Iowa Healthy Kids Program Study Report

February 1997

Presented to
The Honorable Terry E. Branstad
Members of the Iowa General Assembly

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

TO: Senate and House Commerce Committee Members
Senate and House Human Resources Committee Members
Governor Branstad

On behalf of the Healthy Kids Task Force, I am pleased to forward to you the Iowa Healthy Kids Program Study Report.

Pursuant to Senate File 2442, the General Assembly requested the Insurance Division to conduct a study for the purposes of determining how to develop and implement a program for increasing access to health care services for uninsured children. As part of this study process, I appointed a 16-member Task Force with representatives of various groups interested in children's health issues. The Task Force met over a four-month period and studied various programs which have been implemented in other states as well as programs currently existing in Iowa which serve children's health care needs. The Task Force was provided with technical assistance by State Public Policy Group, a consulting organization with extensive experience providing technical assistance in the study of public policy issues in Iowa.

The Task Force Report outlines a wide range of programs designed to promote coverage of health care needs of children. Particularly noteworthy are programs which have been established in the states of New Hampshire and Florida. Both states have enacted legislation which establishes private non-profit entities to promote the availability of private health insurance offered on a group basis through the public school system. Each state has taken a different approach in its program funding: Florida relies heavily on public dollars, and New Hampshire relies almost exclusively on private funding streams. More detail about those state programs is contained within this Report.

The Report provides four recommendations for your consideration:

1. a state seed funded model to establish a program similar to New Hampshire's,
2. a state subsidized model to establish a program similar to Florida's,
3. a state subsidy to expand the current Caring Program for Children, and
4. an expansion of the current Iowa Medicaid program.

During the course of this study, the Division assembled an impressive amount of background information and technical data to help in your deliberations. I have designated Jo Oldson to facilitate your use of that material as the legislature further examines these important issues. Please feel free to contact either me or Jo if you should have any questions.

Sincerely,

Terri M. Vaughan

Terri. M. Vaughan
Commissioner of Insurance

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EXECUTIVE SUMMARY

Health care coverage enables children to obtain medical care. Children without health insurance are less likely to have routine doctor visits, seek care for injuries, or have a regular source of medical care. Their families are more likely to take them to the emergency room rather than a primary health care provider. Children without health care coverage are also less likely to be immunized -- an important process in preventing childhood illnesses. In addition, children without routine health care can be prone to perform poorly in school, while parents confront increased absenteeism at work to attend to their children's needs.

In 1996, the Iowa General Assembly enacted SF 2442. A portion of this legislation authorized the Iowa Insurance Division of the Department of Commerce to study all aspects of implementing a Healthy Kids Program, a health insurance program for children. Because thousands of Iowa children do not receive adequate health care coverage, the creation of the Iowa Healthy Kids Program Study was recognized as a way to identify solutions to address the unmet health care needs of Iowa children.

The Iowa Healthy Kids Program Study combines several elements from different perspectives to provide information to the Governor and the Iowa General Assembly. This Study is designed to offer recommendations that will aid in making important policy decisions affecting children's health care coverage in the future. The Study consists of four major components:

* Iowa Healthy Kids Program Study Task Force,
* Research,
* Public information and outreach, and
* Actuarial analysis.

The Iowa Healthy Kids Program Study Task Force was appointed by Terri Vaughan, Iowa Insurance Commissioner. The Task Force provided guidance through all phases of the study and developed and made the final recommendations. Iowa-based research and research that examined other state initiatives was critical to the development of the proposed recommendations. An outreach plan was implemented during the early stages of the study to gather additional information and opinions from Iowa stakeholders. A public information effort was undertaken to make Iowans aware of the Healthy Kids Study. Finally, the actuarial analysis was critical to determine the financial feasibility of the proposed options.

The report addresses federal government and private foundation activities as they relate to children's health care coverage. Pilot project sites and potential program funding sources are also suggested.

None of these recommendations should be viewed as a total fix to the health care coverage problem for Iowa children. All recommendations should be viewed as incremental steps. The report provides three proposed recommendations, outlining models that may be considered for expanding existing health care coverage for Iowa

children. The models provide an opportunity for policy makers to implement individually or to blend the recommendations for an Iowa Healthy Kids program. One recommendation proposes the establishment of a not-for-profit organization, initially seeded with state funds, to provide health insurance for children through private insurance carriers. A second recommendation provides for a state subsidy to buy down premiums for participating families based on a sliding-fee-scale. This recommendation offers two alternatives. One alternative provides for a state subsidy via a non-profit entity to buy down premiums for participating families based on a sliding fee scale. The second alternative expands the Caring Foundation for Children.

The final recommendation should be viewed as an add-on to the other recommendations. It offers an expansion of the current Medicaid program to include coverage for children ages 6 to 18 with family incomes up to 133 percent of the federal poverty level (fpl). This would bring Medicaid coverage into line with the current coverage for children one through five. It would allow Medicaid and an Iowa Healthy Kids Program to work in concert providing services to children within the school setting.

Children are Iowa's most valuable resource. Their good health ensures a bright future for this state. The State of Iowa should continue to move forward to implement its own initiative to promote the health and well-being of our children.

INTRODUCTION AND OVERVIEW

It is estimated that 9.5 million American children lack health care coverage or access to health care services. Percentages of uninsured persons vary widely among states, ranging from a low of less than 10 percent to a high of about 25 percent. Much of the variation relates to three factors:

- Differences in Medicaid eligibility levels among states;
- Availability of employment-based insurance coverage, affected by the type and size of businesses; and
- Local unemployment rates.

In Iowa, there is an ever-increasing number of children who are uninsured or underinsured. Research from different sources indicate the number of uninsured children in Iowa to be between 50,000 to more than 173,000. These statistics do not include underinsured children. It is estimated that approximately 30,000 Iowa children are living at or below the poverty level, and have not been determined eligible for public assistance. These children fall through the cracks of the health system and lack financial access to the most basic primary and preventive health care services. Although several programs such as the Caring Program for Children and Medicaid are available to provide health care services to lower income Iowans, many Iowa children still do not have access to basic primary health care services. It is also recognized that there are a number of Iowa children who move "in and out" of the Medicaid system as a result of fluctuations in family income and sometimes the intricacies of the federal Medicaid eligibility requirements.

The impact of inadequate health care coverage for children is far-reaching, adversely impacting society in a number of ways. Most significantly, those unable to afford health care coverage typically forego services until their health deteriorates. When they finally do seek health care services, these services are much more costly, are often conducted in the emergency room, and include complications that require hospitalization. If these individuals are unable to pay for the health care, providers are forced to cost shift to other payors. Finally, children with unmet health care needs do poorly in school and their parents face increased absenteeism from work to obtain services for their children or to care for ill children. Required immunizations, routine check-ups, and basic care is often unaccessible for these children, resulting in less healthy and less productive children and, in the long-term, adults.

The lack of private health care coverage is expected to continue to increase and creates a greater impetus to solve this problem. A key trend noted by the Urban Institute is for employers to drop health insurance benefits for employees or their families earning below 200 percent of the federal poverty level. It is reasonable to expect that number to continue to increase in the future.

Recent changes in federal public policy, such as the Welfare Reform legislation, will have an immediate, as well as cumulative impact on Iowa's low-income children and their families. Changes in eligibility for Supplemental Security Income (SSI) for children will decrease cash assistance available to families with children with disabilities. The Congressional Budget Office projects that 22 percent of children who are now eligible or would be eligible under current guidelines will no longer be eligible for SSI. The Congressional Budget Office (CBO) estimates that the impact on Medicaid will be negligible as children who lose SSI benefits will most likely still qualify for Medicaid under another coverage group. Iowa's current caseload for children is more than 7,000, which would mean that up to 1,500 Iowa children could be removed or denied continued SSI benefits.

The five year lifetime limit on the Family Investment Program (Iowa's AFDC), sanctions families unable to meet the work requirements to remain eligible for the program. Across-the-board cuts in food stamps and other entitlement programs could increase the financial strain for low income families, creating an even greater need for covering preventive health services.

At the same time, devolution creates an environment for communities to become more supportive and involved in public policy, decision making and the provision of health and human services at the local level. This increased community involvement could serve as the catalyst to support and sustain initiatives to increase the number of poor children who have health care coverage.

In 1993, a concerned Iowan seeking more affordable health care coverage for Iowa children approached legislators and Governor Branstad to discuss this problem and develop possible solutions. From these meetings the Iowa Healthy Kids Coalition was established. The Coalition brought together legislators, health care providers, educators, human services providers, insurance executives, and others to meet on a regular basis to study this problem.

In November 1995, the Coalition sponsored the Iowa Healthy Kids Conference featuring representatives from the Florida Healthy Kids Program. The Florida Healthy Kids Program offers health care coverage for uninsured children based on their eligibility in the national school lunch program subsidized through a state appropriation. The school enrollment-based insurance plan offers coverage on a sliding fee premium based on family income levels and size. Conference participants also used this time to explore solutions to Iowa's problem and as a result of the conference, established on-going working subcommittees to continue to address the issues.

During the 1996 Iowa General Assembly, SF 2442 was enacted. A portion of this legislation authorized the Iowa Insurance Division of the Department of Commerce to study all aspects of implementing an Iowa Healthy Kids Program. With the passage and signing into law by Governor Branstad, it was recognized that increasing children's access to health care services could improve children's health and reduce the incidence and costs of childhood illnesses and disabilities in the state. Because thousands of Iowa children do not receive adequate health care coverage, the creation of the Iowa Healthy Kids Program Study was determined as a means to identify solutions to address unmet health care coverage needs in the state.

STRUCTURE OF STUDY

The Iowa Healthy Kids Program Study is structured to solicit a variety of perspectives to provide the most beneficial outcomes. This approach integrated the direction of the Task Force with research and a public information and outreach strategy. These activities also included a review by an actuary to provide cost analysis and a review of long-term funding for an Iowa Healthy Kids Program.

The study approach contains five components:

1.) Task Force
2.) Research
3.) Public Information and Outreach
4.) Actuarial Analysis
5.) Recommended Program Structures

Task Force

The Task Force developed the overall parameters of the study. Throughout the process, Task Force members directed the scope of the plan, the research activities, and the outreach process. As a result of that process, the Task Force developed recommendations based on the need to create an Iowa Healthy Kids initiative that recognizes the financial aspects that must be considered by policy makers.

Research

An important element of the Iowa Healthy Kids Program Study was research. Accurate Iowa statistics and experiences of other states are critical sources of information necessary to ensure the success of an Iowa Healthy Kids Program. In addition, a complete review of existing programs enabled the Task Force to identify opportunities for linkages. Research was conducted in four major areas:

- Iowa statistics,
- National statistics,
- Health insurance programs for children in other states, and
- Allied Iowa programs for possible coordination of efforts.

Public Information and Outreach

A primary element of the study was outreach to a larger group of concerned citizens. The Task Force determined that the public should have an opportunity to discuss their concerns and conducted focus group meetings that were held in four locations across the state. The structured meetings provided valuable information to the Task Force as they developed a list of recommendations for possible Iowa Healthy Kids Program structures.

Actuarial Analysis

While there has been much attention given to developing a Healthy Kids initiative over the last two years, not much attention was given to the cost and fiscal policy implications. Carl Harris, of Deloitte & Touche LLP, was retained to study the Iowa statistical data obtained and to determine the feasibility and cost analysis of the proposed program structures recommended by the Task Force.

Recommended Program Structures

In recommending alternative structures for health insurance programs for children, the Task Force benefited from the research, focus group meetings, and the actuarial analysis. The Task Force also reviewed the structures of health insurance programs for children offered in other states. Particular attention focused on the Healthy Kids Programs operating in Florida and New Hampshire.

TASK FORCE MEMBERS

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TASK FORCE EFFORT

The Iowa Healthy Kids Program Study was coordinated by a 16 member task force, appointed by Terri Vaughan, Iowa Insurance Commissioner. The Task Force was comprised of persons representing a variety of health, insurance, children's advocates, education, and human service disciplines. Jo Oldson, First Deputy Insurance Commissioner, served as the Task Force Chair.

The Iowa Healthy Kids Program Study Task Force developed a process to examine the issues and make recommendations in the time frame required by the General Assembly. Members of the Task Force focused on studying alternatives and developing options that would address the charge of the legislation. The group met four times between October 1996 and January 1997 and developed the following Mission Statement:

> *"To study and design program parameters for a feasible and coordinated comprehensive health care coverage program for uninsured and underinsured children."*

To better focus on the Mission Statement and outcomes to be included in the study within the limited time frame the Task Force agreed to the following Scope of Effort:

- ❑ Obtain valid Iowa statistics on populations to be served
- ❑ Identify barriers to health insurance for children
- ❑ Research other state's healthy kids programs
- ❑ Review existing related public or private programs
- ❑ Identify alternative program structures for meeting the needs of uninsured/underinsured kids, including the relationship of those alternative structures with existing programs
- ❑ Conduct actuarial review and cost analysis
- ❑ Determine interest of potential insurance carriers
- ❑ Conduct focus group meetings
- ❑ Direct public information effort
- ❑ Recommend feasible program parameters
- ❑ Identify pilot project sites

The Task Force implemented a work plan to accomplish its scope of effort by the January 1997 deadline. The Task Force focused its efforts on developing a practical set of recommendations for consideration by the Governor and the Iowa General Assembly. The recommendations were provided to give policy makers the opportunity to implement one or integrate the recommendations to create an Iowa Healthy Kids Program. The Task Force also recognized that detailing the specifics of a Healthy Kids program can best be determined when policy makers decide the model structure most appropriate for Iowa.

PUBLIC INFORMATION AND OUTREACH

In order for the Task Force to obtain input from a cross-section of Iowa citizens, four focus group meetings were held across the state. Invitations were sent to 900 targeted individuals, representing consumer groups, health care professionals, local, regional and state government representatives, insurance and business leaders, and educators. These individuals were identified by the Task Force as persons interested in providing Iowa children access to health care services. All members of the Iowa General Assembly also received invitations to attend the focus group sessions.

Approximately 80 people participated in the focus group meetings held in Des Moines, Ottumwa, Clinton, and Waterloo. The meetings lasted two hours and consisted of guided discussions to structured sets of questions developed around issues identified by the Task Force. The focus groups provided a fair, non-threatening structure for obtaining opinions on a variety of issues relating to the design and implementation of an Iowa Healthy Kids Program.

The selection of sites and specific audiences allowed information to be gathered that framed the issues from differing perspectives statewide. Both rural and urban considerations, as well as community-specific cultural or environmental conditions were important for the Task Force to understand. Task Force members attended the sessions to observe and hear first-hand the issues and concerns expressed by the participants.

There was a consensus among those participating in the focus groups that this problem will only intensify if it is not addressed immediately. The groups concurred that the State of Iowa should be a partner in any initiative developed to increase access to health care for Iowa children. It was agreed that if steps are not taken to address this health care crisis, Iowa will continue to have children who cannot succeed in school or life due to poor health.

The focus group findings were considered by the Task Force in its process to develop alternative Iowa Healthy Kids Program parameters and recommendations contained within this report. The public information and outreach process was included in this study to ensure the report addressed not only the issues identified by the Task Force, but also the issues and concerns faced by the families in Iowa.

The complete focus group script and the four meeting findings are included in the appendices of this report.

RESEARCH

IOWA STATISTICS

The first step in determining the scope of the program parameters was to obtain reliable Iowa statistics. The use of data from the Iowa State Access Plan, Iowa Kids Count Data Book, General Accounting Office, the Federal Bureau of Statistics, Health Systems Research Incorporated, as well as other data was utilized to obtain current and accurate Iowa statistics.

The data sources and estimates obtained all fell within the range of 50,000 to 173,420 uninsured children in the state of Iowa. The majority of the indicators fell within the range of 50,000 to 75,000 uninsured Iowa children. Carl Harris, the independent actuary retained to conduct the actuarial analysis, used the number of 82,447 uninsured children for his projections. The Task Force used this information, as well as national statistics provided by the actuary, to determine projected numbers and costs.

Listed below are Iowa and national statistics acquired for use by the Task Force.

- In September, 1996 there were 533,784 students enrolled in public schools in Iowa. Of those, 142,795, or 26 percent, were eligible for the *Free and Reduced Price Meals Program* through the Iowa Department of Education. 108,787 students were eligible to receive free meals and 34,008 qualified for reduced price meals. Of the 1,763 school units reporting, 136, or seven percent, do not have any students in this Section 11 Program. 80 percent of the program participants are located in the southern two tiers of Iowa counties.

- The *Iowa Legislative Service Bureau* in October 1995 estimated that between 51,000 to 75,000 children were uninsured.

- A July 1995 *General Accounting Office* report estimated that the number of Iowa children without health insurance in 1993 was 61,389 or eight percent of the general population. The same report recorded 65,398 on Medicaid (8.5%) and 534,200 (69.3%) with employer-based insurance.

- *The 1995 State-Level Data Book on Health Care Access and Financing* estimated the following:

There were 754,000 Iowans under the age of eighteen:

Type of Insurance	*Number*	*Percent*
Employer-based insurance	527,046	69.9%
Medicaid	99,528	13.2%
Other	76,154	10.0%
None	51,272	6.8%

There were 323,000 Iowans at or below 100 percent of poverty:

Type of Insurance	*Number*	*Percent*
Employer-based insurance	47,804	14.8%
Medicaid	138,890	43.0%
Other	60,724	18.8%
None	75,582	23.4%

There were 503,000 Iowans between 100 percent -199 percent of poverty:

Type of Insurance	*Number*	*Percent*
Employer-based insurance	265,584	52.8%
Medicaid	31,689	6.3%
Other	104,121	20.7%
None	101,606	20.2%

- The Federal Bureau of Statistics reported that in 1994 there were 82,000 Iowa children without health insurance, or 10.9 percent of all children. This is an increase of 22,000 children since 1987. Statistics for the years 1987 to 1994 are listed below:

Year	*Total Children Under 18*	*Medicaid Coverage*	*No Insurance*
1994	754,000	113,000 (15.0%)	82,000 (10.9%)
1993	777,000	108,000 (13.9%)	65,000 (8.3%)
1992	797,000	124,000 (15.6%)	70,000 (8.8%)
1991	754,000	113,000 (14.9%)	47,000 (6.2%)
1990	716,000	89,000 (12.5%)	39,000 (5.5%)
1989	767,000	79,000 (10.2%)	40,000 (5.2%)
1988	751,000	62,000 (8.3%)	50,000 (6.6%)
1987	853,000	113,000 (13.3%)	60,000 (7.1%)

- The American Hospital Association Health Statistics Group provided the following statistics for the State of Iowa for 1994:

Total Children	*Private Coverage*	*Employer - Other*	
753,871	604,564	473,542	131,021

Public Coverage		
Total	*Medicaid*	*No Health Insurance*
121,619	113,031	87,447

- *The 1995 Primary Care Access Plan* prepared by the Iowa Department of Public Health determined the medically indigent population in the state. The State of Iowa population was 2,776,755. Of the total, 20.6 percent or 572,012 were indigent or estimated to be without health insurance.

- *The 1993 Current Population Survey* estimated the number of uninsured persons in Iowa to be 259,559. The estimated number of children without health insurance is 65,000 children, or 25 percent.

- *Iowa Kids Count Data Book* (*1992 Urban Institute Survey*) found that 6.8 percent or 50,000 of Iowa children did not have health insurance in 1995.

- *Employee Benefits Research Institute* indicated that in 1992 the percentage of uninsured Iowans was 11.7 percent of the population or about 300,000 people. If 35 percent of the population are children, then in 1992 the estimate of uninsured children would be 75,000.

- The *Urban Institute* analysis merged *CPS* data for the three year period of 1990-1992. The report estimated that 20 percent, or 51,600, of Iowa's 258,000 uninsured were children.

- *Division of Health Policy Research and the American Academy of Pediatrics* offered the following statistics:

Number of Children Without Insurance by Income Level:

1990-1992:

All children in Iowa - 72,600 (8.0%)

100% of poverty	18,200 (17.0%)
185% of poverty	45,600 (13.7%)
More than 185%	27,100 (4.7%)

**source current population surveys 1991, 1992, and 1993*

This is an increase over 1989 data. Iowa was one of 21 states that saw the number of children without health insurance increase.

NATIONAL STATISTICS

- *1990 Health Systems Research Incorporated (HSRI)* reported that the 1989 Current Population Survey indicated that **nine percent** of the state's population under age 65, or 220,000 Iowans lacked health care coverage. *HSRI* indicated that **25 percent** of the uninsured population are children; which showed that in 1989 the number of uninsured children would have been 55,000.

- *Employee Benefits Research Institute (EBRI)* found that between 1988-1993 the percentage of children 18 and under with employment-based coverage fell **seven percent - from 60.6 percent to 53.6 percent**.

- *1994 General Accounting Office* analysis showed that there were:
  68.8 million children under 18 in the U.S.
  10.0 million (14.2%) had no health insurance.
  15.5 million (22.5%) were covered by Medicaid.
  43.3 million (65.6%) had some private insurance.

  - The percentage of children with private health insurance coverage reached the lowest level in eight years - **65.6 percent** .
  - Among children with a parent working full-time during the entire year, **25 percent** lacked private health insurance and nearly **12 percent** were uninsured.
  - **62 percent** of children covered by Medicaid had a working parent.
  - **50 percent** of the children covered by Medicaid did not receive AFDC or other public assistance.

- *Institute for Child Health Policy* predicts that uninsured children nationwide will increase from **8.4 million to 11.2 million** between 1990 and 1999.

- *U.S. Bureau of Census* found that in *1989*, **8.7 million children** had no public or private health insurance and in *1993*, there were **9.3 million** children without public or private health insurance. Nationally *from 1989 to 1993*, the percentage of children covered by employer-based health insurance decreased from **63.2 percent to 57.6 percent** and from *1989 to 1993*, the number of children enrolled in Medicaid increased by **54 percent, from 8.9 million to 13.8 million**.

Iowa data listed by county is included in the appendices.

STATE HEALTH INSURANCE PROGRAMS FOR CHILDREN

During the past several years, many state legislatures have enacted health care reform initiatives. Some of those initiatives have been targeted toward improving access to quality health care for children, either by expanding Medicaid eligibility or by creating separate insurance programs for children.

The Task Force examined the health benefit programs for children which exist in 30 states. The examination included a review of the corporate and administrative structure, benefit design, eligibility and enrollment criteria, and accounting systems of these various programs. The programs existing in these states fall into three categories:

1.) Public Programs
Financed fully by federal, state, or local government funds.

2.) Public/Private Partnership Programs
Funded through a mix of public, private, or philanthropic funding.

3.) Caring Programs for Children
Private programs administered by regional Blue Cross/Blue Shield plans.

Private Programs include those operated by Blue Cross/Blue Shield. Known as Caring Programs for Children, these programs are often administered by a non-profit entity on behalf of the plan. In 1995 Caring Programs for Children were operating in 23 states and serving 120,000 children in the United States. Some of the states are: Alabama, Georgia, Idaho, Iowa, Kansas, Louisiana, Mississippi, Missouri, North Carolina, Ohio, South Dakota, Utah, and Virginia. In Iowa, as of May 1996, the Caring Foundation has served 2,138 children.

Blue Cross/Blue Shield typically donates administrative services for operating the program. Children are issued a standard Blues identification card. The typical child enrollee lives at home with his/her family and attends school, are not eligible for Medicaid, and cannot afford private insurance. Caring programs are funded entirely with private dollars, except in Iowa, Kansas, and North Carolina, where the state contributes funds.

Public/Private Partnerships are funded through a combination of public and private dollars. These programs are found in the states of Colorado, Delaware, Florida, Michigan, Nebraska, New Hampshire, New York, and Utah. Colorado is jointly funded by state, corporations, and a university hospital center. Florida uses the public school systems as a mechanism for providing health insurance, funded by a combination of federal, state, and local funds supplemented by family premiums and foundation grants.

All these programs provide coverage for routine primary and preventive medical care (well-child visits, diagnostic testing, and immunizations). Other services commonly included in benefits packages are: hearing care, outpatient surgery, emergency care, and prescription drugs. Less commonly provided are: dental care, hospitalization, substance abuse treatment, and transportation.

About one-third of the programs are fee-for-service and one-third provide services in a managed care environment. Fifteen percent combine fee-for-service and managed care. Others have service/payment arrangements (preferred provider organization).

A brief synopsis of several state programs are listed below.

Arkansas
The program began a two year demonstration project subsidized totally by HUD, enrolling 641 rural children with Arkansas Blue Cross/Blue Shield, the insurer. The program, called *"Get Smart,"* is now funded by the Arkansas Industrial Development Commission.

The program covers 100% of check-ups, immunizations, and patient education brochures. The program is not intended to provide comprehensive coverage, but to bridge the gap for families that don't qualify for Medicaid and cannot afford insurance.

California
California Kids is funded by public and private support, aimed at insuring the 1.8 million California children whose parents cannot afford coverage, yet their incomes exceed Medicaid, and the 6,000 children who are enrolled directly in the program. California Kids program covers the primary and preventive care needs of its enrollees.

Seventy percent of the participants, whose annual household incomes are at or above 200 percent of poverty, are enrolled through the schools. To be eligible for the program you must be a California resident between the ages of two and 18. A minimum co-payment for office visits, prescription drugs, and dental visits is required.

Colorado
The Colorado Child Health Plan targets children below the age of 19 who live in rural counties. To be eligible for the program, the child must be ineligible for Medicaid and in a family with an income at or below 185 percent of the federal poverty level. In June 1994, 1,712 children were enrolled in the program, which began as the Child Health Plan Act of 1990. The program is funded through a combination of private donations, modest participant fees, and as part of the teaching allowance paid to The University of Colorado Hospital by Medicaid. The program is administered by the University's Health Sciences Center who has an agreement with Blue Cross/Blue Shield of Colorado. Other in-kind contributions have been made by a variety of corporate partners. Services are delivered through a managed care system with capitated payments to a network of providers. Specialty providers receive fee-for-service under the direction of the network. Capitated payments for physicians is $15.05 per member, per month. Total average cost per child is $124 per month.

Connecticut
In 1990 the General Assembly authorized a state subsidy to purchase health insurance for low income uninsured children. The program, called Healthy Steps, originally targeted school age children, then expanded to include preschoolers enrolled in Head Start. Participating families pay five dollars per month, per child or a maximum of $240 annually. The state subsidizes the insurance premiums with a $1 million appropriation from the state's uncompensated care pool. Premiums are $1,000 annually per child.

Florida
The program began in 1992 as a single county demonstration for the purpose of providing school-based health insurance coverage for uninsured children. The program has expanded to eight additional counties with a total enrollment of 24,225. The program offers a package of benefits through a capitated HMO arrangement to any uninsured child in school under the age of 18. Originally funded by a HCFA grant

for children below 100 percent of the fpl, enrollees pay a sliding-fee premium based on school lunch program status. The program is now funded primarily by state funds with local government paying a percentage in matching funds. The 1996 state appropriation was $16 million.

Hawaii
State Health Insurance Program (SHIP), created in 1989, subsidizes private health insurance coverage for medically uninsured residents with incomes up to 300 percent of the fpl. Persons with family income under the federal poverty level receive a full subsidy and others participate on a sliding fee scale, based on family size and income. Because Hawaii law requires employers to provide insurance coverage to most workers, the SHIP program targets unemployed, self-employed, and part-time workers and students.

Kansas
In July 1993, Kansas began to raise $653,114 in private funds to insure 464 children in a pilot project in Topeka. The program ended due to the inability to generate sufficient funding.

Massachusetts
Lawmakers voted in 1996 to subsidize health care coverage for 110,000 children in low-income working families using a 25 cent tobacco tax increase.

The legislature created the Health Care Access Fund in 1991 and required the Department of Medical Security to establish a program of preventive pediatric health care services for the benefit of dependent and adoptive children through the age of six. Called Healthy Kids, the program subsidizes insurance coverage for uninsured children. The program contracts with two insurers to manage the program. The state pays the full cost of premiums of children in families of incomes through 200 percent of fpl; those with income from 134 through 200 of fpl pay co-payments and deductibles. Families with incomes above 400 percent of fpl pay the full cost of premiums. The legislature appropriated $5 million in 1993, with revenues from cigarette taxes and from federal Medicaid funds. The program focuses on primary and preventive care.

Michigan
The state sponsored Child Health Insurance Program builds on the Caring Program to provide comprehensive Medicaid benefits to enrollees.

Minnesota
MinnesotaCare, adopted in 1992, contains numerous health care reform initiatives. It expands the 1987 legislation, Children's Health Plan, into a more comprehensive program. Under the MinnesotaCare program, children with family income up to 275 percent of the fpl are eligible to participate and pay premiums on a sliding-fee schedule. The program is state run and has close ties to the Medicaid program. The program emphasizes primary and preventive health. The original children's program began with a cigarette tax increase. The program now receives state general fund dollars and families pay $25 per child, per year.

New Hampshire
The New Hampshire Healthy Kids Program began in 1993 with a $240,000 state appropriation for program implementation. The program is open to school children ages 3 to 18 that are not Medicaid eligible. Marketed through 67 school districts, the annual program operating budget is $150,000 to $180,000. New Hampshire selected Blue Cross/Blue Shield as its insurance partner. Families self pay the premium, which is $60 per month, per child. The program enrolls currently 1,300 children with a goal of 3,500 participants, or 20 percent of the eligible population.

