MEMORANDUM

June 17, 1997

TO: Distribution

FR: Chris Jennings

RE: Senate Finance Committee Markup and Children's Health Initiative

Attached is a copy of the letter the President sent up to Senator Roth indicating his support for amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch to the Senate Finance Committee markup on children's health. The President also referenced his support for this amendment at the conclusion of his remarks at the Title IX event this morning.

Also attached is a one-page background on this amendment and the concerns we have about the underlying provisions Chairman Roth has in his mark, as well as a set of Q & A's on possible issues that may be raised by the media on this issue. Lastly, you will find a copy of the letter Frank Raines sent to Chairman Roth this morning that outlines our concerns with all of the provisions in the mark that are either inconsistent with either the Budget Agreement or our policy priorities.

I hope you find this information useful. If you have any questions, please don't hesitate to call me.

THE WHITE HOUSE

WASHINGTON

June 17, 1997

Dear Mr. Chairman:

I urge the Senate Finance Committee to adopt the bipartisan children's health amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch. As you know, I am extremely committed to using the $16 billion for children's health to provide meaningful coverage for as many uninsured children as possible. The bipartisan amendment offers an opportunity to do just that.

It is critical that we continue to work together in this Congress to find ways to provide health care coverage for millions of uninsured children. As you know, over ten million children lack health care coverage -- and the impact on their families is profound. A recent study showed that nearly 40 percent of uninsured children go without the annual check-ups that all children need. One in four uninsured children do not have a regular doctor. And throughout the country, too many parents are living in fear that they may be forced to make the impossible choice between buying medicine for a sick child or food for an entire family.

Because of the importance of this problem, we need to work together to design the most effective way to invest the $16 billion. The bipartisan amendment takes a major step toward this goal. This plan rationalizes Medicaid so that children in the same family are eligible for the same coverage. Children under 6 years old and under 133% of poverty -- about $21,000 for a family of four -- are already eligible for Medicaid. The bipartisan plan provides incentives for states to cover older children up to this same income level. The plan also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. Resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program. In addition, this bipartisan plan offers meaningful coverage that protects vulnerable children from excessive costs.

The bipartisan initiative -- which balances protections for vulnerable children with flexibility to target middle-class children -- stands in sharp contrast to the Commerce Committee's proposal. The plan to simply put out a block grant, with few rules and no benefits requirements, will not result in meaningful coverage for many uninsured children. While your proposal improves

on the Commerce Committee's plan, the claim that it provides a choice between Medicaid and a grant approach is exaggerated. Given the incentives in the proposal, no rational state would choose Medicaid.

The bipartisan amendment merits strong and favorable support from the full Finance Committee. We should take advantage of this opportunity to significantly reduce the number of uninsured children. I look forward to working with you and others on the Finance Committee and in the Congress to achieve this end.

Sincerely,

Bill Clinton

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

PRESIDENT ANNOUNCES SUPPORT FOR BIPARTISAN CHILDREN'S PLAN

Today, the President announced his support for the Senate bipartisan amendment to provide meaningful health coverage to uninsured children. Senators Chafee, Rockefeller, Jeffords and Hatch have designed a consensus proposal on how to invest the $16 billion in the Balanced Budget Agreement. This proposal is consistent with the President's commitment to extending meaningful health coverage through the most cost-effective approach. This important legislation would result in the largest investment in children's health coverage since the enactment of Medicaid in 1965.

The bipartisan amendment protects vulnerable children while offering states flexibility. It:

- **Gives states incentives to rationalize Medicaid.** Today, Medicaid covers children under 6 years old with incomes up to 133% of poverty, or $21,000 for a family of four. The bipartisan plan provides incentives for states to cover all children, regardless of age, up to this income level.

- **Funds innovative state programs to target middle-class uninsured children.** Unlike low-income children, middle-class uninsured children are difficult to target with a single program. A grant program gives states the resources and flexibility to find and cover these children.

- **Offers meaningful coverage that protects vulnerable children from excessive costs.** Children have a wide range of health needs. The bipartisan amendment assures that children covered through the initiative receive meaningful benefits without unaffordable cost sharing.

The Roth proposal, in contrast, does not balance protection for vulnerable children with state flexibility.

- **False choice.** The Roth proposal asserts that states have the choice of expanding coverage to children through a block grant or Medicaid. However, it is a false choice. The rules for the block grant are designed so that no rational state would chose Medicaid, regardless of its merits.

- **Splits families.** The Roth proposal allows states to use the block grant for older, low-income children and Medicaid for younger children. It makes no sense to give a child below 6 years old one type of coverage and a child above 6 years old different coverage.

The President encourages the Senate Finance Committee and the full Congress to support this bipartisan approach. We should take full advantage of this opportunity to provide meaningful health coverage to a significant number of uninsured children.

Questions and Answers

Q: In Robert Pear's *New York Times* story today, the Governors -- who you applaud for their innovative efforts in this area -- are claiming that states will never expand coverage under a proposal with so many strings attached. How do you respond to this letter?

A: As a former Governor, the President well understands that states need flexibility to design programs that best meet the needs of their populations. However, if the taxpayers are going to invest $16 billion in children's health care, there needs to be some accountability for these dollars. We believe that this proposal contains important administrative and financial incentives that will help states expand their programs.

Q: Why don't you support Republican proposals that allow states to use all of the funding for grants?

A: We believe that we should build on the Medicaid program and encourage states to cover all children under 133 percent of poverty so that children in the same family -- whatever age -- are eligible for the same coverage. This approach offers meaningful coverage that protects vulnerable children from excessive costs. The Chafee-Rockefeller-Jeffords-Hatch amendment also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. We believe that resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program.

Q: How can you criticize the Roth grant proposal when your benefit package is less prescriptive than his?

A: Our approach always assumes a strong Medicaid base program. The Roth proposal establishes incentives for states to allocate the entire $16 billion children's health investment to block grants, which would allow for less meaningful health insurance coverage. In so doing, it children 6 years of age and older at income levels less than 133 percent of poverty -- about $21,000 for a family of four -- would not have the same benefit as their younger siblings.

Q: Are you saying that you will veto any proposal that is less prescriptive than the Chafee-Rockefeller Amendment?

A: We will have to evaluate all proposals that come up. There may strengthening provisions that make some sense. But there is no question that relative to all proposals on the table, that the Chafee-Rockefeller-Jeffords-Hatch amendment is far preferable.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

June 17, 1997

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing to express the views of the Administration on the Medicare, Medicaid, and children's health provisions under consideration by the Finance Committee, for inclusion in the FY 1998 budget reconciliation bill. The Administration's views on the other provisions in the Chairman's mark, including Welfare-to-Work, benefits for immigrants and unemployment insurance, will be provided separately.

Overall, the Administration finds much to support in the mark. It incorporates many of the proposals from the FY 1998 President's budget and is generally consistent with the Bipartisan Budget Agreement. It proposes Medicare structural reforms that constrain growth, extend the life of the Hospital Insurance (HI) Trust Fund for at least a decade, and improve preventive care benefits. In addition, the Committee's mark assures that hospitals will receive all of the funding to which they are entitled for graduate medical education and uncompensated care. All of these changes will help strengthen and modernize Medicare for the 21st century. It also allocates the full $16 billion for children's coverage policies without dedicating any of this important investment to an inefficient tax approach.

Medicaid

In a number of areas related to Medicaid, however, the Administration has serious concerns with provisions that do not reflect the budget agreement. If the Committee were to proceed with its legislation in this form, we would be compelled to invoke the provisions of the agreement that call on the Administration and the bipartisan leadership to undertake remedial efforts to ensure that reconciliation legislation is consistent with the agreement.

Investments. After extended negotiations that preceded the budget agreement, the Administration and the Congressional leadership agreed to specified savings and investments in the Medicaid program over five years. Recognizing that premiums represent a significant burden on low-income beneficiaries, the agreement allocated $1.5 billion to ease the impact of increasing Medicare premiums on this population. The Finance Committee mark failed to include this proposal. We strongly urge the Committee to include this proposal.

We are pleased that the Committee mark includes a higher matching payment for the Medicaid program in the District of Columbia and inflation adjustments for the Medicaid programs in Puerto Rico and the territories, but we are concerned that the increases are not sufficient. The matching rate proposed in the mark for the District of Columbia sunsets at the end of FY 2000 and is 10 percentage points lower than the matching rate of 70 percent proposed in the FY 1998 President's budget. It appears that the five-year spending associated with the inflation adjustments for Puerto Rico and the territories proposed in the mark is lower than the level proposed in the President's budget. We strongly urge the Committee to include these provisions at the level proposed in the President's budget.

Restoring Medicaid Benefits for Disabled Children. The budget agreement clearly includes the proposal to restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility. The Finance Committee mark failed to include this proposal. We strongly urge the Committee to include this provision and retain Medicaid benefits for approximately 30,000 children who could lose their health care coverage in FY 1998.

The Committee mark also includes a number of provisions that were not specifically addressed in the budget agreement, and about which the Administration has serious concerns. They include the following:

Disproportionate Share Hospital Savings. We have concerns about the details of the allocation of the disproportionate share hospital (DSH) payment reductions among States included in the mark. The Finance Committee mark may have unintended distributional effects among States. We recommend that the Committee revisit the FY 1998 President's budget proposal, which achieves savings by taking an equal percentage reduction off of states' total DSH spending, up to an "upper limit."

We are very concerned that the Finance Committee mark does not include any retargeting of DSH funds. As the Administration has stated previously, we believe that significant savings from DSH payments should be linked to an appropriate targeting mechanism. It is for this reason that we support proposals to assure that some DSH funds are directed to hospitals that serve a high proportion of low-income and uninsured patients.

Privatization. The Chairman's mark would allow the eligibility and enrollment determination functions of Federal and State health and human services benefits programs -- including Medicaid, WIC, and Food Stamps -- in ten States to be privatized and deems approved such a proposal from the State of Texas. While certain program functions, such as computer systems, can currently be contracted out to private entities, the certification of eligibility for benefits and related operations (such as obtaining and verifying information about income and other eligibility factors) should remain public functions. The Administration believes that changes to current law would not be in the best interest of program beneficiaries and strongly opposes this provision.

Medicaid Cost Sharing. The mark would allow States to require limited cost sharing for optional benefits. We are concerned that this proposal may compromise beneficiary access to quality care. Low-income Medicaid beneficiaries may forgo needed services if they cannot afford the copayments. We urge the Committee to revisit the FY 1998 President's budget proposal, which would allow nominal copayments only for HMO enrollees. This proposal grants States some flexibility and would allow HMOs to treat Medicaid enrollees in a manner similar to non-Medicaid enrollees, without compromising access to care.

Criminal Penalties for Asset Divestiture. The Finance Committee mark would amend Section 217 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to provide sanctions only against those who assist people to dispose of assets in order to qualify for Medicaid. We believe the better solution to the issues that the HIPAA provision created would be to repeal this section altogether.

Children's Health

The Chairman's mark does not include detailed specifics on the children's health provisions. However, we are encouraged by reports that a bipartisan group of Senators are proposing to use this investment to build on Medicaid for low-income children and offer States grants to give children in working families meaningful coverage.

We believe that the $16 billion investment in children's health should be used for health insurance coverage. It is for this reason that the Administration supports proposals that only allow funds to be used for insurance, through Medicaid or a capped grant, and does not allow funds to be used for direct services. Under a direct services option, we are concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and children would not necessarily get meaningful coverage.

We urge the Committee to use the funds in the most cost-effective manner possible to expand coverage to children, as required by the agreement. The Chairman's mark includes both a Medicaid and a grant option; however, the mark should not discourage States from choosing the Medicaid option. We believe that Medicaid is a cost-effective approach to covering low-income children, and would like to work with you on strengthening this option. We also believe that the grant program should be designed to be as efficient as possible. The mark should provide appropriate details to assure that funds are used solely for the purposes intended by the agreement and not used to offset States' share of Medicaid.

It is our understanding that the alternative children's health coverage approach that is being developed by the bipartisan coalition of Senators includes provisions that address many, if not all, of these concerns. We look forward to working with the bipartisan coalition and the Committee on this high priority issue for the President and the Congress.

Medicare

Home Health Reallocation. It is our view that the home health reallocation in the budget agreement is not properly reflected in the Committee's mark. During the negotiations, we discussed at great length the shift of home health expenditures to Part B, and it was always understood to be immediate. The Committee's phase-in of the shift means a loss of two years of solvency on the Part A trust fund, two years which we can ill afford to lose. In addition, a phased-in reallocation would cause significant administrative problems regarding claims processing, appeals, and medical review for Medicare contractors. We urge the Committee to incorporate the same provision that was included in last week's House Commerce Committee bill.

Balance Billing Protections in Medicare Choice. While the Administration supports the introduction of new plan options for Medicare beneficiaries, we believe that any new options must be accompanied by appropriate beneficiary protections. We believe that inclusion of private fee-for-service plans in Medicare Choice without balance billing protections is unnecessary. Beneficiaries should not be exposed to billing in excess of current law protections. Also, we are concerned that this option will attract primarily healthy and wealthy beneficiaries and leave sicker and poorer beneficiaries in the more expensive, traditional Medicare program.

Medical Savings Accounts. While we have agreed to work to develop a demonstration of this concept for the Medicare population, we have concerns about the size and scale of the demonstration in the mark. The Committee's mark provides for a demonstration with 500,000 participants at a cost of approximately $2 billion over five years, which is many times larger than any other Medicare demonstration. We believe the demonstration should be limited geographically for a trial period, which will enable us to design the demonstration to answer key policy questions. We have suggested limiting the demonstration to two states for a three-year period. Further, we strongly believe that the current law limits on balance billing should also be applied to this demonstration to protect beneficiaries from being subjected to unlimited additional charges.

Preventive Benefits. While the preventive benefits are largely the same as those advanced in the President's budget, we bring to your attention the proposal to waive coinsurance for mammograms. As you know, mammography saves lives, yet many Medicare beneficiaries fail to use this benefit. Research has found that copayments hinder women from fully taking advantage of this benefit. Thus, we continue to support waiving copayments for mammograms.

Home Health Copayments. We note that the Committee's mark would impose a Part B home health copayment of $5 per visit, capped at an amount equal to the annual hospital deductible. Medicare beneficiaries who use home health services tend to be in poorer health than other Medicare beneficiaries. Two-thirds are women, and one-third live alone. Forty-three percent have incomes under $10,000 per year. We are concerned that a copayment could limit beneficiary access to the benefit. Imposing a home health copay is not necessary to balance the

budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare.

Medicare Eligibility Age. Raising the eligibility age for Medicare is not necessary to balance the budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare. Moreover, this proposal does not contain provisions to address the fact that early retirees between the ages of 65-67 may not be able to obtain affordable insurance in the private market.

Prudent Purchasing. As you know, the Medicare program is governed by a strict set of provider payment rules that limit the ability of the Federal government to secure the most competitive terms available to other payers in the marketplace. We have advanced a set of proposals to allow Medicare, the nation's largest health insurer, to also take advantage of lower rates providers offer to other payers. At a time when we all agree that Medicare spending has been growing too quickly and the Federal budget faces increasing pressures for scarce resources, we do not understand why the Committee would miss the opportunity to take advantage of all these proposals to allow Medicare to be a more prudent purchaser. We propose adopting practices that work in the private sector. We should let them work in the public sector as well. These practices can work well to save taxpayers money and promote quality. We urge the Committee to include the President's proposals.

HI Tax for State and Local Workers. We note that the Committee's mark includes a proposal to extend the HI tax for State and local government employees. This proposal was not discussed in the negotiations surrounding the development of the budget agreement.

Commission. We note that the Committee's mark includes a Medicare commission. Establishing a bipartisan process that is mutually agreeable is essential to successfully address the challenges facing Medicare. We look forward to working with you on the development of the best possible bipartisan process to address the long-term financing challenges facing Medicare while simultaneously ensuring the sound restructuring of the program to provide high-quality care for our nation's senior citizens.

Cost Allocation Amendment

We understand that amendments may be offered during Committee consideration to prevent costs from increasing in Food Stamps and Medicaid due to cost-shifting for common functions from the TANF block grant, which places a cap on TANF administrative costs. We understand that the CBO baseline includes costs of over $5 billion in FYs 98-02 because CBO assumes administrative cost-shifting from TANF to Food Stamps and Medicaid. This proposal seeks to reduce the extent of the cost-shift to Food Stamps and Medicaid, which could yield substantial savings against CBO's baseline.

While the Administration is generally supportive of this effort -- to prevent States from changing cost allocation plans in order to shift greater administrative costs from the capped TANF block grant to open-ended Food Stamp and Medicaid administrative costs that are matched by the Federal government -- we would need to carefully review the specific mechanism proposed. Furthermore, we would have very serious reservations about proposals that would cap Food Stamps and Medicaid administrative costs and would oppose a cap that would limit the ability of a State to manage its programs.

The budget negotiators discussed changes to the Food Stamp and Medicaid programs at considerable length. Any further savings in this area would require mutual agreement, as would the allocation of those savings either to deficit reduction or to new spending.

The budget agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. It is critical that we do so on a bipartisan basis.

I look forward to working with you to implement this historic agreement.

Sincerely,

Franklin D. Raines
Director

Identical letter sent to the Honorable Daniel Patrick Moynihan

Addendum

Medicare Choice. We would prefer to link the growth in payments for Medicare Choice plans to growth in the fee-for-service sector of Medicare, rather than having two separate growth targets. To do so may lead over time to an erosion of the value of the Medicare Choice benefit package and expose beneficiaries to increased premiums.

Medigap Reforms. The President's bill advanced a number of important Medigap reforms including annual open enrollment (as well as including information about Medigap plans in the annual open enrollment season informational materials), community rating, open enrollment for disabled and ESRD beneficiaries when they become entitled to Medicare, and portability protections similar to those enacted last year in HIPAA for the under-65 population. Many of these important protections were also advanced by bipartisan bills including those sponsored by Senators Chafee and Rockefeller. We urge your reconsideration of the merits of these proposals. They ensure that Medicare beneficiaries are able to purchase affordable Medigap policies to fill in the many areas not covered by Medicare. Medicare beneficiaries should be able to choose which Medigap plans to purchase, or Medicare Choice plans to enroll in, without artificial constraints.

Survey and Certification User Fee Proposal. The Committee mark does not contain a provision allowing HCFA to require state survey agencies to impose fees on health care providers for initial surveys required as a condition of participation in the Medicare program. This provision would authorize states to collect and retain fees from health care providers to cover the cost of initial surveys. Under the budget agreement, the discretionary funding level for HCFA Program Management assumes enactment of this mandatory, government receipt fee proposal. Adequate funding for survey and certification activities is essential to program integrity.

Hospital Capital Property Tax. We are concerned about the inclusion of this provision on the grounds that it results in an inequitable redistribution of inpatient hospital PPS funding among proprietary and not-for-profit hospitals.

Creation of Duplicative Managed Care Bureaucracy. We understand that an amendment may be offered that would establish a new bureaucracy in HHS to administer the managed care reforms in the mark. We would strongly oppose such an amendment. The implications for beneficiary services are serious: one agency is in a much better position to coordinate programs and policies that will permit the 38 million Medicare beneficiaries to make informed choices of the whole new array of plan options under the mark. In addition, at a time when we are trying to reduce the size of the Federal bureaucracy, it seems counter-productive to divide Federal administration of Medicare into two separate, largely duplicative agencies.

May 8, 1997

TO: Jen K. and Carrie G.

FR: Sarah B.

RE: Kids Paper

Here is our most recent kids paper as well as an NEC communications document on the children's policy Budget Agreement, which, as you will note, is much vaguer. Last week they just agreed to a funding level ($16 billion) for children's health policies that would be divided up between Medicaid (including the 12 month eligibility policy) and grant money. The Workers Between Jobs proposal has been dropped, although since the agreement is vague, there is a chance they could add a kids-only version of it back in later.

They may have more detail by next week on the split between the grant money and the Medicaid money and possibly a bit more detail on how these policies will be structured. I will let you know if any more specifics get worked out.

President Clinton Worked to Expand Coverage for Children

TEN MILLION AMERICAN CHILDREN TODAY LACK HEALTH CARE COVERAGE.

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE EXPANDS HEALTH CARE COVERAGE FOR MILLIONS OF CHILDREN.

- *THE PRESIDENT FOUGHT TO ENSURE THAT ANY BALANCED BUDGET AGREEMENT EXPANDS CHILDREN'S HEALTH COVERAGE. HIS CHILDREN'S HEALTH INITIATIVE PROVIDES HEALTH COVERAGE FOR AS MANY AS FIVE MILLION ADDITIONAL CHILDREN BY:*

✔ **Strengthens Medicaid for Children.** The President fought to ensure that the guarantee of Medicaid coverage for all poor children is preserved. Furthermore, the Agreement invests in expanding Medicaid coverage for poor children by:

- Working to enroll many of the three million children who are eligible but not enrolled in Medicaid;
- Providing States with new options to expand coverage to children; and
- Continuing Medicaid coverage for children with disabilities who lost coverage due to definitional changes as well as impoverished legal immigrants.

✔ **Supports Innovative State Programs through a Capped Mandatory Grant Program.** States could receive grants to:

- Cover children whose families earn too much to qualify for Medicaid but too little to afford private coverage; and
- Builds on innovative programs that address the unique needs of children in each State. For example, programs like State/insurance company partnerships and school-based could be expanded.

Budget Agreement Document

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. The President's children's health initiative will extend coverage to up to 5 million uninsured children by 2000.

Strengthening Medicaid for Poor Children

- **12-Month Continuous Eligibility.** Currently, many children receive Medicaid protection for only part of the year. The President's budget gives States the option to provide one year of continuous Medicaid coverage to children. The budget invests $4.9 billion over five years for this health insurance.

