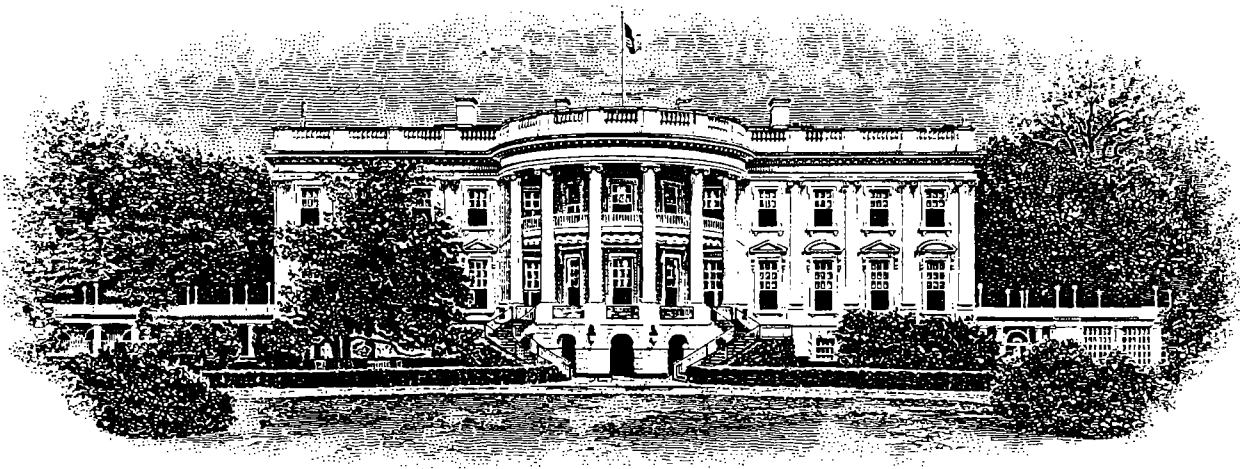


CHIP
EVENT



The White House



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Revised Final 9/29/00 9:15 a.m.
John Pollack

**PRESIDENT WILLIAM JEFFERSON CLINTON
STATEMENT ON
RECORD GAIN FOR CHILDREN'S HEALTH INSURANCE
THE WHITE HOUSE
September 29, 2000**

Good morning. Thank-you, Deborah Bredbenner (BREAD-benner), for sharing your story with us. Your experience echoes that of too many American families, and highlights the need for Congress to take further action to expand access to quality, affordable health care. This is just one of many issues that Congress is overdue in addressing.

Just a few minutes ago, I just signed the Continuing Resolution which Congress sent to me yesterday. This stop-gap funding measure will keep the government running for now, but I hope Congress will get down to business now and pass the remaining appropriations bills. September has come and gone, and the American people are still waiting for Congress to fulfill its obligations. These kids behind me have been back in school for a month, but Congress still hasn't turned in its first assignment – insuring that schools have the resources they need to meet the high standards we expect. The time for tardiness is over; let's see some progress.

Sadly, Deborah's story is all too common. Millions of people like her get up every day, go to work and play by the rules, but still have a tough time finding affordable health insurance. That's why Secretary Shalala, Hillary and I have been working so hard to make sure that families can get the care they need.

Yesterday we got more evidence that our step-by-step approach is working. The census data shows that the number of uninsured Americans fell by 1.7 million in 1999, the first major drop in a dozen years. This is a dramatic turnaround, one that signals a new beginning for American families seeking quality, affordable health care.

I am particularly pleased that nearly two thirds of these newly insured are children – like many of those with us here this morning. Today I am proud to announce that, since I signed CHIP into law, we have enabled 2.5 million children to get insurance through this program.

Vice President Gore has proposed a Family Care initiative, which would expand CHIP to cover the parents of eligible children. If we do this, we can cover another four million adults and, studies show, increase coverage of children by up to 25%.

Parents like Deborah and Chris Bredbenner know what a difference health insurance can make. Not just in emergencies, but for routine care. Consider the child who doesn't get treated for an ear infection, who might suffer permanent hearing loss. If they can't hear, they might have a harder time in school. Or consider the toll of untreated asthma, which will cause American students to miss 10 million school days this year alone.

That's why we need to keep pushing forward until all our children are covered. To help accomplish this, the Department of Health and Human Services is awarding \$700,000 in grants today, to develop new and even more effective ways to identify and enroll uninsured children. These grants will be used not only to get kids enrolled, but keep them enrolled, so that they can get the care they need.

These grants will build on our recent success in improving outreach and enrollment around the country. If you look at how states are doing with CHIP, you'll see that those with the best outreach programs had the most success in boosting the number of people covered. States like Indiana, Ohio and Maine have done a great job, and I hope other states will look to them for leadership. I also hope that every working parent searching for children's health insurance will call the toll-free number on these kids' t-shirts: 1-877-KIDS-NOW.

We need to remember that the rising number of uninsured isn't a problem that developed overnight, and that it won't disappear overnight, either. In some ways, it reminds me of the challenges we faced with the deficit when Vice President Gore and I took office in 1992. Some people told us there was nothing we could do to stem the rising tide of red ink. In fact, the numbers on that national debt clock in New York were flashing by so fast that people's eyes were glazing over.

But we saw a better way. We made the tough choices, cut spending, and invested in the American people. Together, we turned the tide. And today, as this fiscal year comes to a close, we're posting the biggest surplus in American history – \$230 billion – and paying off another \$223 billion in national debt.

This economic turnaround didn't just happen by chance; it happened by choice. And that's what we're seeing with this new turnaround in health care coverage – smart choices starting to pay off. So let's keep moving in the right direction, and take the following steps.

First, Congress should act this fall to enable hundreds of thousands of people between the ages of 55 and 65 to buy into Medicare. These are the Americans who have the most difficulty finding affordable health insurance, and this group is only going to get bigger as the Baby Boomers age.

Second, Congress should pass our proposed tax credit for small businesses, which would strengthen their hand in negotiating quality, affordable health insurance options for their employees.

Third, Congress should restore Medicaid benefits to the most vulnerable of America's legal immigrants, including children. A few days ago, the House Commerce Committee voted to pass this important measure. Surely we can work together to restore these people's benefits, and do it this year.

Finally, America is still waiting for Congress to pass a Medicare prescription drug benefit, our \$3,000 tax credit for long-term care, and a strong Patients' Bill of Rights. It's high

time for Congress to put progress before partisanship, and finally vote on these commonsense proposals.

