SUMMARY -- COST ESTIMATES OF KIDS ONLY HEALTH INSURANCE PROPOSALS

Given these options, if such a program were implemented, at most 37% of program participants would be members of the target population (the presently uninsured). -- Scenario 1

Given these subsidies, keeping out children who currently have Medicaid or employer-sponsored insurance will be non-trivial.

Keeping out children who currently have coverage through non-employment based private insurance will be difficult (consider requirement of 6-month uninsured period). While data from the March 1995 CPS shows fewer such children than the earlier surveys had suggested, the number is still large relative to the number of uninsured children who can plausibly be expected to take advantage of a limited subsidy.

- There are close to 1 million children with other private health insurance with incomes less than 133% of poverty.

These child coverage initiatives based on subsidizing purchase of insurance face two major problems:

- **limited effectiveness** in terms of getting currently uninsured children to enroll, and
- **limited efficiency** in terms of spending new dollars only on the uninsured, and only on services which would not otherwise be received

Scenario 1
Draws in the greatest number of those who are presently uninsured -- both in absolute numbers and in terms of the percentage of the subsidized population which is made up of the target (uninsured now) population. A major reason is that a full subsidy is available to those with incomes less than 133% of poverty, a cohort with a relatively high concentration of uninsured individuals.

Those with Medicaid (and above the Federal floor) come in *only* under this scenario, which offers a full subsidy to those with incomes below 133% of poverty.

Scenario 2
Draws in fewer of the presently uninsured than Scenario 1, because a smaller subsidy (25%) is available to those with incomes less than 133% of poverty. This results in a subsidized population which is smaller overall and consists of a larger percentage of those who had some form of insurance prior to the subsidy.

Scenario 3
Also draws in fewer of the presently uninsured than Scenario 1 (but slightly more than Scenario 2), again due to the less generous subsidy (50%) available to those with incomes less than 133% of poverty.

Draws in more of those who currently have insurance, both other private and ESI, self-insured, than Scenario 2, due largely to its more generous subsidy provisions to those above 250% of poverty.

SPEAKER BIOGRAPHIES

BABY STEPS -- OR GIANT STEPS -- TOWARD BROADENED COVERAGE FOR KIDS?

A Briefing on How Children Can, and Sometimes Don't, Get Health Care

August 16, 1996

PAUL FRONSTIN is an economist with the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. As a research associate at EBRI, Dr. Fronstin's interests include the effectiveness of managed care, trends in health insurance coverage, trends in retiree health benefits, retirement transitions and child welfare. His most recent publication is a chapter in *Driving Down Health Care Costs: Strategies and Solutions, 1996,* on health care cost management strategies. Dr. Fronstin has testified before Congress on rising health care costs and portability of health insurance issues. He earned his bachelor of science degree from SUNY Binghamton and his Ph.D. from the University of Miami.

CHARLES LaVALLEE is executive director of the Western Pennsylvania Caring Foundation, Inc., and director of the Western Pennsylvania Caring Program for Children, a health care initiative for children of the working uninsured. He thus manages a range of programs benefiting economically disadvantaged children and their families. He also works with insurers, providers, legislators, hospital associations, medical societies and school districts to replicate the program throughout the United States. Mr. LaVallee administers the Western Pennsylvania BlueCHIP program (Pennsylvania's Children's Health Insurance Program). He also directs the Pittsburgh Center for Grieving Children, a support center for children who have lost a loved one. Additionally, Mr. LaVallee serves on the advisory board of "Taking Good Care of You," a project of the Mister Rogers' Neighborhood Child Care Partnership, and on the steering committee of the Children's Health Fund's *Kids First...Kids Now* program. A 1976 graduate of Carnegie-Mellon University, Mr. LaVallee holds a bachelor of arts degree in history.

DOUGLAS NELSON is executive director and member of the board of trustees of the Annie E. Casey Foundation, a Baltimore-based charitable organization dedicated to helping build better futures for disadvantaged children. Prior to joining the Foundation in 1990, he was deputy director of the Center for the Study of Social Policy, a Washington, D.C.-based non-profit organization specializing in policy questions affecting services to children and families. He came to the Center following eight years with Wisconsin state government in aging and human services. He is nationally known for his leadership and advocacy on behalf of at-risk children, vulnerable families and persons with disabilities. A frequent lecturer and speaker, Mr. Nelson has written widely on social policy. His social history of the World War II relocation of Japanese Americans, entitled *Heart Mountain,* earned him a Pulitzer Prize nomination in 1976. He is a Phi Beta Kappa graduate of the University of Illinois and holds a master's degree in history from the University of Wyoming.

SARA ROSENBAUM is director of the Center for Health Policy Research at the George Washington University Medical Center and an associate research professor for health services management and policy at the university's School of Business and Public Management. She is also on the faculty of GWU's medical and law schools, and consults on health policy and law matters to both the White House Domestic Policy Council and the Department of Health and Human Services. Previously, Ms. Rosenbaum directed both the Children's Defense Fund's Health Division and its Department of Programs and Policy. Ms. Rosenbaum is known nationally for her work relating to health law for the poor, health care financing, and maternal and child health. She played a major role in the design and enactment of federal health reforms for low-income children and families over the past decade and has served on policy advisory boards for several federal agencies, including the Office of Technology Assessment, the Public Health Service and the Health Care Financing Administration. Ms. Rosenbaum received HCFA's Beneficiary Services Award for distinguished national service on behalf of Medicaid beneficiaries.

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HEALTH REFORM

AGENDA

BABY STEPS -- OR GIANT STEPS -- TOWARD BROADENED COVERAGE FOR KIDS?
A Briefing on How Children Can, and Sometimes Don't, Get Health Care

Room SC-5, U.S. Capitol Building
Washington, D.C.
August 16, 1996

10 to 10:10 a.m. — **Opening Remarks and Introductions**

* **Edward F. Howard,** Executive Vice President, Alliance for Health Reform (moderator)

10:10 to 10:50 a.m. — **Panel Presentations**

* **Paul Fronstin, Ph.D.,** Research Associate, Employee Benefit Research Institute
* **Douglas Nelson,** Executive Director, the Annie E. Casey Foundation
* **Charles LaVallee,** Executive Director, Western Pennsylvania Caring Foundation, Inc.
* **Sara Rosenbaum,** Director, George Washington University Center for Health Policy Research

10:50 a.m. to 12 noon — **Questions and Answers**

12 noon — **Adjourn**

The Alliance for Health Reform is grateful to the Annie E. Casey Foundation for its support of the Alliance's work on health care issues.

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EMPLOYEE BENEFIT RESEARCH INSTITUTE

THE MISSION

- EBRI's mission is to advance the public's, the media's, and policymakers' knowledge and understanding of employee benefits and their importance to our nation's economy and to contribute to, encourage, and enhance the development of sound employee benefit programs and sound public policy through objective research and education.

WHAT IS EBRI?

- EBRI provides credible, reliable, and objective research, data, and analysis. The belief: neither public nor private policy or initiatives, whether institutional or individual, can be successful unless they are founded on sound, objective, relevant information.

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- EBRI does not take advocacy positions on policy proposals, lobby for or against proposals, or recommend specific approaches/prescriptions. EBRI does provide objective data on and analysis of the range of identified options in order to provide others the opportunity to make more informed decisions than might otherwise be possible.

- EBRI is a nonprofit, nonpartisan organization established in 1978. EBRI's Education and Research Fund (ERF), which performs the charitable, educational, and scientific functions of the Institute, is a tax-exempt organization supported by contributions and grants.

THE CHALLENGE

- As employee benefit costs—already in the hundreds of billions of dollars—continue to escalate, as public policy continues to evolve, as the design of employee benefit plans becomes more complex, and as employers change their view of benefits, the need for data and analysis that facilitate individual education regarding savings, health insurance purchasing, investing, and retirement security is greater than ever.

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Dallas L. Salisbury is President and CEO. He can be reached at (202) 775-6322 or by e-mail at salisbury@ebri.org

SOURCE LIST

BABY STEPS -- OR GIANT STEPS -- TOWARD BROADENED COVERAGE FOR KIDS?
A Briefing on How Children Can, and Sometimes Don't, Get Health Care
Washington, D.C.
August 16, 1996

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- Irwin Redlener, Children's Health Fund 212/535-9400
- Diane Rowland, Kaiser Family Foundation 202/347-5270
- William Styring, Hudson Institute 317/545-1000

Additional Sources -- by Organization

- American Academy of Pediatrics, Jackie Noyes 202/347-8600
- Blue Cross & Blue Shield Association, Mary Nell Lenhard 202/626-4780
- Child Welfare League of America, David Liederman 202/638-2952
- Children's Defense Fund, Stan Dorn or Greg Haifley 202/662-3595
- General Accounting Office, Michael Gutowski or Sheila Avruch 202/512-7128
- Packard Foundation Center for the Future of Children, Richard Behrman 415/948-7658
- Robert Wood Johnson Foundation, Robert Hughes 609/452-8701

For other Congressional or Administration sources, call the Alliance for Health Reform, 202/466-5626.

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EDUCATION AND RESEARCH FUND

Health Insurance Coverage of Children

Paul Fronstin, Ph.D.
Employee Benefit Research Institute

Prepared for

"Baby Steps - or Giant Steps - Toward Broadened Coverage for Kids?"

August 16, 1996

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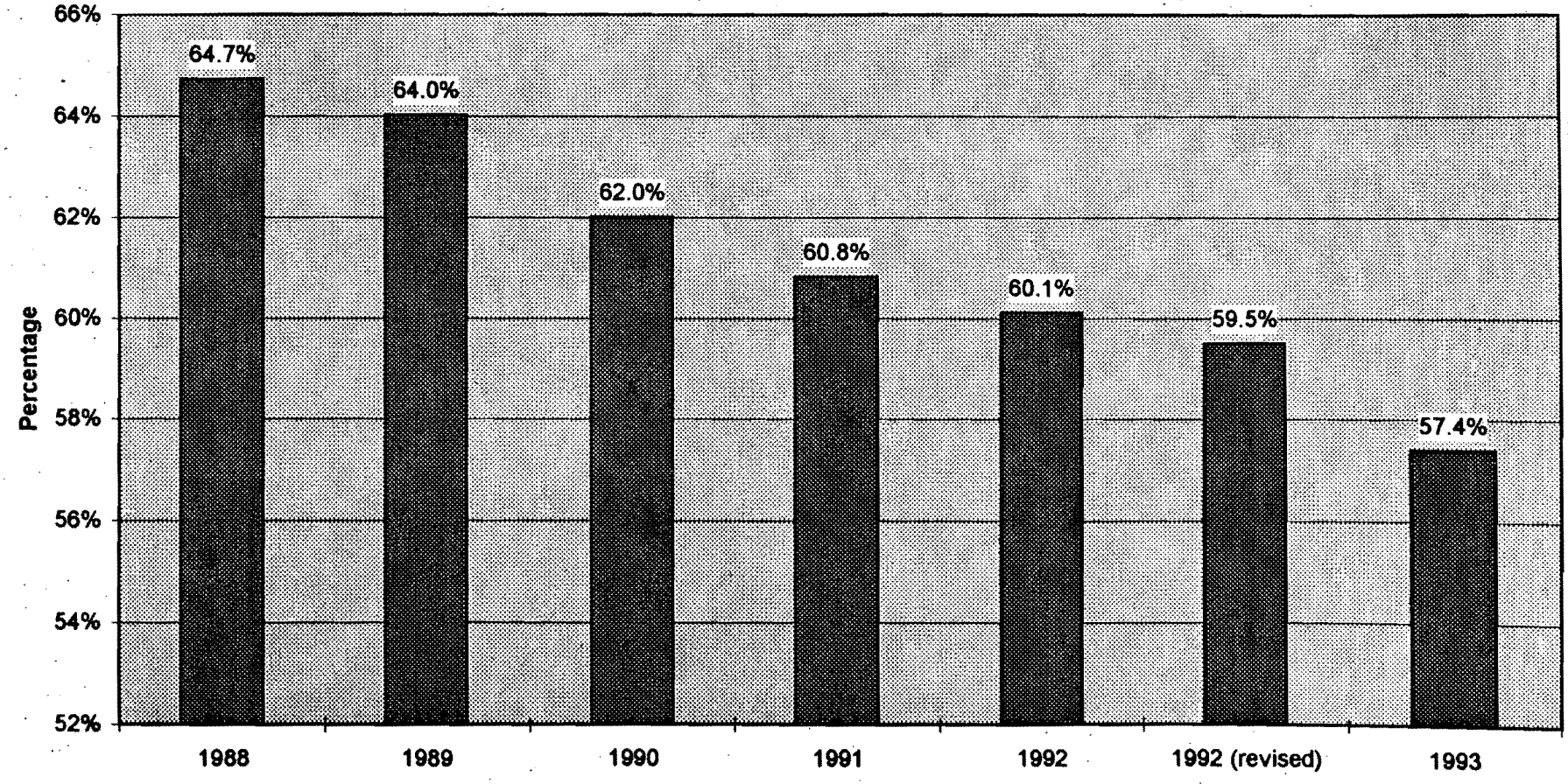
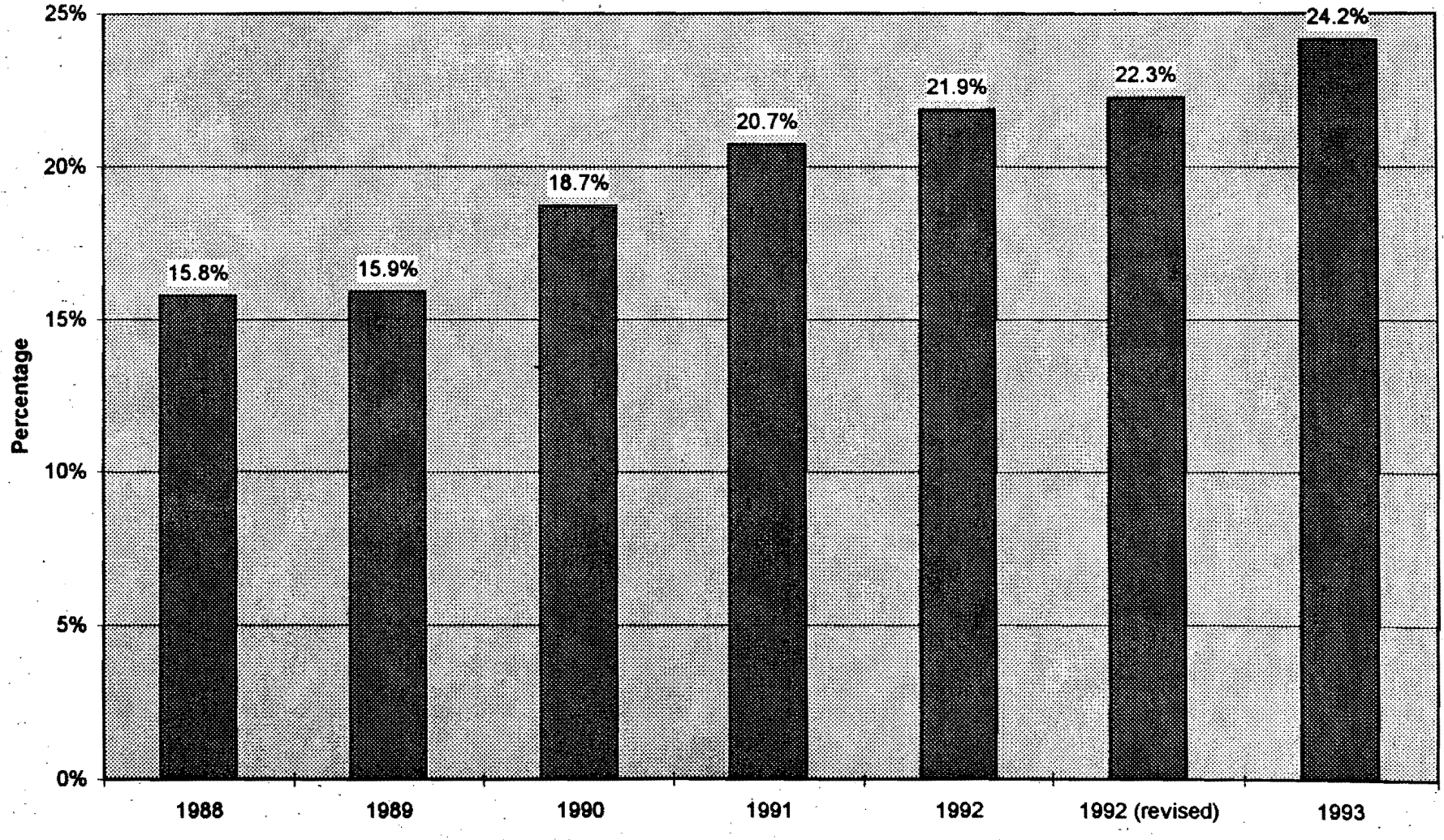
Chart 1
Employment-Based Health Insurance Among Children Aged 0-17, 1988-1993