- **Outreach.** The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

Building Innovative State Programs for Children in Working Families

- **State Partnership Grant Program.** The President's budget provides $3.8 billion between 1998 to 2002 ($750 million a year) in grants to States. States will use these grants to provide insurance for children, leveraging State and private investments in children's coverage through a matching system (as in Medicaid). States have flexibility in designing eligibility rules, benefits (subject to minimums set by the Secretary) and delivery systems.

- The Federal grants, in combination with State and private money, will cover children whose families earn too much to qualify for Medicaid but too little to afford private coverage. The grant program will also increase Medicaid enrollment since some families interested in the new program will learn that their children are in fact eligible for Medicaid.

Continuing Coverage for Children Whose Parents are Between Jobs

- **Workers Between Jobs Initiative.** Nearly half of all children who lose health insurance do so because their parents have lost or changed jobs. The President's budget will give States grants to cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window. The program, which is structured as a four-year demonstration, will offer temporary assistance (up to 6 months) to families. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for workers and their children.

THE PRESIDENT'S FY 1998 BUDGET: CHILDREN'S HEALTH INITIATIVE

BACKGROUND

Numbers and Trends

Who Are Uninsured Children and Why Are Children Uninsured

Challenges to Covering Children

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE

Medicaid Improvements for Children

State Partnership Program for Children

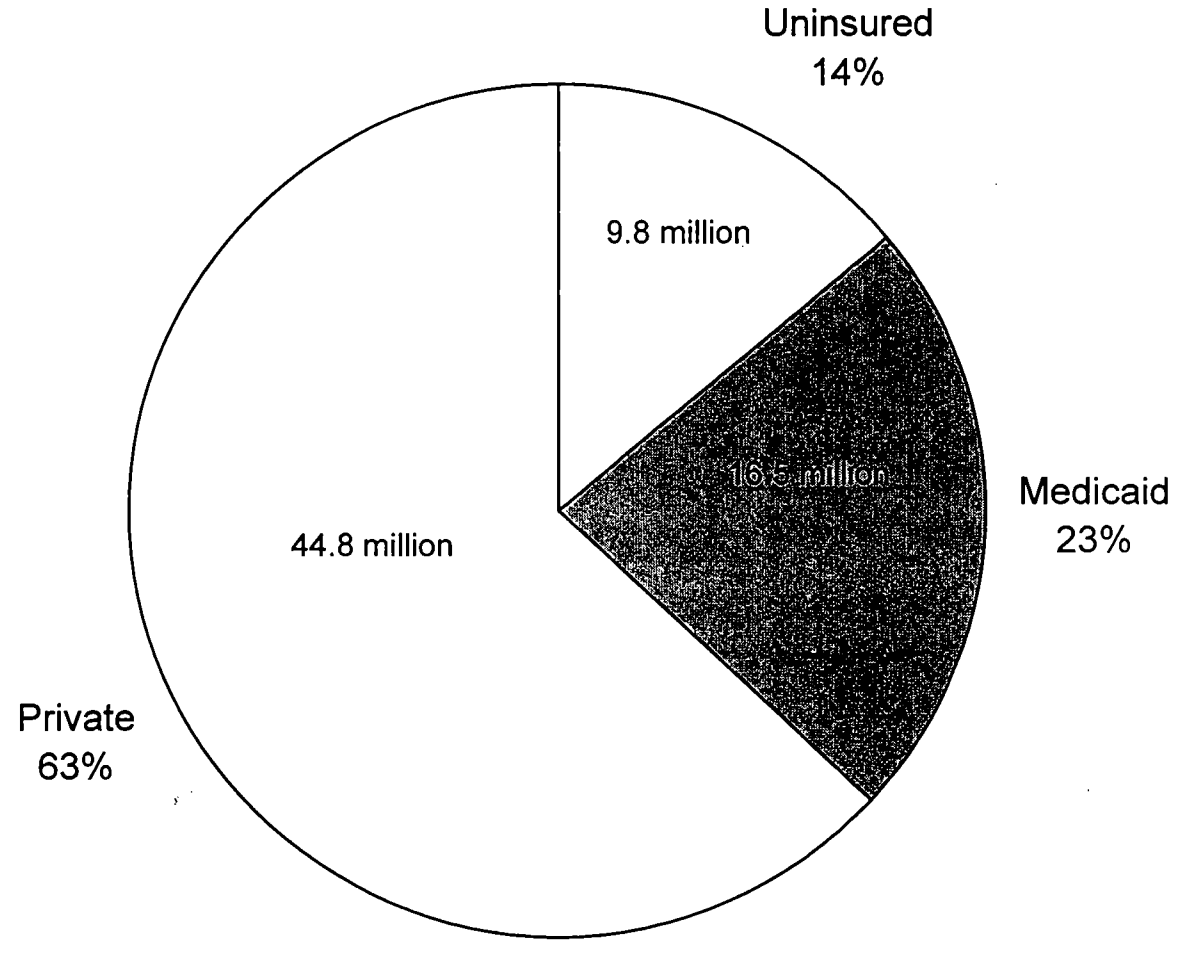
Workers Between Jobs Initiative

Welfare Reform Policies Related to Children

BACKGROUND

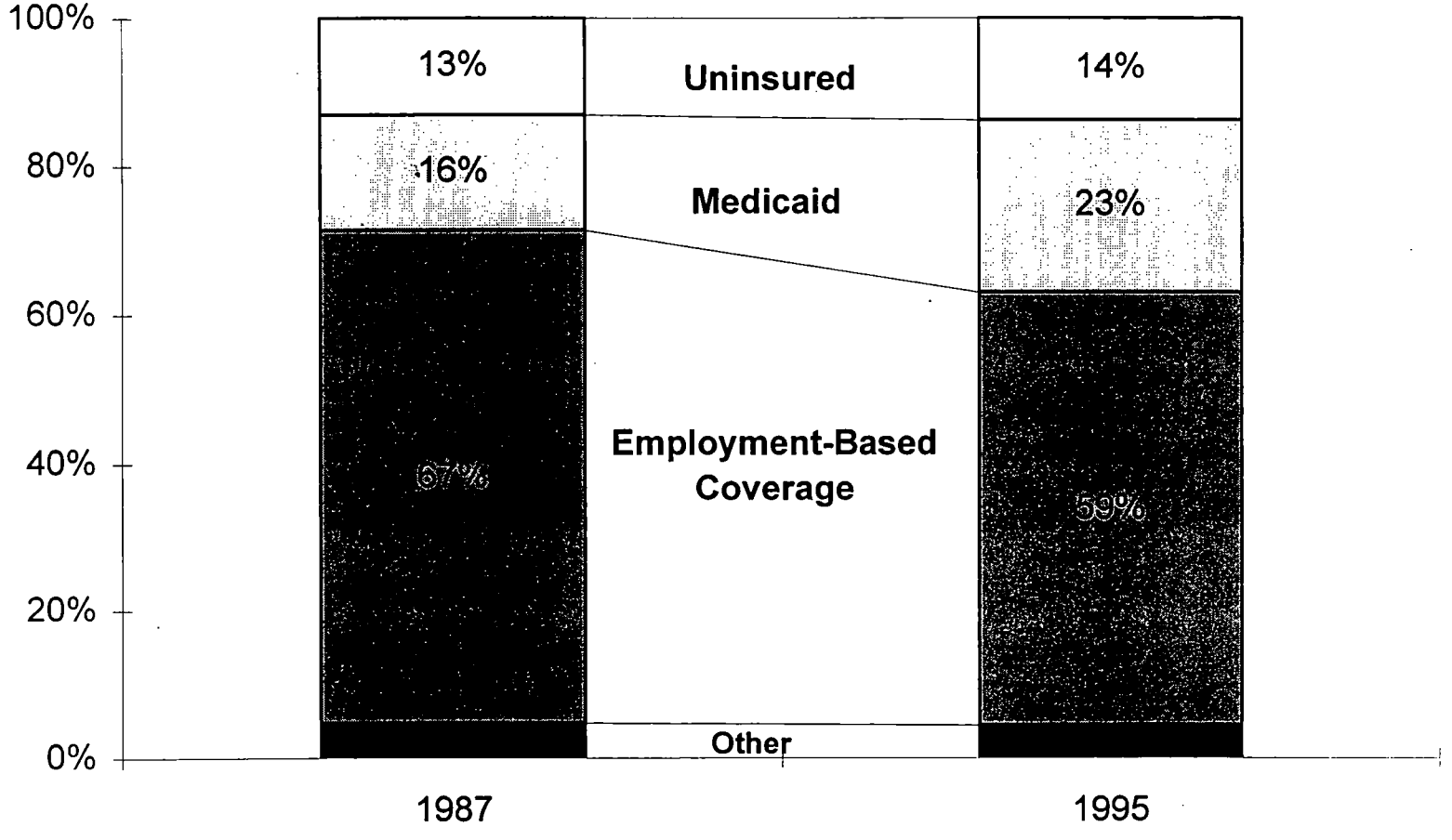
Numbers and Trends

One in Seven Children Are Uninsured



Source: March 1996 Current Population Survey. Children are less than 18 years old.

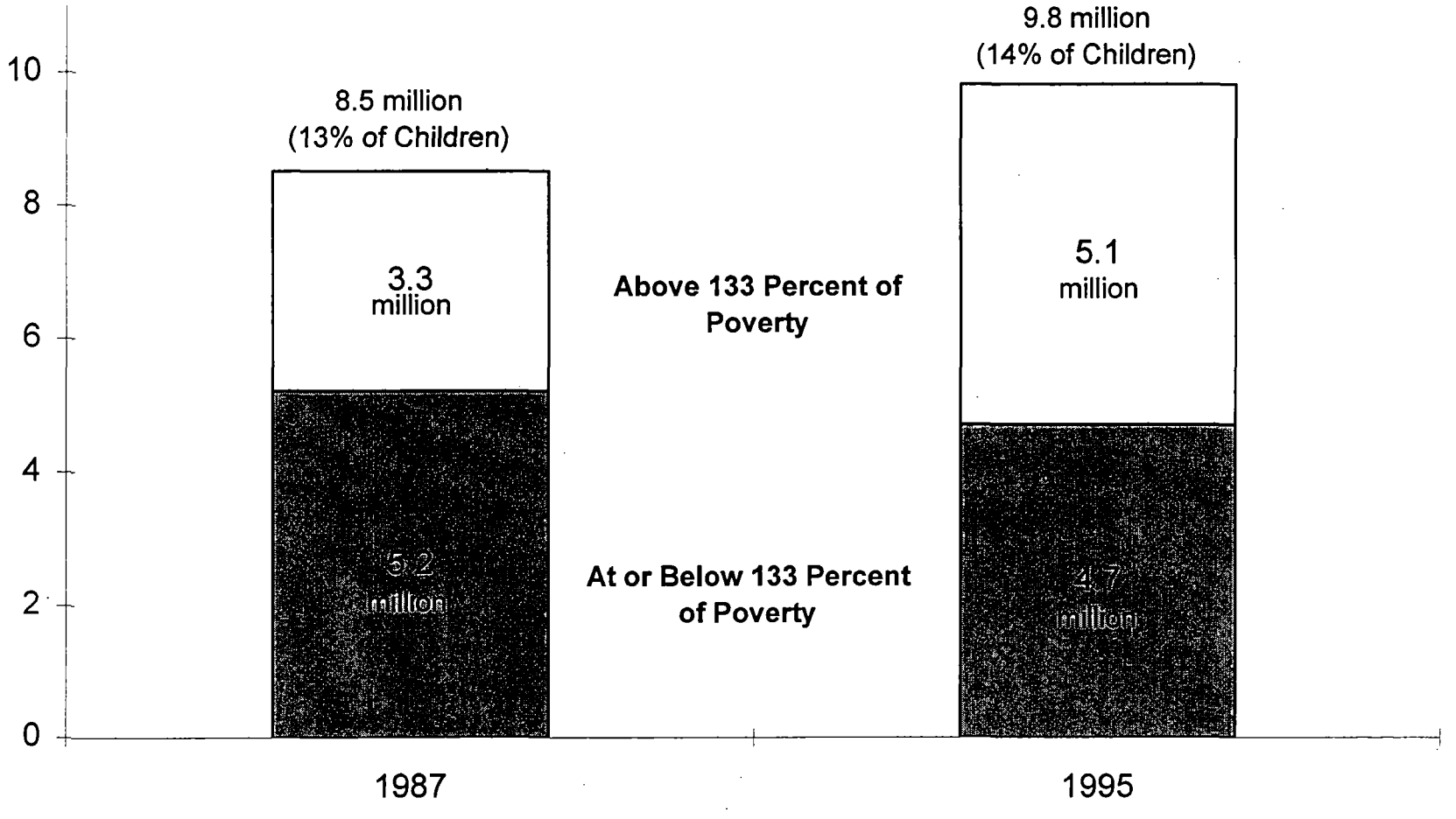
While the Proportion of Uninsured Children Remains Constant, Medicaid & Employer Coverage Have Changed



Note: While it appears that the children losing employer coverage gained Medicaid coverage, recent studies suggest that this is not the case. Medicaid increased coverage of poor children who do not have access to employer insurance.

Source: EBRI 1997. Children are less than 18 years old.

The Number of Uninsured Children Above Medicaid Eligibility Has Increased

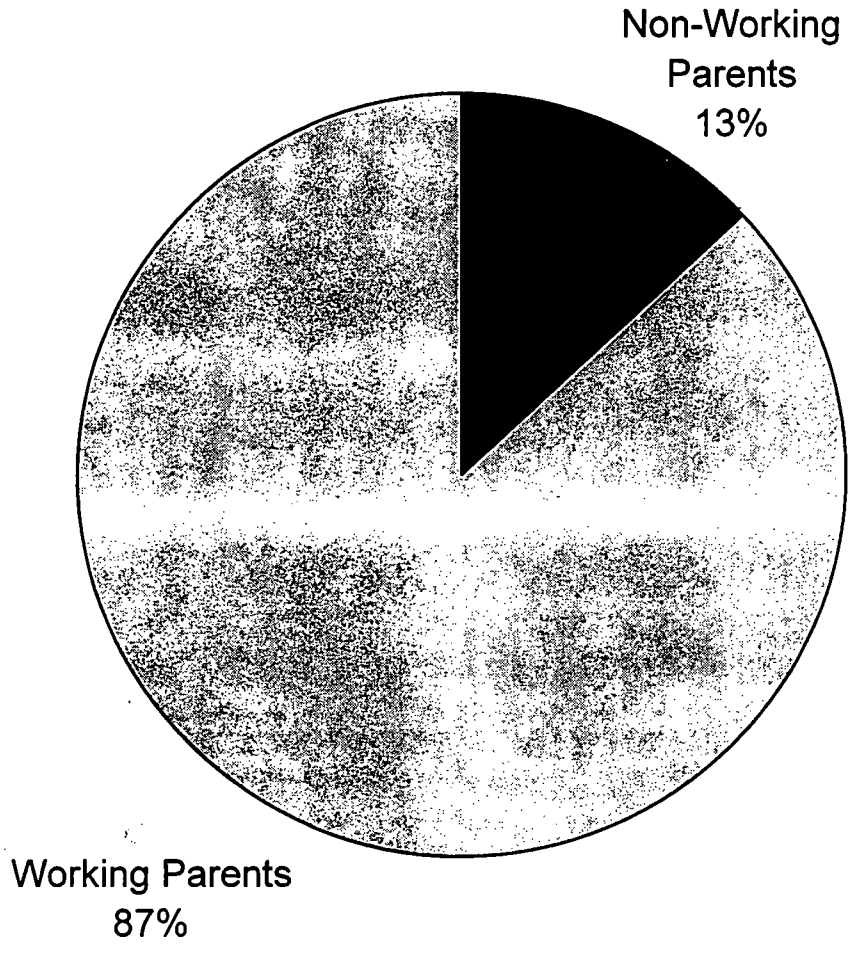


Note: Beginning in 1990, states were required to cover children under 6 to 133% of poverty and phase in coverage for children 6 through 18 below poverty. In 1995, children up to age 13 were eligible for Medicaid. Many states have used options to cover children at higher incomes.

Source: EBRI, 1996

Who Are Uninsured Children and Why Are Children Uninsured

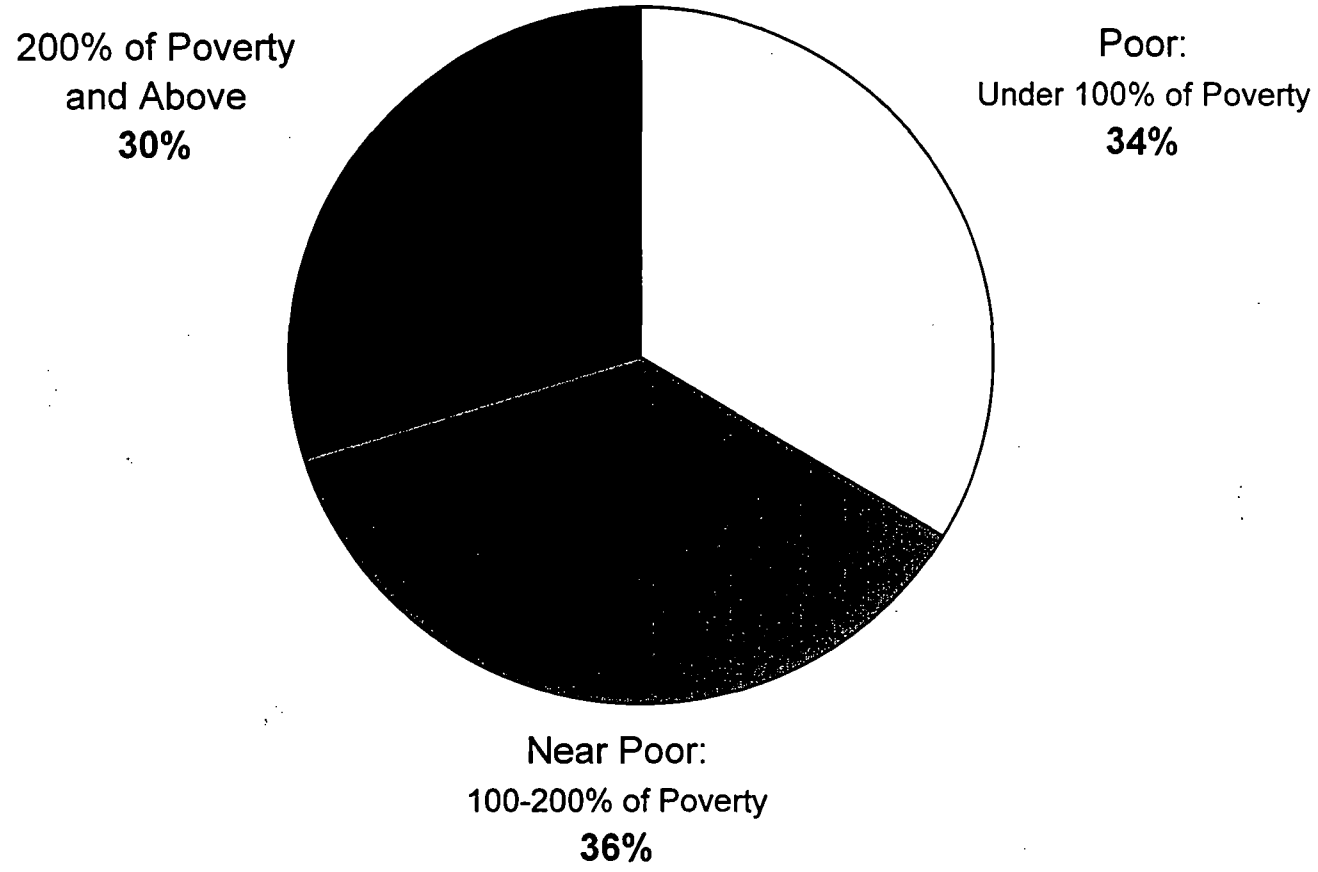
Uninsured Children Come From Working Families



Note: 62% of uninsured children have parents who work full year, full time
Source: March 1996 Current Population Survey. Children are less than 18 years old.

Not All Uninsured Children Are Poor

("Poverty" is about $16,000 for a family of four)



Source: March 1996 Current Population Survey. Children are less than 18 years old.

