Cost and Coverage Estimates for Kids-only Insurance Program

The table below shows a range of preliminary cost and participation estimates for a health insurance subsidy program for children. The table displays cost and participation ranges for the years 1997 and 2002 for two subsidy levels. At both levels, eligibility is restricted to families with 0% employer contribution to health insurance. The ranges are explained by variations in assumptions regarding participation levels and employer dropping (see bullets below for explanation of assumption differences). *These estimates are not intended to be precise indicators of the effects of a kids-only subsidy, rather they are intended only to provide an idea of the potential effects of such a program.*

Cost Estimates for Subsidizing Children-Only Health Insurance
0% employer contribution to health insurance required for eligibility

Low Level of Subsidies:
25% subsidy for families below 250% of poverty; 10% subsidy above 250% of poverty

Year	Average Cost (Premium)	Total Takeup (millions)	% of participants now uninsured	Annual Total Cost (billions)	Annual Federal Cost (billions)
1997	$1,900-$2,700	1.7-7.0	3.0%-14.0%	$4-$13	$1-$2
2002	$2,800-$3,900	1.8-7.5	3.0%-14.0%	$7-$21	$2-$3

High Level of Subsidies:
50% subsidy for families below 250% of poverty; 25% subsidy above 250% of poverty

Year	Average Cost (Premium)	Total Takeup (millions)	% of participants now uninsured	Annual Total Cost (billions)	Annual Federal Cost (billions)
1997	$1,800-$2,200	3.8-9.4	8.0%-11.0%	$8-$17	$3-$6
2002	$2,600-$3,200	4.0-9.9	8.0%-11.0%	$13-$26	$5-$10

The numbers shown here should be considered rough estimates of the effects of a kids-only health insurance subsidy. Official estimation of cost and participation could vary from the ranges shown here.

Key Assumptions

- As the table indicates, we evaluated two potential subsidy programs:
  - "Low Subsidy": 25% subsidy to 250% of poverty, 10% thereafter; and
  - "High Subsidy": 50% subsidy to 250% of poverty, 25% thereafter.

- To arrive at the ranges of estimates shown above, we developed low and high participation scenarios for each of the two subsidy programs. The high participation scenario differs from the low participation case in two major ways: 1) the high participation scenario assumes higher take-up rates across-the-board; and 2) the high participation scenario assumes a substantially larger incidence of substitution -- individuals or employers changing their behavior to take advantage of the subsidy.

- The premium estimates in all cases were adjusted to reflect adverse selection associated with bringing previously uninsured individuals into the insured pools.

- The costs and participation rates are influenced to a large degree by the policy choice of whether the subsidies can be applied to a participant's current coverage or whether participants must join a separate insurance program and other factors. If participants can purchase current coverage we expect participation to be higher than if participants must join a special risk pool.

- These estimates assume that program participation is fully phased in by 1997.

Major Findings

- In the **low subsidy** program, total takeup ranges from 2-7 million children in 1997 (2-7.5 million in 2002), with an average cost of $1900-$2700 per child ($2800-$3900 in 2002). These average costs reflect the impact of adverse selection and are heavily influenced by participation assumptions. Federal costs would be $1billion - $2 billion in 1997 ($2 billion -$ 3billion in 2002).

- In the **high subsidy** program, total takeup ranges from 4-9 million children in 1997 (4-10 million in 2002), with an average cost of $1800-$2200 per child ($2600-$3200 in 2002). These average costs reflect the impact of adverse selection and are heavily influenced by participation assumptions. Federal costs would be $3billion - $6billion in 1997 ($5 billion -$ 10billion in 2002).

- Both the high and the low subsidy programs draw in only a small proportion of the uninsured population. The variations in the proportion of the currently uninsured participants in the program are largely influenced by the assumption regarding the ability to use subsidies for current coverage (and therefore, the number of persons with ESI joining the program).

    - In the **low subsidy** program, approximately 200,000 previously uninsured kids become insured in 1997. This represents about 1.6% of all uninsured kids and 3-14% of program participants.

    - In the **high subsidy** program, approximately 400,000-700,000 previously uninsured kids become insured in 1997. This represents about 3.6-6.3% of all uninsured kids and 8-11% of program participants

- The implementation of a kids-only subsidy could result in some people losing coverage if employers react to the incentive of the program by reducing or eliminating their contribution to ESI.

- As noted elsewhere, whether participants would be able to use the subsidy to pay for their current insurance -- where the risk pool includes individuals not in the subsidy program -- or be required to join a special risk pool that is dominated by individuals in the subsidy program is a key aspect of this policy. We recommend clarification of certain policy parameters prior to further estimation of the effects of this proposal.

