FLORIDA STATE UNIVERSITY

UNINSURED CHILDREN IN FLORIDA:
An Analysis of Options for Health Insurance Coverage

AN ACTION REPORT SUBMITTED TO
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April 5, 2004

Dr. Rhonda Medows  
Secretary, Agency for Health Care Administration  
2727 Mahan Drive  
Tallahassee, FL 32308

Dear Dr. Medows:

I have the honor to submit to you, *Uninsured Children in Florida: An Analysis of Options for Health Insurance Coverage*. The report is the product of evaluation and research of information regarding health care. Health insurance coverage is significant because the number of uninsured children entering the state continues to grow. This growth influences the expenditures on indigent healthcare, children’s health, and citizens paying healthcare premiums, in other words society.

After analyzing several alternatives for health insurance coverage, my suggestion is to increase eligibility levels for qualification in the state Kidcare program. This alternative is recommended based on four evaluative criteria: public support, cost, adequacy, and complexity. This option scored high on cost, adequacy, and complexity. Due to high costs and very low public support, the other proposed options need further improvements to be functioning alternatives to help uninsured children.

This option is not difficult to implement because the same application and administration system currently in place can be used for new enrollees. In addition, with federal matching dollars, Florida does not have full responsibility of funding these families. Public support for increasing eligibility levels is fair, however improving service provided within the components of the program would increase citizens’ views.

Increasing the eligibility levels of Florida Kidcare will continue to make Florida an innovative state, dedicated to the mission of “healthcare coverage for Florida’s uninsured children.” Eligibility levels achieved the highest score because it could provide more families access to low-cost health insurance. This recommendation has the potential to provide thousands of children with insurance coverage.

With insurance Florida’s children will grow up to be healthier adults, which has positive affects on other segments of the healthcare system.
Respectfully,

Princilla Brown-Jefferson
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EXECUTIVE SUMMARY

Citizens want their children to be equipped with the necessary tools to make them contributing adults to society. To reach this goal, Florida strives to bestow a quality education and access to quality healthcare. With health insurance, children receive the recommended immunizations and well-care visits that ultimately improve quality and longevity of life. Unfortunately, insurance is an unreachable resource for needy families.

Health insurance is an expensive commodity to attain. However, it determines whether a family can afford healthcare and fund the care, if a child needs a major procedure. Without insurance, children are exposed to illnesses that could be prevented. With a gradual increase in the number of children without insurance, Florida needs to consider options for coverage.

Information for this report was collected using three methods. First, academic literature was analyzed to provide a historical background on the evolution of public assistance and insurance coverage for children. Second, federal, and state documents were reviewed to determine the financial responsibility of governments and statistical information on the options presented. Third, representatives from Agency for Healthcare Administration, Children Medical Services Network, and Florida Healthy Kids were interviewed to provide insight on the legislature improvements for insurance and the support of these options as ways to increase access.

This report presented three alternatives to the current KidCare Program: Universal Healthcare Plan, Increased Eligibility Levels of KidCare, and a Risk Pool Plan. Each alternative was evaluated using four criteria: public support, cost, adequacy, and complexity.
Based on the assessment of the alternatives against the four criteria, increasing the eligibility levels for KidCare is recommended as the most viable option. It expands the capability of the program to help families. The other two options need reform before they can be implemented. A universal healthcare plan is too costly and complex to help children in a timely matter, and a risk pool plan does not have the public support to make this a favorable alternative.

Increasing the eligibility levels is uncomplicated to incorporate into the current program and has the ability to enroll thousands of children at a low cost to the state, thus providing health insurance coverage to more children.
I. PROBLEM STATEMENT

When parent are unable to obtain private health insurance coverage for their children, they rely on governmental entities to provide this resource for them. Unfortunately, for Floridians, this avenue for coverage is capped due to a lack of funding (Hirth, 2003). In Florida, the percentage of children without health insurance is 18.8%, 7.2% higher than the national average (Holohan, 2003). Sadly, this number may increase due to current restrictions on enrollment in the Florida KidCare Program (the state’s child health insurance program).

The federal government created the State Child Health Insurance Program (SCHIP) to reduce the number of uninsured children, yet the Florida SCHIP has failed the 100,000 children waiting to receive insurance from the program (Florida Healthy Kids, 2003). Due to budget restraints, the SCHIP program was not allotted additional funding to increase enrollment in the program (Hirth, 2003). Hence, the state did not provide funding to cover children in households with incomes between 101% and 200% of the Federal Poverty Level (FPL).

The lack of funding for the program compounded with the number of eligible, yet uninsured children is getting much of the public’s attention. Lorraine Ausley states:

> It seems very shortsighted to be taking away healthcare from the most vulnerable… and then they land in the ER, when it is more cost effective, humane, and sensible to provide health insurance for kids (Hirth, 2003, p. B1).

Health insurance for children should be seamless, affordable, and accessible. Providing a plan that delivers all these elements sounds lofty. However, providing coverage to uninsured children exemplifies a society that values its children.
The Florida KidCare Mission states: “The KidCare partners embrace one shared focus: healthcare coverage for Florida’s uninsured children. To achieve this goal, we continually strive for consistency in message, simplicity in process, and excellence in product” (Florida Healthy Kids, 2002, p.12). Providing health insurance to uninsured children is the mission of the program. However, fulfilling this goal is fading due to the increasing number of children who lack insurance.