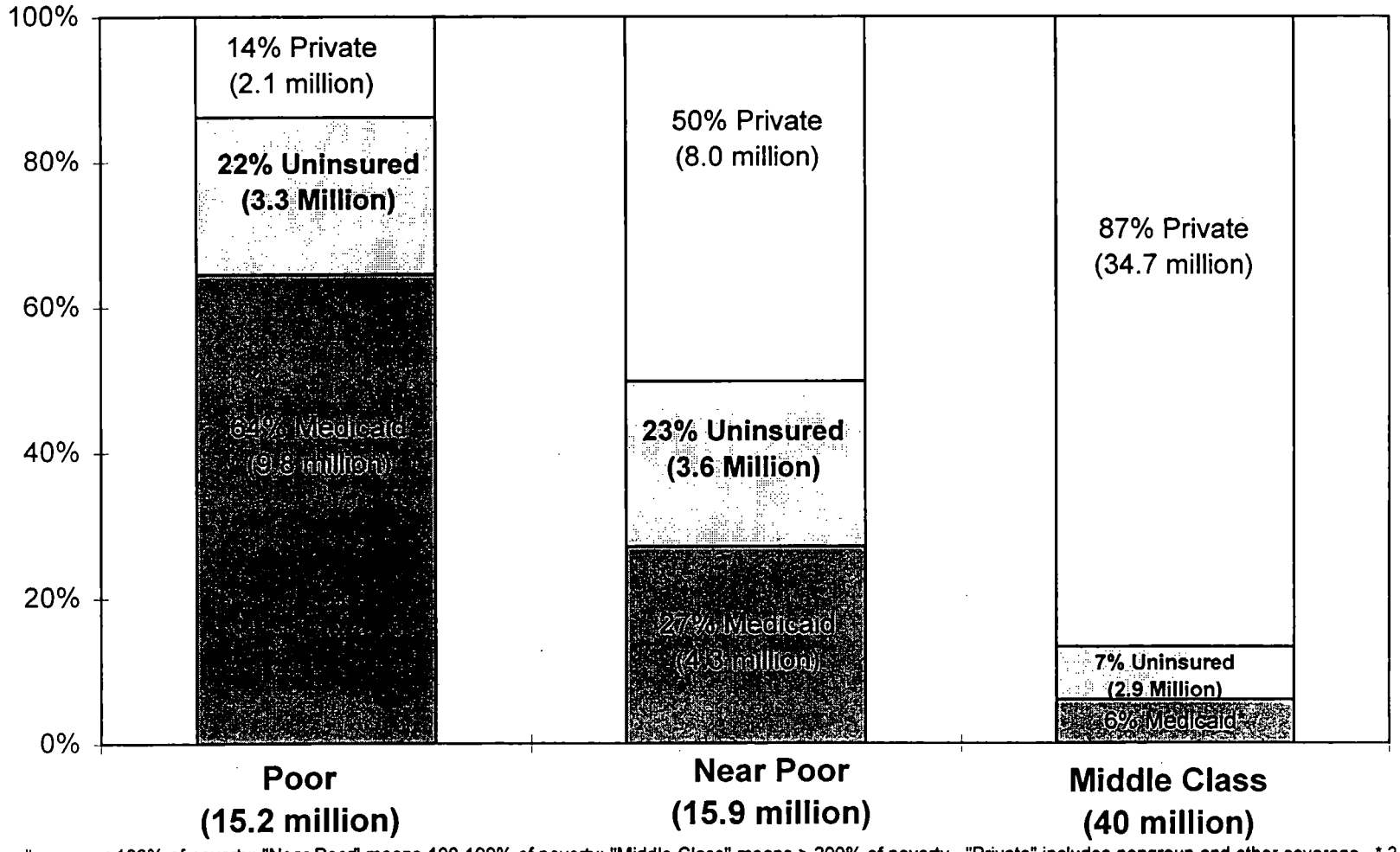
Why Are Children Uninsured

1. **Eligible but not enrolled in Medicaid.** According to the General Accounting Office, an estimated 3 million uninsured children are eligible but not enrolled in Medicaid.

2. **Parents earn too much for Medicaid but too little for private coverage.** When job-related insurance loss is put to the side, the most important reason why children lose insurance is that it is too expensive for the family. The highest rate of uninsured children is in families just above the poverty line.

3. **Parents change jobs.** Nearly half of all children who lose health insurance do so because their parents lose or change jobs

What Is the Distribution of Uninsured Children By Income



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage. * 2.4 million

Note: The number of children covered by Medicaid is less than 18 million due to under-reporting on this survey. Source: March 1996 Current Population Survey.

Challenges to Covering Children

- **Costs.** Although children are the least expensive population to insure, proposals to cover them can be expensive. This results from two major challenges:

- **Substitution or "crowd out".** Costs rise when a new program substitutes Federal dollars for employer or state contributions for kids' coverage.

- **Administration.** Proposals have to strike a balance between complex administrative rules and enforcement — which aim to limit crowd out — and the goals of simplicity and small government.

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE

Medicaid Improvements for Children

- **The President's budget gives States the option to provide one year of continuous Medicaid coverage to children.** This will cost an estimated $3.7 billion between 1998 and 2002 and help an estimated one million children.

    - Currently, many children receive Medicaid protection for only part of the year. Medicaid eligibility is intermittent due to fluctuations in family income throughout the year.

    - This policy allows States to guarantee Medicaid coverage for up to one year even when a family's income changes. This means that children can remain with the same provider for up to a year, improving continuity of care.

- **The President will also work with Governors to enroll eligible Medicaid children.** The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

- **The President's budget preserves and strengthens Medicaid's guaranteed coverage for low-income children.** In addition to protecting coverage for the 18 million children already on Medicaid, the President continues the current law expansion to children aged 13 to 18.

State Partnership Program for Children

- **The President proposes a grant program for States to develop innovative health coverage programs for children.** The President's budget provides $3.8 billion between 1998 and 2002 ($750 million a year) in grants to States. States will use these grants to provide insurance for children, leveraging State and private investments in children's coverage through a matching system.

- The Federal grants, in combination with State and private money, will target uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage.

- States have flexibility in designing eligibility rules, benefits (subject to minimums set by the Secretary) and delivery systems. In return for this flexibility, States will provide annual evidence of positive outcomes of the grant money — including the number of previously uninsured children helped by the program.

- The program builds upon the successful efforts of States that have tailored programs to address the particular gaps in coverage for their children. For example, the Florida Healthy Kids program enlists schools to enroll and insure 40,000 previously uninsured children.

Workers Between Jobs Initiative

- **The President's budget will give States grants to temporarily cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window.**

- The initiative will offer temporary assistance (up to 6 months) to families who would otherwise lose their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. State participation in this grants program is optional.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. This assistance is accessible for most middle class families since income drops for the months between jobs.

- This program, which is structured as a four-year demonstration, will help an estimated 3.3 million working Americans and their families, including 700,000 children, in any given year.

FY 1998 President's Budget Medicaid Proposals: Welfare Reform Policies Related to Children

Retain Medicaid for Disabled Children who Lose SSI

- The President's proposal would retain Medicaid coverage for children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefits because of changes in the definition of childhood disability.
- The welfare law provides a new definition of disability for children separate from that for adults. The comparable severity standard was repealed and replaced with a new, statutory definition of disability for children[1]. The new statutory definition requires a child's impairment or combination of impairments to cause more serious functional limitations in order to be considered disabled than did the old law.
- Under current law, many of these disabled children could lose their Medicaid coverage if they lost their SSI cash assistance due to the new definition and could not requalify for Medicaid based on poverty standards for Medicaid eligibility. States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that determination could affect the individual's Medicaid eligibility.
- HCFA's Office of the Actuary (OACT) estimates Federal Medicaid costs of $0.3 million between FY 1998 and FY 2002. This provision would retain Medicaid coverage for approximately 30,000 disabled children in FY 1998.
- CBO estimates Federal Medicaid costs of $1.0 billion between FY 1998 and FY 2002.

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[1]Before P.L. 104-193, a child was considered disabled for purposes of eligibility for SSI if he or she suffered from any medically determinable physical or mental impairment of "comparable severity" to an impairment(s) that would make an adult disabled.

Exempt Immigrant Children from the Medicaid Bans and Deeming

- The President's budget would exempt immigrant children from the bans on Medicaid eligibility for current and future "qualified aliens." Immigrant children would also be exempt from the new deeming requirements that require the income and resources of an immigrant's sponsor to be counted when determining Medicaid eligibility.

- Under current law, immigrant children could lose their Medicaid eligibility if a state chose to deny Medicaid assistance to immigrants who resided in the U.S. on or before August 22, 1996. Immigrants who enter the country after August 22, 1996 are banned from receiving Medicaid for five years. Current law also requires deeming the income and resources of their sponsors for determining Medicaid eligibility.

- OACT estimates Federal Medicaid costs of $0.2 billion between FY 1998 and FY 2002. This provision would retain Medicaid coverage for approximately 30,000 non-disabled children in FY 1998.

- CBO estimates Federal Medicaid costs of $0.4 billion between FY 1998 and FY 2002.

UNINSURED CHILDREN IN AMERICA: THE FACTS AND THE FUTURE

PRELIMINARY DRAFT
FOR REVIEW ONLY

THIS HAS NOT YET INCORPORATED ALL OF THE EDITS

CITATIONS, TECHNICAL APPENDIX FORTHCOMING

HIGHLIGHTS

I. UNINSURED CHILDREN: A SERIOUS PROBLEM IN THE UNITED STATES

- **About 10 million children under age 18 are uninsured.**

    - However, fully 20 million children are uninsured for at least one month over the course of a 28-month period.

- **Lack of insurance has become a middle class problem.** The number of uninsured children above 133 percent of poverty (about $21,000 for a family of four) has risen by over 50 percent since 1987. Today, almost 90 percent of uninsured children have a parent who works.

- **Uninsured children have worse access to health care.** One in 5 uninsured children who are sick delays or does not receive needed care.

- **The United States ranks poorly when compared to other nations**. It:

    - Remains the only industrialized nation that does not extend basic health protection to its children;

    - Ranks 22nd in its infant mortality rate, 26th for its low birth weight babies, and 22nd for its infants' probability of dying before turning 5 years old.

II. THERE IS NO SINGLE REASON WHY CHILDREN ARE UNINSURED

- **Poverty alone cannot explain the lack of insurance.** About one-third are poor, one-third have income between 100 and 200 percent of poverty, and another third have income above 200 percent of poverty.

- The three main reasons why children are uninsured include:

    - **Lack of access to employer-based insurance**
        - **Health coverage is typically not offered in:**
          Small businesses: The number of children with parents in small firms has increased by 20 percent since 1987; today, 46 percent of uninsured children have parents who work in small firms.

          Certain types of firms: Employment has also shifted to firms less likely to offer insurance. About 25 percent of children of workers in the service, construction, and agriculture sectors are uninsured.

          Part-time employment: Part-time workers are often ineligible for health insurance; 22 percent of their children are uninsured.

- **Change in employment leads to loss of coverage**. Over half of children became uninsured because their parents lost or changed jobs.

- **Unemployment can cause coverage loss.** About 42 percent of children whose parents left a job with health insurance and became unemployed became uninsured.

o **Lack of affordability of insurance**

- **Employer-based insurance can be expensive, as is individually purchased insurance**. Over three-fourths of families who do not take employer-based insurance when offered cannot afford it.

o **Problems accessing existing programs**

- **Eligible but not enrolled in Medicaid.** About 3 million children at any point in time are eligible but not enrolled in Medicaid.

- **Limited size of state programs.** While over 30 states have either a state-funded or a private children's health program, few are large and almost all have waiting lists.

III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

- **Medicaid has made important inroads into children's health coverage.** Beginning in 1990, Medicaid began covering all poor children. Between 1987 and 1995, the number of poor, uninsured children declined by about 10 percent, with much larger reductions in the South.

- **Some states have used innovative programs to target uninsured children**. A number of states have private or state-funded programs to expand coverage to children. These experiences suggest that efficient, creative programs can cover uninsured children without causing major substitution of existing coverage.

- **The 1990 child health tax credit does not appear to have improved coverage.** The child health tax credit was difficult to administer, had low participation rates, and may not be the best way to improve children's coverage.

IV. CONCLUSION

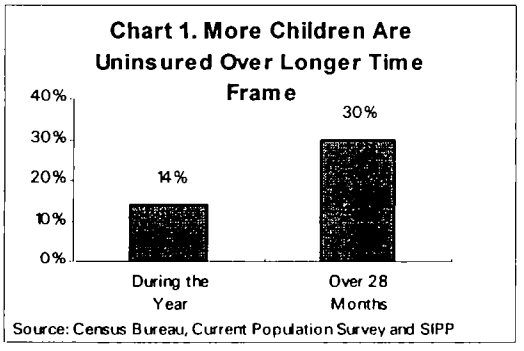
- **Carefully designed policies can improve health coverage for American children.** A sharp focus on the causes of the problem and the lessons learned from past efforts can lead to policies that expand children's health coverage.

I. UNINSURED CHILDREN: A SERIOUS PROBLEM

While the United States has the best health care system in the world, the key to accessing it is health insurance. Although there are systems to care for people without coverage, the facts show that the uninsured have greater problems getting needed health care.

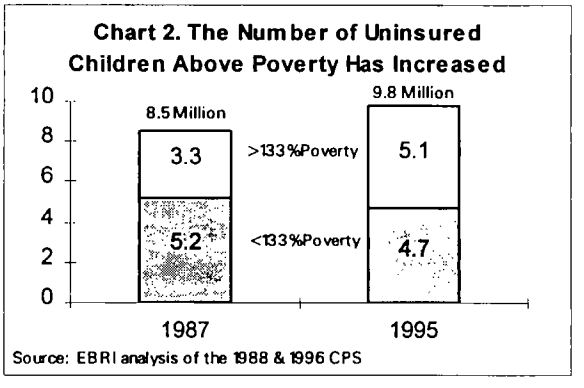
A. THE NUMBERS OF UNINSURED CHILDREN

One in seven right now. In recent years, one in seven children — about 10 million children under 18 years old — lack health insurance at any point during the year. This represents one in seven children or 14 percent of all children. This proportion has remained about the same for the last 10 years. (For details on uninsured children's characteristics, see "Census Bureau Releases New Findings on Health Insurance Coverage for Children in the U.S.", 3/13/97.)



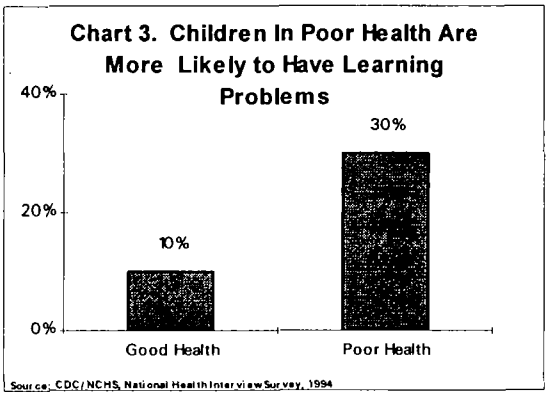
One in three over the course of two years. Yet, looking at more than a snapshot suggests that the problem is much larger. Over a 28-month period, the proportion of children who spent some time without insurance rises to nearly one in three children (Chart 1). In other words, 20 million American children spent at least one month without health insurance over the course of two-years (Census, 1996).

Problem increasing for middle class families. While the proportion of children who are uninsured has remained relatively constant, this masks an underlying trend. The number of poor, uninsured children has been decreasing while the number of middle class uninsured children has been increasing. The number of uninsured children above 133 percent of poverty has risen from 3.3 to 5.1 million — more than a 50 percent increase between 1987 and 1995 (Chart 2).

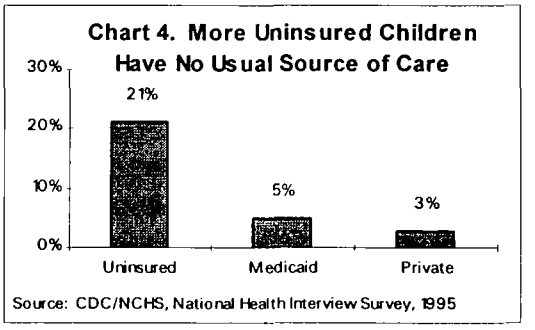


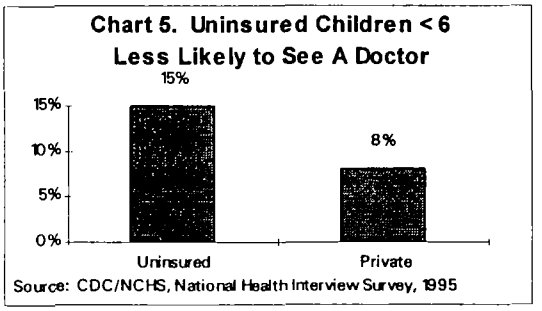
B. WHAT IT MEANS TO BE UNINSURED

Despite their general good health, children have a special set of preventive and primary care needs. Children are generally healthy. Only about 3 percent of children have fair or poor health, relative to 8 percent of 25 to 44 year olds, and 28 percent of people 65 years and older (NCHS, 1995). Yet, children tend to have more acute illnesses than adults. Children under 5 years old experienced an average of 3.6 acute illnesses per child in 1994, relative to 2.2 illnesses per child 5 through 17 years and 1.1 per adult 45 years and older (NCHS, 1995). Children also require immunizations in the early years of life to prevent lifelong health problems. Primary and preventive health care for children allows them to develop to their full capacity (CEA, 1997). In fact, when asked what indicates that a child is ready for kindergarten, teachers overwhelmingly responded that the most essential factor is a child's physical health (NCES, 1996). Children in poor health are three times more likely to experience difficulties in learning than healthy children (Chart 3).



Uninsured children have more difficulty getting health care. About 86 percent of children have some type of health coverage. For children without insurance, Federal, state and local governments have developed a set of "safety net" or publicly supported providers, including community health centers, public health departments and children's hospitals. These providers give critical health services to children with and without insurance (see Appendix A for details). Despite these systems, one in five uninsured children has no usual source of health care (Chart 4).

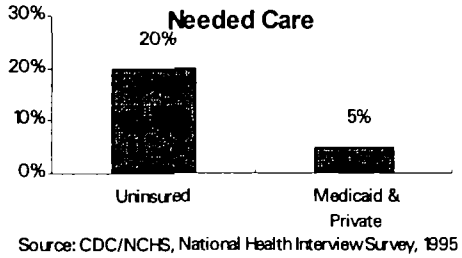




The lack of access appears to lower the use of care as well. Young children usually visit doctors at least once a year for preventive and primary care, since they often experience frequent, minor illnesses at this age. However, 15 percent of uninsured children less than 6 years old did not visit a doctor at all in the past year compared to 8 percent of insured children (NCHS, 1997a).

The problems of uninsured children grow worse when they get sick. Uninsured children are more than four times as likely to delay or not receive needed care as are insured children (Chart 6). Over 40 percent of acute conditions for uninsured kids went unattended as compared to about 30 percent for privately insured children (NCHS, 1997b). This is consistent with other studies that have found that health insurance is essential to connecting children with the health care system (Donnelan, 1996).

Chart 6. Uninsured, Sick Children Are More Likely to Delay or Not Get Needed Care



Source: CDC/NCHS, National Health Interview Survey, 1995

The United States stands alone. The United States leads the world in many important respects, including size of the gross domestic product (GDP) (WHO, 1997) and real level of family income (Luxembourg Income Study, 1995). However, the United States is the only industrialized country that does not extend health protections to its children. Through some combination of regulated private insurance, compulsory coverage for lower-income workers, and publicly provided benefits, other industrialized nations have ensured that all children have basic health coverage (Williams & Miller, 1992; OTA, 1993). These countries also do more to lift their children out of poverty; a survey of 18 industrialized nations found that the U.S. had the highest child poverty rate even after taxes and transfers (Rainwater & Smeeding, 1996). And while it is first in the world in its health spending, it ranks 13th in its public spending on health as a percent of GDP (Chart 7). **[check immun. stats]**

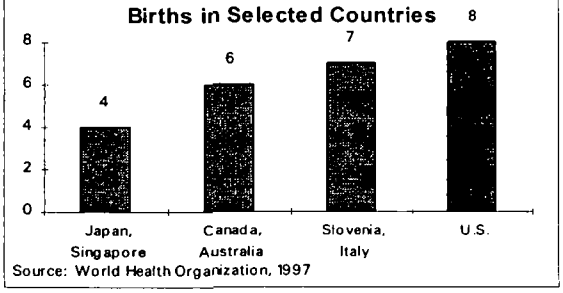
Chart 7. Ranking of the U.S. In Child Health Statistics

Highest Total Health Spending as Percent of GDP:	1st
Highest Public Spending on Health as Percent of GDP:	13th
Highest Percent of Infants Immunized for DPT:	30th
Highest Percent of Infants Immunized for Measles:	52nd
Lowest Infant Mortality Rate:	22nd
Lowest Percent of Babies who are Low Birthweight:	26th
Highest Life Expectancy at Birth:	12th
Lowest Odds that a Newborn Dies before Reaching 5 yrs:	22nd
Highest Mortality Rate Due to Violence for Children 0-24:	1st
Lowest Child Poverty After Taxes and Transfers:	18th

Sources: WHO, 1997; OTA, 1992; Rainwater & Smeeding, 1995

The United States also ranks low on child health statistics. The United States does not lead other nations in any of the major child health indicators. Its immunization rates, while improving, still are worse than most industrialized nations. Twenty-one nations have lower infant mortality rates than the U.S. and 25 have fewer low birthweight babies (Chart 8). Babies born in the United States have lower life expectancies than 10 other nations, and are more likely to die of violence than in any industrialized nation (OTA, 1992).

Chart 8. Infant Deaths per 1,000 Live Births in Selected Countries

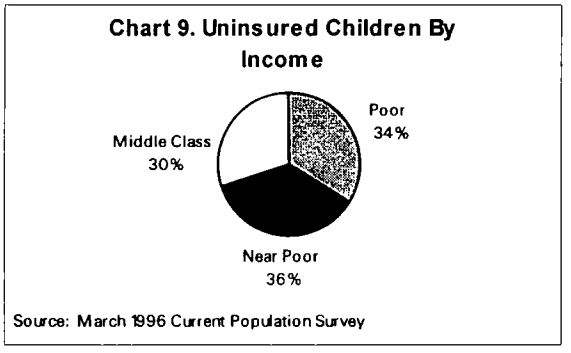


Source: World Health Organization, 1997

System failure. The number of uninsured children in the United States is particularly alarming because there are systems in place to insure them. The United States has developed a unique, employer-based health insurance system that covers 60 percent of the nonelderly population. Preferential tax treatment valued at more than $60 billion per year is intended to encourage health coverage in this way. Additionally, Medicaid, the joint Federal-state health insurance program, offers coverage to virtually all poor children who do not usually have access to employer-sponsored insurance. Yet, as described in greater detail below, about 87 percent of uninsured children have working parents, and nearly 3 million children are eligible but not enrolled in Medicaid. This leads to the question: **why are there large gaps in the health insurance system for children?**

II. THERE IS NO SINGLE REASON WHY CHILDREN ARE UNINSURED

Probably the largest challenge in covering uninsured children stems from the fact that there is no single cause of the problem. Uninsured children are not a homogenous group, nor are there one or two distinct reasons why children are uninsured. One third are near poor (100-199% of poverty), suggesting that the family probably earns too much to qualify for Medicaid but too little to afford private insurance. In fact, nearly one in five children of these children are uninsured (CPS, 1996). Another one-third of uninsured children have family income above 200 percent of poverty (Chart 9). While every uninsured child has his or her own reasons for being uninsured, several patterns emerge.



