THE WHITE HOUSE

WASHINGTON

March 3, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings CCJ

SUBJECT: Response to the Glassman "Monster Kiddie Care" Op Ed

cc: Bruce Reed

You recently forwarded a note referencing the James K. Glassman op ed piece entitled "Monster Kiddie Care". The First Lady saw this article, too, and asked us how we would respond to it.. I am attaching for your information our response.

The critique of the Glassman op ed piece is consistent with the more thorough discussion of tax incentives in the February 21 memo on uninsured children. In our response to Glassman, we cite the weaknesses of the repealed 1990 child health tax credit. A more detailed summary of these weaknesses can be found in the attached two-page document.

RESPONSE TO "MONSTER KIDDIE CARE" OP ED

On February 11, 1997, James K. Glassman wrote an editorial in the *Washington Post* critical of proposals to increase coverage of children. On February 24, 1997, Lawrence McAndrews, president of the National Association of Children's Hospitals, wrote a response (see attachments). The Glassman article is extremely flawed in both its diagnosis of and prescription for the problem. Specifically, Glassman:

- **Misstates the facts.** Glassman implies that all of the $162 billion in Medicaid spending is for children. In fact, only 15 percent, or about $25 billion, is spent on poor children.

- **Misdiagnoses the "real" problem.** Glassman wrongly suggests that the "real problem" is the 1.5 million children whose parents earn more than $40,000, and are willing to "take their chances" and not insure their children.

    - First, the 1.5 million children he cites represents only 15 percent of the 10 million uninsured children.

    - Second, many of these children are uninsured because their parents: (1) are not offered insurance in their jobs; (2) are offered but cannot afford family coverage because, unlike most American workers, their employers make little or no contribution toward coverage; or (3) did buy coverage through their employer but lost their ability to afford it when they lost or changed jobs.

    - Third, most of the 1.5 million children have incomes that are at or just above $40,000, which is below 250 percent of poverty for a family of four — certainly not people who can easily afford to pay a full premium of at least $6,000 (relative to the typical $2,000 employee share of a policy when the employer contributes).

- **Prescribes two extreme and flawed solutions to address the problem:**

1. Tax incentives: Glassman suggests a tax credit for children's health coverage — the same type of approach that was repealed in 1993 due to low participation, poor targeting, and fraudulent insurance practices. His tax credit would be available to anyone who qualifies for it with no overall funding limit — in other words, it would be an open ended entitlement. Ironically, this approach is more like one of the "vote-buying, bureaucracy-building monstrosities" that Glassman denounces than is the President's approach, which more efficiently covers uninsured children and does so with a cap on spending.

2. Charity: Glassman asserts that charity can pick up where the tax credit leaves off: if "government gets out of the way, more charities will eagerly fill whatever gap is created." Although charities make a critical contribution, they are the first to acknowledge that they "cannot do the job alone", as the president of the National Association of Children's Hospitals wrote in response. The fact that meaningful government effort is needed to expand children's coverage is acknowledged by policy experts, consumer and child advocates, providers, insurers as well as the Republicans and Democrats Glassman cites.

HISTORY OF THE 1990 CHILD HEALTH TAX CREDIT

SUMMARY

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

While the EITC remains in effect today, the health insurance credit was repealed in OBRA 1993 due primarily to: (1) low participation; (2) poor targeting of populations in need; (3) fraudulent insurance practices and oversight problems. Despite the Center on Budget and Policy Priorities' support of the EITC, Robert Greenstein testified to the child health tax credit's failure and supported its repeal — as did the Department of Treasury.

PROBLEMS WITH THE 1990 CHILD HEALTH TAX CREDIT

A General Accounting Office study and the Ways and Means Subcommittee on Oversight documented numerous problems with the policy, including:

- **Low participation:** GAO estimated that only about 26 percent of people eligible participated in the program. This is based on a division of 2.3 million into an estimated 8.8 million families eligible for the credit. It is not know how many of the 2.3 million participants gained coverage through the credit versus had coverage already.

- **Probably paid for coverage that would have been purchased anyway:** The policy did not differentiate between subsidizing existing versus new coverage. Thus, if the tax credit was not generous enough to induce uninsured families to purchase a policy, most of the subsidy went to families who would have been covered by health insurance anyway.

- **Amount insufficient to increase coverage**: In 1991, the average employee share of the family premium, according to a GAO study, was about $1,025; the average credit was $233. Thus, the GAO questioned the credit's ability to induce purchase of health insurance. The administration as well as the amount of the credit may also have decreased the effectiveness of the policy. Since the credit was only available at the end of the year, it was retrospective. Low-income families may have had "liquidity" problems: an inability to find the cash during the year to make the payments in hope of reimbursement in the next year.

- **Low awareness:** A GAO survey found that many EITC recipients who had purchased health insurance did not claim the credit. They cited lack of outreach as a major problem.

- **Plans told employees that they could not get any portion of their EITC if they did not purchase health insurance**: Some promotional material implied that the individual had to have health insurance premiums deducted from their paychecks in order to get the EITC advance. For example, an insurance plan in Texas had a notice that said, "COMPULSORY, NOT OPTIONAL: The credit for health insurance came into effect in 1991. Failure to comply can result in 'a penalty equal to the amount of the Advance EITC Payments not made'." Other plans also suggested IRS retribution would occur if they were denied access to employees.

- **Higher than expected premiums:** One of the most common complaints was that plans advertised that health insurance coverage was "free". Some plans falsely claimed that their premiums were totally covered by the health credit when in fact the health tax credit was insufficient and, unbeknownst to the employee, the remainder of the premium was deducted from the non-health EITC.

- **Ineligible and substandard policies**: Families often bought plans that did not qualify for the credit. Amount, duration and scope restrictions were often large, and some policies had pre-existing condition restrictions of 2 years. Some people bought cancer, dread disease, and other supplemental policies that were barely worth the paper that they were written on.

- **Limited information on plans:** People claiming the credit had to name the insurance plan (in 1991 only) and report the amount of the premium paid in filing for the tax credit. This minimal information made it very difficult if not impossible for Treasury to ensure that the credit was going to eligible families for the purchase of qualifying policies.

CONCLUSION

The experience with the OBRA 1990 child health tax credit has relevance to today's debate over insuring children. The Heritage Foundation has stated interest in reviving this particular policy and Senator Gramm has a comparable one in development. While some of the problems described above may be inherent in a tax incentive approach, others were specific to the structure of the 1990 child health tax credit and may be addressed through policy modifications (e.g., enlisting the states in the oversight of plans to reduce fraud).

The Washington Post
TUESDAY, FEBRUARY 11, 1997

THE PRESIDENT HAS SEEN
2-14-97

Monster Kiddie Care

When politicians start talking about how they're going to help poor, sick kids, watch out. Something bigger and more pernicious is afoot—in the latest case, trying to achieve, piecemeal, the government-run health system the nation rejected after President Clinton was elected the first time.

Clinton says in his new budget that he wants "to expand health care coverage to the growing numbers of American children . . . who lack insurance." He's proposing to spend $10 billion over the next five years; but that's just for starters. Senate Democratic Leader Tom Daschle has a more ambitious plan that would assist families that make up to $75,000 a year. Massachusetts Sens. Ted Kennedy and John Kerry want Washington to spend $9 billion annually.

It won't be easy for Republicans in Congress to oppose kiddie care—and don't Democrats know it! But before everyone is swept up in the emotional tide, let's examine some facts, as well as the heroic effort of one unlikely, unnoticed charity.

First of all, the government already helps sick kids. Medicaid, the $162 billion health program for the poor, covers children whose families earn up to 130 percent of the poverty level (even higher in some states). Three million kids who currently qualify for Medicaid don't receive the benefits; outreach may be in order, but not another entitlement.

In fact, the real problem is with the middle class. Michael Tanner of the Cato Institute points out that, according to the Census, 1.5 million families with incomes of more than $40,000 a year don't insure their children. Why not?

"They've simply decided to spend the money elsewhere," Tanner says. Insuring children is actually inexpensive—only about $100 a month, he says—since kids are far healthier than adults. Still, some parents would rather take their chances and pay out of their own pockets when a child breaks an arm. That's their decision, and the rest of us should not subsidize it.

Another reason parents don't insure kids is our insane tax system. Health insurance benefits provided by businesses to employees aren't counted as workers' income, so most of us don't buy our own health insurance directly, the way we buy life insurance, mutual funds or groceries. As a result, the marketplace doesn't provide the choices we truly want—including kiddie insurance that meets our own specifications.

There's an easy remedy. The current health-insurance exclusion reduces federal tax revenues by $85 billion a year—and most of that break aids wealthier Americans. Why not give all Americans the same amount in the form of a personal tax *credit*, which is like cash in their pockets, to use to purchase the insurance they really want? There would still be children who need health care, especially in a catastrophe. But why should we assume that government is the answer?

Last summer, researching another story, I ran across one of the great untold tales in health care: the Shriners Hospitals for Children. Yes, the same Shriners who wear funny hats and drive little motorbikes and hang out in clubhouses with a Mideast motif. While the 650,000 Shriners evidently have fun, they also do remarkably good deeds; and, since they don't blab like Clinton and Kennedy, they don't get proper recognition.

For 75 years the Shriners have been building and running hospitals for children. There are now 22 of them—19 that specialize in pediatric orthopedics and three that provide burn treatment. Last year, they admitted 22,000 children to the hospitals, performed 19,000 operations and recorded 221,000 outpatient visits.

All of this treatment is free. Completely, utterly free. The Shriners take no money from the government, no money from insurance companies or parents. Instead, the $425 million it takes to run the hospitals this year (including $20 million for research) comes from a $5 billion endowment, which itself was built slowly with small and large private contributions, including some from grateful former patients.

The Shriners love their independence, as do the doctors in their hospitals. Members of Congress are astonished to learn that the Shriners *don't* want Washington's money.

"If you start taking insurance money or federal money," Gene Bracewell, chairman emeritus of the Shriners, told me, "then you have to do it their way."

In fact, the process can work the other way around: the Shriners help the government. They've just worked out an agreement with the Veterans' Administration, at no charge, to treat spina bifida (a paralytic disease) in children of Vietnam veterans.

This new entitlement was based on bad science, but the Shriners don't care. As Raoul Frevel, a trustee of the Shriners Hospitals, told senators, "Our mission is to ensure that every child who has spina bifida or some other crippling disease receives top-quality medical care, regardless of ability to pay."

