Children's Health Plan

ADVANTAGES OF PROVIDING CONTINUOUS ELIGIBILITY FOR MEDICAID CHILDREN FOR 12 MONTH PERIODS

Children age one and older are eligible for Medicaid on a month-to-month basis. Federal Medicaid regulations require that agencies redetermine eligibility at least every 12 months. Families are instructed to immediately report changes in income or family circumstances in order for the eligibility agency to decide if the children are still eligible. The result is an unpredictable eligibility status for Medicaid children.

Often children lose and then regain Medicaid coverage as a result of the ups and downs of family income. The on-again/off-again pattern of Medicaid coverage has long frustrated health providers and parents. If the family becomes income ineligible, children can lose Medicaid coverage even if they are sick and in the course of medical treatment.

Providing continuous Medicaid coverage over a known time period on a guaranteed basis will create a more stable environment for the health care of Medicaid children. Continuous coverage has the following advantages:

- **Promotes Continuity of Health Care and Preventive Care for Children.** Providing Medicaid coverage for children over a sustained and predictable period of time such as a year promotes continuity of care which is an essential feature of establishing medical homes. Under continuous eligibility, the longevity of the relationship between the health provider and the family allows the time and the incentive to educate the family about the appropriate use of health services and the informed use of home care. Preventive care can be promoted when providers are able to see children on a regular age-appropriate schedule.

- **Encourages Provider Participation in the Medicaid Program.** Continuous eligibility for children can reduce the frustration voiced by physicians and other health care providers who find it difficult to deal with situations where children are Medicaid eligible today, but possibly not tomorrow. The certainty of Medicaid eligibility guided by a continuous eligibility policy also reduces the provider's administrative burden of participating in Medicaid.

- **Aids Managed Care Providers in Delivering Cost Effective Services.** Experts in Medicaid managed care advise states to utilize continuous eligibility as a method to promote prevention and achieve cost effective service delivery. Continuous eligibility encourages managed care plans to invest in primary and preventive services. Studies have shown that the marginal costs of continuous eligibility can be low.

- **Helps Families Move from Welfare to Work.** Providing continuous Medicaid eligibility to children can assist in efforts to move families from welfare to work. Research has documented that welfare families are insecure about giving up welfare and Medicaid for jobs without health benefits and uncertain futures. Families are concerned about losing Medicaid coverage for their children.

- **Reduces Administrative Costs.** Continuous eligibility provides the opportunity for states to obtain administrative savings by eliminating the need to produce and mail Medicaid cards to recipients each month.

Action Needed to Allow States the Option of Providing Continuous Eligibility for Medicaid Children

An amendment to the federal Medicaid statute is needed to specifically give states the option to provide children with continuous Medicaid coverage for renewable state designated periods without the need for a federal waiver. The amendment should provide permissive language to allow states to designate the period of continuous eligibility and should also allow for renewal of continuous eligibility at the end of the period, if the child is still eligible.

There is precedent for providing continuous eligibility. Section 1902(e) of the federal Medicaid law provides for specific extensions of Medicaid beyond the ordinary time frame. It provides continuous coverage for infants born to Medicaid mothers for a period of one year. Coverage is guaranteed regardless of changes in income as long as the infant continues to reside with the mother. Section 1902(e) also extends eligibility for Transitional Medicaid recipients, enrollees in *federally qualified* Health Maintenance Organizations and pregnant women.

For More Information:

Sarah Shuptrine or Vicki Grant
South Carolina Children's Hospital Collaborative
(803) 779-2607

THE WHITE HOUSE

WASHINGTON

July 22, 1996

To: Chris Jennings
From: Laura Capps, office of G. Stephanopoulos

Attached is a follow-up letter to George from Paul O' Palka of Blue Cross of Western Pennsylvania. George met with him last week.

Blue Cross of Western Pennsylvania has a "Caring Program for Children," providing healthcare to eligible families at no cost to the family. The meeting occurred because Paul O'Palka believes that this program should serve as a national model.

O'Palka would like the President or First Lady to highlight this program if ever in Western Pennsylvania. I'm passing it on to you for your information.

Thanks.

Blue Cross
of Western Pennsylvania
Agent for Pennsylvania
Blue Shield

FIFTH AVENUE PLACE
120 FIFTH AVENUE, SUITE 1924
PITTSBURGH, PA 15222-3099
(412) 255-7855

PAUL O'PALKA, JR.
Vice President
Government Affairs

July 22, 1996

Mr. George Stephanopoulos
Senior Advisor to the President
for Policy and Strategy
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mr. Stephanopoulos:

I am most grateful to you for taking time to meet with Nicky Geanopoulos and me on July 16. In representing Blue Cross of Western Pennsylvania, I was especially impressed with your interest in our perspectives on health care reform legislation and, most notably, our program benefitting economically disadvantaged children.

During the course of our conversation I mentioned that our Caring Program for Children represents the model for the type of program that may be available to children nationally. Over the past 11 years, the Caring Program has served to ensure that primary and preventive health care has been available to eligible families at no cost to the family. This is consistent with our social mission of making coverage available to all segments of the community, regardless of an individual's age, occupation or condition of health.

We commend the President's commitment to ensuring access to health care for all Americans. For nearly 60 years, Blue Cross of Western Pennsylvania has maintained its unique role among insurers offering open enrollment; portability of coverage; non-cancellation due to illness or usage; no medical underwriting; operation of purchasing arrangements for small business; and, specialized programs for the most vulnerable segments of our population.

For this reason, we acknowledge the President's focus and priority on the health care needs of children, and we believe our experience is consistent with this agenda. Although specifics of the Families First Agenda "Kids Only" are evidently not yet available, we would appreciate the opportunity to work with you in articulating and bringing forth the concept, underscored by our history of pioneering The Caring Program for Children.

As I indicated during our meeting we are prepared to host the President and First Lady (together or separately) at an event to emphasize the purpose, need and practicality of his children's health care agenda. We would welcome the privilege of working with you and the campaign staff on an event as we approach the election.

More specifically, we are prepared to bring together both children and parents helped by the program. They could relate their experiences directly to the President and First Lady, thus allowing a forum to discuss the aims of the Administration in elevating the priority of health care for children. To enhance this event, Fred Rogers, honorary chairman of The Caring Program, is likely to be available to stand together with the President in addressing this relevant initiative.

For your further information, I am enclosing a videotaped documentary on The Caring Program.

The Clinton Administration has done extraordinarily well in articulating protection of the Medicare and Medicaid programs for those eligible. Focusing on children can now add yet another dimension for the Administration and its congressional allies.

As you are aware, Blue Cross of Western Pennsylvania has translated its support for the President in a consistent manner. For example, our late President and CEO Eugene J. Barone was invited to the White House in September 1993 as the President sought to demonstrate an array of support for health care reform. More recently, we have contributed to the DNC and its Business Council. We now are prepared to stand together with the President in devising solutions to ensure the health and well-being of our children.

You suggested that you might be receptive to advancing this proposal to the President and First Lady. I trust you will find merit in this approach if and when the President and First Lady plan a visit to metropolitan Pittsburgh. Please let me know if you wish to have a letter issued directly to the President or First Lady.

