HEALTH CARE EVENTS

Announcing Immunization Rates at Historic High. At this event, the President would announce that immunization rates are at a historic high. New immunization data being released in July by the Center for Disease Control (CDC) validates our long-time held assertion that the President's immunization approach has been successful. We also plan to announce new regulations requiring child care centers that receive federal funding to ensure that all children in their care are properly immunized.

Protecting Americans from Genetic Discrimination. This event will: (1) highlight the problem of genetic discrimination for women who are increasingly not taking advantage of new breast cancer genetic tests for fear insurers will no longer cover them and their families; (2) release a new HHS report that underscores the great need for genetic legislation and introduce the Senate companion to legislation introduced by Congresswoman Slaughter that the President has endorsed (by Senator -- Doctor -- Frist). (3) Receive the endorsement of the Human Genome Action Plan, a coalition of hundreds of organizations (including the Alzheimer's Association, the American Cancer Society, and the March of Dimes) concerned about the inappropriate use of genetic discrimination. This issue has received a great deal of press, including a piece on *Prime Time Live*, and an upcoming article in *The New York Times Magazine.*

On the last version of the President's event schedule, this event was tentatively scheduled between June 21 and June 23. It is important to note that Secretary Shalala is not available on June 21 or June 22 because she will be at the Quality Commission meeting in Vermont. Besides that, we are flexible, although we hope to have the event in the next month.

Announcing New Regulations That Requires Drug Companies to Improve Pediatric Labeling Information for Parents. The President would announce new regulatory action that we are taking to ensure that drug companies test their products specifically on children who may need different doses and have different reactions and to ensure that parents are aware of this information. Children suffer from most of the same diseases as adults, however, most drugs have not been tested to understand their unique impact on children. The event could be held any time and would include children's groups, providers, and children.

Recognition of President's Leadership on Breast Cancer by *Self Magazine.* *Self,* a women's health magazine, offers an annual Pink Ribbon Award to outstanding leaders in the area of breast cancer. The President would receive this award for his strong record on breast cancer which includes funding for breast cancer research, prevention and treatment which has nearly doubled since he took office, supporting legislation that would allow women to stay in the hospital at least 48 hours after a mastectomy, and taking a leading role on genetic legislation which is a major concern for women with breast cancer, many of whom are avoiding new genetic tests on breast cancer for fear that it would prevent them or their families from getting insured. This event could be in September or October.

So, 3 of these are mine. What have you been doing?

MEMORANDUM

July 3, 1997

TO: Hillary Rodham Clinton

FR: Chris Jennings

RE: Children's Health Care Coverage

cc: John Hilley, Melanne Verveer, Jennifer Klein

Attached is a memo the President requested on a number of issues related to coverage and health investments. This request stemmed from two articles the President read yesterday -- Robert Pear's *New York Times* article and an article in *USA Today* entitled "Clinton health plan lives again, one bill at a time."

Since you indicated to John H. and me an interest in these issues as well, we are forwarding the memo for your review. As the memo points out, we received some good news today: CBO released higher coverage estimates and the Children's Defense Fund released a report that projected that we could cover up to six million children.

I hope you find this helpful. Please call me if you would like to discuss any of these issues further.

THE WHITE HOUSE

WASHINGTON

July 3, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

SUBJECT: Recent Children's Health Coverage Estimates and Brief Review of Health Investment Alternatives, Including 21st Century Biomedical Research Trust Fund

Following up on our conversation last night, this memo responds to your questions about children's health coverage estimates, policies and health investment issues in general.

CBO's children coverage estimates. First, it is important to explain in more detail the CBO analysis and policies discussed in yesterday's *New York Times* article. The low estimate of around one million children covered by the House and Senate bills reflects both flaws in the policies and particularly conservative assumptions used by CBO. CBO assumes that states will use some of the new funds to lower their current state spending — contrary to many analysts' belief that states will leverage, not reduce, existing state investments. They also think that having a higher matching rate for the new program will create an incentive to classify children already covered in Medicaid as higher income children to receive the extra Federal funding. In addition, CBO assumes that a number of children will switch from private insurance coverage to the new program.

Updated estimates. Since yesterday's *Times* article, two estimates have been released that increase the figures cited by Robert Pear. Just today, I received a copy of CBO's final analysis of the Senate bill. It reports that 1.7 million uninsured children would be covered by the $24 billion proposal — 2.0 million uninsured children without the mental health parity provision. This estimate is higher because of the tobacco tax revenue and the effect of new accountability rules. Combined with HHS's estimate that 2 million eligible uninsured children could be enrolled in Medicaid without Federal funds (through outreach, etc.), we could easily claim up to 4 million uninsured children even using some of CBO's new yet still conservative estimates. At least as noteworthy, the Children's Defense Fund released a report today that estimates that 6.1 million uninsured children could be helped by the $24 billion Senate bill (and over 4 million for $16 billion). We are analyzing both reports, but they are clearly headed in the right direction.

Validity of some CBO concerns. While we believe that CBO estimates are excessively conservative, we do share their legitimate concern about how to best to target the funds. In fact, as I mentioned last night, the article will likely be helpful in that it will provide the needed push to get more effective targeting provisions into conference. As we do this, however, we must balance the need to ensure accountability with the need to avoid onerous provisions that do little more than provide disincentives for states to participate in this voluntary program in the first place. We also must guard against the inclination of helping make CBO the final arbitrator of insurance take-up rates. We empower them at our peril, since few believe they will significantly move off of their current assumptions.

Potential solutions. We are working on perfecting and are promoting two general approaches to better assure that the Federal investment goes to the greatest number of children. The first deals with providing better financial incentives to states to do the "right thing." The second focuses on additional accountability rules that give the new Federal dollars if states meet certain conditions.

The financial incentives we are working on would provide greater Federal matching rates for <u>all</u> newly enrolled child, not just children above current mandatory levels. We would give a state a higher matching rate for any additional child enrolled in Medicaid or the grant program above the number of children currently enrolled in Medicaid. This takes away the inefficient incentive in the Senate and House bills for states to get higher matching for a child above poverty. Another approach is to reward states that use proven methods for covering children, such as targeting children whose parents have changed jobs or using school-based enrollment approaches, such as the Florida "Healthy Kids" program.

The accountability rules we are promoting would build on and reform the different maintenance of effort (MOE) provisions that are included in both the Senate and House bills. They are designed to protect the new Federal dollars from being used to substitute for current expenditures by either the States or employers/employees wanting to reduce their health care premium costs. The approaches we think most worth considering are asking states to maintain their current programs' eligibility — to prevent states from moving optional Medicaid kids into the new program — and maintain current spending on existing programs. We also support the Senate bill that does not allow states to cover the employee share of the premium or family coverage. CBO and our staff agree that this would allow funds to be used by families who would have been insured anyway. And, consistent with the Senate bill and Medicaid rules, we strongly oppose the use of provider taxes and donations for the state share of the new program.

There is no question that it will be a great challenge in the coming weeks to balance provisions that promote efficiency with state flexibility. States will assert that policies like those outlined above interfere with their own ability to target funds efficiently. Furthermore, states like Rhode Island and Vermont, which have already expanded children's coverage through Medicaid, will argue that the maintenance of effort is unfair. They contend that they should not be penalized permanently for deciding to have voluntarily chosen to expand coverage.

Lessons of targeted reforms. The difficulty — politically and policy-wise — in targeting uninsured children has two important implications. First, additional money alone will not result in all children receiving health insurance. One-third of uninsured children are already eligible for Medicaid — a free program with generous benefits. Another third have incomes above 200 percent of poverty; policies that try to find those children will surely end up enrolling two to three times as many already-insured children. For these reasons, allocating more than $24 billion for children's coverage may not be very cost-effective. Keeping this in mind, it is prudent that you and the economic team are now recommending dedicating the additional $7 billion (on top of the $8 billion currently allocated for children's coverage) to other children's issues -- such as adoption and child care.

Second, these same problems hold true for insuring Americans in general. Stated bluntly, no voluntary health insurance program will ever cover all uninsured Americans, even with an unlimited budget. If there is some financial contribution required, many families will voluntarily opt to not purchase insurance. On the other hand, there will always be people who join these programs who already have insurance. There is no failsafe mechanism that completely prevents "crowd out." Moreover, the larger the initiative, the higher the income eligibility, the greater the risk. Thus, the assertion in yesterday's *USA Today* may be right: without a government policy that requires everyone to be covered, it is virtually impossible to cover all 40 million uninsured.

Consequently, we are approaching possible uses of additional revenue from an increased tobacco tax and/or from the tobacco settlement with caution. As with children, focusing on low-income adults or groups who are unlikely to have access to private insurance may be the most fruitful. For example, job loss and job change are the single largest reason why families lose health insurance. Creating a Medicaid option for these families would increase their access to insurance. Similarly, people between 55 and 65, who have either retired early or whose firms have downsized often find themselves with few affordable insurance options. A Medicare buy-in or premium assistance for COBRA may help these people, as we discussed. We are also exploring other options such as strengthening the public health infrastructure and augmenting our research budget.

21st Century Research Trust Fund Update

To explore biomedical research investment opportunities within the context of the Tobacco Settlement, I met with Dr. Varmus and researchers throughout the Federal government today. As you requested, I pulled Dr. Varmus aside and asked him what he thought of a 21st Century Research Trust Fund concept. He was very interested and wanted to have additional conversations about it. His only immediate concern was that we make sure any new dollars supplement -- and not supplant -- those the NIH are already getting from the Hill. We will keep you apprised of his recommendations and our ongoing discussions with him.

