SB

290

JAN 29 1992

OFFICE OF THE TREASURER
DEPARTMENT OF INSURANCE
The Capitol, Tallahassee, Florida 32399-0300

TOM GALLAGHER
TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

FOR IMMEDIATE RELEASE
January 27, 1992

CONTACT:
Jill Chamberlin
Press Secretary
The Capitol, PL-11
Tallahassee, FL 32399-0300
904/922-3108 ext.2840

"HEALTHY KIDS" SET FOR VOLUSIA COUNTY; EFFORTS SEEK TO OFFER HEALTH CARE TO 10,000 CHILDREN

TALLAHASSEE -- "Healthy Kids," the state initiative to offer school children health care benefits and preventive health care, kicks off Feb. 1 in Volusia County, State Treasurer Tom Gallagher and Education Commissioner Betty Castor announced today.

The program is under the direction of the Florida Healthy Kids Corp., created in 1990 by the Florida Legislature, and believed to be the first of its kind in the nation. Gallagher and Castor first announced the program in 1990 and plan to take it to all of Florida's 67 counties.

The pilot program in Volusia County will enroll as many as 10,000 uninsured school children age five to 19. Eligibility requirements include that the children are uninsured and do not qualify for Medicaid or other public programs.

"This first-of-its-kind program will provide children with the health care they so need and deserve to succeed in school," Castor said.

-More-

"Healthy Kids" is offering comprehensive, 24-hour health coverage and will emphasize the importance of preventive care, including medical checkups, eye exams and immunizations. Also covered are prescription medicines, hospital care, emergency services, eyeglasses, surgery and physician office visits. Medical service will be through Florida Health Care Plan, a local health maintenance organization (HMO). Some small co-payments may apply.

The Florida Healthy Kids Corp., a non-profit organization, was created in response to the health needs of Florida's school children, and established with state appropriations.

Gallagher said the program "is an encouraging example of how government is responding to the soaring health care costs that Florida and the nation are experiencing."

The school enrollment-based family health insurance concept of "Healthy Kids" will provide free and reduced-price health insurance to children, based on family income. The cost of the insurance coverage will range from zero to $60 per month. The coverage will be available to families with children who have no insurance and are enrolled in school.

Potential benefits:

• Healthy children tend to perform better in school.

• Access to health care and insurance will be an incentive to remain in school.

-More-

• With access to health care, many children will be healthier and will have fewer sick days from school.

For more information, Volusia parents should contact the Florida Healthy Kids Corp. at 800/367-3253 or their child's school.

-30-

[redacted]RST COMMITTEE OF REFERR[redacted]

DATE: 5/13/91

FURTHER: HESS
Finance

Date of 5-Day Notice: 1/29/92
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: ~~1/1/92~~

L&C Committee considered SB 290

Access for children to preventive health services; efd.

and recommended:

[✓] replace with _____ CS SB 290 (L+C) [ ] same title [ ] new title

[ ] attached amendment(s)

[ ] _____ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

[ ] fiscal note(s) _____

Department(s)/Date:

[✓] zero fiscal note(s) DCED / 2-7-92

[ ] appropriation-no fiscal note

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

Shirley Cratty

OTHER RECOMMENDATIONS:

Ine Rouce - Do Pass

Chair: Signature and Recommendation

**Draft CSSB 290 (7-LS1341\D)**

**Alaska Healthy Kids Corporation**

February 12, 1992

This draft addresses concerns expressed by the Department of Commerce and Economic Development.

I. Page 2, lines 6 - 7: Replaces the director of the Division of Insurance with the commissioner of HSS on the corporation's Board of Directors.

The Division of Insurance viewed its membership on a board implementing a health care program as conflicting with its role as regulator of the insurance industry.

This change remedies that perceived problem.

II. Page 2, lines 21 - 22: Requires director of the Division of Insurance to serve as a consultant to the board.

III. Page 2, line 29: Adds "consultants" to list of those who would not be held liable for actions taken in good faith in the performance of the powers and duties of the corporation.

IV. Deleted item (c) on page 4, lines 17 - 19, of the original bill. This section required DCED to supervise liquidation or dissolution of the corporation.

The department viewed this section as conflicting with federal bankruptcy laws. According to the director of the Division of Insurance, this section of the original bill is not needed since state law already addresses the dissolution of public corporations.

7-LS1341\D
Lauterbach
2/11/92

CS FOR SENATE BILL NO. 290 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR COLLINS

A BILL

FOR AN ACT ENTITLED

"An Act relating to access for children to preventive health services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** LEGISLATIVE INTENT. The legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in the state. Many children do not have preventive services available or funded and, for those who do, lack of access is a restriction to getting service. It is the intent of the legislature that a nonprofit corporation be organized to facilitate a program to bring preventive health care services to children, if necessary, through the use of school facilities when more appropriate sites are unavailable, and to provide comprehensive health insurance coverage to children. A goal for the corporation is to cooperate with existing preventive service programs funded by the public or the private sector.

* **Sec. 2.** AS 18 is amended by adding a new chapter to read:

CHAPTER 27. ALASKA HEALTHY KIDS CORPORATION.



New Text Underlined [DELETED TEXT BRACKETED]

Sec. 18.27.010. CREATION OF CORPORATION. There is created the Alaska Healthy Kids Corporation, a nonprofit public corporation and government instrumentality in the Department of Health and Social Services, but having a legal existence independent and separate from the state.

Sec. 18.27.020. BOARD OF DIRECTORS. (a) The corporation shall operate subject to the supervision and approval of a board of directors chaired by the commissioner of health and social services or a designee of the commissioner, and composed of 10 other members selected by the governor for three-year terms of office as follows:

(1) one member from among three persons nominated by the Alaska Council of School Administrators;

(2) one member from among three persons nominated by the Association of Alaska School Boards;

(3) one member who is an employee of the Department of Education;

(4) two members from among five members nominated by the Alaska chapter of the American Medical Association;

(5) one member representing hospitals in the state;

(6) two members who are representatives of authorized health care insurers or subscribers' groups who do business in the state;

(7) two members who are employees of the Department of Health and Social Services.

(b) The director of the division of insurance in the Department of Commerce and Economic Development shall serve as a consultant to the board when requested by the board.

(c) Members of the board of directors serve at the pleasure of the governor. The board shall appoint an executive director who is responsible for other staff authorized by the board.

(d) Board members who are not state employees do not receive compensation but are entitled to per diem and travel expenses as provided for members of boards and commissions under AS 39.20.180.

(e) There is no liability on the part of, and a cause of action may not arise against, a member of the board of directors, or its employees, consultants, or agents, for an action they take in the good faith performance of their powers and duties under this chapter.

Sec. 18.27.030. POWERS AND DUTIES. (a) The corporation shall phase in a program

to

(1) organize school children groups to facilitate the provision of preventive health care services to children and to provide comprehensive health insurance coverage to children and their family members;

(2) arrange for the collection of family or employer payments or premiums, in an amount to be determined by the board of directors, from all participant families or employers to provide for payment for preventive health care services or premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses incurred during the period for which family or employer payments are made;

(3) establish the administrative and accounting procedures for the operation of the corporation;

(4) establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children and their family members;

(5) establish eligibility criteria that children and their family members must meet in order to participate in the program;

(6) establish procedures under which applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation;

(7) establish participation criteria and, if appropriate, contract with an authorized insurer to provide administrative services to the corporation;

(8) contract with authorized insurers, or any provider of health care services meeting standards established by the corporation, for the provision of comprehensive insurance coverage and preventive health care services to participants; and

(9) develop and implement a plan to publicize the corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

(b) The corporation may

(1) employ staff necessary to properly administer the corporation;

(2) as appropriate, enter into contracts with school districts or other agencies to provide on site information, enrollment, and other services necessary to the operation of the

corporation;

(3) accept grants, loans, or advances of money or property from a public or private source for the purposes of this chapter;

(4) take other actions necessary to implement the purposes of the corporation.

Sec. 18.27.040. COVERAGE IS SECONDARY. Coverage under the corporation's program is secondary to any other available private coverage held by the participant child or family member. The corporation may establish procedures for coordinating benefits under this program with benefits under other public and private coverage.

Sec. 18.27.050. LICENSING NOT REQUIRED; FISCAL OPERATION. (a) The corporation is not considered an insurer. The officers, directors, and employees of the corporation are not considered to be agents of an insurer. Neither the corporation nor an officer, director, or employee of the corporation is subject to the licensing requirements of AS 21 or the regulations of the Department of Commerce and Economic Development adopted under AS 21. However, the division of insurance may require that a marketing representative used and compensated by the corporation be appointed as a representative of the insurers or health services providers with which the corporation contracts.

(b) The board is responsible for all corporate operations.