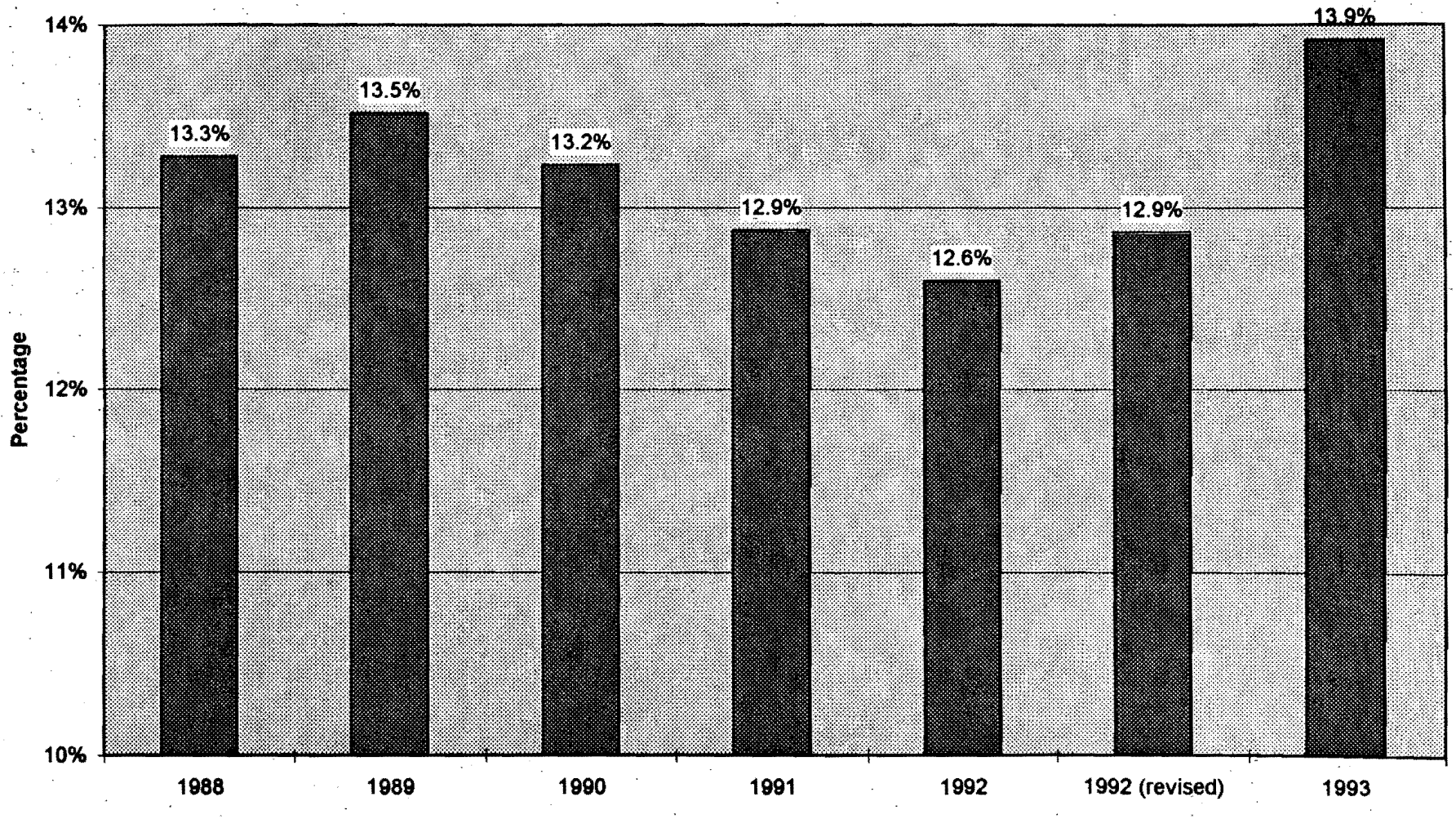
Source: Employee Benefit Research Institute tabulations of the March 1989-1994 Current Population Survey.

Chart 2
Medicaid Coverage of Children Aged 0-17, 1988-1993



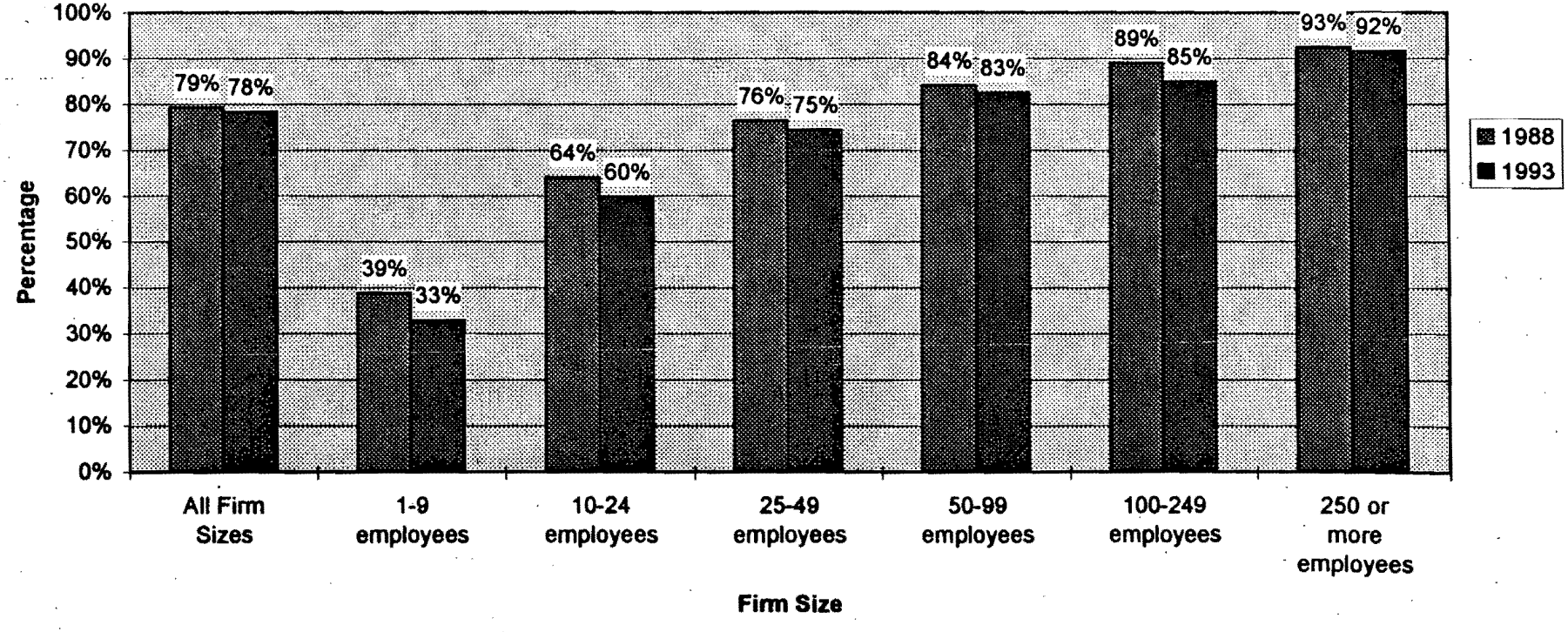
Source: Employee Benefit Research Institute tabulations of the March 1989-1994 Current Population Survey.

Chart 3
Uninsured Children, Aged 0-17, 1988-1993



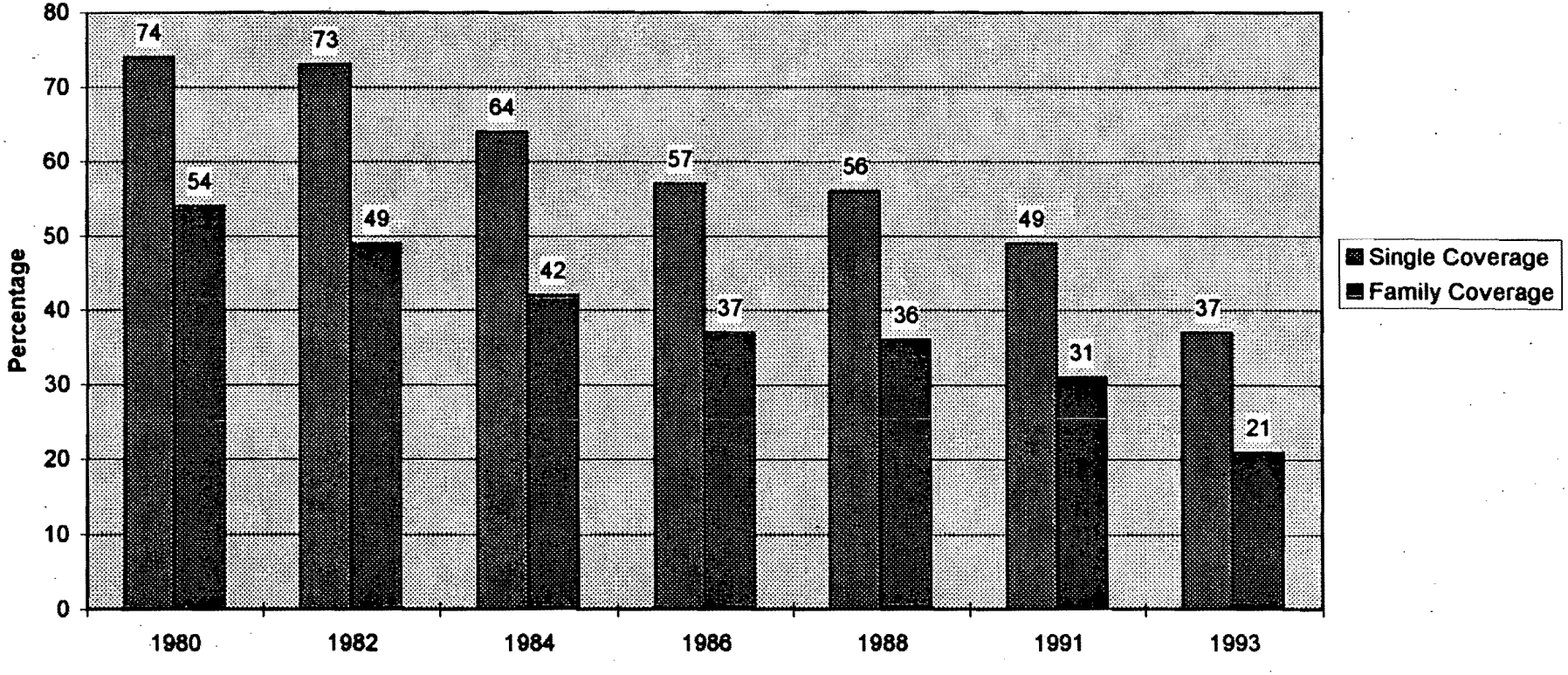
Source: Employee Benefit Research Institute tabulations of the March 1989-1994 Current Population Survey.

Chart 4
Civilian Wage and Salary Workers Aged 18-64 Offered Health Insurance by Their Employer, by Firm Size, 1988 and 1993



Source: Employee Benefit Research Institute Analysis of the May 1988 and April 1993 Current Population Survey

Chart 5
Percentage of Full-Time Workers in Medium and Large Private Establishments with Fully Employer Financed Health Insurance, 1980-1993



Source: U.S. Department of Labor, Bureau of Labor Statistics.

Table 1

Children Under Age 18 with Selected Sources of Health Insurance, 1988-1994

Employee Benefit Research Institute tabulations of the March 1989-1995 Current Population Survey

Source of Coverage	1988	1989	1990	1991	1992	1992 (revised)	1993	1994
	(Weight based on 1980 Census)					(Weight based on 1990 Census)		
	(millions)							
Total Population	62.8	63.2	64.2	65.1	66.1	67.7	68.8	69.5
Total Private	46.1	46.5	45.6	45.3	45.7	46.4	46.2	46.0
Employment-Based	40.6	40.5	39.8	39.6	39.8	40.3	39.5	40.8
Other private	5.5	6.1	5.8	5.7	6.0	6.1	7.3	5.2
Total Public	11.2	11.2	13.2	14.7	15.7	16.3	17.7	17.5
Medicare	0.1	0.0	0.1	0.1	0.1	0.1	0.0	0.2
Medicaid	9.9	10.1	12.0	13.5	14.5	15.1	16.6	16.1
CHAMPUS	1.4	1.3	1.3	1.3	1.4	1.4	1.3	1.7
Uninsured	8.3	8.5	8.5	8.4	8.3	8.7	9.6	10.0
	(percentage)							
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Private	73.4%	73.5%	71.0%	69.5%	69.1%	68.5%	67.2%	66.2%
Employment-Based	64.7%	64.0%	62.0%	60.8%	60.1%	59.5%	57.4%	58.7%
Other private	8.8%	9.6%	9.1%	8.8%	9.1%	9.0%	10.5%	7.5%
Total Public	17.8%	17.7%	20.6%	22.6%	23.7%	24.1%	25.7%	25.2%
Medicare	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.3%
Medicaid	15.8%	15.9%	18.7%	20.7%	21.9%	22.3%	24.2%	23.2%
CHAMPUS	2.2%	2.1%	2.1%	2.0%	2.1%	2.1%	1.9%	2.4%
Uninsured	13.3%	13.5%	13.2%	12.9%	12.6%	12.9%	13.9%	14.4%

Note: Details may not add to totals because children may receive coverage from more than one source.
Children of active duty military personnel are excluded from sample.
The 1988 data through the first set of 1992 data are based on 1980 Census-based population controls. The second set of 1992 data (as revised) and the 1993 and 1994 data are based on 1990 Census-based population controls. While the change in the weighting has little effect on the percentage distributions, it does affect levels. Thus, by reweighting the 1992 data, these estimates may more accurately be compared with the more recent data. The March 1995 Current Population Survey (CPS) utilized a more detailed set of health insurance questions, with the new questions appearing to have an effect on types of coverage. Caution should be used in making comparisons between the March 1995 CPS and previous years.

Table 2

Civilian Workers Aged 18–64 Offered Health Insurance by Their Employer, by Firm Size, 1988 and 1993 [a]
Employee Benefit Research Institute Analysis of the May 1988 and April 1993 Current Population Surveys

Firm Size	1988 Total Workers	1988 Employer Sponsors Health Plan	1988 Employer Does Not Sponsor Plan	1988 Not Determinable	1993 Total Workers	1993 Employer Sponsors Health Plan	1993 Worker Coverage Only Offered	1993 Worker and Family Coverage Offered	1993 Don't Know If Family Coverage Offered	1993 Employer Does Not Sponsor Plan	1993 Not Determinable
					(millions)						
Wage and Salary Workers	98.5	78.1	15.8	4.6	103.2	80.9	5.1	74.0	1.9	18.3	4.0
Fewer than 10 employees	13.3	5.2	7.4	0.7	13.6	4.5	0.9	3.5	0.1	8.6	0.5
10–24 employees	7.8	5.0	2.4	0.4	8.3	5.0	0.7	4.2	0.2	2.8	0.5
25–49 employees	6.6	5.0	1.3	0.3	6.5	4.8	0.4	4.3	0.2	1.4	0.3
50–99 employees	5.4	4.5	0.6	0.2	6.1	5.0	0.4	4.5	0.2	0.9	0.2
100–249 employees	7.3	6.5	0.6	0.2	7.6	6.5	0.3	6.1	0.1	0.8	0.4
250 or more employees	49.8	46.1	2.0	1.7	53.4	49.8	2.0	47.0	0.8	2.4	1.2
250–499 employees	b	b	b	b	5.3	4.9	0.2	4.6	0.1	0.3	0.1
500–999 employees	b	b	b	b	5.4	5.0	0.3	4.7	0.1	0.3	0.1
1,000 or more employees	b	b	b	b	42.7	39.9	1.5	37.8	0.6	1.8	1.0
Not determinable	8.4	5.9	1.6	0.9	7.5	5.3	0.4	4.5	0.4	1.4	0.9
Unincorporated Self-Employed	9.4	0.3	0.2	9.0	9.4	1.4	0.3	1.0	c	7.9	0.1
Total	108.0	78.4	16.0	13.5	112.5	82.3	5.4	75.0	1.9	26.2	4.0
					(percentage within firm size categories)						
Wage and Salary Workers	100.0%	79.3%	16.1%	4.6%	100.0%	78.4%	4.9%	71.7%	1.8%	17.7%	3.8%
Fewer than 10 employees	100.0	38.8	55.7	5.5	100.0	33.0	6.5	25.4	1.1	63.1	3.9
10–24 employees	100.0	64.1	30.9	5.0	100.0	59.8	7.9	49.9	2.0	34.1	6.1
25–49 employees	100.0	76.4	19.2	4.4	100.0	74.5	6.4	65.8	2.3	21.3	4.1
50–99 employees	100.0	84.1	11.4	4.5	100.0	82.6	6.2	73.6	2.8	14.4	3.0
100–249 employees	100.0	89.0	7.7	3.3	100.0	85.0	3.8	79.6	1.7	10.0	5.0
250 or more employees	100.0	92.5	4.1	3.5	100.0	91.7	4.6	85.8	1.3	5.7	2.5
250–499 employees	b	b	b	b	100.0	92.9	5.2	86.4	1.3	5.5	1.7
500–999 employees	b	b	b	b	100.0	92.9	5.2	86.4	1.3	5.5	1.7
1,000 or more employees	b	b	b	b	100.0	93.5	3.6	88.5	1.4	4.2	2.3
Not determinable	100.0	70.0	18.8	11.3	100.0	69.7	5.5	59.6	4.7	18.7	11.6
Unincorporated Self-Employed	100.0	2.9	2.1	95.0	100.0	14.8	3.6	11.1	c	84.2	0.9
Total	100.0	72.6	14.8	12.5	100.0	73.1	4.8	66.7	1.7	23.3	3.6

Note: Of the 13.5 million individuals for whom we do not know if their employer offered coverage in 1988, 9 million were unincorporated, self-employed workers who were not asked the question concerning employer coverage. Previous Employee Benefit Research Institute analysis of the self-employed suggests that most of them were not offered coverage by their employer and that their health insurance status has not changed significantly between 1988 and 1993, with a slight movement away from employer coverage in their own name to employer coverage obtained through a spouse.

