CENTER ON BUDGET AND POLICY PRIORITIES

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# MILLIONS OF UNINSURED AND UNDERINSURED CHILDREN ARE ELIGIBLE FOR MEDICAID

by
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## Summary of Findings

A new study completed by the Center on Budget and Policy Priorities finds that millions of children who are likely to be eligible for Medicaid are not enrolled in the program.

- Nationally, in 1994, one-fifth of all poor and near-poor children under age 11 who were income-eligible for Medicaid — nearly 2.7 million children — were neither enrolled in Medicaid nor covered by any other form of health insurance.

- These 2.7 million children accounted for nearly one-half of all the children under age 11 who were uninsured in 1994. If these children had been enrolled in the Medicaid program, the number of uninsured children under age 11 would have been reduced by as much as 45 percent.

- Nearly 80 percent of these uninsured children who were income-eligible for Medicaid lived in families with earnings.

- An additional 2.1 million children under age 11 who were income-eligible for Medicaid but not enrolled in the program had some form of private health insurance coverage at some time during the year. These children also could have benefitted from Medicaid either because their private health care coverage was not continuous throughout the year or because the services covered under their private plan were much more limited than coverage available under Medicaid. Additionally, Medicaid could have helped their families pay premiums, copayments and deductibles that can create barriers to care particularly for very low-income children.

Of particular significance, in light of the changes in welfare and Medicaid program rules that result from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, is the very low Medicaid participation rate among children who are not receiving cash assistance (either AFDC or SSI).

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- In 1994, only 38 percent of the Medicaid-eligible children under age 11 who did not receive cash assistance were enrolled in the Medicaid program. In other words, almost two-thirds (62 percent) of all children who were not receiving welfare but who were income-eligible for Medicaid were not enrolled in the program. More than half of these children were *wholly uninsured.*

Welfare law changes are likely to give rise to even lower Medicaid participation rates in the future, unless states revamp their Medicaid application procedures and outreach strategies. Under the new law, the eligibility link between Medicaid and welfare is ended, and states are no longer required to enroll all children who are receiving TANF-funded aid onto the Medicaid program. Although Medicaid eligibility guarantees are maintained, Medicaid enrollment could plummet if steps are not taken to maximize coordination between welfare programs and Medicaid.

Even if states continue to enroll children who receive aid funded with TANF block grant dollars onto the Medicaid program, Medicaid enrollment is likely to be adversely affected by other welfare law changes. Over time fewer children are expected to receive cash aid because welfare rules will be more restrictive and because a large number of families are expected to leave the welfare rolls as parents find work. Children who no longer qualify for cash aid due to time limits and other restrictions, as well as many of the children whose parents find low-wage jobs, will continue to be eligible for Medicaid, but the data examined here strongly suggests that if current patterns persist only a small portion of these children will actually be enrolled in the Medicaid program.

It is particularly important for states to devise new systems for reaching children whose parents find work because these children are unlikely to be covered by employer-based health insurance. Department of Labor data show that in April 1993, only roughly 40 percent of workers earning less than $5 an hour had employers that offered any of their employees health care coverage, and many of these workers were not eligible to enroll in the employer-based plans because they worked part-time. Only 13 percent of all workers earning less than $5 an hour had employer-based coverage for both themselves and their families.

The Center's study also includes tables with estimates of Medicaid participation rates for young children in all fifty states, based on data covering the years 1992 through 1994. Participation rates across states vary considerably. A variety of factors influence these rates, including the scope of coverage under the state's welfare program, the uninsured rate within the state, as well as steps the state has taken to make the Medicaid program accessible to diverse populations. Due to limited sample sizes in a number of states, however, comparisons between individual states should generally be avoided.

The national and state data examined in this report demonstrate the potential for the Medicaid program to provide health care coverage to a large portion of the children who are uninsured or underinsured. The program is falling short of its potential, however, and the changes in the welfare law and trends in the private market are likely to widen the gap between eligibility and enrollment unless the states undertake aggressive new strategies to reach out to eligible children.

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## Overview

In 1995, some 3.1 million poor children under age 18 — approximately 21 percent of all poor children — had no health insurance coverage.[1] Yet, many of these children could have been insured because they were eligible for Medicaid, but were not enrolled in the program.

Medicaid now offers health insurance coverage to a broad group of poor children as a result of expansions in eligibility that began in the late 1980's and that are being phased in over time. Under federal law, children under age six are eligible for Medicaid if their family income is below 133 percent of the federal poverty line. Children between the ages of six and 13 are currently eligible if their family income is below 100 percent of the poverty line. Each year a new age group of children is "phased in" so that by the year 2002, all poor children under age 19 will be eligible for Medicaid.

*Eligibility* for coverage, however, does not necessarily translate into *actual coverage*. This analysis examines national and state-specific Medicaid participation rates for children under age 11 and finds that large numbers of income-eligible children were not enrolled in the program.[2] Many of these children lacked any health insurance

[1] U.S. Bureau of the Census, Current Population Survey, 1996.

[2] National participation rate estimates are for 1994 based on data from the Census Bureau's 1995 Current Population Survey which provides income and health insurance information for 1994. For this analysis, participation rates for children under age 11 were considered because in 1994, federal law mandated Medicaid coverage for poor children under age 11. State-specific estimates were calculated using data from Current Population Surveys for 1992, 1993, and 1994. Three years of data were used to assure larger sample sizes. While some states have expanded coverage to older children or to children with higher incomes, only the federal minimum standards were considered for both the national and state level estimates. A description of the methodology used for the analysis is presented in Appendix II.

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coverage, while the rest had some health insurance but likely received less adequate coverage than is available under state Medicaid programs.

- Nationally, in 1994, one-fifth of all poor and near-poor children under age 11 who were income-eligible for Medicaid — nearly 2.7 million children — were neither enrolled in Medicaid nor covered by any other form of health insurance.[3] Nearly 80 percent of these children lived in families with earnings.

- These 2.7 million children accounted for nearly half of all the children under age 11 who were uninsured in 1994. If these Medicaid-eligible children had been enrolled in the program, the number of uninsured children under age 11 would have been reduced by as much as 45 percent.

- An additional 2.1 million children under age 11 who were eligible for Medicaid but not enrolled in the program had some form of private health insurance coverage at some time during the year. Despite being covered by private health insurance, many of these children could have benefitted from participating in the Medicaid program. First, private plans available to families with very low-paying jobs often provide only minimal coverage and frequently require families to pay a high portion of the costs of coverage and services. Medicaid can supplement private insurance and relieve families of unaffordable premiums, deductibles and copayments that can create barriers to accessing health care. In addition, some of these children had health insurance for only part of the year. Medicaid coverage would have allowed them to be insured throughout the year.

This analysis also provides state-level estimates of the number and proportion of children eligible for Medicaid but not enrolled in the program. These figures show that there are substantial numbers of children in every state who are not currently reached by the Medicaid program, despite their eligibility for coverage. Participation rates across all states do vary considerably. However, due to the limited sample sizes in a number of states, comparisons between individual states should generally be avoided.

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[3] In this analysis, children are defined as "income-eligible" for Medicaid if they meet the federal age and income eligibility requirements of the Medicaid program. States also may impose assets tests, and therefore, some poor and near-poor children who are income-eligible may not qualify for Medicaid coverage if the countable value of assets the family owns exceeds the allowable limits. The data did not allow for consideration of assets, but consideration of assets would likely have had only a small effect on the estimates here. (Currently, only ten states impose an asset test for children.) For simplicity, this analysis will hereafter refer to those children who are "income-eligible" simply as children "eligible" for Medicaid.

The new welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or "PRWORA") could lead to even lower Medicaid participation rates in the future. The new law makes profound changes in the welfare system and in the relationship between cash assistance and Medicaid. The AFDC program is replaced with a block grant that allows states broad flexibility to develop new rules for income support and work programs while imposing stringent new work requirements and time limits. Large numbers of families may no longer be eligible for assistance as a result of federally-mandated or state-imposed restrictions that will limit eligibility for cash aid and work programs. While the new law preserves Medicaid eligibility for families who would have qualified for Medicaid under the prior law, the data show that children in families who do not receive cash aid are much less likely to enroll in the Medicaid program.

- In 1994, only 38 percent of children under age 11 who did not receive cash assistance but were eligible for Medicaid were enrolled in the Medicaid program. In other words, almost two-thirds — 62 percent — of all children who were not receiving welfare but who were eligible for Medicaid were not enrolled in the program. More than half of these children were *wholly uninsured.*[4]

Moreover, Medicaid participation may drop even among those children who remain eligible for cash assistance under the new block grant programs. Under the new law, states are no longer required to automatically enroll children who receive assistance under the block grant in the Medicaid program. This could result in significant numbers of eligible children not receiving Medicaid if states do not take steps to assure that these very poor children are enrolled in the program.

The welfare changes also are expected to result in many families becoming ineligible for cash assistance because more parents will find jobs. Children in these families are likely to remain eligible for Medicaid if their parents have low earnings, but participation rates among children in working poor and near-poor families are particularly low. As noted above, nearly 80 percent of the uninsured children under age 11 who were eligible for Medicaid in 1994 but not enrolled in the program lived in families with earnings.

Children in families that become ineligible for cash assistance because their parents find jobs are unlikely to be covered by employer-sponsored health insurance.

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[4] Because children receiving Supplemental Security Income (SSI) benefits are also automatically enrolled in the Medicaid program, these figures represent the proportion of children living in families that receive neither AFDC nor SSI benefits.

- In April 1993, only roughly 40 percent of workers earning less than $5 an hour had employers that offered *any* of their employees health care coverage, and many workers whose employers did offer coverage were not eligible to enroll in the employer-based plans often because they worked part time.

- Only 13 percent of all workers earning less than $5 an hour had employer-based coverage for both themselves and their families.[5]

The expansions in Medicaid eligibility, still being phased in, could offset the reduction in coverage resulting from the decline in employer-sponsored coverage among poor children and could allow millions of uninsured and underinsured children greater access to health care. These data indicate, however, that the changes in welfare policy and declining employer-based coverage are likely to result in even more children being uninsured despite their eligibility for Medicaid unless states improve outreach and redesign their Medicaid enrollment procedures.

## Eligibility For Medicaid Has Expanded In Recent Years

To consider Medicaid participation rates both nationally and in individual states, it is important to begin with a review of the Medicaid eligibility rules. Medicaid began as a program that provided health care coverage exclusively to individuals and families receiving cash assistance. Over the last decade, bipartisan support for covering a greater portion of uninsured children under the Medicaid program has allowed large numbers of poor and near-poor children who are not receiving cash assistance to qualify for Medicaid coverage. The shift in the Medicaid caseload has been dramatic. In 1990, fewer than one-third of the children covered by Medicaid did not receive cash assistance. Four years later, 45 percent of the children served by the Medicaid program were not receiving cash aid.[6]

Recent changes in federal Medicaid eligibility rules are largely responsible for the expansions in Medicaid coverage among low-income children who do not receive cash assistance. Currently, under federal law, children under age six with income below 133 percent of the poverty line and children ages six through 13 with income below 100 percent of the poverty line are eligible for Medicaid. Eligibility for older

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[5] U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, and Pension Benefit Guaranty Corporation, *Pension and Health Benefits of American Workers: New Findings from the April 1993 Current Population Survey*, 1994.

[6] Calculations based on data from the Urban Institute.

poor children is being phased in, so that by the year 2002, all poor children under age 19 will be eligible for coverage.[7]

These minimum federal eligibility requirements, moreover, have been augmented in many states; 40 states have expanded coverage beyond the federal requirements to make the Medicaid program available to even more children who need health insurance coverage. Currently, some 35 states and the District of Columbia provide Medicaid coverage for infants at income levels above those mandated by federal law, and eight states have raised the income limits for children through age six. In addition, 21 states have speeded up the phase-in of eligibility for older children, extending Medicaid coverage to children above the age limits required by federal law. A table listing state Medicaid income eligibility standards for children, based on a Center on Budget and Policy Priorities' survey of the 50 states and the District of Columbia, is presented in Appendix I.

In addition, since the passage of the Family Support Act in 1988, Medicaid coverage has been available to families who become ineligible for welfare because they have new or increased earnings or child support. This "transitional" Medicaid coverage is time-limited, but nonetheless is intended to assure that families do not lose their health care coverage immediately upon finding a job or receiving child support that makes them ineligible for welfare.[8]

## Many Children Who Are Eligible for Medicaid Are Not Enrolled in the Program

Millions of children who are eligible for Medicaid under these expanded Medicaid eligibility rules are not participating in the program. Although Medicaid income eligibility standards vary among states, it is possible to examine Medicaid participation rates across all states by determining the portion of children whose family income is below the federal minimum standards who are participating in the Medicaid program. In 1994, the most recent year for which data are available, children under age six with family incomes below 133 percent of the federal poverty line and children ages

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[7] Under federal law, children age six and older and born after September 30, 1983 are eligible for Medicaid if their family income is below the poverty line. Thus, as of October, 1996, all states must cover children who are 13, and the age limit rises over time. In addition to these income eligibility standards, federal law allows states to impose an asset limit. Currently, only ten states impose an asset test for children, and two of these states do not consider assets for very young children.

[8] Transitional Medicaid coverage due to earnings is limited to 12 months while transitional Medicaid coverage due to child support is limited to four months. Twelve states, however, have used the waiver process to increase the number of months of transitional Medicaid coverage.

six through 11 with family incomes below 100 percent of the federal poverty line were eligible for Medicaid.[9]

- More than one-third of all children under age 11 who were eligible for Medicaid were not enrolled in the program in 1994. This represented 4.8 million children.

- More than half of the 4.8 million children eligible but not enrolled in Medicaid — nearly 2.7 million children — were wholly uninsured. *Stated another way, one-fifth of all children who were eligible for Medicaid lacked any form of health insurance.*

- These 2.7 million children account for 45 percent of the 5.9 million children under age 11 who were uninsured in 1994.

- Nearly 80 percent of the children who were eligible for Medicaid but who were wholly uninsured — more than 2 million children — lived in families with earnings.

- An additional 2.1 million children who were eligible for Medicaid but not enrolled had some form of private health insurance. Despite having private health insurance, many of these children could have benefitted from the Medicaid program. Medicaid pays for those benefits that are covered by Medicaid but not covered by the private plan and helps families afford the premiums, deductibles and copayments charged by their private health insurance.

It is not possible to determine from the data what type of insurance these 2.1 million children had. However, many poor children with private insurance coverage are likely to have limited benefit packages that may not cover preventive care or specialty services. Thus, while these 2.1 million children fall into the "insured" category, they may lack access to routine care, and those with special health care needs may not be able to access the medical care they require. In addition, some of these 2.1 million children were covered by private health insurance for only part of the year. (The Census data do not distinguish between children covered for part and all of the year.)

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[9] The following data are based on the Census Bureaus' 1995 Current Population Survey. The calculations reflect Medicaid income eligibility rules in effect in 1994.

Medicaid coverage would have ensured that these children were not left uninsured during those months when they were not covered by private insurance.[10]

Since cash assistance recipients in 1994 were automatically enrolled in Medicaid, the Medicaid participation rates among children who did *not* receive cash aid are particularly telling. These rates are quite low:

- Nationally, in 1994, only 38 percent of poor and near-poor children who did not receive AFDC or SSI but who were eligible for Medicaid were enrolled in the program. In other words, almost two-thirds — 62 percent — of all children under age 11 who were not receiving welfare but who were eligible for Medicaid were not enrolled. *More than half of these children were wholly uninsured.*

These very low participation rates among children who do not receive cash assistance are particularly worrisome given program changes prompted by the new welfare law that are likely to result in many fewer children receiving cash aid.

*State Estimates*

Table I shows estimates for each state of the number and proportion of Medicaid-eligible children who were not enrolled in the program. These estimates are based on data from 1992-1994. While small sample sizes make comparing participation rates across states ill-advised, taken as a whole, the data do show significant state variation in the participation rates among eligible children in the Medicaid program.

There are many reasons for such variation. One reason why participation rates will vary is that states in which a larger proportion of poor and near-poor children participate in the AFDC or SSI programs will tend to have a larger proportion of eligible children participating in the Medicaid program. Table II addresses this issue and show the number and proportion of income-eligible children not receiving AFDC and SSI who were not enrolled in Medicaid.

In addition, states in which a larger portion of Medicaid-eligible children have private health insurance coverage may have lower Medicaid participation rates. Table III shows the number and proportion of eligible children not receiving AFDC or SSI who were wholly uninsured.

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[10] A May 1996 Census report, "Who Loses Coverage and For How Long," shows that while 93 percent of all people had health insurance at some point during 1993, some 15 percent of these "insured" individuals lacked health insurance for at least one month during the year.

The variations in Medicaid participation rates across states may also be due in part to state administrative procedures and outreach efforts. Some states, for example, use one-page application forms and allow applicants to submit their forms by mail. Such simplified procedures are particularly important for working poor families unable to take time off from their jobs to apply in person and to families in rural areas or other communities where a lack of public transportation makes it difficult for families to come to the Medicaid office. In some communities, child care agencies, schools and health care providers, such as visiting nurses, community health centers, and hospitals help to enroll eligible families onto the program. In addition, some states have taken advantage of opportunities to improve participation rates by linking Medicaid eligibility determinations to other programs with similar eligibility rules, such as the WIC program, Head Start, and other child care programs.

**More Eligible Children Could Be Uninsured In the Future**

Provisions in the new welfare law coupled with low and declining rates of employer-provided health care coverage for children could mean even greater numbers of Medicaid-eligible children not participating in the program in the future. A large portion of these children will likely be wholly uninsured.

*New Welfare Law Could Affect Medicaid Participation*

Although it is commonly believed that the welfare law enacted in August 1996 did not include any significant changes in the Medicaid program, the new law does affect Medicaid eligibility and participation in fundamental ways. These changes could result in greater numbers of children who are eligible for Medicaid but not enrolled in the program.

Since the beginning of the Medicaid program, eligibility for AFDC and Medicaid have been linked. Families receiving AFDC have been automatically eligible for Medicaid and enrolled in the Medicaid program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, however, replaced the AFDC program with the Temporary Assistance to Needy Families ("TANF") block grant. Under the block grant, states have broad flexibility to design income support and work programs for low-income families with children and are required to impose federally-mandated restrictions, such as time limits, on federally-funded assistance. The law does assure, however, that children and parents who would have qualified for Medicaid based on their eligibility for AFDC continue to be eligible for Medicaid regardless of whether they qualify for assistance under a program or programs that states establish with block

**Continued Phase-In of Medicaid Coverage for Poor Children Will Increase the Number of Children Eligible for Medicaid and the Need for Outreach**

In addition to the changes in the new welfare law, the continued phase-in of the recent Medicaid expansions means that large numbers of additional children will become eligible for Medicaid in the future. Under federal law, children under age six below 133 percent of the poverty line and poor children ages six and older born after September 30, 1983 are eligible for Medicaid. As a result, in 1994 poor children ages six through 11 were eligible for Medicaid while currently poor children ages six through 13 are eligible. By 2002, poor children under the age of 19 will be eligible for Medicaid.

In 1994, there were nearly 2.4 million poor children over the age of 11 who did not receive Medicaid, a rough estimate of the number of additional children who will become eligible and could be enrolled in Medicaid in the coming years.

grant funds. This is accomplished by carrying over to the Medicaid program certain eligibility rules from state AFDC programs.[11]

While children will not lose *eligibility* for Medicaid due to the new law, other changes in the law may cause Medicaid participation rates to drop substantially.

- Fewer children are likely to receive cash assistance under the new law due to restrictions placed on receipt of aid. States are required to impose a maximum five-year time limit on assistance funded with federal block grant dollars and are permitted to impose shorter time limits. States are also given vast new authority to limit access to assistance in other ways, such as by lowering income-eligibility limits and by limiting aid to teen parents.

  Children who no longer receive cash assistance due to such restrictions generally will be eligible for Medicaid, but they are likely to have low Medicaid participation rates. As noted above, close to two-thirds of the

[11] Under the welfare law, children and parents whose income and assets are below the state's AFDC income and resource standards in effect as of July 1996 and who meet the AFDC family composition rules in effect as of July 1996 will qualify for Medicaid. If a state has an AFDC waiver that affects these eligibility rules, the state may have the option to continue applying its waiver rules. States also have certain options to vary their income and asset standards and their rules for calculating financial eligibility. A state may lower the income standards for determining eligibility for older children and parents, but not below the levels that were in place in the state's AFDC program in May 1988. States may also raise their income and asset standards, but not by an amount that is greater than the raise in the Consumer Price Index. For more discussion of these new rules see, Cindy Mann, *An Analysis of the AFDC-Related Medicaid Provisions in the New Welfare Law*, Center on Budget and Policy Priorities, revised November 7, 1996.

children eligible for Medicaid who did not receive cash assistance — 62 percent — were not enrolled in the program in 1994.

- Medicaid participation may decline even among children who remain eligible for cash assistance and work programs funded under the block grant. Under the new law, there is no requirement that states automatically enroll children who receive aid funded under the TANF block grant in the Medicaid program. States have a number of options, however, under the law that allow them to keep Medicaid and welfare program rules aligned and to assure that children who receive cash aid and who are eligible for Medicaid are enrolled in the Medicaid program. (See box on page 11.)

- Fewer children may also qualify for cash assistance because their parents find jobs. The new law requires states to place increasing numbers of parents in work activities, and the law is expected to result in greater number of parents finding employment. While many of the children whose parents become employed are likely to remain eligible for Medicaid due to the low earnings of their parents, Medicaid participation rates among children in poor and near-poor working families are quite low.

In addition to these welfare-related changes, the new law makes significant changes in eligibility for children under the federal Supplemental Security Income (SSI) program. Under the law, a substantial number of children will lose SSI benefits — and, therefore, their automatic eligibility for Medicaid — due to new restrictions in the definition of disability. A majority of the children who are no longer eligible for SSI will be eligible for Medicaid under alternative avenues of coverage — many, for example, will meet the age and income eligibility criteria for Medicaid — but enrollment of these poor children who have significant medical problems will no longer be automatic.[12]

The extent to which states develop new approaches to assure that eligible children are enrolled in Medicaid thus will have a considerable effect on Medicaid

[12] Children who are currently receiving SSI but who become ineligible under the new disability standards should not be terminated from Medicaid coverage unless and until the state determines that they are not eligible under an alternate eligibility category. See HCFA fact sheet entitled "Link Between Medicaid and SSI Coverage of Children Under Welfare Reform." The Medicaid enrollment issue discussed here, therefore, concerns children who would have qualified for SSI in the future, not to current SSI recipients.

**States Can Coordinate Medicaid and Welfare Program Enrollment**

Although the new law does not require states to enroll all children who receive cash assistance under the TANF block grant into the Medicaid program, states could design their welfare and Medicaid systems so there is a single eligibility determination for both programs. The new law allows states flexibility in determining how they will administer their Medicaid program and the extent to which Medicaid rules and the rules for the program(s) funded with TANF block grant dollars will be the same.

