REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF A SCHOOL-BASED HEALTH INSURANCE PLAN PURSUANT TO HJR 191 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 19

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

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Preface

House Joint Resolution (HJR) 191 of the 1994 Session requested the Joint Commission on Health Care to study the feasibility of implementing a school-based health insurance program.

Approximately 900,000 Virginians, or 15 percent of Virginia's population, are uninsured. About one-quarter of Virginia's uninsured population is between the ages of 0 -17 years. Research indicates that, compared to children with insurance, children without insurance are less likely to have a usual source of care and more likely to have hospitalizations which could have been avoided.

School-based health insurance is a relatively new initiative designed to provide coverage for school children with no other means of insurance. In these programs, uninsured children who are enrolled in school and not eligible for Medicaid can purchase comprehensive health insurance through the school-based program. The school systems play a key role in providing administrative support and in-kind services to the program.

New Hampshire and Florida have implemented school-based insurance programs. Florida is the only state which has enrolled children. In Florida, premium subsidies are provided for children based on family income. Florida's experience indicates that without subsidies, few children are likely to enroll. As such, subsidies are a critical element to the success of such a program.

Based on Florida's experience, the success of a school-based health insurance program in Virginia would depend on stable, long-term funding sources to provide premium subsidies. Funding alternatives include general fund appropriations, private donations, local government funding, and federal grant money. In addition, the success of such a program would depend on the level of administrative support provided by local school divisions.

The study offers two policy options for consideration. Option I would maintain the status quo. Option II would direct the Department of Education, in cooperation with the Bureau of Insurance and the Department of Medical Assistance Services to conduct further analysis to determine the level of interest among school divisions and families of uninsured school children, develop potential benefit designs and costs, and identify potential premium subsidies.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

December 30, 1994

TABLE OF CONTENTS

Authority for Study

House Joint Resolution (HJR) 191, which was passed by the 1994 Session of the General Assembly, directs the Joint Commission on Health Care to study the feasibility of developing a school-based alternative health insurance plan. Specifically, HJR 191 requests that the Joint Commission (i) review available data on the programs in existence in other states, including the costs and impact of such programs, and (ii) explore funding alternatives for such a program.

Background

Children Comprise a Significant Portion of the Nation's Uninsured Population

Estimates of the number of uninsured children (ages 0-18) in the United States range from 9 to 11 million. A 1992 health insurance survey conducted by the Employee Benefit Research Institute found that 9.5 million children, or 14.7 percent of the total population of children (ages 0-18) do not have health insurance of any kind.

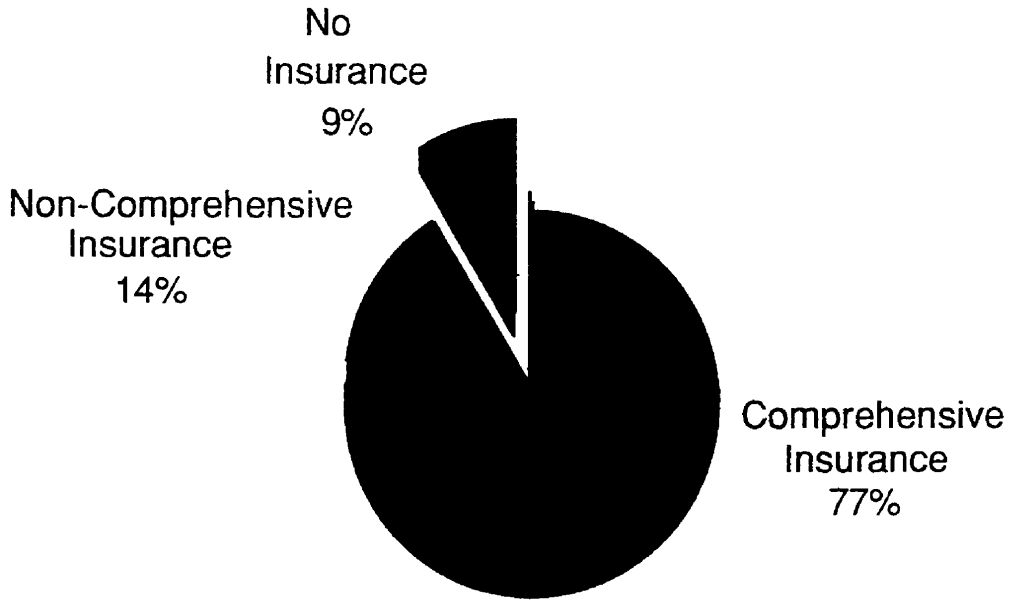
Research conducted in 1992 by the Children's Defense Fund found that employment-based insurance for dependent children dropped 13.6 percent between 1977 and 1987. For families with incomes between 100 percent and 200 percent of the federal poverty level, the decline was almost 26 percent. Even when family coverage is offered to an employee, premium costs for dependents often exceed the ability of workers to pay. About 75 percent of the nation's uninsured children live with workers who earn less than twice the federal poverty level.