The limitation on enrollment into the program now raises concerns on the policy needed to provide insurance for children needing coverage. Without Florida providing matching funds, the number of uninsured children will continue to rise. The current Florida KidCare Program is an incremental policy used to reduce the number of children lacking healthcare, not eliminate the issue. Uninsured children without a primary source of healthcare increase healthcare expenditures by the over-utilization of the emergency room that increases the costs of indigent care.

The program needs to address alternatives that may provide insurance to uninsured children. The purpose of this Action Report is to examine options for providing insurance to uninsured children in the State of Florida.
II. BACKGROUND AND LITERATURE REVIEW

**Background**

Two key developments are examined to understand the extent to which uninsured children is a public concern: the creation of the Medicaid Entitlement Program and the evolution of the State Children Health Insurance Program (SCHIP). Each program plays a significant role in the expansion of insurance coverage for children in Florida.

Assistance for the poor, which primarily consist of women and children, is a societal consensus. America’s commitment to assuring healthcare for its poorest children developed through the Social Security Act. Assisting families with dependent children was among the leading priorities for the enactment of the Social Security Act in 1935, which created the U.S. public assistance system.

As part of the public assistance provisions, states provide additional funds to families receiving welfare to help cover the cost of medical care. Rooted in the maternal and child health programs of the Depression Era, health coverage became an entitlement for low-income children with Medicaid’s enactment in 1965 (Mann, Rowland, and Garfield, 2003).

Medicaid is Title 19 of the Social Security Act. The state and federal government fund the Medicaid program. Medicaid programs vary by states; therefore, a person who is eligible for Medicaid in one state may not be eligible in another state. In addition, the services provided may be considerably different (Agency for Healthcare Administration, 2003).

Over its 35-year history, Medicaid has grown to be an essential safety net, in
terms of healthcare coverage for millions of low income Americans. Currently, Medicaid is the source of insurance for more than 1 in 7 Americans and accounts for 15% of the nation’s spending on healthcare (Rowland and Garfield, 2000).

The necessity of the program for children is enormous. Medicaid provides insurance to 21 million children and finances 40% of all births in the US (Rowland and Garfield, 2000). Without the program, millions of children would not have access to preventive care and treatments that are vital for longevity and a quality life.

Medicaid is beneficial to the poorest citizens in attaining insurance coverage, yet the number of near-poor children who lacked insurance coverage increased. Despite the creation of the Medicaid program, approximately 12% of all children under the age of 17 and 21% of children in families below 200% of the Federal Poverty Level (FPL) lacked health insurance coverage in 1997. The vast majority of these children lived in households where 75% of the parent(s) worked full-time. To fill the gap between Medicaid and employer based coverage, the Balanced Budget Act (BBA) allocated funds to enact the State Children Health Insurance Program (SCHIP) (Urban Institute, 2000).

President Clinton signed the BBA into law in August of 1997. This act allowed states to receive 20 billion in matching funds over a five-year period for the expansion of health care (Florida Healthy Kids, 2002). Created in 1997, the SCHIP program provided comprehensive coverage to children in families above Medicaid standards, yet with incomes too low to afford employer sponsored coverage or private insurance. Most SCHIP programs cover children between 101% and 200% of the FPL, with a few states covering incomes up to 300% of the FPL (American Academy of Pediatrics, 2001).

SCHIP reflects a political compromise between those advocating access to
comprehensive healthcare for all children and Medicaid expansion to insure children (Mann, Rowland, and Garfield, 2003). The program builds on the idea that the “near poor” are most vulnerable, thus they are the “needy” population that would benefit the most from this program.

Children would benefit the most from preventive and maintenance healthcare. For instance, the State of Florida found that children without health insurance are four times more likely to miss school due to sickness. This has a “trickling effect” where the child is more likely to fall behind in school. In addition, excessive absences have shown to cause academic difficulties and failure (Community and Public Health, 2003).

Florida ranked fourth in the nation for the percentage of the population without health coverage (Florida Chamber of Commerce, 2004). The increasing concerns for insurance coverage pushed the enactment of the Florida Medicaid Program in the year of 1970. The program is one of the largest in the country with 2.1 million beneficiaries, in which 57% are children (Agency for Healthcare Administration, 2003).

Despite eligibility expansions in the Florida Medicaid program, there were more than 823,000 uninsured children in 1993. Of this number, 293,885 lived in families below 100% of the FPL, 259,336 lived in families with income between 101% and 200% of the FPL, and 270,246 lived in families with income above 200% of the FPL (Florida KidCare, 1999).

Understanding that children with health insurance are likely to be fully immunized, have fewer emergency room and physician visits, and lower healthcare costs, the Florida KidCare Program was implemented. Enacted in 1998, the program furthered the ability of the state to cover uninsured children by picking up where Medicaid left off.
The program covered children from birth to 18 years of age that lived in families with incomes between 101% and 200% of the FPL (Florida KidCare, 1999). KidCare currently covers 261,350 children. Despite the growth of KidCare, there are still 593,213 uninsured children in Florida (Institute for Child Health Policy, 2002).

The state and federal government efforts to decrease the number of uninsured children through Medicaid and SCHIP still have room for improvement. On a national level, the implementation of the SCHIP has allotted funds for states to increase the scope of insurance coverage; however, 8.6 million children still lack coverage. At the state level, there are more than 340,000 low-income uninsured children in Florida needing insurance for adequate healthcare (Families USA, 2002).

To conclude, with the number of low income uninsured children in Florida, an analysis of the options proposed is addressed. In examining the evolution of the uninsured child population, if no change in current policy is sought, this will continue to be a growing problem. Medicaid and SCHIP are important programs that provide access and coverage for those who are in need. However, these programs alone are grossly deficient in filling the greater voids in our system (McCanne, 2002).