Changing Parameters

Using background information, we have roughly estimated the impact on cost and participation of changing the income threshold for subsidies to 200% of poverty (with no subsidy above 200% of poverty -- we will probably need to design a phase-out of the subsidy over an income range if this option is pursued) and the effects of limiting eligibility to children 13 years of age and under.

The following estimates are very rough. They do not account for the increase in the average cost per child which would result from limiting the risk pool in a way that increases the percentage of the currently uninsured in the program, and therefore increases the effect of adverse selection. It is not clear what impact this would have on these estimates: costs may rise as premiums go up, but reductions in participation may offset this increase.

Lowering the income threshold to 200% of poverty results in:

- Participation of between 1.3 million and 2.3 million children in the **low subsidy case,** with a loss of approximately 18% of the previously uninsured category and a 22-67% reduction in overall participation in 1997. Federal costs would be about $1 billion in this case, and the percentage of participants who were previously uninsured would rise to 8-14% of those participating.

- Participation of between and 1.8 million to 3.7 million children in the **high subsidy scenario,** with a loss of approximately 23% of the previously uninsured category and a 53-60% reduction in overall participation in 1997. Federal costs would range from about $2 billion to $3 billion, and the percentage of participants who were previously uninsured would rise to 15-17% of those participating.

Lowering the age limit from the insurance definition of child to age 13 would result in:

- Participation of between 700 thousand and 4.2 million children in the **low subsidy case,** with a loss of approximately 45% of the previously uninsured category and a 40-55% reduction in overall participation. Federal costs would range from about $500 million to $1 billion, and the percentage of previously uninsured in the program would not change much.

- Participation of 2 million to 5.8 million children in the **high subsidy scenario**, with a loss of approximately 51-53% of the previously uninsured category and a 38-46% reduction in overall participation. Federal costs would range from about $2 billion to $4 billion in the high subsidy case, and the percentage of previously uninsured in the program would go down slightly.

Cost and Coverage Estimates for Kids-only Insurance Program

The table below shows a range of preliminary cost and participation estimates for a health insurance subsidy program for children. The table displays cost and participation ranges for the years 1997 and 2002 for two subsidy levels. At both levels, eligibility is restricted to families with 0% employer contribution to health insurance. The ranges are explained by variations in assumptions regarding participation levels and employer dropping (see bullets below for explanation of assumption differences). *These estimates are not intended to be precise indicators of the effects of a kids-only subsidy, rather they are intended only to provide an idea of the potential effects of such a program.*

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The numbers shown here should be considered rough estimates of the effects of a kids-only health insurance subsidy. Official estimation of cost and participation could vary from the ranges shown here.

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  - "Low Subsidy": 25% subsidy to 250% of poverty, 10% thereafter; and
  - "High Subsidy": 50% subsidy to 250% of poverty, 25% thereafter.

- To arrive at the ranges of estimates shown above, we developed low and high participation scenarios for each of the two subsidy programs. The high participation scenario differs from the low participation case in two major ways: 1) the high

participation scenario assumes higher take-up rates across-the-board; and 2) the high participation scenario assumes a substantially larger incidence of substitution -- individuals or employers changing their behavior to take advantage of the subsidy.

- The premium estimates in all cases were adjusted to reflect adverse selection associated with bringing previously uninsured individuals into the insured pools.

- The costs and participation rates are influenced to a large degree by the policy choice of whether the subsidies can be applied to a participant's current coverage, or whether participants must join a separate insurance program. While the lower end of the ranges incorporates the assumption that participants would be required to join a special risk pool (which limits substitution), the upper end of the ranges given above incorporate the assumption that subsidies can be applied to current coverage. In this later case, the average premium reflects an average across more than one risk pool. Premiums in the "special" risk pool would likely be substantially higher than the high end of the range. The other risk pools would include individuals not in the subsidy program.

- These estimates assume that the subsidies are fully phased in by 1997.

Major Findings

Without adverse selection = $1248 premium

- In the **low subsidy** program, total takeup ranges from 2-7 million children in 1997 (2-7.5 million in 2002), with an average cost of $1900-$2700 per child ($2800-$3900 in 2002). These average costs reflect the impact of adverse selection and are heavily influenced by participation assumptions. Federal costs would be $1billion - $2 billion in 1997 ($2 billion -$ 3billion in 2002).

More people participating & they are healthier

- In the **high subsidy** program, total takeup ranges from 4-9 million children in 1997 (4-10 million in 2002), with an average cost of $1800-$2200 per child ($2600-$3200 in 2002). These average costs reflect the impact of adverse selection and are heavily influenced by participation assumptions. Federal costs would be $3billion - $6billion in 1997 ($5 billion -$ 10billion in 2002).

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    - In the **low subsidy** program, approximately 200,000 previously uninsured kids become insured in 1997. This represents about 1.6% of all uninsured kids and 3-14% of program participants.

