

MEMORANDUM

June 23, 1997

TO: Bruce R., John H, Gene, Nancy-Ann, Jen K.

FR: Chris J. and Sarah B.

RE: Children's Health One-Pager and Q&As

Attached is a one-pager on children's health that will be used as background for the President's speech tomorrow on children's health with Kaiser Permanente. (Kaiser is announcing that they are donating \$100 million to cover up to 50,000 uninsured children in California). We have also included our most up-to-date Q&As on children's health, Medicare, and AIDS.

We hope you find this information helpful. Please call with any questions.

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today the President joined Kaiser Permanente in announcing that the health plan will give \$100 million to provide health care coverage to up to 50,000 uninsured children in California. Kaiser is responding to the President's challenge at the Summit Service, and their initiative complements the President's commitment to a national effort to extend health insurance.

This President will continue to fight hard to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President fought hard to ensure that the balanced budget agreement included \$16 billion to provide meaningful health care coverage to uninsured children. The President also supports the action by the Senate Finance Committee to raise a 20 cent tobacco tax to allocate additional Federal support for children's health.

The President outlined the principles he will use in evaluating children's health initiatives emerging from the Budget Agreement. The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful:** from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted:** through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than new money to replace public or private money that already covers children.

The Balanced Budget and the Kaiser announcement build on the President's previous successes in strengthening health care coverage for children.

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law, the President helped millions of Americans -- and their children -- keep their health care coverage when they change jobs.
- **Children and Medicaid.** Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children.
- **Children and the Environment.** The President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.
- **Children and Tobacco.** The President has also taken action to limit children's access to tobacco. Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- **Children and Immunization.** During the Clinton Administration, childhood immunizations have reached a historic high. The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- an historic high.

CHILDREN'S HEALTH

Q: DO YOU BELIEVE THAT A CHILDREN'S HEALTH INITIATIVE CAN EMERGE FROM CONGRESS THAT YOU SUPPORT? DO YOU HAVE A PREFERENCE FOR HOUSE- OR SENATE-PASSED LEGISLATION?

A: Yes. We are working with the Congress to ensure that they produce a children's health initiative that provides meaningful health care coverage to millions of uninsured children. It is imperative that the single largest investment for children's health care since Medicaid was enacted in 1965 is efficiently spent to cover the most number of uninsured children.

I am committed to making sure that any investment in children's health care meets three principles: (1) that coverage is meaningful: from checkups to surgery -- children should get the care they need to grow up strong and healthy; (2) that coverage is targeted: through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and (3) that this investment supplements not supplants coverage: this investment should cover children who do not currently have insurance -- rather than new money to replace public or private money that already covers children.

I am optimistic that the House and certainly the Senate will improve their legislation. It is encouraging that Republicans and Democrats are working to ensure that the children's health package that is produced will ensure that benefits are meaningful and that low-income children are protected from excessive out-of-pocket costs. We will do everything that we can to work with these Members as the bill is debated on the House and Senate floor this week.

Q: WITH THE TOBACCO SETTLEMENT IN MIND, SENATOR LOTT RECENTLY IMPLIED THAT THE SETTLEMENT MIGHT UNDERMINE SUPPORT FOR THE TOBACCO TAX. DO YOU BELIEVE THAT THE CONGRESS SHOULD RESIST PASSING A TOBACCO TAX BEFORE THE FINAL TOBACCO AGREEMENT IS WORKED OUT?

A: No. The Finance Committee, on a bipartisan basis, passed out an increase in the tobacco tax to provide additional funding for children's health care coverage. The Congress should not alter its decisions based on an assumption that an acceptable tobacco settlement might be reached.

Q: DO YOU BELIEVE THAT RESOURCES FROM THE TOBACCO SETTLEMENT COULD COVER THE REST OF THE UNINSURED CHILDREN? HOW WOULD YOU RECOMMEND INVESTING THESE NEW DOLLARS?

A: We just heard the details of the tobacco settlement on Friday. Any final decisions about how any money from the potential settlement might be spent are obviously premature. The tobacco settlement could provide significant new funding for children's health and other public health initiatives. While we should be and are looking into possible options, we cannot count on any of these dollars. We should not let the possibility of additional revenue from a tobacco settlement undermine the investment for children that has already been agreed to in the balanced budget agreement.

Q: DO YOU SUPPORT THE TOBACCO TAX THAT WAS INCLUDED IN THE FINANCE COMMITTEE MARK-UP?

A: Yes. I do hope, however, that we can dedicate more of the savings from the revenue -- beyond the \$8 billion -- to other children's priorities.

Q: WHY DID YOU OPPOSE THE HATCH-KENNEDY LEGISLATION? AND WHY DID YOU NOT OPPOSE THE ADDITIONAL \$8 BILLION FOR CHILDREN'S HEALTH FROM TOBACCO REVENUE IN THE SENATE FINANCE MARK-UP. HOW DO YOU RECONCILE THIS INCONSISTENCY?

A: I have been supportive of using revenue raised from tobacco for health care since the beginning of his Administration. It was explicitly used as a revenue source for the Health Security Act.

I did not support adding the Hatch-Kennedy amendment in the context of the budget agreement because the Republican Leadership strongly asserted it would have undermined the budget deal and the \$16 billion already allocated for children's health care. I have repeatedly said how difficult it was for me to oppose that legislation, which encompasses goals I clearly support.

In the recent Finance Committee mark-up, the Republican Leadership accepted a down-sized tobacco tax (20 cents) and allocated some of the savings (\$8 billion) for children's health. Their support for this revenue source removes any barrier for me to support it.

Q. DO YOU BELIEVE THAT THE VOTE AGAINST THE CHAFEE-ROCKEFELLER CHILDREN'S AMENDMENT WAS A REJECTION OF THE YOUR HEALTH CARE PRIORITIES?

A. No. While we were disappointed that Chafee-Rockefeller amendment did not pass, the Senators made improvements that responded to a number of the concerns that I had raised about the Chairman's mark and the Commerce Committee bill.

Before the final compromise was reached, the original Finance legislation fell well short of assuring that the \$16 billion for children's health care was being effectively targeted to ensure that the greatest number of children would be given a meaningful benefits package. For example, it would have permitted states to use the \$16 billion for purposes other than expanding health insurance coverage to children, and it would have allowed states to offer health plans that would not have included many important benefits that children need.

I do, however, believe that we need to continue to work to ensure that the final bill includes provisions that guarantee that low-income children are not exposed to excessive cost sharing and to ensure that the benefit that is provided to children is meaningful.

I fought extremely hard to ensure that the \$16 billion for children's health was in the Budget Agreement. I will continue to work to ensure that the final children's health legislation provides children with a meaningful benefits package and covers the most children possible.

MEDICARE

Q: DO YOU SUPPORT THE INCOME-RELATED PREMIUM PROPOSAL THAT WAS IN THE SENATE FINANCE COMMITTEE MARK?

A: First, what passed the Senate Finance Committee was not an income-related premium but rather an income-related deductible that would allow high-income beneficiaries to pay deductibles beyond the current limit.

The proposal is also outside of what was decided in the Budget Agreement. We decided on what beneficiary savings were in the agreement and all assumed there would be no other beneficiary cost-sharing burdens.

I agree with the former Congressional Budget Office Director, Robert Reischauer that it would be administratively complex and potentially unworkable in a practical context. Regardless, it needs much consideration before we could support it as an addition to the Medicare program.

For this reason, we do not support this proposal in the context of the budget negotiations. However, we would be happy to have discussions with Senator Kerrey and others about this provision in another context.

Q: DO YOU SUPPORT EXTEND THE AGE OF MEDICARE AGE OF MEDICARE ELIGIBILITY OLDER AMERICANS FROM 65 TO 67 YEAR OLD?

A: **Raising the eligibility age for Medicare from 65 to 67 is not consistent with the spirit of the balanced budget agreement.** We do not support this provision in the context of the balanced budget negotiations. It was not thoroughly discussed in the budget agreement, and we believe that it raises a number of issues that have not been thoroughly considered.

Many early retirees would lose their private health insurance if Medicare was not available to them. There 4.1 million retirees between the ages of 55 and 64 -- 24 percent of all retirees. Having no alternative available, many would become uninsured while they were waiting for Medicare.

Health care coverage for early retirees is already dropping. The proportion of all retirees covered by health insurance from a former employer dropped from 37 percent in 1998 to 27 percent in 1994.

The decline in coverage among active workers, which decreases the likelihood of retiree health benefits, is a significant factor in this decline of coverage. The proportion of workers who with coverage from their employer upon reaching retirement declined from 65 percent to 1988 to 60 percent in 1994.

Only 30 percent of early retirees (age 55-64 years i.e. non-Medicare eligible) have health insurance from a former employer.

The cost of health care is also a significant factor for retirees. One-fourth of all retirees who elected not to carry their insurance into retirement reported they made their decision to drop insurance because it was too expensive.

Unlike Social Security, if we raised the age limit for Medicare, beneficiaries who retire early would not be eligible for a portion of benefits.

With Social Security, Americans who retire early are eligible for a portion of their benefits until they reach the age of eligibility. There are no options for partial benefits for Medicare beneficiaries who need access to health care coverage before they reach the age of eligibility.

Q: DO YOU SUPPORT THE HOME CARE COPAYMENT INCLUDED IN THE BILL FROM THE SENATE FINANCE COMMITTEE?

A: No. It is outside the context of the Budget Agreement and it needs further review before proceeding further in the legislative process.

We must remember that Medicare beneficiaries who use the home health services tend to be in poorer health. Two-thirds are women, and one-third live alone. Forty-three percent have incomes less than \$10,000. We would want to therefore make certain that a copayment would not place excessive burdens on beneficiaries who truly needed the benefit.

While we do not support this proposal in the context of the Budget Agreement, we do believe that proposals like it merit consideration in any serious review of options to address the long-term financing challenges confronting the Medicare program.

Q: THE HOUSE COMMERCE COMMITTEE, THE WAYS AND MEANS COMMITTEE AND THE SENATE FINANCE COMMITTEE ALL VOTED TO FORM A MEDICARE COMMISSION. DO YOU SUPPORT THIS AS WELL?

A: We have always indicated our support for a bipartisan process to address the long-term needs of the Medicare program. However, our first goal is to pass the Medicare reforms in the Budget Agreement that will extend the life of the trust fund for at least a decade. We still have lots of work to do on this deal to ensure that we get the provisions agreed to in the Budget Agreement.

A Commission similar to the different approaches outlined in Congress may or may not be the best bipartisan process. We will continue our conversations with the Democrat and Republican Leadership to determine the most advisable course of action.

AIDS

Q: WHAT IS YOUR POSITION ON THE MAYORS' RESOLUTION IN SUPPORT FOR FEDERAL FUNDING OF NEEDLE EXCHANGE PROGRAMS?

A: Current law prohibits the Administration from authorizing the use Federal funds for needle exchange programs unless there is conclusive evidence that they do not encourage drug use. Although there is strong evidence that indicates that needle exchange programs help reduce the spread of AIDS, we have not concluded our review on whether these programs increase the use of drugs.

We are consulting with HHS and the Office of National Drug Control Policy in this regard. But once again, we are explicitly prohibited from releasing Federal public health dollars until and unless a formal determination is made that the use of these programs does not increase drug use. It is important to point out that local communities remain can and do use non-Federal funds to support such programs.

Q: HOW DO YOU RESPOND TO AIDS ACTIVISTS CALL FOR MORE FUNDING OF PROTEASE INHIBITORS FOLLOWING UP THE HHS-ISSUED GUIDELINES LAST WEEK ON AIDS TREATMENT?

A: The Department is reviewing the budget implications of the new treatment guidelines for the AIDS Drug Assistance Programs (ADAP). We are working with states to determine whether our current budget does enough to help states treat those in need. If it becomes clear that there is a severe shortage in this area than we will -- as we always have -- make every effort to address these problems.

Last year, when we determined we needed more funding for this program to cover the then new protease inhibitor drugs, we sent two budget supplementals to the Hill. My Administration has nearly tripled funding for ADAP since I took office, and my current budget represents an 168 percent increase for Ryan White.

Q: WHY NOT EXPEND THIS KIND OF ENERGY AND RESOURCES ON A CURE FOR BREAST CANCER OR HEART DISEASE OR DIABETES AS IT SEEMS TO FOR AIDS?

A: This Administration has made a strong improving biomedical research an extremely important priority. We have increased investments in biomedical research at the National Institutes of Health by an impressive 16 percent since the I took office.

These additional investments has been used to increase investments in biomedical research in a number of important areas. For example, funding for breast cancer research has increased by 76 percent since 1993 .

WHITE HOUSE STAFFING MEMORANDUM

DATE: 6-21-97

ACTION/CONCURRENCE/COMMENT DUE BY:

9:00 AMMonday

SUBJECT:

Kaiser Permanente Remarks

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☒	☐	McCURRY	☐	☒
BOWLES	☒	☐	McGINTY	☐	☐
McLARTY	☐	☐	NASH	☐	☐
PODESTA	☒	☐	RUFF	☐	☐
MATHEWS	☒	☐	SMITH	☐	☐
RAINES	☒	☐	REED	☒	☐
BAER	☒	☐	SOSNIK	☒	☐
ECHAVESTE	☐	☐	LEWIS	☒	☐
EMANUEL	☒	☐	YELLEN	☐	☐
GIBBONS	☐	☐	STREETT	☐	☐
IBARRA	☐	☐	SPERTING	☒	☐
RADD	☐	☐	TARULLO	☐	☐
HIGGINS	☐	☐	VERVEER	☐	☐
HILLEY	☒	☐	<u>Klein</u> →	☒	☐
KLAIN	☐	☐	<u>Kunings</u>	☒	☐
BERGER	☐	☐	<u>Waldman</u>	☒	☐
LINDSEY	☐	☐		☐	☐

REMARKS:

Comments to Laura Capps & Terry Edmonds

RESPONSE:

on the road

Draft 6/21/97 3:30 pm

**PRESIDENT WILLIAM J. CLINTON
REMARKS FOR KAISER PERMANENTE EVENT
LOS ANGELES, CALIFORNIA
JUNE 23, 1997**

Acknowledgments: Sen. Barbara Boxer; Mayor Richard Riordan; SBA Administrator Aida Alvarez; Dave Lawrence, CEO/Pres. Kaiser Permanente; Dolores Palacio [pah-LAH-kee-oh], Principal Mar Vista Elementary School; Dr. Sharon Levine; [PARENT TBD]; Lois Salsbury of Children Now; parents, students, teachers of Mar Vista Elementary.

I am here to talk to you about something most of you have but many of you take for granted: the ability to go to a doctor for a checkup or if you are sick, to get medicine that you need, or to have an operation to make you healthy.

If we are going to give all of you the future you deserve, we must make sure that you can be healthy and ready for the challenges that life will bring. Too many children just like you all across America and all across California don't have that chance. Many of you here today don't have that chance, either. I am here today because we are taking a major step to change that, and I wanted to congratulate the people who are doing it -- and tell you why it is so important.

You have just heard from Dave Lawrence about the very important pledge by Kaiser Permanente to spend \$100 million to provide health care coverage for many children in California. It is a remarkable act of civic leadership and generosity that will make a difference in the lives of thousands of children and their families. I thank you.

I want you all to think about why this is so important. We know that we have the highest quality health care system in the world -- but in too many ways, too many Americans do not have access to the best that system has to offer. Today, over 10 million American children do not have health insurance -- 1.6 million of them in California. Nearly 40% of uninsured children go without the annual check-ups all children need. One in four uninsured children don't have a regular doctor.

What does this mean for our people? It means too many children have trouble seeing a blackboard do not get the glasses they need to correct their vision; too many nagging coughs go untreated until they worsen into life-threatening conditions that may require costly treatments and lengthy hospital stays; too many parents face the impossible choice between buying medicine for that sick child or food for the entire family. We must do better -- and we can.

