

Coverage Expansion / Clinton 2000
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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

January 19, 2000

REMARKS BY THE PRESIDENT
ON HEALTH CARE

The Oval Office

11:50 A.M. EST

THE PRESIDENT: Good morning, everyone. I'm glad to be joined today by Secretary Shalala, Secretary Herman, Deputy Secretary Eizenstat, and OPM Director Janice Lachance. We want to talk to you about the health care of America's families, one of the biggest challenges we face still in this new century.

Today I want to talk about two major proposals that are in my budget for 2001, which will help Americans to shoulder the cost of health care, by extending coverage to millions of people who do not now have it and by helping Americans of all ages meet the demands of long-term care. These proposals are a significant investment in the health of Americans, another step toward giving every American access to quality health care.

As our nation ages and we live longer lives, we face the need to provide long-term care to larger and larger numbers of Americans. Yesterday we put forward proposals to help Americans to face these new challenges, first by providing a \$3,000 tax credit for the cost of long-term care. That is three times the one I proposed in last year's State of the Union. Second, by expanding access to home-based care through Medicaid; and third, by establishing new support networks for care givers. We shouldn't let another year go by without helping those who are doing so much to help others. And I will say again, we should also, this year, pass the patients' bill of rights.

We must also keep fighting to extend affordable health care to Americans who lack it. This is a continuing problem in our nation, as all of you know. Still there are too many children who lose their hearing because an ear infection goes untreated, or wind up in the emergency room because they couldn't see a doctor in a more regular way. Too many parents skimp on their own health to provide coverage for their children; too many missed chances to prevent illness and prepare young people to lead healthy lives -- all these the product of the fact that tens of millions of Americans still don't have affordable health care.

So today I'm announcing that my budget will set aside more than \$100 billion over 10 years to expand health care coverage. If enacted, this would be the largest investment in health coverage since the establishment of Medicare in 1965, one of the most significant steps we could take to help working families.

This proposal has four components. First, it's hard to have healthy children without healthy parents. We know parents who have access to health care themselves are more likely to get care for their children. And children who see their parents getting regular medical care learn good habits that last a lifetime. Yet, most of the parents of the children covered in our Children's Health Insurance Program, the CHIP program, are themselves uninsured.

That's why, as the Vice President has urged, I propose to allow parents to enroll in the same health insurance program that now covers

their children. I thank the Vice President for this proposal. I believe it can make a difference to millions of families. You all remember that we set up the CHIP program in the 1997 Balanced Budget Act.

Second, we will work with states to reach every child now eligible for CHIP or for Medicaid. We've doubled the enrollment in the CHIP program in just the last year, as the states have really gotten up and going and taken the right initiatives on this. We now have something over 2 million children in the program.

But, still, many children are missing out. To find them, we have to take information and enrollment to where they and their parents are -- in school lunch programs, in day care facilities, in centers for the homeless. Our budget will fund efforts to do just that, because there is no reason for any child in America to grow up without basic health care.

Third, we are reaching out to Americans who have few or no options for affordable insurance. The numbers of people without insurance are growing fastest among those nearing retirement, an age when many people already on fixed income or have limited health insurance choices.

I met a woman who lost her home trying to pay medical bills on a retirement income while she was waiting to become eligible for Medicare. This shouldn't happen to anyone. I've already proposed that this group of Americans be allowed to buy into Medicare coverage -- that is, those between the ages of 55 and 65. And now, this new budget will provide for them a 25-percent tax credit to help them do it.

It's also hard to keep insurance for those who change jobs or are laid off, something that happens more and more in our fast-moving economy. That's why we have the COBRA benefits, allowing workers to pay to stay enrolled in health insurance when they're laid off. But too many workers cannot pay the full costs themselves. That's why we're also proposing tax credits that will make COBRA insurance affordable to more people, and help workers take advantage of job flexibility without worrying every single day that they may lose their health insurance coverage if they do so.

We will also build on public and private sector insurance programs to help cover 19 and 20-year-olds aging out of insurance, people moving from welfare to work, employees of small businesses and legal immigrants.

Finally, we must strengthen the network of clinics, hospitals and dedicated professionals who serve the uninsured. They care for families in need and help to provide the referrals that get children and parents into insurance programs. And their resources are stretched very thin. So I will ask Congress to make a significant investment in these public health facilities next year.

Investing in health care coverage is a smart choice for America. We're meeting our responsibilities to all our American citizens, supporting seniors, helping make our children more ready for the future. I look forward to working with Congress to seize these opportunities this year.

Again, let me say what I have said so many times: In my lifetime we have never had this much economic prosperity and social progress with the absence of paralyzing internal crisis or external threat. We have an opportunity now to really make a dent in this problem of health insurance coverage, in the problem of long-term care, and we ought to do it. I hope we will.

Q Mr. President, are you happy that health care is an issue on the campaign trail? And what do you think of Bill Bradley's plan? You seem to be endorsing Gore here.

THE PRESIDENT: His plan is more extensive than mine, too, the Vice President's is. But they're in a different position. Number one -- let me answer your first question -- I am elated that health care is an issue in the campaign. It is a good thing. It's an issue in people's lives. You can see that every time we debate a health care issue. You can see that support we got for the Children's Health Insurance Program in '97. You can see it in the enormous grass-roots support for the patients' bill of rights.

And, just as Hillary and I predicted in 1994, when the health care proposal was defeated, we said there would be an increase in the number of uninsured people because the cost of insurance would go up and it would be harder for employers, particularly smaller business employers, to continue to cover their employees. So I think that what's going on in the campaign is a great thing for America.

Both the candidates have proposed -- made proposals even more sweeping than the one I make today, even though if this were adopted, as I said, it would be the biggest expansion in health coverage since Medicare. But the reason -- they should be doing that because they're looking at what they can do over four years, what they can do over eight years. This is a proposal for this year's budget, and it is a very ambitious one-year proposal that will add millions of people to the ranks of those with insurance.

It also is very important because of the \$3,000 long-term care tax credit. That's something that I've been involved with, well, for more than 20 years now, something that I feel I know something about and I care a great deal about, and I believe there will be a lot of bipartisan support for that.

Go ahead, Mark.

Q What makes you think that you can get a more expansive health care program through Congress this year than you were able to get through last year?

THE PRESIDENT: Well, for one thing, the budget picture is clearer. At least so far the Republican leadership in the Congress has not put on the table a tax program which would make it impossible to pay the debt off and make it impossible to meet our fundamental obligations.

And I believe if you just look at what's going on in the election season this year, the public cares a lot about health care and they're talking a lot about it. And all these people, without regard to their party, who come here in the Congress, they've been home talking to the people they represent, they've been listening to this, they know what their folks are up against, they know what kind of problems people face with long-term care. And I think they also, those with a lot of experience, understand how very complex this is and how difficult it is to add to the ranks of the insured in a cost-effective way. And this is clearly, based on our experience, the most cost-effective way to add people to the ranks of the insured.

Let the parents of kids in the CHIP program buy into CHIP -- or cover them with our funds. And let the people between the ages of 55 and 65 buy into Medicare and give them a tax credit to do so. Republicans, you know, naturally are inclined to have tax solutions to social problems, and in the case of long-term care, that is exactly the right thing to do. The tax credit is exactly the right way to go there, because there are so many different kinds of long-term care options out there that are appropriate for different families given different circumstances. So I'm actually quite hopeful that we can work together and get something done on this.

Q Do you think Harry and Louise will support you this time?

THE PRESIDENT: Well, I hope so. They've been acting like they want to support me. And I'd like to get together with Harry and Louise; I thought they were pretty effective last time, and we ought to be on the same side. So I'm hoping old Harry and Louise --

Q After what they did to you?

THE PRESIDENT: I wish they would come into the Oval Office here and we could have a little press conference, a Harry and Louise press conference, endorsing this expansion of health coverage.

Q Can we cover it? (Laughter.)

THE PRESIDENT: You bet. I want you all to be here. It will be a crowded room if they come, but I'd love it if Harry and Louise would just sidle right on in here and say that they think this is the greatest idea since sliced bread and we could go forward together. And it would be great.

Q Mr. President, you've spoken to President Assad. Do you have any reason to believe that the peace talks will restart soon?

THE PRESIDENT: Well, first of all, I think it's very important that you -- I think this has been well and accurately reported, as nearly as I can tell. But I want to reiterate, neither side has decided to back away from the peace talks, call an end to them, call a freeze to them. That's not what's going on. They are having a genuine dispute about sequencing now that I'm trying to work through for both of them.

But the good news about this is that both these leaders I think want a peace that meets each other's needs. That is, they're both quite mindful of the fact that there won't be a peace agreement unless the legitimate concerns of both sides are met.

And I would not say the gaps in the positions are 90 percent; I'd say they're much closer to 10 percent than 90 percent. But keep in mind, these folks had not dealt with each other in a very long time. And that week they spent together at Shepherdstown was really the first time they had had these kind of direct contacts, get a feel for where they were, they wanted to go home and reassess their positions. And so we need to do some trust-building, we've got some work to do, but I'm actually quite hopeful.

And I see that both sides have continued to evidence a fairly high level of confidence that they can succeed, and that's good news. So we're in a little patch here where I've just got a little extra work to do, and I'm working at it. And hopefully, we can do it.

Q -- Assad today or yesterday?

THE PRESIDENT: Yes, I talked to President Assad, I think yesterday, wasn't it --

Q But since then --

THE PRESIDENT: No, not since yesterday morning. But I'll be in regular contact with him continuously. So we're working this very, very hard. And, of course, we're also working on the Palestinian track, and tomorrow Chairman Arafat will be here and I expect to have a good meeting with him. You know, if this were easy it would have been done a long time ago -- but we're working at it, and I'm pretty hopeful.

Q Are you mournful that tomorrow is the last -- the start of your last year in office, sir?

THE PRESIDENT: Yes, tomorrow is the day, isn't it?

Q Yes.

THE PRESIDENT: Well, I will certainly mark the day.

Q In what way?

THE PRESIDENT: I mean, I'll just be conscious of it, in all kinds of little ways. When I go in a room in the White House now I look around more carefully to make sure there's something -- that I've actually noticed something that I may not have seen. You'd be amazed when you're living a busy life and you're working really hard -- I bet it happens to you, too -- how many times you walk in and out of a room and you'll see something in a room that, you've been in the room for five years and you never noticed before. So I'm sensitive to all that.

But I'm actually very -- I'm so grateful that the country is in the shape that it's in. And I'm so grateful that I've had the chance to serve. And I'm so energized about the State of the Union and, in many ways, in the sweep and depth of the proposals that I will make to the Congress and the country in the State of the Union are arguably the most far-reaching since the very first one I made. So I'm feeling good and grateful, and I just want to milk every last moment of every day.

The only thing, I wish I didn't have to sleep at all for a year. (Laughter.) I wish that God would give me the capacity to function for a year without sleep. That would make me very happy. (Laughter.) But I think it highly unlikely; therefore, I will keep trying to get some.

Thank you.

END

12:03 P.M. EST

THE WHITE HOUSE

WASHINGTON

January 18, 2000

STATEMENT ON HEALTHCARE COVERAGE EXPANSION

DATE: January 19, 2000
LOCATION: Oval Office
BRIEFING TIME: 9:30am – 10:00am
EVENT TIME: 11:05am – 11:15am
FROM: Bruce Reed, Gene Sperling, Chris Jennings

I. PURPOSE

To unveil your new initiative, which invests over \$110 billion over 10 years to expand health insurance coverage to an estimated 5 million uninsured people.

II. BACKGROUND

Attached is the press summary of the health insurance expansion initiative that you are announcing tomorrow. This initiative invests over \$110 billion over 10 years. It expands coverage to an estimated 5 million uninsured people and gives millions more access to care. We have categorized policies into four categories, as follows:

- (1) **Providing a new, affordable health insurance option for families.** This proposal, to expand coverage to the parents of children eligible for Medicaid or CHIP, is the centerpiece of the initiative. The NGA has advocated for expanding CHIP to parents on a number of occasions and we expect states will be enthusiastic about this option. There is also a “failsafe mechanism” so that, if by 2006 states have not expanded coverage to parents at or below poverty, they would be required to do so. This makes a big difference in assuring that this initiative is efficient, well-targeted and gets a lot of take-up by the uninsured.
- (2) **Accelerating enrollment of uninsured children eligible for Medicaid and S-CHIP.** As we announced last week, CHIP enrollment doubled in the last year, to 2 million enrolled. This does not include the increased enrollment of children in Medicaid, which counts towards our target of covering up to 5 million uninsured children. This initiative includes a number of policies that both states and advocates agree are effective at improving enrollment. An additional 400,000 uninsured kids are expected to enroll as a result.

(3) **Expanding health insurance options for Americans facing unique barriers to coverage.** The budget includes a number of policies targeted to special groups of Americans who lack access to affordable options: older Americans, people in transitions (between jobs, turning 19 and entering the workforce, leaving welfare for work), workers in small businesses, and legal immigrants. The policies build on Medicare, private insurance and Medicaid to give these people affordable options and cover an estimated 600,000 uninsured people. They include:

- Medicare Buy-In Option and 25 Percent Tax Credit (\$5.4 billion over 10 years)
- 25 Percent Tax Credit for COBRA Continuation Coverage (\$10.3 billion over 10 years)
- Promoting Small Business Coalitions (\$313 million over 10 years)
- Option to Insure Children Through Age 20 in Medicaid and CHIP (\$1.9 billion over 10)
- Extending Transitional Medicaid (\$4.3 billion over 10 years)
- Restoring State Options to Insure Legal Immigrants (\$6.5 billion over 10 years)

(4) **Strengthening programs that provide health care directly to the uninsured.** Finally, we have included in this initiative your commitment of \$1 billion over 5 years to "safety net" providers, which complements the insurance proposals.

Overall, this is a very powerful initiative that we expect will be well received by health policy experts, advocates, Congressional Democrats and perhaps even some moderate Republicans. It also will give you the opportunity for you to acknowledge and commend the Vice President for his leadership, particularly on the FamilyCare (parents of children eligible for Medicaid/CHIP).

III. PARTICIPANTS

Briefing Participants:

Jack Lew
Bruce Reed
Gene Sperling
Joe Lockhart
Loretta Ucelli
Chris Jennings
Heather Hurlburt

Statement Participants:

YOU
Secretary Donna Shalala
Secretary Alexis Herman
Undersecretary Stuart Eizenstat

IV. PRESS PLAN

Pool Press.

V. SEQUENCE OF EVENTS

- YOU will proceed from the Cabinet Room into the Oval Office, accompanied by Secretary Donna Shalala, Secretary Alexis Herman, and Undersecretary Stuart Eizenstat.
- YOU will make a statement from the podium and depart.

VI. REMARKS

To be provided by speechwriting.

VI. ATTACHMENTS

Press paper for tomorrow's announcement.

PRESIDENT UNVEILS MAJOR NEW HEALTH INSURANCE INITIATIVE

January 19, 2000

Today, President Clinton will unveil a 10-year, \$110 billion initiative that would dramatically improve the affordability of and access to health insurance. The proposal would expand coverage to at least 5 million uninsured Americans and expand access to millions more. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative will: (1) provide a new, affordable health insurance option for families; (2) accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP; (3) expand health insurance options for Americans facing unique barriers to coverage; and (4) strengthening programs that provide health care directly to the uninsured.

THE CHALLENGE OF THE UNINSURED AND ITS IMPLICATIONS. Over 44 million Americans lack health insurance. Although there are many causes of this problem, it generally results from lack of affordability and/or access to coverage. Family health insurance premiums cost on average \$5,700 – which represents a large share of income for a family trying to make ends meet. Purchasing affordable, accessible insurance is a particular challenge for many older people, workers in transitions between jobs, and small businesses and their employees. Lacking health insurance has serious consequences. The uninsured are three times as likely to not receive needed medical care, 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes, and four times more likely to rely on an emergency room or have no regular source of care than the privately insured.

The President's four-pronged initiative significantly expands coverage and improves access by:

I. PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES (\$76 billion over 10 years, about 4 million uninsured covered). Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured. Yet, while states have aggressively expanded insurance options for children through Medicaid and the State Children's Health Insurance Program (S-CHIP), parents are often left behind. There are about 6.5 million uninsured parents with income in the Medicaid and S-CHIP eligibility range for children. These parents frequently do not have access to employer-based insurance, and when they do, cannot afford it. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, the National Governors' Association, and a wide range of groups including Families USA and the Health Insurance Association of America have called for building on S-CHIP to cover parents. The President's budget adopts this approach by:

- **Creating a New “FamilyCare” Program.** This proposal would provide higher Federal matching payments for state coverage of parents of children eligible for Medicaid or S-CHIP. Under FamilyCare, parents would be covered in the same plan as their children. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP today, and the program would be overseen by the same state agency. State spending for FamilyCare would be matched at the same higher matching rate as S-CHIP (up to 15 percentage points higher than the Medicaid rate). To ensure adequate funding, \$50 billion over 10 years would be added to the current state S-CHIP allotments. To access these higher allotments, states would have to first cover children to 200 percent of poverty as 30 states now have done. Given states’ enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state responses and significant expansions to parents under FamilyCare. If after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty (\$16,700 for a family of four), a fail-safe mechanism would be triggered to require states to expand coverage to that level.
- **Assisting Families in Affording Private Employer-Based Coverage.** FamilyCare would also facilitate the option to pool state funding with employer contributions towards private insurance, which can be a cost-effective way to expand coverage. Under this option, families otherwise eligible for FamilyCare coverage could get assistance in purchase their employers’ health plan if it meets FamilyCare standards and their employer pays for at least half of the premium. This minimum employer contribution, along with the S-CHIP crowd-out policies, should discourage employers from reducing or dropping coverage. This option is supported by the National Governors’ Association as well.

II. ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP (\$5.5 billion over 10 years, an additional 400,000 uninsured children covered). The State Children’s Health Insurance Program (S-CHIP) helps children in families with income too high to be eligible for Medicaid but too low to afford private insurance. Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The budget would give states needed tools to increase coverage by:

- **Allowing School Lunch Programs to Share Information with Medicaid (\$345 million over 10 years).** Since 60 percent of uninsured children are in the school lunch program, sharing eligibility information can efficiently help outreach efforts.
- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid (\$1.2 billion over 10 years).** This includes schools, child care resource and referral centers, homeless programs, and other sites.
- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (\$4.0 billion over 10 years).** Most states have carried over their S-CHIP simplification strategies like eliminating assets tests and using mail-in applications and 12-month eligibility redeterminations into the Medicaid program. This proposal would have all states do so to make enrollment easier for both programs.

III. EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE (\$28.7 billion over 10 years, about 600,000 million uninsured people covered). Some vulnerable groups of Americans often lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. These include older Americans, people in transitions (between jobs, turning 19 and entering the workforce, leaving welfare for work), and workers in small businesses. This plan addresses these specific and other problems by:

- **Establishing a Medicare Buy-In Option and Making It More Affordable Through a Tax Credit (\$5.4 billion over 10 years).** The rate of uninsured is growing fastest among people ages 55 to 65 and is expected to increase even faster in the future. Recognizing this, the President has called on Congress to pass legislation that allows people ages 62 through 65 and displaced workers ages 55 to 65 to pay premiums to buy into Medicare. The proposal also would require employers who drop previously promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make this policy more affordable, the President proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described below), this policy will address both access to and the affordability of health insurance for this vulnerable group.
- **Making COBRA Continuation Coverage More Affordable (\$10.3 billion over 10 years).** Consolidated Omnibus Budget Reconciliation Act (COBRA), passed in 1985, allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 to 36 months after leaving their job. This policy is intended to improve the continuity of health coverage as workers change jobs. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. The President's budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change.
- **Improving Access to Affordable Insurance for Workers in Small Businesses (\$313 million over 10 years).** Nearly half of uninsured workers are in firms with fewer than 25 employees. The President proposes to give small firms that have not previously offered health insurance a tax credit equal to 20 percent their contribution – twice the credit he proposed last year -- towards health insurance obtained through purchasing coalitions. In addition, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and the Federal Employees' Health Benefits Program would make available technical assistance to purchasing coalitions.
- **Expanding State Options to Insure Children Through Age 20 (\$1.9 billion over 10 years).** Nearly one in three people ages 18 to 24 are uninsured mostly because they age out of Medicaid or S-CHIP or no longer are dependents in private plans. However, they often do not have jobs that offer affordable coverage. The budget would give states the option to cover people ages 19 and 20 through Medicaid and FamilyCare.

- **Extending Transitional Medicaid (\$4.3 billion over 10 years).** Many people leaving welfare for work take first jobs that do not offer affordable health insurance. Recognizing this, Congress passed a requirement in 1988 that extends Medicaid coverage for up to a year for those losing it due to increased earnings. This provision was extended in the welfare reform law to 2001. The President's budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.
- **Restoring State Options to Insure Legal Immigrants (\$6.5 billion over 10 years).** States are prohibited from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin, some of whom are legal immigrants, was 35 percent in 1998 – over twice the national average of 16 percent. The proposal would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

IV. STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED (At least \$1 billion over 10 years).

In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the uninsured and receive inadequate compensation for doing so. Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs. The President will renew his commitment to helping these providers by:

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (+\$100 million for FY 2001, \$1 billion over 5 years).** Last year, the President and Secretary Shalala proposed an historic new program to coordinate systems of care, increase the number of services delivered and establish an accountability system to assure adequate patient care for the uninsured and low-income. The Congress funded an initial \$25 million investment for this program. This year, the President proposes funding this initiative at \$125 million, a \$100 million increase over 2000. This represents a down payment on the President's proposal to invest \$1 billion over 5 year. The Administration will also aggressively pursue an authorization to ensure that the program is established as a core element of the health care safety net.
- **Investing in Community Health Centers (+\$50 million for FY 2001).** The budget proposes an increase of \$50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans – for total funding of over \$1.069 billion in FY 2001.

DRAFT 1/17: ROLLOUT FOR FAMILY COVERAGE ANNOUNCEMENT
INTERNAL WHITE HOUSE DOCUMENT

TUESDAY, JANUARY 17

8 pm: **Conference Call with Policy Validators (66755 / 66766 code 3794)**

- ✓ Len Nichols - 223-1149
- Bob Reischauer
- ✓ Bob Greenstein - 401-6848 FAX
- Henry Aaron
- John Hollahan

9 pm: **Conference Call with Policy Validators (66777 code 3794)**

- Ed Howard
- ✓ Bob Blendon
- ✓ Stu Altman
- ✓ Uwe Reinhardt (609) 924-6083
- ✓ Diane Rowland

Late Evening: **Calls to Policy Validators**

- Chip Kahn 702 525 7660 home / pager 1800 790 6607
- ✓ Ron Pollack 703 780 8158
- Drew Altman 628 9100 (the Willard)
- ✓ Mike McCurry 301.588 3288 - Fax 628-5379
- ✓ Jane Lowenson 202 234 0640
- ✓ Andie King 202 544 1003

*Dusenberry
Courtney.C@MAIL.HHS.GOV*

WEDNESDAY, JANUARY 18

Before 9:30: **Heads Up Calls - Members, Staff, IGA**

- Senator Breaux
- Senator Kerry *bury*
- Courtney Dusenberry *387 7601*
- Ray Sheppak *— (A3) 237 4940*

*10
9:00:*

Conference Call with Democratic Staff
Commerce, Ways and Means, Finance, House and Senate Leadership
(HHS / Treasury) *1800 403 2010*

9:30: **POTUS Briefing in Oval Office Dining Room**

*code
855 040*

10:00: **CABINET MEETING**

10:15:

Conference Call with Advocates (OPL to schedule; Chris, Jeanne, Gary)

AAP	March of Dimes
AMCHP	NACHRI
Catholic Charities	AHA
CBPP	ASTHO
CWLA	ANA
CDF	SEIU
CHF	AMA

10:30:

Conference Call for Congressional Staff

Bipartisan Commerce, Ways and Means, Finance, House and Senate Leadership
(HHS / Treasury)

Calls to Intergovernmental Groups

SMDs / State Legislators / Governors (HHS)

11:00:

ANNOUNCEMENT IN THE OVAL

Phone Briefings

Degette, Hatch, Rockefeller, Kennedy, Jeffords, Frist, Graham, and Conrad (HHS)

11:15:

OFF CAMERA / OFF THE RECORD BRIEFING

Secretary Shalala, Gene Sperling, Chris Jennings

After 1 pm:

In-person briefings for Congressional Staff

House Commerce and Ways and Means bipartisan member and Committee staff / Leadership staff
(HHS to schedule; Chris, Rich, Jeanne, Bonnie, Gary)

2 Senate Finance Committee bipartisan member and Committee staff
Senate HELP bipartisan member and Committee staff
Leadership staff at either meeting
(HHS to schedule; Chris, Jeanne, Rich, Bonnie, Gary)

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DRAFT 1/17: ROLLOUT FOR FAMILY COVERAGE ANNOUNCEMENT
INTERNAL WHITE HOUSE DOCUMENT

SUNDAY, JANUARY 16

Early Afternoon: DPC / NEC circulates press paper.