The more closely the eligibility rules for the welfare and Medicaid programs are aligned, the easier it will be to coordinate program enrollment. For example, if a state keeps the basic financial eligibility rules for its new welfare program and for Medicaid consistent, a single application form can be used to determine eligibility under both programs and a single agency could make the eligibility determination. Coordination also can be achieved even in states that choose to change their welfare rules as long as the new rules are no more restrictive than the rules that were in effect in July 1996. The new welfare law maintains current rules as the *minimum* standard for Medicaid; states can modify and simplify their rules so long as the changes do not result in families losing coverage under the Medicaid program.[a]

Even if a state imposes restrictions or lowers eligibility standards for its TANF-funded program in ways that would not be allowed under Medicaid rules, a single application could still be used for the two programs since all TANF program recipients would likely still be eligible for Medicaid. The state could maximize participation in Medicaid (and limit state administrative costs) by coordinating eligibility between the two programs. The state would, however, have to ensure that children and parents who did not qualify for TANF-funded assistance are separately evaluated for Medicaid eligibility.

[a] States that keep welfare and Medicaid rules consistent may be able to minimize their state administrative costs and maximize their federal reimbursement. States can claim federal Medicaid administrative matching funds to cover the cost of determining eligibility under Medicaid, whereas under the TANF block grant, states do not receive additional federal funds for administration. If the eligibility process for the two programs remains closely linked, the work done on Medicaid could significantly simplify the administrative tasks required to determine eligibility for aid under TANF.

participation rates both among children who remain eligible for cash assistance and those who no longer qualify.[13]

[13] There are other changes in the new welfare law affecting Medicaid. Most significant is that most legal immigrants of any age who enter the country on or after August 22, 1996 (the day the new law was enacted) will not be eligible for Medicaid. Immigrants who are already in the country can be covered *at state option*. States that choose to withdraw Medicaid coverage for legal immigrants could see significant increases in the number of uninsured people.

The number of low-income parents who work may increase as a result of changes in welfare programs and policies. However, few of the children in these families are likely to be covered in an employer-sponsored health plan.

- In April 1993, when the minimum wage stood at $4.25, only 21 percent of workers between the ages of 25 and 34 who earned less than $5 an hour were covered by an employer-provided health insurance plan.

- Similarly, among all workers earning less than $5 an hour, only 13 percent had employer-provided health care coverage for both themselves and their families. Among those earning between $5 and $7.50 an hour, only 26 percent had employer-provided coverage for both themselves and their families.

- Some low-wage workers who are not covered by an employer-based health care plan are covered by other private health insurance plans, including employer-based plans of other family members. Among those earning less than $5 an hour in private sector firms, however, nearly 60 percent worked in firms that did not offer *any* of their employees health insurance coverage. Among those that worked in firms that offered health insurance coverage to at least some of their workers, almost one-third reported being ineligible for coverage. The most common reason cited for ineligibility was that the employee worked part time.[14]

- Census figures show that in 1995, only about two-thirds of children under age 18 — 66.4 percent — had private health insurance coverage, down from about three quarters — 73.8 percent — in 1988.

## Conclusion

Already, large numbers of eligible children are not enrolled in the Medicaid program, and many of those eligible but not enrolled lack any form of health insurance. Changes in the new welfare law coupled with low and declining rates of health insurance coverage through the workplace could mean that more Medicaid-eligible children will lack adequate health care coverage in the future. It is, therefore, more important than ever for states to improve their efforts to inform low-income families of their potential eligibility for Medicaid and to reexamine their systems for enrolling children and families in the Medicaid program.

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[14] U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, and Pension Benefit Guaranty Corporation, *Pension and Health Benefits of American Workers: New Findings from the April 1993 Current Population Survey*, 1994.

Table I

**Percent and Number of Children Under 11 Who Were Income-Eligible For Medicaid But Not Enrolled**

| | Percent | | Number | |
|---|---|---|---|---|
| | Low | High | Low | High |
| Alabama | 36.9% | 51.0% | 72,000 | 130,000 |
| Alaska | 24.7% | 38.7% | 4,200 | 8,900 |
| Arizona | 35.4% | 48.3% | 74,700 | 130,800 |
| Arkansas | 36.2% | 49.7% | 42,000 | 75,200 |
| California | 33.5% | 38.1% | 673,700 | 838,100 |
| Colorado | 28.9% | 46.2% | 29,100 | 66,200 |
| Connecticut | 22.8% | 40.1% | 22,900 | 58,600 |
| Delaware | 30.2% | 49.1% | 5,400 | 13,000 |
| Dist. of Col. | 13.7% | 24.1% | 5,700 | 13,000 |
| Florida | 29.6% | 35.7% | 216,100 | 296,500 |
| Georgia | 29.1% | 43.8% | 70,200 | 142,500 |
| Hawaii | 34.5% | 51.8% | 12,800 | 26,800 |
| Idaho | 36.2% | 48.5% | 18,800 | 32,400 |
| Illinois | 24.0% | 30.7% | 135,200 | 200,400 |
| Indiana | 22.1% | 34.8% | 55,500 | 116,600 |
| Iowa | 39.7% | 56.2% | 34,800 | 68,100 |
| Kansas | 29.0% | 43.6% | 25,500 | 51,900 |
| Kentucky | 17.8% | 28.9% | 33,400 | 70,700 |
| Louisiana | 29.9% | 41.4% | 92,400 | 160,500 |
| Maine | 21.1% | 36.7% | 8,700 | 21,100 |
| Maryland | 36.2% | 52.2% | 62,500 | 124,400 |
| Massachusetts | 25.3% | 34.4% | 41,500 | 68,500 |
| Michigan | 20.2% | 26.4% | 93,200 | 141,100 |
| Minnesota | 25.0% | 40.5% | 35,500 | 80,100 |
| Mississippi | 22.3% | 33.1% | 33,800 | 63,300 |
| Missouri | 26.1% | 39.8% | 62,000 | 125,800 |
| Montana | 23.4% | 37.7% | 7,300 | 15,600 |
| Nebraska | 36.7% | 52.6% | 18,600 | 36,400 |
| Nevada | 51.6% | 66.1% | 27,200 | 46,500 |
| New Hampshire | 21.5% | 39.0% | 7,200 | 19,200 |
| New Jersey | 28.0% | 36.5% | 68,400 | 106,800 |
| New Mexico | 30.4% | 42.7% | 26,700 | 47,600 |
| New York | 25.4% | 30.4% | 230,600 | 307,300 |
| North Carolina | 30.3% | 37.6% | 87,000 | 125,300 |
| North Dakota | 25.7% | 41.3% | 4,600 | 10,300 |
| Ohio | 24.2% | 31.0% | 116,400 | 173,600 |
| Oklahoma | 43.5% | 56.4% | 75,400 | 125,700 |
| Oregon | 31.1% | 47.4% | 32,200 | 68,400 |
| Pennsylvania | 32.1% | 40.0% | 144,900 | 212,400 |
| Rhode Island | 21.4% | 38.2% | 6,200 | 16,300 |
| South Carolina | 23.8% | 34.4% | 46,300 | 84,100 |
| South Dakota | 40.3% | 53.8% | 11,800 | 20,500 |
| Tennessee | 17.1% | 28.3% | 37,000 | 80,500 |
| Texas | 37.1% | 43.2% | 427,100 | 560,900 |
| Utah | 40.5% | 55.6% | 26,600 | 48,800 |
| Vermont | 10.9% | 25.1% | 1,800 | 6,000 |
| Virginia | 40.2% | 56.2% | 66,400 | 127,600 |
| Washington | 24.7% | 39.6% | 40,600 | 89,300 |
| West Virginia | 20.6% | 33.1% | 18,200 | 38,200 |
| Wisconsin | 27.4% | 42.7% | 41,900 | 89,300 |
| Wyoming | 34.0% | 53.4% | 4,700 | 11,000 |
| U.S. | 35.2% | 37.5% | 4,650,700 | 4,946,900 |

**How to Read This Table:**

In the period 1992-1994, between 37 and 51 percent of children income-eligible for Medicaid were not enrolled in Alabama. This translates into between 72,000 and 130,000 children who were eligible but not enrolled in Medicaid in 1994.

Source: Center on Budget and Policy Priorities calculations based on pooled data from the Census Bureau's 1993, 1994, and 1995 March Current Population Surveys.

## Table I NOTES:

1. To determine the Medicaid participation rates, children were considered income eligible for Medicaid if they met the age and income-eligibility requirements for Medicaid in the year they were interviewed for the Current Population Survey. In each year, children under age six with incomes below 133 percent of poverty were considered income-eligible for Medicaid. Those interviewed in 1993 were considered income-eligible for Medicaid if they were between the ages of 6 and 8 and had incomes below the poverty line. Those interviewed in 1994 were considered income-eligible for Medicaid if they were between the ages of 6 and 9 and had incomes below the poverty line. Those interviewd in 1995 were considered income-eligible for Medicaid if they were between the ages of 6 and 10 and had incomes below the poverty line. To calculate the number of children income eligible for Medicaid but not enrolled, the Medicaid participation rates were multiplied by the estimate of the number of children who would have met the 1994 Medicaid eligibility standards averaged over each of the three survey years.

2. For detailed description of the methodology used, see Appendix II.

Table II

**Percent and Number of Children Under 11 Who Did Not Receive AFDC or SSI And Who Were Income-Eligible for Medicaid But Not Enrolled**

| | Percent | | Number | |
|---|---|---|---|---|
| | Low | High | Low | High |
| Alabama | 48.2% | 64.2% | 70,000 | 126,900 |
| Alaska | 50.1% | 71.5% | 4,100 | 8,900 |
| Arizona | 55.5% | 71.4% | 76,000 | 132,700 |
| Arkansas | 47.8% | 64.2% | 35,800 | 66,600 |
| California | 59.7% | 65.8% | 657,900 | 820,100 |
| Colorado | 51.8% | 73.9% | 28,800 | 65,300 |
| Connecticut | 64.7% | 88.8% | 21,100 | 53,900 |
| Delaware | 55.1% | 77.1% | 5,500 | 12,700 |
| Dist. of Col. | 42.5% | 65.6% | 5,100 | 12,500 |
| Florida | 50.4% | 58.9% | 209,900 | 290,300 |
| Georgia | 45.9% | 64.4% | 70,600 | 143,100 |
| Hawaii | 60.5% | 81.4% | 12,300 | 25,500 |
| Idaho | 57.0% | 72.0% | 18,900 | 32,400 |
| Illinois | 57.3% | 68.6% | 130,600 | 195,800 |
| Indiana | 37.3% | 55.4% | 54,400 | 116,900 |
| Iowa | 65.7% | 84.2% | 33,100 | 64,300 |
| Kansas | 50.9% | 70.8% | 24,100 | 50,000 |
| Kentucky | 38.2% | 56.7% | 32,700 | 70,900 |
| Louisiana | 58.2% | 74.0% | 85,400 | 150,200 |
| Maine | 39.7% | 62.5% | 8,500 | 20,800 |
| Maryland | 63.7% | 82.8% | 60,900 | 120,800 |
| Massachusetts | 59.8% | 74.1% | 39,300 | 65,700 |
| Michigan | 50.3% | 61.9% | 91,600 | 140,900 |
| Minnesota | 59.6% | 83.1% | 33,400 | 77,200 |
| Mississippi | 46.3% | 63.6% | 34,500 | 65,600 |
| Missouri | 45.1% | 64.2% | 55,500 | 116,200 |
| Montana | 41.5% | 61.3% | 7,000 | 15,200 |
| Nebraska | 60.0% | 79.3% | 17,700 | 34,900 |
| Nevada | 65.9% | 80.5% | 26,300 | 44,700 |
| New Hampshire | 52.2% | 78.7% | 7,900 | 20,500 |
| New Jersey | 62.9% | 75.2% | 68,400 | 106,600 |
| New Mexico | 51.3% | 67.6% | 26,000 | 46,700 |
| New York | 63.0% | 71.4% | 222,700 | 298,900 |
| North Carolina | 49.3% | 59.2% | 83,500 | 121,500 |
| North Dakota | 47.8% | 70.2% | 4,600 | 10,400 |
| Ohio | 60.4% | 72.3% | 108,900 | 165,300 |
| Oklahoma | 67.9% | 81.5% | 76,800 | 125,400 |
| Oregon | 57.3% | 78.0% | 31,500 | 66,900 |
| Pennsylvania | 64.0% | 74.7% | 141,000 | 206,500 |
| Rhode Island | 49.6% | 77.3% | 5,500 | 15,200 |
| South Carolina | 44.6% | 60.5% | 44,700 | 82,900 |
| South Dakota | 62.5% | 77.9% | 12,300 | 20,800 |
| Tennessee | 36.1% | 55.4% | 35,300 | 79,900 |
| Texas | 50.9% | 58.2% | 413,400 | 545,000 |
| Utah | 54.7% | 71.4% | 26,500 | 48,500 |
| Vermont | 26.4% | 57.2% | 1,500 | 5,800 |
| Virginia | 56.7% | 74.3% | 66,300 | 125,900 |
| Washington | 62.4% | 81.0% | 41,500 | 86,800 |
| West Virginia | 43.3% | 63.2% | 17,800 | 38,100 |
| Wisconsin | 66.8% | 85.9% | 42,700 | 87,600 |
| Wyoming | 60.9% | 83.9% | 4,600 | 10,600 |
| U.S. | 60.6% | 63.6% | 4,542,900 | 4,768,000 |

**How To Read This Table:**

In the period 1992-1994, between 48 and 62 percent of children who did not receive AFDC or SSI and were income-eligible for Medicaid were not enrolled in Alabama. This translates into between 70,000 and 126,900 children who did not receive AFDC or SSI and who were eligible but not enrolled in Medicaid in 1994.

Source: Center on Budget and Policy Priorities calculations based on pooled data from the Census Bureau's 1993, 1994, and 1995 March Current Population Surveys.

**TABLE II NOTES:**

1. To determine the Medicaid participation rates, children were considered income eligible for Medicaid if they met the age and income-eligibility requirements for Medicaid in the year they were interviewed for the Current Population Survey. In each year, children under age six with incomes below 133 percent of poverty were considered income-eligible for Medicaid. Those interviewed in 1993 were considered income-eligible for Medicaid if they were between the ages of 6 and 8 and had incomes below the poverty line. Those interviewd in 1994 were considered income-eligible for Medicaid if they were between the ages of 6 and 9 and had incomes below the poverty line. Those interviewed in 1995 were considered income-eligible for Medicaid if they were between the ages of 6 and 10 and had incomes below the poverty line. To calculate the number of children income eligible for Medicaid but not enrolled, the Medicaid participation rates were multiplied by the estimate of the number of children who would have met the 1994 Medicaid eligibility standards.

2. In this analysis, children whose families received any income from AFDC or SSI were excluded. Due to data limitations, we could not determine whether the child was an SSI recipient or whether someone else in the family received SSI benefits.

3. For detailed description of the methodology used, see Appendix II.

Table III

**Percent and Number of Children Under 11 Who Did Not Receive AFDC or SSI Who Were Income-Eligible For Medicaid But Were Not Covered by Medicaid or Any Other Health Insurance Plan**

| | Percent | | Number | |
|---|---|---|---|---|
| | Low | High | Low | High |
| Alabama | 19.1% | 33.1% | 27,800 | 65,500 |
| Alaska | 5.8% | 20.6% | 500 | 2,600 |
| Arizona | 30.8% | 46.6% | 42,200 | 86,600 |
| Arkansas | 20.8% | 35.8% | 15,600 | 37,100 |
| California | 36.7% | 42.9% | 404,800 | 535,000 |
| Colorado | 15.6% | 34.4% | 8,700 | 30,400 |
| Connecticut | 10.2% | 35.9% | 3,300 | 21,800 |
| Delaware | 6.9% | 24.1% | 700 | 4,000 |
| Dist. of Col. | 18.3% | 36.9% | 2,200 | 7,000 |
| Florida | 26.6% | 34.5% | 110,900 | 170,100 |
| Georgia | 23.2% | 40.4% | 35,800 | 89,800 |
| Hawaii | 17.0% | 38.5% | 3,500 | 12,100 |
| Idaho | 19.4% | 33.2% | 6,400 | 14,900 |
| Illinois | 23.2% | 33.7% | 52,800 | 96,200 |
| Indiana | 9.6% | 22.9% | 14,100 | 48,300 |
| Iowa | 21.8% | 39.9% | 11,000 | 30,500 |
| Kansas | 13.2% | 29.9% | 6,300 | 21,100 |
| Kentucky | 15.0% | 31.3% | 12,800 | 39,100 |
| Louisiana | 35.4% | 51.8% | 51,900 | 105,200 |
| Maine | 4.7% | 19.7% | 1,000 | 6,600 |
| Maryland | 16.7% | 35.7% | 15,900 | 52,000 |
| Massachusetts | 23.1% | 36.8% | 15,200 | 32,700 |
| Michigan | 21.1% | 31.4% | 38,400 | 71,500 |
| Minnesota | 5.1% | 20.5% | 2,800 | 19,100 |
| Mississippi | 20.6% | 36.4% | 15,300 | 37,400 |
| Missouri | 12.2% | 26.3% | 15,000 | 47,600 |
| Montana | 9.2% | 22.6% | 1,500 | 5,600 |
| Nebraska | 12.0% | 28.4% | 3,500 | 12,500 |
| Nevada | 29.8% | 45.7% | 11,900 | 25,400 |
| New Hampshire | 19.1% | 44.0% | 2,900 | 11,400 |
| New Jersey | 23.6% | 35.9% | 25,700 | 50,800 |
| New Mexico | 30.8% | 46.9% | 15,600 | 32,400 |
| New York | 25.8% | 33.9% | 91,100 | 142,200 |
| North Carolina | 19.7% | 28.1% | 33,300 | 57,600 |
| North Dakota | 9.6% | 27.2% | 900 | 4,000 |
| Ohio | 23.5% | 34.9% | 42,300 | 79,800 |
| Oklahoma | 41.0% | 56.9% | 46,400 | 87,500 |
| Oregon | 17.9% | 37.6% | 9,800 | 32,200 |
| Pennsylvania | 24.6% | 35.2% | 54,100 | 97,300 |
| Rhode Island | 19.4% | 45.5% | 2,200 | 8,900 |
| South Carolina | 18.7% | 32.5% | 18,800 | 44,600 |
| South Dakota | 12.6% | 26.0% | 2,500 | 7,000 |
| Tennessee | 6.8% | 20.2% | 6,700 | 29,200 |
| Texas | 31.4% | 38.3% | 255,100 | 358,900 |
| Utah | 17.5% | 32.4% | 8,400 | 22,000 |
| Vermont | 0.9% | 20.3% | 0 | 2,100 |
| Virginia | 23.5% | 40.8% | 27,500 | 69,300 |
| Washington | 19.1% | 40.8% | 12,700 | 43,700 |
| West Virginia | 20.1% | 38.3% | 8,300 | 23,100 |
| Wisconsin | 25.9% | 48.8% | 16,500 | 49,800 |
| Wyoming | 22.2% | 46.9% | 1,700 | 6,000 |
| U.S. | 32.4% | 35.3% | 2,427,200 | 2,646,700 |

**How To Read This Table:**
In the period 1992-1994, between 19 and 33 percent of children who did not receive AFDC or SSI and were income-eligible for Medicaid were wholly uninsured in Alabama. This translates into between 27,800 and 65,500 children who did not receive AFDC or SSI and who were eligible for Medicaid but lacked any form of health insurance in 1994.

Source: Center on Budget and Policy Priorities calculations based on pooled data from the Census Bureau's 1993, 1994, and 1995 March Current Population Surveys.

**TABLE III NOTES:**

1. To determine the proportion of Medicaid-eligible children who lacked health insurance, children were considered income eligible for Medicaid if they met the age and income-eligibility requirements for Medicaid in the year they were interviewed for the Current Population Survey. In each year, children under age six with incomes below 133 percent of poverty were considered income-eligible for Medicaid. Those interviewed in 1993 were considered income-eligible for Medicaid if they were between the ages of 6 and 8 and had incomes below the poverty line. Those interviewd in 1994 were considered income-eligible for Medicaid if they were between the ages of 6 and 9 and had incomes below the poverty line. Those interviewed in 1995 were considered income-eligible for Medicaid if they were between the ages of 6 and 10 and had incomes below the poverty line. To calculate the number of children eligible for Medicaid but lacking any health insurance, the estimates of the proportion of Medicaid eligible children with no health insurance were multiplied by the estimate of the number of children who would have met the 1994 Medicaid eligibility standards.

2. In this analysis, children whose families received any income from AFDC or SSI were excluded. Due to data limitations, we could not determine whether the child was an SSI recipient or whether someone else in the family received SSI benefits.

3. For detailed description of the methodology used, see Appendix II.

**Appendix I: Medicaid Income Eligibility Guidelines for Children Expressed As A Percent of the Federal Poverty Line**

| STATE | Infants (0-1)[1] | Children (1-6)[1] | Older Children[2] |
|---|---|---|---|
| Alabama | 133% | 133% | |
| Alaska | 133% | 133% | |
| Arizona | 140% | 133% | 100% (under 14) |
| Arkansas | 133% | 133% | |
| California[3] | 200% | 133% | |
| Colorado | 133% | 133% | |
| Connecticut | 185% | 185% | 185% (under 13) |
| Delaware | 185% | 133% | 100% (under 19) |
| D.C. | 185% | 133% | |
| Florida | 185% | 133% | |
| Georgia | 185% | 133% | 100% (under 19) |
| Hawaii[3] | 185% | 133% | 133% (under 19) |
| Idaho | 133% | 133% | |
| Illinois | 133% | 133% | |
| Indiana | 150% | 133% | |
| Iowa | 185% | 133% | |
| Kansas | 150% | 133% | 100% (under 17) |
| Kentucky | 185% | 133% | 100% (under 19) |
| Louisiana | 133% | 133% | |
| Maine | 185% | 133% | 125% (under 19) |
| Maryland[3] | 185% | 133% | |
| Massachusetts[3] | 185% | 133% | |
| Michigan | 185% | 150% | 150% (under 15) |
| Minnesota[3/4] | 275% | 133% | |
| Mississippi | 185% | 133% | |
| Missouri | 185% | 133% | 100% (under 19) |
| Montana | 133% | 133% | |
| Nebraska | 150% | 133% | |
| Nevada | 133% | 133% | |
| New Hampshire | 185% | 185% | 185% (under 19) |
| New Jersey | 185% | 133% | |
| New Mexico | 185% | 185% | 185% (under 19) |
| New York[3] | 185% | 133% | |
| North Carolina | 185% | 133% | |
| North Dakota | 133% | 133% | 100% (under 18) |

| STATE | Infants (0 - 1)[1] | Children (1 - 6)[1] | Older Children[2] |
|---|---|---|---|
| Ohio | 133% | 133% | |
| Oklahoma | 150% | 133% | |
| Oregon | 133% | 133% | 100% (under 19) |
| Pennsylvania[3] | 185% | 133% | |
| Rhode Island | 250% | 250% | 100% (born after 6/30/83) |
| South Carolina | 185% | 133% | |
| South Dakota | 133% | 133% | 100% (born after 6/30/83) |
| Tennessee | 185% | 133% | |
| Texas | 185% | 133% | |
| Utah | 133% | 133% | 100% (under 18) |
| Vermont | 225% | 225% | 225% (under 18) |
| Virginia | 133% | 133% | 100% (under 19) |
| Washington | 200% | 200% | 200% (under 19) |
| West Virginia | 150% | 133% | 100% (under 19) |
| Wisconsin | 185% | 185% | |
| Wyoming | 133% | 133% | |

1. To be eligible in the infant category, a child is under age 1 and has not yet reached his or her first birthday. To be eligible in the 1-6 category, the child is older than age 1 and has not yet reached his or her sixth birthday.

