DRAFT DRAFT

Talking Points -- Child Health Initiatives
To Enhance Child/Family Health Coverage and Services

BACKGROUND

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

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

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

PROPOSED CHILD HEALTH INITIATIVES

The goal of the following proposals is to address incrementally the insurance and access needs of some 10 million uninsured children. Because there is no single reason why these children are uninsured, no single solution effectively and efficiently addresses the problem. These proposals also build on the knowledge that an insurance card alone does not insure access to quality care.

The proposals call for fulfilling the promise of our existing programs and building upon innovative state programs for uninsured children. They do not include federal subsidies to families with uninsured children because subsidies are generally costly, may require very high subsidy levels to attract the currently uninsured into a program, and may inadvertantly substitute for employer subsidized insurance.

These proposals also provide an opportunity to learn about the most effective ways to meet the needs of our children before embarking upon further expansions. They also allow states to design programs that best meet the needs of their children.

I. To Increase Coverage:

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

- Fulfill the promise of Medicaid for eligible children and working families who are already eligible for Medicaid to expand enrollment of Medicaid eligible children. An estimated 3 million children are currently eligible for Medicaid but not enrolled. This proposal assumes that at least one-third, up to two-thirds of these children could be enrolled into Medicaid with enhanced outreach and other efforts targeted at enrolling

eligible children. Full enrollment of all Medicaid eligible individuals has been a challenge since the enactment of Medicaid, but this challenge will be even more difficult as the new welfare reform bill is implemented. To accomplish this, efforts must be enhanced to:

- eliminate barriers to effective enrollment of eligible children through managed care and other Medicaid state programs.
- streamline eligibility by enhancing the federal/state partnership and providing best-practice models and other technical assistance to states.
- increase coordination with other federal programs (food stamps, WIC, Head Start, school health, community health centers) to improve outreach and enrollment.
- increase collaboration with foundations and insurers/managed care organizations to identify innovative ways to improve enrollment
- develop public information campaigns to inform the public about opportunities to enroll in Medicaid.
- encourage state use of 1115 authority to expand Medicaid coverage and enrollment.

- Allow states to accelerate coverage for children born after September 30, 1983. Approximately 250,000 children per year are being phased into Medicaid through Year 2002. This proposal would allow states to cover more children.

- Extend continuous coverage for children age 1 year and older. Currently, the eligibility of children to receive Medicaid benefits is determined on a monthly basis. In 1990, Congress required continuous eilibility for pregnant women and their infants through the first 12 months of life. This proposal would provide continuous coverage to children and would reduce the administrative burden on Medicaid officials, health care providers, social service providers, and families who are required to refile paperwork for children's eligibility determination.

II. To Enhance Partnerships with States and the Private Sector to Help Insure Children:
Provide funding for to states to support innovative partnerships to insure children not otherwise qualified to receive Medicaid or employer sponsored benefits

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

including well-child care and other related services to reduce childhood morbidity and mortality. To manage costs, programs may include cost-sharing, managed care, and competitive billing.

- Under this program, States will be encouraged to enhance efforts to enroll eligible children in Medicaid and to expand coverage to other children by creating new opportunities for insurance coverage thereby creating a seamless system of care for children in their state.

- For children not otherwise eligible for Medicaid, States will establish income guidelines, eligibility criteria including limits on access to employer-subsidized insurance, benefits, copayments and premiums up to the full cost of the program. States may limit coverage of items and services under the project, but will be required to assure the receipt of critical services including well-child care and other related services to reduce morbidity and mortality.

- For each demonstration project, the Secretary will assure that an evaluation is conducted on the effect of the project with respect to: (1) access to health care; (2) changes in health care insurance coverage; (3) costs with respect to health care; (4) benefits, premiums and cost sharing.

III. To Expand Access to Community-Based Services:

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

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

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

Improve access for children and working families through targeted funding for Consolidated Health Centers (CHCs).

- Provide increased targeted funding for CHCs to enhance and expand services to working

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

Child Health Initiatives

Program	FY 98	FY 99	FY 00	FY 01	FY 02	FY 98-02
Fulfill promise of Medicaid - outreach to currently eligible					$3b 700,000 (3 mil families)	$3b
33% enrollment by 2002	$144m 250,000 kids	$305m 500,000 kids	$486m 750,000 kids	$690m 1 mil kids	$736m 1 mil kids	$2.4b
66% enrollment by 2002	$288m 500,000 kids	$611m 1 mil kids	$973m 1.5 mil kids	$1.4b 2 mil kids	$1.5b 2 mil kids	$4.7b
State option to accelerate phase-in coverage of Waxman children	$288m 500,000 kids	$152m 250,000 kids	$162m 250,000 kids	$0 0 kids	$0 0 kids	$603m
State option for 12 month Medicaid eligibility determination for children	$300m 450,000 kids	$500 m 670,000 kids	$700m 900,000 kids	$900m 1.26 m kids	$1.1b 1.29 m kids	$3.5b
Enhance partnerships with States - create new Title XIX demo authority	$750m 1.5 m kids	$750m 1.5 m kids	$750m 1.5 m kids	$750m 1.5 m kids	$750m 1.5 m kids	$3.75b
Expand access to community-based services through CHC/School Health	$200m 440,000 kids	$200m 440,000 kids	$200m 440,000 kids	$200 m 440,000 kids	$200m 440,000 kids	$1b

FY 2001 Kids Covered | 2002 cost | 5 yr cost

1. All 4 option	Currently 01 3 million dollars 5.5 mill	02 7.3 billion	5 years $ 15 billion
2. All 4 merging	4.8	4.3	$12 billion
3. Same as 2 w/ 2 other dropping 12 more w/reg. billing or state performance	3.3 - 3.5	2.3 - 4 3.6	$ 7.25 — 8.5
		27.2	5.85 6
4			

Table 1
Insurance Coverage of Pregnant Women and Children, 1993

All Pregnant Women and Children Through Age 18

Poverty Level	Total[1]	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	18.0	5.7%	77.1%	3.3%	13.9%
100-133%	4.8	26.6%	41.9%	7.6%	23.9%
134-185%	7.4	49.6%	18.7%	7.6%	24.1%
186-299%	15.4	72.5%	5.5%	7.6%	14.4%
300% +	28.5	85.0%	1.6%	6.0%	7.5%
All	72.1	55.0%	25.7%	6.0%	13.4%

Pregnant Women and Infants

Poverty Level	Total[1]	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	2.2	5.6%	82.7%	2.5%	9.3%
100-133%	0.5	24.0%	54.5%	8.6%	12.9%
134-185%	0.7	51.3%	30.1%	5.9%	12.6%
186-299%	1.3	72.4%	11.3%	8.2%	8.1%
300% +	2.4	87.1%	1.5%	4.6%	6.7%
All	7.0	50.9%	35.3%	4.9%	8.9%

Children Age 1 to 5 Years

Poverty Level	Total[1]	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	5.7	3.5%	87.3%	1.9%	7.3%
100-133%	1.2	21.2%	58.0%	4.3%	16.6%
134-185%	1.9	45.7%	28.4%	4.1%	21.8%
186-299%	3.7	78.6%	6.7%	3.0%	12.7%
300% +	6.2	86.8%	2.1%	4.4%	6.7%
All	18.7	50.7%	23.3%	3.7%	10.3%

Children Age 6 to 12 Years

Poverty Level	Total[1]	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	5.9	7.1%	77.1%	2.8%	13.1%
100-133%	1.7	30.6%	36.3%	6.0%	27.1%
134-185%	2.7	57.7%	12.6%	6.1%	23.7%
186-299%	5.9	75.4%	4.2%	5.7%	14.6%
300% +	9.2	85.8%	1.5%	5.0%	7.7%
All	25.4	58.4%	23.2%	4.6%	13.4%