If I may be of further service to you, please do not hesitate to call upon me at (412) 255-7855. Once again, thank you for your courtesy and best wishes for continued success to you in serving the President.

Sincerely,

Paul O'Palka, Jr.

SUMMARY OF ATTACHMENTS

1. **Child Health**

   --Summary

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

   --Partnerships for Children and Families Through Targeted Funding for Consolidated Health Centers

   --Use Existing Authorities to Work with States to Increase Medicaid Funding for Children and Working Families

2. **Cost Estimates on Gephardt Proposal**

3. **Purchasing Cooperatives**

4. **Consumer Protections**

   --Establishment of a Commission

   --Bradley Bill (48/96 Hour Hospital Stays for Mothers and Newborns)

   --Ganske Bill (Patient Right to Know Act of 1996)

5. **Worker Transition Initiative**

   --Description of Health Insurance for the Temporarily Unemployed (from President Clinton's Balanced Budget: Health Reform Proposals, released March 25, 1996)

   --Worker Transition Initiative (prepared by White House staff)

1. **Child Health**

--Summary

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

--Partnerships for Children and Families Through Targeted Funding for Consolidated Health Centers

--Use Existing Authorities to Work with States to Increase Medicaid Funding for Children and Working Families

DRAFT

CHILD HEALTH INITIATIVES
Summary

Issue: Today, 10 million--14 percent--of children are uninsured. Many more children are underinsured, with limited access to critical preventive and primary care services. To expand health coverage for these children we propose a three-part strategy.

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

- Work with states and local communities to take additional steps to increase the enrollment in Medicaid of currently eligible children: (1) develop Federal-state partnerships to identify and enroll eligible children through outreach in schools, including special education providers, churches and other community service providers; (2) take additional steps to ensure that all federally supported programs meet specific goals of facilitating the enrollment of eligible children; (3) dedicate a portion of the additional $500 million for state administrative expenses associated with the welfare law based on state performance with respect to enrolling eligible individuals (e.g., children) in Medicaid; (4) develop a program to better market Medicaid enrollment to the public through partnerships among states, provider groups (e.g., American Academy of Pediatrics) 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; and (5) take steps to renew state interest in undertaking demonstrations and other activities that involve expansion of Medicaid coverage for children and working families.

Challenge the health care industry and health professional organizations 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 seeking to develop and implement 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 in order to develop and operate school-based/linked health centers, and/or to designate school-based/linked health centers as a site for delivering primary care services.

- 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.

Enhance funding for communities considering expanding access to health services by bringing school-based or school-linked health centers to their communities.

- Expand the **Healthy Schools, Healthy Communities** initiative. New school-based health centers funded under this initiative would: (1) have the option of expanding services to the parents and siblings of the school's students; (2) link to other appropriate programs, including Healthy Start, state Maternal and Child Health, Head Start, Community Schools, and Empowerment Zones/Enterprise Communities; (3) 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; (4) develop billing systems to enable center 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. Other options are also possible.

- Expand funding for **Consolidated Health Centers** (CHCs) to work with communities to develop school-based or school-linked health programs to improve the health and school performance of children. Recognizing the benefits of interactions between education and health efforts, many communities have established links between schools serving low-income children and CHCs as a method of providing comprehensive health services to underserved children. This linkage provides children with preventive and primary care, links to an established health care system and access to reimbursement mechanisms for Medicaid and other third party payers. Approximately 250 CHCs have developed school-based or school-linked service programs. In addition, CHCs' expertise and participation in managed care would be a valuable resource to school health programs.

- Provide technical assistance to help school-based/linked health centers create effective linkages to Medicaid, managed care organizations, and other health insurers by: (1) identifying steps to facilitate Medicaid reimbursement for health services delivered in school-based/linked health centers; (2) using 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-based/linked health centers into Medicaid managed care and other payment arrangements; (3) using 1115 waiver authority to encourage states to use Medicaid to facilitate Medicaid managed care providers to reimburse school-based/linked health centers for services delivered; (4) distributing guidance to communities forming school-based/linked health centers 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; and (5) encouraging state Medicaid programs to provide outstationed eligibility workers to schools with health centers to enroll Medicaid eligible children into the program.

Draft: 8/21/96

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

Background

- The current generation of 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 these problems, 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.

- School health programs provide an opportunity for health care workers to be in frequent contact with students, allowing for ready access to health professionals, health information and clinical services. They also can provide an effective way for both educators and health care providers to reach hard-to-reach parents.

- School health centers serving adolescents allow students to exercise more control over their decisions to use health care services, unlike the use of community-based providers which may require direct parental involvement.

- Offering health services in schools can be an effective tool to bring Medicaid eligible children into preventive and appropriate follow-up care and to provide access to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.

- School health programs have the added benefit of helping to identify and support children with developmental delays.

- Support for school health programs may come from multiple sources, including HHS funding for the consolidated health centers program.

- School health programs provide a unique opportunity to improve the health status of young children and adolescents using one of two strategies: school-based or school linked health centers.

- **School-based health centers (SBHC)** are a cost effective means of providing health care services to students. The average annual operating budget for a school-based health center is estimated to be $180,000. The cost to operate a health center is $179 per year per student or $66 per student visit. There are estimated to be at least 650 school-based health centers out of approximately 80,000 schools.

- Nearly 40% of students using SBHCs are uninsured. Most SBHCs do not receive full Medicaid reimbursement.

- While adolescents traditionally underutilize health care services, a recent study found students using SBHCs had higher visitation rates for medical and health care than students using conventional health care sources. Adolescent SBHC users, in comparison to the general adolescent population, used medical, mental health and substance abuse services more often. Student visitation rates, for general medical services, were greater than the rate for adolescent visits to community-based medical providers.

- The use of SBHCs may also reduce the demand for costly emergency services. A recent study found that adolescents enrolled in managed care who had access to a SBHC had markedly fewer emergency visits. In addition, the study found that fewer students sought emergency services.

- **School-linked health centers** provide many of the same services as SBHCs. They provide medical, psychosocial and dental services through special arrangements between schools and other agencies. Such services are not necessarily located at the school and may be provided full or part time. While school-based services might not be appropriate for all communities, any site can develop and benefit from a school-linked program because of the flexibility they afford to target specific needs.

Proposal

- Expand the **Healthy Schools/Healthy Communities** initiative to improve the health of children in a school setting. Through this program now in its third year, school-based primary health care sites have been developed in 27 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, community schools, and EZ/ECs.
- 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;
- 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 that meet their basic needs. 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 community controversy associated with the delivery of particular services, such as family planning or reproductive health services, on the school site. School-linked health centers provide services that might not be as comprehensive in scope as a SBHC, but can be targeted to specific community needs such as screenings, health education or mental health services.

- Expand funding for **Consolidated Health Centers** (CHCs) to work with communities to develop school-based or school-linked health programs to improve the health and school performance of children. Recognizing the benefits of interactions between education and health efforts, many communities have established links between schools serving low-income children and CHCs as a method of providing comprehensive health services to underserved children. This linkage provides children with preventive and primary care, links to an established health care system and access to reimbursement mechanisms for Medicaid and other third party payers. Approximately 250 CHCs have developed school-based or school-linked service programs. In addition, CHCs' expertise and participation in managed care would be a valuable resource to school health programs.