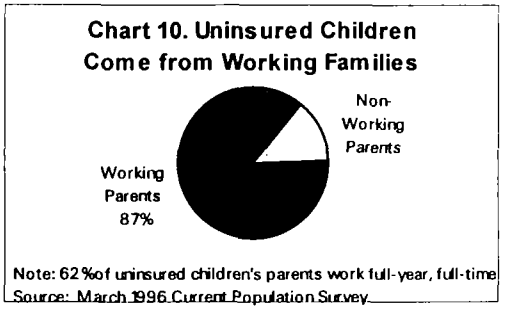
Children appear to be uninsured because of:

- Lack of access to employer-based insurance
- Lack of affordability of insurance
- Problems accessing existing programs.

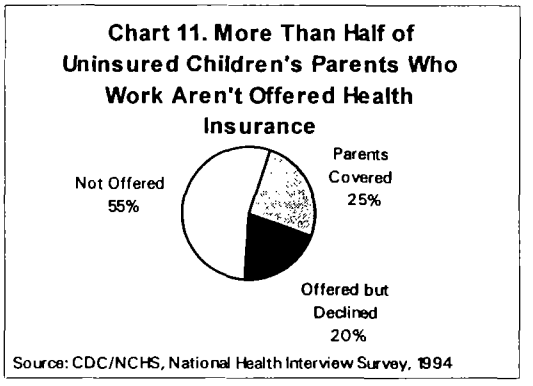
A. LACK OF ACCESS TO EMPLOYER-BASED INSURANCE

Employers play a central role in providing health insurance to workers and their families. Over 60 percent of nonelderly Americans are covered through employer-based plans. In 1994, employers paid for about one-fifth of all health expenditures accounting for 6.7 percent of all compensation (Cowan et al., 1996; DOL, 1995).

Nearly all of uninsured children have a connection to the workforce. Most employers cover their workers' children. About 60 percent of children have employer-based health insurance (CPS, 1996). However, most uninsured children also have parents who work as well. Nearly 90 percent of uninsured children's parents work, and about two-thirds of uninsured children have parents who work full time (Chart 10).

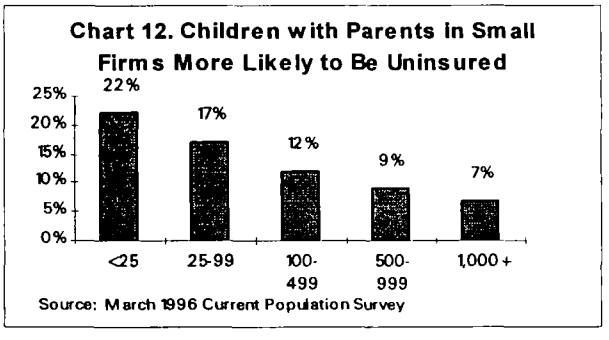


Many uninsured children's families work in businesses without health coverage. Many workers and their children lack insurance because their employers do not offer it to them. Nearly 20 percent of all children with working parents do not have the option of family coverage through work (NCHS, 1997b). In contrast, more than half of uninsured children with working parents are not offered health coverage through work (Chart 11). This is especially true for low-income workers. Nearly 70 percent of uninsured children of workers below poverty and 51 percent of uninsured children of workers between 100 and 200 percent of poverty are not offered employer-based insurance (NCHS, 1997b).



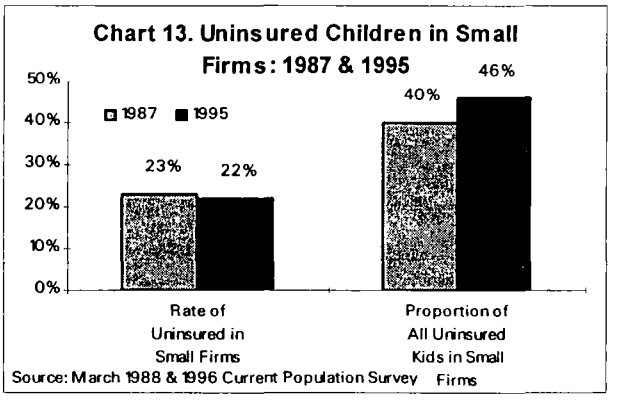
These families are most likely to work in (1) small businesses, (2) industries like services and construction; and (3) and part-time jobs.

1. Small businesses are less likely to offer insurance. Children whose parents work in firms with fewer than 25 employees are more than twice as likely to be uninsured as those whose parents work in medium to large firms (Chart 12). This is especially true for low-income children. Over 35 percent of children whose parents work in small businesses and earn between 100 and 200 percent of poverty are uninsured, compared to 20 percent of children with family income between 200 and 299 percent of poverty and 10 percent of children with incomes of 300 percent of poverty or more (CPS, 1996). Children of self-employed parents also frequently lack insurance; about 23 percent are uninsured (CPS, 1996).

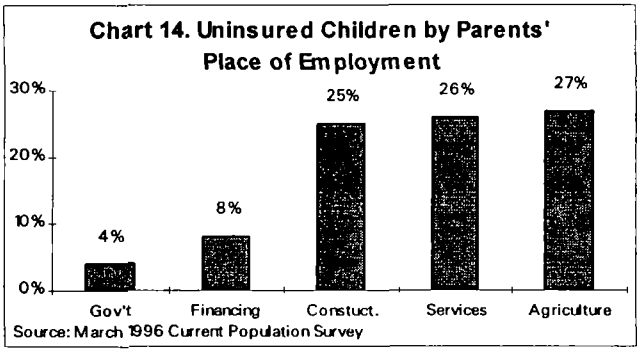


Small businesses pay much more for group insurance. A central problem with the employer-based health insurance system is that the same coverage is more expensive for small groups. When a small business wants to purchase health insurance for its employees, it is faced with higher premiums. Insurers charge higher premiums because the administrative costs and risk of covering fewer employees are greater. As a consequence, only about 40 percent of employees in businesses with fewer than 10 employees were offered coverage in 1993, compared to about 70 percent of employees in firms with 10 to 24 employees, and nearly 100 percent of employees in firms with 100 or more employees (NEHIS, 1993).

More children's parents work in small businesses. In 1988, 40 percent of uninsured children had parents who worked in small firms; in 1995, this rose to 46 percent (Chart 13). This did not result from an increased rate of uninsured kids among employees of small businesses. In fact, in both 1987 and 1995, about 22 percent of children with workers in small firms were uninsured. However, since the last decade, there has been a very large increase in the number of workers with children in small businesses. The total number of children whose parents work in firms with fewer than 25 employees increased by over 20 percent between 1987 and 1995 (CPS, 1988; 1996). In contrast, the number of children with parents working in medium and large firms dropped over the same period.

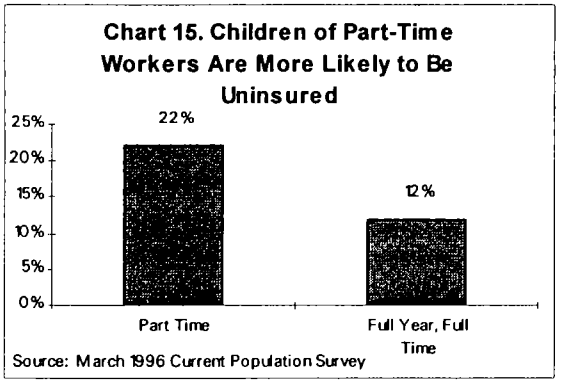


2. Companies in certain types of industries are less likely to offer insurance. Certain industries are less likely to offer coverage than others. Specifically, the rate of uninsured children whose parents work in the service (e.g., restaurants, hair cutters), construction and agriculture sectors is about twice as high as that for kids with parents in other types of jobs (Chart 14). In part, this reflects the fact that many of these businesses are small or have low-wage, part-time or part-year jobs. Nearly 60 percent of children whose parents work in these types of jobs have incomes below 200 percent of poverty (CPS, 1996). It may also reflect the higher cost of insurance for these types of employers. Traditionally, health insurers have "red lined" or charged higher rates for certain kinds of businesses. While this practice has been limited in many states, it may still account for some of the lack of insurance (cite).

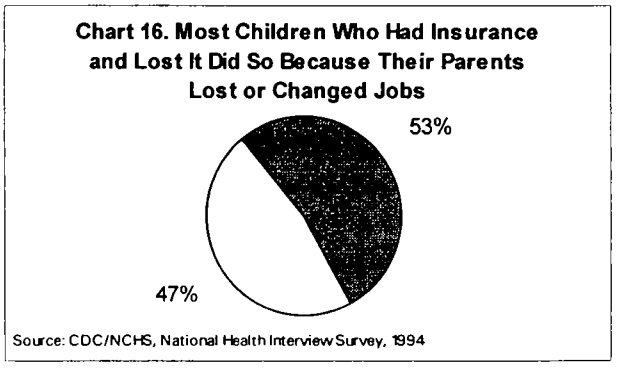


Like the trend for small business employment, there is an increase in the number of children with parents in service, construction and agriculture jobs — not an increase in the rate of uninsurance in those industries. Over 20 percent more children had parents working in these types of jobs in 1995 than in 1987 (CPS, 1996).

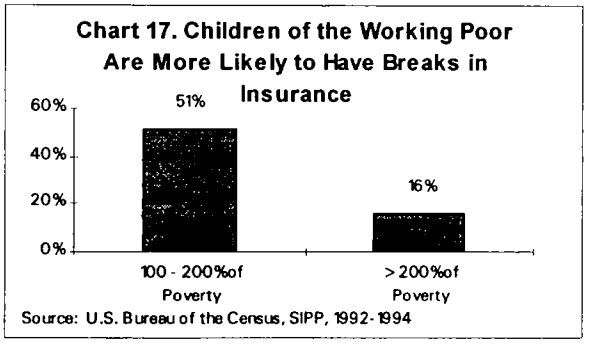
3. Part-time workers are less likely to be insured. Part-time and outsourced workers have less access to employer-based health insurance. Many employers only offer coverage to permanent employees or those who work more than 30 hours per week. As a result, children of part-time workers are more likely to be uninsured. About 22 percent lack health insurance compared to 12 percent of full-time workers' children (Chart 15). This rate of uninsured children is slightly lower than it was in 1987, when 26 percent of part-time workers' children lacked insurance. However, there has been a slight increase in the number of children whose parents hold part-time work, dampening the effect of the lower rate of uninsurance. In 1995, about 8 percent of all children and 15 percent of all uninsured children had a parent who worked part-time (CPS, 1996).



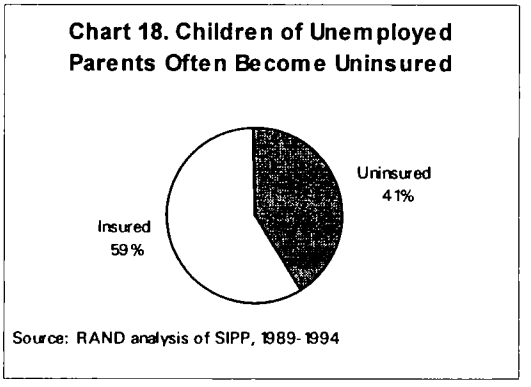
Parents changing jobs often means children lose coverage. Given the strong link between health insurance coverage and employment, it is not surprising that changes in employment disrupt coverage. In fact, over half of uninsured children who had coverage within the past three years lost their coverage because their parents lost or changed jobs (Chart 16). This reason for losing insurance is more prevalent among children whose parents work in small firms — over 60 percent of these children lose coverage because of job change (NCHS, 1997b). It is also the reason 54 percent of uninsured children above 250 percent of poverty and 58 percent with income between 100 and 250 percent of poverty lost coverage in 1994.



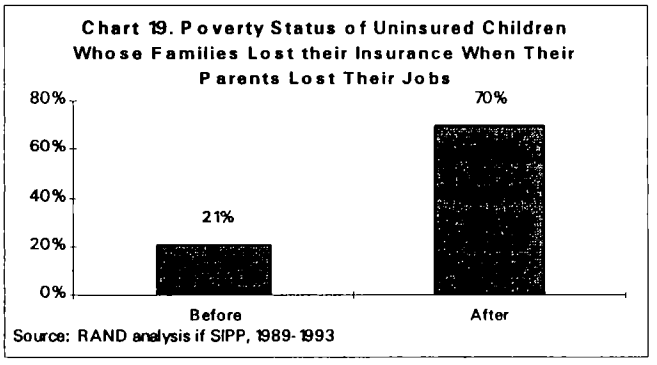
Changing jobs leaves children with breaks in coverage. Probably because of job transitions, over 50 percent of all children between 100 and 200 percent of poverty had a lapse in their health insurance coverage over a 28-month period (Chart 17). This compares to 16 percent of children in families with income greater than 200 percent of poverty.



For families who spend time unemployed between jobs, the problem is worse. Some of the uninsured families who lose insurance when their parents lose or change jobs do not immediately gain jobs and insurance. About 13 percent of uninsured children have parents who are unemployed or out of the labor force. Over 40 percent of children with unemployed parents who had received employer-based insurance become uninsured (Chart 18). Most of these children have parents who worked in manufacturing, transportation, communication, or construction jobs (RAND, 1997). The typical family spends about [check] looking for a job.



Parents cannot afford insurance when unemployed. In part, the loss of insurance for these children results from the dramatic change in family income during these periods without work. When looking at uninsured children of unemployed parents, only 20 percent were in poverty when the parents worked while 70 percent are in poverty when the parent loses his or her job (Chart 19). While these periods are usually short-lived, they are problematic because children need preventive and primary care, which may be neglected if there is no coverage.



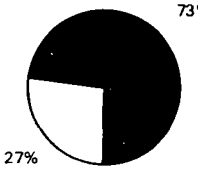
COBRA and HIPAA are just first steps to helping insure children. Several policies have been enacted to increase access to employer-based insurance for families who are between jobs. In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers with 20 or more employees to allow former employees and their families to buy into their health insurance plan for up to 18 months at their group rate (but without an employer contribution plus an additional 2 percent for administration costs). This is intended to give these families an alternative to the expensive nongroup health insurance market. Further, in 1996, the Health Insurance Portability and Accountability Act (HIPAA) limited preexisting condition exclusions and other practices that bar children from re-entering group insurance when their families change jobs. However, studies have shown that participation in COBRA is relatively low (Flynn, 1992; Klerman & Rahman, 1992; Klerman, 1996), and if children whose parents are between jobs spend enough time without insurance, they lose their recently gained portability protections.

B. LACK OF AFFORDABILITY OF HEALTH INSURANCE

While access to insurance is important, it may not be sufficient. A growing number of families cannot afford to purchase employer-based insurance. Furthermore, insurance in the private, nongroup market can be prohibitively expensive. This suggests that making insurance accessible is only the first step in covering children: making it affordable is at least as important.

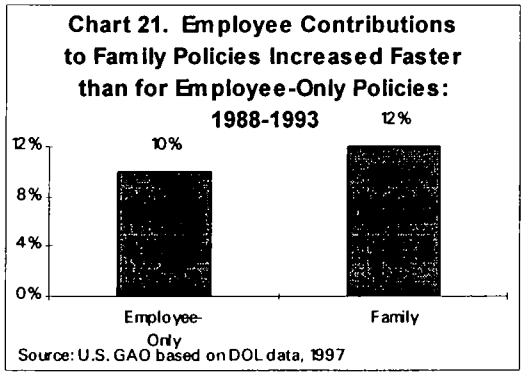
High cost of employer-based insurance. While employers typically pay for some of their employees' family coverage, the family contribution can be expensive. Nearly three-quarters of uninsured children whose parents were offered coverage at work are uninsured because their families cannot afford coverage (Chart 20). In 1993, 16 percent of employees paid $150 or more a month for family coverage (DOL, 1993). While affordable for middle and upper class families, such premiums are often out of range for low-wage workers. In part because they face higher premiums, small businesses typically ask families to pay more of the premium costs (DOL). [ADD}

Chart 20. Most Children with Access to Employer-Based Insurance Remain Uninsured Because of Cost



Source: CDC/NCHS, National Health Interview Survey, 1994

Family contributions are increasing. Between 1988 and 1993, the average family contribution for employees in large firms increased 20 percent faster than did the contribution for employee-only policies (Chart 21). Part of this stems from rapid cost growth in family premiums. Family premiums grew 13 to 23 percent faster than did employee-only premiums between 1989 and 1996 (GAO, 1997). [ADD]



Individual insurance is an option for families without access to employer-based insurance but is expensive or may be hard to obtain. Families without access to employer-based insurance may turn to the individual insurance market. About 4 percent of American children are covered by individual insurance (U.S. GAO, November 1996). Through insurance agents, associations, or direct marketing, these families can purchase one of a multitude of health benefits packages. The variation in the individual market is huge, since premiums depend on the amount of cost sharing, covered benefits and, in most cases, health status, age, and other sociodemographic characteristics of the individual. This means that a large family or one with a sick child will likely face premiums that are much higher than if obtained through a group. More dramatically, in most states, applicants can be denied coverage based on health status. Insurers in states without guaranteed issue and renewal in the individual market deny nearly 20 percent of applicants (U.S. GAO, November 1996).

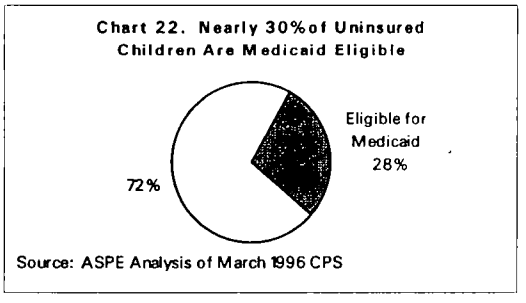
Family coverage is more expensive than children-only coverage. Additionally, most policies offered in the individual market are for families, not for children alone. This means that a family interested in insuring its children will likely be offered family coverage, which can be three to five times as expensive as kids' only coverage. However, even children's policies may be costly for low-income families. One analyst estimated that the monthly premium for two children without their parents would be about $100, or $1,200 per year (Lack, 1997). While affordable for most middle class families, this represents a large proportion of income for a family just above Medicaid eligibility (about $16,000 for a family of four).

C. PROBLEMS ACCESSING EXISTING PROGRAMS

A third reason why children lack health insurance is that they do not or cannot take advantage of available options. The Federal and state governments have developed programs to help insure children. However, many families whose children would be eligible for such programs are barred due to lack of information or lack of program funding.

Medicaid has become a major insurer of children. Medicaid is the joint Federal-state health insurance program that serves 37 million Americans, including over 18 million children. States are required to cover poor children under the age of 14 (for 1997) and will cover all poor children through 18 by 2002. Additionally, most states have taken advantage of the options available to cover older and/or higher income children (see Appendix B).

Many children are eligible but not enrolled in Medicaid. While most poor children are eligible for Medicaid, about three million uninsured children are not enrolled (Chart 22). Researchers estimate that participation rates for Medicaid-eligible children range from about 40 to 70 percent (Center on Budget, 1997; Urban Institute, 1995). However, Medicaid in general has the highest participation rate of all types of public assistance programs (Census, 1996).

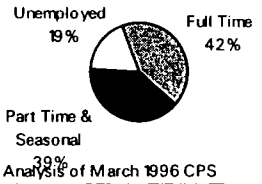


Why children who are eligible for Medicaid remain uninsured. There is no conclusive research on why eligible children without insurance do not enroll in this program which offers free insurance. Suggested explanations include lack of awareness of the option, the fear that work disqualifies children, the uncertainty of Medicaid coverage, and the extent of states' outreach efforts.

Families' lack awareness of Medicaid eligibility. One of the main reasons why children are not enrolled is that their families do not know that they are eligible. One study that interviewed AFDC recipients — who are or were on Medicaid —found that 23 to 41 percent did not know that their children could remain on Medicaid if they lost AFDC but remained poor (Shuptrine et al., 1994). A study of uninsured people in Minnesota who were eligible for MinnesotaCare (the Medicaid buy-in program for low-income families, described later) found that many were not certain if they were eligible or did not know enough to be able to enroll (Call et al., 1996).

Fear that work disqualifies them. Many workers do not know that their children may qualify for Medicaid so long as their family income is below poverty. In fact, most eligible (through poverty-related coverage) but unenrolled children do have working parents (Chart 23). However, Medicaid's historical connection as a "welfare" program may lead families to believe that they are not eligible.

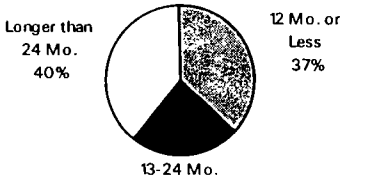
Chart 23. Most Uninsured Children Who Are Eligible For Medicaid Have Parents Who Work



Source: ASPE Analysis of March 1996 CPS

Uncertainty of Medicaid coverage. For a significant number of children, Medicaid coverage does not last long. About 37 percent of children spend less than one year on Medicaid (Chart 24). Short spells probably result from the Federal requirement that monthly changes in income or family status must be reported, which can disqualify the child from Medicaid. There appear to be many families whose incomes fall below and rise above the poverty threshold regularly. Over half of children eligible for Medicaid at some point during a 28-month period were not continuously poor (and thus Medicaid eligible) but went in and out of poverty (ASPE, 1997). The family income for about half of children on Medicaid for a short period of time is typically just above poverty when they are off Medicaid (ASPE, 1997).