Between 9 and 14 Percent of Virginia's Children are Uninsured

With respect to children in Virginia, research conducted by the Children's Defense fund in 1992 estimated that 14 percent of Virginia's children are uninsured. A 1993 survey conducted by the Survey Research Laboratory of Virginia Commonwealth University estimated that 9 percent of Virginia's children (ages 0-17) are uninsured. The results of the VCU survey regarding the health insurance status of children in Virginia are presented in Figure 1.

Based on population estimates published by the Virginia Employment Commission and the estimated percentage of children without health insurance, the number of uninsured children (ages 0-17) in Virginia likely is between 160,000 and 250,000.

Figure 1
Insurance Status of Virginia's Children
(Ages 0-17)



Source: Survey Research Laboratory, Virginia Commonwealth University

Research Indicates That Children Without Health Insurance Generally Are Less Healthy

One of the more troubling aspects of uninsured children is that, on the average, these children are less healthy than children with health insurance. Research conducted by the U.S. Agency for Health Care Policy and Research found that, when compared to children with insurance, uninsured children:

- are less likely to have a usual source of care; and, therefore, see their doctor less often;
- are more likely to use hospital emergency rooms as their usual source of care;
- may delay or forgo medical care for serious conditions;
- are less likely to receive physician services, dental care, and prescription drugs; and
- are more likely to have hospitalizations which could have been avoided with better primary care.

Efforts to Expand Health Insurance Coverage to Uninsured Children

Several States Have Implemented Various Programs to Reduce the Number of Uninsured Children

To address the pressing health needs of uninsured children, a number of states have taken steps to reduce the number of uninsured children. The programs implemented by these states generally fall into three categories:

(i) programs which expand Medicaid eligibility;

(ii) programs which subsidize insurance premiums for low-income families; and

(iii) programs which provide preventive and primary care services.

Expansion of Medicaid: Numerous states have expanded their Medicaid programs to cover uninsured children by revising their eligibility criteria such that a greater number of children are eligible to enroll in Medicaid. For example, West Virginia passed legislation during its 1994 legislative session to expand Medicaid coverage to an additional 75,000 children between the ages of 2 and 18. The children covered under West Virginia's expansion of Medicaid are those in families with incomes less than 150% of the federal poverty level.

In addition to those states which have expanded the number of persons eligible for Medicaid, several states have requested approval from the Health Care Financing Administration (HCFA) to implement health reform demonstration projects to modify their respective Medicaid programs. To modify certain aspects of a state's Medicaid program, a Section 1115 Waiver must be submitted to and approved by HCFA.

Subsidized Insurance Programs: At least 11 states have implemented or are in the process of implementing programs in which health insurance premiums are subsidized for children in low-income families ineligible for Medicaid. These states are identified in Figure 2.

Figure 2

States Which Have Implemented Subsidized Insurance Programs for Children in Low-Income Families

California	Colorado
Connecticut	Maine
Massachusetts	Michigan
Minnesota	New York
Pennsylvania	Vermont
Washington	

Source: "State Initiatives to Cover Uninsured Children, The Future of Children," Vol. 3, No. 2

Preventive and Primary Care Initiatives: A number of states, including Virginia, have implemented programs to provide preventive and primary care services to uninsured children. (The Virginia programs are discussed later in this issue brief.) Blue Cross and Blue Shield (BCBS) Plans in at least 20 states, including Virginia, sponsor "Caring Programs" for children. While the specifics of each plan are determined by the respective BCBS Plan and the host state, these programs typically provide preventive, primary and emergency care services as well as outpatient surgery. The individual BCBS plans provide the administrative services for these "Caring Programs" at no cost. The cost of providing the medical services is financed through private donations from individuals and organizations in the community.