- 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. Under the terms of the contract, the managed care provider reimburses the SBHC using Medicaid reimbursement rates.

- 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, and other insurers. The Department can:

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

  - develop strategies to strengthen linkages between school health programs and health insurance and managed care organizations in both rural and urban settings;

  - 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; and

  - encourage state Medicaid programs to provide outstationed eligibility workers to schools with health programs to enroll Medicaid eligible children into the program.

- Encourage states to expand funding for school health programs through the **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. The MCH Block Grant provides maximum flexibility to states to design programs that are appropriate to their individual population needs.

- 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.

Draft: 8/21/96

Establish "Partnerships for Children and Working Families" Through Targeted Funding for Consolidated Health Centers (CHCs)

Background

- Federally funded CHCs are an essential part of the safety net. They provide comprehensive health care to 8.1 million patients, 44% of whom are children through age 19. The overwhelming majority of center users are low-income (66% are below the Federal Poverty Level (FPL); 86% are below 200% of FPL) and roughly 40% are uninsured.

- Because CHCs must serve medically underserved areas and populations, they are located in communities where people lack access to health care because of financial barriers, cultural barriers, geographic isolation, or provider shortages. In fulfilling their mandate, CHCs historically have given high priority to improving the health status of children and mothers.

- The FY 96 budget is approximately $755 million for community health centers, migrant centers, health care for the homeless, and public housing centers, providing care at a total of 2,204 sites.

- CHCs are required to serve all who present themselves for care, regardless of their ability to pay. Federal grant funds make up approximately 30% of CHC revenues and are used in large measure to subsidize care for the uninsured.

- CHCs focus on providing preventive and primary care services to uninsured and underserved populations, as well as a full range of enabling services, such as transportation, outreach, translation, and case management to help children and their families use services appropriately. CHCs also provide jobs, job training opportunities, and economic stimulus to the communities they serve.

Proposal

- 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 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 and their partners would 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.

- Successful collaborations which might be replicated in other areas could be showcased through national meetings and publications. The Maternal and Child Health Bureau's CISS funding or the Bureau of Primary health Care's Models that Work initiative might be sources of funding for this type of effort.

Draft: 8/21/96

Use Existing Authorities to Work with States to Increase Medicaid Services for Eligible Children and Working Families

Background

- Under legislation enacted in the late 1980s and early 1990s, Medicaid coverage for poor children was greatly expanded by decoupling it from eligibility for AFDC. The legislation extends Medicaid coverage to all poverty-level children under age 19, on a phase-in basis, by FY 2002. (Effective 10/1/96, all those under age 14 will be eligible.) *In spite of the expansions, many children who are eligible for Medicaid are not enrolled in the program.* In fact, the proportion of poverty-level eligible children who are not enrolled is very substantial in some subgroups.

- Although a few states have used the demonstration authority under section 1115 to expand Medicaid to cover families and children who were otherwise ineligible, the pronounced trend among demonstration states has been away from coverage expansions and toward programs focused more narrowly on increasing Medicaid enrollment in managed care arrangements.

- The linkage of Medicaid eligibility to AFDC facilitated enrollment of many poor children in Medicaid since eligibility for both programs was established simultaneously. Because families receiving cash learned automatically of their Medicaid eligibility, no special outreach was necessary to enroll them in Medicaid. On the other hand, for poor children with no connection to AFDC, no mechanism for easy or automatic identification and enrollment exists. Some measures, such as the streamlining of eligibility applications and the stationing of outreach workers in FQHCs, have been taken to increase enrollment, but gaping inadequacies remain.

- Under the newly passed welfare reform law, states have the option of terminating Medicaid for persons who fail to comply with the new work requirements. Although Medicaid for minor children who are not heads of households is protected, parents who lose welfare assistance may still have to apply for Medicaid separately. States must continue Medicaid for (1) families losing cash benefits because of child support income, (2) minor mothers who are denied cash assistance because they do not live with a parent or adult relative and (3) families who lose eligibility for cash assistance because of increased hours or earnings.

- These changes in Medicaid may be significant in terms of enrollment. Currently, more than half of all children (one-third of all Medicaid recipients) receive Medicaid automatically as incident to their welfare payments. Altering the welfare eligibility standards and curtailing automatic coverage for welfare recipients may affect both current

and future Medicaid recipients.

- The new welfare reform law provides an additional $500 million in federal funds to states for administrative expenses associated with the Medicaid provisions in the welfare law (i.e., potentially, for maintaining two separate eligibility systems - one for welfare and one for Medicaid.) Under this provision, the Secretary will determine the percentage by which the Federal matching rates for administrative expenditures should be increased.

Proposal

- Take additional, more aggressive steps to increase the enrollment in Medicaid of eligible children:

  - Federal-state partnerships could be developed to identify and enroll eligible children through outreach in schools, including special education providers, churches and other community service providers.

  - Additional steps could be taken to ensure that all federally supported programs meet specific goals of facilitating the enrollment of eligible children.

  - Some portion of the additional $500 million for state administrative expenses associated with the welfare law could be distributed based on state performance with respect to enrolling eligible individuals (e.g., children) in Medicaid. Specifically, the Secretary could tie the receipt of some of the additional administrative funds to *measurable achievements in enrollment* of Medicaid eligibles (e.g., children).

- Develop a program to better market Medicaid enrollment to the public. Partnerships could be formed among states, provider groups (e.g., American Academy of Pediatrics) 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. In addition, with the passage of the new welfare law, initiatives to help families understand what steps they need to take to continue Medicaid for themselves and/or their children should be undertaken.

- Take steps to renew state interest in undertaking demonstrations and other activities that involve expansion of Medicaid coverage for children and working families, including but not limited to:

  - developing a specific solicitation of demonstration proposals designed to test the use of premiums as a mechanism for enrolling uninsured low-income families.

- providing technical assistance to states on such matters as pricing the Medicaid benefit package.

- distributing information on state "best practices" with respect to expanding coverage.

- encouraging states to provide guaranteed, uninterrupted eligibility for children to encourage continuity of care.

2. Cost Estimates on Gephardt Proposal

1) **Key Program Parameters and Behavioral Assumptions**

- We evaluated two potential subsidy programs:
  - "Low Subsidy": 25% subsidy up to 250% of poverty, 10% thereafter; and
  - "High Subsidy": 50% subsidy up to 250% of poverty, 25% thereafter.

- To achieve a reasonable range of estimates, we developed low and high participation scenarios for each of the two subsidy programs.

  - The high participation scenario varies from the low participation scenario in two major ways. In addition to an across-the-board increase in participation rates, the high participation scenario assumes a significantly larger incidence of substitution, wherein individuals and employers change their behavior (drop or end contributions to coverage) in order to take advantage of the subsidy program.

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

2) **Major Findings**

- In the **low subsidy** program, total take-up ranges from 2-7 million children, with an average cost of $1900-2700 per child, a range which reflects the effect of adverse selection and is heavily influenced by the participation assumptions. The Federal share of program costs is estimated to be $1-2 B.

