THE WHITE HOUSE

WASHINGTON

November 24, 1998

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings, Jennifer Klein, Jeanne Lambrew

SUBJECT: Response to Questions about Coverage Expansions

cc: Melanne Verveer, Neera Tanden, Nicole Rabner

In a recent discussion of the uninsured, you asked about several coverage expansion proposals, including a 55 to 65 coverage option, a Medicaid buy-in, a Federal Employees Health Benefit Plan (FEHBP) buy-in, and a new health insurance option for young adults. This memo summarizes these proposals, discusses their rationale, and provides you with a budget and Congressional status update. As was discussed in the memo to the President on the uninsured, the absence of substantial subsidies and the omission of an individual or employer mandate significantly limits the number of Americans who will be newly insured as a result of these policies. Having said this, each of these options (or modifications to them) can improve access to needed health insurance and are being considered for the FY2000 budget.

Medicare Buy-In / Health Insurance Options for People Ages 55 to 65

Policy. In our FY 1999 budget, we proposed three policies: (1) a Medicare buy-in for people ages 62 to 65 that is fully self-financed through an unsubsidized, two-part premium (an up-front premium plus a smaller, post-65 premium to compensate for any risk selection); (2) a similar Medicare buy-in for displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) guaranteed access to former employers' insurance for retirees age 55 and over whose retiree health benefits have been ended. According to CBO, this entire initiative costs about $1.5 billion over 5 years (mostly a temporary cost until the participants begin contributing their post-65 premium) and would assist about 300,000 people.

Rationale. This initiative, according to the latest data, is needed more than ever. Although still low, the number of uninsured people ages 55 to 65 grew the fastest in 1997 -- and will grow exponentially in the future since the number of people in this age cohort is projected to rise by over 60 percent by 2010. Moreover, we have increasing evidence that the individual insurance market -- relied on by this age group more than any other -- is raising its rates dramatically. Kaiser Permanente, for example, will double its individual insurance premiums for its older enrollees on January 1. This initiative gives people in this age group options to purchase insurance that they might not otherwise have. It also would be the bare minimum policy needed if the age eligibility for Medicare were raised -- an idea seriously being contemplated by the Medicare Commission.

Issues. Despite the need, this initiative was victimized by conflicting "too much - too little" criticisms. Republicans (and some conservative Democrats) claimed that the buy-in creates a huge loophole in Medicare that will ultimately lead to large costs. In part, this reflects a disbelief in our technical ability to set premiums that are self-financing in the long run. But mostly, it results from a strong belief that, even if the premium estimates are accurate, we will eventually succumb to the pressure to subsidize these premiums to make them more affordable for the lower income uninsured. In contrast, a number of traditionally liberal advocates and academics criticized the policy for helping too few people to justify the political capital that would be necessary to expend to get the proposal any serious attention by the Republican Congress.

Regardless of its political viability in this Congress, this proposal addresses a population in need, remains generally popular outside the beltway, and will continue to be seriously considered for inclusion in the FY 2000 budget. It is unclear whether it will make the final cut, however. The short-term savings needed to finance this initiative are controversial and/or likely to be used for other priorities (such as for underwriting the costs of the Jeffords/Kennedy disability coverage expansion bill). Also, there is concern about putting this proposal out so close to the final report released by the Medicare Commission this March. No matter how we resolve the budget question, however, we expect Senators Moynihan and Daschle as well as Congressman Gephardt to introduce this bill at the beginning of the next Congress.

Medicaid Buy-In

Policy. A Medicaid buy-in would allow states to charge income-related premiums for people in optional eligibility groups with income above 150 percent of poverty (the level at which states may charge cost sharing under the Children's Health Insurance Program (CHIP)). This proposal could be broadened to allow all people below a fixed income level -- not just those in current optional eligibility groups -- to buy into Medicaid.

Currently, states cannot charge premiums to Medicaid beneficiaries. A lesser known fact is that Medicaid law limits who can be covered as well. Historically, adults were eligible for Medicaid only if they were: (a) single parents, or married but unemployed parents, who receive welfare; (b) low-income elderly or people with disabilities who receive SSI; or (c) nursing home residents. During this Administration, however, new Medicaid eligibility options have been created. Welfare reform gave states the option to cover higher income single parents and unemployed married parents. The exclusion of married employed parents -- which is anti-work and anti-family -- was changed last summer with "100-hour rule" regulation. This lets states define "unemployed" as working more than 100 hours a month -- meaning that they may cover parents working 40-hour weeks if they so choose. And, in the Balanced Budget Act, we created a Medicaid buy-in for people with disabilities with incomes below 250 percent of poverty.