[a]Both the May 1988 and April 1993 Current Population Survey ask respondents if their employer offers a health insurance plan to any of its employees. The 1988 survey does not distinguish between employee only and family coverage.

[b]Data not available.

[c]Fewer than 50,000 respondents (weighted) in this category.

Table 9.9
Contributory and Noncontributory Health Insurance

Percentage of Full-Time Employees Participating in Employer-Sponsored Medical Plans, by Plan Type: Medium and Large Private Establishments, Selected Years 1979–1993; State and Local Governments, 1987,1990, and 1992; and Small Private Establishments, 1990 and 1992

	Medium and Large Private Establishments[a]													State and Local Governments[b]			Small Private Establishments[c]	
	(old scope)									(new scope)				(old scope)	(new scope)			
Type of Coverage	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1991	1993	1987	1990	1992	1990	1992
Percentage of Employees Participating in Medical Care Plans	97%	97%	97%	97%	96%	97%	96%	95%	92%	90%	92%	83%	82%	93%	93%	90%	69%	71%
Single Employee Coverage																		
Wholly employer financed	73	74	73	73	67	64	64	57	55	56	53	49	37	65	62	57	58	52
Contributory	27	26	27	27	33	36	36	43	45	44	47	51	61	35	38	43	42	47
Not determinable	d	d	d	d	d	d	d	d	d	d	d	d	2	d	d	d	d	d
Family Coverage																		
Wholly employer financed	d	54	51	49	46	42	44	37	37	36	34	31	21	29	35	28	32	27
Contributory	d	46	49	51	54	58	56	63	63	64	66	69	76	71	65	72	67	72
Not determinable	d	d	d	d	d	d	d	d	d	d	d	d	3	d	d	d	d	d

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1979–1989* (Washington, DC: U.S. Government Printing Office, selected years); *Employee Benefits in Medium and Large Private Establishments*, 1991 and 1993 (Washington, DC: U.S. Government Printing Office, 1993 and 1995); *Employee Benefits in State and Local Governments*, 1987, 1990, and 1992 (Washington, DC: U.S. Government Printing Office, 1988, 1992, and 1994); *Employee Benefits in Small Private Establishments*, 1990 and 1992 (Washington, DC: U.S. Government Printing Office, 1991 and 1994).

Note: See Appendix B for a technical explanation of this source.

[a]The Bureau of Labor Statistics' (BLS) survey scope was expanded significantly in 1988 to include private nonfarm establishments employing 100 or more workers. The former survey coverage, which previously included full-time employees in establishments with either 50, 100 or 250 workers, depending on industry, is referred to as old scope. The expanded survey coverage, which in 1988 and after includes full-time employees in private nonfarm establishments employing 100 or more workers in the District of Columbia and all states except Alaska and Hawaii, is referred to as new scope. In order to permit comparisons of 1988 findings with those of prior years, BLS also tabulated selected 1988 survey responses for old scope establishments. In 1991 and following years, the survey includes establishments in Alaska and Hawaii.

[b]The BLS survey scope was expanded significantly in 1990 to include part-time workers, all governments regardless of size, and Alaska and Hawaii. The former survey coverage, which included only full-time workers in government units employing 50 or more workers in the 48 contiguous states and the District of Columbia, is referred to as old scope. The expanded survey coverage is referred to as new scope.

[c]These tabulations provide representative data for full-time employees in private, nonagricultural establishments with fewer than 100 employees.

[d]Data not available.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

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FAX Number: .....

FROM: ....Jeanne.....

Pages:

Comments:

I WORRY THAT I DIDN'T CLEARLY EXPLAIN THE OPTIONS & ADVANTAGES / DISADVANTAGES. HERE IS A SUMMARY. THIS DOES NOT PRELUDE A ½ hour DISCUSSION ABOUT THE OPTIONS + HOW WE PROCEED — I HAVE AN IDEA.

S

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State Program for Kids

Eligibility: Kids in working families with income below 200 percent of poverty without insurance (previous 6 months) or access to employer-based insurance (previous 18 months). This includes Medicaid children in working families, except for SSI and institutionalized children. Coverage would be phased in.

Benefits: FEHBP Blue-Cross, Blue-Shield like package

Delivery System: State designed. States may cover children through Medicaid, State employee health plans, private HMOs or any other program suited to the State's circumstances.

Funding:

Federal: Federal Medicaid per capita cap amount for kids in the State

- Full amount for kids below 133 percent of poverty
- Partial amount for kids between 133 and 200 percent of poverty (for States that currently optionally cover these kids, they would get the full per capita, as under the per capita cap).

Note: A significant proportion of the total program funding would be a transfer from Medicaid to the new program. New spending would be for increased participation and States that do not now cover children at higher levels.

Participant: No premiums or cost sharing for children below 133 percent of poverty

Sliding scale premium for children 133 to 200 percent of poverty; co-payments for some services (not for preventive or primary care)

State/Private: The residual funding needed to assure that all eligibles receive the nationally-defined benefits package.

Discussion of Kids' Options

Why Kids:

- One of four uninsured is a child. Children are one of the fastest growing groups of uninsured.
- Probably have greater coverage per dollar spent than TU program [although I am not sure yet]
- Given the problems with the Chafee-Breaux amendment, this offers a substitute. Creates a uniform, national safety net of benefits and eligibility — the intent but the not effect of the OBRA '90 expansion.
- Counterbalances State reductions in welfare coverage

Why State Program:

- Less expensive than a full subsidy program since (a) only Federal share of per capita; (b) indexed through per capita cap; and (c) State optional.
- Given limited availability of new funding, allows States to use some current Medicaid funding in a more flexible program to pool for greater purchasing power.
- Builds on State Medicaid programs and other initiatives to cover children. Over 30 States have either State-only or public / private partnerships for coverage of children. Both Republican and Democratic governors have supported these initiatives; this is one of Chiles' and Romer's top issues.
- May reduce pressure on Medicaid for greater flexibility. If States can have more program flexiblity for healthy kids, they may not feel the same need to change the Medicaid program which would remain the source of coverage for kids with special needs.

Disadvantages:

- Likely to have some employer dropping.
- Advocates might feel that it goes back on EPSDT and other Medicaid protections
- If it becomes too flexible, it could do more harm than good by putting current Medicaid kids at risk.

DRAFT

Health Care Options - Next Steps

The following outlines incremental HHS health care proposals for the post-Kennedy/Kassebaum "next steps" initiatives.

1. **Update current incremental plan linked to implementation of Kassebaum/Kennedy:** some elements of the health care reform plan advocated as administration policy since last June will continue to serve as the basis for next steps, as part of the effort to build on the Kassebaum/Kennedy provisions for insurance reforms and portability of coverage for those with coverage making transitions among jobs.

    a. **Health care for transitionally unemployed**: grants to states to fund 6 months of health benefits (income-related subsidy) for unemployed workers who had coverage in their last job and are receiving unemployment compensation.

    b. Grants to states to help them establish **purchasing cooperatives** for small businesses, coupled with the option for states to get participation of FEHBP carriers.

    c. A third policy statement could be continued support for **mental health parity** as currently expressed in the Domenici compromise bill.

2. **Consumer protections/health plans**: there is strong interest in developing consumer protections for health plans, along with a quality agenda -- this should be extended to all plans (not just managed care arrangements). We would work with interested parties to develop a "consumers bill of rights" for all health plans. At the same time, we would continue to advance the quality of care agenda and seek to develop and incorporate updated quality standards for federal health purchasing programs. In the interim the administration would support enactment of the 48-hour rule as well as the Ganske bill.

3. **Children and working families:** An initiative for children and working families could accomplish most if we focus on fulfilling the promises of our current programs targeted in these areas, including Medicaid, school health, and health centers.

    (a) Work with states to enhance the reality of Medicaid services for eligible children under current law through outreach and other efforts (possibly as part of steps to help assure that families and children get coverage available under welfare reform changes); in addition, we would encourage enhanced coverage for working families through the waiver process.

    (B) Target increased funding for consolidated health centers, school health programs, and maternal and child health, to improve services for children and working families.

Preliminary background one-pagers on items two and three are attached.

DRAFT

Expand Targeted Funding for Consolidated Health Centers (CHCs) to Improve Services to Children and Working Families

Background

- Federally funded health centers provide comprehensive health care to 10 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.

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

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

- CHCs are an essential part of the safety net, effectively serving over 3000 communities today. They focus on providing preventive and primary care to uninsured and underserved populations as well as a full range of enabling services 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 services to children and working families.

- Existing and new CHCs could identify special needs of children and working families in their community and develop specific interventions targeted to those needs.

- CHCs can also be utilized to expand outreach to hard-to-reach populations. CHCs are committed to providing a wide array of health and social services including outreach and follow-up to patients and their families. They offer the enabling services, first line care, and case management that addresses all aspects of health and keeps people from using more expensive curative care.

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

Background

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

- School health centers 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.

- Across the U.S. there are estimated to be at least 650 school health centers out of approximately 80,000 schools.

- School-based/linked health programs provide a unique opportunity to improve the health status of our young children and adolescents. A health center directly linked to a school, where health care workers are in frequent contact with students, provides children with ready access to health professionals and to necessary information and clinical services. They also can provide an effective way for both educators and health care providers to reach hard-to-reach parents. Approximately 250 community health centers have already developed school-based or school-linked service programs to improve the health and school performance of children.

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

- In addition, offering school-based services 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.

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

Proposal

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- Expand the **Healthy Schools, Healthy Communities** initiative to improve the health of our 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/linked health centers in communities with high rates of uninsurance. Children of all ages from kindergarten through grade twelve could be served. Centers would have the option of expanding services to the parents and siblings of the school's students. Centers could provide comprehensive primary care services at the school including diagnosis and treatment of acute chronic conditions, preventive health services, mental health services, health education and preventive dental care. Reproductive health services could be provided at the option of the community.

- In addition, funding for **CHCs** can be expanded to work with communities to develop school-based or school-linked service 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 health centers as a method of providing comprehensive health services to underserved children. This linkage provides schools an opportunity to tap into health center funding sources (e.g. federal grants). This linkage also provides the schools with access to reimbursement mechanisms for Medicaid and other third party payers. Approximately 250 Health Centers have developed school-based or school-linked service programs. In addition, CHCs have begun to build expertise in managed care which would be a valuable resource to school health centers.

- In order to assure integration of school health programs within the managed care marketplace, the Department will provide technical assistance to help school centers create effective linkages to Medicaid and managed care organizations.

- Another approach is to 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. Further funding targeted to the development of school-based/linked 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.

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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 10/1/97, 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.* Indeed, the proportion of poverty-level eligible children who are not enrolled is very substantial in some subgroups.

- The linkage of Medicaid eligibility to AFDC facilitated enrollment of poor children in Medicaid since eligibility for both programs was established simultaneously and 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 similar 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. Medicaid for minor children who are not heads of households is protected, although parents 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.

- Although a few states have used the demonstration authority under section 1115 to expand Medicaid to cover families and children who were otherwise uninsured, 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.

Proposal

- Work with states to take steps to increase the enrollment in Medicaid of already eligible children. Federal-state partnerships might be developed to identify and enroll eligible children through outreach in schools, including special education providers, churches and other community service providers.

- Work with states to improve access to better quality primary and preventive care for Medicaid-eligible children.

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- With the passage of the new welfare law, states should help families understand what they will have to do to continue Medicaid for themselves and/or their children.

- Take steps to renew state interest in undertaking demonstrations and other activities that involve expansion of Medicaid coverage for children and working families. These steps could include but not be limited to: a specific solicitation of demonstration proposals designed to test the use of premiums as a mechanism for enrolling uninsured low-income families; diffusion of information on state "best practices" with respect to expanding coverage; and technical assistance to states on such matters as pricing the Medicaid benefit package.

EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE

ALLIANCE FOR HEALTH REFORM

FOR IMMEDIATE RELEASE **Contacts:** **Merit Kimball (Alliance -- 202/466-5626)**
August 8, 1996 **Bill Pierron (EBRI -- 202/775-6353)**

BABY STEPS -- OR GIANT STEPS -- TOWARD BROADENED COVERAGE FOR KIDS?
A Briefing on How Children Can, and Sometimes Don't, Get Health Care

When Congress and the President agreed last week on a set of health insurance reforms, analysts and the bill's sponsors agreed: these are modest steps in the right direction, and are not likely to make much progress in getting health coverage for the uninsured or underinsured. How can leaders get past the partisan and ideological obstacles to broadening coverage?

One possible starting point: cover more kids. Not only does better coverage for children yield family and society-wide improvements, but, since kids are generally healthy, it's relatively inexpensive. What's more, analysts across the political spectrum are coming to agree that the current base for kids' coverage -- through employers -- is eroding. So we see private and public initiatives around the country: Medicaid coverage for low-income children has been extended beyond federal requirements in dozens of states. Voluntary efforts in more than 20 states, often led by Blue Cross plans, provide coverage to scores of thousands of kids.

But how fast is the employer base for kids' coverage deteriorating? How likely are further Medicaid expansions as Congress considers reductions in the program's growth rate? And will welfare reform legislation affect coverage for poor kids? Can private sector efforts handle a major portion of the task? And where will the money come from to finance even a modest initiative?

These and other issues will be discussed by a panel of experts at an August 16 briefing cosponsored by the Alliance for Health Reform and the Employee Benefit Research Institute. Speakers will include **Charles LaVallee**, head of the Western Pennsylvania Caring Foundation, which runs a private program providing coverage for children up to more than 200 percent of the federal poverty line; **Douglas Nelson**, executive director of the Annie E. Casey Foundation, which focuses on helping disadvantaged children; **Paul Fronstin, Ph.D.**, research associate at EBRI and **Sara Rosenbaum** (invited), director of George Washington University's Center for Health Policy Research. Alliance Executive Vice President **Ed Howard** will moderate the panel.

WHEN: **10 a.m. to 12 noon, Friday, August 16**
WHERE: Room SC-5 on the Senate side of the Capitol Building
RSVP: *By noon, Wednesday, August 14*, by faxing the attached form to 202/466-6525 or telephoning 202/466-5626. Space is limited.

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MEMO

FROM: Cathi Callahan
Jim Mays

DATE: 7 August 1996

RE: Cost Estimates: Clarifications and Next Steps

Below are responses to the next steps noted in Laura's memo of 7 August 1996:

1. Modeling the premiums for groups of children.

   a. This involves converting the per child cost to a per unit cost based on the average number of children in families.
      i. We will be modeling the premium costs associated with covering child units, in addition to our current basis where we price each child individually. If a two-way basis is used (one price for a single child, a second price for two or more), then families with more than two children get something of a break, at the expense of families with only two children. This is a cross-subsidy from smaller families to larger families, rather than a "discount" in the normal sense. We will be developing estimates of the distributions of children by family size and by family income.

2. Providing an explanation of take-up assumptions for the various populations.

   As we refine our estimates and overall participation assumptions, the specific numbers mentioned below are also subject to revision.

   a. Case A is a 'high' participation rate case for each scenario. Rules for participation in Case A are as follows:
      i. Children with or eligible for Medicaid participate only under all of the following conditions:
         (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
         (2) Receive a 100% subsidy.
      ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.
      iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80%

available if reform legislation passes * marginal tax rate of 35%).

iv. Other children with employer sponsored insurance who are under 200% of poverty come in with an average of 10% participation. Participation is sloped by poverty group as follows:
   (1) under 100% of poverty: 16.0% participation
   (2) 100-124%: 13.7% participation
   (3) 125-132%: 11.3% participation
   (4) 133-149%: 9.0% participation
   (5) 150-174%: 6.7% participation
   (6) 175-184%: 4.3% participation
   (7) 185-199%: 2.0% participation

v. Children who are uninsured
   (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 50% participation for those who are partially subsidized (between 133% and 250% of poverty), scaled as follows:
      (a) 133-149%: 96.0% participation
      (b) 150-174%: 78.0% participation
      (c) 175-184%: 60.0% participation
      (d) 185-199%: 42.0% participation
      (e) 200-224%: 24.0% participation
      (f) 225-249%: 6.0% participation
   (2) Scenario 2: 20% participation for those under 250% of poverty, and 10% participation for those at or above 250% of poverty. These rates do not slope by poverty level.
   (3) Scenario 3: 30% participation for those under 250% of poverty, and 15% participation for those at or above 250% of poverty. These rates do not slope by poverty level.

b. Case B is a 'medium' participation rate case for each scenario. Rules for participation in Case B are as follows.

i. Children with or eligible for Medicaid participate only under all of the following conditions:
   (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
   (2) Receive a 100% subsidy.

ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.

iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).

iv. Other children with employer sponsored insurance who are under 200% of poverty come in at 5% participation. The rates used

above for the 10% participation for this class were halved to reach 5% participation.

v. Children who are uninsured
   (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 25% participation for those who are partially subsidized (between 133% and 250% of poverty),scaled as follows:
      (a) 133-149%: 50.0% participation
      (b) 150-174%: 40.5% participation
      (c) 175-184%: 31.0% participation
      (d) 185-199%: 21.5% participation
      (e) 200-224%: 12.0% participation
      (f) 225-249%: 2.5% participation
   (2) Scenario 2: 10% participation for those under 250% of poverty, and 5% participation for those at or above 250% of poverty.
   (3) Scenario 3: 15% participation for those under 250% of poverty, and 7.5% participation for those at or above 250% of poverty.

c. Case C is a 'low' participation rate case for each scenario. Rules for participation in Case C are as follows.
   i. Children with or eligible for Medicaid participate only under all of the following conditions:
      (1) Are above the federal floor for Medicaid (see definition page for explanation of federal floor), and
      (2) Receive a 100% subsidy.
   ii. Children with non-employer sponsored insurance come in at 80% participation if the subsidy available is greater than 20%.
   iii. Children with employer sponsored insurance who are dependents of the self-employed come in at 90% participation if the subsidy available is greater than 28% (calculated using tax subsidy of 80% available if reform legislation passes * marginal tax rate of 35%).
   iv. Other children with employer sponsored insurance who are under 200% of poverty come in at 2.5% participation. The participation rates used for the 5% participation (Case B) were halved to reach 2.5%..
   v. Children who are uninsured
      (1) Scenario 1: Full participation for those fully subsidized and no participation for those without subsidies. There is 10% participation for those who are partially subsidized (between 133% and 250% of poverty),scaled as follows:
         (a) 133-149%: 20.0% participation
         (b) 150-174%: 16.2% participation

(c) 175-184%: 12.4% participation
(d) 185-199%: 8.6% participation
(e) 200-224%: 4.8% participation
(f) 225-249%: 1.0% participation

(2) Scenario 2: 5% participation for those under 250% of poverty, and 2.5% participation for those at or above 250% of poverty.

(3) Scenario 3: 7.5% participation for those under 250% of poverty, and 3.75% participation for those at or above 250% of poverty.

3. Providing an explanation of how adverse selection for the uninsured population was determined.

a. Selection effect here is ONLY the effect of bringing in uninsured persons with partial subsidies. Additional effects for age and insurance mix have not been calculated yet.

(1) % of uninsured with partial subsidy calculated for each Scenario/Case.

(2) ARC Small Group Model (multi-year claims based model) used to determine relative cost of those participating.

(a) Model uses prior-use based premiums to model effects.

(b) it was assumed that half of the participants were at the top of the distribution (for X% participation, then X/2% were the most expensive persons), and the other half were randomly distributed from the rest of the distribution.

(3) Starting per capita premium adjusted to reflect contribution by the uninsured to the overall average premium.

(4) Deficit due to selection is calculated as (number of persons receiving partial subsidy) * (actual cost - adjusted uninsured cost).

(5) Selection Impact is defined to be the deficit divided by the gross cost of the program.

4. Modeling adverse selection for those with other private and ESI (self-employed).

a. We will be replicating the logic used with respect to selection in the uninsured population for a subset of these persons.

5. Providing an explanation of how this base premium ($1246) was derived, and then how it compares with numbers from the HSA era.

a. Derivation of the $1246 per child premium:
   i. NMES based covered expenses for the privately insured population calibrated to CBO projections of the National Health Accounts for CY 1996 and inflated to 1997.
      (1) This includes all channels of payment for the following services:
         (a) hospital
         (b) physician
         (c) prescription drugs
         (d) other professionals
         (e) dental
      (2) This is for the entire non-institutionalized population, with the following subgroups looked at specifically
         (a) under 65 (per capita covered expense of $2081)
         (b) under 18 (per capita covered expense of $1466)
   ii. Blue Cross/Blue Shield FEHBP Standard Option plan used to calculate medical and dental benefit rates (average fraction of benefits paid).
      (1) For under 65 (adults), the benefit rates used were as follows:
         (a) medical: 0.7812
         (b) dental: 0.1400
      (2) For under 18 (children), the benefit rates used were as follows:
         (a) medical: 0.7555
         (b) dental: 0.3000
   iii. Benefits adjusted for age and insurance composition of exposed population, as compared to total non-institutionalized.
      (1) Adjustments made for the under 18 population only. The composite factor of 1.0017 was broken down as follows:
         (a) age composition: 1.0374
         (b) insurance composition: 0.9656.
   iv. Benefits adjusted for expected induction by the uninsured. The induction assumption used was that the uninsured would have their expenses brought up to the levels of the privately insured ("Jim-Bob" assumption during HSA). This results in an overall factor of 1.0712.
   v. Benefits adjusted for expected discounts gotten by the federal government (5% reduction).
   vi. Premiums calculated based on an assumed 15% administrative loading charge.

vii. Resulting per child premium is $1246.

b. Comparison of the $1246 per child premium with HSA-era numbers.
   i. HSA starting per family premiums (HCFA) by type of family for 1994 are as follows:
      (1) Single: $1933
      (2) Couple: $3866
      (3) 1 Adult + Kid(s): $3894
      (4) 2 Adults + Kid(s): $4361
   ii. Using counts, per family, and per person costs from the ARC model used at the same time for ASPE, the above per family premiums were converted into per capita premiums for adults and children. Premiums are as follows (1994 terms):
      (1) Per Adult: $1704
      (2) Per Child: $927
   iii. Inflating the HSA per child premium to 1997 (using CBO based factors for private health insurance) results in $1173/child, which is approximately 6% lower than our current estimate.
   iv. Possible differences include:
      (1) HCFA estimates are for the 'alliance' population only (excluding large employer, medicare, medicaid).
      (2) Differences in assumptions for administrative load and discounts.
      (3) Possible differences in the baseline historical national health accounts being used (revisions have occurred since HSA).

6. Modeling changes in employer behavior for the ESI population with the 50% vs. 0% employer contribution requirements.
   a. Refine estimates of persons affected at 50% and 0% level by looking at March 94 CPS and NMES PUF 15 file (employer survey).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

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Number of Pages (Including Cover): 7

Comments:
FYI – Additional info on AKC cost estimates of child health insurance proposals

Fall '94 Proposal (Scenario 1) -- Summary Cost Estimates

50% Emp Contribution (top) and 0% Emp Contribution (Bottom) Requirements

				Participants - Coverage Prior to Program					
Scenario 1 (50% Req)	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1300	9.1 m	36%	2.8 m	0.4 m	1.1 m	3.2 m	1.1 m	0.4 m
B	$1300	7.9 m	33%	2.3 m	0.3 m	1.1 m	3.2 m	0.5 m	0.4 m
C	$1300	7.2 m	30%	1.9 m	0.2 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$11.7 B	$10.5 B	68%	$1100	$400 m	3.5%
B	$10.4 B	$9.4 B	68%	$1200	$540 m	5.5%
C	$9.4 B	$8.7 B	68%	$1200	$460 m	5.2%

				Participants - Coverage Prior to Program					
Scenario 1 (0% Req)	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1300	9.3 m	37%	2.8 m	0.6 m	1.1 m	3.2 m	1.1 m	0.4 m
B	$1300	8.0 m	34%	2.3 m	0.4 m	1.1 m	3.2 m	0.5 m	0.4 m
C	$1300	7.2 m	31%	1.9 m	0.3 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$12.0 B	$10.6 B	68%	$1100	$400 m	3.7%
B	$10.5 B	$9.4 B	68%	$1200	$600 m	5.8%
C	$9.5 B	$8.7 B	68%	$1200	$500 m	5.5%

ARC Estimates of Kids-Only Health Insurance Proposals

50% Employer Contribution Requirement

Scenario 1: Full Subsidy<133% Poverty, Partial Subsidy to 250% Poverty (Fall '94 Proposal)

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 50% participation for those from 133% to 250% poverty
Case B had 25% participation for those from 133% to 250% poverty
Case C had 10% participation for those from 133% to 250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 1	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1300	9.1 m	36%	2.8 m	0.4 m	1.1 m	3.2 m	1.1 m	0.4 m
B	$1300	7.9 m	33%	2.3 m	0.3 m	1.1 m	3.2 m	0.5 m	0.4 m
C	$1300	7.2 m	30%	1.9 m	0.2 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$11.7 B	$10.5 B	68%	$1100	$400 m	3.5%
B	$10.4 B	$9.4 B	68%	$1200	$540 m	5.5%
C	$9.4 B	$8.7 B	68%	$1200	$460 m	5.2%

ARC Estimates of Kids-Only Health Insurance Proposals

0% Employer Contribution Requirement

Scenario 1: Full Subsidy<133% Poverty, Partial Subsidy to 250% Poverty (Fall '94 Proposal)

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

- Case A had 50% participation for those from 133% to 250% poverty
- Case B had 25% participation for those from 133% to 250% poverty
- Case C had 10% participation for those from 133% to 250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

- Case A assumed those under 200% poverty come in at 10% participation
- Case B assumed those under 200% poverty come in at 5% participation
- Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 1	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1300	9.3 m	37%	2.8 m	0.6 m	1.1 m	3.2 m	1.1 m	0.4 m
B	$1300	8.0 m	34%	2.3 m	0.4 m	1.1 m	3.2 m	0.5 m	0.4 m
C	$1300	7.2 m	31%	1.9 m	0.3 m	1.1 m	3.2 m	0.3 m	0.4 m

	Financing					
Scenario 1	Total Cost	Federal Share	% Premium Subsidized for Partials	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$12.0 B	$10.6 B	68%	$1100	$400 m	3.7%
B	$10.5 B	$9.4 B	68%	$1200	$600 m	5.8%
C	$9.5 B	$8.7 B	68%	$1200	$500 m	5.5%

Hasselbeck

Andie King Proposals -- Summary Cost Estimates

Medium Participation Assumption (Case B), Low Subsidy (Scenario 2) and High Subsidy (Scenario 3)

					Participants - Coverage Prior to Program					
		Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
0% Emp Contribution	Low subsidy	$1800	2.3 m	24%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
	High subsidy	$1600	4.4 m	19%	0.6 m	0.2 m	2.5 m	0.00	0.5 m	0.5 m
50% Emp Contribution	Low subsidy	$1800	2.3 m	23%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
	High subsidy	$1600	4.4 m	18%	0.6 m	0.2 m	2.5 m	0.00	0.5 m	0.5 m

		Financing					
		Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
0% Emp Contribution	Low Subsidy	$4.3 B	$1.0 B	22%	$440	$1.4 B	49%
	High Subsidy	$6.9 B	$2.9 B	46%	$660	$1.4 B	25%
50% Emp Contribution	Low Subsidy	$4.2 B	$1.0 B	22%	$440	$1.3 B	47%
	High Subsidy	$6.8 B	$2.8 B	46%	$660	$1.3 B	24%

Scenario 2: 25% Subsidy up to 250% Poverty, 10% Subsidy for 250% Poverty and Above
(Scenarios 2 and 3 taken together are based upon Andie King's parameters)

0% Employer Contribution Requirement

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:
Case A had 20% participation for those <250% poverty, 10%participation for >=250% poverty
Case B had 10% participation for those <250% poverty, 5%participation for >=250% poverty
Case C had 5% participation for those <250% poverty, 2.5%participation for >=250% poverty
If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:
Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 2	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1700	3.4 m	33%	0.8 m	0.3 m	1.2 m	0.00	1.1 m	0.00
B	$1800	2.3 m	24%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
C	$1900	1.8 m	17%	0.2 m	0.09 m	1.2 m	0.00	0.3 m	0.00

	Financing					
Scenario 2	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$5.9 B	$1.4 B	22%	$410	$1.6 B	38%
B	$4.3 B	$1.0 B	22%	$440	$1.4 B	49%
C	$3.4 B	$0.8 B	22%	$450	$1.2 B	54%

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

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 30% participation for those <250% poverty, 15%participation for >=250% poverty
Case B had 15% participation for those <250% poverty, 7.5%participation for >=250% poverty
Case C had 7.5% participation for those <250% poverty, 3.75%participation for >=250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 3	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1500	5.8 m	29%	1.3 m	0.4 m	2.5 m	0	1.1 m	0.5 m
B	$1600	4.4 m	19%	0.6 m	0.2 m	2.5 m	0	0.5 m	0.5 m
C	$1600	3.7 m	11%	0.3 m	0.1 m	2.5 m	0	0.3 m	0.5 m

	Financing					
Scenario 3	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$8.6 B	$3.7 B	46%	$640	$1.3 B	19%
B	$6.9 B	$2.9 B	46%	$660	$1.4 B	25%
C	$6.0 B	$2.5 B	46%	$670	$1.3 B	29%

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

(Scenarios 2 and 3 taken together are based upon Andie King's parameters)

50% Employer Contribution Requirement

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 20% participation for those <250% poverty, 10%participation for >=250% poverty
Case B had 10% participation for those <250% poverty, 5%participation for >=250% poverty
Case C had 5% participation for those <250% poverty, 2.5%participation for >=250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 2	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1700	3.3 m	31%	0.8 m	0.2 m	1.2 m	0.00	1.1 m	0.00
B	$1800	2.3 m	23%	0.4 m	0.1 m	1.2 m	0.00	0.5 m	0.00
C	$1900	1.8 m	16%	0.2 m	0.06 m	1.2 m	0.00	0.3 m	0.00

	Financing					
Scenario 2	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$5.7 B	$1.4 B	22%	$400	$1.5 B	36%
B	$4.2 B	$1.0 B	22%	$440	$1.3 B	47%
C	$3.3 B	$0.8 B	22%	$450	$1.1 B	51%

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

Assumptions:
The cases represent high, medium, and low participation levels: A=high, B=medium, C=low
For the uninsured:

Case A had 30% participation for those <250% poverty, 15%participation for >=250% poverty
Case B had 15% participation for those <250% poverty, 7.5%participation for >=250% poverty
Case C had 7.5% participation for those <250% poverty, 3.75%participation for >=250% poverty

If had Medicaid, and subsidy was 100%, then persons above federal floor come in, else no one
If had other private insurance, if subsidy >20%, then 80% come in
If had ESI, self-employed, if subsidy >28%, then 90% come in
If had ESI:

Case A assumed those under 200% poverty come in at 10% participation
Case B assumed those under 200% poverty come in at 5% participation
Case C assumed those under 200% poverty come in at 2.5% participation

				Participants - Coverage Prior to Program					
Scenario 3	Avg Cost	Total takeup	%Unins in Prog	Unins	Unins Offd ESI	Other Private	Medicaid (Sub)	ESI (Sub)	ESI Self-emp
A	$1500	5.7 m	28%	1.3 m	0.3 m	2.5 m	0	1.1 m	0.5 m
B	$1600	4.4 m	18%	0.6 m	0.2 m	2.5 m	0	0.5 m	0.5 m
C	$1600	3.7 m	11%	0.3 m	0.08 m	2.5 m	0	0.3 m	0.5 m

	Financing					
Scenario 3	Total Cost	Federal Share	% Premium Subsidized	Subsidy/ Person	Cost due to Adv Sel	Selection Impact
A	$8.4 B	$3.6 B	46%	$640	$1.3 B	18%
B	$6.8 B	$2.8 B	46%	$660	$1.3 B	24%
C	$5.9 B	$2.4 B	46%	$670	$1.2 B	27%

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. While the lower end of the ranges incorporates the assumption that participants would be required to join a special risk pool (which limits substitution), the upper end of the ranges given above incorporate the assumption that subsidies can be applied to current coverage. In this later case, the average premium reflects an average across more than one risk pool. Premiums in the "special" risk pool would likely be substantially higher than the high end of the range. The other risk pools would include individuals not in the subsidy program.

- These estimates assume that the subsidies are 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 participation of the currently uninsured 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 provided by ARC, 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.