Sec. 18.27.060. THE ALASKA HEALTHY KIDS TRUST FUND. There is created the Alaska healthy kids trust fund in the Department of Health and Social Services. It consists of appropriations made to it. Money in the fund may be used only by the corporation.

Sec. 18.27.070. ACCESS TO RECORDS; CONFIDENTIALITY; PENALTIES. (a) Notwithstanding any other laws to the contrary, the corporation shall have access to the medical records of a student upon receipt of permission from a parent or guardian of the student. The medical records may be maintained by state and local agencies. Confidential information obtained by the corporation under this subsection shall remain confidential and is exempt from public inspection and copying under AS 09.25.110 - 09.25.120. The corporation or the staff or agents of the corporation may not release to a state or federal agency, to a private business or person, or to another entity confidential information received under this subsection.

(b) A violation of this section is a class B misdemeanor.

Sec. 18.27.080. DEFINITIONS. In this chapter,

(1) "board" means the board of directors of the corporation;

(2) "corporation" means the Alaska Healthy Kids Corporation.

* Sec. 3. Notwithstanding AS 18.27, as enacted by sec. 2 of this Act, the Alaska Healthy Kids Corporation may not select more than four sites at which to implement its program without prior approval of the legislature by law.

* Sec. 4. This Act takes effect July 1, 1992.

# SENATE BILL 290 SECTIONAL ANALYSIS

*"An Act relating to access for children to preventive health services; and providing for an effective date."*

***Sec. 1. LEGISLATIVE INTENT.*** Intent is to organize a nonprofit organization to facilitate a program to bring preventive health care services to children who are unable to access care. This may be through the use of school facilities. Corporation would cooperate with existing preventive service programs.

***Sec. 2.*** AS 18 is amended by adding a new chapter.

**CHAPTER 27. ALASKA HEALTHY KIDS CORPORATION.**

**Sec. 18.27.010. CREATION OF CORPORATION.** Alaska Healthy Kids Corporation, nonprofit public corporation and government instrumentality, is created in the Department of Health & Social Services, but the corporation has a legal existence independent and separate from the State.

**Sec. 18.27.020. BOARD OF DIRECTORS.** Corporation operates under supervision and approval of an 11-member board. The chair is the director of the division of insurance. Other members serve three-year terms and at the pleasure of the governor.

Board appoints an executive director who is responsible for other staff authorized by board.

Board members only receive per diem and travel expenses.

No liability for board members for actions taken in good faith performance of their powers and duties.

**Sec. 18.27.030. POWERS AND DUTIES.** (a) Corporation will (1) organize school children groups to provide health insurance coverage to children and family members, (2) arrange for collection of premiums which include administrative coverage, (3) establish administrative procedures for operation, (4) establish standards for services and

benefits, (5) establish eligibility criteria for participation in program, (6) establish procedures for grievances by applicants and participants in program, (7) establish participation criteria, contract with authorized insurers or health care service provider to provide insurance coverage to participants, (9) develop and implement plan to publicize the corporation (b) Corporation may (1) employ staff if necessary, (2) if appropriate, enter into contracts with school districts or other agencies to provide other services necessary to the operation of the corporation, (3) accept grants, loans, or advances of money or property from a public or private source, (4) take other actions necessary to implement purposes of corporation.

**Sec. 18.27.040. COVERAGE IS SECONDARY.** Coverage under the corporation's program is secondary to any other available private coverage held by the participant child or family member. Corporation may establish procedures for coordinating benefits under this program with benefits under other public and private coverage.

**Sec. 18.27.050. LICENSING NOT REQUIRED; FISCAL OPERATION.** (a) Corporation is not considered an insurer and officers, directors, and employees are not considered to be agents of an insurer; therefore not subject to licensing requirements. Division of insurance may require marketing representative used and compensated by the corporation be appointed as a representative of the insurers or health services providers with which the corporation contracts. (b) Board responsible for all corporate operations. (c) Division of insurance shall supervise liquidation or dissolution of the corporation.

**Sec. 18.27.060. THE ALASKA HEALTHY KIDS TRUST FUND.** Fund created in Department of Health and Social Services. Consists of funds appropriated to it. Money in fund may only be used by the corporation.

**Sec. 18.27.070. ACCESS TO RECORDS; CONFIDENTIALITY; PENALTIES.** (a) Notwithstanding any other laws to the contrary, corporation shall have access to the medical records of a student upon receipt of permission from a parent or guardian of the student. Records may be maintained by state and local agencies. Confidential information obtained by the corporation under this subsection shall remain confidential. (b) Violation of this section is a class B misdemeanor.

Sec. 18.27.080. DEFINITIONS.

*Sec. 3. Corporation may not select more than four sites at which to implement its program without prior approval of the legislature by law.

*Sec. 4. Act effective July 1. 1992.

# FISCAL NOTE

**STATE OF ALASKA**
**1992 LEGISLATIVE SESSION**

**BILL NO.** SB 290

**Revision Date:** 5/13/91 **Department Affected:** Commerce & Economic Dev.

**Title:** Access for children to preventive health services **BRU:** Insurance

**Component:** Operations

**Sponsor:** Sen. Collins

**Requestor:**

**COMPONENT SERIAL NO.** 0354

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

| OPERATING | FY 93 | FY 94 | FY 95 | FY 96 | FY 97 | FY 98 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE FUND SOURCE: | 0 | 0 | 0 | 0 | 0 | 0 |

**FUNDING: (Thousands of Dollars)**

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER FUND SOURCE: | | | | | | |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

**POSITIONS:**

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

**Estimate of current year impact:**

**ANALYSIS: (Attach a separate page if necessary.)**

No fiscal impact.

**Prepared By:** Joan Brown, Admin. Officer **Phone:** 465-2597

**Division:** Insurance **Date:** 1/31/92

**Approved by Commissioner:** Glenn A. Olds, Commissioner by Asst Comm

**Agency:** Commerce & Economic Development **Date:** 12-7-92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies).

Rev 10/7/91

Department of Commerce & Economic Development / POSITION PAPER

SB 290: "An Act relating to access for children to preventive health services; and providing for an effective date."

This department is not in favor of this bill as currently drafted. The principal objection is that the Director of Insurance is Chairman of the Board of Directors created in Section 2 of the bill (see 18.27.020(a)).

The role is in conflict with the Director of Insurance's regulatory role. The Director of Insurance regulates health care provision by insurers but does not perform a role in the direct or indirect provision of coverages.

We ask that the Director of Insurance be removed from the board established in this bill in order to avoid any appearance of conflict of interest, real or perceived.

A further difficulty with the bill appears in Section 2 (Sec. 18.27.050(c)) (Page 4, line 17). This subsection provides that a "noninsurer" be subject to AS 21 for liquidation and dissolution. It is our belief that this is in conflict with federal bankruptcy laws since the exception provided in the McCarran Ferguson Act (P.L. 15) cannot extend to other than an insurer.

Glenn A. Olds, Commissioner

Date: 2-7-92

GAO/JB/dgl1413D
020792a

# Alaska State Legislature

During Session
P.O. Box V
Juneau, Alaska 99811
(907) 465-2828

During Interim
3111 C Street, Suite 510
Anchorage, Alaska 99503
(907) 561-2040

## Senator Virginia Collins

### Senate Bill 290

Alaska Healthy Kids Corporation

While children represent a low-risk health insurance pool, according to the Children's Defense Fund, nine to twelve million children have no health insurance.

Senate Bill 290 would give school children the opportunity to have low-cost health care coverage by placing them in one insurance pool. For years, universities have offered lower-cost group insurance to post-secondary students. SB 290 applies this concept to school children.

SB 290 is based on the Florida Healthy Kids Corporation which was created in 1990. The corporation has just started a pilot program in Volusia County that will offer as many as 10,000 uninsured school children, ages five to nineteen, health care benefits and preventive health care.

Like its Florida paradigm, SB 290 limits the program to no more than four pilot sites.

To be eligible for coverage under the program, a child must:

- not have had health insurance for six months;
- be five to nineteen years of age;
- be in grades K through 12; and,
- not be enrolled in Medicaid or other government-sponsored health programs.

The program would offer comprehensive health care coverage on a sliding fee scale using the national school lunch program criteria as a basis for determining cost.

Care would include regular check-ups, lab tests, physicals, and treatment of minor childhood illness. It would also provide coverage for specialists, hospital stays, and surgery.

SB 290 offers a solution to part of the current health care crisis by offering health care and preventive care to an uninsured segment of Alaskans.