2. If the last column in the chart is left blank, the state provides Medicaid coverage to children age six or older who were born after September 30, 1983 and who have family incomes below 100 percent of the poverty line, as required by law. By October 1, 2002 all poor children under age 19 will be covered. If there is a notation in this column, it indicates that the state covers children in this age group who have family incomes higher than 100 percent of the poverty line, or that the state covers children born before September 30, 1983, thereby accelerating the phase-in period. States that have taken such steps have done so either through Medicaid waivers or the 1902(r)(2) provision of the Social Security Act.

3. The states noted operate state-funded health insurance programs available to children not eligible for Medicaid. Such programs may provide benefits similar to the Medicaid program or they may provide a limited benefits package. State-funded health insurance programs for children are as follows:

California (under age 2): 300 percent of the poverty line
Hawaii (under age 19): 300 percent of the poverty line; children older than 6 pay a premium
Maryland (under age 13): 185 percent of the poverty line
Massachusetts (under age 19): insurance buy-in program with sliding fee scale
Minnesota (under age 19): 275 percent of the poverty line
New York (under 15): insurance buy-in program with sliding fee scale
Pennsylvania (under 15): 185 percent of the poverty line

Colorado and Florida have state-funded health insurance programs for children, but these programs only are available to children in certain counties.

4. The Medicaid program in Minnesota covers infants and children under age 2 with family incomes below 275 percent of the poverty line.

## Appendix II: Methodology for Calculating State Estimates

In this analysis, the March Current Population Surveys for 1993, 1994, and 1995 were used to develop state estimates of the number and percent of children eligible for Medicaid who were not enrolled in the program and who lacked any form of health insurance.[1] Three years of data were pooled to increase the sample size, and therefore the accuracy, of state estimates. The methodology for pooling the data and calculating the appropriate standard errors used in this analysis follows the Census Bureau's recommended procedures.[2]

*Estimating the Proportion of Children Eligible for Medicaid Who Were Not Enrolled or Who Lacked Health Insurance*

This paper looks at two different groups of children. Medicaid participation rates and overall insurance coverage are reported for each of these two groups of children.

The first group is comprised of all children who appear income-eligible for Medicaid. Children were considered income-eligible for Medicaid if they met the federal age and income eligibility requirements of the Medicaid program in place during the year about which they were interviewed. For example, children interviewed in 1993 about their income and health insurance coverage in 1992 were considered income-eligible for Medicaid if, in 1992, they were below age 6 and had incomes below 133 percent of the poverty line or if they were between the ages of 6 and 8 and had incomes below the poverty line. For those children interviewed in subsequent years, the Medicaid eligibility rules for the subsequent years were applied to determine if the child was income-eligible for Medicaid.[3] For each state in each survey year, estimates were made of the proportion of income-eligible children who received Medicaid or had some other form of health insurance. Following the methodology of the Census Bureau, these estimates were averaged and then the "standard error" of that estimate calculated in order to determine the appropriate range or "confidence interval" around the estimate.[4]

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[1] The Current Population Survey is conducted in March of each year and asks respondents about their income and health care coverage for the prior year.

[2] See the revised source and accuracy statement for the March 1995 CPS Microdata File.

[3] Children above the age thresholds were not considered Medicaid-eligible even if they received AFDC or SSI.

[4] Ninety percent confidence intervals were used.

The second group is a subset of the first group and is comprised of those children who both appeared income-eligible for Medicaid and lived in families that received neither AFDC nor SSI benefits. Due to data limitations, it was impossible to determine whether children were SSI recipients or whether other family members were receiving SSI.

### *Estimating the Number of Children Eligible for Medicaid Who Were Not Enrolled or Who Lacked Any Form of Health Insurance*

The estimates of the proportion of Medicaid-eligible children who either were not enrolled in the Medicaid program or who lacked any form of health insurance were then applied to estimates of the number of children who met the *1994 Medicaid eligibility rules*.[5] This was done for both all children who were Medicaid eligible and those children who were Medicaid eligible and whose families did not receive AFDC or SSI.

For example, suppose that using the methodology described above, it is estimated that in a particular state between 20 and 30 percent of children who were income eligible for Medicaid did not receive Medicaid coverage. To translate that estimate into the *number* of children lacking Medicaid coverage, the number of children in that state who would have met the 1994 Medicaid eligibility guidelines was calculated. This was done by determining the number of children in each of the three survey years who would have met the 1994 Medicaid eligibility rules, averaging those estimates, and creating a confidence interval around that average. Suppose in this state, over the three year period, an average of between 130,000 and 160,000 children would have met the 1994 eligibility standards. The estimate that between 20 and 30 percent of these children would have failed to actually receive coverage was used to calculate that in 1994 roughly 26,000[6] to 48,000[7] children in this state lacked Medicaid coverage.

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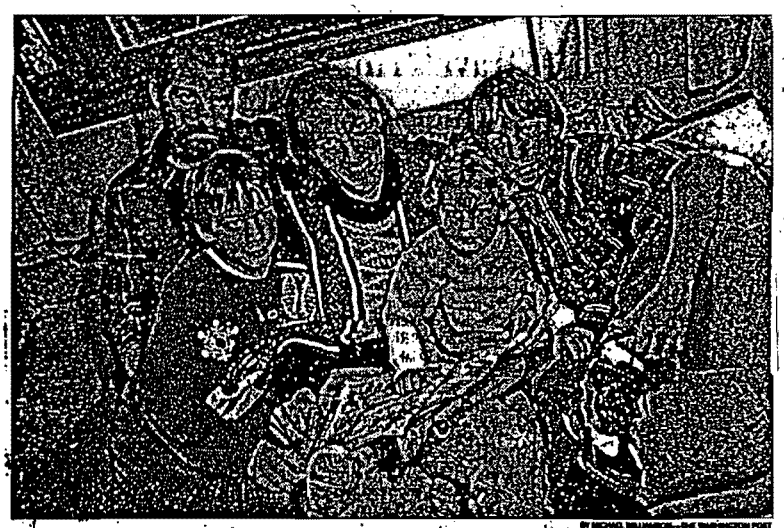
[5] These are the eligibility rules used in the calculations to determine the proportion of children not receiving Medicaid or lacking health insurance for those children interviewed in 1995.

[6] Calculated by taking 20 percent of 130,000 children.

[7] Calculated by taking 30 percent of 160,000 children.

WASHINGTON POST DECEMBER 7, 1996

# Democrats to Seek Expansion of Health Coverage for Children



Rod and Elaine Gaither with their children, from left, Joshua, 8, Annmarie, 2, and Rod, 10, in their Clarksville, Md., home. The Gaithers, who don't get health insurance coverage from their employers, say they can't afford to buy it.

By Spencer Rich
Washington Post Staff Writer

Looking for a more measured way to expand health care to those without it, congressional Democrats have decided to make medical coverage for uninsured children one of their top legislative priorities in the new Congress.

The proposals, being drafted by Senate Minority Leader Thomas A. Daschle (S.D.), House Minority Leader Richard A. Gephardt (Mo.) and other key Democrats, essentially could create a new class of federal social support. Some of the initiatives would offer a tax credit to help a family buy their children a health care policy, while others would offer a direct federal subsidy of some type.

Although the details are still being worked out, most of the measures focus on children in families that fall between the cracks: They're not poor enough to qualify for Medicaid but not affluent enough to pay for private insurance entirely out of their own pocket.

By focusing on children's health, the Democrats believe they have seized on an issue that is politically more palatable than the ambitious health care reform plan that collapsed in Clinton's first term. And by taking a more tempered approach, they hope to build on the successes achieved last year in the bipartisan effort to pass the Kassebaum-Kennedy bill that strengthened coverage for the unemployed.

"We will be attempting to improve access to health care, especially for children, in the 105th Congress," said Daschle after his reelection to the leadership post last week. He called this one of his top priorities.

Within the administration, Secretary of Health and Human Services Donna E. Shalala has made it known she strongly favors some action to expand coverage of children, and on several occasions President Clinton himself has indicated an interest in expanding coverage of children as long as it were within the context of a balanced budget.

About 10 million American children are without health insurance, according to estimates by the General Accounting Office. Because nearly 3 million of those are eligible for Medicaid, part of the Democrats' effort will be aimed at spurring these parents to take advantage of this already existing federal program.

But many more ambitious plans are in the works. Among the most detailed thus far is a proposal being drafted by Sens. Edward M. Kennedy (D-Mass.) and John F. Kerry (D-Mass.) that would provide grants to the states to help families afford health insurance for their children.

The plan would target families in that no man's land—that is, those who are not poor enough to be eligible for Medicaid but who don't get insurance on the job and can't afford to pay for it themselves. Under the Kennedy-Kerry plan, families would be paid a federal subsidy that would gradually decrease as their income went up.

The plan would cost between $20 billion to $24 billion over five years and would allow subsidies for a majority of uncovered children, according to one estimate. As conceived, it would be paid for through an additional 75-cent-a-pack cigarette tax.

"Every American child deserves a healthy start in life, and every family should have the opportunity to help that child get that start," Kennedy said.

Few would disagree, but Republicans, whose support would be crucial for any of these efforts to succeed, say they want to see the actual proposals before signaling their support.

"Senator Roth is concerned that health care be available to children," said an aide to Senate Finance Committee Chairman William V. Roth Jr. (R-Del.). "He would like to see the details of the proposals before commenting."

Already, though, a coalition of children's groups is gathering behind the "Kiddycare" concept, the label being attached to many of these proposals. And, as their Democratic backers realize, the concept has strong political appeal for the millions of families without coverage, people such as Rod and Elaine Gaither of Clarksville, Md.

The Gaithers earn about $40,000 a year, but they don't get health insurance on the job and say they can't afford the $3,600 to $4,500 that buying insurance would cost them.

The size of the family paycheck sounds pretty respectable, admits Elaine Gaither. "But it shrinks very substantially after taxes, house costs, cars to go to work, food and clothing for three really fast-growing children and other day-to-day expenses," she said. "I get very creative with how far a pound of meat can go."

Once they had insurance based on a job she held, but when she left the job a few years ago, they lost it. Since then they have been searching for a modest-cost insurance policy, or at least something that would protect their children. But so far they haven't found a good policy that is also affordable.

"I worry every day," said the Howard County woman. "I've got three kids, one with asthma, which really frightens me. Once in a while he gets a bad attack. It's a scary proposition."

Groups lining up in support of these initiatives say that children who aren't covered often end up never getting treatment when they become ill.

"What happens to uninsured children? Usually their financially strapped families tend to delay or forgo needed pediatric medical care because of the out-of-pocket expense," said David Tayloe, a physician speaking for the American Academy of Pediatrics in a recent plea for action on the Kiddycare concept. They tend to get less preventive care, fewer immunizations and contract more diseases, he said.

Stan Dorn of the Children's Defense Fund, another backer of Kiddycare, said the 1987 National Medical Expenditure Survey, the most recent, found that one-third of uninsured children with two or more ear infections and a majority of uninsured children with asthma "never saw a physician."

Despite the emotional appeal of broadening coverage for children, the proposals could bog down in disputes over how much to spend, where to get the money, whether the plans would affect existing workplace insurance coverage of children and whether the initiatives would create a new federal entitlement.

The most frequently cited concern is the potential for something called "substitution"—the notion that employers may stop offering coverage for children of their workers if they know the government will provide it.

"My only concern is that whatever they do, it should not weaken the existing employer system," said Bill Gradison, president of the Health Insurance Association of America. "They might say, 'We don't have to do it. The government will do it.' "

Gradison and others are also concerned that if insurers are required to take any subsidized child who applies to them, part of the cost of covering these children may be pushed onto existing policyholders.

On the political front, obstacles also loom.

Congressional Republican aides note that conservatives have generally shown a resistance to initiatives that involve mass federal subsidies.

"Republicans generally prefer tax credits that would allow the market system to work," said one aide.

While some conservative policy groups such as the Heritage Foundation agreed that the problem of children's health is one worth addressing, they were quick to challenge the Kennedy plan or anything like it that establishes what they view as a new federal entitlement.

"We hope to draft a plan or policy concepts that conservatives could accept," said Heritage's Carrie Gavora. That plan, she assured, would bear little resemblance to the Kennedy proposal.

# UNINSURED CHILDREN

1. Background
2. Challenges to Covering Children
3. Options for Covering Children
4. Current Budgetary and Political Environment
5. Next Steps

# BACKGROUND

## Numbers and Trends

- **Currently**: 10 million, or 14 percent, of all children are uninsured

- **In the past**: The proportion of uninsured children has remained constant

  - Employer coverage has declined (from 67 percent in 1987 to 59 percent in 1995), due to:

    - Increased outsourcing and part-time work

    - Shift to industries less likely to offer insurance

    - More workers in small firms

  - But, Medicaid coverage has increased (from 16 percent in 1987 to 23 percent in 1995), stabilizing the proportion of uninsured children

- **In the future:** The proportion of uninsured children may increase

## Who Are Uninsured Children

- **Working families**: 80 percent of uninsured children are in working families.

- **Income varies**: Uninsured children are not just poor children (see chart).

- **Concentrated in the south and southwest:**

  - In 1995, about 43 percent of all children but 55 percent of all uninsured children resided in the south and southwest.

  - Reasons why these states have higher proportions of uninsured children include:

    - Lower use of Medicaid options to expand children's coverage

    - Higher prevalence of:

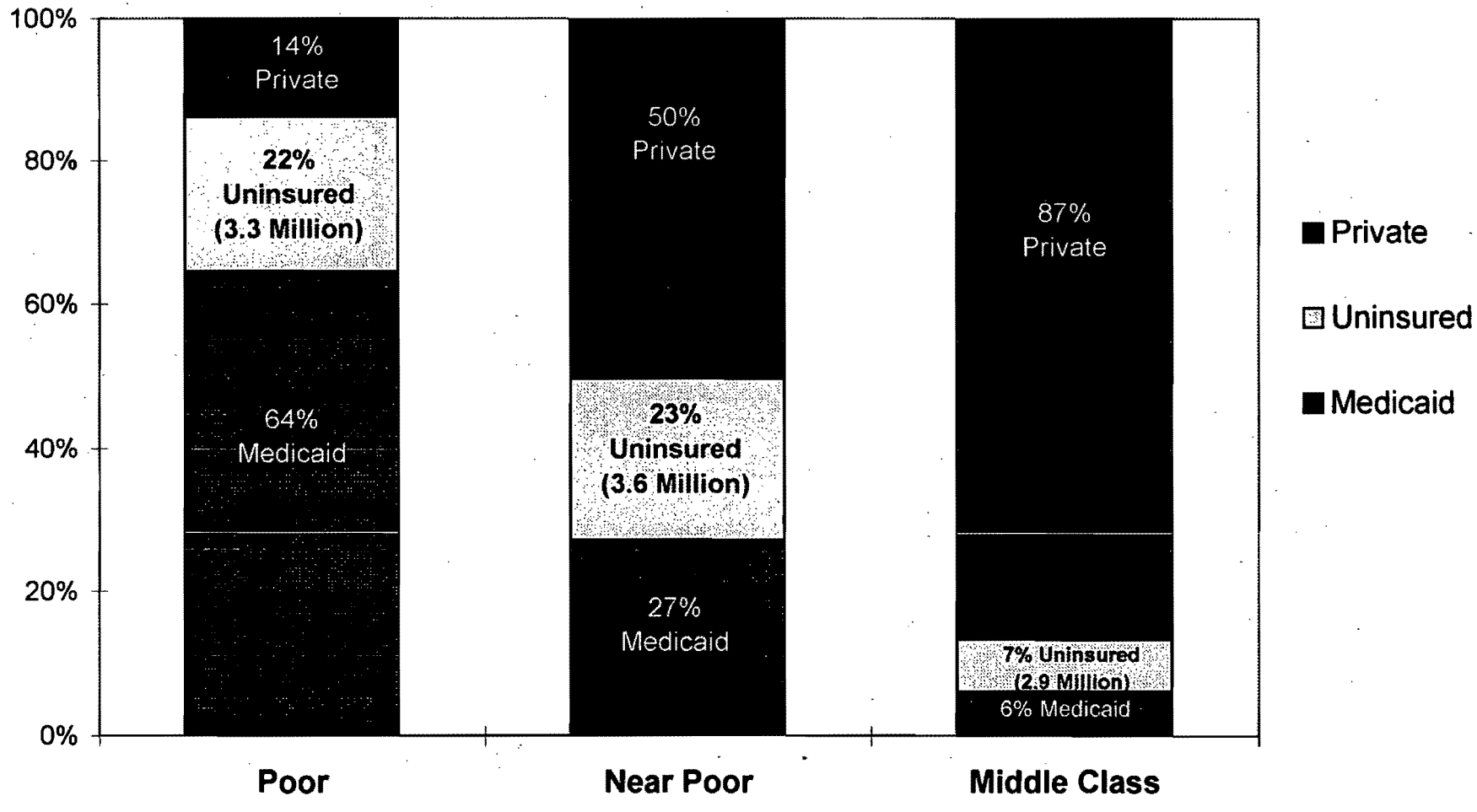
      Low-income families

      Industries that don't provide health insurance

      Racial and ethnic groups less likely to be covered by insurance, and

      Noncitizens

# Children's Health Coverage, 1995
## Proportion of Children Covered by Different Sources




"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage.
Source: EBRI, 1996

# Why Are Children Uninsured

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

2. **Parents earn too much for Medicaid but too little for private coverage.** When job-related insurance loss is put to the side, the most important reason why children lose insurance is that it is too expensive for the family.

3. **Eligible but not enrolled in Medicaid.** An estimated 3 million uninsured children are eligible but not enrolled in Medicaid.

# CHALLENGES TO COVERING CHILDREN

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

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

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

- **Covering all uninsured children is prohibitively expensive.** Given these issues, it is impossible in a voluntary system to cover more than two-thirds to three-quarters of the 10 million uninsured children without large-scale substitution of Federal dollars for current employer health insurance payments.

# OPTIONS FOR COVERING CHILDREN

1. **Tax Credits**

2. **State Grants**

3. **Medicaid Expansion**

   - Improving the current program
   - Making optional coverage more attractive
   - Requiring expansions

4. **Vouchers**

# CURRENT BUDGETARY AND POLITICAL ENVIRONMENT

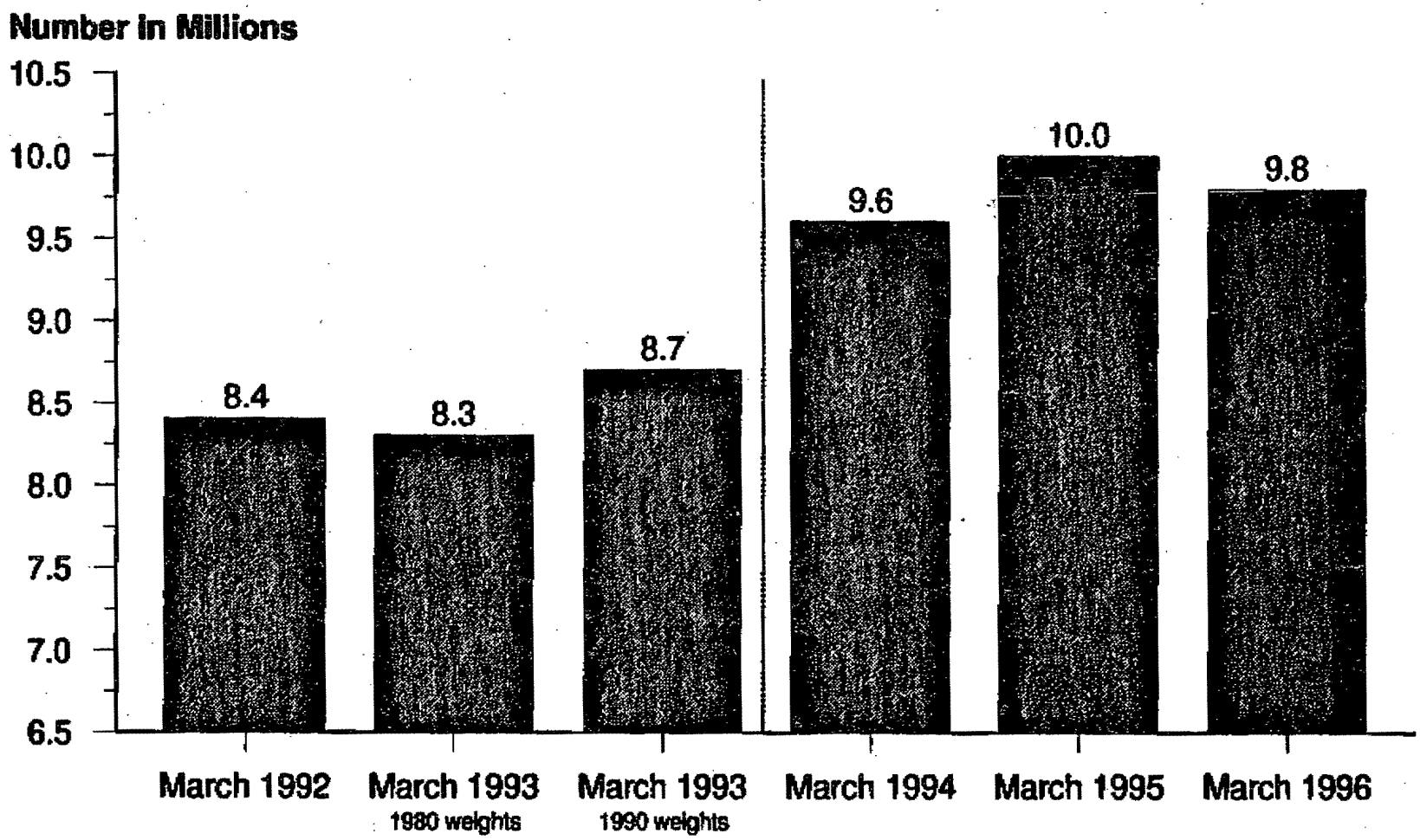
- **Groups**
- **Governors**
- **Congress**
- **Departments**

# NEXT STEPS

- **Internal strategy**
  - Review in detail evolving policies in Congress
  - Prepare for POTUS meeting
    - Deputies meeting for principals meeting
    - Principals meeting for POTUS meeting
  - Policy process for:
    - Responding to criticisms of our policy
    - Modifying Congressional alternatives
    - Developing bottom-line positions on alternatives
  - Review our position on size and sources of funding

- **External strategy**
  - Develop and implement a validator and group strategy to support the general goals of our policies
  - Develop and implement communications strategy including events to highlight the need for coverage expansions
  - Develop and implement strategy to attract gubernatorial support for our state-based approach
  - Develop Congressional strategy to ensure that:
    - Republicans are invested and/or worried about not supporting expansions
    - Democrats are committed to support policy and not just an issue
    - Budget resolutions contain an investment for expansions
    - Members and staff rely on us for technical assistance