By any measure, we are living in extraordinary times. But we still have work to do. Step by step, we need to build on the success we celebrate today. If we tackle these challenges together – and I know we can – every American family can look forward to getting the health care they need, and enjoying the peace of mind they deserve.

Thank you.

STATEMENT BY DEBORAH BREDBENNER

Thank you, Secretary Shalala.

Good morning, Mr. President and other distinguished guests.

I am here to share my story with you so that you will understand how important health insurance coverage is to me and my children – and to millions of families across the country just like mine.

Mr. President, I know that thanks to your leadership, my family is a lot luckier than most – because of the CHIP program, we have insurance for our kids. The most important thing to me as a working mother is to make sure my children have health insurance. My children have been enrolled in the Maryland CHIP program for two years now, and I want to tell you: this program has been a blessing to our family.

Bryant, my son, has asthma. He uses inhalers and sees the doctor regularly. Without careful monitoring, his asthma attacks could spiral out of control. Because of the CHIP program, we can afford the medication he needs – without going broke.

My daughter Melissa is a pretty healthy toddler – but she needs to see her pediatrician regularly, just like every other child. Because of the Maryland CHIP program, she gets the preventive care she needs to stay healthy. And I know that if she were ever to get sick, we'd be able to afford to take her to the doctor.

Recently, we had a scare. The doctors thought that Bryant had viral meningitis. Thankfully, he's okay, but he was in and out of the hospital for three days. And thanks to the CHIP program, all I had to worry about during those three days was his health – not how we would pay for his care.

Mr. President, you know how it is being a parent – you care more about your kids than you do your own self. And if I had to choose between having health insurance for them or for me, I'd choose them every time.

Frankly, we can't afford to purchase health insurance for me. I wanted to sign up through my job, but over half of my paycheck would have gone for the premiums for the first three months, and then, a third of my check each month after that. Mr. President, my husband and I are trying to support two children. We can't afford to lose a third of my paycheck each month – so I don't have health insurance.

I'm very fortunate to have good health, and I don't need to see the doctor often. But because I don't have insurance, I haven't been able to the doctor for my regular checkups. Recently, I had to go to the doctor for an attack of bronchitis, and I had to pay out of pocket. And I thought, what would happen if I got really sick? It would devastate my family financially. All I can do is hope that I don't get sick.

Mr. President, I've worked all my life, and I want to be clear that I don't want a handout. It would be a big relief if I had access to health insurance because I know that then, I would be able to be there for my family. And I know that every day you're in office, you're working to help with that.

And now, it is my honor to introduce someone who has fought harder than anyone else to ensure that America's families have access to affordable, high quality health insurance – the President of the United States, William Jefferson Clinton.

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PRELIMINARY HIGHLIGHTS OF IMPLEMENTATION AND EXPANSION

President Clinton, with overwhelming bipartisan support from the Congress, created the State Children's Health Insurance Program (S-CHIP) in 1997, allocating \$48 billion over the next 10 years to expand health care coverage to uninsured children. This new program, together with Medicaid, provides meaningful health care coverage to millions of previously uninsured children – including coverage for prescription drugs, vision, hearing, and mental health services. Today, every state has implemented S-CHIP, providing health insurance coverage to over 2 million children nationwide since the beginning of the program. The success of this Federal-State partnership is one of the most significant achievements of the Clinton-Gore Administration. This summary includes highlights from state-submitted evaluations of their S-CHIP programs.

BACKGROUND

The State Children's Health Insurance Program (S-CHIP) enables states to insure children from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance through separate state programs, Medicaid expansions, or a combination of both. Each state with an approved plan receives enhanced Federal matching payments for its S-CHIP expenditures up to a fixed state "allotment". As of July 1, 2000, 50 States, the District of Columbia and five U.S. Territories have implemented S-CHIP, covering over 2 million children. In addition, the number of children enrolled in Medicaid has increased because of state-wide outreach and eligibility simplification efforts.

Of these approved plans, 15 States have created a separate child health program, 23 States have expanded Medicaid, and 18 States have developed a combination of a separate state program and a Medicaid expansion program. In addition, many states have already amended their programs to expand eligibility beyond their original proposal. 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.

However, millions of eligible children remain uninsured. One study found that two-thirds of eligible uninsured children are in two-parent families. Over seventy-five percent of the parents of these children work, and only 5 percent receive welfare. Nearly all low-income parents believe having health insurance coverage for their child is very important, and two-thirds of them have tried to enroll their children in Medicaid. However, over 57 percent of these attempts were unsuccessful. Studies indicate that lack of coverage negatively affects access to care among low-income children – 41 percent of parents of eligible uninsured children postponed seeking medical care for their child because they could not afford it.

States have made strong progress in implementing their S-CHIP programs, seeking and implementing new and innovative ways to identify and enroll uninsured children in both Medicaid and S-CHIP. The steady growth of the S-CHIP program is evidence of the success of this Federal-State partnership and the nation's commitment to ensuring that all children have health insurance coverage.

STATE EVALUATIONS

The S-CHIP statute requires States to regularly report on their progress toward covering low-income children under S-CHIP, and required that each State or Territory with an approved child health plan must submit to the Secretary of Health and Human Services an evaluation of its S-CHIP Program by March 31, 2000. These evaluations provide States with an opportunity to document program achievements, assess the effectiveness of their programs, and identify ways in which the State or the Federal government might improve program performance.

Working with the states, the Department of Health and Human Services (HHS), and other interested parties, the National Academy of State Health Policy facilitated the evaluation process and created an “evaluation framework” for the States that enabled them to report their findings in a standardized manner. The states’ evaluations provided HHS with valuable information on best practices as well as challenges facing states in the implementation of their programs. This information, which is available to the public, will be used to provide continuing technical assistance to facilitate future program innovations. The States’ evaluations will be posted on the HCFA web site at www.hcfa.gov.

The forty-seven state evaluations submitted as of July 1, 2000 offer important insights into the experiences and future direction of S-CHIP. The information that follows is a short description of preliminary findings from the States’ reports, quarterly enrollment data currently available, and regional office reviews of Medicaid enrollment and eligibility processes.

STRONG ENROLLMENT TRENDS CONTINUE

Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998, and initial reports indicate that these strong enrollment trends are continuing through the first quarter of 2000 (although data from all states is has not yet been submitted). For example, from the second quarter of fiscal year 1999 (April 1 – June 30, 1999) to the second quarter of 2000 (April 1 – June 30, 2000), enrollment increased by more than 80 percent in the 43 states for which there are data. During that time period, 19 states reported that their enrollment had more than doubled, and nine of those states reported that their program enrollment had tripled.