In addition to the BCBS "Caring Programs," states have implemented similar types of programs designed to provide preventive and primary care services to uninsured children in low-income families. (Virginia has implemented "Kids Care" for uninsured children ages 0-1. This program is discussed in more detail in the next section.) The "California Kids" program provides preventive and primary services to school aged children up to age 18 at participating HMOs. Instead of paying a premium for these services, parents pay a $5 co-pay for office visits, and $5-$10 for prescription drugs.

Virginia Has Taken Several Steps to Expand Insurance Coverage and Improve Access to Care for Children

Medicaid Expansion: Like several other states, Virginia has expanded its Medicaid program to include additional children. In 1988, Medicaid was expanded to cover pregnant women and children younger than age 6 in families with income up to 133% of the federal poverty level, and children ages 6 to 19 up

to 100% of the federal poverty level. By expanding eligibility for Medicaid, an additional 60,000 children have received Medicaid services in the past five years.

"Kids Care": In December, 1991, the Governor's Child Health Task Force recommended that a plan be available to cover the basic health needs for uninsured children under age 18 whose families earn less than 200% of the federal poverty level. The Governor proposed, and the 1993 General Assembly approved $3.4 million to implement a program to provide preventive and primary care services for children from birth to age 1 with family income less than 200% of the federal poverty level. The new program, called "Kids Care," was implemented by the Department of Medical Assistance Services (DMAS). "Kids Care" began enrolling children in the program in December, 1993.

Originally, it was estimated that "Kids Care" would reach approximately 6,000 children. However, as of August, 1994, only 24 children were enrolled in "Kids Care." House Joint Resolution 183, which was adopted by the 1994 General Assembly, directed the Joint Commission on Health Care to review the "Kids Care" program and make recommendations regarding possible expansion or revision of the program such that services are provided to a greater number of uninsured children. (The results of the HJR 183 study are being presented to the Joint Commission as a separate report.)

The 1994 General Assembly authorized DMAS to submit a waiver request to HCFA seeking approval of a demonstration project to incorporate the "Kids Care" program under Medicaid and extend the program to children up to age 3. If approved, "Kids Care" would receive federal matching funds to help pay for the expanded coverage. DMAS expects to receive HCFA's final response on the waiver request in October.

"Caring Program for Children": As noted previously, Blue Cross and Blue Shield Plans have implemented "Caring Programs" for children in at least 20 states. The Virginia Caring Program, Inc., a 501(c)(3) public charity formed by Trigon Blue Cross Blue Shield, administers the "Caring Program for Children" in Virginia. The "Caring Program for Children" provides preventive and primary care services for children ages 1-19 whose family income does not exceed 200% of the federal poverty level.

The cost of the medical care provided through the program is paid from contributions made by concerned organizations and individuals. Trigon Blue Cross Blue Shield provides administrative services for the program at no cost. The "Caring Program for Children," which was implemented in 1993, currently has 1,708 children approved to receive services through the program.

Other Programs for Children: In addition to the statewide programs discussed above, other programs have been implemented by some localities to expand insurance coverage and/or access to care for uninsured children. For example, in Fairfax County, "Medical Care for Children" is a public-private alliance which provides care to uninsured children. The medical care is provided almost entirely through in-kind contributions from private doctors, hospitals and HMOs. The "Medical Care for Children" program currently enrolls approximately 3,000 children.

Comprehensive Health Investment Project (CHIP): CHIP was founded in 1988 in Roanoke to establish "medical homes" for low-income children aged 0-6, and to provide family based support services to parents. The model program was established as a public-private partnership with three essential partners: (i) community action, (ii) local public health, and (iii) local private physicians and dentists.

The CHIP program includes three basic service components: (i) provision of care coordination/case management; (ii) facilitation of children's access to primary health care services; and (iii) provision of family support services.

Through the CHIP program, a "medical home" is created for each child by recruiting a local private physician as the child's primary medical care giver. The "medical home" provides the child with access to regular and continuous medical care. The CHIP services permit early detection of health problems and promote early intervention and preventive care. In addition to the services provided for the children, CHIP staff develop and coordinate with the parents an individualized plan of care for the child; make referrals to other health services; and teach parents how to promote the overall health and development of their children.