    - In the **high subsidy** program, approximately 400,000-700,000 previously uninsured kids become insured in 1997. This represents about 3.6-6.3% of all uninsured kids and 8-11% of program participants

- The implementation of a kids-only subsidy could result in some people losing coverage if employers react to the incentive of the program by reducing or eliminating their contribution to ESI.

- As noted elsewhere, whether participants would be able to use the subsidy to pay for their current insurance -- where the risk pool includes individuals not in the subsidy program -- or be required to join a special risk pool that is dominated by individuals in the subsidy program is a key aspect of this policy. We recommend clarification of certain policy parameters prior to further estimation of the effects of this proposal.

Changing Parameters

Using background information provided by ARC, we have roughly estimated the impact on cost and participation of changing the income threshold for subsidies to 200% of poverty (with no subsidy above 200% of poverty -- we will probably need to design a phase-out of the subsidy over an income range if this option is pursued) and the effects of limiting eligibility to children 13 years of age and under.

The following estimates are very rough. They do not account for the increase in the average cost per child which would result from limiting the risk pool in a way that increases the percentage of the currently uninsured in the program, and therefore increases the effect of adverse selection. It is not clear what impact this would have on these estimates: costs may rise as premiums go up, but reductions in participation may offset this increase.

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- Participation of between and 1.8 million to 3.7 million children in the **high subsidy scenario,** with a loss of approximately 23% of the previously uninsured category and a 53-60% reduction in overall participation in 1997. Federal costs would range from about $2 billion to $3 billion, and the percentage of participants who were previously uninsured would rise to 15-17% of those participating.

Lowering the age limit from the insurance definition of child to age 13 would result in:

- Participation of between 700 thousand and 4.2 million children in the **low subsidy case**, with a loss of approximately 45% of the previously uninsured category and a 40-55% reduction in overall participation. Federal costs would range from about $500 million to $1 billion, and the percentage of previously uninsured in the program would not change much.

- Participation of 2 million to 5.8 million children in the **high subsidy scenario**, with a loss of approximately 51-53% of the previously uninsured category and a 38-46% reduction in overall participation. Federal costs would range from about $2 billion to $4 billion in the high subsidy case, and the percentage of previously uninsured in the program would go down slightly.

Andie King Proposals -- Summary Cost Estimates

Medium Participation Assumption (Case B), Low Subsidy (Scenario 2) and High Subsidy (Scenario 3)

					Participants - Coverage Prior to Program					
		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
0% Emp Contribution	Low subsidy	$1800	2.3 m	24%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
	High subsidy	$1600	4.4 m	19%	0.6 m	0.2 m	2.5 m	0.00	0.5 m	0.5 m
50% Emp Contribution	Low subsidy	$1800	2.3 m	23%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
	High subsidy	$1600	4.4 m	18%	0.6 m	0.2 m	2.5 m	0.00	0.5 m	0.5 m

		Financing					
		Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
0% Emp Contribution	Low Subsidy	$4.3 B	$1.0 B	22%	$440	$1.4 B	49%
	High Subsidy	$6.9 B	$2.9 B	46%	$660	$1.4 B	25%
50% Emp Contribution	Low Subsidy	$4.2 B	$1.0 B	22%	$440	$1.3 B	47%
	High Subsidy	$6.8 B	$2.8 B	46%	$660	$1.3 B	24%

Scenario 2: 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above
(Scenarios 2 and 3 taken together are based upon Andie King's parameters)

0% Employer Contribution Requirement

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 20% participation for those <250% poverty, 10%participation for >=250% poverty
Case B had 10% participation for those <250% poverty, 5%participation for >=250% poverty
Case C had 5% participation for those <250% poverty, 2.5%participation for >=250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 2	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1700	3.4 m	33%	0.8 m	0.3 m	1.2 m	0.00	1.1 m	0.00
B	$1800	2.3 m	24%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
C	$1900	1.8 m	17%	0.2 m	0.09 m	1.2 m	0.00	0.3 m	0.00

	Financing					
Scenario 2	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$5.9 B	$1.4 B	22%	$410	$1.6 B	38%
B	$4.3 B	$1.0 B	22%	$440	$1.4 B	49%
C	$3.4 B	$0.8 B	22%	$450	$1.2 B	54%

Scenario 3: 50% Subsidy up to 250% Poverty, 25% Subsidy for 250% Poverty and Above

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 30% participation for those <250% poverty, 15%participation for >=250% poverty
Case B had 15% participation for those <250% poverty, 7.5%participation for >=250% poverty
Case C had 7.5% participation for those <250% poverty, 3.75%participation for >=250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 3	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1500	5.8 m	29%	1.3 m	0.4 m	2.5 m	0	1.1 m	0.5 m
B	$1600	4.4 m	19%	0.6 m	0.2 m	2.5 m	0	0.5 m	0.5 m
C	$1600	3.7 m	11%	0.3 m	0.1 m	2.5 m	0	0.3 m	0.5 m