ELIMINATING BARRIERS TO INITIAL AND CONTINUED ENROLLMENT

States reported having worked aggressively to simplify their application, enrollment, and re-enrollment processes to ensure that eligible families can easily apply, enroll, and remain enrolled. Steps such as using a joint and mail-in applications, offering presumptive eligibility, allowing retroactive eligibility, and providing continuous eligibility are all important strategies for simplifying the enrollment process and providing opportunities for families to apply and remain enrolled in Medicaid and S-CHIP.

Coordinating Enrollment and Eligibility Requirements for Medicaid and S-CHIP

In order to ensure that children receive the most generous benefit package for which they are eligible, 29 states – over 85 percent of those with separate state programs or combination programs – report using a joint application to enroll families in their Medicaid or separate child health program. These states confirmed that using one application for both Medicaid and their separate child health program reduces paperwork, minimizes processing errors, and offers a less intrusive, more family-friendly approach to the application process.

In addition, 39 states have eliminated face-to-face interviews in Medicaid for children or in both Medicaid and the State's separate S-CHIP program.

In addition, only seven states currently require an assets test for children enrolling in Medicaid or the S-CHIP program. Out of the 17 states with combination programs, 16 have dropped the assets test in both their Medicaid expansion and their separate state program, while one has dropped it for the S-CHIP program but not Medicaid. Thirteen of the 17 states with Medicaid expansions have dropped their assets test. Over the past several years, states have dropped this requirement in the face of mounting evidence and state experience that it serves as a barrier to enrollment.

North Carolina's Health Choice For Children Program. North Carolina has successfully implemented strategies to simplify the application and enrollment procedures for families for both Medicaid and S-CHIP. The state:

- Uses a joint application for Medicaid and S-CHIP;
- Guarantees eligibility for 12 months in S-CHIP and Medicaid;
- Provides a simplified two-page application in English and Spanish;
- Allows mail-in applications;
- Cross-trained eligibility workers so they would have the expertise to determine Medicaid or S-CHIP eligibility from the application in one review, shortening the time involved in processing applications and minimizing potential errors; and
- Automatically notifies families when it is time for them to re-enroll their children in Medicaid or S-CHIP.

Ohio's Healthy Start. Ohio recently eliminated burdensome eligibility verification requirements, such as proof of residency and birth date, for children applying for Medicaid (which includes their S-CHIP Medicaid expansion). In addition, the state:

- Uses a two page simplified application;
- Allows applications to be mailed-in; and
- Eliminated requirement for a face-to-face interview before determining eligibility.

As of July 1, 2000, Ohio also expanded coverage for parents through Medicaid up to 100 percent of the poverty level.

Oklahoma's SoonerCare. Oklahoma, which has also implemented important simplification measures in its Medicaid expansion program, has been consistently successful in its outreach and enrollment efforts. The state has:

- Simplified their application from 16 pages to 1 page;
- Over 40 outstationed eligibility workers that travel the state and conduct on-site enrollment at community based sites; and
- Eliminated the assets tests and accepts self-declaration of income.

Providing Children With Immediate Access to Health Care Services

The Balanced Budget Act of 1997 provided states with new authority to make children "presumptively eligible" for Medicaid in order to provide them with immediate access to health care services. This new authority allows designated providers/individuals to enroll children in the programs on a temporary basis, relying on information supplied by the family, until the final eligibility determination is made by the appropriate State agency. Ten states have taken advantage of this new authority in either Medicaid or S-CHIP. In the states with separate programs, five states have taken advantage of this new authority in both programs, despite evidence that this option allows children to receive health care services promptly, ensures providers are paid for services delivered, and enhances opportunities for families to apply for coverage in community based settings.

Nebraska's Kids Connection. Nebraska allows providers eligible to receive Medicaid payments and agencies authorized to determine eligibility for programs such as Head Start, child care services, or WIC to determine presumptive eligibility for Medicaid. Nebraska has found that presumptive eligibility provides an opportunity for continuity of care and implementation of treatment upon evaluation by the provider.

Providing Consistent Access to Health Care Services

The Balanced Budget Act of 1997 gave states the option to enroll children in S-CHIP and Medicaid for up to 12 months, regardless of changes in income or family circumstances. Thirty-two states –over 60 percent – have taken advantage of this new authority to ensure that children enrolled in S-CHIP do not lose their coverage unnecessarily as a result of temporary changes in income or fluctuation in monthly paychecks. All but four States have taken advantage of this new option in Medicaid as well as S-CHIP. These states provide continuous eligibility for either 6 or 12 months after a child has been determined eligible for S-CHIP, even if there is a change in the family's income, assets, or size.

Maine's CubCare. Families have a simple renewal process in which the family is sent a letter containing their income information and is asked simply to respond to the letter to continue their eligibility for the program.

- Single application for CubCare and Medicaid;
- Mail-in applications; and
- Eliminated the assets test.

Redetermination processes also affect continuity of care, since unnecessary disenrollment disrupts access to care, and hinders state efforts to increase enrollment. States reported that disenrollment rates from separate child health programs were, on average, lower than Medicaid expansion disenrollment rates; and attributed this to the more stringent requirements in Medicaid that require families to report changes in age or income. It is important to note that income and other eligibility reporting requirements are state options and not mandatory.

This information can yield important insights for States regarding processes that may need to be simplified or barriers to enrollment or retention that merit further examination.

Ensuring that Families Moving From Welfare to Work Retain their Health Insurance

Welfare reform created a unique challenge to ensuring that eligible families enroll in Medicaid and now S-CHIP. Prior to reform, Medicaid eligibility was linked to welfare. The President insisted in signing the welfare reform law that all families who would have been eligible for Medicaid prior to the law remain eligible. However, HCFA received a number of reports indicating that states had not made the necessary adjustments to state and/or local policies, systems and procedures in order to ensure that individuals in families transitioning to work were enrolled Medicaid and S-CHIP when eligible. To address this issue, last August, HCFA initiated comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes. These reviews included interviews with state officials and case file checks to assess compliance with current law and to develop recommendations for improvements. After completion of the reviews in all 50 states, we are aware of serious problems in a number of states.