Early Evening: CJ gets drafts of long paper and Q&A and edits immediately, ignoring all other personal and professional priorities.

MONDAY, JANUARY 17

Morning: DPC / NEC circulates long backup paper, and Q&A for comment

3 pm: Comments due on press paper.

COB: Comments due on long backup paper, and Q&A.
Eric Liu / Gene receive copies of press paper for comment.

7 pm: Conference call with Jim Mays
He will call here.

8 pm: Conference call with principal briefers to review talking points and Q&A.
(call line 66755 code 2002; Chris, Jeanne, Nancy Ann, Dan, Bonnie, Gary, Rich, and Melissa.)

TUESDAY, JANUARY 18

Morning: DPC / NEC circulates final copies of press paper, long backup paper, and Q&A.

Calls to Policy Validators

Judy F. (CJ/ JL/ GC?)

Jack Ebler (CJ)

Len Nichols (CJ/JL?) *John Haliburton*

Bob Reischauer (JL)

Bob Greenstein (GS?)

Diane Rowland (CJ)

> Ar rbn

Calls to Key Congressional Staff

Bridgett Taylor (JL)

David Nexon (CJ)

Jane Lowenson (CJ)

Chip Kahn (CJ)

Ken Thorpe (CJ/SB?)

Stu Altman (CJ/ JL?)

Karen Davis (?)

Ron Pollack (CJ)

Larry Levitt (GC)

Reinhardt

Andie King? (CJ)

Blue Dogs?

Dr. Ebler
(2002)
686
1/31

Afternoon:

Calls to Print Reporters (Chris)

Pear (NYT)

Goldstien (WP)

Rubin (LAT)

Page (USA)

McGinley (WSJ)

Gullow (AP)

Terry Tang (NYT)

Peter Milieus (WP)

Evening:

Calls to Intergovernmental Groups

Ray Sheppach (Chris)

SMDs / State Legislators / Governors (HHS)

6 pm:

Conference Call with Democratic Staff

Commerce, Ways and Means, Finance, House and Senate Leadership
(ASL to schedule; Chris, Jeanne, Rich, Bonnie, Gary, Laura)

7 pm:

Phone Briefings

Degette, Hatch, Rockefeller, Kennedy, Jeffords, Frist, Graham, and
Conrad (HHS)

Breaux, Kerrey, and Blue Dog staff (CJ)

Other Commerce Republicans and Democrats?

8 pm:

Conference Call for Congressional Staff

Bipartisan Commerce, Ways and Means, Finance, House and Senate
Leadership

(ASL to schedule; Chris, Jeanne, Rich, Bonnie, Gary, Laura)

Evening:

Conference Call with Advocates (OPL to schedule; Chris, Jeanne, Gary)

AAP

AMCHP

Catholic Charities

Catholic Health Assn

CBPP

CWLA

CDF

CHF

March of Dimes

NACHRI

Public Hospitals

AHA

ASTHO

FamiliesUSA

ANA

SEIU

AMA

NACHRI's Stankone

WEDNESDAY, JANUARY 19

9:30 am:

CABINET MEETING AND ANNOUNCEMENT

Early Afternoon:

In-person briefings for Congressional Staff

House Commerce and Ways and Means bipartisan member and
Committee staff / Leadership staff

(HHS to schedule; Chris, Rich, Jeanne, Bonnie, Gary)

Senate Finance Committee bipartisan member and Committee staff

Senate HELP bipartisan member and Committee staff

Leadership staff at either meeting

(HHS to schedule; Chris, Jeanne, Rich, Bonnie, Gary)

DRAFT: BACKGROUND ON COVERAGE

GENERAL FACTS

- **About 44 million Americans lack health insurance.** This is nearly a 1 million increase from 1997 and about a 5 million increase from 1993.¹ This includes:
 - About 11 million children
 - About 18 million parents, and
 - About 15 million childless adults.
- **Most uninsured work or are in working families.** Three-fourths of the uninsured work or are in working families, with income above poverty. Although the uninsured rate remains highest among the poor (33 percent), it has been growing faster for the middle class. All income groups experienced increases in the uninsured rate since 1993, but the increase was 50% higher for the middle class than that of the poor.²
- **For some, health insurance options are limited.** Employer-based insurance is the predominant form of health insurance. In 1996, about 82 percent of workers had access. However, a significant number of workers and their families lack access to job-based coverage; 45 percent of low-wage workers and about one-third of workers in small business do not have access to group insurance.³ Individual insurance can be hard to obtain, especially for older and sicker people. In addition, Medicaid, the State Children's Health Insurance Program, and Medicare have strict state and Federal limits on who can enroll. This leaves too many Americans willing to pay a fair amount for insurance without the opportunity.
- **For others, affordability of health insurance remains the biggest barrier.** Health insurance premiums for employer-based coverage in 1999 averaged \$2,300 for an individual and \$5,700 for a family – with the workers' share being \$420 and \$1,740 respectively.⁴ People purchasing coverage in the individual insurance market not only lack employer contributions but usually face higher premiums due to higher administrative costs and, if ill, medical underwriting.

CONSEQUENCES OF LACKING HEALTH INSURANCE

- **Less likely to receive needed health care.** The percent of uninsured adults who did not receive needed medical care in the last year was more than three times that of privately insured adults (30 versus 7 percent).⁵ The proportion of uninsured adults who postponed care was even higher (55 versus 14 percent).⁶ Compared to people with private insurance, the uninsured are more than twice as likely to have no doctor visits in the past year (adults: 39 percent of uninsured versus 18 percent of privately insured; children: 33 percent of uninsured versus 16 percent of all insured).⁷ Similarly, over one in four uninsured children needed health care (e.g., prescription medicine, needed surgery) but did not get it.⁸

- **More likely to have rely on emergency rooms or have no regular source of care.** One-fourth of the uninsured adults rely on the emergency room or have no regular source of care, compared to 6 percent of the privately insured.⁹ Over three times the proportion of uninsured children lack a usual source of care as privately insured children (20 versus 6 percent).¹⁰
- **More likely to suffer adverse health effects and need expensive health care.** The uninsured are 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes than the privately insured.¹¹ Children without health insurance are nearly twice as likely to forego health care for conditions like asthma (odds of 1.7 to 1) or recurring ear infections (odds of 2.1 to 1).¹²

INSURING PARENTS OF MEDICAID / SCHIP CHILDREN

- **About half of uninsured parents (9 million) have children who could be eligible for Medicaid or CHIP** (family income below 200 percent of poverty or \$33,000 for a family of 4). A large number of these parents have children already enrolled in Medicaid or SCHIP.
- **Current, few states cover low-income parents.** While all states cover poor children and most states cover children up to 200 percent of poverty (about \$33,000 for a family of four), only 13 states cover parents at or above poverty. The median upper eligibility limit for parents in Medicaid is about 60 percent of poverty.¹³ In part, this disconnect between parents and children's options has resulted from SCHIP, which has given states a financial incentive to increase coverage for children.
- **Access to health care may be hurt when parents are uninsured.** A recent survey found that 40 percent of families with a mix of members who are uninsured and covered by Medicaid (probably their children) experienced barriers to medical care – nearly 4 times the percent of privately insured families and higher than all-uninsured families. This is because families typically use the same providers when they have the same insurance coverage, improving continuity of care.
- **Covering parents would increase enrollment of uninsured children.** Families are more likely to learn about Medicaid and CHIP and to enroll their children in the programs if the whole family is eligible. As such, this option would likely reduce the number of uninsured children as well as parents.
- **Promotes welfare to work efforts.** Many families do not know about or participate in current Medicaid options and thus become uninsured when leaving welfare for work. Policies extending and promoting family coverage could help these families access affordable health insurance.

WORKERS IN SMALL BUSINESSES

- **Nearly half of uninsured workers are in firms with fewer than 25 employees.** The likelihood of being uninsured is greater for workers in small firms – nearly three times higher than that of workers in large firms.¹⁴
- **Fewer small firms offer health insurance – and the number is declining.** The number-one reason cited was the high cost of premiums. Small businesses typically pay higher premiums for benefits, and administrative costs may consume as much as 40 percent of premium dollars.¹⁵ Despite the fact that three-fourths of the new jobs created by the strong economy are in small businesses, the proportion offering health insurance declined from 59 to 54 percent between 1996 and 1998 alone. In addition, eligibility for such coverage has become more restricted.¹⁶
- **Purchasing coalitions are a small but growing option for small businesses.** Although still relatively unknown, nearly one in 10 businesses with 3 to 9 employees participated in cooperatives in 1998, and interest and participation is growing.¹⁷

MEDICARE BUY-IN

- **People ages 55 to 65 are the fastest growing number of uninsured.** The rate of uninsured is growing fastest among people ages 55 to 65 (by 5 percent between 1997 and 1998). All of this increase occurred among people with income above poverty, with a dramatic increase for those with income between 300 and 400 percent of poverty – from 10.2 to 14.6 percent.
- **As the number of 55 to 64 year olds rises, so will the number who are uninsured.** As the Baby Boom generation enters its 50s, both the number and proportion of pre-65 year olds will rise. The number of people between 55 and 64 years old is expected to increase from 21 to 30 million by 2005 and 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.¹⁸ One study projects that the percent of people ages 55 to 65 with private insurance will decline by 4.5 percent by 2005.¹⁹
- **Access to individual health insurance is a problem for people ages 55 to 65.** People ages 55 to 64 are less likely to be covered by employer-based insurance (66 percent v 75 percent for people ages 45-54) and nearly twice as likely to purchase individual insurance (8.4 percent versus 4.8 percent for people ages 45-54). Yet, in 38 states where 16 million people ages 55 to 65 (76 percent of this group) live, individual insurance policies can be denied outright.²⁰ A health condition can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage altogether. For example, having mild hypertension or emphysema typically increases rates by 25 percent and rheumatoid arthritis or angina can cause outright denials.²¹

People ages 60-64 are nearly 3 times more likely to report fair to poor health as those ages 35 to 44. The probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke & cancer is twice that of people ages 45 to 54.²²

CHILDREN

- **The number of children enrolled in the State Children's Health Insurance Program (SCHIP) has doubled in less than a year.** Nearly 2 million children were served by SCHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998.
- **The number of states covering children up to 200 percent of poverty has increased by more than seven fold.** In March 1997, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about \$33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.
- **In 1998, over 11 million children were uninsured.** This is virtually the same as in 1997, and up from 9.6 million in 1993.
- **About 40 percent of poor children -- nearly 5 million -- are uninsured.** The vast majority of these poor children are eligible for Medicaid. Their parents do not enroll them because: (a) lack of awareness of eligibility; (b) belief that work or not receiving welfare disqualifies them; (c) fear that legal immigrants could be deported if they enroll their children; and (d) complicated and burdensome application process.
- **Even fewer families know that their children may be eligible for SCHIP.** Created in 1997, SCHIP allows states to cover children in working-class families, through Medicaid, a separate program, or a combination. Educating families about SCHIP is an even greater issue since it is new and targets families that typically do not receive such government assistance.
- **States have had varying degrees of success at insuring children.** The proportion of uninsured children ranges from 6 percent in Hawaii and Wisconsin to 24 percent in Texas and 25 percent in Arizona. This reflects both the different eligibility levels in states, but also the states' use of and commitment to aggressive outreach initiatives.
- **Uninsured children are often in programs like schools and child care that can help enroll them.** A number of programs, like the school lunch program, subsidized child care, Head Start, and others target the same children who are eligible for Medicaid and CHIP. A recent study by the Urban Institute found that approximately 60 percent -- almost 4 million -- of the uninsured children nationwide are currently enrolled in school lunch programs.

¹ Data from the March 1999 Current Population Survey.

² Data from the March 1999 Current Population Survey.

³ Cooper PF; Steinberg S. (1997). More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996. *Health Affairs* 16(6): 142-149.

⁴ The Kaiser Family Foundation and Health Research and Educational Trust. (1999). *Employer Health Benefits: 1999 Annual Survey*. Washington, DC: Henry J. Kaiser Family Foundation.

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- ⁵ Hoffman C. (June 1998). *Uninsured in America: A Chart Book*. Menlo Park, CA: Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. Data: Kaiser/Commonwealth 1997 National Survey of Health Insurance.
- ⁶ *Ibid.*
- ⁷ *Ibid.* Data: Adults: Kaiser/Commonwealth 1997 National Survey of Health Insurance. Children: Newacheck PW et al. "Health insurance and access to primary care for children," *NEJM* 338(8): 513-519.
- ⁸ *Ibid.* Data: Simpson G. et al. (1997). "Access to Health Care, Part 1: Children," *Vital Health Statistics*. Rockville, MD: U.S. Department of Health and Human Services, National Center for Health Statistics.
- ⁹ *Ibid.* Data: Kaiser/Commonwealth 1997 National Survey of Health Insurance.
- ¹⁰ *Ibid.* Source: Weigers ME; Weinrick RM; Cohen JW. (1998). *Children's Health, 1996*. Rockville, MD: U.S. Department of Health and Human Services, Agency for Health Care Policy and Research (Pub. No. 98-0008).
- ¹¹ *Ibid.* Data: Maryland and Massachusetts Hospital Discharge Data, as reported in Weissman JS; Gastonis C; Epstein AM, (1992). "Rates of avoidable hospitalization by insurance status in Massachusetts and Maryland." *JAMA* 268(17): 2388-94.
- ¹² *Ibid.* Data: National Medical Expenditure Survey as reported in Stoddard JJ et al. (1994). "Health insurance status and ambulatory care for children." *NEJM* 330(20): 1421-25.
- ¹³ Center on Budget and Policy Priorities.
- ¹⁴ Frontin P.
- ¹⁵ Gabel J et al. (February 1999). *Health Benefits of Small Employers in 1998*. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- ¹⁶ *Ibid.*
- ¹⁷ *Ibid.*
- ¹⁸ U.S. Census Bureau. (1998). Population projections by age.
- ¹⁹ Glied S; Stabile M. (1999). "Covering older Americans: Forecast for the next decade." *Health Affairs* 18(1): 208-213.
- ²⁰ National Economic Council / Domestic Policy Council (March 1998). State-by-state analysis of Medicare Buy-In. Washington, DC: The White House, NEC/DPC.
- ²¹ Chollet DJ; Kirk AM. (March 1998). *Understanding Individual Health Insurance Markets*. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- ²² Data from National Center for Health Statistics, National Health Interview Survey.

CLINTON-GORE ADMINISTRATION UNVEILS MAJOR NEW HEALTH INSURANCE INITIATIVE

January 19, 2000

Today, President Clinton will unveil a 10-year, \$110 billion initiative that would dramatically improve the affordability of and access to health insurance. The proposal would expand coverage to at least 5 million uninsured Americans and expand access to millions more. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative will: (1) provide a new, affordable health insurance option for families; (2) accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP; (3) expand health insurance options for Americans facing unique barriers to coverage; and (4) strengthen programs that provide health care directly to the uninsured.

THE CHALLENGE OF THE UNINSURED AND ITS IMPLICATIONS. Over 44 million Americans lack health insurance. Although there are many causes of this problem, it generally results from lack of affordability and/or access to coverage. Family health insurance premiums cost on average \$5,700 – which represents a large share of income for a family trying to make ends meet. Purchasing affordable, accessible insurance is a particular challenge for many older people, workers in transitions between jobs, and small businesses and their employees. Lacking health insurance has serious consequences. The uninsured are three times as likely to not receive needed medical care, 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes, and four times more likely to rely on an emergency room or have no regular source of care than the privately insured.

The President's four-pronged initiative significantly expands coverage and improves access by:

I. PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES (\$76 billion over 10 years, about 4 million uninsured covered). Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured. Yet, while states have aggressively expanded insurance options for children through Medicaid and the State Children's Health Insurance Program (S-CHIP), parents are often left behind. There are about 6.5 million uninsured parents with income in the Medicaid and S-CHIP eligibility range for children. These parents frequently do not have access to employer-based insurance, and when they do, cannot afford it. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, the National Governors' Association, and a wide range of groups including Families USA and the Health Insurance Association of America have called for building on S-CHIP to cover parents. The Administration's budget adopts this approach by:

- **Creating a New “FamilyCare” Program.** This proposal, which has been advocated by Vice President Gore, would provide higher Federal matching payments for state coverage of parents of children eligible for Medicaid or S-CHIP. Under FamilyCare, parents would be covered in the same plan as their children. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP today, and the program would be overseen by the same state agency. State spending for FamilyCare would be matched at the same higher matching rate as S-CHIP (up to 15 percentage points higher than the Medicaid rate). To ensure adequate funding, \$50 billion over 10 years would be added to the current state S-CHIP allotments. To access these higher allotments, states would have to first cover children to 200 percent of poverty as 30 states now have done. Given states’ enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state response and significant expansions to parents under FamilyCare. If after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty (\$16,700 for a family of 4), a fail-safe mechanism would be triggered to require states to expand coverage to that level.
- **Assisting Families in Affording Private Employer-Based Coverage.** FamilyCare would also facilitate the option to pool state funding with employer contributions towards private insurance, which can be a cost-effective way to expand coverage. Under this option, families otherwise eligible for FamilyCare coverage could get assistance in purchasing their employers’ health plan if it meets FamilyCare standards and their employer pays for at least half of the premium. This minimum employer contribution, along with the S-CHIP crowd-out policies, should discourage employers from reducing or dropping coverage. This option is supported by the National Governors’ Association as well.

II. ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP (\$5.5 billion over 10 years, an additional 400,000 uninsured children covered). The State Children’s Health Insurance Program (S-CHIP) helps children in families with income too high to be eligible for Medicaid but too low to afford private insurance. Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The Administration’s budget includes ideas advocated by the Vice President that would give states needed tools to increase coverage by:

- **Allowing School Lunch Programs to Share Information with Medicaid (\$345 million over 10 years).** Since 60 percent of uninsured children are in the school lunch program, sharing eligibility information can efficiently help outreach efforts.
- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid (\$1.2 billion over 10 years).** This includes schools, child care resource and referral centers, homeless programs, and other sites.
- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (\$4.0 billion over 10 years).** Most states have carried over their S-CHIP simplification strategies like eliminating assets tests and using mail-in applications into the Medicaid program. This proposal would have all states do so to make enrollment easier for both programs.

III. EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE (\$28.7 billion over 10 years, about 600,000 uninsured people covered).

Some vulnerable groups of Americans often lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. These include older Americans, people in transitions (between jobs, turning 19 and entering the workforce, leaving welfare for work), and workers in small businesses. This plan addresses these specific and other problems by:

- **Establishing a Medicare Buy-In Option and Making It More Affordable Through a Tax Credit (\$5.4 billion for both the buy-in and credit over 10 years).** The rate of uninsured is growing fastest among people ages 55 to 65 and is expected to increase even faster in the future. Recognizing this, the President and Vice President have called on Congress to pass legislation that allows people ages 62 through 65 and displaced workers ages 55 to 65 to pay premiums to buy into Medicare. The proposal also would require employers who drop previously-promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make this policy more affordable, the President proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described below), this policy will address both access to and the affordability of health insurance for this vulnerable group.
- **Making COBRA Continuation Coverage More Affordable (\$10.3 billion over 10 years).** Consolidated Omnibus Budget Reconciliation Act (COBRA), passed in 1985, allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 to 36 months after leaving their job. This policy is intended to improve the continuity of health coverage as workers change jobs. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. The Administration's budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change.
- **Improving Access to Affordable Insurance for Workers in Small Businesses (\$313 million over 10 years).** Nearly half of uninsured workers are in firms with fewer than 25 employees. The President proposes to give small firms that have not previously offered health insurance a tax credit equal to 20 percent their contribution – twice the credit he proposed last year -- towards health insurance obtained through purchasing coalitions. In addition, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and the Federal Employees' Health Benefits Program would make available technical assistance to purchasing coalitions.
- **Expanding State Options to Insure Children Through Age 20 (\$1.9 billion over 10 years).** Nearly one in three people ages 18 to 24 are uninsured mostly because they age out of Medicaid or S-CHIP or no longer are dependents in private plans. However, they often do not have jobs that offer affordable coverage. The budget would give states the option to cover people ages 19 and 20 through Medicaid and FamilyCare.

- **Extending Transitional Medicaid (\$4.3 billion over 10 years).** Many people leaving welfare for work take first jobs that do not offer affordable health insurance. Recognizing this, Congress passed a requirement in 1988 that extends Medicaid coverage for up to a year for those losing it due to increased earnings. This provision was extended in the welfare reform law to 2001. The President's budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.
- **Restoring State Options to Insure Legal Immigrants (\$6.5 billion over 10 years).** States are prohibited from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin, some of whom are legal immigrants, was 35 percent in 1998 – over twice the national average of 16 percent. The proposal would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

IV. STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED (At least \$1 billion over 10 years). In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the uninsured and receive inadequate compensation for doing so. Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs. The President will renew his commitment to helping these providers by:

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (+\$100 million for FY 2001, \$1 billion over 5 years).** Last year, the President and Secretary Shalala proposed an historic new program to coordinate systems of care, increase the number of services delivered and establish an accountability system to assure adequate patient care for the uninsured and low-income. The Congress funded an initial \$25 million investment for this program. This year, the President proposes funding this initiative at \$125 million, a \$100 million increase over 2000, representing a down payment on the President's proposal to invest \$1 billion over 5 years. The Administration will also aggressively pursue an authorization to ensure that the program becomes a core element of the health care safety net.
- **Investing in Community Health Centers (+\$50 million for FY 2001).** The budget proposes an increase of \$50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans – for total funding of over \$1.069 billion in FY 2001.

**THE CLINTON-GORE ADMINISTRATION'S
HEALTH INSURANCE INITIATIVE
BACKGROUND INFORMATION**

January 19, 2000

THE UNINSURED IN AMERICA

- **Most of 44 million uninsured work or are in working families.** Three-fourths of the uninsured work or are in working families. Although the uninsured rate remains highest among the poor (33 percent), it has been growing faster for the middle class. All income groups experienced increases in the uninsured rate since 1993, but the increase was 50 percent higher for the middle class than that of the poor.¹
- **Access to health insurance can be a major barrier.** Employer-based insurance is the predominant form of health insurance. In 1996, about 82 percent of workers had access to it. However, 45 percent of low-wage workers and about one-third of workers in small business do not have access to group insurance.² The private-sector alternative, individual insurance, is frequently inaccessible, particularly for older and less healthy people. In addition, Medicaid, the State Children's Health Insurance Program, and Medicare have state and Federal rules which limit who can enroll.
- **For others, affordability of health insurance remains the biggest barrier.** Health insurance premiums for employer-based coverage in 1999 averaged \$2,300 for an individual and \$5,700 for a family – with the workers' share being \$420 and \$1,740 respectively.³ People purchasing coverage in the individual insurance market not only lack employer contributions but usually face higher premiums due to higher administrative costs and, if ill or older, medical underwriting and age rating.

CONSEQUENCES OF LACKING HEALTH INSURANCE. Compared to people with insurance, those without insurance are likely to:

- **Forego needed health care.** The percent of uninsured adults who did not receive needed medical care is more than three times that of privately insured adults (30 versus 7 percent).⁴ The proportion of uninsured adults who postponed care is even higher (55 versus 14 percent).⁵ Over one in four uninsured children need health care (e.g., prescription medicine, surgery) but do not get it.⁶
- **Suffer adverse health effects and need expensive health care.** The uninsured are 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes than the privately insured.⁷ Children without health insurance are nearly twice as likely to forego health care for conditions like asthma or recurring ear infections.⁸
- **Rely on emergency rooms or have no regular source of care.** One-fourth of the uninsured adults rely on the emergency room or have no regular source of care, compared to 6 percent of the privately insured.⁹ The proportion of uninsured children lacking a usual source of care is 3 times that of privately insured (20 v. 6 percent).¹⁰

OVERVIEW OF THE INITIATIVE. The Clinton-Gore Administration's budget invests over \$110 billion over 10 years in a multi-faceted health coverage initiative. It would expand coverage to at least 5 million uninsured Americans¹¹ and expand access to millions more through its four-pronged approach of:

I. PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES (\$76 billion over 10 years, about 4 million uninsured covered). The budget proposal would build on S-CHIP to pay higher Federal matching payments to states for covering parents as well as their children. In the new "FamilyCare" program, parents would be enrolled in the same health plan as their children, and states could help families afford job-based insurance.

II. ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP (\$5.5 billion over 10 years, an additional 400,000 uninsured children covered). States would be given new outreach tools:

- Allowing School Lunch Programs to Share Information with Medicaid for Outreach (\$345 million over 10 years)
- Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid, Including Schools, Child Care Referral Centers, and Other Sites (\$1.2 billion over 10 years)
- Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (e.g., No Assets Tests, Mail-In Applications) (\$4.0 billion over 10 years)

III. EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE (\$28.7 billion over 10 years, about 600,000 million uninsured people covered). Some Americans like older people, workers in job transitions, and workers in small businesses, have limited health insurance options. This initiative broadens Medicare and Medicaid options and makes private insurance more accessible through tax incentives by:

- Establishing a Medicare Buy-In Option and Making It More Affordable Through a 25 Percent Tax Credit (\$5.4 billion for both buy-in and credit over 10 years)
- Making COBRA Continuation Coverage More Affordable (\$10.3 billion over 10 years)
- Improving Access to Affordable Insurance for Workers in Small Businesses through Health Insurance Purchasing Coalitions (\$313 million over 10 years)
- Expanding State Options to Insure Children Through Age 20 (\$1.9 billion over 10 years)
- Extending Transitional Medicaid (\$4.3 billion over 10 years)
- Restoring State Options to Insure Legal Immigrants (\$6.5 billion over 10 years)

IV. STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED. (At least \$1 billion over 10 years). The budget expands a new program that coordinates and expands systems that increase access to health care for the uninsured and invests in community health centers.

**PROVIDING A NEW, AFFORDABLE
HEALTH INSURANCE OPTION FOR FAMILIES**

562 -
562 -

Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, National Governors' Association, consumer advocates and insurers have called for expanding S-CHIP to cover parents. The Administration's proposal does this by building on S-CHIP to provide higher Federal matching payments for states to insure parents through the same health plan as their children. "FamilyCare" costs \$76 billion over 10 years and will insure an estimated 4 million uninsured people when fully implemented.

BACKGROUND

- **Most uninsured children are in families with uninsured parents.** Over 80 percent of parents of uninsured children with income below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured.¹²
- **Nearly two-thirds of uninsured parents – 6.5 million -- have children who are in Medicaid and S-CHIP eligibility range** (income below 200 percent of poverty). This represents about one in seven of the uninsured in the U.S.¹³
- **Medicaid eligibility limits are much lower for parents than their children.** While all states cover poor children and many states cover children up to 200 percent of poverty, only 13 states cover parents at or above the poverty level.¹⁴ The median upper eligibility limit for parents in Medicaid is about 60 percent of poverty. In 32 states, uninsured parents who work full time at minimum wages jobs are not eligible for Medicaid because their incomes are too high.¹⁵ S-CHIP does not include an explicit authority to cover parents.
- **Many low-income families decline employer-based insurance, primarily due to cost.** About 20 percent of all uninsured people have access to employer-sponsored insurance. Families with lower incomes are especially likely to turn down such coverage and remain uninsured. Three-fourths of these uninsured people cite cost as the major barrier. The amount that low-wage families pay for the employee share of premiums is, on average, over 50 percent higher for a family with a worker earning less than \$7 per hour than those with a worker earning over \$15 per hour.¹⁶

• Building
in
current
programs
- to help
address

★

UPPER ELIGIBILITY IN MEDICAID / SCHIP (14)		
	CHILDREN	PARENTS
	(Percent of Poverty)	
ALABAMA	200	22
ALASKA	200	83
ARIZONA	200	51
ARKANSAS	200	22
CALIFORNIA	250	100
COLORADO	185	45
CONNECTICUT	300	185
DELAWARE	200	108
DC	200	200
FLORIDA	200	34
GEORGIA	200	45
HAWAII	185	100
IDAHO	150	36
ILLINOIS	133	52
INDIANA	150	33
IOWA	185	93
KANSAS	200	43
KENTUCKY	200	54
LOUISIANA	150	23
MAINE	185	108
MARYLAND	200	46
MASSACHUSETTS	200	133
MICHIGAN	200	48
MINNESOTA	280	275
MISSISSIPPI	133	40
MISSOURI	300	100
MONTANA	150	73
NEBRASKA	185	43
NEVADA	200	90
NEW HAMPSHIRE	300	60
NEW JERSEY	350	47
NEW MEXICO	235	62
NEW YORK	192	59
NORTH CAROLINA	200	56
NORTH DAKOTA	100	74
OHIO	150	85
OKLAHOMA	185	37
OREGON	170	100
PENNSYLVANIA	200	71
RHODE ISLAND	300	193
SOUTH CAROLINA	150	58
SOUTH DAKOTA	140	70
TENNESSEE	200	67
TEXAS	200	32
UTAH	200	58
VERMONT	300	158
VIRGINIA	185	33
WASHINGTON	250	96
WEST VIRGINIA	150	30
WISCONSIN	185	185
WYOMING	133	69

- **Covering parents would increase enrollment of uninsured children.** Families are more likely to learn about Medicaid and S-CHIP and to enroll their children in the programs if the whole family is eligible. As such, the NGA and policy experts believe that this option would reduce the number of uninsured children as well as parents.¹⁷ Wisconsin, Minnesota and Vermont are among the states using Medicaid state plan options or 1115 demonstrations to achieve this effect.
- **Cost-effective way to expand coverage.** A recent study compared the effectiveness of covering uninsured adults through a refundable tax credit for group or individual insurance and expanding S-CHIP. It found that S-CHIP would much more efficiently expand coverage to the uninsured than a tax credit. The study found that the tax credit would subsidize 5 already-insured people for every single newly insured person at a total cost 6 times higher than that of the S-CHIP proposal.¹⁸
- **Widespread support.** The concept of extending S-CHIP to parents is one of the few ideas for expanding coverage that is supported by a broad range of groups. The National Governors' Association supported expanding S-CHIP to cover parents in its 1999 policy resolutions, arguing that "CHIP is a promising vehicle to promote the goal shared by the Governors, Congress, and the Administration – decreasing the number of Americans without health insurance."¹⁹ At a January 13, 2000 conference to discuss ideas on expanding coverage, Families USA, the Health Insurance Association of America, the American Hospital Association, the Catholic Health Association and the Service Employees International Union all recommend using S-CHIP or a similar model to cover the parents of Medicaid and S-CHIP children.²⁰

PROPOSAL. The Clinton-Gore Administration would expand S-CHIP to provide higher Federal matching payments for expanding affordable health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. This new "FamilyCare" program:

- **Provides higher Federal matching payments for expanding coverage to parents.** States that raise their eligibility for parents above their Medicaid level as of 1/1/00 would be eligible for the enhanced S-CHIP matching rate for this expansion group. The S-CHIP matching rate is up to 15 percentage points higher than the regular Medicaid matching rate. States' plans for covering parents would only be approved if they first expand eligibility for children up to 200 percent of poverty (30 states have already done so²¹) and do not have waiting lists for S-CHIP. This preserves the bipartisan commitment made in 1997 to focus funding on children first.
- **Increases S-CHIP allotments.** To ensure adequate funding for parents and their children, the current S-CHIP allotments would be increased by \$50 billion for 2002 through 2010 and made permanent. The higher Federal matching payments for the expansion group of parents would generally come from increased S-CHIP state allotments, called FamilyCare allotments. Allotments are fixed dollar amounts allocated to each state based on a formula similar to S-CHIP for the higher Federal matching payments. As in S-CHIP, should the allotment limits be reached, states expanding through Medicaid may continue to cover parents at the regular Medicaid matching rate or roll back eligibility while states expanding through non-Medicaid programs may use state-only funds to continue coverage or limit enrollment.

- **Enrolls parents in the same program as their children.** Parents would be insured in the same program as their children to promote continuity of care and administrative simplicity. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP, and coverage for parents would be overseen by the same state agency that runs their children's program. Parents of children eligible for Medicaid would be enrolled in Medicaid, while parents of children eligible for non-Medicaid S-CHIP programs would be enrolled in those programs.
- **Covers lower income parents first.** As in S-CHIP, states would cover lower-income parents before covering higher-income parents. States could not cover parents at income eligibility levels above those of children, but could set eligibility limits for parents lower than that of children. For the first five years, states could set parents' eligibility limit anywhere between their current minimum levels for parents and their maximum levels for children. Given states' enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state responses and significant expansions to parents under FamilyCare. If, after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty (about \$16,700 for a family of four), a fail-safe mechanism would be triggered to require these states to go to this level of coverage. Thus, by 2006, all poor parents would be eligible for coverage like their children are today.
- **Creates more equitable funding structure.** From 2001 to 2005, all enhanced matching payments for states' expansion group of parents would come from the FamilyCare allotment, as would all payments for S-CHIP children. For example, a state that covered parents to 50 percent of poverty prior to 1/1/00 and then expanded coverage above that would receive enhanced matching payments drawn from their allotments for coverage of the newly eligible parents (as well as S-CHIP kids). Beginning in 2006, two changes would be made. First, the enhanced Federal matching payments for parents below poverty would no longer be deducted from the allotment. States would still receive the enhanced matching payments for poor parents covered under expansions implemented after 1/1/00, but these payments would come from uncapped Medicaid funding and would no longer be subtracted from allotments. Second, all states could receive enhanced matching payments for covering any parent above the poverty line and any child above the Medicaid mandatory coverage levels²² – irrespective of when the state expanded coverage. This ensures that states that have already expanded coverage would be rewarded.
- **Facilitates employer-based coverage.** FamilyCare would also expand the option to pool allotment funding with employer contributions towards the purchase of private insurance, which can be a cost-effective way to expand coverage. States could enable families otherwise eligible for FamilyCare to purchase their employers' health plan as long as it meets FamilyCare standards. Under this option, employers would have to contribute at least half of the family premium cost to discourage them from reducing or dropping coverage because of this program. In addition, the S-CHIP crowd-out policies would apply. One study found that over one in five families whose children were enrolled in the Florida Healthy Kids program previously had access to employer-based coverage but their parents could not afford the premium so they remained uninsured.²³ This option, supported by states²⁴, would help keep such families in private coverage.

ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP

The State Children's Health Insurance Program (S-CHIP) helps children in families with incomes too high for Medicaid eligibility but too low to afford private insurance. Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The budget would give states needed tools to increase coverage. About an additional 400,000 uninsured children would be covered because of these policies. The initiative costs about \$5.5 billion over 10 years.

BACKGROUND

- **The number of children enrolled in the State Children's Health Insurance Program (S-CHIP) has doubled in less than a year.** Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998.²⁵
- **The number of states covering children up to 200 percent of poverty has increased by more than seven fold.** Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about \$33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.²⁶
- **However, over 4 million eligible children remain uninsured.**²⁷ One study found that two-thirds of eligible uninsured children are in two-parent families, 75 percent of parents of these children work, and only 5 percent receive welfare.²⁸
- **Barriers include lack of knowledge of eligibility and complex application processes.** A survey of parents whose uninsured children are likely to be eligible for Medicaid found that 58 percent did not try to enroll their children because they did not think that their children were eligible and over half (52 percent) said that they believed that the application process would take too long or believed that the forms are too complicated (50 percent).²⁹
- **Uninsured children are often in programs like the school lunch program that can help enroll them.** A number of programs, like the school lunch program, subsidized child care, and Head Start, target the same children who are also eligible for Medicaid and S-CHIP. A recent study by the Urban Institute found that approximately 60 percent – almost 4 million – of the uninsured children nationwide are currently enrolled in school lunch programs.³⁰ However, Federal law prohibits school lunch programs from sharing enrollment information with Medicaid and does not allow states to use school lunch eligibility as a proxy for Medicaid eligibility.

PROPOSALS

- **Allowing School Lunch Program to Share Information with Medicaid (\$345 million over 10 years).** This proposal, similar to bipartisan legislation proposed by Senator Lugar and Congresswomen Carson, would allow school lunch programs to share application information with Medicaid staff for the sole purpose of outreach and enrollment (this is already allowed for S-CHIP).
- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid (\$1.2 billion over 10 years).** The Administration's proposal expands the Medicaid "presumptive eligibility" option for children by authorizing additional sites for enrollment including schools, child care centers, homeless shelters, agencies that determine eligibility for Medicaid, TANF, and S-CHIP, and other entities approved by the Secretary. Presumptive eligibility means that qualified entities, at the states' discretion, may immediately enroll potentially eligible children in Medicaid and S-CHIP on a temporary basis while their applications are formally processed. With the help of Congresswomen DeGette, the law that created the children's health program in 1997 included presumptive eligibility as an option in S-CHIP and Medicaid. However, it limited the types of entities that could presumptively enroll children in Medicaid to Medicaid providers and entities determining eligibility for WIC, Head Start and Child Care & Development Block Grant services. To date, 9 states have opted to use presumptive eligibility for children in Medicaid³¹ and 12 states for S-CHIP.³² Expanding the sites authorized for this option can help states provide critical health care services to children pending official enrollment and increases the likelihood that families complete the application process. More than half (53 percent) of parents of uninsured but eligible children think that immediate enrollment with completion of forms later is one of the best ways to encourage enrollment.³³
- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (\$4 billion over 10 years).** Studies confirm that complicated, long application processes for Medicaid and S-CHIP discourage enrollment. While many states have recognized this and have simplified the process in S-CHIP, not all states have carried over all of their S-CHIP simplification strategies to Medicaid. To ensure that children do not fall through the cracks in states that have different rules and procedures for Medicaid and S-CHIP, this proposal would require that states conform certain Medicaid eligibility rules and procedures for children to the simplified rules and procedures used in S-CHIP. If a state, in S-CHIP: (1) does not require an assets test; (2) uses simplified eligibility requirements and a mail-in application; and (3) determines eligibility for S-CHIP no more than once a year, it would need to apply these same rules and procedures for children in Medicaid. Both conforming Medicaid and S-CHIP and these specific simplifications are recommended by the National Governors' Association as best practices.³⁴ Over 40 states have already made Medicaid as simple as S-CHIP.³⁵

ESTABLISHING A MEDICARE BUY-IN OPTION AND MAKING IT MORE AFFORDABLE THROUGH A TAX CREDIT

People ages 55 to 65 are at greater risk of developing health problems. Recognizing that this age group is also the fastest growing group of uninsured, the President has called on Congress to pass legislation that allows certain people ages 55 to 65 to buy into Medicare. The proposal also would require employers who drop previously-promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make the policy more affordable, the Clinton-Gore Administration proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described later), this policy will address both access to and the affordability of health insurance for this vulnerable group. The Medicare buy-in plus the tax credit for this buy-in cost about \$5.4 billion over 10 years.

BACKGROUND

- **Fastest growing number of uninsured.** Between 1997 and 1998, the proportion of people ages 55 to 65 who are uninsured increased from 14.3 to 15.0 percent – about five times the rate increase for the general population. All of this increase occurred among people with incomes above poverty, with a dramatic increase for those with income between 300 and 400 percent of poverty (between \$33,000 and \$44,000 for a couple) – from 10.2 to 14.6 percent.³⁶
- **Less access to employer-based coverage.** The major reason for the increase in the uninsured in this age group is their lower access to employer-based insurance. In 1998, 66 percent of people ages 55 to 64 had employer-based insurance compared to 75 percent of people ages 45 to 55.³⁷ Some lose their employer-based health insurance when their spouse becomes eligible for Medicare. Many lose coverage because they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their employer drops retiree health coverage unexpectedly.
- **Greater reliance on individual insurance.** Because of a weaker connection to the workplace, a disproportionate percent of people ages 55 to 65 rely on individual insurance. However, the nature of individual insurance makes it easier to avoid people likely to have health problems. In addition to being subject to age rating, a health condition can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage.³⁸ People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. Their probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke and cancer is double that of people ages 45 to 54.³⁹
- **Problems will get worse with demographic changes.** As the Baby Boom generation enters its 50s, the proportion of people ages 55 to 65 is expected to increase from 21 to 30 million by 2005 and to 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.⁴⁰ Even if the uninsured rate remained the same, the proportion of uninsured in this age group would climb. One study projects that the uninsured rate for people ages 55 to 65 will rise even faster given the decline in access to private insurance for this group.⁴¹

PROPOSALS

- **Providing a New 25 Percent Tax Credit for New Options for People Ages 55 to 65.** This year, for the first time, the President will propose a 25 percent tax credit for people eligible for the buy-in. It helps make the original option – which already is more affordable than alternatives in the individual insurance market – even more attractive to people with limited income. In addition, people participating in the extended COBRA coverage would be eligible for the new COBRA tax credit (described later). This tax credit has the advantage of encouraging greater participation in these options for people ages 55 to 65 which could, in turn, reduce the premium costs for these programs over time since new participants are likely to be healthier. It would not, however, be large enough to encourage firms to drop their early retiree coverage or individuals to retire earlier.

This policy builds on the three-pronged initiative advocated by the President, the Vice President and the Democratic Congressional leadership (Daschle, Gephardt, Moynihan, Rangel, Dingell, Rockefeller, Stark, Brown), described below.

1. **Enabling Americans Ages 62 to 65 to Buy Into Medicare.** People ages 62 to 65 who do not have access to employer-based insurance would have a one-time option to buy into Medicare. The premium they would pay would be divided into two parts. First, participants would pay a base premium of about \$300 per month — the average cost of insuring Americans this age range. Second, participants would pay an additional monthly payment, estimated at \$10 to \$20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, covers the extra costs of sicker participants. This two part “payment plan” enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the financing for the buy-in option is sustainable in the long run.
2. **Allowing Displaced Workers Ages 55 to 65 to Buy Into Medicare.** Workers who have involuntarily lost their jobs and their health care coverage would be eligible for a similar Medicare buy-in option. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remain uninsured. Individuals choosing this option would pay the entire premium at the time they receive the benefit without any Medicare “loan,” in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65.
3. **Giving Americans Ages 55 and Older Whose Employers Reneged on Providing Retiree Health Benefits Access to COBRA until Eligible for Medicare.** In recent years, the number of companies offering retiree benefits has declined. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. This policy provides much-needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. It allows these retirees to buy into their former employers’ health plan through age 65 by extending the availability of COBRA coverage to these families. Retirees would pay a premium of 125 percent of the average cost of the employer’s group health insurance.

MAKING COBRA CONTINUATION COVERAGE MORE AFFORDABLE

To improve continuity of health coverage as workers change jobs, the Clinton-Gore budget includes a 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. This tax credit address the issue of cost to help reduce the number of Americans who experience a gap in coverage due to job change. It costs \$10.3 billion over 10 years.

BACKGROUND

- **Changing jobs risks losing health insurance.** Since most insurance is job based, changing jobs puts workers and their families at risk of becoming uninsured. One study found that 58 percent of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage.⁴² About 44 percent of workers with one or more job changes experienced a gap in health insurance coverage. This is even more pronounced for men, over half of whom were uninsured for a month or more when they had a job interruption.⁴³
- **COBRA continuation coverage provides an important option.** Passed in 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) included a provision aimed at minimizing the disruption in health insurance due to job change. It allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. On the whole, evidence supports claims that COBRA decreases the probability that a person between jobs is uninsured, reduces "job lock", and covers workers during pre-existing condition waiting periods.⁴⁴
- **Participation in COBRA is low, primarily due to cost.** Studies suggest that only 20 to 25 percent of COBRA eligibles purchase this coverage. Although some of these people had access to insurance through other family members, the primary reason cited for declining COBRA is its high cost.⁴⁵

PROPOSAL

- **New Tax Credit To Make COBRA More Affordable.** The budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change. It not only helps workers and families access insurance but may help employers, since the current tendency for only people with health problems to participate would be reduced.

IMPROVING ACCESS TO AFFORDABLE INSURANCE FOR WORKERS IN SMALL BUSINESSES

Recognizing the problems that small businesses face in offering their workers insurance, the President proposes a set of policies to harness the purchasing power of large employers and provide assistance for premium payments. It would give small firms that have not previously offered health insurance a tax credit equal to 20 percent of their contribution – twice the credit proposed last year -- towards health insurance obtained through purchasing coalitions. In addition, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and technical assistance would be provided. Altogether, this initiative costs \$313 million over 10 years.

BACKGROUND

- **Nearly half of uninsured workers are in firms with fewer than 25 employees.** The likelihood of being uninsured is greater for workers in small firms – nearly three times higher than that of workers in large firms.⁴⁶
- **Small firms are less likely to offer health insurance.** The proportion of small businesses offering health insurance declined between 1996 and 1998 – from 53 to 49 percent for firms with 3 to 9 workers and from 78 to 71 percent for firms with 10 to 24 workers.⁴⁷ Businesses blame the high cost of premiums for this problem. Small businesses typically pay higher premiums for the same benefits and administrative costs may consume as much as 40 percent of premium dollars. Trends suggest that the situation will worsen.
- **Purchasing coalitions a growing option for small businesses.** Although still relatively unknown, nearly one in 10 businesses with 3 to 9 employees participated in cooperatives in 1998, and interest and participation are growing.⁴⁸

PROPOSAL

- **Provide a 20 Percent Tax Credit for Employer Contributions.** A tax credit equal to 20 percent of employer contributions toward health premiums would be given to eligible small businesses. Small businesses with between 3 and 50 employees that have not offered coverage in the past could receive this credit if they purchase coverage for their workers through a qualified coalition. This credit is time-limited.
- **Financial Assistance in Creating Coalitions.** Start-up costs are a barrier to developing purchasing coalitions. Yet the current tax provisions for foundations makes private foundations reluctant or, in some cases, prohibited from offering grants for these costs. Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This provision is time-limited.
- **Technical Assistance in Creating Coalitions.** Since the Federal Employees Health Benefits Program is a model for coalitions, its managers would provide technical assistance to coalitions, sharing its administrative experience.

EXTENDING MEDICAID TO VULNERABLE POPULATIONS

Medicaid has proven to be a critical source of health insurance for millions of Americans. However, some vulnerable groups of people – children aging out of Medicaid and S-CHIP, people leaving welfare for work, and legal immigrants – cannot or will not be allowed into Medicaid due to current restrictions. The President's budget includes several important provisions to remove these barriers.

EXPANDING STATE OPTIONS TO INSURE CHILDREN THROUGH AGE 20 (\$1.9 billion over 10 years)

- About 1.2 million people ages 19 and 20 have low incomes (below 200 percent of poverty) and are uninsured.⁴⁹ Mostly, this results because they age out of Medicaid or S-CHIP or no longer qualify as dependents in their parents' private plans.
- The budget would give states the option to cover people ages 19 and 20 through Medicaid and S-CHIP.

EXTENDING TRANSITIONAL MEDICAID (\$4.3 billion over 10 years)

- Many people leaving welfare for work take first jobs that do not offer affordable health insurance.⁵⁰ As such, transitional Medicaid provides a critical bridge to work. Created in 1988, transitional Medicaid extends coverage for up to a year for those losing it due to increased earnings. The 1996 welfare reform bill extended this provision through 2001. A recent survey found that nearly half of former welfare recipients had Medicaid coverage, most likely due to this benefit.⁵¹
- The budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.

RESTORING STATE OPTIONS TO COVER LEGAL IMMIGRANTS (\$6.5 billion over 10 years)

- Over the strong objections of the Administration, the 1996 welfare law prohibited states from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin was 35 percent – over twice the national average of 16 percent.⁵²
- The President's budget would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED

BACKGROUND

- **Greater demand.** In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the millions of uninsured. About 6 percent of all hospitals and 26 percent of safety net hospitals annual costs are estimated to be uncompensated, and 2,500 community health center sites serve an estimated 4 million uninsured.⁵³
- **Fewer resources.** Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs.

PROPOSALS

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (At least \$1 billion over 10 years, +\$100 million for FY 2001).** Last year, the President and Secretary Shalala proposed an historic new grant program to support community providers of services to the uninsured. The Congress funded an initial \$25 million investment for this program. This year, the Administration proposes funding this initiative at \$125 million, a \$100 million increase over 2000. This represents a down payment on the its proposal to invest \$1 billion over 5 year. The Administration will also aggressively pursue an authorization to ensure that the program is established as a core element of the health care safety net.
 - **Providing new services to the uninsured.** These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services.
 - **Preserving access to critical tertiary care services.** These funds will help support large public hospitals, that often are the only source for trauma care, burn units, neonatal intensive care units, and other specialized services that are critical to all of the residents in a service area. If these institutions succumb to the burden of uncompensated care costs, both the insured and uninsured residents of the service area will be forced to seek these essential health care services elsewhere.
 - **Holding providers accountable for health outcomes.** These grants will help local providers develop the financial, information, and telecommunication systems that are necessary to appropriately monitor and manage patient needs. This will improve the efficiency and effectiveness of service delivery within the safety net, permitting more clients to be served with existing resources.
- **Investing in Community Health Centers (+\$50 million for FY 2001).** The budget proposes an increase of \$50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans – for total funding of over \$1.069 billion in FY 2001.

