January 18, 2000

DRAFT PRESS PAPER / BACKGROUND INFORMATION ON HEALTH CARE COVERAGE INITIATIVE

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Attached are draft (1) press paper and (2) a longer backup document compiled by the Departments and us on the health care initiative to be announced tomorrow. It has not been finally cleared, but we thought that it might be useful for you to have something to read tonight if you are interested.

We will also be circulating the qs and as later.

Thank you, and please call with questions.

CLINTON-GORE ADMINISTRATION UNVEILS MAJOR NEW HEALTH INSURANCE INITIATIVE

January 19, 2000

Today, President Clinton will unveil a 10-year, $110 billion initiative that would dramatically improve the affordability of and access to health insurance. The proposal would expand coverage to at least 5 million uninsured Americans and expand access to millions more. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative will: (1) provide a new, affordable health insurance option for families; (2) accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP; (3) expand health insurance options for Americans facing unique barriers to coverage; and (4) strengthen programs that provide health care directly to the uninsured.

The Challenge of the Uninsured and Its Implications. Over 44 million Americans lack health insurance. Although there are many causes of this problem, it generally results from lack of affordability and/or access to coverage. Family health insurance premiums cost on average $5,700 -- which represents a large share of income for a family trying to make ends meet. Purchasing affordable, accessible insurance is a particular challenge for many older people, workers in transitions between jobs, and small businesses and their employees. Lacking health insurance has serious consequences. The uninsured are three times as likely not to receive needed medical care, 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes, and four times more likely to rely on an emergency room or have no regular source of care than the privately insured.

THE PRESIDENT'S FOUR-PRONGED INITIATIVE SIGNIFICANTLY EXPANDS COVERAGE AND IMPROVES ACCESS BY:

I. **PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES ($76 billion over 10 years, about 4 million uninsured covered).** Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about $33,000 for a family of four) are themselves uninsured. Yet, while states have aggressively expanded insurance options for children through Medicaid and the State Children's Health Insurance Program (S-CHIP), parents are often left behind. There are about 6.5 million uninsured parents with income in the Medicaid and S-CHIP eligibility range for children. These parents frequently do not have access to employer-based insurance, and when they do, cannot afford it. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, the National Governors' Association, and a wide range of groups including Families USA and the Health Insurance Association of America have called for building on S-CHIP to cover parents. The Administration's budget adopts this approach by:

- **Creating a New "FamilyCare" Program.** This proposal, which has been advocated by Vice President Gore, would provide higher Federal matching payments for state coverage of parents of children eligible for Medicaid or S-CHIP. Under FamilyCare, parents would be covered in the same plan as their children. States would use the same systems and follow

most of the same rules as they do in Medicaid and S-CHIP today, and the program would be overseen by the same state agency. State spending for FamilyCare would be matched at the same higher matching rate as S-CHIP (up to 15 percentage points higher than the Medicaid rate). To ensure adequate funding, $50 billion over 10 years would be added to the current state S-CHIP allotments. To access these higher allotments, states would have to first cover children to 200 percent of poverty as 30 states now have done. Given states' enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state response and significant expansion to parents under FamilyCare. If, after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty ($16,700 for a family of 4), a fail-safe mechanism would be triggered to require states to expand coverage to that level.

- **Assisting Families in Affording Private Employer-Based Coverage.** FamilyCare would also facilitate the option to pool state funding with employer contributions toward private insurance, which can be a cost-effective way to expand coverage. Under this option, families otherwise eligible for FamilyCare coverage could get assistance in purchasing their employers' health plan if it meets FamilyCare standards and their employer pays for at least half of the premium. This minimum employer contribution, along with the S-CHIP crowd-out policies, should discourage employers from reducing or dropping coverage. This option is supported by the National Governors' Association as well.

II. ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP ($5.5 billion over 10 years, an additional 400,000 uninsured children covered). The State Children's Health Insurance Program (S-CHIP) helps children in families with income too high to be eligible for Medicaid but too low to afford private insurance. Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The Administration's budget includes ideas advocated by the Vice President that would give states needed tools to increase coverage by:

- **Allowing School Lunch Programs to Share Information with Medicaid ($345 million over 10 years).** Since 60 percent of uninsured children are in the school lunch program, sharing eligibility information can efficiently help outreach efforts.

- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid ($1.2 billion over 10 years).** This includes schools, child care resource and referral centers, homeless programs, and other sites.

- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple ($4.0 billion over 10 years).** Most states have carried over their S-CHIP simplification strategies like eliminating assets tests and using mail-in applications into the Medicaid program. This proposal would have all states do so to make enrollment easier for both programs.

III. EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE ($28.7 billion over 10 years, about 600,000 million uninsured people covered). Some vulnerable groups of Americans lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. These

include older Americans, people in transition (between jobs, turning 19 and entering the workforce, leaving welfare for work), and workers in small businesses. This plan addresses these and other problems by:

- **Establishing a Medicare Buy-In Option and Making It More Affordable Through a Tax Credit ($5.4 billion for both the buy-in and credit over 10 years).** The rate of uninsured is growing fastest among people ages 55 to 65 and is expected to increase even faster in the future. Recognizing this, the President and Vice President are calling on Congress to pass legislation that allows people ages 62 through 65 and displaced workers ages 55 to 65 to pay premiums to buy into Medicare. The proposal also would require employers who drop previously-promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make this policy more affordable, the President proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described below), this policy will address access to and the affordability of health insurance for this vulnerable group.

- **Making COBRA Continuation Coverage More Affordable ($10.3 billion over 10 years).** Consolidated Omnibus Budget Reconciliation Act (COBRA), passed in 1985, allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 to 36 months after leaving their job. This policy is intended to improve the continuity of health coverage as workers change jobs. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. The Administration's budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change.

- **Improving Access to Affordable Insurance for Workers in Small Businesses ($313 million over 10 years).** Nearly half of uninsured workers are in firms with fewer than 25 employees. The President proposes to give small firms that have not previously offered health insurance a tax credit equal to 20 percent their contribution -- twice the credit he proposed last year -- towards health insurance obtained through purchasing coalitions. In additional, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and the Federal Employees' Health Benefits Program would make available technical assistance to purchasing coalitions.

- **Expanding State Options to Insure Children Through Age 20 ($1.9 billion over 10 years).** Nearly one in three people ages 18 to 24 are uninsured mostly because they age out of Medicaid or S-CHIP or no longer are dependents in private plans. However, they often do not have jobs that offer affordable coverage. The budget would gives states the option to cover people ages 19 and 20 through Medicaid and FamilyCare.

- **Extending Transitional Medicaid ($4.3 billion over 10 years).** Many people leaving welfare for work take first jobs that do not offer affordable health insurance. Recognizing this, Congress passed a requirement in 1988 that extends Medicaid coverage for up to a year for those losing it due to increased earnings. This provision was extended in the welfare

reform law to 2001. The President's budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.

- **Restoring State Options to Insure Legal Immigrants ($6.5 billion over 10 years).** States are prohibited from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin, some of whom are legal immigrants, was 35 percent in 1998 -- over twice the national average of 16 percent. The proposal would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

IV. STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED (At least $1 billion over 10 years). In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the uninsured and receive inadequate compensation for doing so. Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs. The President will renew his commitment to helping these providers by:

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (+$100 million for FY 2001, $1 billion over 5 years).** Last year, the President and Secretary Shalala proposed an historic new program to coordinate systems of care, increase the number of services delivered and establish an accountability system to assure adequate patient care for the uninsured and low-income. The Congress funded an initial $25 million investment for this program. This year, the President proposes funding this initiative at $125 million, a $100 million increase over 2000, representing a down payment on the President's proposal to invest $1 billion over 5 years. The Administration will also aggressively pursue an authorization to ensure that the program becomes a core element of the health care safety net.