"CHIP of Virginia" is a statewide initiative to replicate and expand the CHIP model program. Through CHIP of Virginia, the program has expanded to the New River Valley, Abingdon, Charlottesville, Richmond, the greater Williamsburg area, Petersburg, Portsmouth, Norfolk and Chesapeake. The CHIP network currently serves 1,600 children.

School-Based Health Insurance Programs

School-Based Health Insurance Programs Are Relatively New Initiatives Which Provide Coverage to Uninsured School Children

Traditionally, Americans have obtained individual and family health insurance coverage in one of three ways: (i) employer-sponsored health insurance, (ii) direct purchase of coverage, or (iii) public assistance programs such as Medicaid. Most persons obtain coverage through their employer. However, many employers contribute only to the employee's coverage, rather than the entire family. As a result, in many low-income families, parents cannot afford to purchase dependent coverage for their children.

School System as Pooling Mechanism: School-based health insurance programs are relatively new initiatives designed to provide insurance coverage to uninsured children enrolled in school. In more traditional insurance programs, employers, businesses, and other groups serve as a pooling mechanism to provide enrollees a means of spreading their health risks among a larger group of individuals. In school-based health insurance programs, the school system is used as the pooling mechanism for spreading the risk of uninsured children, and as the basis for negotiating insurance contracts with carriers.

Children, as a group, typically have lower health costs than the general population. Therefore, one of the purported benefits of school-based health insurance is that premiums are lower for children insured through this type of program than by insuring them through a group which includes older, less healthy persons.

Eligibility Limited to Children with No Other Coverage: Eligibility for school-based health insurance programs is limited to only those children enrolled in school (grades K-12), who have no other sources of private health insurance, and who are not eligible for Medicaid coverage. Coverage may be offered to pre-school siblings of enrolled children; however, parents and other siblings typically are not eligible for the coverage.

Premium Subsidies May Be Provided: Depending on the amount of available funding, school-based health insurance programs may provide premium subsidies for children from the lowest income families.

Benefits May Be Comprehensive or Primary/Preventive Services Only: Unlike some insurance coverage currently offered to school children which is limited to accidents only, school-based health insurance programs provide more

comprehensive coverage, and are not limited to only conditions or accidents which occur at school. As discussed in detail later in this issue brief, school-based programs may provide comprehensive coverage for physician services, inpatient hospital care, diagnostic testing, prescription drugs and mental health services. Others may limit coverage to only primary and preventive services.

Benefits of School-Based Health Insurance May Go Beyond Improved Health Status of Children

The principal objective of school-based health insurance is to improve the health status of uninsured children. However, advocates of school-based health insurance programs also state that these programs have other potential benefits, including:

* improving attendance at school due to fewer absences for illness;
* reducing the likelihood of a student "dropping out" of school (children who drop out of school would become ineligible for coverage); and
* enhancing the parents' ability to change jobs without fear of losing benefits coverage for children.

School-Based Health Insurance Programs in Other States

HJR 191 directed the Joint Commission on Health Care to review data available from other states, including the costs and impact of such programs. This section provides information regarding other states which have implemented school-based health insurance programs.

Florida, Kansas and New Hampshire Are the Only States Which Have Implemented School-Based Health Insurance Programs

As previously noted, many states have implemented various types of programs designed to provide health insurance coverage and/or primary care services to uninsured children, including school aged children. In some instances where the state provides insurance premium subsidies, the programs resemble a "school-based health insurance" program. However, it appears that only Florida, Kansas and New Hampshire have implemented programs specifically designed as "school-based" insurance, and based on school enrollment. The distinguishing features of these programs are: (i) eligibility is tied to school enrollment, and (ii) the key role(s) that the school systems play in administering the program.

Only Florida Has Enrolled Children: Florida was the first state to implement a school-based health insurance program, and currently is the only

state which has enrolled any children. Kansas passed legislation in 1993 to implement such a program; however, the program was abandoned and never fully implemented. New Hampshire also passed its legislation in 1993, and currently is implementing its program.

The following paragraphs summarize the Florida and New Hampshire programs. Because the New Hampshire program is in its infancy, there is less data available than that which is available from the Florida program.