Rationale. A Medicaid buy-in could be an incentive for states to expand coverage to working adults, since even small family contributions improve the acceptance of such expansions. It also gives all states the flexibility that we have permitted through Medicaid waivers and supported in CHIP, as well as in the Medicaid buy-in for workers with disabilities.

Issues. Despite its sound policy basis, the likelihood that a Medicaid buy-in will significantly reduce the uninsured is low. Since large subsidies are required to encourage low-income, uninsured people to purchase health insurance, states would have to charge the families low premiums and pay for most of the costs themselves in order to get meaningful participation. Moreover, only states that have already expanded coverage to 150 percent of poverty could charge premiums to all new participants. Unfortunately, states typically cover few adults with incomes above 50 percent of poverty. Thus, premiums collected through a Medicaid buy-in would not come close to offsetting the large Federal and state costs. Additionally, while allowing premium payments from beneficiaries may be attractive to states, Republicans, and moderate Democrats, it would be vehemently opposed by advocates and liberal Democrats who believe that this opens the door to high premiums for lower-income Medicaid beneficiaries.

One idea that could possibly address the financial limitations of this proposal is to link the Medicaid buy-in proposal to a tobacco recoupment bill. The recent state tobacco settlement will likely lead to legislation about whether and under what terms states may keep the Federal share of that settlement. In such legislation, we could make expansion through a Medicaid buy-in one of the uses (or the sole use) of the Federal share. Congressional Democrats and advocates have long argued that tobacco settlements should be directly linked to health care, health insurance expansions, and Medicaid. It is possible they would accept a buy-in in a recoupment bill that assures Medicaid expansions. States, obviously, do not want any strings on the uses of the Federal share of the settlement, but may have the hardest time arguing against Medicaid investments since the settlement itself is premised on Medicaid costs resulting from tobacco use. The clear downside to this option is that money spent on expansions would limit the money used for other priorities like child care. This issue will be debated in our budget process.

FEHBP Buy-In

Policy. Another proposal for expanding coverage is opening up the Federal Employees Health Benefits Plan (FEHBP) to various groups of people (e.g., workers in small businesses, people ages 55 to 65 years old). In order to participate in FEHBP, health plans would have to offer health insurance to the designated group of eligibles. There are two options for how premiums would be set: first, new participants could be charged the same premiums as Federal employees; second, new participants could be charged premiums separately, depending on their own costs.

Rationale. The FEHBP buy-in would give certain groups of uninsured people the benefit of accessing the health plan options, information and possibly premiums that Federal government negotiates for its employees. It also reinforces our support for group health insurance purchasing, plan choices, and adequate information with which to make such choices.

Issues. Depending on how premiums are set, the FEHBP buy-in would either be costly to new participants or affect the premiums and choices of all Federal employees. Because newly eligible people who wish to purchase insurance who are healthy can likely find individual insurance that is cheaper, the population that decides to go into FEHBP is likely to be sicker. This will increase premiums of all current Federal employees if they are charged the same premium. It could also reduce plans participating in FEHBP if their enrollees include more costly, new participants than

Federal employees (which could happen in rural areas). As a consequence, most FEBHP buy-in proposals assume a risk pool separate from that of Federal employees for setting premiums. But because this pool would be a smaller and include less healthy people, premiums would be more expensive than FEHBP. As a consequence, most analysts project a relatively small effect on coverage. The only way to address this would be subsidies which carry significant cost implications. These complexities explain why there have been few FEHBP buy-in bills.

Given concerns about its use as a source of coverage, FEHBP may be better used as a model for other coverage expansion proposals. What makes FEHBP successful -- purchasing power for a large group of people; consumer information; plan choices -- could be incorporated into small businesses purchasing coalitions. These coalitions, promoted in previous budgets, provide any small business in the area with a set of plan choices and more affordable premiums. This year, we are examining options to aggressively encourage their development. For example, FEHBP managers could provide technical assistance in establishing these coalitions. They could also be granted non-profit status to facilitate private foundation support.

Catastrophic Coverage for Young Adults

Proposal. You mentioned an interest in policy options that would provide catastrophic coverage for young adults. Medicare, Medicaid, and FEHBP all provide comprehensive coverage, although we could conceivably develop a special program for catastrophic coverage. It is also possible through regulation to require individual insurers to offer such coverage to young adults.