Initial program implementation focused on creating a children's health insurance program that is comprehensive and emphasizes preventive and primary care. The program began to find alternative (non-public) funding streams, created a premium structure, and selected Blue Cross/Blue Shield as its insurance partner, which agreed to cover the administrative, printing, and marketing expenses. Blue Cross also accepts all risk for the program.

In the first year, the program reduced the number of uninsured children by four percent, serving a total of 827 children. The program initiated dental coverage in its second year and also extended eligibility to infants and toddlers. It is a stop-gap program designed for working families. Records show that 98 percent of the people who leave the program move on to private insurance plans.

The New Hampshire program is currently exploring long-term funding options. They are identifying potential private partners and have initiated a fundraising campaign. The program's budget was $590,000 in fiscal year 1995 and $1.2 million in 1996.

The program realized that premium affordability is the key to participation. The current cost of participation is $60.50 per child, per month over the age of two; $77 for infants and toddlers. This includes the increase of $8.50 for dental coverage. The rate is guaranteed until February 28, 1997. There are co-payments for certain services, provide patients access to care through their primary care physician: preventive care is paid 100 percent; physician visits for illness, injury, or prescriptions require a $5 co-pay; and mental health visits, eyeglasses, and hearing aids require a $10 co-pay. There is increased cost-sharing if care is not accessed through their primary care provider.

The program offers the following coverage benefits: dental, immunizations, physician visits for illness or injury, prescriptions, eyeglasses, hearing aids, diagnostic tests, home health visits, mental health, outpatient surgery and anesthesia, qualified hospitalization, emergency room, and occupational, physical, and speech therapy.

In 1996 New Hampshire started a one county pilot project which uses a sliding-fee scale payment system.

The New Hampshire program is currently exploring long-term funding options. They are identifying potential private partners and have initiated a fundraising campaign. The program's budget was $590,000 in fiscal year 1995 and $1.2 million in 1996.

New York

The New York legislature created a child health insurance plan in 1990, called Child Health Plus. The program subsidizes private sector insurance premiums for eligible children. Administered by the Department of Health, the plan covers children through age 12 in families with incomes below 220 percent of the fpl. Higher income families may purchase unsubsidized coverage for uninsured or underinsured children. The state contracts with local insurers or health plans to market, underwrite, and provide primary, preventive health services to participants. Funding comes from New York's bad debt and charity care pool, in addition to participant premiums.

North Carolina

In July 1994 North Carolina legislation allowed public schools, through local boards of education to purchase group health insurance to cover students based on a plan that precludes individual risk selection. The law allows any insurance company or HMO to offer a low cost policy for school age children focusing on preventive and primary care services. Premiums are paid jointly by the board of education and student's family or anyone else on behalf of the student.

Pennsylvania

The Children's Health Insurance Program (CHIP) provides comprehensive benefits to more than 40,000 children. The program began in 1992 as part of the Children's Health Care Act of 1992. The child must be a resident of the state for at least 30 days and be between the ages of one and fifteen years. Families below 185 percent of the federal poverty level are provided free health insurance. Children under the age of six living in families with income between 185 percent and 235 percent are provided insurance subsidizes. CHIP is administered by a management team of the Secretaries of Health and Budget and the Insurance Commissioner. The program is financed by a two cent per pack cigarette tax.

Children receive health care services in a statewide managed care system and indemnity plan provided by five regional grantees. The program budget was $21 million in 1994. Single child monthly premiums are $64.13 in the unsubsidized program and $84.48 in the subsidized. CHIP pay 50 percent of the cost of the premiums for the subsidized group. A broad array of primary and preventive services are included in the benefits package, with a co-pay only for prescription drugs.

Vermont

Vermont's Dr. Dynasaur program began in 1989 as a state-funded health insurance program for uninsured children up to age six in families with income up to 225 percent of the federal poverty level and for pregnant women with family income up to 200 percent of the fpl. The program expanded in 1992 and converted all Medicaid enrollees into the program.

West Virginia
The West Virginia legislature adopted a measure in 1993 that allows non-profit organizations to offer loans or vouchers for insurance to encourage low and moderate income individuals to use earned income tax credits to buy health insurance for their children.

School Based Clinics
Other states including Connecticut, Texas, and Missouri have recently passed legislation expanding school based clinics as a way to enhance children's access to health care.

A summary of the state programs is highlighted below:

Types of coverage

- 17 programs are offering coverage through a managed care arrangement.
- 11 of these provide coverage solely through a managed care system.
- 9 programs are operating on a fee-for-service basis.
- 8 states have some other service delivery arrangement - usually preferred provider organizations.

Covered Services

- All programs cover physician visits, all but two specifically cover well-child visits.
- Nearly all provide coverage for immunizations - none require co-payments for this service.
- Other services covered by nearly all are: diagnostic tests, emergency care, and out-patient services.
- Two-thirds of the programs offer prescription drugs for a nominal co-pay.
- More than half the programs offer mental health services - often with caps or limits on the number of visits.
- Transportation and dental services are the least common services to be reimbursed.

Eligibility

- Majority of the programs target children.
- In five states, children's health insurance is part of a larger health care program.
- All target low income families.
- The lowest level of financial eligibility is at or below 100 percent of federal poverty level.
- The highest level is 300 percent of the federal poverty level (Hawaii).
- Five programs (Florida, Massachusetts, New Hampshire, New York, Wisconsin) permit family participation regardless of income; upper income families pay full premium cost.

Cost and Premiums

The average cost per child/per month for state programs range from $17 to $192. Programs vary as to whether parents are asked to contribute to the cost of the program. In Caring Programs, parents do not contribute any portion of the premium. In almost all public/private partnerships parents pay a portion of the premium. In public programs more than half of the states require parents to contribute to the premium on a sliding-fee scale.

Enrollment

The number of children enrolled in the program is related to the size of the population of the state, program's eligibility requirements, and the program outreach efforts. Enrollment is also related to the maturity of the program. Enrollees range from 31 to 98,500. Annual budgets range from $70,000 to $76.5 million.

Barriers

States face many challenges in instituting programs directed toward improving access to health care for children. Expanding Medicaid eligibility or creating a health care program for children does not guarantee access to care for the intended population, although managed care is a means of improving access for Medicaid recipients. A common challenge states face is finding creative ways to finance health programs while facing budget constraints. Other challenges presented to a health care program are those faced by the people the program is intended to benefit. Potential participants' lack of knowledge of the program's existence, difficulty in dealing with eligibility and application procedures, lack of transportation, and language and cultural barriers are issues which must be addressed for a program to work efficiently and effectively.

A listing of state-by-state health insurance programs for children is provided in the appendices section of this report. Also provided are charts reviewing health benefits covered and types of coverage offered by state programs.

COORDINATION WITH IOWA ALLIED PROGRAMS

To achieve the most efficient means of implementing an Iowa Healthy Kids Program, existing programs and organizations with similar purposes were identified and brought into the planning process. Presentations were made to the Task Force describing existing Iowa programs that provide health insurance coverage for children, including one on the Iowa Medicaid program and one on the Iowa Caring Program for Children. Task Force members felt it was important not to create a new program if there were existing Iowa programs that could be modified to meet Iowa Healthy Kids Program objectives.

It is apparent that many entities are addressing the insurance gap that currently exists in coverage for Iowa children. Both the private and public sectors are involved in trying to meet the needs of the uninsured in the state. Ten Iowa programs were reviewed to determine if any current programs could be expanded or coordinated with the Iowa Healthy Kids Program Study to increase the number of children served.

It should be noted that this is not a complete listing of all Iowa programs. The ten summarized were selected for review by members of the Task Force. The problem of uninsured children may not be solved solely by combining or expanding existing programs. An Iowa Healthy Kids Program would offer another opportunity to fill the void that exists in health care coverage for children.

Below is a brief summary of each Iowa program studied as part of the Task Force effort:

Area Education Agencies

There are sixteen Area Education Agency offices in the state. Programs are provided in three general categories- special education, media and educational/instructional services. Special education support is a major function of AEAs.

Area Education Agencies provide special education services to school populations consisting of students with special needs ages birth to 21. Special education is provided through cooperative efforts of AEAs and the local school districts. They work with both public and private schools. Some AEAs offer special instructional services and all sixteen provide support services. AEA staff members include psychologists, social workers, speech/language pathologists, audiologists and curriculum/instruction specialists. Special education nurses serve special needs students directly as well as serve as consultants to the nurses employed by local school districts.

Child Development Coordinating Council

This Council, comprised of the directors of the state departments of Health, Human Services, Economic Development, Law Enforcement, and Education is responsible for administering specific programs such as Head Start and serves as a clearinghouse for the discussion of issues affecting child development.

Child Health Speciality Clinics/The University of Iowa Hospitals

The Child Health Speciality Clinics is a statewide program serving children with special health care needs, that is children and youth with, or at risk, for a chronic disease, disabling condition or developmental problem. CHSC services are available through 13 Regional Centers in cooperation with Area Education Agencies and other community resources and mobile clinics are conducted throughout Iowa in community facilities by staff from The University of Iowa.

The program was established in 1935 as part of Title V of the Social Security Act. CHSC operates through the Iowa Department of Public Health's Maternal and Child Health Department with consultation from the U.S. Department of Health and Human Services. Funding is through federal Maternal and Child Health block grants, state appropriations, and Medicaid.

CHSC provides diagnosis, evaluation, and clinical care to Iowa children birth to age 22. Fees for clinic services are adjusted by using a sliding fee scale which incorporates income and family size. 5,500 children are seen annually in the program.

Early, Periodic Screening, Diagnosis Treatment Benefit

EPSDT is a Medicaid benefit that was created in 1967 to provide a wide array of preventive, primary care, and follow-up diagnostic and treatment services. It is intended to ensure that all Medicaid eligible children under age 21 receive comprehensive, periodic assessments of their physical and mental health, and follow-up services to diagnose and treat any problems discovered as part of the screening process.

The emphasis is on preventive and primary care, with the eventual goal of preventing childhood illness or disability through immunizations and health education, and early identification and treatment of conditions. States must inform all families of Medicaid eligible children about the services through EPSDT; offer assistance in obtaining services, including scheduling appointments and arranging transportation; and coordinate any necessary follow-up care.

Health Insurance Premium Payment (HIPP) Program
HIPP is a Medicaid program that pays for the cost of employer-based private insurance premiums, coinsurance, and deductibles. The program pays for employer related and private health care insurance for Medicaid eligible persons when it is deemed to be cost effective. Cost effective meaning it will cost less to buy health insurance to cover Medicaid care than to pay for the care with Medicaid funds.

The Department of Human Services will pay premiums, coinsurance, and deductibles of group health insurance available to Medicaid eligible individuals through their employer. It is up to the individual to notify Human Services of the availability of group health insurance through their employer.

Home Town Health Project
The Home Town Health Project uses a community planning model in 15 Iowa counties and is funded jointly by the Iowa State University Extension Service, Social and Behavioral Research Center for Rural Health, and the Iowa Department of Public Health. The model may be expanded to include an assessment of services for children and families.

Innovation Zones
Effective July 1, 1996, the Iowa legislature enacted legislation authorizing Innovation Zones. This project will involve piloting block grants in three Iowa communities to combine funding provided through the Departments of Public Health, Human Services, Education, Workforce Development, and Elder Affairs.

Iowa Caring Program for Children
Blue Cross/Blue Shield of Iowa established The Caring Foundation as a non-profit affiliate under section 501(c)(3) of the Internal Revenue Code. The Foundation serves as the funding mechanism for The Caring Program for Children. The program is designed to provide preventive care to Iowa children who meet age and financial eligibility requirements. It is the state's first and only public/private health insurance program for Iowa children.

The program is supported by donations from state government, religious organizations, community groups, businesses, and private foundations. The program services are provided to eligible children of households whose family income is less than 133 percent of the current federal poverty level. The program covers primary health care and preventive services. Benefits include office visits, diagnostic tests, emergency accident care, immunizations, routine physicals, and preventive care services. No in-patient coverage is offered.

In May 1996, there were 2,138 children enrolled in the program from all 99 Iowa counties.

Iowa Women Infant Children (WIC)
Food, nutrition counseling, and access to health care services are provided to low-income women, infants, and children under the WIC program. The program was established in 1974. WIC services are available to pregnant, breast-feeding, and postpartum women and infants and children up to the age of five. Vouchers are used at authorized grocery stores to purchase foods prescribed for participants. In 1996, over 712,000 monthly food packages were provided in Iowa at a cost of $33 million.

WIC clinics are held in every county in Iowa and are staffed by health professionals. Access to health services is provided through referrals to community-based health programs and providers. In many Iowa WIC clinics, well-child services are available on-site through integrated service delivery with the Title V Child Health Program.

Income guidelines are set at 185 percent of the federal poverty level. In October 1996, 47 percent of the infants and children enrolled in the program participated in Medicaid. In 1996, the Iowa WIC program served an average of 66,075 participants per month. Sixty percent of the participants are children between the ages of 1 and 5 years of age.

Maternal and Child Health
The Family Services Bureau of the Iowa Department of Public Health provides primary care services for children by funding local agencies to provide direct services. These services include both direct patient care as well as outreach and care coordination to assist children and families in using these services.

Medical Assistance (Medicaid) Title XIX

Medicaid is a program of medical assistance funded by the federal government and the states for individuals of low income who are aged, blind or disabled, pregnant, under age 21, or members of families with dependent children. The program includes mandatory services and mandatory eligibles, as well as optional services and optional eligibles. All payments through the program, except for transportation, are made directly to the provider of services. Currently, Iowa has 233,000 people enrolled in Medicaid. Eligibility requirements, benefits, and length of stay differ. Listed below is a brief summary of the major eligibility categories as they apply to coverage for children.

Family Investment Program (FIP)

Age Limit: 18

Full time students in a secondary school or its equivalent can be eligible if they can be reasonably expected to complete the program before the age of 19. The fundamental qualification to receive FIP benefits is a dependent child who is living with a specified relative, but who is deprived of parental support or care.

Child Medicaid Assistance Program (CMAP)

Age Limit: 21

Medicaid under CMAP is available to persons under the age of 21 who meet all FIP financial eligibility requirements, except: deprivation, work requirements.

Mothers and Children Program (MAC)

Age Limit: 13 (must be born after 9/30/83)

Medicaid is available through MAC coverage groups to all children born after 9/30/83 who have not attained the age of 19. The child does not have to be deprived to qualify

Supplemental Security Income (SSI)

Age Limit: None

Children who are blind or disabled may qualify for SSI. Eligibility is determined by the Social Security Administration. Persons who quality for SSI are usually automatically eligible for Medicaid. This program provides coverage to children at varying income levels:

<1 year - 185% FPL
1-6 years - 133% FPL
6-19 years - 100% FPL

Medically Needy Program

Age Limit: 21

The Medically Needy program is designed to provide Medicaid coverage to persons who exceed income or resources levels for cash assistance, yet do not have adequate medical care. If the household's Medical Needy Income Level (MNIL) is exceeded, it must meet a "spend down" process by which the person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

The benefit costs are funded by substantial funding with state and federal funds. Effective October 1, 1996, federal financial participation in program expenditures is 62.94 percent.

School Nursing

School nurse services for both children with special health care needs as well as the general student population are provided by the Iowa Department of Education.

Governor's Campaign for the Family

This campaign provides templates for the coordination of health, human services, economic development, law enforcement, and education to develop coordinated systems of services to support families. The emphasis of the campaign is that traditional families are to be encouraged, that families have primary responsibility for their children, and that communities have secondary responsibility for families within their community. The state should have less responsibility for the provision of services and more for assuring families abilities to meet their own needs.

ACTUARIAL ANALYSIS

The Iowa Insurance Division engaged Carl Harris, FSA, MAAA, of Deloitte & Touche LLP, to prepare estimates of the enrollment, per member, per month (PMPM) program costs, and total program costs for the development of an Iowa Healthy Kids program. In performing the analysis Mr. Harris used data supplied by the State of Iowa. It should also be noted that there is a lack of data on historical medical utilization which required the development of assumptions.

Enrollment Projections

The data provided summarize the estimated number of children in Iowa in 1994, with the following detail:

- Age
- Income as a percent of the federal poverty level (percent fpl)
- Health coverage, whether private, public, or no health coverage

The total estimated children without health coverage was 82,447. Based on the detail provided, the number of uninsured children at or below the various points of the federal poverty levels was estimated. This information is summarized in the following table:

Percent FPL	Estimated Number of Uninsured Children, 1994
0 - 100.0% FPL	32,500
0 - 142.5% FPL	52,000
0 - 185.0% FPL	67,000

The estimates were affected by the following:

- The accuracy of the initial data provided.
- General population growth in Iowa.
- Economic conditions which will affect income levels relative to the fpl.
- Welfare reform and any impact this may have on traditional Medicaid eligibility.

It was assumed that all of the children without health coverage and below the specific percentage of the federal poverty level would be enrolled in the program. Actual program enrollment will be affected by several factors, including:

- Contribution levels.
- Benefit design.
- The level of public awareness of the Iowa Healthy Kids Program and the level of publicity and marketing of the program.

- Program regulations and the behavior of other health coverage providers, who may try to shift costs to the Iowa Healthy Kids Program.

Benefit Design

The program cost projections developed assumed the following benefit design:

- A comprehensive benefit set for preventative and acute care medical services, similar to that provided by most HMO's. This includes hospital inpatient and outpatient care, physician services, and prescription drugs.
- Limitations on substance abuse and mental health services.
- $25 co-pay on hospital emergency room visits.
- $5 co-pay for physician office visits, physical medicine, and ambulance trips.
- $10 co-pay for mental health visits and corrective lenses.

In addition, cost estimates were developed with a second benefit design, identified as "Low Option":

- Preventative care physician services only, including well child care and immunizations and injections.
- $5 co-pay for physician office visits.

Utilization of Cost Per Service Assumptions

A pricing model was developed which incorporated utilization and cost per service assumptions to develop an estimated cost per member, per month.

Due to the lack of insured experience data on this uninsured population, estimates were developed of health care utilization which were appropriate for this population. Factors which were considered include:

- Age distribution of the projected Iowa Healthy Kids population.
- Benefit design.
- A moderate level of managed care utilization management.
- Experience from commercial HMO populations.
- Experience from other state programs for similar populations.

The utilization is expressed as the number of services per 1,000 eligibles per year. The service units are the number of hospital days, surgeries, office visits, tests, or prescriptions.

The cost per service assumptions reflect the assumed intensity and the following reimbursement assumptions:

- Hospital inpatient reimbursement at existing Medicaid AFDC levels based upon data provided by the State of Iowa.
- Hospital outpatient reimbursement based upon the inpatient reimbursement and reflecting normative relationships between inpatient and outpatient costs.
- Physician services at 100 percent of the Resource-Based Relative Value Scale (RBRVS) levels for Iowa.

The reasonableness of these cost per service assumptions will have a material impact on program cost estimates.

Administrative Costs

Since the Iowa Healthy Kids Program will be provided by insurers or HMO's an assumed administrative cost was added to the program cost estimate. This estimate reflects:

- $3.00 PMPM for the high option benefit plan, plus eight percent of claims.
- $1.00 PMPM for the low option benefit plan, plus eight percent of claims.

There is no assurance that the state will be able to achieve these cost levels in negotiations with carriers.

Total Program Costs

Exhibits are included in the appendices that summarize the calculations of total program costs from the various assumptions.

FEDERAL AND PRIVATE FOUNDATION ACTIVITY

Seeking a more measured way to expand health care to those without it, some congressional leaders have decided to make medical coverage for uninsured children one of their top legislative priorities in the new Congress. The proposals currently being drafted could create a new class of federal social support. Other initiatives would offer a tax credit to help a family buy their children a health care policy, while others would offer a direct federal subsidy. Most of these proposals would appear to focus on children in families that "fall between the cracks." These are families who are not poor enough to qualify for Medicaid but cannot afford to pay for private insurance on their own.

The label being attached to these proposals is "Kiddycare." A coalition of children's groups is forming to support these initiatives. Among the most detailed plans outlined to date is a proposal that would provide grants to states to help families afford health insurance for their children.

Despite the strong appeal to broaden coverage for children, the proposals are certainly controversial and much of the debate will center on how much to spend, where to find the funding, and whether the initiatives would create a new federal entitlement.

In another initiative, the Robert Wood Johnson Foundation (RWJ) is expected to send requests for proposals this month to all Governors and insurance commissioners in the country for Healthy Kids Program Implementation Grants. RWJ plans to provide financing in the amount of $500,000 per state, for two years to assist five to seven states in designing and implementing a Healthy Kids Program. The application deadline is tentatively set for April 1997. Certainly, if possible, policy makers should link any Iowa initiatives to the RWJ application.

RECOMMENDATIONS

The responsibility for ensuring health care coverage for children may fall directly on a state, its local communities (including private sector providers and non-profit organizations), and children's families. This report has attempted to bring together these groups to learn how to expand children's access to health care.

The Iowa Healthy Kids Program Study Task Force's mission was to study and design program parameters for a feasible and coordinated comprehensive health care coverage program for uninsured and underinsured Iowa children. Ideally, any Iowa Healthy Kids Program option selected should do the following:

- ☐ Complement existing or expanded Medicaid coverage
- ☐ Cover children who would not have otherwise been covered
- ☐ Keep per child costs to a minimum
- ☐ Provide preventive and comprehensive primary health care services
- ☐ Offer an uncomplicated application process
- ☐ Offer a wide network of providers
- ☐ Require families to share part of the cost
- ☐ Use existing administrative systems of state, nonprofit, and private organizations

Based on the primary components of the study, research, and public outreach, the following three initiatives are recommended for consideration by the Governor and Iowa General Assembly. It is important to note that the three options outlined are not mutually exclusive, the state may choose to combine elements of different options.

Remaining issues, such as eligibility, funding levels, and school-based marketing, cannot be resolved until a program framework is selected. Specific details will have to be determined with further study.

1.) State Seed Funded Option - New Hampshire Healthy Kids Program Model

A non-profit corporation would be established to administer an Iowa Healthy Kids Program with private insurance carriers assuming the risk. The non-profit corporation markets the plan, negotiates with the insurance companies, and administers the plan. State dollars would be used for start-up seed capital. Premiums would be paid totally by the participating families, and administrative costs would be covered through premiums and other private funding sources.

2.) *State Subsidized Option*

A.) Premium Buy Down Subsidy

The state via a non-profit entity would buy down premiums for participating families based on a sliding-fee scale, based on income and family size. A two tier benefits package could be available - preventive only, or a more comprehensive health care package.

B.) State Expansion of the Caring Program for Children

One way this could be accomplished is to expand the level of funding for the Caring Program for Children. The increased appropriation would be used to subsidize benefits for uninsured children between 133 percent and 185 percent of poverty. A two tier benefits plan could be available. Other companies or trusts may also be interested in administering this program. Alternatives should be explored if this option is selected.

Based upon the assumptions provided by Carl Harris, of Deloitte & Touche, there are an estimated 82,447 uninsured children in Iowa. If the state were to subsidize the $44 per month premium for a comprehensive benefit package on a sliding scale basis for children of all ages under 185 percent of fpl, the total cost would exceed $24 million annually (assuming all children participated). The following provides an estimate of those costs:

Category	# Children	Subsidy	Amount Subsidized	Total Cost of Subsidy
0-100% fpl	32,500	100%	$528/year/child	$17,160,000
100-142% fpl	19,500	50%	$263/year/child	$ 5,148,000
142.5-185% fpl	15,000	25%	$132/year/child	$ 1,980,000
>185% fpl	15,447	------	----------	----------
Totals:	82,447			$24,305,160

Recommendation 2.A. (Premium Buy Down Subsidy) and 2.B. (State Expansion of the Caring Program for Children) each requests a state funding level of $1 million for subsidized premiums. Based upon this funding level, it is estimated that 3,000 children could receive some level of subsidized premium.

3.) *Expanded Medicaid Coverage Option*

The current Iowa Medicaid program would be expanded to include coverage for children ages 6 to 18 with family incomes up to 133 percent of the federal poverty level. The federal government has mandated that all states phase-in coverage for children up to 100 percent of the federal poverty level into their Medicaid programs by the year 2002. The benefits would be the same as what currently exists for children ages 1 to 13. This recommendation may be in addition to support of new Healthy Kids initiatives. An Iowa Healthy Kids Program would complement the current Medicaid program. Simply expanding the Medicaid program would not be enough to meet the existing health care

The recommended options provide policy makers with suggestions on several initiatives to expand health insurance coverage for Iowa children by taking a systematic approach to addressing specific levels of need that exist in the state.

The following pages provide further rationale to support each recommendation as well as highlighting barriers to care that could still exist upon program implementation.

PROGRAM OPTIONS

1.) State Seed Funded Option

Funding Level: $250,000 - $300,000

Purpose: The state appropriates a determined level of funding for the development and start-up of an Iowa Healthy Kids Program. These dollars would be used for establishing an entity to administer the program. The corporation would be required to determine methods to become financially independent. This program would be developed to mirror the New Hampshire Healthy Kids Program model.

Eligibility:

- Full-time Iowa resident
- School-aged children 5 to 18
- No income eligibility required. The program would cover uninsured children at any income level as long as the families paid the full premium costs.

Benefits:

Option 1:
Comprehensive level of benefits. These would include primary and preventive services such as well-child visits, immunizations, outpatient and inpatient physician services, and diagnostic testing, outpatient emergency services, mental health services, vision and hearing care, and prescription drugs.

Option 2:
Basic preventive benefits. The program would offer basic primary and preventive care services, including emergency and accident care.

Premiums:

Option 1: $44.00 per child, per month
Option 2: $ 8.00 per child, per month

These numbers are approximations depending upon enrollment figures, cost-sharing, and the use of competitive bidding. The program could also have deductibles or co-payments for certain services.

Financing: Beyond the start-up funding the program would rely on grants, and corporate contributions, premium payments, and in-kind services to operate.

Barriers:

- This program design option would be considered a stop-gap measure aimed at working families.
- Although this program would be open to any Iowa child whose family paid the full premium cost, there is concern that the high cost of the premiums would discourage families from enrolling their children.
- Must have partnerships with schools for marketing purposes.
- The program would not cover children birth to five years old and ages 18 to 21. The education system in Iowa serves children with disabilities ages birth to 21 years.
- Unlike the Medicaid program, the State Seed Funded Option would operate on a limited and fixed budget. The non-profits' budget would be limited by the amount of money that could be raised by premiums and corporate and individual donors.
- Fundraising efforts could be a challenge. The New Hampshire program has initially been successful at fundraising. However, the continued existence of the program is uncertain.
- The initiative would require a state appropriation to infuse the necessary capital for program start-up. There will continue to be a void in health insurance coverage until an infrastructure is developed.

2.) State Subsidized Option

A.) Premium Buy Down Subsidy

Funding Level: $1,250,000 ($250,000 administrative costs)
Estimated number of children covered - 3,000

Purpose: To provide funding to establish an Iowa Healthy Kids non-profit corporation that would offer unsubsidized and subsidized premiums for eligible children. This program design is similar to the Florida Healthy Kids Program in the area of sliding-fee premiums.

Eligibility: The program eligibility would be limited to cover children most in need of insurance. The program would not duplicate existing public coverage. Eligibility includes:

- Full-time Iowa resident
- School aged children ages 5 to 18
- Not eligible for Medicaid health coverage
- Uninsured

Benefits:

Option 1:
Comprehensive level of benefits. These would include primary and preventive services such as well-child visits, immunizations, outpatient and inpatient physician services, and diagnostic testing, outpatient emergency services, mental health services, vision and hearing care, and prescription drugs.

Option 2:
Basic preventive benefits. The program would include the basic primary and preventive care services, including emergency and accident care.

Premiums:

Option 1: $44.00 per child, per month
Option 2: $ 8.00 per child, per month

Enrollees would pay a monthly premium that would be determined using a sliding scale linked to income level and household size. The program could also have deductibles or co-payments for certain services.

Financing: The State would subsidize the program. The funding level is an estimate. The exact amount of funding required cannot be determined until the sliding fee scale levels are selected. A limited amount of funding would be received by premiums, co-payments, and deductibles.

Barriers:

- Whether the state budget can support this initiative should be carefully analyzed.
- The program could be limited in its effectiveness by the number of children that would be subsidized.
- Proposal will not cover all of the children identified as being uninsured in Iowa under 185 percent of fpl.
- Lack of funding could force the program to restrict enrollment or develop waiting lists. This could undermine the program credibility. The program could be phased in starting with the most needy children first and adding children as the program matures.
- The program would not cover children birth to five years old and ages 18 to 21. The education system in Iowa serves children with disabilities ages birth to 21 years.
- Must have partnerships with schools for marketing purposes.

2.) State Subsidized Option

B.) State Expansion of the Caring Program for Children

Expansion of the Caring Program for Children is an <u>example</u> of how a state subsidized program could operate. There are other Iowa insurance companies that may fit into this model. The program could be administered by another company or other 501(c)(3). Since the Caring Program is a current Iowa program that could be built upon to develop an Iowa Healthy Kids Program, it is believed to be an appropriate mechanism to use as an example.