We cannot rest until more of our children have access to quality health care. This national mission demands action by all of us, in every walk of life. When I spoke to the President's Summit on Service in Philadelphia in April, I said that while the era of big government is over, the era of big citizenship must begin. That means taking responsibility -- and that is what Kaiser has done.

We know how complex this subject is, and extending \$100 million of coverage is no simple task. The steps that Kaiser has outlined to reach out to employees of small businesses, to work through the schools, and to encourage people to enroll in the Medicaid program are the kinds of smart approaches that can make a real difference.

We will never reach all our children unless more private companies do their part, as Kaiser is doing. But let's be clear: government must play its part, too. And step by step, we are making real progress. Last year, I signed a law that helps families to keep their health care coverage as mothers or fathers move from job to job.

Now we are taking the next step. As you know, we have reached a bipartisan budget agreement with the leaders of Congress. I said I wanted a balanced budget that was in balance with our values. And one of my top goals was to extend health care coverage to millions more of our young children. This balanced budget agreement includes \$16 billion to extend health care for uninsured children.

This was a tremendous breakthrough for all our children. Now, the congressional committees are working with us to write into law the details of this investment. I want everyone who cares about the health of our children to watch this process and make sure that we do it right. First, the coverage must be meaningful -- from checkups to surgery -- so that children get all the care they need. And we should not charge families excessive new fees for this coverage. Second, we should cover as many uninsured children as possible, through state programs and the Medicaid program. Finally, we should really expand coverage -- not just use the new money to replace money that already comes from government or private insurance or charities.

This is a good example of how we can meet all of our challenges -- government and business, working together, everybody taking responsibility and everybody playing a role. All of you are growing up in a very hopeful time for our country. You will be seeing and learning things that your parents can only dream about. We want all of you to be as healthy as possible so that you are ready for the exciting and challenging times of the 21st Century. With the action announced by Kaiser today -- and with millions more children getting good health care through our balanced budget plan -- we are doing our part to give you the opportunity you deserve. The rest is up to you -- and I know how well you will do.

Thank you, and God Bless You.

**GMMB&A Fax Cover Sheet**Date: 6/20/94To: Jennifer KleinFrom: Roy BehrNumber of Pages to Follow: 3**Comments:**

If you should have any problems with transmission, please call:**Los Angeles: (310) 314-4800**
Washington: (202) 338-8700**PERSONAL & CONFIDENTIAL**

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DAVID M. LAWRENCE, MD

David M. Lawrence, MD, was named Chief Executive Officer in 1990 and Chairman of the Boards of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals in 1991. He began his career with Kaiser Permanente with the Northwest Permanente Medical Group in 1981.

Dr. Lawrence currently serves on the Boards of Hewlett-Packard, Pacific Gas and Electric Company, Raffles Medical Group of Singapore, the Conference Board, the Bay Area Council, and the Bay Area Economic Forum among others. Prior to joining Kaiser Permanente, Dr. Lawrence worked in academic medicine, public health, and international health.

Dr. Lawrence earned his BA degree from Amherst College, his MD from the University of Kentucky, and his MPH from the University of Washington. He is Board Certified in General Preventive Medicine. He attended the Advanced Management Program at Harvard. He is a member of the Alpha Omega Alpha Society and the Institute of Medicine.

DOLORES PALACIO

Dolores Palacio has been the principal of Mar Vista Elementary School since 1994. Prior to this, she was the principal at El Dorado Elementary School in Sylmar for 6 years and the assistant principal at Pinewood Elementary School in Tujunga for 2 years. Ms. Palacio joined the Los Angeles School District (LAUSD) in 1973, when she began teaching at Sierra Vista Elementary. Since that time, she has taught in bilingual classrooms throughout LAUSD, been selected as a Fulbright Exchange Teacher to London, and been the district advisor for the Capacity Adjustment Program (CAP) which helps relocate students to less crowded schools.

Ms. Palacio is currently on the Steering Committee for Center X at UCLA, which sponsors professional development institutes for principals. She is also actively involved in several Mar Vista community organizations including, the Booster Club, the Parent-Teacher Association, and the Educational Technical Committee. She has a dual master's degree in elementary education and in educational administration.

SHARON LEVINE, MD

Sharon Levine, MD, is Associate Executive Director for The Permanente Medical Group (TPMG) Physician Support Services. In this role, which she assumed in October, 1991, she oversees programs and policies related to TPMG physicians, including: clinical and non-clinical skills training; management development; recruitment and retention; compensation and benefits; communication; diversity issues; quality of professional life; and related issues of interest to the Medical Group.

Prior to assuming this role, Dr. Levine was Physician-in-Charge at the Fremont Medical Offices for three years. A pediatrician, she joined the Program in 1977 after working for what is now part of Kaiser Permanente's Central East Division the Mid-Atlantic States Region (formerly, the Georgetown University Community Health Plan). She served as Chief of Quality Assurance for the Fremont facility for five years, Assistant Chief of Pediatrics, and Chief of Pediatrics from 1985 to 1988.

Dr. Levine received her undergraduate degree from Radcliffe College, and her MD from Tufts University School of Medicine. She completed her pediatric internship and residency at Tufts New England Medical Center, and a year of research in infant nutrition at the National Institutes of Health.

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MAR VISTA

PRE-PROGRAMME

14:30 MAGS OPEN
MUSIC
15:10 STAR PROGRAMME
DIRECTED BY: LADY *Gardner*
15:30 STAR PROGRAMME STOPS
15:40 ACKNOWLEDGEMENTS
OLIVER GOLDSMITH, PERMENTED CODOCTORS FOR
SOUTHERN CALIFORNIA
15:50 OFF-STAGE
16:00 PROFESSOR BODY WISE
16:20 OFF STAGE
MUSIC

MUSIC-CROWD WORKING

STAGE SEATING AT MAR VISTA ELEMENTARY SCHOOL

SENATOR BARBARA BOXER

~~CONGRESSMAN X~~

~~CONGRESSMAN Y~~

LOIS SALISBURY

DR. SHARON LEVINE

MAYOR RICHARD RIORDAN

DAVE LAWRENCE

DOLORES PALACIO

Parent + thd.

BEHIND THESE FOLKS

SEATED ON CHORAL RISERS APPROX. 15 KIDS 10 ADULTS (PARENTS AND
TEACHERS) STILL TBD

STANDING BEHIND THEM 12-15 HEALTH CARE WORKERS FROM KAISER (TBD)

AIDA Alvarez, SBA administrator

EXECUTIVE DIRECTOR, CHILDREN NOW

CHAIRMAN AND CEO, KAISER FOUNDATION
HEALTH PLAN

PRINCIPAL, MAR VISTA ELEMENTARY SCHOOL

SPEAKERS PROGRAMME

MAR VISTA ELEMENTARY SCHOOL

MAYOR RICHARD RIORDAN

DOLORES PALACIO

DR. SHARON LEVINE

DAVE LAWRENCE

PARENT TBD

POTUS

OTHER ACKNOWLEDGEMENTS

The Permanente Medical Group
Government Affairs
1950 Franklin, 13th Floor
Oakland, CA 94612

F A X M E M O R A N D U M

DATE: 6/19/97

TO: Jennifer Klein FROM: Linda Kotis , Director
West Wing, Second Floor Kaiser Permanente
The White House Cares for Kids

FAX: 202 - 456-2878 FAX: 510-873-5203

PHONE: 202-456-2599 PHONE: 510-987-2589

TOTAL PAGES (including cover sheet): 34

SUBJECT: Excerpted version of the concept document for "Kaiser Permanente
Cares for Kids" Initiative

As you requested. A hard copy follows via UPS Express Mail for delivery tomorrow.
Please call with questions. Thank you.

- ☒ If there is a problem, call Marilyn at 8-427-2724 or 510-987-2724 .
- ☒ Urgent, please deliver immediately.
- ☐ Call to confirm receipt of fax.
- ☐ Response requested.

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The Permanente Medical Group, Inc.
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June 19, 1997

Jennifer Klein
West Wing, Second Floor
The White House
1600 Pennsylvania Avenue
Washington, DC 20502

Via Facsimile and Express Mail

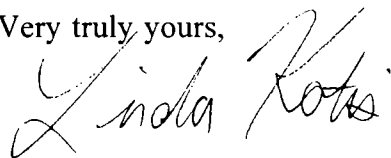
Dear Jennifer:

As we have discussed, enclosed is an excerpted version of the concept document which resulted in the creation of "Kaiser Permanente Cares for Kids," the Initiative being undertaken by Kaiser Permanente's California Division. I hope this will provide you with useful background information.

This document contains some information about participation in subsidized coverage programs, although specific requirements are still under development. With respect to eligibility status, the following will apply. For children enrolled into the HIPC demonstration project, employers determine the eligibility of their parents as part of the employment process. For children enrolled through the schools into the Medi-Cal program, existing state and federal eligibility guidelines apply. For children enrolled into the school children subsidy demonstration project, the application will require a social security number for the parent or the child; this information is currently required as part of Kaiser Permanente's application for other individual coverage programs.

We are looking forward to working with you.

Very truly yours,



Linda Kotis
Director
Kaiser Permanente Cares for Kids

cc: Sharon Levine, M.D.
Ron Wacker
Roy Behr





Feasibility Study Report

“Kaiser Permanente Cares for Kids”



March 4, 1997

**Presentation to the
California Government Relations Committee**

“KP Cares for Kids” Project Team

This report was prepared by Suzanne Corkins, Linda Kotis and Jean Nudelman. The information contained within the report is the product of the work of the "KP Cares for Kids" Project Team, which was completed between December 1, 1996 and February 27, 1997.

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EXCERPTS FROM THE FEASIBILITY STUDY REPORT FOR THE CHILDREN'S HEALTH CARE INITIATIVE "Kaiser Permanente Cares For Kids" Project Team

I. INTRODUCTION

This report is the product of a feasibility study commissioned by the senior leadership of Kaiser Permanente's California Division. As part of the feasibility study, the "Kaiser Permanente Cares for Kids" team (KPCK) identified potential strategies for establishing universal coverage for and improving the health status of children in California.

A. Goal

Kaiser Permanente's primary goal is to provide leadership for a coalition which will ensure that all California children from birth through age 18 have access to health coverage over the next five years. Our secondary goal is to enhance access to appropriate health care for children; coverage without access to and utilization of services is illusory.

Uninsured children are a heterogeneous group, with different needs and resources; therefore, the goal of universal coverage for California's 1.7 million uninsured children will be achieved through a series of legislative, community benefit, and communication/advocacy strategies over the next five years, the "Kaiser Permanente Cares for Kids" Initiative.

The Initiative will be undertaken in collaboration with other health plans, advocacy groups, government, employers, and trade organizations. Kaiser Permanente's cost for community service will be \$100 million over five years, which will serve between 40,000 - 50,000 children annually. The legislative strategy will result in approximately 850,000 children receiving access to coverage, through other plans and programs. We will work with our coalition partners to seek solutions to cover the balance of uninsured children.

B. Critical Success Factors

Successful implementation of the strategies outlined in this report is predicated upon several factors. First, Kaiser Permanente must establish a strong functional coalition of health plans, advocacy organizations, employers, trade associations and government officials. Second, passage of legislation will be required to extend coverage to broader segments of the population. In addition, barriers to access and service, such as lack of transportation, cultural and linguistic capabilities, and education about preventive care, will need to be overcome.

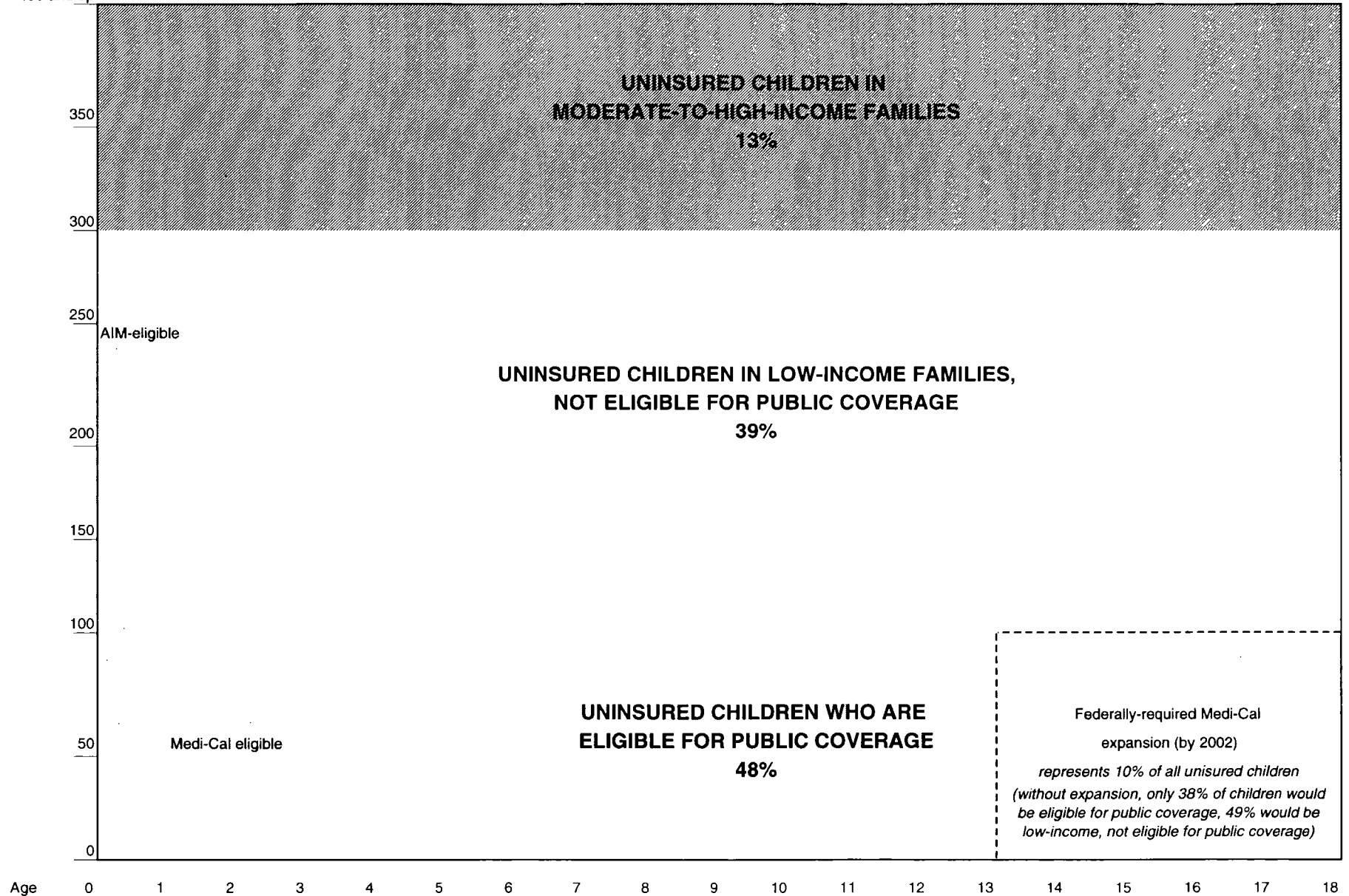
C. Methodology

The feasibility study was conducted in three phases:

- Hypothesis development and data gathering. In this phase, the team inventoried existing models for universal coverage; developed hypotheses regarding how Kaiser Permanente might structure its own initiative for universal coverage in California; developed a profile of the public policy environment; gathered data on uninsured children; and developed an understanding of Kaiser Permanente's experience providing coverage and medical services to children.
- Scenario development. Using the information gathered above, the team developed scenarios to illustrate how Kaiser Permanente might lead efforts to achieve universal coverage. These scenarios ranged from a comprehensive "Medicare for Children" approach to a more segmented strategy of leveraging resources in the existing health care system.
- Analysis and development of recommendations. The team designed analyses to test the feasibility of the various scenarios. The feasibility assessments guided the development of specific recommendations for Kaiser Permanente's approach to achieving universal coverage for children in California.