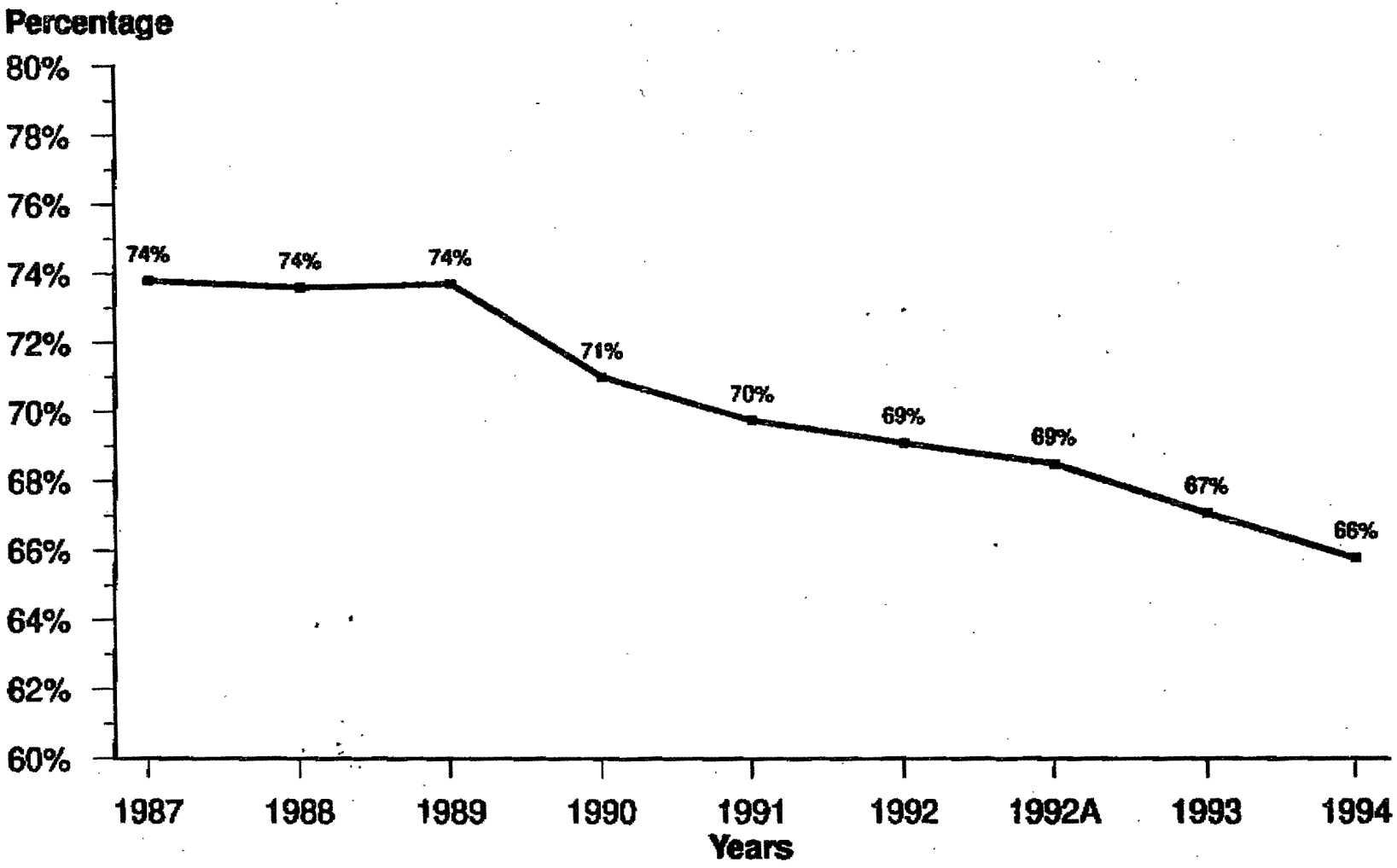
# Number of Uninsured Children
# March Supplement CPS




*New questions in March 1994-1996 make comparisons with earlier years inappropriate*

# Percent of Children Covered by Private Insurance, 1987-1994

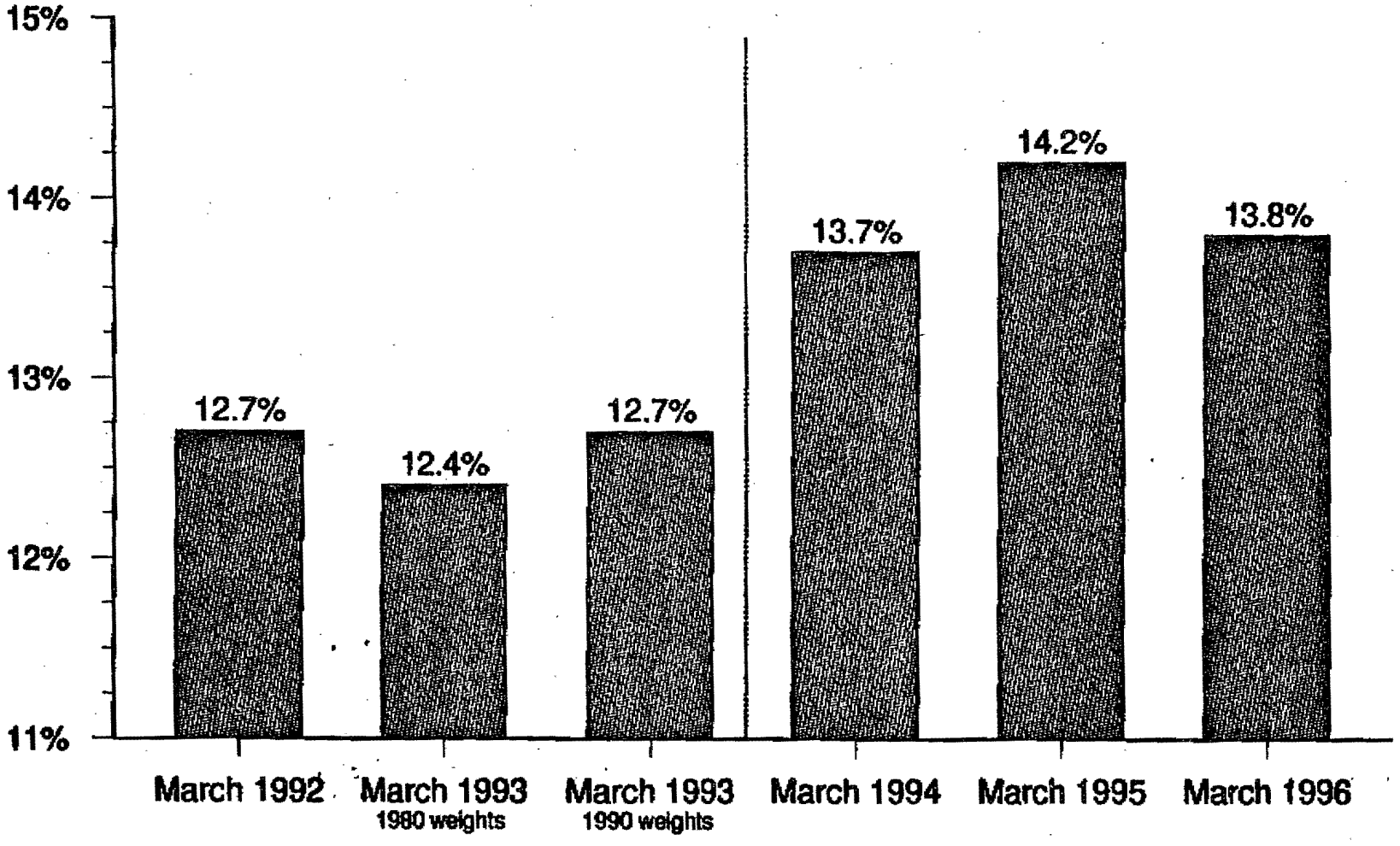
**(Includes those who report both private coverage and Medicaid)**




1992A reflects implementation of 1990 census population weights, which affected the estimates.
Source: GAO, HEHS-96-129, June, 1996. Data from the Current Population Survey.

# Percent of Children Uninsured

## March Supplement CPS




*New questions in March 1994-1996 make comparisons with earlier years inappropriate*

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

December 5, 1996

**MEMORANDUM FOR NANCY-ANN MIN**
**ASSOCIATE DIRECTOR FOR HEALTH**
**OFFICE OF MANAGEMENT AND BUDGET**

**FROM:** **ERIC TODER** Eric Toder
**DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)**

**SUBJECT:** **Estimates of Health Insurance Subsidies for Children**

At a meeting on November 12th, the Treasury was asked to prepare estimates of two health insurance subsidy proposals for children. Because details of these proposals have not yet been specified, the estimates are very preliminary. In addition to providing revenue estimates, I am including a list of caveats which give an indication of how the estimates might change depending on further specification of the proposal. As noted below, the estimates are for a proto-type plan. It was assumed that the proposal is administratively feasible and that families would receive subsidies in a timely manner. There are concerns in both these areas, but these concerns have not been identified nor taken into account in the estimates due to the nature of the estimation exercise.

Under both proposals, health insurance providers "that do business with the Federal government" would be required to offer child health insurance policies to all families with eligible children. Eligible children include all children under the age of thirteen, who are not eligible for Medicaid, and whose families are not eligible to obtain an employer contribution towards a health insurance policy that could include children. Families would purchase a separate policy for each child. These policies would provide benefits similar to those found in the Blue Cross/Blue Shield Standard Option plan available through the Federal Employees' Health Benefits Program (FEHBP). Each insurer would establish a separate risk pool for these special child policies. Subsidies would be made available in the form of a refundable tax credit for health insurance purchased after December 31, 1997. Estimates are provided for two options.

**Option 1:** Under the first option an 80 percent tax credit would be available up to the EITC income cut-off. Above the EITC income cut-off, the tax credit would be phased down to reach a 10 percent tax credit in the neighborhood of 275 percent of poverty. Families with incomes above this level would be eligible for the 10 percent tax credit.

**Option 2:** Under the second option a 50 percent tax credit would be available up to the EITC income cut-off. Above the EITC income cut-off the tax credit would be phased down to reach a 10 percent tax credit in the neighborhood of 275 percent of poverty. Families with incomes above this level would be eligible for the 10 percent tax credit.

**Preliminary Estimates**

The estimates are for a proto-type plan. It was assumed that a tax credit subsidy program could be made to be administratively feasible. The estimates do not take into account many of the problems that might be encountered in administering the subsidy through the tax system. Furthermore, it is assumed that families would benefit from the subsidy in a timely manner, so that they may participate in the program.

The first option is estimated to lose $4.8 billion in revenue in the period FY 1998 - FY 2002 and $17.0 billion in the period FY 1998 - FY 2006. Under a fully phased-in program, incorporating 2002 law but estimated at 1998 levels (e.g. population etc.), 2.7 million children are estimated to obtain health insurance through the subsidy program. Actual participation in 1998 would be much lower than this fully phased-in number. For comparison, a fully phased-in program would lose $2.1 billion in revenue in 1998. Because it would take a number of years before the program is likely to reach full level, actual revenue loss in FY 1998 would be very small by comparison.

In contrast, the second option is estimated to lose $1.9 billion in revenue in the period FY 1998 - FY 2002 and $5.7 billion in the period FY 1998 - FY 2006. Under a fully phased-in program, under 2002 law and at 1998 levels, 1 million children are estimated to participate. A fully phased-in program would lose $0.7 billion in 1998. Actual participation and revenue loss in FY 1998 is estimated to be much lower than these fully phased-in numbers.

Caveats

- There is great uncertainty around the premiums under both the proposals. The premium depends upon the amount of adverse selection, which in turn depends on the amount of the subsidy and the amount of the premium. High premiums are likely to result in low participation, which in turn is likely to reinforce high premiums, as participants are likely to be less healthy than average. More moderate premiums are likely to cause a small, but significant, number of employers to drop health insurance coverage for children. As a result of employer dropping, and because premiums are moderate, participation would be higher under this scenario than under the previous scenario.

  -- Revenue and participation estimates are based on the long-run estimate of premiums with the exception that premiums in the early years are expected to be somewhat higher than long-run premiums because it will take time for employers to drop health coverage for children.

  -- If insurers begin by pricing policies at higher levels than estimated the long-run estimate of premiums may never be reached. Participation would be lower than estimated. Revenue loss may be higher or lower than estimated depending upon the interaction of participation and premiums. Higher premiums would result in greater revenue loss per policy. Lower participation would result in lower revenue loss. Insurers may price policies at higher levels because they fear underestimating adverse selection.

-- The long-run estimate of premiums also might not be reached if employers and employees believe that the initial high level of premiums reflect the long-run equilibrium premium.

-- Mechanisms may need to be put into place to increase the likelihood that these long-run targets are hit. However, it has not been determined whether any such mechanisms could achieve this goal.

- The premiums were estimated based on benefits similar to the Blue Cross/Blue Shield Standard Option, a fee for service plan with some managed care features. Allowing staff model Health Maintenance Organizations (HMOs) may affect both premiums as well as participation.

- The estimates assume that families are able to pay for premiums on a current basis. Some individuals may be able to adjust their withholding to eliminate potential cash-flow problems. Many other individuals may not be able to adjust withholding to accommodate their premium payments. Without effective mechanisms to relieve cash-flow problems, participation is likely to be lower, perhaps even substantially lower than the current estimates. Premium and tax credit estimates would also have to be adjusted, although the direction of the adjustment has not been determined.

- Employer dropping is likely to result in increased Medicaid participation. The effect of the proposal on Medicaid has not been included in the estimates.

- Employer dropping could result in employees becoming uninsured. Several factors may lead to this result. Employers that drop coverage may be slow to increase wages to compensate employees. Some employees, particularly low-wage employees, may currently receive implicit cross-subsidies from other workers. If so, these low-wage employees would be unlikely to receive wage increases when employers drop coverage. Under both these situations, employees may not be able to afford health insurance, or they may not value health insurance enough to purchase insurance for their children. Other workers that receive wage increases as their employers drop coverage may decide to allocate these wages to other family needs, with the result that their children become uninsured.

  -- Although the estimates assume that almost all currently insured children remain insured, there is a great deal of uncertainty in this area.

- Because the subsidy is designed in the form of a tax credit, the subsidy is phased down based on adjusted gross income (AGI). The Earned Income Tax Credit (EITC) income cutoffs determine the beginning of the phase-down of the tax credit. The tax credit is phased down to 10 percent at an AGI level in the neighborhood of the poverty level targets. Due to rounding, the tax credit is phased down to the 10 percent level at slightly different poverty level targets, depending on family size.

- Premiums were assumed to grow at the rate of per capita premiums under the 1997 budget assumptions. The AGI thresholds that determine the beginning of tax credit phase-down were assumed to grow at the rate of inflation as reflected in the Consumer Price Index (CPI). This is similar treatment to the EITC. The phase-down rate was determined in the first year. As a result of maintaining this phase-down rate in future years, the income level at which the 10 percent subsidy is reached increases over time. These combined effects cause subsidies to grow slightly faster that the growth rate of per capita premiums.

- The current estimate assumes that there is no cap on the tax credit. For example under the first option, the tax credit would be 80 percent of the premium regardless of the premium. It has not been determined how a cap on the tax credit amount would effect the estimates. The uncertainty in premiums, especially during the first years of a program, would have to be taken into consideration in designing a cap.

- The estimates are based on 1997 budget assumptions.

- Estimates are likely to change as details become specified and as new information leads to improvements in modeling areas of great uncertainty, (including but not limited to premiums and employer dropping).

# Health Insurance Subsidies for Children

## Participation

| | Option 1 80/10 | Option 2 50/10 |
|---|---|---|
| **Participation (% of Total)** | | |
| **Employer Sponsored** | 1,670 (63%) | 525 (54%) |
| **Other Private*** | 375 (14%) | 220 (22%) |
| **Uninsured** | 615 (23%) | 235 (24%) |
| **Total** | 2,660 | 980 |
| **Costs:** | | |
| **Average Premium** | $1,427 | $1,860 |
| **Total Premiums** | 3.8 billion | $1.8 billion |
| **Tax Credit** | $2.4 billion | $0.7 billion |
| **Net Revenue Loss** | $2.1 billion | $0.7 billion |

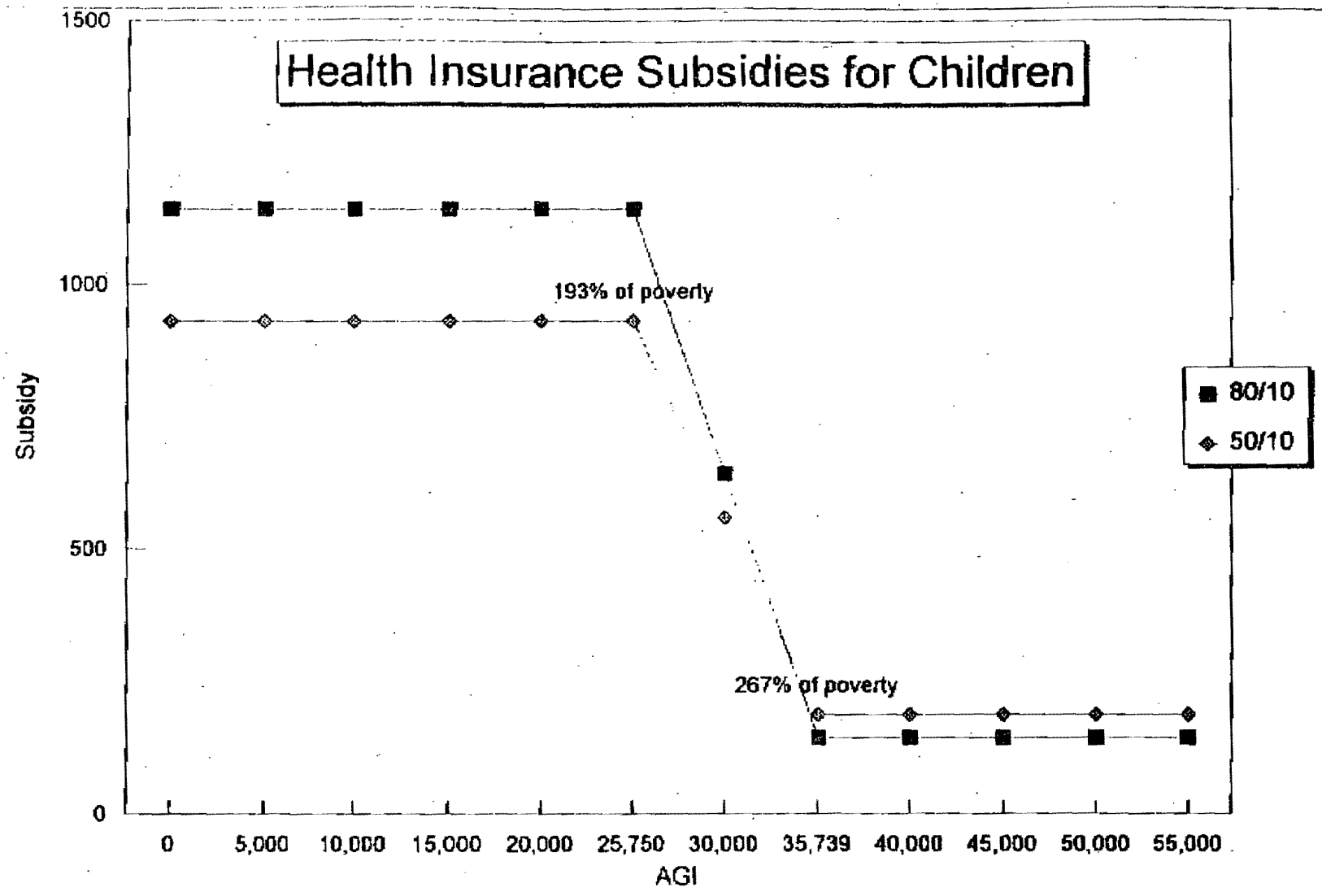
*Includes self-employed, employer plans where the employer does not contribute, and other private health insurance.

# Health Insurance Subsidies for Children

## Participation

| | Option 1: 80/10 | | Option 2: 50/10 | |
|---|---|---|---|---|
| | (000) | Percent of | (000) | Percent of |
| $0 - $20,000* | 337 | 13% | 201 | 21% |
| $20,000 - $30,000 | 1,138 | 43% | 499 | 51% |
| $30,000 - $40,000 | 566 | 21% | 126 | 13% |
| $40,000 - $50,000 | 303 | 11% | 57 | 6% |
| $50,000 - $75,000 | 160 | 6% | 42 | 4% |
| $75,000+ | 157 | 6% | 54 | 6% |
| Total | 2,661 | 100.00% | 979 | 100.00% |

*Children eligible for Medicaid would not be eligible for a tax credit. Most of the children in the $0 - $20,000 bracket would be in the $10,000 - $20,000 bracket. Some children could be in the $0 - $10,000 bracket because they would not be eligible for Medicaid the entire year.




80/10 Premium of 1427 and Maximum Subsidy of 1142
50/10 Premium of 1860 and Maximum Subsidy of 930

November 26, 1996

TO: Nancy-Ann Min
Chris Jennings
Glen Roselli
Meredith Miller
Mark Miller

FROM: Christy Schmidt

SUBJECT: Child Health Proposals

The attached papers deal with the child health proposals that will be discussed at tomorrow's 10:00 AM meeting.

Attachments

1. **Enhance Child/Family Health Coverage and Services (an Overview)**

2. **Fulfilling the Promise of Medicaid for Eligible Children and Working Families Who are Already Eligible for Medicaid**

3. **Grants to States to Support Innovative Partnerships to Insure Children**

4. **Expand Investment in School Health Programs to Serve the Health Needs of Children and Adolescents**

5. **Partnership for Children and Working Families Through Targeted Funding for Consolidated Health Centers (CHCs)**

# ENHANCE CHILD/FAMILY HEALTH COVERAGE AND SERVICES

Today, 10 million--14 percent--of children are uninsured. Children may be uninsured because their parents are unemployed, because their parents' employers do not offer health insurance to their children, or because their parents cannot afford to purchase health insurance for themselves or their children.

Many more children are underinsured, with limited access to critical preventive and primary care services. They may live in urban or rural areas that are underserved by private providers, or they may lack the insurance and other resources necessary to access care.

To address the reasons why children may be uninsured requires a multi-dimensional approach: increase insurance coverage through Medicaid, enhance partnerships with the states and private sector to help provide insurance for children, and expand access to community based care.

I. Increasing Insurance Coverage

**Work with states to continue to fulfill the promise of Medicaid for children who are already eligible under current law.**

- Fulfill the promise of Medicaid for eligible children and working families who are already eligible for Medicaid through administrative and legislative changes that expand enrollment of Medicaid eligible children; provide states with incentives and options for expanding Medicaid to working families; create new optional eligibility categories for individuals adversely affected by the new welfare law; and market Medicaid enrollment to the public. Specific provisions include improve the eligibility process to ensure that eligible children are enrolled; expand outreach; accelerate enrollment of children's poverty-related eligibility groups; create new optional eligibility categories for legal immigrants and non-pregnant adults with families; establish a marketing campaign.

II. Enhance Partnerships with States and the Private Sector to Help Insure Children

**Provide grants to states to support innovative partnerships to insure children**

- Numerous states have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. Under this proposal, the federal government would provide matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs. States would be given wide latitude in program design but would be required to assure the receipt of critical services related to immunization, injury prevention, well-child care, and other related services to reduce morbidity and mortality.

III. Expand Access to Community-Based Services

**Enhance funding for communities through school-based or school-linked health centers.**

- Expand funding for new school-based health centers. This initiative would provide school age children with comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, health education and preventive dental care. Communities would have the option of expanding services to the parents and siblings of the school's students; would be encouraged to link to other appropriate programs, including Healthy Start, state Maternal and Child Health, Head Start, Community Schools, and Empowerment Zones/Enterprise Communities; and would be encouraged to develop billing systems to collect third party payment and enable centers to participate in a community-wide health care delivery system.

- In addition this initiative would support school-linked health centers. School-based health centers may not be the right choice for every community. School-linked health centers can serve students from several schools in a particular catchment area and provide continuity of care as students are promoted to the next school. School-linked health centers provide services that might not be as comprehensive in scope as a school-based health center, but can be targeted to specific community needs.