ENDNOTES

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- ¹² Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
- ¹³ Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.
- ¹⁴ Upper income eligibility limits for children from: DHHS. (January 2000). *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 - September 30, 1999*. Washington, DC: U.S. Department of Health and Human Services, Health Care Financing Administration. Upper income eligibility limits for parents from: Guyer J; Mann C. (February 1999). *Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance*. Washington, DC: Center on Budget and Policy Priorities; updated verbally.
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DRAFT 1/17: QUESTIONS AND ANSWERS ON COVERAGE INITIATIVE

POLICY PRIORITIES, BUDGET COSTS AND CHANCES OF ENACTMENT

Q: Why are you proposing this major initiative now?

A: There is no questioning the President's commitment to expanding health insurance coverage. Every time the opportunity to extend affordable coverage to uninsured Americans has arisen, he has made a proposal to do so. Two years into the increasingly successful implementation of S-CHIP, with the country's growing resources and the booming economy, it makes perfect sense to implement new options for individuals without health insurance.

Q: How are you paying for this initiative? Are you raiding the Social Security surplus?

A: No. This proposal will be fully paid for in the context of a balanced budget.

Q: Isn't this a small investment in relation to the problem of the uninsured?

A: This investment is clearly a significant investment and is one of the largest initiatives in the budget. While the investment is less than what some are advocating for in the Presidential election, it certainly lays the foundation for additional enhancements at a later time.

Q: What are the chances of this initiative's passing?

A: Similar to the S-CHIP proposal, which received broad bipartisan support, we believe this initiative has an excellent chance of becoming law this year. If the Congress is serious about responding to the needs of the American public, we have great confidence that they will come back motivated to get the job done.

LINK TO PRESIDENTIAL CAMPAIGN

Q: Isn't the introduction of this proposal timed specifically to help Vice President Gore in his Presidential campaign?

A: The Vice President has made a valuable contribution to the health care debate. We are simply tapping into some of his ideas because they are thoughtfully constructed policies and have great potential for success. The timing of this policy announcement occurs around the release of our budget, just like other major initiatives in this year's budget. We would have unveiled this initiative at this time of year regardless of whether or not it was an election year.

Q: Why isn't the Vice President's entire health care proposal included in your budget?

A: Much of the Vice President's initiative is clearly integrated into the President's policy. Its inclusion represents the President's belief that this is sound policy that merits Congressional approval. Provisions in our proposal that do not exactly mirror the VP's initiative or don't go as far as his proposal does simply represents the Administration's vision on health care for the FY 2001 budget. As the President has made clear from the beginning, he believes the Vice President has exhibited extraordinary leadership on this issue.

Q: What is the difference between the Vice President's proposal and the proposal in the President's FY 2001 budget?

A: The Vice President has additional children's health insurance initiatives including the expansion of S-CHIP up to 250 percent of poverty and a requirement that all states offer parents with incomes over 250 percent of the poverty level the option to buy into Medicaid and CHIP programs. He also advocates for an individual refundable tax credit of 25 percent for those without employer sponsored coverage. These are thoughtful proposals worthy of serious consideration, but we chose not to include them in this initiative. Unlike the longer-range policy considerations of a Presidential campaign, the FY 2001 budget is focused on those policies that we believe have the best chance of passing the Congress this year. Should the Congress have interest in some of the additional proposals the Vice President is promoting, we would clearly be open to discussing those as well.

Q: Isn't this proposal an implicit rejection of Senator Bradley's proposal?

A: We're not going to engage on the positive or negative elements of Senator Bradley's or any other candidate's proposal. This proposal has been designed in an attempt to reach across party lines to pass a long overdue coverage expansion in this session of Congress in the final year of the Clinton Administration.

Q: So far, the Republicans have not engaged to any significant degree in the debate over expanding health care coverage. How do you believe the unveiling of this initiative will impact on the Republican Presidential primary?

A: We believe it is notable that the Republican presidential candidates, with the possible exception of Senator McCain, have not made health care a focus of their campaigns. We do believe, however, that there is potential for Republican interest in targeted health care expansions on Capitol Hill and we hope that the President's unveiling of his health care coverage initiative will spur interest in this issue in both the Congress and in the Presidential election. This issue is too important to ignore. It is interesting to note, however, that the Republican candidates are now advocating for a strong, enforceable, Patients Bill of Rights such as the Norwood-Dingell legislation. Perhaps this interest can translate into broader support for coverage initiatives as well.

Q: Have you stopped supporting universal coverage? Is this a repudiation of previous policy priorities?

A: The President believes that expanding high quality, affordable coverage to all Americans should be the goal of any Administration. It has become clear, however, that other approaches need to be considered to achieve the level of consensus necessary to pass legislation in Congress. We had two options after the Health Security Act. We could ignore the problem, do nothing, and assume that no consensus could be reached, or we could take a targeted step by step approach. We have chosen the latter, and believe our proposal will successfully extend coverage to millions of uninsured Americans, building on our previous successes such as S-CHIP.

ACCELERATING ENROLLMENT IN MEDICAID AND CHIP

Q: Doesn't the fact that you have to spend more money covering children in this year's budget explicitly validate that the original S-CHIP legislation was flawed and that you're just throwing good money after bad to address the situation?

A: Absolutely not. The program has already enrolled two million children, and proposals included to help states accelerate enrollment of children are simply additional tools to make their job easier. We believe they will ensure even greater success of the programs than we've seen in recent months and enable states to more quickly tap into their S-CHIP allotments.

FAMILYCARE

Q: Are you eliminating the S-CHIP program and replacing it with something new? Isn't the philosophy of this proposal closer to Senator Bradley's than the Vice President's?

A: No. This proposal does not eliminate S-CHIP; it simply builds upon it to provide another option for working families, called FamilyCare. FamilyCare allows states to take advantage of the flexibility of S-CHIP to create a seamless system of health insurance coverage for uninsured working families. This proposal, since it builds on the success of S-CHIP and Medicaid, is very similar to the proposal put forth by the Vice President – targeted but extremely bold proposals that dedicate unprecedented amounts of the surplus to expanding coverage and have real potential to build the type of consensus necessary to pass bipartisan legislation on health care.

Q: Won't this new proposal distract states from the original goal of S-CHIP – to cover uninsured children?

A: Quite the contrary. Studies have shown that uninsured children are more likely to become insured when the whole family has access to new coverage options. Moreover, this proposal continues the current financial incentives that states have to expand coverage to uninsured children, and actually provides states with an additional incentive to expand coverage to children, as they will not be able to access the enhanced matching rate for parents until they have covered children up to 200 percent of the poverty level. This helps explain why the National Governor's Association supports the creation of an additional family coverage option built on the S-CHIP program.

Q: By many accounts, S-CHIP has not been a particularly successful program. Why are you putting new funds into expanding a program that just doesn't work?

A: We disagree. Now that all 50 states have their programs up and running, we are seeing a steady rise in enrollment rates nationwide. In fact, the program's enrollment doubled in less than a year, serving two million children as of October 1, 1999. Since the enactment of S-CHIP, we've also seen a sevenfold increase in the number of states (from 4 to thirty) who have expanded their eligibility levels to 200 percent of the poverty level. Since the creation of S-CHIP, the NGA and other state advocates have called for additional flexibility to be able to cover families under S-CHIP. This proposal will provide them with the necessary flexibility to provide a seamless system of health insurance coverage to families.

Q: Isn't your failsafe trigger mechanism just a fancy way of saying "unfunded state mandate"?

A: First, we don't believe that there will be many – if any – states who will not take advantage of the new option to extend coverage to families. However, to ensure that all states will eventually establish a basic level of coverage for parents with incomes at or below the poverty line (\$16,700 for families), it was necessary to have a failsafe mechanism.

It is important to point out, however, that this policy is very different than the approach the Federal government took in the late 1980s when implementing state Medicaid mandates. Those were immediate or phased-in mandates, giving little or no opportunity for voluntary mechanisms to work. These mandates did not provide for enhanced match, as we are proposing, to further support states choosing to expand.

Q: The Vice President's proposal doesn't include a requirement for states to expand coverage to parents below 100 percent of the poverty line. This sounds like [the President's proposal is actually intrusive and involves more government regulation] or [the President's proposal is actually bolder than the Vice President's].

A: The Vice President's proposal assumes that all states will take up this option to expand family coverage within the first five years of the program. If it is necessary to have a failsafe trigger in 2006, it is our understanding that he supports this provision.

Q: Isn't the requirement for states to cover children up to 200 percent of FPL before they can cover parents an implicit admission that the voluntary nature of the S-CHIP program failed? Isn't that why you've also included a new mandate to cover parents by 2006?

A: By most accounts, S-CHIP is becoming a major success. Every state in the country has taken advantage of this new option, and 30 states have expanded coverage to children with family incomes up to 200 percent of the poverty level. The reason for this prerequisite is to maintain the bipartisan agreement that our first priority is to insure children. Given our experience in S-CHIP and the strong state support for expanding S-CHIP to parents, it is extremely likely that the vast majority of states – if not all – will take this new option, making the failsafe trigger unnecessary.

Q: Doesn't this policy continue this Administration's long-standing policy of punishing states that have done a good job of expanding coverage to low-income people and rewarding states that have not done anything to help this population?

A: Absolutely not. The FamilyCare program is designed to create consistent national incentives for states to expand coverage beyond what is required.

First, all states will receive enhanced match for any coverage expansion they implement under FamilyCare. Second, in 2006, even those states who have expanded coverage before the FamilyCare program was implemented will receive enhanced match for covering families with incomes above poverty.

Q: In 2006, when states like Minnesota and Vermont will be able to access enhanced match to fund programs that have been running for years, won't you just be wasting Federal funds?

A: The structure of this new policy will ensure that those states who have consistently worked to expand coverage to low income workers will receive the similar financial support from the Federal government as those states expanding for the first time under this policy.

Q: Won't this new coverage option encourage low-wage workers to drop the health insurance coverage they have for a free government plan? Won't employers drop the health insurance they currently offer, simply trading private sector funds for taxpayer dollars?

A: First, very few low income families have access to employer sponsored health insurance, and our experience with S-CHIP to date demonstrates that crowd-out is not a big problem. Second, we give states the option in FamilyCare to supplement employer policies that contribute more than half the cost of the policy so there is less incentive for those who do have coverage to drop. This, coupled with S-CHIP policies to prevent substitution, should minimize the effect of existing crowd-out.

Q: What about [insert policy detail]? Will the current requirements in S-CHIP apply to the new FamilyCare program?

A: Under FamilyCare, states would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP. We are willing to work with the states and the Congress to ensure that the mechanics of the FamilyCare program provide the flexibility necessary for states to run the programs efficiently while ensuring the delivery of high quality affordable health care with comprehensive benefits.

MEDICARE BUY-IN

Q: Why do you keep proposing the Medicare buy-in when it is clear that the Republican Congress will never pass it?

A: We believe that members of Congress will begin to recognize that adults aged 55 to 65 are the fastest growing population of the uninsured in America. As they consider this fact within the context of our new proposal to make providing coverage to this population even more affordable within the context of a tax credit, we believe the proposal has the potential to receive broader bipartisan support. This is the right policy for one of the nation's most vulnerable populations, and we make no apologies for continuing to push for it.

Q: The Clinton Administration keeps saying that the Medicare program is in trouble, and that's why Congress needs to act on the President's reform plan. If the program is in so much trouble, why are you proposing to expand it?

A: This proposal does not hurt the Trust Fund. Participants pay a full premium for coverage; the cost of the proposal is primarily due to the temporary costs of a lower premium up-front, which beneficiaries pay off over time.

Q: Why aren't you making this tax credit refundable? Wouldn't that be more fair to low income taxpayers?

A: Many elderly and near-elderly individuals with no income tax liability have no reason to file a tax return under current law. Making the Medicare buy-in tax credit refundable would entail bringing many new filers into the tax system, placing significant burdens on both the recipients, who would have to file a return only to obtain the new tax credit, and the IRS, who would have to process many more returns. But we are very concerned about the health insurance needs of low-income early retirees, and we welcome the opportunity to explore with Congress alternative, less burdensome means of providing assistance to this population.

SMALL BUSINESS PURCHASING COALITIONS

Q: Why do you continue to push this proposal at the same time that you have consistently opposed HealthMarts, a Republican proposal that does essentially the same thing?

A: The President believes that we need to work together to find the best way to provide greater access to affordable insurance for small business, as nearly half of uninsured workers are in firms with fewer than 25 employees. The President's policy makes it much easier for businesses to come together in a manner that does not detrimentally affect the insurance market and segment healthy populations from unhealthy ones. Because, in essence, the HealthMart approach would bypass the oversight of state health insurance commissioners, the fear is that it would have precisely this type of negative impact on the marketplace.

COBRA EXPANSION

Q: Many employers already oppose COBRA, and very few Americans actually take advantage of the option. Isn't this a waste of money? Why are you expanding it?

A: Costs have been named as one of the major reasons why fewer than 25 percent of the people eligible do not take advantage of COBRA. One other benefit of this option is that reducing costs will encourage healthier people to take this option, and guard against the problem of only sicker populations taking their COBRA option.

TRANSITIONAL MEDICAID EXPANSION

Q: Aren't you applying a new Federal mandate to welfare programs with this provision? Isn't this just another way to try to control state welfare programs?

A: No. This is an existing statutory provision, created by the Family Support Act of 1988 and reauthorized on a bipartisan basis as part of the 1996 Personal Responsibility and Work Opportunity Act, that recognizes the importance of Medicaid and other social support programs for families returning to work. This proposal merely extends this provision permanently.

GIVING STATES NEW OPTIONS TO COVER LEGAL IMMIGRANTS

Q: Won't this new extension of coverage just encourage illegal immigrants to come to the United States?

A: First, this policy does not apply to illegal immigrants, who are not eligible for coverage – except in emergency cases – under the Medicaid program. Second, lack of insurance is a serious problem for legal immigrants. Forty-three percent of non-citizens (most of whom are legal immigrants) lack health insurance coverage. This policy restores important options and social services for individuals who pay taxes just like all other American citizens that were taken away over the Administration's objections in 1996.

IMPROVING THE EQUITY OF TAX TREATMENT OF HEALTH INSURANCE

Q: What is the relation of this proposal to the access provisions in the Patients' Bill of Rights?

A: This proposal contrasts starkly with the so called access provisions included in the Republican Patients Bill of Rights. Unlike those initiatives, the President's plan will significantly expand coverage in an extremely efficient manner. In contrast, the Republican tax initiative is highly regressive, poorly targeted, and will do little to expand coverage. It is our hope that those members on both sides of the aisle will keep their minds open in order to determine the best and most effective coverage expansion available to the Congress.

Q: How can the tax code be used to expand coverage?

A: Clearly, we believe that the Administration's proposals on health care are the best policies to use to expand insurance coverage. We do not believe that tax initiatives can be used effectively to expand coverage without at the same time crowding out employer sponsored coverage – that is, reducing coverage for some workers.

Q: Do you believe that tax approaches have a role to expand coverage or at least ensure equity?

A: Tax policies, carefully structured and targeted, can be designed to address inequities and supplement other approaches to expanding health care. In this year's budget, we are using the tax code to target the particularly unique population to target workers in-between jobs, the near elderly, and workers in small businesses. Our carefully targeted approach sharply contrasts with large, ill-designed tax credits that threaten to undermine the current employer based health insurance market and in some cases, result in coverage loss.

Q: Why are you expanding public programs rather than using a comprehensive set of tax incentives, an approach which already has broad-based support among Republicans and growing interest among some Democrats in Congress?

A: First, our proposal builds on existing health insurance programs – including private employer sponsored insurance – to provide new coverage to individuals. It does include a series of targeted tax incentives to increase access to health care insurance, including new tax credits for workers in between jobs, the near elderly, and small businesses and their employees. We are wary, however, of regressively structured tax deductions or expensive tax credits that are extremely inefficient and costly. Most experts believe that such an approach will undermine the employer market by increasing incentives for firms to drop their current contributions to health insurance premiums for their workforce. They believe that such an approach could cause younger and healthier workers to abandon the employer market, raising premiums for older, sicker workers left behind. As a result, untargeted health insurance tax credits could induce firms to drop their current health insurance coverage, causing some workers to become uninsured.

Q: Isn't it unfair to disallow a deduction for workers who pay for their own insurance when workers with employment-based health insurance benefit from a tax exclusion?

A: No. The purpose of health insurance tax incentives is to encourage pooling of risks, especially in the employment setting. This encourages employers to sponsor health insurance and allows most workers to receive health insurance at low cost. Our proposals address specific gaps in that system—workers between jobs, early retirees, and those who work for firms that are too small to benefit from large group rates. It would be unfair to undermine the viability of the system that already provides high quality relatively low-cost health insurance coverage for the majority of Americans. We look forward to working with Congress to try to find other approaches to expanding coverage that would build upon, rather than threaten, the current system.

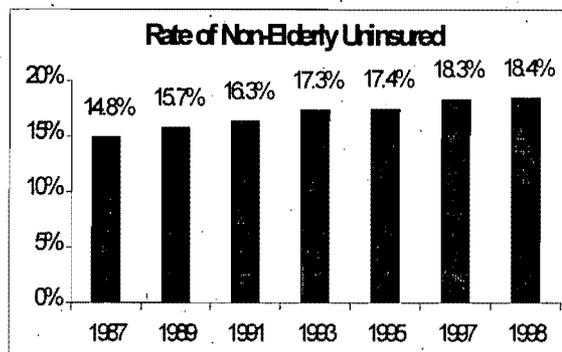
Q: Why don't the tax credits for Medicare and COBRA coverage phase out with income? Doesn't this mean that people with the highest incomes will receive the largest benefits?

A: No. The tax credit is much more progressive than a deduction. It is worth the same 25 percent to a family earning \$60,000 as to a family earning \$600,000.

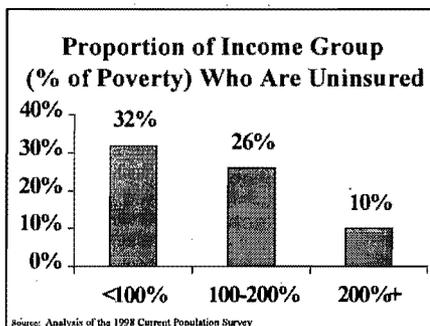
HEALTH INSURANCE: BACKGROUND

UNINSURED IN THE UNITED STATES

- **About 44.3 million Americans lack health insurance.** This is a 0.9 million increase from 1997 and about a 5 million increase from 1993. Although the new Children's Health Insurance Program will likely slow if not reverse the trend, the number of uninsured Americans is one of the few social indicators that has not improved under the strong Clinton-Gore economy.



- **Risk of being uninsured is higher among the low-income, but the majority of the uninsured are middle-class Americans.** The likelihood of being uninsured is greater among the low-income. However, because there are many more Americans with higher income, these proportions translate into 11.5 million uninsured who are poor, 13.3 million who are lower-income working class (between 100 and 200 percent of poverty) and 18.6 million who have income above 200 percent of poverty.



The reasons why this diverse range of Americans lack health insurance are complicated, but mostly relate to access and affordability. Too many people do not have options like employer-based insurance or state insurance program available to them. Others have such options but cannot afford them.

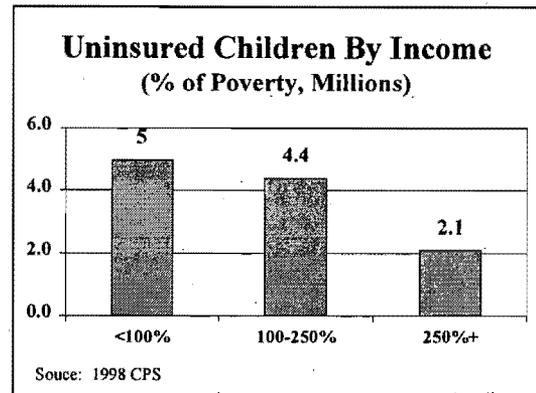
CONSEQUENCES OF LACKING HEALTH INSURANCE

- **Less likely to receive needed health care.** The percent of uninsured adults who did not receive needed medical care in the last year was more than three times that of privately insured adults (30 versus 7 percent).¹ The proportion of uninsured adults who postponed care was even higher (55 versus 14 percent).² Compared to people with private insurance, the uninsured are more than twice as likely to have no doctor visits in the past year (adults: 39 percent of uninsured versus 18 percent of privately insured; children: 33 percent of uninsured versus 16 percent of all insured).³ Similarly, over one in four uninsured children needed health care (e.g., prescription medicine, needed surgery) but did not get it.⁴
- **More likely to have rely on emergency rooms or have no regular source of care.** One-fourth of the uninsured adults rely on the emergency room or have no regular source of care, compared to 6 percent of the privately insured.⁵ Over three times the proportion of uninsured children lack a usual source of care as privately insured children (20 versus 6 percent).⁶
- **More likely to suffer adverse health effects and need expensive health care.** The uninsured are 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes than the privately insured.⁷ Children without health insurance are nearly twice as likely to forego health care for conditions like asthma (odds of 1.7 to 1) or recurring ear infections (odds of 2.1 to 1).⁸

TARGETED GROUPS OF UNINSURED

CHILDREN

- **In 1997, before CHIP took full effect, over 11 million children were uninsured.** A large fraction of these children are eligible for Medicaid or will become eligible for the Children's Health Insurance Program, which targets children from working families.
- **About 40 percent of poor children – nearly 5 million -- are uninsured but not enrolled in Medicaid.** Although some of these children are in states that have not yet fully phased in their poverty-related coverage, others have parents who do not enroll them because: (a) lack of awareness of eligibility; (b) belief that work or not receiving welfare disqualifies them; (c) fear that legal immigrants could be deported if they enroll their children; and (d) complicated and burdensome application process.
- **Even fewer families know that their children may be eligible for CHIP.** Created in 1997, the Children's Health Insurance Program (CHIP) allows states to cover children in working-class families, through Medicaid, a separate program, or a combination. States are in varying degrees of implementing CHIP, but as of June 1999, well over 1 million children on average were enrolled in CHIP. Although this is considerable progress in a short period of time, there are millions more uninsured but eligible children not yet helped by this program. Some of the reasons are the same as for Medicaid, but education is an even greater issue in CHIP since it is new and targets families that typically do not receive such government assistance.
- **Access problems for children in other, middle-class families.** Another 2 million uninsured children are in families with income above Medicaid or CHIP eligibility. These children typically have parents that work in small businesses (over 50 percent have parents working in firms with fewer than 100 employees)⁹ or otherwise lack access to affordable coverage.
- **States have had varying degrees of success at insuring children.** The proportion of uninsured children ranges from 6 percent in Hawaii and Wisconsin to 24 percent in Texas and 25 percent in Arizona. This reflects both the different eligibility levels in states, but also the states' use of and commitment to aggressive outreach initiatives. (See attached table)
- **Clinton-Gore efforts to promote enrollment of uninsured children.** In addition to securing \$24 billion over 5 years for the children's health initiative, the Administration helped implement programs in all states and launched a public-private campaign to raise awareness of children's health. This outreach effort includes: mobilizing over 10 Federal agencies to work on educating families about children's health insurance (e.g., through school lunch programs, housing projects, IRS walk-in centers); working with the states to create a new, nationwide hotline – 1-877-Kids Now (1-877-543-7669) – to provide families with information; and encouraging private sector to run public service announcements, post information in stores and on products, and participate in local education campaigns.



PARENTS OF CHILDREN ELIGIBLE FOR CHIP AND MEDICAID

- **Uninsured children almost always have uninsured parents.** Over 85 percent of the parents of uninsured children in families with income below 200 percent of poverty are themselves uninsured.¹⁰ This is nearly 7 million uninsured adults, who often have no affordable options.
- **Access to health care may be hurt by mixed family coverage.** A recent survey found that 40 percent of families with a mix of members who are uninsured and covered by Medicaid (probably their children) experienced barriers to medical care – nearly 4 times the percent of privately insured families and higher than all-uninsured families.¹¹ This is because families typically use the same providers when they have the same insurance coverage, improving continuity of and access to care.
- **Covering parents would increase enrollment of uninsured children.** Families are more likely to learn about Medicaid and CHIP and to enroll their children in the programs if the whole family is eligible. This appears to be the case in BadgerCare in Wisconsin, whose Medicaid waiver combined with CHIP has enabled coverage of the entire family.