- **Investing in Community Health Centers (+$50 million for FY 2001).** The budget proposes an increase of $50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans -- for total funding of over $1.069 billion in FY 2001.

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THE CLINTON-GORE ADMINISTRATION'S HEALTH INSURANCE INITIATIVE BACKGROUND INFORMATION

January 19, 2000

THE UNINSURED IN AMERICA

- **Most of 44 million uninsured work or are in working families**. Three-fourths of the uninsured work or are in working families. Although the uninsured rate remains highest among the poor (33 percent), it has been growing faster for the middle class. All income groups experienced increases in the uninsured rate since 1993, but the increase was 50 percent higher for the middle class than that of the poor.[1]

- **Access to health insurance can be a major barrier.** Employer-based insurance is the predominant form of health insurance. In 1996, about 82 percent of workers had access to it. However, 45 percent of low-wage workers and about one-third of workers in small business do not have access to group insurance.[2] The private-sector alternative, individual insurance, is frequently inaccessible, particularly for older and less healthy people. In addition, Medicaid, the State Children's Health Insurance Program, and Medicare have state and Federal rules which limit who can enroll.

- **For others, affordability of health insurance remains the biggest barrier**. Health insurance premiums for employer-based coverage in 1999 averaged $2,300 for an individual and $5,700 for a family – with the workers' share being $420 and $1,740 respectively.[3] People purchasing coverage in the individual insurance market not only lack employer contributions but usually face higher premiums due to higher administrative costs and, if ill or older, medical underwriting and age rating.

CONSEQUENCES OF LACKING HEALTH INSURANCE. Compared to people with insurance, those without insurance are likely to:

- **Forego needed health care**. The percent of uninsured adults who did not receive needed medical care is more than three time that of privately insured adults (30 versus 7 percent).[4] The proportion of uninsured adults who postponed care is even higher (55 versus 14 percent).[5] Over one in four uninsured children need health care (e.g., prescription medicine, surgery) but do not get it.[6]

- **Suffer adverse health effects and need expensive health care.** The uninsured are 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes than the privately insured.[7] Children without health insurance are nearly twice as likely to forego health care for conditions like asthma or recurring ear infections.[8]

- **Rely on emergency rooms or have no regular source of care**. One-fourth of the uninsured adults rely on the emergency room or have no regular source of care, compared to 6 percent of the privately insured.[9] The proportion of uninsured children lacking a usual source of care is 3 times that of privately insured (20 v. 6 percent).[10]

OVERVIEW OF THE INITIATIVE. The Clinton-Gore Administration's budget invests over $110 billion over 10 years in a multi-faceted health coverage initiative. It would expand coverage to at least 5 million uninsured Americans[11] and expand access to millions more through its four-pronged approach of:

I. **PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES ($76 billion over 10 years, about 4 million uninsured covered).** The s budget proposal would build on S-CHIP to pay higher Federal matching payments to states for covering parents as well as their children. In the new "FamilyCare" program, parents would be enrolled in the same health plan as their children, and states could help families afford job-based insurance.

II. **ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP ($5.5 billion over 10 years, an additional 400,000 uninsured children covered).** States would be given new outreach tools:

- Allowing School Lunch Programs to Share Information with Medicaid for Outreach ($345 million over 10 years)
- Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid, Including Schools, Child Care Referral Centers, and Other Sites ($1.2 billion over 10 years)
- Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (e.g., No Assets Tests, Mail-In Applications) ($4.0 billion over 10 years)

III. **EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE ($28.7 billion over 10 years, about 600,000 million uninsured people covered).** Some Americans like older people, workers in job transitions, and workers in small businesses, have limited health insurance options. This initiative broadens Medicare and Medicaid options and makes private insurance more accessible through tax incentives by:

- Establishing a Medicare Buy-In Option and Making It More Affordable Through a 25 Percent Tax Credit ($5.4 billion for both buy-in and credit over 10 years)
- Making COBRA Continuation Coverage More Affordable ($10.3 billion over 10 years)
- Improving Access to Affordable Insurance for Workers in Small Businesses through Health Insurance Purchasing Coalitions ($313 million over 10 years)
- Expanding State Options to Insure Children Through Age 20 ($1.9 billion over 10 years)
- Extending Transitional Medicaid ($4.3 billion over 10 years)
- Restoring State Options to Insure Legal Immigrants ($6.5 billion over 10 years)

IV. **STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED. (At least $1 billion over 10 years).** The budget expands a new program that coordinates and expands systems that increase access to health care for the uninsured and invests in community health centers.

PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES

Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about $33,000 for a family of four) are themselves uninsured. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, National Governors' Association, consumer advocates and insurers have called for expanding S-CHIP to cover parents. The Administration's proposal does this by building on S-CHIP to provide higher Federal matching payments for states to insure parents through the same health plan as their children. "FamilyCare" costs $76 billion over 10 years and will insure an estimated 4 million uninsured people when fully implemented.

BACKGROUND

- **Most uninsured children are in families with uninsured parents.** Over 80 percent of parents of uninsured children with income below 200 percent of poverty (about $33,000 for a family of four) are themselves uninsured.[12]

- **Nearly two-thirds of uninsured parents – 6.5 million -- have children who are in Medicaid and S-CHIP eligibility range** (income below 200 percent of poverty). This represents about one in seven of the uninsured in the U.S.[13]

- **Medicaid eligibility limits are much lower for parents than their children.** While all states cover poor children and many states cover children up to 200 percent of poverty, only 13 states cover parents at or above the poverty level.[14] The median upper eligibility limit for parents in Medicaid is about 60 percent of poverty. In 32 states, uninsured parents who work full time at minimum wages jobs are not eligible for Medicaid because their incomes are too high.[15] S-CHIP does not include an explicit authority to cover parents.

- **Many low-income families decline employer-based insurance, primarily due to cost**. About 20 percent of all uninsured people have access to employer-sponsored insurance. Families with lower incomes are especially likely to turn down such coverage and remain uninsured. Three-fourths of these uninsured people cite cost as the major barrier. The amount that low-wage families pay for the employee share of premiums is, on average, over 50 percent higher for a family with a worker earning less than $7 per hour than those with a worker earning over $15 per hour.[16]

UPPER ELIGIBILITY IN MEDICAID / SCHIP (14)		
	CHILDREN	PARENTS
	(Percent of Poverty)	
ALABAMA	200	22
ALASKA	200	83
ARIZONA	200	51
ARKANSAS	200	22
CALIFORNIA	250	100
COLORADO	185	45
CONNECTICUT	300	185
DELAWARE	200	108
DC	200	200
FLORIDA	200	34
GEORGIA	200	45
HAWAII	185	100
IDAHO	150	36
ILLINOIS	133	52
INDIANA	150	33
IOWA	185	93
KANSAS	200	43
KENTUCKY	200	54
LOUISIANA	150	23
MAINE	185	108
MARYLAND	200	46
MASSACHUSETTS	200	133
MICHIGAN	200	48
MINNESOTA	280	275
MISSISSIPPI	133	40
MISSOURI	300	100
MONTANA	150	73
NEBRASKA	185	43
NEVADA	200	90
NEW HAMPSHIRE	300	60
NEW JERSEY	350	47
NEW MEXICO	235	62
NEW YORK	192	59
NORTH CAROLINA	200	56
NORTH DAKOTA	100	74
OHIO	150	85
OKLAHOMA	185	37
OREGON	170	100
PENNSYLVANIA	200	71
RHODE ISLAND	300	193
SOUTH CAROLINA	150	58
SOUTH DAKOTA	140	70
TENNESSEE	200	67
TEXAS	200	32
UTAH	200	58
VERMONT	300	158
VIRGINIA	185	33
WASHINGTON	250	96
WEST VIRGINIA	150	30
WISCONSIN	185	185
WYOMING	133	69

- **Covering parents would increase enrollment of uninsured children**. Families are more likely to learn about Medicaid and S-CHIP and to enroll their children in the programs if the whole family is eligible. As such, the NGA and policy experts believe that this option would reduce the number of uninsured children as well as parents.[17] Wisconsin, Minnesota and Vermont are among the states using Medicaid state plan options or 1115 demonstrations to achieve this effect.