Children Age 13 to 18 Years

Poverty Level	Total[1]	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	4.2	6.9%	60.3%	6.6%	26.7%
100-133%	1.4	27.5%	29.5%	12.3%	30.7%
134-185%	2.1	43.0%	14.3%	13.3%	30.3%
186-299%	4.5	66.0%	4.6%	12.0%	17.3%
300% +	8.9	82.2%	1.2%	8.6%	8.0%
All	21.0	56.2%	16.6%	9.6%	17.3%

Source: Urban Institute tabulations from the March Current Population Survey, 1994.
Note: Percentages may not sum to 100 because of rounding. Medicaid enrollment reflects corrections by the Urban Institute's TRIM2 model, as well as corrections for individuals reporting both employer-sponsored insurance and Medicaid. The populations excluded the elderly, the institutionalized and families with an active military member. "Other" coverage groups include the non-elderly covered through Medicare, VA, CHAMPUS, and military health
[1] Millions of persons

POTENTIAL CHILDREN'S HEALTH INITIATIVES

1. Base Proposal: Premium Assistance to Families with Workers in Transition

Our FY97 Budget proposal builds on the Kassebaum-Kennedy law by providing premium assistance to temporarily unemployed workers and their families for up to 6 months. Recipients have to have had employer-provided health insurance, be receiving unemployment insurance, and have incomes below 240% of poverty. It is a 4-year demonstration grant program to states, under which states would have flexibility in using the funds, such us through COBRA, a private insurance product, Medicaid buy-ins, or state high risk pools.

Cost and Number Benefiting: About $2 billion per year. Our FY97 Budget assumed about $9 billion over 4 years. Our FY97 Budget proposal was estimated to help about 3 million people each year, including 700,000 children. Funding the program for 5 years would increase the number of adults and children helped, but would cost about $3 billion in 2002.

2. Target the 3 Million Children Now Eligible But Not Receiving Medicaid

Under this proposal, we would try to enroll the 3 million children currently eligible but not enrolled in Medicaid through a variety of administrative and legislative proposals. These proposals include changing the law to let states more easily accelerate the OBRA90 children's expansion, working with states administratively to simplify their enrollment process and eligibility requirements, and expanding outreach through agreements with states, schools, providers, and federal grantees.

Cost and Number Benefiting: $500-$800 per child per year, so expanding coverage to 1 million of the 3 million eligible but not enrolled cost the federal government $500-$800 million a year. Additional costs from administrative actions would show up in the baseline. The actual scoring could depend on the timing and credibility of the proposal and/or agreements with states. There would also be a cost to states.

3. Add State Options to Further Expand Coverage.

This proposal would allow states, at their option, to expand coverage to children. For states who had voluntarily expanded their coverage of children up to 133% of poverty, this proposal would allow states to develop Medicaid buy-

in programs for children of families up to 185% of poverty. This program would be cost-effective for states because it would permit family contributions to help offset costs and allows states to limit the number of children covered -- as was done in TENNCARE. This proposal would also allow, at the state's option, to extend eligibility from one month to 12 months, thus increasing the number of children covered and the length for which their covered.

Cost and Number Benefiting: Unknown at this time, but states and health plans would likely be very interested in pursuing this approach.

4. Grants to States to Develop Innovative Partnerships to Insure Children

This proposal builds on existing innovate state programs to insure children by providing matching grants to states to provide insurance coverage to children. States would have tremendous discretion.

Cost and Number Benefiting: Flexible. A $100 million per year federal program could provide preventive service insurance for 2 million children or traditional insurance coverage for 180,000 children. So, for example, a $550 million investment could provide traditional coverage to about 1 million children. The proposal could be a demonstration program involving 5-10 states or a national program.

5. Health Care to Children in Targeted Communities Through Health Centers

This proposal provide uninsured children in targeted high-need communities with health services (not insurance) through school-based or school-linked health centers and/or consolidated health centers, which have strong support on the Hill, by providing targeted increases in their funding.

Cost and Number Benefiting: Flexible. Each $100 million a year could provide services to 500,000 children though school based health centers or to 1 million people including 440,000 children though CHCs each year. Medicaid would cover some of the services.

6. Set-Aside Funding to Expand Health Insurance or Services to Children Through Medicaid, Grants to States, and/or Tax Credits.

This proposal would not specify the mechanism by which insurance and/or health care services would be provided. Instead, the budget would set aside between $1 billion and $2 billion each year to expand health care to children

through Medicaid, outreach, grants to states, health centers, and/or tax credits. This proposal would make clear the President's strong commitment to expanding children's health care while providing additional time to develop the specific proposal in coordination with Congress.

Cost and Number Benefiting: While the number of children benefiting varies depending on the specific proposal, providing comprehensive health care coverage through either Medicaid or grants to states will cost at least $500 per child. Therefore, a $1-$2 billion a year proposal could cover as many as 2-4 million additional children per year.

POTENTIAL CHILDREN'S HEALTH INITIATIVES

1. **Base Proposal: Premium Assistance to Families with Workers in Transition**

   Cost and Number Benefiting: About $2 billion per year. Our FY97 Budget assumed about $9 billion over 4 years. Our FY97 Budget proposal was estimated to help about 3 million people each year, including 700,000 children. Funding the program for 5 years would increase the number of adults and children helped, but would cost about $3 billion in 2002.

2. **Target the 3 Million Children Now Eligible But Not Receiving Medicaid**

   Cost and Number Benefiting: $500-$800 per child per year, so expanding coverage to 1 million of the 3 million eligible but not enrolled cost the federal government $500-$800 million a year.

3. **Add State Options to Further Expand Coverage.**

   Cost and Number Benefiting: Unknown at this time, but because this approach would provide for greater flexibility in designing benefits and copayments, and would -- at states' option -- extend eligibility of children's coverage from one to 12 months, states and health plans would likely be very interested in pursuing this approach.

4. **Grants to States to Develop Innovative Partnerships to Insure Children**

   Cost and Number Benefiting: Flexible. A $100 million per year federal program could provide preventive service insurance for 2 million children or traditional insurance coverage for 180,000 children. So, for example, a $550 million investment could provide traditional coverage to about 1 million children. The proposal could be a demonstration or a national program.

5. **Health Care to Children in Targeted Communities Through Health Centers**

   Cost and Number Benefiting: Flexible. Each $100 million a year could provide services to 500,000 children though school based health centers or to 1 million people including 440,000 children though CHCs each year.

6. **Set-Aside Funding to Expand Health Insurance or Services to Children Through Medicaid, Grants to States, and/or Tax Credits.**

File CJ
" HHS
Kids Q+A's

QUESTIONS AND ANSWERS

TABLE OF CONTENTS

State Partnership Grants

Crowd-Out

Kennedy-Hatch and Specter Bills

Public Health Issues

Other

Public Health Issues

Other

THE PRESIDENT'S CHILD HEALTH INITIATIVE - GENERAL

HOW WILL YOU HELP UNINSURED CHILDREN?

QUESTION:

What are you proposing to help uninsured children? How many kids will benefit from these proposals?

ANSWER:

- There is growing consensus that we must help families who do not have insurance for their children. We believe this issue requires a multi-faceted strategy that builds on existing programs and embodies a partnership among federal and State governments and the private sector.

- Our goal is to improve the insurance coverage and health care access of one-half of the 10 million children who are uninsured today. These steps include:

Medicaid Initiatives

- **Work with States to Fulfill the Promise of Medicaid for Children Who Are Already Eligible under Current Law** - An estimated 3 million children currently are entitled to Medicaid coverage but are not enrolled. Working with State officials, private insurers and managed care organizations, Head Start and day care centers, school health centers, community health centers, and others, we will seek to identify and enroll at least 1.6 million of these children. This is particularly important during the implementation of welfare reform.