UNINSURED CHILDREN IN CALIFORNIA, 1994

Income as a Percentage of Federal Poverty Level
400 and up



II. BACKGROUND

This section describes the segments of the population of uninsured children, some existing programs, the political climate, and Kaiser Permanente's opportunity.

A. Population

Summary: Over 1.7 million, or 20%, of California's children lack health care coverage, a greater number than the California Division's membership of about 1.3 million children. Uninsured children cannot be characterized as a homogenous group; rather, they span all age and income categories, although they are concentrated in low-income families. For the purposes of devising solutions to this problem, we have segmented the population of uninsured children into three groups, each distinguished by the children's degree of financial need and the availability of resources to address this need.

(1) Uninsured Children Who Are Eligible for Public Coverage

48% of uninsured children in California

Eligibility for public health care coverage in California is determined on the basis of age, family income, disability status and (in most cases) family asset level. Demographic data indicate that about 630,000 of California's uninsured children are currently income-eligible for Medi-Cal, under Aid to Families with Dependent Children (AFDC). This number jumps to 797,000 under new eligibility rules which will be in place by 2002, when, by federal mandate, all states must expand Medicaid eligibility to include all poor children under 18. Another 27,500 children would have been eligible for California's Access for Infants and Mothers (AIM) program, had their mothers enrolled in the program while pregnant. In total, almost half of California's uninsured children meet the eligibility requirements for publicly subsidized insurance programs that are currently in place or will be in place by 2002.

(2) Uninsured Children in Low-Income Families, Not Eligible for Public Coverage

39% of uninsured children in California

About 677,000 of the uninsured children in California are not eligible for publicly subsidized health care coverage and are in families with incomes between 100% and 300% of the Federal Poverty Level (FPL). Evidence from some pilot programs suggests that health care premiums which consume more than 2% of gross income are not affordable for these families; this implies that families in this income range can contribute only \$17 to \$43 each month to a child's health care. Commercial dependent coverage products, which typically cost between \$65 and \$125 per child per month, are therefore largely out of reach for these families, unless the premiums are generously subsidized. Although families of children in this group are typically headed by full-time workers, they are low-wage earners whose employers often do not provide subsidized health care coverage for their workers' dependents. Thus, these children "fall through the cracks" by being too poor to afford commercial health plans, yet not poor enough to qualify for Medi-Cal.

(3) Uninsured Children in Moderate-to-High-Income Families

13% of uninsured children in California

Among uninsured children in California, 13% are in families with incomes above 300% of FPL. Based on the affordability guideline of 2% of gross income, such families are in a position to spend \$40 or more per month on their children's health care. While this is a greater level of resources than is available to the two groups described above, it still may not be adequate to allow the purchase of a comprehensive health care benefit package at commercial rates.

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Many families in this group are headed by workers whose employers, often small businesses, do not subsidize dependent benefits. For these families, coverage for their children often remains out of reach.

B. Children's Programs

(1) Features of Model Programs

Many states have struggled with the challenge of providing coverage to uninsured children. Efforts by both public and private entities, or partnerships between the two, offer potential solutions to this problem. Programs frequently cited for their innovation in expanding children's health coverage include: Florida's Healthy Kids Program, Blue Cross/Blue Shield's Caring Programs, MinnesotaCare and Pennsylvania's Children's Health Insurance Program. These programs were assessed by the Government Accounting Office (GAO) in a 1996 report and found to be promising models for increasing children's access to comprehensive health care benefit packages. Factors common to these programs include operation within fixed and limited budgets, restriction of enrollment and use of waiting lists, simplification of administrative structures, lack of adverse selection, and avoidance of the stigma of welfare. The cost per child per month in these programs ranges from \$46.50 to \$70.60. Premiums are subsidized for children who meet family income requirements. Depending on the program, families up to 275% of FPL are eligible for subsidies.

(2) Experience with Previously Unmet Demand

During the design phases of these programs, many developers expressed the concern that the subsidies would attract children who, having been previously uninsured, would have lower health status and would utilize services more heavily than other children, particularly in their first year of coverage. These fears proved to be largely unfounded: the GAO reports that "according to managers from all the programs, the children served were not significantly sicker and did not use services more than privately insured children. . . . Alabama and Florida reported a slight increase in the use of services due to initial demand, but that soon stabilized. The lower-than-anticipated use of services led to cost-savings for Pennsylvania's Children's Health Insurance Program and the Florida Healthy Kids Program."

(3) Application of Analysis to Kaiser Permanente Operations

In addition to learning from the experiences of model programs, the KPCK team also studied Kaiser Permanente data to determine whether any differences could be found in costs and utilization rates among the major populations of children that Kaiser Permanente currently serves. We sought to address the concern that the primarily low-income, previously uninsured children who may enroll in a proposed program will be costly to serve, with utilization patterns similar to those of Medi-Cal recipients.

Our hypothesis is that these children will have somewhat higher costs and utilization rates than commercial members, due to previously unmet demand for health care. Nonetheless, we also hypothesize that these children will utilize services less than Medi-Cal children if they are enrolled in subsidized commercial plans which, unlike Medi-Cal, have copays. We conducted a formal comparison of data on Kaiser Permanente members enrolled through Medi-Cal (AFDC) and enrolled in commercial groups to measure the gap in costs and utilization rates between these groups. Interpolating between these data points may offer some guidance regarding the costs and utilization rates anticipated from a group of low-income, previously uninsured children who are enrolled in plans with reasonable copays.

Consistent with this cost data, the utilization of both inpatient and outpatient services by Medi-Cal (AFDC) children appears to be significantly higher than that of commercial plan children. Again, however, this higher utilization may result from the lack of copays in Medi-Cal coverage. Thus, we would not expect as great a difference in utilization rates as is suggested by a comparison of Medi-Cal and commercial member data.

The team acknowledges that these results are preliminary. An exhaustive analysis of this topic will require additional time and resources, and will be limited by the relatively short length of Kaiser Permanente's experience serving the Medi-Cal population.

C. Political Climate

Recent activities at both the national and state levels demonstrate a strong interest by lawmakers, trade associations and advocacy groups in seeking solutions to covering uninsured children. Both the Clinton Administration and a number of Senators and Congressional Representatives have offered proposals for children's health care. In addition, federal welfare reform and insurance reform will offer an opportunity to shape state legislation into health reform for children. Finally, the California legislature likely will debate several proposals which may deliver expanded coverage for children. Although passage of these proposals is not guaranteed, their existence enhances Kaiser Permanente's chances of garnering support for its strategies. For further details, see Section V and Appendix A.

D. An Opportunity for Kaiser Permanente

Kaiser Permanente has historically supported universal coverage. Addressing coverage for a portion of the population, such as children, is a more attainable goal than universal coverage for all populations. Significant support exists within the leadership and employees of Kaiser Permanente for developing such an approach. The National Partnership Group and the Health Policy Committee (HPC) have endorsed a recommendation from the Program Office-sponsored Children's Health Workgroup that Kaiser Permanente should be a national public policy leader on establishing universal coverage for children. The HPC also acknowledged that a leadership role encompasses a commitment to providing subsidized coverage for low-income uninsured children.

These recommendations are consistent with guidelines for the organization's overall community health programs, which focus upon children's health, the uninsured, and clinical and health services research. Moreover, on a Program-wide level, other initiatives currently underway support this policy, including programs in the Mid-Atlantic States and Colorado which subsidize uninsured children.

III. RECOMMENDATIONS

A. Community Health Strategy

Kaiser Permanente will undertake two demonstration projects designed to test new community health strategies over the next two years. Our first recommendation is to collaborate with the Managed Risk Medical Insurance Board (MRMIB) and other health plans to test the capability of a statewide purchasing cooperative to increase enrollment of children from working, low income

families in qualified health plans. Our second recommendation is to enhance Kaiser Permanente's relationships with a school or school district to achieve coverage of children through outreach, assistance in Medi-Cal enrollment, and offering of subsidized benefit packages for low-income non-Medi-Cal eligible children. We recommend a focus on schools which provide some school-based health services.

In addition to new community service programs, Kaiser Permanente will organize our existing community health efforts which serve children to increase their effectiveness and demonstrate their contribution to the goal of universal coverage. We recommend a communications campaign to enhance key internal and external audiences' awareness of these programs as part of an integrated and cohesive approach to enhancing children's health status. In the longer-term, we recommend disseminating best practices within the Division and learning from successful efforts undertaken throughout the Program.

B. Legislative Strategy

The legislative strategy consists of articulating a set of principles and adopting an approach to sponsoring legislation. Working with the Program Office Children's Health Workgroup, we have developed a set of legislative principles, which build upon previous versions reviewed by senior leadership of the California Division. The legislative approach recommends that Kaiser Permanente co-sponsor or support three pieces of legislation over the next three years, to expand programs for children through Medi-Cal and the Health Insurance Plan of California (HIPC).

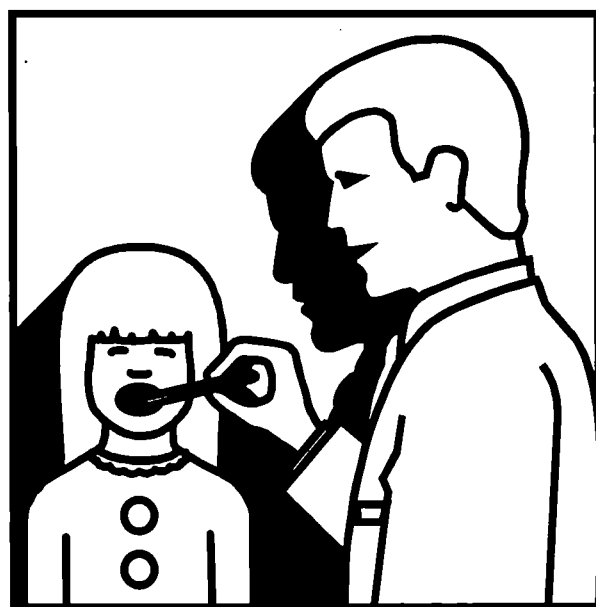
C. Communication Strategy

Kaiser Permanente has made the strategic decision to provide leadership at the national level to seek solutions to the problems of children who are uninsured. To effectuate the Initiative within California, Kaiser Permanente will need to build the case for its community benefit and legislative strategies through outreach to the media, community and government opinion leaders. Communication objectives will be achieved through building and sustaining a coalition of organizations dedicated to achieving universal coverage for children in California and convening such organizations at a Children's Health Care Forum in late 1997. The Forum will also serve as a mechanism to structure the balance of the solution to covering uninsured children, by focusing upon the populations not addressed by the expansion of Medi-Cal, HIPC, and other private initiatives.

D. Implementation Process

Successful implementation of the recommendations requires commitment and support from senior leadership. Health Plan and Hospitals executives and Medical Group physicians will need to participate actively in efforts to build coalitions, promote Kaiser Permanente's positions, and conduct its communications campaign. Our recommendation is that the California Division authorize the creation of a Core Implementation Team, which will be accountable for execution over the next five years of the strategies presented in this report. The Implementation Team will be responsible for coordinating work with other staff at the Program Office, Division and Local Market Level.

Community Health Strategy



IV. COMMUNITY HEALTH STRATEGY

This section describes each of the recommendations in greater detail.

A. Demonstration Project with HIPC

Summary: Among the voluntary community health projects we have considered, our top recommendation is a pilot project with the California Managed Risk Medical Insurance Board (MRMIB) to encourage the participation of small businesses in the Health Insurance Plan of California (HIPC) and to increase the access of HIPC enrollees to health care coverage for their children. In collaboration with other health plans, Kaiser Permanente will launch a time-limited program to provide low-income HIPC enrollees with partial subsidies for dependent coverage, with the remainder of the premium to be shared by enrollees and their employers. The program will be evaluated periodically to determine its effectiveness at enrolling previously uninsured children, providing access to care, attracting employers to HIPC, and encouraging employer sponsorship of dependent health coverage.

Background: HIPC is a state-sponsored purchasing cooperative for businesses with 2 to 50 employees (beginning July 1, 1997). By pooling the purchase of health insurance, these businesses gain access to a wider range of health plan options at more affordable prices than are otherwise available to small group purchasers. To participate in HIPC, employers must contribute at least 50% of the cost of their employee's coverage; however, no contribution is required toward dependent coverage. On average, employers in HIPC subsidize 80% of their employees' health plan premiums and 60% of dependent premiums.

Approximately eight million Californians either are employed by small businesses (firms with 3 to 50 employees) or are dependents of these employees, but only half of these individuals have health care coverage. In general, the smaller a business is, the less likely it is to finance coverage for its employees; employer-subsidized coverage of dependents becomes even more rare as firm size decreases. Not surprisingly, many of the uninsured children in California are dependents of small business employees. MRMIB is in the process of exploring ways to increase HIPC membership, currently 120,000, to reach this large population of working uninsured and their dependents. A bill before the California legislature this year, SB 393 (Rosenthal), would expand eligibility for HIPC membership to firms with up to 100 employees; this, in addition to enhanced marketing efforts, will allow HIPC to grow substantially over the next few years.

The expansion of HIPC is a promising component of a long-term strategy to achieve universal coverage for children in California. We recommend that Kaiser Permanente support MRMIB's efforts to expand overall HIPC enrollment. In addition, we recommend that Kaiser Permanente and HIPC take the lead this year on a demonstration project focusing specifically on dependent coverage.

Description: We envision working with MRMIB toward the goal of increasing the enrollment of children, from birth through 18, of HIPC members in qualified health plans during the May 1998 open enrollment period. To achieve this goal, we will launch a program to enable low-income HIPC enrollees to obtain coverage for their children through a combination of direct subsidies, employer sponsorship, and family cost-sharing. To leverage our financial commitment, we will encourage other health plans to commit funds to a subsidy pool; each plan's funds, in turn, will be allocated to qualified applicants who choose that plan's dependent coverage option. In order to contribute to the body of knowledge on "best practices" in uninsured programs, we will evaluate the effectiveness of this approach at predetermined intervals.

Development of the demonstration project will occur as follows.

(1) Background Research

A survey of HIPC enrollees and employers will be conducted to determine the number and percentage of employees' child dependents who have health care coverage through HIPC, the extent to which such coverage is subsidized by HIPC employers, and the characteristics of employers that do not subsidize dependent insurance. Through interviews and a literature review, Kaiser Permanente and MRMIB will attempt to assess the major barriers to provision of dependent coverage by employers, methods of encouraging employer-sponsored dependent coverage and evidence of their efficacy, and barriers to health care for children who are uninsured and have parents who are either insured or uninsured.

(2) Legislative and Regulatory Issues

MRMIB has authority to enter into contracts with health care service plans and insurers to provide health benefits coverage to eligible employees and their dependents. MRMIB also has statutory authority to define health benefits coverage which is purchased from health plans as well as to approve benefit plan designs sold by participating carriers.

We believe that this authority is broad enough to allow MRMIB to establish this demonstration project, without legislation. Additional regulations may be necessary to enable MRMIB to define eligibility criteria for subsidized dependent coverage, including limiting the definition of dependents for purposes of the project to children ages 0-18. Promulgating regulations requires a public notice and comment period, hearing and review by the Office of Administrative Law (OAL). This process may last between 4.5 months and 14 months. If certain criteria is met, regulations may be promulgated on an emergency basis, thereby expediting the process. Under either scenario, we do not anticipate that the regulatory process will delay the design or implementation of the project.

During the demonstration project, all necessary funding will come from health plan and philanthropic donations. California law allows the donation of funds to the state and permits a donor to designate the appropriation or fund to receive the money. Because the contributions to MRMIB from Kaiser Permanente and other health plans will not be unconditional, the Director of Finance will have to approve the donation.

(3) Funding

This project will require a commitment of resources to finance two key activities: the administration of the project and the subsidy of premiums for eligible children. We estimate that the cost of administration will be \$500,000 for a two year project, and the cost of subsidies for new Kaiser Permanente members will be \$4 million. See Table A for projected cost.