- **Cost-effective way to expand coverage.** A recent study compared the effectiveness of covering uninsured adults through a refundable tax credit for group or individual insurance and expanding S-CHIP. It found that S-CHIP would much more efficiently expand coverage to the uninsured than a tax credit. The study found that the tax credit would subsidize 5 already-insured people for every single newly insured person at a total cost 6 times higher than that of the S-CHIP proposal.[18]

- **Widespread support.** The concept of extending S-CHIP to parents is one of the few ideas for expanding coverage that is supported by a broad range of groups. The National Governors' Association supported expanding S-CHIP to cover parents in its 1999 policy resolutions, arguing that "CHIP is a promising vehicle to promote the goal shared by the Governors, Congress, and the Administration – decreasing the number of Americans without health insurance."[19] At a January 13, 2000 conference to discuss ideas on expanding coverage, Families USA, the Health Insurance Association of America, the American Hospital Association, the Catholic Health Association and the Service Employees International Union all recommend using S-CHIP or a similar model to cover the parents of Medicaid and S-CHIP children.[20]

PROPOSAL. The Clinton-Gore Administration would expand S-CHIP to provide higher Federal matching payments for expanding affordable health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. This new "FamilyCare" program:

- **Provides higher Federal matching payments for expanding coverage to parents.** States that raise their eligibility for parents above their Medicaid level as of 1/1/00 would be eligible for the enhanced S-CHIP matching rate for this expansion group. The S-CHIP matching rate is up to 15 percentage points higher than the regular Medicaid matching rate. States' plans for covering parents would only be approved if they first expand eligibility for children up to 200 percent of poverty (30 states have already done so[21]) and do not have waiting lists for S-CHIP. This preserves the bipartisan commitment made in 1997 to focus funding on children first.

- **Increases S-CHIP allotments**. To ensure adequate funding for parents and their children, the current S-CHIP allotments would be increased by $50 billion for 2002 through 2010 and made permanent. The higher Federal matching payments for the expansion group of parents would generally come from increased S-CHIP state allotments, called FamilyCare allotments. Allotments are fixed dollar amounts allocated to each state based on a formula similar to S-CHIP for the higher Federal matching payments. As in S-CHIP, should the allotment limits be reached, states expanding through Medicaid may continue to cover parents at the regular Medicaid matching rate or roll back eligibility while states expanding through non-Medicaid programs may use state-only funds to continue coverage or limit enrollment.

- **Enrolls parents in the same program as their children.** Parents would be insured in the same program as their children to promote continuity of care and administrative simplicity. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP, and coverage for parents would be overseen by the same state agency that runs their children's program. Parents of children eligible for Medicaid would be enrolled in Medicaid, while parents of children eligible for non-Medicaid S-CHIP programs would be enrolled in those programs.

- **Covers lower income parents first.** As in S-CHIP, states would cover lower-income parents before covering higher-income parents. States could not cover parents at income eligibility levels above those of children, but could set eligibility limits for parents lower than that of children. For the first five years, states could set parents' eligibility limit anywhere between their current minimum levels for parents and their maximum levels for children. Given states' enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state responses and significant expansions to parents under FamilyCare. If, after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty (about $16,700 for a family of four), a fail-safe mechanism would be triggered to require these states to go to this level of coverage. Thus, by 2006, all poor parents would be eligible for coverage like their children are today.

- **Creates more equitable funding structure.** From 2001 to 2005, all enhanced matching payments for states' expansion group of parents would come from the FamilyCare allotment, as would all payments for S-CHIP children. For example, a state that covered parents to 50 percent of poverty prior to 1/1/00 and then expanded coverage above that would receive enhanced matching payments drawn from their allotments for coverage of the newly eligible parents (as well as S-CHIP kids). Beginning in 2006, two changes would be made. First, the enhanced Federal matching payments for parents below poverty would no longer be deducted from the allotment. States would still receive the enhanced matching payments for poor parents covered under expansions implemented after 1/1/00, but these payments would come from uncapped Medicaid funding and would no longer be subtracted from allotments. Second, all states could receive enhanced matching payments for covering any parent above the poverty line and any child above the Medicaid mandatory coverage levels[22] – irrespective of when the state expanded coverage. This ensures that states that have already expanded coverage would be rewarded.

- **Facilitates employer-based coverage.** FamilyCare would also expand the option to pool allotment funding with employer contributions towards the purchase of private insurance, which can be a cost-effective way to expand coverage. States could enable families otherwise eligible for FamilyCare to purchase their employers' health plan as long as it meets FamilyCare standards. Under this option, employers would have to contribute at least half of the family premium cost to discourage them from reducing or dropping coverage because of this program. In addition, the S-CHIP crowd-out policies would apply. One study found that over one in five families whose children were enrolled in the Florida Healthy Kids program previously had access to employer-based coverage but their parents could not afford the premium so they remained uninsured.[23] This option, supported by states[24], would help keep such families in private coverage.

ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP

The State Children's Health Insurance Program (S-CHIP) helps children in families with incomes too high for Medicaid eligibility but too low to afford private insurance. Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The budget would give states needed tools to increase coverage. About an additional 400,000 uninsured children would be covered because of these policies. The initiative costs about $5.5 billion over 10 years.

BACKGROUND

- **The number of children enrolled in the State Children's Health Insurance Program (S-CHIP) has doubled in less than a year.** Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998.[25]

- **The number of states covering children up to 200 percent of poverty has increased by more than seven fold.** Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about $33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.[26]

- **However, over 4 million eligible children remain uninsured.**[27] One study found that two-thirds of eligible uninsured children are in two-parent families, 75 percent of parents of these children work, and only 5 percent receive welfare.[28]

- **Barriers include lack of knowledge of eligibility and complex application processes.** A survey of parents whose uninsured children are likely to be eligible for Medicaid found that 58 percent did not try to enroll their children because they did not think that their children were eligible and over half (52 percent) said that they believed that the application process would take too long or believed that the forms are too complicated (50 percent).[29]

- **Uninsured children are often in programs like the school lunch program that can help enroll them**. A number of programs, like the school lunch program, subsidized child care, and Head Start, target the same children who are also eligible for Medicaid and S-CHIP. A recent study by the Urban Institute found that approximately 60 percent – almost 4 million – of the uninsured children nationwide are currently enrolled in school lunch programs.[30] However, Federal law prohibits school lunch programs from sharing enrollment information with Medicaid and does not allow states to use school lunch eligibility as a proxy for Medicaid eligibility.

PROPOSALS

- **Allowing School Lunch Program to Share Information with Medicaid ($345 million over 10 years).** This proposal, similar to bipartisan legislation proposed by Senator Lugar and Congresswomen Carson, would allow school lunch programs to share application information with Medicaid staff for the sole purpose of outreach and enrollment (this is already allowed for S-CHIP).

- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid ($1.2 billion over 10 years).** The Administration's proposal expands the Medicaid "presumptive eligibility" option for children by authorizing additional sites for enrollment including schools, child care centers, homeless shelters, agencies that determine eligibility for Medicaid, TANF, and S-CHIP, and other entities approved by the Secretary. Presumptive eligibility means that qualified entities, at the states' discretion, may immediately enroll potentially eligible children in Medicaid and S-CHIP on a temporary basis while their applications are formally processed. With the help of Congresswomen DeGette, the law that created the children's health program in 1997 included presumptive eligibility as an option in S-CHIP and Medicaid. However, it limited the types of entities that could presumptively enroll children in Medicaid to Medicaid providers and entities determining eligibility for WIC, Head Start and Child Care & Development Block Grant services. To date, 9 states have opted to use presumptive eligibility for children in Medicaid[31] and 12 states for S-CHIP.[32] Expanding the sites authorized for this option can help states provide critical health care services to children pending official enrollment and increases the likelihood that families complete the application process. More than half (53 percent) of parents of uninsured but eligible children think that immediate enrollment with completion of forms later is one of the best ways to encourage enrollment.[33]

- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple ($4 billion over 10 years).** Studies confirm that complicated, long application processes for Medicaid and S-CHIP discourage enrollment. While many states have recognized this and have simplified the process in S-CHIP, not all states have carried over all of their S-CHIP simplification strategies to Medicaid. To ensure that children do not fall through the cracks in states that have different rules and procedures for Medicaid and S-CHIP, this proposal would require that states conform certain Medicaid eligibility rules and procedures for children to the simplified rules and procedures used in S-CHIP. If a state, in S-CHIP: (1) does not require an assets test; (2) uses simplified eligibility requirements and a mail-in application; and (3) determines eligibility for S-CHIP no more than once a year, it would need to apply these same rules and procedures for children in Medicaid. Both conforming Medicaid and S-CHIP and these specific simplifications are recommended by the National Governors' Association as best practices.[34] Over 40 states have already made Medicaid as simple as S-CHIP.[35]

ESTABLISHING A MEDICARE BUY-IN OPTION AND MAKING IT MORE AFFORDABLE THROUGH A TAX CREDIT

People ages 55 to 65 are at greater risk of developing health problems. Recognizing that this age group is also the fastest growing group of uninsured, the President has called on Congress to pass legislation that allows certain people ages 55 to 65 to buy into Medicare. The proposal also would require employers who drop previously-promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make the policy more affordable, the Clinton-Gore Administration proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described later), this policy will address both access to and the affordability of health insurance for this vulnerable group. The Medicare buy-in plus the tax credit for this buy-in cost about $5.4 billion over 10 years.

BACKGROUND

- **Fastest growing number of uninsured.** Between 1997 and 1998, the proportion of people ages 55 to 65 who are uninsured increased from 14.3 to 15.0 percent – about five times the rate increase for the general population. All of this increase occurred among people with incomes above poverty, with a dramatic increase for those with income between 300 and 400 percent of poverty (between $33,000 and $44,000 for a couple) – from 10.2 to 14.6 percent. [36]

- **Less access to employer-based coverage.** The major reason for the increase in the uninsured in this age group is their lower access to employer-based insurance. In 1998, 66 percent of people ages 55 to 64 had employer-based insurance compared to 75 percent of people ages 45 to 55.[37] Some lose their employer-based health insurance when their spouse becomes eligible for Medicare. Many lose coverage because they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their employer drops retiree health coverage unexpectedly.

- **Greater reliance on individual insurance.** Because of a weaker connection to the workplace, a disproportionate percent of people ages 55 to 65 rely on individual insurance. However, the nature of individual insurance makes it easier to avoid people likely to have health problems. In addition to being subject to age rating, a health condition can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage.[38] People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. Their probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke and cancer is double that of people ages 45 to 54.[39]

- **Problems will get worse with demographic changes.** As the Baby Boom generation enters its 50s, the proportion of people ages 55 to 65 is expected to increase from 21 to 30 million by 2005 and to 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.[40] Even if the uninsured rate remained the same, the proportion of uninsured in this age group would climb. One study projects that the uninsured rate for people ages 55 to 65 will rise even faster given the decline in access to private insurance for this group.[41]

PROPOSALS

- **Providing a New 25 Percent Tax Credit for New Options for People Ages 55 to 65.** This year, for the first time, the President will propose a 25 percent tax credit for people eligible for the buy-in. It helps make the original option – which already is more affordable than alternatives in the individual insurance market – even more attractive to people with limited income. In addition, people participating in the extended COBRA coverage would be eligible for the new COBRA tax credit (described later). This tax credit has the advantage of encouraging greater participation in these options for people ages 55 to 65 which could, in turn, reduce the premium costs for these programs over time since new participants are likely to be healthier. It would not, however, be large enough to encourage firms to drop their early retiree coverage or individuals to retire earlier.

  This policy builds on the three-pronged initiative advocated by the President, the Vice President and the Democratic Congressional leadership (Daschle, Gephardt, Moynihan, Rangell, Dingell, Rockefeller, Stark, Brown), described below.

1. **Enabling Americans Ages 62 to 65 to Buy Into Medicare.** People ages 62 to 65 who do not have access to employer-based insurance would have a one-time option to buy into Medicare. The premium they would pay would be divided into two parts. First, participants would pay a base premium of about $300 per month — the average cost of insuring Americans this age range. Second, participants would pay an additional monthly payment, estimated at $10 to $20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, covers the extra costs of sicker participants. This two part "payment plan" enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the financing for the buy-in option is sustainable in the long run.

2. **Allowing Displaced Workers Ages 55 to 65 to Buy Into Medicare.** Workers who have involuntarily lost their jobs and their health care coverage would be eligible for a similar Medicare buy-in option. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remain uninsured. Individuals choosing this option would pay the entire premium at the time they receive the benefit without any Medicare "loan," in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65.

3. **Giving Americans Ages 55 and Older Whose Employers Reneged on Providing Retiree Health Benefits Access to COBRA until Eligible for Medicare.** In recent years, the number of companies offering retiree benefits has declined. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. This policy provides much-needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. It allows these retirees to buy into their former employers' health plan through age 65 by extending the availability of COBRA coverage to these families. Retirees would pay a premium of 125 percent of the average cost of the employer's group health insurance.

MAKING COBRA CONTINUATION COVERAGE MORE AFFORDABLE

To improve continuity of health coverage as workers change jobs, the Clinton-Gore budget includes a 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. This tax credit address the issue of cost to help reduce the number of Americans who experience a gap in coverage due to job change. It costs $10.3 billion over 10 years.

BACKGROUND

- **Changing jobs risks losing health insurance.** Since most insurance is job based, changing jobs puts workers and their families at risk of becoming uninsured. One study found that 58 percent of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage.[42] About 44 percent of workers with one or more job changes experienced a gap in health insurance coverage. This is even more pronounced for men, over half of whom were uninsured for a month or more when they had a job interruption.[43]

- **COBRA continuation coverage provides an important option.** Passed in 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) included a provision aimed at minimizing the disruption in health insurance due to job change. It allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. On the whole, evidence supports claims that COBRA decreases the probability that a person between jobs is uninsured, reduces "job lock", and covers workers during pre-existing condition waiting periods.[44]

- **Participation in COBRA is low, primarily due to cost.** Studies suggest that only 20 to 25 percent of COBRA eligibles purchase this coverage. Although some of these people had access to insurance through other family members, the primary reason cited for declining COBRA is its high cost.[45]

PROPOSAL

- **New Tax Credit To Make COBRA More Affordable.** The budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change. It not only helps workers and families access insurance but may help employers, since the current tendency for only people with health problems to participate would be reduced.

IMPROVING ACCESS TO AFFORDABLE INSURANCE FOR WORKERS IN SMALL BUSINESSES

Recognizing the problems that small businesses face in offering their workers insurance, the President proposes a set of policies to harness the purchasing power of large employers and provide assistance for premium payments. It would give small firms that have not previously offered health insurance a tax credit equal to 20 percent of their contribution – twice the credit proposed last year -- towards health insurance obtained through purchasing coalitions. In addition, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and technical assistance would be provided. Altogether, this initiative costs $313 million over 10 years.