Rationale. Young adults are more likely than any other age group to be uninsured -- nearly one in three 18 to 24 year olds lacks insurance. In part, this problem results because young adults are usually healthy and do not think that their need justifies the cost of comprehensive coverage. Thus, catastrophic coverage may be the best option for young adults since it is cheaper and protects them from the real risk of illness or injury that can be financially devastating.

Issues. Catastrophic coverage options probably would not insure many young adults. Few young adults would purchase even the lowest-cost catastrophic coverage without significant subsidies. In fact, some analysts believe that only an individual mandate will make young adults pay any level of premium for health insurance. This is because they rarely recognize their financial risk (e.g., one in four young adults sustains major injuries in a year and one in 20 is hospitalized). Second, while catastrophic coverage makes economic sense, people interested in insurance do not appear to like it. The lack of interest in the medical savings account (MSA) demonstration has shown that people prefer lower cost sharing and coverage of primary care.

Recognizing these challenges, we continue to examine policies to allow young adults to buy into Medicaid. Some of the most needing of insurance in this age group are foster care children who have aged past their 18th birthday (and thus last year of Medicaid eligibility.) We are working with OMB to provide a new state option for those Governors interested in expanding Medicaid coverage to this population. We believe it will be affordable (about $50 million over 5), sound policy that a number of states will pick up. As of this writing, the chances of this proposal being included in the budget appear to be quite good.

THE WHITE HOUSE

WASHINGTON

November 13, 1998

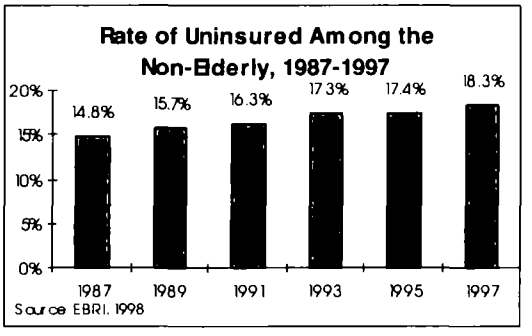
INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew

THROUGH: Bruce Reed, Gene Sperling

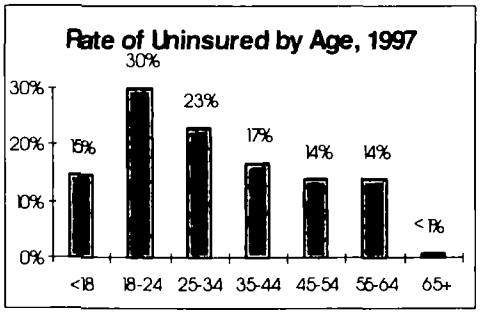
SUBJECT: Recent Uninsured Trends and Analyses

As you know, the Census Bureau recently estimated that 43.7 million Americans are uninsured -- an increase of 1.7 million from 1996 and nearly 5 million from 1992. Insurance coverage is one of the few social indicators that has not improved in the last several years. This contradicts the theory that a strong economy with low unemployment yields a high demand for workers, and thus better benefits like health insurance. It is even more disappointing given record-low health care cost growth in the last several years, which should make insurance more affordable and thus more common. This increase has important consequences since the uninsured are four times more likely to not receive needed health care, have hospitalization rates for preventable conditions that are 50 to 75 percent higher, and place growing uncompensated care burdens on the nation's providers.



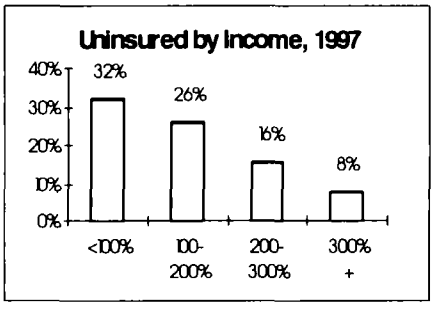
Because of the importance of this problem and your expressed interest in these data, we are providing you an analysis of the numbers and recent insurance coverage trends, as well as a summary of their policy implications.

Uninsured by age: Most of the uninsured in America are young; over 80 percent are under age 45 (35.2 million). These uninsured are disproportionately ages 18 to 24 -- 30 percent of whom are uninsured compared to 15 percent of children. The number of uninsured children did not increase in 1997, remaining at 10.7 million. This contrasts dramatically with last year's data that showed that 800,000 of the 1.1 million additional people who were uninsured were children. The change appears to be the result of the unprecedented focus on children's health in 1997. Beginning with the State of the Union and ending with the establishment of your Children's Health Insurance Program (CHIP), the Federal Government and the states started taking actions to address this serious problem. Next year, after Census' data reflects a full year's operation of CHIP, we would expect the number of uninsured children to fall.