Funding Level:

$1,000,000
(FY '97 state appropriation - $75,000)
Estimated number of children covered - 3,000

Purpose:

To increase the amount of state appropriation to the Caring Foundation. The increased appropriation would be used to subsidize benefits for uninsured children between 133 percent and 185 percent of poverty. Currently, the Caring Program for Children only serves children up to 133 percent of poverty at Option 2 benefit levels.

Eligibility:

- Household income is at or below the specific percentage of the fpl.
- Children not eligible for Medicaid.
- School aged children ages 5 to 18
- Currently enrolled in school if of school age.
- Living with parent or legal guardian.
- Legal resident of Iowa with intent to stay.

Benefits:

Two options are proposed:

<u>Option 1:</u>
Comprehensive level of benefits. These would include primary and preventive services such as well-child visits, immunizations, outpatient and inpatient physician services, and diagnostic testing, outpatient emergency services, mental health services, vision and hearing care, and prescription drugs.

<u>Option 2:</u>
Basic preventive benefits. The program would include the basic primary and preventive care services, including emergency and accident care.

Premiums:

Option 1: $44.00 per child, per month
Option 2: $ 8.00 per child, per month

Assumptions used include the following:

- This appropriation would be used in addition to levels of current funding which are used to finance the existing Caring Program for Children.
- Projected children covered includes children currently enrolled in the Caring Program for Children.
- Current Caring Program covers children from ages birth to age nineteen or between ages 19 and 21 if the child has a disability. Estimated Monthly premium may change with expanded age categories.
- Current Caring Program coverage is comparable to Option 2 coverage with the addition of dental benefits. Adding dental would increase monthly premium by $13.00.

Financing:

The administrative costs would be met by grants or corporate contributions.

Barriers:

- Must have partnerships with the schools for marketing purposes. To date this has not been accomplished in the current program.
- Providing state appropriation to the Caring Foundation will not allow other insurers to get involved with the program.
- Proposal will not cover all of the children identified as being uninsured in Iowa and under 185 percent of fpl.
- Significant appropriation of taxpayers funds to a private enterprise when the proposal does not allow for competitive bidding of insurance product.

3.) Expanded Medicaid Coverage Option

Funding Level: $5,064,000 state funds.
$8,829,004 in federal match.

Purpose: The Expanded Medicaid Option would expand the Iowa Medicaid program eligibility to include children ages 14 to 18, and to provide coverage to all children under age 18 whose family income does not exceed 133 percent of the fpl. It is estimated there are 13,400 eligible children, ages 6 to 18 who could be added to the Medicaid roles. This expands program eligibility beyond federal requirements. Medicaid is the nation's number one insurer of low-income children. There are more than 144,000 Medicaid-eligible children in Iowa.

Eligibility:

- Current Iowa Medicaid eligibility rules would apply
- Persons who are eligible for other public assistance
- Children up to the age of 18 with family incomes that do not exceed 133 percent of the federal poverty level

Benefits: Current Medicaid benefits, including required preventive and comprehensive health benefits, dental services, eyeglasses, mental health, and substance abuse services.

Premiums: No charge to participants.

Financing: The federal match program would require an additional five million dollars to include the expanded age and income eligibility. Potential funding sources could be a direct state appropriation.

Barriers:

- Increased Medicaid costs are pressuring states towards different types of program changes. These changes may make expanding eligibility difficult.
- Expanding eligibility criteria for Medicaid does not guarantee coverage for eligible individuals. It is known that a large number of children are currently eligible for Medicaid coverage but are not enrolled. Many low-income families may not realize they qualify for benefits, which could be addressed through expanded outreach efforts.
- Families covered under Medicaid may not be aware of the recommended services for their children. Many find the application process complicated and demeaning.

Other Considerations

The Task Force discussed whether changes to Iowa law would be necessary in order for the private insurance market to be able to offer a health benefit policy geared to children. It was determined that Iowa insurance law does not prohibit a private insurer from offering either a group or individual insurance policy specifically covering school children. Current laws covering large group coverage allow for individual underwriting. This may need to be changed for the particular program. However, the problem goes beyond just the offering of a children's health policy. Issues such as marketing and premium cost must be addressed.

Schools would play a very important role in the marketing of a group plan targeted at school-aged kids. Schools should be encouraged to assist insurers in making available children's plans. For example, schools could provide opportunities for insurers to communicate information regarding the insurance plans to parents.

It is likely that some level of financial assistance from the state would be required to make the cost of such plans affordable for the targeted population. Potential types of assistance include premium subsidies to qualified families or premium tax exemption.

PILOT PROJECT SITES

As required by SF 2442, the study includes a review of the feasibility of initially operating a program on a pilot project basis, encompassing both urban and rural areas. One of the key factors in selecting a pilot site is choosing an area with a large enough pool of potential participants to make the project financially feasible. Other factors to consider include a demonstration of need in the particular community/area, and the capacity and willingness of the local schools, parents, health care providers, and community leaders to take an active role in the pilot project.

The Task Force reviewed both the Florida and New Hampshire Healthy Kids Programs. The Florida program was able to successfully operate initially on a pilot site basis because of the large urban areas from which it could market its benefit plan. On the other hand, New Hampshire made the determination that its population was too rural overall to start with a pilot site and thus started the program on a statewide basis.

Whether or not a pilot project is feasible is dependent upon which of the program options recommended by the Task Force is ultimately implemented. Should the determination be made that the State Seed Funded Option (New Hampshire Model) or the State Subsidized Option (Florida Model) be implemented, a pilot may be desirable, assuming a geographic area with a large enough targeted population can be found.

FUNDING SOURCES

The Task Force would be remiss if the study did not address the issue of possible funding sources to finance an Iowa Healthy Kids Program. It should be noted that in three of the four recommendations, the enrolled families would participate financially in the program by paying all or part of the insurance premium.

As reviewed in the State Health Insurance Programs for Children section of this report, there are many acceptable methods of financing state sponsored insurance programs for children. Public programs are financed fully by federal, state, or local government funds. In the majority of states, new insurance programs for children initiatives were created and funded by either state general revenue funds, cigarette or tobacco taxes, or health care provider taxes, bad debt, or charity care pool funds.

Private foundation funding such as the Robert Wood Johnson Foundation Healthy Kids Program Implementation grants should also be considered as the Iowa Program is pursued.

CONCLUSION

The Iowa Healthy Kids Program Study Report is provided to the Governor and members of the Iowa General Assembly to help them make important policy decisions that will affect children's health care coverage.

Programs are currently in place in the State of Iowa which are designed to improve the health status of children, but there are still thousands of Iowa children lacking health insurance and access to appropriate health care services. Concerns exists, however, about fragmented efforts that address certain health needs of children without providing continuity of care, and coordination among services and service providers. Public perception and the complexity of current programs remain barriers to many Iowans.

The Iowa Healthy Kids Program Study Task Force is offering three recommendations for consideration of ways to improve access to quality health care services for Iowa children. The models provide an opportunity for policy makers to implement individually or to blend the recommendations for an Iowa Healthy Kids program. One recommendation proposes the establishment of a not-for-profit organization, initially seeded with state funds, to provide health insurance for children through private insurance carriers.

A second recommendation provides for a state subsidy to buy down premiums for participating families based on a sliding-fee-scale. This recommendation offers two alternatives. One alternative provides for a state subsidized program to buy down premiums for participating families based on a sliding fee scale. The second alternative expands the Caring Foundation for Children.

The final recommendation should be viewed as an add-on to the other recommendations. It offers an expansion of the current Medicaid program to include coverage for children ages 6 to 18 with family incomes up to 133 percent of the federal poverty level (fpl). This would bring Medicaid coverage into line with the current coverage for children one through five. It would allow Medicaid and an Iowa Healthy Kids Program to work smoothly within the school setting.

Expanding Medicaid eligibility or creating new insurance programs does not guarantee access to care for the targeted populations. Many persons do not realize they may be eligible for assistance. Others may lack the understanding of appropriate treatment. Others face barriers to care including cultural and language differences, shortage of willing providers, difficult application procedures, and lack of transportation.

Certainly, all Iowans have a responsibility to address the growing numbers of children who are uninsured or underinsured. The challenge is to blend the resources of the public and private sectors to develop a comprehensive initiative to give Iowa's children an equal opportunity to be safe and healthy. Private business and industry, Iowa's labor community, Iowa's schools, insurance industries, and health care providers are

key to the implementation of any one of these proposals or an alternative Healthy Kids initiative.

Ideally, as called for in the federal Healthy Children 2000 objectives, all children should have a medical home to address all their primary and preventive health care needs. Linkages should be developed between any Iowa Healthy Kids Program with existing health and human services programs to help ensure Iowa children's total health.

Even with "Kiddycare" being considered at the federal level, the State of Iowa should continue to move forward to implement its own state-based initiatives to promote and ensure the health of Iowa children.

Iowa Healthy Kids Program Study Task Force

Legislation

Senate File 2442

c. Notwithstanding any provision to the contrary, the unit may collect the fee through any legal means by which support payments may be collected, including but not limited to income withholding under chapter 252D or income tax refund offsets, unless prohibited under federal law.

d. The unit is not required to file these judgments with the clerk of the district court, but shall maintain an accurate accounting of the fee assessed, the amount of the fee, and the recovery of the fee.

e. Support payments collected shall not be applied to the recovery of the fee until all other support obligations under the support order being enforced, which have accrued through the end of the current calendar month, have been paid or satisfied in full.

f. This subsection applies to fees that become due on or after July 1, 1992.

Sec. 40. Section 426B.2, subsection 5, Code Supplement 1995, is amended to read as follows:

5. The department of human services shall notify the director of revenue and finance of the amounts due a county in accordance with the provisions of this section. The director of revenue and finance shall draw warrants on the property tax relief fund, payable to the county treasurer in the amount due to a county in accordance with subsections 1 and 3 and ~~mail~~ distribute the warrants to the county auditors ~~in September~~ on July 1 and ~~March~~ January 1 of each year. Warrants for the state payment in accordance with subsection 2 shall be ~~mailed~~ distributed in January of each year.

Sec. 41. NEW SECTION. 514I.1 IOWA HEALTHY KIDS PROGRAM -- LEGISLATIVE INTENT.

1. The general assembly 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 this state. Many children do not have health care services available or funded, and for those who do, lack of access is a restriction to obtaining such services. It is the intent of the general assembly that

a program be implemented to provide health care services and comprehensive health benefits or insurance coverage to children. A goal for the program is to cooperate with any existing programs with similar purposes funded by either the public or private sector.

2. For the purposes of this chapter, unless the context otherwise requires:

a. "Advisory council" means the advisory council created by the division under section 514I.4.

b. "Division" means the insurance division of the department of commerce.

c. "Program" means the program developed by the division in accordance with section 514I.3.

Sec. 42. NEW SECTION. 514I.2 IOWA HEALTHY KIDS PROGRAM AUTHORIZATION.

1. The general assembly authorizes the division to implement the Iowa healthy kids program. The division shall have all powers necessary to carry out the purposes of this chapter, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any person and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of the program.

2. The program shall operate initially on a pilot project basis to include urban and rural areas. Expansion beyond the initial pilot project is subject to authorization by law.

3. Implementation of the program shall be limited to the extent of the funding appropriated for the purposes of the program.

Sec. 43. NEW SECTION. 514I.3 IOWA HEALTHY KIDS PROGRAM OBJECTIVES.

The division shall develop a program to attain all of the following objectives:

1. Organize groupings of children for provision of comprehensive health benefits or insurance coverage.

2. Arrange for the collection of any payment or premium, in an amount to be determined by the division. The payment or

premium shall be collected from a family of a participating child or other person to provide for payment for health care services or premiums for comprehensive health benefits or insurance coverage and for the actual or estimated administrative expenses incurred during the period for which the payments are made. The amount of payment or premium charged shall be based on the ability of the family of a child to pay. The division shall provide for adjustment of the amount charged to reflect contributions, public subsidy, or other means used to defray the amount charged.

3. Establish administrative and accounting procedures for the operation of the program.

4. Establish, in consultation with appropriate professional organizations, standards for health care services, providers, and comprehensive health benefits or insurance coverage appropriate for children and their family members.

5. Establish eligibility criteria which children and their family members must meet in order to participate in the program.

6. Establish participation criteria for the program and, if appropriate, contract with an authorized insurer, health maintenance organization, or insurance or benefits administrator to provide administrative services to the program.

7. Contract with authorized insurers, benefits providers, or any provider of health care services meeting standards established by the division, for the provision of comprehensive health benefits or insurance coverage and health care services to participants.

8. Develop and implement a plan to publicize the program, eligibility requirements of the program, and procedures for enrollment in the program and to maintain public awareness of the program.

Provide for administration of the program.

As appropriate, enter into contracts with local school other agencies to provide on-site information,

enrollment, and other services necessary to the operation of the program.

11. Provide an interim report on or before March 1, 1997, to the governor and general assembly, on the development of the program to date and an annual report thereafter until the program is terminated or extended statewide.

Sec. 44. NEW SECTION. 514I.4 ADVISORY COUNCIL.

1. The division may create an advisory council to assist the division in implementing the program. The advisory council membership may include, but is not limited to, the following:

a. A school administrator.

b. A member of a school board.

c. An employee of the state or local government in public health services.

d. A pediatrician who is a member of the American academy of pediatrics, Iowa chapter.

e. The director of human services or the director's designee.

f. A member of the association of Iowa hospitals and health systems.

g. A representative of authorized health care insurers or health maintenance organizations.

h. A representative of a university center for health issues.

i. A family practice physician who is a member of the Iowa academy of family physicians.

j. A school nurse who is a member of the Iowa nurses association.

k. The director of public health or the director's designee.

l. A citizen who is knowledgeable concerning health care and children's issues.

m. A citizen who is a parent with children at home who is active in a school-parent organization.

2. Advisory council members are entitled to receive, from funds of the division, reimbursement for actual and necessary expenses incurred in the performance of their official duties.

Sec. 45. NEW SECTION. 514I.5 LICENSING NOT REQUIRED -- FISCAL OPERATION.

1. Health benefits or insurance coverage obtained under the program is secondary to any other available private or public health benefits or insurance coverage held by the participant child. The division may establish procedures for coordinating benefits under this program with benefits under other public and private coverage.

2. The program shall not be deemed to be insurance. However, the insurance division may require that any marketing representative utilized and compensated by the program be appointed as a representative of the insurers or health benefits services providers with which the program contracts.

Sec. 46. NEW SECTION. 514I.6 THE IOWA HEALTHY KIDS TRUST FUND.

1. An Iowa healthy kids trust fund is created in the state treasury under the authority of the commissioner of insurance, to which all appropriations shall be deposited and used to carry out the purposes of this chapter. Other revenues of the program such as grants, contributions, matching funds, and participant payments shall not be considered revenue of the state, but rather shall be funds of the program. However, the division may designate portions of grants, contributions, matching funds, and participant payments as funds of the state and deposit those funds in the trust fund.

2. The trust fund shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys in the trust fund are not subject to section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered except as provided in this section. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the trust fund shall be credited to the trust fund.

Sec. 47. NEW SECTION. 514I.7 ACCESS TO RECORDS -- CONFIDENTIALITY -- PENALTIES.

1. Notwithstanding any other law to the contrary, the program shall have access to the medical records of a child

who is participating or applying to participate in the program upon receipt of permission from a parent or guardian of the child, including but not limited to the medical records maintained by the state or a political subdivision of the state. Notwithstanding chapter 22, any identifying information, including medical records and family financial information, obtained by the program pursuant to this subsection is confidential. Except as provided in section 252B.9, chapter 252E, or any federal law or regulation to the contrary, the program, the program's employees, and agents of the program shall not release, without the written consent of the participant or the parent or guardian of the participant, to any state or federal agency, to any private business or person, or to any other entity, any confidential information received pursuant to this subsection.

2. A violation of the provisions of subsection 1 is a serious misdemeanor.

Sec. 48. FEDERAL WAIVERS.

1. The department of human services shall submit a waiver request or requests to the United States department of health and human services as necessary to implement the changes in the family investment program and host home provisions under section 239.23 as enacted by this Act. In addition, the department may submit additional waiver requests to the United States department of health and human services to make changes to the medical assistance program under chapter 249A, as necessary to revise the program in accordance with any waiver provision implemented pursuant to section 239.23.

2. The waiver request or requests submitted by the department of human services to the United States department of health and human services shall be to apply the provisions of section 239.23 statewide. If federal waiver approval of the provisions is granted, the department of human services shall implement the provisions in accordance with the federal approval. If an approved waiver is in conflict with a provision of state law, the waiver provision shall apply and the department shall propose an amendment to resolve the

Iowa Healthy Kids Program Study Task Force

Task Force Meeting Schedule

Tuesday, October 8, 1996
9:00 a.m. - 12:00 p.m.
Insurance Commissioner's Office
Sixth Floor
Lucas State Office Building
Des Moines, Iowa

Friday, November 8, 1996
12:30 p.m. - 4:30 p.m.
Room 308
Hotel Fort Des Moines
10th and Walnut
Des Moines, Iowa

Thursday, December 5, 1996
9:00 a.m. - 12:00 p.m.
Insurance Commissioner's Office
Sixth Floor
Lucas State Office Building
Des Moines, Iowa

Thursday, December 19, 1996
1:00 p.m. - 4:00 p.m.
Capitol Room
Hotel Fort Des Moines
10th and Walnut
Des Moines, Iowa

Iowa Healthy Kids Program Study Task Force
Tuesday, October 8, 1996
Iowa Insurance Division
Des Moines, Iowa

Agenda

9:00 a.m. Welcome, Introductions, and Overview
Terri Vaughan, Insurance Commissioner
Jo Oldson, First Deputy Insurance Commissioner

9:45 a.m. Scope of Task Force - Discussion
* Mission Statement Development and Approval
* Scope of Activities/Development and Approval
* Work Plan Development and Approval

10:15 a.m. Research Component - Discussion
* Iowa Statistics
* Other States Programs
* Related Iowa Programs/Organizations
* Cost Analysis

10:45 a.m. Public Outreach Process - Discussion
* Focus Group Meeting Sites/Dates
* Focus Group Methodology
* Identify Focus Group/Invitations

11:45 a.m. Task Force Meeting Schedule
* Potential Speakers

12:00 p.m. Adjournment

Iowa Healthy Kids Program Study
Task Force Meeting
Tuesday, October 8, 1996
Insurance Commissioner's Office * Des Moines, Iowa

Meeting Summary

Task Force Members Present
Jo Oldson, Chair, Iowa Insurance Division
Jane Borst (Mary Anderson), Iowa Department of Public Health
David Carlyle, M.D., Iowa Academy of Family Physicians
Mary Hansen, Ph.D., Drake Center for Health Issues
Ellen Johnson, Area Education Agency IV
Molly Kurtz, Iowa Caring Foundation
Pat Markham, Cass County Memorial Hospital
Janice Merz, Iowa Association of School Boards
Merle Pederson, Principal Financial Group
Barbara Philibert, Scott County Decatergorization Program
Anita Smith, Iowa Department of Human Services
Richard Sundblad, School Administrators of Iowa
Rod Turner, American Republic Insurance Company

Iowa Insurance Division
Terri Vaughan, Insurance Commissioner

Guests
Elaine Szymoniak, Iowa State Senator, Des Moines
Michael Treinan, Principal Financial Group

Staff
Tom Slater, Julie Blum, Tori Squires, and Clark Conover

Welcome, Introductions, and Overview

Terri Vaughan, Iowa Insurance Commissioner, welcomed the task force members and presented a brief background of the project, explaining why the Iowa Legislature directed the Insurance Division to coordinate the project. State Public Policy Group has been retained to provide administrative support to the Iowa Healthy Kids Program Study.

One year ago an informal group met to study the creation of an Iowa Healthy Kids initiative. Some members of the Task Force were on the initial working committee, while the remainder are new to the issue. Ms. Vaughan identified some of the issues which will be dealt with over the next sixty days: cost; other related programs; identifying target populations; delivery mechanisms; program structure and design; and the rural nature of the State of Iowa.

Jo Oldson, Chair welcomed State Senator Elaine Szymoniak and asked her for initial comments. Senator Szymoniak gave a brief synopsis of the evolution of health care

reform in Iowa. She challenged the Task Force members to find new and innovative ways to meet the health insurance needs of Iowa working poor and their children.

Ms. Oldson asked the members to introduce themselves and give a brief description of their backgrounds. Introductions followed.

Scope of Task Force

Jo Oldson asked Tom Slater of State Public Policy Group to reviewed the proposed mission statement and scope of work for the Task Force.

After discussion the task force elected to revise the mission statement as follows:

"To study and design program parameters for a feasible and coordinated comprehensive health care coverage program for uninsured and underinsured children."

Mr. Slater asked the task force to review the proposed scope of work. After discussion the Task Force approved the following scope of work:

* Obtain Valid Iowa Statistics on Populations to be Served
* Identify Barriers to Health Insurance for Children
* Research Other State's Healthy Kids Programs
* Review Existing Related Public or Private Programs
* Identify Alternative Program Structures for Meeting the Needs of Uninsured/Underinsured Kids, Including the Relationship of Those Alternative Structures with Existing Programs
* Review Actuarial and Conduct Cost Analysis.
* Determine Interest of Potential Insurance Carriers
* Conduct Focus Group Meetings
* Direct Public Information Effort
* Recommend Feasible Program Parameters
* Identify Pilot Project Sites

Mr. Slater reviewed the proposed Iowa Healthy Kids Program Study work plan. No revisions were made by the Task Force members.

Research Component

Julie Blum of State Public Policy Group reviewed the list of organizations which have been contacted to obtain statistics for use in determining the number of uninsured children in Iowa. She asked for suggestions of other sources which may provide data. After discussion the group offered the following sources:

Iowa Hospital and Health Systems Association
The Caring Foundation
American Public Welfare Association
Iowa and United States Departments of Labor
Health Insurance Association of America
Blue Cross/Blue Shield Marketing Research Department
Iowa School Nurses Association
Area Education Associations
Principal Marketing Research Department
School At-Risk Programs
School Consent Forms

Staff is identifying various states which are providing insurance programs for children, through public, private, or a combination of funding sources. A chart will be provided at the November meeting which will describe the activities in each state. A discussion of potential public and private programs followed..

Task Force members reviewed a list of existing Iowa programs and organizations with shared or similar purposes. Staff asked for additional programs to research. Sugestions were as follows:

School-Based Youth Services
Health Insurance Premium Payment Program
Iowa Comprehensive Health Association
School At-Risk Programs

Ms. Oldson informed the group that an actuary will be retained to assist in empirical research. The Task Force members discussed areas that should be addressed by the actuary and by staff.

Public Outreach Process

Mr. Slater described the focus group methodology which will be used as a public outreach information source. He explained that this outreach is not designed to develop constituencies, but provide information and give people a chance to talk about their local concerns.

A focus group script will be developed by staff and approved by the Task Force chair. Three or four premises are developed from the script, with specific questions designed for each premise and participants will provide their perspectives. The audience will be a mix of experts, consumers, parents, school officials, health care providers, administrators, local elected officials, and others. A form was provided to Task Force members to offer names of invitees to the focus group. Staff asked that all names be provided by October 15, 1996.

The Task Force members approved the following sites for focus group meetings: Des Moines, Ottumwa, Shenandoah, Storm Lake, Waterloo, and Clinton. It was suggested that two of the meetings be held in the evening.

Task Force Meeting Schedule

Ms. Oldson asked Task Force members for names of potential speakers for the November meeting. Molly Kurtz offered to explain The Iowa Caring Foundation program. Jane Borst suggested that a representative of the Iowa Medicaid Office explain the various Medicaid programs and Dr. Carlyle asked that a synopsis of the Healthy Kids committee which met informally last year be added to the agenda.

Ms. Oldson asked Task Force members to suggest state programs they would like to learn more about. The states of New Hampshire, Florida, and Pennsylvania were suggested, with the preference of New Hampshire cited. Staff was directed to make the necessary arrangements.

Adjournment and Next Meeting

Ms. Oldson adjourned the meeting at 11:50 a.m. The next meeting of the Iowa Healthy Kids Program Study Task Force is scheduled for Wednesday, November 6, 1996 at the Hotel Fort Des Moines in Des Moines from 1:00 p.m. - 5:00 p.m.

Iowa Healthy Kids Program Study Task Force
12:30 - 4:30 p.m.
Friday, November 8, 1996
Hotel Fort Des Moines * Room 308
10th and Walnut
Des Moines, Iowa

Agenda

12:30 p.m. **Call to Order and Introductions**
Jo Oldson, Chair

12:45 p.m. **Presentations**
* Iowa Healthy Kids Coalition
David Carlyle, M.D.
Mary Hansen, Ph.D.

* Iowa Medicaid Programs
Anita Smith

* The Caring Foundation
Molly Kurtz

* New Hampshire Healthy Kids
Tricia Brooks, Executive Director

3:45 p.m. **Public Outreach Component**
* Focus Group Meetings
* Focus Group Script Outline
* Focus Group Registrants

4:15 p.m. **Research Component Update**
* Iowa Statistics
* Other States Programs

4:30 p.m. **Adjournment**

Iowa Healthy Kids Program Study
Task Force Meeting
Friday, November 8, 1996
Hotel Fort Des Moines * Des Moines, Iowa

Meeting Summary

Task Force Members Present
Jo Oldson, Chair, Iowa Insurance Division
Mary Anderson, Iowa Department of Public Health
David Carlyle, M.D., Iowa Academy of Family Physicians
Mary Hansen, Ph.D., Drake Center for Health Issues
Mannie Holmes, Peoples Community Health Clinic
Ellen Johnson, Area Education Agency IV
Molly Kurtz, Iowa Caring Foundation
Pat Markham, Cass County Memorial Hospital
Janice Merz, Iowa Association of School Boards
Merle Pederson, Principal Financial Group
Barbara Philibert, Scott County Decatergorization Program
Rizwan Shah, M.D., Family Ecology Center
Anita Smith, Iowa Department of Human Services
Richard Sundblad, School Administrators of Iowa
Rod Turner, American Republic Insurance Company

Guests
Tricia Brooks, New Hampshire Healthy Kids
Carl Harris, Deloitte and Touche
Steven Jacobson, Employee Benefits
Marcia Oliver, Iowa Caring Foundation

Staff
Tom Slater, Julie Blum, and Clark Conover

Welcome, Introductions, and Overview
Jo Oldson, Chair, welcomed the task force members and asked for self-introductions. She introduced Carl Harris, of Deloitte and Touche, who will be performing the actuarial study for the study. Mr. Harris explained the concept of an independent actuarial process to the Task Force members.

Presentations
Iowa Healthy Kids Coalition
David Carlyle, M.D. showed the members an *ABCNews* video clip on the Florida Healthy Kids Program. Florida has 47,000 children enrolled in their program, which was one of the factors for the creation of the Iowa Healthy Kids Coalition. The group was formed in 1995 after information was passed from Steve Jacobson and the Iowa Academy of Family Physicians to the General Assembly and the Governor's office. This offered a directive, in 1995, from the Governor and the Iowa Senate to fund a feasibility study of an Iowa Healthy Kids program.

Mary Hansen, Ph.D. explained the result of this directive was the formation of a study group to examine the needs of uninsured children and find potential solutions. A

Healthy Kids Conference was held the following Fall, explaining the Florida Healthy Kids concept to interested parties. The current Task Force begins its efforts where the original study group left off.

Iowa Medicaid Programs
Anita Smith explained the structure of the various Iowa Medicaid programs. Currently, Iowa has 233,000 people enrolled in various state programs. Eligibility requirements, benefits, and length of stay differ. Listed below is a brief summary of each program.

Family Investment Program (FIP)
Age Limit: 18
Full time students in a secondary school or its equivalent can be eligible if they can be reasonably expected to complete the program before the age of 19. The fundamental qualification to receive FIP benefits is a dependent child who is living with a specified relative, but who is deprived of parental support or care.

Child Medicaid Assistance Program (CMAP)
Age Limit: 21
Medicaid under CMAP is available to persons under the age of 21 who meet all FIP eligibility requirements, except: deprivation, work requirements, and striker rules.

Mother and Children Program (MAC)
Age Limit: 13 (must be born after 9/30/83)
Medicaid is available through MAC coverage groups to all children born after 9/30/83 who not have attained the age of 19. FIP methodologies are used to count income except 50% work incentive deductions to earned income. CMAP exceptions apply.

Supplemental Security Income (SSI)
Age Limit: None
Children who are blind, death or disabled may qualify for SSI. Eligibility is determined by the Social Security Administration. Persons who quality for SSI are usually automatically eligible for Medicaid.

Medically Needy Program
Age Limit: 21
The Medically Needy program is designed to provide Medicaid coverage to persons who exceed income or resources levels for cash assistance, yet do not have adequate medical care. If the household's Medical Needy Income Level (MNIL) is exceeded, it must meet a "spend down" process by which the person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

Discussion of the Medicaid programs by Task Force Members followed.

Blue Cross/Blue Shield Caring Programs for Children
Molly Kurtz, Executive Director, explained the Iowa Caring Program for Children. The program is designed to provide preventive care to Iowa children who meet age and financial eligibility requirements. It is the state's first and only public/private health insurance program for children of the unemployed and marginally employed, who

otherwise could not afford health care coverage. The program is supported by donations from state government, religious organizations, community groups, businesses, private foundations, and contributors.