OFFICE OF THE TREASURER
DEPARTMENT OF INSURANCE
The Capitol, Tallahassee, Florida 32399-0300

TOM GALLAGHER
TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

FOR IMMEDIATE RELEASE
January 27, 1992

CONTACT:
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The program is under the direction of the Florida Healthy Kids Corp., created in 1990 by the Florida Legislature, and believed to be the first of its kind in the nation. Gallagher and Castor first announced the program in 1990 and plan to take it to all of Florida's 67 counties.

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"This first-of-its-kind program will provide children with the health care they so need and deserve to succeed in school," Castor said.

-More-

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The Florida Healthy Kids Corp., a non-profit organization, was created in response to the health needs of Florida's school children, and established with state appropriations.

Gallagher said the program "is an encouraging example of how government is responding to the soaring health care costs that Florida and the nation are experiencing."

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Potential benefits:

• Healthy children tend to perform better in school.

• Access to health care and insurance will be an incentive to remain in school.

-More-

• With access to health care, many children will be healthier and will have fewer sick days from school.

For more information, Volusia parents should contact the Florida Healthy Kids Corp. at 800/367-3253 or their child's school.

-30-


## What is HEALTHY KIDS?

A program of health insurance offering comprehensive health care coverage.

## How does it work?

Your school district is used in the same manner as employers with large groups of employees. Generally, group insurance is cheaper than individual insurance.

## What will it cover?

The program will offer comprehensive health care coverage. The care provided under this program includes regular check-ups, lab tests, physicals and minor childhood illnesses. It also provides coverage for specialists, hospital stays, and surgery.

## Who can sign up?

Your child must:

- have no health insurance for 6 months
- be 5 to 19 years old
- be in grades K-12
- not be enrolled in Medicaid or other government sponsored health programs.

...continued on back

FLORIDA HEALTHY KIDS CORPORATION
345 S. Magnolia Drive, Suite E-17 • Tallahassee, Florida 32301 • 904/878-8566 • Fax: 904/878-3078

# MONTHLY INCOME DETERMINES COST

| FAMILY SIZE | GROSS MONTHLY INCOME | |
|---|---|---|
| 2 People | $0 - $ 740 | If you can find your family |
| 3 | 0 - 928 | size and income here, |
| 4 | 0 - 1117 | then you pay nothing |
| 5 | 0 - 1305 | for coverage.* |
| 6 | 0 - 1493 | |

| FAMILY SIZE | GROSS MONTHLY INCOME | |
|---|---|---|
| 2 People | $ 741 - $ 962 | If you can find your family |
| 3 | 929 - 1207 | size and income here, |
| 4 | 1118 - 1452 | then your cost each month |
| 5 | 1306 - 1697 | is $3 for each child.* |
| 6 | 1494 - 1942 | |

| FAMILY SIZE | GROSS MONTHLY INCOME | |
|---|---|---|
| 2 People | $ 963 - $1369 | If you can find your family |
| 3 | 1208 - 1718 | size and income here, |
| 4 | 1453 - 2066 | then your cos each month |
| 5 | 1698 - 2415 | is $16 for each child.* |
| 6 | 1943 - 2763 | |

| FAMILY SIZE | GROSS MONTHLY INCOME | |
|---|---|---|
| 2 People | $1370 & over | If you can find your family |
| 3 | 1719 & over | size and income here, |
| 4 | 2067 & over | then your cost each month |
| 5 | 2416 & over | is $60 for each child. |
| 6 | 2764 & over | |

GROSS MONTHLY INCOME INCLUDES:

- EARNINGS FROM WORK BEFORE DEDUCTIONS ARE MADE
- PENSIONS / RETIREMENT / SOCIAL SECURITY
- WELFARE / CHILD SUPPORT / ALIMONY
- ALL OTHER INCOME AVAILABLE TO PAY FOR HEALTH INSURANCE

* If your children are enrolled in the National School Lunch Program at school, you will be eligibie for reduced price coverage. If you have not applied for the school lunch program and would like to, please contact your child's school.

If you are not able to locate your family size and/or income, please call Healthy Kids at 1-800-367-3253.

# FLORIDA HEALTHY KIDS BENEFITS COVERAGE

The Florida Healthy Kids Program offers comprehensive healthcare benefits for your children including coverage of prescription medications and eye care services. To receive maximum benefit coverage, you must select one of the Florida Health Care Plan (FHCP) primary care physicians to direct all of your child's care. By selecting a primary care physician who will manage your child's healthcare needs, your personal costs will be kept to a minimum and you will feel secure in knowing a single trusted physician is managing your child's care.

Although a few services require a co-payment (a small fee paid for each visit or service), most healthcare services are covered at no charge. Services with no co-payment include:

- Primary Care Office Visits
- Hospital Stays
  (If authorized by Florida Health Care Plan)
- Surgeon Fees
  (If authorized by Primary Care Physician)
- Vision Screening, Hearing Screening
  (If provided by Primary Care Physician)
- Emergency Ambulance Services
  (If life or limb threatening emergency)
- Podiatry Services
  (Limited to Florida Health Care Plan Providers)
- Specialist Office Visits
- Diagnostic Testing (Lab, X-rays, etc.)
- Outpatient Surgery
  (If provided by Florida Health Care Plan)
- Maternity Care
  (If authorized by Florida Health Care Plan)
- Chiropractic Services
  (Some limits apply)
- Durable Medical Equipment
  (If authorized by Florida Health Care Plan)

Those services which require a small co-payment include:

| SERVICE | CO-PAYMENT |
|---|---|
| • Prescription Medications (Up to a 31 day supply) | $3 |
| • Prescription Eyeglasses (Limit one pair every two years unless head size changes) | $10 |
| • Physical or Speech Therapy (24 sessions within 60 day period) | $3 |
| • Emergency Room Visits (No co-payment if sent by Primary Care Physician) | $25 |
| • Mental Health Outpatient Visits (Some limits apply) | $10 |


Dear Parent:

Florida's first "Healthy Kids" program of comprehensive health insurance is coming to Volusia County.

Healthy Kids is a non-profit program set up by the Florida Legislature to provide health insurance for school children. Insurance coverage will be available to children 5-19 years of age who attend Kindergarten through 12th grade. Your children must also have been without health insurance for the last 6 months and not be covered by Medicaid or other public health insurance programs.

The cost to you will depend on the size of your family and the amount of your family's gross monthly income and will be on a sliding scale.

More details and enrollment forms will be sent home later this fall. If this health insurance program sounds interesting and you think you would like an application when they become available, please fill out the section below and return this letter to your child's school.

PLEASE SEND ME MORE INFORMATION ON THE HEALTHY KIDS PROGRAM:

Name: _____ _____
FIRST LAST

Address: _____
STREET NUMBER OR APARTMENT NUMBER

_____ _____ _____
CITY ST ZIP

Phone Number: ___-___-____ Number of Children: ___
AREA CODE

Schools Attended: _____

_____

_____

FLORIDA HEALTHY KIDS CORPORATION
345 S. Magnolia Drive, Suite E-17 • Tallahassee, Florida 32301 • 904/878-8566 • Fax: 904/878-3078
1/800-367-3253

# INTERIM REPORT

# Healthy Kids

FLORIDA HEALTHY KIDS CORPORATION
345 S. Magnolia Drive, Suite E-17 • Tallahassee, Florida 32301 • [redacted]

This interim report is provided to the Governor, Insurance Commissioner, Commissioner of Education, Senate President, Speaker of the House of Representatives, Minority Leaders of the Senate and House of Representatives and other interested persons, by the Florida Healthy Kids Corporation and its Board of Directors as required by Chapter 90-199, Laws of Florida, the Healthy Kids Corporation Act.

## BACKGROUND

By the Spring of 1990, it had become abundantly clear that Florida's children were in need. The signals observed were many. Pre-school immunizations were down, measles cases had increased 290%, utilization of wellness benefits provided by insurance was low, Florida school drop-out rates were at an all time high, and the number of children uninsured for health care in Florida rose to 27.7%

The Florida Departments of Education and Insurance in consultation with the Institute for Child Health Policy, University of Florida, urged the creation of the Florida Healthy Kids Corporation in response to the health needs of Florida's school children. The proposed Corporation was to be given two missions: One, to create a comprehensive insurance product for school children and two, to facilitate the provision of preventive care for all children. These two primary assignments were the foundation upon which the Corporation would operate.

While under consideration by the 1990 Florida Legislature, other parties became interested in what was being proposed. The University of Florida's Institute for Child Health Policy received grant funding from the Maternal and Child Health Bureau under the U.S. Public Health Service and from Robert Wood Johnson, a private foundation. These grants financed further study of the school enrollment based health insurance concept, first described in the New England Journal of Medicine in 1988. With this financing, the Institute began product research and development with Medimetrix Group of Cleveland, Ohio, a health care financing consultant. This early development provided a solid base from which the Florida Healthy Kids Corporation could launch its mission without hesitation.