Both Florida and New Hampshire Created Private, Non-Profit Corporations Exempt from Insurance Regulation; Florida Received A Demonstration Grant From HCFA

Florida: Florida passed legislation in 1990 creating the "Healthy Kids Corporation," a private non-profit corporation. The state legislature initially appropriated only $83,000. However, once the program received a four-year, $7 million demonstration grant from HCFA to help establish the program, the legislature appropriated an additional $2.2 million in 1991. Since the initial start-up funding, Florida has appropriated an additional $8.3 million. Florida's program began as a pilot in Volusia County, which is located near the Daytona Beach area. The Volusia County site enrolled its first children in 1992.

Florida has expanded the "Healthy Kids" program to four additional sites: Highlands County (September, 1993), Okeechobee County (April, 1994), Santa Rosa County (August, 1994), and Broward County (September, 1994). A sixth site, St. Lucie County began on October 1, 1994.

New Hampshire: New Hampshire, which passed its legislation in 1993, patterned its law after Florida's legislation. It, too, established a private, non-profit corporation called the New Hampshire "Healthy Kids" Corporation to implement its program. The state legislature appropriated $240,000 as start-up funding. No additional appropriations were provided, and no other funds were secured from HCFA or other sources.

Eligibility: Criteria are Similar in Florida and New Hampshire: School Children Without Insurance and Ineligible for Medicaid

Florida: To be eligible for the "Healthy Kids" program, children must be: (i) between the age of 5 and 19, (ii) enrolled in school (grades K -12), (iii) uninsured, and (iv) not eligible for Medicaid. In some pilot sites, pre-school siblings of enrolled school children also are eligible for coverage.

New Hampshire: To be eligible for "Healthy Kids," children must be (i) of pre-school age or enrolled in school (grades K-12), (ii) between the age of 3 and 21, (iii) uninsured, and (iv) not eligible for Medicaid.

Benefit Design: Both Florida and New Hampshire Provide Managed Care Benefits; No Waiting Periods for Pre-Existing Conditions

Florida: Florida offers a comprehensive benefits package, including inpatient hospitalization, well child care visits and immunizations, primary and preventive care physician services, prescription drugs, diagnostic testing, vision screening and glasses, and mental health services. The benefits are provided through a managed care delivery system wherein every child must select a primary care physician who coordinates all care. There are no waiting periods for pre-existing conditions.

There are no co-payments or deductibles for most preventive care, wellness visits or hospital stays. Some co-payments are required for emergency services, prescription medicines, mental health services, and vision screening.

New Hampshire: New Hampshire currently is evaluating proposals from insurers on different benefit packages. It has requested rates for the following benefit designs: (i) primary care/preventive services, (ii) a comprehensive package of benefits similar to Florida without maternity care, and (iii) a comprehensive package of benefits with maternity care. Like Florida, New Hampshire will utilize a managed care delivery system in which each child will be required to select a primary care physician.

New Hampshire's preliminary benefit design includes co-payments for most primary care services, a $1 million lifetime maximum for medical services and a $20,000 lifetime maximum for mental health services.

Financing: Florida and New Hampshire Programs Differ Significantly: Florida Offers Substantial Premium Subsidies

Florida: Florida received a total of $2.3 million in start-up appropriations from the Florida state legislature as well as additional appropriations totaling $8.3 million. In addition, Florida received a four year, $7 million demonstration grant from HCFA. The HCFA funding has been used primarily to subsidize premiums for children from the poorest families in the initial pilot location, Volusia County.

The cost of "Healthy Kids" is paid with three funding sources: (i) state funding, (ii) local funding, and (iii) enrollee premiums and co-payments. (In addition to these funding sources, HCFA funding is used in Volusia County.) The

actual percentage paid by each entity varies among the six Florida counties in which the "Healthy Kids" program has been/is being implemented. Generally, the locality pays between 5 and 10 percent, enrollees pay between 25 and 30 percent, and the state pays the remaining amount. "Healthy Kids" requires that a locality pay at least 5 percent of the total costs in the first year, and 10 to 15 percent in the second year. Florida's financing plan is to have the locality pay at least 50 percent of the total cost by year four, and eventually pay the entire cost except the amount paid by the enrollees.

The cost per child is $48.00 per month. However, those children who qualify for the National School Lunch Program receive a premium subsidy. Based on family income, the monthly cost per child is $5, $13 or $48. In Volusia County where HCFA funding is available, families pay $0, $2.50, $5, $13 or $48.