In some situations, state policies have been out of compliance with Federal regulations. For example, in some states, families and children are disenrolled from Medicaid without the state reviewing whether the parent or child continues to be eligible under another eligibility category. More frequently, State practices and procedures, often due to delays in reprogramming computer systems to account for the delinking of cash assistance and Medicaid, have led to problems. For example, in some states, when cash assistance ended, Medicaid was automatically terminated even though in almost all cases the children and the parent would have been eligible for continued coverage.

While states have made great strides in reducing the barriers to enrollment for children, many of these same barriers continue to operate to keep low-income families from receiving the Medicaid coverage they need as they move from welfare to the workplace. These barriers undermine State welfare reform goals and limit our ability reach our enrollment targets for children. For example, most states still retain a face to face interview requirement for low-income families needing Medicaid, and do not allow families to apply or to retain eligibility through a mail-in systems.

However, despite these problems, a number of states have taken strong action to ensure that families are not unnecessarily or erroneously terminated from health insurance coverage. They include:

Delaware. The state of Delaware has developed a computerized eligibility system that automatically evaluates an individual's eligibility across programs, ensuring that families retain their eligibility for Medicaid and food assistance as they move in and out of the welfare systems. The system evaluates the eligibility of everyone in the family, because even if a parent is determined to be ineligible, the children in the family could still retain their eligibility.

Washington. Upon identifying that the state's computerized eligibility and enrollment system was automatically disenrolling individuals leaving welfare who were still eligible for Medicaid, the state has attempted to reinstate close to 100,000 individuals to coverage. In addition, the state streamlined its Medicaid eligibility reviews by relying on available information in Food Stamp files to recertify Medicaid eligibility. This eliminates unnecessary requests for information from low-income working families and reduces burdens for State and local Medicaid agencies

IMPLEMENTING INNOVATIVE OUTREACH STRATEGIES

The success of S-CHIP programs nationwide is dependant on aggressive, broad-based outreach efforts to identify and enroll eligible children. Low-income working families who have never been eligible for traditional public assistance programs – but who are now eligible for S-CHIP and Medicaid – may not realize that they can receive benefits. In some states, the application process can be long, arduous, and beyond the ability of many families to complete. Cultural barriers, like difficulties in language comprehension, also pose a barrier for some families. States have taken strong action to reach out to families to educate them about this new program and encourage them to apply.

School-based Outreach Strategies

Because schools are accepted by parents as a conduit for important information, school systems are an ideal place to identify and enroll uninsured children in Medicaid or CHIP. In addition, health insurance promotes access to needed health care, which experts confirm contributes to academic success. Children without health insurance suffer more from asthma, ear infections, vision problems - treatable conditions that dramatically interfere with classroom participation. And children without health insurance are absent more frequently than their peers. States with particularly innovative and aggressive school-based outreach strategies include:

New Jersey's KidCare. At the beginning of the school year, Governor Whitman sent a letter to school principals about KidCare and provided each school with 500 brochures on S-CHIP and Medicaid to distribute to parents. Schools, together with local parent-teacher organizations, are also using report card days and direct mailings as opportunities to share information about S-CHIP. Parents completing the application for the Free and Reduced Cost Lunch program can request to receive information about NJ KidCare. School nurses and child study team members have been trained to assist families in completing applications. As a result, New Jersey has signed over 19,000 children to Kid Care, the state's S-CHIP and Medicaid program through strong school-based strategies.

Illinois KidCare. Applications for the free and reduced price lunch program in Illinois have a check-off box on the application form for parents interested in receiving further information about KidCare. The Chicago Public Schools distributed information on KidCare as part of their Report Card Pick-up Days in November 1998 and April 1999 at over 600 public schools. KidCare staff have presentations statewide to school administrators, principals, nurses, social workers, and teachers interested in learning more about KidCare to get eligible students enrolled.

Community-Based Efforts

Many states collaborate with community based organizations to ensure that outreach and enrollment strategies are precisely targeted to the needs of local communities. States with particularly innovative and aggressive community-based outreach strategies include:

Indiana's Hoosier Healthwise. In an attempt to reduce the stigma associated with local welfare offices, a key barrier to Medicaid enrollment, the State successfully identified 500 independent enrollment centers throughout Indiana. These enrollment centers include community action centers, child care centers, health centers and hospitals, schools, and various service providers. They have processed over 20,000 applications through the enrollment centers.

Targeted Populations

Outreach efforts geared towards the mainstream population may not be effective for many children eligible for Medicaid and S-CHIP. Vulnerable populations often face socioeconomic or linguistic issues, low literacy levels, geographic isolation, or other barriers that make it difficult for them to enroll in health insurance. States with particularly innovative and aggressive community-based outreach strategies include:

Arizona's KidsCare has launched a concerted effort to reach children in Hispanic families. Activities include:

- Developing Spanish-language applications;
- Creating mass media messages that appealed to the Hispanic population;
- Airing announcements about the program on Spanish language radio and television stations;
- Producing special editions of the Arizona Farmworkers Coalition on KidsCare; and
- Placing the KidsCare logo on the side of traditionally Hispanic businesses, such as "Paletas," ice cream pushcarts used during the summer.

Georgia's PeachCare. Georgia has implemented a concerted effort to reach children in rural areas. The state has:

- Sponsored public service announcements by well-known community members, participated in local parades, and made presentations at local churches;
- Working with local businesses to provide table mats in restaurants, print flyers on grocery bags, and insert "stuffers" in local phone bills; and
- Distributing information on PeachCare to fast food restaurants and small businesses to pass on to their employees.

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 times 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 Americans¹¹ 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
IOVA	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 so²¹) 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 levels²² – 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 states²⁴, 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 Medicaid³¹ 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, Rangel, 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 give 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

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- 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 Health 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.
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President Clinton, Ms. [Debbie] Bredbenner and distinguished guests.

First let me welcome each of you to the White House – especially today's special guests – all of whom are praying that the adults keep their remarks short and snappy.

I'm going to do my part – I promise.

* * *

President Clinton generously sent me to the first week of the Olympics.

As you know, in the opening ceremonies, the members of each delegation dress the same – and the clothes they choose tell us something about their country.

Well, today, we have our own delegation of champions, . . .

. . . and the shirts they're wearing send a message that everyone – especially Congress – needs to hear: Insure Kids Now.

This is the same message that President Clinton, Vice President Gore and our entire Administration have been saying loud and clear since our first day on the job.

That's why we created the State Children's Health Insurance Program – which is now up and running in every state and territory.

Under President Clinton's leadership, we continue to make this program better – approving over 50 amendments to state plans, . . .