Program promotion is done through public events and literature distribution by affiliated partners such as school nurses, shelters, religious organizations, public programs, charities, and affiliate hospitals. Grants, donations, and fundraising efforts are also keys to the program's success.

Eligibility

1. Under the age of 19; must be a full-time student if of school age.
2. Health cannot be a determining factor, all children in the family must be enrolled.
3. Enrollment limited to persons not eligible under any government health insurance program.
4. Child must be an Iowa resident, for a minimum of six months, with the intent to stay in Iowa.

Benefits

The program fully funds primary and preventive health care, with a full range of outpatient hospital services. Pediatric preventive benefits are also provided. No benefits for inpatient hospital services are included except for those hospitals who have agreed to underwrite all expenses related to inpatient care. The benefit costs are offset by substantial discounts from hospitals and physicians who participate in the program.

New Hampshire Healthy Kids

Tricia Brooks, Executive Director, of the New Hampshire Healthy Kids program explained the New Hampshire Healthy Kids program to task force embers. NHHK is a private, non-profit corporation governed by a seventeen member, volunteer Board of Directors. The program is based on the Florida model and was started in 1993 from a $250,000 state appropriation.

Initial program implementation focused on creating a children's health insurance program that is comprehensive and emphasizes preventive and primary care. The program began to find alternative (non-public) funding streams, created a premium structure, and selected Blue Cross/Blue Shield as its insurance partner, which agreed to cover the administrative, printing, and marketing expenses. Blue Cross also accept all risks for the program..

In the first year, the program reduced the number of uninsured children by four percent, serving a total of 827 children. The program initiated dental coverage in its second year and also extended eligibility to infants and toddlers. Ms Brooks explained that the it is a stop gap program designed for working families. Their records show that 98% of the people who leave the program move on to private insurance plans.

The New Hampshire program is currently exploring long term funding options. They are identifying potential private partners and have initiated a fundraising campaign. The program's budget was $590,000 in fiscal year 1995 and $1.2 million in this year.

Premium Structure

The program realized that premium affordability is the key to participation. The current cost of participation is $60.50 per child per month over the age of two; $77 for infants and toddlers. This includes the increase of $8.50 for dental coverage. The rate is guaranteed until February 28, 1997. There are co-payments for certain services, provide patients access to care through their primary care physician: preventive care is paid 100%; physician visits for illness, injury, or prescriptions require a $5 co-pay; and mental health visits, eyeglasses, and hearing aids require a $10 co-pay. There is increased cost-sharing if care access not through their PCP.

Benefits

The program offers the following coverage benefits: dental, immunizations, physician visits for illness or injury, prescriptions, eyeglasses, hearing aids, diagnostic tests, home health visits, mental health, outpatient surgery and anesthesia, qualified hospitalization, emergency room, and occupational, physical, and speech therapy.

Open Discussion

Tom Slater led an open discussion with Task Force members reviewing the presentations. The Task Force responses are listed below:

- The concept is solid, but a state appropriation is needed to supply the necessary capital for program start-up. There will be a gap of people without coverage until an infrastructure is built.
- State legislators want results-based programs, so the more data compiled the more support the program will garnish in the general assembly and with private industry (fundraising).
- By tieing educational outcomes to the child's health and welfare may convince some policy makers of the importance of this project.
- The New Hampshire program makes sense. New Hampshire Blue Cross/Blue Shied is assuming high risk, but that component is what makes the program work. Finding such a partner in Iowa is the key to success.
- Florida is rated as a private product with good loss ratios and ratings. They have a very good product, in fact they donated $300,000 back to the sponsoring HMO last year. What is the possibility of an Iowa Healthy Kids program obtaining the same insurance exemptions that New Hampshire and Florida received?
- The New Hampshire program appears to be marketing their product primarily to the working middle class. Under that model, Iowans who are working poor will not be able to purchase the insurance plan unless it is at least partially subsidized by the state or an outside interest. The sliding fee scale that is being tested in New Hampshire may be the solution to making this plan accessible to Iowa's poorest communities.

- Vermont's Medicaid program, Dr. Dynasaur, has removed all references to state and federal assistance programs. By removing the "Medicaid" stigma they have increased the program's participation.

- Iowa has a good system, the problem lies within the fragmentation of programs. The state needs to develop a seamless delivery system that provides services to entire families. By treating families as a unit, you can provide the same physician, use existing resources, encourage self-reliance, and develop a user-friendly Medicaid system.

- Today's children are using the school nurse as their primary medical provider. Children with long-term, chronic problems are not being treated adequately.

- Pennsylvania is where the Caring Programs were founded through cigarette tax money. The program includes multiple insurance carriers integrated into a seamless delivery system, with the Caring Program providing safety net coverage. The program does not cover children beyond 185% of poverty.

- Who determines who receives the coverage and what are the benefit packages? One set of rules and simplicity in administration is important.

- Who are these children, where are they, how will the program reach them, and how will the delivery system be structured? This issue should not be political, but instead should be fundamental. Can the use of the cigarette tax, the local option sales tax, an alcohol tax, or a percentage of gambling revenues by used to fund the program?

- Is there some way to coordinate this program with existing programs? For example, some physicians already hold free clinics in area schools. Can these programs be incorporated?

- There are too many Iowans who do not understand insurance and how it functions. How do we reach and educate these people? How do we explain the principles of reduced rate insurance programs, make them understand the benefits, and enroll them?

- Should we look at consolidation and expansion of existing products instead of creating a new product?

- If we are going to provide coverage and market to the correct constituencies, how can get the number of children to make it work? Education may be the key. One way may be to offer a series of walk-in clinics to attract people who are non-traditional users.

- Iowa has to start small and build. Companies may not want to participate in this program due to cost, unless foundation match money can be found. If the program proves successful it can pay for itself. The working poor needs to be the target beneficiary.

- The reality is that some parents would rather feed their drug habit than ensure their children's future through inexpensive health care coverage. Iowa has a competitive insurance market and employers are willing to insure their employees. The costs to incrementally cover children is not high. The idea of a purchasing pool is attractive.

- There was discussion during the Clinton health care proposal about these ideas, which has laid the initial groundwork this project. Insurance companies should not be adversarial to this proposal, they should work with this group to find plausible solutions. I do not think there is an insurance company in this state that would not want to cover each and every one of these children.

- What is the charge and can the Task Force concentrate on finding solutions using current programs to create a seamless delivery system?

Public Outreach Component
Julie Blum informed the Task Force that the model focus group script was included in their packet and that 90 people have pre-registered for the six focus group meetings. A draft synopsis of participant responses will be available at the next meeting.

Research Component Update
Ms. Blum asked the Task Force members to review the updated state synopsis research which was provided in the packets.

Next Meeting and Adjournment
The next Task Force meeting is scheduled for Thursday, December 5, 1996 in the Insurance Commissioner's Conference Room, from 9:00 a.m. to 12:00 p.m. The meeting was adjourned at 4:30 p.m.

Iowa Healthy Kids Program Study Task Force
9:00 a.m. - 12:00 p.m.
Thursday, December 5, 1996
Insurance Commissioner's Office
6th Floor * Lucas State Office Building
Des Moines, Iowa

Agenda

Call to Order and Introductions
Jo Oldson, Chair

Review of Focus Group Meetings
Tom Slater

Discussion of Proposed Program Parameters
Jo Oldson & Tom Slater

* Benefit Cost Structure
* Program Models

Proposed Final Report Format
Tom Slater

Adjournment

Next Meeting Date: Thursday, December 19, 1996

Iowa Healthy Kids Program Study
Task Force Meeting
Thursday, December 5, 1996
Division of Insurance * Des Moines, Iowa

Meeting Summary

Task Force Members Present
Jo Oldson, Chair, Iowa Insurance Division
Mary Anderson, Iowa Department of Public Health
David Carlyle, M.D., Iowa Academy of Family Physicians
Paula Dierenfeld, Office of the Governor
Mary Hansen, Ph.D., Drake Center for Health Issues
Ellen Johnson, Area Education Agency IV
Molly Kurtz, Iowa Caring Foundation
Pat Markham, Cass County Memorial Hospital
Janice Merz, Iowa Association of School Boards
Merle Pederson, Principal Financial Group
Barbara Philibert, Scott County Decatergorization Program
Anita Smith, Iowa Department of Human Services
Rod Turner, American Republic Insurance Company

Guests
Carl Harris, Deloitte and Touche
Ed Schor, M.D., Iowa Department of Public Health

Staff
Tom Slater, Julie Blum, and Clark Conover

Jo Oldson, Chair, called the meeting to order at 9:10 a.m.

Welcome and Introductions
Jo Oldson, Chair, welcomed the task force members and asked for self-introductions.

Next Meeting
Jo Oldsonannounced that the next meeting of the Task Force will be Friday, January 17, from 10:00 a.m. to 12:00 p.m. in the Insurance Commissioner's conference room.

Public Outreach Component
Tom Slater reported that focus groups were scheduled in six sites: Des Moines, Ottumwa, Shenandoah, Storm Lake, Clinton, and Waterloo. Two sites (Shenandoah and Storm Lake) were canceled due to inclement weather and lack of registrants. Questionnaires were sent to registered participants at those two sites and their responses were incorporated into the report.

Tom SLater advised the members that many of the concerns that were mentioned at the focus group meetings are ones that the Task Force had identified. Mr. Slater highlighted some of the key aspects in the focus group report.

Proposed Program Parameters

Carl Harris detailed the scope of a cost structure for an Iowa Healthy Kids Program. He established two parameters: a low option and a high option. Within each of these options were three separate utilization models: 100% of poverty; 185% of poverty; and 143% of poverty. This accounts for six separate cost runs.

Within each utilization model were a number of categories examining factors such as: utilization per 1000; cost per health benefit; and cost per member per month; etc.

Mr Harris detailed how the calculations were determined and how each model's computations were developed. He also factored in appropriate administrative charges for the a still unknown insurance carrier.

The following rates were determined:

100% of poverty (32,500 eligible children)

High Option ($17 pmpm) Low Option ($3.1 pmpm)

143% of poverty (52,000 eligible children)

High Option ($27 pmpm) Low Option ($5 pmpm)

185% of poverty (67,000 eligible children)

High Option ($35 pmpm) Low Option ($6.5 pmpm)

The following factors are constant in each model:

-Low Option is a basic preventive medicine package while the High Option is comparable to a full coverage insurance package.

-Benefits are not included the models;

-A lifetime max of $1 million on small groups (except for substance abuse and mental health);

-No limit on office visits (annual assumed cost);

-Capitation/Fee-for-Service will have an affect on these numbers according to how the provider's contracts are structured;

-The models have no components of the New Hampshire cost sharing models. Those arrangements will have a dramatic impact on final premium rates;

- Deloitte and Touche have done similar models for Minnesota;

- These models are the approximate figures for preliminary discussion;

- Add-in programs (dental) can be incorporated;

Anita Smith will provide to Mr. Harris what the State of Iowa is already spending, at each appropriate poverty level, to incorporate into his report. He also noted that the Low Option is similar to the Option 1 of the earlier Healthy Kids work group, while the High Option is similar to a combination of portions of Options 2 and 3 of the previous work group report.

Mr. Harris said that insurance carriers will need a minimum participant number, but these numbers will suffice for discussion and calculation purposes. The premises are solid.

Rod Turner reminded that Task Force that the smaller the enrollee numbers in the plan, the larger the premiums will be. If the numbers get too small there will be an "Anti-Selection" issue. This will raise the premiums on those people who feel the program is worthwhile, while those who do not will opt out. That minimum number is unknown at this time, but Mr. Turner speculated that at 185% of poverty the minimum number would be about 3,000. Any drop below this threshold and the plan will not be fiscally sound. Factors such as private contributions, state supported funds, etc. must also be considered.

Mr. Harris reminded the Task Force that each of the models only covers children between the ages of 5 to 18. The 0 to 5 age group is not covered in these models. If this group were included in the presented actuarial examination the numbers will be drastically different. This is due to increased services.

Ms. Smith suggested that since Iowa has mandated that all children 0-18 at 100% poverty must be covered by Medicaid by the year 2002, it would be feasible for the Healthy Kids program to expand the current coverage. It will cost approximately $3 million to cover 14-18 year old who are not currently covered by Medicaid. Step two would involve additional funding to bring 5 to 18 year olds up to a new level of percentage of poverty. After discussion, the Task Force commented that this idea by Ms. Smith, of a targeted population, would have an immediate positive impact. Furthermore, the patient numbers and the costs are known and the enrollment process would be a concentrated effort to provide a niche for kids whose parents cannot afford health care at a reasonable cost.

Molly Kurtz stated that the Caring Foundation would consider administering the program. Blue Cross/Blue Shield may discontinue the Caring Program if their client population was included in the Healthy Kids program. She felt that the administrative experience of the Caring Foundation would be a natural fit for the new non-profit administration entity.

<u>Models Discussion</u>

1.) New Hampshire Model

A non-profit corporation would administer the program, with the private insurance carriers assuming the risk. The non-profit corporation markets the plans, negotiates with the insurance companies, and administers the plan. The New Hampshire approach addresses fractions of the populations at a time.

-program with an Insurance Provider

-no subsidy money from state towards premium, family pay.

2.) State Subsidy Model

Buying down premiums based on a sliding-fee scale

-with menu of options.

3.) Insurance Waiver Model

By changing Iowa law you could provide a middle model of insurance specifically targeted for underinsured and uninsured populations. Currently insurance companies cannot sell this product due to state law. To offer this product it would require legislative approval.

-direct marketing by Insurance HMOs
-marketing by Non-Profit
-for Iowa-only insurance carriers?
-Arkansas Medicaid spend down to $29 using similar method
-sliding fee scales.

Part of the problem will be reaching eligibles who are not reachable through traditional insurance marketing approaches. The non-profit could be an effective marketing agent. The state would mandate what benefits would be offered by each entity.

4.) DHS/Medicaid Supplement Model

Three million dollars would allow the state to buy-in 14 to 18 year olds who are currently excluded from Medicaid at 100% of poverty. This measure has been mandated to be accomplished by the year 2002. The buy-in would allow for it to occur immediately.

-need to suggest a funding source
-possible provider tax?

The Task Force agreed to place Mr. Harris' numbers in the report as an example for discussion purposes, along with the four program options which were discussed.

Member Assignments

The rough draft of the report will be sent to Task Force members on January 10, 1997. Margin comments are due back to staff on January 15, 1997.

Adjournment

The meeting was adjourned at 12:00 p.m.

Iowa Healthy Kids Program Study Task Force
Focus Group Outline

I. Introductions
   A. State Public Policy Group
   B. Task Force members

II. Rationale for Healthy Kids Focus Groups
   A. Locations
   B. Seek valid local information
   C. Identify issues and input

III. Task Force Members
   A. Self-introduction and individual role/organization
   B. Composition of focus group participants

IV. Purpose of Focus Group
   A. Solicit points of view from participants
   B. Define issues, needs, and recommendations for solutions

V. Structure of Focus Group
   A. Use of script (including a premise and follow-up questions) as a discussion guide
   B. Non-attributable comments and discussions
   C. Notes and report
   D. Time constraint - two hour session

VI. Begin Focus Group

Script

You have been asked to come to this meeting today to participate in an effort to provide information that will assist in the study of alterative methods to offer health insurance coverage for children. You will not be solicited or asked to do anything more than spend two hours in a facilitated discussion. No special expertise is required for you to participate.

Premise one: For many years Iowans have faced an increasing crisis: thousands of Iowa children are uninsured or underinsured resulting in less healthy and less productive children and in the long-term adults. Although accurate statistics are unavailable it is estimated that between 50,000 and 75,000 Iowa children are without health insurance. These estimates do not include underinsured children, nor do they take into account the changing public policy environment in which Medicaid cuts may result in even more children dropped from Medicaid eligibility. Whatever the current number of uninsured children, it is reasonable to expect the number to continue to increase.

Question 1: What experiences have you had in your local community demonstrating the increasing need for health care for Iowa children?

Questions 2: In your area where do uninsured families go for health care services?

Question 3: In your opinion, what solutions address this growing number of uninsured children?

Premise two: Children who have health care coverage are more likely to receive health care. Children without health care coverage are less likely to have routine doctor visits, seek care for injuries or have a regular source of medical care. Children without health care coverage are also less likely to be immunized - an important step in preventing childhood illnesses. In addition, children without adequate health care are more likely to perform poorly in school, while parents face increasing absenteeism at work to attend to their children's needs.

Question 1: Who are the people in your area that have unmet health care needs?

Question 2: What methods do you believe would encourage these families to obtain health care for their children?

Questions 3: Who besides the individual family should be responsible for meeting these needs?
Should local communities and/or schools be more directly involved in the provision of health care?

Question 4: Are you familiar with any programs in your local area that could be coordinated with a new initiative to offer health care coverage for children?

Premise 3: In the mid-1980s states and private organizations began developing health insurance programs to increase health care access for children. Most of these programs are designed for children who are caught in the gap between private insurance and Medicaid, the federal/state program that insures some low-income people. A recent study indicated that there are 34 insurance programs for children operating in 30 states. These programs are categorized into three types: 1) public programs - financed totally by federal, state or local government funds; 2) public/private partnerships - funded through a mix of public, private and charity dollars and 3) Caring Programs for Children - private programs administered by regional Blue Cross/Blue Shield Plans.

Question 1: What reasons can you give that support Iowa establishing a health care coverage program?

Question 2: What barriers do you see for the State of Iowa in developing a similar health insurance program for children?

Question 3: Of the three structures mentioned, what structure do you think would work best in Iowa and why?

Question 4: What groups or individuals do you believe would be instrumental in developing a program in Iowa?

Premise 4: We appreciate the thoughtful comments you have offered. We have discussed several important issues related to improving access to children in our state. We would like to conclude these meeting by asking each of you to share your thoughts on the following two questions. (Round Robin Response)

Question 1: What should the State of Iowa do next on this critical issue?

Question 2: If the State of Iowa decides to do nothing what implications do you believe this will have on the future of Iowa's children?

Thank you for your participation. Your comments will be presented to the Iowa Healthy Kids Program Study Task Force and considered in the formulation of the report to the General Assembly and Governor Branstad.

Healthy Kids Program Study
Public Outreach
Ottumwa Focus Group
November 11, 1996

Name	City
Cheryl Jones	Ottumwa
Carol Mitchell	Oskaloosa
Berdette Ogden	Oskaloosa
Lori Sholker	Oskaloosa
Kathy Welsch	Albia

Premise 1: For many years Iowans have faced an increasing crisis: thousands of Iowa children are uninsured or underinsured resulting in less healthy and less productive children and in the long-term less healthy adults. It is estimated that between 50,000 and 75,000 Iowa children are without health insurance. These estimates do not include underinsured children, nor do they take into account the changing public policy environment in which Medicaid cuts may result in even more children dropped from Medicaid eligibility. Whatever the current number of uninsured children, it is reasonable to expect the number to continue to increase. Recognizing that there are uninsured and underinsured children in Iowa, consider the following questions.

1. What evidence to you see in your local community demonstrating the increasing need for health care for Iowa children?

I just spent half of the day trying to find insurance for a child that does not qualify for anything. I'm not sure how to resolve this or if we will. One of the issues with Medicaid is that children go on and off the program. With the managed care system, we are increasingly limited to where we can send children, especially if the children are uninsured. In the last twenty years, I have seen that the number of families employed at lower paying jobs without benefits is increasing.

I agree that there are lower paying jobs with fewer benefits. People are also hiring more temporary workers.

Two years ago In Oskaloosa, we started a free clinic. The clinic is staffed by volunteer nurses and doctors. It has been so successful that we have had to put a limit on the number of people we saw. These are children who are underinsured or not insured. The clinic has actually established a clientele. People start lining up at 6:00 pm. The clinic is run on free will donations.

I see a lot of school aged kids that come in for treatment and then the parents cannot afford to purchase the medication. I refer a lot of these kids to the free clinics in the area, but I don't know if they take advantage of the services that are available to them.

2: In your community where do uninsured families go for health care services?

We have a doctor that comes to town from Grinnell, it is not a free clinic. We do not have a community-based school clinic, yet. The community has to decide if they want it and I haven't heard anything from the community. We also experience a problem in that we have a lot of people who move around in the county, that's when we lose track of the kids.

I would say that if they can't afford it, they don't go. There is some immunizations that are done, but there are not free clinics available.

Recently, we took over becoming the child health provider for the area. The emergency room is another place they go. Most of these people don't want to fill-out the paperwork for the emergency room, though. The last resort is that they may check with county relief or call the public health office.

In my area, people call MCH. They are busy and they see a lot of children. There is a clinic in Ottumwa and Centerville, with outreach services in Davis and Van Buren counties. The majority of our families are under the poverty level. The Title V program resources are diminishing. Private health offices carry some of these families, but they can't always do this. We have such incredibly high numbers of families who are uninsured or under insured. It doesn't take long to run up a medical bill.

3. In your opinion, what solutions may begin to address this growing number of uninsured children?

I wish I had an answer.

Affordable pharmaceutical products for children. Why can't they sell to parents at a reduced cost? Most parents won't go to a doctor if they know they can't buy the prescription

Better utilization of the Title XIX programs in Iowa. In a number of cases, public health nurses have been incorporated into hospitals. The whole issue of private health infrastructure is an issue. Our agency has been excluded from providing service to insured persons. The managed care program is limiting people from programs we have served for years. One of the issues we have to look at in Iowa is economic development, not the $5/hour jobs.

I like the free clinic system, it's a good network. There are specialists

that can be referred to in the clinic.

Premise 2: Children who have health care coverage are more likely to receive health care. Children without health care coverage are less likely to have routine doctor visits, seek care for injuries, or have a regular source of medical care. Children without health care coverage are also less likely to be immunized - an important step in preventing childhood illnesses. In addition, children without adequate health care are more likely to perform poorly in school, while parents face increasing absenteeism at work to attend to their children's needs. Considering this, please answer the following questions.

1: Who are the people in your community that have unmet health care needs?

Single parents working at five dollar/hour jobs, who have to be at that job, are the ones who rarely seek well baby check ups, or immunizations. They are actually the second generation of the same situation. They are not able to get welfare benefits. I have seen an increase in divorced families, where the non-custodial parent will not help pay.

I see a lot of blended families and because maybe the Mom doesn't live with the children and the step-mom doesn't really care about the health care needs. Nobody is managing the children.

For special needs, the new SSI is going to be devastating. With the working poor, as long as nobody gets sick and nothing happens, they can get by, but if something happens they are devastated.

2: What do you believe would encourage these families to obtain health care for their children?

Longer hours, if you have two parents working, it's hard to get to the doctor.
The State of Iowa has a law that says a child entering kindergarten must be immunized. The school must enforce this law, currently no one is. The law is also poor, because a child should really be immunized by age 2. I have even told parents where reduced or free immunizations are available and they don't go.

There ought to be an incentive program, pay them to bring the kids to the clinic. We've brought immunization clinics to the school at kindergarten round-up and parents still don't utilize the service.

They've used incentive for lots of things, e.g. contraceptives. There also needs to be better education of providers. We' try to check immunization records, private practitioners won't provide the information without permission from the families.

The majority of families that I've followed want to get their

immunizations. The mother felt that the reception received had was that they were not welcome at health care places - both public and private clinics. The perception of these women is that they are not treated like the other patients.

We need to market ourselves - advertising. We're going to try to start doing some free evaluation visits to more educate the families.

A lot of parents are chastised for not bringing in their children sooner.

3: Who, if anyone, besides the individual family should be responsible for meeting these needs? Should local communities and/or schools be more directly in providing health care?

Yes. The state has a big push for community health needs. I see a lot of finger pointing by community members, the power players. Those that have the money and don't understand the needs. They should be somewhat more responsible. A community needs to take ownership, not be a "we and they", must become an "us".

The whole health care community. The insurers need to be involved. I seeing the employers bottom-lining health coverage. They want to see how cheap they can get it. The power brokers in the community must look at bottom-line containment. All of the people have a part.

I think that the insurance industry runs health now. They have an active role, they need to set at the table, instead of at the head of the table.

4: Are you familiar with any programs in your local area that could be coordinated with a new initiative to offer health care coverage for children?

The Title V programs, both the primary care and special needs, have a long history.

I think Title X and 20 programs can be a benefit to children. Sometimes we leave out family planning, it is a must for everyone under 21. I need another nurse practitioner now. I could actually use two more. I'm booked six weeks in advance right now. I could interface with any program that comes along and is willing to provide services. The key is that to have a healthy child, you need a healthy mother.

I think the AEA is a natural foundation for all our children, they have the ability to tap into some of those kids they we are not. Develop a community-based referral system, with transportation.

Premise 3: In the mid-1980s states and private organizations began developing health insurance programs to increase health care access for children. Most of these programs are designed for children who are caught in the gap between private insurance and Medicaid, the federal/state program that insures some low-

income people. A recent study indicated that there are 34 insurance programs for children operating in 30 states. These programs are categorized into three types: 1) public programs - financed totally by federal, state or local government funds; 2) public/private partnerships - funded through a mix of public, private and charity dollars and 3) Caring Programs for Children - private programs administered by regional Blue Cross/Blue Shield Plans. Recognizing these different program options, please consider the following questions.

1: Do you support Iowa establishing a health care coverage program? Why or why not?

They should be establishing something, because the healthier children that we have the better future they are going to have. Each child that we can keep healthy and in school, is going to lead a more productive life. It's part of educating everybody. The better we keep our kids healthy, the better it is for everybody.

There are a tremendous number of kids that are not covered and need services. If they did get the services, then they would be more healthy. When I first went to family planning 20 years ago. If I had an abnormal pap smears for someone under 18 once every six months, I would freak. Now it happens on a regular basis. I have trouble finding money for treatment for these people. They have no money. I have a hard time getting that 16 or 17 year old taken care of. It might cost $400-500.

It's a basic issue of fundamental fairness. All people deserve basic health care in the State of Iowa. It economically makes sense. To continue a system where children don't have access to care, doesn't work. Someone is going to have to pay somewhere along the line.

The poorest may be covered by Medicaid, but we can't cover those in between. It just doesn't make sense.

We have to make people aware that they are responsible for their own health. We can give them all the information and education, but they have to take responsibility at some time.

There's a spin off question, are you saying that the State of Iowa should be responsible for the children if the parents are not going to? If the parents aren't willing to do it, I think the state should take that on.

One of the realities for rural providers is that they are over booked and overextended. You have to look at the system. It is over taxed now.

2: What barriers do you see for the State of Iowa in developing a similar health insurance program for children?

There's still a mind set that poor people are poor because they aren't willing to work hard. I think the economics of the state are working against us, especially in southern Iowa. I think that this is not a popular thing with the electorate. People must recognize that the state can't do

it alone.

There has to be a buy in from the private sector.

People want to know why they should pay for the free health care with taxes when they are already working and paying for their own health care.

Having a group of people decide what the biggest needs are and then also find the minimum level of need.

There is a political revolving door. If you can't get the thing done in two years, you might as well not do it. The people you work with may not be there again in the next two years.

3: Of the three structures mentioned, which do you think would work best in Iowa and why?

Without worrying about where the funding would come from, people are more apt to like the government because they don't see it directly coming out of their pocket.

I would tend to do more of the public/private mind set because it is more community-based and allows for more input.

I really don't know, I don't like any of them. I would probably go with a private, non-profit and public partnership. The Caring Programs for Children programs are working well.

I think in an ideal world, the public/private relationship would be good. Not sure that now it would work, they aren't on equal footing. He who holds the purse strings, calls the shots. The Caring Program is not helpful for my type of children. There is a limited number of providers that participate in the program.

4: What groups or individuals do you believe would be instrumental in developing a program in Iowa?

We need a variety of the professional health care representation. This would include private, IDPH, Insurance Commission, economic development groups, etc. There needs to be broad spectrum representation. I served on the children and adolescent sub-committee and we did make recommendations for a plan. Some of the groups recommendations did lead to legislative recommendations. We need a group of individuals who go in working for the needs of the children.

Premise 4: We appreciate the thoughtful comments you have offered. We have discussed several important issues related to improving access to children in our state. We would like to conclude this meeting by asking each of you to share your

thoughts on the following two questions.

1: What should the State of Iowa do next on this critical issue?

Establish a broad-based, blue ribbon task force. Some group that would meet and make assurances that what happens will be turned into policy one day.

Develop a coalition with real people that can work together to form resources and work to provide.

Each county should develop a task force to develop what their community needs and then have a state-wide meeting to frame a program. A blanket is not going to work for the entire state.

By July 1, every child should have at least five basic items: immunizations, well-children check-ups, pharmaceuticals, acute care, and ill care.

Dentistry is a big need, as well as well-child preventative care. The UPSTD proposed plan is a good one. We need to better look at children's nutrition overall.

Funding, unless you're on a WIC program, where there are no funds.

2: If the State of Iowa decides to do nothing what implications do you believe this will have on the future of Iowa's children?

You will have sick adults, mentally, physically, emotionally.

We will have a lot more people in the same situation that you are talking about now, only more increased. It's a generational situation. It's kind of like the welfare system. Things passed down from one generation to another.

We will probably limp through and not very well. There is an increasing number of frustrated health providers who will opt out of the system. I have seen more frustration and burnout and felt more in the last two years then I ever have.

It will have a profound impact on health care providers.