Cost of Administration

Administrative expenses are for a two year period:

• Administration of baseline survey	\$15,000
• Periodic evaluation of program	\$50,000
• Funding for one additional MRMIB staff	\$200,000
• Communication, education and advocacy	<u>\$235,000</u>

Total \$500,000

To cover administrative expenses, we recommend that MRMIB submit a grant application through Governor Wilson's office to the Robert Wood Johnson Foundation (RWJF). The Foundation recently issued a call for proposals under the category of "State Initiatives in Health Care Reform," outlining criteria for awards which this project appears to meet. Grant funds of \$7.5 million, with an average of \$500,000 per successful state applicant, are available from RWJF to support staff salaries, consultant fees, data processing, supplies, and other direct expenses. RWJF policy prohibits the award of grants for premium subsidies.

Subsidy Costs

The proposed contribution by Kaiser Permanente to premium subsidies is a preliminary estimate based on the number of children who may be eligible for and participate in this program in May of 1998. Before an actual commitment of funds, more precise data on the numbers of potentially eligible children must be collected; such data will become available through the survey mentioned above. We estimate that as many as 26,000 children will participate in this program in its first year; of these, up to 9,000 will elect Kaiser Permanente coverage, based on the current 34% share of HIPC enrollment. Kaiser Permanente's proposed commitment of \$4 million represents the amount necessary to subsidize 50% of a \$75 pmpm premium for these children for one year. For more detailed cost and operational impact estimates, see Table A at the end of this section.

In order to leverage the subsidy money, Kaiser Permanente will work with MRMIB to solicit proportionate contributions from other health plans that participate in HIPC. A "critical mass" of support for the project will be gained with commitments of at least \$1 million from the five other health plans with greater than 5% shares of HIPC enrollment: Aetna, Blue Shield, Health Net, Lifeguard, and Pacificare. Eighteen months into the project, after demonstrating its effectiveness, legislation will be introduced in order to obtain public funds to expand the subsidy pool.

(4) Program Design

Timeframe Subsidies will be available beginning July 1, 1998 through June of 2000. HIPC enrollees will apply for subsidies during open enrollment in May of 1998.

Eligibility Children up to age 18 who are in families with incomes up to 300% of FPL and are not eligible for publicly subsidized health insurance will qualify for a premium subsidy. Subsidies will be disbursed on a first-come, first-served basis until the subsidy fund is exhausted.

Subsidy Participating health plans will subsidize 50% of the lowest-priced dependent premium for all eligible children who enroll in those plans' coverage through HIPC. Each carrier's subsidy funds will be "earmarked" such that each carrier only subsidizes enrollment in its own plans. If enrollment in a particular plan does not exhaust that carrier's subsidy funds, the unused portion will be returned to the carrier. The remaining 50% of the premium cost will be shared by the employer and the employee. Employer contributions to this cost will be at the discretion of each employer, but could not represent a reduction in the dependent benefit subsidy level by any individual employer. For example, an employer which is already paying 25% of its employees' children's premiums will be required to continue this level of support in order to participate in the subsidy program.

Outreach Additional services may be provided to participating employers, such as enhanced transportation, care for siblings while parents are taking others to medical appointments, and expanded evening or weekend appointments. Such services could be offered to those employers who provide significant dependent benefit subsidies, as an added incentive to do so; additionally, outreach services could be targeted to those employees for whom barriers to children's health care are particularly great.

(5) Marketing

Once participating health plans have determined the levels of funding they will contribute, the number of slots available under the subsidy program will be calculated, allowing marketing efforts to begin. Information will be provided to employers and agents regarding the program; the specific marketing strategy will be largely shaped by information gained from the survey of employers at the beginning of the project.

(6) Evaluation

Evaluation will occur periodically to measure progress toward the goals of the project:

- to increase the enrollment of previously uninsured children in health care coverage
- to increase the utilization of appropriate health care services by newly insured children
- to increase the number of employers who subsidize dependent coverage for their employees

**TABLE A
PROJECTED COST OF HIPC PROJECT**

HIPC Data	
HIPC enrollment as of 1/97	120,999 lives
HIPC enrollment growth, 1996 to 1997	20,000 lives
# of enrollees per employee (implied family size)	1.8
KP North share of HIPC enrollment	20%
KP South share of HIPC enrollment	14%

Demonstration Project Design
• Eligibility: children in families with incomes between 100% and 300% of FPL who are not eligible for publicly subsidized health insurance programs • KP will subsidize 50% of premiums of eligible children who enroll in KP coverage • Average cost of such coverage will be \$900 per member per year (\$75 pmpm)
Assumptions
(need to be confirmed by survey of HIPC employers and enrollees)
• Actual average family size of HIPC employees is 2.2 • Of dependents currently enrolled in HIPC coverage, 30% will be eligible for subsidy • Of dependents not currently enrolled in HIPC coverage, 50% will be eligible • Of those eligible, 75% will accept subsidy

Projections for May 1998 Enrollment Period	Low Scenario	Moderate Scenario	High Scenario
HIPC growth rate, 1997-1998	10%	17%	25%
HIPC enrollees in May 1998	133,099	140,099	151,249
enrolled dependents	58,873	62,368	66,901
estimated number of uncovered dependents ¹	30,198	31,990	34,316
% of enrolled dependents eligible for subsidy	30%	30%	30%
% of uncovered dependents eligible for subsidy	50%	50%	50%
% of eligibles who accept subsidy	75%	75%	75%
total number of eligible dependents who accept subsidy	24,571	26,029	27,921
% of those accepting subsidy who elect KP coverage	34%	34%	34%
number of new KP enrollees (ages 0-18)	8,403	8,902	9,549

¹ Estimates the difference between the total number of dependents of HIPC employees and the number of *enrolled* dependents of HIPC employees using the formula:
(Actual family size x number of employees) - number of enrollees

B. School-Based Project

Summary: Kaiser Permanente will sponsor and publicize a demonstration project, located in two sites, one in Northern California and one in Southern California. The project will be designed to test models for coordination between School Based Health Centers (SBHCs) and Kaiser Permanente. The goal of the project will be to assess whether specific partnerships between Kaiser Permanente and SBHCs are sustainable and replicable. Kaiser Permanente will select schools or school districts in which the percentage of children who are uninsured is higher than the state average of 20%.

The project will also develop mechanisms to help children obtain access to existing subsidized health coverage programs, both public and private. Kaiser Permanente may develop a special Dues Subsidy product for children, who are enrolled through the demonstration school sites. Eligibility criteria will focus upon children in families with incomes between 100% and 300% of FPL who are not eligible for publicly subsidized health insurance programs. Kaiser Permanente will subsidize 50% of premiums of eligible children.

Background: School Based Health Centers have been called by the Office of Technology Assessment "the most promising recent innovation to address the health and related needs of adolescents." Although the number of SBHCs has increased significantly over the past 25 years, they still do not operate extensively in the United States. Health care reform proposals have supported an expanded role for SBHCs as an integral part of an improved health care system of services for children and adolescents.

Many different models of SBHCs exist. Their services may include health screening, case management, referral, health education, mental health, first aid and comprehensive primary care. In California, SBHCs face significant difficulties establishing stable sources of funding and consequently rely heavily upon grants or other subsidies. SBHCs affiliated with community clinics appear to be more sustainable than freestanding models, as they are designated to provide primary care and are eligible for participation in the Medi-Cal Managed Care Two-Plan model. An opportunity exists to explore cementing relationships between community clinics and SBHCs, which may result in enhanced stability for SBHCs.

Description: The demonstration project will require the development of a detailed implementation workplan for each site, with a strong evaluation component. We envision that Kaiser Permanente staff who currently have relationships with the schools will be key members of Site Advisory Committees and will coordinate our existing efforts with the schools as well as provide input and guidance into program development and implementation. Kaiser Permanente may also wish to develop Memoranda of Understanding with principals and school boards, as we have done with some schools and other community based organizations, to clarify mutual expectations and accountabilities.

Development of the project will proceed as follows.

(1) Background Research

Schools do not collect good data on the insurance or health status of their students, or where they seek and obtain health care. Both Kaiser Permanente and school staff have expressed interest in collaborative research, either through surveys or focus groups, to establish important baseline indicators of coverage and utilization. An inventory of existing relationships between Kaiser Permanente, the schools, and other health care and social service providers will be critical to determine the system of care available to children and to define the most appropriate roles for each provider to play.

(2) Program Design

Options for project design include both direct service and providing enabling services. The range of potential models to explore include the following: (1) enhancing referrals between school-linked programs and Kaiser Permanente; (2) sharing information between Kaiser Permanente and school linked programs about Kaiser Permanente members; (3) providing case management and triage on school sites, with linkages back to managed care medical "homes." For example, Kaiser Permanente may assist children in gaining access to public or private coverage by funding an eligibility worker on the school site to enroll children in public health programs. For those not eligible for government sponsored care, the worker may direct them to other sources of subsidized care. Kaiser Permanente will develop a special Children's Dues Subsidy Program and provide 50% subsidy on average for children who meet eligibility criteria. The demonstration project will also test the effectiveness of increased outreach on school sites in gaining access to health coverage.

A demonstration project will provide an opportunity to analyze the cost effectiveness of various types of nonphysician providers in the clinics. We recommend focusing on programs which serve adolescents, because they face unique barriers to health care including privacy issues and compliance problems.

(3) Funding

Resource requirements for the development of model relationships are projected at \$500,000 per year, which may be modified based upon program size and participation by other funding sources. Resources will be used to support staff, who will be responsible for coordination, program development and evaluation; technical assistance to schools, which may include supporting the development of health education or case management expertise; and resources to conduct outreach to school children and assess eligibility for public or privately subsidized health coverage. See Table B for projected cost of school-based enrollment project.

TABLE B
PROJECTED COST OF SCHOOL-BASED ENROLLMENT PROJECT

Demonstration Project Design	
• Eligibility: children in families with incomes between 100% and 300% of FPL who are not eligible for publicly subsidized health insurance programs • KP will subsidize 50% of premiums of eligible children who enroll in KP coverage • Average cost of such coverage will be \$900 per member per year (\$75 pmppm) • KP will select schools in which the percentage of children who are uninsured is equal to or higher than the state average of 20%	
Assumptions	
(need to be confirmed by survey of selected school sites)	
• Among a given population of uninsured children, 39% would be eligible for subsidy (based on percentage of uninsured children in California whose family incomes are between 100% and 300% of FPL) • Among eligible children, 75% would accept subsidy	

Projections for Fall 1998 Enrollment Period¹	Low Scenario	Moderate Scenario	High Scenario
total number of children in demonstration project schools	NA	NA	NA
% uninsured	NA	NA	NA
number of uninsured children in demonstration project schools	NA	NA	NA
% children eligible for subsidy	NA	NA	NA
% of eligibles who accept subsidy	NA	NA	NA
new KP enrollees (ages 0-18)	NA	NA	NA

¹Data is in process of being refined and is not currently available.

C. Existing Community Health Efforts

Summary: Kaiser Permanente will organize existing community health efforts which serve children to increase their effectiveness and demonstrate their relationship to the goal of universal coverage. Kaiser Permanente will communicate to internal and external audiences about existing programs which address children's health status, positioning them as part of an integrated and cohesive approach to enhancing children's health. In the immediate future, we recommend taking an inventory of all current efforts in which the California Division participates. In the longer-term, we recommend disseminating best practices within the Division and learning from successful efforts undertaken throughout the Program.

Background: Kaiser Permanente has devoted substantial effort and resources to providing services and supporting community based organizations that enhance children's health and increase access to health coverage. In part, these long-standing efforts influenced the recent decision by the Kaiser Foundation Health Plan/Hospitals Board to adopt a policy which focuses voluntary community health activities upon improving the health of children. Examples include: Educational Theatre; partnering with local schools and school districts on projects that range from adopt-a-school to mentoring programs for at-risk youth; community-wide efforts to increase immunization rates; tattoo removal clinics; participating in school-based Healthy Start initiatives; asthma management programs; the Dues Subsidy Program; and the Campaign for Children's Health and Safety, in partnership with Children Now.

These efforts have different histories and origins; many were developed in response to Local Market needs, and some, such as Educational Theatre and our partnership with Children Now are Program-wide. Moreover, the hospital needs assessment, in compliance with SB 697, identified children and youth's health needs as among the top priorities within the communities served by Kaiser Permanente.

Description: The objective is to build and promote a coherent, compelling California-wide Children's Community Health program. All community-oriented activities conducted throughout the California Division which focus upon children will be catalogued. The inventory will build upon the existing assessments undertaken for compliance with SB 697. But, this effort must be broader in order to identify programs supported by resources from Health Plan and the Permanente Medical Groups, as well as those from Hospitals.

Kaiser Permanente will create forums and mechanisms for sharing and replicating best practices within California as well as nationally; this may encompass the development and execution of a national children's community benefit program. Rigorous and meaningful evaluation of the programs will be critical to assess their effectiveness and potential for replication. A strong communication plan is necessary to promote these activities, and to link them into an overall commitment to enhancing children's health. Messages will focus upon the demonstration of a significant financial commitment to improving children's health.

Legislative Strategy



V. LEGISLATIVE STRATEGY

A. Kaiser Permanente's Approach

Summary: As a preeminent health plan and provider of health care, Kaiser Permanente is committed to playing a significant leadership role in developing and advocating health care policy. Kaiser Permanente is committed to working with other providers and advocates to ensure health coverage for all Californians. Leadership in working toward establishing universal coverage for children would require that Kaiser Permanente:

- Articulate a set of principles and programmatic options
- Build a coalition to advance legislation
- Dedicate resources to children's coverage
- Undertake a multi-year commitment to pursuing the goal of universal coverage
- Utilize a grassroots approach to build public support for universal coverage

B. Support for Legislation

Kaiser Permanente will support proposals which accomplish the objectives listed below.

(1) Population Covered

Kaiser Permanente is committed to expanding health coverage to all California children, from birth through 18, as a step toward achieving universal coverage for all populations. Kaiser Permanente is also supportive of efforts to expand coverage to pregnant women. Specifically, expansion of coverage for children should focus on individuals who do not receive coverage through employer-sponsored plans or existing programs and prevent erosion of progress made by existing programs. Many states have used Medicaid waivers or have implemented programs to expand coverage for children. These efforts should be sustained. Kaiser Permanente supports efforts that would increase the enrollment of children and pregnant women who are eligible for Medicaid, but not currently enrolled.

(2) Benefits

Children's coverage should incorporate comprehensive inpatient and outpatient medically necessary health care services, with appropriate cost-sharing. Cost-sharing should be structured to provide appropriate incentives for preventive care, to discourage inappropriate use of emergency services, and to ensure that low-income families have access to care without undue financial constraints. Very low-income families should have no cost-sharing.

(3) Financing

Kaiser Permanente believes that federal and state governments should play an active role in financing coverage for children. While Kaiser Permanente is willing to commit resources to expanding coverage, private sector contributions alone will not solve the problem and should not replace government financing. Kaiser Permanente is willing to participate in programs to expand coverage, and make direct contributions to subsidized care. Kaiser Permanente will also support financing options which include "sin" taxes (tobacco and alcohol) and general revenues.

(4) Employer Based Coverage

Kaiser Permanente believes that viable solutions for expanding coverage for children in California should incorporate employer based plans. Furthermore, employers should be both encouraged to expand as well as discouraged from decreasing participation in health coverage. Possible remedies include imposing eligibility requirements such as waiting periods for children who were recently covered through employer-sponsored plans. Another option is a tax credit for employers who provide affordable dependent coverage.

(5) Quality

Kaiser Permanente supports a quality assurance/assessment review process based on organizational performance using objective and specific measures. However, Kaiser Permanente does not support proposals which mandate physician practice through defining benefits as based upon the guidelines of professional associations.

(6) Administration

Kaiser Permanente believes the administrative structure should reduce burdens to achieve desired results. Administration could be provided by either a private or public entity. Kaiser Permanente supports the use of standards to ensure adequate consumer protections but believes that requirements for children's health programs should rely as much as possible on existing standards.