THE PRESIDENT HAS SEEN
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THE WHITE HOUSE

WASHINGTON

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July 3, 1997

cc HRC

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PRINCIPLES FOR CHILDREN'S HEALTH INITIATIVE

- **MEANINGFUL COVERAGE**

  To ensure that health insurance for children is meaningful, reforms should:

  - Include the range of services needed by children for a healthy childhood
  - Protect low-income children and their families from excessive cost sharing
  - Ensure consumer and quality protections

- **EFFECTIVE**

  To be most effective at covering the largest number of uninsured children, reforms should:

  - Strengthen not undermine the Medicaid program, which has efficiently served millions of low-income children
  - Give states incentives and flexibility to target hard-to-reach, middle class, uninsured children
  - Not include tax-based approaches which have been ineffective in the past

- **ACCOUNTABLE**

  To ensure that taxpayer-supported assistance achieves the goal of covering uninsured children, states should:

  - Use the funds for new coverage, not to replace existing state spending
  - Make appropriate contributions if there is state matching as they do in Medicaid

Draft Statement

Today, the Department of Health and Human Services released a report that describes why children are uninsured and what we can do about it. It has three main findings.

First, health insurance matters. Despite the strong efforts of our public safety net providers, uninsured children do not have the same access to health care as insured children.

- Parents are four times more likely to delay care or not seek care at all when their child gets sick but lacks insurance.

- Children in poor health are much more likely to experience learning problems.

Second, this problem affects all Americans, not just the poor. Nearly 90 percent of uninsured children have parents who work.

- Although Medicaid has effectively covered millions of low-income children, there are still 2 million children just above Medicaid (below 133 percent of poverty, or 21,000 for a family of four) who lack health insurance.

- And, since 1987, the number of uninsured children above 133 percent of poverty has increased by 50 percent. This occurs mainly because many families lack access to affordable insurance options.

Third, Medicaid and state programs have proven that this problem can be addressed.

- While the number of uninsured middle class children has climbed, Medicaid has reduced the number of poor uninsured children by 10 percent.

- And states have demonstrated that, given resources and flexibility, they can design innovative, targeted programs that extend meaningful coverage to their children.

This study serves as a road map for how we use the $16 billion in the budget for children's health coverage. My goal of covering up to 5 million uninsured children has been embraced by Republicans as well as Democrats. I thank Congress for allowing us this unprecedented opportunity to expand children's coverage.. Now our challenge is to draw from these facts and experiences the keys to efficiently expanding coverage.

It is clear that we should begin with Medicaid. Medicaid should be simplified and expanded through increased flexibility and incentives. I applaud bipartisan efforts to free Medicaid from unnecessary administrative burdens; most of my flexibility provisions have been adopted. And I support efforts to give states incentives to enroll all kids to the same level of eligibility. Today, Medicaid's eligibility rules are complex, particularly with respect to the age of the child. If all children were treated as though they were less than 6 years old, about 2 million uninsured children would gain access to Medicaid.

It is also evident that a flexible grant program can best target middle class uninsured children. In my budget, I proposed state partnership grants to help fund innovative state programs. Innovation is needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program. States are best able to find and cover these children. Several counties in Florida, for example, have used schools to educate and enroll children in reduced-price insurance plan. Such creativity should be fostered nationwide. I continue to urge Congress to consider this approach in combination with a strengthened Medicaid program.

Finally, proposals should offer meaningful, quality health coverage for children. Improving the safety net is important but will not ensure that children get the full range of care that they need. Any plan that I sign should promise of meaningful health coverage.

The proposal put forward by Senators Rockefeller and Chafee embraces these principals. They recognize that meaningful coverage for children begins by strengthening Medicaid but ensures that states may use grant funds to target middle class children. I applaud their efforts and encourage the rest of the Senate and Congress to follow their lead.

UNINSURED CHILDREN IN AMERICA: THE FACTS AND THE FUTURE

FINAL DRAFT

A Report by the
U.S. Department of Health and Human Services
[and the U.S. Department of Labor]

HIGHLIGHTS

UNINSURED CHILDREN: A SERIOUS PROBLEM IN THE UNITED STATES

- **About 10 million children under age 18 are uninsured.** Fully 20 million children are uninsured for at least one month over 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 despite the public safety net.** Sick, uninsured children are 4 times as likely to delay or not receive needed care. Children in poor health are more likely to have learning problems.

- **The United States ranks poorly when compared to other nations**. It remains the only industrialized nation that does not extend basic health protection to all its children, and 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.

THERE IS NO SINGLE REASON WHY CHILDREN ARE UNINSURED

- **Poverty alone cannot explain the lack of insurance.** About one-third of uninsured children have income between 100 and 200 percent of poverty, and another third have income above 200 percent of poverty. Reasons include:

    - **Lack of access to employer-based insurance**

        - ***Small businesses are less likely to offer health coverage.*** Among working families, almost half of all uninsured children's parents work in small businesses. Employment has also shifted to part-time work and firms less likely to offer insurance.

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

    - **Lack of affordability of insurance**

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

- **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.

  - **Uneven Medicaid eligibility.** About 2 million uninsured children would be eligible for Medicaid if all children were offered the same coverage as children under 6 years old.

  - **Limited size of state programs.** Over 30 states have state-funded or private children's health programs, but most are small.

LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

- **Medicaid has made important inroads into children's health coverage.** As a result of the Medicaid expansion, the number of poor, uninsured children has declined by about 10 percent — with much larger reductions in the southern and mountain states.

- **Some states have used innovative programs to target uninsured children**. Experience in private and/or state-funded programs suggests that states can design efficient programs that target hard-to-reach uninsured children.

- **The 1990 child health tax credit did not appear to have improved coverage.** The child health tax credit was difficult to administer and had low participation rates. Similarly, making insurance more available through health insurance reform is important but not necessarily the best tool to increase coverage.

CONCLUSION

- **Carefully designed policies can improve health coverage for American children.** Focusing on the causes of the problem and the lessons from past efforts can lead to policies that succeed in covering children. These include:

  - Equalizing Medicaid eligibility for children of all ages

  - Making insurance more affordable through targeted state programs

  - Assisting small employers through purchasing cooperatives, and

  - Encouraging outreach through schools and other proven approaches

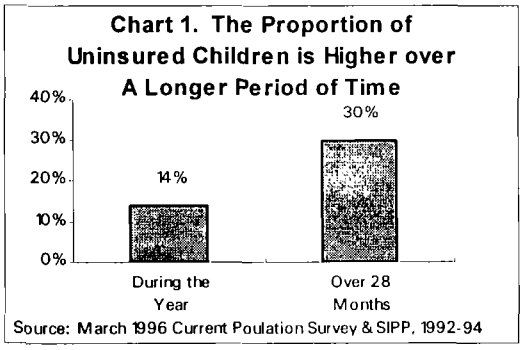
I. UNINSURED CHILDREN: A SERIOUS PROBLEM

The key to access to the nation's high quality health care system is affordable health insurance. Although there are systems to care for people without coverage, evidence suggests that the uninsured have greater problems getting needed health care.

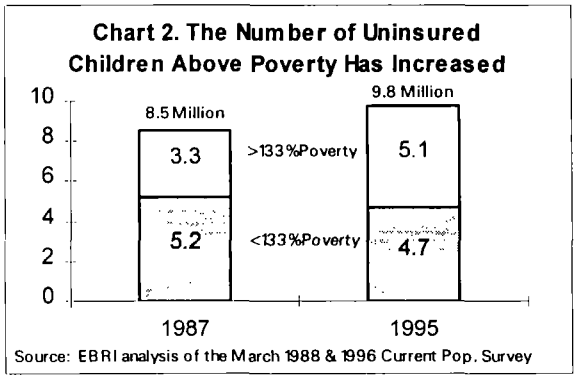
A. THE NUMBERS OF UNINSURED CHILDREN

One in seven right now. 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, 3/13/97.)

Nearly 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). Of these children, two-thirds were uninsured for at least six months, while nearly half were uninsured for at least one year (ASPE, 1997).

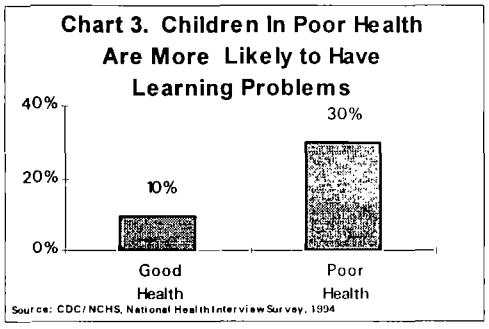


Problem increasing for middle class families. While the proportion of children who are uninsured has remained relatively constant, this masks an underlying trend. The number of poor, uninsured children has been decreasing while the number of middle class uninsured children has been increasing. The number 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). This outpaces the general increase in the number of children in this income range, which was about 15 percent.

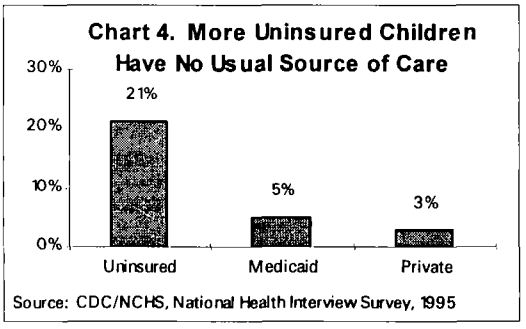


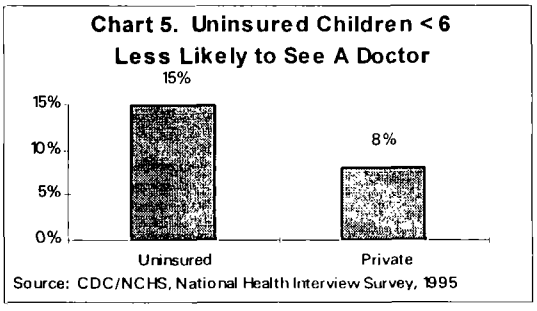
B. WHAT IT MEANS TO BE UNINSURED

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 4 percent of 18 to 24 year olds, 8 percent of 25 to 44 year olds, and 28 percent of people 65 years and older (NCHSb, 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 (NCHSb, 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). Children in poor health are three times more likely to experience difficulties in learning than healthy children (Chart 3). When asked what indicates that a child is ready for kindergarten, teachers overwhelmingly respond that the most essential factor is a child's physical health (NCES, 1996). Mental health is equally important. About 7.5 million children suffer from one or more mental disorders that disrupt their ability to function socially, academically, and emotionally (IOM, 1994).