## THE CORPORATION

The Healthy Kids Corporation Act was passed by the Florida Legislature and signed into law to be effective July 1, 1990.

The Governor, Commissioner of Education and Insurance Commissioner named their appointees to the Healthy Kids Board of Directors and an organizational meeting was held on October 30. At that meeting an Executive Director was named and an office site approved. Healthy Kids opened its offices on November 1, 1990.

**A federal grant provides subsidized premium for approximately 7,000 eligible children in one Healthy Kids pilot site.**

## THE GRANT

A joint proposal was prepared and forwarded to the Health Care Financing Administration by the Florida Medicaid Program, the Institute for Child Health Policy and Healthy Kids. This proposal called for the establishment of a demonstration site for the extension of the school enrollment based health insurance concept which would provide free and reduced price health insurance for school children based on eligibility for the school lunch program. The Florida program was selected and a cooperative agreement established which will bring up to seven million dollars in federal assistance over the next four years. State and private contributions are required to ensure the flow of these federal dollars. A mechanism which could provide some subsidy of premium for families with income exceeding 185% of poverty is also desired.

## WHAT IS SCHOOL ENROLLMENT BASED HEALTH INSURANCE?

Traditionally, Americans have obtained individual and family health insurance coverage in one of three ways. Some have been covered by public programs, and some have paid directly for policies, but by far the largest number of people have obtained health coverage in the form of group insurance provided through their employers. Insurance programs for members of large employer groups have had the lowest prices. Because employers typically pay for coverage of workers rather than families, children as a group are disproportionately uninsured. It is estimated that approximately 500,000 of Florida's school children are uninsured. The chance of being uninsured is 37% higher for a child than an adult. In addition, a lack of insurance coverage translates directly to a lack of health care. Uninsured persons use medical care less often than do insured, and they are more likely than the insured to be in poorer health. In a recent study of Florida families with children, it was found that uninsured children had hospital lengths of stay nearly twice that of insured children.

> 500,000 of Florida's school children are uninsured

An alternative is School Enrollment Based Health Insurance. To enhance access to health care for children, state school systems are used as grouping mechanisms for negotiating preventive care and comprehensive group health insurance policies. Coverage will be offered to all families with children enrolled in school. Policies are designed to accommodate the school child up to age 19, dependents, and non-school age siblings. Coverage could be extended to the parents of these children in the future.

> School systems are used as grouping mechanisms

## THE SCHOOLS

During the first month of operation, 25 of Florida's 67 school districts expressed their interest and intent to prepare a proposal for consideration as a Healthy Kids pilot site. On January 24, 1991, the Healthy Kids Board of Directors selected the districts of Volusia, Hillsborough, Leon and Highlands as the first four Healthy Kids pilot sites. The first open enrollment held in Volusia County will be in the Fall of 1991. Other pilot sites will be implemented as funding becomes available.

> Volusia County School System
> Students: 48,141
> Implementation: Fall 1991
>
> Pilot Site

Those districts submitting proposals during this phase which were not selected, will be added when the cap on pilot sites can be increased. Those districts the Healthy Kids Board of Directors would like to extend this program to are Duval, Alachua, Collier, Lee, Pinellas and Dade counties.

In selected districts, the feasibility of delivering health care services to children at school sites will be tested. In many areas, transportation is difficult for the families of school children. Bringing health care providers to the school site may be the means necessary to provide access to medical care. This blends well with the Florida Department of Education's call for full service schools.

> ALACHUA
> COLLIER
> DADE
> DUVAL
> HIGHLANDS
> HILLSBOROUGH
> LEE
> LEON
> PINELLAS
> VOLUSIA

## THE BENEFITS

The potential social benefits of this program are far reaching. Children with a more positive health status tend to perform better in school. As with insurance in the work place, access to health benefits will provide an incentive for staying in school. With access to better health care, many children are healthier and lose fewer days from school.

Better performance in school
Increased tendency to stay in school
Fewer sick days

Benefits

*The Healthy Kids Corporation is a cooperative venture involving the Florida Departments of Insurance, Education and Health and Rehabilitative Services, local school districts, and the US Health Care Financing Administration, as well as private foundations and the Office of the Governor, State of Florida.*



Board of Directors

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NATIONAL ACADEMY FOR STATE HEALTH POLICY

PORTLAND, MAINE

# *Access and the Uninsured:*

# *A Guide for States*

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Over the past several years, Congress has substantially expanded both mandatory and optional eligibility categories bringing, for the first time, some uniformity to income eligibility guidelines and starting the process of uncoupling Medicaid from welfare programs These changes have, to date, been limited to certain particularly vulnerable groups like infants and pregnant women. In addition, Congress has authorized a series of state demonstrations that test new eligibility categories and sliding scale premium payments to permit persons with slightly higher incomes to enroll in Medicaid. Beyond this, states have acted on their own, without federal matching funds, to "piggy-back" access programs on Medicaid, using state-established eligibility criteria and state funds. These federally-sponsored and state-initiated changes to the Medicaid program are discussed below.

## *Medicaid Expansions and Changes*

### New Eligibility Criteria

Driven primarily by concern in Congress for the health of infants and children, the last several years have seen rapid expansions in both mandatory and optional eligibility categories for Medicaid. The improvement in infant mortality rates seen over the past several decades has apparently stalled, and the gap between rates for blacks and whites has not only remained distressingly large, but actually widened. Faced with convincing evidence that appropriate prenatal care can help prevent high risk and low birth weight babies, Congress moved to increase access for pregnant women and young children. Effective in 1990, Medicaid coverage became mandatory for pregnant women and children below age six whose household income was below 133 percent of the federal poverty level. Children in families with incomes below poverty up to age eight have also been made eligible without regard to categorical criteria, and those through age 18 will be phased in over the next twelve years. Starting in 1988, states also obtained the option to cover pregnant women and infants up to 185 percent of the federal poverty level. In addition, states were given the option of using presumptive eligibility for pregnant women and removing assets tests for pregnant women and children. Eligibility has also been extended to the elderly and disabled with incomes up to the federal poverty level.

### Medicaid Demonstration Projects

In 1990, Congress authorized three Medicaid demonstration projects to extend eligibility, without regard to categorical requirements, to otherwise uninsured pregnant women and children up to age twenty below 185 percent of the poverty line. The federal authorization requires the participating states to impose sliding scale premium contributions for those above the poverty level, but prohibits contributions more than three percent of household income. Foreshadowing the OBRA 1990 requirement that Medicaid programs pay premiums and cost sharing for private group coverage when it is cost-effective to do so (see discussion, Chapter IV), these demonstrations also permit coordination with private, employer-based coverage. In 1991, Congress is authorizing a second, similar round of demonstrations, this time

extending eligibility to all persons, regardless of age or category, below 150 percent of the poverty line.

These demonstrations mark several departures for the Medicaid program. The use of sliding scale contributions for people in slightly higher income categories explores strategies that move Medicaid away from the "all or nothing" coverage approach that has resulted in rapid eligibility turnover. The use of non-traditional coverage options (excluding inpatient care, for example) by states with rich Medicaid benefits offers "compromise" coverage extending needed preventive and primary care services to broad population groups at low cost to the states. Further, these demonstrations mark new precedents in developing links to private sector coverage. To date, Medicaid programs in many states have been able to offer their recipients the choice (or, in some cases, the requirement) of enrollment in HMOs, a private sector health coverage option shared by many employer groups. In addition, several states (**California, Minnesota, New York**) have been enrolling Medicaid recipients in employment-based private insurance plans, when a review of the recipients' likely use of health services indicates that it is cost-effective to do so (see description of Medicaid "buy out" plans, Chapter IV). The new demonstrations differ in that indemnity insurers are being used to enroll recipients without regard to health status and that plans are being developed that merge Medicaid populations with other, somewhat higher income groups.

In the first round of demonstrations, awards were granted to Florida, Maine and Michigan, whose programs are described below. A request for proposals for the second round of demonstrations had not yet been issued when this report went to publication.

*Florida*

Florida is using the demonstration authority to set up a program of health coverage for children, organized around the school system. In this program, children will be subscribers for an insurance plan, administered by an insurer or HMO and underwritten by the state Medicaid agency. All school children within the demonstration school districts up to age twenty will be eligible to join, as will their siblings and dependents (in the case of teen parents). Parents and other family members will not be eligible. For children up to 133 percent of the federal poverty level, the premiums will be fully subsidized by the state; for those between 133 percent and 185 percent, the state will pay 72 percent of the premium. Those with incomes above this level can join at cost. These eligibility categories duplicate the eligibility criteria for the school lunch program, allowing a single determination process for both programs.