	Financing					
Scenario 3	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$8.6 B	$3.7 B	46%	$640	$1.3 B	19%
B	$6.9 B	$2.9 B	46%	$660	$1.4 B	25%
C	$6.0 B	$2.5 B	46%	$670	$1.3 B	29%

Scenario 2: 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above

(Scenarios 2 and 3 taken together are based upon Andie King's parameters)

50% Employer Contribution Requirement

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 20% participation for those <250% poverty, 10%participation for >=250% poverty
Case B had 10% participation for those <250% poverty, 5%participation for >=250% poverty
Case C had 5% participation for those <250% poverty, 2.5%participation for >=250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
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B	$1800	2.3 m	23%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
C	$1900	1.8 m	16%	0.2 m	0.06 m	1.2 m	0.00	0.3 m	0.00

	Financing					
Scenario 2	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$5.7 B	$1.4 B	22%	$400	$1.5 B	36%
B	$4.2 B	$1.0 B	22%	$440	$1.3 B	47%
C	$3.3 B	$0.8 B	22%	$450	$1.1 B	51%

Scenario 3: 50% Subsidy up to 250% Poverty, 25% Subsidy for 250% Poverty and Above

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

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- Case B had 15% participation for those <250% poverty, 7.5%participation for >=250% poverty
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B	$1600	4.4 m	18%	0.6 m	0.2 m	2.5 m	0	0.5 m	0.5 m
C	$1600	3.7 m	11%	0.3 m	0.08 m	2.5 m	0	0.3 m	0.5 m

	Financing					
Scenario 3	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$8.4 B	$3.6 B	46%	$640	$1.3 B	18%
B	$6.8 B	$2.8 B	46%	$660	$1.3 B	24%
C	$5.9 B	$2.4 B	46%	$670	$1.2 B	27%

MEMORANDUM

TO: Chris Jennings

FROM: Irwin Redlener, MD

DATE: July 19, 1996

RE: Proposed New **Child Health Access/Medical Homes Initiative**

^^^

Although efforts to create a stable national health care safety net for all children need to continue, it is not likely that an economically and politically viable mechanism to do so will arise any time soon. Proposals which have been discussed in the past, including those generated by political leaders (Senators Dodd and Kerry among others) or organizations (e.g., the AAP), should continue to be evaluated and fine-tuned. In the meantime, there are reasons why a bold Presidential initiative in this area might be important and particularly timely. Justifications for such an effort include:

1) There are already known to be at least 10 million children who have no health insurance coverage whatsoever, public or private. In addition, as we have discussed in the past, The Children's Health Fund will issue a report early this fall **suggesting that 22.1 million of approximately 72 million 0 - 18 year olds do not have a stable medical home and will be labeled as "access fragile" and "medically homeless".**

2) The President has been and should continue to be underscoring his administration's commitment to the health and well being of American families and children. A major initiative that could potentially be developed with existing funds would be most appropriate.

3) In the rapidly changing health environment, including the continued growth of managed care presence and a redefining of the role of existing institutions like academic medical centers, there is an excellent opportunity to introduce a new concept.

I am proposing the creation and announcement of a major new program entitled something on the order of "**Medical Homes for America's Children: Helping Families and Communities Identify the Resources They Need**". The idea here is <u>not</u> to establish new government health service delivery programs but to give aid to states, communities and local institutions in order to expand the availability and accessibility of medical homes.

In essence, this means a new grants program which I would suggest be administered through states and localities, providing money for existing institutions to expand medical home access for children in their catchment areas, particularly in medically underserved communities. The program, in effect, acknowledges that there are serious resource and access distribution problems in many parts of the country. Funds provided under this program would go to existing health care institutions with a mandate to create satellite services in underserved areas to provide comprehensive medical homes for children who are not getting appropriate care.

Chris, let me know how I might be helpful in exploring further details as needed with respect to this concept.

FAMILIES FIRST AGENDA

HEALTH CARE SECURITY

This Congressional Democratic agenda assumes that the Kennedy-Kassebaum Health Insurance Reform bill will be enacted sometime in 1996. However, if it is not enacted in 1996, it will be the first item of the Democratic agenda in 1997.

The Kennedy-Kassebaum bill contains a number of important provisions for working families, including:

- Guaranteeing the portability of health insurance coverage for workers who change or lose their jobs;
- Prohibiting health insurance companies from denying coverage for pre-existing medical conditions; and
- Prohibiting health insurance companies from denying coverage to employers with two or more employees.

Once the Kennedy-Kassebaum bill has become law, Congressional Democrats also endorse a step in expanding the health care coverage available to the children of working parents, as described below.

MAKING THE HEALTH COVERAGE OF CHILDREN MORE AVAILABLE AND AFFORDABLE FOR WORKING FAMILIES

In millions of American working families, both spouses work and yet neither spouse works at a job that offers health insurance benefits.