PEOPLE AGES 55 TO 65

- **Fastest growing number of uninsured.** The number of uninsured increased from 41.7 million in 1996 to 43.4 million in 1997, a 4 percent increase. The number of uninsured ages 55 to 64 increased from 2.8 million to 3.2 million, a 7 percent increase. Only the number of uninsured ages 35 to 44 grew as fast.¹²
- **The number of 55 to 64 year olds will rise rapidly in the next decade – and private coverage will drop.** As the Baby Boom generation enters its 50s, both the number and proportion of pre-65 year olds will rise. As a result, the number of people between 55 and 64 years old is expected to increase to from 21 to 30 million by 2005 and 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.¹³ One study projects that, given current trends, the percent of people ages 55 to 65 with private insurance will decline by 4.5 percent by 2005.¹⁴
- **Access to individual health insurance is a problem for people ages 55 to 65.** People ages 55 to 64 are less likely to be covered by employer-based insurance (64 percent v 69 percent for people ages 25-54) and twice as likely to purchase individual insurance (10 percent versus 5 percent for people ages 25-54).¹⁵ Yet, in 38 states where 16 million people ages 55 to 65 (76 percent of this group) live, individual insurance policies can be denied outright.¹⁶ A health condition -- or even the risk of a health condition -- can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage altogether. For example, having mild hypertension or emphysema typically increases rates by 25 percent and rheumatoid arthritis or angina can cause outright denials.¹⁷

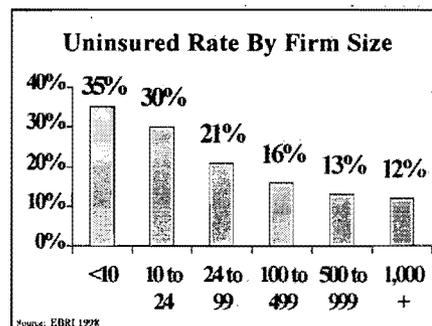
People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. The probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke & cancer is double that of people ages 45 to 54.¹⁸

PEOPLE WITH DISABILITIES

- **Millions of working-age adults have disabilities.** About 1.6 million working-age adults have a disability that leads to functional limitations (i.e., needs help with at least one activity of daily living). About 14 million working-age adults are disabled using a broader definition (e.g., uses a wheelchair, or walker; has a developmental disability).¹⁹
- **The unemployment rate among people with disabilities is staggering.** Nearly 75 percent of people with disabilities are unemployed. Not only is it more difficult for people with disabilities to work; when they do work, their earnings are lower. According to one study, the average earnings for men with disabilities are 15 to 30 percent below those of men without disabilities.²⁰
- **Multiple barriers to work.** People with disabilities face a number of challenges, including:
 - **Lack of adequate health insurance.** In most places in the U.S., people with health problems can be charged high premiums by private insurance companies or denied coverage altogether. Those who are insured may not be covered for some of their needs, such as personal assistance. Medicaid covers these services, but eligibility is generally restricted to people who cannot work. Thus, there is little incentive to return to work.
 - **Higher costs of work.** People with disabilities not only face lower than average wages, but typically pay more to get to and from work and to function at work. Thus, for some, returning to work may decrease rather than increase their savings.
 - **Disconnected employment service system:** A variety of vocational rehabilitation, educational, training and health programs exist to facilitate work for people with disabilities, but they rarely work together in a coordinated way.

PEOPLE IN SMALL BUSINESSES

- **Nearly half of uninsured workers are in firms with fewer than 25 employees.** The likelihood of being uninsured is greater for workers in small firms – nearly three times higher than that of workers in large firms.²¹
- **Fewer small firms offer health insurance – and the number is declining.** The number-one reason cited was the high cost of premiums. Small businesses typically pay higher premiums for benefits, and administrative costs may consume as much as 40 percent of premium dollars.²² Despite the fact that three-fourths of the new jobs created by the strong economy are in small businesses, the proportion offering health insurance declined from 59 to 54 percent between 1996 and 1998 alone. In addition, eligibility for such coverage has become more restricted.²³
- **Purchasing coalitions are a small but growing option for small businesses.** Although still relatively unknown, nearly one in 10 businesses with 3 to 9 employees participated in cooperatives in 1998, and it appears that interest and participation is growing.²⁴



ENDNOTES

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- ²⁰ President's Task Force on the Employment of Adults with Disabilities. (11/18/98). *Re-charting the Course: First Report to the President*. Washington, DC: Department of Labor.
- ²¹ Frontin P.
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**THE CLINTON-GORE ADMINISTRATION'S
HEALTH INSURANCE INITIATIVE
BACKGROUND INFORMATION**

January 19, 2000

THE UNINSURED IN AMERICA

- **Most of 44 million uninsured work or are in working families.** Three-fourths of the uninsured work or are in working families. Although the uninsured rate remains highest among the poor (33 percent), it has been growing faster for the middle class. All income groups experienced increases in the uninsured rate since 1993, but the increase was 50 percent higher for the middle class than that of the poor.¹
- **Access to health insurance can be a major barrier.** Employer-based insurance is the predominant form of health insurance. In 1996, about 82 percent of workers had access to it. However, 45 percent of low-wage workers and about one-third of workers in small business do not have access to group insurance.² The private-sector alternative, individual insurance, is frequently inaccessible, particularly for older and less healthy people. In addition, Medicaid, the State Children's Health Insurance Program, and Medicare have state and Federal rules which limit who can enroll.
- **For others, affordability of health insurance remains the biggest barrier.** Health insurance premiums for employer-based coverage in 1999 averaged \$2,300 for an individual and \$5,700 for a family – with the workers' share being \$420 and \$1,740 respectively.³ People purchasing coverage in the individual insurance market not only lack employer contributions but usually face higher premiums due to higher administrative costs and, if ill or older, medical underwriting and age rating.

CONSEQUENCES OF LACKING HEALTH INSURANCE. Compared to people with insurance, those without insurance are likely to:

- **Forego needed health care.** The percent of uninsured adults who did not receive needed medical care is more than three times that of privately insured adults (30 versus 7 percent).⁴ The proportion of uninsured adults who postponed care is even higher (55 versus 14 percent).⁵ Over one in four uninsured children need health care (e.g., prescription medicine, surgery) but do not get it.⁶
- **Suffer adverse health effects and need expensive health care.** The uninsured are 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes than the privately insured.⁷ Children without health insurance are nearly twice as likely to forego health care for conditions like asthma or recurring ear infections.⁸
- **Rely on emergency rooms or have no regular source of care.** One-fourth of the uninsured adults rely on the emergency room or have no regular source of care, compared to 6 percent of the privately insured.⁹ The proportion of uninsured children lacking a usual source of care is 3 times that of privately insured (20 v. 6 percent).¹⁰

OVERVIEW OF THE INITIATIVE. The Clinton-Gore Administration's budget invests over \$110 billion over 10 years in a multi-faceted health coverage initiative. It would expand coverage to at least 5 million uninsured Americans¹¹ and expand access to millions more through its four-pronged approach of:

I. PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES (\$76 billion over 10 years, about 4 million uninsured covered). The budget proposal would build on S-CHIP to pay higher Federal matching payments to states for covering parents as well as their children. In the new "FamilyCare" program, parents would be enrolled in the same health plan as their children, and states could help families afford job-based insurance.

II. ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP (\$5.5 billion over 10 years, an additional 400,000 uninsured children covered). States would be given new outreach tools:

- Allowing School Lunch Programs to Share Information with Medicaid for Outreach (\$345 million over 10 years)
- Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid, Including Schools, Child Care Referral Centers, and Other Sites (\$1.2 billion over 10 years)
- Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (e.g., No Assets Tests, Mail-In Applications) (\$4.0 billion over 10 years)

III. EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE (\$28.7 billion over 10 years, about 600,000 million uninsured people covered). Some Americans like older people, workers in job transitions, and workers in small businesses, have limited health insurance options. This initiative broadens Medicare and Medicaid options and makes private insurance more accessible through tax incentives by:

- Establishing a Medicare Buy-In Option and Making It More Affordable Through a 25 Percent Tax Credit (\$5.4 billion for both buy-in and credit over 10 years)
- Making COBRA Continuation Coverage More Affordable (\$10.3 billion over 10 years)
- Improving Access to Affordable Insurance for Workers in Small Businesses through Health Insurance Purchasing Coalitions (\$313 million over 10 years)
- Expanding State Options to Insure Children Through Age 20 (\$1.9 billion over 10 years)
- Extending Transitional Medicaid (\$4.3 billion over 10 years)
- Restoring State Options to Insure Legal Immigrants (\$6.5 billion over 10 years)

IV. STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED. (At least \$1 billion over 10 years). The budget expands a new program that coordinates and expands systems that increase access to health care for the uninsured and invests in community health centers.

PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES

Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, National Governors' Association, consumer advocates and insurers have called for expanding S-CHIP to cover parents. The Administration's proposal does this by building on S-CHIP to provide higher Federal matching payments for states to insure parents through the same health plan as their children. "FamilyCare" costs \$76 billion over 10 years and will insure an estimated 4 million uninsured people when fully implemented.

BACKGROUND

- **Most uninsured children are in families with uninsured parents.** Over 80 percent of parents of uninsured children with income below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured.¹²
- **Nearly two-thirds of uninsured parents – 6.5 million -- have children who are in Medicaid and S-CHIP eligibility range** (income below 200 percent of poverty). This represents about one in seven of the uninsured in the U.S.¹³
- **Medicaid eligibility limits are much lower for parents than their children.** While all states cover poor children and many states cover children up to 200 percent of poverty, only 13 states cover parents at or above the poverty level.¹⁴ The median upper eligibility limit for parents in Medicaid is about 60 percent of poverty. In 32 states, uninsured parents who work full time at minimum wages jobs are not eligible for Medicaid because their incomes are too high.¹⁵ S-CHIP does not include an explicit authority to cover parents.
- **Many low-income families decline employer-based insurance, primarily due to cost.** About 20 percent of all uninsured people have access to employer-sponsored insurance. Families with lower incomes are especially likely to turn down such coverage and remain uninsured. Three-fourths of these uninsured people cite cost as the major barrier. The amount that low-wage families pay for the employee share of premiums is, on average, over 50 percent higher for a family with a worker earning less than \$7 per hour than those with a worker earning over \$15 per hour.¹⁶

UPPER ELIGIBILITY IN MEDICAID / SCHIP (14)		
	CHILDREN	PARENTS
	(Percent of Poverty)	
ALABAMA	200	22
ALASKA	200	83
ARIZONA	200	51
ARKANSAS	200	22
CALIFORNIA	250	100
COLORADO	185	45
CONNECTICUT	300	185
DELAWARE	200	108
DC	200	200
FLORIDA	200	34
GEORGIA	200	45
HAWAII	185	100
IDAHO	150	36
ILLINOIS	133	52
INDIANA	150	33
IOWA	185	93
KANSAS	200	43
KENTUCKY	200	54
LOUISIANA	150	23
MAINE	185	108
MARYLAND	200	46
MASSACHUSETTS	200	133
MICHIGAN	200	48
MINNESOTA	280	275
MISSISSIPPI	133	40
MISSOURI	300	100
MONTANA	150	73
NEBRASKA	185	43
NEVADA	200	90
NEW HAMPSHIRE	300	60
NEW JERSEY	350	47
NEW MEXICO	235	62
NEW YORK	192	59
NORTH CAROLINA	200	56
NORTH DAKOTA	100	74
OHIO	150	85
OKLAHOMA	185	37
OREGON	170	100
PENNSYLVANIA	200	71
RHODE ISLAND	300	193
SOUTH CAROLINA	150	58
SOUTH DAKOTA	140	70
TENNESSEE	200	67
TEXAS	200	32
UTAH	200	58
VERMONT	300	158
VIRGINIA	185	33
WASHINGTON	250	96
WEST VIRGINIA	150	30
WISCONSIN	185	185
WYOMING	133	69

- **Covering parents would increase enrollment of uninsured children.** Families are more likely to learn about Medicaid and S-CHIP and to enroll their children in the programs if the whole family is eligible. As such, the NGA and policy experts believe that this option would reduce the number of uninsured children as well as parents.¹⁷ Wisconsin, Minnesota and Vermont are among the states using Medicaid state plan options or 1115 demonstrations to achieve this effect.
- **Cost-effective way to expand coverage.** A recent study compared the effectiveness of covering uninsured adults through a refundable tax credit for group or individual insurance and expanding S-CHIP. It found that S-CHIP would much more efficiently expand coverage to the uninsured than a tax credit. The study found that the tax credit would subsidize 5 already-insured people for every single newly insured person at a total cost 6 times higher than that of the S-CHIP proposal.¹⁸
- **Widespread support.** The concept of extending S-CHIP to parents is one of the few ideas for expanding coverage that is supported by a broad range of groups. The National Governors' Association supported expanding S-CHIP to cover parents in its 1999 policy resolutions, arguing that "CHIP is a promising vehicle to promote the goal shared by the Governors, Congress, and the Administration – decreasing the number of Americans without health insurance."¹⁹ At a January 13, 2000 conference to discuss ideas on expanding coverage, Families USA, the Health Insurance Association of America, the American Hospital Association, the Catholic Health Association and the Service Employees International Union all recommend using S-CHIP or a similar model to cover the parents of Medicaid and S-CHIP children.²⁰

PROPOSAL. The Clinton-Gore Administration would expand S-CHIP to provide higher Federal matching payments for expanding affordable health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. This new "FamilyCare" program:

- **Provides higher Federal matching payments for expanding coverage to parents.** States that raise their eligibility for parents above their Medicaid level as of 1/1/00 would be eligible for the enhanced S-CHIP matching rate for this expansion group. The S-CHIP matching rate is up to 15 percentage points higher than the regular Medicaid matching rate. States' plans for covering parents would only be approved if they first expand eligibility for children up to 200 percent of poverty (30 states have already done so²¹) and do not have waiting lists for S-CHIP. This preserves the bipartisan commitment made in 1997 to focus funding on children first.
- **Increases S-CHIP allotments.** To ensure adequate funding for parents and their children, the current S-CHIP allotments would be increased by \$50 billion for 2002 through 2010 and made permanent. The higher Federal matching payments for the expansion group of parents would generally come from increased S-CHIP state allotments, called FamilyCare allotments. Allotments are fixed dollar amounts allocated to each state based on a formula similar to S-CHIP for the higher Federal matching payments. As in S-CHIP, should the allotment limits be reached, states expanding through Medicaid may continue to cover parents at the regular Medicaid matching rate or roll back eligibility while states expanding through non-Medicaid programs may use state-only funds to continue coverage or limit enrollment.

- **Enrolls parents in the same program as their children.** Parents would be insured in the same program as their children to promote continuity of care and administrative simplicity. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP, and coverage for parents would be overseen by the same state agency that runs their children's program. Parents of children eligible for Medicaid would be enrolled in Medicaid, while parents of children eligible for non-Medicaid S-CHIP programs would be enrolled in those programs.
- **Covers lower income parents first.** As in S-CHIP, states would cover lower-income parents before covering higher-income parents. States could not cover parents at income eligibility levels above those of children, but could set eligibility limits for parents lower than that of children. For the first five years, states could set parents' eligibility limit anywhere between their current minimum levels for parents and their maximum levels for children. Given states' enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state responses and significant expansions to parents under FamilyCare. If, after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty (about \$16,700 for a family of four), a fail-safe mechanism would be triggered to require these states to go to this level of coverage. Thus, by 2006, all poor parents would be eligible for coverage like their children are today.
- **Creates more equitable funding structure.** From 2001 to 2005, all enhanced matching payments for states' expansion group of parents would come from the FamilyCare allotment, as would all payments for S-CHIP children. For example, a state that covered parents to 50 percent of poverty prior to 1/1/00 and then expanded coverage above that would receive enhanced matching payments drawn from their allotments for coverage of the newly eligible parents (as well as S-CHIP kids). Beginning in 2006, two changes would be made. First, the enhanced Federal matching payments for parents below poverty would no longer be deducted from the allotment. States would still receive the enhanced matching payments for poor parents covered under expansions implemented after 1/1/00, but these payments would come from uncapped Medicaid funding and would no longer be subtracted from allotments. Second, all states could receive enhanced matching payments for covering any parent above the poverty line and any child above the Medicaid mandatory coverage levels²² – irrespective of when the state expanded coverage. This ensures that states that have already expanded coverage would be rewarded.
- **Facilitates employer-based coverage.** FamilyCare would also expand the option to pool allotment funding with employer contributions towards the purchase of private insurance, which can be a cost-effective way to expand coverage. States could enable families otherwise eligible for FamilyCare to purchase their employers' health plan as long as it meets FamilyCare standards. Under this option, employers would have to contribute at least half of the family premium cost to discourage them from reducing or dropping coverage because of this program. In addition, the S-CHIP crowd-out policies would apply. One study found that over one in five families whose children were enrolled in the Florida Healthy Kids program previously had access to employer-based coverage but their parents could not afford the premium so they remained uninsured.²³ This option, supported by states²⁴, would help keep such families in private coverage.

ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP

The State Children's Health Insurance Program (S-CHIP) helps children in families with incomes too high for Medicaid eligibility but too low to afford private insurance.

Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The budget would give states needed tools to increase coverage. About an additional 400,000 uninsured children would be covered because of these policies. The initiative costs about \$5.5 billion over 10 years.

BACKGROUND

- **The number of children enrolled in the State Children's Health Insurance Program (S-CHIP) has doubled in less than a year.** Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998.²⁵
- **The number of states covering children up to 200 percent of poverty has increased by more than seven fold.** Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about \$33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.²⁶
- **However, over 4 million eligible children remain uninsured.**²⁷ One study found that two-thirds of eligible uninsured children are in two-parent families, 75 percent of parents of these children work, and only 5 percent receive welfare.²⁸
- **Barriers include lack of knowledge of eligibility and complex application processes.** A survey of parents whose uninsured children are likely to be eligible for Medicaid found that 58 percent did not try to enroll their children because they did not think that their children were eligible and over half (52 percent) said that they believed that the application process would take too long or believed that the forms are too complicated (50 percent).²⁹
- **Uninsured children are often in programs like the school lunch program that can help enroll them.** A number of programs, like the school lunch program, subsidized child care, and Head Start, target the same children who are also eligible for Medicaid and S-CHIP. A recent study by the Urban Institute found that approximately 60 percent – almost 4 million – of the uninsured children nationwide are currently enrolled in school lunch programs.³⁰ However, Federal law prohibits school lunch programs from sharing enrollment information with Medicaid and does not allow states to use school lunch eligibility as a proxy for Medicaid eligibility.

PROPOSALS

- **Allowing School Lunch Program to Share Information with Medicaid (\$345 million over 10 years).** This proposal, similar to bipartisan legislation proposed by Senator Lugar and Congresswomen Carson, would allow school lunch programs to share application information with Medicaid staff for the sole purpose of outreach and enrollment (this is already allowed for S-CHIP).
- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid (\$1.2 billion over 10 years).** The Administration's proposal expands the Medicaid "presumptive eligibility" option for children by authorizing additional sites for enrollment including schools, child care centers, homeless shelters, agencies that determine eligibility for Medicaid, TANF, and S-CHIP, and other entities approved by the Secretary. Presumptive eligibility means that qualified entities, at the states' discretion, may immediately enroll potentially eligible children in Medicaid and S-CHIP on a temporary basis while their applications are formally processed. With the help of Congresswomen DeGette, the law that created the children's health program in 1997 included presumptive eligibility as an option in S-CHIP and Medicaid. However, it limited the types of entities that could presumptively enroll children in Medicaid to Medicaid providers and entities determining eligibility for WIC, Head Start and Child Care & Development Block Grant services. To date, 9 states have opted to use presumptive eligibility for children in Medicaid³¹ and 12 states for S-CHIP.³² Expanding the sites authorized for this option can help states provide critical health care services to children pending official enrollment and increases the likelihood that families complete the application process. More than half (53 percent) of parents of uninsured but eligible children think that immediate enrollment with completion of forms later is one of the best ways to encourage enrollment.³³
- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (\$4 billion over 10 years).** Studies confirm that complicated, long application processes for Medicaid and S-CHIP discourage enrollment. While many states have recognized this and have simplified the process in S-CHIP, not all states have carried over all of their S-CHIP simplification strategies to Medicaid. To ensure that children do not fall through the cracks in states that have different rules and procedures for Medicaid and S-CHIP, this proposal would require that states conform certain Medicaid eligibility rules and procedures for children to the simplified rules and procedures used in S-CHIP. If a state, in S-CHIP: (1) does not require an assets test; (2) uses simplified eligibility requirements and a mail-in application; and (3) determines eligibility for S-CHIP no more than once a year, it would need to apply these same rules and procedures for children in Medicaid. Both conforming Medicaid and S-CHIP and these specific simplifications are recommended by the National Governors' Association as best practices.³⁴ Over 40 states have already made Medicaid as simple as S-CHIP.³⁵

ESTABLISHING A MEDICARE BUY-IN OPTION AND MAKING IT MORE AFFORDABLE THROUGH A TAX CREDIT

People ages 55 to 65 are at greater risk of developing health problems. Recognizing that this age group is also the fastest growing group of uninsured, the President has called on Congress to pass legislation that allows certain people ages 55 to 65 to buy into Medicare. The proposal also would require employers who drop previously-promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make the policy more affordable, the Clinton-Gore Administration proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described later), this policy will address both access to and the affordability of health insurance for this vulnerable group. The Medicare buy-in plus the tax credit for this buy-in cost about \$5.4 billion over 10 years.

BACKGROUND

- **Fastest growing number of uninsured.** Between 1997 and 1998, the proportion of people ages 55 to 65 who are uninsured increased from 14.3 to 15.0 percent – about five times the rate increase for the general population. All of this increase occurred among people with incomes above poverty, with a dramatic increase for those with income between 300 and 400 percent of poverty (between \$33,000 and \$44,000 for a couple) – from 10.2 to 14.6 percent.³⁶
- **Less access to employer-based coverage.** The major reason for the increase in the uninsured in this age group is their lower access to employer-based insurance. In 1998, 66 percent of people ages 55 to 64 had employer-based insurance compared to 75 percent of people ages 45 to 55.³⁷ Some lose their employer-based health insurance when their spouse becomes eligible for Medicare. Many lose coverage because they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their employer drops retiree health coverage unexpectedly.
- **Greater reliance on individual insurance.** Because of a weaker connection to the workplace, a disproportionate percent of people ages 55 to 65 rely on individual insurance. However, the nature of individual insurance makes it easier to avoid people likely to have health problems. In addition to being subject to age rating, a health condition can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage.³⁸ People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. Their probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke and cancer is double that of people ages 45 to 54.³⁹
- **Problems will get worse with demographic changes.** As the Baby Boom generation enters its 50s, the proportion of people ages 55 to 65 is expected to increase from 21 to 30 million by 2005 and to 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.⁴⁰ Even if the uninsured rate remained the same, the proportion of uninsured in this age group would climb. One study projects that the uninsured rate for people ages 55 to 65 will rise even faster given the decline in access to private insurance for this group.⁴¹

PROPOSALS

- **Providing a New 25 Percent Tax Credit for New Options for People Ages 55 to 65.** This year, for the first time, the President will propose a 25 percent tax credit for people eligible for the buy-in. It helps make the original option – which already is more affordable than alternatives in the individual insurance market – even more attractive to people with limited income. In addition, people participating in the extended COBRA coverage would be eligible for the new COBRA tax credit (described later). This tax credit has the advantage of encouraging greater participation in these options for people ages 55 to 65 which could, in turn, reduce the premium costs for these programs over time since new participants are likely to be healthier. It would not, however, be large enough to encourage firms to drop their early retiree coverage or individuals to retire earlier.

This policy builds on the three-pronged initiative advocated by the President, the Vice President and the Democratic Congressional leadership (Daschle, Gephardt, Moynihan, Rangel, Dingell, Rockefeller, Stark, Brown), described below.