- **Guarantee 12 Months of Coverage for Eligible Children** - To guarantee more stable coverage for children and better continuity of health care services, we will provide States with the option to provide continuous Medicaid coverage to children for 12 months after eligibility is determined or redetermined. Without this proposal, about 1 million children would have intermittent Medicaid coverage in any given month.

- **Scheduled Phase-in of Low Income Adolescents** - Under current law, we will add an estimated 1 million children to Medicaid over the next four years under the scheduled phase-in of adolescents in families below the federal poverty line.

HOW WILL YOU HELP UNINSURED CHILDREN, continued

Private Insurance Initiatives

- **Provide Funding for States to Support Innovative Partnerships to Insure Children Not Otherwise Qualified to Receive Medicaid or Employer Sponsored Benefits** - Numerous States have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. Building on the innovative steps that States have begun to take to insure children, we will provide $750 million in annual support to States to help them expand insurance coverage for an estimated 1 million children in their States.

- **Protect the Health of Working Families** - To assist families of temporarily unemployed workers, the Healthy Working Families program will provide financial assistance to unemployed workers and their families in maintaining health insurance. An estimated 3.3 million Americans, including nearly 700,000 children, will benefit. In addition, purchasing cooperatives can expand coverage for families employed in small firms by lowering prices and introducing a greater choice of plans.

BACKGROUND:

- The President's Budget contains $750 million a year for the State Partnership grants.

- We anticipate that the outreach efforts of the State Partnership Grant program will have an impact on Medicaid enrollment as Medicaid eligible children are identified and referred to the State Medicaid Office for enrollment. The estimated cost of this outreach overflow is $1.1 billion dollars from FY 1998 to 2002.

- The cost of providing 12-month continuous eligibility for children will be $3.7 billion from FY 1998 - 2002.

- In addition to these budgetary proposals, we are working on an outreach initiative to increase Medicaid enrollment of eligible children. This initiative is not part of the budget process.

DIFFERENCES IN ESTIMATES OF NUMBER OF UNINSURED KIDS, contd.

BACKGROUND:

Families USA used data from two separate surveys, SIPP and CPS, to derive their estimates. In order to evaluate what they did, it is important to understand the characteristics, strengths, and weaknesses of each survey. Because SIPP follows a panel of survey participants over a period of several years, the SIPP data provide the most detailed information on the nature and length of uninsured spells (e.g., SIPP data can answer questions such as how many individuals who lost private coverage wee uninsured for three months or less?). However, the accuracy of SIPP data has been questioned due to attrition from the survey and other technical problems. In addition, the SIPP sample is too small to permit accurate State-level estimates. The CPS data are widely used for estimates of uninsurance because the CPS is based on a very large sample, it is designed to produce credible State-level estimates, it is available on a timely basis, and it provides information on coverage rates for socio-demographic subgroups of the population. CPS purports to count the number of persons uninsured for an entire calendar year; however, some argue that CPS over-counts the number of individuals who have been uninsured for an entire year, possibly because respondents answer based on current, rather than previous, coverage status.

STATE EFFORTS TO COVER UNINSURED CHILDREN

QUESTION:

What types of efforts are currently underway in the States to cover uninsured children?

ANSWER:

- State efforts to cover uninsured children vary widely in their type of financing (State, State/federal, private, or public/private), the size of the program, and the type of benefit offered. Programs can be generally categorized into one of three types by their source of funding: Medicaid, State-only funds, and private-only or public/private funds.

Medicaid Expansions:

- Many States have gone beyond the federal minimum age and income requirements for children in their efforts to provide coverage to uninsured children. Some States have used 1902 and 1115 Medicaid waivers to develop programs to cover children not otherwise eligible for Medicaid; such programs include **Vermont's** Dr. Dynasaur, **Washington's** Basic Health Plan Plus, and **Minnesota**Care.

State-Funded Programs

- The largest non-Medicaid programs are those funded with State public funds. Such programs include **Pennsylvania's** Children's Health Insurance Program (CHIP), **New York's** Children's Health Plan, **Massachusetts'** Children's Medical Security Plan, and **Florida's** Healthy Kids (which also uses local public funding). All of these programs are large (20,000 to more than 100,000 enrollees) and several have recently announced expansions of benefits, eligible groups, or both.

EFFORTS IN STATES TO COVER UNINSURED CHILDREN, contd.

Private or Public/Private Programs:

- There are approximately two dozen Blue Cross/Blue Shield Caring Programs for Children nation-wide. The original Caring Program arose in **Western Pennsylvania** in the wake of steel mill shut-downs, and the program has been replicated in a number of States. In most of the Caring Programs, the sponsoring Blue Cross or Blue Shield program donates administrative costs and, in some cases, BC/BS matching donations supply the funds for premium costs. Many programs include a network of participating providers who accept a discounted fee schedule as payment in full. The Caring Programs vary widely in size, from a few hundred enrollees to more than 8,000 in **California**. Although some of the larger programs offer comprehensive benefits, most exclude inpatient hospitalization from their benefit package. Some of the Caring Programs (e.g., **Kansas**) are sponsored or cosponsored by organizations other than Blue Cross/Blue Shield.

- **Colorado's** Child Health Plan is a public/private program that provides coverage to 5600 uninsured children in rural counties. Kaiser recently announced a program in **Colorado** to provide comprehensive coverage to 2,000 children in cooperation with area school-based health clinics.

ARE IMMIGRANTS ELIGIBLE FOR THE PRESIDENT'S INITIATIVE?

QUESTION:

Are immigrant children eligible for assistance under the Administration's new children's health insurance grant program?

ANSWER:

- As you know, the Administration has proposed to repeal some of the provisions in last year's welfare reform legislation that restrict access to Medicaid and SSI for disabled legal immigrants and legal immigrant children. Our view is that immigrants who are not able to work -- the disabled and children -- should not be denied access to Medicaid and SSI if they are legal residents.

- Consistent with our position on the welfare reform legislation, we do not believe the Federal government should force States to exclude legal immigrant children from receiving health insurance coverage.

BACKGROUND:

- The President's health insurance initiative for children does not specify any eligibility criteria beyond age and insurance status, and is therefore neutral on the subject of immigrant eligibility.

- States are free to determine how they will target their assistance to vulnerable uninsured and underinsured children and may choose to offer coverage to immigrant children.

WOULD ILLEGAL IMMIGRANTS BE ELIGIBLE?

QUESTION:

Under the President's Initiative, would illegal aliens be eligible for assistance under the State grant program?

ANSWER:

- Illegal immigrants would not likely be eligible for these programs, but it would be premature for me to confirm these provisions at this time. We are still examining the interaction of the immigrant restrictions with other statutes and will be issuing guidance on these issues shortly.

BACKGROUND: *Since we have not yet made public our interpretations of "federal public benefits" and "means tested benefits", we need to decide whether to make public statements that speak to them. If so, the following more directly answer the question.*

- The immigrant provisions of the PRWORA and the IIRIRA (Illegal Immigration Reform and Immigrant Responsibility Act of 1996) are relevant. Because our proposed federal children's program does not have income-eligibility restrictions, it would not be considered a federal means-tested public benefit. Therefore qualified ("legal") immigrant children would *not* be subject to the five-year ban on receipt of such services.

- The program *may* be considered a federal public benefit, subject to statutory exemptions, which would mean that eligibility would be restricted to citizens and qualified aliens. We are still considering this issue.

No
All immig only elig for emergency programs
- expect governors to follow the rule
Legal immig should be able to use it
OK for state to verify immig status
Treat like Medicaid as to who is eligible

WOULD ILLEGAL IMMIGRANTS BE ELIGIBLE?

QUESTION:

Under the President's Initiative, would illegal aliens be eligible for assistance under the State grant program?