**Literature Review**

The literature on uninsured children has three themes: (1) tax credits as funding mechanisms, (2) state waivers to expand coverage, and (3) mandated health insurance coverage.

First, the literature discusses ideas that may help fund the high cost of insurance. Some authors argue for a decrease in the tax cut for the richest 1% of citizens (Larsen,
2003; Shearer, 2002). Legislation that reduce the tax cuts for the wealthy and use the excess monies to fund insurance coverage would eradicate the uninsured problem (Larsen, 2003). According, to the Citizens for Tax Justice, last year the richest 1% (1.3 million) shared 32 billion dollars in tax cuts. One author found that 1,000 dollars in tax credits for every uninsured child would cost 8.6 billion dollars, which is considerably less than the tax cut given to the richest 1%. If money went into a fund for providing children with health insurance, there would not be 8.6 million children without coverage (Larsen, 2003).

Several authors are pushing for tax credits for parents to provide their children with health insurance. They suggest that the federal government provide refundable tax credits to pay for premiums (Dyer, 2003; Lemieux, 2002; Donnelly, 2002; Moffit, 2001). In order to pay for health insurance, a tax credit plan for low and middle class citizens should be available (Dyer, 2003; Lemieux, 2002; ACP-ASIM, 2001). Research indicates a tax credit program could help subsidize premiums for employees and help 13,000 Floridians receive 65% of the monies paid for insurance premiums (Florida Chamber of Commerce, 2004). A couple of authors advocating tax-credit policies recognize that a tax credit plan is beneficial for parents if the credits are given “in advance” for funding healthcare (Lemieux, 2002; Blumberg, 2001).

Other authors oppose the benefits of tax credits, claiming they do not work (Blumberg, 2001; Pollack, 2002; McCanne, 2003). One study found that tax credits would make employers reduce coverage and reduce the number of uninsured by only 2 million, which is 5% of the current uninsured population (McCanne, 2003). In addition, the current unsubsidized premium for children on Healthy Kids living above 200% of the
FPL is $92 dollars a month per child, this sum up to $1,104 dollars a year (Florida Healthy Kids, 2003). This amount is $104 dollars more than the $1,000 credit advocates are proposing.

Lastly, arguments for incentives to help parents face the challenge of healthcare costs are Medical Savings Accounts (MSA). MSA’s are free from penalties and taxes, and the monies deposited are for medical expenses. In addition, Congress should authorize rollover for MSA to ensure employees do not lose unspent funds each year, so that families utilize this avenue for funding healthcare (McCanne, 2003; Florida Chamber of Commerce, 2004).

Second, the literature addresses the concerns of Medicaid benefits by reviewing the use of state waivers. The Health Insurance Flexibility and Accountability Initiative (HIFA) and Section 1115 waivers (see Appendix for more information on HIFA and Section 1115 waivers) are an opportunity for states to receive monies to implement innovative ideas that may provide healthcare services to needy populations (American Legislation Exchange Council (ALEC), 2001; Spearman, 2001; Jordan, Adamo, & Ehrmann, 2000). Under a Section 1115 waiver, Rhode Island, Tennessee, and Hawaii expanded insurance eligibility to more than 500,000 individuals (Jordan, Adamo & Ehrmann, 2000). Waivers advance consumer choice and competition, so that low-income families have access to quality healthcare (ALEC, 2001).

Declining access to quality healthcare is a growing problem under the Medicaid program (Owcharenko, 2003). Several authors indicate that states should utilize HIFA waivers to allow enrollees to change from state-sponsored coverage to a private coverage option of their choice (Owcharenko, 2003; Moffit, 2002). The HIFA initiative gives
states the flexibility to expand coverage to the uninsured, and states can shift individuals and families of poorly performing public health programs to help them secure private coverage (Owcharenko, 2002). HIFA waivers break the association of poor with inadequate healthcare by adding choice and aid in purchasing comprehensive insurance (Owcharenko, 2002; ALEC, 2001).

In short, several authors are critical of state waivers due to the monetary consequences they can pose to state budgets. A few authors argue that waivers may not be budget neutral and cost the state additional monies to enhance a program (Engquist and Burns, 2002; Alcalde, 2001). Waivers are recent developments that may pose a financial challenge to states. Many states are in dire fiscal constraints and may see HIFA waivers as an opportunity that can increase Medicaid costs (Alcalde, 2001; Sachs, 2003). Therefore, states may not be excited about taking on new challenges and incurring additional costs (Alcalde, 2001).

Third, numerous authors support the idea of mandatory health insurance coverage for children (Rubiner, 2004; Meier, 2003; Beck, 2003). They argue that health insurance for children should be an “American Birthright” (Dyer, 2003; Stark, 2001). As a policy change, Halstead and Rubier claim mandated insurance would solve the problem of uninsured children (2003). To supplement this idea, mandated insurance is a promising path for universal healthcare and a reduction in healthcare premiums (Halstead and Rubier, 2003). Mandated coverage is beneficial to society because it increases the number of participants in insurance pools. In principle, healthcare premiums reduce by adding healthier individuals that contribute monies to the pool. However, the healthier individuals do not use health services that have high expenditures (Berman, 2003).
Legislation that mandates parents to have insurance coverage for children is debatable by some authors (Giesel, 1992; Meir, 2003). Mandating Americans to purchase health insurance would be less effective than other mandates, such as automobile insurance because the costs of healthcare are considerably higher. Penalizing those without adequate disposable income for not having health insurance cannot be an effective public policy (McCanne, 2002). Not only is the idea of mandated insurance for children unrealistic, Linda Daves notes: mandated coverage does not address the “real problem,” which is runaway medical malpractice premiums that augment premiums for Americans (Dyer, 2003, p. B2). Mandated coverage will result in another entitlement program funded by the government that citizens would not benefit from (Dyer, 2003).