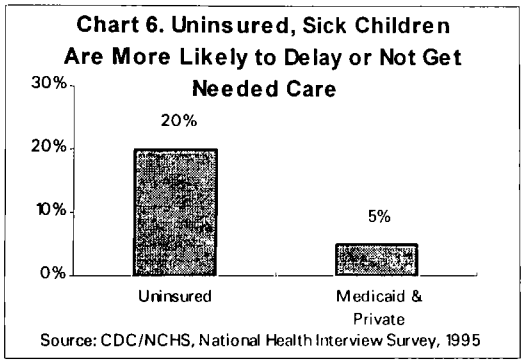
Uninsured children have more difficulty getting health care. About 86 percent of children have some type of health coverage. For children without insurance, Federal, state and local governments have developed a set of "safety net" or publicly supported providers, including community health centers, public health departments and children's hospitals. These providers give critical health services to children with and without insurance (see Appendix A for details). However, 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 children with private insurance and Medicaid (Chart 5).

The problems of uninsured children grow worse when they get sick. Uninsured children are 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, 1994). This is consistent with other studies that have found that health insurance is essential to connecting children with the health system (Donnelan, 1996).



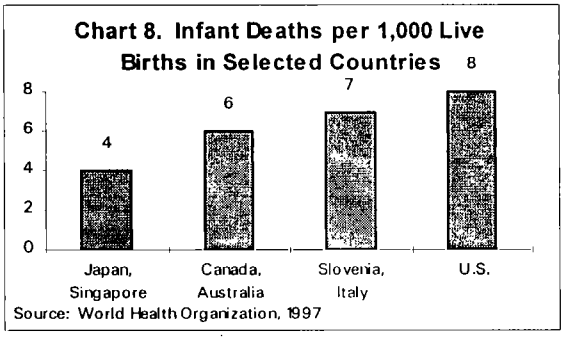
The United States stands alone. The United States leads the world in many important respects, including size of the gross domestic product (GDP) (World Bank, 1997) and real level of family income (Luxembourg Income Study, 1995). However, the United States is the only industrialized country that does not extend health protection to all its children. It is with Turkey and Mexico at the bottom of a league of nearly developed 30 nations in its coverage of children, and since several developing nations offer greater protections, the U.S. ranks even lower (OECD, 1997). Many countries also do more to lift their children out of poverty as well; 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).

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:	52th
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: World Bank, 1997; OAT, 1992; Rainwater & Smeeding, 1995

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

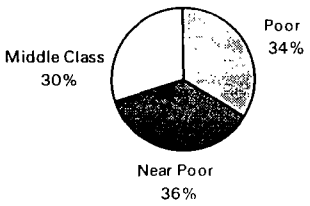


System failure. The number of uninsured children in the United States is particularly alarming because there are systems in place to insure them. The United States has developed a unique, employer-based health insurance system. Preferential tax treatment valued at almost $80 billion per year is intended to encourage health coverage in this way. Additionally, Medicaid, the joint Federal-state health insurance program, offers coverage to most 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 for 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 is poverty the sole reason 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 25 percent 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.

Chart 9. Uninsured Children By Income



Source: March 1996 Current Population Survey

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 (CPS, 1996). 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).

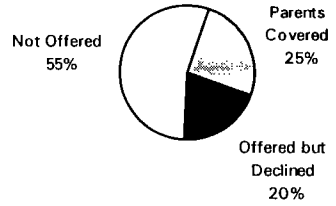
Nearly all uninsured children have a connection to the workforce. Most employers cover their workers' children. About 60 percent of children have employer-based health insurance (CPS, 1996). However, most uninsured children also have parents who work as well. Nearly 90 percent of uninsured children's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

Chart 10. Uninsured Children Come from Working Families

Note: 62%of uninsured children's parents work full-year, full-time
Source: March 1996 Current Population Survey

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. One study found that 80 percent of children with working parents had at least one parent who was offered family health insurance (Mark & Schur, 1996). However, 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 with family income below poverty and 51 percent of uninsured children with family income between 100 and 200 percent of poverty have parents who are not offered employer-based insurance (NCHS, 1994).

Chart 11. More Than Half of Uninsured Children's Parents Who Work Aren't Offered Health Insurance

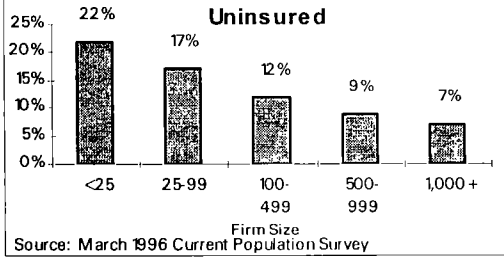


Source: CDC/NCHS, National Health Interview Survey, 1994

These families are most likely to work in small businesses, industries like personal services, and part-time jobs (Mark & Schur, 1996).

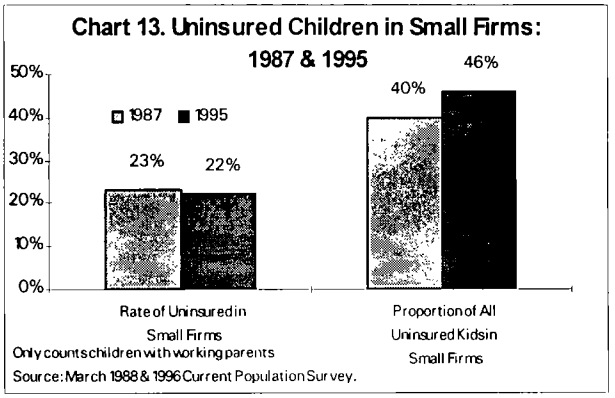
Small businesses are less likely to offer insurance. Children whose parents work in firms with fewer than 25 employees are more than twice as likely to be uninsured as those whose parents work in medium to large firms (Chart 12). This is especially true for low-income children. Over 35 percent of children 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). Only about 40 percent of employees in private businesses with fewer than 10 employees were offered coverage in 1993, compared to about 70 percent of employees in private firms with 10 to 24 employees, and nearly 100 percent of employees in firms with 100 or more employees (NEHIS, 1993).

Chart 12. Children with Parents in Small Firms More Likely to Be Uninsured

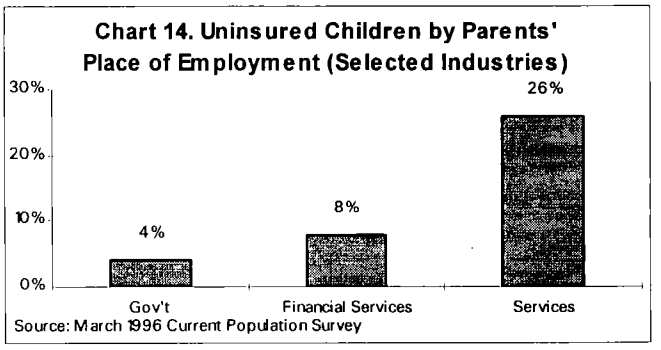


Source: March 1996 Current Population Survey

More children's parents work in small businesses. In 1988, 40 percent of uninsured children in working families had parents employed by 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 of workers in small firms were uninsured. Since the last decade, however, there has been a 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). At the same time, the number of children with parents working in medium and large firms dropped.



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 industry (e.g., restaurants, cleaning services), is about twice as high as that for kids with parents in most other types of jobs (Chart 14). In part, this reflects the fact that many of these businesses have part-time or part-year jobs. About 22 percent of children whose parents work part-time or part-year lack health insurance compared to 12 percent of full-time workers' children (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.

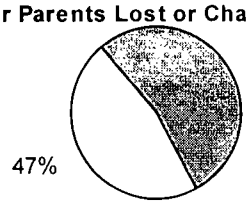


Like the trend for small business employment, there is an increase in the number of children with parents in service jobs — not an increase in the rate of uninsurance in those industries. Over 10 percent more children had parents working in these types of jobs in 1995 than in 1987 (CPS, 1996).

JOB CHANGE AND JOB LOSS

Parents' job changes 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 15). This reason for losing insurance is more prevalent among children whose parents now work in small firms — over 60 percent of these children lost coverage because of job change (NCHS, 1994). It is also the reason why 58 percent of uninsured children in families between 100 and 250 percent of poverty and 54 percent above 250 percent of poverty lost coverage in 1994. Since higher income families are more likely to have job-related insurance, it makes sense that job-related reasons are the primary reason why they lose insurance.

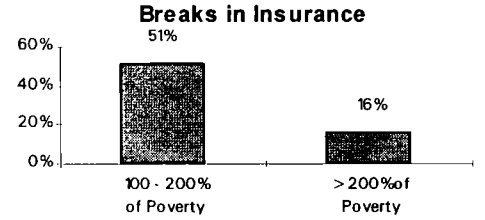
Chart 15. Most Children Who Had Insurance and Lost It Did So Because Their Parents Lost or Changed Jobs



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

Changing jobs leaves children with breaks in coverage. 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 16). This compares to 16 percent of children in families with income greater than 200 percent of poverty. This probably reflects the lower rate of job transition for higher income workers.

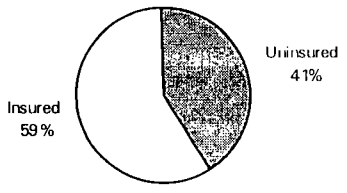
Chart 16. Children of the Working Poor Are More Likely to Have Breaks in Insurance



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

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 (CPS, 1996). Over 40 percent of children with unemployed parents who had received employer-based insurance become uninsured (Chart 17). Most of these children have parents who worked in manufacturing, transportation, communication, or construction jobs (Klerman, 1997). Most families spend 8 weeks or less looking for a job.

Chart 17. Children of Unemployed Parents Often Become Uninsured



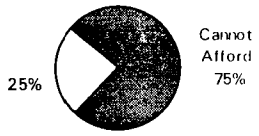
Source: Kerman (1997) analysis of SIPP, 1989-1994

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. Three-quarters of uninsured children whose parents were offered coverage at work report that they are uninsured because their families cannot afford coverage (Chart 18). A recent survey found that the monthly family premium is about $423 per month, with the family contribution averaging 32 percent or $135 ($1,620 per year) (Jensen et al., 1997). While affordable for middle and upper class families, such premiums may be out of range for low-wage workers. Additionally, small businesses typically ask families to pay more of the premium costs; the family contribution for workers in firms with less than 100 employees was nearly twice as high as that for workers in firms with greater than 100 employees (EBS, 1993-1994).