What a wonderful credo! I suspect that if the government gets out of the way, more charities will eagerly fill whatever gap is created.

Still, politicians of both parties prefer vote-buying, bureaucracy-building monstrosities like kiddie care. Instead of changing the tax code to open a competitive, robust health insurance market, they'd rather pose as the healers of sick children. In truth, the healers are unsung Shriners and millions of other compassionate private Americans.

Idea for Op Ed Piece

Response to Tony Snow's "Clinton's 'Kids First' hatched 4 years ago"

How do we address the 10 million uninsured children in America? This important question is being asked in Washington and in State capitols across the nation. Just recently, *USA Today* presented the compelling facts and faces of children who lack protection.

Yet, an honest discussion on children's health coverage is being clouded by misleading analysis if not intentional misinformation. A recent editorial by Tony Snow typifies the attempt to short-circuit the debate. Mr. Snow accurately states that most children have insurance through their parents' employers. He then implies that those who don't either are wealthy or immigrants, and consequently there is no problem to solve.

Let's look at the facts. While 70 percent of children were insured for the last two years, nearly one in three children spent time without insurance. Mr. Snow may think that this is "lamentable but hardly any reason for federal intervention". But, as *USA Today* reported, for parents like Janet and Daryl Thomas, whose nine-year old son has cerebral palsy, it is more than lamentable: annual medical bills of $12,000 can cause both financial and family ruin.

Second, Mr. Snow states that three-quarters of uninsured kids are immigrants. This is totally inaccurate. Not one of the 10 million children counted as uninsured is an illegal immigrant. By suggesting that immigrants are the major problem (wrong by any definition), Mr. Snow attempts to tap into the strain of anti-immigrant sentiment that has polluted open, fair policy debates in the past several years.

Third, Mr. Snow would be hard pressed to find many families who chose not to insure their children because they are willing to "take their chances". In fact, one study found that two-thirds of children who lose coverage do so either because their parents lose or change jobs or because they cannot afford coverage.

The truth is that about one-third of uninsured children are below poverty, most of whom are eligible but not enrolled in Medicaid. Another one-third are in families earning too much to qualify for Medicaid but too little to afford private coverage. And, the rest, with incomes above 200 percent of poverty are uninsured because their parents either have no access to affordable coverage or lost their ability to afford it when they lost or changed jobs.

These problems are undeniable, and these children are real. And State governors and legislators, Congress, and the President understand this. Most States have expanded Medicaid or funded their own special programs to improve kids' coverage. In Congress, bills are being written, hearings scheduled, seminars occurring — signs that a thoughtful, bipartisan debate about how to help children is about to begin. And the President has made a commitment in both his state of the union address and his budget to tackle this issue.

Yet, while the President has joined a large and growing group of concerned citizens, Mr. Snow singles him out. "ClintonCare" is back: the President has made up a problem in order to impose universal coverage on a public that does not want it, according his letter. This claim — that the only solutions are large, costly entitlement programs — has become the refrain of opponents of children's coverage. James Glassman, in the *Washington Post*, described such efforts as "vote-buying, bureaucracy-building monstrosities".

In fact, the President's budget contains several modest but important and targeted proposals. Without creating any new entitlement, it helps children eligible for Medicaid, just above Medicaid eligibility, and in families with workers between jobs. It does this without mandates through state grant programs that let them tailor their programs to meet their particular needs. This can hardly be called "ClintonCare", and certainly is not scary enough to end the debate before it begins.

It is time to put aside misleading facts and mischaracterizations. It is time to engage in a bipartisan, thoughtful dialogue to design ways to help ~~some if not all of the uninsured children.~~ expand coverage to the 10 million American children without insurance.

Clinton's 'Kids First' hatched 4 years ago

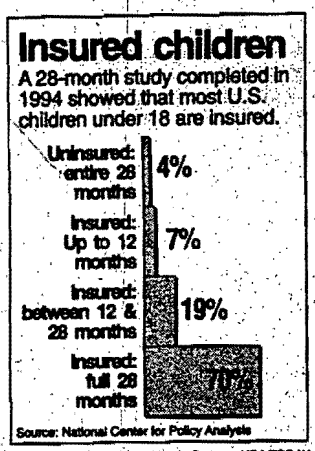
Who'd be against kids? No one, but the problem of uninsured children is overstated.

By Tony Snow

Call him cocky. Call him impetuous. Call him suicidal. President Clinton has decided to revive the health-care scheme that almost scuttled his presidency three years ago.

"We must continue ... to give more families access to affordable, quality health care," he declared in his State of the Union address. "Forty million Americans still lack health insurance. Ten million children still lack health insurance. ... My balanced budget will extend health coverage to up to 5 million of those children."

Now this may not seem like an attempt to revive ClintonCare. But a memo to Clinton dated April 4, 1993, outlined one politically tempting way to impose universal health care on the public. The idea was to start with kids — who can say no to children? Then-health care czar Ira Magaziner wrote: "The proposal is designed in two parts which will be implemented simultaneously: 1. The quick coverage of children — 'Kids First'; and 2. The development of structures for transitioning to the new system and phasing in of certain population groups."



This year's budget follows that outline. The president says he wants to help not only children, but also others such as AIDS patients and drug abusers. Yet now, as in 1994 when ClintonCare crashed and burned, the key question is whether we need such a heaping dose of government assistance.

The key to Clinton's plan is the assertion that 10 million children lack health insurance. This is true, but it's also misleading. At any given time, more than 40 million Americans lack coverage. More than 30 million of those people plug the gap within six months, however, according to The National Center for Policy Analysis. Only about 2.5% of our population (or 6 million) will go without insurance for two years or more. The point is, most of the "uninsured" don't stay that way long.

I'm a perfect example: My family had no insurance for one month in 1993 when I was moving from the Bush White House to profitable employment in the private sector. And my son spent the first 15 months of his life without coverage because I goofed up when filling out my medical forms. This was lamentable but hardly reason for federal intervention.

Secondly, the "insurance gap" is less a national problem than a border phenomenon. Three of every four uncovered children are in families that have immigrated recently. The states with the largest percentages of uninsured residents are New Mexico, Texas, California, Louisiana and Arizona.

Finally, lack of insurance is no indicator of helplessness. More than half of all uninsured children come from families with incomes of at least $30,000 or households eligible for Medicaid. And virtually no children get turned away when they need care. So the "crisis" is anything but. Despite the absence of a pressing crisis, Kiddie Care has a much better chance of passage than the president's ill-fated effort three years ago.

Clinton hasn't picked fights with any deep-pocketed enemies this time. His plan gives insurance companies a shot at covering those without insurance. He kept the American Medical Association quiet by leaving open the question of who should treat the young. And his plan wouldn't cost much at the outset. At $1.7 billion a year, it would consume less than 1/10th of 1% of the federal budget.

Still, there's a good reason to oppose Kiddie Care. Its "solutions" don't address the real problem. Federal regulations and tax laws, not insufficient government spending, have inflated health-insurance costs while forcing insurers to play Scrooge.

Today's system caters almost exclusively to large corporations because businesses alone can deduct from their taxes the costs of health insurance. As a result, people can't get coverage tailored to their own needs. Instead, workers purchase "cafeteria" plans designed to help "average" employees in vast companies or purchasing groups. Clinton's plan doesn't change that. In fact, it places even more power in the hands of the folks who have destroyed the old-fashioned family doctor — the insurance conglomerates and the HMO bean counters.

Give him credit for brazenness, though. ClintonCare is back. It's following a blueprint drafted three years ago. And it has a chance to become law, unless Republicans find some way to explain why it makes financial, economic and medical sense to say "no" to a program that says it can mean free salvation for 5 million uninsured kids.

Tony Snow is a syndicated columnist, host of Fox News Sunday *and member of USA TODAY'S board of contributors.*

USA TODAY
WEDNESDAY, MARCH 5, 1997

(202) 544-5321 - Fax

THE WHITE HOUSE

WASHINGTON

March 1, 1997

MEMORANDUM TO THE FIRST LADY

FROM: Chris J. CJ

SUBJECT: Follow-up on Monday's Meeting on Uninsured Children

cc: Bruce R., Gene S., Melanne V.

At last Monday's meeting on uninsured children, you asked for three items:

1. A response to the Glassman "Monster Kiddie Care" op ed piece (FYI, the President also noted that piece and we plan on forwarding a similar response to him as well).

2. More details on the repealed 1990 EITC child health tax credit.

3. An amended "uninsured children" chart that adds the distribution of the total number of children.

The President's briefing on child health issues is on hold pending a final conversation with Sylvia about how the President would best like it structured. We are also waiting to see if he has had a chance to review the February 21 memo. If the President decides he would like an internal staff briefing, we are of course ready to be responsive at any time. The one exception to this is Monday, when I will be in Fayetteville at the request of David Pryor to teach a few of his classes, to brief some of his new faculty colleagues and to meet with some local health care providers.

Speaking of the President, Rahm told me last night that the communication folks are still thinking that we might want to use the March 14 radio address (when the President will be down in Florida) for a children's coverage message event. We think it might be a very good opportunity because of Governor Chiles' school-based children's coverage program, which his staff believes could be expanded by our proposed grant initiative. Gene informed me today, however, that we may focus on a new health care fraud and abuse package that the President could unveil in Florida; Florida is a good place for this unveiling because it is the fraud and abuse capitol of the country and because of Chiles' aggressive efforts in this area. It is unclear whether we have time to do more than one health event during the Florida trip.

Lastly, I saw a number of Republican Congressional staff yesterday. Although they do not have an idea of what their final budget constraints will be, they are currently assuming that Republican members will probably include some type of children's health expansion. More importantly, they did acknowledge that there are legitimate concerns about tax incentive approaches (this is not to say that they won't find it necessary to include them for political reasons). We will keep you apprised of ongoing developments.

RESPONSE TO "MONSTER KIDDIE CARE" OP ED

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- **Misdiagnoses the "real" problem.** Glassman wrongly suggests that the "real problem" is the 1.5 million children whose parents earn more than $40,000, and are willing to "take their chances" and not insure their children:

    - First, the 1.5 million children he cites represents only 15 percent of the 10 million uninsured children.

    - Second, of the 1.5 million children, most of them have incomes that are at or just above $40,000, which is below 250 percent of poverty for a family of four — certainly not people who can easily afford annual premiums of at least $6,000 (about the average family premium).