BACKGROUND

- **Nearly half of uninsured workers are in firms with fewer than 25 employees.** The likelihood of being uninsured is greater for workers in small firms – nearly three times higher than that of workers in large firms.[46]

- **Small firms are less likely to offer health insurance.** The proportion of small businesses offering health insurance declined between 1996 and 1998 – from 53 to 49 percent for firms with 3 to 9 workers and from 78 to 71 percent for firms with 10 to 24 workers.[47] Businesses blame the high cost of premiums for this problem. Small businesses typically pay higher premiums for the same benefits and administrative costs may consume as much as 40 percent of premium dollars. Trends suggest that the situation will worsen.

- **Purchasing coalitions a growing option for small businesses.** Although still relatively unknown, nearly one in 10 businesses with 3 to 9 employees participated in cooperatives in 1998, and interest and participation are growing.[48]

PROPOSAL

- **Provide a 20 Percent Tax Credit for Employer Contributions.** A tax credit equal to 20 percent of employer contributions toward health premiums would be given to eligible small businesses. Small businesses with between 3 and 50 employees that have not offered coverage in the past could receive this credit if they purchase coverage for their workers through a qualified coalition. This credit is time-limited.

- **Financial Assistance in Creating Coalitions.** Start-up costs are a barrier to developing purchasing coalitions. Yet the current tax provisions for foundations makes private foundations reluctant or, in some cases, prohibited from offering grants for these costs. Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This provision is time-limited.

- **Technical Assistance in Creating Coalitions.** Since the Federal Employees Health Benefits Program is a model for coalitions, its managers would provide technical assistance to coalitions, sharing its administrative experience.

EXTENDING MEDICAID TO VULNERABLE POPULATIONS

Medicaid has proven to be a critical source of health insurance for millions of Americans. However, some vulnerable groups of people – children aging out of Medicaid and S-CHIP, people leaving welfare for work, and legal immigrants – cannot or will not be allowed into Medicaid due to current restrictions. The President's budget includes several important provisions to remove these barriers.

EXPANDING STATE OPTIONS TO INSURE CHILDREN THROUGH AGE 20 ($1.9 billion over 10 years)

- About 1.2 million people ages 19 and 20 have low incomes (below 200 percent of poverty) and are uninsured.[49] Mostly, this results because they age out of Medicaid or S-CHIP or no longer qualify as dependents in their parents' private plans.

- The budget would gives states the option to cover people ages 19 and 20 through Medicaid and S-CHIP.

EXTENDING TRANSITIONAL MEDICAID ($4.3 billion over 10 years)

- Many people leaving welfare for work take first jobs that do not offer affordable health insurance.[50] As such, transitional Medicaid provides a critical bridge to work. Created in 1988, transitional Medicaid extends coverage for up to a year for those losing it due to increased earnings. The 1996 welfare reform bill extended this provision through 2001. A recent survey found that nearly half of former welfare recipients had Medicaid coverage, most likely due to this benefit.[51]

- The budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.

RESTORING STATE OPTIONS TO COVER LEGAL IMMIGRANTS ($6.5 billion over 10 years)

- Over the strong objections of the Administration, the 1996 welfare law prohibited states from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin was 35 percent – over twice the national average of 16 percent.[52]

- The President's budget would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED

BACKGROUND

- **Greater demand.** In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the millions of uninsured. About 6 percent of all hospitals and 26 percent of safety net hospitals annual costs are estimated to be uncompensated, and 2,500 community health center sites serve an estimated 4 million uninsured.[53]

- **Fewer resources.** Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs.

PROPOSALS

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (At least $1 billion over 10 years, +$100 million for FY 2001).** Last year, the President and Secretary Shalala proposed an historic new grant program to support community providers of services to the uninsured. The Congress funded an initial $25 million investment for this program. This year, the Administration proposes funding this initiative at $125 million, a $100 million increase over 2000. This represents a down payment on the its proposal to invest $1 billion over 5 year. The Administration will also aggressively pursue an authorization to ensure that the program is established as a core element of the health care safety net.

    - **Providing new services to the uninsured.** These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services.

    - **Preserving access to critical tertiary care services.** These funds will help support large public hospitals, that often are the only source for trauma care, burn units, neonatal intensive care units, and other specialized services that are critical to all of the residents in a service area. If these institutions succumb to the burden of uncompensated care costs, both the insured and uninsured residents of the service area will be forced to seek these essential health care services elsewhere.

    - **Holding providers accountable for health outcomes.** These grants will help local providers develop the financial, information, and telecommunication systems that are necessary to appropriately monitor and manage patient needs. This will improve the efficiency and effectiveness of service delivery within the safety net, permitting more clients to be served with existing resources.

- **Investing in Community Health Centers (+$50 million for FY 2001).** The budget proposes an increase of $50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans – for total funding of over $1.069 billion in FY 2001.

ENDNOTES

[1] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE .
[2] Cooper PF; Steinberg S. (1997). "More Offers, Fewer Takers for Employment-Based Health Insurnace: 1987 and 1996." *Health Affairs* 16(6): 142-149.
[3] The Kaiser Family Foundation and Health Research and Educational Trust. (1999). *Employer Health Benefits: 1999 Annual Survey.* Washington, DC: Henry J. Kaiser Family Foundation.
[4] Hoffman C. (June 1998). *Uninsured in America: A Chart Book.* Menlo Park, CA: Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. Data: Kaiser/Commonwealth 1997 National Survey of Health Insurance.
[5] Hoffman C. (June 1998). *Uninsured in America: A Chart Book.* Menlo Park, CA: Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. Data: Kaiser/Commonwealth 1997 National Survey of Health Insurance.
[6] Simpson G. et al. (1997). "Access to Health Care, Part 1: Children," *Vital Health Statistics.* Rockville, MD: U.S. Department of Health and Human Services, National Center for Health Statistics.
[7] Hoffman C. (June 1998). *Uninsured in America: A Chart Book.* Menlo Park, CA: Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. Data: Maryland and Massachusetts Hospital Discharge Data, as reported in Weissman JS; Gastonis C; Epstein AM. (1992). "Rates of avoidable hospitalization by insurance status in Massachusetts and Maryland." *JAMA* 268(17): 2388-94.
[8] Hoffman C. (June 1998). *Uninsured in America: A Chart Book.* Menlo Park, CA: Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. Data: National Medical Expenditure Survey as reported in Stoddard JJ et al. (1994). "Health insurance status and ambulatory care for children." *NEJM* 330(20): 1421-25.
[9] Hoffman C. (June 1998). *Uninsured in America: A Chart Book.* Menlo Park, CA: Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. Data: Kaiser/Commonwealth 1997 National Survey of Health Insurance.
[10] Weigers ME; Weinrick RM; Cohen JW. (1998). *Children's Health, 1996.* Rockville, MD: U.S. Department of Health and Human Services, Agency for Health Care Policy and Research (Pub. No. 98-0008).
[11] Preliminary coverage estimates are for 2007, the first year in which all policy initiatives are fully implemented. The fraction of covered persons coming from previously uninsured persons was based on relative participation rates used on similar proposals analyzed under the Kaiser Project on Incremental Helath Reform, applied to population distributions from March CPS data for 1996-1999. (See Feder, J., C. Uccello, and E. O'Brien, "The Difference Different Approaches Make Comparing Proposals to Expand Health Insurance", Kaiser Family Foundation, October, 1999.)
[12] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
[13] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
[14] Upper income eligibility limits for children from: DHHS. (January 2000). *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999.* Washington, DC: U.S. Department of Health and Human Services, Health Care Financing Administration. Upper income eligibility limits for parents from: Guyer J; Mann C. (February 1999). *Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance.* Washington, DC: Center on Budget and Policy Priorities; updated verbally.
[15] Families USA. (January 2000). *The Building Blocks of Universal Coverage: Families USA's Proposal for Expanding Health Coverage.* Princeton, NJ: The Robert Wood Johnson Foundation's Health Coverage 2000 Project.
[16] Cunningham PJ; Schaefer E; Hogan C. (October 1999). "Who Declines Employer-Sponsored Insurance and Is Uninsured?" *Issue Brief,* Center for Health System Changes, Number 22.
[17] Thorpe KE; Florence CS. (July 1998). *Covering Uninsured Children and their Parents: Estimated Cost and Number of Newly Insured.* New York: The Commonwealth Fund; and National Governors' Association (January 4, 1999). "State Tools to Provide Family Health Insurance Coverage." *NGA Issue Brief.* Washington, DC: NGA.
[18] Feder J; Uccello C; O'Brien E. (October 1999). *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance.* Washington, DC: The Kaiser Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation.
[19] National Governors' Association (1999). Policy Resolution NR-15.9. Children's Health, Family Coverage. See also: NGA. (January 4, 1999). "State Tools to Provide Family Health Insurance Coverage." *NGA Issue Brief.* Washington, DC: NGA.
[20] The Robert Wood Johnson Foundation, Health Insurance Association of American, Families USA. (January 13, 2000). *Health Coverage 2000: Meeting the Challenge of the Uninsured.* Princeton, NJ: RWJF.
[21] DHHS. (January 2000). *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999.* Washington, DC: U.S. Department of Health and Human Services, Health Care Financing Administration.
[22] All states must extend Medicaid eligibility to children to the poverty level for those ages 6 through 18, 133 percent of poverty for those ages 1 through 5, and 185 percent of poverty for infants.
[23] Shenkman E et al. (September 1999). "Crowd Out: Evidence From the Florida Healthy Kids Program." *Pediatrics, 104*(3): 507-513.
[24] National Governors' Association (1999). Policy Resolution NR-15.3. Children's Health, State Flexibility. See also: NGA. (October 15, 1998). "Using S-CHIP Funds for Health Insurance Premium Contributions: Policy Issues and Operational Challenges." *NGA Issue Brief.* Washington, DC: NGA.