Natalie Ong -

226-0938

ALLIANCE FOR HEALTH CARE REFORM:

BRIEFING ON CHILDREN'S HEALTH CARE

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August, 1996

TABLE V-1. FEDERALLY FUNDED AND ADMINISTERED VOLUNTARY MODELS

Voluntary model	Federally administered public benefit program	Individual insurance subsidies	Individual and employer insurance subsidies	MSA-style individual health care subsidies
General description	•**Model**: Government-administered defined benefit program for children which would replace Medicaid pediatric provisions. Available to any uninsured pregnant woman or child without insurance. Federally administered. •**Source of financing:** General revenues, payroll contributions from employers that do not provide subsidized family coverage.	•**Model**: Insurance subsidies for children. Could supplement or replace Medicaid. Tax credit or vouchers which could be used to pay family portion of employer-based premium or purchase coverage through certified health plans in the case of individuals without employer coverage access. •**Source of financing:** General and dedicated revenues; assessment on employers that do not subsidize family coverage.	•**Model:** Employer subsidies to employers for family coverage plus individual subsidies for workers and unemployed. Could supplement or replace Medicaid. •**Source of financing**: General and dedicated revenues.	•**Model**: Medical savings accounts system of direct funding plus catastrophic coverage. Could supplement or replace Medicaid. •**Source of financing**: General federal revenues plus contributions from employers that do not offer dependent coverage.
Similar models	•No similar legislative models.	•Bush Proposal- 102nd Cong. (1992) -refundable tax credit for low income workers; vouchers for unemployed. •Santorum (H.R. 3918 , 103rd Cong.) and Gramm (S. 3918, 103rd Cong) - refundable tax credit for catastrophic insurance for individuals ineligible for Medicare or Medicaid. •Bentsen health insurance tax (additional component to basic EITC) adopted in OBRA 1990 and repealed in OBRA, 1993. •McCain (S. 28, 103rd Cong.) - refundable tax credit for health insurance expenses for children in families below 200% of poverty; credit can be used only for school-based health programs (see also S. 2347, 102nd Cong.). •McConnell, (S. 728, 103rd Cong.) - tax credits for purchase of health insurance, including long-term care policies. •Cohen (S. 314, 102d Cong.) - refundable tax credit for health insurance for individuals not covered under employer plans or Medicare; Federal grants for state risk pools for uninsurables.	•Cooper (H.R. 3222, 103rd Cong.) and Breaux (S. 1579, 103rd Cong); employer tax deductions for certain forms of group insurance coupled with subsidies for low-income individuals. •Tax deduction for self-employed individuals - P.L. 104-7)restoring the deduction to 25% in 1994 and increasing it to 30% thereafter)(see also Chandler (H.R. 2453, 102nd Cong.); Rostenkowski (H.R. 3626, 102nd Cong.); Michel (H.R. 3080, 103rd Cong.); Lott (S. 1533, 103rd Cong.) - all increasing the deduction for self-employed individuals to 100%). •Rowland/Bilirakis (H.R. 3955, 103rd Cong.) - subsidies to employers and individuals for purchase of private plans.	•H.R. 2491 (104th Cong.) creating MSA option under Medicare. •Archer (H.R. 1818, 104th Cong.) - allows tax-advantaged MSAs for individuals covered by catastrophic health insurance plans. •Hastert (H.R. 150, 103rd Cong.) - allows tax deduction for MSA/catastrophic health insurance plans. •Jacobs (H.R. 3065, 103rd Cong.) - allows tax-free employer contributions to MSA/ catastrophic plans.

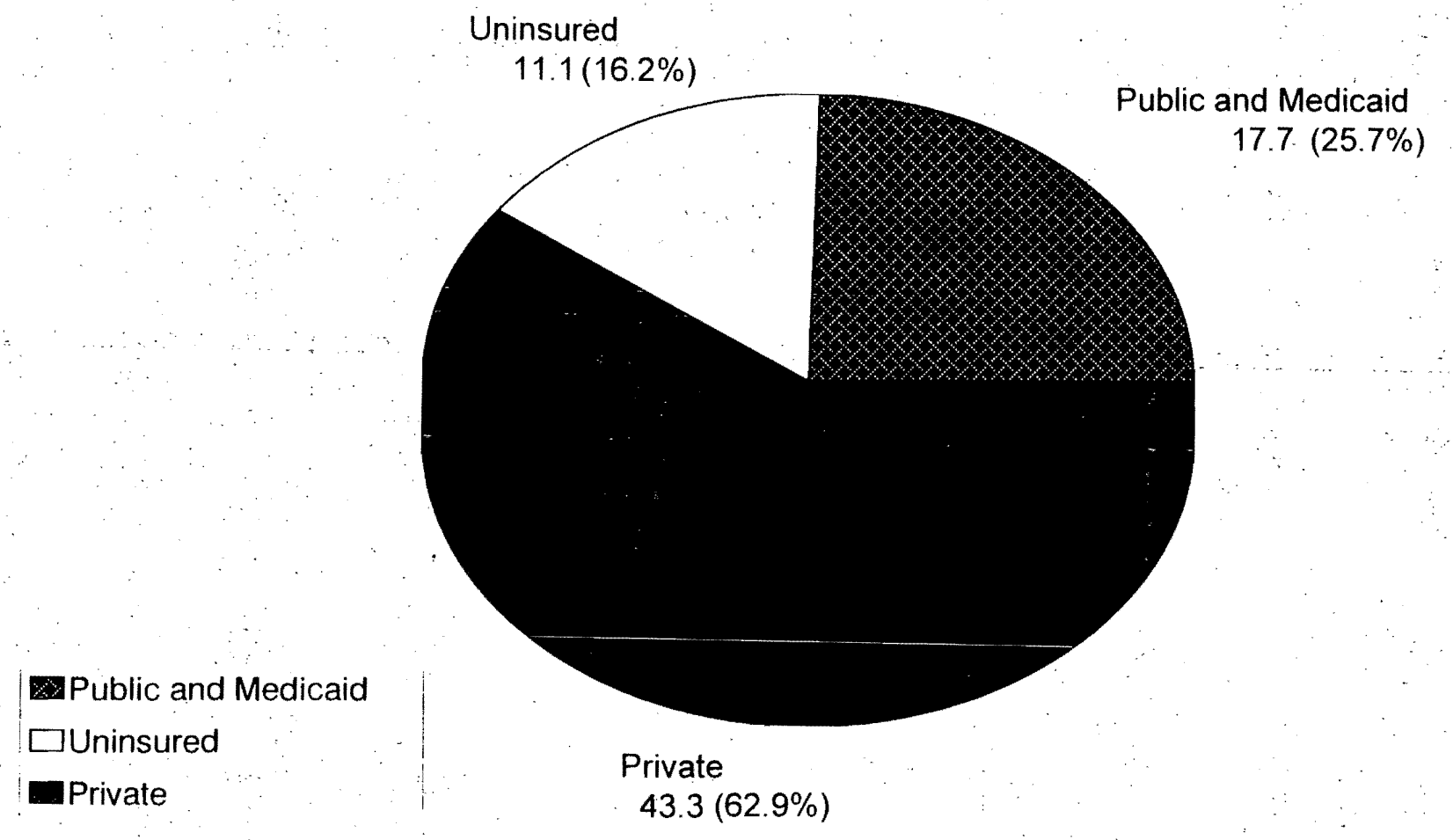
M-1. MANDATORY MODELS

Mandatory Model	Federally mandated government insurance	Federally mandated employer-based insurance	Federal mandate for individuals	State mandated, federally assisted in states that elect to adopt a mandate
General description	•**Model**: Universal coverage of all children under government insurance offering defined benefit package. Either federally financed and either federally or state administered. •**Financing:** General revenues, employer contributions, other revenues, and potentially individual premiums . In state administered model, states would contribute toward cost of coverage.	•**Model**: Universal employer coverage of all children; supplemental federally or state administered plan for persons without access to employer coverage. Model could be defined benefit or defined contribution, employer mandate or "pay or play." •**Financing:** General revenues, special taxes, individual premiums, state contributions toward cost of coverage for individuals without access to employer plans.	•**Model:** Universal coverage of all children. Through individual subsidies and compulsory enrollment. Subsidies up to a defined contribution level in the form of either vouchers or tax credits. Individuals could elect MSA-type coverage. •**Financing:** General revenues, special taxes, and individual payments.	•**Model**: state mandate meeting minimum federal requirements (state public insurance plan, state employer based system, individual mandate, or other state system of compulsory coverage). Federal waiver of ERISA preemption and federal subsidies toward cost of coverage. •**Financing:** State revenues, employer contributions (at state option) federal general and dedicated revenues.
Similar models	•Medicare. •Russo (H.R. 1300, 102nd Cong.) - single payer. •McDermott (H.R. 1200, 103rd Cong.) and Wellstone (S. 491, 103rd Cong.) - single payer. •Dingell/Waxman (H.R. 5514, 102d Cong.) and Kerry (S. 1446, 102d Cong.) - universal public program for all U.S. residents. •Ford (H.R. 5050, 102d Cong.) - MediKids: children only. •Stark (H.R. 650, 102d Cong.) - Medicare for all. •Gibbons (H.R. 1777, 102d Cong.) - Medicare for all. •Dodd (S. 1456, 103rd Cong.) - program under Public Health Service Act for children.	•H.R. 3600/S. 1751 (Clinton Health Security Act, 103rd Cong.). •Pepper Commission ("pay or play") H.R. 2523 and (Waxman, 102nd Cong.); S. 1177 (Rockefellar, 102nd Cong.). •Jackson Hole Group •Kennedy (S. 768, 101st Cong.); Waxman (H.R. 1845, 101st Cong.) - "pay or play." •Matsui (H.R. 3393, 102d Cong.) - employer mandate for children. •Matsui (H.R. 727, 103rd Cong.) - employer mandate for children. •Chafee (S. 1770, 103rd Cong.) - individual mandate; employers required to offer coverage but not pay.	•Thomas (H.R. 3704, 103rd Cong.); individual entitlement though mandatory enrollment in private plans offered by purchasing cooperatives. •Sterns (H.R. 3698, 103rd Cong.) And Nickles (S. 1743, 103rd Cong.); described as voluntary, but in essence mandatory because of heavy financial penalties for failure to enroll. •Sterns (H.R. 1424, 104th Cong.) - individuals required to purchase health insurance through plan meeting federal standards; refundable tax credit; tax credit for establishing of MSA.	•Garamendi proposal (universal coverage implemented as state level; one HIPC per geographic area; Medicaid & Medicare (if appropriate waivers granted) folded in. •Hawaii (basic coverage plus QUEST, including Section 1115 waiver). •Kerry (S. 1446, 102d Cong.). •Jeffords (S. 1057, 103rd Cong.).

TABLE V-2. FEDERALLY ASSISTED, STATE ADMINISTERED VOLUNTARY MODELS

Voluntary Model	Federal grants to states for the provision, or purchase, of a defined benefit style insurance program for pregnant women and children	Federal grants to states for development and administration of a defined contribution-style insurance program for pregnant women and children	Federal grants to states for subsidized health services for pregnant women and children
General overview	•Federal grants to states to assist in the cost of defined benefit-style insurance program for eligible categories of children. Federal payments conditioned on state compliance with federal standards regarding coverage, benefits, premiums and cost-sharing. •**Financing:** Federal contributions toward state expenditures.	•Federal grants to states to assist in the cost of a defined contribution-style insurance program for children. Federal rules on eligibility, with broad benefit guidelines. •**Financing:** Federal contributions toward state expenditures, with lower level of state contribution required.	•Federal grants to assist states furnish medical care for children. Care may be in the form of insurance, MSAs, direct grants to providers, or assistance to local units of government . No federal rules other than broad targeting to children. •**Financing:** Federal contributions toward state expenditures, with a lower level of state contribution required than under Medicaid.
Similar models	•Medicaid. •President Clinton's December, 1995, Medicaid proposal. •Chafee (S. 1139, 100th Cong.) -states would have option of extending Medicaid coverage to individuals with incomes up to 200% of poverty. •Health Insurance Association of America (1989) - states would have the option of allowing all individuals with family incomes above 100% but below 150% of poverty to buy into Medicaid .	•NGA Medicaid proposal. •Child Health Plus, state subsidized insurance program (such as Caring programs), Connecticut Healthy Steps, Florida Healthy Kids, Washington Basic Health Plan.	•MediGrant. •Title V Maternal and Child Health Block Grant.

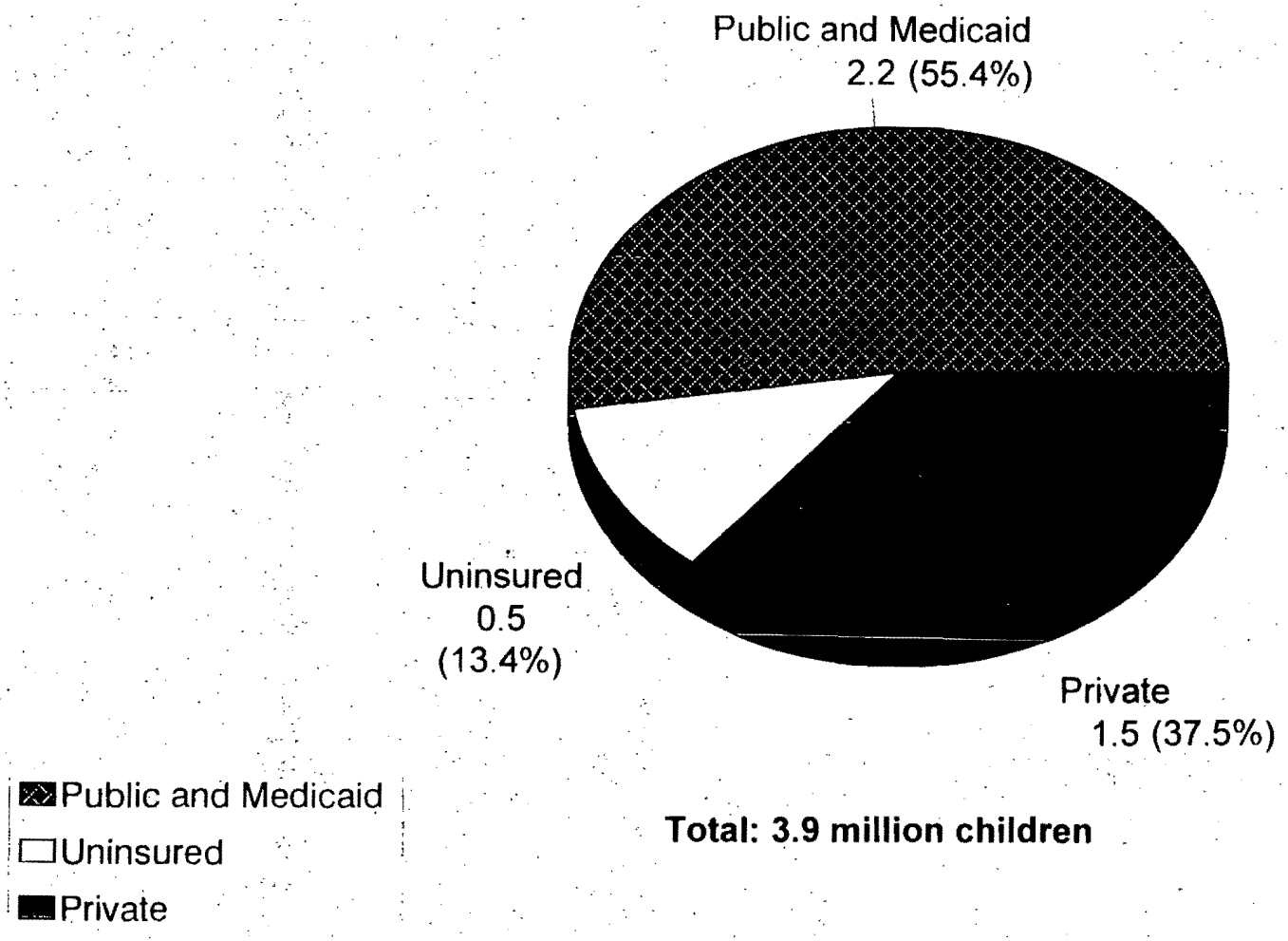
1. Health Insurance Status, Children Under Age 18: In Millions (and by percent), 1993*



Total: 68.8 million children

*Number of children by insured status may be greater than total number of children as a result of dual coverage.
Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

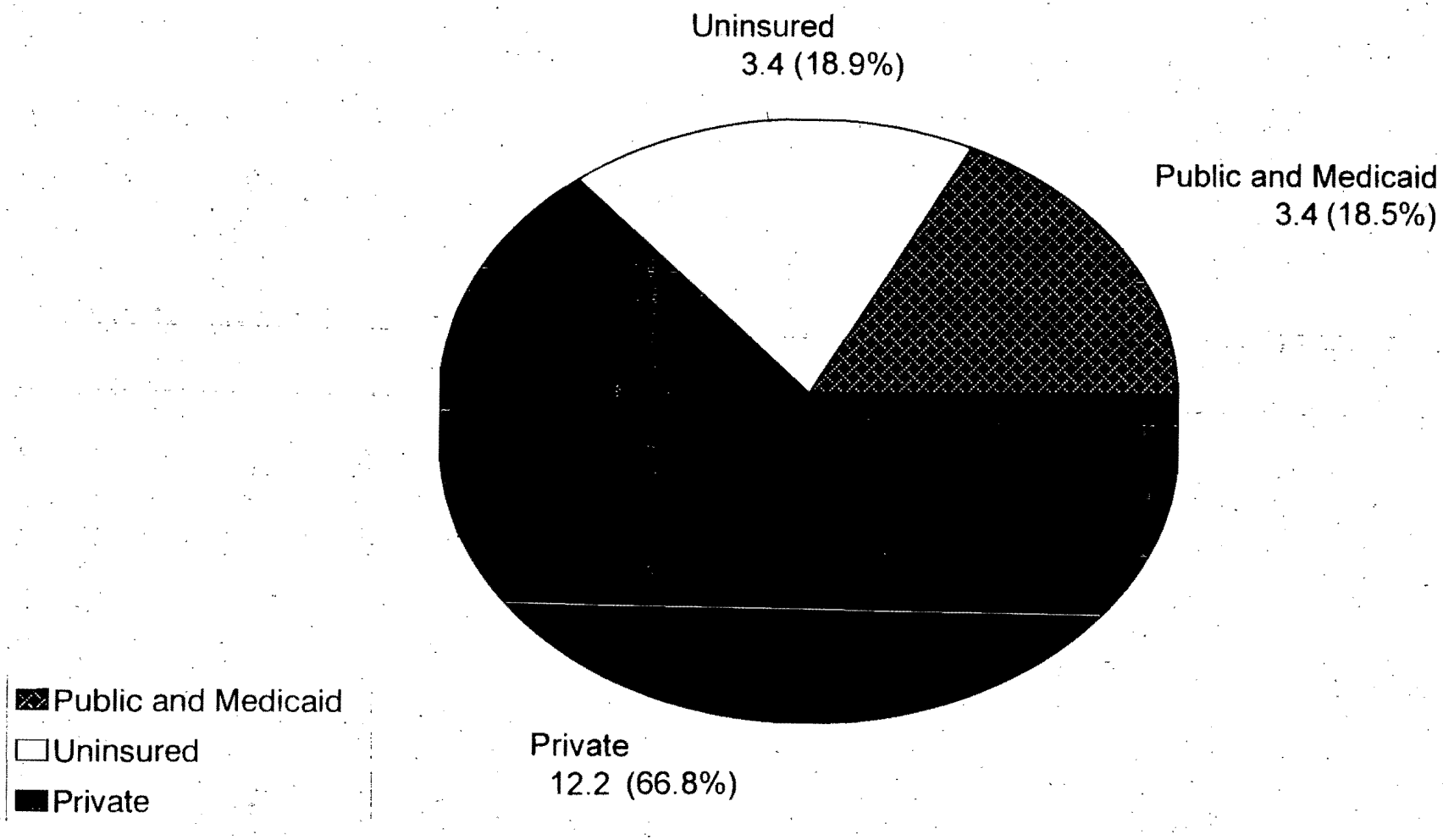
1a. Health Insurance Status, Children Under One Year: In Millions (and by percent), 1993*