Hence, millions of American children have working parents and yet have no health insurance coverage whatsoever.

Many working parents are kept awake at night worrying about the lack of health coverage for their children – and how they will be able to ensure good care for their child if the child has an accident or becomes seriously ill.

Children are much less expensive to insure than whole families – and yet few insurers allow families to purchase "children-only" policies. It is estimated that a health insurance policy for a child under 13 would cost about $1,000.

This initiative will help working parents obtain health insurance for their children, by making "kids-only" policies available, accessible, and affordable.

This initiative represents a first step in ultimately ensuring that all American children have access to affordable health care.

This initiative has three components:

1. TO MAKE "KIDS-ONLY" INSURANCE AVAILABLE

- Mandate that all insurance companies and managed care plans that do business with the Federal Government (through FEHBP, Medicare, Medicaid, etc.) offer " children-only" policies – for children up to the age of 13.

- Require these policies to cover no less than the benefits offered in their government packages.

2. TO MAKE "KIDS-ONLY" INSURANCE ACCESSIBLE

- Mandate various consumer protections in these "kids-only" policies (similar to the protections contained in the Kennedy-Kassebaum bill), including guaranteed issue, guaranteed renewability, no discrimination based on health status, etc.

3. TO HELP MAKE "KIDS-ONLY" INSURANCE MORE AFFORDABLE

- Provide assistance to working families to cover a portion of the cost of the premium.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Jack Ebeler

To: Mark Miller - 395-3910
Glenn Rosell - 622-2633
Chris Jennings - 456-5542
Jen Klein - 456-2878

Phone: (202) 690- _____
(202) 690-6870
FAX: (202) 401-7321

Phone: _____

Fax: _____

Number of Pages (Including Cover): 2

Comments: Draft follow-up from Andy K. meeting for review. We can get preliminary estimates based on this.

Kids coverage - specifics beyond original proposal

1. Benefit package - as noted in draft (whatever policy the carrier offers in the federal program) -note - she will consider narrowing benefit package if needed based on costs.

2. Insurance reform: K/K rules; allow 12 month pre-ex exclusion; for newborns, no pre-ex if enrolled w/in 30 days.

3. Substitution: Clear intent is to target program on those w/out employer based or public program coverage; presume state Medicaid maintenance of effort to preclude state coverage cutbacks; employer criteria still unclear - for purpose of initial estimate, we can set parameter for definition of employer offer (i.e., "x" percent" employer contribution required for offer)

4. Subsidies: form, schedule still pretty open -

   a. In general, would provide subsidy for 50-80 percent of premium
   b. Form of the subsidy could be deduction, and/or credit

   The obvious problem is that we need specifics to do estimates, but need estimates to do specifics. As an intitial step:

   c. We should assume some gross subsidy levels (without getting into form in which the subsidy is provided through the tax code). The following assumes a low and high end subsidy for two income groups.

Portion of premium subject to subsidy

	Income < "x" percent poverty	*Income > "x" percent poverty*
Low percent subsidy	25 %	10 %
Higher percent subsidy	50 %	25 %

Note: there is no merit to these percentages - simply wanted to establish framework for initial analysis.

The initial questions would be to estimate the premiums for such a plan, and the take up rates, and selection issues. Based on that, would then begin to get into more detail w/ Treasury and OMB on form of tax subisdy by income level.

This Democratic initiative, contained in the Families First Agenda, will help working parents obtain health insurance for their children, by making "kids-only" policies available, accessible, and affordable.

This initiative represents a first step in ultimately ensuring that all American children have access to affordable health care.

This initiative has three components:

1. TO MAKE "KIDS-ONLY" INSURANCE AVAILABLE

- Mandate that all insurance companies and managed care plans that do business with the Federal Government (through FEHBP, Medicare, Medicaid, etc.) offer "children-only" policies -- for children up to the age of 13.

  Require these policies to cover no less than the benefits offered in their government packages.

2. TO MAKE "KIDS-ONLY" INSURANCE ACCESSIBLE

  Mandate various consumer protections in these "kids-only" policies (similar to the protections contained in the Kennedy-Kassebaum bill), including guaranteed issue, guaranteed renewability, no discrimination based on health status, etc.

3. TO HELP MAKE "KIDS-ONLY" INSURANCE MORE AFFORDABLE

- Provide assistance to working families to cover a portion of the cost of the premium, including tax relief and premium subsidies.

TO: Chris Jennings
FROM: Andie King
RE: costs for kids health coverage proposal

As you will recall, you kindly offered to get some Administration folks to look at the possible costs of a "health insurance for kids" package. Following are the specs for such a proposal. Further,

-- I would like to look at costs for a tax break on 50, 60, 75, 80, and 100% of the premium cost.

