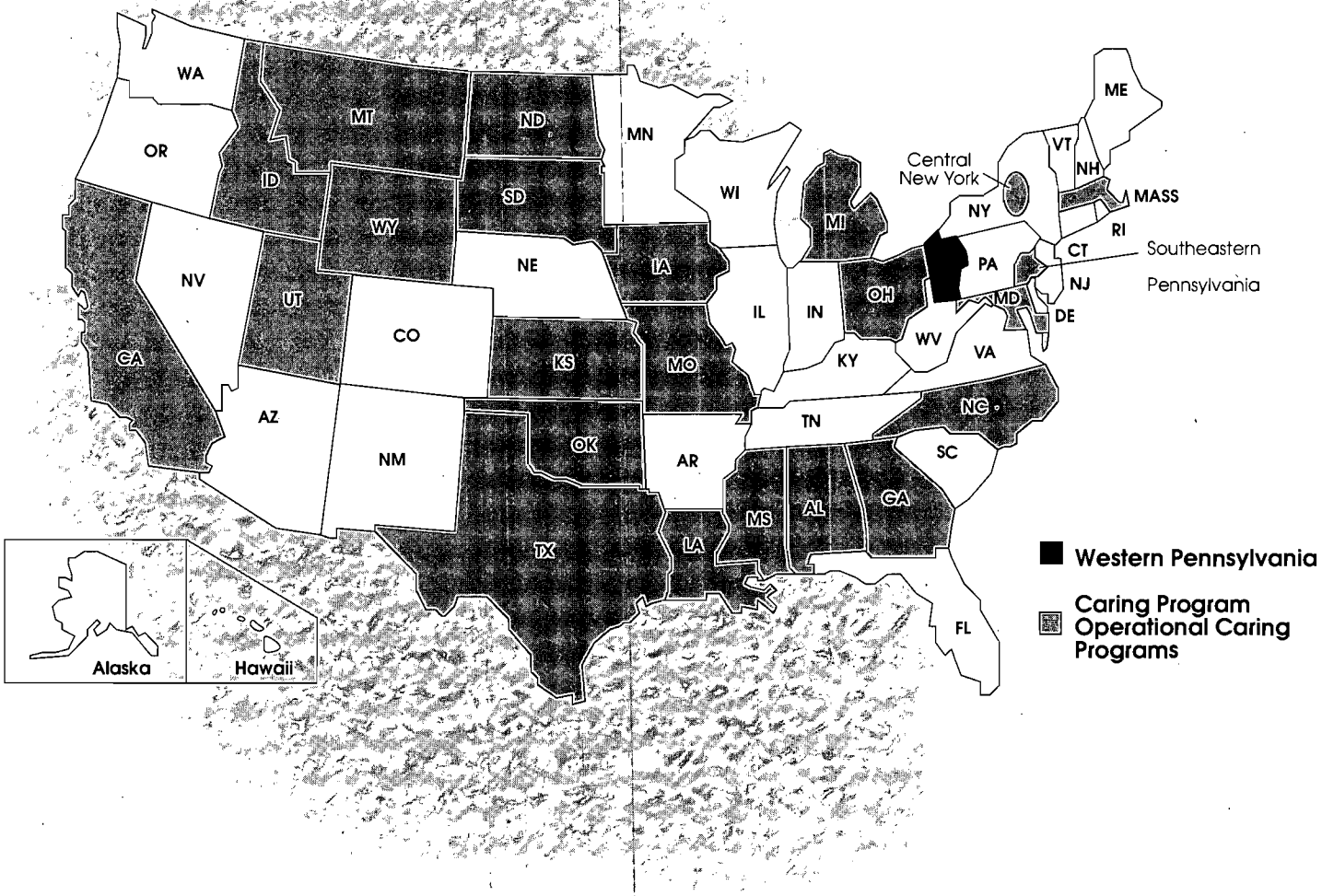
"This is a note to thank the Caring Foundation for the wonderful help it has been to my 14-year-old son. He suffered with tonsillitis for two years and would miss nearly 20 days of school each year because we had no health insurance to afford having his tonsils removed. Thanks to the program, his tonsils were taken out, and he recovered quickly. He also was able to have his first eye exam and have a dental check-up and filling done that was needed. I just became employed full-time and now have health insurance. Thanks again."

"I wanted very much to take the time to thank everyone involved in the Caring Program. I am a mother of three children and guardian of my niece, who is also in the Caring Program. I lost my husband last year; he was diagnosed with heart disease. My brother passed away five months ago of diabetes. His wife died of bone cancer, leaving behind an 11-year-old daughter. Having the Caring Program has helped tremendously with the four children. Again, thank you and all who are involved in this from the bottom of our hearts."

For more information on the Western Pennsylvania Caring Foundation's programs for uninsured children, or to speak directly to a family, contact Charles P. LaVallee at 412-645-6202.

CARING PROGRAM REPLICATION

Through a grant from the U.S. Department of Health and Human Services, the Western Pennsylvania Caring Foundation has replicated Caring Programs in 23 states across the nation. Nationwide, more than 250,000 children have been covered by the Caring Programs.



THE WESTERN PENNSYLVANIA CARING FOUNDATION

Western Pennsylvania: A Working Solution

Health Care for Children

An innovative public/private partnership provides health care coverage to children from working uninsured families.

The comprehensive coverage enables families to obtain needed health care services for their children while significantly reducing cost shifting.

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File Children's Health: State programs

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United States General Accounting Office

GAO

Report to the Ranking Minority Member, Subcommittee on Children and Families, Committee on Labor and Human Resources, U.S. Senate

January 1996

HEALTH INSURANCE FOR CHILDREN

State and Private Programs Create New Strategies to Insure Children

GAO/HEHS-96-35

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-259618

January 18, 1996

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.