(7) Health Plan Choice

Proposals should encourage broad choice of health plans. One mechanism to promote choice is to provide coverage through purchasing pools that offer a variety of plans, including HMOs.

Current proposals merit Kaiser Permanente's consideration of support.

Description: Numerous advocacy organizations as well as the Clinton Administration believe that part of the solution to covering uninsured children is enrollment into Medi-Cal. As previously stated, a significant number of California's uninsured children are eligible for Medi-Cal, but not enrolled. Furthermore, California has historically failed to take advantage of Medicaid expansion opportunities other states have used to cover their uninsured.

Children Now is sponsoring two pieces of legislation to expand coverage for California's uninsured children and has invited Kaiser Permanente to show its active support in part through participation at a media event on March 13, 1997. One bill will expand eligibility for Medi-Cal programs to cover children from birth to age 18 in families with incomes up to 200% of FPL. The second bill will streamline the Medi-Cal application process for families of children applying for Medi-Cal; the proposal eliminates the assets test for children in the federal poverty level, and allows for a mail-in form to eliminate barriers to enrollment. The bill will also strengthen Medi-Cal outreach to inform working families that they are eligible for publicly supported programs.

Children Now believes that children covered by the proposed Medi-Cal expansion programs will not enroll in Medi-Cal managed care in the Two-Plan and Geographic Managed Care counties. The current waivers from the Health Care Financing Administration (HCFA) which allow California to implement these managed care models specify the aid categories which may enroll.

If the Children Now legislation is successful in expanding Medi-Cal to cover children from higher income families, these children will be assigned to a new aid code not covered by the current HCFA waivers.

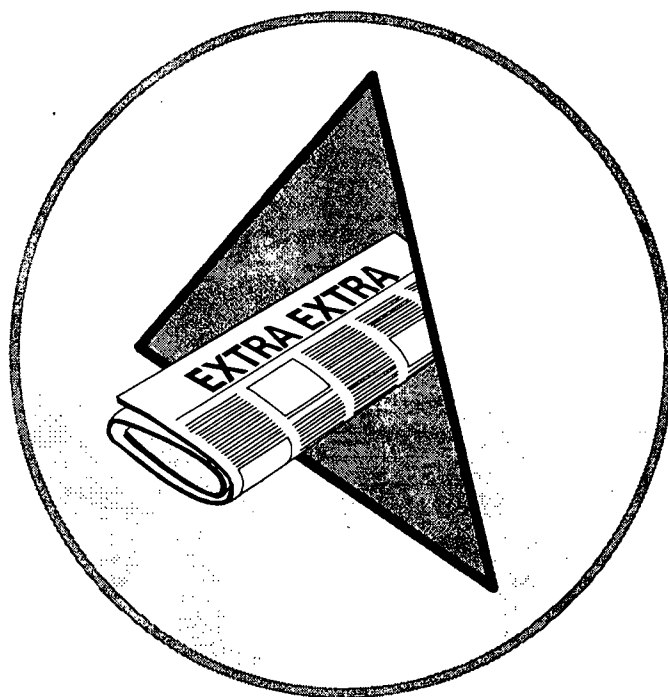
An earlier analysis from Children Now estimates that expansion of Medi-Cal eligibility will cost the state general fund over \$300 million annually, to be matched by federal funds. Opposition is likely from the Wilson Administration, which seeks to contain general fund expenditures. Further, the anticipated access to federal funds may not be available if federal proposals to cap Medicaid are enacted. The second piece of legislation may have a greater likelihood of passage, as it is consistent with proposals advanced by the California Medical Association (CMA), the California Healthcare Association (CHA), and others. Moreover, the Clinton Administration has declared support for reducing barriers to Medicaid enrollment.

As a long-term strategy, Kaiser Permanente should sponsor a bill which authorizes the HIPC to provide subsidized coverage for the dependents of eligible enrollees. Although not necessary for the demonstration project, this authority eventually will be needed to obtain government funding, or to expand HIPC eligibility criteria to allow enrollment of businesses larger than 50 employees. Moreover, if the program is to grow to become an individual plan purchasing pool, MRMIB would also need enhanced statutory authority.

Other Legislative Proposals: Several proposals addressing expanded coverage for the uninsured have been or will be introduced into the California legislature. Kaiser Permanente's support will be requested on proposed bills. Kaiser Permanente should consider whether to take positions on particular bills based on their conformance with the legislative principles. Alternatively, Kaiser Permanente may wait until Senator Lockyer's Conference Committee is established, at which time all issues contained in these bills, as well as many other health and welfare reform topics, will be subject to discussion.

Coalition: Kaiser Permanente should develop a broad based coalition to support its endeavors in expanding access to health coverage for children. To our knowledge, no broad based coalition has yet been developed with representatives from health care plans and providers, advocacy organizations and employers, which is seeking public policy changes for children's health care. If such a coalition were to reach agreement on basic principles, bills such as those advocated by Children Now might face greater legislative success.

Communication Strategy



VI. COMMUNICATION STRATEGY

A. Focus and Objectives

Summary: Kaiser Permanente has made the strategic decision to provide leadership at the national level to seek solutions to the problem of children who are uninsured. Communications will be integral to the effort to position Kaiser Permanente as a health care and public policy leader within California through outreach to the media, community and government opinion leaders. An advocacy strategy will be essential to ensure that the public understands the plight of children who lack health care and acknowledges the positive consequences of Kaiser Permanente's approach to resolving the crisis. These objectives may be achieved in part through a Children's Health Care Summit. Communications to internal audiences will also be critical, to build a sense of ownership in the Initiative, and to encourage active participation by Kaiser Permanente employees and physicians in demonstration projects and grassroots advocacy.

Description: Kaiser Permanente will launch an aggressive media and print campaign, to announce its \$20 million commitment to subsidized coverage. The announcement will incorporate Kaiser Permanente's Program-wide principles for community health programs and emphasize the substantial financial commitment, as part of an overall strategy to achieve universal coverage for California's children over the next five years.

Immediately prior to external communications, other senior leadership within the Division and Program Offices, as well as physicians and employees, must be informed and educated about the Initiative and its goals. This will be accomplished through a series of presentations to Health Plan/Hospitals Leadership Teams, TPMG and SCMPG Boards, Chairs of Chiefs, and other key peer groups. Targeted audiences and appropriately defined messages are integral to establishing the internal basis of support mandated for such an extensive endeavor.

In order to achieve communication and advocacy objectives, Kaiser Permanente will play a leadership role in building and sustaining a coalition of organizations dedicated to achieving universal coverage for children in California. This will be accomplished in part through a Children's Health Care Summit to be held in late 1997.

B. Children's Health Care Summit

Background: On January 31, 1997 Linda Kotis and Steve Zatzkin participated in a statewide conference entitled "Getting the Uninsured Insured: Public and Private Efforts", organized by Lucien Wulsin. Conference attendees, including representatives from Children Now, Children's Partnership, Institute for the Future, the Managed Risk Medical Board, and the California Medical Association indicated their perception that Kaiser Permanente stands in a unique position to lead the way to expanding coverage for children. A brief statement about our intention to convene a summit brought statements of enthusiasm as well as interest in participating from those groups. In fact, Institute for the Future staff expressed its willingness to assist in organization and coordination of the summit. The summit will serve as a mechanism to construct the remainder of the solution to covering uninsured children, by focusing on the populations not addressed by the expansion of Medi-Cal, HIPC, and private initiatives.

Description: Summit objectives will be designed to elevate the debate about universal coverage for children, as well as position Kaiser Permanente as the leader in the debate. Furthermore, the summit will provide credibility to a publicly discredited issue and attract coalition partners. Coalition partners will have the opportunity to highlight existing efforts and to craft a common agenda for legislative, advocacy, business, and voluntary efforts to achieve the goal of universal coverage for children. Another objective will be to communicate measurable outcomes at the end of the five-year evaluation effort.

We envision this will not be a public conference, but instead a working session for a critical group of coalition members and policy experts. One possible approach is for Kaiser Permanente staff to set up a series of meetings with potential participants, four or more months prior to the summit. The purpose of the meetings would be to clarify participant roles, goals, and contributions, such as a proposed legislative agenda or new privately sponsored initiative. We further envision the founding of a series of summits, to continue to refine and coalesce the ideas and strategies of participants.

C. Coalition Development

Coalition members must be carefully considered. The coalition must balance competing interests, by assembling organizations and representatives that give a breadth and depth of skills and perspectives. A sample includes health care providers and plans, community-based

and advocacy organizations, trade associations, government officials and employers. Criteria for selection as a coalition partner would differ among potential categories of members.

(1) Health Care Providers and Health Plans

Participants must have reputations for innovative outreach to children, as well as strong name identification and clout with government officials. Organizations with which Kaiser Permanente has had preliminary discussions include HealthNet and Blue Shield.

(2) Community-based Organizations and Advocates

Organizations encompassing health care access, women's rights, children's rights and children's health issues should be included. Each organization must have a demonstrated history of advocating for its interest group along with solid connections with key government officials. Kaiser Permanente has established a strong relationship with Children Now, and has also been approached by other children's health rights groups, such as The Children's Partnership.

(3) Medical and Trade Associations

Groups such as the California Medical Association (CMA), the American Academy of Pediatrics (AAP), and the California Association of Health Maintenance Organizations (CAHMO) should be included. These organizations bring technical expertise and credibility with government officials whose support will be critical to enactment of legislation.

(4) Government Officials

Representatives and key staff from the legislature, the Wilson Administration, and state health care agencies should be considered and invited to participate. As for elected officials, the preference would be to have representation from various geographic regions.

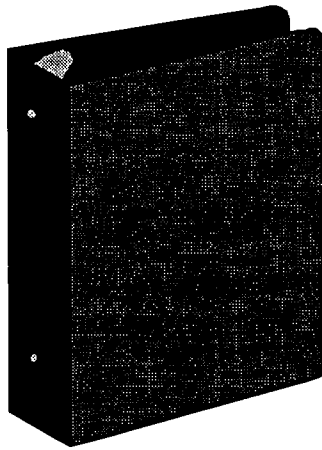
(5) Business

To encourage the continuation of employer-sponsored coverage, and recognize the concerns of small businesses, the Small Business Association and the Chamber of Commerce should be considered an integral part of an effective coalition. In addition, business organizations whose mission is to focus on health benefits and policy, such as the Pacific Business Group on Health, should be considered.

D. Implementation

Communication plans must be developed for achieving each objective, and for each target audience. Kaiser Permanente has the option of providing these services in-house or contracting with a communications or public relations firm to develop more detailed plans and to assist in implementation. Outreach mechanisms, depending on the audience, may include public polling (which can be emphasized to the media), direct mail (for communicating the coalition's work), and print and electronic media.

Appendices



APPENDIX A

Federal Legislation: In 1996, at least five bills on children's health care were introduced, none of which progressed through Congress. Some of these bills have been reintroduced in 1997, along with additional proposals. One plan, backed by Senators Kennedy and Kerry, gives vouchers to families at lower and middle income levels, to purchase health insurance. Senators Coverdell and Gramm have proposed that a low-income family should be able to purchase a tax-deductible major medical insurance policy through a medical savings account (MSA). Another proposal will penalize health plans and insurers which do not offer well-baby and well-child coverage, with a 25% premium tax. Carriers which do offer such coverage will receive an 80% tax credit.

The common goal of these disparate approaches is to create insurance programs or products for families or for their children, when the income level is too high to qualify for Medicaid, but too low to purchase coverage otherwise. Federal legislators disagree, however, on the nature of the solution as well as the source of funding. Therefore, to rely on a federal resolution without concurrently pursuing opportunities at the state level would be unwise.

Administration Proposal: Other federal plans may actually enhance California's ability to utilize Medi-Cal as part of the solution for covering uninsured children. First, President Clinton is advocating for state authority to guarantee Medicaid coverage to children for a 12 month period; currently, states are mandated to recertify eligibility every six months. Advantages of guaranteed eligibility include continued enrollment of beneficiaries whose slight income fluctuations disqualify them from coverage for short periods of time, as well as reduced paperwork. Also, opportunities are enhanced to educate individuals newly enrolled in Medi-Cal managed care plans about unfamiliar health care systems, which increases the likelihood that Medi-Cal beneficiaries will access services from their Medi-Cal managed care plans and enjoy greater member satisfaction. Nationally, one million children would temporarily retain the Medicaid coverage which otherwise would have been lost because of fluctuations in family income. Therefore, this plan would at a minimum prevent the number of uninsured children in California from increasing.

Second, the Clinton administration also supports aggressive efforts by states to locate and enroll the 3,000,000 children who are currently eligible for, but not enrolled in, Medicaid. This implies a commitment to providing states with federal matching funds to enroll such children. Not only would this effort forestall an increase in but it could also decrease the number of uninsured children.

Unfortunately, the Clinton administration's fiscal year 1998 budget request which includes a proposal to curb federal Medicaid spending may affect both the total amount available for such a Medi-Cal expansion, as well as the portion of the total funding from state sources. President Clinton's plan would incorporate a per-capita cap on Medicaid spending into the federal budget, tied to growth in the gross domestic product plus growth in enrollment. No limits would be established for state spending. Therefore, the potential exists for California's share of expenditures to increase, in order to fund costs incurred by the Medi-Cal program after the federal limit has been reached. Given the Wilson administration's previous reluctance to expand Medi-Cal, the potential federal action may become an impediment to the passage of the Children Now proposal.

Another element of the Clinton proposal supports state-sponsored solutions. Federal grants would be given to the states to design innovative programs in collaboration with health care providers and employees, which would provide coverage to children who are ineligible for Medicaid and who do not receive employer-based coverage. Grants for 1997 would equal \$750 million, with \$3.8 billion available for 1998-2002. Federal funding therefore could augment other state public and private resources, allowing the creation of a larger program than previously anticipated. Alternatively, a federal grant could reduce the financial burden of other sources, thereby preserving dollars for future program expansion.

Welfare Reform: The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform) necessitates state changes for implementation of its provisions. One of the consequences of federal welfare reform is to disconnect eligibility for financial assistance through the Aid to Families with Dependent Children (AFDC) program from eligibility for medical care through Medicaid. Therefore, the AFDC program has been repealed and in its stead is a block grant program to states, Temporary Assistance for Needy Families (TANF). The result is that some former AFDC recipients will no longer receive cash assistance, but will still qualify for health care coverage through Medicaid. Because states have the option of establishing separate processes for application to TANF and Medicaid, some individuals may not be aware of their continued eligibility for Medicaid.

Another effect of the new law is that some legal immigrants will no longer qualify for food stamps and Supplemental Security Income. SSI provides cash assistance on a monthly basis to some disabled children, as well as to other disabled and poor elderly adults. In most states, disabled children who are SSI recipients automatically qualify for Medicaid. Through the mandated reassessment, state welfare departments will determine that some disabled children are still eligible for Medicaid because of family income, so long as states have chosen to continue Medicaid coverage for qualified aliens. Indications exist that California will continue to provide such coverage.

Unfortunately, implementation of federal welfare reform could potentially increase the number of uninsured children in California and diminish their health status. First, the creation of separate application processes for TANF and Medi-Cal could create further confusion around eligibility for Medi-Cal and preclude some families who have never received welfare from enrolling their children. Second, some no longer eligible for cash assistance may mistakenly believe they do not qualify for Medi-Cal and unnecessarily lose coverage. Clearly, the current number of individuals eligible but not enrolled in Medicaid demonstrates the difficulty in reaching potential beneficiaries.

Moreover, even if families do comprehend that their children remain eligible for Medi-Cal, the unavailability of cash assistance decreases the likelihood that such families enroll their children while healthy. Instead, a family may procrastinate until a child requires medical attention and thereby alter the risk pool and increase health care costs. Finally, the withdrawal of financial payments could lead to a decline in children's health status. For those families who do not immediately access other means of support, such as employment, less income may be available to purchase the food, clothing and housing necessary to keep children healthy.