In summary, the literature encompasses an array of arguments that suggest alternative methods to decrease the number of uninsured children. The literature does not provide a comparison of these alternatives for the uninsured population. This report will add to the literature by examining three program changes against evaluative criteria to help policy leaders determine the best appropriate alternative.
III. RESEARCH METHODOLOGY AND EVALUATIVE CRITERIA

Research Methodology

Information for this report was gathered using the following sources:

• Databases: Web LUIS Academic Index and Full Text (1996 to date); Lexis-Nexis Academic Universe (pre-Colonial to date); and Gale Net-Expanded Academic ASAP (1996 to date).

• Newspaper media: Tallahassee Democrat; Miami Herald; and Palm Beach Post.

• State documents: Florida KidCare Reports (1999-2002).

• Research Organizations: The Urban Institute and Institute for Child Health Policy.

• Unstructured interviews (n=six), approximately 25-30 minutes, with staff at the Florida Department of Children and Families, Florida Healthy Kids Corporation, and Agency for Healthcare Administration.

The academic literature, along with popular media, was helpful in providing an overview of the historical development of the policies to reduce the number of children uninsured. The literature presents insights on what options are available to ensure children have access to insurance. In addition, it contributes opinions on the policies implemented to address the population of uninsured children.

State documents examine the financial role and responsibility of governments in providing insurance to children. These documents contain statistical analysis of the alternatives available to expand insurance coverage and options taken by other states. Interviews with key players in social policy offer information on the public support of an option to reduce the number of uninsured children. Representatives give expertise about the constraints on health insurance coverage for children.

There were several obstacles to this report: no survey of Florida citizens concerns
about uninsured children in the state. However, interviews with directors and policy administrators supply the comments and concerns received from parents. Another disadvantage is no interviews with legislature staff due to time constraints from the legislative session. In spite of this, the most important criteria was used and any report using the same methodology outlined would find similar recommendations.

**Evaluative Criteria**

Four criteria evaluate the policy options: public support, cost, adequacy, and complexity. Each criterion is measured based on a scale ranking, thus assigning a number to an aspect of the policy option based on the negative or positive aspect of the option. A score of one means the option is negative in that aspect of the criteria and a score of five means the option is positive based on that criteria. The scores from the evaluative criteria are added to apply a total score to each option. A high total score means a proposed option is highly beneficial for children (Cuba, 2002). For objectivity, each criterion is ranked one to four based on its benefit to society and given a weighted score.

- Public support rates the popularity of the option. Assigning a high rating on support means citizens and policymakers support the option as a way to change the number of uninsured children. The data sources are interviews and academic literature.

- Cost rates the expenses accrued by the state to implement the policy. This includes the monies needed for additional enrollees and program administration. An option scores high, if it is inexpensive for the state to implement. The data sources come from estimates used in academic literature, interviews, and state budgets.
• Adequacy evaluates how well the option provides insurance coverage to children. This criterion includes reducing the uninsured gap by increasing the number of uninsured children. The option would score high if it makes an expansion in insuring children not previously covered under the KidCare program. The data sources for adequacy will be academic literature, interviews, surveys, and state documents.

• Complexity examines if the option is simple enough to incorporate into the current Florida KidCare Program. If the option uses the same KidCare application and the Child Health Administration System (CHAS), it will be less complicated to implement. The option would score low if a new application and administrative system needs to be developed. The data sources used to evaluate complexity are academic literature and government documents.
IV. POLICY OPTIONS

In the policy options section, four options are examined for insurance coverage to children: the current Florida KidCare program, a universal healthcare plan, expansion of eligibility levels, and a risk pool health insurance plan. They are evaluated by four criteria: public support, cost, adequacy, and complexity. These options are examined to guide policymakers on the most viable option in increasing coverage for children.

POLICY OPTION ONE: FLORIDA KIDCARE

Florida KidCare is pivotal to healthcare access for children. The program provides comprehensive coverage at a low cost for children living in families with incomes below 200% of the Federal Poverty Level (FPL). There are four components of the KidCare program: (1) KidCare Medicaid (Title 19 of the Social Security Act (SSA)) for children living in families below 100% of the FPL; (2) Healthy Kids (FHK) that cover children aged 5-18 in households with income between 101% and 200% of the FPL (subsidized); (3) Children Medical Services Network (CMS) for children with special needs in families with income below 200% of the FPL; and (4) MediKids (MK) for children aged 1-4 with family incomes between 101% and 200% of the FPL. FHK, CMS, and MK are Title 21 of the SSA and subsidize insurance cost for families (Florida Kidcare, 1999). Without Title 19 and Title 21, millions of children would be uninsured and unable to receive routine care in physician offices.

Due to the efforts of the SCHIP, the percentage of children in the US without insurance declined from 13.9% in 1997 to 10.8% in 2001. In addition, the percentage of
children reporting an unmet healthcare need or delayed care fell from 57% to 16% (Families USA, 2002). Unfortunately, Title 21 programs are not entitlement programs, so the state is not obligated to provide benefits to all children who qualify (Institute for Child Health Policy, 2002).