Healthy Kids Program Study
Public Outreach
Des Moines Focus Group
November 11, 1996

Name	City
Brenda Van Deer	Webster City
Paula Kloche	Carroll
Holly Smith	Des Moines
Janice Lane	Des Moines
Rick Shannon	Des Moines
Mary Fuller	Des Moines
Paul Bishop	West Des Moines
Nardelle Dallager	Des Moines
Cindy Johnson	Iowa City
Jane Bell	Des Moines
Rose Beady	Clear Lake
Jane Heathoff	Carroll
Rose Marie Serca	Des Moines
Janet Glaze	Des Moines
Todd Huesman	Adel
Gail Meyer	Des Moines
Jason Birdie	Des Moines
Kaye Grossmickle	Fort Dodge
Mary Ellis	Des Moines
Judy Dierenfeld	Des Moines
Chris Manson	Creston
Marilyn Walker	Webster City
Mary Ann Nielsen	Des Moines
Lori Devlin	Des Moines
Marcy Harms	Fort Dodge
Sandra Price	Fort Dodge
Anna Hines	Altoona
Janne Barnett	Atlantic
Teresa Wickman	Atlantic
Becky Miles Pole	Des Moines

Task Force Members Present:
Jo Oldson, Chair
Janice Merz
Molly Kurtz
Mary Hansen

Legislators Present:
Senator Elaine Szymoniak
Representative Betty Grundberg

Premise 1: For many years Iowans have faced an increasing crisis: thousands of Iowa children are uninsured or underinsured resulting in less healthy and less productive children and in the long-term less healthy adults. It is estimated that between 50,000 and 75,000 Iowa children are without health insurance. These estimates do not include underinsured children, nor do they take into account the changing public policy environment in which Medicaid cuts may result in even more children dropped from Medicaid eligibility. Whatever the current number of uninsured children, it is reasonable to expect the number to continue to increase. Recognizing that there are uninsured and underinsured children in Iowa, consider the following questions.

1. *What evidence to you see in your local community demonstrating the increasing need for health care for Iowa children?*

Exposed to many children and in general their attention spans are not what they use to be; children's behavior is not the same.

Deal with equity in schools and behavioral disorders, hear more and more about society ills that affect the way we educate children; it is not just reading and writing.

At clinics we see an increasing number of people with no routine health care, average 400 visits a month and the majority of those are children.

Des Moines has a fragmented health care delivery system, its putting band aids on. We need to try to find a medical home for children. 37% of Des Moines school children qualified for free or reduced lunch program through the schools, now it is up to 45%.

Mental health and emotional issues are having a big effect on health care.

Increasing number of children do not have parental guidance and it is affecting health care.

Of the children we see, if they have health insurance it is very limited.

Families are struggling we see children at the Des Moines homeless shelter.

Teen do not receive health benefits if they do not live with their parents.

Kids go on and off Medicaid, big gaps in care.

Kids who are on medication don't get medicine on a regular basis.

Community fund in one community has a prescription program for children.

We see families who have a parent laid off and lose health care coverage.

Some are afraid to bring children in to provider because they can not pay for the visit.

2: *In your community where do uninsured families go for health care services?*

Child and youth clinic in Cass County and private provider who offers services at no charge.

Well child clinics, Title 5 , but they have lost some funding, there are not many options.

Private physicians, if they do not have any outstanding bill at the office.

People go in and out of coverage.

Community health centers.

County hospitals

Emergency Room

Do not go for care

Call local ministry and ask for money.

In Mason City (9 county area) they have moved all people in title 19 into private providers, offering case management for kids, screen children for the Caring Program, and school free lunch program.

3: *In your opinion, what solutions may begin to address this growing number of uninsured children?*

Insurance may not be the answer. This might not be the right way to approach the problem.

Offer program to provide preventive care for children.

Insurance may not be the only barrier, too many independent programs, we need coordinated system of care, find all kids a medical home.

Children with mental and developmental disabilities have insurance but may be underinsured. There are real concerns with the threat of changes in Medicaid that will affect kids eligible through SSI.

Premise 2: Children who have health care coverage are more likely to receive health care. Children without health care coverage are less likely to have routine doctor visits, seek care for injuries, or have a regular source of medical care. Children without health care coverage are also less likely to be immunized - an important step in preventing childhood illnesses. In addition, children without adequate health care are more likely to perform poorly in school, while parents face increasing absenteeism at work to attend to their children's needs. Considering this, please answer the following questions.

1: *Who are the people in your community that have unmet health care needs?*

Working poor with low wages and no fringes.

People with multiple part-time jobs, that make too much money to qualify for Title 19.

Poor who are beat by the system. We need to invest in our children from the public policy perspective.

Homeless.

Minority populations.

Farmers who are self-insured and rates are too high too afford.

People without transportation.

Single women with children.

System must be user friendly. Government people are not friendly, they need to make an attitudinal change.

Employers need to offer low cost insurance to employees.

People need to take advantage of school insurance policies, they are playing with the luck of the draw. People will not pay, it would be better to take money out of their pay checks.

Communities could buy providers and the community would own the health care system.

2: *What do you believe would encourage these families to obtain health care for their children?*

People need to see a benefit in the policy they sign up for, which they currently do not see.

Make application materials easy to read and understand.

Mandate that parents must provide care or they will not send their children for care.

Children with chronic disabilities need more care than others.

Consider peoples priorities, health care typically is not a priority until it is an emergency situation.

Educate parents with face-to-face contacts.

3: *Who, if anyone, besides the individual family should be responsible for meeting these needs? Should local communities and/or schools be more directly in providing health care?*

County resources should be used to put a system in place that starts to serve children when the babies are born.

Do not wait for the school systems, they do not see children until the are five years of age.

Schools can't do everything for all people, but children can not learn if they are not healthy.

School based youth services programs could do more if they were not so fragmented.

There is a problem with turf issues, the money is in the system if the services could be coordinated and not offer duplicative services.

4: *Are you familiar with any programs in your local area that could be coordinated with a new initiative to offer health care coverage for children?*

Beyond Medicaid, different models serve different groups of children.

Keep programs that we have in place now, no more cuts.

School based clinics

Do not forget the dignity of the client, we need appropriate care, get rid of two tier system of health care.

School linked programs.

Way To Grow program- program for families to help them with various needs, food, shelter, health care, etc, they have an individual in the program to assist them.

Put health providers on-site at schools.

Premise 3: In the mid-1980s states and private organizations began developing health insurance programs to increase health care access for children. Most of these programs are designed for who are caught in the gap between private and Medicaid, the federal/state program that insures some low-income people. A recent study indicated that there are 34 insurance programs for children operating in 30 states. These programs are categorized into three types: 1) public programs - financed totally by federal, state, or local government funds; 2) public/private partnerships - funded through a mix of public, private and charity dollars and 3) Caring Programs for Children - private programs administered by regional Blue Cross/Blue Shield Plans. Recognizing these different program options, please consider the following questions.

1: *Do you support Iowa establishing a health care coverage program? Why or why not?*

No, government can be wasteful.

The state should do something. Healthier will learn more and have better futures. It will benefit the state in the long run.

We need a program to cover the children that do not qualify for Medicaid but can not afford to pay their own way.

Families need to be responsible for their own health, we need to offer more education about the existing programs.

We need to change the delivery system of care, make it more accessible and user friendly.

2: What barriers do you see for the State of Iowa in developing a similar health insurance program for children?

Too expensive, not fair to all citizens.

The cost will be high, and may be too much of a financial burden.

We need to have the private sector involved, they need to assist with the cost and support the idea.

The group needs to design something and find a way to pay for it.

Families need to support the idea, the state can't do it alone.

Need strong legislative leadership and support.

3*: Of the three structures mentioned, which do you think would work best in Iowa and why?*

Iowa should pursue a public/private partnership, so all share equally in the cost.

Number two would be better because it would be community based and could fit the needs of the different parts of the state.

Iowa should expand the Caring Program that is already operating in Iowa.

The government should support the program.

4. What groups or individuals do you believe would be instrumental in developing a program in Iowa?

The legislature needs to endorse the concept.

The insurance industry should help develop and pay for the program.

Local community leaders, health providers, churches and hospitals.

We would need a cross section of professionals, from insurance, economic development, child advocates and health care providers.

People who understand the problem and know how to develop a program that will offer a realistic solution.

Premise 4: We appreciate the thoughtful comments you have offered. We have discussed several important issues related to improving access to children in our state. We would like to conclude this meeting by asking you to share your thoughts on the following question.

1*: If the State of Iowa decides to do nothing what implications do you believe this will have on the future of Iowa's children?*

Devastating.

A greatly reduced opportunity for a healthy future.

Sicker children, leading to less productive and unhealthy adults.

The general society will be negative impacted.

The problem will only increase in both numbers and illness. The situation will continue to passed down to the next generation.

Local community groups will try to tackle the problem. Smaller networks within parts of the state will emerge.

More sick children that do not have the capacity to learn. The social implications will be enormous.

Healthy Kids Program Study
Public Outreach
Clinton Focus Group
November 14, 1996

Name	City
Melody Conner	Clinton
Teresa Francea	Lowden
Michelle Blackmer	Erie, IL
LeRoy Levis	Davenport
Dr. Karen Congett	Clinton
Denise Schrader	Clinton
Darrell Bolender	Iowa City

Task Force Member
Barbara Philibert

Premise 1: For many years Iowans have faced an increasing crisis: thousands of Iowa children are uninsured or underinsured resulting in less healthy and less productive children and in the long-term adults. Although accurate statistics are unavailable it is estimated that between 50,000 and 75,000 Iowa children are without health insurance. These estimates do not include underinsured children, nor do they take into account the changing public policy environment in which Medicaid cuts may result in even more children dropped from Medicaid eligibility. Whatever the current number of uninsured children, it is reasonable to expect the number to continue to increase.

1. What experiences have you had in your local community demonstrating the increasing need for health care for Iowa children?

We have gone through a new project -- a new 30,000-square feet facility for community health care. The project was driven by the clear need for community health care for children and other people. Now we can address childrens' situations in a more timely manner. We used federal and state funds, a bond issue, and community funds. We saw a need to have a place for these children to be served. The space is adequate for the present, but we are looking at outside places too.

We have an increasing number of children coming to school with increasing problems in the classroom. Parents sometimes cannot or do not take them to doctor. Ailments go untreated for a long time. Transportation and work are both issues for parents. We need more clinics, more personnel, and on-site

contact both in the mental health, medical , and substance abuse areas .

Of 690 children seen last year, most fell into the Child and Welfare program. 30% were Title 19; 20% were pre-pay. There is a big need out there.

In the public health sector, there are big increases in childhood lead poisoning. Behavioral learning disabilities are associated with this. The screening is excellent -- the best in the state -- but there are not enough resources to take care of the environment that the children are in. Sometimes parents are low functioning.

We have, in the Clinton school system, a population of special needs children that is skyrocketing. These are long term Clinton families, not newcomers. There is a significant rise in special needs among the early childhood population. Lead and other factors contribute to this rise.

We are a certified rural health clinic and provide care to those who are needy. We keep statistics on this. We have gone from 11% to 23% of family units being uninsured. This is true of a lot of single family farmer units. Insurance that does not cover clinics, according to us, are considered as no insurance. Medicare, Medicaid, no insurance, and private insurance were the four categories. Our clinics are open on off-hours. We try to collect money, but if they do not have it, we do not send a bill. We try hard to do the teaching and to get nurse practitioners in there, but parents see us as a way to get kids a shot in five minutes and get them back into school. We are catching things missed in other places. Public health nurses do a great job of getting things done, but if kids are not immunized and do not have a high fever, and do not have a tooth knocked out, then parents don't care. Parents think if kids do not complain, then everything is okay -- like that rotting baby teeth will fall out anyway so what's the big deal. Rural health clinics have to try to do services at no charge, but people are not aware we are there to help them. Both public health nurses and rural health clinics are set up by federal funds to provide services to underinsured and non-insured groups. There is no excuse for parents not getting aid for their children. I think most just do not know the services are there.

I started working on this four years ago. In Scott County 600,000 - 700,000 children are estimated to be uninsured. Another 100,000 will come off welfare and may not have access to health insurance. Then there will be those children coming off SSI. And the children of illegal and legal aliens. There is a major dental problem out there. Many children look like Third World children. In Clinton county, the poverty rate is going up, and the percentage of the insured is going down. I checked at the state level, and they verified some companies are now insuring the worker, but not their dependents.

My clients include many who have lost Medicaid. One mother with a heart defect lost her job and has no way to get her child to the doctor. There is no

transportation available. She has a sick child that doctors will not accept without a fee.

2. In your area where do uninsured families go for health care services?

The emergency room.

We have school based services. 39% of kids in Davenport inner city schools do not have insurance. We do not refuse anybody.

If children are real sick, the ER drives them to the University of Iowa.

Doctors will treat kids to get them out of the office, but provide no continual care

I am getting more calls at night to get medicines. People do not show for an appointment. Sometimes I say I will not charge anything if you come in. It is hard to do phone triage.

People are coming in now. 92% of people come in and pay the co-payment. It is working out with set times. They are returning because they know the system. That relieves the fear they have. We have a dental clinic along with Community Health Care.

There is a high rate of child abuse in Clinton and Scott Counties. They avoid health care professionals a lot.

Child abuse is a symptom of other family stresses, such as not having access to services.

In some cases it is chronic neglect or a historical abuse situation. Clinton county has had the top unemployment rate in the state, 6-9%. We have unemployed people and teen pregnancy. If they have been out of work more than 18 months, they are dropped from the rolls. Plus, there are a lot of underemployed. A lot of jobs with benefits have been lost and more low-wage jobs are moving in. There is more drug abuse now. Crack is not just an urban issue.

3. In your opinion, what solutions address this growing number of uninsured children?

Schools could play a big part. Get more services into the schools. A lot of problems show up in the school system. We did some clinics in the schools. We have a social worker, nurse practitioner, and dental hygienist that go. Once we catch kids, they stay with us.

I support this. We need some central access point. It is difficult to get kids into an office. Usually they get to school.

Jobs that pay more than minimum wage are important. Employers are moving to not cover dependents.

Public education. There must be a way to educate the importance of things other than shots. I get forms from nurses' office to sign off on a kid I 've never seen. Public health nurses got grants to give kids MMRs, but one school system would not let nurses in to give kids free MMRs. They don't want strangers in their town, so kids don't get their care. The only thing that will help is the enactment of laws that call for a second mark that will get them to shots. Somehow, parents don't know there is more to raising a healthy child other than getting them enough shots to not classify them as a truant.

Single parent families. It is difficult with a low energy level. It is difficult to get them to do health prevention. When they visit a clinic, it's a reaction, not anything proactive.

Getting the parent to take time off to help a child get to a doctor. Sometimes, parents cannot take off work and hope the school nurse will take care of it.

Schools are doing a good job, but sometime parents not sending children to school or do private/home schooling. No one comes to the house. They do follow-up, but if it is a school of 600 and 50 are truant on a given day, then you can only do so much. Some of it is avoidance. This is also high turnover. When you finally check on it, they have moved. You may be tracking a child abuse case -- a child that needs medical services. It's hard. We have some flexible monies for health care. The system is fragmented; we have to look at five different funding streams. We have a problem with supplying insulin and Raelene. It requires a lot of begging to get these. Funds only provide one month's supply of Raelene, but we need more.

Nationwide, states invest more money and time in remediation efforts than in prevention -- 85% and 15% respectively. The Annie B. Casey Foundation report found Iowa spent only 7% on prevention. When is the state going to make healthy kids and kids in general a priority? That message must be sent to policymakers and to the Governor. We can do things on the local level and the state level. There are barriers that the state and legislature puts up. They also help sometimes, but there are some things they will not bend on.

Premise 2: Children who have health care coverage are more likely to receive health care. Children without health care coverage are less likely to have routine doctor visits, seek care for injuries, or have a regular source of medical care. Children without health care coverage are also less likely to be immunized - an important step in preventing childhood illnesses. In addition, children without adequate health care are more likely to perform poorly in school, while parents face increasing absenteeism at work to attend to their children's needs.

1. Who are the people in your area that have unmet health care needs?

Unemployed people. They have no transportation, no money, and previous large medical bills. They avoid the system completely.

The poor, at any age. They cannot access services.

Homeless people. We get a grant for just the homeless. There are a lot of families in shelters.

The one major cause of homelessness is a large medical bill.

It can also be people with insurance that does not cover medical procedures adequately. Medical bills add up, and people stop going because the bills are too high. But eventually they need to go to the hospital and end up in an emergency.

Working families often make a choice not to spend on health care or insurance because they have other expenses.

Those in small business who have no benefit package and can spend money and take risks instead.

2. What methods do you believe would encourage these families to obtain health care for their children?

Doctors like to be paid. People have pride and feel a stigma receiving relief.

The University of Iowa is starting a nurse practitioners program in children's medicine. This should help fill in the void and make the public more aware. Until this last year, no one had to pay except Medicare. Finding qualified people and funds is difficult because the State of Iowa discourages mid-level practitioners. Most leave the state when they graduate.

Prove why they should do what they should do. Sometimes there is a drop off in immunizations because diseases go away. Then they come back. We must educate people to the benefits and prove how it will impact them. Unless there are personal examples, this is difficult.

Our education efforts tend to be traditional. I think we should adopt a different approach. We need to find some way to make marketing and advertising more appealing to each income and ethnic group.

I know one pre-natal care program that gives incentives to comply. One may buy supplies for newborns with points received for doing preventive care. Consumers can be clinics, mental health centers, hospitals, etc. This is a March of Dimes program.

The system is fragmented. It depends on donations. This is not a reliable source of child preventive care. It is not a medical home. There is no one overseeing the well being of children. There are five and six different funds covering something, and recipients have to be a certain income or age.

Develop a health insurance program for kids with a card to oversee care. Kids should not see an emergency room unless in an emergency condition.

I think we have a lot in Clinton County. We have done a lot through Decat, school-based services, etc. so, rather than starting over, I think providing opportunities to strengthen existing collaboratives will be most beneficial. If one resource of funding dries up, we can divert funds from another source. With lead screening, it is a collaborative effort. That puts responsibility on health care providers in the area to work together for a common purpose.

We have school based clinics with nurse practitioners in school, but we are talking about a medical home where kids can receive care anytime of year. We did this through the CHC and kids became clients. We had a medical provider who would see them. There is not continual care now. Many children are fragile and need access. They should feel good about using the payment system. However, there are social barriers to public care.

We were contacted by IDPH asking us to be a coordinator for a 4-5 state area to set up a tracking system to make sure it informs them of services qualified for. They will pay us a $1 a month. It is a pilot project I do not understand.

We had a contract with the CHC to provide medical services in schools. We had a medical backup. Children are seen regardless of ability to pay in the Davenport school district. We had a medical provider 24 hours a day. It is not always office hours that kids get sick. We brought immunizations to schools...

Along with the student, anyone in the family could go there and be seen by that person.

I think it is reasonable because of the transportation. There are also social and cultural barriers. You still have to pay the practitioner. We had a school-based grant which runs out in a year. I don't know if we can fund that in addition to everything else. The money may be there, but it is so disparate. Things get up, start, then stop. 60% of childrens' services are grant funded. There is no security from year to year.

In every area of the city there are fire stations. There should be some way to integrate them. If people would feel comfortable going there, maybe there is a way there to get first contact. Then you can go on to the second step. Link the service site with the medical home via a management information system.

Something has to be done about the paperwork. There would be a lot more dollars. A $5,000 grant requires a proposal that takes 40 hours, quarterly reports, obtaining information for reports, then documentation forms, applications, requirements, etc. Grants are in such small parts. Think of the people at the state level to manage all these micro sums and reports.

It varies by who issues the grant. It could be IDPH, IDHS, etc. They all have separate databases, forms, reporting process -- then we have to often double report them with double paperwork. There are several similar grants out targeting a slightly different focus. Departments at the state level are not coordinating this. An at-risk children grant came cross my desk. The deadline is in two weeks, and the grant for only one year. Why should I apply?

It is also a duplication of Title 19 when three or four other funding sources cover it.

We had very similar grants on tobacco with another county, but different funding sources.

Why not one statewide reporting system that has all the data?

Categorical funding.

Computer systems are set and territorial issues and confidentiality issues are barriers. If IDHS offers grants for something, they do not want to share that information with others in the community. The linkage with who you serve creates barriers to sharing. There is no community-wide case management. Different agencies follow different guidelines with little flexibility. Laws are interpreted in ways not facilitative to case management.

Premise 3: In the mid-1980s states and private organizations began developing health insurance programs to increase health care access for children. Most of these programs are designed for children who are caught in the gap between private insurance and Medicaid, the federal/state program that insures some low-income people. A recent study indicated that there are 34 insurance programs for children operating in 30 states. These programs are categorized into three types: 1) public programs -- financed totally by federal, state or local government funds; 2) public/private partnership -- funded through a mix of public, private and charity dollars and 3) Caring Programs for Children -- private programs administered by regional Blue Cross/Blue Shield Plans.

1. What reasons can you give that support Iowa establishing a health care coverage program?

A lot of the stuff is there; people just don't know how to get it. Paperwork takes up money. If there is some way to make it more spend thrifty and accessible.

There are too many territories you will have to invade that will resist.

Ultimately, it would be the best of all worlds here. Refining the current system would be better than funding another albatross though.

Is anyone going to evaluate the system and do away with the things not working? For example, with Blue Cross Blue Shield, there are some people who will not fit. Starting again with a new system may not be the best way. What about working with the current system? What population is uninsured and what barriers are there to insurance? The reasons why people are not insured need to be discerned. Statewide they should be gathering that information. This focus groups is gathering opinions and experience, but you need the facts and figures too. Who are these children? I don't know how you will get the information on Clinton, for example. I don't know if it even exists.

A comprehensive medical system with a card on a sliding fee scale. All insured children would have access to services on that card. We might just want to do primary health care first. Start using a consortium of insurance companies to underwrite it. Foundations and fee for service could start the funding. Most kids ages 1 to 18 are usually a pretty healthy group. A significant number would support a safe investment. We would not need a band-aid program. It would be paid through universal billing as now.

2. What barriers do you see for the State of Iowa in developing a similar health insurance program for children?

Some providers will not serve patients even for a fee. They may say they have other current patients.

True, but school-based services would not have that problem.

We need to take employers into consideration.

Positive tax breaks for insurance plans would help.

If a person has gone to the doctor's office recently, almost every office requires you to present an insurance card in advanced. Now there is no stigma because everybody does it. There needs to be re-education.

I think the idea of the card and comprehensive is important. I would hope it would include vision and dental, not just primary care. Kids with special needs have particular difficulty now.

3. Of the three structures mentioned, what structure do you think would work best in Iowa and why?

I hate to be dependent on the federal government, nor do I have a great trust

in insurance companies. But the insurance companies need to be on the forefront. If we don't pay for kids, we will pay later. Insurance companies in Iowa should support this.

A public-private mix. I think Iowa is obligated to provide opportunity for coverage, but not necessarily the coverage. We must convince the Department heads and Governor. The current system is not common sense practical. The state is obligated to reduce paperwork, increase collaboration, decrease the time it takes to provide for Medicaid, etc. The State should lead in quality assurance and monitoring.

4. What groups or individuals do you believe would be instrumental in developing a program in Iowa?

Not solely insurance companies, but they must be included. Force them to have a noble purpose. The group could not solely be government either because of politics.

National health care providers. They think they have a handle on what we do, but they don't always.

It cannot only be large corporate health care providers either. Look at the bottom line too.

Find people (consumers) willing to state why changes must occur.

Look at Hillary Clinton's recommendations for Iowa.

The State Health Reform Council looked at that. It had a sub-committee on adolescence. Drs. Alexander and Charles Donaldson were co-Chairs. They took the report to the Council who did not take it up. We have to find some way to influence those people. We have to be consistently grassroots, on the local level with letters and phone calls to get them to respond.

The legislature has responded. It has approved money to test the feasibility of providing insurance. They worked hard last Spring.

Premise 4: We appreciate the thoughtful comments you have offered. We have discussed several important issues related to improving access to children in our state. We would like to conclude this meeting by asking each of you to share your thoughts on the following two questions.

1. What should the State of Iowa do next on this critical issue?

I would make sure the people here saw the report and get other focus groups around the state. A year or so ago at the Iowa Healthy Kids Conference at

Drake Center, the Florida plan was examined (Florida started with a state subsidy and moved to a public-private system, but it is not yet statewide). We must try to reduce paperwork, procedures , and get assurance that programs out there meeting needs will not get cut.

I would look at large groups like farmers that may not have insurance. Pool them as a group and offer a lower rate that way.

I would not poke around and study it for five years. We need a reasonable time frame with a deadline. I would paint a picture of what Iowa children should look like and how to get to that. Immunization goals, for example, would be a start. Then look around the state to see where we are at. We have to measure this if it will make any difference. If you can show that difference, the side effects will be positive too. Information already gathered also needs to be brought together.

Set goals to achieve with the time line and keep pushing forward. All those studies four years ago got put on the back burner. Don't keep things in the middle of the state -- have focus groups around the state like this one.

Many health indicators are set. There is a lot of data in Iowa. Healthy Iowa 2000 objectives are set. There must be a collaborative effort between public and private systems. Take information from the focus groups. I would look at other states' demonstrated success. If something can fit we'd modify it, or else create it ourselves.

Look through studies, do focus groups, devise a strategic plan, charge it, and enforce it through.

One gentleman in Canada advocating full inclusion had that approach. They provided vision and support, then listened to people, made it happen, and got continual feedback from them and kept communications going. You got to get the right group of motivated managers, who don't have the preset political obligations, to get program done in a timely manner. They must have empathy and not worry about what some people might think. They need to be able to put up with criticism.

I would like to see every Iowa child have access to health insurance. I believe the best approach is public-private. Begin with seed money then spread the risk pool . Start with primary health care and go out into other services. Do it well, efficiently, but have data so that there are no catastrophic health care costs we cannot manage. Someone has to underwrite this, but don't connect it to the Medicaid system.

Set plans, find funds, and find physicians willing to support it.

2. If the State of Iowa decides to do nothing what implications do you believe this will

have on the future of Iowa's children?

There will be epidemics again if there are no immunizations.

I think the overall well-being of children will be negative. There will be increased use of emergency rooms and children turned away from emergency rooms. Children are our future and we need workers who can show up for work and think.

Things will only get worse unless someone changes the system.

It depends upon the geographic area and economics. We have to have an educated group of kids. They cannot learn if they are sick, and we will have a low-skill work force.

You need healthy kids for them to learn. There will be a socioeconomic impact with a bigger top-bottom gap. It will just perpetuate into a vicious cycle.

Iowa will regress. You can never maintain the status quo. We are sending a message to Iowa kids we don't value them. We do well in test scores now, but they will slide.

We have always been a top state. Test scores have started to slide. We need to stop that.

I think it will get extremely worse, and I am very fearful. I would see Iowa passing its own alien immigrant law. Medicaid, welfare reform, and SSI impacts on overburdened schools will be that kids with disabilities and special needs will have no space. It will be a real disaster.

If we cannot provide universal coverage for all people, we should at least do it for kids.

Healthy Kids Program Study
Public Outreach
Waterloo Focus Group
November 14, 1996

Name	City
Kay Leeper	Waterloo
Joyce Legg	Toledo
Toni Wallum	Waterloo
Monica Watters	Waterloo
Sharon Anton	Independence
Kris Tiernan	Dubuque
Gina Greene	Waterloo
Marie Whannel	Marshalltown
Sister Kathleen Grace	Waterloo
Rhonda Bottke	Waterloo
Larry W. Puqh	Waterloo
Jackie Meyer	Decorah

Premise 1: For many years Iowans have faced an increasing crisis: thousands of Iowa children are uninsured or underinsured resulting in less healthy and less productive children and in the long-term adults. Although accurate statistics are unavailable it is estimated that between 50,000 and 75,000 Iowa children are without health insurance. These estimates do not include underinsured children, nor do they take into account the changing public policy environment in which Medicaid cuts may result in even more children dropped from Medicaid eligibility. Whatever the current number of uninsured children, it is reasonable to expect the number to continue to increase.

1. What experiences have you had in your local community demonstrating the increasing need for health care for Iowa children?

With unemployment, one of the bigger things we see is children going on and off Medicaid. As family situations change, income eligibility changes and child goes on and off.

Tama County has had a large influx of Hispanics. These children are often not eligible because of alien status. In families and schools, there is an increasing need for dental care especially. The children are in a real quandary. Cedar Rapids allows a few into their clinic.

I am aware also of an influx of people from Mexico. We do have general relief, but a lot do not apply because they are unacquainted with the resources out here. If they have come here illegally they are afraid to apply anyway.

We have that influx also. But there is also the population of parents with limited skills working low paying jobs and having no insurance. The local facility in Marshalltown is providing care three days a week rather than emergency care which is expensive. For women who are not documented or have had limited pre-natal care, needs will be impacted.

The need is increasing, especially with new infants and children. State grants have funded our center for over 30 years. The loan keeps getting greater and our giving free care will eventually collapse. We need to reach out more into the home, not just the hospital. There is no reimbursement for that, but there really is a need. We feel obligated to continue.