Data from the four sites currently in operation indicate that nearly all enrolled children (94%) receive some level of premium subsidy. Approximately one-half of the total program enrollees receive the coverage at no charge. (These enrollees are in Volusia County only.)

New Hampshire: New Hampshire received a $240,000 start-up appropriation from the state legislature. However, at this time there is no funding to subsidize premiums. Blue Cross and Blue Shield of New Hampshire has been awarded the contract to administer the program, and has agreed to provide the administrative services at no cost. However, enrollees will have to pay the full cost of the medical services provided under the program.

As noted earlier, New Hampshire is considering three benefit designs. The estimated monthly cost of the medical services of each benefit package is as follows:

(i) primary care/preventive services ($21.32);
(ii) a comprehensive package of benefits similar to Florida, without maternity care; ($57.69) and
(iii) a comprehensive package of benefits with maternity care ($70.53).

Once the program has implemented its "enrollee pay all" product, New Hampshire plans to focus its efforts on raising private funds to subsidize premiums.

<u>Administration:</u> School Divisions Play An Integral Role in Administration of Florida's Program; New Hampshire Contracts Out All Administrative Services

Florida: The Florida "Healthy Kids" Corporation provides oversight of the program and contracts many administrative responsibilities to the insurer/HMO

in each participating site. The school divisions play key administrative roles, including: verifying family income and eligibility for premium subsidies, distributing and collecting enrollment forms, providing facilities for meetings, and orienting new enrollees. Determining eligibility for participating in the program and receiving premium subsidies relieves the Florida "Healthy Kids" Corporation from developing its own eligibility system which can be quite costly to develop and maintain.

Florida has been able to gain the support and involvement of the school divisions because of the funding that is available to subsidize the premiums of the school division's children who enroll in the program.

New Hampshire: New Hampshire contracts out nearly all administrative services to Blue Cross and Blue Shield of New Hampshire, which has agreed to provide these services at no cost to the program. Because there are no premium subsidies provided by the program, New Hampshire does not have the same "leverage" to get the school divisions to perform any significant administrative functions. New Hampshire officials indicate that they anticipate the schools will assist in the distribution of program materials and will refer potential enrollees to the program.

Results/Impact of Programs: While Relatively New, Florida Has Been Successful in Enrolling Uninsured Children; New Hampshire Plans to Begin Enrollments in the Fall of 1994

Florida: In Volusia County where the program has been in place since 1992, Florida has been successful in enrolling uninsured children. There are approximately 50,000 children in Volusia County schools, 15,000 of which are uninsured and eligible for the "Healthy Kids" program. There are currently 7,369 children enrolled in the program; thus, approximately 49% of the eligible uninsured children have been enrolled in the program.

Only one other program site (Highlands County) has been in operation longer than four months. In Highlands County, there are approximately 10,000 school children, of which an estimated 2,550 are uninsured. Currently, there are 646 children enrolled in the "Healthy Kids" program, or 25% of the uninsured children. The remaining four sites have just become operational and do not have useful data on their enrollments.

At this time, there is little other evidence regarding the impact of the "Healthy Kids" program. However, anecdotally, the largest acute care hospital in Volusia County reports a 35% decline in emergency-room visits by low-income children since the program started.

New Hampshire: New Hampshire plans to begin enrollment in its program in the fall of 1994. Therefore, there is no data to measure the impact of the program. There are approximately 25,000 uninsured children in New Hampshire. Program officials have indicated that their goal is to enroll 10% of these children in the first year, and 25% by the third year of the program.

It is important to keep in mind that, at this time, the New Hampshire program does not have funding to subsidize premiums. Therefore, the program likely will have a more difficult time enrolling New Hampshire's poorer children whose families have the most difficulty affording health insurance.

The Feasibility of School-Based Health Insurance in Virginia

A Significant Number of Uninsured Children in Virginia Potentially Could Benefit from a School-Based Health Insurance Program

As previously noted, there are as many as 250,000 children in Virginia who potentially could benefit from a school-based health insurance program. While there are other programs available for these children, these programs typically provide only primary care/preventive services. School-based health insurance could provide a comprehensive level of benefits for these children.