-- If possible, for each of the premium percentages, I would like two runs, assuming: (1) the subsidy is set at the 17% rate for everyone and (2) the subsidy varies normally by income bracket

-- I would also like the deduction and credit costs broken out and displayed separately.

-- Of course, I need the take-up assumption, displayed in as much specificity as possible (i.e., numbers of families at different income levels)

-- Re the substitution issue: the tax break would be available only for those who are not eligible or do not have available to them another option for covering their kids (i.e., Medicaid or employer-provided coverage).

Ballpark would be fine. Let me know if anything else is needed from me. Thanks for your help.

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NEWS FROM THE HOUSE DEMOCRATIC LEADER

For Immediate Release:
Thursday, July 11, 1996

Democratic Leader Richard A. Gephardt
H-204, U.S. Capitol

OPENING STATEMENT BY HOUSE DEMOCRATIC LEADER RICHARD A. GEPHARDT
HEARING ON KIDS-ONLY HEALTH CARE PROPOSAL
FROM FAMILIES FIRST AGENDA

As all of you know, just a few weeks ago House and Senate Democrats unveiled our Families First agenda, to describe the ways in which a new Democratic majority would rededicate itself to working and middle-class families -- to help them in ways that really make a difference in their everyday lives.

It's about common-sense, kitchen-table change -- such as helping people pay for education, and making pensions more secure. And I believe it is the kind of non-controversial, non-partisan progress that has been conspicuously absent from the Gingrich-Dole Congress -- proposals that speak not to party ideology, but to the cares and concerns we share as Americans.

One of the most crucial of those concerns is health care. Just because health care became a problem for politicians a couple of years ago doesn't mean it stopped being a problem for average families. And one of the biggest problems is that too many children from hard-working families don't have health care at all. Without health care, even a minor childhood illness can become a major catastrophe.

As far as I'm concerned, putting families first means putting kids first -- fighting to keep them healthy and strong, without emptying their parents' wallets. So one of the central parts of the Families First Agenda is our plan to make it easier and more affordable to get health coverage for your kids.

First, we'll ask insurance companies and managed care plans to create special "kids-only" health plans, with good benefits to protect your children.

Then we'll establish the kinds of common-sense rules Democrats have been trying to establish for all Americans: that your children can't be denied or dropped from health coverage if they get sick, or if your family moves. In today's economy, so many families are changing jobs, or losing jobs -- and sometimes moving from town to town. I think it makes sense for a child's health care to go with them if they move. Parents shouldn't be locked into a job because they're afraid their child won't get health coverage at a new job, or in a new town.

And insurance companies shouldn't be allowed to drop sick children, or deny them coverage at the very moment they need care. To me, that's a very personal, moral issue. My own son Matt had cancer as a very young child -- and while we managed to beat it, Matt still needs a

lot of expensive medical care.

So if insurance companies want to do business with the government, we're going to ask them to stick to these common-sense rules. I believe most of them will, because most children are very healthy, and very inexpensive to insure. This is going to be a big, new market for health insurers.

Finally, we'll make it easier for parents to pay for their children's health plans.

The bottom-line is that Democrats believe that you shouldn't need a big checkbook to give your children check-ups. So the Families First Agenda is about fighting for kids -- but it's also about the fighting for parents. Today's parents work hard to raise their children, and give them the very best. We think their children's health, and their ability to pay for it, should be the last thing they have to worry about.

# # #

CONTACT: Dan Sallick (202) 225-0100

KIDS-ONLY HEALTH INSURANCE HEARING

Thursday, July 11, 1996

I	Opening of the Hearing by Democratic Leaders Gephardt and Daschle
II	Senator Christopher Dodd (D-CT)
III	Elaine Gaither, Clarksville, MD
IV	Dr. David Tayloe, Jr., M.D., F.A.A.P., Goldsboro, NC
V	Marcia Buckminster, Director of School Health, Framingham Public School System, MA
VI	Maureen Lampe, Brookville, MD
VII	Stan Dorn, Children's Defense Fund, Washington, DC
VIII	Dr. Peter Holbrook, Children's Hospital, Washington, DC

American Academy of Pediatrics

TESTIMONY

on

HEALTH CARE SECURITY FOR OUR CHILDREN

Presented by:

David Tayloe, Jr., M.D., F.A.A.P.

July 11, 1996

Department of Government Liaison
The Homer Building
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / FAX: 202-393-6137

Good morning. I am David Tayloe, Jr., M.D., a pediatrician in private practice located in Goldsboro, North Carolina. I am here today on behalf of the American Academy of Pediatrics, representing over 50,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Thank you for inviting me to address the important issue of health care security for our nation's children.