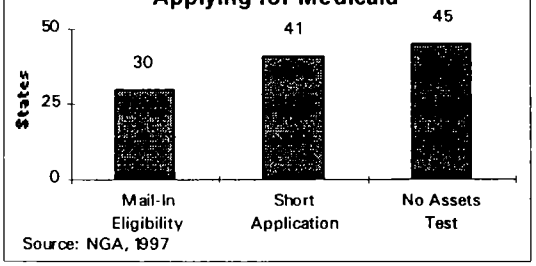
Chart 24. Children's Medicaid Coverage Over 28 Months



Source: U.S. Bureau of the Census, SIPP, 1992-1994

States' emphasis on Medicaid outreach. The lack of awareness of eligibility for Medicaid can be — and has been, in many states — addressed through outreach efforts. The Medicaid program has requirements, options, and incentives for states to reach out to eligible but unenrolled children. States have used a variety of these measures, including simplified applications, mail-in applications, no assets test (meaning only income and not assets like cars are counted toward eligibility), annual rather than 6-month redetermination, and outstationed eligibility workers (Chart 25). In New York, for example, there is a single, one-page application for both WIC and Medicaid. In Ohio and Arkansas, coupon books are used as an incentive for families to seek health care: if they receive care, the provider validates the coupon which may be used for discounted baby care and health products. Many states have hot lines that direct families to needed health services and media campaigns (NGA, 1997).

Chart 25. States' Efforts to Simplify Applying for Medicaid



Source: NGA, 1997

State and private programs offer an option for many children's families. In over 30 states, families may have access to either a state run or a private program for children's coverage. These programs have developed outside of Medicaid for a variety of reasons, including their ability to limit the size of the program since there is no entitlement; limit benefits; offer coverage at the county or city level; and use private donations as a funding source. This flexibility has produced wide variation in the size and scope of the programs. However, they are similar in that they target children who are not eligible for Medicaid.

Outreach is central to these program. One of the features of these state programs has been their innovative efforts to enroll children. In several programs, private businesses helped advertise; for example, one fast-food restaurant used tray liners to describe the program and several chain stores hung posters and distributed fliers. Some states have solicited the help of church groups, parents' groups, and other community-based organizations to educate families about eligibility. One program uses school coaches and shop teachers to promote the program. In a state with a privately sponsored plan, Blue Cross/Blue Shield produced radio and TV announcements using college football coaches to encourage enrollment. Another state used Mister Rogers television ads (U.S. GAO, 1996).

However, enrollment is low since budgets are limited. While these outreach efforts have generally been successful, state and private programs may not cover all eligible children due to funding limits. None of the state-funded or private programs are entitlement programs, or programs that guarantee coverage for all children meeting the eligibility criteria. Most programs have "enrollment caps" so that only a certain number of children may be enrolled. Others limit the program's size through restricting where in a state it is offered. According to a recent study, only half a million children are covered through these programs (Gauthier & Schrodel, forthcoming).

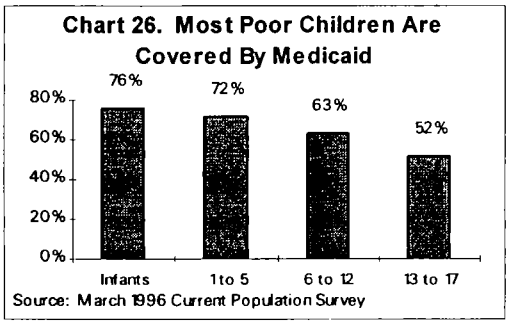
III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

On the face of it, the problems that come with being uninsured, coupled with many reasons why children are uninsured, seem difficult if not impossible to address. Undoubtedly, no simple answer exists. However, there is considerable experience in Medicaid and state programs that can tell us how to expand coverage. Additionally, a child health tax credit was tried; its failure has implications for future attempts at using this type of approach.

A. MEDICAID

When created in 1965, Medicaid was intended to consolidate spending for the low-income elderly and public assistance recipients into one program. Children were eligible for Medicaid if their family received cash assistance or were income eligible for such assistance ("Ribicoff" children). Enrollment of children remained at about 10 million for the first 25 years of the program (HCFA, 1996). Beginning in the mid- to late 1980s, however, changes were made that began de-linking children's eligibility for Medicaid from welfare. A series of bills first offered states the option of covering certain groups of poor children, then required this coverage. This led to the final piece of legislation, OBRA 1990, which made all poor children born after September 30, 1983, are eligible for Medicaid.

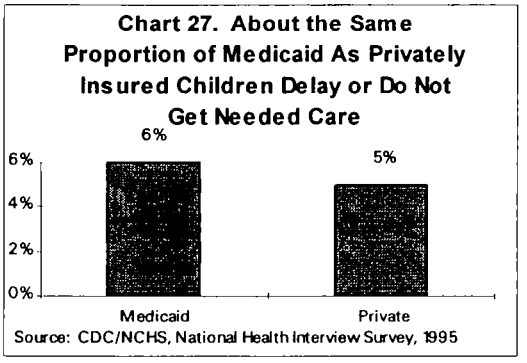
Millions more children covered. Today, about 18 million children receive Medicaid coverage. In 1995, a large proportion of poor children received Medicaid's basic health protections (Chart 26). It also has been instrumental in keeping the proportion of uninsured children from rising. As seen in Chart 2, the number of uninsured children below 133 percent of poverty has fallen — probably because of Medicaid — while the number of children above this level has increased dramatically. Had Medicaid not been expanded, more children would likely be uninsured today.



Major improvements in children's coverage in the South. One of the most pronounced effects of the Medicaid expansion occurred in the South. Southern states have historically had low welfare eligibility levels, which leads to low Medicaid eligibility levels. This meant that the Medicaid expansion to 100 percent of poverty was a larger increase for these than for states with more generous welfare eligibility. In fact, between 1989 and 1993, the number of Southern, uninsured, poor children declined by over 60 percent for children ages 0 to 5 and nearly 40 percent for children ages 6 to 12. At the same time, the number of uninsured poor children ages 13 to 18 — who were not included in the Medicaid expansion — increased (Shuptrine & Grant, 1996). While there is still a higher proportion of uninsured children in the South, the expansion has reduced the disparity in children's coverage across the nation.

Has Medicaid "crowded out" private coverage? One question raised about the Medicaid expansion is whether all of the children gaining Medicaid were uninsured before enrolling. Some families, faced with the choice of paying the family share of a premium or enrolling their children in Medicaid, may chose the latter. This substitution of public for private coverage is known as "crowding out". While almost all researchers acknowledge that the incentive exists, there is some disagreement on the degree to which this occurred (Cutler & Gruber, 1996; Dubay & Kenney, 1995; Shore-Sheppard, 1996; Yazici, 1996). However, evidence of a decline in the number of poor children who are uninsured, as well as the fact that there is not that much private coverage for families in Medicaid eligibility range, suggests that if it did occur, it was not on a large-scale basis.

Medicaid improves access to care. While Medicaid children do not have the same level of access to care that privately insured children do, they are better off than uninsured children on all measures. Only 5 percent of children with Medicaid lack a regular source of care, compared to 20 percent of uninsured children (NCHS, 1997a). Whereas 20 percent of uninsured children delays or does not get needed care, only 6 percent of Medicaid children experience these problems (Chart 27). One study found that children with Medicaid coverage had significantly more preventive care visits than did uninsured children (Gavin & Bencio, 1995). Another found that for illness-related care (physician visits and hospitalization), Medicaid children appeared to have better access than uninsured children (Gavin & Bencio, 1996).



B. STATE EXPERIENCES

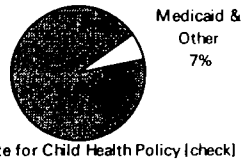
In addition to their role in Medicaid, many states have expanding coverage to children through state-funded or private programs. From these experiences, different lessons may be learned. The approach that each state has taken is unique, reflecting its particular problem, availability of funding, and health care system among other factors (see Appendix B). The following is a description of several of the largest programs (in alphabetical order) that have been operational for several years and have been evaluated for their preliminary successes and failures.

Florida

School-based system. Using schools to educate and enroll children, the Florida Healthy Kids program began as a demonstration in one county and has expanded to 13 counties, with plans to expand further. This program offers comprehensive coverage to uninsured children aged 5 to 19 and, in some counties, their pre-school siblings. Parents pay a sliding-scale premium for the coverage; the amount of the premium is determined by a child's eligibility for the School Lunch Program. There is no upper income limit for participation. Families with incomes above 185% of federal poverty pay the full premium. Services are funded by a mix of state, local public and private funds, and family premiums.

Not displacing private insurance. About 40,000 children are covered through the Florida Healthy Kids program. Almost all of the children were uninsured before enrolling (Chart 28). Of the 7 percent of children who were insured, 94 percent had been on Medicaid. This suggests that the program is not serving as a substitute for existing coverage, but is efficiently targeting uninsured children. About 80 percent of the children are in families with incomes below 185 percent of poverty.

Chart 28. Previous Insurance Status of Children Enrolled in Florida Healthy Kids



Source: Florida Institute for Child Health Policy [check]

Lower emergency room use. An evaluation of the original demonstration project found that children enrolled in Florida Healthy Kids program were much less likely to use emergency rooms. It also found that the health care utilization patterns of these children more closely resembles those of privately insured than Medicaid covered children (Abt, 1996). This suggests that the program is not attracting "bad risks" and is successful at insuring children without creating excessive demand. The program has received a grant from the Robert Wood Johnson Foundation to promote replication in other states, and also recently received an Innovations in American Government award from the Ford Foundation and Harvard University.

Minnesota

Evolution from a small state program to a large Medicaid expansion. In the late 1980s, Minnesota established the Children's Health Plan that offered subsidized coverage to uninsured children. In 1992, it replaced this program with MinnesotaCare that covers children as well as some uninsured adults. Minnesota is using an 1115 Medicaid waiver to cover children and pregnant women enrolled in MinnesotaCare; the state finances its share of the program through a 2 percent provider tax.

Nearly 50,000 children covered. As of July 1995 MinnesotaCare covered approximately 44,000 children. They receive comprehensive benefits provided through the state's network of Medicaid providers. Children are eligible if (1) their family income is below 275 percent of the federal poverty level, (2) they are uninsured for four months prior to enrollment, and (3) are ineligible for employer-subsidized insurance (where the employer subsidizes at least 50 percent of the cost of the premium). Exceptions to the disqualifications are made for children with income less than 150 percent of poverty. One study found that only 2.8 percent of MinnesotaCare participants gave up private employer-based insurance to join (Lurie et al., 1995).

Positive attitude toward MinnesotaCare. One of the concerns about publicly subsidized programs is stigma: the negative "welfare" association with such a program that can discourage enrollment. In a study of enrollees of MinnesotaCare, however, researchers found that enrollees felt positive about the program (Lurie et al., 1995). About 85 percent of enrollees responding to the survey felt as though they were treated like anyone else. They also felt good about toward contributing to the cost of coverage (Chart 29).

Chart 29. Good Feeling About Contributing to Costs of Health Insurance in MinnesotaCare

Source: Lurie et al., 1995

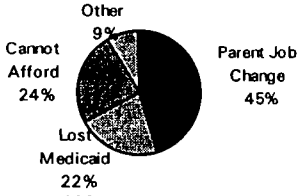
New York

Insurer-based children's program. New York's Child Health Plus program was enacted in 1990, became operational in 1991, and was expanded in June 1996 to cover additional age groups and include inpatient services. Unlike most states, New York pays direct subsidies to 15 participating insurers to provide health insurance coverage to children meeting eligibility criteria. Children are eligible for Child Health Plus if they (1) are under the age of 19, (2) reside in New York State in a household having a gross income at or below 222 percent of the federal poverty level, (3) are not eligible for Medicaid, and (4) do not have equivalent health coverage. This is the largest state program; the funding appropriated for 1997 is $109 million. The program is funded by the Statewide Health Care Initiatives Pool as well as from premium contributions from families.

Enrollment is expanding. In September 1996, about 110,000 children were enrolled in Child Health Plus. About 383,000 children will be eligible for enrollment after the expansion of age limits (to include ages 15-18 years old). Families whose incomes are between 160 and 222 percent of poverty pay $25 per child per year (up to a $100 maximum per family per year). Families with gross incomes that exceed 222 percent of the federal poverty level can purchase Child Health Plus for the cost of the full premium (ranging from $498 to $798 per year). The program provides comprehensive primary, preventive, outpatient care, inpatient care (in the process of implementation), prescription drugs and therapeutic services, with no pre-existing condition exclusions.

Fills important gaps in insurance coverage for children. An evaluation of the Child Health Plus program found that the program filled an important, unmet need. As indicated in national statistics, most children enrolled in the program had become uninsured because their parents lost or changed jobs; others lost Medicaid or could not afford coverage (Chart 30). The evaluation also found significant improvements in access and quality of care. For example, parents of children with asthma reported that their children received more primary and specialist visits, and that the health status of their child had improved (Szilagyi et al., 1996).

Chart 30. Reasons Why NY Child Health Plus Enrollees Became Uninsured Before Enrolling

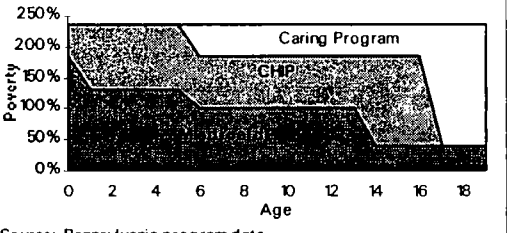


Source: Szigalyi et al., 1996

Pennsylvania

Seamless health coverage for children. One of the earliest state programs for children developed in western Pennsylvania. In 1985, steel mills in that region shut down, leaving many children and their families without insurance. In response, the Western Pennsylvania Caring Foundation was created by local ministers in cooperation with Blue Cross of Western Pennsylvania. It began by providing only preventive and primary care, but now provides comprehensive coverage. Pennsylvania now has a three-tiered, comprehensive, seamless insurance program for children (Chart 31). The first tier is Medicaid, which covers poor children. The second is the Children's Health Insurance Program (CHIP), funded by a dedicated two-cent state cigarette tax and administered by the Caring Foundations. Third, the Caring Program subsidizes children who fall between Medicaid and CHIP eligibility and 235 percent of poverty. The Caring Program is funded by BC/BS and private donations.

Chart 31. Eligibility for Pennsylvania's Children's Health Programs



Source: Pennsylvania program data

Successful outreach. Currently, approximately 50,000 children are enrolled in these programs and there is a waiting list of 5,000 children. Children receive comprehensive benefits, and families above 185 percent of poverty contribute toward this coverage. The state's high participation is due to aggressive outreach. For example, members of the Pittsburgh Steelers football team have been active in educating families about their eligibility. [add information from J. Lave evaluation; other state caring programs.]

C. 1990 CHILD HEALTH TAX CREDIT

The tax system offers an alternative to state administration of subsidies for health coverage. Today, most insured Americans benefit from preferential tax treatment of health insurance. Extending deductibility of health insurance or creating a tax credit for children's health coverage could encourage some families to insure their children.

The use of child health tax credits was tried in 1991 to 1992. The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a tax credit for health insurance that covers children. It was added to the earned income tax credit (EITC). An EITC-eligible family could receive a tax credit for its health insurance premium payments if its plan was not an indemnity type and included coverage for children. It was administered as an end-of-the-year credit against taxes or refund if it exceeded the family's tax liability. Unlike the EITC, it could not be received in "advances". About 2.3 million families received the health tax credit in 1991 at a cost of $496 million.

This health insurance credit was repealed in OBRA 1993. Following two years of experience, the President and Congress repealed this provision in 1993. The Treasury Department itself recommended its repeal. There are two main reasons for this. First, it was difficult for the Internal Revenue Service (IRS) to efficiently and accountably administer the credit. For example, the IRS could not determine whether a health insurance plan met the eligibility criteria for the credit. The only information that the IRS received was the amount of the premium paid and (in 1991 only) the name of the insurance plan. A House oversight committee study found that families often bought ineligible policies like cancer and dread disease policies and policies with two-year pre-existing condition restrictions. The IRS could not prevent this.

A second problem was low participation. The GAO estimated that only 26 percent of the people eligible for the credit received it. Of those, who received it, it is not clear how many, if any, of these families had previously been uninsured. However, given the low subsidy (the average credit was $233) it is unlikely that it served as a great incentive for many uninsured families to purchase coverage.

IV. CONCLUSION [NOTE: VERY PRELIMINARY: STILL WORKING ON IT]

The lack of insurance for millions of American children is clearly a problem. About 10 million American are uninsured during the year, 20 million over the course of 28 months. These children have difficulty accessing the United States' health care system, which is arguably the best in the world. This lack of access may contribute to the relatively low standing of the U.S. in international comparisons. We rank lower than 29 nations on immunization rates and 21 nations in both infant mortality and the probability that an infant will die before reaching the age of 5 years old.

Yet the cause of the problem is not simple or easily addressed. American children receive health coverage through a fragmented system of employer-based coverage, individually purchased coverage, Medicaid, state programs, the public safety net and philanthropy. Employer-based insurance is the primary source of coverage, so it is not surprising that most coverage loss relates to changes in employment. The dynamic U.S. economy has caused shifts of employment to firms that typically do not offer coverage: small business, service jobs, and part-time work, for example. Yet, even if they have access to employer-based insurance or individual market insurance, families may not be able to afford it. Family premiums have rapidly risen, as has the share of the premium paid for by the family. And, simply navigating this complex system to find affordable options presents a challenge to many. Millions of uninsured children have the opportunity to be covered through public or private programs but do not take advantage of it. This complexity suggests that, in the absence of a requirement that every employer and / or family purchase health coverage, the problem cannot be completely solved. However, past and present experience provides ideas on how to design, implement and operate efforts that can make significant improvements in coverage for children.

State experiences. Through Medicaid, state-funded, and private programs, states have led the way in improving children's coverage. Beginning in 1990, states began to phase in nationwide eligibility for poor children for Medicaid. This has resulted in major gains for children in the South, where eligibility through welfare has historically been low. States have also demonstrated that they can efficiently target coverage toward the children who need it. In Florida, the Healthy Kids program appears to be filling an important need while not substituting for existing coverage. Similarly, Pennsylvania was able to coordinate its Medicaid, state-funded, and private efforts to most efficiently create seamless coverage for children. We have also learned from the state experiences that funding is a major barrier; most of the programs have waiting lists.

Tax credits. The Federal government has tried using tax credits to encourage low-income families to purchase coverage for their children. However, this attempt was aborted given oversight problems and low participation. Some of the reasons for the failure could have been addressed with policy changes. For instance, some type of state certification of health plans eligible for the credit could have limited the mistaken

purchase of substandard plans. However, the experience raises serious questions about the effectiveness of tax approaches at encouraging families to cover their children.

Nationwide initiative is needed. The President and the Congress have agreed that additional funding for children's health coverage is needed. Balancing the budget is critical to our children's future. So, too, is investing in children's health coverage so that they will be able to take full advantage of that future. This priority is reflected in the Budget Agreement, which dedicates $16 billion between 1998 and 2002 to expand health coverage for children. This amount represents a meaningful commitment toward covering up to 5 million uninsured children.

Policies should reflect the problem: targeted and state-based. This study focuses on the problem of uninsured children and existing efforts to alleviate it. However, several of its findings may also be useful in establishing policies for this investment.

First, since there is no single group of uninsured children, a targeted approach is needed. Groups of uninsured children to target include: children of workers without access to employment-based insurance; families who cannot afford premiums; children whose parents change or lose jobs; and children for whom Medicaid is an untried or temporary option. For example, Medicaid could be extended for longer periods of time since many children are covered only for several months. Focusing on children whose parents are changing jobs may help to lower the 50 percent of children between 100 and 200 percent of poverty who experience breaks in their private coverage. Or, creating an affordable insurance option for families just above Medicaid eligibility may improve children's coverage.

Second, states may be the best partner for this investment. States have considerable experience in designing and implementing children's health programs. They have also proved that they are interested in expanding coverage to children. This spring alone, about 15 states have planned and/or implemented new or expanded programs for children. Both a grant program and Medicaid options could build upon states' experiences and interest.

Regardless of the specific approach, the policies should build upon the facts and experiences of the past. The problem of 10 million uninsured children is both critical and complicated. This presents policy makers with an enormous challenge, and an enormous opportunity. Carefully designed policy can — and hopefully will — make significant improvements in children's coverage.

APPENDIX A. HEALTH CARE SAFETY NET FOR CHILDREN

The nation's health care provider safety net consists of hospitals, ambulatory care facilities, and other providers who offer care to all regardless of their ability to pay. They operate under both public and private auspices. As a group they are diverse, with varied funding sources which include Medicaid and Medicare, Federal grant support, state and local public funding, a limited amount of private third party insurance, patient fees (often sliding scale), and private philanthropy.

Federal support for safety net providers of particular importance to uninsured children includes:

- The Maternal and Child Health Block Grant The Maternal and Child Health Block Grant is funded at $681 million in FY 1997. Of this amount, $565 million is allocated to States on a formula based on FY 1981 levels of funding for related activities and the relative number of low income children in the State. States must match Federal funds at the rate of three State dollars for every four Federal dollars. They must earmark at least 30 percent of their Federal allotment for preventive and primary care for children and at least 30 percent for children with special health care needs. States use these earmarked funds in a variety of ways: they may provide services directly, award funds to counties and other sub-state units for the direct provision of services, or purchase services either directly or through contract with individual providers, professional groups or health care institutions. In addition to primary and preventive care, services provided through these funds can include enabling services, including outreach, case management, transportation and translation and population-based services such as newborn screening and lead paint screening Approximately 17 million women, infants, children, adolescents and children with special health care needs receive services of some type through this program.