    - Third, and most importantly, many of these children are uninsured because their parents: (1) are not offered insurance in their jobs; (2) are offered but cannot afford family coverage because, unlike most American workers, their employers make little or no contribution toward coverage; or (3) did buy coverage through their employer but lost their ability to afford it when they lost or changed jobs.

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PROBLEMS WITH THE 1990 CHILD HEALTH TAX CREDIT

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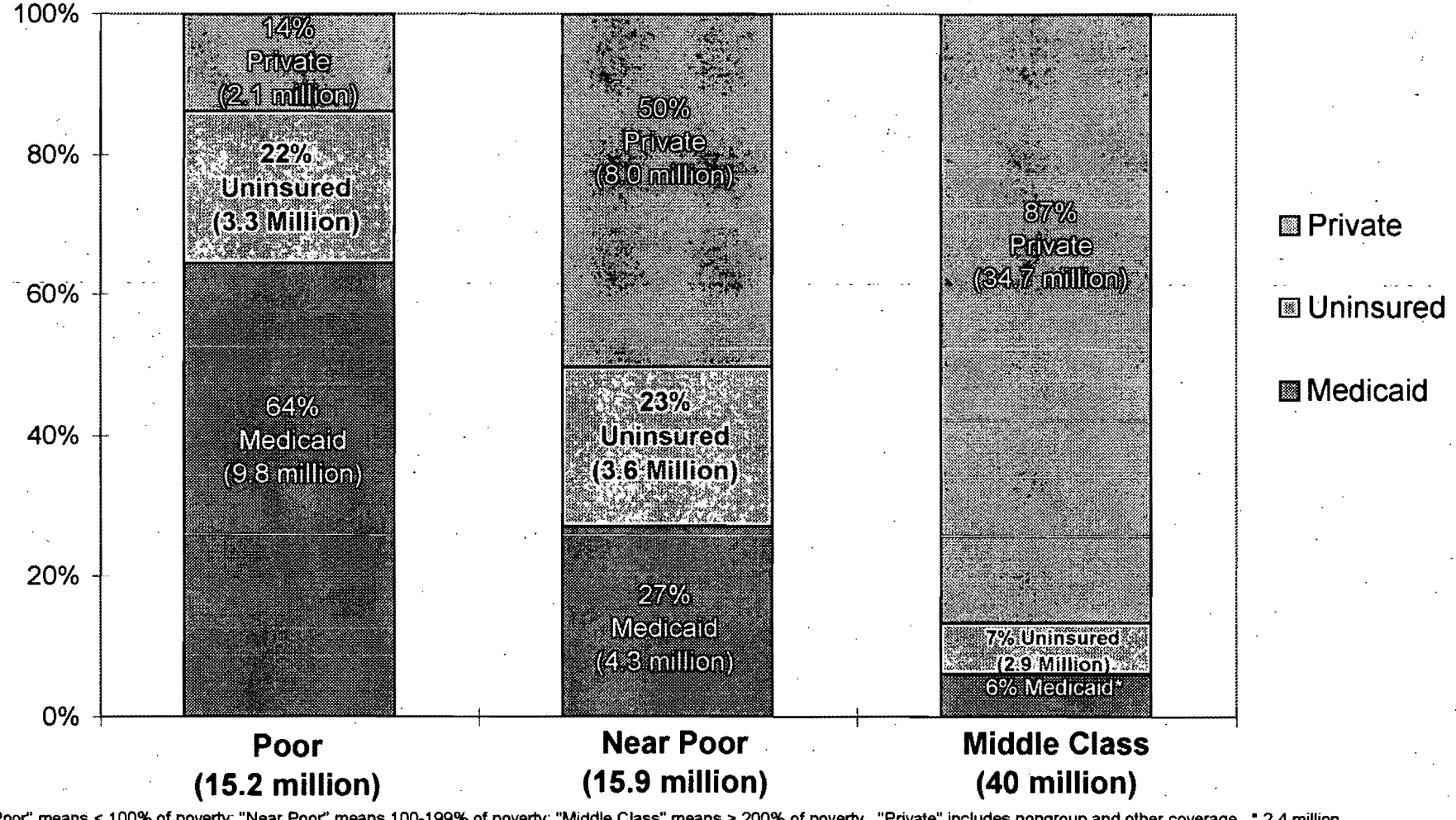
Children's Health Coverage, 1995
Proportion of Children Covered by Different Sources



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage. * 2.4 million.
Note: The number of children covered by Medicaid is less than 18 million due to under-reporting on this survey. Source: EBRI, 1996

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TUESDAY, FEBRUARY 11, 1997

James K. Glassman

Monster Kiddie Care

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In fact, the real problem is with the middle class. Michael Tanner of the Cato Institute points out that, according to the Census, 1.5 million families with incomes of more than $40,000 a year don't insure their children. Why not?

"They've simply decided to spend the money elsewhere," Tanner says. Insuring children is actually inexpensive—only about $100 a month, he says—since kids are far healthier than adults. Still, some parents would rather take their chances and pay out of their own pockets when a child breaks an arm. That's their decision, and the rest of us should not subsidize it.

Another reason parents don't insure kids is our insane tax system. Health insurance benefits provided by businesses to employees aren't counted as workers' income, so most of us don't buy our own health insurance directly, the way we buy life insurance, mutual funds or groceries. As a result, the marketplace doesn't provide the choices we truly want—including kiddie insurance that meets our own specifications.

There's an easy remedy. The current health-insurance exclusion reduces federal tax revenues by $85 billion a year—and most of that break aids wealthier Americans. Why not give all Americans the same amount in the form of a personal tax *credit*, which is like cash in their pockets, to use to purchase the insurance they really want? There would still be children who need health care, especially in a catastrophe. But why should we assume that government is the answer?

Last summer, researching another story, I ran across one of the great untold tales in health care: the Shriners Hospitals for Children. Yes, the same Shriners who wear funny hats and drive little motorbikes and hang out in clubhouses with a Mideast motif. While the 650,000 Shriners evidently have fun, they also do remarkably good deeds, and, since they don't blab like Clinton and Kennedy, they don't get proper recognition.

For 75 years the Shriners have been building and running hospitals for children. There are now 22 of them—19 that specialize in pediatric orthopedics and three that provide burn treatment. Last year, they admitted 22,000 children to the hospitals, performed 19,000 operations and recorded 221,000 outpatient visits.

All of this treatment is free. Completely, utterly free. The Shriners take no money from the government, no money from insurance companies or parents. Instead, the $425 million it takes to run the hospitals this year (including $20 million for research) comes from a $5 billion endowment, which itself was built slowly with small and large private contributions, including some from grateful former patients.

The Shriners love their independence, as do the doctors in their hospitals. Members of Congress are astonished to learn that the Shriners don't want Washington's money.

"If you start taking insurance money or federal money," Gene Bracewell, chairman emeritus of the Shriners, told me, "then you have to do it their way."

In fact, the process can work the other way around: the Shriners help the government. They've just worked out an agreement with the Veterans' Administration, at no charge, to treat spina bifida (a paralytic disease) in children of Vietnam veterans.

This new entitlement was based on bad science, but the Shriners don't care. As Raoul Frevel, a trustee of the Shriners Hospitals, told senators, "Our mission is to ensure that every child who has spina bifida or some other crippling disease receives top-quality medical care, regardless of ability to pay."

What a wonderful credo! I suspect that if the government gets out of the way, more charities will eagerly fill whatever gap is created.

Still, politicians of both parties prefer vote-buying, bureaucracy-building monstrosities like kiddie care. Instead of changing the tax code to open a competitive, robust health insurance market, they'd rather pose as the healers of sick children. In truth, the healers are unsung Shriners and millions of other compassionate private Americans.

Health Care for Poor Children

Monday, February 24 1997; Page A18
The Washington Post

On behalf of the nation's children's hospitals, which devote a disproportionate share of their care to children of low-income families, I take strong exception to James Glassman's muddled Feb. 11 op-ed column "Monster Kiddie Care."

Mr. Glassman is correct that Medicaid is the sine qua non of public health coverage for children of low-income families. It pays for the health care of one in four children and one in three infants.

But Mr. Glassman misrepresents the issue of uninsured children. He focuses on the 1.5 million children in families with incomes of more than $40,000 but ignores the fact that 7 million uninsured children live in families with incomes of less than $26,000 -- most of them working families. He also ignores the fact that this nation's health insurance system is built on employer-based insurance, yet it is rapidly disappearing as companies drop coverage they feel is too expensive.

While tax credits may have the potential to help families, a guarantee of their effectiveness is by no means as simple as Mr. Glassman suggests. Congress created an earned income tax credit for children's health insurance in 1990 and was forced to repeal it within a few years because it didn't work.

Finally, the charitable motivation that drives and sustains the Shriners is to be commended and honored, just as is true of the extraordinary charitable giving that children's hospitals receive. But these same hospitals know from firsthand experience that charity, no matter how strengthened, cannot do the job alone.

Our nation's 75 million children deserve basic health protection if for no other reason than because they will grow up to work longer and harder to support Mr. Glassman's generation. They deserve better than his ill-conceived proposals.

LAWRENCE A. McANDREWS

President and Chief Executive

National Association of Children's Hospitals

Alexandria

Back to the top

THE WHITE HOUSE
WASHINGTON

THE PRESIDENT HAS SEEN
3-10-97

February 21, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed and Gene Sperling

SUBJECT: Background Information on Uninsured Children

Following up your meeting with Erskine on Friday, we asked Chris Jennings to provide you with the attached detailed background memo on the status of uninsured children in the nation, a description of possible policy options to address the problem, and an overview of the budgetary and political environment that surrounds this issue. We have also asked him to give you a status report on TennCare and the possible lessons Governor McWherter's legislative success could teach us about the upcoming debate on children's coverage.

Both parties in Congress are considering a number of ways to expand coverage to children: tax incentives, grants to states, Medicaid reform, and vouchers. There is no consensus yet either on the most sensible policy or on the most politically viable approach.

Because we expect this issue to be a top priority in budget negotiations, we have begun a joint DPC-NEC process to review and analyze continually evolving options that are emerging from the Congress. We will use this process to provide you with updated information and to develop sound policy options as the budget debate progresses. We have scheduled a meeting with you on Monday to discuss this issue with you further.