Providing Children Health Care Coverage is Achievable:

Working to improve health coverage of children seems like an achievable task. Therefore, I wonder why we seem to be forever fighting the same battles. The Academy has long advocated for a "children first" approach, focusing on guaranteed access to health care for children and pregnant women as an important and practical first step towards an improved health care system. Back in 1989, the Academy began the development of what was to become its "Children First" legislative proposal. This proposal guaranteed health care coverage and access to comprehensive health care benefits for all children through age 21 and all pregnant women through a one-tier, private insurance system. The proposal was introduced in the 103rd Congress as legislation by Representative Robert Matsui (D-CA) and Senator Chris Dodd (D-CT). However, at that time, the Congressional debate focused on universal health care coverage, rather than our more targeted approach.

Since then, with the defeat of universal health care reform, providing health insurance coverage for children and pregnant women has taken on a new urgency and become the next logical step. Keeping children well and preventing illness makes sense. Having a sick child is one of the toughest things parents have to deal with. Unfortunately, their anxiety is compounded by a health care system gone awry. The time has come for the United States to become a nation that makes the health and well-being of its children its highest priority. We must make health care for America's children available, accessible, and affordable. <u>This is an achievable goal</u>.

The importance of addressing child health issues must not be viewed simply as an act of compassion. Providing children and adolescents access to quality health care, with an emphasis on prevention, is the single most important economic decision that will be made in any health care debate. As children go, so goes our country.

Children face many obstacles in the health care system, but one of the hardest to overcome is how most people view child health issues. Too often it is assumed that if we take care of adults, then children will be provided for. The fact is, children are not "little adults" and have unique health care needs. Unfortunately, even health plans that do cover dependents often fail to meet the health care needs of children. Most child health services are provided as outpatient services and are often not covered by health insurance. Private health insurance plans most often have an array of benefits designed to cover an adult pattern of utilization (inpatient care and high-cost procedures), but not those of a child.

Our children deserve better. As the public and private sectors continue to discuss the future structure of our health care system, we must focus on the health care needs of our children.

The American Academy of Pediatrics calls for:

-Guaranteed Health Care Coverage for all pregnant women and infants, children, and adolescents through age 21;

-A comprehensive benefit package appropriate for children which contains preventive care, including immunizations, and acute and chronic care services (e.g., the AAP's Scope of Health Care Benefits for Infants, Children and Adolescents Through Age 21 Years). If a standard benefit package is established that is deficient, that then is probably all that most children will get. While adults may purchase supplemental benefits, chances are that children will be left with whatever benefits they get from the standard benefit package;

-A timely schedule for the delivery of those benefits and services. The use of an age-appropriate schedule of visits such as the Academy's own "Recommendations for Preventive Pediatric Health Care" or Health and Human Service's "Bright Futures" Report should be followed. The earlier we get children in for visits, the better chance those children have for a healthy and productive future.

-A medical home for every child. The medical home concept goes to the very heart of the issue of quality. A medical home is a regular and ongoing comprehensive source of health care, available around the clock, 365 days a year. It provides preventive care, early treatment of acute diseases and the coordination of care for those with chronic or disabling conditions. The Academy believes that for children and adolescents, this medical home is best provided by pediatricians.

Preventive Care is Affordable:

Providing preventive health care coverage to all children is not only achievable, it is affordable. The Academy retained the Actuarial Research Corporation to prepare a report estimating the premium cost of insurance coverage for all services recommended in the Academy's 1995 "Recommendations for Preventive Pediatric Health Care." The analysis confirmed that children's preventive health care is inexpensive. The 1996 average monthly premium for first dollar coverage of the AAP recommended preventive services for children ages 0-21 is $8.01 per family. The family premium for first dollar coverage of just immunizations is $2.37 per month.

These estimates are based on 1995 physician fees and 1992 insurance fees for immunizations and screening tests updated to 1996. The age distribution for children and adolescents is obtained from the March 1994 Current Population Survey (CPS) of persons with employer or union sponsored health insurance. Participation rates are derived after reviewing data from a number of sources, but reflect the level that would be adopted by a prudent actuary facing uncertainty and are set accordingly at a conservative level. The estimates include an allowance for the additional administrative expenses that an insurance program would find necessary to add the preventive benefits.

Children's Health Care Coverage is Necessary:

Children's health care coverage is desperately needed. There are approximately 12.2 million children under the age of 21 who do not have health insurance coverage. Others are underinsured. They are without adequate insurance coverage for necessary treatment services and for even the most basic care needed to prevent unnecessary disease and death. Still others are "uninsurable" because of pre-existing chronic or recurring conditions. Such pre-existing condition exclusion clauses in insurance represent a serious and unnecessary barrier to care for children.

What happens to uninsured children? Usually, their financially strapped families tend to delay or forgo needed pediatric medical care because of the out-of-pocket expense. Studies have shown that children without insurance coverage are less likely to receive basic preventive care and immunizations, are less likely to seek care from a physician for both acute and chronic illness, and are more likely to delay care. Without preventive care, these children are much more susceptible to communicable and other illness and, once sick, have no insurance to pay for their care.