Total: 3.9 million children

*Number of children by insured status may be greater than total number of children as a result of dual coverage.
Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

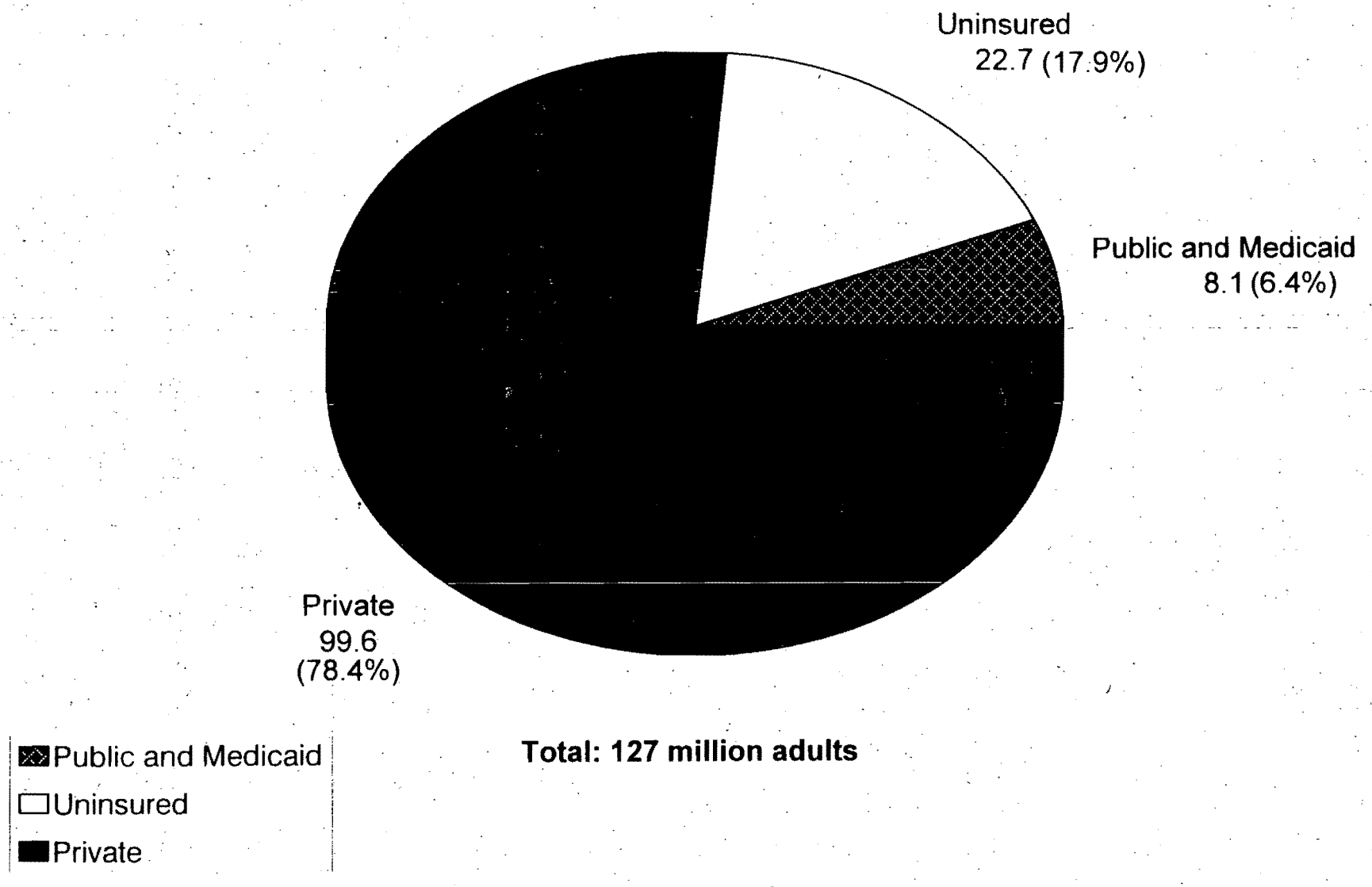
1b. Health Insurance Status, Children Ages 13-17: In Millions (and by percent), 1993*



Total: 29 million children

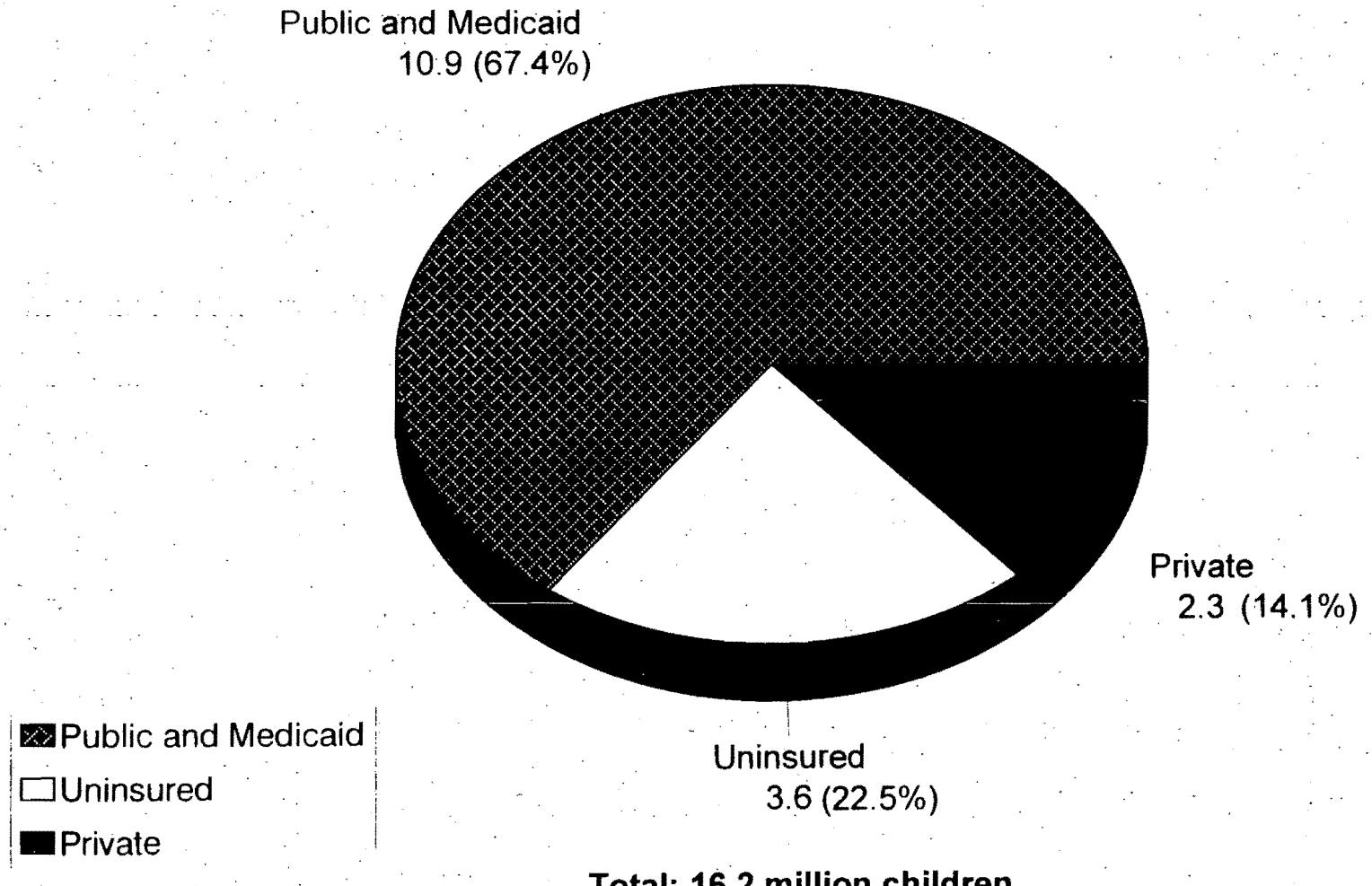
*Number of children by insured status may be greater than total number of children as a result of dual coverage.
Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

1c. Source of Coverage for Adults, Age 18-64 with Selected Sources of Health Insurance: In Millions (and by percent), 1993*



*Health insurance totals may not add up to total number of adults as a result of dual coverage.
Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

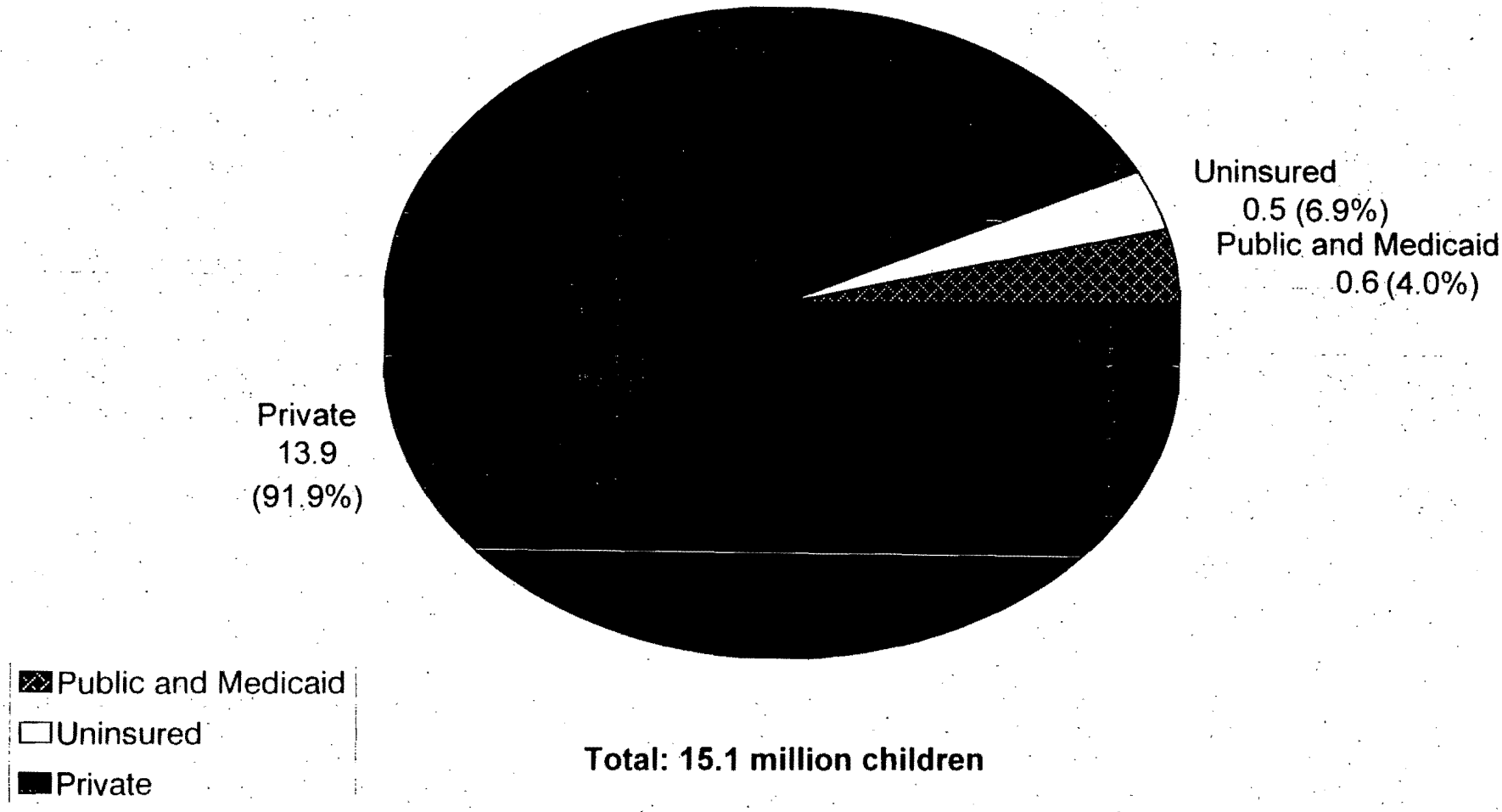
1d. Health Insurance Status, Children with Family Incomes under 100% of the Federal Poverty Level: In Millions (and by percent), 1993*



Total: 16.2 million children

* Number of children by insured status may be greater than total number of children as a result of dual coverage.
Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

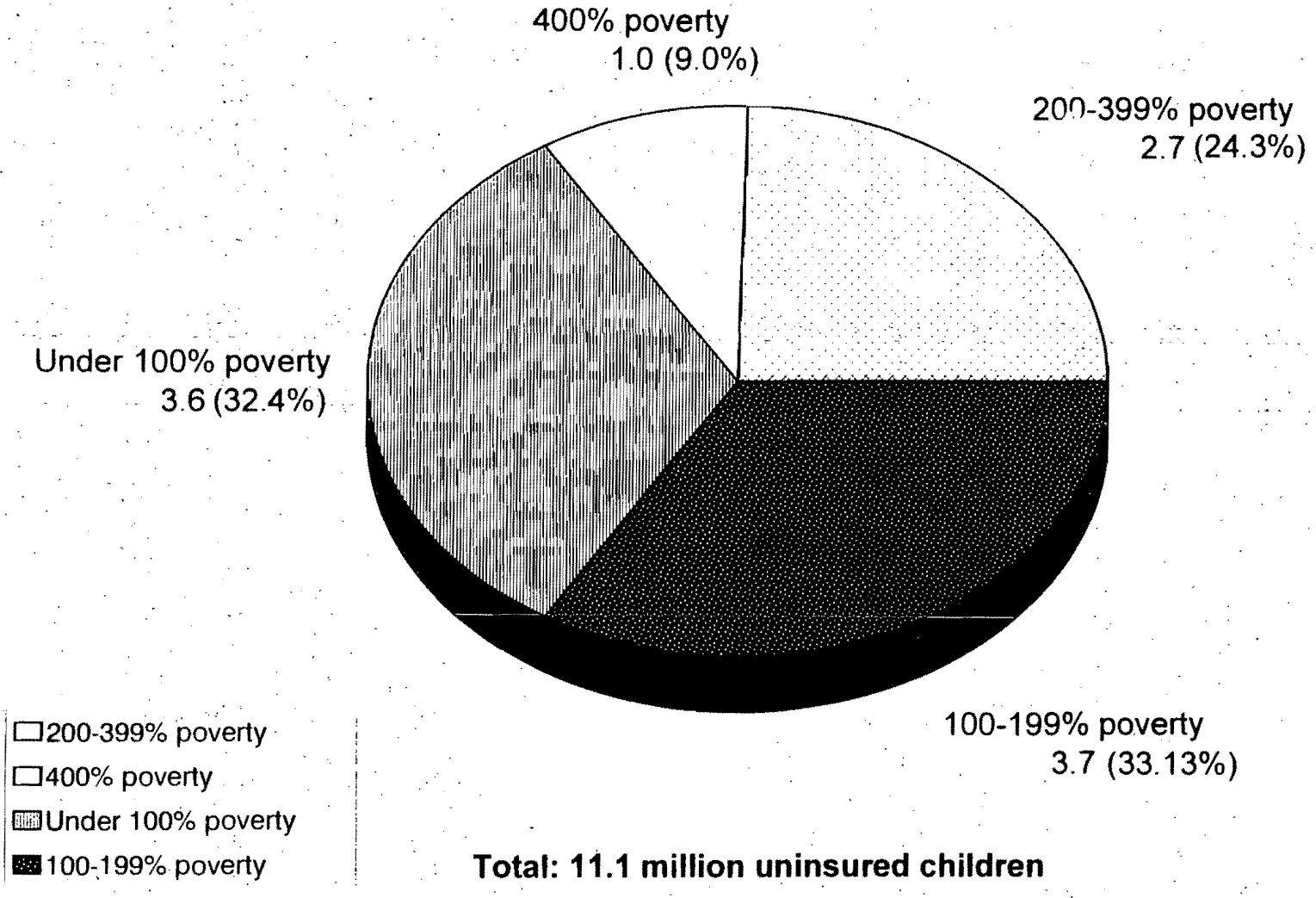
1e. Health Insurance Status, Children with Family Incomes Four Hundred Percent of the Federal Poverty Level or Greater: In Millions (and by percent), 1993*