- Community Health Centers (CHCs) The Federal appropriation for health centers for FY 1997 totals $802 million. Funds support community health centers, migrant health centers, health centers for the homeless, health centers in and near public housing and the school health centers funded under the umbrella Healthy Schools, Healthy Communities. Federal grants represent about 30 percent of CHC funding: other funding sources include Medicaid; Medicare; other third party payers; patient fees, which are on a sliding scale, and State, local and other sources of funds. On the average, Federal grant funding per CHC user is approximately $100 for a comprehensive package of primary care and preventive health services. In FY 1995, approximately 42 percent of health center patients were uninsured. Approximately 44 percent of the FY 1997 estimated 8.3 million CHC users are children through age 19.

- The Indian Health Service (IHS) funds the delivery of health care to 555 federally recognized Indian tribes and 34 urban health projects located in 35 States. Its FY 1997 appropriation totals $2.054 billion. Care is provided through 49 hospitals, 195 health centers, 8 school health centers, and 289 health stations, satellite clinics, and Alaska village clinics which are administered either by the Tribes or directly by the IHS. Of the 1.3 million active users of the system, about 43.8 percent are children through age 19. The IHS collects payments from those it serves who are insured through Medicaid, Medicare or private insurance, but provides care without charge to those without insurance.

- Federal Disproportionate Share Hospital Payments/Hill Burton Uncompensated Care Obligations Federal funds help to subsidize hospital costs for uncompensated care for uninsured children are provided through payments to States under the Medicaid Disproportionate Share Hospital (DSH) program. It is estimated that Federal payments will total $9.8 billion in FY 1997 for this purpose. Hospitals which received construction funds through the Hill Burton Act are required to provide a reasonable volume of support for persons unable to pay for services for a 20 year period. In FY 1996, approximately 1650 institutions had such obligations. They provided approximately $700 million in care to about 2 million individuals. The number of obligated facilities is decreasing: by 2000, fewer than 700 institutions will have Hill-Burton obligations.

- Childhood Immunization The Vaccines for Children (VFC) program provides for the purchase of vaccines for all children who are uninsured, those eligible for Medicaid, Native American children, and for those children whose insurance does not cover immunization who receiving care through Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Vaccines are now provided to private providers at 28,000 sites with multiple providers and to approximately 9,000 public clinics in addition to FQHCs and RHCs. Expected expenditures in FY 1997 for VFC are $373 million.

Much of the care delivered to children through the safety net is provided by public health clinics and children's hospitals. Public health clinics operated by the State, county, or local municipality are a significant source of ambulatory care for uninsured children. Freestanding children's hospitals represent only one percent of all hospitals but are a particularly important source of care for uninsured children. Most children's hospitals are affiliated with academic institutions. Roughly half of the care they provide is to poor children and three quarters of their care is to children with chronic or congenital conditions. In FY 1995, they were responsible for 4.6 million primary and specialty outpatient visits, over 1.6 million emergency department visits, and 2.1 million inpatient days, with gross patient revenues of $7.8 billion. On average, 42 percent of the care they provide is to Medicaid children, an additional 5 percent is to uninsured children.

APPENDIX B: STATE PROGRAMS

[note: to be checked; will add initiatives from the Spring of 1997]

State	Uninsured under 19	Medicaid Expansions	State Program	State Funds?	Current Enrollment
AK	19,000	None	None		
AL	193,000	None	Alabama Caring Program for Children	N	6,353
AR	129,000	None	None		
AZ	248,000	Infants: 140%			
CA	1,775,000	Infants: 200% 13-19: 100%	Access to Infants and Mothers (AIM) (pregnant women and infants <2; <300%) CaliforniaKids (Caring Program)	Y N	11,000 (AIM) 8500 (CalifKids)
CO	125,000	None	Child Health Plan (public/private) School Connections (Kaiser Permanente) Caring Program	Y	6,200 (CHP) New (SC) 3,500 (CP)
CT	85,000	0-13: 185%	Healthy Steps	Y	
DC	25,000		None		
DE	22,000	Infants: 185% 13-19: 100%	None		
FL	652,000	Infants: 185%	Florida Healthy Kids Program (1-19; no income limits, sliding scale premium)	Y	36,000
GA	319,000	Infants: 185% 13-19: 100%	Caring Program for Children	N	900
HI	24,000	0-19: 300%			
IA	92,000	Infants: 185%	Caring Program for Children	Y	2000
ID	49,000	None	Caring Program for Children	N	490
IL	344,000	None	None		
IN	184,000	Infants: 150%	None		
KS	82,000	Infants: 150% 13-17: 100%	Kansas Caring Program for Children Caring Program of Kansas City	Y	2700
KY	139,000	Infants: 185% 13-19: 100%			
LA	268,000	None	Caring Program for Children	N	375
MA	140,000	Infants: 185%	Children's Medical Security Plan	Y	20,000

MD	158,000	0-13: 185% (primary and preventive care only)	Kids Count (Caring Program for Children)	N	1300
ME	40,000	Infants: 185% 6-19: 125%	None		
MI	235,000	Infants: 185% 6-15: 150%	Caring Program for Children	Y	4,650
MN	85,000	0-21: 275%			
MO	155,000	Infants: 185% 13-19: 100%	Caring Foundation for Children--St. L Caring Foundation for Children--K City	N	5500
MS	146,000	Infants: 185%	Caring Program for Children (Discontinued)	N	860
MT	29,000	None	Caring Program	Y	1400
NC	221,000	Infants: 185% 13-19: 100%	Caring Program	Y	5,500
ND	16,000	13-18: 100%	Caring Program for Children	N	450
NE	47,000	Infants: 150%	None		
NH	31,000	0-19: 185%	Healthy Kids	Y	1,600
NJ	243,000	Infants: 185%	Health Access New Jersey	Y	5800
NM	137,000	0-19: 185%	None		
NV	76,000	None	None		
NY	627,000	Infants: 185%	New York's Child Health Plus Program	Y	110,500
OH	317,000	None	Caring Program for Children (Closed to new participants)	N	2680
OK	216,000	Infants: 150%	Oklahoma Caring Program for Children	N	760
OR	109,000	13-19: 100%	None		
PA	323,000	Infants: 185%	Pennsylvania's Children's Health Insurance Program and Caring Programs for Children	Y	43,000
RI	28,000	0-7: 250%	RiteCare (1115)		
SC	157,000	Infants: 185%	None		
SD	23,000	13-19: 100%	Caring Program for Children	Y	370
TN	182,000	Infants: 185% 13-18: 100%	None		

TX	1,347,000	Infants: 185%	Caring Program for Children	N	
UT	72,000	13-18: 100%	Caring Program for Children	N	1,100
VA	204,000	13-19: 100%			
VT	13,000	0-18: 225%			
WA	141,000	0-19: 200%			
WI	98,000	0-5: 185%	None		
WV	60,000	Infants: 150% 13-19: 100%	Caring Program	Y	149
WY	22,000	Minimum	Caring Program	N	400

May 14, 1997

MEMORANDUM

TO: Frank Raines

FROM: Marian Wright Edelman

RE: Child Health in the Budget

I understand that the budget agreement may be finished in the next couple of days. I urge you to make sure that there is no language in the documents or the White House description of the budget agreement that in any way interferes with our ability to build on the budget agreement this year and to pass legislation to cover all uninsured children through the Hatch-Kennedy bill.

I was encouraged by the President's statement a couple of weeks ago on "Face the Nation" that he would like to find a way to combine the various child health proposals and cover all 10 million children. As you know, the Children's Defense Fund's top priority this year is passage of the Hatch/Kennedy CHILD health bill, S. 525 and S. 526. Momentum is growing for insuring all 10 million uninsured children through Hatch/Kennedy and the complementary Medicaid initiatives.

In this context:

- Language about the money in the budget agreement representing "full funding" to cover uninsured children would not be helpful, since fewer than half of uninsured children are covered within its parameters.

- Any other language in the budget agreement or documents describing it that suggests the money in the budget agreement finishes the process of covering uninsured children or precludes other steps also would be unhelpful.

- Any language that suggests the next 5 million uninsured children are a more complicated group to cover (for reasons of employer crowd-out or otherwise) would be counter-productive, particularly since we believe the Hatch/Kennedy bill solves these problems.

Also, I hope that the rumors I am hearing that the budget agreement's health money may be described as a tax credit in order to improve the distribution tables for the tax cuts are wrong. Given the failed history of tax credits for child health and the momentum in Congress in more positive directions, it would be a shame to harm children's health in order to give the appearance that the tax cuts are less regressive. Anything that moves child health money toward tax credits will undercut all of the good work that has been done to build momentum for Medicaid expansions and vouchers to cover children.

Q: WHY DID YOU OPPOSE THE HATCH-KENNEDY AMENDMENT TO EXPAND HEALTH CARE COVERAGE TO MORE CHILDREN?

The President's position on extending health coverage to children has been clear. The debate on the Senate floor did not reflect our overall position on this issue. We have an agreement --to which both sides have committed --to not attach anything to the resolution.

We support the efforts of Hatch-Kennedy. But a deal is a deal and passing Hatch- Kennedy as an amendment to the budget resolution would be inconsistent with that agreement. Our commitment to health care coverage is well known, and I will fight this year and beyond to build on the $16 billion investment for children's health we have already achieved in the balanced budget agreement.

Q: WHY DID YOU OPPOSE THE HATCH-KENNEDY AMENDMENT TO EXPAND HEALTH CARE COVERAGE TO MORE CHILDREN?

I do not oppose the tobacco tax to be used as a financing mechanism for more health coverage, nor do I oppose the goals of the Hatch-Kennedy legislation. In fact, I am committed to building on the $16 billion we have achieved in the balanced budget agreement. I look forward to working with Senator Hatch, Senator Kennedy, and other members in this regard.

My primary concern with the budget amendment offered yesterday was that I feared that it would severely undermine the possibility of a balanced budget agreement, including the $16 billion investment for children. My commitment to health care coverage is well known, and I will fight this year and beyond to expand health care coverage.

Q: REP. GEPHARDT CRITICIZED THE BUDGET AGREEMENT BECAUSE AT THE SAME TIME YOU STRESS THE IMPORTANCE OF INVESTING IN CHILDREN'S COVERAGE YOU CUT MEDICAID SPENDING, WHICH HELPS HOSPITALS THAT SERVE UNINSURED CHILDREN. HOW DO YOU RESPOND TO THIS CRITICISM?

A: Studies have shown strong evidence that our Medicaid disproportionate share spending is not being appropriately allocated to hospitals that serve a greater portion of low-income and uninsured populations (e.g. Urban Institute). It is for this reason that even the public hospitals have said that we can get more savings from DSH if we better target this funding to these types of hospitals. We are currently working with the public hospitals to push the Congress to do just that.

Moreover, since we are investing $16 billion to cover millions of uninsured children, these hospitals will treat more children who have health care coverage, thereby reducing their need for DSH funding to help offset uncompensated care.

Q: DOESN'T YOUR CHALLENGE TO DEVELOP AN AIDS VACCINE IN TEN YEARS RING HOLLOW SINCE YOU ARE NOT INVESTING ANY ADDITIONAL FUNDING IN THIS EFFORT?

A: According to National Institutes of Health Director, Dr. Varmus, and Director of the Office of AIDS Research at NIH, Dr. Paul, challenging the scientific community greatly enhances the likelihood that we will develop an AIDS vaccine. Moreover, we have backed this challenge with a series of

investments and initiatives to increase the likelihood that we will reach our goal. In the last two years, I have increased funding for the AIDS vaccine by 33 percent, and my FY 1998 budget increases spending for AIDS vaccine research by $17 million.

Moreover, I have announced that there will be a new AIDS Vaccine Center at NIH. Our medical and scientific leaders believe that uniting scientists in immunology, virology, and vaccinology will create a highly collaborative effort to help develop an AIDS vaccine. I am also asking the leaders of the eight major industrialized nations meeting at the Denver summit in June to support a worldwide AIDS vaccine research initiative. To fully commit ourselves to developing an AIDS vaccine, we need to make sure that the best minds throughout the world are working together towards this goal.

Q: FOLLOW: WHY ARE YOU ISSUING THIS CHALLENGE NOW? AND WHY ARE YOU FOCUSING ON AN AIDS VACCINE RATHER THAN OTHER DISEASES?

A: In the last twelve months we have made tremendous progress in our understanding of the AIDS virus. The leaders at NIH have told me that we are moving forward on developing a vaccine for AIDS and that we have an opportunity now to focus our efforts on developing an AIDS vaccine. They believe that by issuing a challenge to the scientific community, bolstered by our new investments and initiatives, will greatly increase the likelihood that we will be able to develop a vaccine in the next decade.

Scientific leaders have also told me that we have made progress in our understanding of immunology. They believe that bringing together all of this new knowledge will not only increase the likelihood that we will develop an AIDS vaccine but also could provide a new paradigm for vaccines that will help develop effective vaccines for other diseases.

While developing an AIDS vaccine is an important priority, it in no way undermines our commitment to biomedical research in other areas. Since I took office, we have increased overall spending at the National Institutes of Health by 16 percent, including a 76 percent increase in breast cancer research. My FY 1998 budget allocates $13.1 billion for NIH.

It is also important to note that this commitment in no way undermines our investments in AIDS treatment and prevention, both of which have consistently received increased funding since I have been in office. We recognize that millions of people around the world already have AIDS, and we must continue to develop treatments and provide them to as many people

as possible, while at the same time stressing prevention. I will continue to bolster our efforts in those areas.

Q: REPORTS HAVE SUGGESTED THAT THE ORIGINAL MEDICARE PREMIUM ESTIMATES WERE TOO LOW AND THE ACTUAL INCREASE WILL BE TWICE AS HIGH AS PREVIOUSLY PROJECTED (ABOUT A DOLLAR A MONTH). IS THIS TRUE?

A: **While original preliminary CBO projections may have been slightly off, we still estimate that the Part B premium will be only about $1 more in 1998 than under current law.** In subsequent years within the 5-year Budget Agreement, the annual increase should be no more than about $2 more per month. As a result, by 2002, we project the premium being approximately $8 more than it otherwise would have been without the home health reallocation.

Regardless of the final projection, the Part B premium will be almost $20 per month less than it would have been if it was set at the same 31.5 percent level that I vetoed. The monthly premium under the 1997 Budget Agreement will be about $69 in 2002. If the policy were a 31.5 percent premium instead of 25 percent, the premium would be about $87. In 2002 alone, this would equate to about $215 a year more for a single beneficiary, $430 for a couple.

Low-income beneficiary protections are expanded. Unlike the 1995 Budget Agreement that I vetoed, which eroded current-law low-income protections, the 1997 Balanced Budget Agreement invests $1.5 billion to expand premium assistance to low-income beneficiaries. We believe this commitment will help many of the estimated 2.5 million Medicare beneficiaries who have incomes between 125 and 150 percent of poverty--just above the current eligibility level for Medicare premium protection.

Savings from the new premium are offset by investments in beneficiary improvements. The $9 billion in savings that comes from gradually including home health in the 25 percent premium is virtually identical to the amount of money dedicated to the investment in new benefits. Specifically, the 1997

Balanced Budget Agreement invests $3-4 billion in new preventive benefits (which will, for example, detect breast and colon cancer, and cover the management of diabetes), $4 billion to limit excessive hospital outpatient coinsurance to beneficiaries, and $1.5 billion in premium protections for low-income Medicare beneficiaries. (This contrasts with the vetoed 1995 balanced budget agreement, which reinvested virtually none of its much greater beneficiary savings for benefit enhancements.)

- I know that many of you may be thinking about children's health because of the action taken in Congress yesterday. In fact, I wrote my column about children's health this week.

- I want you to know that the President is committed to children's health, which is why he worked so hard to get a $16 billion investment in the budget resolution. He couldn't support the Hatch-Kennedy proposal yesterday because he had to safeguard this agreement. But he supports the thrust of the bill, and he will look for ways to advance this effort in the months ahead.

- [OPTION: I believe the tobacco tax is one good way of addressing the many needs of children that confront our nation while reducing dependence on tobacco, especially by young people.]

June Shih
05/20/97 01:03:46 PM

Record Type: Record

To: cre8ors @ aol.com @ inet, Jennifer L. Klein/OPD/EOP

cc:
Subject: HRC COLUMN

FIRST LADY HILLARY RODHAM CLINTON
COLUMN FOR RELEASE MAY 21, 1997
TALKING IT OVER/CREATORS SYNDICATE

When my daughter Chelsea was 9, she had to have her tonsils taken out. Though we knew it was a low-risk medical procedure, Bill and I were nervous wrecks.

But we knew that our family was lucky because we had health insurance. Paying for Chelsea's hospital stay was the least of our worries.

Given the stress we felt when our own child was hospitalized overnight for a relatively minor illness, I can barely imagine the heartache parents who can't afford health insurance for their children must feel each time a child becomes ill. In too many cases, they are overwhelmed by questions not only of how and when their sick child will respond to treatment, but of whether they will be able to afford the necessary medical care in the first place.

The time is long overdue for all of us to address what I believe is an economic, social, and moral crisis in our country. The United States is the only industrialized nation that does

not extend health coverage to all of its children. There is no good reason why our country, which is blessed with the most advanced and innovative medical facilities and talent in the world, continues to allow so many of our children to grow up without regular access to basic health care.

Today, nearly 10 million American children under 18 have no health insurance. A recent study has shown that 20 million children were without insurance for at least one month over a two-year period. As health care costs and insurance premiums continue to rise, fewer employers are offering health insurance to their workers. And more and more working parents are finding that, after paying the rent, heat, electricity and grocery bills, they cannot afford insurance for their children.

What is most surprising is that the majority of our uninsured children is not poor. At least two-thirds of all uninsured children are being raised by working parents whose incomes are above the official poverty level. In fact, the number of poor, uninsured children has been decreasing, (thanks to Medicaid), while the number of uninsured middle class children has been increasing.

What this means is that too many children having trouble seeing a blackboard do not get the glasses they need to correct their vision; too many nagging coughs go untreated until they worsen into life-threatening conditions that may require costly treatments and lengthy hospital stays; too many parents are forced to forbid their children to play sports or visit the

playground for fear that every scrape or fall could lead to an impossible choice between buying medicine for that sick child or food for the entire family.

Some people believe we cannot guarantee health care to all children because of cost. But, as other countries have already found, a sensible child health insurance system is a critical, cost-effective investment. That's because most children who become seriously ill or injured are eventually treated somewhere and at a much greater cost than their parents -- or we -- would have paid if their symptoms had been treated earlier.

In negotiations over the new balanced budget, the President has made sure that as many as five million children currently living without health insurance can get the coverage and care they deserve. And this Spring, several bills are making their way through Congress that build on innovative efforts begun in individual states to cover uninsured children and make it easier for working parents to buy health insurance for their children.

In recent years, many states have been able to insure thousands of children by expanding Medicaid benefits to cover older children and children living in families whose incomes are slightly above the poverty level. Others have created new state-funded child insurance programs or joined forces with private insurance companies to subsidize premiums for needy families. Some states have even implemented a combination of all these strategies.

These efforts represent a good start. But the question of whether a sick American

child gets needed medical treatment should not depend on where he or she lives. We must encourage members of Congress to create a plan that ensures every single child in our country enjoys the health care and security Bill and I would provide our own daughter.

Providing health care to all of our children is more than just a political challenge. It is a test of our faith in the future and of whether our rhetoric about family values will be translated into action on behalf of our children. We can not afford to fail.

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May 5, 1997

Jordan J. Cohen, M.D.
President
Association of American
Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037-1127

Dear Dr. Cohen:

Thank you so much for your letter. I appreciate the AAMC's strong support of my Administration's efforts to extend health care coverage to millions of our nation's uninsured children.

Hillary and I were delighted that you attended the Conference on Early Child Development and Learning. Your participation that day set a wonderful example for all the leaders in the field of health care. I am confident that with the continued support of leaders like you and groups like the AAMC, we can succeed in our mission and create a stronger, healthier future for our children.

Hillary joins me in sending best wishes.

Sincerely,

BILL CLINTON

BC/SSF/RLM/jfc (Corres. #3489073)
(5.cohen.jj)

cc: Jim Dorskind/TDS, 94 OEOB
cc: Jenn Klein, West Wing
cc: Wayna Wondwossen, 93 OEOB

THE WHITE HOUSE

WASHINGTON

April 14, 1997

Mr. Ronald Compton
Chairman and Chief Executive Officer
Aetna, Inc.
151 Farmington Avenue
Hartford, Connecticut 06156

Dear Mr. Compton:

As you may know, this Thursday, April 17, 1997, the First Lady and I will host the *White House Conference on Early Childhood Development and Learning: What New Research on the Brain Tells Us About Our Youngest Children.* This conference will showcase current scientific research on early brain development and examine applications of this research for parents, caretakers, and policy makers. The conference is designed to give all of us -- families, medical, business, and faith communities, policy makers, and caretakers -- the best information on how to enhance our children's development during their earliest years of life.

I understand that our conference coincides with a forum you are convening with representatives of teaching hospitals and medical schools from around the country on Academic Medicine and Managed Care, and I commend you for your efforts to address this issue.

I am pleased that medical schools and teaching colleges have been important leaders in the struggle to improve health care for our nation's children. Because of our mutual determination to achieve this goal, I would like to invite you and your forum participants to the reception that follows the White House Conference. I believe that you will all find this reception to be a wonderful opportunity to meet a broad-based group of experts who share your commitment to children's health.