- In the **high subsidy** program, total take-up ranges from 4-9 million children, with an average cost of $1800-2200 per child, again a range which reflects the effect of adverse selection and is heavily influenced by the participation assumptions. The Federal share of programs costs is estimated to be $3-6 B.

- Both the high and the low subsidy programs are characterized by large amounts of substitution and draw in only a small proportion of the uninsured population:

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

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

- While moving from the low subsidy to the high subsidy program increases the total take-up (as well as Federal costs), the targeting of the program to the currently uninsured is not significantly changed.

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

3) **Effect of Changes in Program Parameters**

- If the age limit is lowered from the insurance definition of child to age 13:
  - we lose approximately 45% of the previously uninsured group, relative to a 40-55% drop in program participation overall, in the **low subsidy** program.
  - we lose approximately 51-53% of the previously uninsured group, relative to a 38-46% drop in program participation overall, in the **high subsidy** program.
- If the upper income level for participation is reduced to and capped at 200% of poverty, costs and participation would be affected as follows:
  - in the **low subsidy** program, we lose approximately 18% of the previously uninsured group, relative to a 22-67% decrease in program participation overall.
  - in the **high subsidy** program, we lose approximately 23% of the previously uninsured group, relative to a 53-60% decrease in program participation overall.
- The costs and participation rates of the subsidy program are influenced to a large degree by the program structure, i.e., whether subsidies can be applied to the participant's existing coverage, or whether participants must join a separate insurance program. Our basic model assumed that participants are required to join a separate program; this requirement limits substitution. However, the upper ranges given above indicate the number of participants we can expect if subsidies can be applied to existing coverage.
- The numbers presented here reflect a "0% contribution rule," meaning that any employer contribution to coverage precludes participation in the program. If we allowed participation for individuals with an employer contribution of up to 50%, the effect increases the upper range:
  - in the **low subsidy** program, participation increases to 2-9 million, and Federal costs increase to $1-3 B, depending upon the participation assumptions.
  - in the **high subsidy** program, participation increases to 4-16 million, and Federal costs increase to $4-10 B, depending upon the participation assumptions.
  - the targeting of the program to the currently uninsured is not significantly changed.

Cost Estimates for Subsidizing Children-Only Health Insurance

Low Levels of Subsidies
25% Subsidy Below 250% of Poverty; 10% Subsidy Above 250% of Poverty

50% Employer Contribution Required

Avgerage Cost	Total Takeup	Annual Total Cost	Annual Federal Cost
$1,700 - $2,500	1.9 mil. - 8.6 mil.	$5 bil. - $15 bil.	$1 bil. - $3 bil.

0% Employer Contribution Required

$1,900 - $2,700	1.7 mil. - 7.0 mil.	$4 bil. - $13 bil.	$1 bil. - $2 bil.

High Levels of Subsidies
50% Subsidy Below 250% of Poverty; 25% Subsidy Above 250% of Poverty

50% Employer Contribution Required

Avgerage Cost	Total Takeup	Annual Total Cost	Annual Federal Cost
$1,500 - $2,100	4.0 mil. - 16.1 mil.	$9 bil. - $24 bil.	$4 bil. - $10 bil.

0% Employer Contribution Required

$1,800 - $2,200	3.8 mil. - 9.4 mil.	$8 bil. - $17 bil.	$3 bil. - $6 bil.

3. Purchasing Cooperatives

PURCHASING COOPERATIVES INITIATIVE

I. PURCHASING COOPERATIVES INITIATIVE

This provision overrides restrictive state laws and provides $25 million per year for five years to develop purchasing cooperatives, which can provide greater access to and lower cost of health benefits for small employers (and individuals, if a state elects to include them in the cooperatives). States would have the option of establishing cooperatives through public or private organizations, or they could establish cooperatives in coordination with the Federal Employees Health Benefits Plan.

II. PURPOSE

Voluntary health purchasing cooperatives (HPCs) allow small employers to pool their employees, and thereby exert greater leverage in the market and obtain insurance at more affordable rates. The Kassebaum-Kennedy bill guarantees small employers access to the health insurance market; cooperatives are an effective means of lowering the costs of health insurance plans.

III. IMPACT

- Funds provide critical capital to help start up and initially run approximately 100 purchasing cooperatives.
- Cooperatives can lower administrative and marketing costs and provide a mechanism for negotiating lower prices on behalf of thousands of workers in small firms.
- Provides states with the flexibility to design cooperatives to operate successfully based on their population and markets.

IV. SPECIFIC PROVISIONS

- Overrides state "fictitious group" laws which may prohibit employers from forming cooperatives.
- Allows HPCs to negotiate price reductions even in states where community rating laws would otherwise preclude them from doing so.
- Allow HPCs to sell all products to small businesses that the state permits other insurers to sell.

V. ADMINISTRATION HISTORY ON ISSUE

The President has been a strong proponent of purchasing cooperatives as a means of increasing affordable access to health insurance for small employers. They were included in the health care reform package that the President included in his balanced budget proposal last year, and he endorsed the purchasing cooperative provisions included in the Kassebaum-Kennedy proposal. This proposal builds upon the President's previous proposal and the initial Kassebaum-Kennedy proposal.

4. Consumer Protections

--Establishment of a Commission

--Bradley Bill (Maternal Discharge Bill)

--Ganske Bill (Patient Right to Know Act of 1996)

ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

I. ADVISORY COMMISSION

The President will sign an Executive Order creating an Advisory Commission on Consumer Protection and Quality in the Health Care Industry to review changes occurring in the health care system and, where appropriate, make recommendations on how best to promote and assure consumer protection and health care quality.

II. PURPOSE

The Advisory Commission will respond to concerns about the rapid changes in the health care financing and delivery system. It will provide a forum for developing a better understanding of the changes in the health system and for making recommendations on how to address the effects of those changes.

III. IMPACT

- The Advisory Commission will provide recommendations that will allow public and private policy makers to define appropriate consumer protection and quality standards.

IV. SPECIFIC PROVISIONS

- The Advisory Commission will be appointed by the President and co-chaired by the Secretaries of HHS and Labor will have a membership of no more than 20 representatives from: health care professions, institutional health care providers, other health care workers, health care insurers, health care purchasers, state government, consumers, and experts in health care quality, financing, and administration. The Vice President will review the final report prior to its being submitted to the President.

- The Advisory Commission will study and, where appropriate, develop recommendations for the President on: (1) consumer protection; (2) quality; and (3) availability of treatment and services in a rapidly changing health care system.

- The Advisory Commission will submit a preliminary report by September 30, 1997 and a final report 18 months from the date of its first meeting.

V. BACKGROUND

The Clinton Administration has a long history of strong support of consumer protection in all health care plans, including the Medicare program. Two such examples are his support of initiatives to assure new mothers and babies have access to necessary hospital care and to protect communications between health professionals and their patients.

Office of the Press Secretary

For Immediate Release September 5, 1996

EXECUTIVE ORDER

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ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the "Commission"). The Commission shall be composed of not more than 20 members to be appointed by the President. The members will be consumers, institutional health care providers, health care professionals, other health care workers, health care insurers, health care purchasers, State and local government representatives, and experts in health care quality, financing, and administration.