Schools is the focus I come form. We have had increasing numbers of Hispanics with dental and health problems. Translation is a big problem, especially with home visits, although those are much needed. The economy needs a boost. Kids are doing screenings and need services. We are trying to plug them in, but we are seeing more and more kids we need to get into different programs. Both parents are working more than one job so it is difficult to get in touch. Eye care is a big problem as well as immunizations this year.

I would add that I see my staff trying to piece things together for families. A lot of time is spent to try to find places for people falling through cracks.

I would echo what I've heard so far. There is the lack of a cohesive system and needs are becoming more and more complex for case management services. The health care structure is changing so there is no local access point. Most public health facilities are merging with private health agencies. There is no free care place to touch base with. Access to services is an issue. These is a trend to more in-home services, but no funding from any major source. We need to identify a major problem to get funded in the home, but going to the home as a routine visit would be much more effective in a preventive manner before kids have problems when they reach the school system. We need mental health care in our community. A lot of kids are in trouble but there is no way to get early mental health intervention because they do not meet our crises criteria. We have a mental health center able to treat children and have some funding from counties to do it on a sliding fee scale. Insurance is often not there. The county subsidizes remaining costs. New legislation for 1997 says supervisors will no longer be required to meet those needs for mental health care. This happened with the change to the CPC system. There will be tons of kids who will have no care for mental health soon.

I work with a Hispanic population in Waterloo. It is almost impossible to find dental care for a reasonable price. A check up would be $25, but for people

who are poor, when they need dental care it is a $200 thing like tooth extraction and serious work. Insurance often does not kick in until people are working six months at some companies like at IBP.

Some people at IBP don't understand about insurance and don't take advantage of what is there.

By the time people have coverage and use it they have a $200 deductible and think it doesn't pay for what they need. They are not educated.

Volunteer Co-op is a small government agency. We work with pre-natal care, immunizations, and support for parents. We try to tie them up with health care, help budget for it, etc. The baby clinic does immunization located in the hospital. If families are not insured we get children on care for kids, or some form of insurance.

I work for a visiting nurses association in Dubuque. We have a home-based program. We go into the home after a baby is born. I do physicals on kids. We have a strong immunization program. The problem was to find families and get them into clinics. Now we are going to them in small towns, schools and now day cares, but the problem is funding. We don't know how to be able to continue to support all these people. Dubuque County has a lot of unemployment and low income jobs. Probably half the families in our communities have a strong need. More and more, teen pregnancies seem to be a growing problem. Often we don't find kids until too late.

If we could have gotten in earlier with nutrition and immunization... I think the increase in school age children with behavior disorders and learning disabilities are due to improper nutrition. The need for a medical home is key. Families need to have a constant person who can monitor that family. Care is fragmented rather than having people who know what you have had and are working with whole family.

2. *In your area where do uninsured families go for health care services?*

They don't.

The Family Service Bureau and Child and Health (federally and state funded) have a system set up in some places. Less than 20% of children we served were on Title 19. Only 21% continued in the program. 85% of kids did not get any care If we overuse money for 4,000 kids, what can we do about others? We looked at the crisis. The problem is the amount of money, not the system.

In Waterloo, the People's Community Health Clinic helps those underinsured, but they cannot serve every child in Waterloo. I have never had anyone refused.

They do refuse people though; they cannot handle more than they are handling. Other groups too. We have opened one free clinic and will open others in churches. These are people who have no access and who have no money. People without money do not access the system except in a crisis. They are distrustful of the system. Hispanics, in addition, have a different culture.

Schools have three clinics spread out in Logan, West High, and one at Expo. With this new health care system we can plug in some kids. Kids need a little boost like a good GPA and get in for a physical. There are also kids in crises situations.

Similar funding from the Iowa Department of Public Health funds school-based centers. Children are not utilizing resources as much as they ought too.

People do not stress wellness. A lot of counties are going to Medipass with a managed health care provider. If I can get kids in for wellness, we can usually get them in for treatment. Funding is cut back though. We can identify problems, but cannot pay for them.

A lot of kids who need the most help are not going out for sports. There is no way to draw those kids in.

If we had required wellness tests, we could catch them.

The problem seems to be at home There is no motivation for parents because it costs money.

Coming from a rural area, I see the access here and wish we had it. The school-based programs are a wonderful piece that have not reached their potential. They have only been around less than 10 years. Most are newer. In rural communities, there is a big stigma to being involved with programs. If there were a community site that is more open and programs better perceived, the system might work better.

3. In your opinion, what solution address this growing number of uninsured children?

We have to fit advanced registered nurse practitioners and providers into the system, because no one has more experience than those doing it now. Many insurance providers will not pay nurse practitioners. Iowa has its own license, but we are still tied in that health insurance companies will not pay us to do same things at a different address. They don't see us as qualified. With all the medical providers we couldn't even reach all kids. If we are excluded from being paid for what we are doing, we cannot exist. Insurance companies exclude us.

From insurance companies, every time they add a payor, whoever it may be,

they contend that it increases their costs.

If we want to talk about rural Iowa, we will need access.

We have no access to acute care. When a child comes, I need to call a doctor's office and beg for free care because they have a huge deductible or their insurance company cannot pay.

Somewhere, we need incentives for programs to develop well child care. The incentive now is wait until you are desperate then throw the kid in emergency care.

I believe that it is a national problem and a matter of focus. We need national insurance for every child. This could be paid for with current Medicare funds that are unneeded.

The money is always there and it is a matter of distribution. The core of healthy communities is healthy kids. But the lowest human being in the community is the child or person with no money. That has to be changed. We have the resources to give priority to children.

We might have to give priority to parents too. Punitive measures against unwed mothers, ADC programs -- if we continue this way these things happen. People are not poor because they want to be poor.

We are all aware of health care crises. Most of our families identify that as a real need. Policy makers don't understand our system and think they fixed it. Over half insurers not affected by latest law. There is no recourse for uninsured groups

Premise 2: Children who have health care coverage are more likely to receive health care. Children without health care coverage are less likely to have routine doctor visits, seek care for injuries, or have a regular source of medical care. Children without health care coverage are also less likely to be immunized - an important step in preventing childhood illnesses. In addition, children without adequate health care are more likely to perform poorly in school, while parents face increasing absenteeism at work to attend to their children's needs.

1. *Who are the people in your area that have unmet health care needs?*
   People that work part-time jobs in a lot of different places.

   Working poor.

   Farm families.

   Minorities. We tried very hard to increase the percentage of kids up to date -- but how do we define what care is.

I don't think people really recognize when children are ill. It is difficult to decide sometimes.

People working more than one job. There is not a lot of quality family time together. Parent's schedules are not allowing it. Something always has to give -- often it is health care for the kids. We can only call so many times. We are working against the current.

A priority issue is jobs. If the parent has to go to a job, then the kid has to go to school. We don't take care of employees and don't take care of kids. We have the attitude that if someone works less than 40 hours we give them no insurance.

Even people with insurance do not access well child care. People are not using immunization. Education and preventive medicine are not ingrained. A doctor's appointment is an unexcused absence for parents working at IBP. Now schools are doing much transporting to get them to a doctor.

You don't need to be low-income to have a lot of stresses in life. It's not because parents don't care; it's how it all fits into life and schedules. School should not take responsibility away from parents, but should help.

Current hours for clinics are 8-5 and 9-6. If they do not come there, they go to emergency rooms which are open 24 hours. This greatly increase the costs and managed care does not pay for it. The hospital bites the costs.

If the patient has a medical home, there will be follow-up. In an emergency room, there is no continuity of care or signal that there is more going on than the current problem.

It is more costly for the hospital too because there is no background.

People don't go back to the doctor and emergency room because they cannot pay. They don't access other places because they don't like the hassle. They will come to free clinics once hey know it is free. Transportation really is a problem. Clinics are all providing it and not getting paid.

Public transportation does not go where and when you need it.

We have to help provide transportation everywhere.

Local DHS office people can get long distance travel. A case manager needs to be part of the insurance package so there is someone who can work on preventive care. In a study three years ago, children needed services but could not get them. The costs of care were biggest, but transportation was also an issue. We have had trouble implementing our transportation program with dollars we have.

2. What methods do you believe would encourage these families to obtain health care for their children?

I think the school-based health clinics are wonderful. We need to be starting to think about new systems. We cannot go back to the old way of doing things. We need a system that makes health care become an expectation, with accessible and universal coverage. I believe we lack the conviction that health care is a right our children have. We speak it but don't put the money there. We only expect children will have immunization and legislate it by time they go to school. The system values immunizations and allows people to get them without strings attached. There are strings for other programs, including huge forms to apply (state Title 18 form), hours available, and other disincentives to entering the system. In countries where they have national health insurance, the core difference is an expectation of routine care, pre-natal care, etc. Society expects this and systems are designed around this.

A medical home has to be re-defined to include school-based clinics,nurse practitioners, and medical practitioners.

Schools, work, churches and wherever people congregate should have health care available.

It would work, but funding is the major problem.

To encourage people to get involved, a place must be friendly and take a minimal amount of stress and effort to reach. We need to provide a translator. Reduce paperwork, make sites easy to find, central location, transportation to and from, and hours are key.

Optimal hours are 24 hours a day.

Public clinics do one night a week in Marshalltown. They take in 15 people a night and then shut the doors. From 6- 8 pm there is only so much manpower.

It is not who is the most sick. It is who is there. If we did not have to deal with eligibility requirements, we could deal with more families. No wonder they don't trust us -- if there income changes, they have to go through the whole thing. And to turn someone away...

This can be a disincentive for more work. If they can only make a certain amount of dollars to get insurance, they will not work more for fear of losing insurance.

A system issue is having more services at school-based health clinics. Substance abuse, mental health, and classes could be integrated. A free clinic in the church basement sets people aside and says they are different.

3. Who besides the individual family should be responsible for meeting these needs? Should local communities and/or schools be more directly involved in the provision of health care?

Everybody who lives within that community. We all must make it possible to make that child healthy. When we see the child without the parent we cannot see an interactional problem. Care would be more effective if parents were there too.

But what do we do in the summer or with kids under school age?

In summer we do not see the same kind of kids. Mostly we see healthy kids for wellness tests. We try to track kids we treat by having them come in.

Kids don't eat well in the summer.

There is free or reduced-price lunch in Waterloo, but nowhere I else I know of.

I agree that it really is a community thing. People do have an interest in issues they can get their hands around, but they get disillusioned with programs with a lot of negative aspects -- paperwork, turn away people, etc. People would buy into supporting things available to everybody without hassles and bureaucracy. If we could get rid of barriers, people would get help. People with money won't come for free care anyway!

The majority of people think health care is the responsibility of parents. It is the 1990s. Young parents don't know how to be parents. That has to change. We have to educate the mothers and give support to parents.

Our society is a different place. Young women are dealing with a lot of pressures. Troubled children are not necessarily the product of a dysfunctional family. Societal pressures are influential.

Consumption of junk food is a problem.

Premise 3: In the mid-1980s states and private organizations began developing health insurance programs to increase health care access for children. Most of these programs are designed for children who are caught in the gap between private insurance and Medicaid, the federal/state program that insures some low-income people. A recent study indicated that there are 34 insurance programs for children operating in 30 states. These programs are categorized into three types: 1) public programs -- financed totally by federal, state or local government funds; 2) public/private partnership -- funded through a mix of public, private and charity dollars and 3) Caring Programs for Children -- private programs administered by regional Blue Cross/Blue Shield Plans.

1. *What reasons can you give that support Iowa establishing a health care coverage program?*

The Caring program does not pay for any medication or diagnostics. The Medicaid program varies according to income. If you go off Title 19, it covers the first year after childbirth and then that's it. Sometimes there is a waiting period of 2 years for programs. If you miss appointments, it is a big barrier. Then there are big forms for getting back on.

Gambling money should go to kids.

Money cannot be totally free. Recipients must come in for wellness exams once a year on a regular basis. The Child Wellness Program has that stipulation. I send out a card and tell them next exam. They know if they don't come they will lose eligibility. Parents don't have to be present; the child just has to be screened.

Often in a rural area, there is only one provider and if the insurance does not cover that, then there is no way to get services.

2. What barriers do you see for the State of Iowa in developing a similar health insurance program for children?

The huge negative publicity is based mainly on erroneous information about the attempt for national health care. People think that involved a vast amount of paper work and bureaucracy. Iowa could do this, but we need public education to get whole communities into this idea to make this work so there are no barriers and no triplicate forms.

Iowa has taken pride in literacy but it is going downward. The health of children is key to anything we are trying to do.

Children must be a priority, especially their health.

We need to have care for all the children. There is a stigma attached to being in the state insurance pool.

There needs to be a way to ensure that whatever system comes about works the same for everybody. Whoever provides services must provide whatever other providers do. We must look at the needs of families, not children. An insurance pool in itself is not a solution. It needs to be coupled with changes in attitude.

30 years ago what changed things for elderly people was that they all had a red, white, and blue card. Every child born now -- give them a card.

We need incentives for preventive services and manageable disincentives for

acute care.

3. Of the three structures mentioned, what structure do you think would work best in Iowa and why?

None. We need a plan appropriate for the family. The Caring program is not successful. Title 19 is not successful. Why build on this system?

I would vote for the second option. I think it will build consensus around providing for children, bu t I don't know if it will be easy logistically. We don't have a great history of partnerships in Iowa. Administration, funding and other roles r eed to be defined.

If they have a card, it does not matter who funds, then the middle option is fine.

Why Medicare got into trouble is there was no constraint on costs. Case managers are important, not to restrict access, but to make appropriate choices.

In the Oregon plan they define basic services that are covered.

When I refer to a case manager, I mean somebody in the child's medical home, not with the health insurance company. An advocate, not a gatekeeper. Not expanding costs, but trying to make them reasonable. There are hundreds of definitions of case manager though.

I have never seen an HMO have a case manager to help people out.

Physicians see themselves as the case manager.

I am in favor of an Iowa medical card, but this cannot exclude children here undocumented. Now children are basically seen by free clinics regardless of status.

When people travel in other countries they get taken care of, then get a bill. But not here.

4. *What groups or individuals do you believe would be instrumental in developing a program in Iowa?*

Providers of care, medical associations, private business, insurance, Department of Public Health, Human Services, alterative health care providers, legislators, the DoT, citizens, consumers...

We need a well-chosen representative group of people you can divide out.

Large employers should be involved -- John Deere, IBP, etc.. It may save them trouble.

Education.

Chambers of Commerce.

Hospitals.

Professional associations outside of health care

Rural groups -- Farm Bureau, DOW Chemical, Pioneer, etc.

Premise 4: We appreciate the thoughtful comments you have offered. We have discussed several important issues related to improving access to children in our state. We would like to conclude this meeting by asking each of you to share your thoughts on the following two questions.

1. *What should the State of Iowa do next on this critical issue?*

We first need analysis of what has come from the state, hear that information, and get those who can make a difference involved

The public should be more involved in the beginning. Get input from the private sector and let them know it is an important issue

Educate the public. Get to rural persons without support outside homes.

Broad base of listening to different groups.

Educate different people in small group settings and get input.

Collect information from families to see how to best impact.

Include all stakeholders in work groups.

Analyze all of this information; hold small family focus groups.

Bottom line is to look at costs of programs out there to taxpayers and the benefit package we are suggesting and compare.

The process you're going through is vital. When through, we need to state and clearly define this problem and present alternative solutions. There must be public debate until people will do something.

The vehicle will be the Iowa Legislature to put this in the public eye, debate,

and enact laws and funding.

I'm thinking we've done this and now government has to state conviction if it is really true and formulate a vision statement. "We believe" these are issues and are committed to looking for solutions within a set time period.

2. If the State of Iowa decides to do nothing what implications do you believe this will have on the future of Iowa's children?

We will see things worsening because there have been a lot of start up without means to continue funding. There are a lot of legislative things like welfare and governmental reform leaving us more underserved.

We will continue with a more and more patchwork system. More children will fall through gaps and become troubled adolescents.

Social decay will continue and less industry will come and state will get less capable to deal with problem.

More parallel systems with a lot of money thrown at problem but no care

Kids will go without care.

I agree with all the above.

We will self destruct and will not have a work force.

If we don't get healthy kids early on, education will suffer. When they get older, what work will they be able to provide to society?

For each dollar you spend on prevention, it saves a lot of bills later.

Prevention is #1.

If something is not done, less and less children will receive prevention care and there will be more problems.

It has all been said.

OFFICE OF THE SCHOOL NURSE

Red Oak Community School District
2011 N. Eighth Street
Red Oak, Iowa 51566
15 November 1996

Iowa Healthy Kids Program Study Task Force
200 Tenth Street -- Fifth Floor
Des Moines, Iowa 50309

Apparently, I was the only person signed up to attend the Shenandoah Task Force meeting, so it was not surprising that the meeting was canceled. I do, however, want to provide you with some input from Southwest Iowa.

This is my twelfth year as the Red Oak School Nurse. I have not kept statistics on health insurance during this time, but over the years I can remember instances where the lack of money and insurance has impacted directly upon the health care of students and the situation seems to be getting worse.

Twenty-seven percent of our students qualify for the free-lunch program. Some of these students are enrolled in Title XIX, but many are not.

More parents are utilizing the school nurse as the gate-keeper to medical care. I am asked to determine whether or not the doctor visit is necessary. While this provides for a better use of our medical resources, in some instances, the school nurse is being utilized as the only source of medical care. The reasons given are "No money" and "No Insurance". I have documented six instances since September, ranging from severe ankle sprains and the need for medications to liver dysfunction, where the lack of insurance has prevented or delayed treatment. A very small Nurse Discretionary Fund has been the only resource for these students.

The small claims actions for our county are published in the local newspaper. Increasingly, I am seeing the names of my families listed as owing money to the doctor or the local hospital. This is a change from previous years.

An actual percentage of uninsured students was obtained while preparing to provide Hepatitis B immunizations for our 7th grade. Public Health asked for an indication of insurance, no insurance, or Medicaid. Of the 45 parents who answered that specific question, 20% marked no insurance.

Healthy children, Ready to learn is a motto for Iowa School Nurses. To benefit from education, children must be healthy. Otherwise, their energy is expended meeting survival needs with little energy left for learning. The social implications resulting from the lack of an education can be seen daily on our local streets and in the media.

Your efforts to address the health care of Iowa children are applauded by school nurses and the other professionals who work with our children. I hope that some of this information will prove useful.

Sincerely,

Bernadette Ellerman, BSN, RN

HEALTHY KIDS PROGRAM STUDY PUBLIC OUTREACH
CITY FOCUS GROUP
DATE

Name: Jennifer Lightbody, Executive Director City: Sioux City, Iowa

Premise 1:

1. **What evidence do you see in your local community demonstrating the increased need for health care for Iowa children?**
   Twenty-five percent of the children seen at the Siouxland Community Health Center have no insurance or are underinsured. Sioux City School District administrators have reported students with health problems who have no family doctor. Welfare reform will probably decrease the number of children who are eligible for Medicaid. Service sector and manufacturing (meat processing) jobs are the fastest growing employment sectors in Siouxland. Family health benefits are not usually offered.
2. **In your community, where do uninsured families go for health care services?**
   Siouxland Community Health Center, private physicians (case-by-case), emergency rooms at Marian Health Center and St. Luke's Regional Medical Center
3. **In your opinion, what solutions may begin to address this growing number of uninsured children?**
   Move from employer-based health insurance to some type of universal coverage.

Premise 2:

1. **Who are the people in your community that have unmet health care needs?**
   The working poor and people facing language or cultural barriers. It is difficult to find a personal physician even if there is insurance coverage because of the shortage of primary care physicians.
2. **What do you believe would encourage these families to obtain health care for their children?**
   Outreach, interpretive services, help in negotiating the medical care system and physicians willing and able to see them.
3. **Who, if anyone, besides the individual family should be responsible for meeting these needs? Should local communities and/or schools be more directly in providing health care?**
   The community as a whole has a responsibility for assuring access to services for all. Services need to be provided in settings that reach a majority of the families.
4. **Are you familiar with any programs in your local area that could be coordinated with a new initiative to offer health care coverage for children?**
   Children's Miracle Network - St. Luke's Regional Medical Center
   Light A Child's Life - Marian Health Center

Premise 3:

1. **Do you support Iowa establishing a health care coverage program? Why or why not?**
   Yes, but expand it to all ages.
2. **What barriers do you see for the State of Iowa in developing a similar health insurance program for children?**
   Physician supply may be a problem in some areas. Complicated access/filing processes could make the program too cumbersome. It should not be another layer to existing systems and must be truly integrated with public and private programs.
3. **Of the three structures mentioned, which do you think would work best in Iowa and why?**
   Public/private partnerships could combine resources to maximize use of public, private and charity dollars.
4. **What groups or individuals do you believe would be instrumental in developing a program in Iowa?**
   Business leaders, Iowa Department of Public Health, Community leaders and consumers. Groups with a vested interest (i.e., doctors, health systems, insurance companies) should be brought in for technical advice only.

Premise 4:

1. **If the State of Iowa decides to do nothing, what implications do you believe this will have on the future of Iowa's children?**
   We will continue to have children who are unable to succeed in school/life due to poor health.

Concern:
Will business discontinue family health insurance benefits if it will be provided through a public/private program?

Healthy Kids Program Study Public Outreach
City Focus Group
Date

Name City

Task Force Members Present:

Opening: You have been asked to come to this meeting today to provide information that will assist in the study of alternative methods to offer health insurance coverage for children. You will not be solicited or ask to do anything more than spend two hours in a facilitated discussion. No special expertise is required for you to participate

Premise 1: For many years Iowans have faced an increasing crisis: thousands of Iowa children are uninsured or underinsured resulting in less healthy and less productive children and in the long-term less healthy adults. It is estimated that between 50,000 and 75,000 Iowa children are without health insurance. These estimates do not include underinsured children, nor do they take into account the changing public policy environment in which Medicaid cuts may result in even more children dropped from Medicaid eligibility. Whatever the current number of uninsured children, it is reasonable to expect the number to continue to increase. Recognizing that there are uninsured and underinsured children in Iowa, consider the following questions.

1. What evidence to you see in your local community demonstrating the increasing need for health care for Iowa children?

   Many Young teen moms
   poverty in youth in Polo alto Co.

2: In your community where do uninsured families go for health care services?

   Upper Des Moines Opportunity – Matanal child clinics

3: In your opinion, what solutions may begin to address this growing number of uninsured children?

   New laws about mandatory insurance
   benefits by employers.

Premise 2: Children who have health care coverage are more likely to receive health care. Children without health care coverage are less likely to have routine doctor visits, seek care for injuries, or have a regular source of medical care. Children without health care coverage are also less likely to be immunized - an important step in preventing childhood illnesses. In addition, children without adequate health care are more likely to perform poorly in school, while parents face increasing absenteeism at work to attend to their children's needs.
Considering this, please answer the following questions.

1: Who are the people in your community that have unmet health care needs?
The middle income people - under or uninsured

2: What do you believe would encourage these families to obtain health care for their children?
Free or reduced rates or insurance coverage

3: Who, if anyone, besides the individual family should be responsible for meeting these needs? Should local communities and/or schools be more directly in providing health care?
School clinics would be helpful.

4: Are you familiar with any programs in your local area that could be coordinated with a new initiative to offer health care coverage for children?
Ruthven School - based clinic

Premise 3: In the mid-1980s states and private organizations began developing health insurance programs to increase health care access for children. Most of these programs are designed for children who are caught in the gap between private insurance and Medicaid, the federal/state program that insures some low-income people. A recent study indicated that there are 34 insurance programs for children operating in 30 states. These programs are categorized into three types: 1) public programs - financed totally by federal, state or local government funds; 2) public/private partnerships - funded through a mix of public, private and charity dollars and 3) Caring Programs for Children - private programs administered by regional Blue Cross/Blue Shield Plans. Recognizing these different program options, please consider the following questions.

1: Do you support Iowa establishing a health care coverage program? Why or why not?
No - Cost can be wasteful

2: What barriers do you see for the State of Iowa in developing a similar health insurance program for children?
Expensive, Not fair to all citizens equally

3: Of the three structures mentioned, which do you think would work best in Iowa and why?
#2 So the burden will be shared

4: What groups or individuals do you believe would be instrumental in developing a program in Iowa?

Insurance leaders, hospitals, churches

Premise 4: We appreciate the thoughtful comments you have offered. We have discussed several important issues related to improving access to children in our state. We would like to conclude these meeting by asking each of you to share your thoughts on the following two questions. (Round Robin Response)

1. If the State of Iowa decides to do nothing what implications do you believe this will have on the future of Iowa's children?

Decreased opportunity for healthy future

Thank you for your participation. Your comments will be presented to the Iowa Healthy Kids Program Study Task Force and considered in the formulation of the report to the General Assembly and Governor Branstad.

Children with Selected Sources of Health Insurance, by Poverty Level and Age, 1994

	Income as a % of Poverty Level	Total Children Population	Private Coverage			Public Coverage		No Health Insurance
			Total	Employer	Other	Total	Medicaid	
Iowa								
All Children		753,871	604,564	473,542	131,021	121,619	113,031	82,447
Infant	Total	42,134	22,545	18,701	3,844	3,291	3,291	17,827
	0-99%	11,192	—	—	—	—	—	11,192
	100%-124%	3,291	1,529	—	1,529	3,291	3,291	—
	125%-149%	4,240	—	—	—	—	—	4,240
	150%-199%	2,315	2,315	—	2,315	—	—	—
	200%-399%	12,799	10,404	10,404	—	—	—	2,395
	400% or more	8,297	8,297	8,297	—	—	—	—
Aged 1-5	Total	197,714	146,291	117,406	28,855	53,796	53,796	18,082
	0-99%	34,706	2,048	—	2,048	20,788	20,788	11,870
	100%-124%	3,594	1,568	—	1,568	3,594	3,594	—
	125%-149%	12,656	10,805	5,850	4,955	4,319	4,319	—
	150%-199%	27,183	20,024	7,730	12,294	8,888	8,888	4,048
	200%-399%	102,893	97,164	90,912	6,252	16,207	16,207	2,164
	400% or more	14,682	14,682	12,914	1,768	—	—	—
Aged 6-12	Total	303,961	261,158	201,847	59,312	39,321	35,141	23,937
	0-99%	36,641	7,329	—	7,329	19,957	19,957	13,536
	100%-124%	4,681	4,681	—	4,681	2,980	2,980	—
	125%-149%	22,556	20,374	12,347	8,027	2,522	2,522	2,182
	150%-199%	51,590	45,270	26,442	18,828	—	—	6,320
	200%-399%	133,111	128,122	115,161	12,961	10,659	10,659	1,899
	400% or more	55,382	55,382	47,897	7,486	3,203	3,203	—
Aged 13-17	Total	212,063	174,571	135,588	39,981	25,213	20,806	22,601
	0-99%	34,254	14,092	5,074	9,017	13,838	13,838	10,423
	100%-124%	3,154	1,511	—	1,511	1,644	1,644	—
	125%-149%	8,197	5,713	3,435	2,278	—	—	2,483
	150%-199%	23,100	15,573	9,250	6,323	—	—	7,527
	200%-399%	94,927	91,275	78,019	13,255	6,265	3,300	2,168
	400% or more	48,131	46,407	39,810	6,957	3,466	2,024	—

Iowa Data

County	Population ≤ 200% of Poverty	Rank	Child Poverty	Rank	Population Medicaid Eligible	Rank	Population Medically Indigent	Rank
Adair	3,347	18	1,522	20	740	74	2,607	9
Adams	1,990	13	1,119	7	672	23	1,371	29
Allamakee	5,667	11	1,857	55	1,289	68	4,557	5
Appanoose	6,473	2	3,876	1	2,680	2	3,944	20
Audubon	2,736	33	1,195	32	704	65	2,119	18
Benton	7,177	65	3,297	43	2,288	54	5,047	63
Black Hawk	38,130	71	24,017	16	17,827	16	22,407	85
Boone	6,800	92	4,796	81	2,871	43	4,256	90
Bremer	6,274	88	2,418	84	1,620	89	5,088	67
Buchanan	8,067	25	4,670	9	2,585	33	5,690	36
Buena Vista	5,910	77	2,056	88	1,857	68	4,472	65
Butler	5,820	36	1,919	69	1,557	59	4,389	30
Calhoun	3,901	52	1,680	45	1,267	47	2,800	52
Carroll	7,777	43	2,378	81	1,800	84	6,127	22
Cass	5,960	20	2,375	36	1,770	37	4,357	19
Cedar	5,040	80	2,225	61	1,477	80	3,650	73
Cerro Gordo	13,225	84	4,767	89	5,468	37	8,131	87
Cherokee	5,174	40	2,002	48	1,398	59	3,962	27