[25] DHHS. (January 2000). *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999.* Washington, DC: U.S. Department of Health and Human Services, Health Care Financing Administration.
[26] DHHS. (January 2000). *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999.* Washington, DC: U.S. Department of Health and Human Services, Health Care Financing Administration.
[27] Selden TM; Banthin JS; Cohen JW. (May/June 1998). "Medicaid's Problem Children: Eligible but Not Enrolled." *Health Affairs*, 17(3): 192-200.
[28] Perry M; Kannel S; Valdez R; Chang C. (January 2000). *Medicaid and Children: Overcoming Barriers to Enrollment.* Washington, DC: The Kaiser Commission in Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation.
[29] Perry M; Kannel S; Valdez R; Chang C. (January 2000). *Medicaid and Children: Overcoming Barriers to Enrollment.* Washington, DC: The Kaiser Commission in Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation.
[30] Kenney G; Haley J; Ullman F. (January 2000). *Most Uninsured Children Are In Families Served by Government Programs.* Washington, DC: The Urban Institute.
[31] Center on Budget and Policy Priorities (December 1999). Unpublished, for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC.
[32] National Conference of State Legislatures and the National Governors' Association. (1999). *1998 State Children's Health Insurance Program Annual Report.* Washington, DC.
[33] Perry M; Kannel S; Valdez R; Chang C. (January 2000). *Medicaid and Children: Overcoming Barriers to Enrollment.* Washington, DC: The Kaiser Commission in Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation.
[34] National Governors' Association. (May 11, 1998). "How States Can Increase Enrollment in the State Children's Health Insurance Program." *NGA Issue Brief.* Washington, DC: NGA; National Governors' Association. (September 16, 1999). "Retention and Reenrollment of Children in S-CHIP and Medicaid." *NGA Issue Brief.* Washington, DC.
[35] Center on Budget and Policy Priorities (December 1999). Unpublished, for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC; National Conference of State Legislatures and the National Governors' Association. (1999). *1998 State Children's Health Insurance Program Annual Report.* Washington, DC.
[36] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
[37] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
[38] Chollet DJ; Kirk AM. (March 1998). *Understanding Individual Health Insurance Markets.* Menlo Park, CA: Henry J. Kaiser Family Foundation.
[39] Data from National Center for Health Statistics, National Health Interview Survey.
[40] U.S. Census Bureau. (1998). Population projections by age.
[41] Glied S; Stabile M. (1999). "Covering Older Americans: Forecast for the Next Decade." *Health Affairs* 18(1): 208-13
[42] Sheils J; Alecxih L. (1996). *Recent Trends in Employer Health Insurance Coverage and Benefits.* Washington, DC: Final Report prepared for the American Hospital Association.
[43] Bennefield RL. (August 1998). Who Loses Coverage and for How Long? Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. U.S. Census Bureau, Department of Commerce, Economics and Statistics Administration, Current Population Reports P70-64.
[44] Gruber J; Madrian BC. (1994). "Health Insurance and Job Mobility: Mobility: The Effects of Public Policy on Job-Lock," *Industrial and Labor Relations Review*, 48(1). Berger MC, Black DA, Scott FA. (1996). *Health Insurance Coverage of the Unemployed.* Washington, DC: Final Report prepared for the Pension and Welfare Benefits Administration, U.S. Department of Labor.
[45] See Rice T. (October 1999). *Subsidizing COBRA: An Option for Expanding Health Insurance Coverage.* Washington, DC: The Kaiser Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation.
[46] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
[47] Gabel J et al. (February 1999). *Health Benefits of Small Employers in 1998.* Menlo Park, CA: Henry J. Kaiser Family Foundation.
[48] *Ibid.*
[49] Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
[50] Guyer J; Mann C. (August 20, 1988). *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents.* Washginton, DC: Center on Budget and Policy Priorities.
[51] Loprest P. (August 1999). *How Families That Left Welfare Are Doing: A National Picture.* Washington, DC: New Federalism: National Survey of America's Families, Publication B-1. The Urban Institute.
[52] U.S. Census Bureau. (October 1999). *Health Insurance Coverage 1998.* U.S. Department of Commerce, Economics and Statistics Administration, Current Population Reports P60-208.
[53] American Hospital Association. (March 1998). *Uncompensated Care Hospital Cost Fact Sheet.* Chicago, IL: AHA; National Association of Public Hospitals & Health Systems. Hospital Characteristics Survey Data, 1996. National Association of Community Health Centers, website.

QUESTIONS AND ANSWERS ON COVERAGE INITIATIVE
January 19, 2000

POLICY PRIORITIES, BUDGET COSTS AND CHANCES OF ENACTMENT

Q: Why are you proposing this major initiative now?

A: There is no questioning the President's commitment to expanding health insurance coverage. Every time the opportunity to extend affordable coverage to uninsured Americans has arisen, he has made a proposal to do so. Two years into the increasingly successful implementation of S-CHIP, with the country's growing resources and the booming economy, it makes perfect sense to implement new options for individuals without health insurance.

Q: How are you paying for this initiative? Are you raiding the Social Security surplus?

A: No. This proposal will be fully paid for in the context of a balanced budget.

Q: Isn't this a small investment in relation to the problem of the uninsured?

A: This investment is clearly a significant investment and is one of the largest initiatives in the budget. If enacted, it would represent the largest single expansion of coverage since Medicare and Medicaid were created. While the investment is less than what some are advocating for in the Presidential election, it certainly lays the foundation for additional enhancements at a later time.

Q: What are the chances of this initiative's passing?