(b) The Secretary of Health and Human Services and the Secretary of Labor shall serve as Co-Chairs of the Commission. The Co-Chairs shall report through the Vice President to the President.

Sec. 2. Functions. (a) The Commission shall advise the President on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system. In particular, the Commission shall:

(1) Review the available data in the area of consumer information and protections for those enrolled in health care plans and make such recommendations as may be necessary for improvements;

(2) Review existing and planned work that defines, measures, and promotes quality of health care, and help build further consensus on approaches to assure and promote quality of care in a changing delivery system; and

(3) Collect and evaluate data on changes in availability of treatment and services, and make such recommendations as may be necessary for improvements.

(b) For the purpose of carrying out its functions, the Commission may hold hearings, establish subcommittees, and convene and act at such times and places as the Commission may find advisable.

Sec. 3. Reports. The Commission shall make a preliminary report to the President by September 30, 1997. A final report shall be submitted to the President 18 months after the Commission's first meeting.

Sec. 4. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies, and independent agencies (collectively "agencies") shall provide the Commission, upon request, with such information as it may require for the purposes of carrying out its functions.

(b) Members of the Commission may receive compensation for their work on the Commission not to exceed the daily rate specified for Level IV of the Executive Schedule (5 U.S.C. 5315). While engaged in the work of the Commission, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the Government service (5 U.S.C. 5701-5707) to the extent funds are available for such purposes.

(c) To the extent permitted by law and subject to the availability of appropriations, the Department of Health and Human Services shall provide the Commission with administrative services, funds, facilities, staff, and other support services necessary for the performance of the Commission's functions. The Secretary of Health and Human Services shall perform the administrative functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission.

Sec. 5. General Provision. The Commission shall terminate 30 days after submitting its final report, but not later than 2 years from the date of this order, unless extended by the President.

WILLIAM J. CLINTON

THE WHITE HOUSE,
September 5, 1996.

# # #

STATEMENTS SUPPORTING

THE "ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY"

"The American Association of Health Plans applauds President Clinton's leadership in establishing the new commission on health care quality. We are confident the commission, which is designed to examine how the health care system works for patients, will contribute to a better understanding of how health care is delivered as we approach the next century."

— American Association of Health Plans
(trade organization of managed care plans)

"We welcome the government and industry scrutiny the President has proposed."

— BlueCross BlueShield Association

"President Clinton's call for the National Commission on Health Care Quality provides an excellent opportunity for policy makers to review the many different types of health care financing arrangements that currently exist in the marketplace ..."

— Health Insurance Association of America

"We eagerly applaud the formation of the President's new commission to protect patients and guarantee quality care."

— American Medical Association

". . .the right time for this kind of commission to go to work."

— American Hospital Association

"The President's decision to examine the entire issue of managed care quality and access should be applauded by every consumer in America."

— Citizen Action

"We support any effort to identify and rectify problems with our health care system and applaud the President for creating a forum where these problems will be addressed."

— Consumers Union

KEY GROUPS IMMEDIATELY SUPPORTING

THE "ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY"

(As of September 6, 1996 - 12:00pm)

Health Care Insurers/Managed Care Representatives

American Association of Health Plans (the managed care industry group)
Blue Cross Blue Shield Association
Health Insurance Association of America

Health Care Providers

American Hospital Association
American Nurses Association
American Medical Association
Catholic Health Association
Federation of American Health Systems (the for-profit hospitals)
National Association of Children's Hospitals and Related Institutions

Consumers and Unions

AFL-CIO
AFSCME
Citizen Action
Consortium of Citizens with Disabilities
Consumers Union
Families USA
National Council of Senior Citizens

I. 48-HOUR HOSPITAL STAYS FOR MOTHERS AND NEWBORNS

This legislation requires health insurers to allow mothers and newborns to remain in the hospital for a minimum of 48 hours after a normal vaginal delivery and 96 hours after a Caesarean section.

II. PURPOSE

This legislation responds to public concerns that health insurers are requiring new mothers and newborns to leave the hospital earlier than is appropriate, and that these early discharges are leading to serious health consequences for some patients. The legislation requires health insurers to allow mothers and their newborns to remain in the hospital for a minimum of 48 hours after a normal vaginal delivery and 96 hours after a Caesarean section. Coverage of fewer days is permissible, if agreed to by the attending provider in consultation with the mother, and if a timely follow-up visit is covered.

III. IMPACT (Based on analysis of Senate Bill 969, as included as an amendment to the Senate version of the VA/HUD appropriations bill)

According to CBO, this bill would cost the Federal government a total of $265 million between 1997 and 2002. These costs would result largely from increased Federal Medicaid outlays and decreased tax revenues due to increases in employer-paid premiums. CBO estimates that the bill would increase private sector costs by $130 million in 1997, rising to $220 million in 2001. These costs would result from a 0.06 percent increase in total premium payments for health insurance. In addition, if women receive any additional care as a result of this bill (such as an extra day in the hospital or a follow-up visit which they would not have received otherwise), they could be required to pay a copayment for these services.

IV. SPECIFIC PROVISIONS (As contained in the Senate VA/HUD Appropriations bill)

- 48/96-Hour Minimum Stays Must Be Allowed This legislation requires health insurers to allow mothers and their newborns to remain in the hospital for a minimum of 48 hours after a normal vaginal delivery and 96 hours after a Caesarean section.

- Shorter Stays Permitted Shorter hospital stays are permitted provided that the attending health care provider, in consultation with the mother, determines such a stay to be appropriate.

- Requirement for Follow-Up Care If discharge occurs earlier than 48 hours after birth (96 hours after a Caesarean), follow-up care must be provided and covered by the insurer. This follow-up care must occur within 72 hours following discharge.

- Does Not Apply to Medicaid The Bradley bill does not apply to women covered under Medicaid, who comprise roughly one-third of new mothers each year. However, it is expected that if the bill were passed, some Medicaid mothers would still receive the option

of a 48/96 hour stay. This is because a large percentage of them are covered under private managed care plans, and since these plans will be required to offer 48/96 hour stays to their privately-insured patients they may also offer them to their Medicaid patients as well.

- Interaction with State Legislation This legislation would not preempt state legislation on early discharge as long as the minimum of 48/96 hours for an inpatient stay is met **OR** the state legislation meets guidelines established by the American College of Obstetricians or Gynecologists, the American Academy of Pediatrics, or other medical professional organizations such as nurse midwives. (Note that over 25 states have already passed legislation similar to the Bradley bill, but due to the ERISA preemption these bills cover only about half of their states' women.)

V. ADMINISTRATION HISTORY ON ISSUE

- In his radio address on May 11, 1996, President Clinton expressed support for legislation on this issue, stating "I urge Congress to move legislation forward as soon as possible that makes this protection for mothers and children the law of the land." However, he did not endorse any specific bill.

- In her September 30, 1995 newspaper article, the First Lady discussed the dangers which can result from early discharge, stating that "I think that protecting the health of new mothers and infants is a clear case of where government safeguards are needed."

- In their speeches at the convention, both the President and the First Lady expressed support for a bill allowing minimum 48-hour stays following a normal birth.

