July 29, 1996

Medicine & Health
PERSPECTIVES

Kids' Coverage Crisis: Next Target for 'Consensus' Reform ?

After watching Congress muddle its way from consensus to stalemate on insurance market reform this year, it seems almost cruel to suggest that universal coverage for children may be emerging as the next major target for bipartisan, incremental policymaking.

But the rapid erosion of private health insurance for children is raising alarm in both liberal and conservative circles, and giving new life to old proposals for a kids-first approach to problems of coverage and access to care. The General Accounting Office (GAO) reported last month that the number of uninsured children rose above 10 million in 1994, the highest level in eight years. The American Academy of Pediatrics estimates the number of currently uninsured children under 21 at 12.2 million.

"Neither the general public nor policy makers understand that the existing system of providing medical coverage for children is collapsing," writes David Rosenbloom, associate professor at the Boston University School of Public Health.

The number of children covered by Medicaid increased by almost 5 million from 1989-93, temporarily masking the decline in employment based coverage. But as that expansion has slowed and stopped, the startling decline of private dependent coverage has become apparent, falling from a peak of 67.7 percent of all children in 1977 to just 53.6 percent in 1993, with 900,000 losing coverage in '93 alone, according to a summary of the trends presented by Rosenbloom at a forum in Washington DC earlier this month. In the words of forum participant Sara Rosenbaum, Director for the Center of Health Policy Research at George Washington University, "It is fair to say that where employer coverage is concerned, children are 'the canaries in the coal mine'" — the first casualties in a dangerously deteriorating situation.

The threat to children offers reformers who failed to rescue the uninsured in 1993-94 a tempting second chance to get it right on a more modest scale. The notion of taking care of "children first" has political appeal comparable to the Medicare program.

"When it comes to health care for children and the elderly, the public is far less suspicious of government than is generally believed," according to a group of analysts headed by Wendy Lazarus and Laurie Lipper at the Santa Monica CA-based Children's Partership. "In summary, the experts we interviewed and the research we reviewed supported the conclusion that there is a reservoir of public support for moving a children's health agenda at the federal and state levels," Lazarus, Lipper, and colleagues concluded in a February 1996 report.

"If human service programs are substantially reduced," they wrote, "Congress may look for a 'sympathetic' and relatively inexpensive initiative that shows members to be caring and humane. Health care for uninsured children could be attractive in this context."

The social and economic payoff for establishing a comprehensive system of primary and preventive care would be enormous in the long run. Best of all, this kind of coverage is relatively cheap. An actuarial analysis done for the American Academy of Pediatrics estimates the monthly premium for first dollar coverage of the full regime of preventive services recommended by AAP for children to age 21 — including regular doctor visits, vision and hearing screening, immunizations, lab tests, and counseling — at just $8 per family.

"Having a regular source of care has been shown to reduce per child expenditures by 21.7 percent compared with not having a regular source of care," says AAP representative David Tayloe, a pediatrician from Goldsboro NC. "Providing preventive health care coverage to all children is not only achievable, it is affordable," Tayloe told a panel of Democratic legislators in Washington July 11.

Subsidies for children's health and related programs are already flowing through more than 100 different federal programs, which generate substantial state and local community matching contributions as well and create at least an optimistic starting point for theoretical discussions of how a universal program of children's coverage could be financed. Opportunities abound also for doing creative things with the children's health care delivery system and its supporting mechanisms. Many state and local initiatives have made considerable progress knitting together networks of providers, schools, churches, social service agencies, and philanthropic sources.

"All this is doable, and it doesn't break the bank," says Charles LaVallee, executive director of the Western Pennsylvania Caring Foundation Inc., a model local program launched in Pittsburgh in 1984 by Blue Cross of Western Pennsylvania for children of unemployed steel workers which has been replicated at least in part by more than 20 other Blue plans and has been built on in several state programs.

The principle of local initiative "is something we lost in the health care debate," says LaVallee. "You say to someone, '37 million uninsured' or '10 million kids,' which is what we saw in the GAO report, and I think the average person goes, 'Oh, brother, what can I do?' But if you tell them '1,000 in your county; 100 in your child's school district,' all of a sudden people's eyes open and they go, 'Well, we can be a part of that.'"

But synergy can't be legislated. If universal coverage for children catches on as next year's consensus health reform issue, the trick will be to make national policy that stimulates local energies rather than stifling them.

Visions and Revisions

Testifying to the depth of bipartisan interest in major health system changes for children, a former official in the Bush Administration presented the most radical vision of reform at this month's policy forum in Washington. Martin Gerry, a former assistant secretary of Health & Human Services, called for a thorough rethinking of goals, assumptions, and institutional structures involved in the provision of children's health and wellness services.

It would be "a mistake to think that we can buy our way out" with a system built on professional services, Gerry argued. His proposal, developed at the University of Kansas where Gerry heads the Center for the Study of Family, Neighborhood and Community Policy, is predicated on a broad, nontraditional concept of health encompassing food and shelter as well as school, family and environmental factors. Among the negative health outcomes of the current system, he cites not only poor immunization and low birth weight rates, but also "serious difficulties in learning as a result of depression and anxiety... high rates of undernourishment and malnutrition, accidental injury, abuse and neglect, and high-risk social behaviors." In a paper presented at the forum, Gerry warned that poor child health and wellness outcomes presage "serious long-term economic problems for our nation."

Most proposals for addressing child health needs fall short because of their "failure to focus on the primary causes and *community* nature of most of the problems," he reasoned. Gerry stressed high-risk behavior by adolescents involving drinking, driving, drugs, and sex as particularly glaring examples of the unmet challenges in child health policy.

Accordingly, Gerry's vision of reform entails broad but locally based partnerships as the fundamental units in a new kind of health and wellness system for children and families. The local networks could include school systems, youth groups, neighborhood and civic organizations, Head Start programs, churches, law enforcement, and service agencies as well as doctors, clinics, hospitals, and mental health providers. He calls for creation of a national child health board to oversee the promulgation of goals and coordination of resource allocation for the local partnerships.

Gerry's proposal highlights a paradox that underlies the discussion about children's health reform: Locally based approaches with broad community participation seem to hold the most promise but also to be the least likely to jell as coherent national policy. Historically, most attempts to address the special health needs of children have been much less imaginative, generally focusing on ways to stretch Medicaid or eke out subsidies to make private coverage affordable for working families. Radical reimagining and restructuring of the system of care and family support have not been on the agenda.

Indeed, a review of current policy options entails a painful reprise of earlier efforts that fell short, Rosenbaum noted. The most obvious example is the health insurance earned income tax credit authored by former Senator and Treasury Secretary Lloyd Bentsen, which was enacted in 1990 and then repealed in 1993 after a series of malfunctions. President Bush took a similar tack with his 1992 proposal for a low income tax credit coupled with a new health insurance deduction for higher tax brackets.

The AAP made its initial "Children First" proposal in 1989, to guarantee comprehensive benefits for children through age 21 and all pregnant women. The proposal was incorporated into a legislative proposal by Rep. Robert Matsui (D-CA) in the 102nd and 103rd Congresses, with a companion measure proposed by Sen. Christopher Dodd (D-CT) but eclipsed by the debate over the Clinton plan. Rep. Sam Gibbons (D-FL) proposed a Medicare model for children during the 102nd Congress, and has now renewed the idea in the current session as one of several options in the Democrats "Families First" election year platform.

The serious operational problems and eventual repeal of the Bentsen tax credit bill warn of the difficulties of a subsidy program built on the employer based system, according to Rosenbaum. But in an analysis of policy options for children co-authored by GWU colleague Phyllis Borzi, she concludes that "the purchase of employer coverage is an essential element of any reform plan considered for children in the next few years." Despite its weaknesses, the employment-based system still insures a majority of all children, and subtracting children from that system to create a separate insurance pool could lead to a catastrophic collapse of the existing system for adults, Rosenbaum cautions.

Steel City Blues

As with insurance reform and the transformation of Medicaid into a state-based managed care program,

children's health reform is a policy area that is evolving out of the interplay of community, state, and federal experiments with public and private programs. In this process, western Pennsylvania's experience with the Blue Cross Caring Program for Children has been a seminal event.

As heartening as the story is, the Caring Program began under ominous circumstances, with the loss of 125,000 jobs in the steel industry in the Pittsburgh area in the early '80s. A Presbyterian clergyman who in a former life had been a steel executive and a member of the Blue Cross board of directors launched the effort with a call to the CEO at Blue Cross in Pittsburgh in 1984. The plan had fashioned a low-cost product for unemployed steel workers the previous year, and responded to the new request by negotiating special rates with providers, focusing on primary care, donating administrative costs, and matching private donations to subsidize children's coverage for the city's new echelons of working poor.

"Neither the general public nor policy makers understand that the existing system of providing medical coverage for children is collapsing"

LaVallee remembers a fund raising event in Lawrence County, about 65 miles from Pittsburgh, where three local hospital executives convened a group of 100 community leaders to hear his pitch. "I told them none of their money would go down to Pittsburgh. It would all stay right here," he recalls. "In one night they raised enough for a third of their kids."

The success of the Caring Program in western Pennsylvania can be measured by several indicators. The program has provided free private coverage to 45,000 children since 1985. It has been replicated by other Blue plans in 23 states serving an estimated 120,000 children in 1995. And it forms the foundation for a state-sponsored, tax-supported children's health insurance program that was created in Pennsylvania in 1993 and currently provides subsidized coverage to 50,000 kids. Blue Cross and Blue Shield Caring Programs in other states have also given rise to a variety of public-private hybrids.

But the most significant lesson from the Pennsylvania experience may lie in the progression of the Caring Program from a bare bones subsidy for limited primary care benefits to a much more comprehensive program built on extensive local provider and support networks, which was also politically attractive enough to win tax funding.

In the process of building the program, the western Pennsylvania community has created interlocking networks of institutional support that bring Gerry's notion of community child health partnerships to mind. Reaching out to engage underserved populations is a crucial piece of all safety net programs, but is also a process that can create new relationships and tap new resources.

"It's not like you can just put up a sign on a billboard and say come get your free insurance," says LaVallee. "You really have to work the community." School systems are major outreach partners in the Caring Programs in Pennsylvania and elsewhere, as are physicians, hospitals, pharmacists, churches, and social agencies. Pittsburgh's professional athletes are major public relations assets in Pennsylvania, as is children's TV immortal Fred Rogers.

"We have tried to build it into the fabric of the community," LaVallee says. "We knew philanthropy [alone] couldn't solve it. But if you could develop a model with a strong provider network, administrative efficiency, and outreach expertise, if you could put those components together, you would be in a position later to receive larger dollars and help more kids, and that's what happened to us," he says. "Now we get more money in a month from the cigarette tax than we do in a year of fund raising, which was a dream come true."

The GAO reported early this year that in 1995, 31 states had either public or privately funded children's health insurance programs, including 14 state-sponsored programs funded primarily with public dollars. The largest of the state programs, New York's Child Health Plus, had nearly 105,000 children enrolled in primary care coverage in 1995 on a budget of $76.5 million funded by a surcharge on hospital rates and beneficiary cost sharing on a sliding scale, according to Lazarus and Lipper.

The largest of the state experiments, apart from Medicaid expansions and a major state program in Minnesota that has now been rolled into Medicaid, served respectable but limited numbers in 1995. They include:

- the Florida Healthy Kids Corp., with 13,500 enrollees receiving inpatient and outpatient coverage on a $12.2 million budget that includes state and local community funding as well as cost sharing;
- the Massachusetts Children's Medical Security Plan, with 16,400 children covered for primary care and preventive services on a $14 million budget funded by a state cigarette tax and cost sharing; and
- California's Access for Infants and Mothers, which provides comprehensive benefits to 11,000 children on a $58 million budget also funded by a tobacco tax and cost sharing.

The GAO notes that the New York program covers

only about one-fifth of the state's half-million uninsured children, and that the dent made by other programs was usually even smaller. Similarly, even the most energetic private efforts may have only minimal impact. Confronting hard core rural poverty, for example, Blue Cross and Blue Shield of Alabama's Caring Program has been providing coverage since 1988 and has woven a network of 6,000 providers. But in 1995 the program covered fewer than 6,000 of the state's 156,000 uninsured children on its $1.2 million charity budget

"Almost all of these programs have had to restrict enrollment and develop waiting lists of children who could not enroll because of insufficient funding," the GAO report observed. Lazarus and Lipper cite a 1995 National Governors Association estimate that 317,000 previously uninsured children have obtained new coverage from state financed programs. "However, important as they are, state-level programs are generally modest and their effects are proportionally small," they note, and state officials are bracing themselves to cope with new increases in the ranks of the uninsured as planned Medicaid austerity measures take hold.

"You Don't Need $10 Billion"

In its most recent report on uninsured children in June, the GAO estimated that of 14.3 million children eligible for Medicaid, 2.9 million, more than 20 percent, were for some reason not enrolled and not receiving benefits under the program — were, in other words, still effectively uninsured. Lack of knowledge, procedural barriers, unwillingness to accept public handouts, and provider availability all seem to contribute to the gap.

The GAO notes that outreach to children's families in the traditional Medicaid fee-for-service program "has focused more on encouraging the use of preventive care by enrolled children than on informing nonenrolled families that their children may be eligible." The report goes on to say that, "Fiscal pressures may have made some states less interested in expanding the number of children receiving Medicaid than they were several years ago."

Similarly, managed care plans in states with Medicaid waivers have little incentive to beat the bushes for Medicaid eligibles, as traditional publicly-funded, mission-oriented safety net providers such as community health centers have done. Currently, health centers and public health agencies provide many essential primary care services such as immunization and screening to uninsured children. But they have been subsidizing these services through the bounty of the traditional Medicaid fee for service program, which pays health centers on the basis of costs. As states turn to capitated payment for Medicaid, these subsidies will quickly dry up. Rather than masking the decline in employment based coverage for children, the impending contractions in Medicaid funding are sure to exacerbate it. Not only will coverage ebb, but the already tenuous community infrastructure that links children with services may begin to crumble.

Democrats are offering a range of proposals. Earlier this month, Rep. Frank Pallone (D-NJ) outlined a "'kids-only' insurance" concept that would require any insurer that does business with the federal government to offer comprehensive policies for children under 13. Such coverage could be underwritten for an estimated $1,000 per child per year, and the proposal includes unspecified subsidies. Gibbons proposes a similarly ambitious program of comprehensive coverage modeled on Medicare. The Republican majority counters by referring to its 1995 $500 per child income tax credit proposal as a more prudent approach.

If the least common denominator turns out to be a modest subsidy program, and Congress miraculously comes to closure on it, the deterioration of the existing system might be at least temporarily checked. But Gerry's theoretical model as well as the Blue Cross experience in western Pennsylvania suggest that with or without subsidies, the responsibility for building an adequate infrastructure of children's health services will ultimately rest on state legislatures, town and county governments, school districts, municipalities, hospitals, clinics, doctors, nurses, druggists, nonprofit social service agencies, private insurers, the business community, families, neighborhoods, churches, and friends.

"Taking care of our children is a rather simple issue. Unfortunately we have politicized it and we've overcomplicated it," says LaVallee. Policymakers too often excuse inaction by citing the overwhelming numbers, wringing hands over where to find $1,000 each for 10 million uninsured kids. "That's not the reality. You don't need $10 billion because they're not all going to come right away. You gotta find them first." —*R.C. Next week: community health centers and managed care.*

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HEALTHCARE INFORMATION CENTER

MEMORANDUM

TO: Chris Jennings

FROM: Irwin Redlener, MD

DATE: July 19, 1996

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

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

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

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

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

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

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

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

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FOUR APPROACHES THE U.S. COULD TAKE TO PROVIDE HEALTH COVERAGE TO MILLIONS OF UNINSURED CHILDREN

In 1994 alone, almost 1 million of this country's children lost their medical care coverage. That number continues to rise, primarily due to a rapid collapse of employer-based health insurance for employee's children. Given this trend, The Robert Wood Johnson Foundation commissioned health care experts from a broad ideological spectrum to identify what the nation can do to provide our nation's children with the health care coverage they need. These experts presented four proposals that the nation could adopt to solve this problem. (See attached summaries)

For a complete copy of the papers, "Providing Universal Health Insurance Coverage to Children: Four Perspectives," please contact The Robert Wood Johnson Foundation at 609-243-5931.

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OPTIONS FOR CHILDREN'S UNIVERSAL HEALTH ACCESS

McManus Health Policy, Inc.

Center for Health Policy Research,
The George Washington University Medical Center

The Center for the Study of Family, Neighborhood and Community Policy, University of Kansas

Hudson Institute

McManus Health Policy, Inc.

Options for Children's Universal Health Access

	Option 1 - A Voluntary and Incremental Approach	Option 2 - Basic Health Insurance and a Special Wrap-Around Plan	Option 3 - A Community Formula-Grant Approach
Basic Approach	Builds on existing systems by adding two new programs. Health insurance purchasing cooperatives would be created to reduce insurance costs and increase family choice. Premium subsidy programs would be created to help families with uninsured children purchase coverage.	Expands access to basic health insurance through employers and Medicaid. Establishes a new public "wrap-around" health insurance plan to meet the special health needs of all children.	A new state and community formula grant program would replace all existing forms of health insurance and publicly funded children's health programs. Communities would decide how to use grant funds in meeting their children's health needs.
Eligibility	All children could obtain reasonably priced health insurance through employer-sponsored coverage, Medicaid or the premium subsidy programs.	Basic coverage would be provided through expanded employer and Medicaid coverage, including subsidized premiums. A new supplemental insurance program for all children would be created for specialized service needs.	All children would be automatically enrolled for coverage in the new community service delivery system.
Benefits	A standard schedule of benefits would be created, similar to those offered by large HMOs. This schedule would be used by plans participating in the purchasing cooperatives.	The basic insurance benefit package would offer traditional medical services. The public wrap-around plan would include comprehensive therapies and other services needed by children with chronic physical, behavioral, emotional and developmental conditions.	The benefits would be comprehensive and include both traditional medical services and all therapeutic and other services to meet children's specialized health care needs.