. . . while also helping communities streamline their applications, breakdown barriers to enrollment, and increase the number of eligible children.

We are absolutely committed to finding and helping uninsured children – not only through the State Children's Health Insurance Program, . . .

. . . but by expanding Medicaid outreach – so that no child who is eligible for Medicaid falls through the cracks.

But as much as we love children, the President's agenda has always been about increasing access to health insurance for every American who needs it.

And we've done just that.

Eight years ago – before President Clinton signed the Kennedy-Kassebaum law – if you lost your job or got sick, you could lose your health insurance too, . . .

. . . but not any more.

Eight years ago, if you aged out of foster care, your Medicaid coverage ended – but not any more.

Eight years ago, if you were disabled and wanted to go back to work, you had to give up your Medicaid or Medicare – but not any more.

So we've come a long way in expanding access to health care.

But we're not home yet. And, unfortunately, we cannot do what Dorothy did – just click our heels together.

Instead, we have to put our heads together and make sure that working families get coverage they need.

I'm talking about parents like Debbie Bredbenner.

Ms. Bredbenner's two children are covered under Maryland's S-CHIP.

So she understands the blessing – and security – of having her children protected.

But she also understands the fear of not having insurance for herself.

It is both a heartwarming and harrowing story, and I'm pleased to introduce the person who is here to tell it, . . .

. . . Debbie Bredbenner.

CHILDREN'S INSURANCE COVERAGE

	UNINSURED		PRIVATE		GOVERNMENT	
	1998	1999	1998	1999	1998	1999
OVERALL	15.0%	13.6%	68.0%	69.2%	22.7%	22.8%
Below 125%	25.6%	22.4%	26.0%	28.4%	55.1%	56.2%
125% to 149%	24.4%	23.5%	51.0%	50.0%	35.4%	34.9%
150% to 174%	23.3%	21.1%	59.4%	59.4%	23.3%	28.1%
175% to 199%	19.4%	17.8%	68.6%	65.9%	20.2%	23.3%
200% and above	8.4%	8.1%	83.2%	83.4%	8.3%	8.5%

NOTE: Percents do not sum to total because some people report multiple insurance categories

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- **Invest \$300,000 in 20 rural communities to reach children in rural areas.** These funds will be used to provide door-to-door outreach for families in farming communities; outstation eligibility workers to guide families through the eligibility process; and provide application assistance to families in their native languages.

In addition, in coordination with the Clinton-Gore Administration, the Robert Wood Johnson Foundation's Covering Kids Campaign has worked to heighten awareness of the national toll-free number for children's health insurance outreach, **1877 KIDS NOW**. As of August 31, 2000, the hotline has received 378,850 calls – 58,000 in August alone.

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DESPITE HISTORIC GAINS, THE CHALLENGE OF THE UNINSURED REMAINS. Millions of Americans lack health insurance. Although there are many causes of this problem, it generally results from lack of affordability or access to coverage. Family health insurance premiums cost on average \$6,350 annually— 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 transition between jobs, and small businesses and their employees. Lacking health insurance has serious consequences. The uninsured are three times as likely to not 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.

STRONG OUTREACH AND ENROLLMENT EFFORTS CONTINUE. Today, President Clinton will announce that the Department of Health and Human Services will invest \$700,000 in grants to states and rural communities to enhance S-CHIP outreach and enrollment efforts. These grants:

- **Invest \$400,000 in five states implementing innovative strategies to enroll kids and help them stay enrolled in S-CHIP and Medicaid.** Today, the Department of Health and Human Services will provide \$400,000 to five states developing new strategies to identify and enroll uninsured children, as well as to ensure that enrolled children stay in the program. With these funds, Florida will be piloting a new electronic application process targeted at minority children served by day care centers. Massachusetts will attempt to increase S-CHIP and Medicaid retention rates by simplifying their renewal process, allowing primary care providers to renew a child's coverage whenever the family comes in for care. Ohio and Pennsylvania will eliminate burdensome income verification requirements for families applying for coverage. Finally, Washington will increase their efforts to link children receiving school lunch subsidies with health care coverage.

- **Invest \$300,000 in 20 rural communities to reach children in rural areas.** These funds will be used to provide door-to-door outreach for families in farming communities; outstation eligibility workers to guide families through the eligibility process; and provide application assistance to families in their native languages.

In addition, in coordination with the Clinton-Gore Administration, the Robert Wood Johnson Foundation's Covering Kids Campaign has worked to heighten awareness of the national toll-free number for children's health insurance outreach, **1877 KIDS NOW**. As of August 31, 2000, the hotline has received 378,850 calls – 58,000 in August alone.

PRESIDENT CLINTON URGES THE CONGRESS TO ACT NOW TO PASS HIS HEALTH INSURANCE INITIATIVE. Today, President Clinton will urge the Congress to ensure that the number of insured Americans continues to increase by passing his comprehensive health insurance initiative without further delay. The Clinton-Gore initiative includes proposals to:

- **Provide 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. This proposal invests \$76 billion over 10 years to provide health insurance to the uninsured families through FamilyCare. This plan: provides higher Federal matching payments for expanding coverage to parents; increases S-CHIP allotments and makes them permanent to ensure adequate funding for parents and their children; enrolls parents in the same program as their children; covers lower income parents first; and requires all states to cover at least all poor parents by 2006, providing the same coverage their children have today. Studies indicate that expanding coverage to parents will increase the number of children enrolled by up to 25 percent.
- **Expand health insurance options for Americans facing unique barriers to coverage.** Some vulnerable groups of Americans lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. This proposal: restores state options to provide Medicaid and S-CHIP coverage to pregnant women, and children; expands state options to insure children aged 19 and 20 through Medicaid and S-CHIP; establishes a Medicare buy-in option for vulnerable persons age 55-65 and makes it more affordable through a tax credit equal to 25 percent of their Medicare premiums; provides a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs; improves access to affordable insurance by providing tax incentives and technical assistance to establish voluntary purchasing coalitions for workers in small businesses; and extends the transitional Medicaid program for people leaving welfare for work.

THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO INCREASING HEALTH INSURANCE OPTIONS FOR THE UNINSURED. The Clinton-Gore Administration's accomplishments include: S-CHIP, the single largest investment in children's health care since 1965; providing new options for individuals with disabilities to keep their health insurance when returning to work; a state option providing health insurance for young people leaving foster care; approval of 17 state-wide Medicaid waivers providing an estimated 1.4 million low income Americans with health insurance coverage; launching the national Insure Kids Now Campaign; issuing new guidance to ensure that Medicaid applications are properly processed; and issuing new guidance to assure families that the receipt of Medicaid, S-CHIP, or other benefits will not affect immigration status.