VI. LEGISLATIVE HISTORY

- In June 1995, Senators Bradley (D-NJ) and Kassebaum (R-KS) introduced Senate bill 969, which requires health insurers to allow mothers and newborns to remain in the hospital for a minimum of 48 hours after a normal vaginal delivery. (The bill's provisions are discussed in detail above.) In early 1996, several largely technical changes were made to the bill and it was reintroduced as the Bradley-Kassebaum-Frist bill.

- In late spring 1996, the Senate Labor Committee marked up Senate Bill 969 and approved it on a 14-2 vote.

- On September 5, the Senate voted unanimously to include the text of Senate Bill 969 as an amendment to the VA/HUD Appropriations bill. The House had already passed its version of VA/HUD, but the Republican leadership agreed to retain the Bradley language in the conference version.

- Ten bills similar to Bradley-Kassebaum-Frist were introduced in the House during the 104th Congress. No hearings or mark-ups were held on these bills.

Presidential Statements In Support of the 48 Hour Rule

"I urge members of Congress to move legislation forward as soon as possible that makes this protection for mothers and their children the law of the land. No insurance company should be free to make the final judgment about what is medically best for newborns and their mothers. That decision should be left up to doctors, nurses and mothers themselves."

President Bill Clinton
May 11, 1996

"We should protect mothers and newborn babies from being forced out of the hospital in less than 48 hours."

President Bill Clinton
Democratic National Convention
August 30, 1996

"That's why I'm supporting the legislation I mentioned, dealing with not forcing new mothers and their newborns out of the hospital."

President Bill Clinton
September 5, 1996

(NOTE: The First Lady also endorsed the 48 hour rule in her speech before the Democratic National Convention on August 28, 1996)

I. ANTI-GAG RULE LEGISLATION (The Patient Right to Know Act of 1996)

This bill would prohibit health plans (including ERISA plans) from restricting or prohibiting any medical communications, oral or in writing, between health care providers and their patients.

II. PURPOSE

This bill responds to public concern that health care providers are being forbidden by health plans from providing patients with full information about their medical conditions and treatment options. It would prohibit health plans from placing any restrictions on providers' medical communications with their patients.

III. IMPACT

If enacted, this bill would allow, and perhaps encourage, physicians to discuss treatment options with patients, and would increase consumers' confidence that their medical providers are offering them full information.

IV. SPECIFIC PROVISIONS

The following are the major provisions of the bill:

- Health plans (including ERISA plans) may not restrict or prohibit any medical communications, oral or in writing, between health care providers and their patients. Medical communication is defined as communication regarding the patient's physical or mental condition or treatment options.

- Violation of these provisions is punishable by civil money penalties of up to $25,000 for each violation.

- States may establish additional requirements that are more protective of medical communications.

- Health plans are not prohibited from restricting medical communications that recommend one health plan over another if the sole purpose of the communication is to secure financial gain for the health care provider.

V. ADMINISTRATION HISTORY ON ISSUE

This bill has enjoyed bipartisan support and has been approved by a unanimous vote in one of the three committees of jurisdiction. Additional committee approval is expected this fall.

5. Worker Transition Initiative

--Description of Health Insurance for the Temporarily Unemployed (from President Clinton's Balanced Budget: Health Reform Proposals, released March 25, 1996)

--Worker Transition Initiative (prepared by White House staff)

HEALTH INSURANCE FOR THE TEMPORARILY UNEMPLOYED

Building on the Health Insurance Portability and Accountability Act, funds would be made available to states to finance up to six months of coverage for unemployed workers and their families. The program would be available to those who had employer-based coverage in their prior job, are now receiving unemployment benefits, and have income below certain thresholds. The program would be a four year demonstration project and would provide States with substantial flexibility in how to administer the program.

I. Federal Funds for States

- Establishes a four year demonstration project. Provides annual grants to states which choose to participate. HHS would operate a program in a state that chooses not to participate.
- The funding would be a capped entitlement to the state.
- States would be allowed to accumulate a small surplus to cover years with shortfalls, and the federal government would also operate a loan program to assist States with shortfall.
- Funds would be allocated based on the proportion of unemployed persons in the State who collected unemployment income (UI) benefits relative to all persons in the nation who collected UI benefits.

II. Eligibility for Coverage

- Recipients must be in active unemployment insurance claims status.
- Coverage would not exceed 6 months.
- Individuals must have had health insurance coverage through their last employer for at least the six previous months (including plans where the employee paid the full cost).
- A full subsidy is provided up to 100% of the poverty level for family income and phased out at 240% of the poverty level.
- An employed spouse must not have health insurance coverage or, if covered, the employer contributes less than 50% of the premium.
- The individual or family must not be eligible for Medicaid or Medicare.
- Individuals will be eligible based on their place of residence.
- No reduction can be made in the duration or amount of unemployment benefits as the result of an individual participating in the health care coverage program.

III. Benefits

- o States would have the flexibility in how to use funds to assure access to an insurance product:

  --COBRA coverage from their prior employer;
  --An insurance product in the private market;
  --Alternative means of coverage (e.g., state high risk pools, Medicaid buy-in, special plan for the temporarily unemployed);

- o State would have the option of extending eligibility periods or providing a more generous package using state funds.

- o Any reduction in either the duration or extent of health coverage, benefits would have to be approved by the Secretary of HHS.

IV. Administration

- o The state (or its contractor) must conduct all eligibility determinations.

- o Unemployment claimants are informed of possible coverage eligibility at the time that an eligibility determination for UI benefits is made.

- o Recipients must be informed that program funds are limited, and that benefits could be reduced or eliminated if funds become exhausted.

- o Funds from the grant will take the form of letters of credit to the states.

- o Program information and applications will be available in every local unemployment office/one-stop office.

Worker Transition Insurance Program

Description and Rationale

Building on the President's insurance portability provisions, federal funds will be made available to states to finance up to six months of coverage for unemployed workers and their families. The program would be available to those who had employer-based coverage in their prior job, are now receiving unemployment benefits, and have income below 240 percent of the poverty level. The states will have substantial flexibility in how to administer the program.

For many years the states have successfully operated programs for providing unemployment insurance benefits to people who have lost their jobs. The benefits of these programs are twofold: they cushion the economic loss of income for individuals and families while the unemployed seek new jobs; and by providing this cushion, the workforce has been remained more mobile than virtually any other workforce in the industrialized world, providing a significant economic advantage to the United States in international competition.

Unemployment insurance benefits, however, do little to address an increasingly significant hole in the safety net for our nation's workers: unemployment often means the loss of health insurance coverage, and even when the unemployed have options', such as COBRA coverage or access to an individual health plan, the cost can be prohibitively high, particularly when an individual or family has just experienced a sharp decline in income.

The President's proposal fills this hole in the safety net for America's working individuals and families. The Health Insurance Portability and Accountability Act increases access for the unemployed who had employer provided insurance; this proposal will provide financial assistance to the middle class, many of whom would not otherwise be able to afford the insurance available to them.

WORKER TRANSITION INITIATIVE

I. WORKER TRANSITION INITIATIVE

This provision addresses affordability of health care coverage for workers in transition from job-to-job. Through a grant program with the states, it would provide premium assistance to temporarily unemployed workers and their families for up to six months of coverage.