	Option 1 - A Voluntary and Incremental Approach	Option 2 - Basic Health Insurance and a Special Wrap-Around Plan	Option 3 - A Community Formula-Grant Approach
Administration	The premium subsidy program and purchasing cooperatives would be operated by states under federal guidelines. Medicaid agencies and premium subsidy program administrators would purchase coverage through the cooperatives. Employer participation would be encouraged.	Basic health insurance plans would be provided by Medicaid and employers. The wrap-around plans would be administered by new state agencies under federal guidelines.	Operating under federal guidelines, new community child healthy development agencies could choose to purchase private health insurance, provide for direct delivery of services, or some combination of both.
Financing	The purchasing cooperatives would be self-funded. The premium subsidy programs would be financed federally and could be funded through a variety of means, including a hike in tobacco taxes.	No new funds would be required for basic health insurance. A federal children's health care trust would be created to finance the wrap-around plans. Monies would come from discontinued public programs such as MCH block grants and special education, and new taxes.	A federal children's health care trust would be created to finance services through formula grants. Monies would come from discontinued programs, such as MCH block grants and special education, and new taxes.
Strengths	The approach is based on volunteerism rather than mandates. Managed care and increased competition would be used to achieve savings and increase choices. Only modest increases in public spending would be needed.	Children's health care needs, including developmental and chronic care needs, would be addressed in a comprehensive fashion. Categorical programs for children would be eliminated and replaced with uniform coverage for all children.	Communities would be empowered to address the health care needs of their children. All children would have access to a comprehensive array of services. Inefficient categorical programs would be eliminated.
Weaknesses	Would not result in universal coverage. Builds in inefficiencies and waste in current system. Reduces pressures to adopt fundamental reform.	Significant new revenue sources would be required to provide supplemental coverage for comprehensive services.	Differences in access to services could result across communities. Some communities would fail in their attempts. Significant new revenues required.

Center for Health Policy Research, The George Washington University Medical Center

Options for Children's Universal Health Access

Basic Approach	Voluntary and universal approach; builds on existing system by offering insurance subsidies to families with uninsured children to buy into employer-sponsored health plans; retains Medicaid for low-income children with no access to workplace coverage and for children's chronic and long-term care needs. Federal grants to states to develop purchasing pools for enrollment of uninsured children without employer coverage in plans meeting specific standards.
Eligibility	All children could obtain reasonably priced coverage through employer-sponsored health plans, state purchasing pools, or Medicaid.
Benefits	A standard schedule of benefits would be provided, including coverage of preventive services, medical care, hospital coverage, laboratory and x-ray and other diagnostic services; short-term rehabilitative services, prescription drugs, and other services commonly used by children; Federal guidelines for family coverage definitions, deductibles and copayments.
Administration	The purchasing pools would be operated by states under Federal guidelines; premium subsidies could be administered either at the state or Federal level. The existing Medicaid Section 1902(r)(2) option would be retained to permit states to cover any child with a need for medical care but would be modified to permit the use of premiums in the case of families with moderate incomes or higher (in excess of 250% of Federal poverty level).
Financing	Once established, the purchasing pools would be largely self-financed. Federal grants would be available to states to develop pools. The premium subsidy program would be financed federally through general and dedicated revenues (e.g. tobacco tax). Depending on family income, premiums would be required.
Strengths	Voluntary approach rather than mandate; builds on familiar approach; existing system of employer-provided coverage; retains children who are less costly to insure in the financing base of employer plans, thus keeping adult coverage more affordable; encourages employers to continue dependent coverage; state purchasing pools would increase choice for families; retains Medicaid for types of services employer plans unlikely to provide; politically more viable because not a mandatory approach and not threatening to employer plans.
Weaknesses	Would not result in universal coverage; expansion of coverage for children directly related to the generosity of the subsidy structure; retains the inefficiencies and lack of portability inherent in employer coverage for children; exacerbates the problem of lack of consumer protections for individuals under ERISA-covered plan because children currently in Medicaid where some protection exists would be moving into employer plans where virtually none does; reduces pressures to adopt fundamental reform.

The Center for the Study of Family, Neighborhood and Community Policy, The University of Kansas

Options for Children's Universal Health Access

	Community Child Health and Wellness Systems
Basic Approach	A new trust fund-financed network of community child health and wellness systems would replace all existing public and private health insurance for children and all publicly funded children's health programs. Community systems would set priorities and design the infrastructure to respond to a wide range of child health and wellness needs (including information, clinical preventive services, active care and treatment, and health maintenance.) These systems will also address complex wellness problems (e.g., depression) and cross-cutting health and wellness issues (e.g., prevention of adolescent pregnancy).
Eligibility	Universal for all children (aged 0 - 17), pregnant women and new mothers.
Benefits	Comprehensive and tailored to individual communities. Built around 12 core capacities, including sick child care, food and nutrition, emergency shelter, environmental health and prevention of high-risk adolescent behavior.
Administration	A combination of community health and wellness partnerships and local child health and wellness consortia, with state certification, oversight and equity protection. Systems are designed to link naturally with other children's services and community-building and revitalization efforts.
Financing	Through the reprogramming of existing funds and a new, dedicated Federal payroll tax. Incentives are created for prudent purchasing leading to positive child wellness outcomes. Global budgets provide automatic cost-containment, and local negotiation of provider fees permits elimination of intrusive managed care approaches.
Strengths	Universal access to care; creation of a primary care infrastructure for children; comprehensive child wellness orientation; community-owned, managed and accountable; stable and dedicated financing structure; built-in cost containment and incentives for prudent, outcomes-driven management; potential cost-saving to business; and elimination of current interference by managed care strategies in the provision of care.
Weaknesses	Significant new revenues required; major investment in community capacity-building; potential for equity/fairness problems; untested in the United States.

Hudson Institute

Options for Children's Universal Health Access

	Option 1 -The Longer Term Repeal tax exclusion for health insurance. Credits allowed/required for purchase of health insurance.	**Option 2- The Short Run** Piggyback on the welfare reform debate.
Basic Approach	Wait as political support for the health insurance tax exclusion erodes, with ever smaller shares of the population covered, and finally collapses as Baby Boomers contemplate retirement. Uses resources made available by repeal to allow/require purchase of health insurance through tax credits. Those resources approximate those necessary to purchase high deductible policies. As employers exit the health insurance market because repeal removes their reason for being there, "reverse" Medical Savings Accounts become prevalent.	Utilizes the welfare reform debate to address the question of coverage for low income families generally. Uses AFDC-Medicaid funds in a particular state to establish an income based sliding scale of health insurance subsidies for low income families, both former welfare recipients and former working poor. Preferred arrangement would be subsidized MSA's.
Eligibility	All children would have access to at least catastrophic coverage.	All low income households. "Low income" would be determined in each state by AFDC-Medicaid resources, numbers of former welfare recipients and working poor, and the phase-out schedule calculated by authorities.
Benefits	Would depend upon the type/deductible level purchased.	At a given income level, would vary state by state.
Administration	Would be handled by a more competitive version of the current individually-acquired insurance market. Purchasing "cooperatives" might be arrived at through voluntary arrangements: place of work, churches, etc.	Could take a variety of forms. Authorities could purchase a blanket high deductible for enrollees.
Financing	Self-financing	Self-financing
Strengths	No "new" public resources needed. Prevalence of "reverse" MSA's should produce cost-controlling pressures. Relies on a broad political consensus that is highly likely to evolve naturally.	No "new" public resources required. Uses a political debate that is taking place anyway to force the political system to address health coverage for low income families generally. Coverage for "low income" (often uninsured) families would be universal. MSA's would teach a sense of personal responsibility to former welfare recipients without risk of catastrophic consequences from unwise behavior.
Weaknesses	Very long-run strategy. Requires 10-20 years for the political consensus to evolve. Does not wholly address the question of below-catastrophic coverage.	Not every state will tackle major welfare reform. Requires acceptance of a new lower-class entitlement.

	Option 3 - The Short Term COBRA counseling.	**Option 4 - The Short Run** Make the EITC a better vehicle for purchase of health insurance.
Basic Approach	Observes that many employers fail to notify leaving employees of COBRA rights. Many state Unemployment Compensation agencies also do not do so. Uses small "planning" grants to encourage UC agencies to inform new registrants of COBRA rights.	Low income uninsured have a "liquidy constraint" in using their future lump sum ETIC payment to purchase health insurance should they so choose. Uses either private markets or a transferable credit to facilitate health insurance purchase.
Eligibility	Employees and their children who would have bought COBRA coverage had they known about it.	All EITC recipients.
Benefits	For one year, former employer's insurance coverage.	Whatever health insurance EITC recipients might choose to purchase.
Administration	Former employer.	Would require cooperation of IRS and state employment authorities.
Financing	Voluntary, from former employee.	Self-financing.
Strengths	Immediate, simple, cheap.	No "new" public resources. Utilizes existing vehicle already targeted to low income families with children.
Weaknesses	Targets only a particular subgroup of uninsured; those COBRA-eligible, uninformed about COBRA, and unwilling to buy more expensive individually-acquired insurance but willing to pay the COBRA amounts.	Administrative problems may be large compared to benefits. Targets only a (possibly small) group of EITC recipients who want to buy health insurance but cannot budget for it.

Kids coverage - specifics beyond original proposal

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

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

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

4. Subsidies: form, schedule still pretty open -

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

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

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

Portion of premium subject to subsidy

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

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

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

Extended Page 1.1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
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Number of Pages (Including Cover): 2

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

"Children's Health: ~~Congress~~ Grant v. Medicaid"

Children's Crusade

There's at least $16 billion available to help more children get health care. But on Capitol Hill, there's a bitter dispute over how the money should be spent. Give the states the money, some say, and let them bolster novel health care programs such as Florida's Healthy Kids. Others want to expand Medicaid.

BY MARILYN WERBER SERAFINI

HOLLY HILL, FLA.—When Marlene Telfare took her 10-year-old son, Michael Smith, to the Halifax Hospital emergency room last year, his high fever wasn't the only thing worrying her. Medicaid had dropped Michael's coverage six months earlier. "Oh, my gosh," Telfare said, "they didn't want to see him at all."

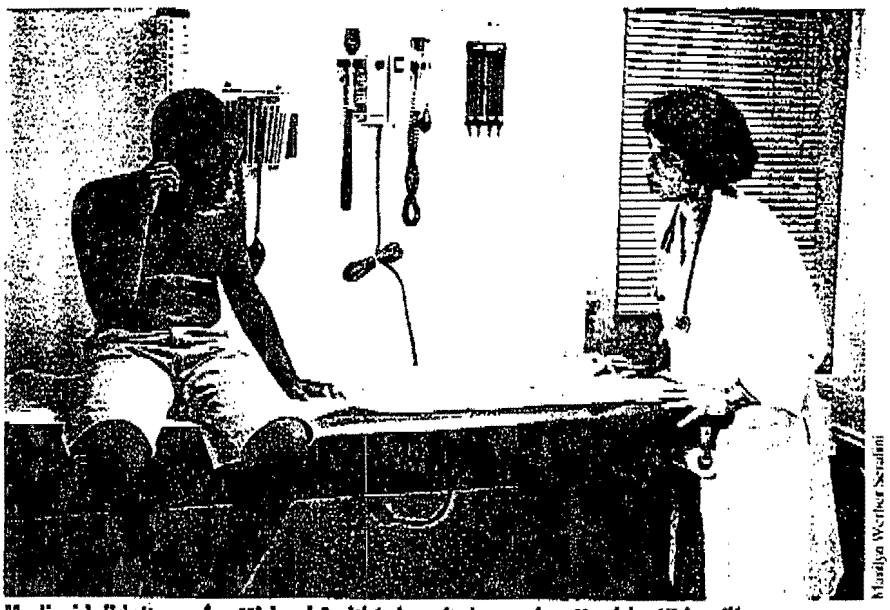
Telfare, a single mother of two who earns $22,000 a year, reluctantly dug out her credit card and decided that she'd deal with how to pay the $500 bill another day. Fortunately, Michael was fine and the hospital forgave the bill. But what about getting Michael insurance? Telfare makes too much money to qualify for Medicaid. Her job doesn't offer health insurance to new employees, and buying an individual policy is just too expensive.

Telfare turned to the state's Healthy Kids program. Michael is one of 60,000 children in Florida who next year will get medical care through Healthy Kids. Local and state governments subsidize the coverage, then parents pay on a sliding scale depending on what they can afford. Telfare, for example, pays a $10 monthly premium (some people pay as much as $50), plus modest co-payments for office visits, prescription drugs and other medical services.

As Congress and the Clinton Administration agonize over providing health care to the nation's 10 million uninsured children, health policy analysts are looking to state programs like Healthy Kids for lessons. During the past several years, many states have established health care programs for uninsured children. Their approaches vary, from public-private partnerships such as Healthy Kids to expansions of Medicaid programs.

In Washington, for once, finding the money isn't the problem. As part of the proposed budget deal, Republicans and Democrats have agreed to appropriate $16 billion on children's health care over five years. The Senate agreed to an additional $8 billion, which will be funded by an increase in the excise tax on tobacco. The House and Senate will have to resolve their differences. But the bigger question is, how do you spend the money so as to deliver health care to the most children? Members of Congress are divided over the issue.

Some key Members of the House as



Marilyn Werber Serafini

Medicaid didn't pay for Michael Smith's hospital care, but Healthy Kids will.

well as the National Governors' Association (NGA) prefer block grants for the states. The money in the block grants would allow states to expand Medicaid eligibility to some children whose families now earn too much to qualify. The states could use the money to reach out to the three million kids nationally who now qualify for Medicaid but who aren't signed up. They could also use the federal dollars to start programs such as Florida's Healthy Kids. Or the states could approve tax credits that would allow parents to buy insurance to cover their children. Or states could do some of each.

The states, according to the NGA, have the experience to make the best health insurance decisions, and Congress should give them the flexibility to do so. They already cover a total of 17 million children on Medicaid and regulate private insurance.

"States can use [the block grants'] flexibility to design new programs to fill gaps in existing systems of care. Or, funds could be used to expand existing programs to reach new populations," says an NGA position paper.

But critics complain that there's no accountability with block grants. "You don't give money to governors who are under [financial] pressure and hope they'll use it for kids," Sen. John D. (Jay) Rockefeller IV, D-W.Va., said. "It might end up transporting seniors to centers where they can get nutritious meals, and that's good, but it's not going to kids."

Some states might use the federal dollars to replace state money currently being spent on children's health care, said Ronald F. Pollack, executive director of Families USA, a nonprofit advocacy group. "Some want to provide more money to hospitals and other providers that may serve kids, but maybe not *more* kids."

The Senate voted on June 25 to give the money to the states through a block grant, but only if the states agree to cover poor children through age 18 under Medicaid. The Senate adopted a Finance Committee compromise that may further complicate House-Senate negotiations on the balanced budget bill.

Finance Committee chairman William V. Roth Jr., R-Del., along with Senate GOP leaders, had wanted a block grant similar to the one that the House passed. But Rockefeller and Sen. John H. Chafee, R-R.I., two influential Finance Committee members, offered a proposal that would have required states to spend any additional federal dollars to expand Medicaid enrollment. Chafee argued there was no need to create an expensive bureaucracy to cover children when an efficient system is already in place. The compromise includes elements of both proposals.

Senate and House conferees are also likely to revisit the Senate's new tax on tobacco—$8 billion of which is earmarked for kids' health care. The House bill has no such provision. Sens. Edward M. Kennedy, D-Mass., and Orrin G. Hatch, R-Utah, had originally proposed a bigger tax on tobacco. But the Senate rejected the proposal when it considered the fiscal 1998 budget resolution.