THE WHITE HOUSE

WASHINGTON

February 21, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings CCJ

SUBJECT: Background Information on Uninsured Children

This memo responds to your request for background information about uninsured children. It includes:

(1) A summary of the problem and recent trends that define it;
(2) A description of who the uninsured children are and why;
(3) A brief description of the challenges of covering children;
(4) An overview of the major approaches to covering children; and
(5) An overview of the budgetary and political environment surrounding this issue.

In addition, there are two attachments, one that describes in detail our children's policies and a second on TennCare. Since you have indicated an interest in the status of TennCare, we have attached a three-page summary of the history and status of this innovative program. I asked Nancy-Ann Min to review and edit this document to make certain it provides you with a balanced and up-to-date portrayal of the TennCare experience.

UNINSURED CHILDREN: DESCRIPTION AND TRENDS

Number of Uninsured Children

- **In 1995, 10 million, or 14 percent, of all children lacked health insurance.** This proportion is higher than age groups over 45 years old (13 percent), but less than the 18 to 44 year old age group (about 25 percent). Despite major changes in the private health care coverage (outlined below), the proportion of uninsured children has hovered around 13-14 percent for almost a decade.

Trends

- **Employer coverage has declined.** While the proportion of uninsured kids is unchanged, it hides an underlying trend: coverage of children through employer plans has decreased (from 67 percent in 1987 to 59 percent in 1995). While some have asserted that this decrease stems from employers dropping dependent coverage, two facts challenge this theory. First, the proportion of adults as well as kids with employer coverage has declined, from 70 percent in 1988 to 64 percent in 1995. Second, about 80 percent of uninsured children have uninsured parents. This suggests that the decline in employer coverage is a family problem, not just a children's problem.

  One of the major reasons for the decline in employer-sponsored insurance has to do with the change in the U.S. labor market. Since the 1980s, industries have tended to outsource (subcontract with smaller firms) and hire more part-time workers; these workers are less likely to have health insurance. Additionally there has been a shift away from industries that are more likely to offer insurance, like manufacturing, to industries that often don't offer insurance, like retail. Finally, there has been an increase in workers in firms with less than 25 workers; about 30 percent of workers in firms with fewer than 25 employees lacked health insurance in 1995, relative to about 12 percent for workers in firms with 500 or more employees. In short, it is not that firms are dropping children's coverage so much as employment is shifting to firms less likely to offer insurance.

- **Medicaid coverage has increased, but is slowing.** The reason why the decline in employer coverage has not increased the number of uninsured children is Medicaid. In 1990, Federal law required states to begin phasing in coverage of poor children. As a result, the proportion of children covered by Medicaid increased from 16 percent in 1987 to 23 percent in 1995.

  Recent research suggests, however, that Medicaid did not necessarily help the children who lost their parents' employer coverage. Instead, it expanded coverage to families who did not have full-time workers, lowering the number of uninsured poor children at the same time as the employer trend increased the number of uninsured near poor children.

  While Medicaid has stabilized the proportion of the nation's children without insurance, its expansion is subsiding. In 1994 and 1995, the number of children covered by Medicaid barely increased. This is now reflected in lowered projections of the number of children covered by Medicaid in the future. The Congressional Budget Office (CBO) projects that the number of children covered by Medicaid will grow no faster than general population growth over the next 10 years.

- **Proportion of uninsured children may increase.** If recent trends continue (employer coverage declines and Medicaid expansions slow) and state and Federal government efforts are not stepped up, the number of uninsured children will rise.

WHO ARE UNINSURED CHILDREN

- **Most in working families.** Over 80 percent of uninsured children have a parent who works (two-thirds of these children's parents work full year, full time) (Chart 1).

- **Income varies.** There are large numbers of uninsured children across the income spectrum. In 1995, more than 3 million uninsured children were in families in each of the following income groups: poor, near poor (between 100 and 200 percent of poverty), and middle class (above 200 percent of poverty). Families just above poverty (between 100 and 150 percent of poverty) had the highest rate of uninsured children (24 percent), probably because they are above the Medicaid thresholds but have too little income to afford private coverage (Chart 2).

- **Concentrated in the south and southwest.** There is wide variation in the proportion of uninsured children across states. A disproportionate number of children reside in the south and southwest; in 1995, about 43 percent of all children but 55 percent of all uninsured children resided in these states (Chart 3). In part this reflects those states' Medicaid programs: southern states are less likely to have taken advantage of Medicaid options to expand coverage to children. This concentration also reflects these states' higher prevalence of low-income families, industries that don't provide health insurance, racial and ethnic groups less likely to be covered by insurance, and noncitizens (up to 22 percent of uninsured children — 2.2 million — may be legal immigrants).

WHY ARE CHILDREN UNINSURED

1. **Parents change jobs.** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs (Chart 4). About 30 percent of all children, regardless of income, spent at least one month without insurance between 1992 and 1994. In fact, when looking at workers with one or more job interruptions, they are over three times more likely to spend some time without insurance (42 percent relative to 13 percent of workers continuously employed). Thus, middle class children are at risk of losing insurance due to parents' job changes.

2. **Parents earn too much for Medicaid but too little for private coverage.** The highest rate of uninsured children is among families above poverty but below middle class. Low-wage workers are more likely to be employed by firms that do not offer health insurance; only 36 percent of workers earning less than $5 per hour in 1993 were employed by a firm sponsoring health insurance. Since the individual market for health insurance is volatile and costly, families without access to employer coverage may have few options. Even when these families are offered employer-sponsored insurance, they cannot always afford it. When job-related insurance loss is put to the side, the most important reason why children lose insurance is that it is too expensive for the family.

3. **Eligible but not enrolled in Medicaid.** Medicaid has not reached all of the children who qualify for it. An estimated 3 million uninsured children are eligible but not enrolled in Medicaid. Nonparticipation in Medicaid varies considerably across states; one report estimated that the proportion of these children ranged from a low of 7 percent in Vermont to 46 percent of eligibles not enrolled in Nevada. While there are no definitive studies on this problem, some reasons why this occurs include: lack of awareness of eligibility; the welfare stigma associated with Medicaid; cumbersome application processes; and availability of other coverage in the state (employer or state program).

CHALLENGES TO COVERING CHILDREN

Policy options to cover uninsured children usually share the goal of trying to cover the most children for the least amount of money. Children are probably the least expensive population to insure. Their health insurance premiums range from $800 to $1,600, depending on factors like the child's health status, the benefits, and the delivery system. Assuming that an initiative could successfully cover all and only uninsured children at $1,000 per child, the Federal costs would be $10 billion annually — not a small sum. While this amount does not take into account any state, private and family contributions, it also does not consider upward pressures on costs resulting from two challenging issues: (1) substitution of Federal dollars for current employer and state contributions; and (2) administrative complexity of the option. The extent to which an option addresses these issues is central to determining both its cost and coverage potential.

- **Substitution or "crowd out".** Given that uninsured children are not a homogenous group, it is important to design policies that encourage the enrollment of uninsured children but discourage enrollment of already-insured children. Participation in any health insurance program depends both on the families' interest in health insurance and the attractiveness of the policy. While the former cannot be altered, the latter is determined by a policy's visibility, benefits, ease of application, and, most importantly, cost. The higher the premium subsidy, the greater the likelihood of participation.

  The goal of encouraging participation of the uninsured is often at odds with an equally strong desire to ensure that already-insured children do not drop their current coverage. Almost any new initiative risks substitution of Federal coverage for employer coverage, known as "crowd out". Generally, employer crowd out is a problem with policies that extend above 200 percent of poverty, since the number of children with employer coverage increases with income. A different type of crowd out happens when the new initiative replaces state or Medicaid coverage of children. Since most states have used Medicaid options or have funded state-only programs for children, it is nearly impossible to design a policy that does not overlap with at least a few states' programs. Both types of crowd out are problematic because they increase Federal costs without increasing covered children.

- **Administration.** In any subsidy program, there is a conflict between the desire to target efficiently and to limit complexity and bureaucracy. Targeting requires sophisticated rules and protections against substitution of existing coverage and fraud and abuse. This results in a large bureaucratic role in determining eligibility, implementing the program, and enforcing the rules. However, the organization charged with administering the program (probably states and/or the IRS) may not be willing or able to manage this role. Finding the appropriate administrative balance is particularly important in children's initiatives given the heightened complexity of the problem, described above.

Given these issues, it is impossible in a voluntary system to cover more than two-thirds to three-quarters of the 10 million uninsured children without large-scale substitution of Federal dollars for current employer health insurance payments. If one tried, the costs would be prohibitive — much more than the $10 billion per year in the theoretical, perfectly targeted situation. This is because it would unavoidably cover children who now have employer insurance. Moreover, to the extent to which the policy is designed to mitigate employer crowd out with rules, it risks penalizing responsible employers. The best way to prevent employer crowd out is to prevent employers who insure children from eliminating that coverage. Yet, this effectively mandates the employers who have responsibly insured children to maintain that coverage, while letting employers who have not been so responsible off the hook. This helps explain why at some level one cannot get beyond a certain threshold of uninsured people without an individual or employer mandate.

OPTIONS FOR COVERING CHILDREN

Recognizing the complexity of the problem and the challenges in addressing it, proponents have considered four general approaches to increase health insurance coverage for children: tax credits, state grants, Medicaid expansions, and more traditional subsidy programs linked to a new entitlement (usually called vouchers). Clearly, there are other types of approaches, such as employer/individual mandates or a Medicare program for children. While such policies might well be more efficient to administer and more comprehensive in effect, they are not viable by any measure of today's economic and political environment. This section describes the four most considered approaches generally and discusses the major issues surrounding them.

1. **Child health tax credits.** Child tax credit proposals use a built-in system to give subsidies to families that have purchased coverage for their children. Usually this subsidy is granted either in a retrospective, annual refundable tax credit or as "advances", using changes in the withholding on payroll checks like in the earned income tax credit (EITC). While some proposals make the amount of the credit income-related, others have proposed flat credit amounts for all families. All rely on the IRS to administer and to some extent monitor the credit through tax withholdings, filings, refunds and audits.

Proposals for tax credits for children's health coverage are frequently poorly targeted since their goal is to help all families — not just uninsured families — afford coverage. While this approach is equitable, it also is an expensive way to increase coverage since more money will go to families with insurance than without insurance. Additionally, the ability of the IRS to administer a child health tax credit is not proven. In 1991-1992, it oversaw a child health tax credit that was repealed in 1993 for many reasons, including problems that Treasury encountered in monitoring fraud and abuse.