II. PURPOSE

This provision would take the next logical step toward improving coverage to millions of working Americans are at risk of not being able to afford coverage. In so doing, it would assure that individuals retain the continuous health care coverage necessary to receive portability benefits under the Kennedy/Kassebaum health insurance reform bill.

III. IMPACT

- Approximately 3 million people, including at least 700,000 children, would benefit each year.
- The program would cost an estimated $2 billion/year.
- This program would be paid for in the context of the President's balanced budget proposal. It demonstrates that the nation can invest in important programs while still being fiscally responsible.

IV. SPECIFIC PROVISIONS

- The program would give assistance to states to provide health care coverage to individuals who are between jobs.
- The program would give states substantial flexibility to administer the program. Under the program states could decide how to deliver benefits and whether to expand eligibility and benefits.
- Program information and applications would be made available through local unemployment offices.

V. ADMINISTRATION HISTORY ON ISSUE

Over the past few years, the President fought long and hard for health care reform. In passing the Kennedy/Kassebaum legislation, Congress took the first steps toward meaningful reform. The next logical step is to ensure affordability of health care and to guarantee that individuals do not lose the protections gained in the Kennedy/Kassebaum legislation.

This provision has been included in all of the President's balanced budget proposals and is paid for in this context.

Career Transitions

- Mental health parity

To: Maggie Williams
From: Bill Curry
Re: School Based Health Clinics

The Problem
At least 11 million American children are without health insurance of any kind. Millions more have only catastrophic or second rate primary coverage. Frequently, even children who have coverage are underserved because parents can not/will not attend to non emergency needs or because there is insufficient primary care available in their communities.

There exists a network of school based and community based health clinics struggling to meet the needs of these children. There is strong evidence that these clinics- in particular the school based clinics- are far and away the best means at our disposal of reaching underserved children. They are certainly the most cost effective way of delivering care.

But school based clinics are just getting off the ground while community health clinics are taking a financial pounding from Medicaid's transition to managed care and from cuts in federal, state and local human service budgets. Typically, these clinics are not organized to discriminate between their insured and uninsured patients. Nor are they equipped to secure third party reimbursements for those who are insured. Thus, ironically, the clinics,while straining to provide health care to the uninsured, must subsidize private insurance plans by providing uncompensated care to milions of their insured dependents.

The Opportunity
At present there are about 700 school and community based clinics in the United States. Most provide a wide range of primary care services at a cost that is likely as much as 40% lower than Medicaid or even capitated HMO costs. One New York plan provides primary health, dental and mental health coverage for $318 per student per year. The average Medicaid primary health care cost per child, without dental coverage, is around $560 per year. Private sector HMOs are even higher.

The immediate and achievable solution to the problem of providing health care to our children lies in the dramatic expansion of school and community based clinics. Of the two, school based clinics are better at accessing kids into the system and are almost certainly cheaper. The President and the First Lady have that rare opportunity to provide the right leadership at just the right moment-- and to nurture and grow a nascent idea into a vibrant healthy system capable of meeting our sacred obligation to protect the health of our children.

This can be done without massive spending, cumbersome bureaucracy or coercive regulation. We need only respond to the grassroots call of parents and communities who know what their children need and fix the system so that it supports what works. Here's how to begin:

1. We must challenge all insurance and managed care companies to devise a system to reimburse school and community based clinics for services rendered to their covered dependents. Some might wish to make an annual contribution in lieu of payments. Some might require in network provision of certain specified services. Some might prefer capitation

to other methods of reimbursement. But the industry must come together to meet the challenge. In so doing, they will help midwife a transition that in the long run will bring down costs and expand service, thus serving their own needs as well as the needs of others.

2. We must get our own house in order by making Medicaid reimbursement much easier than it is now.

3. We must provide or identify funds for the clinics to develop billing systems that enable them to participate in the marketplace.

4. We should condition school constuction funds on at least the submission of a clinic plan.

5. We should consider freeing up other more narrowly programmatic money to this broader purpose.

This is obviously a very brief and incomplete presentation of the issues that need to be addressed. I am of course availabe at any time to talk with anyone concerned underlying issues, language, politics, etc. good luck.

DRAFT

Summary of Cost Estimates of Child Only Health Insurance Proposals - Revised

Fall '94 Proposal (Scenario 1)
- Full subsidy < 133% poverty
- Sliding subsidy from 133% - 250% poverty
- No subsidy for >= 250% poverty

Democratic Leadership Proposals:
Low subsidy (Scenario 2)
- 25% subsidy up to 250% poverty, 10% subsidy thereafter
- no maximum income level

High subsidy (Scenario 3)
- 50% subsidy up to 250% poverty, 25% subsidy thereafter
- no maximum income level

Preliminary estimates from ARC (8/14) for the Democratic Leadership Proposals show the following:
Total take-up is estimated to range from 2 million to 6 million children, with an average cost per child of $1800-$2700 including the effects of adverse selection. Total program costs range from $4-11 billion. *(GH: 7-17 million children; $1400-$1900 per child; total program costs $13-25 billion)*

The Federal share of the program cost is estimated to range from $1-5 billion. *(GH: $2-10 billion)*

The number of previously uninsured children estimated to be drawn into these programs ranges from 0.2 million to 2 million, resulting in 10-30% of the participant population being made up of the target group (those without insurance prior to the program). *(GH: 0.1-2 million previously uninsured children; 2-15% of participant population)*

The remaining 70-90% of the participant population are those which were insured previously (other private, ESI - self-employed, ESI, and Medicaid) but were drawn into the program either by the subsidy level or by changes in employer behavior (the substitution effect).

Those with Medicaid are assumed to substitute into this program if they are above the federal floor for Medicaid and if the subsidy is 100% (therefore occurs only in the Fall '94 proposal).

The effects of adverse selection, modeled for the uninsured receiving partial subsidies, were estimated to increase total program costs by 20-60%. The selection impact is greatest when the subsidies are lower making the total takeup smaller. *(GH: selection impact is 10% to 20%)*

Each of these proposals replaces current coverage more than newly covering the uninsured. This substitution effect varies slightly with the level of subsidy over the ranges given above.

Summary of Participation Assumptions for the Kids Coverage Cost Estimate Model

1. The Self-Employed

ARC: If subsidy >= 28%, then 90% participation (=.80*35%)

GH: If subsidy >= 6.75%, then 90% participation (=.45*15%) -- 100% participation was run to produce a conservative estimate

GH Reason: .45 is the deduction rate for years 1998-2002 (.80 is phased in later); 15% marginal tax rate is more applicable to the low-income population.

2. Other Private (non-employer sponsored)

ARC: If subsidy >=20%, then 80% participation

GH: If subsidy >10%, then 90% participation -- 100% participation was run to produce a conservative estimate

GH Reason: More people will take advantage of this offer if it is implemented through the tax system.

3. Uninsured

ARC: Scenario 2 (25/10) participation equals 2/3 of Scenario 3 (50/25) participation

	Scenario 2:	Scenario 3:
For Case A:	20%/10%	30%/15%
For Case B:	10%/5%	15%/7.5%
For Case C:	5%/2.5%	7.5%/3.75%

GH: Scenario 2 participation should equal 1/3 of Scenario 3 participation (across all cases).