County	Population ≤ 200% of Poverty	Rank	Child Poverty	Rank	Population Medicaid Eligible	Rank	Population Medically Indigent	Rank
Chickasaw	4,880	40	1,490	80	1,130	80	3,816	20
Clarke	3,265	20	1,707	14	1,293	7	1,293	93
Clay	5,416	71	2,040	76	1,776	56	3,728	72
Clayton	7,717	14	3,182	28	1,696	72	6,154	7
Clinton	15,822,	70	6,992	54	6,635	28	9,494	83
Crawford	6,525	23	3,170	17	2,650	6	4,010	56
Dallas	7,885	93	1,580	97	2,618	74	5,415	84
Davis	3,806	5	2,236	2	1,114	26	2,793	3
Decatur	3,494	9	2,135	4	1,467	3	2,367	24
Delaware	6,727	33	2,940	32	1,533	80	5,300	15
Des Moines	12,145	82	7,330	25	5,796	25	6,563	94
Dickinson	4,517	75	1,744	74	1,237	86	3,384	61
Dubuque	23,675	89	10,714	65	7,690	72	17,021	79
Emmet	4,257	39	1,758	40	1,470	32	2,973	43
Fayette	8,693	18	3,866	21	2,796	31	6,160	25
Floyd	6,397	31	2,644	37	2,200	29	4,400	41
Franklin	3,966	49	1,466	59	1,216	51	2,830	47
Fremont	3,052	35	1,210	43	1,152	20	1,990	54
Greene	3,867	27	1,778	21	1,125	45	2,822	27
Grundy	3,669	73	1,167	92	794	93	2,947	50
Guthrie	4,046	36	1,323	71	1,411	29	2,756	45

County	Population ≤ 200% of Poverty	Rank	Child Poverty	Rank	Population Medicaid Eligible	Rank	Population Medically Indigent	Rank
Hamilton	2,710	78	1,462	94	1,736	50	3,070	81
Hancock	4,221	57	1,340	84	1,175	68	3,122	49
Hardin	6,377	57	2,406	62	2140	45	4,563	56
Harrison	5,553	30	2,578	24	2,135	14	3,565	54
Henry	5,480	82	2,385	65	2,115	47	3,845	76
Howard	4,070	10	1,462	42	1,000	54	3,188	6
Humboldt	3,280	73	1,344	63	1,033	65	2,300	71
Ida	3,246	24	995	73	652	87	2,685	8
Iowa	4,140	84	1,300	95	995	92	3,219	68
Jackson	6,324	17	3,212	34	2,335	37	5,788	17
Jasper	9,047	94	2,575	98	3,131	71	6,124	86
Jefferson	5,513	54	2,495	38	1,860	43	4,045	48
Johnson	28,163	78	10,093	86	4,900	99	26,144	37
Jones	6,455	59	2,605	55	1,633	84	5,425	30
Keokuk	4,487	26	1,776	26	1,546	27	3,034	39
Kossuth	6,750	43	2,323	63	1,580	80	5,317	22
Lee	12,460	64	7,118	19	5,571	16	7,389	81
Linn	37,466	99	17,214	89	16,540	61	21,940	98
Louisa	3,838	60	1,495	59	1,611	21	2,295	77
Lucas	3,395	32	1,497	30	1,370	9	2,105	59
Lyon	4,949	12	2,032	26	777	95	4,219	1

County	Population ≤ 200% of Poverty	Rank	Child Poverty	Rank	Population Medicaid Eligible	Rank	Population Medically Indigent	Rank
Madison	3,907	68	2,072	29	1,211	62	2,796	65
Mahaska	7,834	42	3,228	41	2,948	24	5,144	56
Marion	7,110	96	3,510	74	2,640	74	5,070	90
Marshall	9,875	95	4,400	77	4,440	42	5,858	95
Mills	3,643	87	1,492	79	1,571	36	2,284	88
Mitchell	3,737	51	1,442	57	841	88	3,016	34
Monona	4,315	7	2,147	11	1,666	4	2,780	33
Monroe	3,151	28	1,736	11	1,314	5	1,834	62
Montgomery	3,816	66	1,450	72	1,485	34	2,440	74
Muscatine	10,935	89	5,667	48	5,547	21	5,587	97
O'Brien	5,420	48	2,255	45	1,328	78	4,263	34
Osceola	2,689	36	1,018	50	501	90	2,231	12
Page	5,955	46	3,121	18	2,446	14	3,796	63
Palo Alto	4,641	6	2,155	15	1,142	51	3,649	2
Plymouth	7,367	67	2,245	93	1,543	93	6,034	41
Pocahontas	3,410	45	1,333	50	923	62	2,571	38
Polk	75,896	97	39,911	69	38,275	37	39,584	99
Pottawattamie	25,700	69	11,900	47	12,064	12	14,046	89
Poweshiek	5,350	86	2.360	65	1,656	77	4,111	69
Ringgold	2,303	8	1,219	8	764	18	1,600	14
Sac	4,979	15	1,886	38	1,232	58	3,808	10

County	Population ≤ 200% of Poverty	Rank	Child Poverty	Rank	Population Medicaid Eligible	Rank	Population Medically Indigent	Rank
Scott	40,915	91	24,911	30	16,155	51	25,515	90
Shelby	5,000	29	1,469	81	1,257	67	3,890	15
Sioux	10,018	56	2,631	96	1,585	98	9,150	13
Story	21,385	81	7,575	89	4,010	96	20,940	25
Tama	6,131	47	1,986	78	2,038	37	4,268	50
Taylor	3,272	4	1,650	6	1,003	18	2,369	4
Union	5,113	16	2,767	10	1,912	11	3,315	40
Van Buren	3,592	3	1,858	5	921	35	1,950	44
Wapello	14,025	22	7,570	13	7,066	1	7,210	74
Warren	8,143	98	2,486	99	3,100	78	5,405	96
Washington	5,942	75	2,550	58	1,902	62	4,236	69
Wayne	3,484	1	1,860	3	1,067	9	1,781	45
Webster	13,192	62	6,490	34	5,890	12	7,786	80
Winnebago	3,940	63	1,673	53	777	96	3,382	30
Winneshiek	7,067	52	2,918	50	1,438	90	6,421	11
Woodbury	33,807	50	17,297	23	15,233	8	19,460	77
Worth	2,693	55	831	87	807	56	1,947	52
Wright	4,695	61	1,755	68	1,555	49	3,253	60
Totals:	950,911	N/A	383,692	N/A	308,220	N/A	572,012	N/A

Percentage of Children Aged 0-17 without Health Insurance Coverage, by State, 1987-1995
Employee Benefit Research Institute Analysis of the March Current Population Survey

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Total	13.1%	13.3%	13.6%	13.2%	12.9%	12.7%	13.7%	14.2%	13.6%
Maine	6.2%	6.7%	7.9%	12.5%	8.6%	9.6%	8.5%	11.5%	18.1%
New Hampshire	10.9%	15.3%	11.8%	8.9%	9.1%	10.6%	10.8%	13.5%	5.5%
Vermont	9.8%	9.0%	7.1%	8.6%	9.0%	4.0%	7.4%	5.5%	9.7%
Massachusetts	5.0%	6.6%	5.9%	5.4%	6.9%	10.6%	9.1%	8.6%	8.4%
Rhode Island	5.1%	7.7%	5.4%	8.2%	6.0%	7.1%	11.3%	8.0%	12.5%
Connecticut	4.6%	6.5%	7.2%	3.8%	5.4%	5.4%	9.4%	10.9%	9.1%
New York	10.3%	8.5%	9.5%	8.6%	8.9%	10.8%	11.1%	14.1%	11.9%
New Jersey	6.9%	6.2%	8.9%	8.7%	8.2%	10.4%	11.4%	10.8%	12.0%
Pennsylvania	7.3%	6.3%	6.6%	9.2%	6.8%	6.7%	10.0%	11.1%	8.9%
Ohio	8.8%	7.0%	6.7%	9.2%	7.3%	9.1%	8.9%	8.8%	9.4%
Indiana	14.0%	9.2%	12.3%	12.3%	12.1%	8.0%	9.3%	10.3%	13.3%
Illinois	6.8%	8.4%	9.8%	9.9%	9.8%	10.2%	11.0%	8.5%	9.4%
Michigan	5.5%	4.4%	6.4%	6.7%	6.3%	7.6%	8.2%	8.2%	8.5%
Wisconsin	4.4%	6.0%	7.8%	5.8%	7.4%	8.1%	7.4%	6.3%	6.7%
Minnesota	6.1%	6.5%	4.8%	6.3%	5.0%	4.3%	6.9%	7.7%	5.3%
Iowa	7.2%	8.8%	5.2%	5.8%	6.4%	6.8%	8.3%	10.9%	12.3%
Missouri	7.2%	11.4%	12.8%	13.3%	14.4%	13.1%	9.3%	8.8%	14.4%
North Dakota	7.0%	9.9%	7.8%	4.4%	6.0%	5.6%	11.9%	6.9%	6.7%
South Dakota	16.0%	15.2%	11.3%	10.6%	8.3%	16.1%	12.5%	7.9%	8.1%
Nebraska	10.3%	10.8%	7.7%	7.5%	6.6%	8.3%	9.7%	9.0%	8.5%
Kansas	10.0%	7.9%	8.0%	12.1%	12.7%	8.7%	12.8%	8.3%	10.4%
Delaware	9.6%	6.0%	16.5%	12.0%	12.3%	6.8%	11.9%	10.5%	13.9%
Maryland	10.4%	6.6%	11.5%	14.3%	14.0%	6.5%	9.7%	12.3%	12.9%
D.C.	13.1%	16.0%	17.2%	19.2%	29.5%	13.6%	17.0%	14.0%	18.0%
Virginia	9.3%	10.7%	11.6%	16.6%	13.9%	9.8%	13.1%	11.1%	10.5%
West Virginia	14.4%	16.1%	13.0%	14.0%	16.1%	14.2%	18.7%	10.0%	8.8%
North Carolina	14.7%	13.8%	14.5%	13.0%	13.8%	12.2%	14.0%	11.8%	13.0%
South Carolina	12.5%	16.9%	17.1%	18.2%	11.6%	10.8%	13.9%	14.8%	15.1%
Georgia	13.1%	15.6%	15.3%	12.1%	10.2%	20.5%	16.2%	15.5%	14.7%
Florida	20.9%	21.4%	18.0%	18.4%	18.1%	18.3%	18.0%	15.1%	18.2%
Kentucky	17.5%	16.6%	13.3%	15.8%	12.8%	13.9%	11.8%	13.2%	14.0%
Tennessee	14.1%	13.0%	14.0%	12.8%	10.0%	10.4%	10.2%	10.4%	14.8%
Alabama	22.3%	18.8%	17.4%	18.1%	19.3%	15.4%	15.3%	19.7%	12.9%
Mississippi	16.8%	22.1%	15.4%	18.8%	16.4%	16.5%	17.2%	15.8%	20.0%
Arkansas	24.1%	20.2%	20.3%	19.8%	16.3%	22.6%	20.1%	18.2%	17.7%
Louisiana	19.1%	25.2%	19.5%	18.8%	19.1%	18.1%	22.2%	17.3%	20.2%
Oklahoma	18.4%	22.7%	23.3%	19.9%	17.4%	21.5%	26.0%	20.8%	21.1%
Texas	24.5%	27.1%	24.7%	21.1%	23.2%	20.4%	21.8%	24.1%	22.4%
Montana	18.8%	16.3%	13.2%	13.2%	11.4%	4.9%	14.3%	10.0%	8.9%
Idaho	16.7%	14.2%	16.5%	15.5%	15.8%	16.1%	14.3%	13.7%	12.8%
Wyoming	10.2%	10.3%	9.4%	10.5%	8.5%	10.6%	14.2%	13.5%	14.9%
Colorado	12.3%	12.8%	13.5%	16.2%	6.4%	9.6%	8.9%	12.3%	13.7%
New Mexico	26.6%	24.2%	25.1%	22.2%	20.2%	17.3%	24.4%	26.2%	23.7%
Arizona	21.9%	16.5%	20.0%	16.6%	14.8%	12.8%	19.4%	21.1%	20.0%
Utah	11.8%	10.3%	6.1%	7.1%	13.4%	10.1%	10.4%	9.1%	10.0%
Nevada	16.8%	16.8%	14.5%	15.1%	16.3%	25.2%	17.8%	17.5%	20.8%
Washington	11.2%	7.4%	8.9%	9.3%	8.0%	9.4%	9.0%	10.5%	8.5%
Oregon	12.0%	11.6%	15.7%	16.3%	12.5%	8.6%	11.7%	12.7%	10.8%
California	16.4%	16.9%	16.3%	17.7%	17.3%	16.1%	17.6%	20.0%	17.4%
Alaska	13.9%	13.6%	13.1%	12.7%	9.0%	10.0%	8.4%	9.6%	10.7%
Hawaii	6.9%	7.7%	5.3%	7.3%	7.3%	4.6%	8.5%	7.4%	6.9%

Note: Increases and/or decreases in the percentage of the state's population without health insurance should be viewed wit
Some of the differences may be related to sampling error, particularly for small states.

State Health Insurance Programs for Children

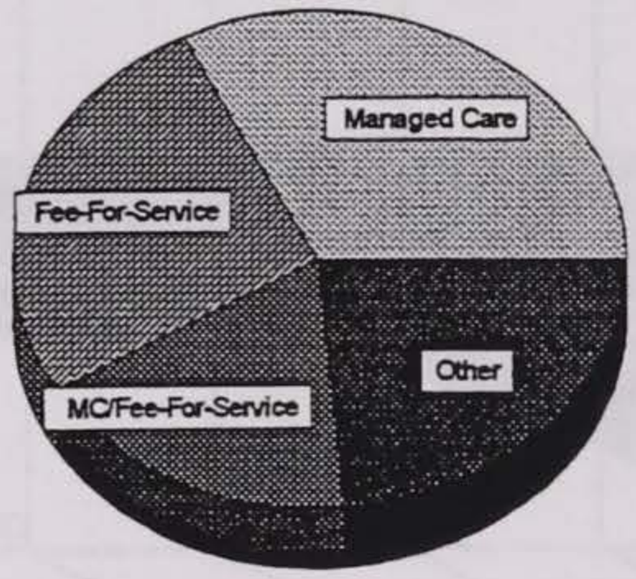
State - *Program*	Date Started	Enroll-ment	Eligibility	Funding Sources	Annual Premium	Annual Budget	Covered Services
Arkansas - *Get Smart*	9/91	686	•Non-Medicaid eligible •Eudora or Elaine Public Schools •K-12	•$2.5 grant HUD start	$678	•$34,000/ month (insurance) •$200,376/ month (office, salaries.	•Check-ups •Five doctor sick visits •Immunizations •Hospitalization •Prescriptions •Pregnancy •Dental •Optical
California - *California Kids*	11/93	10,000	•200% of fpl •2 - 18 years resident	Public/Private	$400	•$4 million (insurance) •$250,000 (operations)	Primary & Preventive care
Colorado - *Colorado Child Health Plan*	1990 - expanded 1993	3,400	•185% of fpl, < age 13 •Rural counties •Ineligible for Medicaid •Metro areas surrounding Denver (excluding Denver)	•Private donations •Participation fees •University of Colorado Hospital teaching allowance (Medicaid) •State funds •Federal funds	No premium	$2.7 million, $516,000 of which is for administration	Preventive care through managed care system with capitated payments to network of physicians
Connecticut - *Healthy Steps*	1991	180	•New Haven demo, •Income under 200% of fpl •5-17 years	•State funds •Families also pay $5/child/month	$1,000	$180,000 (insurance and operations costs)	•Primary, comprehensive health care •Immunizations •Hospitalization •Dental •Vision/hearing

State - *Program*	Date Started	Enroll-ment	Eligibility	Funding Sources	Annual Premium	Annual Budget	Covered Services
Florida - *Healthy Kids*	2/92	20,000 (45,000 by the end of the year)	•100% of fpl •K-12 •Medicaid ineligible •Standards vary by county	•Start $7 million Medicaid grant •State funds •Local govt. match •Sliding fee scale based on school lunch program status	$600-$700	$25 million	Package of benefits through capitated HMO arrangement
Hawaii *State Health Insurance Program (SHIP)*	1989		•Families <300 fpl subsidy, <100 full subsidy •Sliding fee scale	State appropriation uncompensated by care pool	$240	$1.0 million	•Preventive care •Well-child care •Immunizations •In-patient •12 visits a year
Kansas PROGRAM FAILED	7/93	464		•Private foundations •Co-pay	$595 - $539		
Massachusetts *Healthy Kids*	1994	20,000	•< 19 years •Ineligible for Medicaid	•State funds for insurance •Private funds for operations	•<200% fpl, no premium •200%-400%,$10.50 /child/month w/max. of $31.50/ family •<400%, maximum of $52.50/ familiy	•$11.5 million (insurance) •operations costs are privately funded - no info. on amount)	•Primary and preventive •Prescriptions •Medical equipment •Mental health (13 visits/year) •Emergency
Michigan- *Healthy Kids Program (Program L)*			•< 15 years •150% fpl	•Builds on the Blue Cross/Blue Shield Caring Program •Foundation grants			Comprehensive Medicaid benefits

State - *Program*	Date Started	Enroll-ment	Eligibility	Funding Sources	Annual Premium	Annual Budget	Covered Services
Minnesota - *Minnesota Care*	1993 (pilot program in 1988)	95,000	•Adults and children (< 18 years) •below 275% of fpl •adults only up to 135% of fpl	•Provider tax •Enrollee premiums •Sliding fee scale •Cigarette tax •General fund	Varies with average of $4/month	$80 million	•Primary and preventive care •Inpatient hospitalization •Mental health and chemical dependency services
New Hampshire - *Healthy Kids*	1993	1,194	•resident •not eligible for Medicaid or other insurance program •0-18 years	•State seed funding of $240,000 •Private foundations •Premiums •School-based health insurance	$720	$1.5 million (FY97)	•Doctor visits •Dentist visits •Prescriptions •Eyeglasses •Hospital Services
New Jersey - *Health Access*	11/93	18,000	•300% of fpl •children and adults, mostly families	State funds through the hospital charity care provisions, excess unemployment funds, taxes		$10 million	Choice of five policies
New York - *Child Health Plus*	Expanded 6/1994	110,000	•free for children below 160% of fpl •< age 15 •subsidized between 186% and 235% of fpl	•Enrollment fees •Statewide bad debt and charity care pool	$432-$792	$20 million	•Comprehensive outpatient care •Soon it will include inpatient care
North Carolina - Claimed to have no program. Contacted both education and health departments	7/94		Local boards of education purchase group health insurance	•Board of Education •Families			Preventive and primary care

State - *Program*	Date Started	Enroll-ment	Eligibility	Funding Sources	Annual Premium	Annual Budget	Covered Services
Pennsylvania- *Children's Health Insurance Program (CHIP)*	1992	40,563	•Free up to 185 of fpl •< age 13 •Sliding fee scale for children 0 to 5 years between 186% and 235% of fpl 235% of fpl •1 - 13 years, •Resident 30 days	State funds -2 cent per pack cigarette tax and premiums	$770 - $1,014	$21 mm	•Primary and preventive services •Some inpatient •Co-pay for prescription drugs
Washington Basic Health Plan (Plus)	5/1993		All residents to be covered through employer plans, regional purchasing coops, state subsidized basic health plan and other public programs	•State funding •Medicaid funds •Premiums			Uniform benefits plan
West Virginia	1993	21,000	•Low or moderate income families •150% fpl, or children who receive free lunch	Non-profit organizations offer loans or vouchers for earned income tax credits to buy insurance	•$30 for initial partnership •$15/visit	$600,000	•Comprehensive check-ups •Acute care visits •Prescriptions •Dental screening •Lab testing

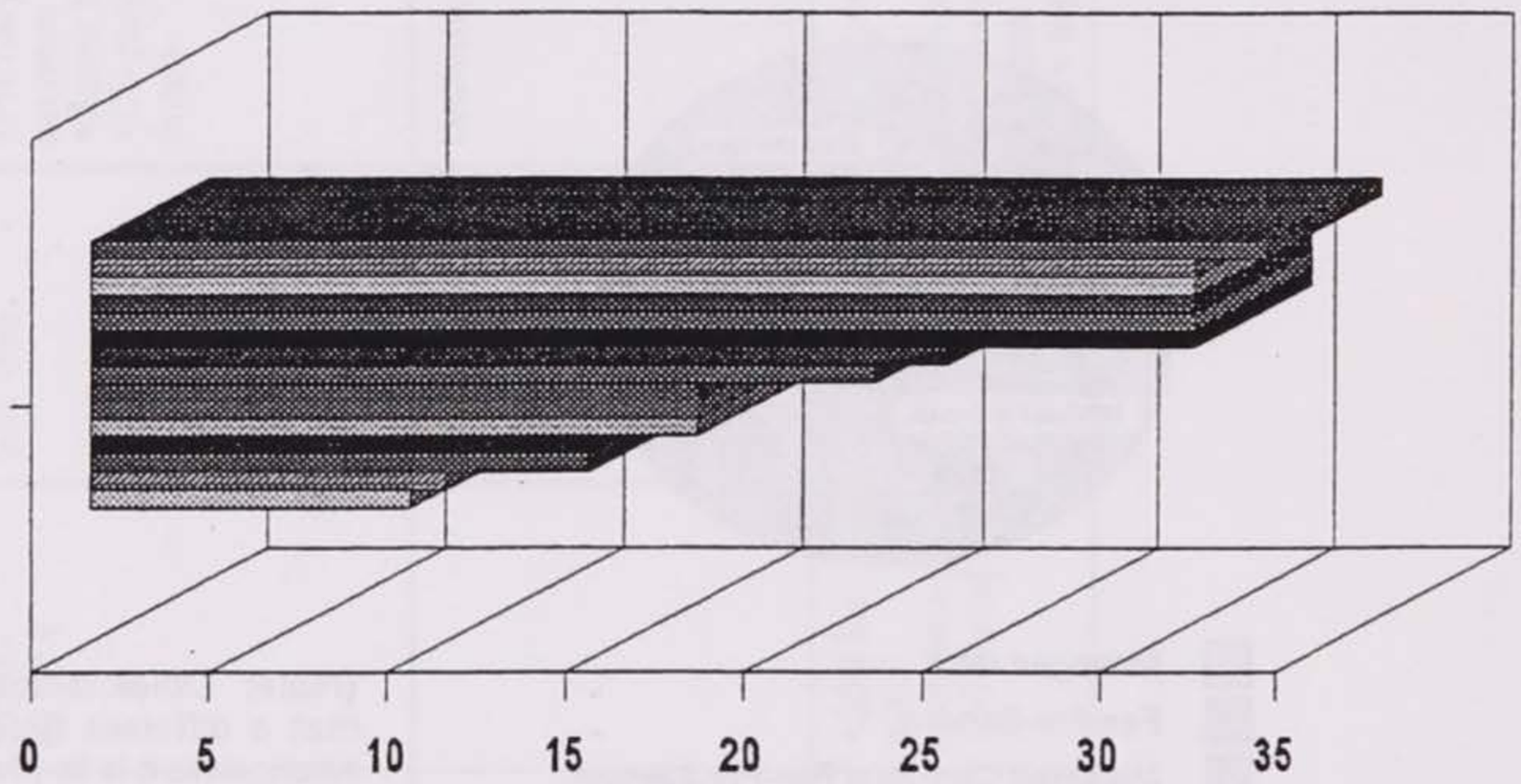
Types of Coverage Offered by State Programs



- Managed Care
- Fee-For-Service
- Managed Care plus Fee-For-Service
- Other

(Note: *Other* indicates that a different type of arrangement is in place, e.g., preferred provider organization.)

Number of Programs Covering Selected Health Services



State Health Insurance Programs for Children
Contacts

Arkansas

Get Smart
Deborah Watkins
800 Marshall St.
Little Rock, AR 72202
501/320-1100

California

California Kids
P.O. Box 71000
Van Nuys, CA 91499
1-800-374-4KID

Colorado

Colorado Child Health Plan
5250 Leetsdale Dr.
Denver, CO 80222
303/372-2060

Connecticut

Healthy Steps
Bea Powell
State Department of Public Health
Office of Policy, Planning, and Evaluation
MS #13PPE
410 Capital Ave.
Hartford, CT 06134-0308
860/509-7130

Florida

Healthy Kids
223 S. Gadeson St.
Tallahassee, FL 32301
904/224-5437

Michigan

Healthy Kids Program (Program L)
Ester Regan
517/335-5003

Minnesota

Minnesota Care
444 Lafayette Rd. N.
St. Paul, MN 55155
1-800-657-3672

Massachusetts

Children Medical Security Plan
P.O. Box 519
Andover, MA 01810-9824
1-800-909-CMSP

New York

Child Health Plus
518/473-7883

Washington

Basic Health Plan - Plus
1-800-826-2444

West Virginia

Pediatric Health Service
304/558-5388

DRAFT

Iowa Healthy Children
Estimated Annual Cost by Plan Type & Poverty Level

	Plan Type	
	High Option	Low Option
Federal Poverty Level 100%		
Enrolling Eligibles	32,500	32,500
Premium PMPM	$ 43.55	$ 7.94
Subtotal	1,415,375	25,408
Annualized	X 12	X 12
Total Annual Cost	$16,984,500	$3,096,600
Federal Poverty Level 142.5%		
Enrolling Eligibles	52,000	52,000
Premium PMPM	$ 43.55	$ 7.94
Subtotal	2,264,600	412,800
Annualized	X 12	X 12
Total Annual Cost	$27,175,200	$4,954,560
Federal Povertly Level 185%		
Enrolling Eligibles	67,000	67,000
Premium PMPM	$ 43.55	$ 7.94
Subtotal	2,917,850	531,980
Annualized	X 12	X 12
Total Annual Cost	$35,014,200	$6,383,760

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Iowa Healthy Kids

Preliminary Pricing Model

Assumptions	
Benefit Type	High Option
FPL Group - Poverty Level	100%
RBRVS %	100%

SERVICE CATEGORY	Utilization/1000 Base	Limits	Net	Cost per Service Base 100%	Limit 100%	Copay	Net	Cost PMPM
HOSPITAL INPATIENT								
MED/SURG/ICU	47	1.00	47	$ 800	$ 800	$ -	$ 800	$3.13
MENT HLTH	20	1.00	20	$ 450	$ 450	$ -	$ 450	$0.75
SUB ABUSE	8	0.15	1	$ 400	$ 400	$ -	$ 400	$0.03
MATERNITY	5	1.00	5	$ 900	$ 900	$ -	$ 900	$0.38
SNF	-	1.00	-	$ 300	$ 300	$ -	$ 300	$0.00
SUBTOTAL	80		73	$ 705	$ 705			$4.29
HOSPITAL OTHER								
O.P. SURGERY	25	1.00	25	$ 600	$ 600	$ -	$ 600	$1.25
EMERGENCY ROOM	200	1.00	200	$ 175	$ 175	$ 25	$ 150	$2.50
OTHER	60	1.00	60	$ 250	$ 250	$ -	$ 250	$1.25
SUBTOTAL	285		285	$ 228	$ 228			$5.00
PHYSICIAN SVCS								
SURGERY - I.P	20	1.00	20	$ 750	$ 750	$ -	$ 750	$1.25
SURGERY - OTHER	75	1.00	75	$ 95	$ 95	$ -	$ 95	$0.59
ANESTHESIA	45	1.00	45	$ 90	$ 90	$ -	$ 90	$0.34
OBSTETRICS	3	1.00	3	$ 955	$ 955	$ -	$ 955	$0.24
INPATIENT VISIT	70	1.00	70	$ 53	$ 53	$ -	$ 53	$0.31
OFFICE VISITS	2,200	1.00	2,200	$ 29	$ 29	$ 5	$ 24	$4.40
WELL CHILD	600	1.00	600	$ 67	$ 67	$ -	$ 67	$3.35
CONSULTS	85	1.00	85	$ 79	$ 79	$ -	$ 79	$0.56
EMERGENCY ROOM	225	1.00	225	$ 51	$ 51	$ -	$ 51	$0.96
MH VISITS	200	0.85	170	$ 61	$ 61	$ 10	$ 51	$0.72
SA VISITS	100	0.15	15	$ 60	$ 60	$ -	$ 60	$0.08
LAB	1,600	1.00	1,600	$ 12	$ 12	$ -	$ 12	$1.60
RADIOLOGY	430	1.00	430	$ 62	$ 62	$ -	$ 62	$2.22
PHYSICAL MEDICINE	90	1.00	90	$ 13	$ 13	$ 5	$ 8	$0.06
IMM. & INJ.	775	1.00	775	$ 17	$ 17	$ -	$ 17	$1.10
REFRACTS	300	1.00	300	$ 40	$ 40	$ -	$ 40	$1.00
MISC	450	1.00	450	$ 55	$ 55	$ -	$ 55	$2.06
SUBTOTAL	7,268		7,153	$ 37	$ 37			$20.84
OTHER SERVICES								
PRESCRIPTION DRUGS	3,100	1.00	3100	$ 28	$ 28	$ 3	$ 25	$6.46
CORRECTIVE LENSES	100	1.00	100	$ 50	$ 50	$ 10	$ 40	$0.33
HOME HEALTH	10	1.00	10	$ 250	$ 250	$ -	$ 250	$0.21
AMBULANCE	8	1.00	8	$ 200	$ 200	$ 5	$ 195	$0.13
DME	70	1.00	70	$ 50	$ 50	$ -	$ 50	$0.29
SUBTOTAL	3,288		3,288	$ 30	$ 30			$7.42
TOTAL MEDICAL COSTS	10,921		10,799					$37.35
ADMIN - % of Claims						8.0%		$3.00
ADMIN - Fixed								$3.00
PREMIUM PMPM								$43.55
NUMBER ELIGIBLES						32,500		
Percent of Eligibles						100.0%		
ELIGIBLES ENROLLING								32,500
TOTAL ANNUAL COST								$16,984,300