2. **Grants to states.** A second option is to give states grant money to let them design their own programs. Today, most states sponsor non-Medicaid programs, often in partnership with the private sector. In Florida, for example, the Healthy Kids Program combines local, state and family contributions to cover low-income children through schools (we may want to highlight this program at or around your visit to Florida in March). Grant programs allow Federal money to either leverage these types of state programs or create new ones (like the workers between jobs initiative).

States are probably the most efficient vehicle for administering a child health coverage initiative, since they already manage the health care coverage for 18 million children on Medicaid. However, the flip side of this advantage is that they have an incentive to use any new grant money to replace state spending. It is hard to design policy "walls" that prevent this from happening.

3. **Medicaid.** Given the central role that Medicaid already plays in covering children, expanding Medicaid is one of the simplest ways to increase kids' coverage. There are three ways that Medicaid could be changed to increase the number of children covered. First, the current program could be improved. As described earlier, Medicaid intends but does not succeed in covering all eligible children. Legislative and regulatory changes could be made to make Medicaid more accessible and last longer once the child is in the system (e.g., improve outreach, allow states to extend continuous coverage for 12 months). Second, states could be given either more flexibility or a financial incentive to expand optional coverage. For example, states could be allowed to charge premiums to children above the mandatory levels, as is done in several 1115 waiver states. Third, Federal law could be changed to require states to cover more children. However, concerns about unfunded mandates makes any Medicaid mandate extremely difficult to support.

Medicaid options, like others, risk crowding out employer coverage, but the potential is usually low since they mostly focus on populations without access to employer insurance. This low employer crowd out, coupled with low state crowd out (since it builds on rather than replaces Medicaid), make Medicaid options among the most efficient. However, using Medicaid places administrative constraints on the option. It is hard to ask states to use Medicaid to administer a policy that is substantially different than Medicaid in terms of eligibility and benefits.

4. **Vouchers.** A fourth option is a 100 percent Federally funded entitlement program for children's health coverage. This approach allows for national standards for coverage and eligibility but usually relies on states to administer the program.

   This approach, like tax credits, is hard to target. Vouchers create a large financial incentive to substitute Federal for employer and/or state funding. Some options have developed complex eligibility rules to minimize this risk (e.g., restricting eligibility to children uninsured for six or more months). However, the more concerted the effort to keep insured children out of the program, the more difficult it is to implement. And, since the Federal government does not have offices equipped to determine eligibility and deliver subsidies (aside from the IRS), this administration would likely fall to states.

These approaches are not mutually exclusive and can be used in combination. For instance, a state grant program can be coupled with a tax credit to assist families in purchasing coverage. Alternatively, a grant program could be designed to begin where Medicaid coverage ends. Not only are these combinations possible; they may be needed since no single approach can cover the diverse group of uninsured children.

In fact, our children's health initiative uses multiple policies rather than a single, one-size-fits-all approach. We take on the three reasons why children lose coverage through: a grant program for children losing coverage when their parents lose their jobs; a grant program for children with too much income for Medicaid but too little to afford coverage; and a package of Medicaid improvements to target children who fall through the cracks (see attachment for more details). We chose this approach because it covers several rather than one group of uninsured children, it limits crowd out, and it strengthens our partnerships with states. The risk of our policies' crowding out private coverage is not large because (a) the workers between jobs initiative only provides dollars when employer contributions cease (ie., when the worker becomes unemployed) and (b) the state grant and the Medicaid proposals focus on kids that usually do not have private coverage. Administratively, the proposal works with existing state systems rather than requiring Treasury to set up a new program.

The disadvantages of the proposal are, first, that it relies heavily on leveraging state and private dollars, so that covering 5 million children is a best-case scenario. The Medicaid improvements and state grant program require state dollars. State and Federal money in the baseline is used to cover the 1 million poor children phased into Medicaid under current law. While we project that 1 to 2 million children will be enrolled in Medicaid through outreach, we have not explicitly funded it in the budget. Second, we have put the least amount of money toward the group that may have the greatest problem: children in working families without access to employer insurance. Beyond the low level of funding of our proposal ($750 million per year), any state grant program targeting this group is vulnerable to states' substituting this money for existing state funding. Third, on the political front, our proposal does not integrate the approach that is most frequently included in Congressional proposals: tax incentives.

While many Congressional proposals also use a combination of policies, they almost always include some type of tax incentive — clearly the option of choice for Republicans and many Democrats. This reflects Members' attempt to avoid the appearance of a new open-ended Federal program [ironically, the provisions in your proposal are all capped, while tax incentives are open ended, since they entitle a class of people to a particular subsidy]. We did not include such a proposal in our children's health initiative because of concerns about crowd out and because the Department of Treasury believes such approaches are extremely difficult to administer. However, given the potential for both additional money for coverage and Republican support that comes with tax proposals, we will work aggressively on options that could integrate them.

CONCLUSION: CURRENT BUDGETARY AND POLITICAL ENVIRONMENT

As described above, there are countless approaches to expanding coverage for children. And, there will inevitably be additional "unveilings" of proposals in the near future. That a consensus has not developed early in the debate is not surprising. In fact, it is a generally positive development for it gives Members the opportunity to be invested in whatever option can emerge from the Congress. It also gives us the ability to provide helpful technical advice that concurrently keeps us informed of Hill approaches and gives us the opportunity to steer policy options in appropriate directions.

Unfortunately, however, the opposition to our Medicaid per capita cap and DSH policies continues to complicate our ability to get a positive "lift" from our $18 billion investment in coverage expansion. The advocates and Governors — who should be our allies on a children's coverage initiative — are dedicating most of their time and resources to fighting our Medicaid policy. This is despite the fact that we are saving only $9 billion off an over $600 billion, 5-year Medicaid baseline. The disappointing consequence of the Governors' and interest groups' lack of advocacy for our proposal may well be that Republican Members and staff may think that there is little price to pay for deleting coverage investments from the budget.

Having said this, there continues to be strong interest among the Democratic Leadership to include a significant health coverage expansion in any final balanced budget agreement. Succeeding in getting such a high priority item in the final budget might help us keep key Democrats on board in what will be an otherwise difficult vote.

The Blue Dogs are planning on releasing their budget proposal next week. Initial reports suggest that they are going to avoid significant tax cuts and investments at this point. This includes initiatives in the area of children's health coverage. However, Blue Dog staff have suggested that they are taking this position for strategic reasons. They believe it enables their Members to bargain back votes using their excess savings, and have suggested that this could include investments in health care. Notably, the most conservative Members of this coalition (Condit and Hall) have expressed interest in policies to address workers between jobs.

Even more noteworthy has been a quiet movement among a number of Republicans (Gramm, Specter, Jeffords, Chafee, Archer and Bliley) to consider a major health coverage expansion investment for children. This obviously contrasts dramatically with the last Congress, which pushed the coverage issue off of any legislative priority list.

Despite this encouraging news, it remains unclear whether the interest in children's coverage, particularly among Republicans, will be retained after budgetary limitations and policy complexities are imposed on Members. In response, many Republicans may conclude that coverage expansions should be a low priority for them.

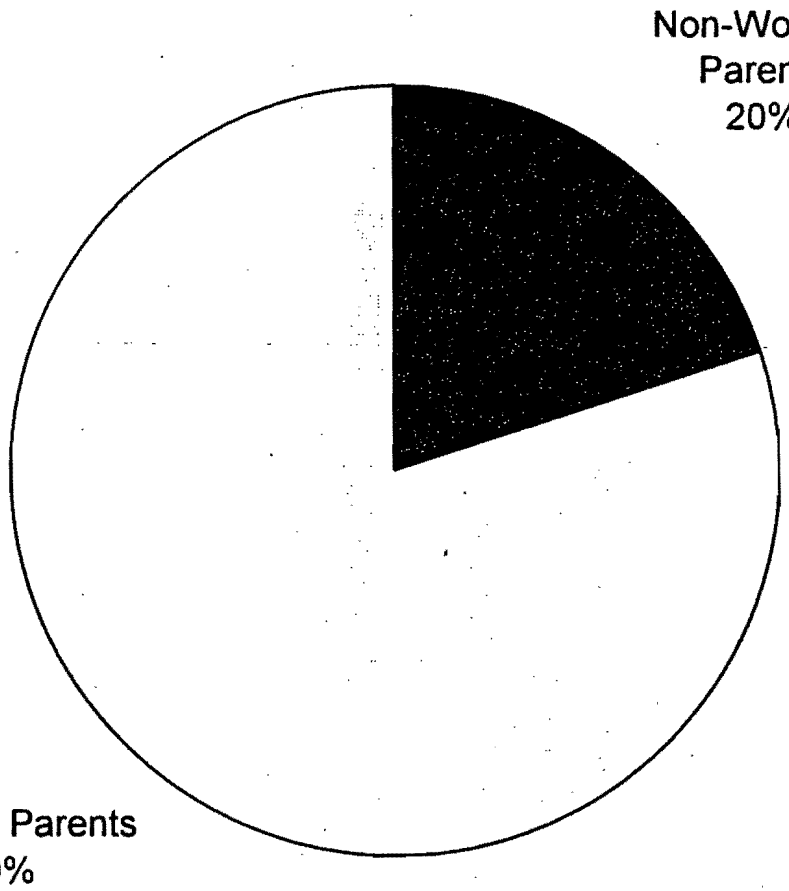
To keep a credible number of Republicans on board will require either major positive or negative incentives (or some combination of both). On the positive side, Republicans will have to believe that they will get at least some of the credit for the policy; they rightly think that Democrats — and particularly you — always get the lion's share of the credit for any health initiative. On the negative side, we will have to create an environment in which they feel they cannot reject a particular children's coverage policy without risking severe political consequences.

To this end, we will need to dedicate time for you and other Administration representatives to highlight the importance of expanding coverage in the context of a balanced budget, stressing the need for a bipartisan commitment in this area. We also will work with influential interest groups to let them know that they need not endorse the particulars of our approach but that they must send strong, unified signals that it is critical to make investments in children's health coverage in this year's budget.

John Hilley agrees that our best Congressional strategy may well be to directly or indirectly continue to encourage Republicans to get out in front of this issue and introduce their own approaches. Even if we find ourselves disagreeing with their policies, we should resist public criticism or comment. The most important goal for now is to get the budget committees to direct the authorizing committees to finance some coverage improvements. If they do, we will have assured funding for an initiative and will still have sufficient time to raise concerns at the authorizing committee level about particular approaches.