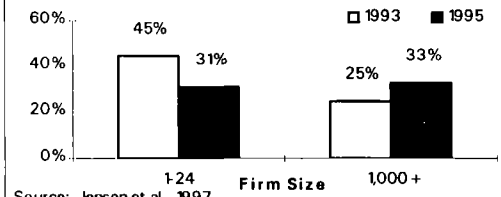
Chart 18. Most Children with Access to Employer-Based Insurance Remain Uninsured Because of Cost



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

Family contributions are changing. One theory on why an increasing number of children whose parents work are becoming uninsured suggests that families' contribution to employer-based insurance is increasing. One study found that the family contribution has remained about the same as a percent of the premium in the last several years (Jensen et al., 1997). However, this does not show a trend in which workers in large firms have seen increases in their share of the family premium (Chart 19). The increases in the family share probably have a greater impact on children than the decreases in small businesses since 19 million children are insured through large firms relative to 8 million children whose parents work in small firms (CPS, 1996).

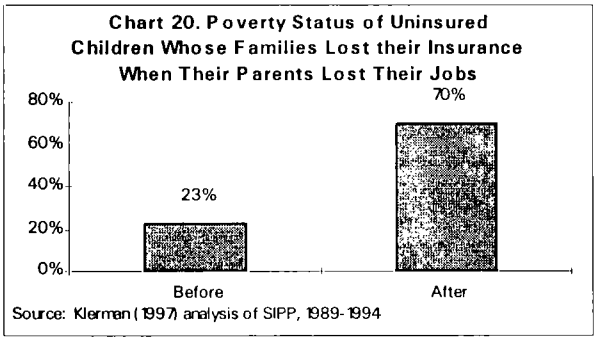
Chart 19. Changes in Family Contribution to Employer Health Coverage



Source: Jensen et al., 1997

Individual insurance is an option for families without access to employer-based insurance. Families without access to employer-based insurance may turn to the individual insurance market. About 4 percent of American children are covered by individually purchased insurance policies (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 family with a sick child will likely face premiums that are much higher than if obtained through the group market. More importantly, 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).

Parents cannot afford insurance when unemployed. Affordability is even a greater problem when parents are in 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 after the parent loses his or her job (Chart 20). 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.



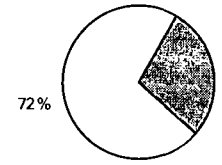
C. PROBLEMS ACCESSING EXISTING PROGRAMS

A third reason why children lack health insurance is that they cannot or do not take advantage of available options. The Federal and state governments have developed programs to help insure children — Medicaid being the largest, single insurer of children. However, many families whose children would be eligible may not enroll in such programs due to lack of information or program funding.

Medicaid and state programs offer coverage to children. Medicaid is the joint Federal-state health insurance program that serves 37 million Americans, including about 20 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, almost all states have used either Medicaid options or state- or privately funded programs 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 21). Researchers estimate that participation rates for Medicaid-eligible children range from about 40 to 70 percent (Center on Budget, 1997; Urban Institute, 1995). There is no conclusive research on why eligible children without insurance do not enroll in this program which offers free insurance (U.S. GAO, June 1996). Explanations include lack of awareness of the option, the fear that work disqualifies children, the uncertainty of Medicaid coverage. Families also may be discouraged by complicated eligibility rules.

Chart 21. Nearly 30% of Uninsured Children Are Medicaid Eligible

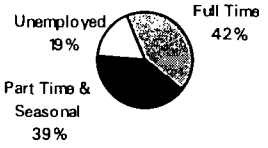


Source: ASPE Analysis of March 1996 Current Pop. Survey

Families lack awareness of Medicaid eligibility. One of the main reasons why children may not be 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 but unenrolled children do have working parents (Chart 22). However, Medicaid's historical reputation as a "welfare" program may lead families to believe that they are not eligible if they work.

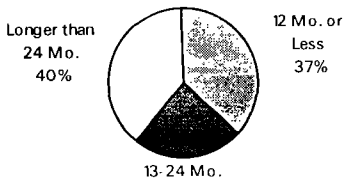
Chart 22. Most Uninsured Children Who Are Eligible For Medicaid Have Parents Who Work



Source: ASPE Analysis of March 1996 Current Population Survey

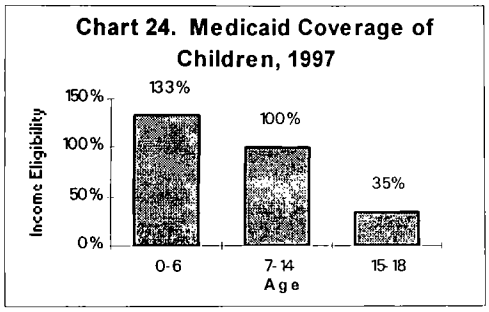
Uncertainty of Medicaid coverage. For a significant number of children, Medicaid coverage does not last long. About 37 percent of children spend less than one year on Medicaid (Chart 23). This may result from the Federal requirement that monthly changes in income or family status that disqualify the child from Medicaid be reported. There appear to be many families whose income regularly rises above and falls below above the poverty line. 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).

Chart 23. Children's Medicaid Coverage Over 28 Months



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

Medicaid may not cover all children in a family. Another reason why families may not enroll in Medicaid is its complex eligibility rules. Today, one child in a family may be eligible for Medicaid while another is not. This is because, in poor families, children 14 years old and younger are eligible while the children above 14 are not. And, in families with incomes below 133 percent of poverty, children below 6 years old are eligible while children above are not (Chart 24).



One consequence of this unevenness in eligibility is that, over time, the number of young, poor uninsured children has decreased while the number of older, poor uninsured children has increased. A study of uninsured children in the South found that between 1989 and 1993, the number of uninsured, poor children ages 0 to 5 declined by over 60 percent for children 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). This inconsistency in eligibility may account for the fact that older poor children are 60 percent more likely to be uninsured than younger poor children (CPS, 1996). If Medicaid eligibility were equalized for children of all ages, about 2 million uninsured children would become eligible for Medicaid.

State programs are small. Although most of the state programs have been able to educate families about eligibility, state and private programs may not cover all eligible children due to funding limits. Many 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 one study, only about 300,000 children are covered through these programs (Gauthier & Schrodel, 1997).

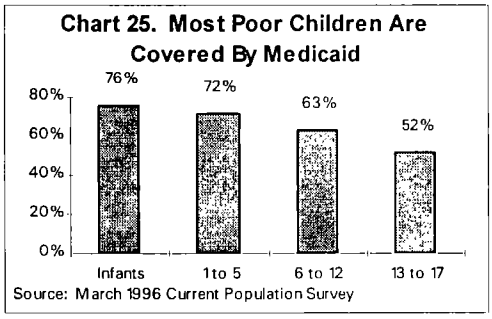
III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

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. However, there is considerable experience in Federal and state health policy that shows how to successfully — and unsuccessfully — expand coverage to children.

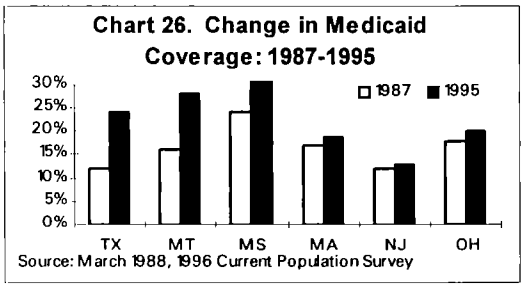
A. MEDICAID

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. 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 eligible for Medicaid.

Millions more children covered. Today, about 20 million children receive Medicaid coverage. In 1995, a large proportion of poor children received Medicaid's basic health protections (Chart 25). 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 — despite the increase of over 400,000 in the overall number of children in this income range between 1987 and 1995. Had Medicaid not been expanded, millions more children would likely be uninsured today.



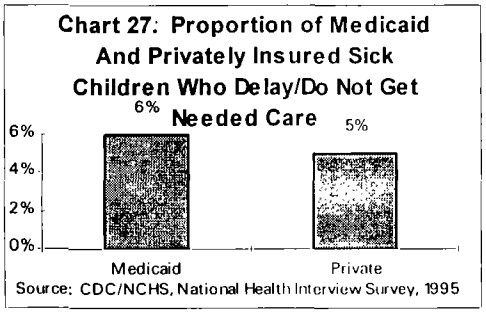
Moves toward a national eligibility "floor" for poor children. Prior to the Medicaid expansion, states varied widely in their Medicaid coverage. States in the South and Mountain regions had much lower Medicaid coverage of children than states in the North East and Upper Midwest (Chart 26). After the expansion, however, the gap in coverage of poor children narrowed by over 20 percent across regions (Shore-Sheppard, 1996). In part, this is because Medicaid was previously linked to welfare, which has very different eligibility levels across states. Moving to a national standard lessened this disparity. Additionally, Southern and Mountain states tend to have more poor children than others. As a result, they had larger expansions since more of their children became eligible.



States' emphasis on outreach. Many states have tried and succeeded in enrolling children eligible for Medicaid through outreach efforts. The Medicaid program has requirements, options, and incentives for states to reach out to eligible but unenrolled children. States have used 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. 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 (NGA, 1997). Some of the state-funded programs 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 (U.S. GAO, January 1996). These efforts explain why some states have high participation and why Medicaid, in general, has the highest participation rate of all types of public assistance programs (Census, 1996). However, as described earlier, significant gaps remain.

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 most 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). Some argue that, given the relatively low level of private coverage for poor children, this effect cannot be large for this population. However, as income eligibility rises, so does the risk of crowd out.

Medicaid improves access to care. Although Medicaid children do not always have the same 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, 1995). Whereas 20 percent of uninsured children who are sick delay or do 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 Medicaid reduced the odds of a child going without a visit by 50 percent (Currie & Gruber, 1996). These access improvements are especially important to children covered by Medicaid since they, on average, have poorer health than privately insured or uninsured children.