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Iowa Healthy Kids

Preliminary Pricing Model

Assumptions	
Benefit Type	High Option
FPL Group - Poverty Level	143%
RBRVS %	100%

SERVICE CATEGORY	Utilization/1000 Base	Limits	Net	Cost per Service - Base 100%	Limit 100%	Copay	Net	Cost PMPM
HOSPITAL INPATIENT								
MED/SURG/ICU	47	1.00	47	$ 800	$ 800	$ -	$ 800	$3.13
MENT HLTH	20	1.00	20	$ 450	$ 450	$ -	$ 450	$0.75
SUB ABUSE	8	0.15	1	$ 400	$ 400	$ -	$ 400	$0.03
MATERNITY	5	1.00	5	$ 900	$ 900	$ -	$ 900	$0.38
SNF	-	1.00	-	$ 300	$ 300	$ -	$ 300	$0.00
SUBTOTAL	80		73	$ 705	$ 705			$4.29
HOSPITAL OTHER								
O.P. SURGERY	25	1.00	25	$ 600	$ 600	$ -	$ 600	$1.25
EMERGENCY ROOM	200	1.00	200	$ 175	$ 175	$ 25	$ 150	$2.50
OTHER	60	1.00	60	$ 250	$ 250	$ -	$ 250	$1.25
SUBTOTAL	285		285	$ 228	$ 228			$5.00
PHYSICIAN SVCS								
SURGERY - I P	20	1.00	20	$ 750	$ 750	$ -	$ 750	$1.25
SURGERY - OTHER	75	1.00	75	$ 95	$ 95	$ -	$ 95	$0.59
ANESTHESIA	45	1.00	45	$ 90	$ 90	$ -	$ 90	$0.34
OBSTETRICS	3	1.00	3	$ 955	$ 955	$ -	$ 955	$0.24
INPATIENT VISIT	70	1.00	70	$ 53	$ 53	$ -	$ 53	$0.31
OFFICE VISITS	2,200	1.00	2,200	$ 29	$ 29	$ 5	$ 24	$4.40
WELL CHILD	600	1.00	600	$ 67	$ 67	$ -	$ 67	$3.35
CONSULTS	85	1.00	85	$ 79	$ 79	$ -	$ 79	$0.56
EMERGENCY ROOM	225	1.00	225	$ 51	$ 51	$ -	$ 51	$0.96
MH VISITS	200	0.85	170	$ 61	$ 61	$ 10	$ 51	$0.72
SA VISITS	100	0.15	15	$ 60	$ 60	$ -	$ 60	$0.08
LAB	1,600	1.00	1,600	$ 12	$ 12	$ -	$ 12	$1.60
RADIOLOGY	430	1.00	430	$ 62	$ 62	$ -	$ 62	$2.22
PHYSICAL MEDICINE	90	1.00	90	$ 13	$ 13	$ 5	$ 8	$0.06
IMM. & INJ	775	1.00	775	$ 17	$ 17	$ -	$ 17	$1.10
REFRACTS	300	1.00	300	$ 40	$ 40	$ -	$ 40	$1.00
MISC	450	1.00	450	$ 55	$ 55	$ -	$ 55	$2.06
SUBTOTAL	7,268		7,153	$ 37	$ 37			$20.84
OTHER SERVICES								
PRESCRIPTION DRUGS	3,100	1.00	3100	$ 28	$ 28	$ 3	$ 25	$6.46
CORRECTIVE LENSES	100	1.00	100	$ 50	$ 50	$ 10	$ 40	$0.33
HOME HEALTH	10	1.00	10	$ 250	$ 250	$ -	$ 250	$0.21
AMBULANCE	8	1.00	x	$ 200	$ 200	$ 5	$ 195	$0.13
DME	70	1.00	70	$ 50	$ 50	$ -	$ 50	$0.29
SUBTOTAL	3,288		3,288	$ 30	$ 30			$7.42
TOTAL MEDICAL COSTS	10,921		10,799					$37.55
ADMIN - % of Claims						8.0%		$3.00
ADMIN - Fixed								$3.00
PREMIUM PMPM								$43.55
NUMBER ELIGIBLES						52,000		
Percent of Eligibles						100.0%		
ELIGIBLES ENROLLING								52,000
TOTAL ANNUAL COST								$27,175,200

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Iowa Healthy Kids

Preliminary Pricing Model

Assumptions	
Benefit Type	High Option
FPL Group - Poverty Level	185%
RBRVS %	100%

SERVICE CATEGORY	Utilization/1000 Base	Limits	Net	Cost per Service Base 100%	Limit 100%	Copay	Net	Cost PMPM
HOSPITAL INPATIENT								
MED/SURG/ICU	47	1.00	47	$ 800	$ 800	$ -	$ 800	$3.13
MENT ILL/TI	20	1.00	20	$ 450	$ 450	$ -	$ 450	$0.75
SUB ABUSE	8	0.15	1	$ 400	$ 400	$ -	$ 400	$0.03
MATERNITY	5	1.00	5	$ 900	$ 900	$ -	$ 900	$0.38
SNF	-	1.00	-	$ 300	$ 300	$ -	$ 300	$0.00
SUBTOTAL	80		73	$ 705	$ 705			$4.29
HOSPITAL OTHER								
O.P. SURGERY	25	1.00	25	$ 600	$ 600	$ -	$ 600	$1.25
EMERGENCY ROOM	200	1.00	200	$ 175	$ 175	$ 25	$ 150	$2.50
OTHER	60	1.00	60	$ 250	$ 250	$ -	$ 250	$1.25
SUBTOTAL	285		285	$ 228	$ 228			$5.00
PHYSICIAN SVCS								
SURGERY - IP	20	1.00	20	$ 750	$ 750	$ -	$ 750	$1.25
SURGERY - OTHER	75	1.00	75	$ 95	$ 95	$ -	$ 95	$0.59
ANESTHESIA	45	1.00	45	$ 90	$ 90	$ -	$ 90	$0.34
OBSTETRICS	3	1.00	3	$ 955	$ 955	$ -	$ 955	$0.24
INPATIENT VISIT	70	1.00	70	$ 53	$ 53	$ -	$ 53	$0.31
OFFICE VISITS	2,200	1.00	2,200	$ 29	$ 29	$ 5	$ 24	$4.40
WELL CHILD	600	1.00	600	$ 67	$ 67	$ -	$ 67	$3.35
CONSULTS	85	1.00	85	$ 79	$ 79	$ -	$ 79	$0.56
EMERGENCY ROOM	225	1.00	225	$ 51	$ 51	$ -	$ 51	$0.96
MH VISITS	200	0.85	170	$ 61	$ 61	$ 10	$ 51	$0.72
SA VISITS	100	0.15	15	$ 60	$ 60	$ -	$ 60	$0.08
LAB	1,600	1.00	1,600	$ 12	$ 12	$ -	$ 12	$1.60
RADIOLOGY	430	1.00	430	$ 62	$ 62	$ -	$ 62	$2.22
PHYSICAL MEDICINE	90	1.00	90	$ 13	$ 13	$ 5	$ 8	$0.06
IMM & INJ	775	1.00	775	$ 17	$ 17	$ -	$ 17	$1.10
REFRACTS	300	1.00	300	$ 40	$ 40	$ -	$ 40	$1.00
MISC	450	1.00	450	$ 55	$ 55	$ -	$ 55	$2.06
SUBTOTAL	7,268		7,153	$ 37	$ 37			$20.84
OTHER SERVICES								
PRESCRIPTION DRUGS	3,100	1.00	3100	$ 28	$ 28	$ 3	$ 25	$6.46
CORRECTIVE LENSES	100	1.00	100	$ 50	$ 50	$ 10	$ 40	$0.33
HOME HEALTH	10	1.00	10	$ 250	$ 250	$ -	$ 250	$0.21
AMBULANCE	8	1.00	8	$ 200	$ 200	$ 5	$ 195	$0.13
DME	70	1.00	70	$ 50	$ 50	$ -	$ 50	$0.29
SUBTOTAL	3,288		3,288	$ 30	$ 30			$7.42
TOTAL MEDICAL COSTS	10,921		10,799					$37.55
ADMIN - % of Claims						8.0%		$3.00
ADMIN - Fixed								$3.00
PREMIUM PMPM								$43.55
NUMBER ELIGIBLES						67,000		
Percent of Eligibles						100.0%		
ELIGIBLES ENROLLING								67,000
TOTAL ANNUAL COST								$35,034,200

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Iowa Healthy Kids

Preliminary Pricing Model

Assumptions	
Benefit Type	Low Option
FPL Group - Poverty Level	100%
RBRVS %	100%

SERVICE CATEGORY	Utilization/1000 Base	Limits	Net	Cost per Service Base 100%	Limit 100%	Copay	Net	Cost PMPM
HOSPITAL INPATIENT								
MED/SURG/ICU	47	-	-	$ 800	$ 800	$ -	$ 800	$0.00
MENT ILLTH	20	-	-	$ 450	$ 450	$ -	$ 450	$0.00
SUB ABUSE	8	-	-	$ 400	$ 400	$ -	$ 400	$0.00
MATERNITY	5	-	-	$ 900	$ 900	$ -	$ 900	$0.00
SNF	-	-	-	$ 300	$ 300	$ -	$ 300	$0.00
SUBTOTAL	80		-	$ -	$ -			$0.00
HOSPITAL OTHER								
O.P. SURGERY	25	-	-	$ 600	$ 600	$ -	$ 600	$0.00
EMERGENCY ROOM	200	-	-	$ 175	$ 175	$ 25	$ 150	$0.00
OTHER	60	-	-	$ 250	$ 250	$ -	$ 250	$0.00
SUBTOTAL	283		-	$ -	$ -			$0.00
PHYSICIAN SVCS								
SURGERY - I.P.	20	-	-	$ 750	$ 750	$ -	$ 750	$0.00
SURGERY - OTHER	75	-	-	$ 95	$ 95	$ -	$ 95	$0.00
ANESTHESIA	45	-	-	$ 90	$ 90	$ -	$ 90	$0.00
OBSTETRICS	3	-	-	$ 955	$ 955	$ -	$ 955	$0.00
INPATIENT VISIT	70	-	-	$ 53	$ 53	$ -	$ 53	$0.00
OFFICE VISITS	2,200	0.50	1,100	$ 29	$ 29	$ 5	$ 24	$2.20
WELL CHILD	600	1.00	600	$ 67	$ 67	$ -	$ 67	$3.35
CONSULTS	85	-	-	$ 79	$ 79	$ -	$ 79	$0.00
EMERGENCY ROOM	225	-	-	$ 51	$ 51	$ -	$ 51	$0.00
MH VISITS	200	-	-	$ 61	$ 61	$ 10	$ 51	$0.00
SA VISITS	100	-	-	$ 60	$ 60	$ -	$ 60	$0.00
LAB	1,600	-	-	$ 12	$ 12	$ -	$ 12	$0.00
RADIOLOGY	430	-	-	$ 62	$ 62	$ -	$ 62	$0.00
PHYSICAL MEDICINE	90	-	-	$ 13	$ 13	$ 5	$ 8	$0.00
IMM & INJ.	775	0.80	620	$ 17	$ 17	$ -	$ 17	$0.88
REFRACTS	300	-	-	$ 40	$ 40	$ -	$ 40	$0.00
MISC	450	-	-	$ 55	$ 55	$ -	$ 55	$0.00
SUBTOTAL	7,268		2,320	$ 36	$ 36			$6.43
OTHER SERVICES								
PRESCRIPTION DRUGS	3,100	-	0	$ 28	$ 28	$ 3	$ 25	$0.00
CORRECTIVE LENSES	100	-	0	$ 50	$ 50	$ 10	$ 40	$0.00
HOME HEALTH	10	-	0	$ 250	$ 250	$ -	$ 250	$0.00
AMBULANCE	8	-	0	$ 200	$ 200	$ 5	$ 195	$0.00
DME	70	-	0	$ 50	$ 50	$ -	$ 50	$0.00
SUBTOTAL	3,288		-	$ -	$ -			$0.00
TOTAL MEDICAL COSTS	10,921		2,320					$6.43
ADMIN - % of Claims						8.0%		$0.51
ADMIN - Fixed								$1.00
PREMIUM PMPM								$7.94
NUMBER ELIGIBLES						32,500		
Percent of Eligibles						100.0%		
ELIGIBLES ENROLLING								32,500
TOTAL ANNUAL COST								$3,096,600

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Iowa Healthy Kids

Preliminary Pricing Model

Assumptions	
Benefit Type	Low Option
FPL Group - Poverty Level	143%
RBRVS %	100%

SERVICE CATEGORY	Utilization/1000 Base	Limits	Net	Cost per Service Base 100%	Limit 100%	Copay	Net	Cost PMPM
HOSPITAL INPATIENT								
MED/SURG/ICU	47	-	-	$ 800	$ 800	$ -	$ 800	$0.00
MENT ILLTH	20	-	-	$ 450	$ 450	$ -	$ 450	$0.00
SUB ABUSE	8	-	-	$ 400	$ 400	$ -	$ 400	$0.00
MATERNITY	5	-	-	$ 900	$ 900	$ -	$ 900	$0.00
SNF	-	-	-	$ 300	$ 300	$ -	$ 300	$0.00
SUB TOTAL	80		-	$ -	$ -			$0.00
HOSPITAL OTHER								
O.P. SURGERY	25	-	-	$ 600	$ 600	$ -	$ 600	$0.00
EMERGENCY ROOM	200	-	-	$ 175	$ 175	$ 25	$ 130	$0.00
OTHER	60	-	-	$ 250	$ 250	$ -	$ 250	$0.00
SUBTOTAL	285		-	$ -	$ -			$0.00
PHYSICIAN SVCS								
SURGERY - LP	20	-	-	$ 750	$ 750	$ -	$ 750	$0.00
SURGERY - OTHER	75	-	-	$ 95	$ 95	$ -	$ 95	$0.00
ANESTHESIA	45	-	-	$ 90	$ 90	$ -	$ 90	$0.00
OBSTETRICS	3	-	-	$ 955	$ 955	$ -	$ 955	$0.00
INPATIENT VISIT	70	-	-	$ 53	$ 53	$ -	$ 53	$0.00
OFFICE VISITS	2,200	0.50	1,100	$ 29	$ 29	$ 5	$ 24	$2.20
WELL CHILD	600	1.00	600	$ 67	$ 67	$ -	$ 67	$3.35
CONSULTS	85	-	-	$ 79	$ 79	$ -	$ 79	$0.00
EMERGENCY ROOM	225	-	-	$ 51	$ 51	$ -	$ 51	$0.00
MH VISITS	200	-	-	$ 61	$ 61	$ 10	$ 51	$0.00
SA VISITS	100	-	-	$ 60	$ 60	$ -	$ 60	$0.00
LAB	1,600	-	-	$ 12	$ 12	$ -	$ 12	$0.00
RADIOLOGY	430	-	-	$ 62	$ 62	$ -	$ 62	$0.00
PHYSICAL MEDICINE	90	-	-	$ 13	$ 13	$ 5	$ 8	$0.00
IMM. & INJ.	775	0.80	620	$ 17	$ 17	$ -	$ 17	$0.88
REFRACTS	300	-	-	$ 40	$ 40	$ -	$ 40	$0.00
MISC	450	-	-	$ 55	$ 55	$ -	$ 55	$0.00
SUBTOTAL	7,268		2,320	$ 36	$ 36			$6.43
OTHER SERVICES								
PRESCRIPTION DRUGS	3,100	-	0	$ 28	$ 28	$ 3	$ 25	$0.00
CORRECTIVE LENSES	100	-	0	$ 50	$ 50	$ 10	$ 40	$0.00
HOME HEALTH	10	-	0	$ 250	$ 250	$ -	$ 250	$0.00
AMBULANCE	8	-	0	$ 200	$ 200	$ 5	$ 195	$0.00
DME	70	-	0	$ 50	$ 50	$ -	$ 50	$0.00
SUBTOTAL	3,288		-	$ -	$ -			$0.00
TOTAL MEDICAL COSTS	10,921		2,320					$6.43
ADMIN - % of Claims						8.0%		$0.51
ADMIN - Fixed								$1.00
PREMIUM PMPM								$7.94
NUMBER ELIGIBLES						52,000		
Percent of Eligibles						100.0%		
ELIGIBLES ENROLLING								52,000
TOTAL ANNUAL COST								$4,954,560

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Iowa Healthy Kids

Preliminary Pricing Model

Assumptions	
Benefit Type	Low Option
FPL Group - Poverty Level	185%
RBRVS %	100%

SERVICE CATEGORY	Utilization/1000 Base	Limits	Net	Cost per Service Base 100%	Limit 100%	Copay	Net	Cost PMPM
HOSPITAL INPATIENT								
MED/SURG/ICU	47	-	-	$ 800	$ 800	$ -	$ 800	$0.00
MENT HLTH	20	-	-	$ 450	$ 450	$ -	$ 450	$0.00
SUB ABUSE	8	-	-	$ 400	$ 400	$ -	$ 400	$0.00
MATERNITY	5	-	-	$ 900	$ 900	$ -	$ 900	$0.00
SNF	-	-	-	$ 300	$ 300	$ -	$ 300	$0.00
SUBTOTAL	80		-	$ -	$ -			$0.00
HOSPITAL OTHER								
O.P. SURGERY	25	-	-	$ 600	$ 600	$ -	$ 600	$0.00
EMERGENCY ROOM	200	-	-	$ 175	$ 175	$ 25	$ 150	$0.00
OTHER	60	-	-	$ 250	$ 230	$ -	$ 250	$0.00
SUBTOTAL	285		-	$ -	$ -			$0.00
PHYSICIAN SVCS								
SURGERY - I.P.	20	-	-	$ 750	$ 750	$ -	$ 750	$0.00
SURGERY - OTHER	75	-	-	$ 95	$ 95	$ -	$ 95	$0.00
ANESTHESIA	45	-	-	$ 90	$ 90	$ -	$ 90	$0.00
OBSTETRICS	3	-	-	$ 955	$ 955	$ -	$ 955	$0.00
INPATIENT VISIT	70	-	-	$ 53	$ 53	$ -	$ 53	$0.00
OFFICE VISITS	2,200	0.90	1,100	$ 29	$ 29	$ 5	$ 24	$2.20
WELL CHILD	600	1.00	600	$ 67	$ 67	$ -	$ 67	$3.35
CONSULTS	85	-	-	$ 79	$ 79	$ -	$ 79	$0.00
EMERGENCY ROOM	225	-	-	$ 51	$ 51	$ -	$ 51	$0.00
MH VISITS	200	-	-	$ 61	$ 61	$ 10	$ 51	$0.00
SA VISITS	100	-	-	$ 60	$ 60	$ -	$ 60	$0.00
LAB	1,600	-	-	$ 12	$ 12	$ -	$ 12	$0.00
RADIOLOGY	430	-	-	$ 62	$ 62	$ -	$ 62	$0.00
PHYSICAL MEDICINE	90	-	-	$ 13	$ 13	$ 5	$ 8	$0.00
IMM & INJ.	775	0.80	620	$ 17	$ 17	$ -	$ 17	$0.88
REFRACTS	300	-	-	$ 40	$ 40	$ -	$ 40	$0.00
MISC	450	-	-	$ 55	$ 55	$ -	$ 55	$0.00
SUBTOTAL	7,268		2,320	$ 36	$ 36			$6.43
OTHER SERVICES								
PRESCRIPTION DRUGS	3,100	-	0	$ 28	$ 28	$ 3	$ 25	$0.00
CORRECTIVE LENSES	100	-	0	$ 50	$ 50	$ 10	$ 40	$0.00
HOME HEALTH	10	-	0	$ 250	$ 250	$ -	$ 250	$0.00
AMBULANCE	8	-	0	$ 200	$ 200	$ 5	$ 195	$0.00
DME	70	-	0	$ 50	$ 50	$ -	$ 50	$0.00
SUBTOTAL	3,288		-	$ -	$ -			$0.00
TOTAL MEDICAL COSTS	10,921		2,320					$6.43
ADMIN - % of Claims						8.0%		$0.51
ADMIN - Fixed								$1.00
PREMIUM PMPM								$7.94
NUMBER ELIGIBLES						67,000		
Percent of Eligibles						100.0%		
ELIGIBLES ENROLLING								67,000
TOTAL ANNUAL COST								$6,383,760

About RWJF

The Robert Wood Johnson Foundation was established as a national philanthropy in 1972 and today is the largest U.S. foundation devoted to health care. The Foundation concentrates its grantmaking toward three goal areas:

- to assure that all Americans have access to basic health care at reasonable cost;
- to improve the way services are organized and provided to people with chronic health conditions; and
- to promote health and reduce the personal, social, and economic harm caused by substance abuse—tobacco, alcohol, and illicit drugs.

This document, as well as many other Foundation publications and resources, is available on the Foundation's World Wide Web site:
www.rwjf.org

THE ROBERT WOOD JOHNSON FOUNDATION

Route 1 and College Road East
Post Office Box 2316
Princeton, New Jersey 08543-2316

CALL FOR PROPOSALS:

Healthy Kids℠

Replication Program

THE ROBERT WOOD JOHNSON FOUNDATION

Purpose

Healthy Kids™ is a program designed to help states develop a comprehensive, affordable health insurance product for uninsured children. The program, initiated in 1988, provides grant funds to replicate a successful model in Florida that helps families that do not qualify for government aid—but that cannot afford private health insurance—buy health insurance for their children. Florida Healthy Kids is a subsidized insurance product sold through schools. School districts are used as a grouping mechanism to lower the cost of insurance for children, similar to the role employers play in providing group coverage to their employees.

Up to $3 million has been made available for the Healthy Kids replication program. Under this three-year competitive program, approximately seven states will be awarded grants. These include planning grants for states to develop their programs and implementation grants for those ready to proceed.

Background

One child out of every seven in America does not have health insurance, according to a 1996 study by the Employee Benefits Research Institute. The number of uninsured children is increasing and current trends in private health care coverage and welfare reform threaten to accelerate the rate of increase.

The majority of Americans get their health insurance coverage from group insurance plans provided through their employers. Historically, covering a worker generally meant covering his or her children as well, but rising health care costs have begun to change that. Recent years have seen a drop in employer-provided dependent coverage (from 61 percent of children in 1988 to 54 percent in 1993). Additionally, many lower-wage workers cannot afford the higher costs of family coverage.

Expansions in state Medicaid programs were able to cover many children who otherwise would have been uninsured. But rising health care costs and recent changes in federal welfare rules have many experts

predicting that further expansions will not be possible. The result of these two trends is that children are 40 percent more likely to be uninsured than adults. For children with medical problems, lack of insurance doubles their chance of not getting care.

Very few insurance companies offer policies only for children, but a model program, Florida Healthy Kids, has demonstrated that a children's insurance product has a place in the market. The feasibility of a children's, school enrollment-based health insurance program was first explored in a 1988 University of Florida study and in a subsequent pilot program, jointly funded by the State of Florida and The Robert Wood Johnson Foundation. The program designed a children's insurance product and used school districts to group children into purchasing pools to make the product affordable. The product was sold to families who did not qualify for government aid, but could not afford private health insurance for their children.

Moving the insurance contract from the employer to the school district also enhanced the portability of coverage, especially for families with a child with a pre-existing condition.

A recent evaluation of the program found a 70 percent decrease in emergency room visits per enrollee. In 1995, enrollees had more than 110,000 primary care visits, more than 9,500 children were immunized and 719 children received eyeglasses. Teachers also reported improved attendance in school.

The Florida Healthy Kids model has two goals: create a comprehensive insurance product for school children and facilitate the provision of preventive care for children. The Florida program has the following components:

- **Eligibility:** All children enrolled in school grades K–12 are eligible to participate in the program. Pre-school age siblings may also join.

- **Benefits:** The benefits package emphasizes prevention and is designed specifically for children's medical needs. It features inpatient and outpatient care, including dental, vision, and mental health. There are no pre-existing condition limitations and no medical underwriting. Co-payments are required for some services, such as emergency rooms, eyeglasses, office visits, and prescriptions. In each school district, insurance companies bid to participate in the program. To participate, companies must demonstrate that they have an adequate and accessible network of providers.
- **Role of the schools:** Schools serve as the central institution within communities, fostering relationships between the local project, community leaders, and area business groups. Schools also verify student enrollment, distribute marketing materials and applications, provide parent outreach, enhance health education opportunities, and provide interpreters and translators for program activities and materials.
- **Financing:** Premiums are covered by a combination of state and local/community funds, as well as family contributions based on a sliding scale. In Florida, the state contributes 25 percent, local/community funds comprise 40 percent, and families contribute approximately 35 percent of the premium. The state's initial contribution is higher, allowing communities to implement the program with minimal start-up contributions (approximately five percent). The state portion declines over time as the local match and program enrollment increases.
- **Administration:** In Florida, the Healthy Kids Corporation facilitates the efforts of all the parties in each site. This state-funded, 501(c)(3) corporate entity, manages the contractual arrangements for billing and administration of the product, and manages the bidding process with insurers at each site. A private third party administrator (TPA) helps with initial eligibility determinations, and handles the

enrollment functions by processing applications and collecting monthly premiums paid by the families. In addition, the TPA verifies continuing eligibility by checking monthly to see that program participants are not receiving any services through the state Medicaid program.

The program

This program will support the replication of the Florida Healthy Kids model in approximately seven states. While states are not expected to develop a Healthy Kids program identical to Florida's, their proposed project is expected to create a comprehensive insurance product for uninsured children that is sold through schools.

The Foundation has made $3 million available under this three-year competitive program. Grant funds will be made available for planning and development activities and for implementation activities. Planning and development grants of up to 15 months may be used for activities such as:

- product design and actuarial assessments;
- securing adequate local and state funding contributions;
- working with the schools and communities; and
- market assessment and marketing plan development.

Implementation grants of up to two years may be used for such activities as:

- enrollment and eligibility verification procedures and processes;
- management information systems;
- billing and claims processes;
- securing suitable insurance partner(s); and
- implementing a marketing plan.

Eligibility and selection criteria

All states are eligible to apply under this program. A single state agency or organization designated by the state must make the application. The applicant must show it can coordinate all relevant agencies and organizations necessary for the program's success (e.g., state departments of insurance, health, social services, or child welfare, and local business groups). The applicant must demonstrate its qualifications to serve as the lead organization. States seeking money for implementation activities must make a one-to-one match of the funds requested in the application; the match may be in-kind or in cash.

Criteria used to assess applicants for replication projects will include:

- evidence of support from key state and local decision makers;
- demonstrated understanding of the technical capacity and resources necessary to carry out the project; and
- evidence of sustainability.

Use of grant funds

Grant funds may be used for program planning, development, implementation, and coordination. They may be used for salaries for staff and consultants involved in product development, data processing, supplies, related travel and office expenses, and a limited amount of equipment related to the project. Planning activities, public outreach, convening, special youth activities, and education campaigns commensurate with the scope of the project will also be supported.

In keeping with Foundation policy, grant funds may not be used to subsidize individuals for the cost of health care, to construct or renovate facilities, or as a substitute for funds currently being used to support similar activities. Grantees will be required to submit annual, final narrative and financial reports. Project directors may be asked to attend periodic meetings and give progress reports.

Program direction

In addition to providing direct grant support, the Foundation has funded a national program office headed by Rose M. Naff, director and Jill E. Meenan, deputy director. Foundation staff responsible for the program are Terri C. Gibbs, program officer; Robert G. Hughes, PhD, vice president; Dolores Slayton, program assistant; Paul Tarini, communications officer; and Sheila Weeks-Brown, financial analyst.

The national program office will provide technical assistance to grantees on key design, implementation, and operational issues. It will conduct workshops and small group meetings for states with similar issues to address. It also will prepare and disseminate technical assistance materials to grantees and other interested parties.

A national advisory committee will help review proposals, participate in site visits during the review process, make recommendations for grants to Foundation staff, and assist in monitoring the progress of the program. Foundation staff will make final recommendations for funding to the Foundation's Board of Trustees.

Evaluation

An evaluation of the national program may be funded by the Foundation. Such an evaluation would be conducted by an independent research group and would focus on key questions regarding the program's impact. As a condition of accepting grant funds, all grantees will be required to participate in such an evaluation.

287- 3170

How to apply

Application forms with complete instructions will be available at the applicant workshop to be held in Dallas, TX on February 25, 1997. After the workshop, application forms and instructions may be obtained by contacting the national program office at the address below. Attendance at the applicant workshop is not required. For those unable to attend, a summary of the major questions raised and the responses may be obtained from the national program office. This information will also be posted on the Foundation's web site <http://www.rwjf.org>. Cassette recordings of the workshops will also be available from the national program office.

Inquiries

All inquiries regarding the applicant workshop and program should be addressed to:

Rose M. Naff, Director
National Program Office
Florida Healthy Kids Corporation
223 South Gadsden Street
Tallahassee, Florida 32301
Phone: 904-224-5437
888-FLA-KIDS
Fax: 904-224-0615
E-mail: NPO@healthykids.org

Faxed proposals will not be accepted.

Timetable

The timetable for proposal submission and review is as follows:

February 25, 1997	Applicant workshop Dallas, TX
May 1, 1997	Application deadline
Summer 1997	Site visits
November 1997	Grant recipients announced