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Friday, September 29, 2000 |  [Print this story](#)

More Americans Have Insurance, Census Reports

By ROBERT A. ROSENBLATT, ALISSA J. RUBIN, Times Staff Writers

WASHINGTON--In another demonstration of the robust economy, the Census Bureau reported Thursday that the percentage of Americans without health insurance declined last year, the first drop since the government began keeping the statistic 13 years ago.

Most people with health insurance get it through employment, either directly as employees or indirectly as spouses and children. The ongoing business boom is creating more jobs, and employers are finding that they need to offer benefits such as health insurance to attract workers in a tight labor market, analysts indicated.

The census reported that 15.5% of Americans were uninsured in 1999, down from 16.3% the previous year. Each year since 1987, the share of the population without coverage had risen or remained the same.

The count of the uninsured was 42.7 million, down 1.7 million from 1998.

Although the percentage of uninsured Californians also dropped, the state still had one of the highest rates in the country--20.3%, down from 22.1% in 1998.

The only states with a greater percentage of uninsured were New Mexico, 25.8%; Texas, 23.3%; Louisiana, 22.5%; Arizona, 21.2%; and Nevada, 20.7%.

Search the archives of the Los Angeles Times for similar stories about: [Census Bureau \(U.s.\)](#), [United States - Economy](#), [Americans](#), [Health Insurance](#), [Census \(2000\)](#), [Statistics](#). You will not be charged to look for stories, only to retrieve one.



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September 29, 2000

Number of Uninsured Americans Drops As Benefits Jump in Tight Labor Market

By YOCHI J. DREAZEN

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON -- The number of uninsured Americans declined last year for the first time since 1987, as the ultratight labor market forced growing numbers of employers to offer health-care benefits as a way of recruiting and retaining workers.

The **Census** Bureau said the number of people lacking some form of health insurance fell 1.7 million to 42.6 million last year, from a record 44.3 million in 1998.

A drop in the number of uninsured children, which fell to 10 million

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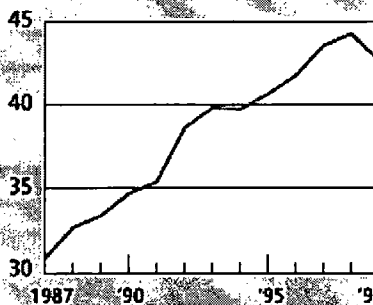
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last year from 11.1 million in 1998, accounted for most of the overall decrease. The number of uninsured blacks and Hispanics also fell.

HEALTHY IMPROVEMENT

Americans without health insurance, in millions



Source: Census Bureau

Census officials said the overall decline, the first since the bureau began tracking the data in 1987, was fueled by a sharp increase in the number of Americans receiving health-care benefits from employers.

Though the decline represents a significant improvement from the previous year, several analysts said they were concerned that the drop would obscure the fact that tens of millions of Americans continue to lack basic health-care coverage despite more than nine years of

unprecedented economic prosperity.

Shaping Up as Big Issue

"The good news in this report was the decline, but the bad news was that it didn't fall by 44 million," said Paul Fronstin, a senior research associate at the nonpartisan Employee Benefit Research Institute.

"Even if the number goes down again next year, you're still talking about 40 million people without health insurance."

Health care is shaping up to be a dominant election issue, but the political impact of the decline is far from clear-cut. The administration said its health-care and economic policies produced the decline.

Vice President Al Gore, the Democratic presidential nominee, will likely use the new data to bolster his case for expanding the Children's Health Insurance Program, proposed by President Clinton early in 1997, and passed by Congress later that year with bipartisan support. Analysts say the CHIP program, which provides coverage to low-income children, was responsible for some of the decline.

But the improvement could also make it harder for Mr. Gore to make the case that there is an urgent need to extend government health-insurance coverage to the uninsured, an issue he has pressed far more than his Republican rival, Texas Gov. George W. Bush.

Bush Prefers Flexibility

A spokesman for Gov. Bush said the Republican candidate supports the CHIP program, though he would try to modify it to give states more flexibility. And the spokesman ridiculed the White House's attempt to claim credit for the decline in the number of uninsured.

The Census data come on the heels of other recent reports suggesting that the nation's tight labor market, which hovers near a 30-year low, is leading more employers to offer health-care benefits to their

workers despite soaring premiums.

Earlier this month, for example, the nonprofit Kaiser Family Foundation reported that the percentage of small companies offering health-care benefits increased from 54% in 1998 to 67% in 1999, while the percentage of larger firms offering insurance remained at 99%.

The gains came despite an 8.3% increase in employer health-insurance premiums, the sharpest advance since 1993. The report also found that companies were bearing the burden themselves rather than passing the added costs on to their workers.

With health-care premiums showing few signs of moderating as prescription-drug costs continue to explode, however, some analysts warn that last year's gains may be hard to duplicate.

"Several years of big premium increases would make employers think twice about whether to offer health-care benefits, regardless of how good the economy is," said Larry Levitt, vice president of Kaiser Family Foundation, Menlo Park, Calif.

-- Shailagh Murray contributed to this article.

Write to Yochi J. Dreazen at yochi.dreazen@wsj.com



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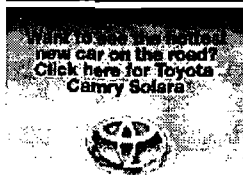
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Percentage of Uninsured Dropped in 1999

By David Brown
Washington Post Staff Writer
Friday, September 29, 2000; Page A05

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The fraction of the population without health insurance decreased last year for the first time in a dozen years, the U.S. Census Bureau reported yesterday.

The slight dip was largely the result of a rise in the number of people offered health insurance on the job, which experts attributed to the robust economy. A new government program targeted at children also contributed to the decline.

A fall in the percentage of uninsured people was recorded among whites, blacks, Hispanics, and in low-income households in general. Nevertheless, the working poor had only a 50-50 chance of having health insurance.

Overall, 15.5 percent of Americans were without health insurance for all of 1999, compared with 16.3 percent in 1998. In 1987, the first year the Census Bureau collected health insurance data, about 12.9 percent of the population had no coverage. The bureau estimated there were 42.6 million people without health insurance last year, about 1.7 million fewer than during the year before.

"I would never call one year a trend," said Charles Nelson, an official in the Census Bureau's income, poverty and health division. "But the fact that it's never happened since we've been measuring it, including in some pretty strong economic years, makes me consider it a pretty significant finding."