As Bruce and Gene mentioned in their memo, we are continuing our DPC-NEC policy review process to monitor legislative evolutions on the Hill and to determine whether we need to re-position our policy or modify our strategy. This process will enable us to evaluate new Hill proposals in great detail, provide you with Administration-wide opinion of them, and to make recommendations to you about legislative, communications and political strategy around children's health proposals.

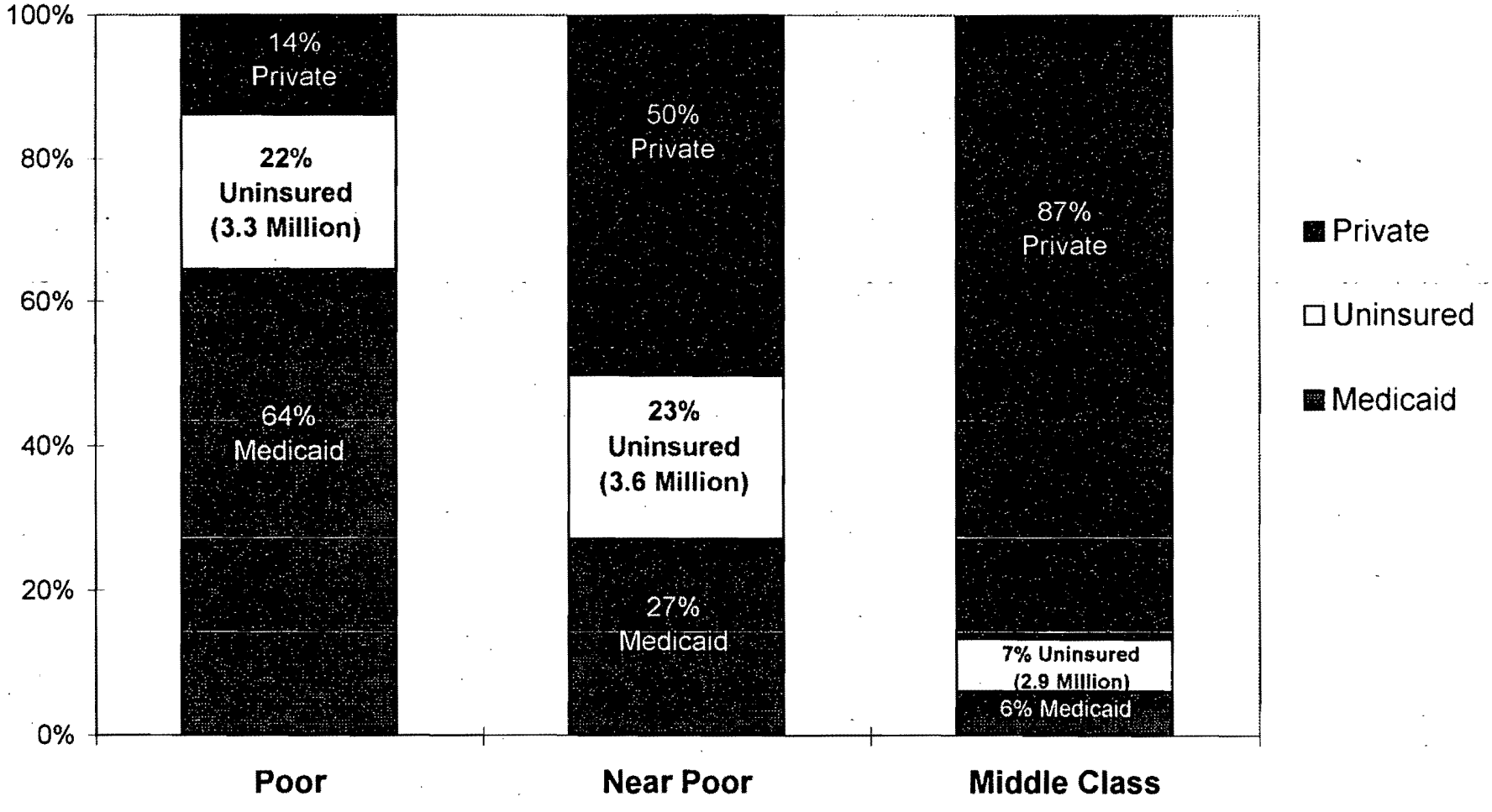
Most Uninsured Children Have a Parent Who Works



Note: 56% of children (two-thirds of working children) have parents who work full year, full time
Source: EBRI, 1996

Chart 1

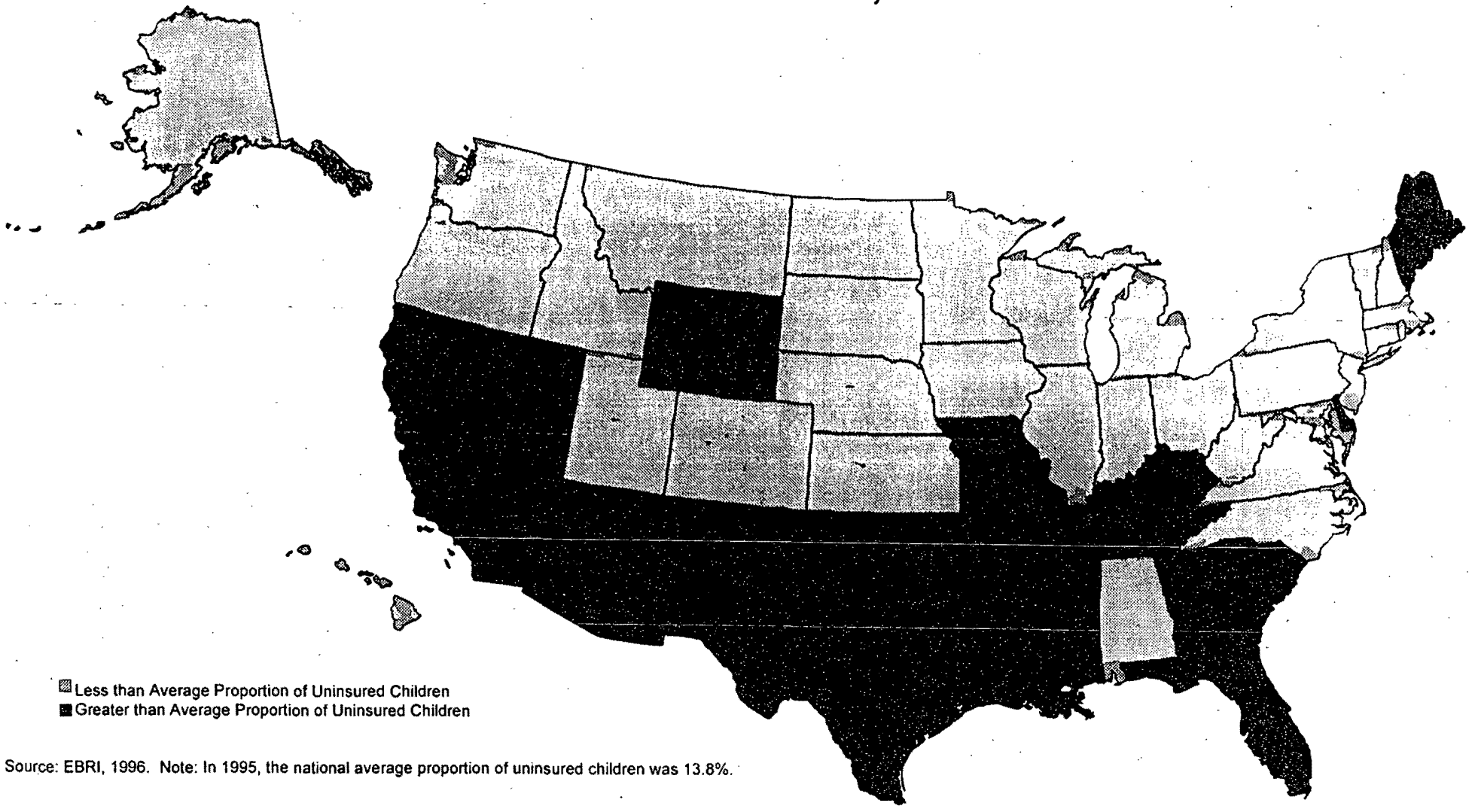
Children's Health Coverage, 1995
Proportion of Children Covered by Different Sources



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

Chart 2

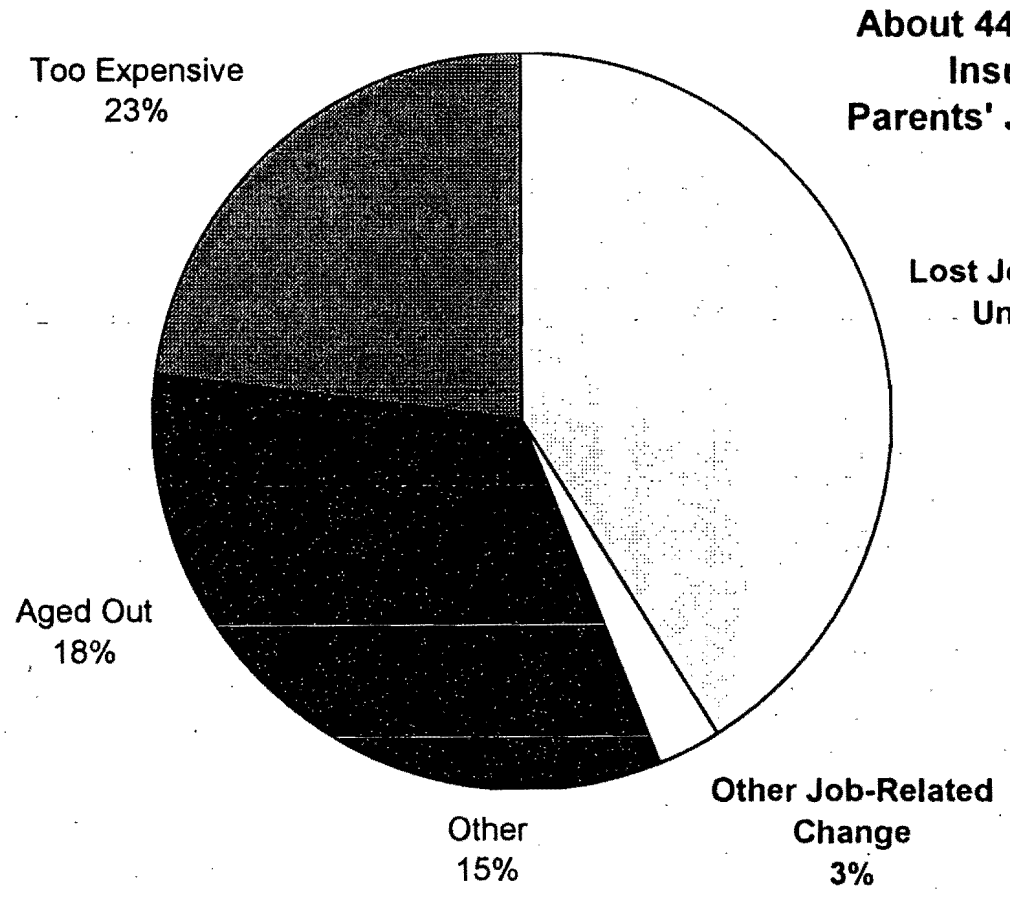
Uninsured Children, 1995



Source: EBRI, 1996. Note: In 1995, the national average proportion of uninsured children was 13.8%.