The program, called the **Healthy Kids Corporation** (HKC), offers two coverage options. A primary care services package covers all visits to primary care providers including screening exams, and routine, office-based lab tests. Children will be required to select a primary care physician who will provide or authorize all services. A comprehensive package adds specialty visits, diagnostic testing, outpatient surgery, limited outpatient mental health, and inpatient services. Prescription drugs at $3.00 per prescription.

glasses and hearing aids are available through Medicaid approved purchasing programs. Organ transplants are not covered. Mental health visits require copayments and there is a $25.00 copayment for emergency room use which is waived for true emergencies. There is no hospital deductible.

School children can elect to have the primary care package only, or the combined primary care and comprehensive package. Non-school-aged siblings and dependents are only eligible for the primary care package.

The program is being implemented and administered by a not-for-profit corporation, authorized and funded by the state legislature ($87,000 for first year administrative expenses). This corporation which was founded expressly for the purpose of operating the Healthy Kids program, reports to a Board jointly appointed by the Governor, the Insurance Commissioner and the Education Commissioner. The Board includes representatives of provider groups, the Department of Education, the Medicaid agency, and other similarly interested parties.

The program is scheduled for implementation in September, 1991 in Voulousa County. It is currently seeking a commercial underwriter for the portion of the program serving children whose income is above Medicaid eligible levels. Seven thousand children are targeted for enrollment during the demonstration phase of the program.

*Michigan*

Michigan's demonstration encompasses a collaboration between the state's Medicaid agency and Blue Cross Blue Shield of Michigan. Under the auspices of this public/private partnership, Blue Cross Blue Shield is developing a Caring Foundation Plan (discussed generically in Chapter VII) to provide coverage to uninsured children under age 18 with incomes up to 185 percent of the federal poverty level. The program will be statewide and, if fully funded, will serve between 14,000 and 15,000 children.

All eligible children in a family will be enrolled simultaneously. The plan covers non-inpatient services, including well-child care. Prescription drugs are covered in full without co-payment. Outpatient substance abuse treatment is covered as well.

Eligible children enroll without premium payment and there is no cost-sharing. Providers are reimbursed at Blue Cross Blue Shield rate schedules. The projected medical services cost of the program is an average of $29.50 per child, per month.

Under the terms of the demonstration, because this program is administered under the umbrella of the Medicaid agency, both state dollars and private donations for the program will be federally matched. Blue Cross Blue Shield of Michigan is contributing $800,000 to fully support the administration of the program, and is undertaking a major fund-raising campaign in collaboration with the state, in which they anticipate generating $1.5

million or more in private donations over the three years of the demonstration. The dollars available to the program will be approximately doubled through federal matching funds.

Enrollment is expected to begin in June, 1991, for a July, 1991 start-up date.

*Maine*

The Maine demonstration is encompassed within a larger state funded and authorized Medicaid buy-in program. This initiative, called The Maine Health Program, has extended eligibility for coverage, very similar to Medicaid coverage, for all adults below 95 percent of the federal poverty level and all children under age eighteen up to 125 percent of the poverty level. Once qualified and enrolled, children and families whose income rises above the eligibility threshold, will remain eligible for up to two years, unless their income rises to more than 150 percent of its level at the time of enrollment. Thus, the program may eventually include those with incomes as high as 180 percent of poverty.

Benefits include all covered Medicaid benefits (which in Maine, are extensive), except prenatal care and long term care. Prenatal care services are omitted because any pregnant woman within the program's income eligibility range will automatically be eligible for Medicaid and will receive benefits through that program.

There are two coverage options under the Maine Health Program. Some individuals and families will receive a card that entitles them to services in the traditional Medicaid manner. Choice of provider is unlimited, and providers bill the Medicaid program and are reimbursed at Medicaid rates. Maine accompanied the implementation of this program with an adjustment in provider reimbursement rates, applicable to both the Medicaid program and the Maine Health Program. Using a relative value scale fee adjustment, the bulk of the upward adjustment will go to primary care providers. The hope is that the enhanced reimbursement rates will increase provider participation in the program simultaneously with the substantially increased demand for Medicaid providers generated by the new program.

The second approach is a "buy-out" that provides coverage through employer-based group plans. In instances where employed eligibles have group coverage available to them, the Medicaid program determines whether paying the premiums and cost-sharing for that plan would be a cost-effective alternative to enrollment in Medicaid. For those participating in the buy-out, the Medicaid program is used as "wraparound" coverage for such services as prescription drugs that are normally not covered under private insurance plans so that coverage is equivalent to that available through Medicaid.

The determination of cost-effectiveness in Maine's program is based primarily on the level of employer contribution toward the premium. Although the program has no

authority to require employer participation, the buy-out is only available in instances where the employer's contribution compensates for the higher per benefit cost of private coverage usually associated with higher provider reimbursement rates and higher insurer overhead.

The Maine Medicaid program decided not to consider health status in determining cost-effectiveness of alternative coverage. Feeling both that the agency did not have the capacity to make accurate "medical underwriting" decisions and that the purpose of coordinating with private sector coverage should not be to shift high risk cases to other carriers, the program determined to measure cost-effectiveness, blind to health status measures, and to assume an average distribution of healthy and unhealthy individuals within the buy-out program. In this regard, the Maine program differs from other buy-out programs such as those in New York and Minnesota where cost effectiveness is measured against expected use of health services, and those targeted to particular illness categories, such as AIDS patients (See description, Chapter IV).

Through the federal demonstration authority, Maine is receiving federal matching funds for coverage of children, up to age eighteen enrolled in this program. (The coverage of adults is a state general fund expense.) Since the program opened in October 1990, over 10,500 individuals have been enrolled, with a ratio of about two adults to every child.[3] At the current time, the continued enrollment of adults is in serious jeopardy due to a state fiscal crisis, brought about by a substantial slowing of the economy in the Northeast.

In summary, these demonstrations offer new flexibility to states in configuring coverage arrangements for the poor through options that are not now generally available under Medicaid. They may, however, foreshadow the direction of Medicaid nationally. It is too early to evaluate the feasibility or success of the new models being tried. Ease of administration and uniformity of program operations are being traded for flexibility in eligibility and cost-sharing with recipients and employers. These demonstrations will test the cost impact of these new options, whether employers can be persuaded to participate, and their administrative feasibility.

## *State-Funded Medicaid Expansions*

For many years, some states have used Medicaid program administrative mechanisms for state-only funded medical assistance programs. Usually in association with state general assistance programs, these states have offered entitlement to a range of medical services to indigent populations not eligible for Medicaid. Most of these programs limit benefits more narrowly than those available through the Medicaid program, sometimes covering just

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[3]Maine has adopted all optional as well as mandatory Medicaid eligibility categories, so many children who would otherwise be eligible for the Maine Health Plan are enrolled in the Medicaid program.

outpatient services, or perhaps a limited number of hospital days. Among the states that have had state-only Medicaid programs for their general assistance populations are: Maryland, Massachusetts, Michigan, Missouri, New York, Oregon, and Pennsylvania (Desonia and King, 1985).

Historically, these state-funded programs, because they lack either federal matching dollars or private sector contributions, have been very vulnerable to cuts during economic recessions. There is some evidence that in the current down-turn of the economy, states with state-funded general assistance programs are once again being forced to curtail funding. Nevertheless, the last few years have seen in some states a new wave of state-funded Medicaid expansions which expand eligibility to categories of individuals whose income is above Medicaid's eligibility level and who may be employed or the dependent of an employed person. Some of these programs have added cost-sharing features, not characteristic of earlier state-funded Medicaid expansions, as they have expanded into higher income eligibility groups. Although these programs piggy-back on Medicaid provider reimbursement systems and eligibility determination process, they are frequently publicized and marketed under names that deliberately disassociate them from Medicaid, with its stigma of welfare participation. These programs are targeted to one of three populations: children, pregnant women, and/or the disabled.

**Children's Programs**

Several states have placed a priority on assuring the broad availability of preventive and primary care services to children. The earliest of these programs is the **Minnesota Children's Health Plan** (CHP), operational since July of 1988. This program is available to children in the state with household incomes up to 185 percent of the federal poverty level, who are not otherwise eligible for Medicaid. Although eligibility was initially limited to children up to the age of nine, the state expanded the program to children through the age of seventeen, in January, 1991. Families who appear to be potentially eligible for Medicaid are required to apply and be rejected before they are accepted into the Children's Health Plan. Those with private insurance that is less comprehensive than CHP may enroll. For those with dual coverage (currently about 30 percent of enrollees), the state employs a "pay and chase" policy with regard to coordination of benefits. The program covers non-inpatient services, including dental care, vision care, eyeglasses, emergency room care, outpatient surgery and lab tests, in addition to routine office care and immunizations. It does not cover mental health or institutional care services.