School-Based Health Insurance Has Been Implemented in Few States; Results Have Been Mixed; Premium Subsidies Appear to Play a Critical Role

There are only a few states which have implemented school-based health insurance programs. There is little evidence regarding the long-term viability of these programs to reduce the number of uninsured children. The state of Kansas abandoned its program. New Hampshire has not yet enrolled any children.

Florida has been successful in covering a significant percentage (49%) of the uninsured children in one pilot site (Volusia County). However, it appears that this success is due in large part to the significant funding available to subsidize premiums. All but 391 of the 7,369 children enrolled in the program in Volusia County are receiving a premium subsidy, with nearly 60% of these enrollees (4,413) receiving the coverage at no cost. Without these premium subsidies, it is unclear whether the program would have attracted as many children.

The other Florida counties where the "Healthy Kids" program has been implemented do not offer the same level of subsidies as in Volusia County. Nevertheless, the subsidies that are available in these counties appear to be critical. Of the three other counties which have begun their enrollment, 88% of the

enrollees are receiving subsidies. (Full premium is $48.00; families with subsidies pay either $5.00 or $13.00). While it is too soon to evaluate the results of the more recent program sites, it appears that the availability of substantial premium subsidies is critical to enrollees' decision to enroll in the program.

If Implemented in Virginia, the Commonwealth Would Need to Establish Stable, Long-Term Funding Sources

For a school-based health insurance program to be attractive to a wide range of uninsured families, it appears that substantial premium subsidies are necessary. Thus, long-term funding sources either at the state and/or local level would be critical to the success of the program. Without sufficient funds to subsidize premiums, it appears that school-based health insurance programs may benefit a limited number of children. Thus, if the Commonwealth decided to pursue such a program, stable, long-term funding sources would be needed.

Funding Alternatives Include General Fund Appropriations, Private Donations, Local Funding, Federal Grant Money, and Enrollee Contributions

There are several funding alternatives for financing a school-based health insurance program. It is likely that, similar to Florida's experience, funding would be needed from several sources. Possible sources of this funding include:

* general fund dollars appropriated by the General Assembly;

* private donations from individuals and businesses in the communities where the program is offered;

* local government funding;

* federal grant money such as HCFA (any grant money eventually would have to be replaced by other sources when the grant expires); and

* enrollee premium contributions.

Program Costs: The cost of such a program would depend on several important factors, including: (i) the cost of the benefits offered to enrollees, (ii) the type of delivery system (e.g., managed care, fee-for-service, etc.) and level of provider reimbursement, (iii) the level of subsidies offered to enrollees, (iv) whether an insurer would donate administrative services, and (v) the type and amount of in-kind services available through the school systems.

Support of School Divisions Would Be Critical

To make a school-based health insurance program successful in Virginia, the support of the local school divisions would be crucial. In a true school-based program, the school divisions play an integral role in distributing and collecting enrollment materials, providing eligibility information, conducting orientation meetings, and actively supporting the program. Thus, prior to launching a school-based health insurance program in Virginia, additional preliminary analysis would be needed to determine the school divisions' level of interest in and support of such an endeavor.

Policy Options

House Joint Resolution 191 directs the Joint Commission on Health Care to review school-based health insurance programs in other states and explore funding alternatives. While the resolution does not direct the Joint Commission to make recommendations regarding the possible implementation of such a program in Virginia, two policy options are presented below for consideration by the Joint Commission.

Option 1: Maintain Status Quo

This option recognizes that while Florida has had success in reducing the number of uninsured children in a few pilot locations, there is little other evidence that school-based health insurance programs provide a long-term solution to reducing the number of uninsured children.

Should the Department of Medical Assistance Services receive approval from the Health Care Financing Administration to expand the "Kids Care" program to children up to age three, this program would be providing services to children currently served by the "Caring for Children" program administered by Trigon, Blue Cross Blue Shield. As a result, the "Caring for Children" program could devote all of its resources to children between the ages of 3 and 19; and, therefore, be able to serve more children.

Under this option, until such time as there is additional information regarding the effectiveness of school-based health insurance programs in reducing the number of uninsured children over an extended period of time, the Commonwealth would not pursue such a program.