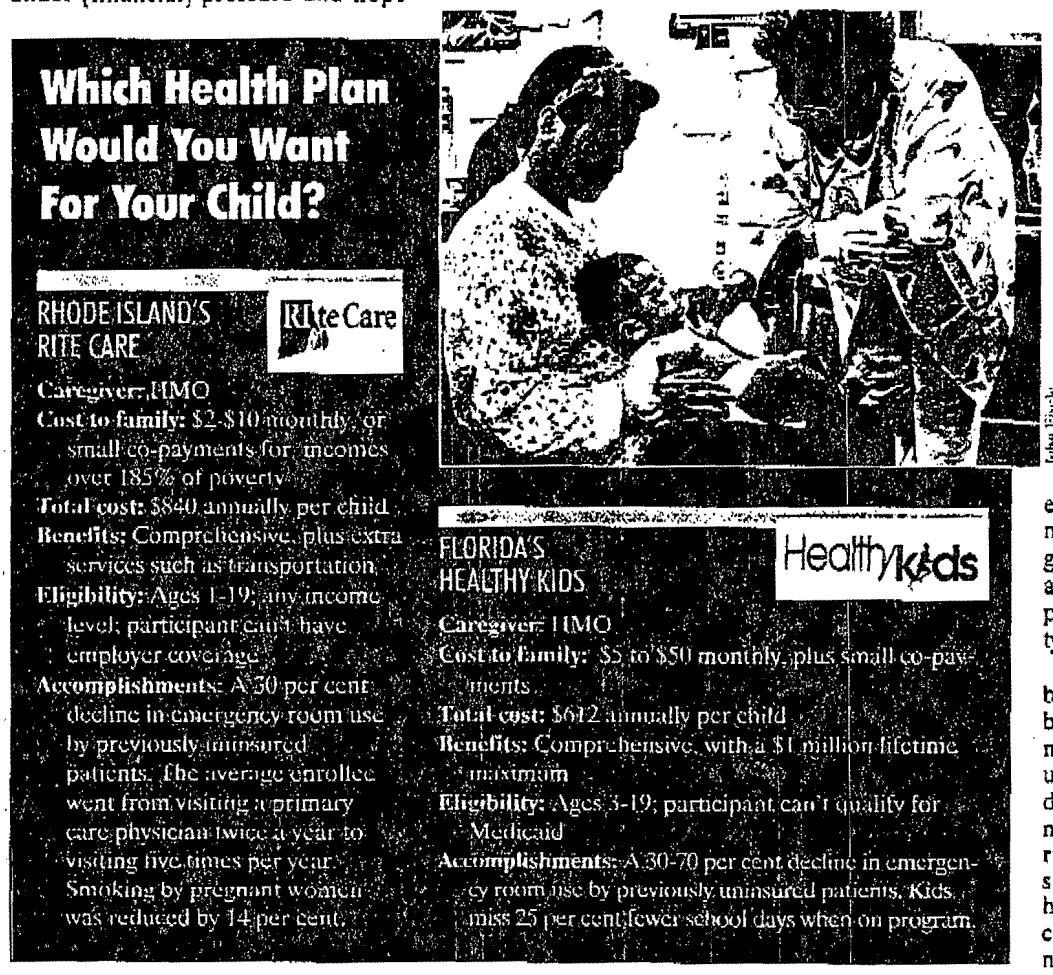
HELPING KIDS

Divided equally, $16 billion could deliver $64 million a year to each state for five years. In Florida, that would be enough money to enable the Healthy Kids program to insure at least 100,000 more children.

But is it more cost-effective for the states to cover children with a program like Florida's Healthy Kids or for Congress to require states to cover more children under Medicaid? Programs such as Healthy Kids appear to cost less.

Under Medicaid, providing health care to a child costs $900 a year, according to a recent report by the Robert Wood Johnson Foundation, a nonprofit organization based in Princeton, N.J. The federal government and the states split the cost, and the family usually pays nothing. Healthy Kids pays selected Florida health maintenance organizations (HMOs) about $612 annually to cover a child for a year, the report said. The federal government kicks in nothing; the state, the local government, the families and sometimes medical providers in the community foot the bill.

Medicaid is expensive because it offers numerous benefits that children don't need, said Rose Naff, executive director of the Florida Healthy Kids Corp., a nonprofit company that runs the program for the state. "Kids are basically healthy, and really high-cost services are rarely needed," she said. So when



John Fischetti

Medicaid pays an HMO to cover a kid, there's plenty in the negotiated benefits package the child will never or rarely use, Naff said.

Healthy Kids—which gets no federal money—can make up its own rules. On the other hand, Congress has imposed numerous mandates on the states that force them to provide generous benefits to Medicaid beneficiaries. Also, states can't ask Medicaid participants to contribute to the cost of their care.

Healthy Kids coverage isn't skimpy. The program includes numerous benefits, from eyeglasses to organ transplants. But there is a limit. There's a $1 million lifetime cap on health care costs. (Naff says no kid has bumped up against it.) Mental health visits are limited to 20 per year; Medicaid has no such limits. Healthy Kids requires a minimum co-payment of about $3 for each doctor visit and for a prescription. Medicaid charges nothing; employer plans charge from $5-$10.

"We asked, what do kids need, and not, what did insurers want to offer," Naff said. The program is big on preventive services. Kids get checkups, which include immunizations, a physical exam and lots of advice about safety and nutrition.

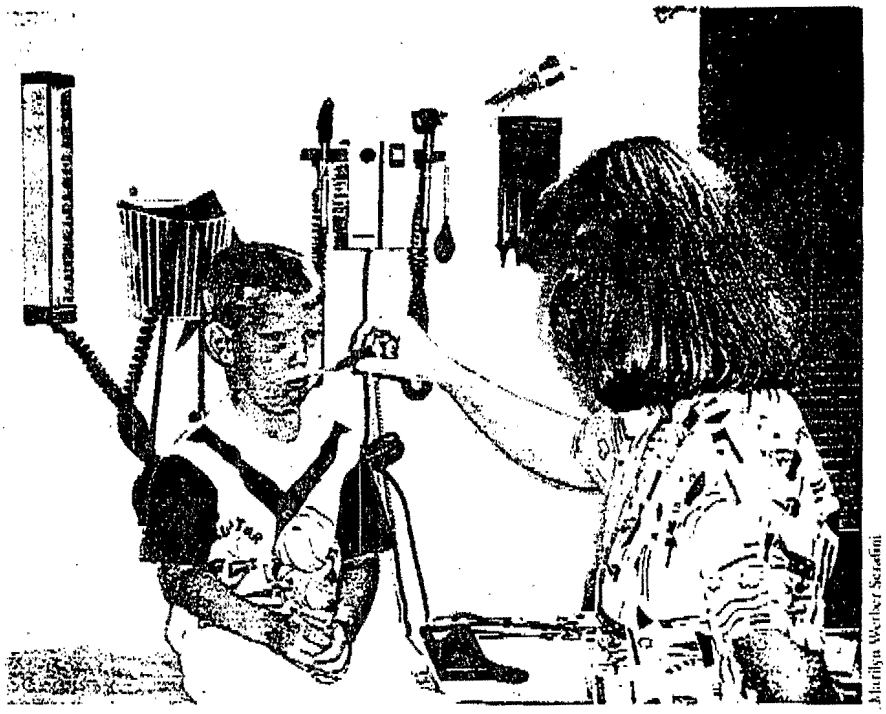
OUNCE OF PREVENTION

In Florida, 4-year-old Brandon Jones had never had a checkup before this year. Brandon and his three siblings, ranging from 2 to 10 years old, have been lucky: Even though they participate in activities such as karate, none has ever broken a bone or been rushed to the emergency room.

Their parents earn about $22,000 a year building pool enclosures. They're currently self-employed, but even the companies that had employed them were so small they didn't offer health insurance. "When the kids get sick, you'd like to run to the doctor or hospital, but it could cost $300. If you don't have it, you've got to stop and think if it's really necessary," said Andrea Jones, Brandon's mother.

With Healthy Kids, though, Brandon recently had his first wellness checkup. These checkups sometimes catch chronic but untreated problems. Asthma, for example, is an ailment that doctors often diagnose during a checkup, according to Gemma D'Souza, a pediatrician with the Healthy Kids program.

Florida Health Care, the HMO that has contracted to treat Healthy Kids participants in Volusia County, is not what you'd expect from a subsidized health care system. It's clean and cheerful, with Disney characters on the walls. Patients are seen promptly—although some would rather stay in the waiting room and watch *The Lion King* on video or run around in the well-equipped playroom.



Marilyn Werber Serafini

Healthy Kids pays for checkups that catch chronic but untreated conditions.

Healthy Kids officials tout several of their program's features as innovative. In fact, the Robert Wood Johnson Foundation has set aside $3 million to help other states replicate the system.

The program has adopted a novel enrollment approach. Schools send students home with notes that inform parents about Healthy Kids, and parent orientations sometimes include a briefing about the program. Eligibility is based on the national school lunch program. Families that are on the free lunch program and earn less than $19,000 a year pay from $5-$10 a month in premiums; families on the reduced-payment lunch pay $15-$20 in premiums; families earning more than $28,000 pay the entire premium. Overall, families contribute 35 per cent of the program's cost. In 1998, families will pay an estimated total of $11.6 million. Meanwhile, Florida kicks in $16 million, and the rest comes from the local communities.

The extra federal money may come in handy for expansions that program officials would like to make. Healthy Kids's greatest limitation: The program doesn't pay for children under 3 years old, because they are the costliest group of kids to cover. "The 1-to-2-year-olds use health care at a higher level than 3 and up. It's a money decision that we made," said Deanna Schaeffer, executive director of Healthy Families, which administers the Healthy Kids program in Volusia County.

ADVANTAGE MEDICAID

Expanding Medicaid also has advantages. For starters, the states already have Medicaid programs in place. Rhode Island pools all of the uninsured kids into one program, called RIte Care. That gives the state enough leverage to secure favorable financial deals with managed care plans that serve children.

There's also less confusion for families in Rhode Island than in states that have more than one program for uninsured children, said Christine C. Ferguson, director of the state's Department of Human Services (and a former Chafee aide).

All uninsured kids in Rhode Island are eligible to join. The program costs $840 a year per child. It has reduced both children's emergency room visits and their hospital use by more than a third. Unlike Florida's Healthy Kids, Rhode Island's RIte Care covers children under 3, and it has improved the health care of expectant mothers. After entering RIte Care, more women got early prenatal care and fewer pregnant women smoked.

So why don't all Members of Congress support using the $16 billion to expand Medicaid programs, as Chafee and Rockefeller want? One reason is, Medicaid has some problems. It's perceived as a huge government bureaucracy, and most Republicans would prefer to hand over the decision of what to do with the money to the states.

As many as three million of the nation's 10 million uninsured children qualify for Medicaid, but their families

don't participate in the program. Nobody is sure why. Part of the problem is that some families don't want to be viewed as getting welfare handouts, according to some health policy analysts.

Many Florida residents have demonstrated their dislike for Medicaid. Hundreds of families in Volusia County that are on Medicaid have applied for the Healthy Kids program.

A recent survey of the Healthy Kids applicants indicated that the families wanted to distance themselves from the government Medicaid program, even though they'd have to go from paying nothing to paying both premiums and copayments. When asked why, one-third of the survey respondents said Healthy Kids was affordable; more than half said it was high-quality; one-quarter said they preferred the choices of doctors; and one-quarter said they didn't want government assistance and the stigma of Medicaid.

"I don't know too much about Medicaid. I would rather have a normal insurance that didn't involve the government so much," a respondent said. Another added: "Medicaid used to send me to a poor doctor. All their doctors are quacks. I feel that Healthy Kids would give me a better choice of doctors."

Telfare said that Medicaid assigned Michael to a primary-care doctor whose office was more than an hour's drive from their home. And they encountered long waits before the doctor could see them.

But while the problems surrounding Medicaid may be hard to shake, it's important to note that today's Medicaid has changed. While it used to be a bureaucratic mess, in many states it's now difficult to differentiate it from a private health care plan.

The Robert Wood Johnson Foundation report says that RIte Care is one of those programs. "Families with children entering . . . RIte Care often do not feel (or know) that they are in a Medicaid program." That's partially because those states have received waivers from the federal government to charge premiums and to deliver care through private-sector managed care plans.

Rhode Island contracts with four health plans to deliver health care to Medicaid recipients. "It's simple, we've got a system in place, we can enroll people easily," Ferguson said. "It doesn't make sense to recreate something . . . for political reasons. Our program is private-sector. We negotiate with the private sector. It makes a whole lot of sense."

LESSONS TO LEGISLATORS

Proponents of the two approaches aren't slamming each other. They just want to make sure that their own programs can continue and even expand. Many involved in the debate think there's a place for both an expansion of Medicaid and innovative state programs—or even a combination of both—if there's flexibility.

"Our goal is for kids to have coverage," Healthy Kids' Naff said. "Any vehicle that creates more access is a good thing. With Healthy Kids, we're meeting 50 per cent of the need [in Florida], but it's obviously not the answer for everybody."

Medicaid and independent programs can work cooperatively together, Naff added. In fact, she is now seeking a Medicaid waiver to allow Healthy Kids to collect Medicaid matching funds. That would make Healthy Kids a little bit more like Medicaid. A federal waiver is needed because Healthy Kids does some things that Medicaid doesn't allow, such as collecting premiums and also contributions from businesses.

Marilyn Wexler Serafini

Schaeffer: Medicaid covers younger kids.

And Healthy Families' Schaeffer said that she wouldn't want Medicaid to disappear, because Healthy Kids can't afford to cover children under age 3.

Program administrators want the flexibility to experiment with how much participating families are willing to contribute to their health care. The Washington Basic Health Plan, for example, saw a spike in enrollment after reducing the family's share of premium rather significantly in 1995. Florida's Healthy Kids, meanwhile, lost 2,000 participants after increasing premiums. The program then dropped the cost of the premium a little.

Children's needs are different even with the Healthy Kids program. In one Florida county, for example, the program collects money from a hospital tax that had been earmarked for indigent care. In another county, which doesn't have a hospital tax, the community collects voluntary contributions from hospitals. Naff says they're willing to pay because it keeps them from doling out free (although expensive to them) emergency room care for basic services that a doctor could handle.

"All health care is local, like politics," said Steve Freedman, who came up with the idea for Healthy Kids and who now sits on the board of the Florida Healthy Kids Corp. "With the Healthy Kids site, locals came together and designed what they wanted for kids."

Flexibility allowed the Healthy Kids program to cut premiums. Within 10 months after starting the program, the contracted managed care plan said that its profit was substantially higher than it had projected. "They said, 'We need to reduce our premium.' As a board, we talked to them and said, 'We'll have a celebration, we'll show that you're ethical and honest.' They reduced the premium 25 per cent," Freedman said.

As a state agency head, which I was, if a company came to me and said they were making too much money, my responsibility would have been to say, 'Thanks for your candor, and now I have to call the inspector general.' The lesson is that . . . you can trust the local people to do what's in the best interest of the kids."

Sen. Bill Frist, R-Tenn., recently said in testimony to the Senate Finance Committee that flexibility can best be achieved through a block grant. "The needs of a state vary depending on a community's employment base, the demographics, provider population and maturity of the health care market," Frist said.

Frist urged policy makers to restrain themselves from ruining what states have already accomplished with their tailored programs. In March, he said, Tennessee started enrolling all children without access to insurance, regardless of income, in a kids health program based on the Maternal Child Health Block Grant. The state has committed $20 million and hopes to enroll 57,000 kids. "Federal assistance must not ignore this effort and lock the state into a new and untested program."

If Tennessee can't maintain its financial commitment to the program, it could lose the option of federal matching dollars. "Tennessee would lose, and Tennesseans' tax dollars would go to assist other states that did not step forward earlier to meet the needs of uninsured children."

For kids like Michael in Florida, that could again mean getting kicked out of a health care plan as quickly as they got into one. ■

File "Kids Study"

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

June 16, 1997

HIGHLIGHTS

UNINSURED CHILDREN: A SERIOUS PROBLEM IN THE UNITED STATES

- **About 10 million children under age 18 are uninsured.** Fully 20 million children are uninsured for at least one month over a 28-month period.

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

- **Uninsured children have worse access to health care despite the public safety net.** Sick, uninsured children are 4 times as likely to delay or not receive needed care. Children in poor health are more likely to have learning problems.

- **The United States ranks poorly when compared to other nations**. It remains the only industrialized nation that does not extend basic health protection to all its children, and ranks 22nd in its infant mortality rate, 26th for its low birth weight babies, and 22nd for its infants' probability of dying before turning 5 years old.

THERE IS NO SINGLE REASON WHY CHILDREN ARE UNINSURED

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

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

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

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

    - **Lack of affordability of insurance**

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

- **Problems accessing existing programs**

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

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

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

LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

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

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

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

CONCLUSION

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

  - Equalizing Medicaid eligibility for children of all ages

  - Making insurance more affordable through targeted state programs

  - Assisting small employers through purchasing cooperatives, and

  - Encouraging outreach through schools and other proven approaches

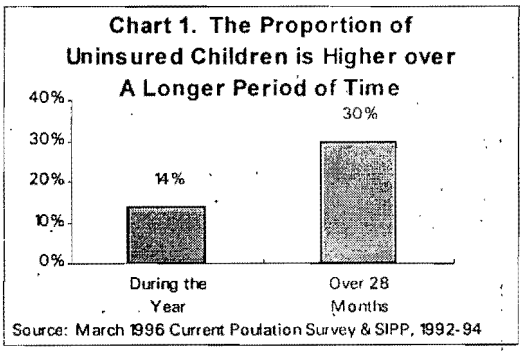
I. UNINSURED CHILDREN: A SERIOUS PROBLEM

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

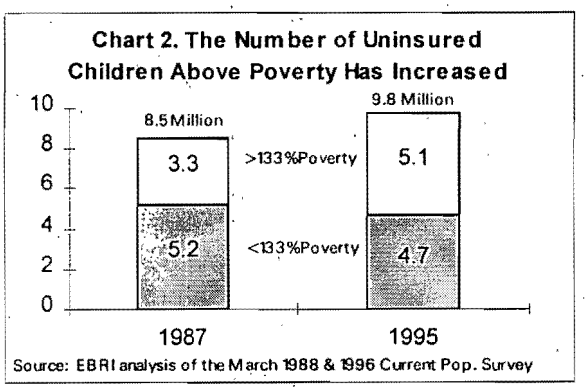
A. THE NUMBERS OF UNINSURED CHILDREN

One in seven right now. About 10 million children under 18 years old lack health insurance at any point during the year. This represents one in seven children or 14 percent of all children. This proportion has remained about the same for the last 10 years. (For details on uninsured children's characteristics, see Census, 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).