**PUBLIC SUPPORT**: Parents are pleased with the KidCare Title 21 and its service to families. Citizens are pleased with the benefits of the program and its affordability for the poor and near poor. Appreciation comes in from emails and letters thanking staff and the program for providing insurance to their children, noting that without KidCare their children would not have health insurance (Florida Kidcare, 2001). Interviews with representatives from Florida Healthy Kids (FHK) and families enrolled believe the current program has done a good job in meeting the needs of children (Director of Operations, Paula Kiger, personal communication, February 26, 2004, Director of Programs, Lisa Gill, personal communication, March 9, 2004, and Florida Kidcare, 2001).

The Florida KidCare program is a model for other states that have incorporated SCHIP programs, in which the Robert Wood Johnson Foundation selected FHK in 1996 as the National Program Office for the Foundation’s Healthy Kids initiative (Florida Healthy Kids, 2001). Until recently, Kidcare has been a milestone for insuring children, but with a long waiting list of children, citizens are concerned with how well the program will continue to meet the needs of children (Hirth, 2003). Due to a decrease in the public support of KidCare since a wait list has occurred, it scores fair on public support.
COST: The funds to administer the KidCare program come from multiple avenues. In the year of 2001, the KidCare budget to insure approximately 1.3 million children cost $312.8 million dollars. Of this cost, the state spent $95 million, which included $5.2 million for administration (Florida KidCare Council, 2001). The program is not enrolling additional children due to budget shortfalls. The current cost for 1.3 million enrollees is $95 million dollars and based on this information the current program rates fair on cost (Florida KidCare Council, 2001).

ADEQUACY: As of January 2003, enrollment reached 1.5 million children in families at or below 200% of the FPL (ACHA, 2003). With the eligibility level set at 200% FPL, 365,877 of 593,211 uninsured children could qualify and enroll (Institute for Child Health Policy, 2002). Enrolling eligible children would significantly reduce the percentage of uninsured children. Unfortunately, with funds for outreach efforts cut from the budget, it is not possible to reach these children (Florida Legislature Budget, 2004).

To add, there was a 26% increase in the number of children that entered the state without insurance (Department of Health and Human Services (DHHS), 2003). Kidcare cannot sufficiently handle the growing population. Due to the staggering number of children eligible yet un-enrolled, the program receives a very low score on adequacy.

COMPLEXITY: A large benefit of the KidCare process is the simple one-page application process and the information is self-attested. With this information, parents do not provide documentation of income (OPPAGA, 2004). Already incorporated in the Child Health Administration System (CHAS) are standard deductions that place children
in the correct program. Standard deductions of income reported qualify families for the correct Florida KidCare Program. Of families surveyed, 95% are very satisfied with the application and enrollment process (Florida KidCare, 2002). With an easy application and storage system in place, the KidCare program marks very high in complexity.

In summary, maintaining Kidcare received an overall high score. The program rates very high on complexity. Due to an easy application, the HK, CMS, and MK are promising based on this criterion. Public support rates fair due to the waiting list. To increase its score, Kidcare needs to fund all children eligible for the program to be beneficial and fully serve children.

**POLICY OPTION TWO: UNIVERSAL HEALTHCARE**

Despite expansions in Medicaid and the implementation of SCHIP, there are 8.6 million children without insurance (Families USA, 2002). Supporters of universal coverage argue that all children should be guaranteed coverage. (“It is unconscious for our society to allow children to go without healthcare coverage because they are stuck between being eligible for public programs and affording private insurance” Starks, 2001, p.1).

“There will always be individuals who do not qualify for services when dealing with governmental entities that have rules and regulations concerning eligibility factors. The rules and regulations governing these programs make sure everyone is treated fairly and uniformly. If families are honest, then the neediest families will be served” (Gail Hansen, personal communication, March 10, 2003). However, universal healthcare
allows all children to receive coverage. In Florida, race and ethnicity increase the risk of being uninsured. The risk of not having insurance for a Hispanic child is 26.6%, 21.8% for black children, and 12.4% for whites (FHA, 2001). A universal healthcare plan lowers these statistics by automatically providing every child with coverage.

**PUBLIC SUPPORT:** Universal healthcare coverage stems from the idea that all children should be provided with comprehensive healthcare coverage. Advocates argue that income should not determine if a child receives quality healthcare. “We should have at least universal coverage for every child in this country, but that does not seem much of a public concern in an era of warfare and tax cuts and we could so easily afford such coverage” (Larsen, 2003, p. B7).

A universal healthcare plan will make sure all children have access to care that keeps them healthy. “I believe that universal coverage for children is the only vehicle that will alleviate the current crisis…with the technology and pharmaceuticals available in the country, it is immoral to refuse the best possible treatment to our children” (Anonymous state policy administrator, personal communication, March 8, 2004).

There is public concern for all children to have insurance. With all children insured indigent costs decrease and children become healthier adults (Berman, 2003; Davis, 2001; and De Sa’, 2002). Unfortunately, when citizens think of universal coverage, socialized medicine, decreased quality, and fewer services causes skepticism. However, this does not overshadow the moral augment for universal healthcare that grips our society conscious. Option two is given a high score for public support.
**COST:** Leaving no child behind comes at a substantial cost. “Proposing a national healthcare program that would automatically enroll every child at birth and guarantee coverage until they become adults…sounds like a wonderful idea, but very costly” (Gail Hansen, representative for the Agency for Healthcare Administration, personal communication, March 10, 2003). The major disadvantage of universal healthcare is funding, estimated at 53 billion dollars a year (Dyer, 2003). This is a huge amount of money considering the projected deficits. This program could add substantial costs to the already large bill for healthcare in the US. In addition, working citizens may not want to fund the cost for another federal entitlement program. The costs for universal coverage are high, therefore scores very low on this criterion.