Notwithstanding the above, California's implementation of federal welfare reform may constitute an opportunity to simplify the eligibility and application process for Medi-Cal. States have the option to retain a unified process for application for cash assistance (TANF) and health care coverage (Medicaid). Moreover, California could establish a mechanism to accommodate automatic re-enrollment of former AFDC beneficiaries who still qualify for Medi-Cal. Finally, California could simplify the process by allowing application by mail and eliminating the asset tests for children whose family income falls within the federal poverty level, or who qualify for the Medically Needy and Medically Indigent programs.

Insurance Reform: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) enacts modest insurance reform and provides opportunities for states to augment its provisions through higher standards or more stringent requirements. The Act primarily makes insurance coverage more available to small group employers, enhances portability of coverage, and creates a demonstration program with medical savings accounts (MSAs) for self-employed individuals and some employees of small businesses. Because California law has already addressed some issues presented by HIPAA through AB 1672, the Small Employer Health Insurance Act, implementation could serve as a vehicle to expand the scope of HIPAA. In any event the likely outcome of state implementation is that some individuals and families who would have lost health insurance coverage due to a job change will now retain coverage through another mechanism. Therefore, this will be a factor in forestalling an increase in the number of uninsured Californians.

State Legislation: Advocacy organizations, trade associations, some legislators and at least one state agency are interested in expansion of coverage for uninsured Californians. Some proposals focus on working uninsured families. For example, one offered by the California Medical Association (CMA) would create a new public health program by consolidating existing funding sources. Other proposals focus specifically upon children's coverage; these include the two bills being sponsored by Children Now, which have been previously discussed. Because of the potential for a significant number of bills, Senator Lockyer has indicated his desire to establish a conference committee on the uninsured.

The staff of the Managed Risk Medical Insurance Board (MRMIB) is attempting to engender support for expansion of its programs. One idea would be to modify the Access for Infants and Mother (AIM) Program to continue coverage for children already enrolled past the current cut-off at age two. Another option would be to allow all children in a family to enroll when a pregnant mother signs up. A third idea would be to offer subsidized coverage to children of adults enrolled in the Health Insurance Plan of California (HIPC) through small employers, as previously discussed.

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DRAFT

**UNINSURED CHILDREN IN AMERICA:
THE FACTS AND THE FUTURE**

A Report by the

**U.S. Department of Health and Human Services
and the U.S. Department of Labor**

*Still using Medicaid
language, but
this is basically
it! jmc*

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.
- **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 are offered employer-based insurance but decline it 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.** Over 2 million uninsured children would become eligible for Medicaid if all children were offered the same coverage as children under 6 (up to 133% of poverty).
 - **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:
 - Making insurance more accessible and affordable through Medicaid and targeted state programs;
 - Assisting small employers through state purchasing cooperatives; and
 - Encouraging outreach through schools and other proven approaches.
- Regardless of the specifics, policies that efficiently extend meaningful coverage to uninsured children should be embraced as essential for today and the next

century.

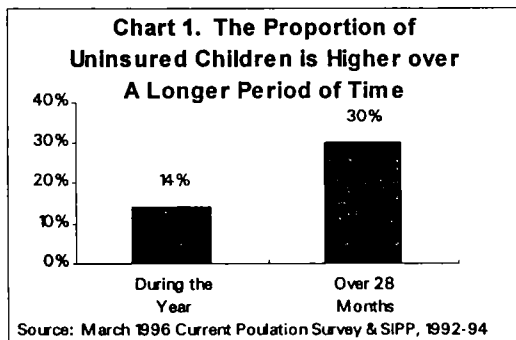
I. UNINSURED CHILDREN: A SERIOUS PROBLEM

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.

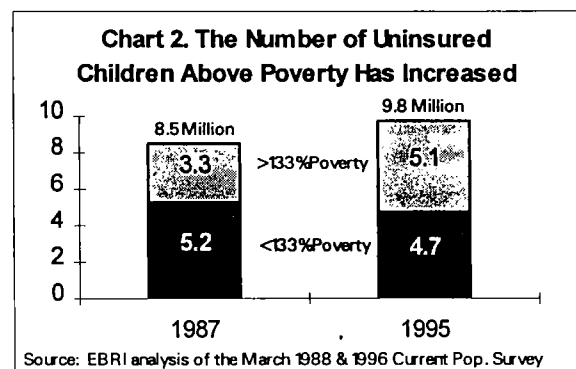
A. THE NUMBERS OF UNINSURED CHILDREN

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, 1997.)

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

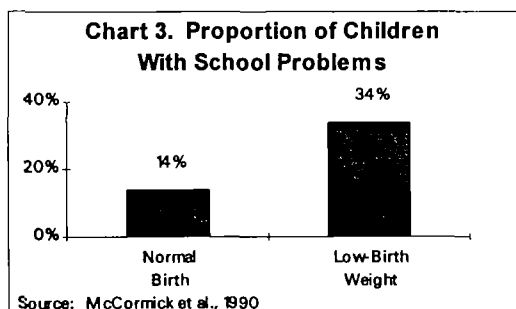


Problem increasing for middle class families. While the proportion of children who are uninsured has remained relatively constant, this masks an underlying trend. The number of poor, uninsured children has been decreasing while the number of middle class uninsured children has been increasing. The number 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.



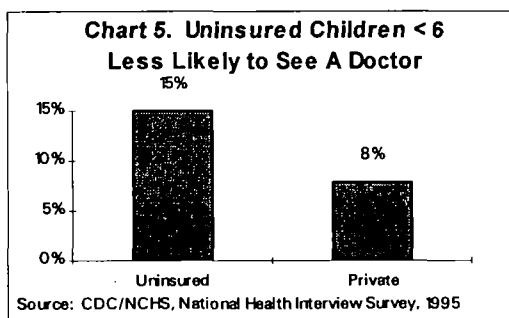
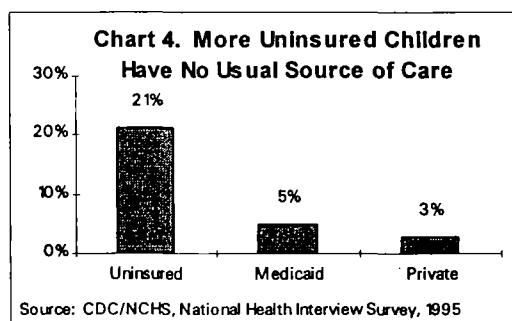
B. WHAT IT MEANS TO BE UNINSURED

Good health is essential to children's development. 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). These illnesses, whether short-term or chronic, can interfere with a child's development. When asked what indicates that a child is ready for



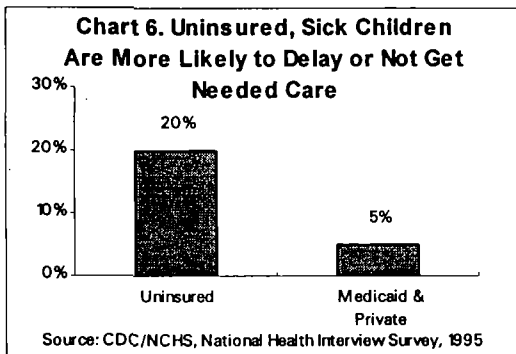
kindergarten, teachers overwhelmingly respond that the most essential factor is a child's physical health (NCES, 1996). Children with low birth weight are more likely to repeat a grade or need special education (Chart 3). Mental health is equally important. About 7.5 million children suffer from one or more mental disorders that disrupt their ability to function socially, academically, and emotionally (IOM, 1994).

Uninsured children have more difficulty getting health care. Primary and preventive health care for children allows them to develop to their full capacity (CEA, 1997). Children also require immunizations in the early years of life to prevent lifelong health problems. 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 (Donelan, 1996).

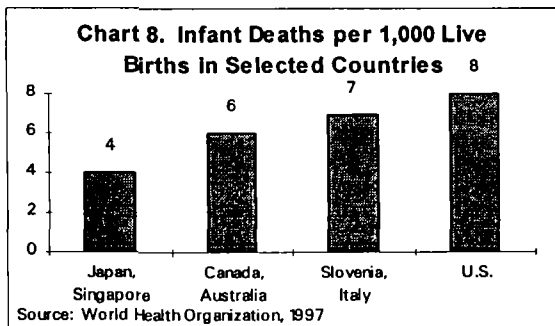
The United States stands alone. The United States leads the world in many important respects, including size of the gross domestic product (GDP) (World Bank, 1997) and real level of family income (Rainwater & Smeeding, 1995). However, the United States is the only industrialized country that does not extend health protection to all its children. It is with Turkey and Mexico at the bottom of a league of nearly 30 developed 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,

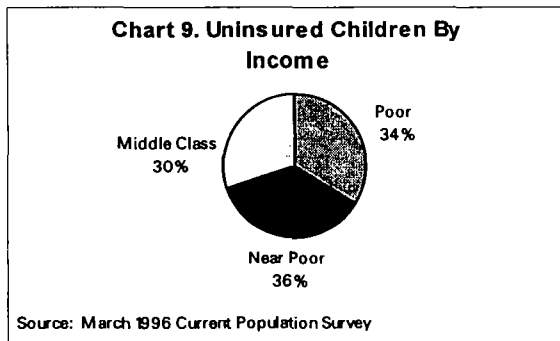


while improving, are still worse than many industrialized nations. Twenty-one nations have lower infant mortality rates than the U.S. and 25 have a lower proportion of low birthweight babies (Chart 8). Babies born in the United States have shorter life expectancies than 10 other nations and are more likely to die of violence than in any industrialized nation (OAT, 1993).

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. It is this group of children that has the greatest likelihood of being uninsured — nearly one in four lack insurance (CPS, 1996). Another one-third of uninsured children have family income above 200 percent of poverty (Chart 9). Although most children have distinct reasons for being uninsured, there are some patterns that explain why this occurs..

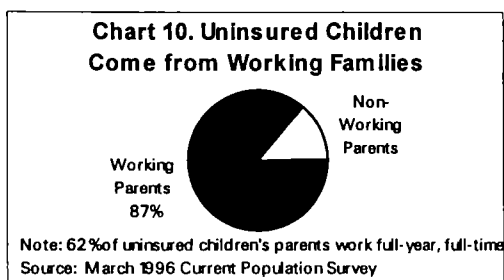
Children often do not have health insurance because of:

- 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).

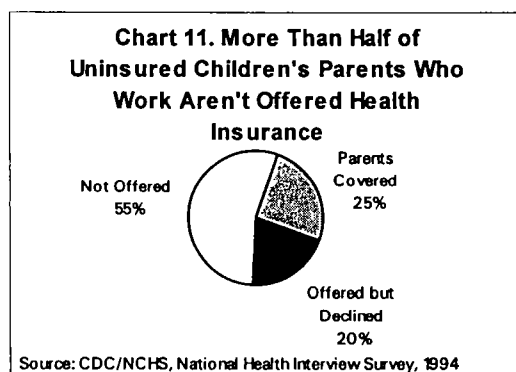
Nearly all uninsured children have a connection to the workforce. Most



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).

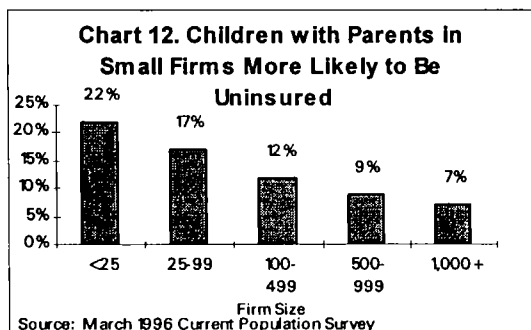
Many uninsured children's families work in businesses without health coverage.

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 have 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 poor uninsured children 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).



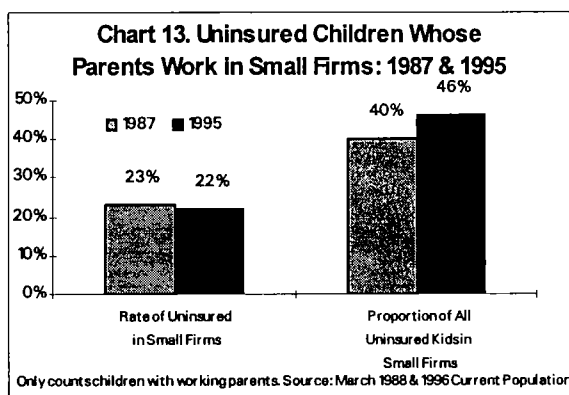
These families are most likely to work in small businesses, industries like personal services, and part-time jobs (Mark & Schur, 1996).

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 (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 (NEHS, 1993).

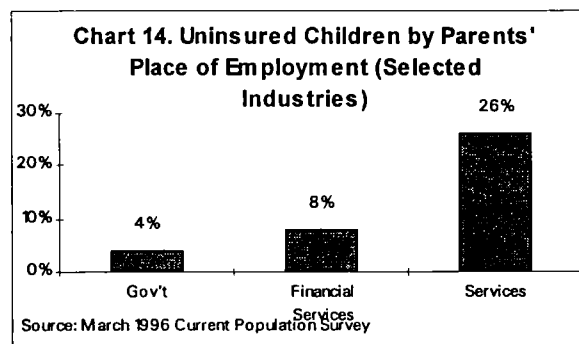
More children's parents work in small businesses. In 1988, 40 percent of uninsured children in working families had parents employed by small firms. In 1995, this rose to 46 percent (Chart 13). This did not result because small businesses are decreasing their health insurance coverage of children. In fact, in both 1987 and 1995,



about 22 percent of children of workers in small firms were uninsured. In 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.

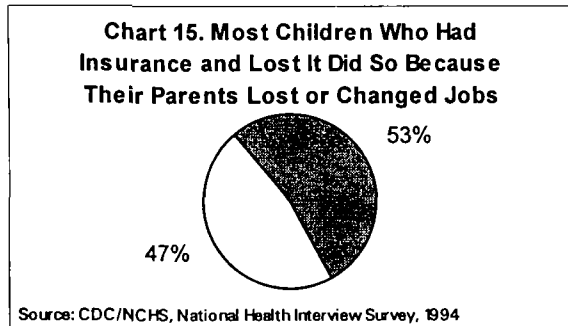
Certain industries are less likely to offer coverage than others. Specifically, the rate of uninsured children whose parents work in the service industry (e.g., restaurants, cleaning services) is about twice as high as that for children with parents in most other types of jobs (Chart 14). In part, this 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.



Similar to the trend for workers in small businesses, there has been an increase in the number of children with parents in service jobs — not an increase in the rate of uninsurance in those industries. The number of children with parents working in these types of jobs increased by over 10 percent between 1995 and 1987 (CPS, 1996).

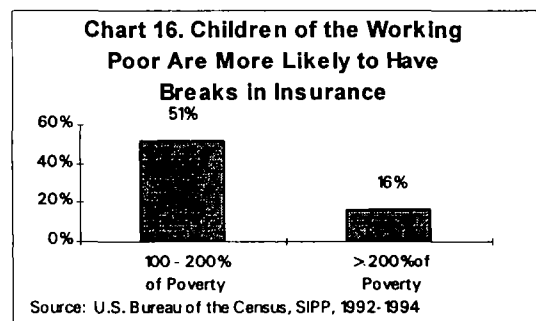
JOB CHANGE AND JOB LOSS

Parents' job changes often mean 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

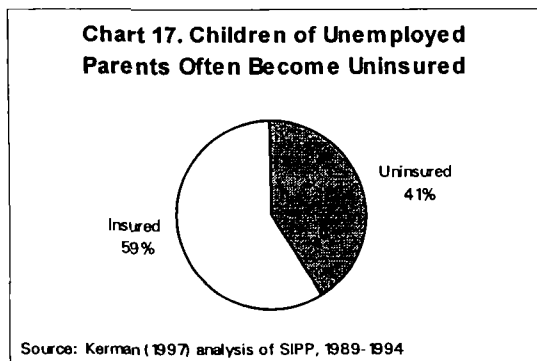


coverage because of job change (NCHS, 1994). It is also the reason why 58 percent of uninsured children in families between 100 and 250 percent of poverty and 54 percent above 250 percent of poverty lost coverage in 1994. Since higher income families are more likely to have job-related insurance, it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

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.