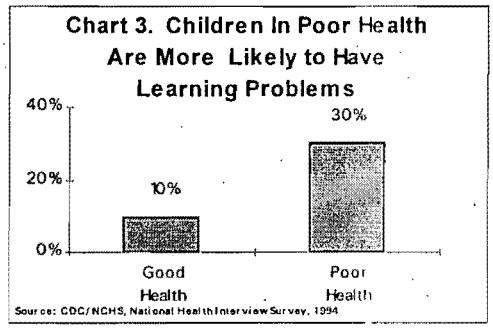


Problem increasing for middle class families. While the proportion of children who are uninsured has remained relatively constant, this masks an underlying trend. The number of poor, uninsured children has been decreasing while the number of middle class uninsured children has been increasing. The number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

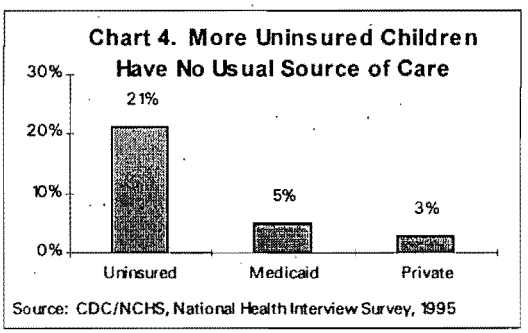


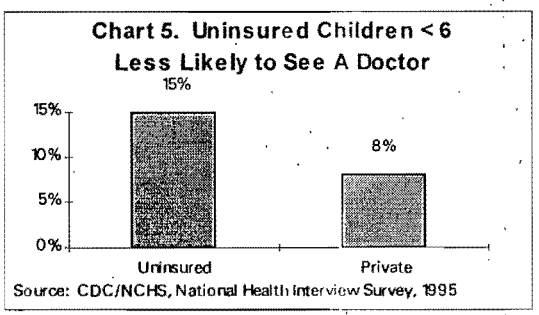
B. WHAT IT MEANS TO BE UNINSURED

Despite their general good health, children have a special set of preventive and primary care needs. Children are generally healthy. Only about 3 percent of children have fair or poor health, relative to 4 percent of 18 to 24 year olds, 8 percent of 25 to 44 year olds, and 28 percent of people 65 years and older (NCHSb, 1995). Yet, children tend to have more acute illnesses than adults. Children under 5 years old experienced an average of 3.6 acute illnesses per child in 1994, relative to 2.2 illnesses per child 5 through 17 years and 1.1 per adult 45 years and older (NCHSb, 1995). Children also require immunizations in the early years of life to prevent lifelong health problems. Primary and preventive health care for children allows them to develop to their full capacity (CEA, 1997). Children in poor health are three times more likely to experience difficulties in learning than healthy children (Chart 3). When asked what indicates that a child is ready for kindergarten, teachers overwhelmingly respond that the most essential factor is a child's physical health (NCES, 1996). Mental health is equally important. About 7.5 million children suffer from one or more mental disorders that disrupt their ability to function socially, academically, and emotionally (IOM, 1994).



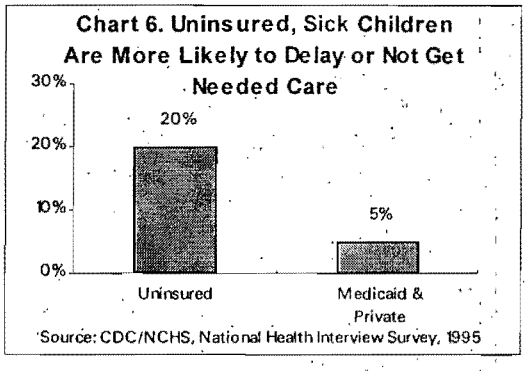
Uninsured children have more difficulty getting health care. About 86 percent of children have some type of health coverage. For children without insurance, Federal, state and local governments have developed a set of "safety net" or publicly supported providers, including community health centers, public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





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

The problems of uninsured children grow worse when they get sick. Uninsured children are four times as likely to delay or not receive needed care as are insured children (Chart 6). Over 40 percent of acute conditions for uninsured kids went unattended as compared to about 30 percent for privately insured children (NCHS, 1994). This is consistent with other studies that have found that health insurance is essential to connecting children with the health system (Donnelan, 1996).



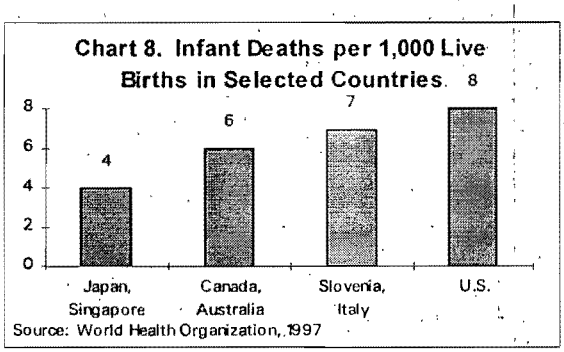
The United States stands alone. The United States leads the world in many important respects, including size of the gross domestic product (GDP) (World Bank, 1997) and real level of family income (Luxembourg Income Study, 1995). However, the United States is the only industrialized country that does not extend health protection to all its children. It is with Turkey and Mexico at the bottom of a league of nearly developed 30 nations in its coverage of children, and since several developing nations offer greater protections, the U.S. ranks even lower (OECD, 1997). Many countries also do more to lift their children out of poverty as well; a survey of 18 industrialized nations found that the U.S. had the highest child poverty rate even after taxes and transfers (Rainwater & Smeeding, 1996).

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

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

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

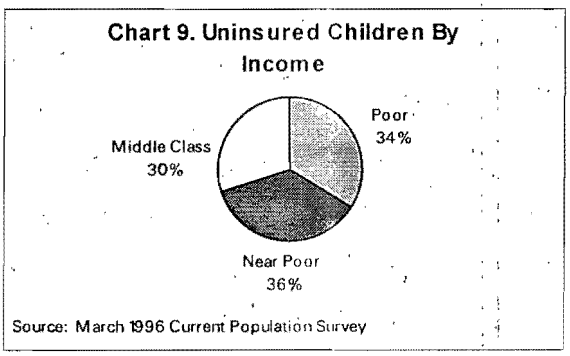
The United States also ranks low on child health statistics. The United States does not fare well internationally on major child health indicators. Its immunization rates, while improving, still are worse than many industrialized nations. Twenty-one nations have lower infant mortality rates than the U.S. and 25 have a lower proportion of low birthweight babies (Chart 8). Babies born in the United States have shorter life expectancies than 10 other nations and are more likely to die of violence than in any industrialized nation (OTA, 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. In fact, nearly 25 percent of these children are uninsured (CPS, 1996). Another one-third of uninsured children have family income above 200 percent of poverty (Chart 9). While every uninsured child has his or her own reasons for being uninsured, several patterns emerge.



Children appear to be uninsured because of:

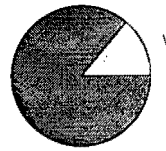
- Lack of access to employer-based insurance
- Lack of affordability of insurance
- Problems accessing existing programs.

A. LACK OF ACCESS TO EMPLOYER-BASED INSURANCE

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

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

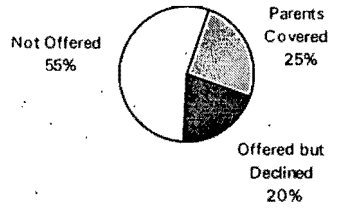
Chart 10. Uninsured Children Come from Working Families



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

Many uninsured children's families work in businesses without health coverage. Many workers and their children lack insurance because their employers do not offer it to them. One study found that 80 percent of children with working parents had at least one parent who was offered family health insurance (Mark & Schur, 1996). However, more than half of uninsured children with working parents are not offered health coverage through work (Chart 11). This is especially true for low-income workers. Nearly 70 percent of uninsured children with family income below poverty and 51 percent of uninsured children with family income between 100 and 200 percent of poverty have parents who are not offered employer-based insurance (NCHS, 1994).

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

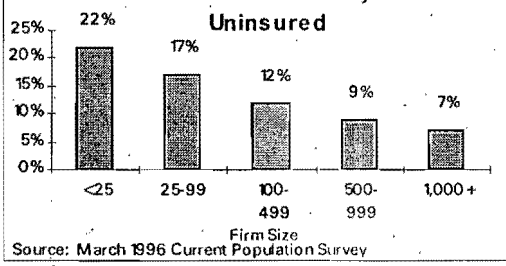


Source: CDC/NCHS, National Health Interview Survey, 1994

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

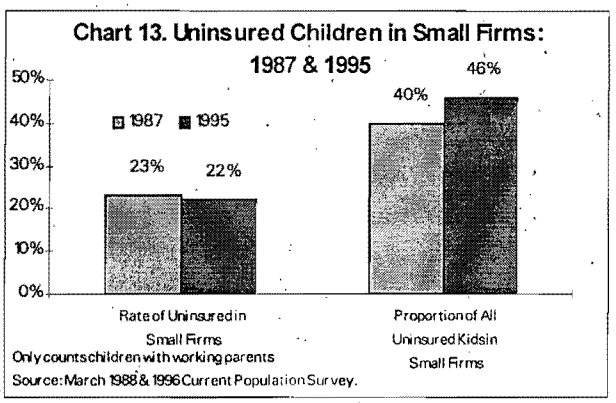
Small businesses are less likely to offer insurance. Children whose parents work in firms with fewer than 25 employees are more than twice as likely to be uninsured as those whose parents work in medium to large firms (Chart 12). This is especially true for low-income children. Over 35 percent of children whose parents work in small businesses and earn between 100 and 200 percent of poverty are uninsured, compared to 20 percent of children with family income between 200 and 299 percent of poverty and 10 percent of children with incomes of 300 percent of poverty or more (CPS, 1996). Only about 40 percent of employees in private businesses with fewer than 10 employees were offered coverage in 1993, compared to about 70 percent of employees in private firms with 10 to 24 employees, and nearly 100 percent of employees in firms with 100 or more employees (NEHIS, 1993).

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

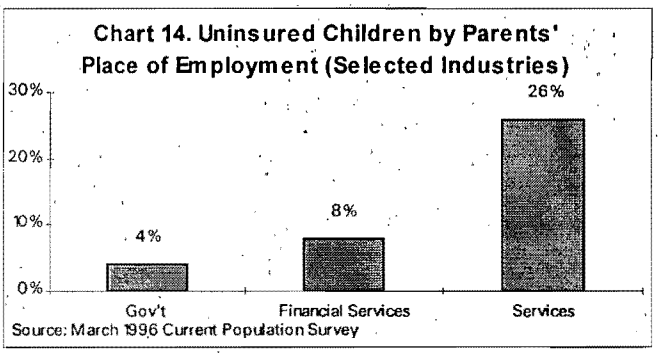


Source: March 1996 Current Population Survey

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



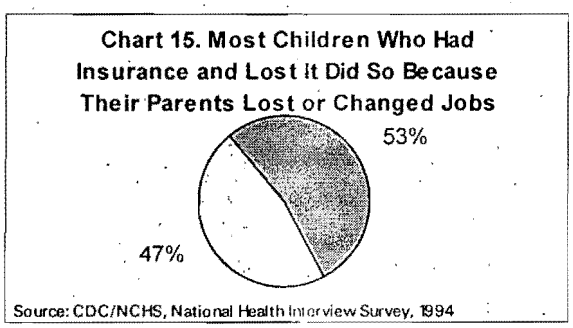
Companies in certain types of industries are less likely to offer insurance. Certain industries are less likely to offer coverage than others. Specifically, the rate of uninsured children whose parents work in the service industry (e.g., restaurants, cleaning services), is about twice as high as that for kids with parents in most other types of jobs (Chart 14). In part, this reflects the fact that many of these businesses have part-time or part-year jobs. About 22 percent of children whose parents work part-time or part-year lack health insurance compared to 12 percent of full-time workers' children (CPS, 1996). It may also reflect the higher cost of insurance for these types of employers. Traditionally, health insurers have "red lined" or charged higher rates for certain kinds of businesses. While this practice has been limited in many states, it may still account for some of the lack of insurance.



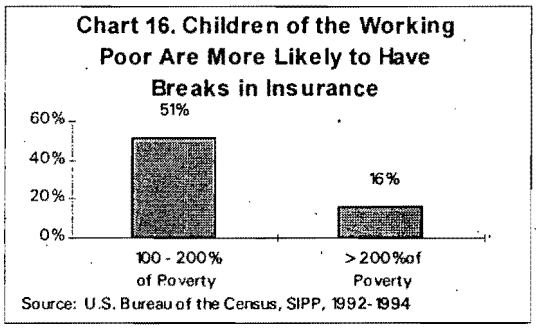
Like the trend for small business employment, there is an increase in the number of children with parents in service jobs — not an increase in the rate of uninsurance in those industries. Over 10 percent more children had parents working in these types of jobs in 1995 than in 1987 (CPS, 1996).

JOB CHANGE AND JOB LOSS

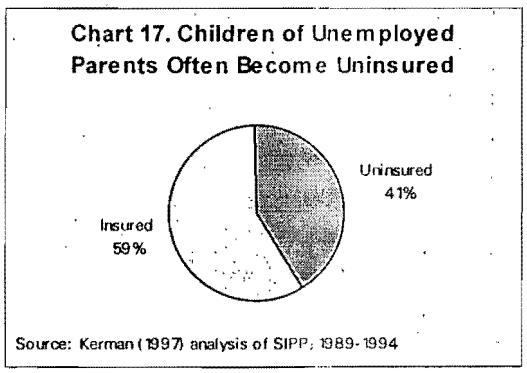
Parents' job changes often means children lose coverage. Given the strong link between health insurance coverage and employment, it is not surprising that changes in employment disrupt coverage. In fact, over half of uninsured children who had coverage within the past three years lost their coverage because their parents lost or changed jobs (Chart 15). This reason for losing insurance is more prevalent among children whose parents now work in small firms — over 60 percent of these children lost coverage because of job change (NCHS, 1994). It is also the reason why 58 percent of uninsured children in families between 100 and 250 percent of poverty and 54 percent above 250 percent of poverty lost coverage in 1994. Since higher income families are more likely to have job-related insurance, it makes sense that job-related reasons are the primary reason why they lose insurance.



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

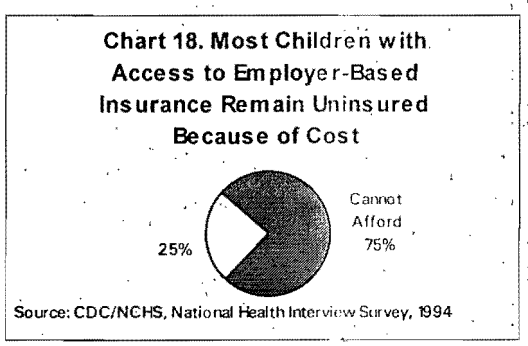


does our proposal address?

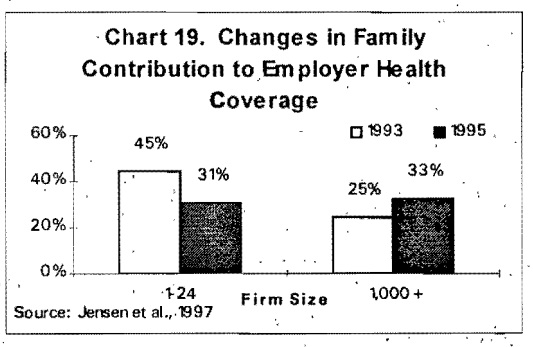
B. LACK OF AFFORDABILITY OF HEALTH INSURANCE

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

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

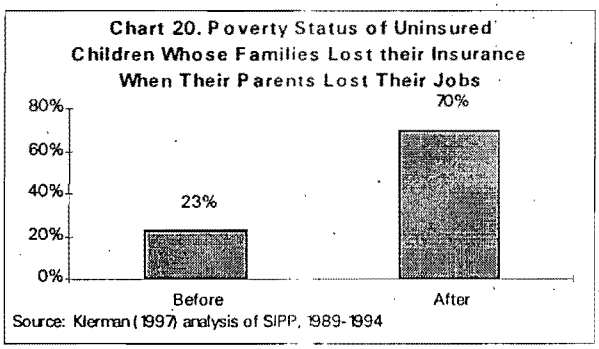


Family contributions are changing. One theory on why an increasing number of children whose parents work are becoming uninsured suggests that families' contribution to employer-based insurance is increasing. One study found that the family contribution has remained about the same as a percent of the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



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

Parents cannot afford insurance when unemployed. Affordability is even a greater problem when parents are in periods without work. When looking at uninsured children of unemployed parents, only 20 percent were in poverty when the parents worked while 70 percent are in poverty after the parent loses his or her job (Chart 20). While these periods are usually short-lived, they are problematic because children need preventive and primary care, which may be neglected if there is no coverage.

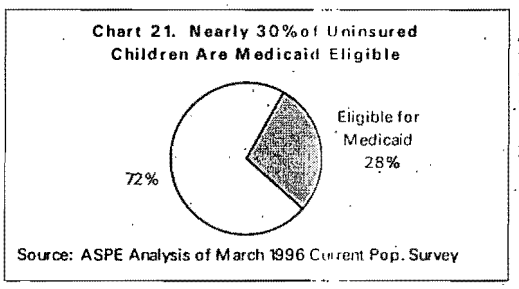


C. PROBLEMS ACCESSING EXISTING PROGRAMS

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

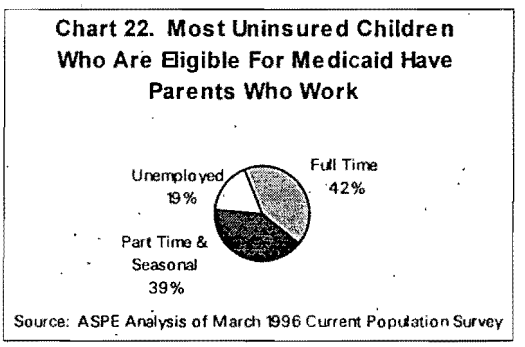
Medicaid and state programs offer coverage to children. Medicaid is the joint Federal-state health insurance program that serves 37 million Americans, including about 20 million children. States are required to cover poor children under the age of 14 (for 1997) and will cover all poor children through 18 by 2002. Additionally, almost all states have used either Medicaid options or state- or privately funded programs to cover older and/or higher income children (see Appendix B).