**Create Partnerships for Children and Working Families Through Targeted Funding for Consolidated Health Centers (CHCs)**

- Provide increased targeted funding for CHCs to enhance and expand services to working families and their children, including children enrolled in day care, Head Start programs, and schools. These funds would be directed to communities with high levels of uninsured children, including EZ/EC communities. Funds would be used to increase CHCs capacity to serve uninsured children and their families and to better meet the needs of those in their community whose insurance coverage is fragmented or incomplete. This could include extended hours, locations, and range of services. In addition to increasing their own capacity, CHCs would serve as a focal point for marshaling public and private community resources directed at child health and, with their partners, taking steps to mesh child health and related services into local integrated systems that serve children and their families.

**Challenge the health care industry to work with communities to improve integration of school-based and school-linked health centers and consolidated health centers into a community's health care delivery system.**

- Encourage managed care organizations and health insurers to work with communities to develop health care delivery settings for children such as school-based/linked health

centers. Managed care organizations could collaborate with community sponsors to create funding mechanisms to develop and operate school-based/linked health centers, and/or to designate school-based/linked health centers as a primary care delivery site. Work with managed care organizations and health insurers to devise a range of approaches for: (1) reimbursing school-based/linked health centers for the services they provide; (2) developing model billing systems that support these approaches.

## IMPACT OF INCREMENTAL NEW FEDERAL FUNDING FOR CHILD/FAMILY HEALTH COVERAGE AND SERVICES

| Federal Funding Level | Federal Challenge Grants--Children Insured[1] | | | Children Served--School Based Health Centers [2] | People (Children) Served--Consolidated Health Centers [3] |
|---|---|---|---|---|---|
| | Preventive Services | Preventive Services/ Primary Care | Comprehensive Coverage[4] | | |
| $25 million | 500,000 | 70,000 | 45,000 | 125,000 | 250,000 (110,000) |
| $50 million | 1,000,000 | 140,000 | 90,000 | 250,000 | 500,000 (220,000) |
| $100 million | 2,000,000 | 280,000 | 180,000 | 500,000 | 1,000,000 (440,000) |

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Assumes 50 percent match from non-Federal sources.

Covers costs of services received in SBHCs but not health care services received at other locations. Assume all costs borne through Federal grant funds at start-up. Offsets from Medicaid reimbursement and other funding sources possible over time.

Comprehensive primary and preventive health services. Based on average Federal grant share of CHC funding of approximately 30 percent, with Medicaid and other sources accounting for balance. Approximately 44 % of CHC users are children through age 19.

Option includes hospitalization coverage.

# Fulfilling the Promise of Medicaid for Eligible Children and Working Families Who Are Already Eligible for Medicaid

## I. Description:

The Goal of this proposal is to increase Medicaid enrollment of eligible children and working families.

## II. Specific Provisions:

1. *Expand enrollment of Medicaid eligible children.*

Improve Eligibility process to ensure that eligible children are enrolled (Administrative)

Working with States, HCFA will use the opportunity of the new Welfare Reform legislation to re-think the current rules and regulations related to Medicaid eligibility. The Welfare Reform legislation essentially creates a Medicaid-only eligibility system for low-income children and working families. While this eligibility system is based on the AFDC eligibility rules in place on July 16, 1996, the new law allows States to focus on simplifying and to some extent expanding eligibility using "less restrictive" methodologies. HCFA will work with States to ensure that these new methodologies are encouraged and adopted.

Expand outreach (Administrative)

Develop Federal-state partnerships to improve outreach to enroll Medicaid eligible children. HCFA will also work with others, such as the Public Health Services and its grantees, and the Department of Education and local schools, to expand Medicaid outreach to increase the enrollment of children who are already eligible for Medicaid but who have not actually been enrolled. Outreach efforts would be directed through schools and other community service providers, as well as health care providers. Additional Federal resources for implementation of expanded outreach would be considered.

Accelerate enrollment of children's poverty-related eligibility groups (Legislation)

Propose legislation for a State option to accelerate the phase-in of coverage (e.g. shorten phase-in to cover two age cohorts within a given year instead of one) so that more children would receive Medicaid coverage sooner. Legislation passed in the late 1980s and early 1990s extends Medicaid coverage to all poverty-level children under age 19, on a phase-in basis by FY 2002. Currently all children under the age of 14, below poverty, are eligible for Medicaid. Each year, approximately 250,000 additional children receive

Medicaid coverage through this phase-in. Over the next four years 1 million more children will become eligible for Medicaid. This option would increase the time frame for enrollment by two years.

2. *Provide states with incentives and options for expanding Medicaid to working families.*

1115 Demonstration waivers (Legislation)

Create a process for a "permanent extension" of statewide health care reform demonstrations. This proposal would allow states to "convert" demonstrations to state plan amendments.

Cost-sharing (Legislation)

Permit states to impose cost-sharing (e.g., premiums) on expansion populations within specific income brackets. The minimum level (floor) for this proposal would be 50 percent.

3. *Create new optional eligibility categories for individuals adversely affected by new welfare law:*

SSI and Legal Immigrants: Create an optional eligibility group for Medicaid for those who lose SSI cash assistance due to their immigration status. Some states are interested in continuing Medicaid coverage to legal immigrants who will lose Medicaid due to the welfare reform provisions, without having to use the current law options.

Non-pregnant adults with families: Create a new optional poverty-related category for non-pregnant women with children. This population is at the greatest risk of losing Medicaid due to the severing of Medicaid and welfare eligibility rules.

4. *Market Medicaid enrollment to the public*

Encourage/ develop partnerships between states, provider groups and foundations to develop public service announcements and appropriate print media to encourage children and families to seek information about Medicaid eligibility, to enroll in Medicaid, and to utilize appropriate services.

A "marketing campaign" would be particularly beneficial for informing families what steps need to be taken to continue Medicaid coverage for children and working families after implementation of the new welfare law.

## III. Impact

The purpose of these proposals is to increase the number of eligible individuals ( and potentially eligible individuals) enrolling in Medicaid and to expand Medicaid coverage to working families without health insurance.

In FY '95, there were approximately 41 million people eligible for medical assistance, however, only 36 million actually received services that fiscal year. Approximately 21 million children were eligible, and only 18 million received services.[5] There are a variety of reasons why this "gap" between eligibility and receipt of services exists and limited enrollment is one reason. The outreach proposal, federal grant proposal and marketing proposal would address this "gap" between eligibility and enrollment.

The state incentive proposals would encourage states to expand Medicaid coverage to low-income working families. Since 1993, HHS has approved 13 statewide health care reform demonstrations. Many of these demonstrations involve an expansion of Medicaid coverage to working families with near-poor income levels. Once all of these demonstrations are implemented, an additional 2.2 million individuals will receive Medicaid coverage due to the expansions.

## IV. Administration and Congressional History on Issue

During the late 1980s and the early 1990s, congress passed legislation to expand Medicaid coverage to children and pregnant women. The phase-in of Medicaid coverage for children below poverty born after Sept. 30, 1983 was part of this expansion.

Although 2.2 million additional individuals will receive Medicaid coverage due to the statewide health care reform demonstrations, recent demonstration applications have focused on enrollment in managed care and not on expanded coverage.

## V. Tables and Attachments

None

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[5] HCFA 2082 data

## Grants to States to Support Innovative Partnerships to Insure Children

### I. DESCRIPTION

The purpose of this initiative is to assist States in assuring that children have access to primary care, comprehensive health supervision and health promotion and disease prevention services and, at a State's option hospitalization coverage in a continuous manner. Through a new grant program, States would receive matching funds to work with communities, parents, providers, employers, and payers to implement cost-effective approaches to providing insurance and services for children who are uninsured or intermittently insured.

Numerous states have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. Development of some of these innovative efforts has been supported by the Federal Government through the Maternal and Child Health Bureau of the Health Resources and Services Administration and the Health Care Financing Administration. This new proposal provides federal matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs.

Despite expansions in Medicaid, significant numbers of children remain without any health insurance. Others are covered only intermittently as their parents' coverage by private insurance or Medicaid changes or are underinsured, lacking coverage for preventive or other services.

### II. SPECIFIC PROVISIONS

The federal government would provide support to States to continue and expand innovative programs to provide insurance for uninsured children. States would be given wide latitude in program design, choosing whether their programs would provide insurance for preventive services and medical supervision; preventive services, medical supervision and ambulatory care; or more complete coverage including inpatient hospitalization insurance. The mix of participants and funding arrangements would vary from State to State. However, all projects would share the following characteristics:

- Encouraging the development of innovative and cost-effective approaches to provide insurance coverage and related services for children, particularly for vulnerable children and their families with limited access to quality health services. Initial efforts would target currently uninsured children and children uninsured for preventive services.

- Encouraging a seamless system that provides continuous health care for children, without regard to source of payment or enrolled health care plan for either the family or provider. This would protect the link between child and health care provider regardless of changes in family income, source of insurance or other change in child or family circumstances.

This would be a logical next step for States which have expanded Medicaid coverage for children through waivers and State only programs. All States would be encouraged to reach out to uninsured families to help assure that eligible children are enrolled in Medicaid and other families are aware of new insurance opportunities.

- Partnerships among community organizations, individuals, and agencies; Federal, State, and local governments; professional organizations; HMO's, managed care organizations, and insurance plans; foundations; employers and corporate leaders; and families to share their knowledge and expertise and commit the necessary resources for mutual problem solving, easy access to services and fair and timely reimbursement.

- Partnerships of pediatricians and other pediatric primary care health professionals and professionals in health, education, social services, government. and business to build self-sustaining programs to assure healthy children and families.

- The Federal Government would work with States to extend waivers and other flexibility to allow States to create innovative systems of health care for children.

- Projects would be tracked so that information would be available on topics such as the number of children covered by these programs, rates of uninsurance among children in participating States, and trends in employer coverage of child preventive services etc.

- Federal technical assistance would be available to assist in areas such as estimating costs of providing additional levels of expanded coverage; information about successful public private partnerships in insurance coverage; data system design; and program evaluation.

## III. IMPACT

This proposal could be implemented in several ways, depending on the amount of Federal funding available. The options presented below are built on the following estimates of the costs of providing children. The cost of providing insurance for those preventive services recommended by the American Academy of Pediatrics is approximately $8 per child per month; for primary care and preventive services, based on the Blue Cross/Blue Shield standard option without hospitalization, is approximately $56 per child per month; when hospitalization coverage is added the cost is $90 per child per month. Additional funds would be needed to support collaboration building, data systems, administrative overhead and evaluation. In the grant program options discussed below, Federal support would be matched on a dollar for dollar basis by States through their choice of a mix of public, corporate and/or private contributions.

The number of children receiving coverage under grants from this proposal would depend on the extent of insurance coverage a State selects.

Option 1 No new funding

Federal actions would be limited to publicizing successful State efforts, convening groups of interested parties, providing information on the impact of State programs, providing technical assistance to the States and encouraging use of Federal funds from existing programs, such as the Maternal and Child Health Block grant, for this purpose.

Option 2 Pilot Program

Grants would be awarded on a competitive basis to 5 to 10 States to implement activities on a demonstration basis, with the possibility of expanding the program to remaining States in the future. Among criteria for selection would be factors such as need, as measured by rates of uninsurance among children, the extent to which proposed activities complement State Medicaid policies, support from State and private sector sources, innovative features, and diversity among the size of States selected and models tested.

Option 3 National Program

Grant funds would be available to all States which meet basic program criteria.

The following table illustrates approximate numbers of children who could receive insurance coverage of various types under this proposal at different funding levels, with an assumed 50 percent match rate.

| Total Federal Grant Support | Insurance for Preventive Services Only | Insurance for Preventive Services and Ambulatory Care | Comprehensive Insurance Coverage |
|---|---|---|---|
| $25 million | 500,000 | 70,000 | 45,000 |
| $50 million | 1,000,000 | 140,000 | 90,000 |
| $100 million | 2,000,000 | 280,000 | 180,000 |

Assuring the receipt of critical services related to immunization, injury prevention, well child care, primary care and other medical services will not only reduce morbidity and mortality and save significant costs associated with these conditions but will enhance child and family well-being.

## IV ADMINISTRATION HISTORY

Expanding insurance and other health coverage for children has been a theme of the Clinton Administration. Several States, such as Hawaii and Rhode Island, have used 1115 waivers to restructure their Medicaid programs to expand coverage for children. This initiative provides a stepping stone for States who are seeking new ways of extending health insurance to the uninsured. This initiative differs from previous efforts by its strong emphasis on drawing into expansion efforts participation and resources from all concerned parties, public and private payers, providers, State and community leaders, and families .

## Expand Investment in School Health Programs to Serve the Health Needs of Children and Adolescents

## I. DESCRIPTION

Students often experience compromised access to health care services because of the combined barriers of poverty, a lack of health insurance and, in some areas, a lack of primary care providers.

To address this problem, school health programs provide preventive, medical and mental health services to elementary, middle and high school students around the country. They currently operate in many states, with the majority in rural and inner city communities where there are many medically underserved and uninsured children.

School health programs provide a wide range of services depending upon the needs of the communities, including primary care, physical examinations, injury treatment, immunizations, dental treatment, counseling, chronic illness management, substance abuse prevention, and health education.

## II. SPECIFIC PROVISIONS

- Expand the **Healthy Schools/Healthy Communities** initiative to improve the health of children in a school setting. Through this Health Resources and Services Administration program sponsored by the Bureau of Primary Health Care in collaboration with the Maternal and Child Health Bureau, school-based primary health care sites have been developed in 26 communities to provide services for 24,000 children who are at risk for poor health, school failure, homelessness and other consequences of poverty. The program has been funded at $16.8 million over a three year period. New funds would be targeted to organizations to establish new school-based health centers in communities with high rates of uninsurance. Current sites link to both Healthy Start and Head Start sites. SBHCs funded under the new initiative would:

  - serve children of all ages from pre-kindergarten through grade twelve;
  - have the option of expanding services to the parents and siblings of the school's students;
  - link to other appropriate programs, including Healthy Start, Head Start, and community schools.
  - provide comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services,

health education and preventive dental care as well as linkage to other health care services and after-hours medical care;

- provide reproductive health services at the option of the community; and
- develop billing systems to enable center to participate in a community-wide health care delivery system.

- Expand the **Healthy Schools/Healthy Communities** initiative to support school-linked health centers. SBHCs may not be the right choice for every community. School-linked health centers can serve students from several schools in a particular catchment area. They also can provide continuity of care as students are promoted to the next school. Such centers provide an opportunity to target out of school youth and aid them in accessing health, psychosocial and other services. The location off school grounds allows greater flexibility for extending operating hours or operating during school vacations and the summer months. School-linked health centers can more easily avoid the controversy in some communities associated with the delivery of particular services, such as family planning or reproductive health services, on the school site.

- Expand funding for **Consolidated Health Centers** (CHCs) to work with communities to develop school-based or school-linked health programs. Recognizing the benefits of interactions between education and health efforts, many communities have established links between schools serving low-income children and CHCs to provide comprehensive health services to underserved children. Approximately 250 CHCs have developed school-based or school-linked health programs: approximately 75 school-based programs and about 175 school-linked programs.

- Encourage states to expand funding for school health programs through the **Title V Maternal and Child Health (MCH) Block Grant**. In 1994, 25 states invested $12 million in MCH block grant dollars and $22.3 million in state general funds for school health programs. Further funding targeted to the development of school-based/linked health programs would directly benefit many of the children who lack adequate health insurance coverage or access to health care services.

- Encourage managed care organizations to work with communities to develop and implement school health programs. Managed care providers in several states authorize SBHCs to provide health care services, then bill Medicaid directly. Managed care organizations may collaborate with community sponsors to create funding mechanisms in order to develop and operate SBHC organizations that designate the SBHC as the primary care clinic for school-aged children and their families.

- Work with managed care organizations and fee-for-service health insurers to devise a range of approaches for reimbursing school health programs for the services they provide and develop model billing systems that support these approaches.

- In order to assure integration of school health programs into the broader health care delivery system, the Department will provide technical assistance to help school health programs create effective linkages to Medicaid, managed care organizations, other insurers and private sector providers. The Department can:

  - identify steps the Department can take to facilitate Medicaid reimbursement for health services delivered in school health programs;

  - use the Medicaid Maternal and Child Health Technical Advisory Group to improve communication between state Medicaid Directors and Maternal and Child Health Directors on incorporating school health programs into Medicaid managed care and other payment arrangements;

  - use the 1115 waiver authority in Medicaid to encourage states to mandate Medicaid managed care providers to reimburse school health programs for services delivered;

  - distribute guidance to communities forming school health programs on becoming Medicaid providers and establishing linkages with health insurance and managed care organizations to devise a system of reimbursement for health services provided to students;

  - encourage state Medicaid programs to provide out stationed eligibility workers to schools with health programs;

  - encourage States and communities to develop linkages with private sector providers of care to supplement services provided in school clinics;

  - expand State Level Partnerships for School Mental Health Services and Centers for School Mental Health Technical Assistance and Training now supported by the Maternal and Child Health Bureau and encourage other efforts which seek to promote stronger linkages between schools and mental health and substance abuse service providers in both the public and private sector.

- Use the **Special Projects of Regional and National Significance (SPRANS)** Maternal and Children Health Block Grant set-aside to encourage states to conduct demonstrations to develop effective models which build the relationship between managed care organizations (including Medicaid managed care providers) and schools to ensure access to health care services for children and adolescents and to promote training and staff development for health professionals engaged in school health activities.

## III IMPACT

The following chart presents total costs, numbers of clinics and numbers of students served which would result from increments of new funding. For purposes of this chart, all funding is assumed to come from grant support, although over time costs will be partially offset by Medicaid reimbursement. These estimates are based on data from the HRSA Healthy Schools/Healthy Communities Program and "School-Based Health Centers" by the National Conference of State Legislatures.

| Federal Support for School Health Clinics | Number of Clinics ($200,000/clinic) | Number of Students ($200/student) |
|---|---|---|
| $25 million | 125 | 125,000 |
| $50 million | 250 | 250,000 |
| $100 million | 500 | 500,000 |

## IV. ADMINISTRATION HISTORY

This proposal builds on the Administration's support for efforts to expand the availability of health services for children through focused use of existing programs, including Medicaid, the Maternal and Child Health Block Grant, the Consolidated Health Center program and Healthy Schools/Healthy Communities, a program implemented during this Administration.

## Partnerships for Children and Working Families through Targeted Funding for Consolidated Health Centers (CHCs)

## I. DESCRIPTION

Federally funded CHCs provide comprehensive health care to 8.1 million people, the overwhelming majority of whom are low income and 44 percent of whom are children through age 19. Because CHCs must serve medically underserved areas and populations, they are located in communities where people lack access to health care and where much of the population lacks health insurance. Federal grant funds make up approximately 30 percent of CHC revenues and are used in large measure to subsidize care for the uninsured. Other sources of funding include Medicaid, Medicare, patient fees, and State, local and other sources. This proposal would target increased CHC funding to areas where there are high levels of uninsurance among children.

## II. SPECIFIC PROVISIONS

Provide increased targeted funding for CHCs to enhance and expand services to working families and their children, including children enrolled in day care, Head Start programs and schools. These funds would be directed to communities with high levels of uninsured children, including EZ/EC communities.

Funds would be used to increase CHCs' capacity to serve uninsured children and their families and to better meet the needs of those in their community whose insurance coverage is fragmented or incomplete. This could include extended hours, more locations, including schools, and expanded range of services provided.

In addition to increasing their own capacity, CHCs would marshall community resources directed at child health and, with their partners, taking steps to mesh child health and related services into local integrated systems that serve children and their families well. CHCs would receive targeted funds to form "Partnerships for Children and Working Families" by linking up with other community organizations, such as:

--managed care organizations to create stronger linkages to community based providers;

--community hospitals and academic health centers who are serving the targeted population and can provide stronger vertical integration of services;

--public health departments to assure that targeted populations receive appropriate service;

--local providers, schools, and other service providers to assure integration of all community service organizations; and

--local philanthropic organizations which may result from a shift in health care delivery systems from non-profit organizations to for-profit entities. This transition often establishes a foundation poised to serve the needs of disadvantaged populations.

Existing and new CHCs would work closely with State Maternal and Child Health programs and other community providers to identify special needs of children and working families in their communities and tailor services to the needs of local populations. Special emphasis would be placed on enabling services, such as transportation, linkages with schools and social service programs, such as WIC. Creative collaboration would be encouraged. For example, taxi companies could be encouraged to provide discounted fares to medical appointments.

## III. IMPACT

By increasing Federal funding for CHCs, their capacity to serve the uninsured--children and their families--is expanded. The average Federal grant cost per CHC user is about $100, an additional investment of $100 million in grants to CHCs would expand their service capacity by 1,000,000, assuming "average" clientele and funding streams. Nationally approximately 44 percent of CHC users are children through age 19. Because funds would be targeted to geographic areas or population groups where levels of uninsurance among children are particularly high and/or growing, the actual increase in numbers served would depend on rates of uninsurance in the sites selected and could be somewhat smaller.

| Federal Grant Support for CHCs | People Served--All Ages | Children Served |
|---|---|---|
| $25 million | 250,000 | 110,000 |
| $50 million | 500,000 | 220,000 |
| $100 million | 1,000,000 | 440,000 |

## IV. ADMINISTRATION AND CONGRESSIONAL HISTORY ON ISSUE

The Fiscal Year 1997 appropriation for CHCs is $802 million. In its preliminary submission to OMB for FY 1998, the Department requested $817 million for CHCs, which includes plans for 50 new delivery sites. CHCs were recently reauthorized by Congress with broad bipartisan support.

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# Children's health insurance and rates of enrollment into employer-sponsored plans

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## Introduction

Children's health insurance coverage comes from a patchwork of private and public sources that left as many as 10 million children without health insurance in 1994.[1] As evidence begins to mount that having insurance affects not only children's access to medical care but also health outcomes such as child mortality[2], it becomes increasingly important that we consider the efficiency and feasibility of various policies to reduce the number of children without coverage.

There are several reasons why the role of employer-sponsored health insurance in providing children's coverage deserves special attention: first, it is the largest source of their coverage, covering about 60% of all children in 1993. Second, there is some evidence that employer coverage has eroded in recent years; Newacheck et al. report that rates of employer coverage for children decreased by 4.5 percentage points from 1988 to 1992[3]. Finally, neither comprehensive coverage mandates (discussion of which effectively died with the Clinton plan) nor expansions of Medicaid beyond those mandated in the late 1980s appears likely in the near future, so that policies focused on expanding the current system of voluntary employer coverage deserve special attention. Given the political interest in incremental approaches, such as the recent "Health Insurance Reform Act of 1995", it makes sense for those concerned about

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[1] "Sources of health insurance and characteristics of the uninsured: Analysis of the March 1995 Current Population Survey," Employee Benefits Research Institute Issue Brief Number 170, February 1996.

[2] Currie J, Gruber J. Health insurance eligibility, utilization of medical care, and child health. *Quarterly Journal of Economics*. May 1996:431-466.

[3] Newacheck P. Children and health insurance: an overview of recent trends. *Health Affairs*, Spring 1995, 245-254

uninsured children to consider the potential of incremental employment-based reforms to affect children's health insurance coverage.

**Methods**

We analyzed data on children's health insurance status from a 1993 household survey sponsored by the Robert Wood Johnson Foundation in ten states: Colorado, Florida, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington. The survey included 21,091 households in these ten states; the subsample we analyzed consists of 24,216 children living in 12,140 families. Children were defined as persons age 18 or younger. Aggregate estimates of health insurance coverage were weighted to represent the total population of these children in the ten states included in the survey.