Families pay $25 per child per year as an enrollment fee up to a maximum of $100. There are no copayments or deductibles for services. Families receive care through any provider enrolled in the Minnesota Medicaid program, and these providers are reimbursed at Medicaid rates, through claims submitted to the Medicaid agency.

CHP has been coordinated with Minnesota's Services for Children with Handicaps (SCH) program, allowing children with dual eligibility to enroll in both programs through a single

application process. Dually eligible children get additional benefits through this double enrollment - services related to their handicap (including up to $15,000 for inpatient care) through SCH, and well-child and preventive services through CHP.

As of January 1991, the program had enrolled a cumulative total of 21,000 children, with an average daily census of about 13,500. The median income from employment for enrolled families in the second year of the program was $16,640 (around 133 percent of the federal poverty level). Ninety-five percent of the households have at least one working parent; in 46 percent of the homes, both parents are employed. The average cost to the state per enrolled child in 1990 was $180. Approximately $10 million was appropriated for this program for the 1990 - 1991 biennium.

Program satisfaction among participants seems to be high. The services most frequently received by enrolled children have been physician and dental services, prescription medications, and hospital outpatient services.

At least two other states are in the process of implementing Medicaid "buy-in" programs targeted to children. **Vermont** initiated a program in July of 1989, marketed as the **Dr. Dinosaur Program**, which extends eligibility to children under age seven to 225 percent of the poverty line and pregnant women with incomes to 200 percent of the poverty line. Those enrolled in the program pay no premiums and pay copayments on office visits of from $1 to $3, based on income. Services, reimbursement and administration are identical to those under the state Medicaid program.

Vermont has for many years permitted a short mail-in application for Medicaid, with no face-to-face interview required. Assets tests have now been waived for both Medicaid and the Dr. Dinosaur Program, making application very simple.

In the first year of the program, due to little publicity, enrollment was low. After some major marketing efforts, the program has expanded to 1,200 children and 38 pregnant women. An enrollment of 2,300 is targeted for July, 1991.

**Colorado** has authorized a similar program, scheduled to begin operations in 1991. Children below the age of nine, in households below 150 percent of poverty will be eligible. The program will cover non-hospital and non-institutional services. Colorado's program has developed a unique funding formula. $650,000 is to come from a "disproportionate share" adjustment to two hospitals in the state that receive public funds for charity care (University Hospital and Denver General). The legislative authorization calls for a match of at least 1:1 by private donations in order for the program to become operational. Colorado is the only state to expand eligibility to children using, in part, private dollars, without first taking the Medicaid optional categories and obtaining the available federal match.

## Pre-natal Care Programs

Many states, concerned about rising rates of low birth weight babies and stagnant rates of infant mortality, have focussed efforts on assuring early and appropriate prenatal care services. In the past few years, these efforts have been significantly bolstered by new options available through Medicaid, and some initially state-funded initiatives have been absorbed into the Medicaid program. As of July 1990, twenty-four states have adopted Medicaid eligibility for pregnant women above the mandatory 133 percent level. These higher eligibility levels range from 140 percent of poverty to 185 percent. In addition, forty-six states had dropped assets tests and twenty-eight adopted presumptive eligibility (NGA, 1990). A few states have expanded coverage of pregnant women even further, using state dollars. California, Massachusetts and Vermont are covering pregnant women to 200 percent of poverty, and Hawaii covers all uninsured to 300 percent (see description of Hawaii's SHIP Program, Chapter VIII).

In addition to more encompassing eligibility guidelines, Medicaid has expanded the range of service options for pregnant women. Case management, risk assessment, nutritional counseling, health education, psychosocial counseling, home visits and transportation are enhanced prenatal care services that have been adopted in part or in full, by thirty-six states (NGA, 1990). Again, in some instances, states have supplemented their own expanded programs with similar benefits. California, for example, has added home visits to its Comprehensive Perinatal Services Program.

An area where states have taken substantial initiative is in developing outreach programs. Many states are concerned that women who are currently eligible for Medicaid services are not enrolled in a timely fashion or do not seek out early prenatal care. Some of the new programs have placed a major focus on making information about program eligibility widely available, and encouraging early entry into prenatal care. Using multi-media campaigns including posters, brochures, television and radio, several states have launched mass educational efforts that emphasize the need for early prenatal care and the availability of coverage.

An early and successful prototype outreach effort is Utah's **Baby Your Baby** program. The Utah Department of Health received support from network television, Blue Cross and Blue Shield of Utah, the March of Dimes, and the Utah Medical Association Foundation to develop a media campaign that included television and radio spots, print advertising, posters and print support material. Women, once enrolled, receive an attractive and informative mother/child health record book which encourages them to record information related to their children's health and health care services and five newborn newsletters featuring developmental information tailored to the current age of each child, up to the first birthday.

The response to the program has been very positive, with applications climbing to close to 300 per month, in the first year of the program, following television and other media promotion. Although it is too early to fully evaluate the impact of the program on birth

outcomes, program administrators are pleased with what they believe is a trend toward earlier commencement of prenatal care.

Other states that have launched similar efforts under such names as "Healthy Beginnings" or "Healthy Baby" include Alabama, Alaska, Idaho, Colorado, Iowa, New Mexico and North Carolina.

### Programs for the Disabled

Two states, **Wisconsin** and **Massachusetts**, have enacted programs that extend medical assistance eligibility to disabled persons who are ineligible for Medicaid, due to earnings or income. Both these programs provide coverage on a sliding fee scale, with no upper income limit, and both offer two options - a full, comprehensive plan for the uninsured disabled, and a supplemental package for those who already have comprehensive insurance. The supplemental package offers services frequently needed by the disabled and often excluded from insurance plans, such as long-term physical and occupational therapy, speech and hearing services, medical supplies and equipment, personal care services and (in the case of Massachusetts) alternatives to institutional care such as independent living center services, private duty nursing and home health aides. In both programs, services are obtained through Medicaid participating providers who are reimbursed at Medicaid rates.

The Wisconsin program is a pilot in Milwaukee County which runs from January 1990 until June 1991. Eligibility is limited to those over 18 years of age. The full coverage package is offered on a sliding scale with a minimum monthly premium of $8 and a maximum of $200. The supplemental package cost is a flat $75 per month.

The Massachusetts program, one of its "**CommonHealth**" initiatives enacted in 1988 as part of its universal coverage plan, offers coverage to both disabled adults and children. The premiums for both the comprehensive plan and the supplemental plan are on income-based sliding scales, ranging from no premium for those below 200 percent of poverty to 10 percent of adjusted annual income for those with adjusted incomes above $75,000.

The program had 2,500 individuals enrolled as of January, 1991; 1,600 adults and the balance, children. The program's appropriation for the current fiscal year is $14,223,000.

## *Summary and Conclusion*

Over the past several years, states have significantly expanded Medicaid eligibility (often under the prodding of federal mandates) and enriched services for certain categories of the medically indigent, taking advantage of partially federally funded option for expanding access. Some states have built upon this foundation to expand services to new categories of the poor, usually with marginally higher incomes than federal standards allow. These Medicaid options and state buy-in programs offer a cost-effective, if traditional means of responding to the needs of the poorest of the uninsured. They are a particularly effective

way to target such vulnerable populations as children and pregnant women, or to make specialized services available to high needs groups, like the disabled. Although more expansive, the programs can suffer from many of the same limitations as traditional Medicaid: poor provider participation levels, categorical and rigid eligibility criteria and reinforcement of the public/private divide in the health delivery system.

The Medicaid demonstrations authorized by HCFA, however, are experimenting with fairly radical departures from Medicaid traditions. Whether by using private sector insurers and administrators, coordinating with work place benefits, or enrolling higher income persons at cost into the same plan as the Medicaid eligibles, these demonstrations are blurring the lines that separate public coverage programs from private. If successful, they may pave the way for new, more generalized flexibility within Medicaid and a new generation of public/private collaborations to meet the challenges of medical indigence.