Many children are eligible but not enrolled in Medicaid. While most poor children are eligible for Medicaid, about three million uninsured children are not enrolled (Chart 21). Researchers estimate that participation rates for Medicaid-eligible children range from about 40 to 70 percent (Center on Budget, 1997; Urban Institute, 1995). There is no conclusive research on why eligible children without insurance do not enroll in this program which offers free insurance (U.S. GAO, June 1996). Explanations include lack of awareness of the option, the fear that work disqualifies children, the uncertainty of Medicaid coverage. Families also may be discouraged by complicated eligibility rules.

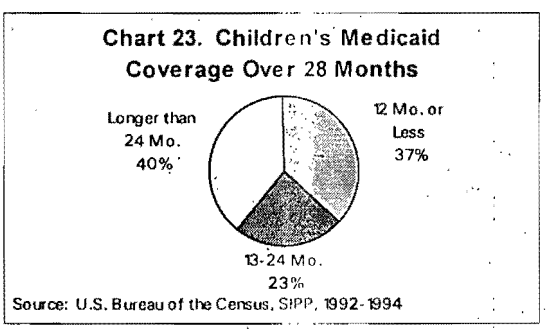


Families lack awareness of Medicaid eligibility. One of the main reasons why children may not be enrolled is that their families do not know that they are eligible. One study that interviewed AFDC recipients — who are or were on Medicaid —found that 23 to 41 percent did not know that their children could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

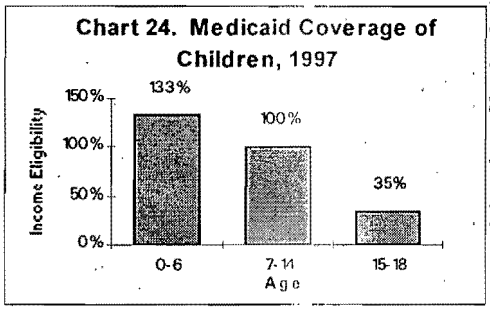
Fear that work disqualifies them. Many workers do not know that their children may qualify for Medicaid so long as their family income is below poverty. In fact, most eligible but unenrolled children do have working parents (Chart 22). However, Medicaid's historical reputation as a "welfare" program may lead families to believe that they are not eligible if they work.



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 14 years old and younger are eligible while the children above 14 are not. And, in families with incomes below 133 percent of poverty, children below 6 years old are eligible while children above are not (Chart 24).



One consequence of this unevenness in eligibility is that, over time, the number of young, poor uninsured children has decreased while the number of older, poor uninsured children has increased. A study of uninsured children in the South found that between 1989 and 1993, the number of uninsured, poor children ages 0 to 5 declined by over 60 percent for children and nearly 40 percent for children ages 6 to 12. At the same time, the number of uninsured poor children ages 13 to 18 — who were not included in the Medicaid expansion — increased (Shuptrine & Grant, 1996). This inconsistency in eligibility may account for the fact that older poor children are 60 percent more likely to be uninsured than younger poor children (CPS, 1996). If Medicaid eligibility were equalized for children of all ages, about 2 million uninsured children would become eligible for Medicaid.

State programs are small. Although most of the state programs have been able to educate families about eligibility, state and private programs may not cover all eligible children due to funding limits. Many programs have "enrollment caps" so that only a certain number of children may be enrolled. Others limit the program's size through restricting where in a state it is offered. According to one study, only about 300,000 children are covered through these programs (Gauthier & Schrodel, 1997).

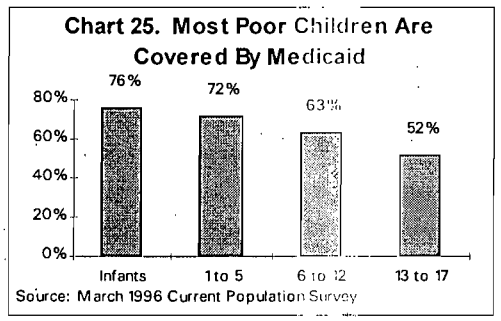
III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

On the face of it, the problems that come with being uninsured, coupled with many reasons why children are uninsured, seem difficult if not impossible to address. However, there is considerable experience in Federal and state health policy that shows how to successfully — and unsuccessfully — expand coverage to children.

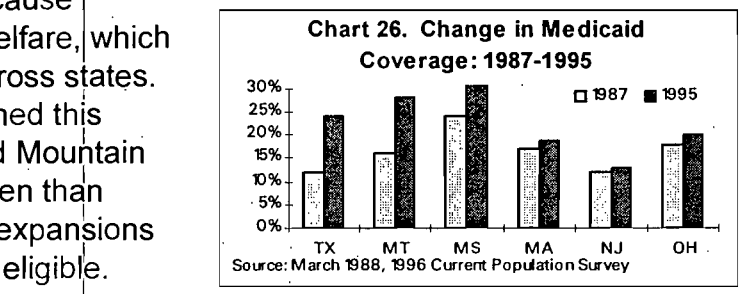
A. MEDICAID

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

Millions more children covered. Today, about 20 million children receive Medicaid coverage. In 1995, a large proportion of poor children received Medicaid's basic health protections (Chart 25). It also has been instrumental in keeping the proportion of uninsured children from rising. As seen in Chart 2, the number of uninsured children below 133 percent of poverty has fallen — despite the increase of over 400,000 in the overall number of children in this income range between 1987 and 1995. Had Medicaid not been expanded, millions more children would likely be uninsured today.



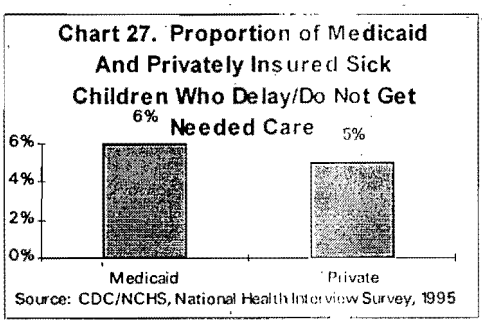
Moves toward a national eligibility "floor" for poor children. Prior to the Medicaid expansion, states varied widely in their Medicaid coverage. States in the South and Mountain regions had much lower Medicaid coverage of children than states in the North East and Upper Midwest (Chart 26). After the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



States' emphasis on outreach. Many states have tried and succeeded in enrolling children eligible for Medicaid through outreach efforts. The Medicaid program has requirements, options, and incentives for states to reach out to eligible but unenrolled children. States have used simplified applications, mail-in applications, no assets test (meaning only income and not assets like cars are counted toward eligibility), annual rather than 6-month redetermination, and outstationed eligibility workers. In New York, for example, there is a single, one-page application for both WIC and Medicaid. In Ohio and Arkansas, coupon books are used as an incentive for families to seek health care: if they receive care, the provider validates the coupon which may be used for discounted baby care and health products (NGA, 1997). Some of the state-funded programs have solicited the help of church groups, parents' groups, and other community-based organizations to educate families about eligibility. One program uses school coaches and shop teachers to promote the program (U.S. GAO, January 1996). These efforts explain why some states have high participation and why Medicaid, in general, has the highest participation rate of all types of public assistance programs (Census, 1996). However, as described earlier, significant gaps remain.

Has Medicaid "crowded out" private coverage? One question raised about the Medicaid expansion is whether all of the children gaining Medicaid were uninsured before enrolling. Some families, faced with the choice of paying the family share of a premium or enrolling their children in Medicaid, may chose the latter. This substitution of public for private coverage is known as "crowding out". While most researchers acknowledge that the incentive exists, there is some disagreement on the degree to which this occurred (Cutler & Gruber, 1996; Dubay & Kenney, 1995; Shore-Sheppard, 1996; Yazici, 1996). Some argue that, given the relatively low level of private coverage for poor children, this effect cannot be large for this population. However, as income eligibility rises, so does the risk of crowd out.

Medicaid improves access to care. Although Medicaid children do not always have the same access to care that privately insured children do, they are better off than uninsured children on all measures. Only 5 percent of children with Medicaid lack a regular source of care, compared to 20 percent of uninsured children (NCHS, 1995). Whereas 20 percent of uninsured children who are sick delay or do not get needed care, only 6 percent of Medicaid children experience these problems (Chart 27). One study found that children with Medicaid coverage had significantly more preventive care visits than did uninsured children (Gavin & Bencio, 1995). Another found that Medicaid reduced the odds of a child going without a visit by 50 percent (Currie & Gruber, 1996). These access improvements are especially important to children covered by Medicaid since they, on average, have poorer health than privately insured or uninsured children.



B. STATE EXPERIENCES

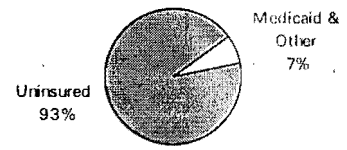
In addition to their role in Medicaid, many states have expanded coverage to children through state-funded or private programs. From these experiences, different lessons may be learned. The approach that each state has taken is unique, reflecting its particular problem, availability of funding, and health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

Florida

School-based system. The Florida Healthy Kids program uses schools to educate and enroll children in an insurance program. It began as a demonstration in one county and has expanded to 16 counties, with plans to expand further. This program offers comprehensive coverage to uninsured children aged 5 to 19 and, in some counties, their pre-school siblings. Parents pay a sliding-scale premium for the coverage, depending on a child's eligibility for the School Lunch Program. Families with incomes above 185 percent of federal poverty pay the full premium. Services are funded by a mix of state, local public and private funds, and family premiums.

Not displacing private insurance. About 40,000 children are covered through the Florida Healthy Kids program. Almost all of the children were uninsured before enrolling (Chart 28). Of the 7 percent of children who were insured, 94 percent had been on Medicaid. Thus, the program appears to efficiently target uninsured children, not serving as a substitute for existing coverage. This suggestion is strengthened by the short duration of coverage and the reasons why families end enrollment. The average child spends about a year covered by the Healthy Kids program. The main reason why parents disenroll these children is that they gain employer coverage. This implies that the Healthy Kids programs serves as temporary coverage for children and that families prefer private insurance when given the choice.

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



Source: Florida Institute for Child Health Policy

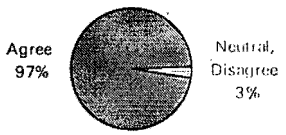
Lower emergency room use. An evaluation of the original demonstration project found that children enrolled in Florida Healthy Kids program were much less likely to use emergency rooms. This use dropped by 70 percent for enrollees in the second year after HMOs were able to educate families about alternatives.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

Minnesota

Evolution from a small state program to a large Medicaid expansion. In the late 1980s, Minnesota established the Children's Health Plan that offered subsidized coverage to uninsured children. In 1992, it replaced this program with MinnesotaCare that covers children as well as some uninsured adults. Minnesota uses an 1115 Medicaid waiver to cover children and pregnant women enrolled in MinnesotaCare; the state finances its share of the program through a 2 percent provider tax. MinnesotaCare provides nearly 44,000 children with comprehensive benefits provided through the state's network of Medicaid providers.

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

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



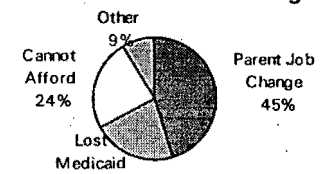
Source: Lurie et al., 1995

New York

Insurer-based children's program. New York's Child Health Plus program began in 1991, and was expanded in June 1996 to cover additional age groups and include inpatient services. Children are eligible for Child Health Plus if they (1) are under the age of 19, (2) reside in New York State in a household having a gross income at or below 222 percent of the federal poverty level, (3) are not eligible for Medicaid, and (4) do not have equivalent health coverage. In September 1996, about 110,000 children were enrolled in Child Health Plus. This is the largest state program; the funding appropriated for 1997 is $109 million. The program is funded by the Statewide Health Care Initiatives Pool as well as from premium contributions from families.

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

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

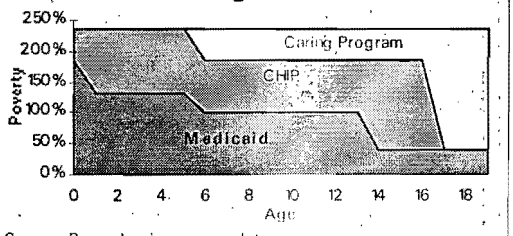


Source: Szigalyi et al., 1996

Pennsylvania

Seamless health coverage for children. One of the earliest state programs for children developed in western Pennsylvania. In 1985, steel mills in that region shut down, leaving many children and their families without insurance. In response, the Western Pennsylvania Caring Foundation was created by local ministers in cooperation with Blue Cross of Western Pennsylvania. It began by providing only preventive and primary care, but today provides comprehensive coverage. Pennsylvania now has a three-tiered, comprehensive, seamless insurance program for children (Chart 31). The first tier is Medicaid, which covers poor children. The second is the Children's Health Insurance Program (CHIP), funded by a dedicated two-cent state cigarette tax and administered by the Caring Foundations. Third, the Caring Program subsidizes children who fall between Medicaid and CHIP eligibility and 235 percent of poverty. The Caring Program is funded by Blue Cross / Blue Shield and private donations. Currently, about 50,000 children are enrolled in these programs and there is a waiting list of 5,000 children.

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



Source: Pennsylvania program data

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

C. 1990 CHILD HEALTH TAX CREDIT

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

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

This health insurance credit was repealed in OBRA 1993. Following two years of experience, this health insurance supplement to the EITC was repeal in OBRA 1993. The Treasury Department recommended its repeal because it was difficult for the Internal Revenue Service (IRS) to efficiently and accountably administer the credit. For example, the IRS could not determine whether a health insurance plan met the eligibility criteria for the credit. The only information that the tax payers reported to the IRS was the amount of the premium paid and (in 1991 only) the name of the insurance plan. The IRS could not verify this information since there were no reporting requirements for insurers. A Congressional oversight committee study found that families often bought ineligible policies like cancer and dread disease policies and policies with two-year pre-existing condition restrictions. The IRS could not prevent this.

A second problem was low participation. The GAO (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. However, their direct effect on coverage of children is not known.

IV. CONCLUSION

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

Yet the cause of the problem is not simple. American children receive health coverage through a fragmented system of employer-based coverage, individually purchased coverage, Medicaid, state programs, the public safety net and philanthropy. Employer-based insurance is the primary source of coverage, so it is not surprising that most coverage loss relates to changes in employment. The dynamic U.S. economy has caused shifts of employment to firms that typically do not offer coverage: small business, service jobs, and part-time work, for example. Yet, even if they have access to employer-based insurance or individual market insurance, families may not be able to afford it. Family premiums have rapidly risen, as has the share of the premium paid for by the family. And, simply navigating this complex system to find affordable options is a challenge to many. Millions of uninsured children have the opportunity to be covered through public or private programs but do not take advantage of it.

There is no easy solution. The complexity of the reasons why children lack insurance, along with the fragmented system that tries to remedy this, make it difficult to design solutions. It may be the case that, in the absence of a requirement that every employer and/or family purchase health coverage, the problem cannot be completely solved. However, past and present experiences provide ideas on how to design, implement and operate initiatives that can make significant improvements in coverage for children.

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

Lessons from tax credits and insurance reform. The Federal government has tried using tax credits in 1991 and 1992 to encourage low-income families to purchase coverage for their children. However, this attempt was aborted given oversight problems and low participation. Some of the reasons for the failure could have been addressed with policy changes. For instance, some type of state certification of health plans eligible for the credit could have limited the mistaken purchase of substandard plans. However, the experience raises serious questions about whether the tax system is the best system to run coverage programs, and whether it can successfully encourage families to cover their children. Similarly, COBRA and HIPAA serve important roles in assuring coverage options, but extending them as currently structured may not be the best way to improve children's coverage.

Translating lessons into laws. The President and the Congress have agreed that additional funding for children's health coverage is needed. Balancing the budget is critical to our children's future. So, too, is investing in children's health coverage so that they will be able to take full advantage of that future. This priority is reflected in the Balanced Budget Agreement, which dedicates $16 billion between 1998 and 2002 to expand health coverage for children. This amount represents a meaningful commitment toward covering up to 5 million uninsured children. The following policies, drawn from past experiences, may assist in achieving this goal.

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

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

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

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

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

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

REFERENCES [to be completed]

Abt. (1996).

Assistant Secretary for Planning and Evaluation (ASPE). (1997). Analysis of the Census Bureau's Survey of Program Participation (SIPP), 1992-1994.

Blue Cross / Blue Shield (BCBS). (1997).

Call.

Census. (March 13, 1997).

Current Population Survey (CPS). 1988, 1996.

Census. (1996). Program Participation memo.

Center on Budget and Policy Priorities (1997). Medicaid participation

Cowan. (1996).

Council of Economic Advisors (CEA). (1997). The First Three Years: Investments that Pay. Washington, DC.

Currie J; Gruber J. (May 1996). Health insurance eligibility, utilization of medical care, and child health. The Quarterly Journal of Economics.

DeLew N. (July 19, 1995). The first 30 years of Medicare and Medicaid. JAMA 274(3): 262-267.

Department of Labor (DOL). 1995

Donelan K et al. (1996). Whatever happened to the health insurance crisis in the United States? JAMA October 23/30, 1996. 276(16): 1346-1350.

Dubay LC; Kenney GM. (1996). Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children. *The Future of Children* 6(1): 152-161.

EBS 1993-1994

Employee Benefit Research Institute (EBRI). (1997). Special analysis.