Chart 3

Reasons Why Children Lost Health Insurance



Note: "Other Job-Related Change" includes shifting to part-time work and employer ending coverage; "Aged Out" means that the child's age change ends eligibility; "Other" includes death or divorce of parent and voluntary termination, etc. Includes children under age 22.

Source: Sheils & Alecxih, 1996.

Chart 4

PRESIDENT' FY 1998 BUDGET
CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. While there are many different reasons why children lack insurance, most uninsured children can be found within three groups, each of which require separate initiatives:

- **Children at risk because their parents change jobs:** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs.

- **Children whose parents earn too much for Medicaid but too little for private coverage:** The highest rate of uninsured children is among families who earn too much to qualify for Medicaid but too little to afford coverage. Nearly one in four children in families with income just above poverty have no health insurance.

- **Children eligible but not enrolled in Medicaid:** Medicaid has not reached all the children who qualify for it. About 3 million children are eligible but not enrolled.

Working with States, communities, advocacy groups, providers, and business, the President's initiative will extend coverage to up to 5 million children by 2000.

Continuing Coverage for Children Whose Parents are Between Jobs

- The President's budget will give States grants to temporarily cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window.

- The program would offer temporary assistance (up to 6 months) to these families between jobs who have lost their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. States have the option to participate in this grants program, which is structured as a four-year demonstration.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. Only families who do not have access to Medicaid or insurance through a spouse's employer and are receiving unemployment compensation are eligible.

- This program will help an estimated 3.3 million working Americans and their families, including 700,000 children.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for their workers and children.

Building Innovative State Programs for Children in Working Families

- The President's budget provides $750 million a year in grants to States ($3.8 billion between 1998 to 2002). States may use these grants to offer reduced-price insurance for children and leverage State and private investments in children's coverage through a matching system (using the Medicaid matching formula).

- The Federal grants, in combination with State and private money, will target uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage. The grant program will also improve Medicaid enrollment since some families interested in the new program will learn that their children are in fact eligible for Medicaid.

- Grants may be used to target the unique problems facing children in each State. The program builds upon the successful efforts of States that have tailored programs to address the particular gaps in coverage for their children. For example, the Florida Healthy Kids program uses schools to enroll and insure children. States have flexibility in designing eligibility rules, benefits and delivery systems. In return for this flexibility, States will provide annual evidence of positive outcomes of the grant money — specifically the number of uninsured children it helps.

Strengthening Medicaid for Poor Children

- The President's budget preserves and strengthens Medicaid's guaranteed coverage for low-income children. In addition to improving coverage for the 18 million children already covered by Medicaid, it continues the commitment to expand coverage to another one million children between the ages of 13 and 17.

- The President's budget gives States the option to extend one year of continuous Medicaid coverage to children. This will cost an estimated $3.7 billion between 1998 and 2002.

    - Currently, many children receive Medicaid protection for only part of the year. This is because Federal law requires a family that has a change in income or some other factor affecting eligibility to report it immediately, possibly making them ineligible for Medicaid.

    - This policy allows States to waive the more frequent redetermination and guarantee coverage for up to one year. This benefits families who will have the security of knowing that their children will be covered by Medicaid for at least a full year. It will also help States by reducing administrative costs and managed care plans by enabling them to better coordinate care.

- The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

PRESIDENT'S FY 1998 BUDGET
CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. While there are many different reasons why children lack insurance, most uninsured children can be found within three groups, each of which require separate initiatives:

- **Children at risk because their parents change jobs:** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs.

- **Children whose parents earn too much for Medicaid but too little for private coverage:** The highest rate of uninsured children is among families who earn too much to qualify for Medicaid but too little to afford coverage. Nearly one in four children in families with income just above poverty have no health insurance.

- **Children eligible but not enrolled in Medicaid:** Medicaid has not reached all the children who qualify for it. About 3 million children are eligible but not enrolled.

Working with States, communities, advocacy groups, providers, and business, the President's initiative will extend coverage to up to 5 million children by 2000.

Continuing Coverage for Children Whose Parents are Between Jobs

- The President's budget will give States grants to temporarily cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window.

- The program would offer temporary assistance (up to 6 months) to these families between jobs who have lost their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. States have the option to participate in this grants program, which is structured as a four-year demonstration.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. Only families who do not have access to Medicaid or insurance through a spouse's employer and are receiving unemployment compensation are eligible.

- This program will help an estimated 3.3 million working Americans and their families, including 700,000 children.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for their workers and children.

Experience in TennCare

- **What is TennCare?** In 1994, under a 1115 waiver granted by you, Tennessee converted its Medicaid program to a managed care program for virtually every one of its Medicaid recipients and also opened enrollment to all uninsured people in the state. It subsidized premiums for the uninsured, on a sliding scale basis, all the way up to 400 percent of poverty. (For example, families just above poverty paid $25 a month; families at 400 percent of poverty paid $366 a month; families above 400 percent of poverty paid $462 a month; and uninsurables — families who have extremely sick individuals — paid $562 a month). Due to a number of factors (explained below), enrollment of the uninsured ended after one year. However, the state plans to re-open enrollment to uninsured children in April 1997.

- **History of Tennessee's Waiver**. The idea for TennCare came from a need to avert a financial crisis facing Tennessee combined with a desire to expand coverage to the uninsured. In 1993, Tennessee and other states with large Medicaid disproportionate share hospital (DSH) programs were about to have their DSH funding limited by recently enacted laws. Tennessee's DSH spending was nearly 20 percent of the state's total Medicaid spending in 1992, among the highest in the nation. Governor McWherter, his Commissioner of Finance, and a small staff put together a plan that would capture the DSH funding through a "demonstration" or 1115 waiver program in which the state would use that money to expand coverage.

  In May 1993, Governor McWherter gained approval of a plan from the state legislature and set about the task of getting it Federally approved and implemented by January 1994, when the state legislature reconvened. During the summer and fall of 1993, he negotiated with the Administration and was granted the waiver in November; by January 1, 1994, the demonstration began.

- **Rapid Expansion in 1994**. In early 1994, TennCare not only switched virtually all of its Medicaid recipients to managed care, it increased its enrollment by nearly 50 percent to cover an additional 400,000 previously uninsured people. By January 1995, when Governor Sundquist took office, TennCare enrollment was at its peak of 1,259,895. This included about 450,000 previously uninsured people. The increase in the number of the uninsured pushed Tennessee's coverage numbers ahead of most states and ALL southern states in the nation; although statistics vary, the state was covering over 90 percent of its population — an impressive achievement by any measure.

  However, the first year was marked by several problems. Many providers rebelled against the "cram down" policy in which the state would not contract with providers for state employees if the providers did not also treat TennCare patients. Additionally, both Medicaid and uninsured people were confused over how to enroll and had difficulty in determining whether their providers were in their network. Finally, there were reports of serious fraudulent marketing practices by managed health care health plans. Specifically, prisoners were illegally enrolled; homeless shelters were targeted to sign up people who would never receive services; young healthy white males were enrolled while anyone who looked ill was avoided; and people who were already covered by Medicaid were told they would lose their Medicaid if they didn't sign up for a particular new managed care plan.

- **Reduced TennCare enrollment in 1995 and 1996.** Due to first year implementation problems and state budget pressures, Governor Sundquist closed enrollment of new uninsured applicants (except for "uninsurables"), increased premiums and collection efforts, and implemented more stringent eligibility verification. As a result, there were 78,500 fewer enrollees as of December, 1995. In August of 1996, the TennCare Bureau announced that it would cut tens of thousands of additional names from the rolls, saying that it lacked current addresses and the enrollees failed to respond to mail inquiries about their eligibility. At the same time, Blue Cross, which covers nearly 50 percent of TennCare enrollees, announced that it would freeze enrollment of TennCare recipients. As a result of these reductions in enrollment, there were 1,148,148 people enrolled in TennCare, as of February 11, 1997.

- **Other challenges facing TennCare.** The provider community has consistently raised major quality, access, and payment concerns about TennCare. They threatened not to serve TennCare patients, but (other than a brief time of protest) most physicians are still serving the beneficiaries. The public hospitals who used to receive large DSH payments, like the "Med" in Memphis, have had a particularly hard time sustaining economic viability. However, with some financial and oversight assistance from the Federal Government, these problems and the marketing abuses outlined above, seem to be being addressed over time. For example, the state has commissioned a detailed study of access, cost and utilization to improve the operation of the program. Probably the most concerning development has been a recent rise in the infant mortality rate. This rate has not increased since 1987 and it happens to coincide with a time in which TennCare is covering over half of the state's live births.

- **Expanding to kids in 1997.** On January 13, 1997, the Governor announced that, for the first time in two years, enrollment in TennCare would be opened. It would extend coverage to poor children between 14 and 18, and would allow families with higher incomes to buy their children into TennCare. Governor Sundquist believes that they will be able to enroll 51,000 more children.

Part of the reason for this initiative is the managed care plans' concerns about the risk selection without re-opening enrollment. According to John Ferguson, State Finance Commissioner, "the addition of uninsured enrollees is needed for the health of the program" since TennCare "has lost the healthier ones whose premiums help pay for the care of others." Tony Garr, head of the advocacy group, Tennessee Health Care Campaign, confirms this more pragmatic rationale: "opening enrollment is the only option for the state. They need to do it to preserve the integrity of the program...."