ANSWER:

- It would be premature for me to address your question at this time. We have been working since the welfare reform statute was signed to determine the impact of its provisions on federal programs and benefits to noncitizens. We are still examining the interaction of the immigrant restrictions with other statutes and will be issuing guidance on these issues shortly.

BACKGROUND: *Since we have not yet made public our interpretations of "federal public benefits" and "means tested benefits", we need to decide whether to make public statements that speak to them. If so, the following more directly answer the question.*

- The immigrant provisions of the PRWORA and the IIRIRA (Illegal Immigration Reform and Immigrant Responsibility Act of 1996) are relevant. Because our proposed federal children's program does not have income-eligibility restrictions, it would not be considered a federal means-tested public benefit. Therefore qualified ("legal") immigrant children would *not* be subject to the five-year ban on receipt of such services.

- The program *may* be considered a federal public benefit, subject to statutory exemptions, which would mean that eligibility would be restricted to citizens and qualified aliens. We are still considering this issue.

IMMIGRANT STATUS OF KIDS WHO ARE ELIGIBLE FOR BUT NOT ENROLLED IN MEDICAID

QUESTION:

The National Center for Policy Analysis says that most of the 3 million children eligible for Medicaid but not enrolled in the program are immigrant children. Is this true?

ANSWER:

- According to the March 1996 Current Population Survey, a total of three million children are eligible for Medicaid, but not enrolled; that is, they are not insured. It seems unlikely that most of those 3 million children are immigrants, given that the CPS estimates the *total* number of uninsured *immigrant* children to be only 900,000.
- To date, no study has been conducted which attempts to find out the proportion of Medicaid-eligible, uninsured children that are immigrants.

WHY PROPOSE A NEW ENTITLEMENT PROGRAM?

QUESTION:

Why is the Administration proposing a new entitlement when we are trying to balance the budget?

ANSWER:

- It is important to remember that the Children's Health Initiative is fully paid for within the context of a balanced budget. The Administration is not proposing a new, open-ended entitlement. While the funds qualify as mandatory spending, there is no entitlement for individuals, and total spending for the state partnership program is capped at a maximum of $750 million each year for five years. As a result, the costs of this program will be predictable and controllable.

- Under the President's Initiative, States will have a variety of options for expanding children's access to health insurance using existing systems and services.

New vote

WHY SETTLE FOR HALF?

QUESTION:

Why aren't you striving to cover all 10 million uninsured kids? Why are you satisfied to settle for covering only half?

ANSWER:

- We think it is important to set realistic achievable goals. We would like every child in America to have adequate health insurance coverage. But we realize that this goal must be achieved in steps. Our proposals set realistic targets to move towards that goal. These targets can be achieved in a relatively short period of time, and within budget constraints.

- Our approach will provide much useful information about the best way to go about reducing the number of uninsured children. By providing States with extensive flexibility to design their own programs, our initiative will encourage them to test a range of innovative approaches to expanding coverage. The information learned from these efforts will help guide future federal and State efforts.

WHY NEW PROGRAMS NEEDED?

QUESTION:

Why do we need a whole new set of Federal programs to address this issue? Why can't we simply expand our current programs, such as community health centers and school-based clinics, and ensure that more kids who are eligible for Medicaid are enrolled?

ANSWER:

- The Administration's FY 1998 proposals are focused on expanding the number of children with health insurance. We see this as a necessary first step to improving children's health, and while we believe direct service programs such as health centers and school-based clinics are critical, we do not think that they are a sufficient substitute for insurance coverage.

- Working families, in which the vast majority of uninsured children live, need a stable source of insurance for their children and the confidence that comes from knowing they have a medical home. And a majority of the States have recognized this need as well, as evidenced by their efforts targeted at expanding children's access to insurance.

- Our proposals build on the Medicaid coverage expansions for children that have been phasing in throughout the 1980's and 1990's, and on other State Medicaid expansions targeted to children. They also build on the range of successful State efforts to expand the availability of insurance for children.

- We do see this initiative as a critical opportunity to link proposed new programs and activities with the full range of Departmental programs, including health centers and school-based clinics which are already underway. Our goal is to have demonstrable results including: more children covered by insurance, more children with a regular source of care, more children immunized and fewer childhood injuries.

WHY NOT JUST EXPAND MEDICAID ELIGIBILITY?

QUESTION:

Rather than start a new Federal entitlement program, why not expand the number of children served under Medicaid by increasing States' options to expand eligibility?

ANSWER:

- First, the new program is not an entitlement. It is a fixed investment to help States stimulate access to the private insurance market for children in "gap" families (families with too much income to quality for Medicaid but too little income to afford private coverage). It builds on a joint private and public commitment to strengthening the private insurance system for working families.

- The program does not propose a single solution for all States or for all children. Indeed, States would have the option of using these funds to expand Medicaid coverage to children at higher income levels. Other States might supplement funding to public-private partnership programs that already exist. Our proposal recognizes the potential of state, local, and community solutions rather than federal solutions. The new grant program also encourages the private sector to become involved in the design of the coverage for children and to participate in the funding.

WHY NOT EXPAND EITC TO INCREASE COVERAGE?

QUESTION:

Working poor families with children already receive the Earned Income Tax Credit. Why not use this proven mechanism to expand access to children?

ANSWER:

- Administering a health insurance subsidy through the Earned Income Tax Credit (EITC) raises several concerns:

  - One is the extent to which we can address the cash-flow difficulties of low-income families who wish to purchase health insurance for their children but who are not able to receive the tax credit until they file their tax return the following year.

  - Second, the EITC program does allow recipients to receive the credit up-front by reducing their withholding for Federal taxes, but this option has not been highly utilized.

  - Third, the EITC program provides smaller credits to those earning less. However, the less a family earns, the greater the need for assistance with insurance costs.

  - Fourth, the cost of health insurance might consume a large percentage of the total value of the EITC. The EITC funds a variety of needs in low-income working families, and these needs could go unmet if the family is forced to spend the credit funds on health insurance.

- Past experience has shown us that certain conditions must be avoided if tax credits are used to provide health insurance subsidies. In 1990, auxiliary tax credits were added for health insurance premiums paid on behalf of a qualifying child; these were repealed in 1993. This add-on to the EITC, intended to reward working families who purchased health insurance for their children, provided for a 100 percent tax credit and yet did not set minimum standards for the purchased policy. As a result, concerns were raised that a door had been opened for the sale of inadequate policies to eligible families. Insurance firms aggressively marketing these policies could take advantage of the fact that consumers were receiving them for free, and therefore had no vested interest in their quality, in conjunction with the fact that government had set no rules as to what standards such policies should meet.

WHY NOT USE THE TAX CODE TO INCREASE COVERAGE?

QUESTION:

Several members of both parties have proposed to increase access to insurance for children through tax credits. Wouldn't it be more efficient to expand access to insurance through the tax code rather than through a new bureaucratic entitlement program?

ANSWER:

- There are several mechanisms that could be used to expand access to insurance for children. We have chosen a State grant framework, but applaud sponsors of tax credit proposals for their commitment to our shared goal of expanding insurance coverage for children.

- After evaluating the options, we concluded that a grant program would allow States to design or expand their own programs more efficiently because they could determine the best way to cover uninsured children given their specific circumstances. The tax system does not offer the same level of flexibility in constructing critical pieces of a children's health insurance program.

- An additional concern with tax credits is the cash-flow problems of low-income families who wish to purchase health insurance for their children and yet are not able to receive the subsidy amount until they file their tax return in the following year. While the Earned Income Tax Credit program has a special provision to allow those eligible to receive the credit "up-front" by reducing their withholding for Federal taxes, this provision has not been highly utilized. For this reason, the tax system may not be a good vehicle for delivering the size of subsidy necessary to encourage low-income workers to purchase health insurance for their children.