**ADEQUACY:** A universal healthcare plan that automatically enrolls children at birth until they turn 19 years of age would cover most children in the US. The proportion of children who are uninsured represent 11.6% of the child population, thus this portion would diminish (US Census Bureau, 2003). In Florida, over 572,000 children would receive health insurance coverage and eliminate the 18.8% of children without insurance (Institute for Child Health Policy, 2002). Of this number, over 366,000 would enroll in Florida KidCare and the state and federal government would subsidize children over income for SCHIP (Starks, 2001).

With a universal plan in place, the current KidCare program would reach eligible children and improve healthcare access as the program intended. With the elimination of the uninsured coverage gap for children, a universal healthcare plan scores very high on
adequacy.

**COMPLEXITY:** Unfortunately, a universal healthcare plan could not use the same KidCare application or Children Health Administration System (CHAS). The current application and system for children will not be compatible for the needs of a universal plan due to the current configuration and modifications existing in the system and on the application. Within the system, the new plan would be unsuccessful because it would exclude certain child populations. For instance, the system rejects children below the age of five living in households with income above 200% of the FPL, thus creating the possibility of not enrolling thousands of young children (Florida Healthy Kids, 2003). Creating a system to track children’s coverage has huge costs that would carry the added burden of including guidelines to the system for stringent confidentiality to make sure information is secure and free from misuse (Florida Kidcare Eligibility Determination Study, 2002).

An application for a universal plan must undergo changes, such as eliminating items from the application that deal with citizenship status. With a universal plan, a task force to brainstorm a new application and member administration system would have to be created, adding to the complexity of this option. This adds additional cost and prolongs the implementation of the universal plan. With major changes to the administration system and changes to the application, a universal plan rates very low on complexity.

In short, a universal healthcare plan rates fair due to its high initial costs and the
complexity involved to upgrade the system and improve the application. At a time when Florida faces fiscal constraints, this option needs to address funding issues before consideration as an option for insuring children.

**POLICY OPTION THREE: INCREASE ELIGIBILITY LEVELS**

Increasing the SCHIP level helps decrease the number of uninsured children. If SCHIP programs reached the millions of uninsured children, more than 7% of these children would be eligible for public coverage (Kenney and Haley, 2001). Expansion of the FPL for SCHIP levels could decrease indigent care and costs. A study by the University of Texas found that healthcare spending on behalf of children is cost effective. Texas estimated spending $1.7 billion on SCHIP over a 10-year period; this saved the state $1.3 billion dollars compared to the $3.0 billion it usually spent on ER care, inpatient hospital stays, and immunizations (Consumers Union, 2002).

Increasing SCHIP levels to assist families with premiums helped the healthcare system in Florida. Florida KidCare program provided care to children in doctor offices, rather than in emergency rooms, thus decreasing utilization of emergency rooms by 70% in some areas, saving consumers 13 million in costs for indigent care (American Medical Student Association, 2003). The benefits of increasing eligibility levels for the Florida KidCare program is two-fold: they provide access to preventive care for children and consumers save monies on healthcare premiums from a decrease in indigent care. This option increases SCHIP levels to include families with incomes above 200% of the FPL.
PUBLIC SUPPORT: Public programs are plagued with stigmas and perceptions, in which citizens are reluctant to participate. Perceptions about state and government-funded programs include poor administration, poor customer service, and limited choice of services. Government programs often contract at low fees with healthcare providers to supply citizens with healthcare needs (Moon, 1993).

According to one survey, 80% of families would enroll in Healthy Kids because they contribute money to the program, unlike Medicaid where there is no cost sharing. With cost sharing, parents contribute monies to fund the program (Institute for Child Health Policy, 1997).

There is support for the Title 21 components of KidCare. However, the support for the Medicaid component is a concern. Comments about the Medicaid program include, “I would rather have a normal insurance that do not involve the government so much” and “Medicaid used to send me to a poor doctor, all their doctors are quacks” (Institute for Child Health Policy, 1997, p.2).

In 2002, 183,000 Florida children were eligible for the Medicaid program, but not enrolled, because parents did not want to be associated with an entitlement program. One parent stated, “Medicaid gets too involved in my business and I cannot stand that” (Institute for Child Health Policy, 1997, p.2).

Noting the variance between Medicaid and Title XXI programs, a study conducted asked families, “Why did you [family] decide to apply to the Healthy Kids program and not Medicaid?” 63% of respondents stated that they did not want the stigma
of needing government assistance (Institute for Child Health Policy, 1997, p.1). The public support to increase SCHIP levels for children is high. However, increasing the eligibility level for Medicaid and placing families in the program with more governmental involvement lowers the support for this option. Therefore, this option rates fair on public support.

**COST:** Cost would increase because the program would need additional staff to effectively assist and support the new enrollees. With the rising cost of healthcare, there will always be substantial costs when adding participants. This change would cost the state millions. For instance, Medicaid spends an average of $113.06 dollars per member per month, adding another 10,000 children could cost the state over $1,000,000 million additional dollars (Florida KidCare, 2002).

Data on the cost to insure all children through the Medicaid program with incomes at or below 200% of the FPL would cost the state $644.8 million and the federal government $835.8 million adding to 1.48 billion (Florida KidCare Council, 2001). Increasing eligibility levels and subsidizing coverage, in order words operating the program within the current standards, rates well on the cost to the state. Increasing eligibility levels to add children is a low burden with federal matching funds, thus it rates high on cost.