Flynn P. (1992). Study 9: Employment-Based Health Insurance: Coverage Under COBRA Continuation Rules. In: U.S. Department of Labor, Health Benefits and the Workforce. Washington, DC: U.S. Government Printing Office; pp. 105-116.

Gauthier AK; Schrodel SP. (May 1997). Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform. Washington, DC: Alpha Center.

Gavin NI; Bencio DS. (1996). The impact of Medicaid on children's health service use: A ten-year retrospective analysis. North Carolina: Research Triangle Institute.

Health Care Financing Administration (HCFA). (1996). Statistical Supplement

Institute of Medicince. (1994). Mental health.

Jensen GA; Morrisey MA; Gaffney S; Liston DK. (January/February 1997). The new dominance of managed care: Insurance trends in the 1990s. Health Affairs; pp. 125-136.

Klerman JA; Rahman O. (1992). Study 8: Employment change and continuation of health insurance coverage. In: U.S. Department of Labor, Health Benefits and the Workforce. Washington, DC: U.S. Government Printing Office; pp. 93-104.

Klerman JA. (1997). Health Insurance Among Children of Unemployed Parents. Santa Monica, CA: RAND, MR-883-DOL/PWBA.

Lack DE. (1997). "The cost of insuring children." Washington, DC: Council for Affordable Health Insurance.

Lave forthcoming

Liu K; Moon M; Sulvetta M; Chawla J. (Summer 1992). International infant mortality rankings: A look behind the numbers. Health Care Financing Review 13(4):105-118.

Lurie N; Pheley A; Finch M. (1995). Is MinnesotaCare Hitting its Target? Minneapolis, MN: Institute for Health Services Research, University of Minnesota School of Public Health and Hennepin County Medical Center.

Luxembourg Income Study.

Mark TL; Schur C. (September 9, 1996). Health Insurance Coverage of Children of Working Parents. Washington, DC: U.S. Department of Labor #41USC252C3.

National Center for Health Statistics (NCHS). Analyses from the National Health Interview Survey, 1994, 1995.

National Center for Health Statistics (NCHSb). 1995. Current Estimates from the National Health Interview Survey, 1994. Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control. Series 10, No. 193.

National Employer Health Insurance Survey (NEHIS). (1993).

National Governors' Association. (1997). Children's health

Office of Technology Assessment (OTA). (November 1993). *International Health Statistics: What the numbers mean for the United States.* Washington, DC: U.S. Government Printing Office.

Organization of Economic Cooperating and Development (OECD). (1997).

Rainwater L; Smeeding TM. (August 1996). Doing Poorly: The Real Income of American Children in a Comparative Perspective. Luxembourg Income Study Working Paper Number 127.

Schieber GJ; Poullier J-P; Greenwald LM. (Summer 1992). U.S. health expenditure performance: An international comparison. Health Care Financing Review 13(4): 1-88.

Schuptrine 1994, 1996

Shore-Sheppard L. (September 1996). The effect of expanding Medicaid eligibility on the distribution of children's health insurance coverage. Paper prepared for the Cornell/Princeton conference on "Reforming Social Insurance Programs."

Szilagyi

Urban Institute. (1995). Data book

U.S. General Accounting Office (U.S. GAO). (1997). Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases. Washington, DC: U.S. General Accounting Office; GAO/HEHS=97-35.

U.S. General Accounting Office (U.S. GAO). (November 1996). Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs. Washington, DC: U.S. General Accounting Office; GAO/HEHS-97-8.

U.S. General Accounting Office (U.S. GAO). (January 1996).

U.S. General Accounting Office (U.S. GAO). (June 1996). Children's health insurance.

U.S. General Accounting Office (U.S. GAO). (October 1994). Child Health Tax Credit

World Bank. (1997). World Development Indicators 1997. Washington, DC: International Bank for Reconstruction and Development/THE WORLD BANK.

Cutler DM; Gruber J. (May 1996). Does Public Insurance Crowd Out Private Insurance? *The Quarterly Journal of Economics*; 392-429.

Shore-Sheppard L. (1996). Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage. Princeton University Industrial Relations Section Working Paper #361.

Yazici EY. (1996). Medicaid Expansions and the Crowding Out of Private Insurance. Presented at the Association for Public Policy Analysis adn Management meeting, November 2, 1996.

United States General Accounting Office

GAO

Report to the Ranking Minority Member, Subcommittee on Children and Families, Committee on Labor and Human Resources, U.S. Senate

June 1996

HEALTH INSURANCE FOR CHILDREN

Private Insurance Coverage Continues to Deteriorate

GAO/HEHS-96-129

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-271717

June 17, 1996

The Honorable Christopher J. Dodd
Ranking Minority Member
Subcommittee on Children and Families
Committee on Labor and Human Resources
United States Senate

Dear Senator Dodd:

As the U.S. health care marketplace changes, having health insurance coverage has become increasingly important for children. The transition into greater reliance on managed care has left hospitals and physicians less willing to provide charity care for those who lack insurance. Children are particularly vulnerable to the lack of health insurance. Although a healthy group, they need preventive and acute care for their optimum development. If they do not get care when they need it, their health can be affected for the rest of their lives.

As we have reported earlier,[1] private health insurance coverage for children decreased between 1987 and 1993. Expanding children's coverage through the publicly funded Medicaid program helped to cushion the effect of this decrease. The Medicaid expansion increased health insurance coverage for poor children.[2] However, it did not lead to an overall increase in the percentage of children covered because children above the poverty level lost private coverage but were less likely to be eligible for Medicaid. Since our earlier report, the Congress has considered restructuring the Medicaid program, including children's eligibility for coverage. It has also considered proposals that would change the private insurance marketplace. In addition, the shift toward managed care in the health care marketplace has continued, which reduces providers' willingness to care for uninsured patients.

Concerned about these issues and their impact on children, you asked us to provide you with updated information for 1994 on whether health insurance coverage for children had increased and in particular how poor children were affected. You also asked us

[1]See Uninsured and Children on Medicaid (GAO/HEHS-95-83R, Feb. 14, 1995), Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995), and Medicaid and Children's Insurance (GAO/HEHS-96-50R, Oct. 20, 1995).

[2]Poor children are children in families with income at or below the Federal Poverty Income Guidelines. These guidelines set income levels by family size to determine poverty. In 1996, a family of three with income at or below $12,980 is considered poor.

- whether more children in working families were depending on Medicaid than had previously been reported,
- how many uninsured children might be eligible for Medicaid but not enrolled in 1994, and
- why families of uninsured but Medicaid-eligible children might not be seeking Medicaid coverage for their children.

To answer these questions, we analyzed the Bureau of the Census' March 1995 Current Population Survey (CPS), which can be used to estimate health insurance coverage for children from birth through 17 years old in 1994. The methodology for the CPS questionnaire and data collection had been improved for the March 1995 CPS. In addition, the sample frame or sample selection process for families had been updated by using 1990 census information. While these changes provide better estimates of insurance coverage for 1994, in our opinion and that of Census Bureau officials, some estimates for 1994 are not comparable to prior years' estimates of insurance coverage primarily because of these methodological changes. In this report, we highlight comparisons of 1994 and earlier estimates that we think are most comparable. (See app. I.) Our work was conducted between January and May 1996 in accordance with generally accepted government auditing standards.

Results in Brief

The number of children without health insurance coverage was greater in 1994 than at any time in the last 8 years. In 1994, the percentage of children under 18 years old without any health insurance coverage reached its highest level since 1987—14.2 percent or 10 million children who were uninsured. (See fig. 1.) In addition, the percentage of children with private coverage has decreased every year since 1987, and in 1994 reached its lowest level in the past 8 years—65.6 percent or 46.3 million children. In comparison, the loss of health insurance coverage for adults 18 to 64 years old appears to have stabilized in the last 2 years. Between 1993 and 1994, the decline in health insurance coverage for children was concentrated among children in poor families. Health insurance coverage remained stable for nonpoor children.

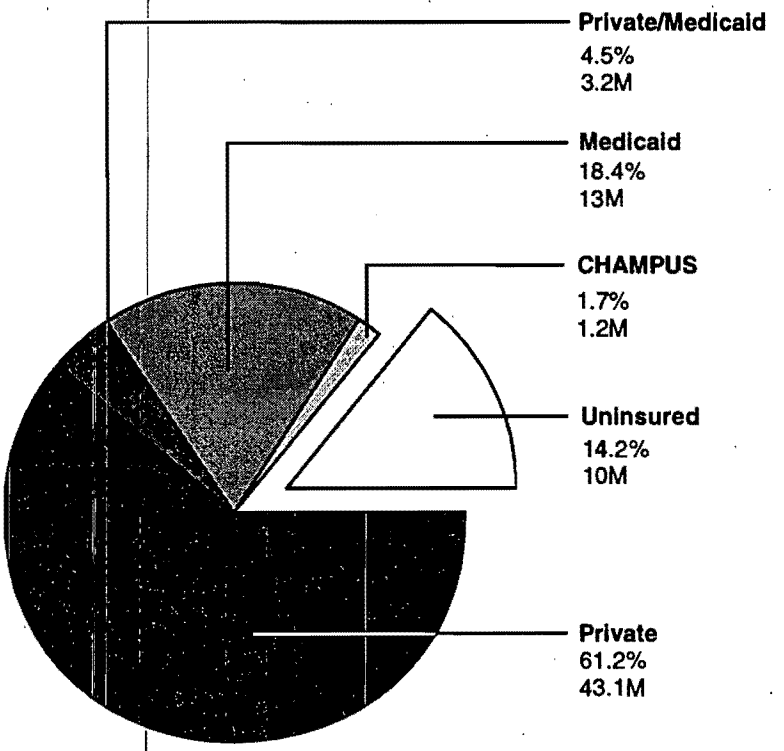
Among children whose parents are working, Medicaid continued to be an important source of insurance coverage. The Medicaid expansions in eligibility for low-income children not on welfare allowed more children of working parents to become insured through Medicaid—a trend that continued in 1994. But Medicaid coverage for children as estimated through the CPS was lower in 1994 than 1993—which may be due to

methodological changes in the CPS. (See app. I for more detail on these CPS changes and their effects.)

Despite greater reliance on Medicaid for covering children of the working poor, many eligible uninsured children do not enroll in Medicaid. For 1994, we estimate that 2.9 million uninsured children were eligible for Medicaid by federal mandate but did not enroll.[3] These Medicaid-eligible uninsured children represent 30 percent of all uninsured children. Unless the Congress changes Medicaid eligibility law, the group of children eligible for Medicaid will grow between now and 2002 because current federal law is phasing in Medicaid eligibility for poor teens 13 to 19 years old. In 1994, there were 4.1 million poor teens in this age group. This continuing expansion could cover more of the uninsured, because 1.3 million poor teens 13 to 19 years old were uninsured in 1994. However, Medicaid can only increase coverage if families of eligible uninsured children are informed that their children are eligible for Medicaid and enroll them.

[3]For 1993, these were children from birth to 5 years old with family income at or below 133 percent of the federal poverty level and poor children 6 to 10 years old. Because coverage is being phased in for children born after Sept. 30, 1983, for 1994, we considered children as Medicaid-eligible according to federal mandate if they were from birth to 5 years old with family income at or below 133 percent of the federal poverty level or if they were poor children 6 to 11 years old.

Figure 1: In 1994, 14.2 Percent of Children Were Uninsured



Note: M=million. Uninsured children are children who were reported to have no insurance coverage at all for the entire year. Children reported as having health insurance coverage may have been uninsured for some part of the year. Children with more than one source of coverage reported may have had duplicate coverage at the same time or may have had different types of coverage at different times of the year. CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. The Census Bureau includes other types of public coverage in the CHAMPUS coverage category, such as health coverage through the Indian Health Service or state-funded programs. For this figure, more than one source of coverage is shown only for children who have both private insurance and Medicaid coverage. Children with Medicare are included with the Medicaid group. Children with both private insurance and CHAMPUS coverage will be shown in the group with private insurance coverage. Children with Medicaid (or Medicare) and CHAMPUS insurance will be shown in the section for Medicaid.

Background

Studies have shown that uninsured children are less likely than insured children to get needed health and preventive care. The lack of such care can adversely affect children's health status throughout their lives. Without health insurance, many families face difficulties getting preventive and basic care for their children. Children without health insurance or with gaps in coverage are less likely to have routine doctor visits or have a

regular source of medical care. When they do seek care, they are more likely to get it through a clinic rather than a private physician or health maintenance organization (HMO).[4] They are also less likely to get care for injuries,[5] see a physician if chronically ill, or get dental care.[6] They are less likely to be appropriately immunized to prevent childhood illness—which is considered by health experts to be one of the most basic elements of preventive care.[7]

The Medicaid program is the major public funding source for children's health insurance. It is a jointly funded federal-state entitlement program that provides health coverage for both children and adults. It is administered through 56 separate programs, including the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. States are required to cover some groups of children and adults and may extend coverage to others. Children and their parents must be covered if they receive benefits under the Aid to Families With Dependent Children (AFDC) program. Children and adults may also be eligible for the program if they are disabled and have low incomes or, at state discretion, if their medical expenses are extremely high relative to family income.

Beginning in 1986, the Congress passed a series of laws that expanded Medicaid eligibility for pregnant women on the basis of family income, and for children on the basis of family income and age. Before these eligibility expansions, most children received Medicaid because they were on AFDC. Before 1989, coverage expansions were optional for states, although many states had expanded coverage.[8] Starting in July 1989, states had to cover

[4]See Barbara Bloom, "Health Insurance and Medical Care: Health of Our Nation's Children, United States, 1988," Advance Data From Vital and Health Statistics of the National Center for Health Statistics, No. 188, U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics (Hyattsville, Md.: 1990), pp. 1-8; and Alexander M. Kogan, and others, "The Effect of Gaps in Health Insurance on Continuity of a Regular Source of Care Among Preschool-Aged Children in the United States," Journal of the American Medical Association, Vol. 274, No. 18 (1995), pp. 1429-35.

[5]Mary D. Overpeck, and Jonathan B. Kotch, "The Effect of U.S. Children's Access to Care on Medical Attention for Injuries," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 402-04.

[6]Alan C. Monheit, and Peter J. Cunningham, "Children Without Health Insurance," The Future of Children: U.S. Health Care for Children, Center for the Future of Children, The David and Lucile Packard Foundation, Vol. 2, No. 2 (Los Angeles, 1992), pp. 154-70.

[7]See David L. Wood, and others, "Access to Medical Care for Children and Adolescents in the U.S.," Pediatrics, Vol. 86, No. 5 (1990), pp. 666-73; Charles N. Oberg, "Medically Uninsured Children in the United States: A Challenge to Public Policy," Pediatrics, Vol. 85, No. 5 (1990), pp. 824-33; and David U. Himmelstein and Steffie Woolhandler, "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 341-44.

[8]Thirty-two states and the District of Columbia had expanded coverage for pregnant women and infants, and 26 states and the District of Columbia had expanded coverage for older children as of December 1988.

pregnant women and infants with family incomes at or below 75 percent of the federal poverty level. Two subsequent federal laws further expanded mandated eligibility for pregnant women and children. By July 1991, states were required to cover (1) pregnant women, infants, and children up to 6 years old with family income at or below 133 percent of the federal poverty level and (2) children 6 years old and older born after September 30, 1983, with family income at or below 100 percent of the federal poverty level. Current law expands the group of poor children over 6 years old eligible for Medicaid year by year until all poor children up to 19 years old are eligible in the year 2002. In addition, states may expand Medicaid eligibility for infants and children beyond these requirements by either phasing in coverage of children up to 19 years old more quickly than required, by increasing eligibility income levels, or both. (See table II.2 for current eligibility levels in states.)

These expansions partially fueled the increase in Medicaid costs in the 1990s, but children still represent less than one-fourth of Medicaid expenditures. In 1994, nondisabled children represented a large percentage of Medicaid recipients—49 percent—compared with the percentage of Medicaid expenditures for medical care that they accounted for—16 percent.[9] Nonetheless, Medicaid's overall cost and the rate of cost increases have raised concerns about the program's impact on the federal budget. Medicaid costs are projected to increase from about $156 billion in 1995 to $243 billion by the year 2000, according to the Congressional Budget Office. The Congress has recently considered different options to lower the cost of the program, including removing guaranteed eligibility for some types of current recipients and giving capped funding to the states as block grants.