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

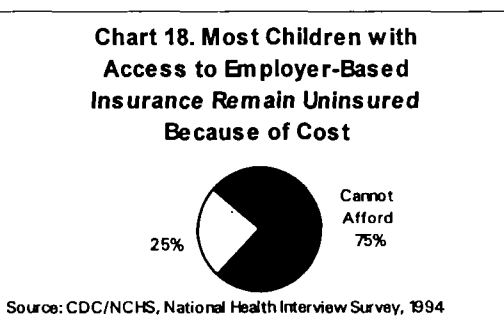


children have parents who are unemployed or out of the labor force (CPS, 1996). Over 40 percent of children who were covered through their parents' employer before their parents became unemployed became uninsured (Chart 17). Most of these children have parents who worked in manufacturing, transportation, communication, or construction jobs (Klerman, 1997). Most families spend 8 weeks or less looking for a job.

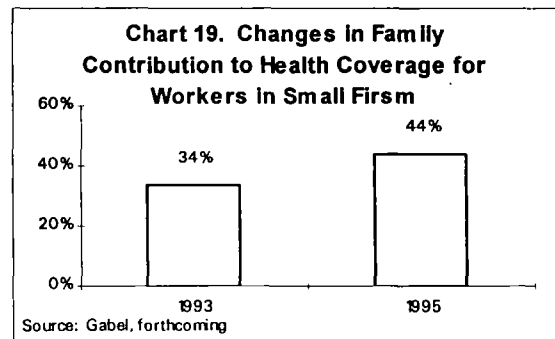
B. LACK OF AFFORDABILITY OF HEALTH INSURANCE

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, individual 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).

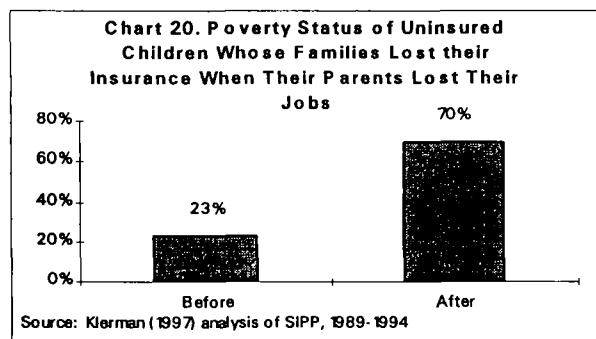


Family contributions are changing. One theory on why workers' children are increasing becoming uninsured is that the families' contribution to employer-based insurance is increasing. There is mixed evidence supporting this theory. One study found that the family contribution has remained about the same as a percent of the premium in the last several years (Jensen et al., 1997). However, several other studies suggest that the family contribution is increasing. One reports that the employees' share of the premium rose from 23.6 to 28.9 percent between 1992 and 1995 (Center..., 1997). Another found that this trend was more pronounced for workers in small firms; the family share increased by nearly one-third, from 34 to 44 percent between 1988 and 1996 (Chart 19).



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



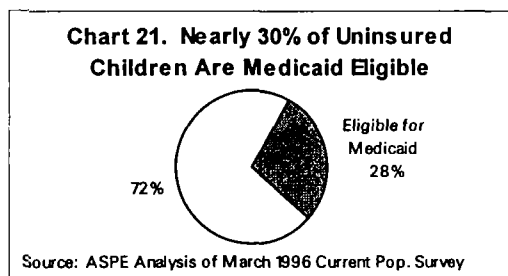
of unemployed parents, only 20 percent were in poverty when the parents worked while 70 percent were in poverty after the parent lost his or her job (Chart 20). While these periods are usually short-lived, they are problematic because children need preventive and primary care, which may be postponed if there is no insurance, or they may experience a severe illness or injury that could make the family's financial situation even more strained.

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, overly complex programs, or limited 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).

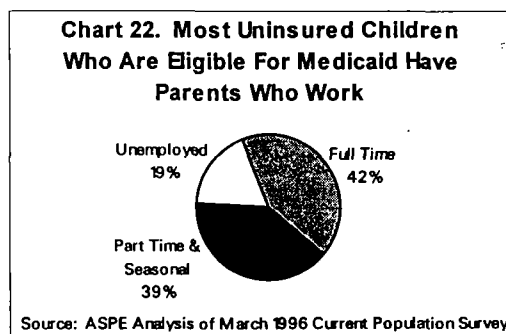
Many children are eligible but not enrolled in Medicaid. While most poor children are eligible for Medicaid, about three million uninsured children are not enrolled (Chart 21). Researchers estimate that participation rates for Medicaid-eligible children range from about 40 to 70 percent (Summer et al, 1997; Winterbottom et al, 1995). There is



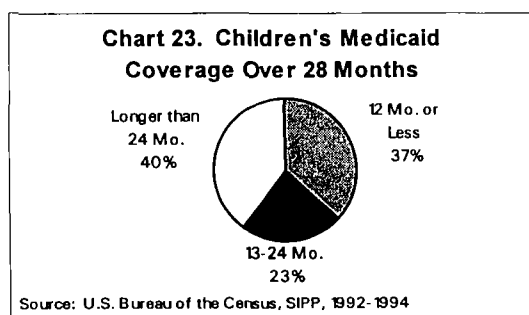
no conclusive research on why eligible children without insurance do not enroll in this program which offers free insurance (U.S. GAO, June 1996). Explanations include lack of awareness of the option, the belief that work disqualifies children, and the uncertainty of Medicaid coverage. Families also may be discouraged by complicated eligibility rules.

Families lack awareness of Medicaid eligibility. One of the main reasons why children may not be enrolled in Medicaid 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).

Belief 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.

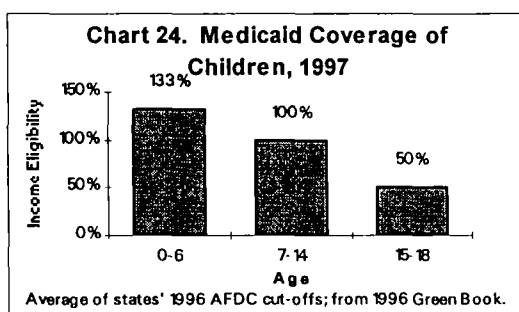


Uncertainty of Medicaid coverage. For a significant number of children, Medicaid coverage does not last long. About 37 percent of children spend less than one year on Medicaid (Chart 23). This may result from the Federal requirement that monthly



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).

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 under 14 years old are eligible while the children 14 years and older are not. And, in families with incomes between 100 and 133 percent of poverty, children below 6 years old are eligible while older children 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 limited. State-funded and private programs often experience similar problems in educating families about eligibility. They may also have difficulty attracting families because of limited benefits, limited duration of coverage, and waiting lists. 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).

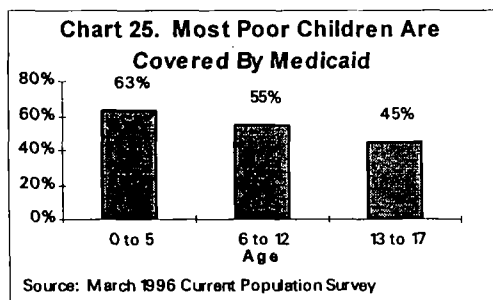
III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

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.

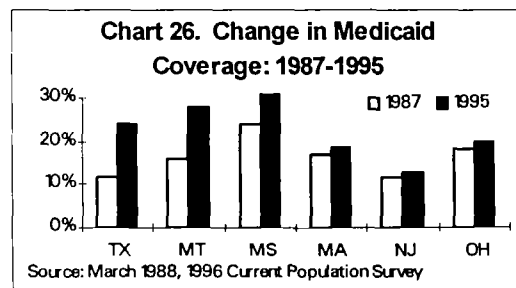
A. MEDICAID

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 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.



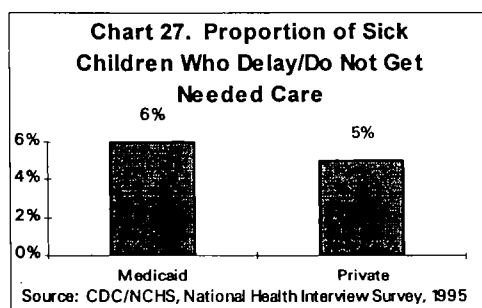
Moves toward a national eligibility "floor" for poor children. Prior to the Medicaid expansion, states varied widely in their Medicaid coverage. States in the South and Mountain regions had much lower Medicaid coverage of children than states in the North East and Upper Midwest (Chart 26). After the 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 (Tin, 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 a year without a doctor's visit by 50 percent (Currie & Gruber, 1996). These access improvements are especially important to children covered by Medicaid since they typically have poorer health than privately insured or uninsured children.

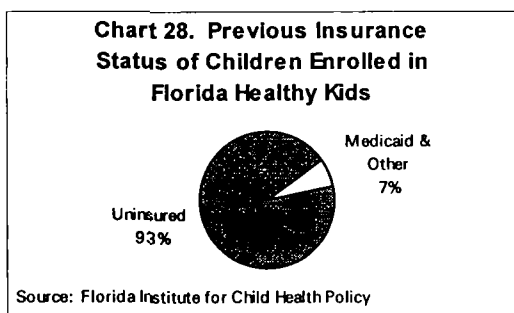
B. STATE EXPERIENCES

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 their 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.



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 these children's health care utilization more closely resembles that of privately insured than Medicaid covered children (Coulam, 1997). 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



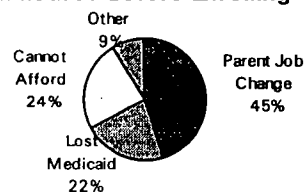
Source: Lurie et al., 1995

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).

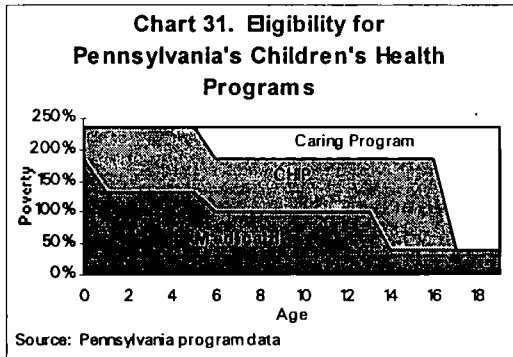
Chart 30. Reasons Why NY Child Health Plus Enrollees Became Uninsured Before Enrolling



Source: 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 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.

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 repealed 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 (1994) 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. COBRA appears to have made a difference (Flynn, 1992; Klerman, 1992) but with HIPAA, it is too early to tell.

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 insurance 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.

Building on Medicaid. States have successfully used Medicaid to cover millions of uninsured children. This success could be extended by giving states options and incentives to expand coverage. For example, states could be encouraged to accelerate the phase-in of coverage for poor children under 19 years old. They could be given higher matching rates for going beyond today's eligibility levels. Administrative flexibility might also increase states' interest in extending Medicaid coverage to children.

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 options. 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 Enrollment
AK	19,000	None	None		
AL	193,000	None	Alabama Caring Program for Children	No	6,353
AR	129,000	<i>ARKids First (proposed): 0-18: 200%</i>	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% <i>Proposed: 13-18: 100%</i>	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 Enrollment
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) <i>Proposed: Thriving by Three</i>	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% <i>Proposed: 0-18: 300%</i>	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 Enrollment
NY	627,000	Infants: 185%	New York's Child Health Plus Program	Yes	110,500
OH	317,000	<i>Proposed: 0-18: 150%</i>	Caring Program for Children (Closed to new participants)	No	2,680
OK	216,000	Infants: 150%	Oklahoma Caring Program for Children	No	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	Yes	50,000
RI	28,000	0-7: 250% <i>Proposed: 0-18: 250%</i>	RiteCare (1115)		
SC	157,000	Infants: 185% <i>Proposed: 0-19: 133%</i>	None		
SD	23,000	13-19: 100%	Caring Program for Children	Yes	370
TN	182,000	Infants: 185% 13-18: 100%	None		
TX	1,347,000	Infants: 185%	Caring Program for Children	No	
UT	72,000	13-18: 100%	Caring Program for Children	No	1,100
VA	204,000	13-19: 100%	Medical Care for Children Partnership <i>Proposed: Virginia Children's Medical Security Insurance Plan</i>	Yes (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	Yes	149
WY	22,000	Minimum	Caring Program	No	400

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Technical note on CPS analysis:

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.

▶ **Diana Fortuna**
06/19/97 11:50:38 AM
.....

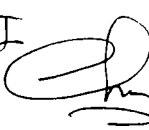
Record Type: Record

To: Jennifer L. Klein/OPD/EOP
cc: Stephen B. Silverman/WHO/EOP, Katherine Hubbard/WHO/EOP
Subject: Kaiser event on Monday and mention of service summit

As we've discussed, it would be great to get into Monday's remarks some passing mention of the service summit, since this was originally a summit commitment. Here's a rough suggestion:

"In making this commitment to children, Kaiser is carrying on the critical work of the summit on citizen service that we held last April in Philadelphia. We brought together over 100 communities, corporations, nonprofit groups, and religious organizations around one goal: using citizen action and volunteers to reach children at risk. I was pleased to join with all the living former Presidents or their representative and Gen. Colin Powell to focus on how programs of citizen service, like AmeriCorps, and volunteer efforts can ensure that more children at risk have the resources they need -- a caring adult in their lives, a healthy start, a safe place, a marketable skill through a good education, and a chance to give back to their communities. This commitment from Kaiser is a shining example of what that summit was all about."

(FYI, technically, it was called the Presidents' Summit for America's Future, but we often call it the service summit to emphasize our view of what was important about it.)

Jen - FYI 

Major Improvements in the Senate Finance Children's Proposal

- The draft of the Senate Finance proposal (June 11, 1997) improved significantly by the time it passed. Major changes include:

	<u>Before</u>	<u>After</u>
Uses of Funds:	Health insurance or direct services (e.g., clinics, transportation)	Health insurance only
Benefits:	Basic health insurance (e.g., no drugs)	Health insurance equivalent to Federal Employee Health Benefit, with HHS Secretary review
Financial Incentives:	Larger for grant (e.g., 75% matching rate which is higher than Medicaid option for 35 states)	Same for both Medicaid and grant
Qualifications for Funding:	None for grant; cover poor children up to 18 in Medicaid option	Cover poor children up to 18 in both options
Accountability:	No rules for state contribution	Medicaid rules for both options (no provider taxes and donations).

- Additionally, the grant is no longer run through the Maternal and Child Health (MCH) block grant.

June 18, 1997

draft

To: Meeghan Prunty
From: Lois Salisbury
Re: a draft
Date: June 19, 1997

Meegs, if this is useful, this is my first crack at it. I am totally amenable to input. Thanks, Cheekah (sp????).

**comments of Lois Salisbury, President, Children Now
Kaiser Permanente News Conference
6/23, 1997**

President Clinton, Mayor Riordan, Dr's. Lawrence, Goldsmith and Levine, Mr. and Mrs. _____ and cute kids #1 and #2.

Children Now is deeply honored to participate in today's event, an event we believe one day will be viewed as an historic one. Five years from now, June 23, 1997 will be looked back upon as the day where some pretty important grown-ups stood together and made a promise to 1.6 million California children. To them, and to their hard working mothers and fathers, we pledged that there won't be uninsured children in California anymore. We pledge that by combining President Clinton's extraordinary leadership in Washington with the exceptional commitments being made by Kaiser Permanente today, we can build the team needed to write this embarrassing chapter off of California's history books.