A: Similar to the S-CHIP proposal, which received broad bipartisan support, we believe this initiative has an excellent chance of becoming law this year. If the Congress is serious about responding to the needs of the American public, we have great confidence that they will come back motivated to get the job done.

LINK TO PRESIDENTIAL CAMPAIGN

Q: Isn't the introduction of this proposal timed specifically to help Vice President Gore in his Presidential campaign?

A: The Vice President has made a valuable contribution to the health care debate. We are simply tapping into some of his ideas because they are thoughtfully constructed policies and have great potential for success. The timing of this policy announcement occurs around the release of our budget, just like other major initiatives in this year's budget. We would have unveiled this initiative at this time of year regardless of whether or not it was an election year.

Q: Why isn't the Vice President's entire health care proposal included in your budget?

A: Much of the Vice President's initiative is clearly integrated into the President's policy. Its inclusion represents the President's belief that this is sound policy that merits Congressional approval. Provisions in our proposal that do not exactly mirror the VP's initiative or don't go as far as his proposal does simply represents the Administration's vision on health care for the FY 2001 budget. As the President has made clear from the beginning, he believes the Vice President has exhibited extraordinary leadership on this issue.

Q: What is the difference between the Vice President's proposal and the proposal in the President's FY 2001 budget?

A: The Vice President has additional children's health insurance initiatives including the expansion of S-CHIP up to 250 percent of poverty and a requirement that all states offer parents with incomes over 250 percent of the poverty level the option to buy into Medicaid and CHIP programs. He also advocates for an individual refundable tax credit of 25 percent for those without employer sponsored coverage. These are thoughtful proposals worthy of serious consideration, but we chose not to include them in this initiative. Unlike the longer-range policy considerations of a Presidential campaign, the FY 2001 budget is focused on those policies that we believe have the best chance of passing the Congress this year. Should the Congress have interest in some of the additional proposals the Vice President is promoting, we would clearly be open to discussing those as well.

Q: Isn't this proposal an implicit rejection of Senator Bradley's proposal?

A: We're not going to engage on the positive or negative elements of Senator Bradley's or any other candidate's proposal. This proposal has been designed in an attempt to reach across party lines to pass a long overdue coverage expansion in this session of Congress in the final year of the Clinton Administration.

Q: So far, the Republicans have not engaged to any significant degree in the debate over expanding health care coverage. How do you believe the unveiling of this initiative will impact on the Republican Presidential primary?

A: We believe it is notable that the Republican presidential candidates, with the possible exception of Senator McCain, have not made health care a focus of their campaigns. We do believe, however, that there is potential for Republican interest in targeted health care expansions on Capitol Hill and we hope that the President's unveiling of his health care coverage initiative will spur interest in this issue in both the Congress and in the Presidential election. This issue is too important to ignore. It is interesting to note, however, that the Republican candidates are now advocating for a strong, enforceable, Patients Bill of Rights such as the Norwood-Dingell legislation. Perhaps this interest can translate into broader support for coverage initiatives as well.

Q: Have you stopped supporting universal coverage? Is this a repudiation of previous policy priorities?

A: The President believes that expanding high quality, affordable coverage to all Americans should be the goal of any Administration. It has become clear, however, that other approaches need to be considered to achieve the level of consensus necessary to pass legislation in Congress. We had two options after the Health Security Act. We could ignore the problem, do nothing, and assume that no consensus could be reached, or we could take a targeted step by step approach. We have chosen the latter, and believe our proposal will successfully extend coverage to millions of uninsured Americans, building on our previous successes such as S-CHIP.

ACCELERATING ENROLLMENT IN MEDICAID AND CHIP

Q: Doesn't the fact that you have to spend more money covering children in this year's budget explicitly validate that the original S-CHIP legislation was flawed and that you're just throwing good money after bad to address the situation?

A: Absolutely not. The program has already enrolled two million children, and proposals included to help states accelerate enrollment of children are simply additional tools to make their job easier. We believe they will ensure even greater success of the programs than we've seen in recent months and enable states to more quickly tap into their S-CHIP allotments.

FAMILYCARE

Q: Are you eliminating the S-CHIP program and replacing it with something new? Isn't the philosophy of this proposal closer to Senator Bradley's than the Vice President's?

A: No. This proposal does not eliminate S-CHIP; it simply builds upon it to provide another option for working families, called FamilyCare. FamilyCare allows states to take advantage of the flexibility of S-CHIP to create a seamless system of health insurance coverage for uninsured working families. This proposal, since it builds on the success of S-CHIP and Medicaid, is very similar to the proposal put forth by the Vice President – targeted but extremely bold proposals that dedicate unprecedented amounts of the surplus to expanding coverage and have real potential to build the type of consensus necessary to pass bipartisan legislation on health care.

Q: Won't this new proposal distract states from the original goal of S-CHIP – to cover uninsured children?

A: Quite the contrary. Studies have shown that uninsured children are more likely to become insured when the whole family has access to new coverage options. Moreover, this proposal continues the current financial incentives that states have to expand coverage to uninsured children, and actually provides states with an additional incentive to expand coverage to children, as they will not be able to access the enhanced matching rate for parents until they have covered children up to 200 percent of the poverty level. This helps explain why the National Governor's Association supports the creation of an additional family coverage option built on the S-CHIP program.

Q: By many accounts, S-CHIP has not been a particularly successful program. Why are you putting new funds into expanding a program that just doesn't work?

A: We disagree. Now that all 50 states have their programs up and running, we are seeing a steady rise in enrollment rates nationwide. In fact, the program's enrollment doubled in less than a year, serving two million children as of October 1, 1999. Since the enactment of S-CHIP, we've also seen a sevenfold increase in the number of states (from 4 to thirty) who have expanded their eligibility levels to 200 percent of the poverty level. Since the creation of S-CHIP, the NGA and other state advocates have called for additional flexibility to be able to cover families under S-CHIP. This proposal will provide them with the necessary flexibility to provide a seamless system of health insurance coverage to families.

Q: Isn't your failsafe trigger mechanism just a fancy way of saying "unfunded state mandate"?

A: First, we don't believe that there will be many – if any – states who will not take advantage of the new option to extend coverage to families. However, to ensure that all states will eventually establish a basic level of coverage for parents with incomes at or below the poverty line ($16,700 for families), it was necessary to have a failsafe mechanism.

It is important to point out, however, that this policy is very different than the approach the Federal government took in the late 1980s when implementing state Medicaid mandates. Those were immediate or phased-in mandates, giving little or no opportunity for voluntary mechanisms to work. These mandates did not provide for enhanced match, as we are proposing, to further support states choosing to expand.

Q: The Vice President's proposal doesn't include a requirement for states to expand coverage to parents below 100 percent of the poverty line. This sounds like [the President's proposal is actually intrusive and involves more government regulation] or [the President's proposal is actually bolder than the Vice President's].

A: The Vice President's proposal assumes that all states will take up this option to expand family coverage within the first five years of the program. If it is necessary to have a failsafe trigger in 2006, it is our understanding that he supports this provision.

Q: Isn't the requirement for states to cover children up to 200 percent of FPL before they can cover parents an implicit admission that the voluntary nature of the S-CHIP program failed? Isn't that why you've also included a new mandate to cover parents by 2006?

A: By most accounts, S-CHIP is becoming a major success. Every state in the country has taken advantage of this new option, and 30 states have expanded coverage to children with family incomes up to 200 percent of the poverty level. The reason for this prerequisite is to maintain the bipartisan agreement that our first priority is to insure children. Given our experience in S-CHIP and the strong state support for expanding S-CHIP to parents, it is extremely likely that the vast majority of states – if not all – will take this new option, making the failsafe trigger unnecessary.

Q: Doesn't this policy continue this Administration's long-standing policy of punishing states that have done a good job of expanding coverage to low-income people and rewarding states that have not done anything to help this population?