Total: 15.1 million children

* Number of children by insured status may be greater than total number of children as a result of dual coverage.
Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

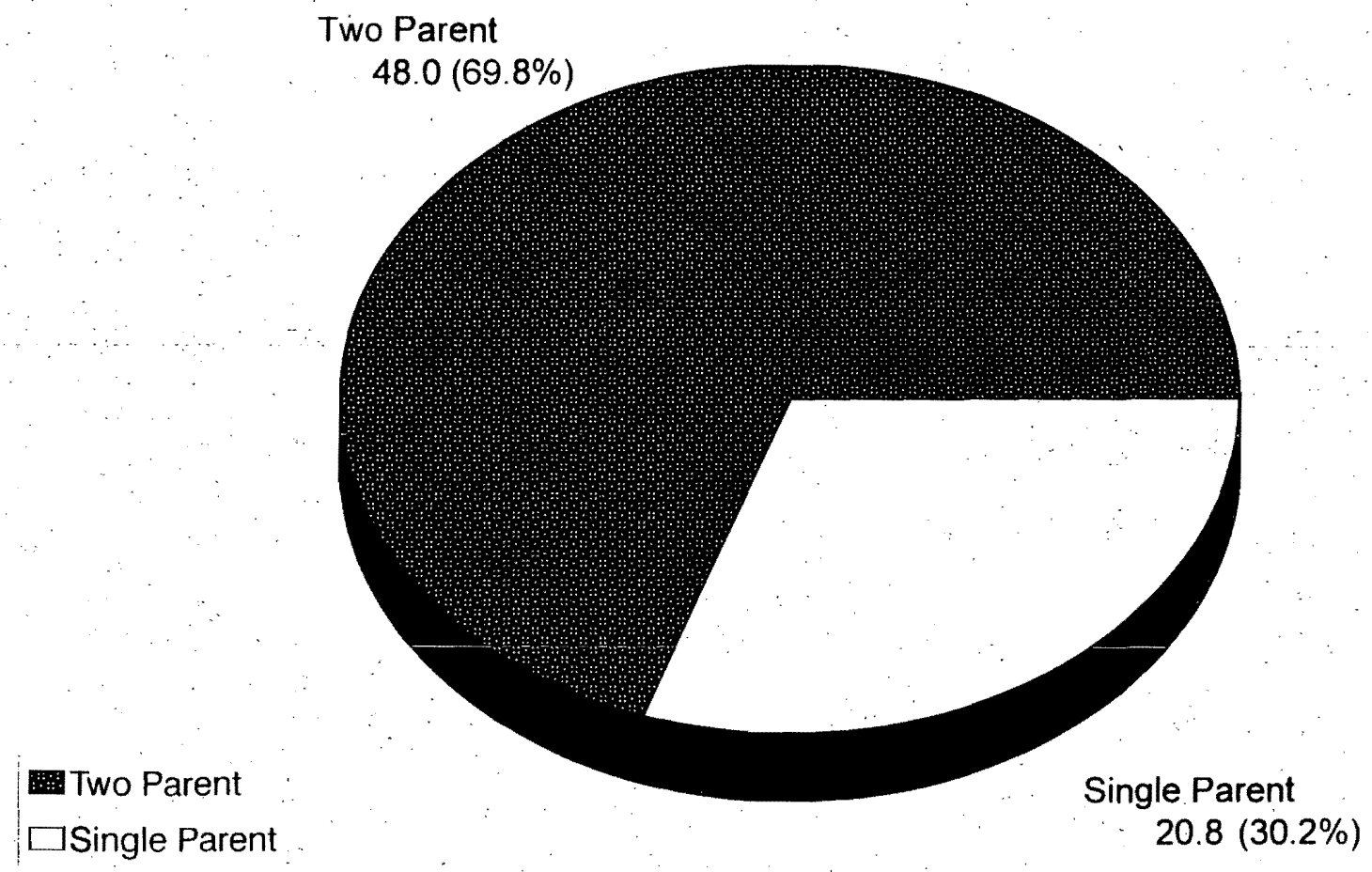
2. Family Income Distribution of Uninsured Children Under 18: In Millions (and by percent), 1993



Total: 11.1 million uninsured children

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

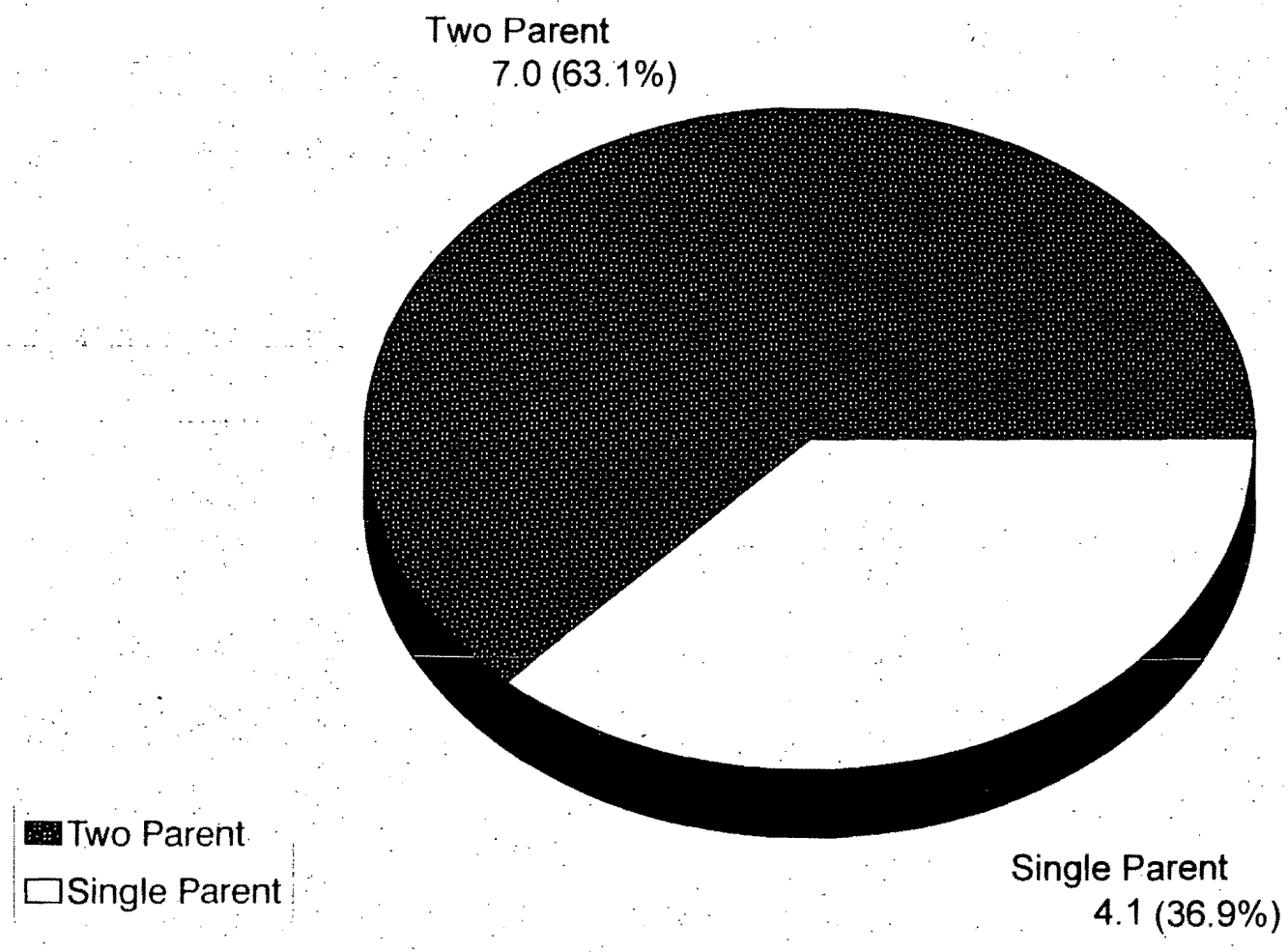
3a. Living Arrangements of Children Under Age 18: In Millions (and by percent), 1993



Total: 68.8 million chilren

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

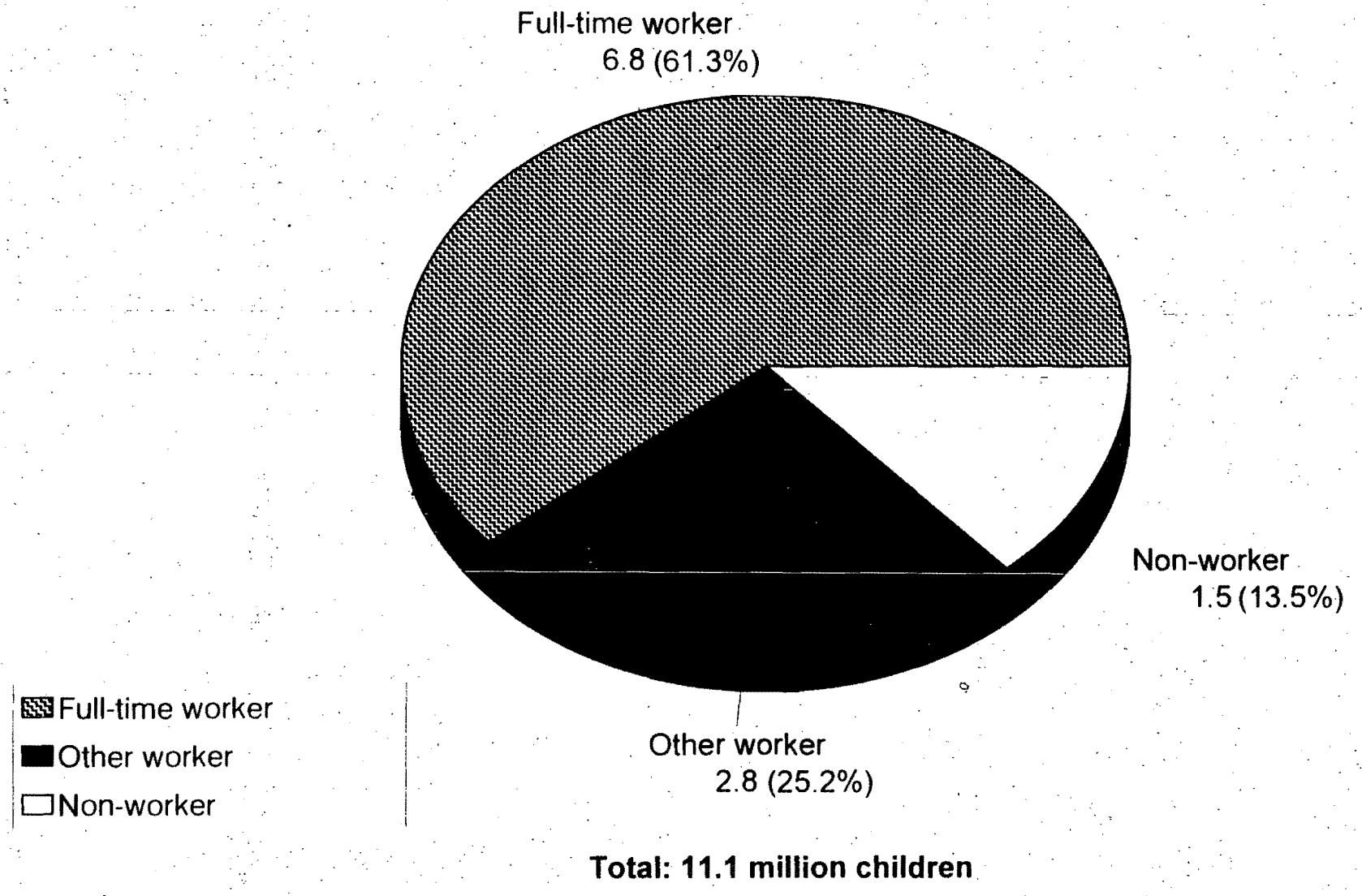
3b. Living Arrangements, Uninsured Children Under Age 18: In Millions (and by percent), 1993



Total: 11.1 million children

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

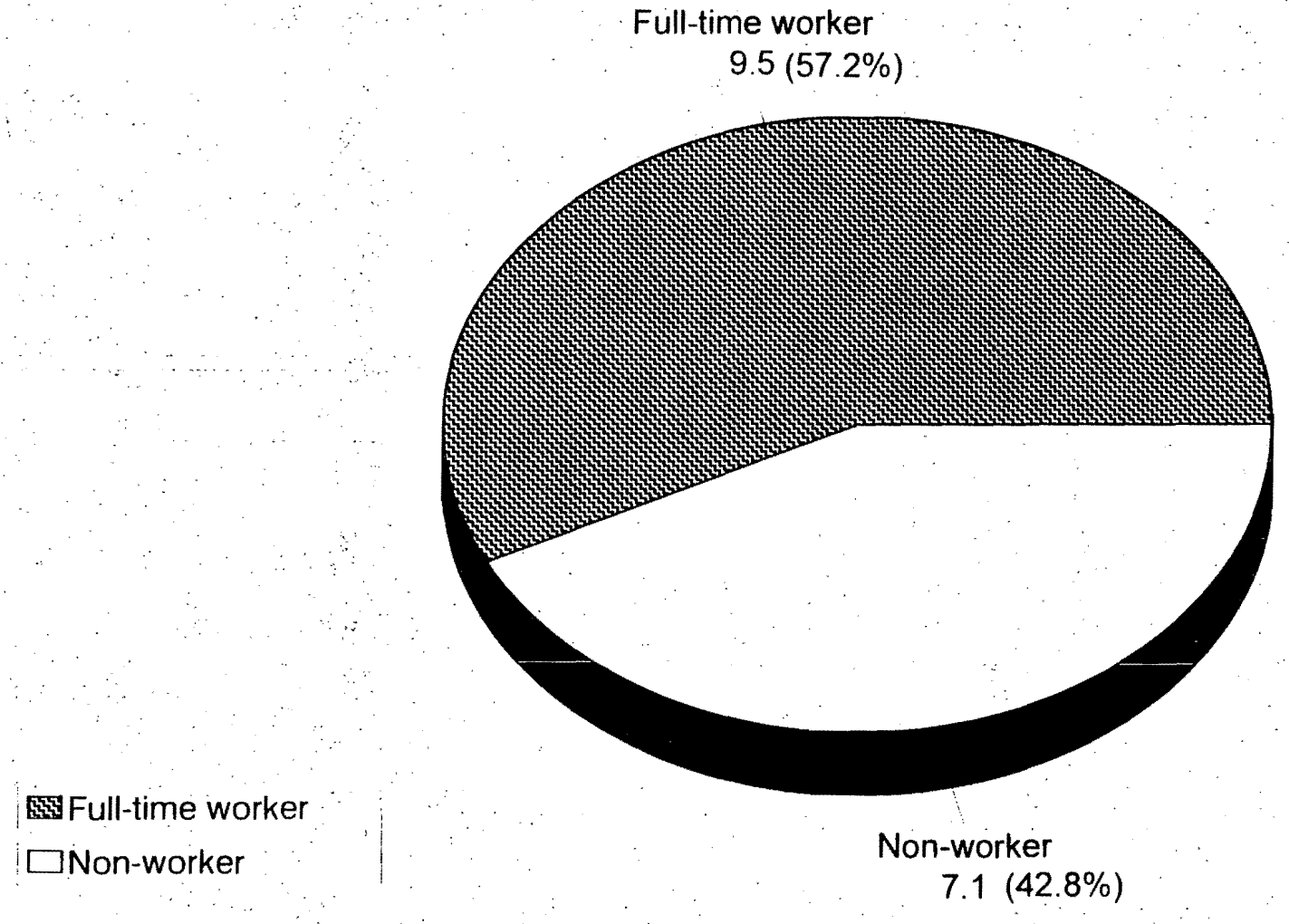
4a. Employment Status of Family Head, Uninsured Children: In Millions (and by percent), 1993