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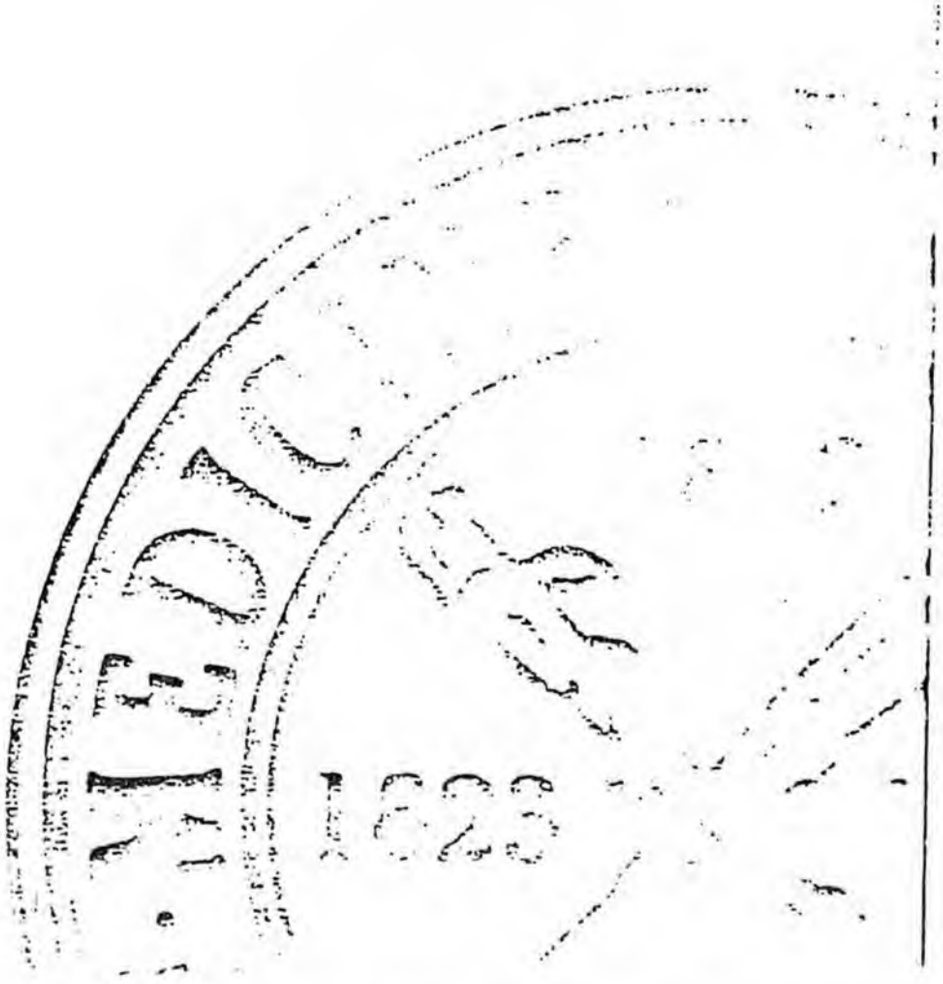
## SOUNDING BOARD

# COVERAGE OF THE UNINSURED AND UNDERINSURED

## A Proposal for School Enrollment–Based Family Health Insurance



## SOUNDING BOARD

# COVERAGE OF THE UNINSURED AND UNDERINSURED

## A Proposal for School Enrollment–Based Family Health Insurance

TRADITIONALLY, Americans have obtained individual and family health insurance coverage in one of three ways. Some have been covered by public programs (Medicaid for the very poor, Medicare for the elderly), and some have paid directly for policies, but by far the largest number of people have obtained health coverage in the form of group insurance provided through their employers. Insurance programs for members of large groups have had the lowest prices. In most cases, however, low prices have not been extended to small employee groups or to individuals. This aspect of health insurance structure has had adverse financial effects on industry, government, and health care providers and has compromised access to health care for many nearly poor, low- and moderate-income Americans who are not members of sizable groups.

In recent years, a large and growing percentage of the population has had inadequate health insurance coverage or none at all. A number of factors have contributed to this problem. The American economy is changing from being a system dominated by industry to one dominated by service, with a commensurate rise in the number of small businesses and the use of part-time labor. With respect to health insurance coverage, there is an inverse relation between group size and premium level,[1] because large groups provide the opportunity to reduce administrative expenses and distribute risk more widely. As a consequence, small businesses have found it difficult to obtain the favorable group rates enjoyed by larger enterprises, and many workers, particularly those working for a minimum wage or part time, receive no health insurance benefits at all. Among firms with fewer than 25 employees, up to 60 percent offer no health insurance to their workers.[2] When the employer elects to make available a health insurance program without subsidy, many employees may find the premium unaffordable. Even when employers provide individual health insurance for their workers at no cost, the employee may be unable to bear the high cost of supplemental family coverage. And for people whose employers do not provide insurance, the premiums associated with individual policies are often out of reach. Even so, 7 million of the 24 million workers who lack access to group health insurance buy the more expensive private coverage.[3]

Other aspects of the nation's changing economic structure have compounded the problem of access to health insurance. First, the number of low-income and poor Americans has grown. Between 1978 and 1983, the number of people living below the federal poverty level increased by approximately 50 percent.[4] Second, people who must pay for their own health insurance have found the costs increasingly high. Premiums rose almost 40 percent in 1981, and another 30 percent in 1982.[5] Finally, states have imposed more stringent eligibility requirements for Medicaid, reducing the percentage of persons who are covered by that program. Between 1975 and 1986, the proportion of the population below the poverty level that was covered by Medicaid declined by one third.[6] In consequence, the population of the uninsured and underinsured has grown, and the gap between them and persons adequately covered under public and private programs has widened.[7,8] In 1982, Medicaid reached less than half the people under the federal poverty level in 36 states, and in 22 of those states, it reached less than a third.[9]

The economic and social consequences of poor access to health insurance are considerable. People unable to qualify for Medicaid or to afford insurance often go without care until their health deteriorates, and as a result, the care they need is more costly.[10] When charges for these services remain unpaid, providers pass them along as a "sick tax" to public and private payers. This cost shifting has become a major problem for taxpayers, as well as for other payers and providers of health care.

### WHO ARE THE INADEQUATELY INSURED?

Here are some statistics relating to Americans with inadequate coverage. First, as many as 65 million Americans, more than 30 percent of the population under 65, have inadequate health insurance protection against large medical bills.[11] Of these, about 35 million, 17.5 percent of the population under 65, are without private or public health insurance coverage at least part of the year.[12,13] Up to 30 million more are underinsured for any serious illness.[2,11]

Second, adequate insurance coverage is strongly related to, but not solely dependent on, income level. One third of the uninsured population have incomes

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above 200 percent of the poverty level, whereas 35 to 40 percent are below the poverty line.[2]

Third, most uninsured adults work. In 1986, 17 million workers, representing about one sixth of the U.S. labor force, were uninsured.[3] More than two thirds of those who have no health insurance coverage live in homes where the head of the household works full time and year round.[13]

Fourth, the number of uninsured Americans is rapidly increasing. The uninsured population rose one third between 1977 and 1984, from approximately 26 million to 35 million.[13]

Furthermore, because employers typically cover workers rather than families, children as a group are disproportionately uninsured. Nearly one American child in five has no coverage, and one third of the uninsured (12 million) are children.[13-15] The chance of being uninsured is 37 percent higher for a child than for an adult. More than a third of all uninsured children (4.1 million) live with a parent or guardian who is insured.[13]

In addition, a lack of insurance coverage translates directly to a lack of health care. Uninsured persons use medical care less often than do insured people, and they are more likely than the insured to be in poorer health.[16,17] In addition, uninsured Americans spend one-third more days per year in bed because of illness than do the insured.[18]

Finally, lack of insurance coverage constitutes a serious financial burden for insurers, providers, and taxpayers. Health insurers, providers, and taxpayers absorb the enormous costs incurred by people who need care but who have neither insurance nor the personal resources to pay. For example, a study of Florida hospital charges in 1985 and 1986 revealed that 72 percent of an estimated $283 million in unresolved hospital care bills was generated by patients under 65 with no health insurance coverage. An additional 16 percent of the unresolved amount was attributable to patients under 65 with inadequate coverage.[19,20]

## Plans under Consideration

Policy makers and health planners have become increasingly sensitive to the plight of the uninsured and the immense costs of catastrophic health conditions. In recent years, a number of state and federal programs have been proposed or implemented that seek to ensure access to health insurance for more Americans.[2,12,21-24]

It is questionable whether the plans proposed to date — e.g., those requiring all small businesses to carry insurance for their employees,[23,25] the establishment of state-sponsored high-risk pools,[26] multiple-employer trust funds,[12] or tax-exempt bonding mechanisms[27] — will address the health insurance crisis in a meaningful way. At best, most of these proposals focus on subsets of the problem. It is important to recognize that the inadequately insured population comprises many discrete subgroups with a variety of constraints on access.[28]

There is no panacea to this multidimensional problem, but alternative strategies can be mounted that redefine groups so as to extend coverage to large segments of the uninsured or underinsured populations. One such alternative strategy is described here.