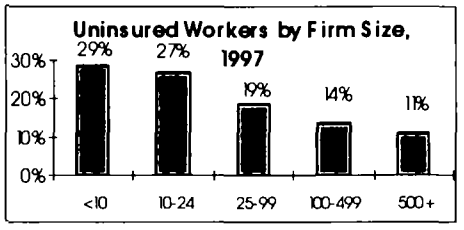
While the likelihood of being uninsured is higher among younger adults, the number of uninsured is growing faster among older adults. One million of the additional 1.7 million uninsured people in 1997 were age 35 or older. The increase is particularly concentrated among people ages 55 to 65; the number of uninsured people in this age group grew faster than all other age groups (7 percent growth). This trend is cause for concern because people ages 55 to 65 become more likely to develop a health problem and less likely to have employer insurance (because their spouses retire and join Medicare, they move to part-time or self-employment which typically does not offer insurance, or they retire). As a result, this age group is disproportionately relies on individual health insurance -- where premiums have been skyrocketing in recent years and underwriting practices remain prevalent. Because of the demographics, there is no doubt that the coverage problem will increase exponentially as the number of people in this age cohort is projected to rise by over 60 percent by 2010.

Uninsured by income: Not surprisingly, people with less income are less likely to have health insurance. Although only 13 percent of the U.S. population, poor Americans (with income less than $16,000 for a family of 4) represent 26 percent of the uninsured -- fully one-third have no insurance. However, reflecting the strong economy, the poverty rate continues to fall and the number of uninsured below 100 percent of poverty did not increase between 1996 and 1997.



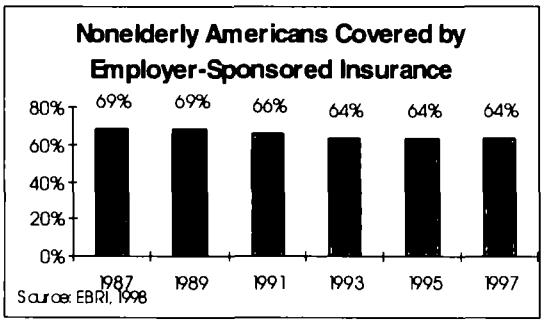
Despite the link between lack of insurance and low income, over 80 percent of the uninsured are in working families. The lack of insurance is growing among the middle class; all of last year's additional 1.7 million uninsured had income above the poverty level, with the greatest concentration of people between 100 and 200 percent of poverty. Inexplicably, although still small in number, the uninsured with income above 500 percent of poverty (over $80,000 for a family of 4) rose at an extraordinary 20 percent growth rate in 1997.

Job characteristics and the uninsured: Workers in small firms are less likely to have access to affordable, job-based health insurance. Nearly half of uninsured workers are in firms with fewer than 25 employees. Compared to over 95 percent of large firms, about half of firms with fewer than 10 employees and three-fourths of firms with 10 to 24 employees offer coverage. These facts underscore the need to find better ways for small businesses to pool resources and leverage to bargain for more affordable benefits.

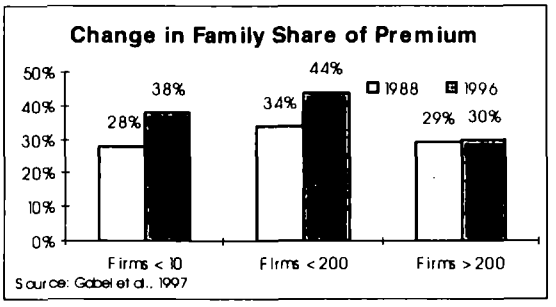


The rate of being uninsured is also high among people who work full time but only for part of the year, most likely due to job change or loss (27 percent). A recent Census study found that over 40 percent of workers with at least one job interruption had a gap in coverage. Because most people are insured through work, insurance coverage often ends with employment changes -- underscoring the importance of the Kassebaum-Kennedy portability and COBRA protections.