My staff will provide you with details, and I hope that many participants in your forum will choose to join us here.

Sincerely,

Bill Clinton

NATIONAL CENTER FOR EDUCATION STATISTICS

Digest of Education Statistics 1996

Thomas D. Snyder
Project Director

Charlene M. Hoffman
Production Manager

Claire M. Geddes
Program Analyst

U.S. Department of Education
Office of Educational Research and Improvement **NCES 96-133**

Table 47.—Child care arrangements of preschool children, by age and household characteristics: 1991 and 1995

Characteristics	Children[1]		Percent in nonparental arrangements[2]			Percent with parental care only
	Number, in thousands	Percent	Relative care	Nonrelative care	Center based program[3]	
1	2	3	4	5	6	7
	1991					
Age, total	8,428	100.0	16.9	14.8	52.9	31.0
3 years old	3,749	44.5	16.1	14.8	42.3	37.8
4 years old	3,636	43.1	18.1	14.8	60.4	25.9
5 years old	1,044	12.4	15.8	15.0	63.9	24.3
Race/ethnicity						
White, non-hispanic	5,867	69.6	14.8	17.3	54.0	30.6
Black, non-hispanic	1,239	14.7	24.1	7.8	58.2	25.0
Hispanic	1,002	11.9	19.5	9.7	38.9	40.8
Other	319	3.8	19.3	12.1	63.2	32.6
Household income						
$10,000 or less	1,495	17.7	19.8	6.3	44.0	42.4
10,001 to 20,000	1,437	17.0	10.3	11.8	44.5	35.0
20,001 to 30,000	1,711	20.3	18.0	12.9	44.5	38.5
30,001 to 40,000	1,319	15.7	15.9	15.7	53.2	29.7
40,001 to 60,000	936	11.1	16.6	21.4	60.0	22.1
60,001 to 75,000	974	11.6	15.6	21.9	68.4	15.2
More than 75,000	556	6.6	9.6	25.9	80.4	9.8
	1995					
Age, total	9,232	100.0	19.4	16.9	55.1	25.9
3 years old	4,126	44.7	21.4	18.5	40.7	32.0
4 years old	4,065	44.0	18.3	15.3	64.7	22.2
5 years old	1,041	11.3	15.1	17.2	74.5	16.2
Race/ethnicity						
White, non-hispanic	6,337	68.6	16.5	19.4	55.9	26.2
Black, non-hispanic	1,396	15.1	28.6	11.3	59.5	20.3
Hispanic	1,042	11.3	22.6	12.6	37.4	38.4
Other	457	5.0	22.6	10.6	66.7	24.2
Household income						
$10,000 or less	1,795	19.4	18.1	10.5	48.8	34.4
10,001 to 20,000	1,204	13.0	25.2	15.1	44.8	32.7
20,001 to 30,000	1,484	16.1	20.7	12.5	46.5	34.2
30,001 to 40,000	1,319	14.3	20.0	20.3	48.1	29.7
40,001 to 50,000	1,037	11.2	18.1	19.8	55.5	23.1
50,001 to 75,000	1,381	15.0	18.8	19.1	71.1	11.8
More than 75,000	1,012	11.0	13.7	26.2	82.2	7.8

[1] Estimates are based only on children 3 to 5 years old who have not entered kindergarten.

[2] Columns do not add up to total because some children participated in more than one type of nonparental arrangement.

[3] Center based programs include day care centers, nursery schools, prekindergarten, preschools and Head Start programs

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Household Education Survey (NHES), 1991 and 1995. (This table was prepared July 1996.)

Table 48.—Percent of public school kindergarten teachers indicating the importance of various factors for kindergarten readiness: Spring 1993

Kindergarten readiness factors	Not at all important	Not very important	Somewhat important	Very important	Essential	Percent rating readiness factor as "Very important" or "Essential," by percentage of school's students eligible for free or reduced-price lunches		
						Less than 20 percent	20 to 49 percent	50 percent or more
1	2	3	4	5	6	7	8	9
Is physically healthy, rested, and well nourished	0	(!)	4	24	72	97	93	93
Finishes tasks	0	11	47	31	8	43	40	37
Can count to 20 or more	00	04	26	0	0	0	0	8
Takes turns and shares	2	8	34	07	10	64	55	56
Has good problem-solving skills	8	23	44	20	5	29	33	33
Is enthusiastic and curious in approaching new activities	1	3	19	43	33	83	76	73
Is able to use pencils or paint brushes	16	27	38	18	5	23	21	19
Is not disruptive of the class	2	8	30	36	24	61	58	61
Knows the English language	13	12	33	24	17	40	45	39
Is sensitive to other children's feelings	1	6	36	41	17	51	58	58
Sits still and pays attention	3	12	43	30	12	48	37	43
Knows the letters of the alphabet	27	30	33	6	4	7	9	13
Can follow directions	2	7	31	41	19	61	61	58
Identifies primary colors and basic shapes	13	24	40	17	7	22	21	27
Communicates needs, wants, and thoughts verbally in child's primary language	1	1	15	41	43	85	84	83

! Less than 0.5 percent.

SOURCE: U.S. Department of Education, National Center for Education Statistics, Kindergarten Teacher Survey on Student Readiness. (This table was prepared April 1994.)

THE PRESIDENT'S FY 1998 BUDGET
CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. While there are many different reasons why children lack insurance, most uninsured children face at least one of three obstacles — each of which calls for a different policy solution.

- **Children at risk because their parents change jobs:** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs.

- **Children whose parents earn too much for Medicaid but too little for private coverage:** The highest rate of uninsured children is among families who earn too much to qualify for Medicaid but too little to afford coverage. Nearly one in four children in families with income just above poverty have no health insurance.

- **Children eligible but not enrolled in Medicaid:** Medicaid has not reached all the children who qualify for it. About 3 million children are eligible but not enrolled. In addition, enrolled children often lose Medicaid when their family income fluctuates.

The President's children's health initiative that addresses each of these groups will extend coverage to up to 5 million uninsured children by 2000.

Continuing Coverage for Children Whose Parents are Between Jobs

- The President's budget will give States grants to temporarily cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window.

- The program, which is structured as a four-year demonstration, will offer temporary assistance (up to 6 months) to families who would otherwise lose their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. State participation in this grants program is optional.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. Only families who do not have access to Medicaid or insurance through a spouse's employer and are receiving unemployment compensation are eligible.

- This program will help an estimated 3.3 million working Americans and their families, including 700,000 children, in any given year.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for their workers' families.

Building Innovative State Programs for Children in Working Families

- The President's budget provides $3.8 billion between 1998 to 2002 ($750 million a year) in grants to States. States will use these grants to provide insurance for children, leveraging State and private investments in children's coverage through a matching system (using the same matching formula as in Medicaid).

- The Federal grants, in combination with State and private money, will target uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage. The grant program will also improve Medicaid enrollment since some families interested in the new program will learn that their children are in fact eligible for Medicaid.

- States may use these grants to target the unique problems facing their children. States have flexibility in designing eligibility rules, benefits (subject to minimums set by the Secretary) and delivery systems. In return for this flexibility, States will provide annual evidence of positive outcomes of the grant money — including the number of uninsured children helped by the program.

- The program builds upon the successful efforts of States that have tailored programs to address the particular gaps in coverage for their children. For example, the Florida Healthy Kids program enlists schools to enroll and insure 40,000 uninsured children.

Strengthening Medicaid for Poor Children

- The President's budget gives States the option to provide one year of continuous Medicaid coverage to children. This will cost an estimated $3.7 billion between 1998 and 2002.

    - Currently, many children receive Medicaid protection for only part of the year. Medicaid eligibility is intermittent due to fluctuations in family income throughout the year.

    - This policy allows States to continue coverage when family's income changes by guaranteeing Medicaid coverage for up to one year. This benefits families who will have the security of knowing that their children will be covered by Medicaid for at least a full year. It also helps States by reducing administrative costs, and managed care plans by enabling them to better coordinate care.

- The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

- The President's budget preserves and strengthens Medicaid's guaranteed coverage for low-income children. In addition to protecting coverage for the 18 million children already on Medicaid, the President continues the current law expansion to another one million children between the ages of 13 and 18.

DETAILED SUMMARY
President's FY 1998 Children's Health Initiative

The Children's Health Initiative includes five different parts:

1. State Grant Program
2. State Option for 12-Month Medicaid Continuous Eligibility for Children
3. Initiative for Workers Between Jobs
4. Medicaid Outreach
5. Continuation of the Poverty-Related Coverage Expansion for Children 14 to 18 years old

The first three elements require legislative changes which have been drafted as part of the President's FY 1998 budget proposal. The initiative for workers between jobs includes both adults and children and is summarized separately. Medicaid outreach will be a process set up with Governors and the private sector. The fifth — the mandatory expansion of Medicaid coverage to poor adolescents — is current law.

1. STATE GRANT PROGRAM

Intent: To enable states to initiate and expand innovative programs extending health insurance assistance to eligible children.

Type of Program: New, mandatory grant program to states (not discretionary spending; appropriate funds; no new entitlement)

State participation is optional. States have flexibility in designing eligibility rules, benefits and delivery systems.

Federal funding available until expended (unexpended appropriated funds redistributed in 2001)

Administered by Department of Health and Human Services

Funding: $3.8 billion between FY 1998 - 2002 ($750 million for FY 1998 and each subsequent year)

State Allotment: States & DC: Minimum of $1 million plus a share of the remaining appropriated amount (after subtracting territories' funding and base $1 million for each state). This share is:

- For 1998, 1999, & 2000: each state's proportion of all uninsured children under 19 in CY 1993-95 (on average)

- 2001 & subsequent years: each state with approved applications' proportion of uninsured children under 19 in 1993-95 in all states with approved applications. In 2001 and subsequent years, all unexpended appropriations from previous years will be reallocate using this formula to states with approved applications.

Territories: 1.5% ($11.25 million) of the total appropriation

State allotments adjusted for geographic price variation

Two-year carry over: allotment remains available to state for two years

Matching payments required (using Medicaid matching rate, FMAP)
No rules on what constitutes state share except that states may not use spending on comparable programs in 1995 or earlier.

Use of Funds: Direct purchase of health insurance or provision of vouchers to families

Insurance that qualifies for funding must cover benefits meeting minimum standards established by the Secretary, including standards for quality and scope of coverage

Insurance must also be provided by any entity licensed to provide health insurance in the state

Administrative costs and outreach (no more than 10% of allotment)

Eligibility for Assistance:

Defined by states within parameters: Children must be:

Under age 21

Not eligible for Medicaid

Have no (or inadequate) health insurance and do not have access to adequate and affordable individual or family health insurance coverage

Premium Assistance Amount:

Defined by the state

State Application: Beginning: January 1, 1998

Deadline: September 30, 2000

Must include description of:
- Current needs and efforts
- Program development process
- Program design including: service area, eligibility restrictions, health insurance coverage provided, ways to prevent substitution for employer coverage
- Budget
- Outreach and coordination
- Plan for data collection, records and reports

Plan approval: a plan is considered approved unless the Secretary notifies the state of disapproval or of the need for new information within 90-days

Reports & Evaluation:

Annual (or more frequent) amendments to initial state application
Annual report including progress made in reducing uninsured children
States' evaluations of their own programs due on March 31, 2000

2. STATE OPTION FOR 12-MONTH CONTINUOUS MEDICAID ELIGIBILITY FOR CHILDREN

Intent: To ensure that once a child is determined eligible for Medicaid, he or she maintains that coverage for a full year

Type of Program: Medicaid state option

Funding: An estimated $3.6 billion between FY 1998 - 2002

Provision: "1902(e)(12) At the option of the State, the plan may provide that an individual who is under the age specified by the State under 1905(a)(I) [upper age limit of 18-21 years] and who is determined to be eligible for benefits under a State plan approved under the title shall remain eligible for those benefits until the earlier of (A) the end of the 12 month period following the determination; or (B) the time that the individual exceeds that age."

3. INITIATIVE FOR WORKERS BETWEEN JOBS

[summarized separately]

4. MEDICAID OUTREACH

Intent: To increase enrollment of children currently eligible for Medicaid but not enrolled

Type of Program: No new program or funding: non-legislative approach; we will work with relevant parties on a process to identify and implement strategy

5. CONTINUATION OF THE POVERTY-RELATED COVERAGE EXPANSION FOR CHILDREN 14 TO 18 YEARS OLD

Intent: To maintain current-law phase in coverage for all poor children born after September 30, 1983 up to age 19 (currently states cover up to age 14 although 20 states have accelerated this coverage to older children).

Type of Program: No new program or funding: Medicaid spending in the baseline

DETAILED SUMMARY
President's FY 1998 Budget: Workers Between Jobs Initiative

Intent: To assist workers and their families who lose their insurance when they lose their jobs

Type of Program: New mandatory grants program to states (not discretionary spending; appropriate funds; no new entitlement)

State participation is optional; for states that do not participate, the Secretary may operate a program under this subtitle

Demonstration: sunsets at the end of FY 2001

Federal funding available until expended (unexpended appropriated funds redistributed through the reserve fund, described below)

Administered by the Department of Health and Human Services in consultation with the Departments of Labor (especially on data issues)

Funding: An estimated $9.8 billion between FY 1998 - 2002;
Maximum Federal funding:

- For CY 1998: $1.738 billion
- For FY 1999: CY 1998 appropriation ($1.738 billion) divided by 0.75 (to make it equivalent to a full, fiscal year) multiplied by the "growth multiplier"
- For FY 2000 and 2001: previous year's appropriation multiplied by the "growth multiplier"

The "growth multiplier" is the product of:

- Growth in unemployment compensation recipients (measured as the annual change in the number of first payment to eligibles) and
- Nominal GDP per capita (measured as the average of the annual change in nominal gross domestic product per capita for the previous 5 years) plus 1 percentage point in each year

State Allotment: On a quarterly basis, states receive an allotment from 95 percent of the Federal appropriation. This share is:

- Each state's proportion of the national average number of people filing for unemployment compensation (note: includes territories)

State allotments adjusted for geographic price variation

No state carryover; unexpended allotments return to the reserve funds

No state matching funds

Reserve funds: The Secretary shall distribute the 5 percent of the annual appropriation not allocated to states plus unexpended state allotments to states whose allocations are insufficient to meet their need

Use of Funds: Premium assistance payments to plans or families (state option)

Premiums used for:

- COBRA continuation coverage or

- Other coverage that is equivalent to the Federal Employees' Blue Cross standard option or meets Secretarial approval, so long as these plans are economical and comply with the new laws for portability, availability and renewability of coverage

Administrative costs not to exceed 5 percent of the state's allotment for that year (with exceptions approved by the Secretary up to 10 percent)

Eligibility for Assistance:

Eligible unemployed individual:

- State resident who received unemployment compensation for at least one week in the previous month

- Received employer-sponsored health insurance for the previous six months of employment

- Not eligible for Medicaid or Medicare

- Combined, monthly family income is less than 240 percent of poverty

- Spouse has no employer-sponsored insurance and no access to employer-sponsored insurance with an employer contribution of greater than or equal to 50 percent

Eligible family members:

- Spouse or dependent of the eligible unemployed individual who is not eligible for Medicaid or Medicare

Premium Assistance Amount:

Monthly premium assistance to individual or family:

- 100 percent of premium for families with monthly income less than 100 percent of poverty (adjusted for family size)

- Sliding scale subsidy for families with monthly incomes from 100-240 percent of poverty

Limited to 6 months for each period of unemployment

State may limit either the duration or extent of premium assistance, or end assistance at the point in the year if allotment and any reserve funds are insufficient to cover need

State Plan:

Deadline: None

Must include description of

- Summary of how the program will operate
- Assurance of use of funds for premiums and administrative costs
- Commitment to provide required coverage
- Methodology for determining eligibility
- Coverage formula
- Coverage reduction method (if funding is insufficient)
- Notices to individuals about eligibility and coverage reduction method
- Commitment to transfer data and furnish records and reports

Plan approval: a plan is considered approved unless the Secretary notifies the state of disapproval or of the need for new information within 90-days

Reports & Evaluation:

Data and reports as determined by the Secretary
Evaluation by Secretaries of HHS and Labor due on January 1, 2001

THE PRESIDENT'S FY 1998 BUDGET: CHILDREN'S HEALTH INITIATIVE

BACKGROUND

Numbers and Trends

Who Are Uninsured Children and Why Are Children Uninsured

Challenges to Covering Children

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE

Medicaid Improvements for Children

State Partnership Program for Children

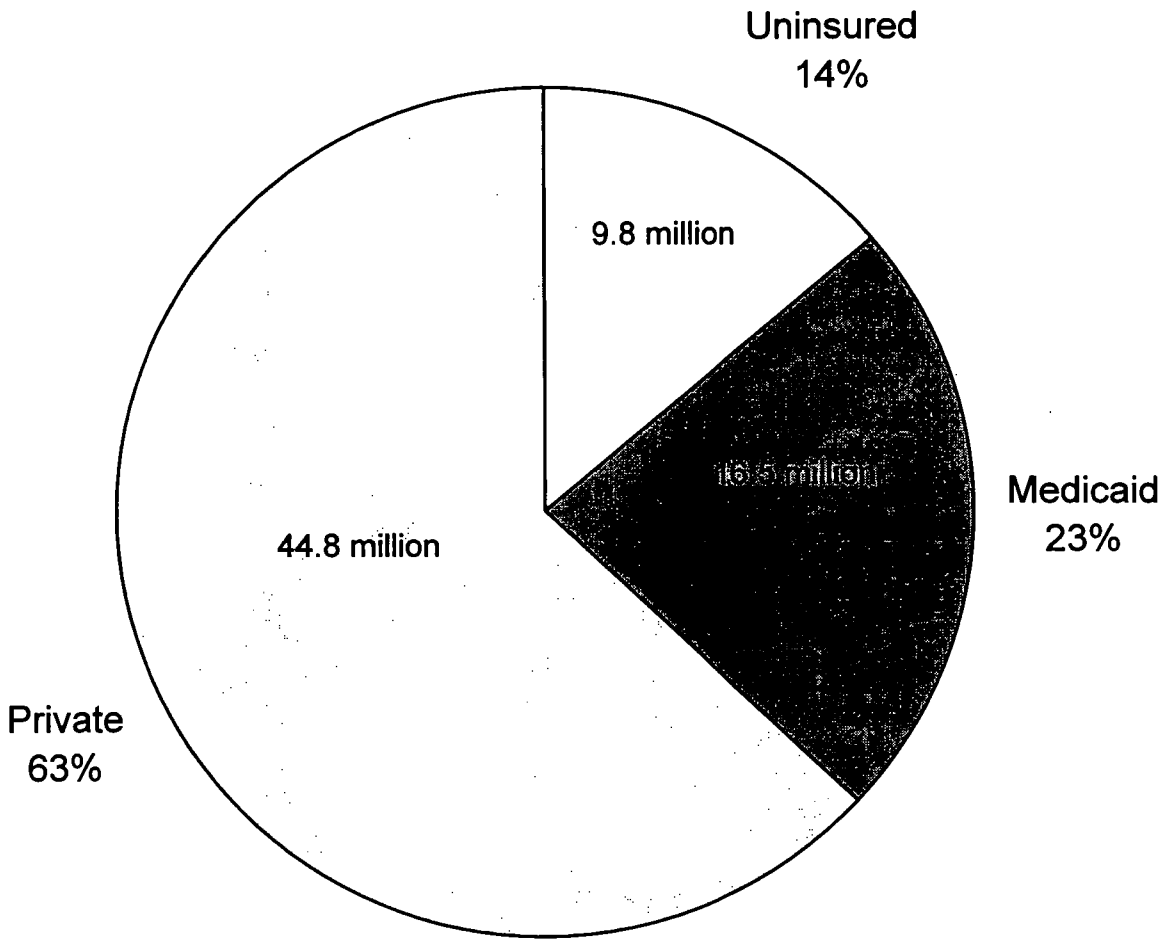
Workers Between Jobs Initiative

Welfare Reform Policies Related to Children

BACKGROUND

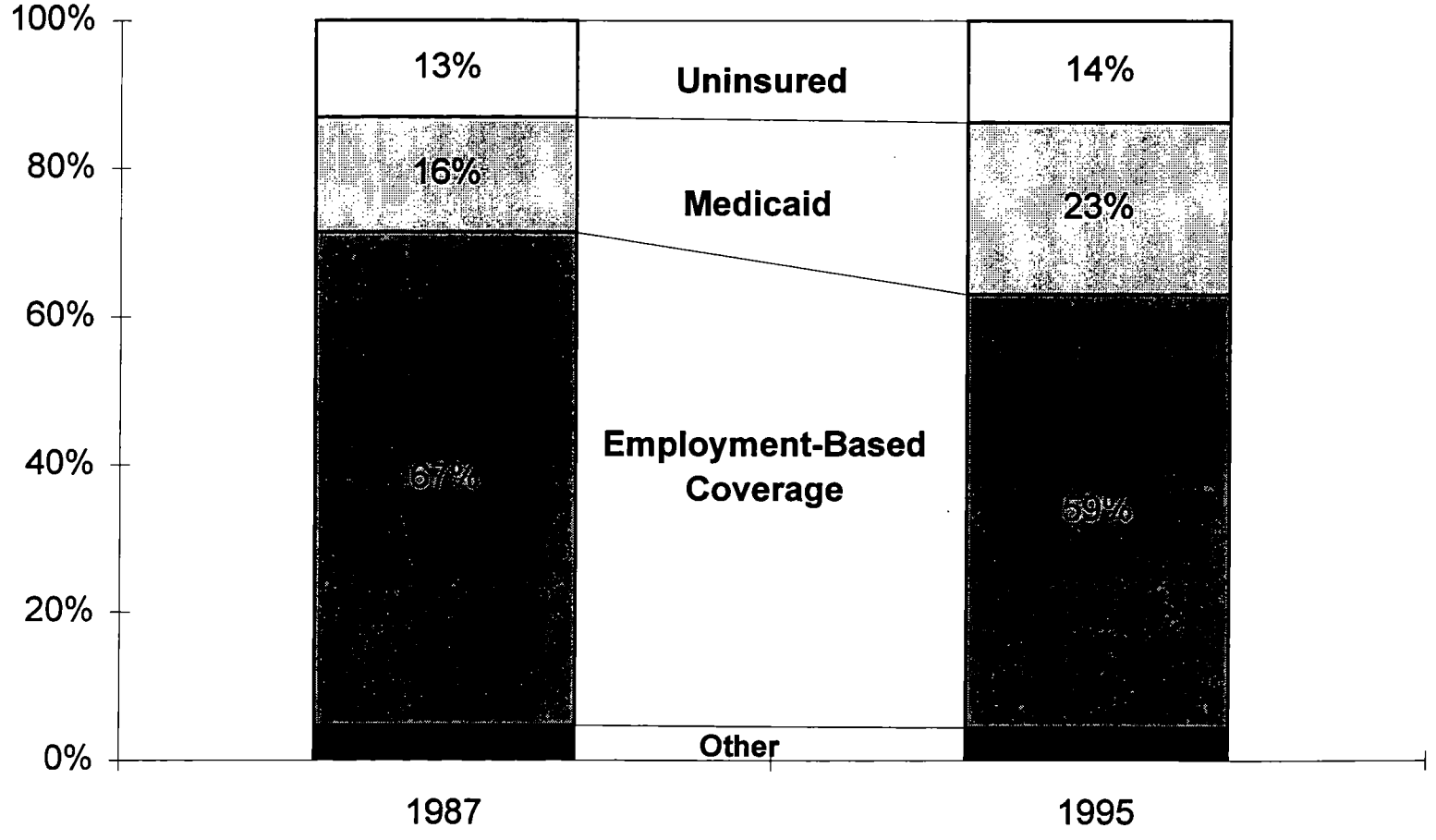
Numbers and Trends

One in Seven Children Are Uninsured



Source: March 1996 Current Population Survey. Children are less than 18 years old.