B. STATE EXPERIENCES

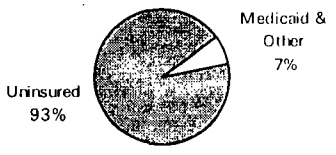
In addition to their role in Medicaid, many states have expanded coverage to children through state-funded or private programs. From these experiences, different lessons may be learned. The approach that each state has taken is unique, reflecting its particular problem, availability of funding, and health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

Florida

School-based system. The Florida Healthy Kids program uses schools to educate and enroll children in an insurance program. It began as a demonstration in one county and has expanded to 16 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, depending on a child's eligibility for the School Lunch Program. Families with incomes above 185 percent 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. Thus, the program appears to efficiently target uninsured children, not serving as a substitute for existing coverage. This suggestion is strengthened by the short duration of coverage and the reasons why families end enrollment. The average child spends about a year covered by the Healthy Kids program. The main reason why parents disenroll these children is that they gain employer coverage. This implies that the Healthy Kids programs serves as temporary coverage for children and that families prefer private insurance when given the choice.

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



Source: Florida Institute for Child Health Policy

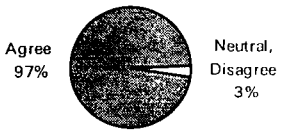
Lower emergency room use. An evaluation of the original demonstration project found that children enrolled in Florida Healthy Kids program were much less likely to use emergency rooms. This use dropped by 70 percent for enrollees in the second year after HMOs were able to educate families about alternatives. It also found that among these children's health care utilization more closely resembles that of privately insured than Medicaid covered children (Abt, 1996). This means that the program is not attracting "bad risks" and is successful at insuring children's without creating excessive demand. The Robert Wood Johnson Foundation is funding other states to create similar programs.

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 uses 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. MinnesotaCare provides nearly 44,000 children with comprehensive benefits provided through the state's network of Medicaid providers.

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 contributing toward the cost of coverage and agreed that MinnesotaCare is fair price for the benefits (Chart 29).

Chart 29. Almost All Agree that MinnesotaCare is a Fair Price



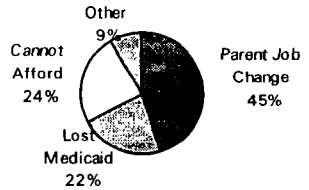
Source: Lurie et al., 1995

New York

Insurer-based children's program. New York's Child Health Plus program began in 1991, and was expanded in June 1996 to cover additional age groups and include inpatient services. 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. In September 1996, about 110,000 children were enrolled in Child Health Plus. 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.

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. Most of the children enrolled in the program had become uninsured because their parents lost or changed jobs; others lost Medicaid or could not afford private coverage (Chart 30). Enrolled children also had 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 their health had improved (Szilagyi et al., 1996).

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

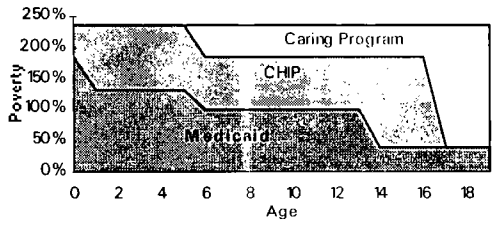


Source: Szigalyi et al., 1996

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 today 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 Blue Cross / Blue Shield and private donations. Currently, about 50,000 children are enrolled in these programs and there is a waiting list of 5,000 children.

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



Source: Pennsylvania program data

Importance of coverage to families. The Caring Program, CHIP and Medicaid have made measurable improvements in the lives of children and their parents. A survey found that three out of four parents of uninsured children postponed receiving care for themselves, saving their money for their children. These parents also were likely to restrict their children's activities, such as bicycle riding and playing ball, for fear that they would get hurt. The children themselves had considerable unmet needs. One-fourth of new enrollees needed to see a doctor for untreated illnesses like asthma, bronchitis, and diabetes. Over 40 percent needed dental care, and nearly 20 percent needed glasses (Lave et al., forthcoming). This program served as a model for Blue Cross / Blue Shield who have helped create Caring Programs in 25 states. About 50,000 children are enrolled nationwide (BCBS, 1997).

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 a supplement 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, this health insurance supplement to the EITC was repeal in OBRA 1993. The Treasury Department recommended its repeal because 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 tax payers reported to the IRS was the amount of the premium paid and (in 1991 only) the name of the insurance plan. The IRS could not verify this information since there were no reporting requirements for insurers. A Congressional 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.

D. COBRA and HIPAA.

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. Both policies are intended to maintain access to employer-based insurance for families with workers between jobs. However, their direct effect on coverage of children is not known.

IV. CONCLUSION

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. 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. 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 is 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.

There is no easy solution. The complexity of the reasons why children lack insurance, along with the fragmented system that tries to remedy this, make it difficult to design solutions. It may be the case 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 experiences provide ideas on how to design, implement and operate initiatives that can make significant improvements in coverage for children.

Lessons from Medicaid and state-funded programs. Through Medicaid, state-funded, and private programs, states have expanded coverage to children. Beginning in 1990, states began to phase in nationwide eligibility for Medicaid for poor children. This has resulted in a more uniform, national "floor" of coverage for children, especially in the South, where eligibility through welfare has historically been low. As a result, millions of the most vulnerable children have seen their access to health care improve. States have also demonstrated that they can efficiently target coverage toward the children who need it. Pennsylvania has been able to coordinate its Medicaid, state-funded, and private efforts to most efficiently create seamless coverage for children. In Florida, the Healthy Kids program appears to be filling an important need while not substituting for existing coverage. We have also learned from the state experiences that funding is a major barrier; most of the programs are quite small.

Lessons from tax credits and insurance reform. The Federal government has tried using tax credits in 1991 and 1992 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 whether the tax system is the best system to run coverage programs, and whether it can successfully encourage families to cover their children. Similarly, COBRA and HIPAA serve important roles in assuring coverage options, but extending them as currently structured may not be the best way to improve children's coverage.

Translating lessons into laws. 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 Balanced 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. The following policies, drawn from past experiences, may assist in achieving this goal.

Meaningful coverage. Despite their critical contributions, public providers alone cannot ensure that children receive the range of benefits that they need. The statistics suggest that uninsured children, even those with access to safety net providers, do not get all the care required for a healthy childhood. New policies should build on the safety net, but also ensure that children receive meaningful coverage.

Medicaid as a foundation. States have successfully used their Medicaid programs to cover millions of uninsured children. Yet its eligibility rules are such that brothers and sisters in the same family may not all be eligible for Medicaid. Options and incentives should aim to make Medicaid eligibility rules consistent. About 2 million uninsured children would be eligible for Medicaid if all children were offered the same coverage as children under 6 years old (who are now eligible for Medicaid if their family income is less than 133 percent of poverty or $21,000 for a family of four).

State programs to target hard-to-reach children. States have considerable experience in designing and implementing children's health programs. Given flexibility, they could target meaningful coverage to those pockets of uninsured children who may otherwise lack affordable options. For example, children whose parents are in between jobs are at particular risk of losing their coverage. States are in the best position to identify and assist such children. States have also demonstrated that they are interested in expanding coverage to children, with over 15 states proposing expansions this spring. This interest should be harnessed through policies such as grant programs.

Affordable insurance for small businesses. Many small employers want to offer health insurance to their workers and their families but cannot afford it. The power of group purchasing should be extended to small businesses in a way that assures affordability as well as consumer protections. For example, voluntary purchasing cooperatives allow small businesses to collectively negotiate for affordable insurance. These cooperatives have been tried and have succeeded In several states, such as California and Wisconsin. Similar approaches could be encouraged nationwide through grants to states.

Education and outreach for existing options. Finally, families should be educated about existing option. The best programs are meaningless if unused. States have shown how families can be made aware of their options and successfully enrolled in insurance programs. Schools are a natural place to educate children and their parents about affordable coverage. Simplified enrollment processes, telephone hot-lines, and media campaigns also appear to work.

Many of these ideas are in the President's budget and Congressional proposals currently being considered. Regardless of the particular approach, the complexity and magnitude of the problem of 10 million uninsured American children should serve as a challenge, not a barrier, to designing policies that aggressively, carefully, extend coverage to these children.

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 HEALTH COVERAGE PROGRAMS FOR CHILDREN

State	Uninsured under 19	Medicaid Expansions	Public or Private State Program	State Funds?	Current Enroll-ment
AK	19,000	None	None		
AL	193,000	None	Alabama Caring Program for Children	No	6,353
AR	129,000	*ARKids First (proposed): 0-18: 200%*	None		
AZ	248,000	Infants: 140%			
CA	1,775,000	Infants: 200% 13-19: 100%	Access to Infants and Mothers (AIM) CaliforniaKids (Caring Program)	Yes No	8,600 (AIM) 8,500 (CalifKids)
CO	125,000	None	Child Health Plan School Connections Caring Program	Yes	6,200 (CHP) New 3,500 (CP)
CT	85,000	0-13: 185%	Healthy Steps	Yes	
DC	25,000		None		
DE	22,000	Infants: 185% 13-19: 100%	None		
FL	652,000	Infants: 185%	Florida Healthy Kids Program	Yes	36,000
GA	319,000	Infants: 185% 13-19: 100%	Caring Program for Children	No	900
HI	24,000	0-19: 300%			
IA	92,000	Infants: 185%	Caring Program for Children	Yes	2,000
ID	49,000	None	Caring Program for Children	No	490
IL	344,000	None	None		
IN	184,000	Infants: 150% *Proposed: 13-18: 100%*	None		
KS	82,000	Infants: 150% 13-17: 100%	Kansas Caring Program for Children	Yes	2,700