A: Absolutely not. The FamilyCare program is designed to create consistent national incentives for states to expand coverage beyond what is required.

First, all states will receive enhanced match for any coverage expansion they implement under FamilyCare. Second, in 2006, even those states who have expanded coverage before the FamilyCare program was implemented will receive enhanced match for covering families with incomes above poverty.

Q: In 2006, when states like Minnesota and Vermont will be able to access enhanced match to fund programs that have been running for years, won't you just be wasting Federal funds?

A: The structure of this new policy will ensure that those states who have consistently worked to expand coverage to low income workers will receive the similar financial support from the Federal government as those states expanding for the first time under this policy.

Q: Won't this new coverage option encourage low-wage workers to drop the health insurance coverage they have for a free government plan? Won't employers drop the health insurance they currently offer, simply trading private sector funds for taxpayer dollars?

A: First, very few low income families have access to employer sponsored health insurance, and our experience with S-CHIP to date demonstrates that crowd-out is not a big problem. Second, we give states the option in FamilyCare to supplement employer policies that contribute more than half the cost of the policy so there is less incentive for those who do have coverage to drop. This, coupled with S-CHIP policies to prevent substitution, should minimize the effect of existing crowd-out.

Q: What about [insert policy detail]? Will the current requirements in S-CHIP apply to the new FamilyCare program?

A: Under FamilyCare, states would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP. We are willing to work with the states and the Congress to ensure that the mechanics of the FamilyCare program provide the flexibility necessary for states to run the programs efficiently while ensuring the delivery of high quality affordable health care with comprehensive benefits.

MEDICARE BUY-IN

Q: Why do you keep proposing the Medicare buy-in when it is clear that it the Republican Congress will never pass it?

A: We believe that members of Congress will begin to recognize that adults aged 55 to 65 are the fastest growing population of the uninsured in America. As they consider this fact within the context of our new proposal to make providing coverage to this population even more affordable within the context of a tax credit, we believe the proposal has the potential to receive broader bipartisan support. This is the right policy for one of the nation's most vulnerable populations, and we make no apologies for continuing to push for it.

Q: The Clinton Administration keeps saying that the Medicare program is in trouble, and that's why Congress needs to act on the President's reform plan. If the program is in so much trouble, why are you proposing to expand it?

A: This proposal does not hurt the Trust Fund. Participants pay a full premium for coverage; the cost of the proposal is primarily due to the temporary costs of a lower premium up-front, which beneficiaries pay off over time.

Q: Why aren't you making the Medicare buy-in or COBRA tax credits refundable? Wouldn't that be more fair to low income taxpayers?

A: This Administration has an unquestionable record of supporting and passing policies that help low-income people. Just last week, the President proposed expanding the Earned Income Tax Credit, a refundable credit that has made a difference in the lives of millions of Americans. In our health coverage expansion initiative, we chose to target low-income people through programs like CHIP Medicaid, which all experts agree is a much more efficient, effective way to expand coverage to low-income people than through the tax code. However, tax credits make sense for the Medicare buy-in and COBRA since workers between jobs and people transitioning to retirement tend to be in the middle class and need that extra amount of assistance to participate in these options. We can't forget that three-fourths of the uninsured work or are in working families. Although the uninsured rate remains highest among the poor (33 percent), it has been growing faster for the middle class.

SMALL BUSINESS PURCHASING COALITIONS

Q: Why do you continue to push this proposal at the same time that you have consistently opposed HealthMarts, a Republican proposal that does essentially the same thing?

A: The President believes that we need to work together to find the best way to provide greater access to affordable insurance for small business, as nearly half of uninsured workers are in firms with fewer than 25 employees. The President's policy makes it much easier for businesses to come together in a manner that does not detrimentally affect the insurance market and segment healthy populations from unhealthy ones. Because, in essence, the HealthMart approach would bypass the oversight of state health insurance commissioners, the fear is that it would have precisely this type of negative impact on the marketplace.

COBRA EXPANSION

Q: Many employers already oppose COBRA, and very few Americans actually take advantage of the option. Isn't this a waste of money? Why are you expanding it?

A: Costs have been named as one of the major reasons why fewer than 25 percent of the people eligible do not take advantage of COBRA. One other benefit of this option is that reducing costs will encourage healthier people to take this option, and guard against the problem of only sicker populations taking their COBRA option.

TRANSITIONAL MEDICAID EXPANSION

Q: Aren't you applying a new Federal mandate to welfare programs with this provision? Isn't this just another way to try to control state welfare programs?

A: No. This is an existing statutory provision, created by the Family Support Act of 1988 and reauthorized on a bipartisan basis as part of the 1996 Personal Responsibility and Work Opportunity Act, that recognizes the importance of Medicaid and other social support programs for families returning to work. This proposal merely extends this provision permanently.

GIVING STATES NEW OPTIONS TO COVER LEGAL IMMIGRANTS

Q: Won't this new extension of coverage just encourage illegal immigrants to come to the United States?

A: First, this policy does not apply to illegal immigrants, who are not eligible for coverage – except in emergency cases – under the Medicaid program. Second, lack of insurance is a serious problem for legal immigrants. Forty-three percent of non-citizens (most of whom are legal immigrants) lack health insurance coverage. This policy restores important options and social services for individuals who pay taxes just like all other American citizens that were taken away over the Administration's objections in 1996.

IMPROVING THE EQUITY OF TAX TREATMENT OF HEALTH INSURANCE

Q: What is the relation of this proposal to the access provisions in the Patients' Bill of Rights?

A: This proposal contrasts starkly with the so called access provisions included in the Republican Patients Bill of Rights. Unlike those initiatives, the President's plan will significantly expand coverage in an extremely efficient manner. In contrast, the Republican tax initiative is highly regressive, poorly targeted, and will do little to expand coverage. It is our hope that those members on both sides of the aisle will keep their minds open in order to determine the best and most effective coverage expansion available to the Congress.

Q: How can the tax code be used to expand coverage?

A: Clearly, we believe that the Administration's proposals on health care are the best policies to use to expand insurance coverage. We do not believe that tax initiatives can be used effectively to expand coverage without at the same time crowding out employer sponsored coverage – that is, reducing coverage for some workers.

Q: Do you believe that tax approaches have a role to expand coverage or at least ensure equity?

A: Tax policies, carefully structured and targeted, can be designed to address inequities and supplement other approaches to expanding health care. In this year's budget, we are using the tax code to target the particularly unique population to target workers in-between jobs, the near elderly, and workers in small businesses. Our carefully targeted approach sharply contrasts with large, ill-designed tax credits that threaten to undermine the current employer based health insurance market and in some cases, result in coverage loss.

Q: Why are you expanding public programs rather than using a comprehensive set of tax incentives, an approach which already has broad-based support among Republicans and growing interest among some Democrats in Congress?

A: First, our proposal builds on existing health insurance programs – including private employer sponsored insurance – to provide new coverage to individuals. It does include a series of targeted tax incentives to increase access to health care insurance, including new tax credits for workers in between jobs, the near elderly, and small businesses and their employees. We are wary, however, of regressively structured tax deductions or expensive tax credits that are extremely inefficient and costly. Most experts believe that such an approach will undermine the employer market by increasing incentives for firms to drop their current contributions to health insurance premiums for their workforce. They believe that such an approach could cause younger and healthier workers to abandon the employer market, raising premiums for older, sicker workers left behind. As a result, untargeted health insurance tax credits could induce firms to drop their current health insurance coverage, causing some workers to become uninsured.

Q: Why don't the tax credits for Medicare and COBRA coverage phase out with income? Doesn't this mean that people with the highest incomes will receive the largest benefits?

A: No. The tax credit is much more progressive than a deduction. It is worth the same 25 percent to a family earning $60,000 as to a family earning $600,000.