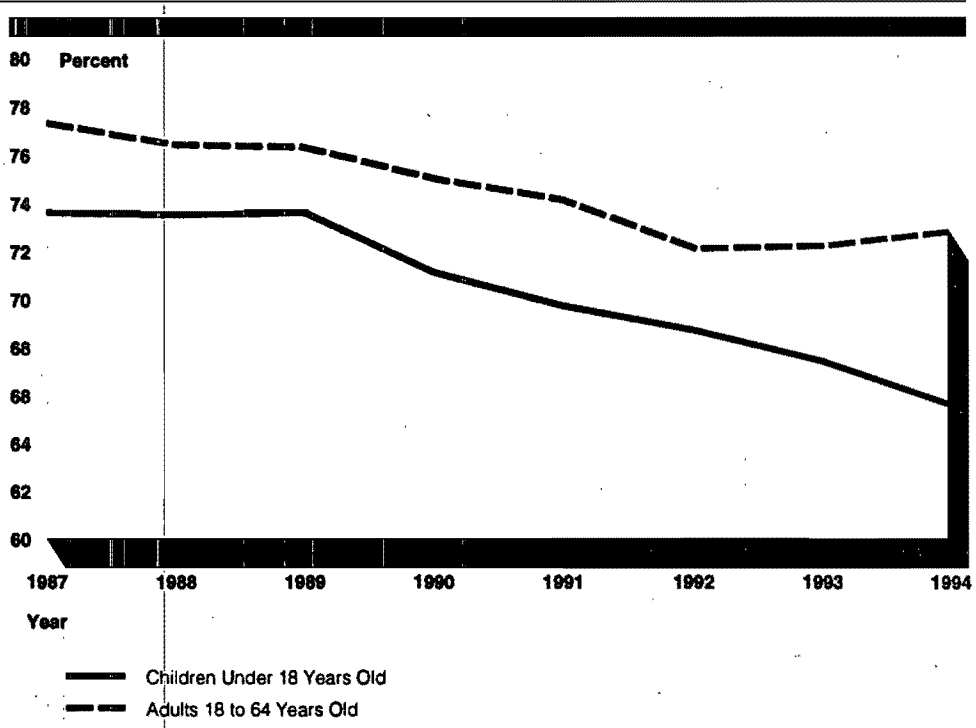
Health Insurance Coverage for Children at Lowest Reported Level Since 1987

In 1994, the percentage of children with private health insurance reached the lowest level reported in the last 8 years—65.6 percent or 46.3 million children.[10] (See fig. 1 and table II.1.) Mirroring this trend, the percentage of children who were uninsured rose to its highest reported level since 1987—14.2 percent or 10 million children. (See figs. 2 and 3 and table II.1.) Compared with adults 18 to 64 years old, for whom private insurance coverage has slightly increased in the last 2 years, coverage for children appears to be decreasing.

[9]This is for children under 21 years old and does not include disabled children. If disabled children under 21 are included, all children on Medicaid under 21 represent 52 percent of recipients and 23 percent of medical expenditures. (HCFA only collects data on children under 21 years old.)

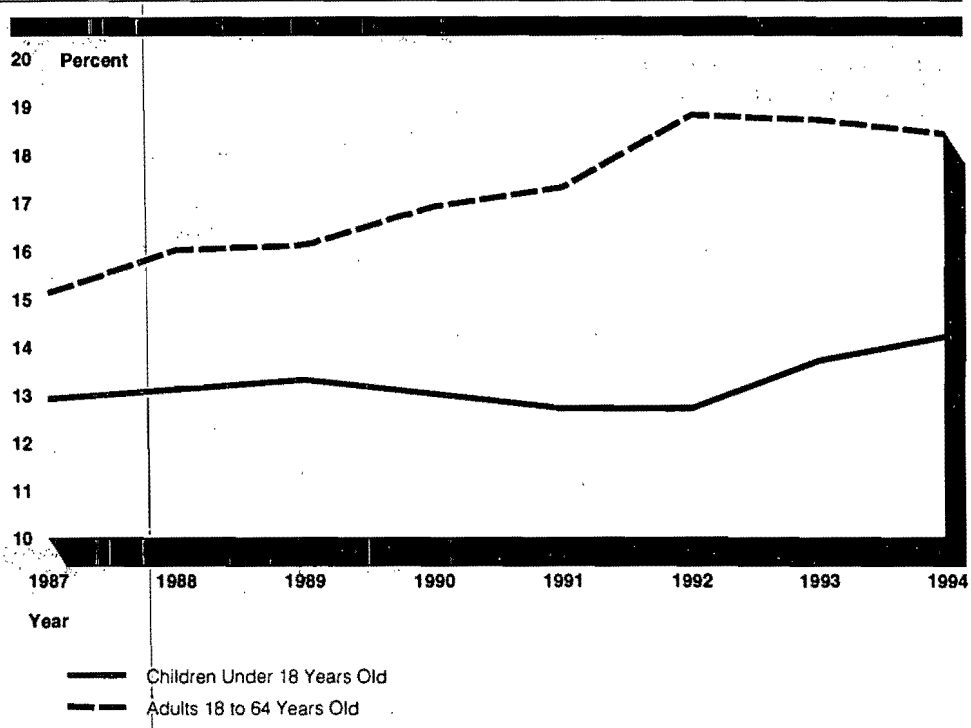
[10]These children might also have had other sources of coverage, such as Medicaid, in the same year.

Figure 2: The Percentage of Children and Adults With Private Insurance Declined Since 1987



Source: The Bureau of the Census.

Figure 3: The Percentage of Uninsured Has Begun to Rise in the Last 2 Years for Children but Not Adults



Source: The Bureau of the Census.

Decreased Coverage Reported Despite Increase in Parents Working Full-Time

The estimated decrease in children's coverage occurred although slightly more children were reported to be in families with a parent who worked full-time in 1994 than in 1993. Children of a parent who worked full-time for the entire previous year are more likely to have private health insurance than other children. However, in 1994, almost 25 percent of children with a parent working full-time did not have privately funded employment-based health insurance. Almost 12 percent of children with a parent working full-time were uninsured.

Children whose parents worked at less than a full-time job for the entire year were worse off for health insurance than children whose parents did not work at all in 1994. Only 37 percent had employment-based insurance (36.8 percent). More children of parents who worked less than full-time all year were uninsured (21.7 percent) than were children of parents who did not work at all in 1994 (14.6 percent). This is because children of parents who are not working tend to be enrolled in Medicaid.

More Poor Children Estimated as Uninsured in 1994 Compared With 1993

A higher percentage of poor children were reported as uninsured in 1994—22.3 percent—than in 1993—20.1 percent. In contrast, reported rates of being uninsured did not differ significantly between 1993 and 1994 for children above poverty. (See table 1.)

Table 1: Percent of Children Without Health Insurance Coverage, by Poverty Level

Figures are percents

	1989	1993	1994	Percentage point difference 1993-94
Poor[a]	25.0	20.1	22.3	2.2[b]
Near-poor[c]	26.5	24.5	24.9	0.4
Above near-poor[d]	7.5	9.1	8.9	(0.2)

Note: Figures in each year are percentages of children who were uninsured for one entire year within each income group. Only children who matched to a parent were included in this table.

[a]Poor families have incomes at or below 100 percent of the federal poverty level.

[b]Statistically significant at the 0.05 level.

[c]Near-poor families have incomes between 101-150 percent of the federal poverty level.

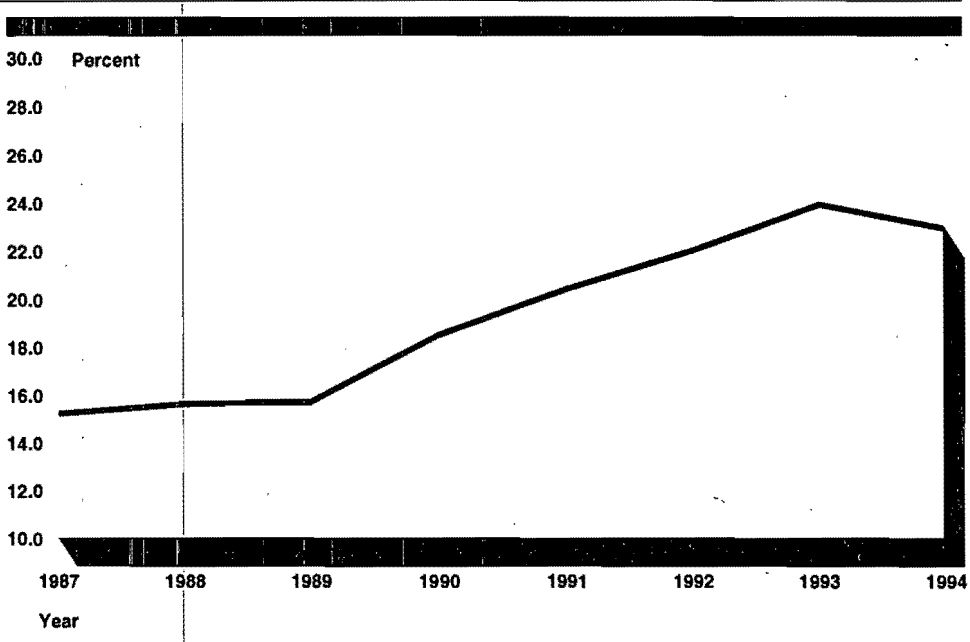
[d]Above near-poor families have incomes above 150 percent of the federal poverty level.

Medicaid Continues to Be a Significant Source of Coverage for Children, but Many Eligible Children Do Not Enroll

In 1994, Medicaid covered 22.9 percent of U.S. children—16.1 million children.[11] This number was lower than the Bureau of the Census estimated in 1993. The difference may be due partially to a reduction in the number of children on AFDC (who are automatically eligible for Medicaid) and partially to changes in CPS methodology that reduced the 1994 estimate, relative to the 1993 estimate. (See app. I.)

[11]These children are reported as having any Medicaid coverage, even if they also have employment-based coverage. Of these children, 3.2 million had private coverage as well as Medicaid coverage at some point in 1994. In our previous reports, children who had both Medicaid and employment-based private coverage were counted as having employment-based coverage and not counted as having Medicaid coverage.

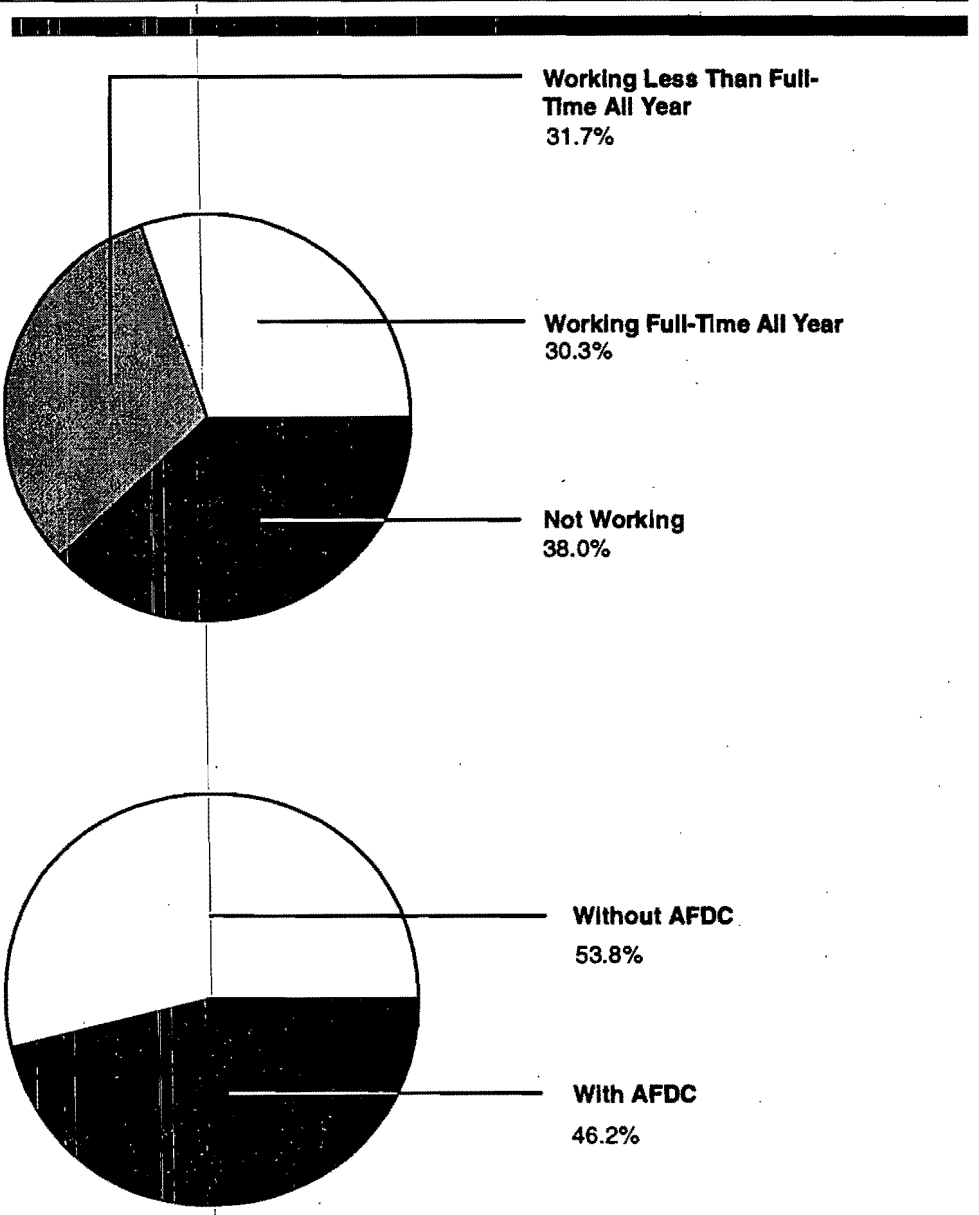
Figure 4: Estimated Medicaid Enrollment for Children Expanded Between 1989 and 1993, but Was Lower in 1994



Source: The Bureau of the Census.

Nevertheless, Medicaid's role as an insurer for children in working families not depending on welfare has grown. In 1994, 62 percent of children on Medicaid had a working parent. Thirty percent of children on Medicaid had a parent who worked full-time for the entire previous year and another 18.8 percent had a parent who worked full-time but for less than the entire year. Another 13 percent had a parent who worked part-time. Only 38 percent had no working parent. In 1994, more than 50 percent of the children on Medicaid did not receive AFDC or other public assistance.

Figure 5: More Than 60 Percent of Medicaid Children Had a Working Parent and More Than 50 Percent Did Not Receive AFDC in 1994



At Least 30 Percent of Uninsured Children Eligible for Medicaid by Federal Mandate

Many uninsured children who are eligible for Medicaid do not enroll. Present law mandates eligibility for children from birth to 5 years old with income at or below 133 percent of the federal poverty level and for poor children born after September 30, 1983. This means that poor children

under 13 years old are now eligible and, year by year, more poor children will become eligible until all poor children under 19 years old will be eligible in 2002. States have the option to expand age and income eligibility beyond this mandate for pregnant women, infants, or children, and 40 states have done so. (See table II.2 for states that have expanded eligibility beyond federal requirements.)

We estimate that 14.3 million children in 1994 were eligible for Medicaid by federal mandate because of their age and family income.[12] Of those children, 11.4 million had private or public insurance coverage and 2.9 million were uninsured (20.3 percent). The 2.9 million uninsured, Medicaid-eligible children accounted for 30 percent of all uninsured children.

Compared with children on Medicaid, higher percentages of uninsured, Medicaid-eligible children had a working parent in 1994 (80.4 percent). Almost three-fourths of these uninsured, Medicaid-eligible children lived in the South (41 percent) or the West (30.4 percent). Over one-half were African-American (21.7 percent) or Hispanic (34.7 percent).

More Uninsured Teens Will Become Eligible for Medicaid Coverage in the Next 6 Years

Poor teens under 19 years old will be phased into Medicaid eligibility in the next 6 years if current federal Medicaid eligibility mandates for children are maintained. In 1994, an estimated 4.1 million children 13 to 18 years old were poor. In 1994, 32 percent of poor teens 13 to 18 years old—1.3 million teens—were uninsured.

Parents May Not Enroll Eligible Uninsured Children in Medicaid for Various Reasons

As we have previously reported, there are several possible reasons why families may not enroll their children in Medicaid. First, low-income families may not know that their children could be eligible for Medicaid even if a parent works full-time or if the family has two parents. A study that interviewed current AFDC recipients and former recipients who had begun working found that 41 percent of AFDC recipients and 23 percent of former recipients did not understand that a parent could work full-time and receive AFDC for his or her children and an even larger percentage did

[12]For 1994 these were children from birth to 5 years old with family income at or below 133 percent of the federal poverty level and poor children 6 to 11 years old—federal law mandates coverage for children from birth to 5 years old, and for poor children older than 5 and born after September 30, 1983. For 1993, we counted children as eligible if they were up to 5 years old with family income at or below 133 percent of the federal poverty level or were poor children 6 to 10 years old.

not understand that children in two-parent families could be eligible for Medicaid.[13]

Families participating in other programs for low-income persons also have low rates of Medicaid enrollment. In 1992, only 48 percent of the women, infants, and children enrolled in the Special Supplemental Program for Women, Infants, and Children (WIC) were enrolled in Medicaid, even though over 72 percent were in families with incomes below 130 percent of the federal poverty level. In 1993, only 68 percent of children in Head Start, an early childhood education program for low-income children, were enrolled in Medicaid.

Second, getting enrolled in Medicaid is difficult for low-income families. In a previous report, we found that many Medicaid applicants never complete the eligibility determination process and about one-half are denied for procedural reasons; that is, applicants did not or could not provide the basic documentation needed to verify their eligibility or did not appear for eligibility interviews.[14] Finally, some families may not seek Medicaid until they face a medical crisis or may not want to enroll in Medicaid because they consider it a welfare program and therefore stigmatizing.

States can obtain federal matching funds to conduct outreach programs about the Medicaid program. States determine their own outreach programs—both the amount and the focus. According to one Health Care Financing Administration (HCFA) official, Medicaid outreach to children's families has focused more on encouraging the use of preventive care by enrolled children than on informing nonenrolled families that their children might be eligible. Some states do try to inform low-income families that they can get health insurance for their children through Medicaid—either by using informational billboards, 800 telephone referral numbers, or other means. In addition, HCFA and the Agency for Children and Families have developed a cooperative agreement to work together and with states and localities to improve outreach to families of potentially eligible low-income children, particularly those enrolled in federally funded child care and Head Start programs.

Fiscal pressures may have made some states less interested in expanding the number of children receiving Medicaid than they were several years

[13]Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie, A Study of the Relationship of Health Insurance Coverage to Welfare Dependency (Columbia, S.C.: Southern Institute on Children and Families, 1994), pp. 21-25.