GH Reason: Few uninsured people will be attracted by the low subsidy of Scenario 2 -- moving from Scenario 2 to 3 (low to high subsidy) should make a bigger difference.

4. Employer Insurance (ESI)

	50% (Cases A/B/C)	0% (Cases A/B/C)
ARC: Scenario 2 or 3		
% participation for those <200%	10%/5%/2.5%	5%/2.5%/1.25%
GH -- Scenario 2 (all cases)	14%	4%
Scenario 3 (all cases)	50%	14%

(up to 250% poverty; less thereafter)

GH Reason: Employers are looking for ways to save money and will change their behavior more dramatically if they are given the "moral out" of knowing that their employees will be able to take advantage of this other program. ARC believes that employer behavior will not change as radically -- at least not as a result of this kids only program.

Democratic Leadership Proposals -- Summary Cost Estimates

Estimates Shown for Medium Participation Assumption (Case B)

					Participants - Coverage Prior to Program							Financing		
Low Subsidy Scenario 2		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
50% Emp Contrib	ARC Assump	$2400	2.4 m	23%	0.4 m	0.1 m	1.2 m	0.1 m	0.00	0.5 m	0.00	$5.7 B	$1.4 B	62%
	GH Assump	$1800	8.6 m	3%	0.2 m	0.04 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$15.0 B	$2.6 B	13%
0% Emp Contrib	ARC Assump	$2300	2.0 m	22%	0.4m	0.02 m	1.2 m	0.1 m	0.00	0.3 m	0.00	$4.7 B	$1.2 B	51%
	GH Assump	$1900	7.1 m	3%	0.2 m	0.009 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$13.4 B	$2.2 B	15%

					Participants - Coverage Prior to Program							Financing		
High Subsidy Scenario 3		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
50% Emp Contrib	ARC Assump	$2000	4.7 m	20%	0.7 m	0.2 m	2.6 m	0.1 m	0.00	0.5 m	0.6 m	$9.7 B	$4.1 B	28%
	GH Assump	$1500	16.3 m	6%	0.7 m	0.2 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$24.0 B	$9.7 B	10%
0% Emp Contrib	ARC Assump	$2200	4.3 m	18%	0.7 m	0.03 m	2.6 m	0.1 m	0.00	0.2 m	0.6 m	$9.4 B	$3.9 B	33%
	GH Assump	$1800	9.4 m	8%	0.7 m	0.03 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$16.7 B	$6.3 B	16%

Democratic Leadership Proposals -- Cost Estimates

Scenario 2 (Low Subsidy): 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above

50% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 2		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$2100	3.6 m	33%	0.9 m	0.3 m	1.2 m	0.1 m	0.00	1.1 m	0.00	$7.4 B	$1.8 B	50%
	B	$2400	2.4 m	23%	0.4 m	0.1 m	1.2 m	0.1 m	0.00	0.5 m	0.00	$5.7 B	$1.4 B	62%
	C	$2500	1.9 m	14%	0.2 m	0.04 m	1.2 m	0.1 m	0.00	0.3 m	0.00	$4.6 B	$1.1 B	59%
GH Assump	A	$1800	8.8 m	6%	0.4 m	0.1 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$15.8 B	$2.8 B	16%
	B	$1800	8.6 m	3%	0.2 m	0.04 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$15.0 B	$2.6 B	13%
	C	$1700	8.4 m	2%	0.1 m	0.03 m	3.2 m	0.2 m	0.00	2.1 m	2.9 m	$14.5 B	$2.6 B	11%

Scenario 3 (High Subsidy): 50% Subsidy up to 250% Poverty, 25% Subsidy for 250% Poverty and Above

50% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 3		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$1800	6.2 m	30%	1.4 m	0.4 m	2.6 m	0.1 m	0.00	1.0 m	0.6 m	$11.2 B	$4.9 B	20%
	B	$2000	4.7 m	20%	0.7 m	0.2 m	2.6 m	0.1 m	0.00	0.5 m	0.6 m	$9.7 B	$4.1 B	28%
	C	$2100	4.0 m	13%	0.4 m	0.1 m	2.6 m	0.1 m	0.00	0.2 m	0.6 m	$8.5 B	$3.5 B	27%
GH Assump	A	$1400	17.2 m	11%	1.4 m	0.4 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$24.9 B	$10.2 B	8%
	B	$1500	16.3 m	6%	0.7 m	0.2 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$24.0 B	$9.7 B	10%
	C	$1400	15.9 m	3%	0.4 m	0.1 m	3.2 m	0.2 m	0.00	9.2 m	2.9 m	$23.1 B	$9.3 B	8%

Scenario 2 (Low Subsidy): 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above

0% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 2		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$2200	2.8 m	33%	0.9 m	0.02 m	1.2 m	0.1 m	0.00	0.5 m	0.00	$6.2 B	$1.5 B	55%
	B	$2300	2.0 m	22%	0.4m	0.02 m	1.2 m	0.1 m	0.00	0.3 m	0.00	$4.7 B	$1.2 B	51%
	C	$2700	1.7 m	14%	0.2 m	0.008 m	1.2 m	0.1 m	0.00	0.1 m	0.00	$4.4 B	$1.1 B	65%
GH Assump	A	$1800	7.3 m	6%	0.4 m	0.02 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$13.4 B	$2.2 B	13%
	B	$1900	7.1 m	3%	0.2 m	0.009 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$13.4 B	$2.2 B	15%
	C	$1800	6.9 m	2%	0.1 m	0.005 m	3.2 m	0.2 m	0.00	0.6 m	2.9 m	$12.9 B	$2.1 B	12%

Scenario 3 (High Subsidy): 50% Subsidy up to 250% Poverty, 25% Subsidy for 250% Poverty and Above

0% Employer Contribution Requirement
High (Case A), Medium (Case B), and Low (Case C) Participation Assumptions Shown

					Participants - Coverage Prior to Program							Financing		
Scenario 3		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Other Priv + MC	MC	ESI	ESI SE	Total Cost	Federal Share	Selection Impact
ARC Assump	A	$2000	5.3 m	29%	1.4 m	0.05 m	2.6 m	0.1 m	0.00	0.5 m	0.6 m	$10.5 B	$4.5 B	27%
	B	$2200	4.3 m	18%	0.7 m	0.03 m	2.6 m	0.1 m	0.00	0.2 m	0.6 m	$9.4 B	$3.9 B	33%
	C	$2200	3.8 m	11%	0.4 m	0.03 m	2.6 m	0.1 m	0.00	0.1 m	0.6 m	$8.4 B	$3.4 B	28%
GH Assump	A	$1700	10.1 m	15%	1.4 m	0.05 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$17.4 B	$6.7 B	15%
	B	$1890	9.1 m	8%	0.7 m	0.03 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$16.7 B	$6.3 B	16%
	C	$1700	9.0 m	5%	0.4 m	0.03 m	3.2 m	0.2 m	0.00	2.4 m	2.9 m	$15.7 B	$5.9 B	13%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
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Comments: Here are the draft we circulated. There is a conf. call today to clear so we can send something to Gordi, I hope

Jack