Total: 11.1 million children

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

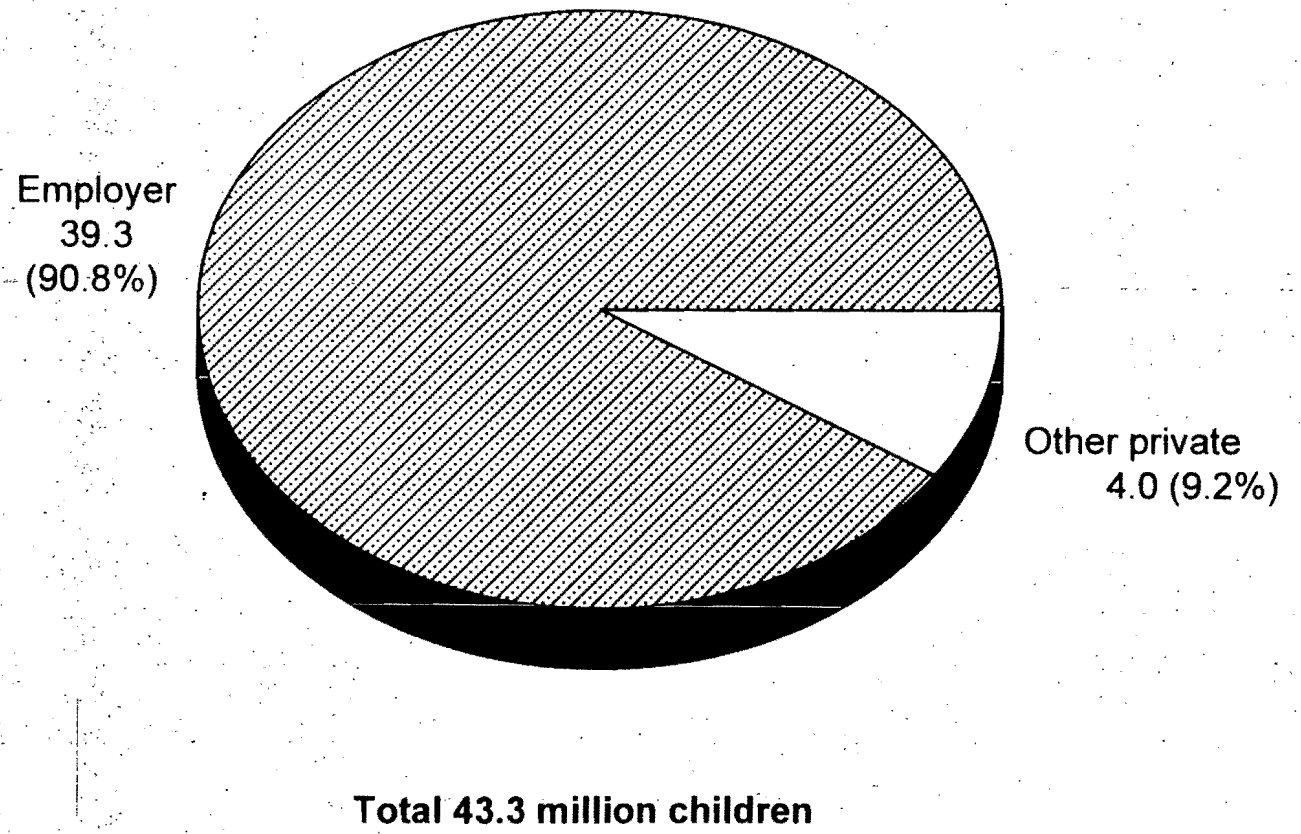
4b. Employment Status of Family Head, Children with Medicaid: In millions (and by percent), 1993



Total 16.6 million children

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

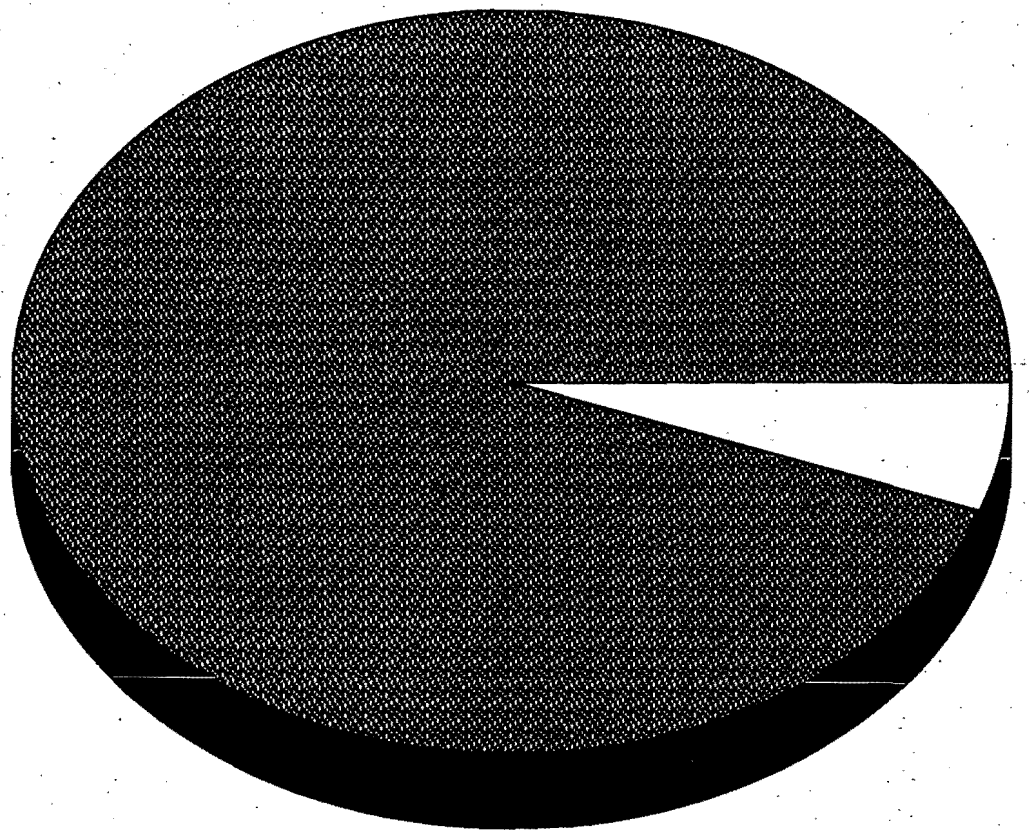
5. Source of Private Insurance for Children Under 18: In Millions (and by percent), 1993



Total 43.3 million children

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

6. Source of Private Insurance, Children Under 18: Inside versus Outside Household: In millions (and by percent), 1993



Total privately insured children: 43.3 million

Source: March, 1994, Current Population Survey; Calculations by the Employee Benefit Research Institute (EBRI)

TABLE V-1. FEDERALLY FUNDED AND ADMINISTERED VOLUNTARY MODELS

Voluntary model	Federally administered public benefit program	Individual insurance subsidies	Individual and employer insurance subsidies	MSA-style individual health care subsidies
General description	•**Model**: Government-administered defined benefit program for children which would replace Medicaid pediatric provisions. Available to any uninsured pregnant woman or child without insurance. Federally administered. •**Source of financing**: General revenues, payroll contributions from employers that do not provide subsidized family coverage.	•**Model**: Insurance subsidies for children. Could supplement or replace Medicaid. Tax credit or vouchers which could be used to pay family portion of employer-based premium or purchase coverage through certified health plans in the case of individuals without employer coverage access. •**Source of financing**: General and dedicated revenues; assessment on employers that do not subsidize family coverage.	•**Model**: Employer subsidies to employers for family coverage plus individual subsidies for workers and unemployed. Could supplement or replace Medicaid. •**Source of financing**: General and dedicated revenues.	•**Model**: Medical savings accounts system of direct funding plus catastrophic coverage. Could supplement or replace Medicaid. •**Source of financing**: General federal revenues plus contributions from employers that do not offer dependent coverage.
Similar models	•No similar legislative models.	•Bush Proposal- 102nd Cong. (1992) -refundable tax credit for low income workers; vouchers for unemployed. •Santorum (H.R. 3918 ; 103rd Cong.) and Gramm (S. 3918, 103rd Cong) - refundable tax credit for catastrophic insurance for individuals ineligible for Medicare or Medicaid. •Bentsen health insurance tax (additional component to basic EITC) adopted in OBRA 1990 and repealed in OBRA, 1993. •McCain (S. 28, 103rd Cong.) - refundable tax credit for health insurance expenses for children in families below 200% of poverty; credit can be used only for school-based health programs (see also S. 2347, 102nd Cong.). •McConnell, (S. 728, 103rd Cong.) - tax credits for purchase of health insurance, including long-term care policies. •Cohen (S. 314, 102d Cong.) - refundable tax credit for health insurance for individuals not covered under employer plans or Medicare. Federal grants for state risk pools for uninsurables.	•Cooper (H.R. 3222, 103rd Cong.) and Breaux (S. 1579, 103rd Cong); employer tax deductions for certain forms of group insurance coupled with subsidies for low-income individuals. •Tax deduction for self-employed individuals - P.L. 104-7)restoring the deduction to 25% in 1994 and increasing it to 30% thereafter)(see also Chandler (H.R. 2453, 102nd Cong.); Rostenkowski (H.R. 3626, 102nd Cong.); Michel (H.R. 3080, 103rd Cong.); Lott (S. 1533, 103rd Cong.) - all increasing the deduction for self-employed individuals to 100%). •Rowland/Bilirakis (H.R. 3955, 103rd Cong.) - subsidies to employers and individuals for purchase of private plans.	•H.R. 2491 (104th Cong.) creating MSA option under Medicare. •Archer (H.R. 1818, 104th Cong.) - allows tax-advantaged MSAs for individuals covered by catastrophic health insurance plans. •Hastert (H.R. 150, 103rd Cong.) - allows tax deduction for MSA/catastrophic health insurance plans. •Jacobs (H.R. 3065, 103rd Cong.) - allows tax-free employer contributions to MSA/ catastrophic plans.

TABLE V-2. FEDERALLY ASSISTED, STATE ADMINISTERED VOLUNTARY MODELS

Voluntary Model	Federal grants to states for the provision, or purchase, of a defined benefit style insurance program for pregnant women and children	Federal grants to states for development and administration of a defined contribution-style insurance program for pregnant women and children	Federal grants to states for subsidized health services for pregnant women and children
General overview	•Federal grants to states to assist in the cost of defined benefit-style insurance program for eligible categories of children. Federal payments conditioned on state compliance with federal standards regarding coverage, benefits, premiums and cost-sharing. •**Financing**: Federal contributions toward state expenditures.	•Federal grants to states to assist in the cost of a defined contribution-style insurance program for children. Federal rules on eligibility, with broad benefit guidelines. •**Financing**: Federal contributions toward state expenditures, with lower level of state contribution required.	•Federal grants to assist states furnish medical care for children. Care may be in the form of insurance, MSAs, direct grants to providers, or assistance to local units of government. No federal rules other than broad targeting to children. •**Financing**: Federal contributions toward state expenditures, with a lower level of state contribution required than under Medicaid.
Similar models	•Medicaid. •President Clinton's December, 1995, Medicaid proposal. •Chafee (S. 1139, 100th Cong.) - states would have option of extending Medicaid coverage to individuals with incomes up to 200% of poverty. •Health Insurance Association of America (1989) - states would have the option of allowing all individuals with family incomes above 100% but below 150% of poverty to buy into Medicaid.	•NGA Medicaid proposal. •Child Health Plus, state subsidized insurance program (such as Caring programs), Connecticut Healthy Steps, Florida Healthy Kids, Washington Basic Health Plan.	•MediGrant. •Title V Maternal and Child Health Block Grant.

M-1. MANDATORY MODELS

Mandatory Model	Federally mandated government insurance	Federally mandated employer-based insurance	Federal mandate for individuals	State mandated, federally assisted in states that elect to adopt a mandate
General description	•**Model**: Universal coverage of all children under government insurance offering defined benefit package. Either federally financed and either federally or state administered. •**Financing**: General revenues, employer contributions, other revenues, and potentially individual premiums. In state administered model, states would contribute toward cost of coverage.	•**Model**: Universal employer coverage of all children, supplemental federally or state administered plan for persons without access to employer coverage. Model could be defined benefit or defined contribution, employer mandate or "pay or play." •**Financing**: General revenues, special taxes, individual premiums, state contributions toward cost of coverage for individuals without access to employer plans.	•**Model**: Universal coverage of all children. Through individual subsidies and compulsory enrollment. Subsidies up to a defined contribution level in the form of either vouchers or tax credits. Individuals could elect MSA-type coverage. •**Financing**: General revenues, special taxes, and individual payments.	•**Model**: state mandate meeting minimum federal requirements (state public insurance plan, state employer based system, individual mandate, or other state system of compulsory coverage). Federal waiver of ERISA preemption and federal subsidies toward cost of coverage. •**Financing**: State revenues, employer contributions (at state option) federal general and dedicated revenues.
Similar models	•Medicare. •Russo (H.R. 1300, 102nd Cong.) - single payer. •McDermott (H.R. 1200, 103rd Cong.) and Wellstone (S. 491, 103rd Cong.) - single payer. •Dingell/Waxman (H.R. 5514, 102d Cong.) and Kerry (S. 1446, 102d Cong.) - universal public program for all U.S. residents. •Ford (H.R. 5050, 102d Cong.) - MediKids: children only •Stark (H.R. 650, 102d Cong.) - Medicare for all. •Gibbons (H.R. 1777, 102d Cong.) - Medicare for all •Dodd (S. 1456, 103rd Cong.) - program under Public Health Service Act for children.	•H.R. 3600/S. 1751 (Clinton Health Security Act, 103rd Cong.). •Pepper Commission ("pay or play") H.R. 2523 and (Waxman, 102nd Cong.); S. 1177 (Rockefellar, 102nd Cong.). •Jackson Hole Group •Kennedy (S. 768, 101st Cong.); Waxman (H.R. 1845, 101st Cong.) - "pay or play." •Matsui (H.R. 3393, 102d Cong.) - employer mandate for children. •Matsui (H.R. 727, 103rd Cong.) - employer mandate for children. •Chafee (S. 1770, 103rd Cong.) - individual mandate; employers required to offer coverage but not pay.	•Thomas (H.R. 3704, 103rd Cong.); individual entitlement though mandatory enrollment in private plans offered by purchasing cooperatives. •Sterns (H.R. 3698, 103rd Cong.) And Nickles (S. 1743, 103rd Cong.); described as voluntary, but in essence mandatory because of heavy financial penalties for failure to enroll. •Sterns (H.R. 1424, 104th Cong.) - individuals required to purchase health insurance through plan meeting federal standards; refundable tax credit; tax credit for establishing of MSA.	•Garamendi proposal (universal coverage implemented as state level; one HIPC per geographic area, Medicaid & Medicare (if appropriate waivers granted) folded in. •Hawaii (basic coverage plus QUEST, including Section 1115 waiver). •Kerry (S. 1446, 102d Cong.). •Jeffords (S. 1057, 103rd Cong.).

TABLE C-1

Annual Premium Assistance for Low and Moderate Income Working Families under Selected Premium-Based Health Reform Proposals

Family Chooses Average-Priced Health Insurance Plan ($3,900)[1]

Poverty and Income Levels		Clinton/Gephardt/Mitchell HR 3600/S 1757					Thomas/Chafee HR 3704/S 1770					Cooper/Breaux HR 3222/S 1579				
Poverty Level	Family[2] Income[3]	Subsidy	Firm Pays	Plan Pays	Family Pays	% of Family Income	Subsidy[6]	Firm Pays	Plan Pays	Family Pays	% of Family Income	Subsidy[7]	Firm Pays[8]	Plan Pays	Family Pays	% of Family Income
100%	$11,890	$423	$3,120	$0	$357	3.0%	$3,900	$0	$0	0	0%	$3,510	$0	$390	$0	0%
130	15,457	177	3,120	0	603	3.9	3,064	0	0	836	5.4	2,457	0	273	1170	7.6
150	17,835	84	3,120	0	696	3.9	2,507	0	0	1,393	7.8	1,755	0	195	1950	10.9
180	21,402	0	3,120	0	780	3.6	1,671	0	0	2,229	10.4	702	0	78	3120	14.6
200	23,780	0	3,120	0	780	3.3	1,114	0	0	2,786	11.7	0	0	0	3900	16.4
250	29,725[4,5]	0	3,120	0	780	2.6	0	0	0	3,900	13.1	0	0	0	3900	13.1
300	35,670	0	3,120	0	780	2.2	0	0	0	3,900	10.9	0	0	0	3900	10.9
400	47,560	0	3,120	0	780	1.6	0	0	0	3,900	8.2	0	0	0	3900	8.2

[1] Based on CBO's estimate of the 1994 average premium cost ($4,095) of a health insurance plan for a one-adult family, deflated to 1993 dollars by assuming 5% growth in the medical component of the CPI

[2] Family of three; full-time working mother with two dependent children; not receiving AFDC or SSI

[3] Federal poverty guidelines for 1993; adjusted gross income

[4] Median income for all households in 1991 was $30,126, Statistical Abstract of the U.S., 1993; 61.6 million people are between 100 and 250% of poverty and 128.5 million people are between 250 and 400% of poverty, Analysis of the March 1993 Current Population Survey by The Urban Institute, Kaiser Commission on the Future of Medicaid

[5] 16.3 million uninsured or 43% are between 100 and 250% of poverty, Analysis of the March 1993 Current Population Survey by The Urban Institute, Kaiser Commission on the Future of Medicaid

[6] Assumes full phase-in of subsidy program

[7] Calculated assuming 90% national subsidy and reference premium is equal to average premium

[8] Assumes no voluntary employer contribution toward cost of premium