While welcoming the news, several experts warned against viewing the decline as a watershed or assuming it will last.

"We still have a pretty significant problem we have to address," said David Helms, president of the Academy for Health Services Research and Health Policy in Washington. "With this much wealth in our society, to still have 43 million people without basic health insurance coverage is not a reason to celebrate."

Diane Rowland, director of a commission funded by the Kaiser Family Foundation on the uninsured, said "nothing magical has happened to turn around the problem. . . . The great concern is what will happen if the economy turns sour, or we have a real recession, in which historically health insurance coverage has eroded."

The report was based on a survey of 50,000 households conducted last

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The uninsured rate varied markedly among states because of differences in race and ethnic mix, age of the population, strength of the local economy, and government policy.

Texas, Arizona and New Mexico each had the largest number of uninsured residents, about 23 percent. Minnesota, Rhode Island and Hawaii had the smallest proportion, about 9 percent. About 16 percent of the District's residents were uninsured last year. And in Maryland and Virginia the number was 14 percent.

About 11 percent of non-Hispanic whites lacked health insurance last year, a decline of 1 percent from 1998. About 33 percent of Hispanics lacked insurance, a drop of 2 percent. The rate among blacks, and Asian and Pacific Islanders was 21 percent, not significantly different from the previous year.

One of the largest differences was between native-born people, 14 percent of whom lacked insurance, and foreign-born people, among whom the rate was 33 percent.

About 63 percent of Americans were covered by employment-based health insurance last year, an increase of about 1 percent. About 84 percent of full-time workers had insurance, compared with 78 percent of part-time workers and 74 percent of non-workers.

Among people below the poverty level, however, working actually reduced a person's chance of having health insurance. About 60 percent of the non-working poor were insured, compared with 53 percent of those who had jobs.

The fraction of children under 18 who had no insurance fell from 15 percent to 14 percent. The biggest gain in coverage occurred among children in families just above the poverty level, who were aided by more employer-based insurance, and the Children's Health Insurance Program (CHIP). The latter is a state and federal program that was enacted in 1997, but was not put into widespread use until 1999.

"The message is that public programs do work, and that we need to renew efforts to enroll all eligible children," said Karen Davis, president of the Commonwealth Fund, a foundation that supports research on health and social issues. She said that about 80 percent of the roughly 10 million still uninsured children could be covered by either CHIP or Medicaid if all eligible families signed up.

However, she said she was particularly troubled by the large number of Hispanics and low-wage workers who were uninsured. The former are a rapidly growing part of the American population. The booming economy is dependent on the latter "and yet it's that part of the labor force that's not benefiting by having access to good health care."

While it's clear that some employers are paying for health insurance to entice workers, the decline in the numbers of uninsured "are a smaller drop than anybody would hope for under these best of times," said Deborah Chollet, an economist with the health policy research company Mathematica.

"It is being driven by unusual circumstances that may not continue. It's hard to imagine how we could get more coverage, how we would get a tighter labor market than we have. But the [recent] increase in health insurance prices suggests that it won't even maintain its current level," she said.

The U.S. Chamber of Commerce, a business trade organization, said the increase in employer-provided insurance is threatened by proposed legislation that would allow patients to sue their health insurance plans. Some employers might choose to stop offering health insurance if such a law were enacted, it said.

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September 28, 2000

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Big Decline in Uninsured Americans

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By THE ASSOCIATED PRESS

Filed at 7:41 p.m. ET

WASHINGTON (AP) -- The number of Americans without health insurance declined last year for the first time since the Census Bureau began collecting data in 1987. Health care advocates and analysts cited the robust economy as the main reason.

About 42.5 million people, or 15.5 percent of the population, lacked insurance in 1999, compared with 44.2 million, or 16.3 percent, in 1998, according to data released Thursday.

The number of uninsured children fell by 1.5 percentage points to 13.9 million, according to the Census Bureau's annual report on health insurance coverage in America.

Analysts attributed the overall drop, in large part, to two factors: more employers offering health coverage as a way to lure or keep workers in a tight labor market and healthy economy, and the Child Health Insurance Program, enacted by Congress in 1997 to assist low-income families.

The report showed that 62.8 percent of Americans had coverage through an employment-related health insurance plan, compared with 62 percent in 1998. The percentage of those covered under Medicare remain constant at 13.2. There was a 0.1 percentage point decline in Medicaid coverage, to 10.2 percent in 1999.

"Although I am pleased with today's development, there is much work to be done," President Clinton said in a statement. "We need to encourage states that are not doing as well to accelerate their activities in reaching out to uninsured children. And we need to provide targeted programs to build on their success."

The report is "a good news-bad news situation," said Diane Rowland, executive director for the Kaiser Commission on

Medicaid and the Uninsured. ``There's a decline in the kinds of increases we've seen. The worst news is we still have 42 million uninsured."

Added Census Bureau analyst Robert Mills: ``The driving force behind this improvement was an increase in the likelihood of people having employment-based health insurance."

Both health care reform advocates and industry supporters used the report to promote their positions on an issue that has drawn attention on Capitol Hill and the presidential campaign.

Chip Kahn, president of the Health Insurance Association of America said that the data proved that ``a private, employer-based system works."

He cited figures showing that since 1993, the number of people covered under employment-based policies increased from 148 million to 172 million.

``It's a function of more jobs being created and a tight labor market which is encouraging more employers to offer more coverage," said Kahn, placing the onus on Congress ``to reduce that number by tens of millions."

The report was not entirely encouraging, said Ron Pollack, executive director of the Washington-based consumer group, Families USA.

For instance, he said, 32.4 percent of people living below the poverty line remained uninsured, along with 47.5 percent of low-income, full-time workers.

``Many people lost health coverage when they moved from welfare into entry-level jobs that have no health benefits," Pollack said. ``The most sobering part ... is that these very high numbers come at a time when the economy is doing very well."

Among the states, 25.6 percent of the residents in New Mexico were uninsured in 1999, the highest in the country. Texas ranked next-to-last, with 23.3 percent; in 1998, it was 50th at 24.5 percent.

Rhode Island had the smallest percentage of uninsured in 1999, 6.9 percent, followed by Minnesota at 8 percent.

Texas Gov. George W. Bush, the Republican presidential nominee, has proposed a number of health insurance initiatives, including a tax credit of up to \$2,000 per family to help low-income working Americans buy health insurance.