1. **Enabling Americans Ages 62 to 65 to Buy Into Medicare.** People ages 62 to 65 who do not have access to employer-based insurance would have a one-time option to buy into Medicare. The premium they would pay would be divided into two parts. First, participants would pay a base premium of about \$300 per month — the average cost of insuring Americans this age range. Second, participants would pay an additional monthly payment, estimated at \$10 to \$20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, covers the extra costs of sicker participants. This two part “payment plan” enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the financing for the buy-in option is sustainable in the long run.
2. **Allowing Displaced Workers Ages 55 to 65 to Buy Into Medicare.** Workers who have involuntarily lost their jobs and their health care coverage would be eligible for a similar Medicare buy-in option. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remain uninsured. Individuals choosing this option would pay the entire premium at the time they receive the benefit without any Medicare “loan,” in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65.
3. **Giving Americans Ages 55 and Older Whose Employers Reneged on Providing Retiree Health Benefits Access to COBRA until Eligible for Medicare.** In recent years, the number of companies offering retiree benefits has declined. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. This policy provides much-needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. It allows these retirees to buy into their former employers’ health plan through age 65 by extending the availability of COBRA coverage to these families. Retirees would pay a premium of 125 percent of the average cost of the employer’s group health insurance.

MAKING COBRA CONTINUATION COVERAGE MORE AFFORDABLE

To improve continuity of health coverage as workers change jobs, the Clinton-Gore budget includes a 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. This tax credit address the issue of cost to help reduce the number of Americans who experience a gap in coverage due to job change. It costs \$10.3 billion over 10 years.

BACKGROUND

- **Changing jobs risks losing health insurance.** Since most insurance is job based, changing jobs puts workers and their families at risk of becoming uninsured. One study found that 58 percent of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage.⁴² About 44 percent of workers with one or more job changes experienced a gap in health insurance coverage. This is even more pronounced for men, over half of whom were uninsured for a month or more when they had a job interruption.⁴³
- **COBRA continuation coverage provides an important option.** Passed in 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) included a provision aimed at minimizing the disruption in health insurance due to job change. It allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. On the whole, evidence supports claims that COBRA decreases the probability that a person between jobs is uninsured, reduces "job lock", and covers workers during pre-existing condition waiting periods.⁴⁴
- **Participation in COBRA is low, primarily due to cost.** Studies suggest that only 20 to 25 percent of COBRA eligibles purchase this coverage. Although some of these people had access to insurance through other family members, the primary reason cited for declining COBRA is its high cost.⁴⁵

PROPOSAL

- **New Tax Credit To Make COBRA More Affordable.** The budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change. It not only helps workers and families access insurance but may help employers, since the current tendency for only people with health problems to participate would be reduced.

IMPROVING ACCESS TO AFFORDABLE INSURANCE FOR WORKERS IN SMALL BUSINESSES

Recognizing the problems that small businesses face in offering their workers insurance, the President proposes a set of policies to harness the purchasing power of large employers and provide assistance for premium payments. It would give small firms that have not previously offered health insurance a tax credit equal to 20 percent of their contribution – twice the credit proposed last year -- towards health insurance obtained through purchasing coalitions. In addition, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and technical assistance would be provided. Altogether, this initiative costs \$313 million over 10 years.

BACKGROUND

- **Nearly half of uninsured workers are in firms with fewer than 25 employees.** The likelihood of being uninsured is greater for workers in small firms – nearly three times higher than that of workers in large firms.⁴⁶
- **Small firms are less likely to offer health insurance.** The proportion of small businesses offering health insurance declined between 1996 and 1998 – from 53 to 49 percent for firms with 3 to 9 workers and from 78 to 71 percent for firms with 10 to 24 workers.⁴⁷ Businesses blame the high cost of premiums for this problem. Small businesses typically pay higher premiums for the same benefits and administrative costs may consume as much as 40 percent of premium dollars. Trends suggest that the situation will worsen.
- **Purchasing coalitions a growing option for small businesses.** Although still relatively unknown, nearly one in 10 businesses with 3 to 9 employees participated in cooperatives in 1998, and interest and participation are growing.⁴⁸

PROPOSAL

- **Provide a 20 Percent Tax Credit for Employer Contributions.** A tax credit equal to 20 percent of employer contributions toward health premiums would be given to eligible small businesses. Small businesses with between 3 and 50 employees that have not offered coverage in the past could receive this credit if they purchase coverage for their workers through a qualified coalition. This credit is time-limited.
- **Financial Assistance in Creating Coalitions.** Start-up costs are a barrier to developing purchasing coalitions. Yet the current tax provisions for foundations makes private foundations reluctant or, in some cases, prohibited from offering grants for these costs. Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This provision is time-limited.
- **Technical Assistance in Creating Coalitions.** Since the Federal Employees Health Benefits Program is a model for coalitions, its managers would provide technical assistance to coalitions, sharing its administrative experience.

EXTENDING MEDICAID TO VULNERABLE POPULATIONS

Medicaid has proven to be a critical source of health insurance for millions of Americans. However, some vulnerable groups of people – children aging out of Medicaid and S-CHIP, people leaving welfare for work, and legal immigrants – cannot or will not be allowed into Medicaid due to current restrictions. The President's budget includes several important provisions to remove these barriers.

EXPANDING STATE OPTIONS TO INSURE CHILDREN THROUGH AGE 20 (\$1.9 billion over 10 years)

- About 1.2 million people ages 19 and 20 have low incomes (below 200 percent of poverty) and are uninsured.⁴⁹ Mostly, this results because they age out of Medicaid or S-CHIP or no longer qualify as dependents in their parents' private plans.
- The budget would give states the option to cover people ages 19 and 20 through Medicaid and S-CHIP.

EXTENDING TRANSITIONAL MEDICAID (\$4.3 billion over 10 years)

- Many people leaving welfare for work take first jobs that do not offer affordable health insurance.⁵⁰ As such, transitional Medicaid provides a critical bridge to work. Created in 1988, transitional Medicaid extends coverage for up to a year for those losing it due to increased earnings. The 1996 welfare reform bill extended this provision through 2001. A recent survey found that nearly half of former welfare recipients had Medicaid coverage, most likely due to this benefit.⁵¹
- The budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.

RESTORING STATE OPTIONS TO COVER LEGAL IMMIGRANTS (\$6.5 billion over 10 years)

- Over the strong objections of the Administration, the 1996 welfare law prohibited states from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin was 35 percent – over twice the national average of 16 percent.⁵²
- The President's budget would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED

BACKGROUND

- **Greater demand.** In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the millions of uninsured. About 6 percent of all hospitals and 26 percent of safety net hospitals annual costs are estimated to be uncompensated, and 2,500 community health center sites serve an estimated 4 million uninsured.⁵³
- **Fewer resources.** Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs.

PROPOSALS

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (At least \$1 billion over 10 years, +\$100 million for FY 2001).** Last year, the President and Secretary Shalala proposed an historic new grant program to support community providers of services to the uninsured. The Congress funded an initial \$25 million investment for this program. This year, the Administration proposes funding this initiative at \$125 million, a \$100 million increase over 2000. This represents a down payment on the its proposal to invest \$1 billion over 5 year. The Administration will also aggressively pursue an authorization to ensure that the program is established as a core element of the health care safety net.
 - **Providing new services to the uninsured.** These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services.
 - **Preserving access to critical tertiary care services.** These funds will help support large public hospitals, that often are the only source for trauma care, burn units, neonatal intensive care units, and other specialized services that are critical to all of the residents in a service area. If these institutions succumb to the burden of uncompensated care costs, both the insured and uninsured residents of the service area will be forced to seek these essential health care services elsewhere.
 - **Holding providers accountable for health outcomes.** These grants will help local providers develop the financial, information, and telecommunication systems that are necessary to appropriately monitor and manage patient needs. This will improve the efficiency and effectiveness of service delivery within the safety net, permitting more clients to be served with existing resources.
- **Investing in Community Health Centers (+\$50 million for FY 2001).** The budget proposes an increase of \$50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans – for total funding of over \$1.069 billion in FY 2001.

ENDNOTES

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DRAFT 1/17: ROLLOUT FOR FAMILY COVERAGE ANNOUNCEMENT
INTERNAL WHITE HOUSE DOCUMENT

TUESDAY, JANUARY 17

8 pm: **Conference Call with Policy Validators (66755 / 66766 code 3794)**
Len Nichols
Bob Reischauer
Bob Greenstein
Henry Aaron
John Hollahan

9 pm: **Conference Call with Policy Validators (66777 code 3794)**
Ed Howard
Bob Blendon
Stu Altman
Uwe Reinhardt
Diane Rowland

Late Evening: **Calls to Policy Validators**
Chip Kahn 702 525 7660 home / pager 1800 790 6607
Ron Pollack 703 780 8158
Drew Altman 628 9100 (the Willard)
Mike McCurry 301 588 3288
Jane Lowenson 202 234 0640
Andie King 202 544 1003

WEDNESDAY, JANUARY 18

Before 9:30: **Heads Up Calls – Members, Staff, IGA**
Senator BreauX 224 4623
Senator Kerry 224 6551
Courtney Dusendury 226 7633 / home 387 7601
Ray Sheppak 624 5300

9:00: **Conference Call with Democratic Staff**
Commerce, Ways and Means, Finance, House and Senate Leadership
(HHS /Treasury)

9:30: **POTUS Briefing in Oval Office Dining Room**

10:00: **CABINET MEETING**

10:15:

Conference Call with Advocates (6755/ 6766 / 6777 / 6799 code 6284)

NACHRI	Nat Ass of Child Advocates
CDF	Nat Ass of Social Workers
AAP	Nat Ass of People with AIDS
CHF	Nat Coalition for the Homeless
CBPP	Nat Council of Senior Citizens
Sarah Shuptrine	Nat Mental Health ass
March of Dimes	Nat Partnership for Women
Catholic Health Assn	Nat Women's Law Center
Families USA	Neighbor to Neighbor
AIDS Action Council	SEIU
AAUW	Summit Health Coalition
AFSCME	The Arc
ANA	National Council o the Aging
Catholic Charities	OWL
United Way	Nat Committee to Preserve SS and Medicare
Lutheran Services	AARP

10:30:

Conference Call for Congressional Staff

Bipartisan Commerce, Ways and Means, Finance, House and Senate Leadership
(HHS / Treasury)

Calls to Intergovernmental Groups

SMDs / State Legislators / Governors (HHS)

11:00:

ANNOUNCEMENT IN THE OVAL

Phone Briefings

Degette, Hatch, Rockefeller, Kennedy, Jeffords, Frist, Graham, and Conrad (HHS)

~~11:15:~~

12
noon

OFF CAMERA / OFF THE RECORD BRIEFING

Secretary Shalala, Gene Sperling, Chris Jennings

After 1 pm:

In-person briefings for Congressional Staff

House Commerce and Ways and Means bipartisan member and Committee staff / Leadership staff
(HHS to schedule; Chris, Rich, Jeanne, Bonnie, Gary)

Senate Finance Committee bipartisan member and Committee staff
Senate HELP bipartisan member and Committee staff
Leadership staff at either meeting
(HHS to schedule; Chris, Jeanne, Rich, Bonnie, Gary)

THE WHITE HOUSE

5-4630

Office of the Press Secretary

For Immediate Release

January 19, 2000

PRESS BRIEFING
BY
SENIOR ADMINISTRATION OFFICIALS
ON HEALTH CARE INITIATIVE

The Briefing Room

12:24 P.M. EST

MR. SIEWERT: Here to brief on the President's new health care initiative are two senior administration officials who should be familiar to all of you. I'll let them start.

SENIOR ADMINISTRATION OFFICIAL: I'd like to be referred to as senior official one. We'll be brief, so we can take your questions.

The President's announcement today is clearly a critical component of the President's overall health agenda and the new opportunity agenda that he will be discussing in his State of the Union. We believe that this is a cost effective, substantial and politically achievable health care package. We believe that it is well designed for coverage, for helping middle class families deal with the burdens of long-term care, and that it is politically achievable to pass it this year.

We feel that the forces of public opinion and momentum are moving in the direction of action on health care, on long-term care, on doing more for coverage for lower income families and children. And I think that, as part of an overall opportunity agenda it will be seen as a component ensuring that in this period of prosperity we're ensuring that all Americans are becoming full partners in our prosperity.

Let me turn it over to my colleague to just give you a quick layout of our steps. We'll be brief and then we're available for any questions you have.

SENIOR ADMINISTRATION OFFICIAL: I'll be brief. I think you've seen the paper. I want to give you a little bit of context and I'll go quickly to the summary and then we'll just do questions.

Clearly, we believe that we have an opportunity this year to get a significant health care coverage initiative passed and enacted. There are many, many issues on health care that there's much greater attention to and I think much greater support for on Capitol Hill -- the patients' bill of rights, long-term care, Medicare prescription drugs and coverage. And all of them are part of a larger -- a piece of larger cloth, a piece of whole cloth that really needs to be webbed together, but certainly are very, very doable. And we've had very encouraging discussions with people on all sides -- very encouraging.

Many of you have written about and talked about the HIAA work, Harry and Louise coming back for coverage. I think it's interesting that Families USA on the other side, the consumer advocates, are also very supportive of initiatives such as the one the President has unveiled today.

There's really four major components of the health care initiative. The first is building on what we now believe is becoming a very successful program. That is the so-called CHIP program, the Children's Health

Insurance Program. That initiative, just this year, doubled enrollment to 2 million. We're seeing a lot of signals that that's increasing more significantly into the future.

There are barriers to enrollment, which we're going to talk about, but it certainly is a good base to start from and build on, and we think it has a very nice private-public interaction, either -- that have been very, very successful.

The parents component initiative that we are unveiling today is something that is not new. It is something that the Vice President and other health policy experts have been advocating in the last year as the most logical next step for coverage expansions. This initiative will provide increased funding for states to provide health coverage for parents. And as they provide coverage for parents and family care policies, it will have the indirect benefit of picking up children, too. When you have a family coverage benefit, you have greater incentives to cover both family and children and we think it will have a double benefit.

That initiative, modeled very carefully after the CHIP program, is \$76 billion over 10 years, and would cover about 4 million uninsured parents and provide access to more affordable coverage for more.

Secondly, as we discussed last week, we are unveiling -- including in our health care initiative -- a whole series of provisions designed to eliminate barriers and enhance enrollment in the Children's Health Insurance Program. Right now, a number of states cannot do presumptive eligibility, enroll kids at schools, at child care centers, at homeless centers. We want to eliminate that barrier, make that an option for the states to do that. We want to eliminate all sorts of other barriers, as well, for the Medicaid program and CHIP programs to finish the job of covering the children and our goal of up to 5 million kids.

Thirdly, we have a whole host of initiatives designed to address the Americans who have very unique barriers to accessing coverage. As the President indicated earlier today, the most rapidly increasing number of uninsured, in terms of rate of uninsured in this country, are seniors, near elderly, 55 to 65-years-olds. They're facing the greatest challenge is finding affordable health coverage.

And as you know, we've been advocating this Medicare buy-in proposal. Now, what we're trying to do is address some of the issues of affordability by superimposing upon that a new tax credit, a 25-percent tax credit to significantly reduce the cost of that option. And we believe it will make it even more attractive, hopefully, to the Congress and also, obviously, to the public as a whole.

Secondly, as the President and my colleague have mentioned, in a very, very successful economy we also are seeing great transitions between the work force, from job to job over periods of times. People get laid off within this economy for periods of time. And if you look at and talk to the experts about uninsured numbers, they'll tell you that one of the biggest numbers that tends to influence the high number of uninsured is there's a lot of people who are uninsured for a period of time during the course of the years. These are the so-called workers in between jobs.

This option provides a 25-percent tax credit for those individuals who take advantage of the COBRA benefit that currently is available for people who get laid off, making it affordable and making it able to enjoy that stop-gap protection. Also it enables them to continue their protection under the Kennedy-Kassebaum legislation on portability. You do not want to have a gap in coverage because you can lose that portability protection under Kennedy-Kassebaum, and this protection will help ensure that does not occur.

Just very quickly, a few others. We doubled the tax credit that we had provided last year for small businesses to form voluntary purchasing coalitions. We extend coverage options for the Medicaid program to cover and CHIP to extend coverage to children from age 18, now, through 19 and 20. It's a population that are aging out of these Medicaid and CHIP programs and frequently don't have access to affordable coverage. And we want to give the options to states to extend that.

And we want to extend something called the transitional Medicaid provisions for people going from welfare to work, so when they do go from welfare to work, they have the ability to access coverage for up to a year. That provision is set to expire in 2001, and if we don't extend it, it will no longer be law. We want to make that a permanent extension. And, lastly, we want to and will continue to advocate for the restoration of a Medicaid option for states to cover legal immigrants, a priority for the President for a number of years.

And then lastly, the fourth prong of this initiative deals with those providers who are providing care directly to the uninsured today. They tend to be the public hospitals, the community health centers, the world health clinic -- these are the entities who are really are incurring significant burdens as we have more and more uninsured in this country, and also as reimbursement rates becomes more and more constrained both in the private sector and the public sectors. And there's a real need to have an investment in that infrastructure, not just to ensure that they continue to be able to provide those services for the uninsured, but also so they can use new technologies to link potential eligible populations of the uninsured into these programs. There is a real belief, both within the department and elsewhere, that this is going to be a critical component that supplements this overall coverage initiative.

So with that, the total package is \$110 billion over 10 years. We anticipate when fully implemented, it will be \$5 million to add to our CHIP goal of, and Medicaid goal, of up to \$5 million. We think it will be at least 10 million people covered if we get this enacted into law. It will be a high priority of this administration. We'll work hard to do it, along with our other health care initiatives we have in this year's budget.

So, with that, I'll turn it back to my colleague and any other general questions you may have.

Q This would still leave 34 million people uninsured; is that correct? And what happens to them?

SENIOR ADMINISTRATION OFFICIAL: Well obviously, this administration did make a major push in the first term for universal coverage. Since then, what we have tried to do is expand coverage in the most cost-effective and realistic way so that we could move incrementally towards that goal.

If you look at the people who are uninsured, it makes sense to look at those in that range of 100 percent to 250 percent of poverty as the ones who would have the most difficulty buying health insurance on their own. The five million that are covered through CHIP, and the additional five million, this 10 million makes up a fairly substantial percentage of the uninsured in the lower income rings.

And so I think that while it covers a substantial chunk of the overall insured, it's an even greater and more substantial percentage of the uninsured families who would have the hardest time purchasing health care on their own. And our hope is that we can move -- continue to move incrementally in a way that covers as many people as possible.

We should know that the CHIP parents initiative at \$76 billion would be a historic achievement. The children's initiative was \$48 billion over

10 -- you start putting these together, you are getting again a substantial chunk of the families who are uninsured who have the hardest time affording health care on their own. And it's what we think that we can effectively get done this year.

And I think that we want to continue the vision of moving toward universal coverage; it's something we ultimately believe in. But we also want to make sure that in our last year, we're doing what we can practically and tangibly to cover people, because for those five or 10 million people, that's an extraordinary number of people, and for those people, this is a huge initiative.

Q Will the President propose using any of the budget surplus to pay for this program?

SENIOR ADMINISTRATION OFFICIAL: This will be proposed as part of an overall initiative that will deal with Social Security solvency, Medicare solvency, and seek to pay off the debt within 15 years. So it will be -- we are proposing this as we always have as part of an overall comprehensive, fiscally-disciplined plan that would pay off our nation's debt within 15 years.

I would look at 1997 as a model where, in that balanced budget initiative, we had a significant expansion of children's health coverage, but we did it in the context of a significant deficit reduction package, a balanced budget package that also had significant improvements for Medicare solvency. So our model would be to do this together as part of a fiscally responsible plan that's paying off the debt, as opposed to different pieces that, while worthy in themselves, need to be packaged together with something that we know maintains the fiscal discipline that's been so important for our prosperity.

Q Well, in simple terms, there are no offsets for this, it comes out of the non-Social Security surplus?

SENIOR ADMINISTRATION OFFICIAL: That is correct.

Q The President was kind of joking around about Harry and Louise, but he was optimistic. Have you looked at the health industry -- what do they call it -- the Insure USA Plan -- which would cost about \$50 billion a year, and do you see anything in there that you can work with them on? Is there reason for optimism here for compromise?

SENIOR ADMINISTRATION OFFICIAL: I honestly believe it is -- -- this might be one of those moments in time where you can get something done. The conventional wisdom, obviously, in Washington is in an election year you can't, but if you look at the players who have been involved in health care reform over the years who everyone goes to to talk about coverage expansion and where they all are and whether they're in conflict or not, just last week there was a conference in which the Health Insurance Association of America -- Chip Kahn, President and former staff member to the Republican Ways and Means Committee, as well as Ron Pollack, who is head of Families USA, who is the advocate for low-income individuals across all age groups -- united on a number of key issues.

One was if you are going to significantly expand coverage, you should look at targeted enhanced reform, such as Medicaid expansions or CHIP enhancements, like the parents policy. I have talked with both of them in the last 24 hours and they're both very, very excited about this. I think that they'll say that this is something that is a very important down payment on moving towards significant expansion of coverage.

And, yes, in the context of this year, we think something can get done because the two groups that have historically been in conflict with one another are coming together, and it's something we hope to be their

partners. I think the President was jesting a little bit, but we'll take any alliance that we can to expand coverage, and we're feeling very, very optimistic that something can happen.

Q You don't see, this year, getting bogged down with Republicans over MSAs?

SENIOR ADMINISTRATION OFFICIAL: I think that in the context of -- for example, you have the patient bill of rights legislation today in conference, and there are access provisions in that. There's tax deductions, there's MSAs, et cetera. There will be people who have different views about how to extend coverage, but no one is arguing that MSAs or tax deductions will significantly pick up coverage.

As Gene mentioned, the most cost-effective approach to expand coverage will be proposals such as the one that the Vice President and the President are advocating. I think that when you have the Health Insurance Association of America and others, almost all health care experts in this country validating that point, I think we can turn this thing around.

And remember one other thing: The CHIP proposal was a great achievement for the President, but it was a bipartisan achievement. It was Republicans and Democrats working together to design a proposal. We're building on that. And I think with that in mind, the concept of going beyond that and extending to parents that, sure, that not only parents get coverage but more children get coverage is something that governors, Democrats, Republicans can all agree on, and our hope is that that will spur this on forward.

SENIOR ADMINISTRATION OFFICIAL: I actually want to just make sure I clarify the answer to your first question. When we were proposing this, as I said, we were proposing it as an overall fiscal discipline package that does deal with debt reduction and Medicare insolvency. Within that overall context, this initiative would be coming out of the non-Social Security surplus. But I don't want to suggest that that means one can simply pull pieces out of -- that one can pull pieces out of our initiative and deal with them alone.

In other words, I think that we have always felt that the -- we have always, when we've talked about first things first, said that first you have to make sure that you are dealing with the fiscal discipline and solvency issues, and that in that context, it can be acceptable to use the non-Social Security surplus for other important issues. That is how we are presenting it.

The question of whether or not one could pull something out and just have it play to the surplus is not one we are -- that is not what we are proposing. We are proposing this as part of an overall fiscal discipline package.

Q You're saying that if Congress is not willing to put a certain amount of the surplus to paying down the debt, you don't want this, either?

SENIOR ADMINISTRATION OFFICIAL: I'm not -- you know, I'm not going to try to pose every hypothetical that would come down the pike. I think what I'm telling you is that what we are proposing and what we will be fighting for is an overall plan that meets our fiscal discipline. One, I think, could pull out elements of anyone's package, Republicans' and our package, and if one did them alone with no fiscal discipline measures, one might decide that even though those are worthy objectives, that without commitments to debt reduction or Medicare solvency, it would not be part of a responsible package.

Q Just one question. I don't know if you have projections for this, but given that the number of uninsured is rising, what's your

projection for, if this passed and was fully phased in, what would be the number of uninsured in 2005?

SENIOR ADMINISTRATION OFFICIAL: In all honesty, I don't have it, but I will say that the most recent data by CPS and others seems to suggest that there is a slowing down of the number of uninsured. I think that we may be capping out. We still have a huge problem. So to project forward about what a baseline is, is really almost impossible to do.

Q Republicans have used the minimum wage bill in the past as a vehicle for access provisions. Given that you have such a focus on this this year and you want it done this year, you previous have insisted on clean minimum wage bills. Do you think that that might be legislation that you could attach to some of those?

SENIOR ADMINISTRATION OFFICIAL: As you said, our view is that with 4.1 percent unemployment, with a previous dollar minimum wage increase over two years that had no negative impact on jobs, we do not think that a modest dollar minimum wage increase over two years with the wage -- with the job market as tight as it is now, requires additional packages that, as you know, often turn into more Christmas trees. So we would continue to press forward proposing the minimum wage as a clean bill.

Whether or not there could be a construction of tax cuts or measures that were fiscally responsible and progressive and reasonable that could be part of an overall package, I don't know. I haven't seen such a bill so far.