That's five years from now. What's life like today for these 1.6 million children and their families? For moms and dads and kids, impossible sometimes life-threatening choices are being made every day between paying the rent late risking eviction and a doctor's visit for that fever that won't go down or the diagnostic test that requires an expensive overnight hospital stay. These families are the backbone of today's thriving economy. They fill the jobs that make California run. They work in bakeries and barber shops, book stores and florists. They are waitresses, health care workers and hotel staff; they pump gas and they pick crops. Unfortunately,

this hard work does not provide them with what it takes for a California family to get by. And it's their kids health that often suffers as a result. That's not what most Americans believe working families deserve. Yet, in California,

- one in six children has no health insurance; only eight states have worse rates
- 90% of these children's parents work and 2/3's have at least one parent who works full time all year
- nearly 3/4's of these uninsured children's families are trying to make ends meet for between \$15,000 and \$30,000 a year for a family of four
- barely half of California's children have coverage through their parent's job.

The good news is that while this is a big problem, there are affordable solutions. Kaiser Permanente today is making a huge downpayment towards solving this problem. We are aware of no other voluntary effort by a health plan anywhere in the country that comes close to covering the 50,000 children a year Kaiser expects to cover through this new program. But every bit as important is their pledge to work in multi-faceted ways until we've solved 3% of the problem, then 20%, then 60% -- all the way until not one more hard working parent in California has to spend another sleepless night worrying about whether to take Rosie or Mark or Pedro to the doctor or not pay the electric bill.

We at Children Now join Dr. Lawrence and President Clinton in promising to end this blight on the California dream. We invite leaders from state and local government -- including our former board member Mayor Riordan, and Governor Wilson to join us. We invite other leaders from health care, from small business, people from San Diego to Salinas, to join us.

When we solve the problem of California's uninsured children we will heal a breach in the unspoken but very American social contract that says working families deserve health care security for their children. It's going to take something from all of us, small business, parents, health plans and

government. Today's announcement by Kaiser Permanente, today's coming together of leaders from both sides of the aisle and from different sectors, tells me -- and tells California's children --- that we adults can make this difference. That we must and that we will.

GREER, MARGOLIS
MITCHELL, BURNS
GMMB&A
& ASSOCIATES, INC.

GMMB&A Fax Cover Sheet

Date: ___/___/___

To: Jennifer KleinFrom: Roy BehrNumber of Pages to Follow: 7**Comments:**

(1) Draft Description of the program
(2) Draft Press Release (a little dated -- it was done when we resumed White House participation via satellite)
(3) Summary of KP's Community Relations programs
Thanks

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KAISER PERMANENTE: OVER 50 YEARS OF CARING FOR KIDS AND COMMUNITIES

As America's leading not-for-profit health care organization, Kaiser Permanente provides top-quality health care to 7.9 million members. But Kaiser Permanente's mission goes beyond improving the health of its members; it is also deeply committed to improving the lives of all people in the communities it serves.

That's why, since its formation in 1945, Kaiser Permanente has devoted over \$x billion to community service, through programs that have touched literally millions of people, and in dozens of ways. Subsidized health coverage for low income families. Pathbreaking medical research. Educational programs to teach children about healthy habits, violence prevention, and adolescence. Medical training for the next generation of health professionals. And tens of millions of dollars in grants to support housing, community health, wellness, and safety.

A Special Focus on Children

Children are a special part of Kaiser Permanente's social mission. That's why Kaiser Permanente has focused much of its community service efforts on supporting programs, policies, and events that directly benefit children of all backgrounds and ages, from prenatal care through the teenage years. "Today's children deal with a frightening range of threats to their health and safety, and many of them are doing so without the advice or participation of adults. All children are impacted, regardless of race, gender, economic status, or family situation," says David M. Lawrence, MD, Chairman and Chief Executive Officer of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals.

Health Care Coverage for the Uninsured

As part of its social mission, each year, Kaiser Permanente subsidizes health care for tens of thousands of uninsured Americans. The centerpiece of the effort will be the "Kaiser Permanente Cares For Kids" initiative, which will provide subsidized care to between 40,000 and 50,000 low income children a year in California. The Initiative also will fund school-based health services in selected sites, and seek to enroll children who are eligible for Medicaid, but are not currently signed up. Kaiser Permanente has committed \$100 million over 5 years toward the Initiative and will work with other health plans, advocacy groups, government officials, employers, and trade organizations to expand its reach to the largest number of children possible.

In addition to the California effort, Kaiser Permanente also provides coverage for approximately 54,000 uninsured children and adults nationwide through other subsidy programs, at an estimated cost of \$43 million a year. Two examples are the Medical Care for Children Partnership

(MCCP) and School Connections. MCCP is a public/private partnership between Kaiser Permanente and several counties in the Washington, DC area, which provides health care and services to about 1,500 underserved children. The School Connections program in Denver offers full health coverage to 1,300 uninsured children for \$3 per month or \$9 per family. This program is supported through a partnership of Kaiser Permanente, school-based health centers, and the state.

Community Service Grants

Kaiser Permanente also provides approximately \$4 million a year in grants to community groups throughout the country. Again, children are a special focus.

In commemoration of its 50th Anniversary in 1995, Kaiser Permanente awarded \$1.2 million in grants for innovative programs aimed at improving children's health and safety. Each Kaiser Permanente region identified programs designed to meet unique local children's needs. For example, the Kansas City Region used part of its grant to help fund a summer mentoring program for at-risk kids ages 5 to 18 years old. The program, run by the Ad Hoc Group Against Crime, enables children whose lives are dominated by crime and violence to be exposed to a more nurturing environment. Other regions used their grants for programs addressing health and disease prevention, interpersonal conflict, the importance of good nutrition, violence and injury prevention, and health screenings.

Community service grants are a regular part of Kaiser Permanente's ongoing social mission to improve the health care for its members and the communities it serves. For example, these grants and in-kind donations support summer camps and art programs for at-risk youths, community health clinics that serve the uninsured and the indigent, educational scholarships for minorities, and community health education programs and immunization clinics.

Educational Theatre

One of Kaiser Permanente most innovative community service efforts is the Educational Theatre Program, which uses live theater to educate young people about a wide range of age-appropriate challenges that can affect their health and safety. For elementary school children, the "Professor Bodywise" program uses puppets and costumed characters to cover basic subjects like smoking, drinking, hygiene, and healthy eating habits. For older children, Educational Theatre offers "Nightmare on Puberty Street," which tackles the whole range of issues facing adolescents; "Secrets," an AIDS awareness program; "RAVES," which is aimed at violence prevention; and "Intersections," which promotes communication and self-responsibility, and helps young people understand the consequences of the many choices they make growing up.

An estimated 10 million kids have seen these live performances in schools and other settings.

Clinical Research

Since the practice of medicine is always changing, Kaiser Permanente is committed to finding the most innovative ways to prevent and treat diseases and disseminating this information to the larger professional community. Our researchers have made significant contributions in the areas of children's health. For example, each year, 1,800 babies are saved thanks to a vaccine developed by Kaiser Permanente researchers to prevent *Haemophilus Influenzae* Type B, the most common cause of meningitis and invasive bacterial disease in infants and young children in this country.

Training and Scholarships

Kaiser Permanente is also committed to developing and educating highly-skilled medical professionals and technicians to ensure the good health of its communities and children throughout the future. That's why Kaiser Permanente has contributed a substantial amount of money and resources to the education and training of health professionals. For example, these resources support the Graduate Medical Education program, nursing scholarships, and post-graduate education programs. Some Kaiser Permanente regions, such as California, offer youth employment programs in which economically disadvantaged high school students are employed throughout the Kaiser Permanente system. This provides an opportunity for young people to be exposed to the health care field and to gain work experience that will enhance their vocational orientation.

**GMMB&A Fax Cover Sheet**Date: 6/12/97To: Jennifer KleinFrom: Roy + ElizabethNumber of Pages to Follow: 2**Comments:**

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To: Jennifer Klein
Karen Finney

From: Roy Behr
Elizabeth Riel

Date: June 12, 1997

Re: Site Visits for Uninsured Announcement

We have just visited the three possible sites for the uninsured press conference and wanted to give you a brief overview of our findings.

Mar Vista Elementary

Mar Vista has four areas which may be suitable for the announcement—the cafeteria, the auditorium, and two outside playground areas. The cafeteria is about 25' x 37' with four separate entrances at each corner of the room. There is a colorful mural on a side wall. The auditorium is about 33' x 50' with four separate entrances. There is a small stage in front and a 5' x 33' space in the back that can be cleared for risers for television cameras. The auditorium has about 120 seats. The outside playground areas are near the STAR enrichment classroom. One possibility is to have the press conference in front of a mural that is painted on the side of the classroom. It is a large, open space with playgrounds on either side. The second possibility is a smaller playground in back of the STAR classroom that has a playhouse and lots of toys and climbing equipment. It is very scenic, but there are quite a few trees which may obscure pictures sight lines.

The school itself is located in an attractive, middle class neighborhood. While it is very close to the 405 freeway, the roads leading to the school are somewhat narrow and very residential.

The student body, as we had mentioned, is quite diverse and there would be about 65 kids in the STAR program at the time of the press conference. Based on the information we got from the principal, our sense is that the percentage of students who lack insurance would be somewhat less than the population as a whole.

**GMMB&A Fax Cover Sheet**

Date: ____/____/____

To:

Jennifer Klein

From:

Roy Behr

Number of Pages to Follow: 1

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GREER, MARGOLIS,
MITCHELL, BURNS
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& ASSOCIATES, INC.

To: Jennifer Klein
From: Roy Behr and Elizabeth Riel
Date: June 10, 1997
Re: Possible Sites for Uninsured Announcement

We wanted to give you a brief update about possible sites for the June 23 uninsured announcement. Currently, we have come up with two locations, other than the Beverly Hills Hilton, that are easily accessible from LAX or Santa Monica Airport and that are on the way to the hotel. We will be conducting site visits this week and will fill you in on the all the logistical considerations of each site.

Mar Vista Elementary School

Mar Vista Elementary is located about 1 mile west off the 405 freeway (which is the most convenient freeway from either airport to get to the Beverly Hills Hilton). Although school will be out of session for the summer, the Star Enrichment Program is held on campus. This program provides sports, theater, arts, and recreation activities for children ages 5-12. Participants are primarily from Mar Vista Elementary, along with children from the neighboring schools. The school has a cafeteria and an auditorium available for the press conference. The demographics of Mar Vista's student population are: 50% Caucasian, 27% Latino, 13% Asian, and 8% African-American. The school is located in a middle class neighborhood. (FYI, Mrs. Clinton recently visited the Mar Vista Children's Center, which is a community center located about 8 miles southwest of Mar Vista Elementary in a very low-income, at-risk neighborhood.)

Kaiser Permanente Culver Marina Medical Offices

This Kaiser Permanente facility is located about three-quarters of a mile west off the 405 freeway. The medical offices provide primary care and pharmacy services to Kaiser Permanente members. (This facility is very near Mar Vista Elementary and there is no logistical reason to go here rather than Mar Vista.)

We have investigated about a dozen elementary schools and other sites, but our top choice is Mar Vista Elementary because its location is convenient, there are children present, it is racially diverse, and it highlights the initiative's partnership with Los Angeles area schools. Please let us know your thoughts.

→ Clinics near Beverly Wilshire

Karen Arney
6-7951

ROUTING SLIP**DATE:** 5 / 27 / 97**FROM:** Stephanie Streett
Deputy Assistant to the President and Director of Scheduling**SUBJECT:** *Satellite Appearance for Kaiser Permanente*Don Baer ✓Katie McGinty Sandy Berger Mack McLarty Erskine Bowles John Podesta Peg Cusack Bruce Reed ✓Rahm Emanuel Dan Rosenthal Maria Echaveste Charles Ruff Jack Gibbons Peter Selfridge ✓Laura Graham ✓Patti Solis-Doyle Marcia Hale Craig Smith Nancy Hernreich Doug Sosnik John Hilley Gene Sperling Kitty Higgins Todd Stern Ron Klain Ann Stock Ann Lewis Kim Tilley Bruce Lindsey Jodie Torkelson Sylvia Mathews Melanne Verveer Mike McCurry ✓Michael Waldman ✓**FILE:** Accept*Jen Klein* ✓**COMMENTS:** Date TBD

ROUTING SLIP**DATE:** 5/21/97**FROM:** Stephanie Streett
Deputy Assistant to the President and Director of Scheduling**SUBJECT:** *Satellite Appearance for Kaiser Permanente*Don Baer ✓Katie McGinty Sandy Berger Mack McLarty Erskine Bowles John Podesta Peg Cusack Bruce Reed ✓Rahm Emanuel Dan Rosenthal Maria Echaveste Charles Ruff Jack Gibbons Peter Selfridge ✓Laura Graham ✓Patti Solis-Doyle Marcia Hale Craig Smith Nancy Hernreich Doug Sosnik John Hilley Gene Sperling Kitty Higgins Todd Stern Ron Klain Ann Stock Ann Lewis Kim Tilley Bruce Lindsey Jodie Torkelson Sylvia Mathews Melanne Verveer Mike McCurry ✓Michael Waldman ✓**FILE:** PendingJon Klein ✓**COMMENTS:** _____

SCHEDULE PROPOSAL

5/18/97

37 MAY 20 P12:50

☐ ACCEPT

☐ REGRET

☒ PENDING

TO: Stephanie Streett
Director of Scheduling

FROM: Bruce Reed

REQUEST: Satellite Appearance for Kaiser Permanente

PURPOSE: To highlight the President's leadership on children's health by participating in the launch of Kaiser Permanente's commitment to spend \$100 million over five years to insure uninsured children in California.

BACKGROUND: We have been working with Kaiser on the development of their children's initiative for about two months and feel comfortable that their proposal complements the President's children's health initiative in the balanced budget. At our request, Kaiser did not include their commitment as part of the service summit and did not do an event with the First Lady during her recent visit to California because senior staff thought this would be a good opportunity for the President.

PREVIOUS PARTICIPATION: None.

DATE AND TIME: Suggested dates are June 16, 17, 19, 20 or 23 (during the President's visit to California). Other dates could also be considered.

DURATION: 15-20 minutes.

LOCATION: The White House or in California.

PARTICIPANTS: David Lawrence, CEO, Kaiser Permanente. Other participants not yet determined.

OUTLINE OF EVENTS: President delivers remarks by satellite to event in California launching initiative.

REMARKS REQUIRED: Prepared by speech writing.

MEDIA COVERAGE: Open press. Kaiser expects significant television coverage in California.

FIRST LADY'S
ATTENDANCE: Not required.

VICE PRESIDENT'S
ATTENDANCE: Not required.

RECOMMENDED BY: Bruce Reed, Rahm Emanuel, Ann Lewis, Chris Jennings.

CONTACT: Jennifer Klein 456-2599

ORIGIN OF PROPOSAL: White House Staff generated with input from Kaiser.

SECOND LADY'S
ATTENDANCE: Not required.

SOURCE OF PAYMENT: Kaiser.

GREER, MARGOLIS
MITCHELL, BURNS
GMMB&A
& ASSOCIATES, INC.

To: Jennifer Klein
Karen Finney

From: Roy Behr
Elizabeth Riel

Date: June 11, 1997

Re: Site Locations for Uninsured Announcement

We just wanted to provide you with the addresses and a few details about the three sites we are looking at tomorrow for the uninsured announcement.

Mar Vista Elementary

The school is located at 3330 Granville Ave.; the major cross-streets are Barrington and National Blvds. The school is approximately 1 mile west of the 405 freeway.

Kaiser Permanente Culver Marina Medical Offices

The address is 12001 W. Washington Blvd.; the cross-streets are Washington and Inglewood Blvds. It is about three-quarters of a mile west of the 405 freeway. The offices offer primary care and pharmacy services.

Kaiser Permanente West Los Angeles Medical Center

The medical center is located at 6041 Cadillac Ave.; the cross-streets are La Cienega and Venice Aves. It is one block north of the 10 freeway. The medical center includes a hospital, medical offices, and emergency care. The majority of the patients served are Latino and African-American. Although this facility is a little closer to the Beverly Hills Hilton than the others, it is not on the way from either airport to the Hilton.

We have attached a map depicting the airport and site locations. We will provide more details about the sites after we visit them tomorrow.