State	Uninsured under 19	Medicaid Expansions	Public or Private State Program	State Funds?	Current Enroll-ment
KY	139,000	Infants: 185% 13-19: 100%			
LA	268,000	None	Caring Program for Children	No	375
MA	140,000	Infants: 185%	Children's Medical Security Plan	Yes	33,000
MD	158,000	0-13: 185% (primary and preventive care only)	Kids Count (Caring Program for Children) *Proposed: Thriving by Three*	No *Yes*	1,300
ME	40,000	Infants: 185% 6-19: 125%	None		
MI	235,000	Infants: 185% 6-15: 150%	Caring Program for Children	Yes	4,650
MN	85,000	0-21: 275%			
MO	155,000	Infants: 185% 13-19: 100% *Proposed: 0-18: 300%*	Caring Program for Children	No	5,500
MS	146,000	Infants: 185%	Caring Program for Children (Discontinued)	No	860
MT	29,000	None	Caring Program	Yes	1,400
NC	221,000	Infants: 185% 13-19: 100%	Caring Program	Yes	5,500
ND	16,000	13-18: 100%	Caring Program for Children	No	450
NE	47,000	Infants: 150%	None		
NH	31,000	0-19: 185%	Healthy Kids	Yes	1,600
NJ	243,000	Infants: 185%	Health Access New Jersey	Yes	5,800
NM	137,000	0-19: 185%	None		
NV	76,000	None	None		

State	Uninsured under 19	Medicaid Expansions	Public or Private State Program	State Funds?	Current Enroll-ment
NY	627,000	Infants: 185%	New York's Child Health Plus Program	Y	110,500
OH	317,000	*Proposed: 0-18: 150%*	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	50,000
RI	28,000	0-7: 250% *Proposed: 0-18: 250%*	RiteCare (1115)		
SC	157,000	Infants: 185% Proposed: 0-19: 133%	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%	Medical Care for Children Partnership *Proposed: Virginia Children's Medical Security Insurance Plan*	Y (county)	4,000
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

APPENDIX C: TECHNICAL NOTES [to be completed]

For CPS estimates:
Many parents report that their children had more than one type of health coverage during the year. Children were sorted into these categories by the following rules; any child with private insurance and some other type of coverage was classified as "private & other"; any child with Medicaid and was uninsured is classified as Medicaid, and other children without any coverage were classified as uninsured.

Charts about parents' employment consider the work status of the family adult. The family adult is the household adult with the most complete work history for the year--the work history closest to being full year/full time. Those classified as non-working did not work during the year. Depicts the firm size of the family adult with the work history closest to being full-year, full time.

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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.**
    - 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.** Uninsured children who are sick are four times as likely to delay or not receive needed care.

- **Children in poor health are more likely to have learning problems.**

- **The United States ranks poorly when compared to other nations**. It:
    - Remains the only industrialized nation that does not extend basic health protection to all 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 least likely to be 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 who became uninsured did so because their parents lost or changed jobs.

- **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.

- **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.

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 phasing in coverage of 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**. Over 30 states have private or state-funded programs to expand coverage to children. While limited in size, these experiences suggest that states can design efficient, creative programs can target uninsured children.

- **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

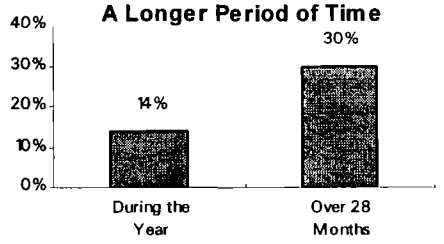
Not surprisingly, the key to obtaining access to the nation's high quality health care system is affordable health insurance. Although there are systems to care for people without coverage, evidence suggests that the uninsured have greater problems getting needed health care.

A. THE NUMBERS OF UNINSURED CHILDREN

One in seven right now. 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, 3/13/97.)

Nearly 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). Of these children, two-thirds were uninsured for at least six months, while nearly half were uninsured for at least one year (ASPE, 1997).

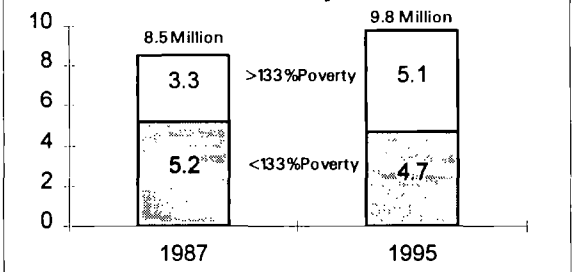
Chart 1. The Proportion of Uninsured Children is Higher over A Longer Period of Time



Source: Census Bureau, March 1996 CPS and SIPP, 1992-94

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).

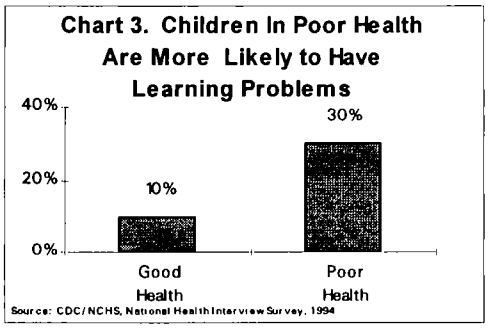
Chart 2. The Number of Uninsured Children Above Poverty Has Increased



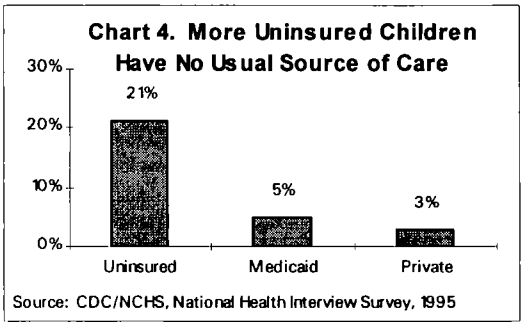
Source: EBRI analysis of the 1988 & 1996 CPS

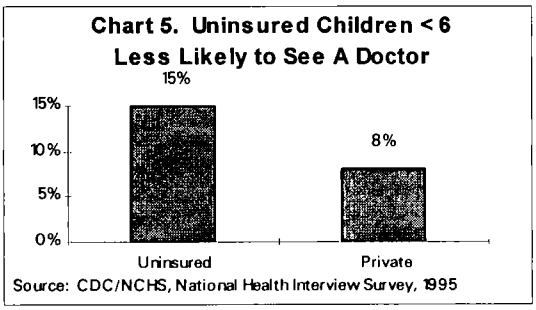
B. WHAT IT MEANS TO BE UNINSURED

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 4 percent of 18 to 24 year olds, 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). Children in poor health are three times more likely to experience difficulties in learning than healthy children (Chart 3). When asked what indicates that a child is ready for kindergarten, teachers overwhelmingly respond that the most essential factor is a child's physical health (NCES, 1996). Mental health is equally important. About 7.5 million children suffer from one or more mental disorder that disrupts their ability to function socially, academically, and emotionally (IOM, 1994).



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). However, despite these systems, one in five uninsured children has no usual source of health care (Chart 4).

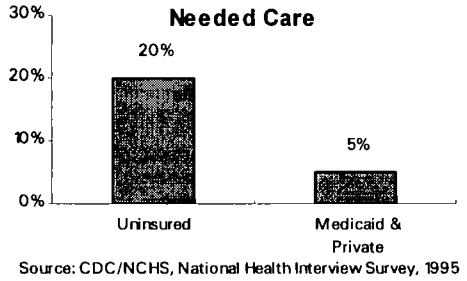




The lack of access appears to lower the use of care as well. Young children usually visit doctors at least once a year for preventive and primary care, since they often experience frequent, minor illnesses at this age. However, 15 percent of uninsured children less than 6 years old did not visit a doctor at all in the past year compared to 8 percent of children with private insurance and Medicaid (Chart 5).

The problems of uninsured children grow worse when they get sick. Uninsured children are 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 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) (World Bank, 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 all its children. It is with Turkey and Mexico at the bottom of a league of nearly developed 30 nations in its coverage of children, and since several developing nations offer greater protections, the U.S. ranks even lower (OECD, 1997). Many countries also do more to lift their children out of poverty as well; 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).

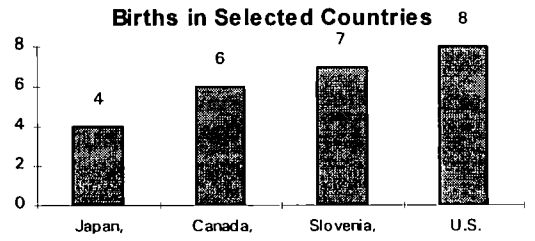
Chart 7. Ranking of the U.S. In Child Health Statistics

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:	52th
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: World Bank, 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 a lower proportion of low birthweight babies (Chart 8). Babies born in the United States have shorter 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

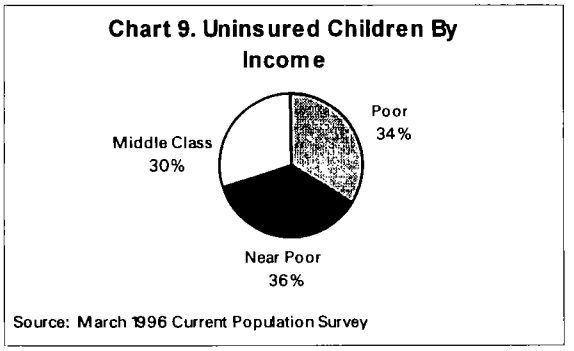


Source: World Health Organization, 1997

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. Preferential tax treatment valued at almost $80 billion per year is intended to encourage health coverage in this way. Additionally, Medicaid, the joint Federal-state health insurance program, offers coverage to most 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 for 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 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:

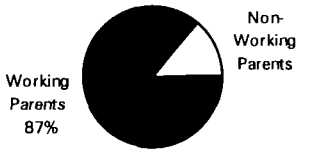
- Lack of access to employer-based insurance
- Lack of affordability of insurance
- Problems accessing existing programs.

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 (CPS, 1996). 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).