- **Does TennCare serve as a model for other states to expand coverage?** Given the experiences in this program, the jury is still out as to whether TennCare is a model program for other states to emulate. It is a major accomplishment that 450,000 Tennessee residents who would otherwise have been uninsured have benefited from this program. And, even though the number of uninsured has been increasing in recent years, there are at least 300,000 more people insured than there were prior to the implementation of TennCare. However, as mentioned above, there are persisting challenges, particularly in terms of risk selection and quality. Most importantly, however, because of the unique disproportionate share financing arrangement the Administration provided to Tennessee, the TennCare model would be extremely difficult to replicate in other states.

- **Why is TennCare difficult to replicate?** First, there are only a handful of states (NH and MO among them) that have enough DSH dollars and political will to divert that money from public hospitals toward new coverage. Second, the low-DSH Governors -- who represent the vast majority of the country -- would oppose such an approach both because they would not benefit and because they believe that those who would only could do so because they "gamed" the system in the first place. Third, DSH money available is being reduced in our balanced budget proposal; it is now contributing about $15 billion of our total $22 billion in gross Medicaid savings. Unfortunately, a reduction in DSH savings would require an increase in savings from the unpopular per capita cap.

- **Lessons of TennCare:**
  First, rapid movement from fee-for-service coverage to managed care achieves savings that can be invested back into coverage expansions. Unfortunately the savings may not be sustainable for long periods of time (TennCare plan premiums have seen some notable increases); moreover, since most states are already moving rapidly toward a greater use of managed care, future savings will be limited. Having said this, as we provide states with easier access to managed care (through the elimination of managed care waivers), we should strongly encourage them to reinvest their savings into coverage expansions.

  Second, outside financing sources (TennCare used their DSH dollars) will be necessary to have any major expansion of coverage. Your budget explicitly recognizes this point by reinvesting about $18 billion in support of increased access to insurance.

  Third, Governors will likely learn that it is extremely difficult to successfully exchange constraint in provider reimbursement for coverage expansion without utilizing a McWherter-type model that rushes the proposal through the legislative process. Unfortunately, providers are now better prepared to oppose this strategy specifically because of the TennCare experience.

  Fourth, the downside of legislative successes like TennCare is that they almost inevitably produce implementation problems (as has been the case in Tennessee) that are extremely challenging. Quality and access issues frequently arise because of rapid and confusing changes in the delivery system. Additionally, providers who oppose the changes are quick to point out — in the most public ways possible — any real and/or perceived problems.

  Finally, the TennCare experience supports the idea that efforts to significantly expand new coverage must be done in a way that covers the healthy as well as unhealthy populations to guard against adverse selection. The problem in a predominantly voluntary program is that it is extremely difficult to entice healthy uninsured people to join without high subsidies. This argues for carefully designed approaches to incremental reform. Expanding coverage to a group like kids, for example, might be a way to both limit the Federal dollars and get healthy people enrolled, since many parents want to cover their children regardless of their health.

Arkansas ArKids File

THE WHITE HOUSE

WASHINGTON

February 11, 2000

MEMORANDUM

TO: John Podesta
FROM: Chris Jennings and Bruce Reed
RE: Arkansas Medicaid Issue
cc: Mickey Ibarra, Karen Tramontano, Bruce Lindsey

As you may recall, we have been reviewing a controversial issue in Arkansas's Medicaid program. The state has been giving poor parents whose children are eligible for Medicaid the option of enrolling them in the ARKids waiver program, which is targeted to higher income children and has higher cost sharing and fewer benefits than Medicaid. HCFA sent a letter to the state in October stating that this practice was not permissible – which set off a firestorm of calls from state advocates, officials and the Governor.

In response, we agreed to review the initial HCFA interpretation in the context of improvements that the Governor committed to implementing to remove barriers to enrolling in Medicaid (which make a fair choice between programs now impossible). HHS recently concluded that, while it has the discretion to allow this practice, it does not believe that it is advisable on policy grounds. In short, they believe that: (1) even if it were possible to eliminate the bias against Medicaid, no family would rationally choose ARKids so why bother; and (2) approving "choice" in Arkansas will make it extremely difficult to refuse additional states' requests and would inevitably lead to a blurred line between Medicaid and CHIP, undermining the Medicaid entitlement.

We let the President know about the HHS decision in a recent weekly report. In the margins, he wrote, "we need to discuss this; this looks like enough to me," referring to the actions that the state has taken to eliminate barriers to Medicaid enrollment. In light of the President's initial response to this situation, but also taking into account the major controversy that will result regardless of the decision that we make, we believe that we need to be sure he is comfortable with any action on this issue. We would like to meet with you about this to discuss how to reach resolution and develop a roll-out strategy.

BACKGROUND

ARKids First is a Medicaid waiver program approved in 1997 that provides health insurance coverage to children between 100 and 200 percent of the poverty level. The waiver gives the state significant flexibility in the provision of cost-sharing and benefits; in fact, ARKids First is charging higher copayments than is allowed even under the new, extremely flexible CHIP program. And, like CHIP, it limits the EPSDT benefit in Medicaid and over other 15 services provided by the traditional Medicaid program.

Last spring, we learned that the state is giving families the option of enrolling their children in ARKids when they are actually below poverty and eligible for Medicaid. State officials – and some advocates – argue that this helps overcome the Medicaid stigma. If not given the option of enrolling in ARKids, some parents wouldn't enroll their children at all because they do not want them in a Medicaid "welfare" program. However, all parties involved acknowledge that, given the different applications, enrollment processes and marketing practices in Arkansas, families may not be presented with a fair choice. For instance, while parents have to go to welfare offices to sign their children up for Medicaid, they can use a mail-in application for ARKids.

(1) Allows them to overcome "welfare" stigma.

In October, HCFA wrote a letter to state officials informing them that it did not view this practice as permissible under the terms of the waiver and told the state to end it. Governor Huckabee immediately responded in a press conference and, the next week, in a Republican response to the President's radio address. He claimed that the President was denying Arkansas's families' "freedom of choice" and that this would cause "thousands of our state's children" to lose their coverage since their parents' pride would prevent them from enrolling them in this "welfare" program. The President wrote a letter to the Governor, informing him that we would look into this matter.

In November, Arkansas officials submitted a proposal to HCFA, stating that it would: (1) use one application for both programs; (2) allow mail-in applications for Medicaid; (3) rename Medicaid to be include "ARKids" so the outreach activities for this new program would carry over to Medicaid; and (4) simplify – but not eliminate – the assets test. All involved agree that these are important improvements, but the biggest single barrier to enrollment is the assets test which would not be removed.

(2) AR simplified enrollment for Medicaid, but retained the assets test.

HHS'S POSITION

HHS has reviewed Medicaid and CHIP law and policy and concluded that: (1) it is a policy and not legal choice to approve the ARKids waiver; and (2) we should not approve it. When HHS approved the ARKids waiver in the first place, a great number of people in the advocacy community (Families USA, Children's Defense Funds, Center for Budget and Policy Priorities, etc.) felt that it sets a bad precedent and puts poor children unnecessarily at risk. Their concerns were reflected in the final compromise on the CHIP legislation included in the BBA 1997. The new statute requires that states cover Medicaid-eligible children under Medicaid and prohibits them from enrolling them in CHIP. The Congress reached this agreement for three major reasons. First, there was concern that states would game the CHIP program to get the higher CHIP matching rate. Second, children's advocates were very concerned that poor children could lose access to Medicaid's more comprehensive benefit package. And third, the same advocates thought that the CHIP block grant would creep into and undermine the Medicaid entitlement. As such, this is probably the most important provision to advocates and Congressional Democrats. They are all watching this situation closely and a decision in favor of the state would not only set off loud criticism but could jeopardize Democratic support for our other Medicaid / CHIP initiatives – since they will fear that we are on a slippery slope to eliminating Medicaid's guarantee to health services.

(3) Advocates feel strongly that Medicaid eligible children only be enrolled in Medicaid.

STATE'S POSITION

The arguments made by the state and advocates are also compelling. Notwithstanding the strong opposition from national children's advocacy groups, consumer advocates and providers in Arkansas seem to be quite pleased with the program. About 50,000 children have been enrolled. Its outreach program is a national model, and Arkansas is one of the few states whose number of uninsured dropped significantly last year. Amy Rossi, a children's advocate and friend of the President, believes that it has been an extremely successful program and validates the Governor's contention that there are parents who would choose no insurance over Medicaid if that were the only option. In fact, she believes that up to 30 percent of the Medicaid-eligible ARKids population would refuse to enroll their children in Medicaid.

Moreover, the Congressional Republicans as well as the NGA have made this a cause celebre – yet another example of the Republican party's support for choice and personal responsibility. They will argue that President's own home state has been forced to patronize families by not giving them the choice to responsibly pay low copayments for their children's health care. We anticipate that this "choice" issue will be a central health policy resolution at the upcoming NGA meeting. It is even possible that our denial will result in legislation to override it and play a role in the election.

OPTIONS AND TIMING

The only option short of a denial is to see if we can work with the state on a constrained demonstration / pilot project. A pre-condition to discussing the demonstration would be eliminating the assets test. As a reminder, one of our budget policies is to require states that have eliminated this test in CHIP to do so in Medicaid. We would also have to construct a set of data monitoring and evaluation requirements to distinguish this from a run-of-the-mill Medicaid waiver. That said, it is not clear that either side would be happy with this conclusion. Such a demonstration would involve state system changes and a concession on the assets test, which may not be forthcoming. From the left, it may not be different enough from ordinary waivers to prevent its use as a blueprint for other states. It would still likely cause outrage from the same Democratic members of Congress that we are working with to pass the patients' bill or rights, the coverage initiative and Medicare reform. Also, the Department is opposed to moving in this area. We would have to bring Donna in to discuss this option before approaching the state and should be prepared for a push-back.

If we choose to deny the waiver, we will need to plan a careful roll-out that minimizes the news. First and foremost, it would have to be after the NGA winter meeting, scheduled for February 26 through 29, to prevent it from becoming a central point of discussion there. Second, given the President's involvement in this issue, we may need to have him make a phone call to the Governor, Skip Rutherford, and/or Amy Rossi. Bruce, Mickey and I are available to meet with you as soon as possible. We all agree, though, that we need to get guidance from you early next week in advance of the upcoming NGA meetings.