[14]Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

ago. Even though children represent a relatively small percentage of Medicaid expenditures (about 16 percent of expenditures are for nondisabled children under 21 years old), growth in the number of children on Medicaid has contributed to program expenditure increases. Medicaid spending increases have become one of the largest budget problems for states—representing 19.4 percent of state expenditures in 1994.

Conclusions

Private health insurance is overwhelmingly employment-based in the United States, but many children do not get this benefit even if their parents work. Health insurance is less likely to be offered in the firms that employ low-income workers. If health insurance is available through work but is costly for workers, it is less likely to be affordable for low-income workers.

Part of the reason that families with children may have difficulty affording health insurance is that many children live in low-income families. Twenty-four percent of children lived in poor families in 1994, and another 21 percent lived in families with income between 101 and 200 percent of the federal poverty level. Moreover, families with employer-sponsored health insurance have faced sharply rising costs over the last decade to purchase family coverage through their employer. These rising costs may prove to be much more of a burden for lower-income families.

Private health insurance coverage has continued to decrease for children. As private coverage has decreased, Medicaid has become a more important source of health insurance coverage, especially for children in working families. Nevertheless, despite the expansion in public insurance funding, 10 million children were uninsured in the United States in 1994. Even more notable, the largest percentage of uninsured children were in families with a working parent or parents. In addition, at least 30 percent of uninsured children were eligible for Medicaid, which means that many uninsured children are not getting the advantage of publicly funded insurance.

As long as private coverage continues to decrease for children, the number of children uninsured or on Medicaid will continue to grow. This strains public resources—either to pay for Medicaid coverage or to provide direct care or subsidies to hospitals to care for the uninsured. In the past, providers have had various sources of funds to recoup some of the cost of caring for the uninsured patient. In the era of managed care and

cost-cutting, it is becoming more difficult for hospitals and physicians to care for patients without insurance. As these trends continue, it will likely become even more difficult to get care without insurance.

Medicaid cost increases are pressuring states and the federal government toward different types of program changes. Changes to the Medicaid program that remove guaranteed eligibility or alter the financing and responsibilities of the federal and state governments may strongly affect health insurance coverage for children in the future. Other types of changes that strengthen the private insurance market may also have significant effects on children's coverage in the future.

Agency Comments

We did not seek agency comments because this report does not focus on agency activities. We did, however, discuss relevant sections of this report with responsible officials in the Department of Health and Human Services, HCFA, and the Department of Commerce, Bureau of the Census. They offered technical suggestions that we included where appropriate in the report.

As agreed with your office, we plan no further distribution of this report for 30 days. At that time, we will make copies available on request. Please contact me at (202) 512-7114 or Michael Gutowski at (202) 512-7128 if you or your staff have any further questions. This report was prepared by Michael Gutowski, Sheila Avruch, and Paula Bonin.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Systems Issues

Contents

Changes in the CPS and Their Effect on Estimated Insurance Coverage and Other Methodological Considerations

The Bureau of the Census has made recent efforts to improve the accuracy and ease of administering the CPS. These changes should improve estimates of coverage, particularly for children. However, these changes can affect the estimates reported. As a result, estimates for 1994 and subsequent years may not be entirely equivalent to those for previous years. Several changes completely or partially implemented this year appear to have affected specific estimates of health insurance coverage.

CPS Improved, but Estimates Before 1994 May Not Be Comparable

Census reworded and reordered existing questions about health insurance and added new ones for the March 1995 CPS, which reports 1994 data. This was done as part of changing to a computer-assisted telephone interviewing methodology. Census also changed the sample frame—or types of families sampled to get a statistically representative estimate—from one based on the 1980 census to one based on the 1990 census. These changes appear to have affected the 1994 estimates of the percentage of people (particularly children) whose private insurance coverage is employer-based versus privately purchased and the percentage of children on Medicaid compared with previous years' estimates.

Most people in the United States who have private insurance get their insurance through their employer or union. The previous CPS questionnaire asked first whether a person had any private insurance, then if that person was the policyholder. Only after that did the questionnaire ask whether the insurance was obtained through an employer or union. The new questionnaire first asks directly whether a person has private insurance through an employer or union. The questionnaire then asks about private, individually purchased coverage.

Private Insurance Comparable, but Type of Private Insurance May Not Be

Officials at Census believe that the 1994 estimate of overall private insurance agrees well with previous years' estimates, and the estimates for individually purchased insurance and employment-based insurance are superior to previous years' estimates. However, the number of people who report that their private insurance came from an employer or union has increased, while the number who report that their private insurance was individually purchased has decreased. Therefore, because these apparent differences may be due to the questionnaire change rather than actual changes in the composition of private insurance coverage, comparisons of employment-based or private individual coverage in 1994 to previous years may not be appropriate to understand trends in coverage. This is why we

compared private coverage rather than employment-based coverage of children over time in this report.

In addition, we are using a different definition of children on Medicaid for this report than our previous report and correspondences. For this report, our group of children on Medicaid are children with any Medicaid coverage, even if they also have employment-based coverage. Previously, we had excluded children with Medicaid coverage who also had employment-based insurance in the same year from the Medicaid group. We considered employment-based insurance their primary source of coverage and included them in that group. But defining insurance coverage this way led to a lower overall number and percentage of children with Medicaid coverage. Therefore, for this report, we are including children with both private and Medicaid coverage reported in both categories. Figure 1 shows the overlap.[15]

Medicaid Estimates for Children May Be Affected by Decreases in AFDC Enrollment Rates and Change in Sampling Frame

In the past, researchers have been concerned that the CPS underreports Medicaid coverage, because CPS estimates of Medicaid enrollment have historically been lower than HCFA numbers on Medicaid program enrollment. Even if the CPS underreported Medicaid enrollment, consistent estimates can be useful to follow overall insurance trends over time. However, the calendar year 1994 CPS estimates of Medicaid coverage for children are lower than the calendar year 1993 estimates. This is puzzling to some researchers who have used the CPS in the past because HCFA data on Medicaid program enrollment showed an increase in coverage between fiscal year 1993 and fiscal year 1994. The apparent drop may be partially due to a reported drop in the number of children enrolled in AFDC and it may also be due to the change in the CPS sampling frame.

Between 1993 and 1994 the percentage of children who were reported to be receiving AFDC or other assistance dropped from 10.6 percent to 9.6 percent—about 600,000 fewer children. Because children on AFDC are entitled to Medicaid coverage, Census assigns Medicaid coverage to AFDC children even if their parents do not report them as receiving Medicaid. This partially explains why Medicaid coverage may have appeared to

[15]In our previous report and correspondences, we assigned a single source of coverage to children if they had multiple insurance sources reported for a single year. We based the assignment for insured children on a hierarchy—if they had any employment-based insurance, they were assigned to that category; if they had no employment-based insurance, but had Medicaid or Medicare, they were assigned to the Medicaid category; if they had neither employment-based insurance, Medicaid or Medicare, but had CHAMPUS, they were assigned to CHAMPUS; if they had private, individually purchased insurance, but none of the above categories, they were assigned to the individual privately purchased coverage category.

decrease. Department of Health and Human Services' data also show a small drop in the average monthly enrollment of children in AFDC between calendar years 1993 and 1994, although because of the differences between months included in calendar years and fiscal years, the drop does not show up in fiscal year data until fiscal year 1995. In fiscal year 1995, average monthly enrollment of children continued to drop.

Medicaid coverage also may have appeared to decrease because Census changed the sample frame—or types of families that Census interviews—from one based on the 1980 census to one based on the 1990 census. Because the March 1995 CPS was a transitional one for the sample frame, half the families were chosen based on the 1980 frame and half were chosen based on the 1990 frame. The percentage of children on Medicaid was lower in the half chosen from the 1990 frame (22.3 percent) than the half chosen from the 1980 frame (23.4 percent). While the sample chosen from the 1990 frame should be a more accurate report of Medicaid coverage, the differences between the two parts of the sample indicate that reported differences between 1993 and 1994 Medicaid coverage levels may be due in part to sampling frame changes rather than actual changes in coverage.

Other types of health insurance coverage did not appear to be affected much by sampling frame differences. Health insurance coverage estimates for workers with private insurance or with CHAMPUS were almost the same in the two halves of the sample frame.

Another issue with the 1993 estimate of children with Medicaid coverage—which Census informed us has been resolved—concerns miscoding. Last year, Census officials discovered some children appeared to be miscoded as receiving Medicaid. Census officials attempted to fix this through editing the CPS data tape, but the edited 1993 data tape may still contain inadvertently included data that show some children in the group with Medicaid who should not be in that group. According to Census, the coding issue was resolved for the 1994 estimates.

Effect on Comparing 1994 With Our Previous Estimates

These changes in reported coverage make some comparisons with our previous reports and others' reports based on the CPS problematic. While the estimate of the uninsured should not be affected to any great extent by changes in the questionnaire, estimates of employment-based insurance and private, individually purchased insurance are not comparable from 1994 to previous years. However, estimates of private insurance (the

combination of both) appear more comparable. Therefore, for this letter we are reporting on comparisons of private coverage. Similarly, whether private coverage came from employment or individual purchase can affect other estimates when using a hierarchy to assign one source of coverage. In addition, we are reporting children on Medicaid if they had any Medicaid coverage (including those who also had employment-based coverage) because this definition of Medicaid coverage should not be as affected by the questionnaire change and is more comparable to previous years' data and better captures the full extent of U.S. children enrolled in Medicaid.

Methodology for Matching Children and Determining Parental Work Status

To determine characteristics of children's parents, we followed a methodology discussed in our previous report (see app. II of Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175)). We matched children to a parent (18 to 64 years old) in their household (or a related adult who served as a parent, such as a grandparent or sister) and then linked that parent to a spouse, if any. We matched about 98 percent of children, but fewer Medicaid and uninsured children matched (about 96 percent) than did children with employment-based insurance. We determined parental work status by searching for a parent with the highest work status—full-time all year, less than full-time all year, or not working. Figures 1 through 4 and table II.1 are based on the total number of children—that is, unmatched children. Any discussions of employment status of parents are based on matched children, as are figure 5 and table 1.

Insurance Status of Children, 1987-94, and Medicaid Eligibility, by State, 1996

Table II.1: Health Insurance Status of Children Under 18 Years Old (1987-94—All Sources of Insurance Reported)

Year	Private Insurance	Medicaid	Uninsured
1994[a]	65.6	22.9	14.2
1993[b]	67.4	23.9	13.7
1992[c]	68.7	22.0	12.7
1992	69.3	21.6	12.4
1991	69.7	20.4	12.7
1990	71.1	18.5	13.0
1989	73.6	15.7	13.3
1988	73.5	15.6	13.1
1987	73.6	15.2	12.9

Source: The Bureau of the Census.

Note: Rows may add to more than 100 percent because children with both private insurance and Medicaid will be counted in both categories. In any year, under 5 percent of children have other coverage, such as CHAMPUS. Children with coverage other than private insurance or Medicaid and who are not uninsured are not counted in this table.

[a]Data collection method changed to entirely computer-assisted telephone interviewing and sample frame partially changed.

[b]Data collection method partially changed to computer-assisted telephone interviewing.

[c]Implementation of 1990 census population weights, which affected the estimates—see other estimate for 1992.

Table II.2: Medicaid Eligibility Levels for Pregnant Women and Children, as of February 1996

State	Percent of federal poverty level[a]			
	Pregnant women and infants[b]	Children under 6 years old	Children 6 years old and older	Age under which children are eligible
Alabama	133	133	**133**	**13**[c]
Alaska	133	133	100	13[c]
Arizona	**140**	133	**100**	**14**
Arkansas	133	133	100	13[c]
California	**200**	133	**100**	**19**
Colorado	133	133	100	13[c]
Connecticut	**185**	**185**	**185**	**13**[c]
Delaware	**185**	133	**100**	**19**
Florida	**185**	133	**100**	**20**
Georgia	**185**	133	100	13[c]
Hawaii	**300**	**300**	**300**	**19**
Idaho	133	133	100	13[c]

(continued)

State	Percent of federal poverty level[a]			
	Pregnant women and infants[b]	Children under 6 years old	Children 6 years old and older	Age under which children are eligible
Illinois	133	133	100	13[c]
Indiana	**150**	133	100	13[c]
Iowa	**185**	133	100	13[a]
Kansas	**150**	133	**100**	**16**
Kentucky	**185**	133	**100**	**19**
Louisiana	133	133	100	13[c]
Maine	**185**	133	**125**	**19**
Maryland	**185**	**185**	**185**	**13[c]**
Massachusetts	**185**	133	100	13[c]
Michigan	**185**	150	**150**	**15[d]**
Minnesota	**275[e]**	133	100	13[c]
Mississippi	**185**	133	100	13[c]
Missouri	**85**	133	**100**	**19**
Montana	133	133	100	13[c]
Nebraska	**150**	133	100	13[c]
Nevada	133	133	100	13[c]
New Hampshire	**185**	**185**	**185**	**19**
New Jersey	**185**	133	100	13[c]
New Mexico	**185**	**185**	**185**	**19**
New York	**185**	133	100	13[c]
North Carolina	**185**	133	100	13[c]
North Dakota	133	133	**100**	**18**
Ohio	133	133	100	13[c]
Oklahoma	**150**	133	100	13[c]
Oregon	133	133	**100**	**19**
Pennsylvania	**185**	133	100	13[c]
Rhode Island	**250**	**250**	100	13[c]
South Carolina	**185**	133	100	13[c]
South Dakota	133	133	**100**	**19**
Tennessee	**185**	133	100	13[c]
Texas	**185**	133	100	13[c]
Utah	133	133	**100**	**18**
Vermont	**225**	**225**	**225**	**18**
Virginia	133	133	**100**	**19**
Washington	**200[f]**	**200**	**200**	**19**

(continued)

State	Percent of federal poverty level[a]			
	Pregnant women and infants[b]	Children under 6 years old	Children 6 years old and older	Age under which children are eligible
West Virginia	**150**	133	**100**	**19**
Wisconsin	**185**	**185**	100	13[c]
Wyoming	133	133	100	13[c]

Source: National Governors' Association, State Medicaid Coverage of Pregnant Women and Children: Winter 1996, MCH Update (Washington, D.C.: National Governors' Association, 1996.)

Note: Percentages and ages in bold type show expansions beyond federal minimum requirements, either for age, family income, or both.

[a]The federal poverty level is the income level below which a family is poor, according to the federal poverty income guidelines published every year by the Department of Health and Human Services. The guidelines are for income by family size. For 1996, a family of three was poor if its family income was below $12,980.

[b]Infants are children less than 1 year old.

[c]Born after September 30, 1983.

[d]Born after June 30, 1979.

[e]Minnesota defines infants as up to 2 years old.

[f]Pregnant women are eligible if they have family income at or below 185 percent of the federal poverty level. Infants receive automatic coverage if their mother was on Medicaid when the child was born. In addition, infants are eligible if they are living in families with income up to 200 percent of the federal poverty level.

Gramm Children Health File Jeanne 207-88-3-9976

THE AMERICAN CHILD HEALTH ASSURANCE ACT OF 1997

In order to fulfill the commitment made in the Balanced Budget Agreement to provide $16 billion over 5 years for children's health insurance, we will:

- Provide additional funding for the existing Maternal and Child Health Block Grant program, funded at an FY 97 level of $681 million. The program is designed to "...provide and ...assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services...".

  The September 1996 report to Congress from the Maternal and Child Health Bureau states, "...(the block grant program) has become so successful that it is seen as a model for designing State Block Grants in the 1990's.".

  States will retain flexibility on how best to utilize the grant funds in order to provide increased opportunities for children's health care coverage. Such initiatives may include---but are not limited to---subsidies for private insurance premiums; vouchers to families for the purchase of health insurance; and provision of health care through community-based organizations.

  Estimated cost 1998-2002.....$7.7 billion

- Approve the President's Medicaid reform proposal to allow states to cover children for 12 consecutive months without regard to changes in family income. The Congressional Budget Office estimates that this policy would reduce the number of uninsured children by 80,000.

  Estimated cost 1998-2002.....$0.7 billion

- Change the effective date, from 2002 to 1998, for Medicaid coverage of all children under the age of 19 whose family income is below 100% of poverty. Increase the federal share for such coverage for only the period of coverage which is earlier than current law would otherwise allow. This mechanism would avoid placing an unfunded mandate on the states and would provide immediate health coverage to approximately 1 million children.

  Estimated cost 1998-2002.....$1.5 billion

- Insure that families with at least one child under age 18 and with family income below 200% of poverty ($32,100 for a family of 4) will be able to deduct health insurance expenses. The deduction will be phased back to current law between 200% and 300% of poverty. This provision will affect 1.2 million children whose parents are covered under an employment-based policy which does not cover the children.

  Estimated cost 1998-2002.....$5 billion

- Repeal the current, arbitrary limitations on the use of Medical Savings Accounts and permit parents to decide whether establishing a MSA would be the most effective means of providing health insurance for their children.

  Estimated cost 1998-2002.....$1.1 billion

- Adopt Medicaid reforms recommended by the National Governors Association, which expand state flexibility and build on the efforts already underway at the state level to strengthen outreach initiatives and expand health care coverage for children. Allow states to use premiums & co-payments in order to provide expanded health care coverage for children; permit the enrollment of individuals in managed care without the need to obtain a federal waiver; expand home and community-based care as an alternative to institutional care without the requirement to obtain a federal waiver; repeal the Boren amendment, thereby allowing states to control provider payment rates; and permit the states to make eligibility determinations in the most efficient and cost effective manner. The savings generated from these reforms would be applied toward the $13.6 billion in Medicaid savings required by the budget agreement.

  Estimated savings 1998-2002....$3.9 billion

May 22, 1997