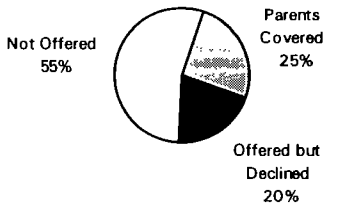
Chart 10. Uninsured Children Come from Working Families



Note: 62%of uninsured children's parents work full-year, full-time
Source: March 1996 Current Population Survey

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. One study found that 80 percent of children with working parents had at least one parent who was offered family health insurance (Mark & Schur, 1996). However, 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 with family income below poverty and 51 percent of uninsured children with family income between 100 and 200 percent of poverty have parents who are not offered employer-based insurance (NCHS, 1997b).

Chart 11. More Than Half of Uninsured Children's Parents Who Work Aren't Offered Health Insurance

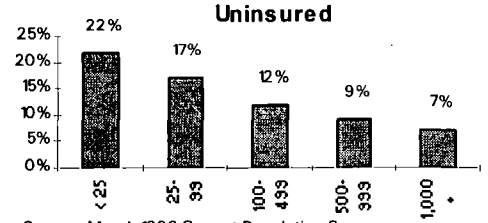


Source: CDC/NCHS, National Health Interview Survey, 1994

These families are most likely to work in (1) small businesses, (2) industries like personal services; and (3) and part-time jobs (Mark & Schur, 1996).

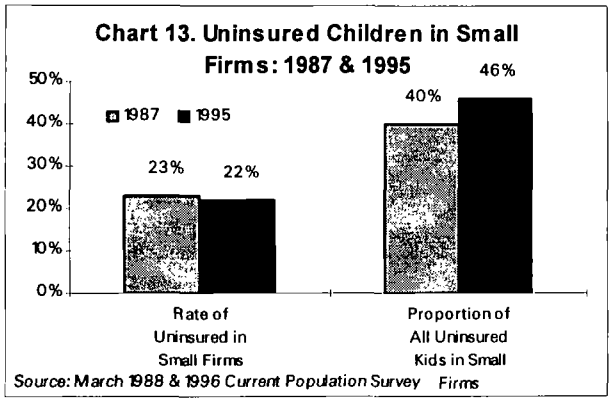
1. Small businesses are less likely to offer insurance. Children whose parents work in firms with fewer than 25 employees are more than twice as likely to be uninsured as those whose parents work in medium to large firms (Chart 12). This is especially true for low-income children. Over 35 percent of 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). 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).

Chart 12. Children with Parents in Small Firms More Likely to Be Uninsured

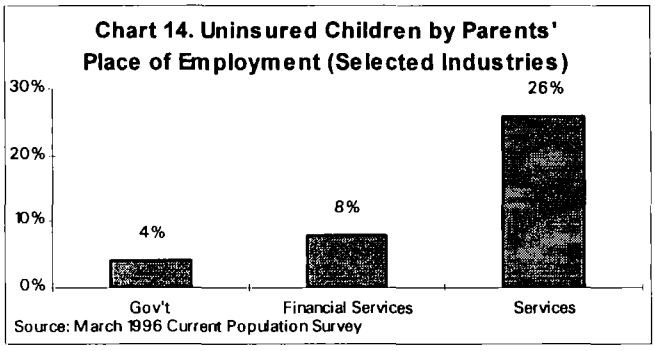


Source: March 1996 Current Population Survey

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. Since the last decade, however, 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.

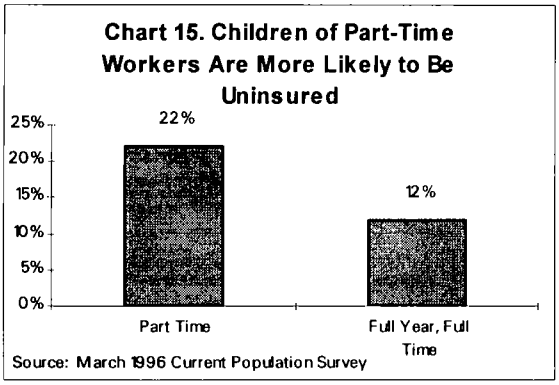


2. Companies in certain types of industries are less likely to offer insurance. Certain industries are less likely to offer coverage than others. Specifically, the rate of uninsured children whose parents work in the service (e.g., restaurants, hair cutters), is about twice as high as that for kids with parents in most 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 70 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).



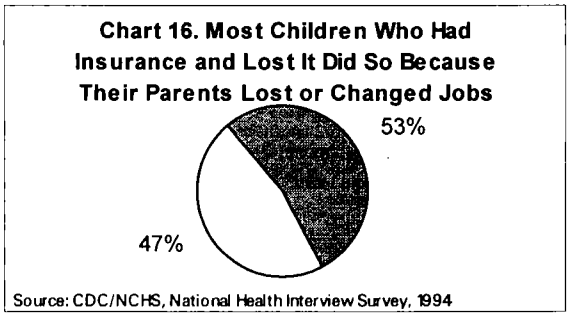
Like the trend for small business employment, there is an increase in the number of children with parents in service jobs — not an increase in the rate of uninsurance in those industries. Over 10 percent more children had parents working in these types of jobs in 1995 than in 1987 (CPS, 1996).

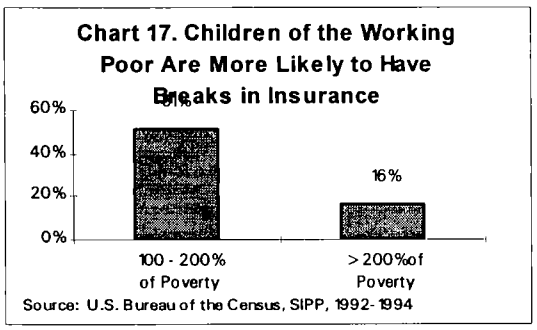
3. Part-time workers are less likely to be insured. Part-time and outsourced workers have less access to employer-based health insurance. Many employers only offer coverage to permanent employees or those who work more than 30 hours per week. As a result, children of part-time workers are more likely 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. There has been a slight increase, however, 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 who was the primary wage earner in the family (CPS, 1996).



JOB CHANGE AND JOB LOSS

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 now work in small firms — over 60 percent of these children lost coverage because of job change (NCHS, 1997b). It is also the reason why 58 percent of uninsured children in families between 100 and 250 percent of poverty and 54 percent above 250 percent of poverty lost coverage in 1994. Since higher income families are more likely to have job-related insurance, it makes sense that they are more likely to lose insurance for job-related reasons.

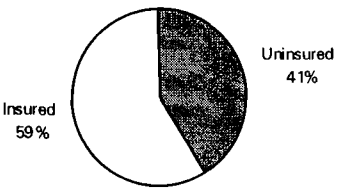




Changing jobs leaves children with breaks in coverage. Over 50 percent of all children between 100 and 200 percent of poverty had a lapse in their health insurance coverage over a 28-month period (Chart 17). This compares to 16 percent of children in families with income greater than 200 percent of poverty. This probably reflects the lower rate of job transition for higher income workers.

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 (CPS, 1996). 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). Most families spend 8 weeks or less looking for a job.

Chart 18. Children of Unemployed Parents Often Become Uninsured



Source: RAND analysis of SIPP, 1989-1994

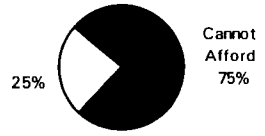
COBRA and HIPAA are just first steps to helping insure children. Several policies have been enacted to increase access to employer-based insurance for families who are between jobs. In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers with 20 or more employees to allow 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. Both policies are intended to maintain access to employer-based system for families with workers between jobs. However, they do little to help make it more affordable.

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. Three-quarters of uninsured children whose parents were offered coverage at work report that they are uninsured because their families cannot afford coverage (Chart 20). A recent survey found that the monthly family premium is about $423 per month, with the family contribution averaging 32 percent or $135 ($1,620 per year) (Jensen et al., 1997). While affordable for middle and upper class families, such premiums may be out of range for low-wage workers. Additionally, small businesses typically ask families to pay more of the premium costs; the family contribution for workers in firms (less than 100 employees) was nearly twice as high as that for workers in firms with greater than 100 employees (EBS, 1993-1994).

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

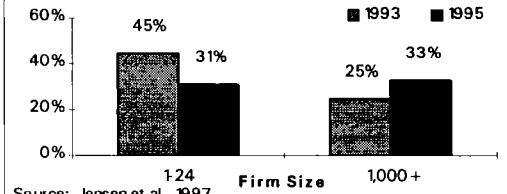


Source: CDC/NCHS, National Health Interview Survey, 1994

Family contributions are changing. One theory on why an increasing number of children whose parents work are becoming uninsured suggests that families' contribution to employer-based insurance is increasing. One study found that the family contribution has remained about the same as a percent of the premium in the last several years (Jensen et al., 1997).

However, this does not show a trend in which workers in large firms have seen increases in their share of the family premium (Chart 21). The increases in the family share probably have a greater impact on children than the decreases in small businesses since 19 million children are insured through large firms relative to 8 million children whose parents work in small firms (CPS, 1996).

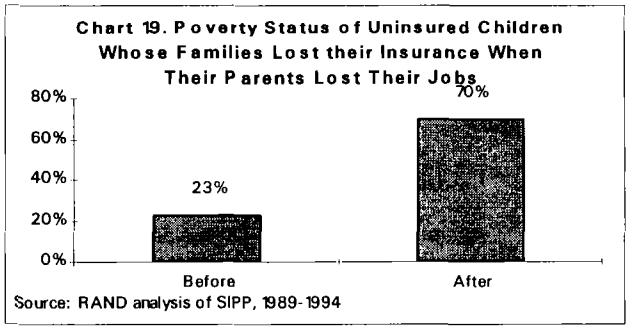
Chart 21. Changes in Family Contribution to Employer Health Coverage



Source: Jensen et al., 1997

Individual insurance is an option for families without access to employer-based insurance. Families without access to employer-based insurance may turn to the individual insurance market. About 4 percent of American children are covered by individually purchased insurance policies (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 family 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).

Parents cannot afford insurance when unemployed. Affordability is even a greater problem when parents are in 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.