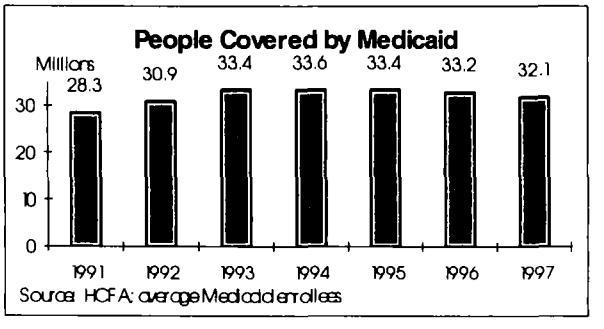
TRENDS IN EMPLOYER-SPONSORED INSURANCE. On the face of it, it does not appear that the increase in the uninsured is directly linked to a decline in employer-sponsored health insurance (ESI). The erosion that occurred in the late 1980s and early 1990s has ended. About 64 percent of nonelderly Americans had employer-based insurance in 1997, virtually unchanged from 1995 and 1996. In recent years, access to job-based health insurance has actually increased, even among small businesses. However, this has not translated into increased ESI coverage because a smaller proportion of people with access to ESI are purchasing it.



Even though more employers are offering health insurance, fewer employees are taking this coverage, primarily because they have to pay more of the premiums. The employee share of premiums has risen, especially in smaller firms. As a result, fewer employees are purchasing this coverage. For example, in 1987, 90 percent of workers in firms with fewer than 10 workers who had access to employer-based coverage took it, compared to 85 percent in 1996. These take-up rates drop as the share of the premium paid by the employee increases. This trend clearly affirms that health insurance affordability plays the most significant role in people's likelihood of buying health insurance.



TRENDS IN MEDICAID. The most notable drop in insurance coverage in 1997, reported by both the Census Bureau and HCFA, appears to come from the number of people covered by Medicaid. There are three possible explanations for this trend. The first and likely most significant factor is that, as the economy has strengthened, fewer people are eligible for Medicaid. This is supported by the fact that the poverty rate has declined, the number of poor covered by ESI has increased, and there was no increase in the number of uninsured children eligible for Medicaid (still 4.7 million). Second, there may be fewer people aware of their continuing Medicaid eligibility in the wake of state and Federal welfare reform. Third, it is becoming more likely that Medicaid beneficiaries misreport that they are covered by private insurance in the Census survey. States have been taking actions to "destigmatize" Medicaid by changing the name of their programs (e.g., TennCare, MinnesotaCare). Also, about 50 percent of Medicaid beneficiaries are enrolled in managed care plans, which are usually private plans. Thus, beneficiaries can easily mistake their coverage for private coverage.



FUTURE TRENDS IN THE UNINSURED. Given the complexity of these trends, it is unclear whether the rise in the number of uninsured will continue. Several compelling factors suggest that it will not and may actually decrease modestly. The Office of National Health Statistics projects that the proportion of Americans covered by employment-based insurance will rise as continued low unemployment will make employers more likely to use insurance to attract workers. Medicaid coverage may increase as well as additional low-income parents become eligible because of the "100-hour rule" welfare-to-work regulation you instituted this past summer and/or due to the states' continued use of Medicaid waivers, which have already covered over one million Americans. We also expect to see a decrease in the number of uninsured children beginning to showing up in next year's Census Report as the effects of CHIP take hold.

As the baby boom generation ages, however, more people will move into the 55 to 65 year old age bracket -- where the proportion of people with ESI is declining and uninsured is increasing. Furthermore, significant premium increases for next year, as some recent reports have projected, may make insurance unaffordable to greater numbers of Americans. While these conflicting trends make it extremely difficult to predict the future with any sense of confidence, it seems unlikely that we will see another significant increase in the uninsured next year.

IMPACT OF ECONOMIC AND EDUCATION SUCCESSES ON THE NATION'S HEALTH. This problem of the uninsured contrasts with tremendous improvements in other national health indicators. Your impressive economic accomplishments have had an impact on the costs of health insurance. For the first time in well over 30 years, health inflation was below general inflation in 1995 and 1996, thus actually reducing the real costs of health insurance. Moreover, gains in education, income and employment have contributed towards record high life expectancy (76.5 years for those born in 1997), a record low infant mortality rate (7.1 deaths per 1,000 live births), an AIDS death rate that is half of what it was in 1992, and a record-high immunization rates. And, historic increases in the investment in biomedical research during your Administration offer real hope for new (and hopefully cost-effective) treatments and cures for the diseases that will otherwise place unprecedented burdens on the nation's economy and health care system when the baby boom retires.