- Finally, tax credits must be refundable to be of value to families whose incomes are so low that they do not pay any income taxes.

RELATIVE AMOUNT OF SPENDING FOR WORKERS BETWEEN JOBS

QUESTION:

Of the approximately $17 billion which the President is proposing to spend on expanding health insurance coverage, $10 billion is going to provide coverage to workers who are temporarily unemployed. Isn't this too much, given that his proposals cover only half of the children who are without insurance, and that most uninsured children have a working parent?

ANSWER:

- The President's Workers Between Jobs initiative, which costs approximately $10 billion over 4 years, offers temporary assistance to families of unemployed workers who would otherwise lose their coverage. Not only will this initiative cover approximately 700,000 children in any given year (or about 3.5 million over the five-year period), but it will also cover approximately 2.6 million working adults who are between jobs.

- This initiative is also an extremely effective approach for minimizing "crowd out," because by definition it will offer coverage only to workers who have lost the jobs though which they received their health insurance.

- Finally, this initiative will help families of workers between jobs to maintain continuous insurance coverage, which will enable them to avoid being subjected to preexisting condition limitations when they apply for other insurance coverage.

IN WHAT STATUTE ARE NEW INITIATIVES?

QUESTION:

In what statute are the Children's Initiative and the Healthy Working Families initiative drafted? Are they both mandatory spending?

ANSWER:

- Both the Children's and the Healthy Working Families initiatives are drafted as freestanding laws, making funds available to States.

- Both initiatives are direct spending programs. As direct spending programs, mandatory funds up to a specified amount are available to each program.

- A State can elect to participate in either or both programs; there is no requirement that they do so.

- Under the Healthy Working Families program, if a State believes it will exhaust its funds before the end of the year, it can obtain a loan from HHS, reduce duration or benefits, use State funds or terminate the program for the remainder of the year.

- Under the Children's initiative, States would determine eligibility for the program and the scope of benefits to be provided. If funds were insufficient to meet demand, typically a waiting list would be used. However, if necessary, a State could also modify eligibility for and benefits of its program, provided that its receives the approval of the Secretary and give sufficient notice to parents of enrolled children,

MEDICAID OUTREACH

CHILDREN WHO ARE CURRENTLY ELIGIBLE BUT NOT ENROLLED IN MEDICAID

QUESTION:

What are the characteristics of children who are eligible but not enrolled in Medicaid?

ANSWER:

- According to the June 1996 GAO report, the 3 million children who were Medicaid-eligible but not enrolled are more likely to be in families with a working parent than are children on Medicaid. Fully 80 percent of these Medicaid-eligible but not enrolled children were in families with a working parent, as opposed to 62% of Medicaid enrolled children who are in families with a working parent.

- Children who are eligible for but not enrolled in Medicaid are more likely to be from the South (41 percent) and the West (30 percent) than from other parts of the country. Due to small sample sizes, there are no reliable estimates available of the number of uninsured children on a State-by-State basis.

- Children who are eligible for but not enrolled in Medicaid are most likely to be White (44 percent), but 35 percent are Hispanic and 22 percent are African-American.

UNINSURED CHILDREN ELIGIBLE FOR MEDICAID

QUESTION:

How many of the 3 million children eligible for Medicaid but not enrolled are uninsured?

ANSWER:

- We believe most of the 3 million children who are currently eligible for Medicaid but not enrolled have no other access to health insurance.
- Our goal is to enroll 1.6 million of these children by the end of year 2000.

WHY ARE MEDICAID CHILDREN NOT ENROLLED?

QUESTION:

Why are non-enrolled Medicaid-eligible children not enrolled?

ANSWER:

The major reasons cited for the lack of participation of eligible children are:

- Families are not aware of eligibility;
- Welfare stigma association with Medicaid;
- Cumbersome application process; and
- Lack of an incentive for States to encourage participation since they pay a share (17 to 50 percent) of the cost of coverage.

ADMINISTRATION'S PLANS TO IDENTIFY UNENROLLED CHILDREN

QUESTION:

How does the Administration plan to enroll the children who currently are eligible for Medicaid but not enrolled?

ANSWER:

- The Department is developing a plan to identify Medicaid-eligible children through a dynamic public/private partnership with the States. The initiative requires partnering among agencies within the Department (e.g., HRSA, ACF) as well as with other Federal agencies (e.g., HUD, DoED, Dept. of Ag.), States, communities and the private sector -- providers, foundations, associations and business leaders.

- We will be contacting the Governors to solicit interest in partnering in the near future. We will work with States to:

  - Determine the best places to reach the uninsured, looking at innovative State strategies that have proven successful in Medicaid waiver States;

  - Provide technical assistance to local communities, including developing guides for child care agencies and school-based services, disseminating information to States on FFP availability for outreach and identifying and resolving any federal barriers that impede outreach efforts; and

  - Contact and develop partnerships with businesses.

- Two examples of the types of service delivery settings that we might target are child care centers and schools. We believe that the ACF child care network could provide an important entree for reaching uninsured preschoolers. In addition, several States -- Florida is the best example -- have actively engaged school systems in helping to identify Medicaid eligible children and getting them enrolled. We will look for ways to encourage States and county school officials to make health insurance coverage a concern of the school system.

ESTIMATE OF THE NUMBER OF CHILDREN WHO WILL BE ENROLLED THROUGH OUTREACH

QUESTION:

How did the Administration determine its estimate of the number of children who will be enrolled in Medicaid as a result of these outreach efforts?

ANSWER:

- Approximately three million children are estimated to be eligible for Medicaid but not enrolled (GAO). Some of these children may be hard to reach, however, so our goal is to enroll at least 1.6 million or approximately half of these children.

- While the State partnership demonstration funds are targeted to non-Medicaid eligible children, there is evidence that some families who apply for these programs actually will be eligible for Medicaid. Special funds have been identified in the grant program for outreach, and States are encouraged to enroll any children who are found to be Medicaid-eligible into Medicaid. The number of children who could be enrolled in Medicaid as a result of the State partnership grant is estimated to be 400,000.

- The remainder of our target population of eligible non-enrolled children are expected to be enrolled through the additional outreach proposals under the Administration's plan. We believe our investment in this effort will be sufficient to identify and enroll another 1.2 million children.

FUNDING FOR OUTREACH

QUESTION:

If outreach to Medicaid eligible children is part of your strategy, why does the President's budget request no funds for this purpose? Won't it cost the States and federal government money to serve these children?

ANSWER:

- Since this can be done under current law by improving our practices, we do not need to request additional funds.

- To the extent that enrollment efforts are successful, the effects will be included in States' estimates of costs when they occur and reflected in HCFA's projections when the baseline is updated.

BACKGROUND:

- The Outreach effort of the State Partnership Grant program will have an impact on Medicaid enrollment as Medicaid eligible children are identified and referred to the State Medicaid office for enrollment.

- The projected cost of this "spillover"effect of the outreach is $1.1 billion from FY 1998-2002. These funds are provided for in the context of our balanced budget plan.

STATE PARTNERSHIP GRANTS

STATE GRANT PROGRAM--PRINCIPLES

QUESTION:

What are the principles that underpin the State grant program?

ANSWER:

Our grant program is based on these core principles:

- Addresses our goal of insuring more children by building on successful State efforts and encouraging State flexibility.
- Promotes a localized commitment and solution to the problem of uninsured children—an approach already underway in many States.
- Does not replace or erode Medicaid or employer-sponsored insurance because it targets children without access to medical coverage, including Medicaid and commercial health insurance.
- Uses Federal funds to supplement, not supplant current efforts.
- Promotes flexibility by allowing States to define program parameters and develop partnerships with other public and private partners for State match.