Unfortunately, these same children are unlikely to maintain a continuous regular source of primary care. Studies have shown that children without a regular source of care are less likely to be completely immunized, have lower rates of visits for well-child care, higher rates of visits for illness care, and have more frequent emergency room visits. Having a regular source of care has been shown to reduce per child expenditures by 21.7% compared with not having a regular source of care.

Problem #1 - Loss of Employer Coverage:

Why are so many children uninsured? The majority of American children are covered by private health insurance, most often through their parent's employment. However, our employer-based private insurance system is not working well for children. According to the United States General Accounting Office, the percentage of children with private coverage has decreased every year since 1987. Studies indicate that from 1991 to 1993 over 3 million children lost their private insurance coverage. The yearly rate at which children lost their coverage increased from 600,000 during the period 1991 to 1992 to 2.5 million during the period 1992 to 1993. In 1993 nearly 5% of privately insured children lost coverage.

As private insurance premiums increase, more and more employers, particularly small firms, are dropping dependent coverage or increasing the amount of the premium contributed by the employee. As a result nearly one fourth of uninsured children have parents with employer-paid health coverage. In addition, the economy has witnessed a shift away from high-paying manufacturing jobs with good health benefits to lower-paying service jobs with poorer benefits. Many employers provide no coverage at all.

Problem #2 - A Threatened Safety Net:

As more and more children lose their private insurance, many of them become eligible for Medicaid. Children not eligible for Medicaid often cannot obtain private insurance coverage unless a parent has a job with good health benefits.

From 1988 to 1992, the number of uninsured children remained relatively constant because expansions in the Medicaid program enacted in the latter half of the 1980s, provided insurance coverage to many of the children who lost private coverage. Currently, over one fourth of U.S. children and adolescents who have health insurance are covered by Medicaid. In addition, Medicaid pays for over one third of all births in the United States.

As you know, Congress is considering turning the Medicaid program into block grants to the States. Such block grants will limit Federal dollars and eliminate the individual entitlement to the Medicaid program. While the issue is still being debated, the fact is that the Medicaid program is going to have fewer Federal dollars to work with in the future. It is important to understand that children under age 21 make up 57% of the Medicaid program population, but account for just 23% of program expenditures. This means that even small budget cuts will translate into large numbers of children losing coverage. Using fiscal year 1993 costs, each billion dollar reduction in Federal Medicaid appropriations eliminates the Federal Medicaid share for over 1.5 million children.

In addition, the possibility of state block grants replacing Medicaid's individual entitlement status indicates that Medicaid may no longer be able to absorb the increasing number of children losing private insurance. This will result in a greater number of uninsured children. Also, reducing the level of services provided by Medicaid could increase the numbers of *under*insured children and increase out-of-pocket expenses of financially strapped families.

What happens to Medicaid will have a direct impact on the number of uninsured children in this country.

Providing Children Health Care Coverage Is The Right Thing To Do:

Providing appropriate health care coverage for all children and pregnant women makes sense for America. It is the right thing to do.

Every child and pregnant woman should have access to appropriate health care. Such care includes child health supervision visits. Child health supervision visits are an integral part of family-focused preventive care, beginning before birth with prenatal visits and continuing into young adulthood. They are designed to monitor a child's growth and development, and identify any physical, behavioral, or psychological abnormality at its earliest stage. Such visits provide guidance to both parents and children on such topics as injury prevention and healthy lifestyles. Promoting healthy lifestyles is critical for our nation's children, particularly adolescents. Issues such as smoking, drug abuse, and violence need to be addressed.

Well-child care can provide early detection and correction of vision defects; hearing defects that can lead to life-long impairment of speech and learning comprehension; iron deficiency anemia; abdominal masses representing potentially curable tumors; congenital hip dislocation, a potential crippler; and elevated levels of lead in the blood that can lead to learning disability, hyperactivity and diminished intelligence.

The costs of unattended malnutrition, anemia, child abuse, substance abuse, preventable injuries and developmental delays rarely show up as health care expenditures, rather they fall heavily on society's ledger in the form of social services, education or correctional systems.

Conclusion:

The American Academy of Pediatrics applauds your determined efforts to provide health care coverage to our nation's children. Providing health care security for our children is achievable, affordable, necessary and makes good sense. If we truly care about our nation's future we must act now to ensure that our children grow up healthy and strong.

As a pediatrician, my intention today is to bring attention to the health care needs of our nation's children. Pursuing an approach that will provide appropriate health care coverage for children is really about giving children a chance to reach their potential in life. If we can keep children well, they can have a fair shot at making the best of their lives, and that benefits all of us.

Thank you.

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