POLICY IMPLICATIONS. The uninsured in America remains one of the most challenging domestic social problems. Not only is the problem large in size, it is complex, crossing income, age and geographic boundaries. Despite its complexity, one fact is clear: making health insurance affordable is and always will be the key to significantly expanding coverage. Even for an employee whose employer pays for 80 percent of the premium, the family share of the premium is typically over $1,100 per year -- more than one out of every $10 of income for a minimum-wage worker. This cost is obviously much higher for people without access to employer-based insurance, especially if they have a history of illness. While traditional insurance regulation can help reduce insurance premium variation and discrimination, independent analysts will not project any substantial coverage expansions resulting from these interventions. In a non-mandate environment, they believe that only significant subsidies can induce a substantial reduction in the uninsured.

Ironically, our ability to propose policies to make insurance more affordable is limited by our success in reducing national health spending. In the last 5 years, hundreds of billions of dollars in excess Medicare and Medicaid spending have been squeezed out of these programs and used productively to help eliminate the deficit, finance children's health coverage, extend the life of the Medicare Trust Fund, and to make the Medicaid program a much more predictable and affordable safety net. However, substantial reductions in Medicare and Medicaid mean that these traditionally utilized funding sources cannot be relied on as offsets for major coverage expansions, let alone long-term Medicare reforms. With this in mind, outside funding sources from the tax code, tobacco, or elsewhere would be needed for a significant coverage expansion.

Administration & Republican coverage expansion ideas. The range of coverage options, currently being prepared through the traditional NEC/DPC/OMB budget process, will include some previous and new targeted coverage expansions. As this memo has documented, the most recent data validate the case for coverage expansions to the pre-65 and "workers-in between-jobs" populations. We also will continue to focus on administrative and possibly legislative outreach policies to encourage enrollment in CHIP and Medicaid to ensure your children's health initiative is a success. However, recognizing the questionable political and budgetary viability of these proposals, we are also reviewing options more likely to be well received in this Congress.

First, we are contemplating policies to encourage states to expand using existing options. With the 100-hour rule regulation, all states can now cover parents of children on Medicaid. Other states have used Medicaid 1115 waivers to cover all people up to certain income levels. Because this would likely require greater financial incentives, one option is making coverage expansions a priority on a short list of acceptable uses for the Federal share of state tobacco settlements.

As an alternative to coverage expansion options, we expect Secretary Shalala to advocate for a significant investment in public health infrastructure. This investment would be used to adapt the safety net to the rapidly changing health system. This idea would likely be better received than a coverage expansion by Republicans. However, if not a capped mandatory grant program, it would either require raising the discretionary caps or place a major strain on the current caps. Also, it would likely be perceived by some Democrats as giving up on coverage expansions.

Since there is bipartisan concern about small businesses' problem in accessing insurance, we are also considering enhancing our previously-proposed small business purchasing coalition grant initiative. We could more aggressively encourage these coalitions by directing OPM to provide technical advice for their establishment and operation, so that they more closely resemble FEHBP. We are also examining granting them non-profit status, to facilitate foundation support.

In 1999, Republicans, too, may consider small business group purchasing policies (although in the past, their versions have been significantly flawed). It is more likely, however, that, if Republicans decide to address the coverage issue at all, they will focus on the use of tax incentives for the purchase of individual health insurance. Encouraging individual insurance is intriguing because nation's reliance on voluntary, employer-based coverage has clearly not been an unqualified success. Moreover, if there is to be any significant investment in health care that the Republicans could possibly support, it would almost inevitably come from the tax code.

While acknowledging that tax credits are at least initially appealing, they are no panacea. They are extremely inefficient and expensive, as many of the assumed recipients would already have coverage. For independent experts to validate that the previously uninsured would take advantage of this policy, the credit would have to be quite large. In addition, if used for individual (rather than employer-based) insurance, they would require the type of major insurance reforms that have been historically opposed by Republicans. The individual market is the least regulated, most expensive, most "cherry-picked" and most unstable insurance market.

Notwithstanding legitimate concerns, we believe that tax credits may be the only health coverage expansion vehicle that could be produced by this Congress. As such, we are reviewing possible options for your consideration. For example, it might be possible to merge policies to promote small group purchasing coalitions with tax credits for participating employers or employees. Limiting the tax credit to such entities could further encourage a long-overdue expansion of small business coops. However, such approaches also raise equity concerns (e.g., why discriminate against an employee/employer who does not have access to, or does not want to be in, a purchasing coop) and political arguments (e.g., isn't this too similar to the Health Security Act). DPC, NEC, OMB, Treasury and HHS are reviewing this purchasing coalition/tax credit idea and other tax incentive approaches. We will keep you apprised of developments in this area, as well as other coverage options, as the budget process unfolds.