STATE GRANT PROGRAM--KEY ELEMENTS

QUESTION:

What are the key elements of the State grant program?

ANSWER:

The State grant program has these key features:

- Provides $750 million in annual funding to States with approved applications.
- Provides $1 million to each State and allocates the remaining funds on the basis of the number of uninsured children in each State.
- Matches State expenditures using the Medicaid matching rate.
- Allows States to use State or local public or private funds for their portion of the program.
- Provides States with wide latitude in designing their program with reference to age, income, geographical areas and benefits.
- Provides coverage to children who are ineligible for Medicaid or any other insurance or for whom insurance is unaffordable.
- Requires that States ensure that the insurance provided under the State program does not substitute for employer-sponsored insurance.

CAN STATES USE NEW GRANT MONEY TO COVER KIDS CURRENTLY COVERED BY MEDICAID?

QUESTION:

Can States roll back their Medicaid expansions and use the new State grant money to provide fewer benefits for the same population?

ANSWER:

We don't expect States to shift children out of an entitlement program like Medicaid into the new Partnership grant program for the following reasons:

- The new grant program is specifically targeted to children who are not eligible for Medicaid, and States will be limited as to the number of additional children they can cover.

- We also are proposing that States "match" the federal contribution to the new grant program at the same rate as the current State FMAP for Medicaid so there would be little incentive to shift children out of Medicaid.

- The Partnership grant development process will provide for public participation in the design of the State's program that would help safeguard against such efforts.

- Finally, when designing this type of program, it is necessary to balance two competing goals: giving States flexibility and maximizing the number of children who will be covered. As any program evolves, it is necessary to frequently reexamine this balance to ensure that it continues to be appropriate.

BACKGROUND:

- The Administration bill has no maintenance of effort requirement for Medicaid; the Hatch-Kennedy bill does.

MAINTENANCE OF EFFORT REQUIREMENTS

QUESTION:

Will States be able to use federal dollars to replace part of their current spending, or are there maintenance of effort requirements?

ANSWER:

- The goal of this initiative is to supplement, not supplant existing sources of insurance coverage, both public and private.

- However, we do not want to tie States' hands by imposing a set of requirements that prevent States from building on existing initiatives.

- To acknowledge the activity already underway in many States, we propose using calendar year 1995 expenditures by the State for similar purposes as the base upon which State matching expenditures are built. Expenditures from State, local public, or private funds that are in excess of the amount expended in calendar year 1995 may be considered as State match for Federal funds under this program.

- We hope to work closely with Congress and the States on this and other aspects of our proposal.

BACKGROUND:

- The Administration bill has no maintenance of effort requirement for Medicaid; the Hatch-Kennedy bill does.

REQUIREMENT THAT STATES ENROLL IN GRANT PROGRAM BY THE YEAR 2000

QUESTION:

Under the President's plan, States that do not participate in the State grants program by the year 2000 become ineligible to participate in the program in any later years. What is the rationale behind this policy?

ANSWER:

- This provision is necessary to ensure a stable funding stream for States who participate in the program. Since there is a predetermined amount of federal funding for this program each year, every time that the number of participating States changes, the amount that each State receives changes as well. Without a provision to ensure stable funding levels, States would face a very uncertain funding stream and would have difficulty in planning their programs.

- In addition, this provision creates an incentive for States to participate in the grant program as soon as possible.

BASIS FOR ESTIMATE OF NUMBER OF KIDS TO BE ENROLLED

QUESTION:

What is your basis for estimating that one million children will be insured under the new State grant program?

ANSWER:

- We expect that at least one million children--and potentially more--could receive health insurance coverage under the new State grant program. However, because the details of program design, in particular, the scope of the benefit package, will be left to the States, the number of children to be insured can only be roughly estimated.

- Under our program, State programs would be allowed to use a small percentage of funds for administration and outreach. The balance would be available for providing insurance to children, and would be matched by the States. We used an estimated total cost of $1,000--from Federal and State/private sources--per child for planning purposes. (Our starting point was the $577 per child in Medicaid federal share expense estimated for FY 1998.)

- We also looked at the experiences in the States. The GAO report "Health Insurance for Children: State and Private Insurance Programs Create New Strategies to Insure Children" published in January of last year reported that the cost per child per year in the Western Pennsylvania Caring Program for Children was about $850 per year.

RESISTANCE TO MEDICAID BLOCK GRANTS

QUESTION:

Your grant program is a new block grant for States. Sen. Kennedy's bill proposes an even bigger block grant for States. Why are you so opposed to Medicaid block grants, when you so willingly embrace the block grant approach for uninsured children?

ANSWER:

- Low-income children are our most vulnerable population. For children who qualify for Medicaid, we believe that it is critical to provide them with a strong safety net in the form of an individual entitlement with a defined set of health care benefits.

- The President's commitment to maintaining and strengthening the Medicaid safety net -- not only for children, but also for low-income pregnant women -- is clear.

- However, there are millions of children with slightly higher incomes who currently receive little or no health coverage. We believe that these children need help as well. In order to help protect this group, we propose to create partnerships with the States that promote innovation and flexibility.

- Many States have already created programs to help children with somewhat higher incomes. We want to work with these States, and we want to give them the tools to continue or to expand their programs as they see fit. We also want to provide other States with the tools to begin new programs.

- The partnership grants will better enable us to provide insurance to children who are not on Medicaid and who are without other insurance while preserving State flexibility. States will have wide latitude designing their programs with reference to age, income, geographic area, and benefits. Under our proposal, this is done without creating a new individual entitlement.

Families may have access to ins but can't afford it
need to fill the gap for working families- focus on private health care matched, not govt. - Transitional
Medicaid is base for people without access to ESI,
basic safety net

GRANTS VS. TAX SUBSIDIES

QUESTION:

Senators Daschle, Kennedy and others have introduced multibillion tax credit and grant programs to provide insurance to uninsured children. Isn't the Administration's approach an implicit rejection of these costly new federal entitlements proposed by Democrats in Congress?

ANSWER:

- No, we believe our proposals are consistent with the goals of those in Congress who have introduced legislation to expand insurance coverage for children.

- Nearly 10 million children --one in seven--are uninsured in America today. That number has increased as employers have been reducing dependent coverage. Our goal must be to significantly reduce the number of uninsured children through practical, incremental reforms. We believe this problem requires a multi-faceted, bipartisan strategy that involves a pragmatic series of incremental steps by both federal and State governments, as well as the private sector.

- We want to build on the knowledge gained by numerous States that have taken steps to help families who cannot afford to purchase insurance for their children. States have formed partnerships with providers, insurers, philanthropic organizations and businesses to solve the problem of uninsured children. These States have found that by localizing the problem of uninsurance, they can develop and reach achievable goals. They have established strong provider networks, administrative efficiencies and strong outreach to their eligible families. Through the success of these efforts, other States are replicating programs to insure children.

- We believe ours is a good approach. There are other approaches that have merit as well. We look forward to working with members of Congress in both parties to enact meaningful legislation this year.

DOES ALLOCATION FORMULA PENALIZE ACTIVE STATES?

QUESTION:

Does your formula for distributing the State grant funds penalize States which currently have aggressive programs for providing coverage to uninsured kids?

ANSWER:

- Our formula is based on need and targets funds to States based largely on their rates of uninsurance among children in a way that is easy to understand and calculate. We think it is important that funds follow need.

- We applaud the actions many States have taken and are taking to expand child health insurance and do not want these efforts to go unacknowledged. For that reason, our bill proposes that expenditures under the State program which can be used to match Federal grant funds include any expenditures from State or local public funds or from private funds in excess of the amount expended by the State in calendar year 1995 for similar child health insurance programs. In a sense, we are rewarding States which are leaders, like Vermont, by making it easier for them to do what they have chosen to do. Small States like Vermont also benefit from $1 million base allocation which our formula awards to all States.