Q Does the administration support any of the provisions the House passed -- patients' bill of rights that's now in conference? Does the administration support any of the Republican access proposals passed by the House?

SENIOR ADMINISTRATION OFFICIAL: Historically, we have supported, for example, the self-employed tax deduction provision. If there's a move towards accelerating that it would not be something that I could imagine us opposing at all.

I think where you get to a problem is when you have a tax deduction on the individual level that's very regressive, that does not cover anyone by the Joint Committee on Taxation's own numbers, that we think is the best way to target dollars? The President asked us to find the most cost-effective way to most significantly expand coverage. This policy that he's unveiling today does just that. We've clearly been on record opposed to medical savings accounts. We think that we should wait until the demonstrations have been completed before we expand those things.

But I think this is a time where we want to say that we believe this year we can get patients' bill of rights done with or without an access component. But our belief is that we can get an access piece done and it can complement the patients' bill of rights. You all remember in the debate on the House side last fall on patients' bill of rights, many Republicans said there should be significant expansions to coverage. Well, if that's really where they are, and I take them at their word, then I think they'll want to work again to build on a bipartisan team that we worked on back in 1997. And we hope and expect that will be the case.

Q Do you have a calculation about how much of this is raw, just tax credits or tax cuts?

SENIOR ADMINISTRATION OFFICIAL: In the package? If you want the full package, then you would need to add the \$110 billion announced today, with the \$26.6 billion that were announced yesterday. I think -- we can do that for you.

Q -- the long-term care?

SENIOR ADMINISTRATION OFFICIAL: Yes.

Q No, but of this \$110 billion, this isn't all tax cuts?

SENIOR ADMINISTRATION OFFICIAL: It's about \$15 billion or so -- \$14 billion or \$15 billion is that, tax cuts, plus the long-term care is \$26.6 billion. So you're about \$40 billion.

SENIOR ADMINISTRATION OFFICIAL: The \$26.6 billion is the total for the long-term care tax credit. A portion of that, about a third of that had been proposed last year. So the total package would be about, then around \$136 billion and I think about \$40 billion of that is tax cut. But we can get that for you more exactly.

Q Are the pharmaceutical people still coming tomorrow? And are you optimistic, have you had any private talks prior to this? Is this just going to be a getting to know you, how do you do? Or is this going to get serious?

SENIOR ADMINISTRATION OFFICIAL: I have met -- my colleague and I have had a meeting with Gordon Binder and Mr. Holmer. So we have had a meeting with them. They came to speak with us and we're very clear that they wanted to play a constructive role. And we made very clear to them that we wanted to work with anyone who wanted to be part of the solution. So we have had discussions with them and we thought they were productive and hopeful. But we'll still, obviously, have to see as it progresses, but they're going to come in for further discussion tomorrow with John Podesta.

Q We heard the first one really didn't go all that well.

SENIOR ADMINISTRATION OFFICIAL: That's not true.

Q What time do they come tomorrow?

SENIOR ADMINISTRATION OFFICIAL: I would encourage you to ask them, specifically.

Q What time are they coming tomorrow? When do they meet with Podesta tomorrow?

SENIOR ADMINISTRATION OFFICIAL: I don't know. We'll find out.

Q Since this is an election year, do you think somebody is playing politics on Capitol Hill about the health bill?

SENIOR ADMINISTRATION OFFICIAL: I think that election years are unpredictable, and I think people are very sensitive, maybe more sensitive to public opinion, public moods. But I think that what's important is that that can often work in the direction of getting legislation, and I think people too often make the mistake of thinking in an election year nothing will get done.

I think the sensitivity to public sentiment, particularly in the case of health care where there is such strong sentiment for action on health care bill of rights, on prescription drugs, on Medicare solvency and coverage, could very well help this be a very legislatively productive year.

THE PRESS: Thank you.

END

12:50 P.M. EST

MEDICAID & SCHIP LEGISLATIVE PROPOSALS: 2001 PRESIDENT'S BUDGET*(Dollars in millions by fiscal years, negative numbers are savings and positive numbers are costs)*

	2001	2002	2003	2004	2005	5-Year Total 2001-2005
MEDICAID						
SAVINGS:						
Provide Additional Rebate from Generic Drug Manufacturers	-35	-50	-55	-60	-65	-265
Medicaid Cost Allocation	-260	-304	-576	-586	-336	-2,063
Child Support Enforcement	-10	-25	-40	-45	-50	-170
Provide Secretary with New Enforcement Tools	-10	-10	-10	-10	-10	-50
Publicize the AMP	-20	-45	-75	-110	-150	-400
Medicaid Interactions with Medicare	-20	-20	-20	-20	-20	-100
<i>Subtotal, Savings.....</i>	<i>-355</i>	<i>-454</i>	<i>-776</i>	<i>-831</i>	<i>-831</i>	<i>-3,048</i>
COSTS:						
Restore Benefits to Immigrant Children/Pregnant Women	+81	+102	+152	+189	+188	+670
Restore SSI to Qualified Immigrants (5-year ban, no deeming)	0	+17	+71	+157	+268	+513
Asthma Initiative	+50	+50	0	0	0	+100
300% Eligibility Expansion	+15	+25	+30	+35	+35	+140
Presumptive Eligibility	+15	+35	+55	+85	+115	+305
Extend Transitional Medicaid	0	+350	+350	+400	+450	+1,550
Family Care Initiative	+600	+1,200	+1,900	+2,800	+3,700	+10,200
Medicaid and CHIP Age Expansions	+114	+123	+128	+138	+147	+650
Smoking Cessation with Match	+12	+13	+13	+14	+14	+66
School Lunch Initiative	+5	+14	+24	+38	+38	+119
Align Medicaid and CHIP Eligibility	+126	+315	+378	+451	+291	+1,561
Breast Cancer	+15	+30	+45	+55	+75	+220
Interactions Among Medicaid Policies	+5	+10	+20	+30	+30	+95
Interactions with Medicare Drug Benefit Proposal	0	0	+2,119	+3,479	+3,733	+9,331
<i>Subtotal, Costs.....</i>	<i>+1,018</i>	<i>+2,284</i>	<i>+5,285</i>	<i>+7,851</i>	<i>+9,082</i>	<i>+25,520</i>
TOTAL MEDICAID IMPACT	+663	+1,830	+4,509	+7,020	+8,451	+22,472
SCHIP						
COSTS:						
Restore Medicaid and SCHIP to Immigrant Children	+2	+4	+6	+6	+7	+25
FamilyCare Initiative	+200	+400	+700	+1,000	+1,300	+3,600
Expand SCHIP Eligibility Age to 19 or 20	+6	+7	+7	+7	+8	+35
Align Medicaid and SCHIP Eligibility	+4	+10	+12	+14	+9	+49
School Lunch Initiative	0	+1	+1	+2	+2	+6
Interactions Among SCHIP Policies	0	0	0	0	0	0
TOTAL SCHIP IMPACT	+212	+422	+726	+1,029	+1,326	+3,715
STATE GRANTS AND DEMONSTRATIONS						
Homelessness Initiative	+10	0	0	0	0	+10

**PRESIDENT'S HEALTH
INSURANCE INITIATIVE**

Background

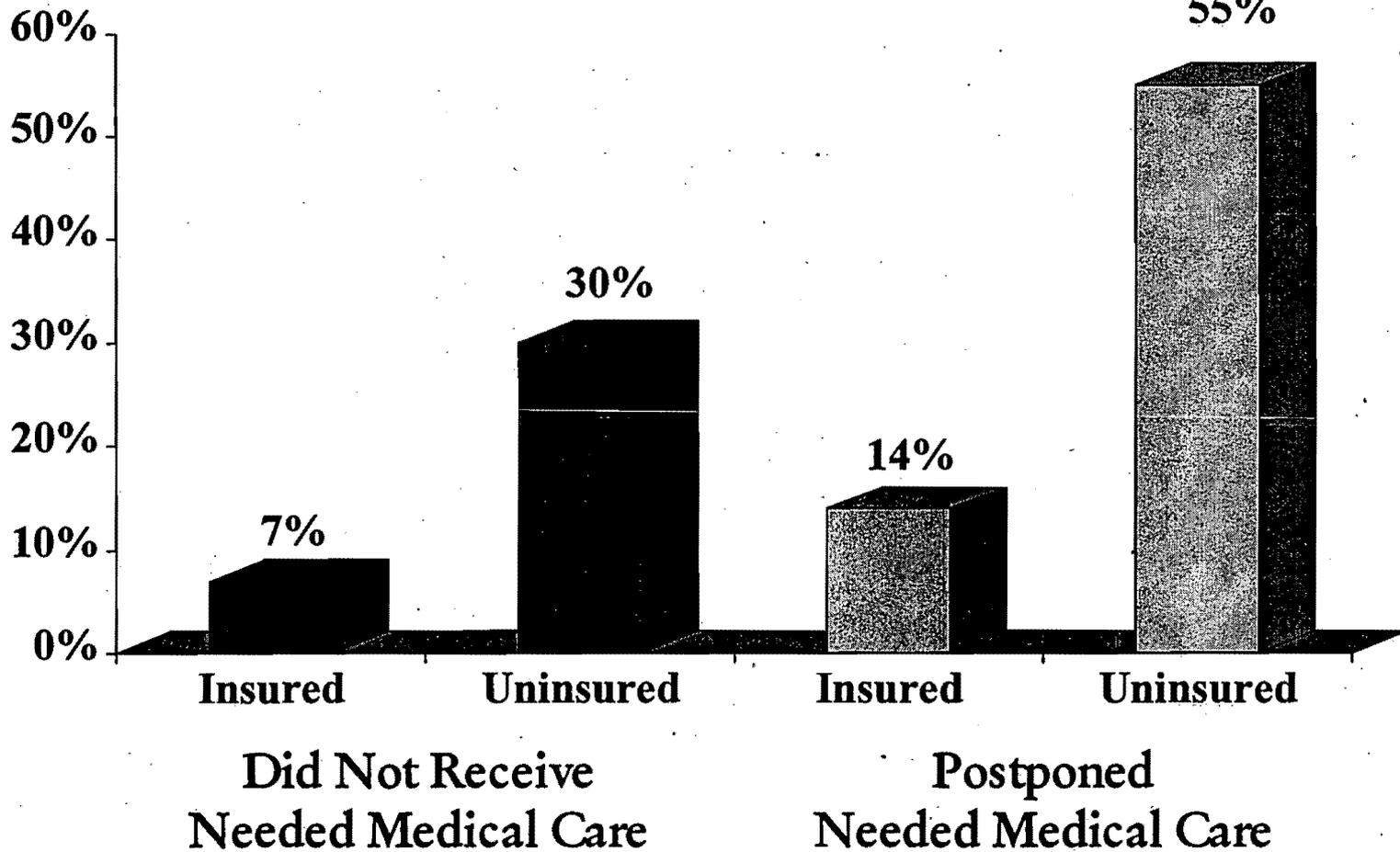
Proposals

February 2000

BACKGROUND

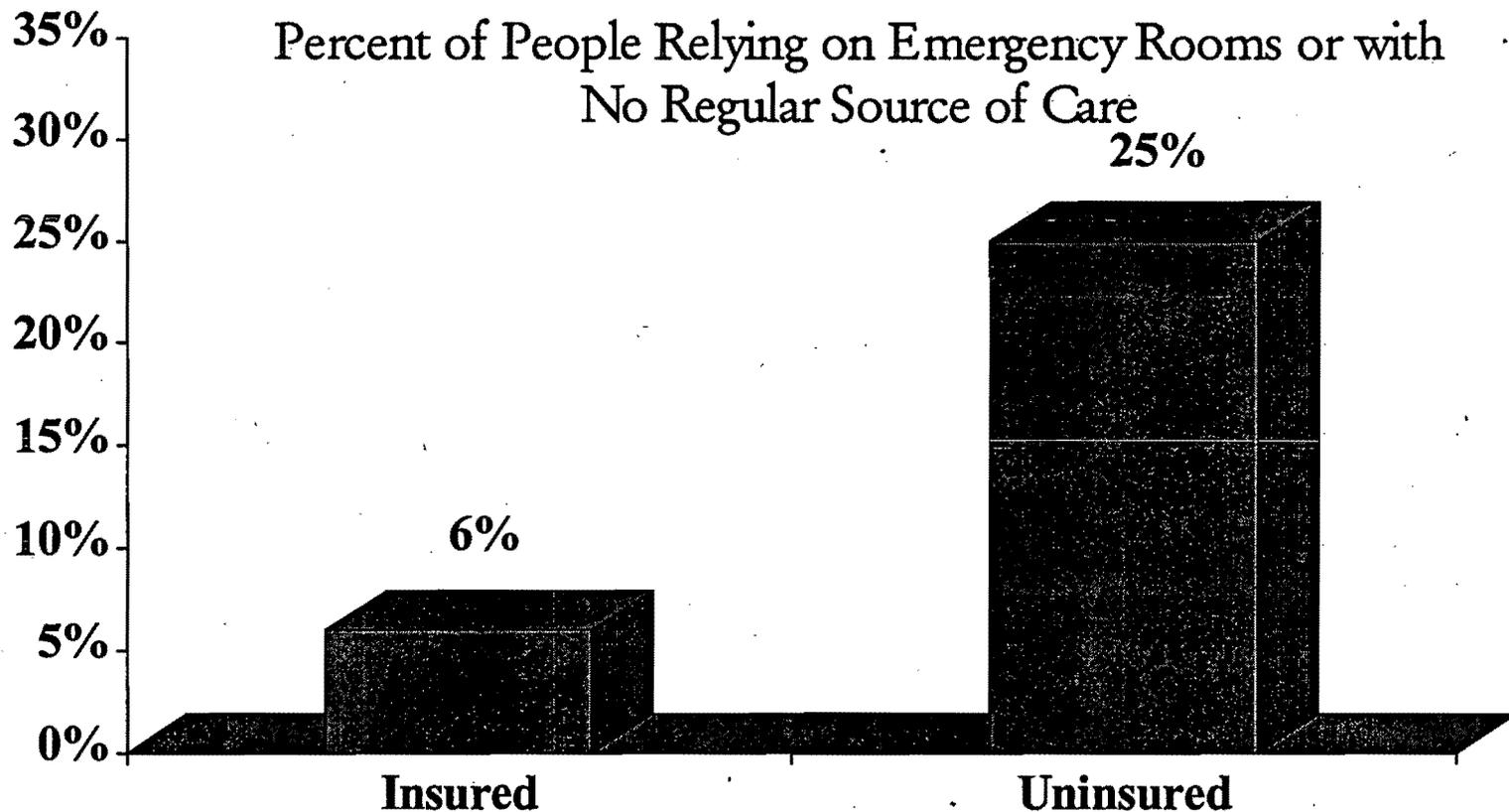
Health Insurance Matters

Uninsured Are More Likely to Postpone or Not Receive Needed Care



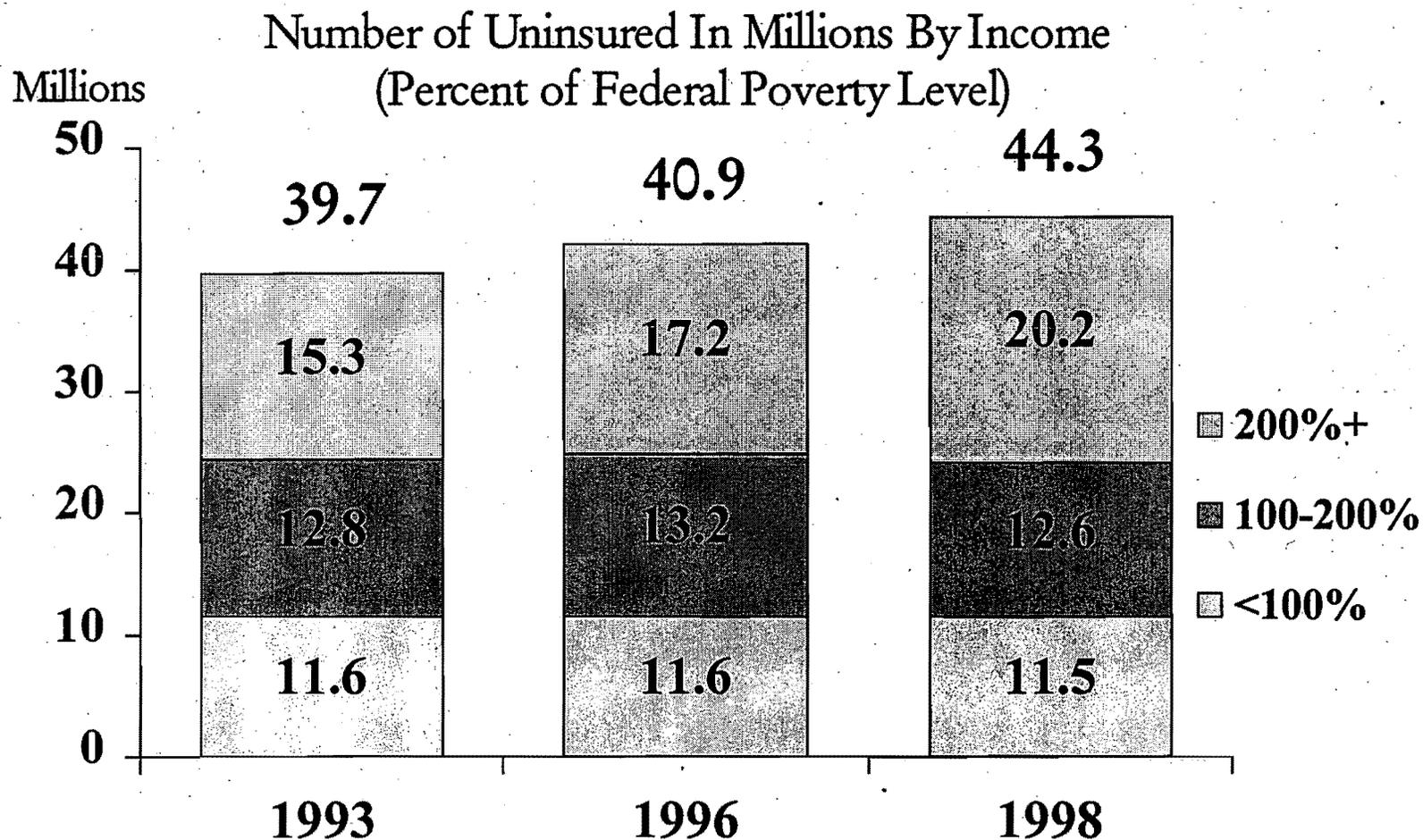
Care for the Uninsured Can Be Costly

*Uninsured Are More Likely to Rely on
Costly Emergency Room Care*



Uninsured Are Not Just Poor

Most Uninsured Are In Working Class Families



Principles For Initiative

- Efficiently and effectively covers the uninsured
- Builds on existing public and private options -- no new bureaucracies
- Targets funds towards those with greatest need -- lower to moderate income working families

PRESIDENT'S HEALTH INSURANCE INITIATIVE

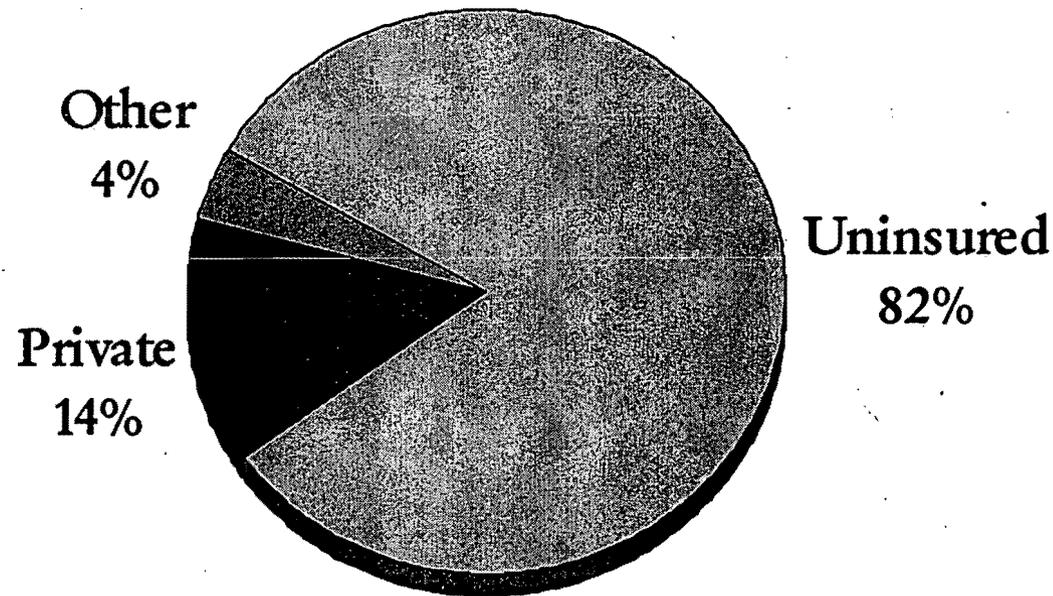
1. Provides Affordable Health Insurance Option for Families
2. Accelerates Enrollment of Uninsured Children Eligible for Medicaid and S-CHIP
3. Expands Health Insurance Options for Americans Facing Unique Barriers to Coverage
4. Strengthens Programs that Provide Health Care Directly to the Uninsured

Costs: \$110 billion over 10 years. Covers: About 5 million uninsured

Millions of Uninsured Parents Have Children Eligible / Enrolled in Medicaid or S-CHIP

Virtually All Low-Income Parents with Uninsured Children Are Themselves Uninsured

Insurance Status of Parents of Low-Income Uninsured Children, 1998



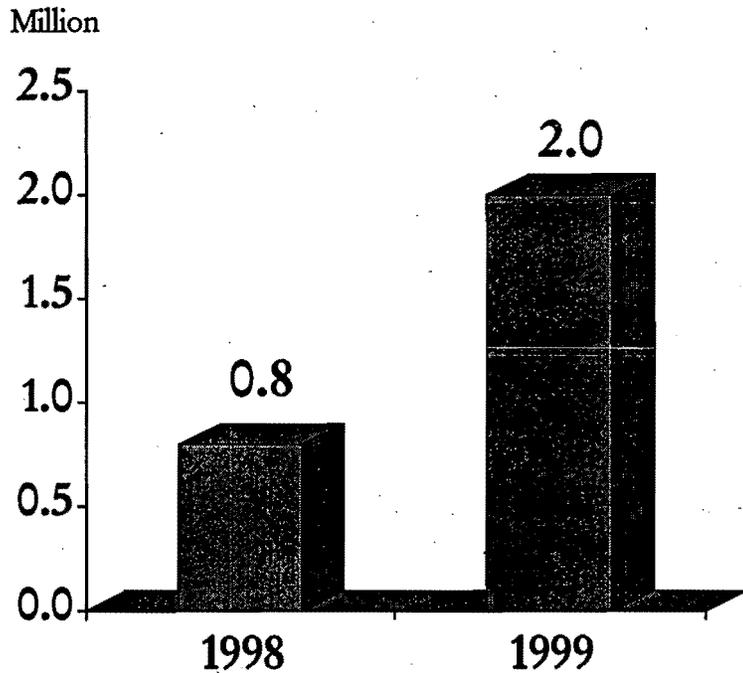
1. Providing Affordable Option for Uninsured Parents

- Provides higher Federal matching payments for expanding to parents and increases state allotments
- Enrolls parents in the same program as their children
- Facilitates employer-based coverage
- After 5-year phase-in, all states, regardless of when they expanded coverage to parents and children above poverty, get enhanced match for them. Any states that have not reached poverty for parents would be required to do so.
- Costs: \$76 billion over 10 years. Covers: About 4 million uninsured

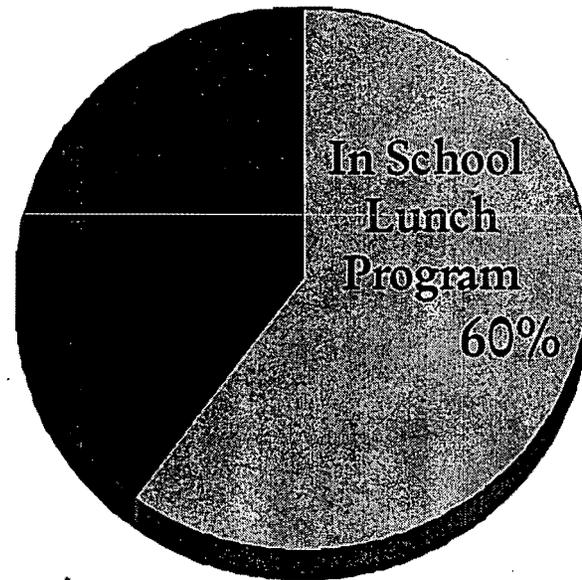
Uninsured Children

About 2 million children have been enrolled in S-CHIP, but millions remain uninsured. About 4 million uninsured children are enrolled in the National School Lunch Program