## An Alternative: Family Health Insurance Based on School Enrollment

Most American children attend public schools. Approximately 23 million, or two thirds, of the uninsured are children of school age and their young parents.[13,29] To enhance access to health care for children and their family members, state school systems could be used as a grouping mechanism for negotiating comprehensive group health insurance policies. Coverage could be offered to all families with children enrolled in public school. Policies could be designed to accommodate either the individual child or the entire family. Such flexibility would be ideally suited to the needs of parents who receive individual coverage as a fringe benefit of employment but who must pay a relatively large premium for supplemental family coverage. This arrangement is identical to current employment-based insurance structures, except that schoolchildren become the "employees," qualifying both themselves and their family members for coverage. A health insurance program based on school enrollment could be structured to target three groups: the uninsured, the underinsured, and those for whom the program would represent an economically competitive choice. Though the benefit package would be the same for all participants, the enticement for each group might be different. A reasonably priced comprehensive health insurance program would afford access to coverage for the uninsured, better coverage for the underinsured, and a better buy for the economically secure. Indeed, for families in which the wage earner already receives employment-based coverage, the option of coverage for the child only through school-based insurance might be a low-cost alternative to the purchase of employment-based coverage for the family.

In examining this proposal, a number of issues must be considered, but two — adverse selection and cost — are of particular importance. Adverse selection refers to the possibility that the resulting group would be characterized by lower health status and hence by potentially higher rates of insurance use. There is no empirical evidence for this argument; on the contrary, some characteristics of a school enrollment–based group suggest favorable selection. For rating purposes, we assume that the group will be defined on a statewide basis. In addition to being large, the group would be disproportionately composed of persons between the ages of 5 and 50 — those with the lowest rates of insurance use and health care expenditure in

the nation."[31] The group would not include the population eligible for Medicaid, which is assumed to be characterized by negative health status due to extreme poverty. Nor would the proposed group include many participants from the older, pre-Medicare population, because such persons are unlikely to have school-aged children. Finally, insurers concerned about the high rate of poor and nearly poor clients among the uninsured should be reassured by the potential for heavy participation from the nonpoor — the underinsured and those who would avail themselves of the buying power of a group so large.

The cost issue is also of central importance. Clearly, a program to provide coverage for an uninsured population cannot be created without cost. However, this proposal suggests an initiative that will enhance private group insurance coverage. That is, given the evidence that large group size can affect the cost of health insurance positively, we assume that premiums could be established at a level that would make this an attractive business opportunity for private insurance carriers. Indeed, substantial evidence affirms that insurers already find school enrollment–based groups actuarially attractive. Some insurers already market gap-filling hospitalization and accident coverage to public school children and standard health coverage to college students.

Despite the potential viability of the proposal, premiums are still likely to be beyond the reach of some lower-income families. To ensure the affordability of basic, adequate coverage for all program participants, states could subsidize insurance premiums on a sliding scale based on income, just as they currently subsidize school lunch programs. In addition, the experience that most school districts already have in administering health insurance programs for their faculty members and other employees would equip the school systems to administer the proposed plan skillfully.

Given the potential size of a statewide group comprising all public school children and their families, it should be possible to design an insurance benefit and premium package that could adequately address some of the difficulties inherent in employment-based health insurance programs. For example, the small employer could easily "buy in" to a school-based program for employees with school-aged children. Furthermore, moving the insurance company's point of contact from the employer to the school system enhances the "portability" of coverage for the family. Under the traditional plan, employees wishing to change jobs often risk disrupting a family member's coverage in the process, especially when the family member has a preexisting illness.

Benefit packages could be designed to meet the comprehensive health needs of schoolchildren. Appropriate benefits for child health and developmental supervision, currently mandated in only one state (Florida), could be part of the design. Special health services provided by the school for physically and educationally handicapped children and not now covered by private health insurance — e.g., physical, occupational, and speech therapies — could be included. Because many school systems already provide a range of health-related services for handicapped children, insurance benefit packages that recognized those services might offset some of the related costs and the associated tax burden.

The social benefits of such a program might be considerable. With access to better health care, including primary and preventive services, children and their parents might become more resistant to illness and lose fewer days from school or work. Children with a more positive health status tend to perform better in school. A less obvious but equally important point is that families that depended on their child's enrollment to maintain their own health insurance would not readily permit the child to drop out of school and risk losing the "fringe benefit" of family health insurance. As with insurance in the workplace, access to health benefits would provide an incentive for staying in school, and thus might contribute to a valuable framework of family responsibility. Finally, with a larger proportion of the population insured for health care, the burden of the sick tax would be reduced dramatically.

The concept of family health insurance based on school enrollment constitutes a private-sector effort to solve an important problem of public policy. Benefit packages and actuarial assessments developed under state supervision would form the basis for bids from private carriers. The mainstream community of health care providers would supply health care. The cost of subsidies, where necessary, could be offset by a reduction in the requirement for publicly supported programs of direct health care delivery. For example, county public health departments often receive state funding to operate public clinics, which are constituted to provide alternative access to health care for the uninsured. To the extent that the proposed program diminished the uninsured population, funding for such clinics could be diverted to premium subsidies. Furthermore, this type of insurance programming might receive the support of industry, which has expressed dismay at the cost of employee health care and is pressing for a redesign of the health delivery system.[32]

The structure of current insurance programs has precluded access to appropriate health insurance coverage for up to one third of all Americans under the age of 65. As Butler et al.[33] have pointed out, this problem "stems primarily from the American system of employer-provided health insurance." Although no single approach will solve all the ills of the insurance crisis, the creation of statewide groups using the school system as the grouping mechanism could make

important progress toward the provision of coverage to uninsured or underinsured people. Such a program, though not providing universal coverage, might relieve many of the complex financial and social problems attendant on the current distribution of health insurance coverage.

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# School-based Approaches

Child-only groups may be an affordable private market option for the substantial number of uninsured, low-income children without employment-based coverage available. One promising child-only coverage approach would use school-based groups. The CPS data show that the vast majority of children under eight years old who could substantially benefit from the new HIEITC are also eligible for Medicaid. The population of children remaining is primarily school-aged. This suggests that school-based strategies might be an effective and efficient approach to harnessing the HIEITC to cover currently uninsured children. The pooling of college students through university enrollment is already a relatively common practice; this might serve as a model for new initiatives (for younger children) that can realize the administrative efficiencies of large groups.

One pilot project demonstrating the feasibility of this approach is already underway: the Florida Healthy Kids Corporation (HKC) is a non-profit organization established by the State to demonstrate the concept of using school systems to group children for the purpose of insurance. The program plans to enroll uninsured children from the Volusia County school district (which contains 52 schools) beginning in

late August 1991. As a result of this program, it is expected that 10,000 of the estimated 17,000 uninsured children in the county will gain coverage. Because cost is often a deterrent to access, the project is subsidizing the participation of some uninsured children with a three-year demonstration project funded by both the state and the federal government through a Medicaid demonstration project, which includes a Medicaid waiver. Three other counties may eventually take part in the demonstration, pending funding.

HKC solicited and received proposals from HMOs, Blue Cross/Blue Shield, and commercial carriers to administer and underwrite the project. Upon evaluation of these proposals, a local staff-model HMO, Florida Health Care Plan, was chosen to join the project. HKC is currently developing billing and enrollment procedures with a state-wide vendor in order to facilitate expansion of the program when it becomes feasible to do so.

The plan will offer two benefit products: a primary care package and a comprehensive services package. The primary care package is intended to meet the preventive health needs of school children, and includes well-care check-ups, immunizations, and health screenings. The comprehensive coverage will include specialist physician services, inpatient and outpatient hospital care, pharmacy, diagnostic testing, and other benefits. The RFP's estimated premium for the primary care package is $11/month and $50 per month for the comprehensive package, for a total of $61 per month for both. Florida Health Care Plan's proposed premium for both packages is $59 per month. (The two dollar difference is due to the fact that the HMO will not be responsible for billing and enrollment.)

Criteria for eligibility for the School Enrollment-Based Health Insurance Program include: full-time enrollment in grade(s) K-12, under age 20; and uninsured for at least the previous six months. Pre-school siblings or dependents of the subscriber will be eligible, but only for the primary care package of benefits.

Premiums will be subsidized based on family income. Children whose family incomes are below 130 percent of the federal poverty level will receive a 100 percent premium subsidy and children whose family incomes are between 130 and 185 percent of poverty will receive a 72 percent subsidy. These poverty level thresholds are the same as those for the school lunch program, and thus avoid the necessity of screening children as to their eligibility for a subsidy. Subsidized enrollees must subscribe to both benefit packages. Children not eligible for a subsidy may purchase the primary care package only or both the primary and comprehensive packages together.

Support of the PTA and medical societies has aided the development of the program in Volusia County. Program development and actuarial estimates have also been supported by the Robert Wood Johnson Foundation.

The Robert Wood Johnson Foundation is also funding a pilot insurance project in Arkansas that hopes to offer a viable insurance plan by 1992 using school districts rather than employers as the basis for an insurance pool. Arkansas officials anticipate using a private carrier to underwrite the initiative.