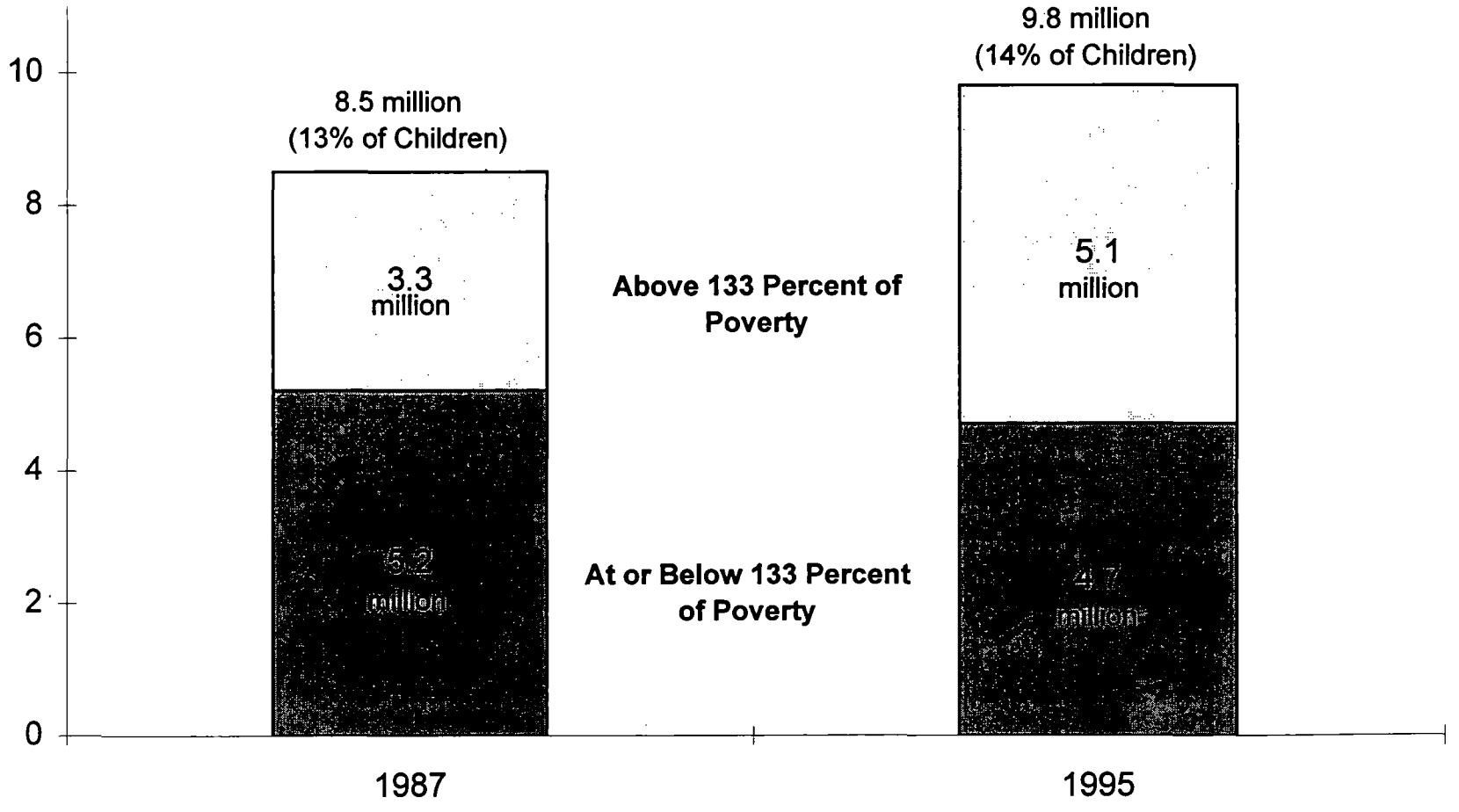
While the Proportion of Uninsured Children Remains Constant, Medicaid & Employer Coverage Have Changed



Note: While it appears that the children losing employer coverage gained Medicaid coverage, recent studies suggest that this is not the case. Medicaid increased coverage of poor children who do not have access to employer insurance.

Source: EBRI 1997. Children are less than 18 years old.

The Number of Uninsured Children Above Medicaid Eligibility Has Increased

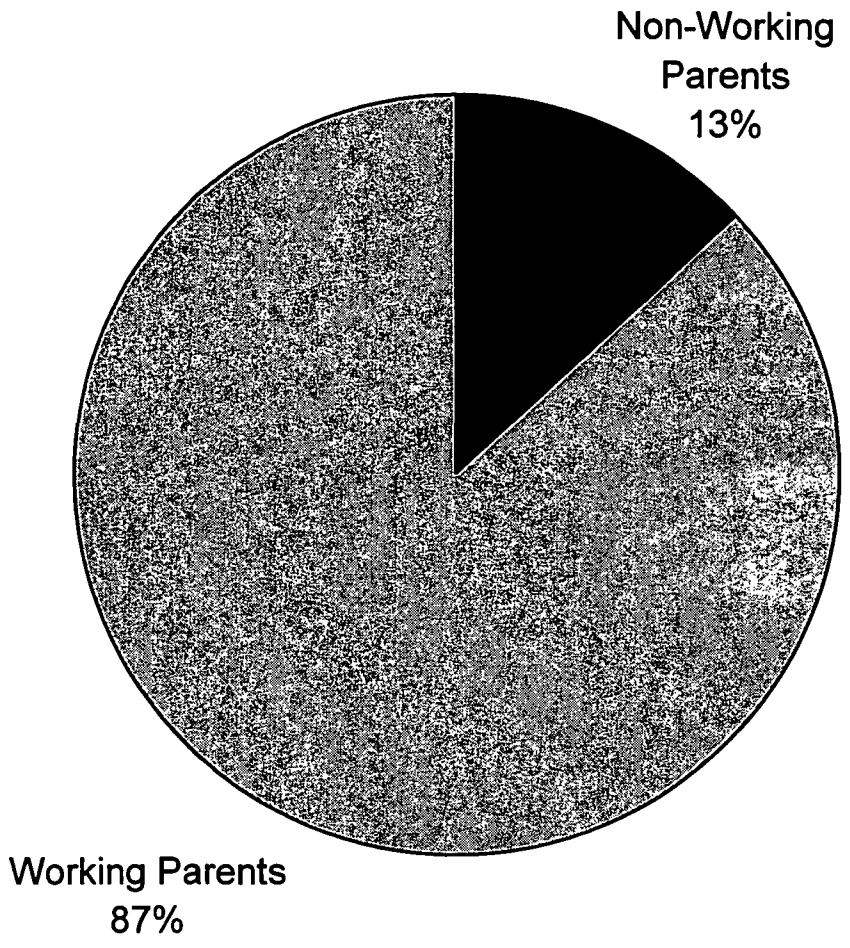


Note: Beginning in 1990, states were required to cover children under 6 to 133% of poverty and phase in coverage for children 6 through 18 below poverty. In 1995, children up to age 13 were eligible for Medicaid. Many states have used options to cover children at higher incomes.

Source: EBRI, 1996

Who Are Uninsured Children and Why Are Children Uninsured

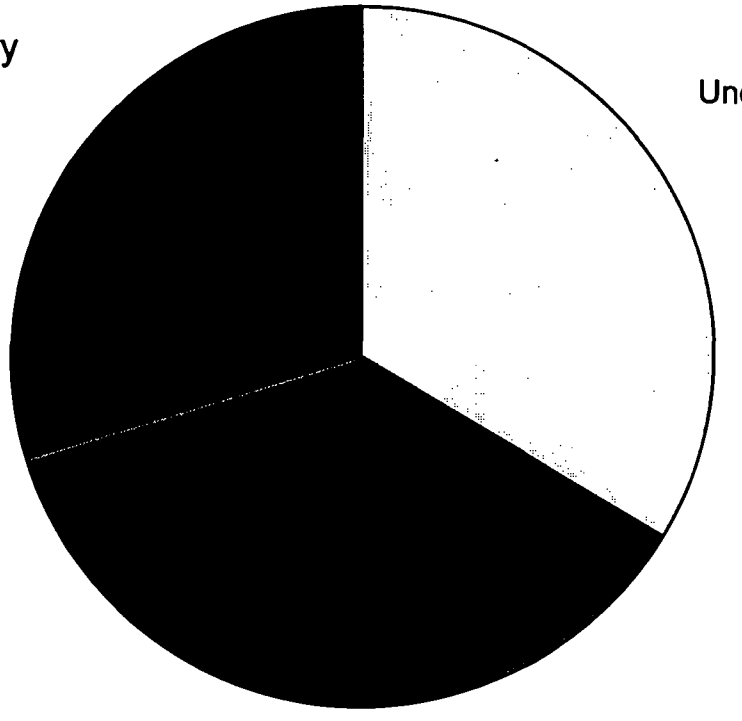
Uninsured Children Come From Working Families



Note: 62% of uninsured children have parents who work full year, full time
Source: March 1996 Current Population Survey. Children are less than 18 years old.

Not All Uninsured Children Are Poor

("Poverty" is about $16,000 for a family of four)



Source: March 1996 Current Population Survey. Children are less than 18 years old.

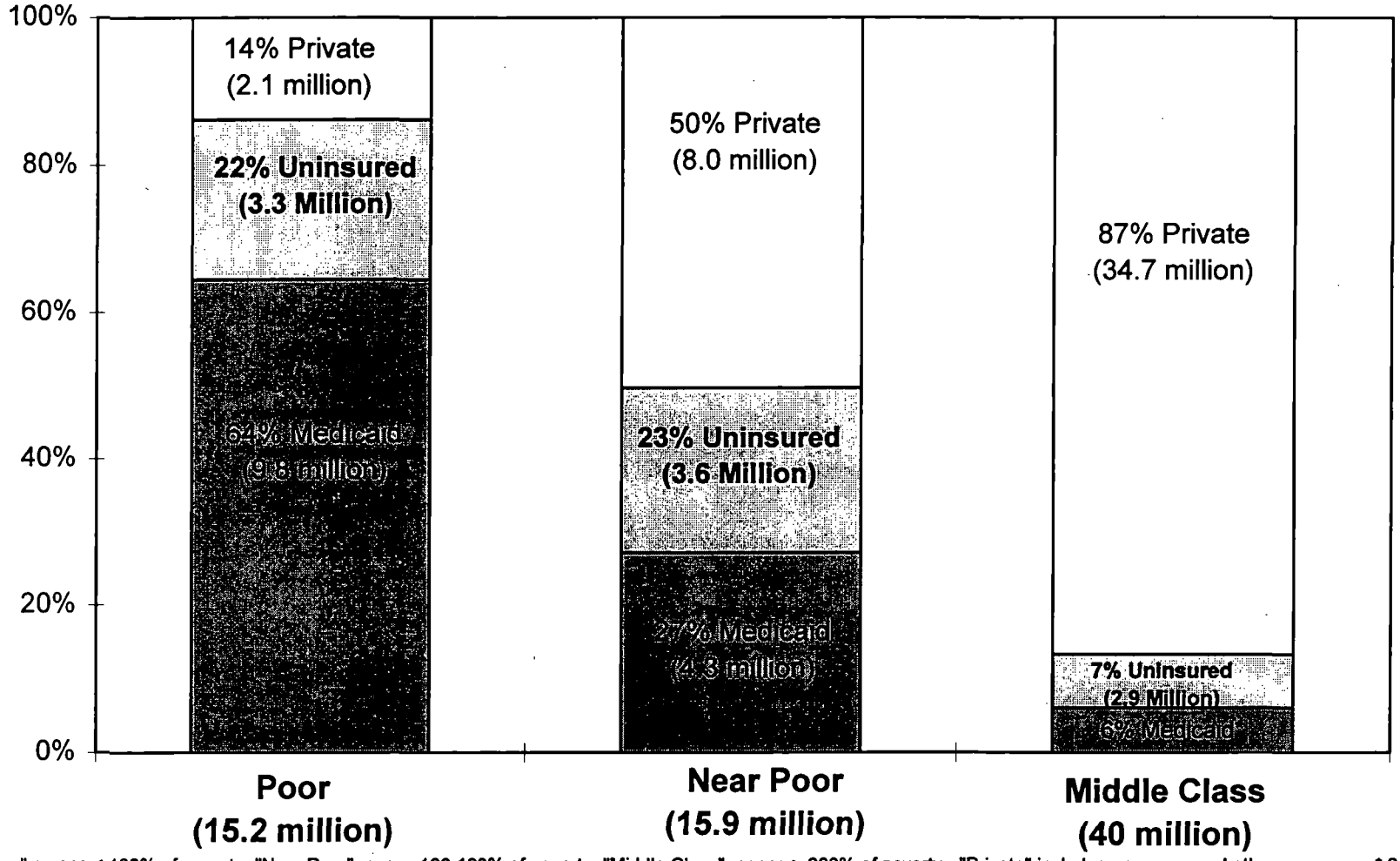
Why Are Children Uninsured

1. **Eligible but not enrolled in Medicaid.** According to the General Accounting Office, an estimated 3 million uninsured children are eligible but not enrolled in Medicaid.

2. **Parents earn too much for Medicaid but too little for private coverage.** When job-related insurance loss is put to the side, the most important reason why children lose insurance is that it is too expensive for the family. The highest rate of uninsured children is in families just above the poverty line.

3. **Parents change jobs.** Nearly half of all children who lose health insurance do so because their parents lose or change jobs

What Is the Distribution of Uninsured Children By Income



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage. * 2.4 million.
Note: The number of children covered by Medicaid is less than 18 million due to under-reporting on this survey. Source: March 1996 Current Population Survey.

Challenges to Covering Children

- **Costs.** Although children are the least expensive population to insure, proposals to cover them can be expensive. This results from two major challenges:

- **Substitution or "crowd out".** Costs rise when a new program substitutes Federal dollars for employer or state contributions for kids' coverage.

- **Administration.** Proposals have to strike a balance between complex administrative rules and enforcement — which aim to limit crowd out — and the goals of simplicity and small government.

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE

Medicaid Improvements for Children

- **The President's budget gives States the option to provide one year of continuous Medicaid coverage to children.** This will cost an estimated $3.7 billion between 1998 and 2002 and help an estimated one million children.

    - Currently, many children receive Medicaid protection for only part of the year. Medicaid eligibility is intermittent due to fluctuations in family income throughout the year.

    - This policy allows States to guarantee Medicaid coverage for up to one year even when a family's income changes. This means that children can remain with the same provider for up to a year, improving continuity of care.

- **The President will also work with Governors to enroll eligible Medicaid children.** The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

- **The President's budget preserves and strengthens Medicaid's guaranteed coverage for low-income children.** In addition to protecting coverage for the 18 million children already on Medicaid, the President continues the current law expansion to children aged 13 to 18.

State Partnership Program for Children

- **The President proposes a grant program for States to develop innovative health coverage programs for children.** The President's budget provides $3.8 billion between 1998 and 2002 ($750 million a year) in grants to States. States will use these grants to provide insurance for children, leveraging State and private investments in children's coverage through a matching system.

- The Federal grants, in combination with State and private money, will target uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage.

- States have flexibility in designing eligibility rules, benefits (subject to minimums set by the Secretary) and delivery systems. In return for this flexibility, States will provide annual evidence of positive outcomes of the grant money — including the number of previously uninsured children helped by the program.

- The program builds upon the successful efforts of States that have tailored programs to address the particular gaps in coverage for their children. For example, the Florida Healthy Kids program enlists schools to enroll and insure 40,000 previously uninsured children.

Workers Between Jobs Initiative

- **The President's budget will give States grants to temporarily cover workers between jobs, *including their children, at a cost of $9.8 billion over the budget window.***

- The initiative will offer temporary assistance (up to 6 months) to families who would otherwise lose their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. State participation in this grants program is optional.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. This assistance is accessible for most middle class families since income drops for the months between jobs.

- This program, which is structured as a four-year demonstration, will help an estimated 3.3 million working Americans and their families, including 700,000 children, in any given year.

FY 1998 President's Budget Medicaid Proposals: Welfare Reform Policies Related to Children

Retain Medicaid for Disabled Children who Lose SSI

- The President's proposal would retain Medicaid coverage for children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefits because of changes in the definition of childhood disability.
- The welfare law provides a new definition of disability for children separate from that for adults. The comparable severity standard was repealed and replaced with a new, statutory definition of disability for children[1]. The new statutory definition requires a child's impairment or combination of impairments to cause more serious functional limitations in order to be considered disabled than did the old law.
- Under current law, many of these disabled children could lose their Medicaid coverage if they lost their SSI cash assistance due to the new definition and could not requalify for Medicaid based on poverty standards for Medicaid eligibility. States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that determination could affect the individual's Medicaid eligibility.
- HCFA's Office of the Actuary (OACT) estimates Federal Medicaid costs of $0.3 million between FY 1998 and FY 2002. This provision would retain Medicaid coverage for approximately 30,000 disabled children in FY 1998.
- CBO estimates Federal Medicaid costs of $1.0 billion between FY 1998 and FY 2002.

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[1]Before P.L. 104-193, a child was considered disabled for purposes of eligibility for SSI if he or she suffered from any medically determinable physical or mental impairment of "comparable severity" to an impairment(s) that would make an adult disabled.

Exempt Immigrant Children from the Medicaid Bans and Deeming

- The President's budget would exempt immigrant children from the bans on Medicaid eligibility for current and future "qualified aliens." Immigrant children would also be exempt from the new deeming requirements that require the income and resources of an immigrant's sponsor to be counted when determining Medicaid eligibility.

- Under current law, immigrant children could lose their Medicaid eligibility if a state chose to deny Medicaid assistance to immigrants who resided in the U.S. on or before August 22, 1996. Immigrants who enter the country after August 22, 1996 are banned from receiving Medicaid for five years. Current law also requires deeming the income and resources of their sponsors for determining Medicaid eligibility.

- OACT estimates Federal Medicaid costs of $0.2 billion between FY 1998 and FY 2002. This provision would retain Medicaid coverage for approximately 30,000 non-disabled children in FY 1998.

- CBO estimates Federal Medicaid costs of $0.4 billion between FY 1998 and FY 2002.

Cost Estimates for FY98 President's Budget Children's Health Proposals
(In Billions)

	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	Total 1998 - 2002	Total 1998 - 2007
Children's Health -- OMB Scoring												
New Mandatory Spending												
State Partnership Demos	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	3.8	7.5
Medicaid Spending												
MCD Outreach Impact of State Demos	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.5	0.5	1.1	3.4
12-mo Continuous Eligibility for Children	0.3	0.5	0.7	1.0	1.2	1.3	1.4	1.5	1.6	1.8	3.6	11.2
Total	1.1	1.3	1.7	2.1	2.3	2.4	2.6	2.7	2.9	3.0	8.5	22.1
Children's Health -- CBO Scoring												
New Mandatory Spending												
State Partnership Demos	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	3.8	7.5
Medicaid Spending												
MCD Outreach Impact of State Demos	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8	1.8
12-mo Continuous Eligibility for Children	0.9	0.9	1.0	1.0	1.1	1.1	1.2	1.3	1.3	1.4	4.9	11.2
Total	1.8	1.8	2.0	2.0	2.1	2.1	2.2	2.3	2.3	2.4	9.5	20.5

In addition, the Administration has an initiative for Health insurance for workers in-bewteen jobs. CBO and OMB estimate that this will cost $9.8 billion from 1998 - 2002. Heatlh insurance for workers in-between jobs will assist approximately 3.3 million people in FY 1998, including 700,000 children.