Children In S-CHIP



Low-Income Uninsured Children



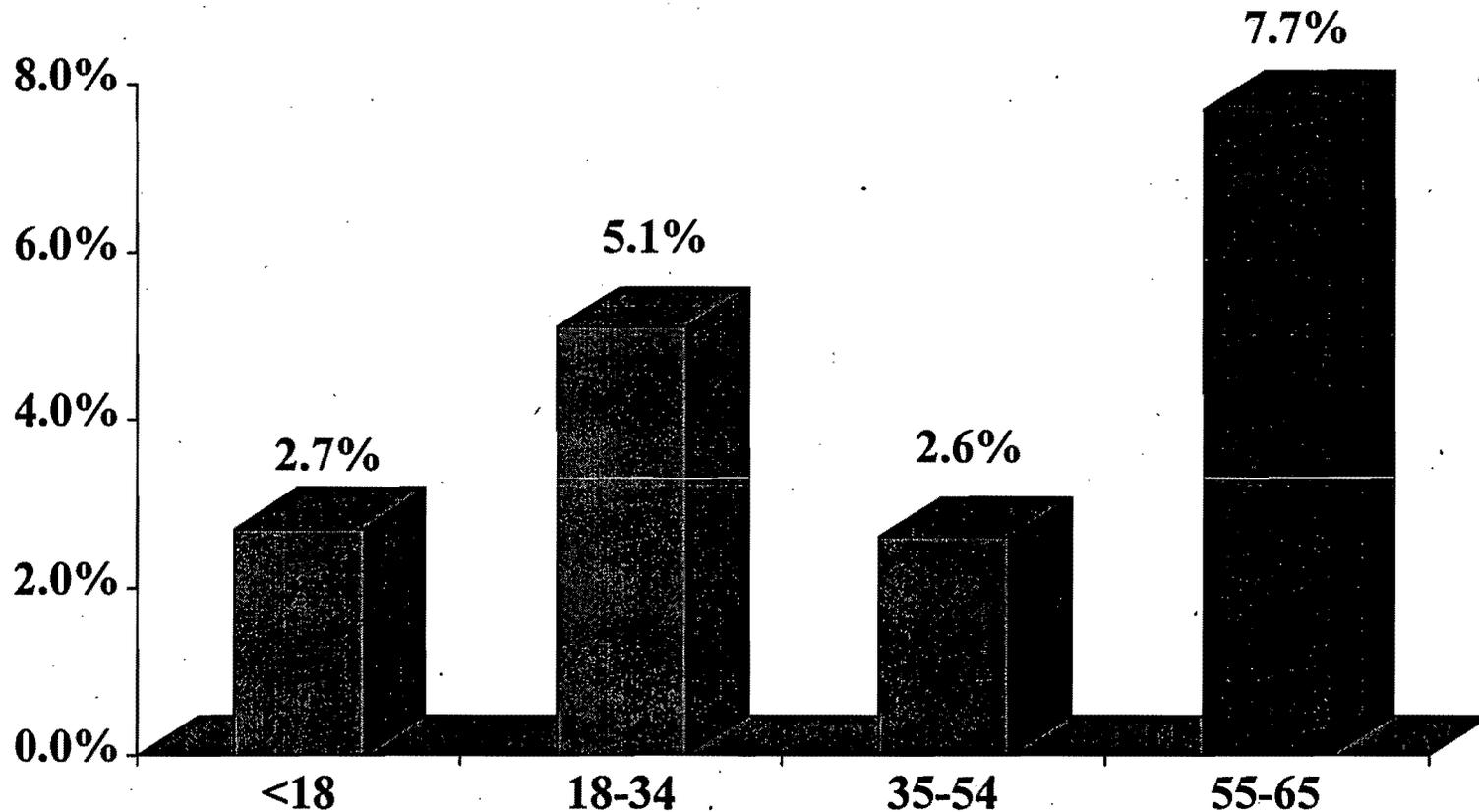
Source: HHS Annual Report on S-CHIP Enrollment, 2000. Kenney GM; Hally JM; Ullman F. (2000). *Most Uninsured Children in Families Served by Government Programs*. Washington, DC: The Urban Institute.

2. Accelerating Enrollment of Uninsured Children

- Allows school lunch programs to share information with Medicaid for outreach
- Expands sites authorized to enroll children in S-CHIP and Medicaid (e.g., schools, child care referral centers)
- Requiring states to make Medicaid and S-CHIP enrollment equally simple (e.g., no assets test, mail-in applications)
- Costs: \$5.5 billion over 10 years. Covers: About 400,000 children on top of baseline 5 million uninsured children

Increase in the Rate of Uninsured People by Age Group, 1996-1998

Uninsured Rate Growing Fastest for People Ages 55 to 65



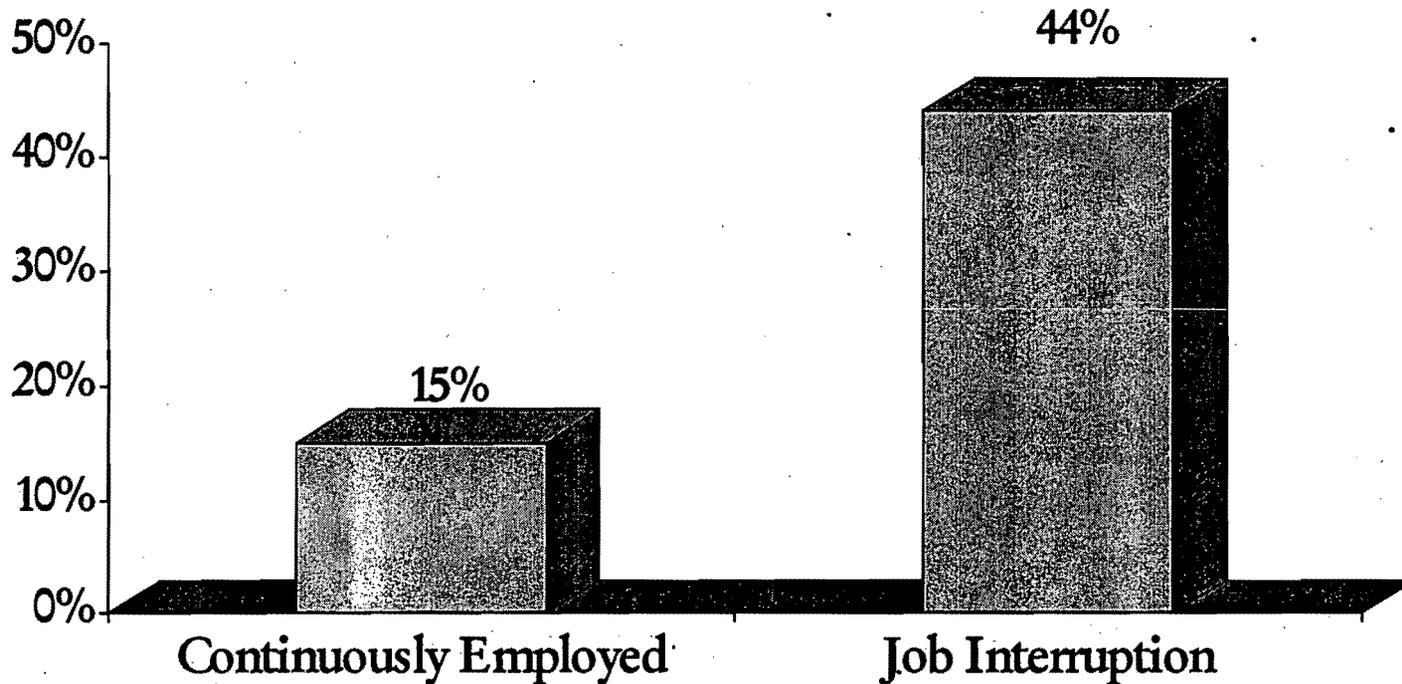
3a. Medicare Buy-In

- Enables people ages 62 to 65 to buy into Medicare
- Allows displaced workers ages 55 to 65 to buy into Medicare
- Gives retirees whose employers renege on retiree health benefits access COBRA until eligible for Medicare
- Provides a new 25 percent tax credit for all new options for people ages 55 to 65
- Costs: \$5.2 billion over 10 years. Covers: About 330,000 people

Job Change Disrupts Health Insurance

About 44 percent of all workers changing jobs go for at least a month without coverage

Proportion With a Gap in Health Insurance Coverage



Source: Bennefield RL. (August 1998). *Who Loses Coverage and for How Long?* Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. U.S. Census Bureau, Department of Commerce, Current Population Reports P70-64.

3b. Tax Credit for COBRA Continuation Coverage

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows workers in most firms to pay a 102 percent of the average cost of group health insurance to buy into their employers' health plan for 18 to 36 months
- This proposal provides a 25 percent tax credit towards the premiums for COBRA continuation coverage
- Costs: \$10.3 billion over 10 years. Covers: About 3 million people

Small Businesses Are Less Likely to Offer Job-Based Insurance

As a result, the proportion of uninsured in small businesses is over twice the rate in large firms

Rate of Uninsured By Firm Size, 1998



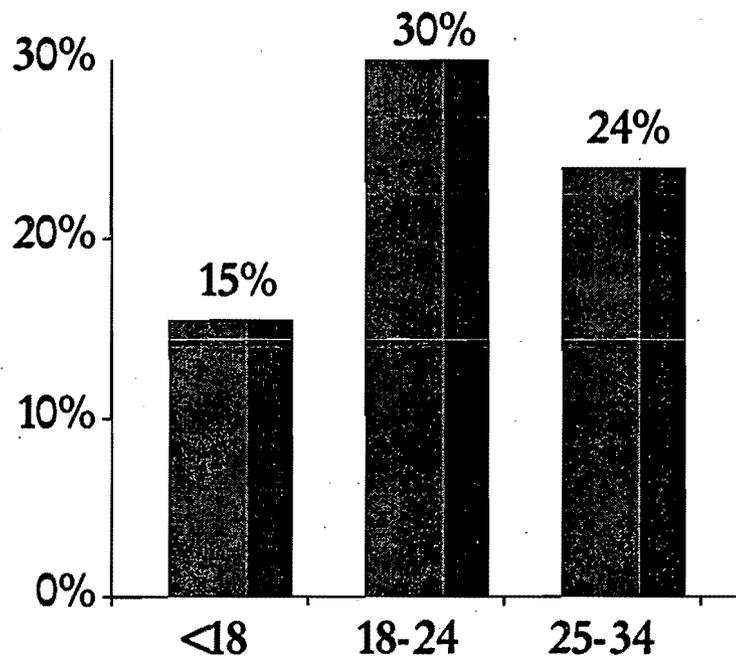
3c. Encouraging Small Business Purchasing Coalitions

- Provides small businesses that have not previously offered health insurance a 20 percent tax credit for contributions toward coverage in small business purchasing coalitions
- Encourages health insurance purchasing coalitions to develop by making foundation contributions towards start-up costs charitable for tax purposes
- Provides technical assistance in creating coalitions
- Costs: \$313 million over 10 years

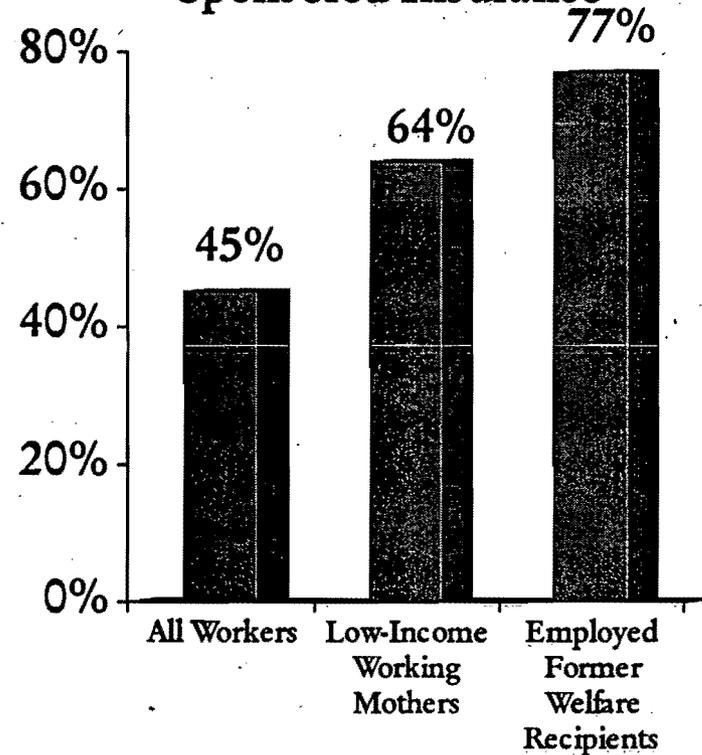
Transitions and Health Insurance

Children aging out of their parents' insurance or Medicaid and people leaving welfare to work are more likely to be uninsured

Uninsured Rate By Age, 1998



People Without Employer-Sponsored Insurance

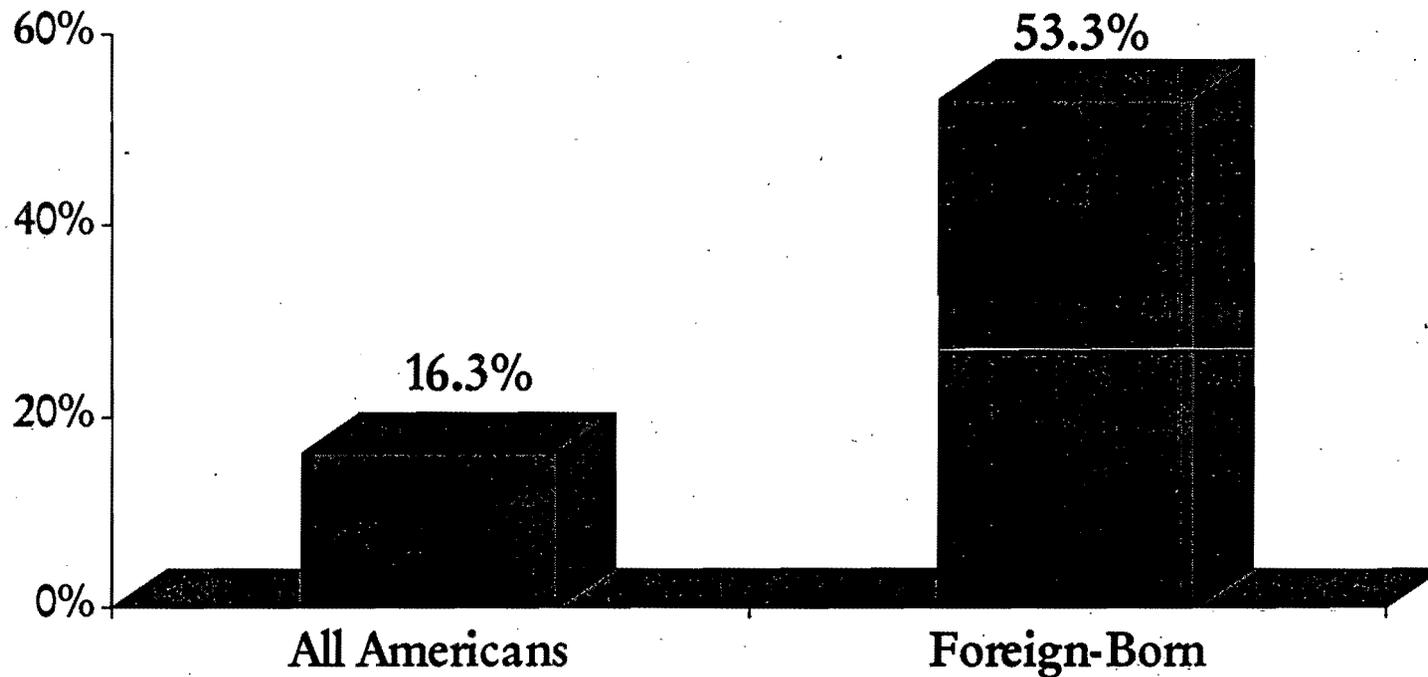


3d. New Medicaid Options for People in Transitions

- Expands state option to insure children ages 19 and 20 in Medicaid and S-CHIP, since they often become uninsured as they age out of these programs or their parents' dependent coverage
- Extends Transitional Medicaid coverage, that provides temporary insurance for people losing Medicaid due to increase earnings
- Costs: \$6.2 billion over 10 years. Covers: About 350,000 uninsured

Legal Immigrants are More Likely to Lack Insurance

Uninsured Rate, 1998



3e. Medicaid and S-CHIP Option to Insure Legal Immigrants

- Gives states the option to insure children and pregnant women in Medicaid and S-CHIP, eliminating the 5-year ban, deeming, and affidavit of support provisions
- Provides Medicaid coverage to legal immigrants who become disabled after entering the U.S. and receive SSI (a proposal to restore SSI coverage is also in the FY 2001 budget)
- Costs: \$6.5 billion over 10 years. Covers: About 250,000 uninsured

4. Strengthening Programs Providing Health Care Directly to the Uninsured

- Increases funding for “Increasing Access to Health Care for the Uninsured” program by \$100 million in FY 2001
 - Funds new services for the uninsured and preserves access to critical care provided by public hospitals
 - Invests in financial, information, and telecommunications systems needed to monitor and improve outcomes
- Invests an additional \$50 million in community health centers in FY 2001
- Costs: About \$1 billion over 10 years

HEALTH INSURANCE INITIATIVE: SUMMARY FACTS

COST: Over \$110 billion over 10 years (\$26 billion over 5). Of this, \$12 b = tax
COVERAGE: 5 million uninsured when fully implemented, expand access to millions more

- I. **PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES (\$76 billion over 10 years, about 4 million uninsured covered).**
 - Builds on S-CHIP to pay higher Federal matching payments to states for covering parents
 - Enrolls parents in same program as children – same systems, no new bureaucracy
 - 80 percent of uninsured children have uninsured parents; about 6.5 million uninsured parents have income < 200 percent FPL
 - Failsafe: Although we expect all states to significantly expand coverage, at least all poor parents have to be covered by 2006.
- II. **ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND CHIP (\$5.5 billion over 10 years, extra 400,000 uninsured children).**
 - Allows school lunch programs to share information for outreach (\$345 million over 10)
 - Expands sites authorized to enroll children in S-CHIP and Medicaid, including schools, child care referral centers, and other sites (presumptive eligibility) (\$1.2 billion over 10)
 - Simplifies enrollment by requiring states to make their Medicaid and S-CHIP the same (e.g., no assets tests, mail-in applications) (\$4.0 billion over 10 years)
- III. **EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE (\$28.7 billion over 10, 600,000 uninsured).**
 - Medicare Buy-In Option, 25 Percent Tax Credit (\$5.4 billion for both Medicare = \$3.8 b, tax credit = 1.6 billion). Over 300,000 participants; fastest growing group of uninsured
 - COBRA 25 Percent Tax Credit. (\$10.3 billion over 10 years). About 3 million participants; helps limit gaps in health insurance caused by job changes. COBRA provides workers in firms > 20 option for 18 to 36 months to buy into group plan at 102 percent of costs for active employee. Only about one in four eligibles participate.
 - Small Business Purchasing Coalitions. (\$313 million over 10 years). Both encourages coalitions to develop (foundation contributions for start-up are made “charitable” and OPM provides technical assistance) and encourages small businesses that do not now offer coverage to join through 20 percent tax credit for their contribution.
NOTE: Differs from Republican “Health Marts” and “Association Health Plans” since coalitions remain subject to state benefit mandates and premium rating rules
 - Medicaid / CHIP Options to Insure Children Through Age 20 (\$1.9 billion over 10). Kids aging out of these programs are vulnerable; 1.2 million low-income people ages 19-20 are uninsured; people ages 18-24 have highest rate of uninsurance: 30 percent
 - Extends Transitional Medicaid (\$4.3 billion over 10 years). Extended in welfare reform, expires in 2002. Provides about 1 year of extra Medicaid when leaving welfare for work.
 - Restores Legal Immigrants Coverage. (\$6.5 billion over 10 years). Welfare reform prohibited states from covering pregnant women and children for first 5 years in U.S.; does not extend SSI and Medicaid to people developing disabilities after coming to U.S.
- IV. **STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED. (At least \$1 billion over 10. Through 2001 +\$100 million community-based program to improve access and +\$50 for public clinics**

STRENGTHENING MEDICARE FOR THE 21st CENTURY: SUMMARY

COST:	<u>Savings:</u>	\$70 billion over 10 years
	<u>Costs:</u>	\$160 billion for drugs, \$9 billion for other (prevention, buy-in)
	<u>NET:</u>	About \$100 billion over 10 years
	<u>Solvency:</u>	About \$300 billion (all transfers since we are using conventional scoring)

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT.

- Gives traditional Medicare new private purchasing and quality improvement (e.g., competitive pricing, authority to contract with disease management firms for services; coordinated care models for dual eligibles)
- Creates the **Competitive Defined Benefit** program that injects true price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices by moving away from competition based on benefits. Saves money over time for both beneficiaries and the program;
- Reduces Medicare spending growth and fraud, ensuring that program growth does not significantly increase after 2002 and continues the Administration's fight against waste, fraud and abuse.

MODERNIZING MEDICARE'S BENEFITS.

- **Voluntary prescription drug benefit** that is affordable and available to all beneficiaries.
 - Affordable, decent benefit: \$26 / mo in first year (to about \$50 in '09); no premiums for low-income; No deductible, pays for half of expenses up to \$5,000 (phased in); provides discounts after limit
 - Accessible: Option for all – irrespective of location, health status, income, type of plan (managed care)
 - Efficiently Administered: Uses competition to get best discounts for beneficiaries; encourages employers to continue providing retiree coverage; no price controls
- **Eliminates preventive services costs sharing:** Eliminates deductibles and copays for Medicare colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, mammographies, etc.
- **Rationalizes cost-sharing requirements** by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation;
- **Reforms Medigap policies** by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and
- **Includes the President's Medicare Buy-In proposal** which provides an affordable coverage option for vulnerable Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY.

- **Dedicates over \$300 billion to Medicare solvency over 10 years.** In addition to slowing Medicare growth through improved efficiency and competition, the plan would dedicate funds from the on-budget surplus to the Medicare HI trust fund. These resources will be used to pay down the debt, helping to prepare the government – and the Nation – to meet the challenge of the retiring baby boomers and rising health costs.

MEDICARE: BACKGROUND FACTS

PRESCRIPTION DRUGS

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drug coverage.**
 - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage. The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years.
 - Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans' Affairs and other public programs.
- **Millions of beneficiaries have no drug coverage.**
 - At least 13 million beneficiaries have absolutely no prescription drug coverage.
 - More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately \$17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.
- **Total prescription drug spending for women on Medicare averages \$1,200 – nearly 20 percent more than that of men.** Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about \$12,750 for a single, \$17,000 for a couple), despite older women's lower average income.
- **Rural beneficiaries are at particular risk.** Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries.

FINANCIAL HEALTH OF MEDICARE

- **Improvements in Medicare Trust Fund.** When President Clinton took office, the Medicare Trust Fund was projected to be bankrupt in 1999. Today, its solvency is projected to last to about 2015 (note: with the BBA givebacks this fall, it is 2104 but this is not public). And, under his plan to strengthen and modernize Medicare, solvency would be extended to at least 2025 – the longest period of solvency in Medicare’s history.
- **Last year, for the first time in Medicare’s history, spending declined.** This resulted from a combination of a strong economy and low inflation, vigilant efforts on reducing Medicare fraud, and legislative and administration actions to effectively manage this program. Recent success in reducing fraud include:
 - Collecting about \$500 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings.
 - Excluded nearly 4,000 providers or organizations that have been convicted of certain health care offenses, lost their licenses, or engaged in other professional misconduct from participating in Medicare, Medicaid or other federally sponsored health care programs
 - Reduced improper Medicare payments by about \$10.6 billion -- a 45 percent drop in over the last two years.

FUTURE CHALLENGES

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires -- from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.
- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (from 3.6 workers per beneficiary in 2010 to 2.3 in 2030).
- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.
- **Inadequate financing:** To significantly extend Medicare solvency, Medicare spending growth per beneficiary would have to be constrained to less than inflation.