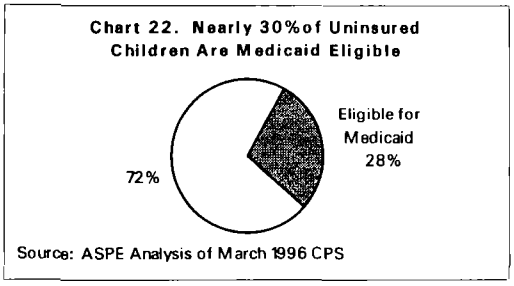


C. PROBLEMS ACCESSING EXISTING PROGRAMS

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 — Medicaid being the largest, single insurer of children. However, many families whose children would be eligible may not enroll in such programs due to lack of information or 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).

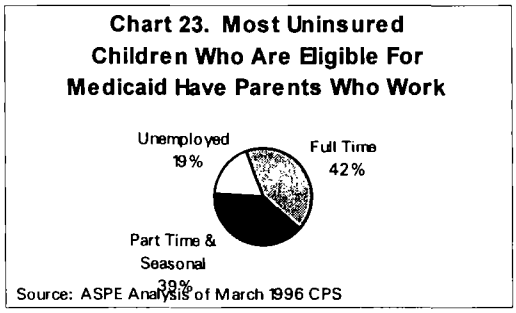
Many children are eligible but not enrolled in Medicaid. While most poor children are eligible for Medicaid, about three million uninsured children are not enrolled (Chart 22). Researchers estimate that participation rates for Medicaid-eligible children range from about 40 to 70 percent (Center on Budget, 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 (U.S. GAO, June 1996). 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.

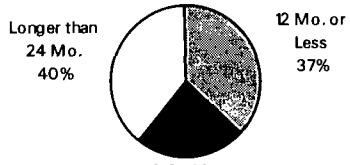
Families' lack awareness of Medicaid eligibility. One of the main reasons why children may not be enrolled is that their families do not know that they are eligible. One study that interviewed AFDC recipients — who are or were on Medicaid —found that 23 to 41 percent did not know that their children 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.



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 regularly fall below and rise above the poverty threshold. 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 the children who have been on Medicaid is typically just above poverty (100-200%) when they are off Medicaid (ASPE, 1997).

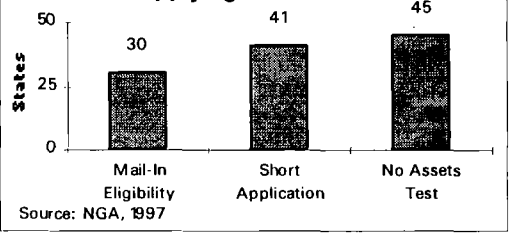
Chart 24. Children's Medicaid Coverage Over 28 Months



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). However, there is little research on which, if any, of these methods work and the statistics suggest that these efforts are not enough.

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 focus benefits on preventive services; 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 programs. 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 television ads featuring Mister Rogers (U.S. GAO, 1996).

However, enrollment is low since budgets are limited. Although most of the state programs have been able to educate families about eligibility, state and private programs may not cover all eligible children due to funding limits. 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 one study, only about 300,000 children are covered through these programs (Gauthier & Schrodel, forthcoming).

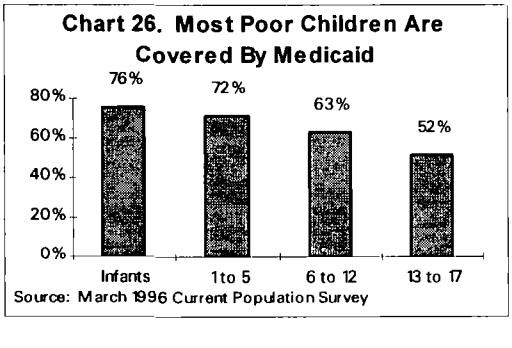
III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

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. 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 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, millions more children would likely be uninsured today.

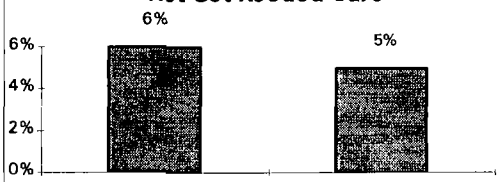


Major improvements in children's coverage in the South. One of the most pronounced effects of the Medicaid expansion occurred in the South. Southern states have historically had low welfare eligibility levels, which leads to low Medicaid eligibility levels. This meant that the Medicaid expansion to 100 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). Some argue that, given the relatively low level of private coverage for poor children, this effect cannot be large. However, as income eligibility rises, so does the risk of crowd out.

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 who are sick delay or do 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 Medicaid reduced the odds of a child not having a visit by 50 percent (Currie & Gruber, 1996). These access improvements are especially important to children covered by Medicaid since they, on average, have poorer health than privately insured or uninsured children.

Chart 27. About the Same Proportion of Medicaid As Privately Insured Sick Children Delay or Do Not Get Needed Care



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

B. STATE EXPERIENCES

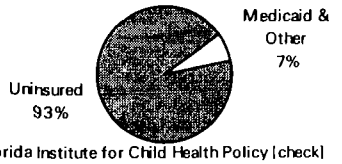
In addition to their role in Medicaid, many states have expanding coverage to children through state-funded or private programs. From these experiences, different lessons may be learned. The approach that each state has taken is unique, reflecting its particular problem, availability of funding, and 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 16 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. This suggestion is strengthened by short duration of coverage and the reasons why families end enrollment. The average child spends about a year covered by the Healthy Kids program. The main reason why parents disenroll these children is that they gain employer coverage. This implies, first, that the Healthy Kids programs serves as temporary coverage for children and, second, that families prefer private insurance when they have access to it (cite).

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



Source: Florida Institute for Child Health Policy [check]

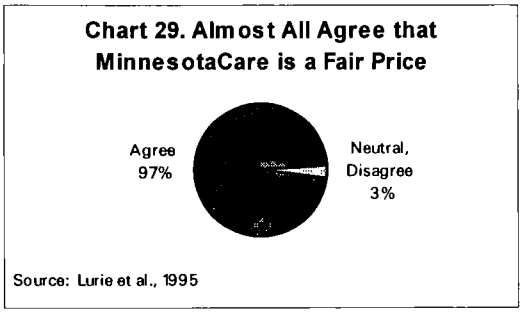
Lower emergency room use. An evaluation of the original demonstration project found that children enrolled in Florida Healthy Kids program were much less likely to use emergency rooms. This use dropped by 70 percent for enrollees in the second year after HMOs were able to educate families about alternatives. 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 contributing toward the cost of coverage and agreed that MinnesotaCare is fair price for the benefits (Chart 29).

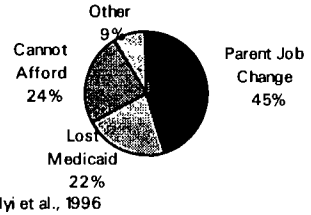


New York

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.

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



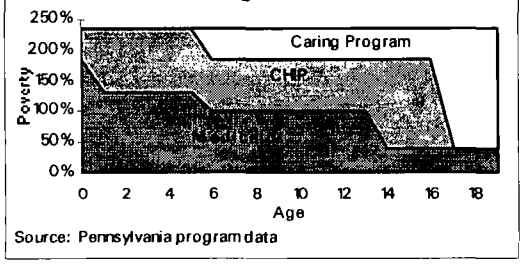
Source: Szigalyi et al., 1996

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).

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. Currently, about 50,000 children are enrolled in these programs and there is a waiting list of 5,000 children.

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



Source: Pennsylvania program data

Importance of coverage to families. The Caring Program, CHIP and Medicaid have made measurable improvements in the lives of children and their parents. A survey found that three out of four parents of uninsured children postponed receiving care for themselves, saving their money for their children. These parents also were likely to restrict their children's activities, such as bicycle riding and playing ball, for fear that they would get hurt. The children themselves had considerable unmet needs. One-fourth of new enrollees needed to see a doctor for untreated illnesses like asthma, bronchitis, and diabetes. Over 40 percent needed dental care, and nearly 20 percent needed glasses (Lave et al., forthcoming).

Replication of Caring Program elsewhere. The Western Pennsylvania Caring Program served as a model for other such programs. Today, about 25 states have a Caring Program. The basic model is that a primary care benefits package is offered to children in low-income families for little or no cost. It is administered by Blue Cross and Blue Shield plans and funded through donations, and in some states matching funds from Blue Cross and Blue Shied. About 50,000 children are enrolled nationwide (BCBS, 1997).

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 a supplement 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 Administration proposed a repeal of this health insurance supplement to the EITC. Congress enacted this repeal in OBRA 1993. The Treasury Department itself recommended its repeal because 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 tax payers reported to the IRS was the amount of the premium paid and (in 1991 only) the name of the insurance plan. The IRS could not verify this information since there were no reporting requirements for insurers. 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

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. 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.

State experiences. Through Medicaid, state-funded, and private programs, states made improvements in 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 are quite small.

Tax credits. The Federal government has tried using tax credits in 1991 and 1992 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 whether the tax system is the best system to run coverage programs, and whether it can successfully encourage 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. This study focuses on the problem of uninsured children and existing efforts to alleviate it. The complexity of the reasons why children lack insurance, along with the fragmented system that tries to remedy this, make it difficult to design solutions. It may be the case 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 experiences provide ideas on how to design, implement and operate efforts that can make significant improvements in coverage for children.

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 demonstrated 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.

Third, the keys to coverage are access and affordability. Options to improve access include tapping into states' Medicaid managed care program and developing small group purchasing cooperatives. Voluntary purchasing cooperatives gives small business the opportunity to purchase decent health insurance at lower rates than they would otherwise be able to negotiate. Helping families as well as firms afford coverage is equally if not more important. Making affordable options available may be one answer. "Buy-in" programs that allow families to purchase children's coverage at a reduced price are another.

Finally, outreach matters. While it is important to make insurance accessible and affordable, it is of no use if a child does not get enrolled. Initiatives should draw upon successful strategies such as school-based enrollment and media campaigns to educate and encourage families to enroll their children.

Regardless of the specific approach, policies will be more effective if they build upon the facts and experiences of the past. The problem of 10 million uninsured children is both critical and complicated. This should serve as a challenge, not a barrier, to policy makers to design policies that aggressively, yet carefully, extend coverage to these children.

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.