We first performed a tabular analysis of health insurance coverage rates for all children by race, age, state of residence, employment characteristics of adults in the family, family income, and family structure. We then used multivariate linear regression analyses to control for the factors that might confound the effect of a single explanatory variable. Three separate regressions were estimated with the dependent variable equal to one if the child had employer-sponsored insurance, Medicaid, or no insurance, respectively. Independent variables included the child's age, sex, race, family income per family member, the highest grade of education attained by anyone in the family, whether the family had only a female head or only a male head, whether at least one family head had a job, whether at least one family head was offered employer-sponsored insurance, and state of residence. Standard errors were estimated using a Huber correction for heteroscedasticity. We then repeated both the tabular and the multivariate

analyses for the subset of children who were in families where at least one family head was eligible for employer-sponsored insurance; we included the industry of employment of the primary working adult in the family as an additional independent variable in these analyses. We also estimated all multivariate analyses using probit models, which yielded very similar results to those from the linear regression and are therefore not reported here, but are available upon request.

## Results

### Health insurance coverage of all children

The primary source of children's coverage was employer-sponsored group health insurance, which covered 59.4% of all children (table 1). Rates of employer coverage generally increased with family income: only 14.5% of children in families with incomes below poverty had employer coverage, compared to 82.8% of children in families with incomes greater than 400% of poverty. Whites had the higher rates of employer coverage than did Black, Native American or Asian children. Children in families with more than one full-time worker had higher rates of employer coverage (81.4%) than children in families without a worker (11.7%). (Children may be covered by employer-sponsored policies of adults living outside the family.) There was significant variation in rates of employer coverage by state, ranging from 45.3% in Oklahoma to 76.3% in Minnesota.

The next largest source of coverage for children was Medicaid, which covers 17.0% of all children. Variation in Medicaid coverage mirrored the variation in rates of private coverage. Rates of Medicaid coverage decreased as income increased: Medicaid covered 58.9% of all poor

children, 14.4% of all children in families with incomes between 100 and 200% of poverty, and less than 5% of all wealthier children. Children in families without a worker were most likely to have Medicaid (69.8%), those in families with more than one full-time worker the least likely (1.8%.) Since eligibility requirements for Medicaid beyond the Federally mandated minimum are determined at the state level, it is not surprising that there was substantial variation across the ten states in rates of Medicaid coverage, from 11.6% in Oregon to 20.6% in New York.

Almost one-fifth (17.2%) of all children had no health insurance. Those most likely to be uninsured were children just above the poverty level, 28.8% of whom were uninsured; Asian children (35.6%); children in families with only a male head (31.7%), and children in families with only a part-time worker (31.2%.) Those least likely to be uninsured were children in families with income greater than 400% of the poverty level (6.0%); Native American/Alaskan children (12.6%); and children in families with more than one full-time worker (11.1%). These patterns of non-coverage reflect the piecemeal nature of children's insurance: while employer-sponsored coverage was the rule among high-income children in families with full-time workers, and Medicaid covered poor children in families without a worker, near-poor children and those who live in families with part-time workers were most likely to be uninsured.

The multivariate analysis, presented in table 2, confirmed the results of the descriptive analysis: children in families with higher family income, more highly educated family heads, or a family head offered employer-sponsored health insurance were all more likely to have employer-coverage, less likely to have Medicaid, and less likely to be uninsured. Age, race and state of residence were all significant determinants of children's insurance coverage as well; the magnitudes of significant effects were the following:

- An additional $10,000 of family income per family member increased the probability of employer coverage by about 2 percentage points, decreased the probability of Medicaid coverage by 2 percentage points, and decreased the probability of being uninsured by 1 percentage points.
- Each additional year of age increased the child's probability of employer coverage by about 1 percentage points and reduced the probability of Medicaid coverage by about 2 percentage points; the probability of being uninsured increased by about 1 percentage points.
- Compared to whites, the probability of employer coverage was 7 percentage points lower for Blacks, 6 points lower for Native Americans/Alaskans, and 5 points lower for Asians. The probability of Medicaid coverage was 9 percentage points higher for blacks than whites; however, for Native Americans and Asians the probability of Medicaid coverage was not significantly different than for whites. Overall, the probability of being uninsured was about the same for Blacks and whites. The probability of being uninsured was 10 percentage points lower for Native American than for white children (mostly due to public coverage through the Indian Health Services, which accounts for the large difference in rates of Medicaid and all public coverage for this group). Asian children were 6 percentage points more likely than whites to be uninsured.
- Hispanics were 3 percentage points less likely than non-Hispanics to have employer coverage; they were 4 points more likely to have Medicaid, and 2 points more likely to be uninsured.

- Children in a family with only one head were significantly less likely than children in two-head families to have employer coverage; for families with a female head only the difference was 5 percentage points and for male head only families it was 6 percentage points. Children in female-headed families were far more likely (19 percentage points) than children in two-head families to have Medicaid coverage; in male-headed families the difference was significant but not as large (5 percentage points). The net effect was quite different for the two types of single-headed families: children in female-headed families were 8 percentage points less likely, and those in male-headed families were about 5 points more likely, to be uninsured than were children in two-head families.
- The effect on insurance status of having a family member who worked depended heavily on whether or not that family member was offered health insurance on the job. Children in families with a worker who was not offered health insurance were 5 percentage points less likely than those in a family without any worker to have employer coverage; they were 24 points less likely to have Medicaid, and 21 percentage points more likely to be uninsured. Children in families with a worker who was offered health insurance were 37 points more likely than children in families without a worker to have employer coverage, 38 points less likely to have Medicaid, and 4 points more likely to be uninsured.
- Variations by state were jointly significant.
- Sex of the child was not a significant determinant of insurance coverage.

**Children and employer-sponsored health insurance**

The importance of having a family member who was offered employer-sponsored health insurance in determining whether or not a child had group coverage suggests that expanding the availability of employer-sponsored health insurance may help reduce the number of uninsured children. In order to know how many children might be affected by such a measure, we need to know how many uninsured children live in families with workers. Table 3 presents the distribution of uninsured children in 1993 by demographic and family characteristics. Most uninsured children (86.2%) were indeed in a family with a worker; most of those (71.6% of the total) were in a family with at least one full-time worker.

Many of these children, however, may already have been eligible for employer-sponsored health insurance: more than one-third (35.6%) of all uninsured children were in families where one of the family heads is eligible for employer-sponsored insurance. And 9.4% of children in families with a head eligible for employer-sponsored insurance remained uninsured. These facts highlight the distinction between insurance eligibility and insurance coverage. Private health insurance requires enrollment well in advance of an adverse health event, in order for the medical bills associated with the event to be covered by the plan. Most employer-sponsored plans have a waiting period before medical bills will be paid, and/or limited periods during which it is possible to enroll, such as the end or beginning of the calendar year. Employer-sponsored insurance typically also requires a premium contribution from the employee. As employee costs increase, employees may be less likely to enroll, increasing the number of eligible enrollees without coverage. Therefore an important component of efforts to reduce the number of uninsured children by expanding the availability of employer-sponsored insurance must be ensuring that children are actually enrolled in coverage when it is available to them.

**Sources of health insurance for children who were eligible for employer-sponsored insurance**

In order to see how family characteristics affect enrollment rates, table 4 presents the results of an analysis of sources of children's health insurance coverage similar to that presented in table 1, but with the sample restricted to children in families where one or both family heads reported that they were eligible for employer-sponsored insurance. This group is not exactly the same as the population of children eligible for employer-sponsored health insurance for the following reasons. First, not all policies offered by employers include the option to purchase family coverage, although most do: our tabulations of the April 1993 Current Population Survey Supplement on Employee Benefits suggest that at least 90% of all workers offered health insurance are offered the option of purchasing family coverage. Second, not all children in the sample were the children of family heads and therefore might not be eligible for coverage as dependents under the terms of the employer-sponsored insurance policy. Third, children may have been eligible for coverage as the dependents of out-of-household adults who were not included in the survey. The first and second reasons will lead to an overcount of the population of eligible children, the third will lead to an undercount. If these errors are small, however, the rate of coverage by employer group insurance for these children (column 2 of table 4) may be regarded as the "enrollment rate" for employer coverage.

Overall, the enrollment rate was 84.2%, but this rate varied by family characteristics. Most noticeably, enrollment rates increased with family income, from 48.1% for children in families with income below the poverty level, to 94.1% of children in families with income

greater than 400% of poverty. Enrollment rates also varied by state (from 73.4% in Oklahoma to 91.4% in Minnesota) and by industry of family head's employment, with children of government employees having the lowest enrollment rate (73.0%) and children of those employed in the financial, insurance and real estate industry the highest (94.0%).

Some children who were eligible for employer-sponsored insurance reported Medicaid coverage (4.2%). The option of Medicaid coverage complicates our analysis of enrollment rates because it may make sense for parents not to enroll their children in private coverage if public coverage through Medicaid is available: Medicaid is typically free, whereas employer-sponsored insurance may require a substantial premium contribution for family coverage. The issue of dual eligibility has prompted a debate about whether recent expansions of Medicaid eligibility has resulted in a net increase in rates of children's insurance coverage, or has simply resulted in the substitution of public for private coverage.[4,5,6,7] It is clear that we cannot simply infer from enrollment rates less than 100% that children must be remaining uninsured as a result, since some of them may be covered by Medicaid. Instead we rely on the presence of a substantial

[4] Cutler D, Gruber J. Does public insurance crowd out private insurance? *Quarterly Journal of Economics*, May 1996, 391-430.

[5] Shore-Sheppard, L. Stemming the tide? The effect of expanding Medicaid eligibility on health insurance coverage. Princeton Industrial Relations Section working paper #361, April 1996.

[6] Dubay L, Kenney G. The effects of Medicaid expansions on insurance coverage of children. *The Future of Children*, Spring 1996, 152-161.

[7] Center for Studying Health Systems Change. Medicaid eligibility policy and the crowding-out effect. Issue Brief #3, October 1996.

fraction of children in this group (9.8%) who report being uninsured as evidence that some children who are eligible for private coverage remain uninsured.

This measure is imperfect, however, because children who report being uninsured may in fact be eligible for but not enrolled in Medicaid. Why would Medicaid-eligible children without private health insurance not enroll in Medicaid? Their families may be unaware of the program or unaware of their eligibility for it; they may not enroll because of stigma; or they may not enroll because they know that they would be covered in the event that the child required medical care. (Medicaid coverage is effective retroactively three months prior to the date of enrollment.) From a purely economic perspective, these children are "insured" by the program in the sense that their families are not at risk of large financial losses due to medical expense; from a more practical perspective, however, these children are likely to experience significant nonfinancial obstacles, or to perceive financial barriers (if they are unaware of the program) that may prevent their getting necessary medical care. For this reason, and because it seems unlikely that *all* children who report being uninsured are in fact Medicaid eligible, we remain concerned that some children who are eligible for employer-sponsored insurance are remaining uninsured, and proceed with our analysis on that assumption.

Table 5 presents the results of our multivariate analysis of enrollment rates for this group of children. We interepet the coefficients in the first column (the regression with employer coverage=1 as the dependent variable) as the effect of the independent variables on enrollment rates. We find that:

- An additional $10,000 of income per family member increased the enrollment rate by 4 percentage points.

- Each year of a child's age increased the enrollment rate by about 1 percentage point.
- Black children's enrollment rate was 9 percentage points lower than the rate for white children. Rates for Native Americans were 13 points lower, and for Asians were 6 points lower, than for whites.
- Hispanic children had an enrollment rate that was 5 percentage points lower than that of non-Hispanic children.
- Each year of education attained by the most highly educated family member increased the enrollment rate for children by 4 percentage points.
- Children in female-headed families had enrollment rates that were 10 percentage points lower, and those in male-headed families had enrollment rates that were 8 points lower, than did children in families with two heads.
- State variables explained a significant amount of variation in enrollment rates.
- The industry in which the family's primary worker was employed also explained a significant amount of variation in enrollment rates.

**Comment**

The most important conclusion to emerge from this analysis is that efforts to reduce the number of uninsured children by expanding eligibility for employer-sponsored coverage must consider the likely rates of enrollment into those programs. The fact that enrollment rates are below 100% will dilute the effect of any policy that aims to expand coverage by increasing eligibility. While the potential for making currently uninsured children *eligible* for employer-sponsored coverage is very good (only 16.2% of all uninsured children are in a family without

any worker), even in homes with a worker who is currently eligible for insurance, nine percent of children remain uninsured. Voluntary employment-based reform is an unpromising vehicle for ensuring that all children are covered by health insurance. Policymakers must keep in mind the distinction between eligibility and coverage in identifying goals for public intervention and in choosing the policies that will best achieve them.

**Table 1**
**Health insurance coverage rates:**
**All children**

| | Fraction of children covered by: | | |
|---|---|---|---|
| | Employer group | Medicaid | No health insurance |
| **Total** | 59.4% | 17.0% | 17.2% |
| **Race** | | | |
| White | 63.5 | 13.1 | 16.5 |
| Black | 42.0 | 39.8 | 18.0 |
| Native American/Alaskan | 40.4 | 25.8 | 12.6 |
| Asian | 49.2 | 10.1 | 35.6 |
| **Age** | | | |
| 0-6 | 53.7 | 25.4 | 15.6 |
| 7-12 | 61.7 | 13.8 | 17.8 |
| 13-18 | 64.2 | 9.8 | 18.5 |
| **Family income** | | | |
| <100% of poverty | 14.5 | 58.9 | 24.6 |
| 100-200% | 48.6 | 14.4 | 28.8 |
| 200-300% | 74.8 | 4.5 | 15.4 |
| 300-400% | 84.8 | 1.7 | 8.2 |
| 400%+ | 82.8 | 1.4 | 6.0 |
| **Family structure** | | | |
| Two family heads | 69.5 | 6.2 | 16.4 |
| Female family head only | 33.5 | 47.6 | 16.9 |
| Male family head only | 43.0 | 17.7 | 31.7 |
| **Work status of adults in family** | | | |
| No worker | 11.7 | 69.8 | 16.2 |
| Part-time worker only | 32.0 | 27.7 | 31.2 |
| One full-time worker | 67.0 | 7.6 | 18.0 |
| >1 full-time worker | 81.4 | 1.8 | 11.1 |
| **Work/insurance offering status of adults in family** | | | |
| No worker | 11.7 | 69.8 | 16.2 |
| Part time worker in firm that does not offer insurance | 19.7 | 30.2 | 36.4 |
| Full-time worker in firm that does not offer insurance | 11.8 | 15.0 | 44.4 |
| Worker in firm that offers insurance but worker is ineligible | 9.6 | 27.8 | 55.6 |
| Worker in firm that offers insurance but worker is ineligible or declines | 16.0 | 20.4 | 28.5 |
| Worker in firm that offers insurance but worker declines | 20.7 | 17.1 | 45.4 |
| Worker covered by employer-sponsored insurance | 88.2 | 3.3 | 7.5 |

**Table 1**
**Health insurance coverage rates:**
**All children**

| | Fraction of children covered by: | | |
|---|---|---|---|
| | **Employer group** | **Medicaid** | **No health insurance** |
| **Total** | 59.4% | 17.0% | 17.2% |
| **State** | | | |
| CO | 63.0 | 12.7 | 17.8 |
| FL | 52.0 | 15.2 | 26.5 |
| MN | 69.3 | 15.3 | 9.0 |
| NM | 47.7 | 17.6 | 24.2 |
| NY | 62.0 | 20.6 | 12.8 |
| ND | 59.8 | 12.7 | 13.3 |
| OK | 45.3 | 19.2 | 22.0 |
| OR | 65.1 | 11.6 | 17.4 |
| VT | 65.0 | 19.7 | 7.7 |
| WA | 64.4 | 15.2 | 14.4 |
| **Sample n** | 24,216 | | |
| **Weighted n** | 15.1 million | | |

**Table 2**
**Children's health insurance: all children**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | |
|---|---|---|---|
| **Independent variables:** | **Employer coverage** | **Medicaid** | **No health insurance** |
| Age | .0071 *** | -.0208 *** | .0100 *** |
| | (.0004) | (.0005) | (.0005) |
| Female | .0053 | .0098 * | -.0061 |
| | (.0047) | (.0053) | (.0050) |
| Black | -.0720 | .0898 *** | -.0088 |
| | (.0081) | (.0102) | (.0093) |
| Native American/Alaskan | -.0636 *** | -.0126 | -.0973 *** |
| | (.0090) | (.0111) | (.0094) |
| Asian | -.0514 *** | -.0155 | .0587 *** |
| | (.0179) | (.0208) | (.0208) |
| Hispanic | -.0292 *** | .0439 *** | .0227 *** |
| | (.0069) | (.0083) | (.0081) |
| Family income per family member ($10,000) | .0247 *** | -.0237 *** | -.0087 *** |
| | (.0010) | (.0065) | (.0020) |
| Highest grade attained by anyone in family | .0247 *** | -.0171 *** | -.0120 *** |
| | (.0010) | (.0012) | (.0011) |
| Female family head only | -.0478 *** | .1899 *** | -.0854 *** |
| | (.0059) | (.0071) | (.0064) |
| Male family head only | -.0585 *** | .0463 *** | .0452 *** |
| | (.0109) | (.0130) | (.0131) |
| At least one family head works | -.0520 *** | -.2357 *** | .2107 *** |
| | (.0055) | (.0082) | (.0076) |
| At least one family head is offered employer-sponsored insurance | .3743 *** | -.3762 *** | .0417 *** |
| | (.0068) | (.0081) | (.0070) |
| CO[1] | -.0853 *** | .0831 *** | .0308 ** |
| | (.0115) | (.0128) | (.0127) |

**Table 2**
**Children's health insurance: all children**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | |
|---|---|---|---|
| **Independent variables:** | **Employer coverage** | **Medicaid** | **No health insurance** |
| FL | -.0751 *** | .0876 *** | .0068 |
| | (.0105) | (.0122) | (.0120) |
| MN | .0228 ** | -.0440 *** | -.0640 *** |
| | (.0114) | (.0121) | (.0117) |
| NM | -.0778 *** | .0651 *** | .0253 ** |
| | (.0103) | (.0120) | (.0119) |
| ND | -.1106 *** | .1941 *** | -.0143 |
| | (.0119) | (.0132) | (.0123) |
| OK | -.1106 *** | .0193 | .0698 *** |
| | (.0110) | (.0126) | (.0128) |
| OR | -.0134 | .0188 | .0321 ** |
| | (.0121) | (.0131) | (.0131) |
| VT | -.0740 *** | .1793 *** | -.1350 *** |
| | (.0116) | (.0131) | (.0113) |
| WA | -.0621 *** | .1255 *** | -.0326 *** |
| | (.0110) | (.0123) | (.0119) |
| Intercept | -.1584 *** | .9270 *** | .2552 *** |
| | (.0167) | (.0195) | (.0187) |
| Number of observations | 24,216 | 24,216 | 24,216 |
| F statistic on state variables | 34.20 | 56.92 | 63.38 |
| $R^2$ | .3397 | .3195 | .1069 |

**Explanatory notes:**
Results are presented as: coefficient
(standard error)

[1]The omitted state category is NY.
*The null hypothesis that the coefficient is equal to zero is rejected at the 1% (***), 5% (**) or 10% (*) level.

**Table 3**
**Demographic characteristics of all children, uninsured children, and children in a family where a family head is eligible for employer-sponsored health insurance**

| | All children | Children in families with a head eligible for health insurance[1] | Uninsured children |
|---|---|---|---|
| **Total population** | 15.1 million | 9.0 million | 2.6 million |
| **Sample size** | 24,216 | 8,835 | 5,154 |
| **Race** | **100.0%** | **100.0%** | **100.0%** |
| White | 80.3 | 83.4 | 76.9 |
| Black | 13.6 | 10.8 | 14.3 |
| Native American/Alaskan | 2.9 | 2.5 | 2.1 |
| Asian | 3.2 | 3.3 | 6.7 |
| **Age** | **100.0%** | **100.0%** | **100.0%** |
| 0-6 | 37.9 | 35.4 | 34.3 |
| 7-12 | 32.3 | 33.0 | 33.6 |
| 13-18 | 29.7 | 31.6 | 32.1 |
| **Family income** | **100.0%** | **100.0%** | **100.0%** |
| <100% of poverty | 21.5 | 7.4 | 30.8 |
| 100-200% | 21.3 | 20.5 | 35.7 |
| 200-300% | 21.4 | 26.0 | 19.2 |
| 300-400% | 13.3 | 18.0 | 6.4 |
| 400%+ | 22.5 | 28.3 | 7.9 |
| **Family structure** | **100.0%** | **100.0%** | **100.0%** |
| Two family heads | 70.9 | 82.8 | 67.9 |
| Female family head only | 25.0 | 14.3 | 24.5 |
| Male family head only | 4.1 | 2.9 | 7.6 |
| **Work status of adults in family** | **100.0%** | **100.0%** | **100.0%** |
| No worker | 14.7 | 0.0 | 13.8 |
| Part-time worker only | 8.0 | 3.4 | 14.6 |
| One full-time worker | 54.2 | 64.9 | 56.7 |
| >1 full-time worker | 23.1 | 31.7 | 14.9 |
| **Work/insurance offering status of adults in family** | **100.0%** | **100.0%** | **100.0%** |
| No worker | 14.7 | 0.0 | 13.8 |
| Part time worker in firm that does not offer insurance | 3.8 | 0.0 | 8.1 |
| Full-time worker in firm that does not offer insurance | 11.0 | 0.0 | 28.5 |
| Worker in firm that offers insurance but worker is ineligible | 2.8 | 0.0 | 9.2 |
| Worker in firm that offers insurance but worker is ineligible or declines | 2.9 | 0.0 | 4.8 |
| Worker in firm that offers insurance but worker declines | 3.3 | 5.4 | 8.7 |
| Worker covered by employer-sponsored insurance | 61.5 | 94.6 | 26.9 |

**Table 3**
**Demographic characteristics of all children, uninsured children, and children in a family where a family head is eligible for employer-sponsored health insurance**

| | | | |
|---|---|---|---|
| **State** | **100.0%** | **100.0%** | **100.0%** |
| CO | 7.0 | 7.7 | 7.3 |
| FL | 21.7 | 22.0 | 33.6 |
| MN | 8.8 | 10.0 | 4.6 |
| NM | 3.6 | 3.0 | 5.1 |
| NY | 34.2 | 31.9 | 25.5 |
| ND | 1.2 | 13.3 | 0.9 |
| OK | 6.2 | 5.9 | 8.0 |
| OR | 5.9 | 6.2 | 6.0 |
| VT | 1.0 | 1.1 | 0.5 |
| WA | 10.3 | 10.9 | 8.6 |
| **Industry of primary worker in family** | **100.0%** | **100.0%** | **100.0%** |
| No worker | 14.7 | 0.0 | 34.8 |
| Agriculture | 2.9 | 2.5 | 4.2 |
| Construction | 7.8 | 7.9 | 12.7 |
| Mining/manufacturing | 11.3 | 16.8 | 7.9 |
| Transportation, Comm & PU | 8.2 | 11.9 | 5.8 |
| Wholesale | 1.0 | 1.4 | 0.5 |
| Retail | 9.9 | 10.6 | 15.2 |
| Financial, Ins & real est. | 5.3 | 7.2 | 2.2 |
| Professional services | 16.8 | 22.0 | 12.4 |
| Other services | 7.1 | 8.3 | 9.2 |
| Government | 7.2 | 31.8 | 9.3 |
| No industry data provided | 7.6 | (1) | 6.8 |

[1]Children in families with a worker with missing industry data are excluded from this column; there are 629 such children in the sample (8.2% of children in a family with a worker who is eligible for employer-sponsored health insurance.)