**ADEQUACY:** With the eligibility level set at 200% of the FPL, there are still uninsured families with higher incomes that have difficulty in affording private or employer-sponsored coverage. Further expanding SCHIP eligibility to families with income above
300% of the FPL could provide coverage for 5% of all currently uninsured children (Lewit et al., 2003). For states with SCHIP levels above 200% FPL, the percentage of uninsured children is affected. For example, Pennsylvania set its SCHIP threshold at 235% FPL. With 3.1 million children in Pennsylvania, only 4.5% are uninsured compared to Florida’s 3.7 million children and a 14.4% uninsured rate (Urban Institute, 2002).

If all children eligible for Medicaid and SCHIP enrolled and the eligibility levels increased, this option has the potential to reach thousands of uninsured children. Increasing eligibility levels has the capability to have a positive impact on the insurance gap and percentage of insured children. Increasing SCHIP levels receives a high score on adequacy.

**COMPLEXITY:** The benefit of increasing the eligibility levels is that this option can still use the same KidCare Application. The application is formatted to reach near-poor families, so no change of the application is needed. Minor modifications to the CHAS system, such as adding more storage space and changing the FPL to a higher percentage; is needed to implement this alternative (Florida Eligibility Determination Study, 2002). This option has minimal complexity; thus, it rates high based on this criterion.

To summarize, increasing eligibility levels scored very high as a workable option to increase coverage for children. Adding children into the existing KidCare program would not add a huge financial burden to the state. The option uses the same KidCare application, thus making this option feasible for policymakers.
POLICY OPTION FOUR: RISK POOL PLAN

This option proposes that the KidCare wait list become a risk pool and the state negotiate terms with local health maintenance organizations (HMO’s) to provide coverage at an unsubsidized rate. The state will determine the costs to provide insurance for over 100,000 children, spread the risk, and provide insurance based on the premium negotiated.

This option allows the state to negotiate an unsubsidized rate for the participants, so that Florida does not have to fund all the children on the waiting list. Quickly implementing a source of insurance for these children is important to decreasing out-of-pocket costs incurred by families. In 2001, about 37% of families waiting for KidCare coverage had to undergo out-of-pocket expenditures to take their child to a primary care physician. Of these families, 44.2% spent more than $50 dollars for a visit. With health insurance, the expenditures for the parent would have been less (Florida KidCare, 2002). A quick solution to the wait list is what a risk pool plan offers.

PUBLIC SUPPORT: The number of uninsured children that applied to the Florida KidCare program and were deemed eligible, yet cannot gain coverage due to an enrollment cap, has risen to over 110,000 children (Florida Healthy Kids, 2004). The quickly growing list created such a huge concern for parents and policy makers that they wanted to call a special session to address the issue. “I voted yes [to call a special session], simply because it’s all about kids and funding dollars. I have been bombarded
with constituents’ emails asking for support of the KidCare issue” (Hirth, 2004, pg. B1). Parents are angry about the waiting list for a number of reasons: they are concerned about the lack of access to affordable insurance for their children and single parents express frustration about being unable to meet the healthcare need for their family (Director of Operations, Paula Kiger, personal communication, February 26, 2004). There is a mass support for change in the waiting list, but no ideas about a risk pool plan have emerged (Hirth, 2003). Several representatives from KidCare indicated a risk pool plan would be a poor way to provide coverage for children (LuMarie Polivka-West, personal communication, March 9, 2004; Program Administrator AHCA, Joyce Raichelson, personal communication, March 9, 2004; and Director of Programs, Lisa Gill, personal communication, March 8, 2004). Accordingly, a risk pool plan rates very low on public support.

**COST:** Supporters of insuring wait list participants’ indicate that Florida has $23 million to provide care to most children. Noting, majority of the monies would come from a federal cash allotment of $132 million dollars (Hirth, 2004). The issue is Florida did not want to spend $23 million on children above 100% of the FPL due projected growth in the Medicaid population (Hirth, 2004).

In a risk pool plan, families pay $155 million to fund the risk pool and the state administers the plan. The cost to administer the plan is 10% of the total costs or $150,000, which is a low to the state (DHHS, 2003). A risk pool score very high on this criterion based on the low cost to the state to administer the plan.
ADEQUACY: Implementing a risk pool plan could help most children on the list. However, children on the list who are illegal immigrants will not be able to participate. A risk pool plan would provide 96% of children with insurance. The remaining 4% are uninsurable due to their immigrant status (Institute for Child Health Policy, 2002). With thousands of children ineligible due to immigrant status, the option does not reach some children who may desperately need the plan. A risk pool plan rates low in the ability to cover additional children not enrolled in KidCare.

COMPLEXITY: To alleviate the waiting list and provide a computer system to track all participants in the plan would generate huge implementation costs. While wait list participants are already in the CHAS system, upgrades to the database need major adjustments to incorporate functions to handle another Florida KidCare plan. Additions to the system to distinguish the risk pool participants from the KidCare participants would need to be created. Changes to the overall CHAS system are complex (Florida KidCare Eligibility Study, 2002).

Adjustments to the system carry substantial costs and prolong the usage of the system after the changes. For example, an Eligibility Determination Study to align the Medicaid and Title XXI eligibility rules in CHAS cost $16,600 for one amendment. After system changes occurred, it may take an additional 6-8 months before the use of the updated system could occur (Florida Eligibility Study, 2002).

Fortunately, the state would not create a new application because participants have provided their information to Kidcare. The time needed for system changes,
amendments to contracts, and budget approvals for adding a “new” plan, a risk pool rates low on complexity. In summary, a risk pool plan received a low total score due to no public support, low adequacy in reducing the number of uninsured children, and high complexity to implement changes. Changes must be made before this can become a viable option for reducing the number of uninsured children.