States using Medicaid

SOURCE OF MATCHING FUNDS

QUESTION:

Can States use private funds to match Federal dollars under the Administration's proposed grant program? What would prevent them using DSH or provider tax funds to match the Federal dollars?

ANSWER:

- States are eligible for Federal matching payments for any expenditures from State or local public funds or from private funds in excess of the amount expended by the State in calendar year 1995 for similar purposes. Thus, private funds can be used as match for our proposed grant program. In many States, private sector funding has been a starting point for efforts expanding insurance coverage for children and we want States to have that option available to them.

- Our goal in this program is to assure more children have health insurance coverage and our focus is results-oriented. Our proposed program would not preclude a provider tax as a source of State funding. Some States have successfully used taxes of this sort to expand insurance coverage and we want this option also to continue to be available to States.

- We wish, however, to avoid the churning of funds at the State level purely to draw down Federal match. To receive continued funding, States are required to submit annual assessments describing progress made in reducing the number of uninsured and underinsured children in their States. We will be monitoring these reports closely to make improvements in the administration of the program, share successful strategies among the States and help assure that abuses, such as the churning of non-Federal funds does not occur.

DO YOU MANDATE A MINIMUM BENEFIT PACKAGE?

QUESTION:

Does your proposal require States to provide a minimum set of benefits in any coverage provided using State funds?

ANSWER:

- Our proposal gives States broad latitude in the design of benefit packages. States must meet any minimum standards the Secretary may set, including standards for quality and scope of coverage, but otherwise are free to establish benefit packages that meet their needs.

REQUIREMENT FOR MENTAL HEALTH PARITY?

QUESTION:

Does your proposal mandate that there be parity between mental health and physical health coverage?

ANSWER:

added new parity requirements

- Our proposal does not explicitly require parity. We will, however, require compliance with applicable federal and State laws. From a federal perspective that means that if a State provides a voucher to help a child receive insurance through a parent's employer group health plan, the mental health parity requirements of HIPAA that apply to employer group plans would apply.

- However, if a child receives insurance through an individual plan, including a special risk pool a State might establish for children's insurance, the mental health parity provisions of HIPAA would not pertain since they apply only to group plans. Also, each State is free to apply additional requirements for mental health parity if it chooses.

No additional MH parity laws
Existing laws apply

CROWD-OUT

HOW DOES THE PRESIDENT'S PLAN REDUCE CROWD-OUT?

QUESTION:

CBO, GAO, and private health care experts claim that a new Federal subsidy program will result in employers reducing dependent coverage (or not offering it in the first place) because children can be insured using taxpayer dollars. How does the President's plan prevent this substitution effect?

ANSWER:

- We recognize that health care experts have concerns about the possibility of public dollars being used to replace private dollars spent on insurance coverage. While we understand and share this concern, we think that most of the children who would receive coverage under the President's initiative currently have very limited access to private health insurance.

- Studies conducted at the Urban Institute and the University of Pittsburgh have shown that there is very little crowd-out among individuals who are below the poverty level. Thus, the President's initiatives to increase the number of Medicaid-eligible children who are enrolled in the program and to extend 12 months of continuous coverage for Medicaid-eligible children will have a negligible crowd-out effect.

- As incomes rise, the potential for crowd-out rises as well. The President's plan contains safeguards to minimize this effect. Specifically, each State must provide a description of the policies and procedures they will use to ensure that only uninsured children receive coverage.

- The President's Workers-between-Jobs initiative will not be affected by crowd-out, since assistance under this program is available only to individuals and families who have already lost their connection with an employer.

BACKGROUND:

Identifying appropriate safeguards against the substitution of government-subsidized insurance for existing private coverage is a critical piece of any children's health insurance proposal. Such safeguards could include requiring a period of uninsurance prior to eligibility for a government subsidy program or requiring that the applicant not have access to affordable private coverage. The latter mechanism avoids requiring children to forgo medical care for a period of time before they become eligible for assistance and allows us to close the gaps for those children who would be without access to insurance for short periods.

CROWD OUT - STATE AND PRIVATE EFFORTS

QUESTION:

How do existing State and private children's health insurance initiatives deal with this crowding out phenomenon?

ANSWER:

Current State and private children's insurance programs vary in their approach to dealing with crowd-out. Some have no requirements regarding previous access to employer-sponsored insurance, some require that children not have access to employer-sponsored insurance, while others simply stipulate that children not be currently enrolled in another plan. Specifically:

- **Minnesota** requires a period without coverage for four months prior to enrollment, but exempts children with family income less than 150% of federal poverty from this requirement. Children are also ineligible for MinnesotaCare if they currently have access to employer-sponsored insurance in which the employer subsidizes at least 50% of the cost of the premium (children from families below 150% of poverty are also exempt from this requirement).

- New **Hampshire** Healthy Kids (which offers a low-cost but unsubsidized premium to eligible children) requires that children not have been enrolled in group or employment-related insurance plans for at least three months, although that requirement is waived in cases of loss of employment or loss of employer-sponsored benefits.

- **Massachusetts** requires only that otherwise eligible children not be currently enrolled in a public or private insurance plan.

CROWD OUT - STATE AND PRIVATE EFFORTS, cont'd

- **Florida Healthy Kids** originally required a six-month period of uninsurance, but dropped it because they felt it was punitive to the child and antithetical to their mission of covering children. They have seen no evidence of problems with employer dropping, and report that 93% of enrollees are uninsured when they enroll in Healthy Kids, while 94% of the remaining children are coming off Medicaid when they enroll. They also monitor disenrollment rates, and report that the main reason for disenrollment is enrollment in other forms of health insurance, and the most common form of new health insurance is employer-sponsored insurance.

- The **Pennsylvania** CHIP and Caring Programs also have chosen not to require periods of uninsurance or lack of access to employer-sponsored insurance as a requirement for their programs, although waiting lists for the programs of several State programs vary in their response to concerns about possible crowd-out months may serve as a deterrent to dropping of employer-sponsored insurance in favor of the Caring Program. The average length of stay in the program is reportedly 19 months, while Florida reports average lengths of stay of approximately 14 months for mature programs. These lengths of stay suggest that neither employers nor employees are dropping employer-sponsored coverage in favor of unlimited stays in the subsidized programs: these programs truly appear to be bridges to other forms of coverage.

- **Other Caring Programs** vary in their approach to this issue: some require that children not have access to employer-sponsored insurance, while others simply stipulate that children not be currently enrolled in another plan. It should also be noted that many of the smaller Caring Programs offer a limited benefit package that excludes benefits such as inpatient care, which may serve as a disincentive to anyone contemplating other coverage in favor of the Caring Program coverage.

MEDICAID EXPANSIONS AND CROWD OUT

QUESTION:

Did the Medicaid expansions of the 1980s and 1990s contribute to crowding out? To what extent will the Administration's proposed Medicaid expansions contribute to crowd out?

ANSWER:

- According to the Employee Benefit Research Institute, the percentage of children with employment-based coverage declined from 67 percent to 59 percent between 1987 and 1995. During the same time period, the percentage of children covered by Medicaid increased from 16 percent to 23 percent.

- But while it appears that some of the children who lost employer coverage gained Medicaid coverage, it would be a mistake to assume that this correlation indicated causality. In fact, the number of uninsured children in families with incomes above the poverty line increased during this period, and today, nearly 90 percent of uninsured children have working parents.

- Along with the fact that the number of uninsured children below poverty declined, this suggests that very few of the children who lost employer coverage were picked up by Medicaid. Studies conducted at the Urban Institute and the University of Pittsburgh have supported this conclusion.

- While we share concerns about the potential for crowd-out among individuals with incomes above the poverty line, we think that most of the children who would receive coverage under the President's initiative currently have very limited access to private health insurance.