**Table 4**
**Health insurance coverage rates:**
**Children in families with a head who is eligible for employer-sponsored insurance**

| | Percent of children covered by: | | |
|---|---|---|---|
| | **Employer group** | **Medicaid** | **No health insurance** |
| **Total** | 84.2% | 4.2% | 9.8% |
| **Race** | | | |
| White | 86.2 | 2.9 | 9.0 |
| Black | 77.1 | 13.5 | 11.6 |
| Native American/Alaskan | 65.3 | 8.9 | 10.0 |
| Asian | 73.2 | 2.1 | 24.7 |
| **Age** | | | |
| 0-6 | 81.6 | 6.8 | 10.0 |
| 7-12 | 85.8 | 2.6 | 9.9 |
| 13-18 | 85.6 | 2.9 | 9.7 |
| **Family income** | | | |
| <100% of poverty | 48.1 | 28.9 | 23.1 |
| 100-200% | 72.5 | 6.2 | 19.1 |
| 200-300% | 86.9 | 1.8 | 10.1 |
| 300-400% | 93.1 | 0.9 | 4.3 |
| 400%+ | 94.1 | 0.5 | 2.9 |
| **Family structure** | | | |
| Two family heads | 86.0 | 2.7 | 9.3 |
| Female family head only | 75.3 | 11.1 | 12.8 |
| Male family head only | 78.5 | 12.0 | 10.2 |
| **State** | | | |
| CO | 84.2 | 3.2 | 9.9 |
| FL | 76.0 | 5.8 | 17.1 |
| MN | 91.4 | 3.7 | 4.5 |
| NM | 75.8 | 5.1 | 12.6 |
| NY | 89.7 | 3.9 | 6.2 |
| ND | 80.8 | 3.3 | 10.2 |
| OK | 73.4 | 4.5 | 15.5 |
| OR | 88.4 | 2.2 | 7.3 |
| VT | 89.5 | 6.6 | 3.5 |
| WA | 84.2 | 3.5 | 9.1 |
| **Industry of primary worker in family** | | | |
| Agriculture | 73.7 | 3.8 | 16.9 |
| Construction | 83.7 | 2.9 | 12.3 |
| Mining/manufacturing | 86.4 | 4.9 | 7.1 |

**Table 4**
**Health insurance coverage rates:**
**Children in families with a head who is eligible for employer-sponsored insurance**

| | Percent of children covered by: | | |
|---|---|---|---|
| | **Employer group** | **Medicaid** | **No health insurance** |
| **Total** | 84.2% | 4.2% | 9.8% |
| Transportation, Comm & PU | 92.5 | 1.9 | 4.2 |
| Wholesale | 92.1 | 2.6 | 4.1 |
| Retail | 75.9 | 7.4 | 14.6 |
| Financial, Ins & real est. | 94.0 | 0.9 | 2.8 |
| Professional services | 85.7 | 5.4 | 7.5 |
| Other services | 84.1 | 5.7 | 8.6 |
| Government | 73.0 | 2.4 | 22.6 |
| **Sample n** | 8,835 | | |
| **Weighted n** | 9.0 million | | |

**Table 5**
**Children's health insurance: children with family heads eligible for employer-sponsored coverage**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | |
|---|---|---|---|
| **Independent variables:** | **Employer coverage** | **Medicaid** | **No health insurance** |
| Age | .0099 *** | -.0195 *** | .0048 *** |
| | (.0009) | (.0008) | (.0007) |
| Female | -.0022 | -.0005 | .0124 * |
| | (.0095) | (.0082) | (.0075) |
| Black | -.0902 *** | .1409 *** | -.0310 * |
| | (.0209) | (.0198) | (.0170) |
| Native American/Alaskan | -.1255 *** | .0063 | -.1179 *** |
| | (.0227) | (.0202) | (.0160) |
| Asian | -.0636 * | -.0169 | .0612 ** |
| | (.0345) | (.0274) | (.0303) |
| Hispanic | -.0520 *** | .0477 *** | .0581 *** |
| | (.0175) | (.0150) | (.0153) |
| Family income per family member ($10,000) | .0417 *** | -.0321 *** | -.0186 *** |
| | (.0058) | (.0047) | (.0030) |
| Highest grade attained by anyone in family | .0395 *** | -.0179 *** | -.0226 *** |
| | (.0022) | (.0019) | (.0018) |
| Female family head only | -.1000 *** | .1278 *** | -.0068 |
| | (.0141) | (.0128) | (.0110) |
| Male family head only | -.0768 *** | .0272 | .0450 ** |
| | (.0254) | (.0216) | (.0222) |
| CO[1] | -.1545 *** | .0973 *** | .0603 *** |
| | (.0234) | (.0198) | (.0192) |
| FL | -.1100 *** | .0953 *** | .0230 |
| | (.0226) | (.0195) | (.0183) |
| MN | .0240 | .0230 | -.0366 ** |
| | (.0208) | (.0172) | (.0161) |

**Table 5**
**Children's health insurance: children with family heads eligible for employer-sponsored coverage**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | | | | |
|---|---|---|---|---|---|---|
| **Independent variables:** | **Employer coverage** | | **Medicaid** | | **No health insurance** | |
| NM | -.1108 | *** | .0571 | *** | .0421 | ** |
| | (.0242) | | (.0199) | | (.0203) | |
| ND | -.1643 | *** | .1856 | *** | .0434 | ** |
| | (.0233) | | (.0206) | | (.0189) | |
| OK | -.1646 | *** | .0204 | | .1143 | *** |
| | (.0246) | | (.0194) | | (.0210) | |
| OR | .0176 | | .0143 | *** | .0173 | |
| | (.0225) | | (.0185) | | (.0184) | |
| VT | -.0983 | *** | .1368 | *** | -.0750 | *** |
| | (.0231) | | (.0203) | | (.0162) | |
| WA | -.1513 | *** | .1244 | *** | .0361 | ** |
| | .0228 | | (.0194) | | (.0182) | |
| Industry of family's primary worker[2]: | | | | | | |
| Agriculture | -.0374 | | -.0182 | | -.0168 | |
| | (.0296) | | (.1243) | | (.0226) | |
| Construction | .0294 | | -.0546 | *** | .0048 | |
| | (.0211) | | (.0173) | | (.0174) | |
| Mining/manufacturing | .0981 | *** | -.0103 | | -.0589 | *** |
| | (.0149) | | (.0132) | | (.0114) | |
| Transportation, Comm & PU | .1411 | *** | -.0511 | *** | -.0730 | *** |
| | (.0180) | | (.0153) | | (.0140) | |
| Wholesale | .1670 | *** | -.0734 | ** | -.0801 | *** |
| | (.0406) | | (.0333) | | (.0293) | |
| Retail | -.0077 | | .0155 | | -.0062 | |
| | (.0176) | | (.0157) | | (.0143) | |
| Financial, Ins & real est. | .0870 | *** | -.0605 | *** | -.0264 | |
| | (.0246) | | (.0207) | | (.0191) | |
| Other services | .0095 | | .0205 | | -.0153 | |
| | (.0196) | | (.0175) | | (.0153) | |

**Table 5**
**Children's health insurance: children with family heads eligible for employer-sponsored coverage**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | |
|---|---|---|---|
| **Independent variables:** | **Employer coverage** | **Medicaid** | **No health insurance** |
| Government | .0555 *** | -.0602 *** | .0070 |
| | (.0199) | (.0163) | (.0160) |
| Intercept | .0506 | .5612 *** | .4362 *** |
| | (.0400) | (.0352) | (.0332) |
| Number of observations | 8,835 | 8,835 | 8,835 |
| F statistic on state variables | 27.68 | 21.61 | 21.99 |
| F statistic on industry variables | 14.29 | 5.54 | 6.79 |
| $R^2$ | .1567 | .1561 | .0688 |

**Explanatory notes:**
Results are presented as: coefficient
(standard error)

[1]The omitted state category is NY.
[2]The primary family head is the family head who works more hours. The omitted industry category is professional services.
*The null hypothesis that the coefficient is equal to zero is rejected at the 1% (***), 5% (**) or 10% (*) level.

**Table 3**
**Demographic characteristics of all children, uninsured children, and children in a family where a family head is eligible for employer-sponsored health insurance**

| | All children | Children in families with a head eligible for health insurance[1] | Uninsured children |
|---|---|---|---|
| **Total population** | 15.1 million | 9.0 million | 2.6 million |
| **Sample size** | 24,216 | 8,835 | 5,154 |
| **Race** | **100.0%** | **100.0%** | **100.0%** |
| White | 80.3 | 83.4 | 76.9 |
| Black | 13.6 | 10.8 | 14.3 |
| Native American/Alaskan | 2.9 | 2.5 | 2.1 |
| Asian | 3.2 | 3.3 | 6.7 |
| **Age** | **100.0%** | **100.0%** | **100.0%** |
| 0-6 | 37.9 | 35.4 | 34.3 |
| 7-12 | 32.3 | 33.0 | 33.6 |
| 13-18 | 29.7 | 31.6 | 32.1 |
| **Family income** | **100.0%** | **100.0%** | **100.0%** |
| <100% of poverty | 21.5 | 7.4 | 30.8 |
| 100-200% | 21.3 | 20.5 | 35.7 |
| 200-300% | 21.4 | 26.0 | 19.2 |
| 300-400% | 13.3 | 18.0 | 6.4 |
| 400%+ | 22.5 | 28.3 | 7.9 |
| **Family structure** | **100.0%** | **100.0%** | **100.0%** |
| Two family heads | 70.9 | 82.8 | 67.9 |
| Female family head only | 25.0 | 14.3 | 24.5 |
| Male family head only | 4.1 | 2.9 | 7.6 |
| **Work status of adults in family** | **100.0%** | **100.0%** | **100.0%** |
| No worker | 14.7 | 0.0 | 13.8 |
| Part-time worker only | 8.0 | 3.4 | 14.6 |
| One full-time worker | 54.2 | 64.9 | 56.7 |
| >1 full-time worker | 23.1 | 31.7 | 14.9 |
| **Work/insurance offering status of adults in family** | **100.0%** | **100.0%** | **100.0%** |
| No worker | 14.7 | 0.0 | 13.8 |
| Part time worker in firm that does not offer insurance | 3.8 | 0.0 | 8.1 |
| Full-time worker in firm that does not offer insurance | 11.0 | 0.0 | 28.5 |
| Worker in firm that offers insurance but worker is ineligible | 2.8 | 0.0 | 9.2 |
| Worker in firm that offers insurance but worker is ineligible or declines | 2.9 | 0.0 | 4.8 |
| Worker in firm that offers insurance but worker declines | 3.3 | 5.4 | 8.7 |
| Worker covered by employer-sponsored insurance | 61.5 | 94.6 | 26.9 |

**Table 4**
**Health insurance coverage rates:**
**Children in families with a head who is eligible for employer-sponsored insurance**

| | Percent of children covered by: | | |
|---|---|---|---|
| | Employer group | Medicaid | No health insurance |
| **Total** | 84.2% | 4.2% | 9.8% |
| **Race** | | | |
| White | 86.2 | 2.9 | 9.0 |
| Black | 77.1 | 13.5 | 11.6 |
| Native American/Alaskan | 65.3 | 8.9 | 10.0 |
| Asian | 73.2 | 2.1 | 24.7 |
| **Age** | | | |
| 0-6 | 81.6 | 6.8 | 10.0 |
| 7-12 | 85.8 | 2.6 | 9.9 |
| 13-18 | 85.6 | 2.9 | 9.7 |
| **Family income** | | | |
| <100% of poverty | 48.1 | 28.9 | 23.1 |
| 100-200% | 72.5 | 6.2 | 19.1 |
| 200-300% | 86.9 | 1.8 | 10.1 |
| 300-400% | 93.1 | 0.9 | 4.3 |
| 400%+ | 94.1 | 0.5 | 2.9 |
| **Family structure** | | | |
| Two family heads | 86.0 | 2.7 | 9.3 |
| Female family head only | 75.3 | 11.1 | 12.8 |
| Male family head only | 78.5 | 12.0 | 10.2 |
| **State** | | | |
| CO | 84.2 | 3.2 | 9.9 |
| FL | 76.0 | 5.8 | 17.1 |
| MN | 91.4 | 3.7 | 4.5 |
| NM | 75.8 | 5.1 | 12.6 |
| NY | 89.7 | 3.9 | 6.2 |
| ND | 80.8 | 3.3 | 10.2 |
| OK | 73.4 | 4.5 | 15.5 |
| OR | 88.4 | 2.2 | 7.3 |
| VT | 89.5 | 6.6 | 3.5 |
| WA | 84.2 | 3.5 | 9.1 |
| **Industry of primary worker in family** | | | |
| Agriculture | 73.7 | 3.8 | 16.9 |
| Construction | 83.7 | 2.9 | 12.3 |
| Mining/manufacturing | 86.4 | 4.9 | 7.1 |

**Table 5**
**Children's health insurance: children with family heads eligible for employer-sponsored coverage**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | |
|---|---|---|---|
| **Independent variables:** | **Employer coverage** | **Medicaid** | **No health insurance** |
| Age | .0099 *** | -.0195 *** | .0048 *** |
| | (.0009) | (.0008) | (.0007) |
| Female | -.0022 | -.0005 | .0124 * |
| | (.0095) | (.0082) | (.0075) |
| Black | -.0902 *** | .1409 *** | -.0310 * |
| | (.0209) | (.0198) | (.0170) |
| Native American/Alaskan | -.1255 *** | .0063 | -.1179 *** |
| | (.0227) | (.0202) | (.0160) |
| Asian | -.0636 * | -.0169 | .0612 ** |
| | (.0345) | (.0274) | (.0303) |
| Hispanic | -.0520 *** | .0477 *** | .0581 *** |
| | (.0175) | (.0150) | (.0153) |
| Family income per family member ($10,000) | .0417 *** | -.0321 *** | -.0186 *** |
| | (.0058) | (.0047) | (.0030) |
| Highest grade attained by anyone in family | .0395 *** | -.0179 *** | -.0226 *** |
| | (.0022) | (.0019) | (.0018) |
| Female family head only | -.1000 *** | .1278 *** | -.0068 |
| | (.0141) | (.0128) | (.0110) |
| Male family head only | -.0768 *** | .0272 | .0450 ** |
| | (.0254) | (.0216) | (.0222) |
| CO[1] | -.1545 *** | .0973 *** | .0603 *** |
| | (.0234) | (.0198) | (.0192) |
| FL | -.1100 *** | .0953 *** | .0230 |
| | (.0226) | (.0195) | (.0183) |
| MN | .0240 | .0230 | -.0366 ** |
| | (.0208) | (.0172) | (.0161) |

**Table 5**
**Children's health insurance: children with family heads eligible for employer-sponsored coverage**
**Linear regression (Huber standard errors)**

| | Dependent variable=1 if child has: | | |
|---|---|---|---|
| **Independent variables:** | **Employer coverage** | **Medicaid** | **No health insurance** |
| Government | .0555 *** | -.0602 *** | .0070 |
| | (.0199) | (.0163) | (.0160) |
| Intercept | .0506 | .5612 *** | .4362 *** |
| | (.0400) | (.0352) | (.0332) |
| Number of observations | 8,835 | 8,835 | 8,835 |
| F statistic on state variables | 27.68 | 21.61 | 21.99 |
| F statistic on industry variables | 14.29 | 5.54 | 6.79 |
| $R^2$ | .1567 | .1561 | .0688 |

**Explanatory notes:**
Results are presented as: coefficient
(standard error)

[1]The omitted state category is NY.
[2]The primary family head is the family head who works more hours. The omitted industry category is professional services.
*The null hypothesis that the coefficient is equal to zero is rejected at the 1% (***), 5% (**) or 10% (*) level.

Parashar B. Patel 10/24/96 10:17:27 AM

Record Type: Record

To: Nancy A. Min/OMB/EOP, JENNINGS_C @ A1 @ CD @ LNGTWY

cc: Barry T. Clendenin/OMB/EOP, Mark E. Miller/OMB/EOP, Sarah A. Bianchi/OMB/EOP
Subject: Kids Estimates

I understand that Chris and you would like to set up a meeting with Andi King for Wednesday, October 30th to review the status of the kids estimate. Such a meeting would be okay with us, although given the schedule described in the summary below, you may wish to postpone the meeting until the week of November 4th. — we do not want to post-pone

In case you do want to meet with her next week, we have some preliminary numbers for her. In this case, we could also use her guidance on another policy-level issue (described below) that has come up during our review of the estimates.

We suggest that HHS, Treasury, and Labor be invited to participate in the meeting if possible.

On Wednesay, October 23rd, we had a conference call with HHS, Treasury, Labor, and the Actuarial Research Corporation (HHS' consultants) to review their latest estimates for the kids subsidy and discuss additional refinements. Below is a summary of the call.

1)Their latest estimates fix a programming error which caused their premiums to be higher than they should have been. This error has been fixed.

2) ARC has completed the first stages of estimating the cost of subsidies using more generous subsidy schedules than orginally proposed by Andi King. These estimates must be refined by changing the "employer dropping" assumptions (these assumptions must be refined because this set of subsidy schedules provide more generous subsidies...which could cause more employers/employees to drop coverage than we had been assuming) and smoothing the eligibility cliffs (i.e., 50% subsidy from 100% to 200% of poverty that immediately drops to 25% for individals with incomes more than 200% of poverty).

3) Treasury and others will think about how to revise the employer dropping assumptions and reasonable ways to smooth out the eligibility cliffs (i.e., using a sliding scale that lowers the subsidy gradually from 50% to 10% for all folks above 300% of poverty).

4) We have set up a conference call to discuss the assumptions that Treasury will develop. Using these assumptions, ARC expects to be able to deliver a second round of estimates by COB Thursday, October 31st.

5) One question that arose is whether children that are eligible under state-option for Medicaid or for state-only kids programs would be eligible for this subsidy. Because we were unaware at the time of the call that we might meet with Andi soon, we requested ARC to provide estimates using both assumptions (i.e., these kids would remain with the state programs or these kids would be eligible for the new subsidy).

Given this schedule, please let us know if you still wish to meet with Andi next week or would like to postpone the meeting until the following week by which time we hope to have a second round of estimates.

Children's Coverage File

DRAFT

October 7, 1996

# Health Financing Branch

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

| | | | |
|---|---|---|---|
| Please route to: | Nancy-Ann Min<br>Chris Jennings | Decision needed<br>Please sign<br>Per your request<br>Please comment<br>For your information | ____<br>____<br>X<br>____<br>____ |
| Through: | Barry Clendenin<br>Mark Miller | With informational copies for:<br>HFB Chron.; HD Chron.; | |
| Subject: | Summary of Estimates for Children's Subsidy | | |
| From: | Parashar Patel | Phone:<br>Fax:<br>E-mail:<br>Room: | 202/395-4930<br>202/395-7840<br>patel_pa@a1.eop.gov<br>#7001 |

Below is a summary of the most recent cost estimates for a subsidy program for children. These estimates use assumptions which have been modified from earlier assumptions based on policy guidance received on September 20th from the staff of the Democratic House Leadership. Please keep in mind that these estimates are preliminary and subject to further refinement. As we have indicated earlier, the average premium, participation levels, and costs are determined by a number of policy factors. We can discuss a number of policy factors which may lower the average premiums from those shown on the following two tables. While lowering the average premium, most of these policy changes could also increase total costs. This will occur because, for the most part, lowering the average premium is accomplished by increasing the number of participants (and therefore lowering adverse selection effects).

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## Subsidy for Children's Health Insurance, 1997

| | Option One (Low Subsidy: 25% for EITC Eligibles; 10% for All Others) | Option Two (High Subsidy: 50% for EITC Eligibles; 25% for All Others) |
|---|---|---|
| **Participation:** (Actual/% of Total) | | |
| **ESI** | 96,317 (22%) | 304,926 (20%) |
| **ESI-Self Employed** | 74,403 (17%) | 438,656 (28%) |
| **Other Private** | 119,754 (28%) | 410,064 (26%) |
| **Uninsured** | 139,341 (32%) | 403,608 (26%) |
| **Total** | 429,816 | 1,557,272 |
| **Costs:** | $1200 | $1400 |
| **Average Premium** | $3,112 | $2,062 |
| **Total Costs** | $1.3 billion | $3.2 billion |
| **Total Subsidy Costs** | $0.3 billion | $1.2 billion |

## Subsidy for Children's Health Insurance, 2002

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| | Option One (Low Subsidy: 25% for EITC Eligibles; 10% for All Others) | Option Two (High Subsidy: 50% for EITC Eligibles; 25% for All Others) |
|---|---|---|
| **Participation:** (Actual/% of Total) | | |
| **ESI** | 99,099 (22%) | 314,972 (20%) |
| **ESI-Self Employed** | 76,495 (17%) | 453,921 (28%) |
| **Other Private** | 123,456 (28%) | 423,276 (26%) |
| **Uninsured** | 144,726 (33%) | 419,729 (26%) |
| **Total** | 443,774 | 1,611,889 |
| **Costs:** | | |
| **Average Premium** | $4,518 | $2,975 |
| **Total Costs** | $2.0 billion | $4.8 billion |
| **Total Subsidy Costs** | $0.5 billion | $1.7 billion |

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Factors That May Lower Premiums

1. Lower the benefit package. Based on the experience with HSA, this will have a small difference, even if one uses a catastrophic benefit package.

2. Increase the subsidy levels. This will have the greatest impact because this will help increase the number of participants, including healthier individuals. The result will be lower average premiums, but higher subsidy costs.

3. Allow individuals whose employer contributes up to 50% of the premium to be eligible for subsidies. This could also lower premiums slightly because more people would participate. However it would increase total costs and lead to other problems such as increased employer dropping.

4. Separate the risk pools for the uninsured and the insured. This would lower the premiums for those currently purchasing coverage, but would be difficult to administer. It would also result in relatively high premiums for the uninsured.

5. Increase the age to 18 years for eligibility. This would probably have a small impact on premiums....they may go up or down.

6. Eliminate eligibility for the uninsured. This may also lower premiums slightly.

7. Allow the currently insured to subsidize their current coverage without having to purchase a specific, kids-only policy. This could lead to lower average premiums, but could also increase total costs since more individuals are likely to participate.