V. CONCLUSION

This analysis presented four options for providing insurance to uninsured children in Florida: (1) the current KidCare program, (2) a universal healthcare plan, (3) increase eligibility levels, and (4) a risk-pool plan. Each option was evaluated by four criteria: public support, cost, adequacy, and complexity. The table below provides a visual analysis of the options presented.
### TABLE 1-SUMMARY OF OPTIONS AND EVALUATIVE CRITERIA

<table>
<thead>
<tr>
<th></th>
<th>Public Support</th>
<th>Cost</th>
<th>Adequacy</th>
<th>Complexity</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>KidCare Program</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Universal Healthcare</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Eligibility Levels</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Risk Pool Plan</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

Ranking Scale: 1-very low, 2-low, 3-fair, 4-high, 5-very high  
Score Range- 10-very low, 11- low, 12- fair, 15- very high

Option one highlight the current program and the wait-list issue. Maintaining the program scored very low on adequacy due to its inability to cover children on the waitlist or additional children who may need the program. With no change in the application or system, it scored very high on complexity. With decreased public support and budget shortfall, this option received fair scores on cost and support. The current program does not meet the score needed to increase insurance for children. In order to be the best avenue for covering uninsured children, this option needs modifications.

Option two presents the possibility of all children receiving healthcare coverage. It is beneficial to children with language, citizenship, and economic barriers to the
healthcare system. This option scored very low on costs and complexity due to the state cost to fund all children, the creation of a new application, and major changes to the administrative system for participants. This option scores high on public support because policy-makers favor the plan as a way to increase insurance coverage. Universal Healthcare Plan scored the highest on adequacy because all children are eligible for the plan. Sadly, this option is costly to state government and needs funding mechanisms to be a practical option.

The benefit of increasing eligibility levels, option three, is two-fold. The first advantage is that more children would be able to enroll due to an increase in the FPL percentage used for coverage. In addition, it can make implementation easier because only minor upgrades to the current KidCare system would have to occur. Children would reap the benefits of coverage expeditiously. An area that needs improvement would be the public opinion of governmental program due to a fair score on public support. Overall, this option scored very high due to high marks on three of the four criteria.

Option four initiates an immediate response to the waitlist. A risk pool scored very low due to its inability to cover future uninsured children, major system changes, and very low public support. A risk pool plan scored high on cost because the state would not have to fund the program. This option needs too many changes to be considered a feasible option for covering uninsured children.

Table 2 summarizes each option based on its “ranked score.” The evaluative criteria were ranked one to four based on its benefit to the public. Public support ranks
third because citizens must utilize the option for it to be effective. Cost receives a four because it affects society the most. Adequacy receives a two because the option should assist different populations. Complexity ranked the lowest because if the option is implemented, then the tools needed to operate the program will be created.

**TABLE 2- SUMMARY OF WEIGHED OPTIONS AND RANKED EVALUATIVE CRITERIA**

<table>
<thead>
<tr>
<th>Public Support (3)</th>
<th>Cost (4)</th>
<th>Adequacy (2)</th>
<th>Complexity (1)</th>
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</thead>
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<td>12</td>
<td>2</td>
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<tr>
<td>Universal Healthcare</td>
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<td>4</td>
<td>10</td>
<td>1</td>
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<tr>
<td>Eligibility Levels</td>
<td>9</td>
<td>16</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Risk Pool Plan</td>
<td>3</td>
<td>20</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

*Ranking Scale Based on Importance: 1- very low, 2-low, 3-fair, 4-high*

In conclusion, after the assessment of all the options using the four evaluative criteria, the recommendation is that increasing eligibility levels is the best option to increase insurance coverage for children. It scored the highest based on the four criteria. In addition, it ranked substantially higher than other options in its benefit to society. It is apparent that increasing eligibility levels will provide children with access to insurance, thus decreasing the percentage of uninsured children.
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http://www.urban.org/url.cfm?ID=309532

Washington, D.C.: Author


HIFA Section 1115 Waivers

The HIFA initiative announced by Health and Human Services (HHS) Secretary Tommy Thompson in 2001, is based on the Medicaid and State Children Health Insurance Program (SCHIP) Section 1115 Waivers. The HIFA program gives states the flexibility to design innovative approaches to increase healthcare coverage for the uninsured by using existing Medicaid and SCHIP resources.

The HIFA waiver is designed specifically for coverage expansions and is easier to obtain than a traditional Section 1115 waiver. These waivers provide states the ability to be exempt from certain Medicaid requirements in Section 1115 of the Social Security Act (SSA).

Major Components of HIFA waivers:

- Must be statewide;
- Expand Coverage to previously uncovered persons;
- Encourage coordination of private and public health insurance coverage
- Can be funded by savings resulting from service reductions or eligibility changes, or by redirecting existing funds;
- Must be budget neutral under Medicaid and allotment neutral under SCHIP

Medicaid Section 1115 Waivers

On July 31, 2000, the flexibility of the SCHIP program was enhanced when the Health Care Financing Administration (HCFA) released guidance on the use of Section 1115 demonstration projects under SCHIP to provide states the opportunity to expand coverage for children, promote participation in SCHIP and Medicaid, and improve the scope and quality of services available to children. Traditional Section 1115 waivers give
states a way to test new ideas for ways to transform Medicaid to better serve those enrolled and adapt the program to the changing marketplace and healthcare environment.
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