WILL CONTINUOUS ELIGIBILITY LEAD TO CROWD OUT?

QUESTION:

Why do you propose to expand Medicaid coverage for one year to all children? Won't that provide a Federal subsidy for those who would find insurance in the private sector?

ANSWER:

- We believe that the 12-month continuous Medicaid eligibility provision will guarantee more stable coverage for children and better continuity of health care services. Without this proposal, approximately 1 million children would have intermittent Medicaid coverage in any given month.

- Most of the children who would be affected by this proposal are in families whose incomes vary from month to month, but which generally are right above or below the poverty line. Given that studies from the Urban Institute and the University of Pittsburgh have indicated that there is almost no crowd out effect for children in families with incomes below the poverty level, we do not believe that crowd-out is a significant concern for this population.

HOW DO CONGRESSIONAL PROPOSALS DEAL WITH CROWD-OUT?

QUESTION:

How do Congressional proposals deal with the crowd-out phenomenon?

ANSWER:

- The children's health bills which have been introduced in Congress attempt to deal with the crowd-out problem through a variety of means. In addition, most of the bills which have been introduced require that the child not be eligible for Medicaid, as does the Administration's proposal.

BACKGROUND:

- Daschle's "Children's Health Coverage Act" requires that the child be uninsured for the previous 12-month period and that the child currently has no access to affordable employer-sponsored insurance.

- Specter's "Healthy Children's Pilot Program of 1997" also requires that the child not be eligible for coverage under employer-sponsored insurance.

- Two other bills require that the child be currently uninsured (Stark's "Healthy Start Act of 1997" and the Hatch/Kennedy bill "Child Health Insurance and Lower Deficit Act"). The Hatch/Kennedy bill specifically requires that the child not been insured under a group health plan during the past 6 months (unless coverage was terminated due to a change in employment status).

KENNEDY-HATCH AND SPECTER BILLS

KENNEDY-HATCH BILL

QUESTION:

What are your views on the Kennedy-Hatch CHILD health bill?

ANSWER:

- The Administration's Child Health Insurance Assistance (CHIA) plan and the Kennedy-Hatch Child Health Insurance and Lower Deficit (CHILD) bill share the same purpose and many structural similarities. While there are differences, we think these two proposals, together with others, will encourage a thoughtful discussion of expanding health insurance coverage for children.

- The parallels between the two bills are striking:

  - Both seek to expand health insurance coverage for children through voluntary State-based grant programs without replacing Medicaid or private insurance.

  - In both bills, the Federal investment is capped: neither bill creates an individual entitlement.

  - Each bill gives States discretion in the design of their programs, particularly with regard to eligibility.

  - Each bill allocates funds to States primarily on the basis of their relative proportion of uninsured children.

- Each bill requires State matching funds.

- Each bill emphasizes outreach.

KENNEDY-HATCH CHILD BILL, cont'd

- There are differences, however:
  - Funding under the CHILD bill is much larger than CHIA ($20 billion over five years, as compared to $3.8 billion) and, when fully implemented would provide insurance coverage for five million children as opposed to the estimated over one million children covered under CHIA.
  - The CHILD bill is funded through a cigarette tax; CHIA is a direct spending program funded through general revenues.
  - The CHILD bill requires that benefits provided under this Act be comparable to those provided under Medicaid; CHIA gives States more latitude in benefit design.
  - The CHILD bill also sets some requirements for subsidy levels. The CHIA bill does not.
  - Under CHIA, the State match rate is equal to the Medicaid match rate. Under CHILD, the State's share is set at 40% of their Medicaid match rate. The CHILD bill also requires Medicaid maintenance of effort.
  - While under CHIA, grant funds are to be used for insurance assistance only, the CHILD bill contains a direct service provision that would fund section 330 health centers directly for children who choose to receive services from a center.
  - The CHILD bill allows States to use up to 5 percent of their allotment to establish a program for pregnant women and infants.
  - Also, under the CHILD bill, one-third of the revenues from the $.43 cent/pack cigarette tax are used for deficit reduction.

CIGARETTE EXCISE TAX TO FUND CHILDREN'S HEALTH INSURANCE EXPANSIONS

QUESTION:

Does the Administration support increasing the cigarette excise tax to fund children's health insurance expansions?

ANSWER:

- We are open to discussing different methods for expanding health insurance coverage to uninsured children. In the past, we supported an increase in the tobacco tax in the context of financing broad health care reform. The President has a proposal which would expand coverage to millions of additional children and is paid for in the context of his balanced budget plan. Regardless of the source of financing, assuring a significant commitment to children's health care will continue to be a top priority for the President.

- That being said, studies of State excise tax increases indicate that they can have significant public health benefits, particularly for children and adolescents, because the increased cost can discourage them from starting and continuing to smoke.

CIGARETTE EXCISE TAX TO FUND CHILDREN'S HEALTH INSURANCE EXPANSIONS

QUESTION:

Does the Administration support increasing the cigarette excise tax to fund children's health insurance expansions?

ANSWER:

- We are open to discussing different methods for expanding health insurance coverage to uninsured children. In the past, we supported an increase in the tobacco tax in the context of financing broad health care reform.

- Studies of State excise tax increases indicate that they can have significant public health benefits, particularly for children and adolescents, because the increased cost can discourage them from starting and continuing to smoke.

SPECTER CHILD HEALTH BILLS

QUESTION:

What are your views on Senator Specter's child health insurance bills?

ANSWER:

- Senator Specter has introduced two similar bills which seek to expand health insurance for children, S. 24, the Health Care Assurance Act, and S.435 Healthy Children's Pilot Program Act. Both bills provide for a program of grants to States to expand health insurance, but S. 435 is smaller in scale and phased in over time. The Administration's Child Health Insurance Assistance (CHIA) bill and both Specter bills share the same purpose and the general structure of a grant program to States.

- We are impressed by the success Pennsylvania has had in making insurance more available for low income children and considered that experience in designing our proposal. We look forward to working with Senator Specter and the Congress on the design of a State grant program that can be enacted this year.

- Parallels between the Specter bills and the Administration proposal include:

  - All seek to expand health insurance coverage for children through voluntary state-based grant programs without replacing Medicaid or private insurance.

  - In each proposal, the Federal investment is capped: no bill creates an individual entitlement. The Federal investment in CHIA is $3.8 billion over 5 years; in S.435 it is $10 billion over the same period. (S. 24 sets the Federal investment at $25 billion over 5 years.)

  - Benefit levels in all three bills are to be specified by the States, although S. 435 states that health plans are to provide coverage for preventive, primary and acute care.

SPECTER CHILD HEALTH BILLS, continued

- There are differences, however:
  - S.435 is funded through a trust fund generated through auction and licensing of spectrum broadcast licenses. CHIA is a direct spending program funded through general revenues.
  - Specter's proposals provide for vouchers to subsidize premium costs. CHIA provides insurance assistance, but does not restrict such assistance to vouchers.
  - Specter's bills specify the income level for eligibility--vouchers covering full costs up to 185 percent of poverty and sliding scale up to 235 percent of poverty. The Administration's proposal gives the States flexibility in setting eligibility levels.
  - The Administration's proposal allows States to determine the age of children to be covered under their programs. S. 435 phases in coverage by age over time.
  - There are no State match requirements in the Specter bills.

Note: S. 24 addresses many additional topics including the health care insurance market, taxes on insurers and qualified associations for failure to comply with health insurance plan standards, authorization of Healthy Start and reauthorization of various PHS preventive health programs, establishment of a comprehensive school health education program, the right to decline treatment, expanded coverage of non-physician providers under Medicaid and Medicare, medical treatment effectiveness, national health insurance data and other topics. This Q and A addresses only child health insurance aspects of this bill.