**Cost and Coverage Estimates for Kids-only Insurance Program**

The table below shows a range of preliminary cost and participation estimates for a health insurance subsidy program for children. The table displays cost and participation ranges for the years 1997 and 2002 for two subsidy levels. At both levels, eligibility is restricted to families with 0% employer contribution to health insurance. The ranges are explained by variations in assumptions regarding participation levels and employer dropping (see bullets below for explanation of assumption differences). *These estimates are not intended to be precise indicators of the effects of a kids-only subsidy, rather they are intended only to provide an idea of the potential effects of such a program.*

**Cost Estimates for Subsidizing Children-Only Health Insurance**
**0% employer contribution to health insurance required for eligibility**

**Low Level of Subsidies:**
**25% subsidy for families below 250% of poverty; 10% subsidy above 250% of poverty**

| Year | Average Cost (Premium) | Total Takeup (millions) | % of participants now uninsured | Annual Total Cost (billions) | Annual Federal Cost (billions) |
|---|---|---|---|---|---|
| **1997** | $1,900-$2,700 | 1.7-7.0 | 3.0%-14.0% | $4-$13 | $1-$2 |
| **2002** | $2,800-$3,900 | 1.8-7.5 | 3.0%-14.0% | $7-$21 | $2-$3 |

**High Level of Subsidies:**
**50% subsidy for families below 250% of poverty; 25% subsidy above 250% of poverty**

| Year | Average Cost (Premium) | Total Takeup (millions) | % of participants now uninsured | Annual Total Cost (billions) | Annual Federal Cost (billions) |
|---|---|---|---|---|---|
| **1997** | $1,800-$2,200 | 3.8-9.4 | 8.0%-11.0% | $8-$17 | $3-$6 |
| **2002** | $2,600-$3,200 | 4.0-9.9 | 8.0%-11.0% | $13-$26 | $5-$10 |

**The numbers shown here should be considered rough estimates of the effects of a kids-only health insurance subsidy. Official estimation of cost and participation could vary from the ranges shown here.**

**Key Assumptions**

- As the table indicates, we evaluated two potential subsidy programs:
  - "Low Subsidy": 25% subsidy to 250% of poverty, 10% thereafter; and
  - "High Subsidy": 50% subsidy to 250% of poverty, 25% thereafter.

- To arrive at the ranges of estimates shown above, we developed low and high participation scenarios for each of the two subsidy programs. The high participation scenario differs from the low participation case in two major ways: 1) the high participation scenario assumes higher take-up rates across-the-board; and 2) the high participation scenario assumes a substantially larger incidence of substitution -- individuals or employers changing their behavior to take advantage of the subsidy.

- The premium estimates in all cases were adjusted to reflect adverse selection associated with bringing previously uninsured individuals into the insured pools.

- The costs and participation rates are influenced to a large degree by the policy choice of whether the subsidies can be applied to a participant's current coverage or whether participants must join a separate insurance program and other factors. If participants can purchase current coverage we expect participation to be higher than if participants must join a special risk pool.

- These estimates assume that program participation is fully phased in by 1997.

**Major Findings**

- In the **low subsidy** program, total takeup ranges from 2-7 million children in 1997 (2-7.5 million in 2002), with an average cost of $1900-$2700 per child ($2800-$3900 in 2002). These average costs reflect the impact of adverse selection and are heavily influenced by participation assumptions. Federal costs would be $1billion - $2 billion in 1997 ($2 billion -$ 3billion in 2002).

- In the **high subsidy** program, total takeup ranges from 4-9 million children in 1997 (4-10 million in 2002), with an average cost of $1800-$2200 per child ($2600-$3200 in 2002). These average costs reflect the impact of adverse selection and are heavily influenced by participation assumptions. Federal costs would be $3billion - $6billion in 1997 ($5 billion -$ 10billion in 2002).

- Both the high and the low subsidy programs draw in only a small proportion of the uninsured population. The variations in the proportion of the currently uninsured participants in the program are largely influenced by the assumption regarding the ability to use subsidies for current coverage (and therefore, the number of persons with ESI joining the program).

    - In the **low subsidy** program, approximately 200,000 previously uninsured kids become insured in 1997. This represents about 1.6% of all uninsured kids and 3-14% of program participants.

    - In the **high subsidy** program, approximately 400,000-700,000 previously uninsured kids become insured in 1997. This represents about 3.6-6.3% of all uninsured kids and 8-11% of program participants

- The implementation of a kids-only subsidy could result in some people losing coverage if employers react to the incentive of the program by reducing or eliminating their contribution to ESI.

- As noted elsewhere, whether participants would be able to use the subsidy to pay for their current insurance -- where the risk pool includes individuals not in the subsidy program -- or be required to join a special risk pool that is dominated by individuals in the subsidy program is a key aspect of this policy. We recommend clarification of certain policy parameters prior to further estimation of the effects of this proposal.

**Changing Parameters**

Using background information, we have roughly estimated the impact on cost and participation of changing the income threshold for subsidies to 200% of poverty (with no subsidy above 200% of poverty -- we will probably need to design a phase-out of the subsidy over an income range if this option is pursued) and the effects of limiting eligibility to children 13 years of age and under.

**The following estimates are very rough. They do not account for the increase in the average cost per child which would result from limiting the risk pool in a way that increases the percentage of the currently uninsured in the program, and therefore increases the effect of adverse selection. It is not clear what impact this would have on these estimates: costs may rise as premiums go up, but reductions in participation may offset this increase.**

Lowering the income threshold to 200% of poverty results in:

- Participation of between 1.3 million and 2.3 million children in the **low subsidy case,** with a loss of approximately 18% of the previously uninsured category and a 22-67% reduction in overall participation in 1997. Federal costs would be about $1 billion in this case, and the percentage of participants who were previously uninsured would rise to 8-14% of those participating.

- Participation of between and 1.8 million to 3.7 million children in the **high subsidy scenario,** with a loss of approximately 23% of the previously uninsured category and a 53-60% reduction in overall participation in 1997. Federal costs would range from about $2 billion to $3 billion, and the percentage of participants who were previously uninsured would rise to 15-17% of those participating.

Lowering the age limit from the insurance definition of child to age 13 would result in:

- Participation of between 700 thousand and 4.2 million children in the **low subsidy case**, with a loss of approximately 45% of the previously uninsured category and a 40-55% reduction in overall participation. Federal costs would range from about $500 million to $1 billion, and the percentage of previously uninsured in the program would not change much.

- Participation of 2 million to 5.8 million children in the **high subsidy scenario**, with a loss of approximately 51-53% of the previously uninsured category and a 38-46% reduction in overall participation. Federal costs would range from about $2 billion to $4 billion in the high subsidy case, and the percentage of previously uninsured in the program would go down slightly.

The POTUS is likely to send up a letter to Gingrich today in support of the 48 hour rule, the mental health parity provision, the Daschle & VA spinal bifida kids protections bill. (There are all riding on the VA/HUD appropriations bill.)

(from John Hilley & other politicos)

The idea is to have one more marker for our support for these popular health care provisions. Also, it is now clear that the House Republican Leadership is greasing the 48 hour rule.

I've been reviewing a letter. I should have a final draft copy in ten minutes. (We may want to do press around this. Perhaps we should talk w/ the Secretary & Podesta?)

HOWARD DEAN, M.D.
Governor

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**EMBARGOED UNTIL 11 a.m.**
**SEPTEMBER 19, 1996**

## Governor Howard Dean, M.D., Calls for Health Care for Kids in 1997

WASHINGTON, D.C. -- Vermont Governor Howard Dean, a medical doctor, today challenged President Clinton and his chief rival, Bob Dole, to inject health care for kids into the national debate.

"There has been no discussion of health care whatsoever during this campaign and we need a commitment from both sides that health insurance for kids is a national priority," Governor Dean said in a key note address to the American Association of Health Plans. "We can insure every child in America under the age of 18 for peanuts.

"One in seven children in the United States lacks health insurance coverage and one quarter of American children are not immunized against diseases like measles, whooping cough, mumps and polio. Providing health care for these kids is a concrete step toward universal access to health care that we can take in 1997."

Using Vermont's experience as a model, Governor Dean proposed a plan to use revenue from tax increases on cigarettes and other tobacco products to provide health care coverage for all children up to 300 percent of the Federal Poverty Level ($46,800 for a family of four)

"Dr. Dynasaur" is Vermont's successful health insurance program for children whose families either do not have health care benefits through work or have inadequate insurance coverage for their children.

(more)

Governor Dean proposed a managed care program -- comprehensive preventative and acute care services, as well as dental and vision coverage -- administered by the states as an adjunct to their Medicaid programs. The plan would be federally funded and states would contract with private insurers to provide care.

Families would pay health care premiums on a sliding fee scale up to $240 annually per household. Nominal copays would be charged for some medical visits, for a maximum per-household, out-of pocket expense of $750 annually.

It is estimated the health insurance program would cost $6.5 billion. Governor Dean proposed increasing the federal excise tax for cigarettes by 24-cents per pack and the excise tax on all other tobacco products by 7 percent to pay for "Dr. Dynasaur."

Immediately following his address, Governor Dean and colleagues from several organizations concerned with children's health care talked with reporters. Dr. Joseph R. Zanga, Vice President-elect of the American Academy of Pediatrics; Eve Brooks, President of the National Association of Child Advocates; and Howard B. Shapiro, Ph.D., Director of Public Policy for the American College of Physicians joined the Governor in his call to insure American children.

"We have tackled this problem in Vermont," said Governor Dean, past chair of the National Governors' Association. "Now it's time for 'Dr. Dynasaur' to go national. It is within this nation's means to insure all children."

--30--

Contact: Stephanie Carter, press secretary

| | |
|---|---|
| **KEY NOTE ADDRESS:** | American Association of Health Plans annual conference<br>September 19, 1996, 10 a.m.<br>Capital Hilton<br>1001 NW 16th St.<br>Washington, D.C. |
| **PRESS AVAILABILITY:** | Immediately following speech<br>Ohio Room<br>Capital Hilton |

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# Dr. Dynasaur: Health Insurance for Kids

Governor Howard Dean, M.D.

Dr. Dynasaur is a national child health care program proposed by Vermont Governor Howard Dean, M.D. It would provide health care coverage to all uninsured children in families earning 300 percent of the Federal Poverty Level or less. Modeled after Vermont's program of the same name, Dr. Dynasaur is the next step, after the new Kennedy/Kassebaum law, towards universal health care coverage.

Vermont ranks second in the nation in the proportion of children with health care coverage and first in the nation in childhood immunizations.

## Eligibility

Children up to the age of 18 from families earning up to 300 percent of the Federal Poverty Level ($46,800 for a family of four) would be eligible for Dr. Dynasaur.

To discourage employers from dropping currently insured children for enrollment in Dr. Dynasaur, participants must be uninsured for at least one year.

Children who are U.S. citizens or legal residents would be eligible.

## Benefits

Dr. Dynasaur would provide a comprehensive managed care plan, including preventive and acute care and dental and vision services.

## Cost Sharing

The parents of Dr. Dynasaur participants would be required to contribute minimal copayments and a monthly premium calculated on a sliding scale based on income.

Program Cost

The annual program cost is estimated to be $900 per child or $6.5 billion.

Financing

In addition to premium revenue, the Dr. Dynasaur program would be paid for by increasing the federal excise tax on cigarettes and other tobacco products (a 24 cent increase on a pack of cigarettes and a 7 percent increase in the tax rate on all other tobacco products).

Administration

Dr. Dynasaur would be a federally funded program administered by the states as an adjunct to state Medicaid programs. State administrative costs are anticipated to be marginal.

To ensure that states continue their current level of support for children, a maintenance of effort would be required as well as a continuation of each state's current Medicaid eligibility level for children.

# Cost Estimates: National Dr. Dynasaur Pogram

Targeted to uninsured children at 100% participation.

Children (< 18 yrs.): 68,018,000

Children under 300% of poverty: 38,566,206
(=56.7% of above)

Proportion of this group who are uninsured: 13% (=5,013,607)

Annual per capita cost to insure: $900

Cost to insure this group: fully mature program.
$4,512,246,300 (4.5 billion)
(5,013,607x$900) - Minus $208 million in premiums to charged households with income above 185% of poverty =
*** approx. $4.3 billion.**

Estimated maximum cost **$6.5 billion** if the number of uninsured grows due to dropped coverage.

## Revenue

Current federal excise tax receipts for tobacco: $5.7 billion (24 cents per pack of cigarettes).

Additional revenues required to cover U.S. uninsured: **$6.5 billion.**

Recommend a 24-cent increase in taxes per pack of cigarettes with additional 7% increase of all tobacco products tax rates will produce $6.5 billion.

*Offsets due to copayments are not factored into savings.

**Data Sources**

Estimated total Vermont population under age 18 (1994): 146,000 (Source: VT Dept of Health).

Estimated Vermont population under 18 years of age, under 300% of poverty: 82,725 (Current Population Survey data).

Estimated U.S. population under age 18 (1994): 68,018,000 (Source: Statistical Abstract of the United States, 1995, Table 22).

Estimated proportion of U.S. under-18 population, not currently insured, 13%. (Source: Annie E. Casey Foundation, Kids Count Databook, State Profiles of Child Well-Being, Washington, DC, 1995.)

Urban Institute March 1994 CPS adjusted using TRIM2 shows 7.4 million uninsured children under 300% of poverty based on 1992 data. However, HCFA shows a growth in children's participation in Medicaid from 15.1 million to 18.3 million from 1992 to 1994 which lends credence to the 5 million uninsured children used in this estimate. Fully half of all States have used the Medicaid options to expand coverage to children beyond mandatory levels (GAO, 1996). Over 30 states have either a supplemental public or a public/private partnership program for health coverage for children (NGA, 1995).

Per capita cost for fee for-service Medicaid coverage for AFDC related under-18 population excluding nursing home and other LTC services: $1,000 (Source: VT Office of Health Access projected 1997). Since the higher-income uninsured can be presumed to be healthier than the current covered group, we are using $900, assuming managed care, comprehensive coverage including dental and vision. (Pacific Health Policy Group, consulting firm to VT., estimated $900 as an adequate national average for the benefit package.)

1994 federal excise receipts for tobacco: $5.7 billion (Source: Statistical Abstract of the United States, 1995, Table 518).

**Assumptions**

Assume proportion of U.S. children under 300% of poverty is the same as for Vermont (56.7%).

Assume a one-year waiting period imposed on anyone who drops insurance coverage.

Assume current Medicaid program remains in place and states provide their share of state matching funds for the existing program under a maintenance-of-effort requirement. Inequities resulting from the current coverage Medicaid options selected by a state would be dealt with over a phased 3 year period.

Assume funds administered by states as adjunct to their Medicaid Programs, but fully federally funded. Services provided through pre-paid managed care arrangements. Administrative costs would be marginal as a Medicaid adjunct, with Federal matching under current law

Households between 185% - 225% of poverty would pay a premium of $120/year. Those between 225% - 300% would pay $240/year. According to Urban Institute, March 1994 CPS data adjusted, there are 2.2 million uninsured children between 185% - 299% FPL. Assuming 1.5 children per household, 1,466,666 households would pay a premium. If 1 million households paid $120/year and 450,000 paid $240/year, premiums would offset expenditures by $208 million.

States will continue to comply with OBRA 1990 Medicaid mandate to increase coverage for children born after 9/30/83 incrementally until 2002.

# SUMMARY - COVERED BENEFITS

# NATIONAL DR. DYNASAUR PROGRAM

## Benefit Plan Summary and Cost Sharing

The following services and cost sharing are included in the proposed National Dr. Dynasaur Program

- inpatient hospital care - no copay
- outpatient services - $2.00 per visit
- physician services and well child care, including immunizations - $2.00, immunizations only - no copay
- transplantation services - no copay
- vision services, including eyeglasses - $2.00 for professional services; $5.00 for glasses
- home health care - $2.00
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) - no copay
- ambulance services - no copay
- short-term inpatient rehabilitation services - no copay
- medical equipment and supplies - no copay
- mental health and chemical dependency services - $2.00
- prescription drugs - $2.00 per prescription or refill
- dental care - no copay

Out-of Pocket maximum co-payments per household: $750 per year

## Annual Household Premium

- Under 185% of FPL - None
- 186% - 225% of FPL - $120
- 226% - 300% FPL - $240

**Table 1**
**Expanded Medicaid Coverage of**
**Pregnant Women and Infants and Children**

| State | *Pregnant Women and Infants* | *Children Below Age Six* | *Children Ages Six and Older* | |
|---|---|---|---|---|
| | Percentage of federal poverty guideline | Percentage of federal poverty guideline | Percentage of federal poverty guideline | Upper Age Limit |
| Alabama | 133% | 133% | 100% | 13* |
| Alaska | 133% | 133% | 100% | 13* |
| Arizona | 140% | 133% | 100% | 14 |
| Arkansas | 133% | 133% | 100% | 13* |
| California | 200% | 133% | 100% | 19 |
| Colorado | 133% | 133% | 100% | 13* |
| Connecticut | 185% | 185% | 185% | 13* |
| Delaware | 185% | 133% | 100% | 19 |
| Florida | 185% | 133% | 100% | 20 |
| Georgia | 185% | 133% | 100% | 19 |
| Hawaii[a] | 300% | 300% | 300% | 19 |
| Idaho | 133% | 133% | 100% | 13* |
| Illinois | 133% | 133% | 100% | 13* |
| Indiana | 150% | 133% | 100% | 13* |
| Iowa | 185% | 133% | 100% | 13* |
| Kansas | 150% | 133% | 100% | 17 |
| Kentucky | 185% | 133% | 100% | 19 |
| Louisiana | 133% | 133% | 100% | 13* |
| Maine | 185% | 133% | 125% | 19 |
| Maryland[b] | 185% | 185% | 185% | 13* |
| Massachusetts | 185% | 133% | 100% | 13* |
| Michigan | 185% | 150% | 150% | 15[c] |
| Minnesota | 275% | 133% | 100% | 13* |
| Mississippi | 185% | 133% | 100% | 13* |
| Missouri | 185% | 133% | 100% | 19 |
| Montana | 133% | 133% | 100% | 13* |
| Nebraska | 150% | 133% | 100% | 13* |
| Nevada | 133% | 133% | 100% | 13* |
| New Hampshire | 185% | 185% | 185% | 19 |
| New Jersey | 185% | 133% | 100% | 13* |
| New Mexico | 185% | 185% | 185% | 19 |
| New York | 185% | 133% | 100% | 13* |
| North Carolina | 185% | 133% | 100% | 19 |
| North Dakota | 133% | 133% | 100% | 18 |
| Ohio | 133% | 133% | 100% | 13* |
| Oklahoma | 150% | 133% | 100% | 13* |
| Oregon | 133% | 133% | 100% | 19 |
| Pennsylvania | 185% | 133% | 100% | 13* |
| Rhode Island[d] | 250% | 250% | [250%] [100%][e] | [8]13* |
| South Carolina | 185% | 133% | 100% | 13* |
| South Dakota | 133% | 133% | 100% | 19 |
| Tennessee[f] | 185%[f] | 133%[f] | 100%[f] | 13* |
| Texas | 185% | 133% | 100% | 13* |
| Utah | 133% | 133% | 100% | 18 |
| Vermont | [200%][225%][g] | 225% | 225% | 18 |
| Virginia | 133% | 133% | 100% | 19 |
| Washington | [185%][200%][h] | 200% | 200% | 19 |
| West Virginia | 150% | 133% | 100% | 19 |
| Wisconsin | 185% | 185% | 100% | 13* |
| Wyoming | 133% | 133% | 100% | 13* |

Source: National Governors' Association

**Notes for Table 1**

* Under the Omnibus Reconciliation Act of 1990, states are required to provide Medicaid coverage to children ages six and older born after September 30, 1983, living in families with income below the federal poverty level (FPL), as defined by the poverty guidelines updated annually in the *Federal Register* by the U.S. Department of Health and Human Services under authority of Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

a. Hawaii's coverage of pregnant women and children is through Hawaii QUEST, a Section 1115 waiver managed care program. Income eligibility is established if income does not exceed 300 percent of the FPL. However, fully subsidized coverage is provided if income does not exceed 185 percent of the FPL. For children age one but below age six, fully subsidized coverage is provided if income does not exceed 133 percent of the FPL. For children ages six or older, fully subsidized coverage is provided if income does not exceed 100 percent of the FPL. When income exceeds the applicable income limits of 185 percent, 133 percent, or 100 percent of the FPL for the respective groups, the recipient is eligible to participate in Hawaii QUEST but must cover the full cost of the premium.

b. For children age one but below age six, fully subsidized Medicaid coverage is provided in Maryland if income does not exceed 133 percent of the FPL. Children below age six receive a primary care benefits package if income is below 185 percent of poverty. For children ages six and older born after September 30, 1983, fully subsidized Medicaid coverage is provided if income does not exceed 100 percent of the FPL. Children ages six and older born after September 30, 1983, and whose income is below 185 percent of poverty, receive a primary care benefits package.

c. Defined in Michigan as being born after June 30, 1979.

d. For individuals in family units with incomes between 185 percent and 250 percent of the FPL, cost sharing in Rhode Island will be incorporated at the point of service or on a premium basis.

e. In Rhode Island, children ages 6 or 7 are covered at 250 percent of the FPL and children ages 8 through 12 are covered at 100 percent of the FPL.

f. Tennessee's coverage of pregnant women and children is through TennCare, a Section 1115 waiver program. Pregnant women and infants are automatically eligible if income is below 185 percent of the FPL. Children below age six are automatically eligible if income is below 133 percent of the FPL; children ages six and older born after September 30, 1983, are automatically eligible if income is below 100 percent of the FPL. Tennessee also covers individuals above the specified income thresholds who were uninsured as of March 1, 1993. When income exceeds the applicable income limits specified above, the TennCare recipient must pay premiums the subsidy for which is fully phased out at 400 percent of the FPL. Under certain conditions, Tennessee may suspend enrollment of expanded eligibility groups.

g. In Vermont, pregnant women are covered at 200 percent of the FPL and infants are covered up to 225 percent of the FPL.

h. In Washington, pregnant women are covered at 185 percent of the FPL and infants are covered up to 200 percent of the FPL.

Source: National Governors' Association, August 1996.

# FAMILY INCOME BASED ON 1996 FEDERAL POVERTY GUIDELINES AND FAMILY SIZE

| FAMILY SIZE# | 100% POVERTY LEVEL | 150% POVERTY LEVEL | 185% POVERTY LEVEL | 200% POVERTY LEVEL | 225% POVERTY LEVEL | 300% POVERTY LEVEL | 400% POVERTY LEVEL | 500% POVERTY LEVEL | AVE. FAMILY INCOME IN VT *** |
|---|---|---|---|---|---|---|---|---|---|
| 1 | $7,740 | $11,610 | $14,319 | $15,480 | $17,415 | $23,220 | $30,960 | $38,700 | $21,582 |
| 2 | $10,360 | $15,540 | $19,166 | $20,720 | $23,310 | $31,080 | $41,440 | $51,800 | $41,191 |
| 3 | $12,980 | $19,470 | $24,013 | $25,960 | $29,205 | $38,940 | $51,920 | $64,900 | $44,660 |
| 4 | $15,600 | $23,400 | $28,860 | $31,200 | $35,100 | $46,800 | $62,400 | $78,000 | $50,806 |
| 5 | $18,220 | $27,330 | $33,707 | $36,440 | $40,995 | $54,660 | $72,880 | $91,100 | $43,764 |
| 6 | $20,840 | $31,260 | $38,554 | $41,680 | $46,890 | $62,520 | $83,360 | $104,200 | ** |
| 7 | $23,460 | $35,190 | $43,401 | $46,920 | $52,785 | $70,380 | $93,840 | $117,300 | ** |
| 8 | $26,080 | $39,120 | $48,248 | $52,160 | $58,680 | $78,240 | $104,320 | $130,400 | ** |
| 8+ | $2,620 * | $3,930 * | $4,847 * | $5,240 * | $5,395 * | $7,860 * | $10,480 * | $13,100 * | N/A |

* Per additional person
** Not statistically reliable
*** Robert Wood Johnson Family Survey, Vermont, 1993 (1992 family income inflated to 1995 by New England CPI)
# Family is a group of two or more persons related by birth, marriage or adoption who live together.

Source: Poverty Guidelines published in the Federal Register, March 4, 1996