Option II: Direct the Department of Education, in Cooperation with the Bureau of Insurance and the Department of Medical Assistance Services to Determine Whether Local School Divisions and Families of Uninsured School Children Would Support a School-Based Health Insurance Program; and Develop Potential Benefit Designs, Costs, and Funding Options

Option II recognizes that Florida has been successful in reducing the number of uninsured children in some pilot sites through its school-based health insurance program, and that this success is due, in large part, to the funding available to subsidize premiums and the involvement and support of the local school divisions. While there does not appear to be enough information about school-based health insurance to recommend implementation of such a program in Virginia at this time, Option II would continue the analysis of whether such a program would be feasible and effective in Virginia.

Under Option II, the Department of Education (DOE) would be directed to assess the interest of local school divisions in pursuing a school-based health insurance program for their uninsured students, and evaluate the school divisions' willingness to provide administrative support and other in-kind services for such a program. DOE would assess whether families of uninsured school children would be interested in such a program, and would determine what level of coverage and premium payments families would support. The Bureau of Insurance could assist DOE by developing and pricing possible benefit packages to be offered through the program. The Department of Medical Assistance Services could assist DOE by investigating the possibility of securing federal grant money to support the implementation of a program, and by providing other analytical support.

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 191

Requesting the Joint Commission on Health Care to study the feasibility of developing a school-based health insurance plan.

Agreed to by the House of Delegates, February 11, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, by some estimates there could be as many as 11.2 million children in this country who are not covered by any health insurance plan, private or public; and

WHEREAS, in 1990 the state of Florida legislatively created the first nonprofit corporation to design a health insurance plan for the state's 720,000 uninsured school children and their siblings; and

WHEREAS, since that time several states have developed alternative methods of providing similar coverage targeting preventative care, with some of the plans being funded by Medicaid grants and HUD grants and others by private foundations; and

WHEREAS, preliminary data indicates that these alternatives are reducing health care costs, both individually and to the public overall, and are improving school attendance particularly by students from low-income families; and

WHEREAS, a growing number of children in the Commonwealth are not covered by either a parent's health care plan or Medicaid; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be requested to study the feasibility of developing a school-based alternative health insurance plan. The Commission shall review available data on the programs in existence in other states, including the costs and impact of such programs, and shall explore funding alternatives for the programs.

The Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 8: School-Based Health Insurance

Comments regarding the "School-Based Health Insurance" Issue Brief were received from the following 5 interested parties:

Secretary of Health and Human Resources, Kay Coles James
The Bureau of Insurance
The League of Virginia Health Systems
The Virginia Farm Bureau Federation
Gregory T. Armstrong

Policy Options Presented in Issue Brief

Two policy options were presented in the Issue Brief for consideration by the Joint Commission on Health Care.

Option I: Maintain status quo.

Option II: Direct the Department of Education, in Cooperation with the Bureau of Insurance and the Department of Medical Assistance Services to Determine Whether Local School Divisions and Families of Uninsured School Children Would Support a School-Based Health Insurance Program; and Develop Potential Benefits Designs, Costs and Funding Options.

Summary of Comments

There was no clear support to implement such a program in Virginia. Secretary James suggested that additional analysis would be needed prior to implementing a school-based program tonsure that it is financially sustainable. The Virginia Farm Bureau recommended that Virginia "stay away" from such a program. Only one commenter, Mr. Armstrong, specifically expressed support for Option II.

Summary of Individual Public Comments

Secretary Kay Coles James

Secretary James indicated that school-based insurance needs to be studied carefully to determine whether the program would financially sustainable. She stated that voluntary enrollee- and grant-funded programs that address the individual needs of localities -- rather than programs mandated by the state which would expend general funds -- appear to most deserve study.

The Bureau of Insurance

Commissioner Steven T. Foster stated that if Option II is adopted, the Bureau would require the assistance of its consulting actuary.

The League of Virginia Health Systems

Donald L. Harris commented that the League of Virginia Health Systems supports efforts to make insurance available for all Virginians, and, as such, would be supportive of initiatives which would make insurance available for all children.

The Virginia Farm Bureau Federation

Mr. C. Wayne Ashworth, President, recommended that Virginia "stay away" from school-based health insurance. He commented that creation of school-based health insurance could potentially create unnecessary confusion for families who are covered through other means for their health insurance.

Gregory T. Armstrong

Mr. Armstrong supported Option II. He noted that Option I would d o nothing to get health care costs under control and would do nothing to relieve the suffering of children without adequate health care because their families lack health insurance. Mr. Armstrong stated that school-based health insurance has the greatest potential of reaching uninsured children in the state.

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