Democratic candidate Al Gore has proposed expanding the federal-state health plan for children to enroll more children and allow parents to join.

Among the report's other findings:

--More Hispanics (33.4 percent) were likely to be uninsured than

any other of the major racial or ethnic group. Still, the percentage fell from 35.3 in 1998.

--Adults age 18 to 24 remained the least likely to be uninsured (29 percent), but the figure was 30 percent in 1998.

--The percentage of uninsured foreign-born residents declined from 34.1 percent to 33.4 percent. The percentage for U.S.-born residents fell nine-tenths of a percentage point, to 13.5 percent.

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On the Net:

Census report:

<http://www.census.gov/Press-Release/www/2000/cb00-160.html>

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September 29, 2000

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Number of Insured Americans Is Up for First Time Since '87

By ROBERT PEAR

WASHINGTON, Sept. 28 — After rising relentlessly for 11 years, the number of Americans without health insurance declined last year, to 42.6 million, a reduction of 1.7 million from 1998, the Census Bureau reported today.

Issue in Depth
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The proportion of people without insurance also declined for the first time since 1987 — to 15.5 percent in 1999, from 16.3 percent in 1998.

The robust economy and an expansion of government programs contributed to the decline, economists and health policy experts said.

With the unemployment rate at 4.1 percent, a 30-year low, many employers have found that they must offer health insurance to attract and retain workers. In addition, low-income people are receiving coverage from government programs created or expanded in recent years.

Robert J. Mills, a statistician at the Census Bureau, said, "The driving force behind this improvement was an increase in the likelihood of people having employment-based health insurance."

The number of people with health insurance through their employers rose last year by 3.4 million, to 172 million. This change accounted for 85 percent of the increase in the number of people with health insurance.

Recent studies have found rapid increases in the cost of employer-paid health coverage, which could make it difficult to sustain the growth in the number of people covered by the plans.

For children, as for the population as a whole, coverage increased last year. The number of uninsured children declined to 10 million last year, from 11.1 million in 1998. The proportion of children without coverage declined as well, to 13.9 percent from 15.4

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The plight of the uninsured has emerged again as a political issue, in Congress and in many of this year's election campaigns, including the presidential race.

President Clinton welcomed the new data, saying: "I am extremely pleased with today's announcement. I believe it validates our health care and economic policies."

The number of uninsured is still nearly three million higher than when Mr. Clinton took office in 1993.

Since Congress rejected his proposal for universal health insurance in 1994, Mr. Clinton has been advocating smaller steps to expand coverage. The White House, Congress and governors of both parties have been working to increase coverage for children, in particular, and today's data offered some evidence that the efforts were beginning to pay off.

The Census Bureau said that government programs, including Medicaid and the new Children's Health Insurance Program, had helped increase coverage among poor children and youngsters with family incomes just above the poverty level (\$13,290 for a family of three).

But overall, the bureau said, in the last year, there was no change in the proportion of the population (24 percent) covered by government health insurance programs.

The number of people without insurance rose by an average of more than a million a year from 1987 to 1998. The trend puzzled and frustrated health care experts because it persisted in a strong economy with low unemployment.

For several years, the number of Americans with employer-sponsored health insurance has been creeping up. But the changes received little notice because they coincided with the erosion of other types of coverage. For example, millions of low-income people, including former welfare recipients, were losing Medicaid. That erosion stopped last year. The number of people covered by Medicaid held steady around 28 million, the Census Bureau said.

Genevieve M. Kenney, an economist at the Urban Institute here, said, "The percentage of poor children without coverage has dropped back to where it was in 1996," the year Congress passed a landmark law limiting access to welfare.

Paul Fronstin, an economist at the Employee Benefit Research Institute, a nonpartisan study center, said he was not surprised by the data.

"Small firms are more likely to offer health benefits today than two years ago," Mr. Fronstin said. "They need to do so to recruit and retain workers. At the same time, the strong economy puts them in a position where they can offer health benefits even though health

costs are increasing."

In recent months, many employers have seen their health insurance premiums rise by 10 percent to 30 percent, mainly because of increased spending on prescription drugs.

Ronald F. Pollack, executive director of Families USA, a consumer group, said: "The new Census Bureau numbers are welcome news, but no cause for celebration. It's like a morning drizzle after a prolonged drought."

In its report, the Census Bureau made these points:

¶ More than one-fifth of all poor children, and nearly one-third of all poor people, are still uninsured. Nearly half of poor people who worked full time last year were uninsured.

¶ Households making less than \$50,000 accounted for almost all of the increase in insurance coverage. Among those with incomes of \$50,000 or more, there was no change in the proportion having coverage.

¶ Hispanics people were more likely to be uninsured than any other major racial or ethnic group. About 33 percent of Hispanic people, 21.2 percent of blacks, 20.8 percent of Asian-Americans and 11 percent of non-Hispanic whites were uninsured last year.

The Census Bureau found a notable increase in insurance coverage among poor children 12 to 17 years old. The proportion of such children without insurance declined to 25.7 percent last year, from 30.4 percent in 1998.

Senator Edward M. Kennedy, Democrat of Massachusetts, an early proponent of the Children's Health Insurance Program, said he was pleased to see that it had contributed to the increase in coverage, adding that Congress should take the next step and let parents enroll with their children.

To compare states, the Census Bureau suggested using three-year averages of data from 1997 to 1999. By this measure, the proportion of people without health insurance ranged from a high of 24.1 percent in Texas to a low of 8.8 percent in Minnesota.

Arizona, New Mexico, California and Louisiana also had high proportions of people without insurance. The comparable figures were low for Rhode Island, Hawaii and Iowa.

The proportion of people without health insurance was slightly above the national average in New York, where 17.1 percent were uninsured. The figures were below the national average in Connecticut (11.5 percent) and New Jersey (15.4 percent).

Among people 18 to 64 years old, the Census Bureau said, workers were more likely than nonworkers to have health insurance. But, it said, the reverse was true among poor people. About 53 percent of poor workers were insured in 1999, compared with 59 percent of poor people who were not working. People who have low-wage jobs

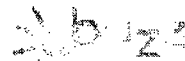
often cannot obtain or afford insurance from their employers.

People from 18 to 24 years old were less likely than any other age groups to have health insurance coverage in 1999, the bureau said. Twenty-nine percent of these young adults were uninsured.

One-third of the foreign-born population lacked health insurance, the Census Bureau found. But, it said, the probability that immigrants will be insured increases with the length of their residence in the United States.

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