



CENTER ON BUDGET AND POLICY PRIORITIES

September 5, 2000

THE IMPORTANCE OF FAMILY-BASED INSURANCE EXPANSIONS: NEW RESEARCH FINDINGS ABOUT STATE HEALTH REFORMS

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A national consensus has emerged in recent years on the importance of extending publicly-funded health insurance coverage to low-income children under the State Children's Health Insurance Program (SCHIP) and Medicaid. Yet substantial numbers of children eligible for these programs remain uninsured.

This analysis presents the result of new research on whether extending insurance coverage to low-income parents affects enrollment among children. This analysis also reviews recent research that examines other effects of state initiatives to extend eligibility for health insurance to low-income parents. The key findings are:

- Most children with incomes below 200 percent of poverty are already eligible for Medicaid or SCHIP, but 25 percent of low-income children remained uninsured in 1998.* In comparison, the eligibility for the parents of these children is much more limited. In a typical state, Medicaid eligibility for parents stops after the family's income reaches about 60 percent of the poverty line, or about \$10,000 for a family of four. More than one-third (34 percent) of low-income parents were uninsured in 1998.
- Family-based Medicaid expansions that include parents can increase Medicaid enrollment among children who already are eligible for Medicaid but are unenrolled.* In 1994, three states (Oregon, Tennessee and Hawaii) implemented broad Medicaid expansions that included parents. These states had a greater increase in Medicaid participation among low-income children under six (from 51 percent in 1990 to 67 percent in 1998) than did states that did not institute broad expansions (where participation from 51 to 54 percent).
- States can reduce the proportion of people who are uninsured through broad Medicaid expansions that include parents.* They can do so with minimal displacement (or "crowd out") of employer-sponsored health coverage; earlier studies indicate that 80 to 90 percent of the participants who enrolled in Medicaid as a result of eligibility expansions would otherwise have been uninsured.

- *Broad Medicaid expansions that include parents can substantially improve health care access and utilization for both adults and children.* Recent studies in Tennessee and Oregon demonstrate that newly covered people make greater use of preventive health services (such as Pap smears for women and dental check-ups for children), have fewer unmet medical needs, and have better continuity of medical care than do similar individuals who lack coverage.

This research is timely because the federal government and a number of states are considering whether to build upon recent insurance expansions for children by adding coverage expansions for their parents. As a result of recent federal policy changes, states have several options available under which they can institute family-based coverage initiatives that include low-income parents. (See box on page 16.)

In the past two years, 10 states — California, Connecticut, the District of Columbia, Maine, Missouri, New Jersey, New York, Ohio, Rhode Island and Wisconsin — have approved or implemented Medicaid eligibility expansions that cover all members of families with children, including the parents, with incomes up at least 100 percent of the poverty line (and in many cases, up to 185 percent or 200 percent of the poverty line), using a new option for family coverage that the 1996 federal welfare law created. These ten states join five that already had expanded Medicaid eligibility for families by using Medicaid waivers — Delaware, Hawaii, Oregon, Tennessee and Vermont — and two other states with state-funded adult expansions that include parents. (These states are Minnesota and Washington.)

In addition, on July 31, 2000, the Health Care Financing Administration of the U.S. Department of Health and Human Services announced it would begin to approve waivers under the SCHIP program under which states may use SCHIP funds in certain circumstances to extend coverage to the parents of children being uninsured. In states that meet the conditions for these waivers and elect to apply, these waivers open a new avenue for parent coverage expansions.

Furthermore, Congress may consider new initiatives in this area. In July, a major new legislative option, the FamilyCare Act of 2000 (H.R. 4927 and S. 2923), was introduced in the Senate by Senator Edward Kennedy and a bipartisan group of sponsors and by Rep. John Dingell and others in the House. The Administration's budget contains a similar proposal. In a recent vote on the Senate floor, a version of this bill drew support from a majority of senators.¹ This legislation would allow states to expand their SCHIP programs to extend coverage to the parents of children covered under Medicaid and SCHIP and would provide \$50 billion in additional federal funding for this purpose between 2002 and 2010. The FamilyCare Act goes substantially beyond the current options by increasing SCHIP funding and permitting the use of the enhanced

¹ A version of the FamilyCare Act was offered as an amendment to the marriage penalty tax bill on July 14, 2000. Despite the fact that there was no advance discussion, the amendment received a favorable vote of 51-47. For procedural reasons, however, the amendment required 60 votes and thus did not pass.

SCHIP matching rate to extend coverage to parents under either Medicaid or separate state programs.²

Insurance Coverage and Uninsurance Rates

Most uninsured low-income children in the nation are now eligible for public insurance coverage. A recent analysis has found that more than 90 percent of uninsured children with incomes below 200 percent of the poverty line are already income-eligible for Medicaid or SCHIP.³ However, many of the eligible children are not participating and 25 percent of the low-income children (i.e., children below 200 percent of the poverty line) were uninsured in 1998. The major challenge facing policy officials is how to increase the rate of enrollment for children who are already eligible for Medicaid and SCHIP.

Most states are much less generous in offering insurance coverage to the parents of these children, however. In a median state, parental eligibility for Medicaid ends at about 60 percent of the poverty line (about \$10,000 for a family of four), about two-thirds lower than the eligibility level for children. The share of low-income parents who are uninsured (34 percent) is substantially higher than the uninsurance rate for children.

Research Findings on the Effect of Parent Expansions on Child Enrollment Rates

In addition to decreasing the proportion of parents who are uninsured, initiatives that expand public insurance coverage of parents may also help stimulate children's enrollment. For example, program administrators in Wisconsin have stated, "The single most important goal of BadgerCare [Wisconsin's program that extends coverage to families, including parents, with incomes up to 185 percent of the poverty line] is to provide health care to uninsured children. We believe that family-based coverage will be more effective than child-only coverage in achieving this goal."⁴

² Under a policy announced by HCFA on July 31, states may seek a waiver to use SCHIP funds and enhanced matching rate to extend coverage to parents. These waivers are necessarily limited in their impact because both children and parents must be accommodated within existing state SCHIP allocations. The FamilyCare Act would provide substantially more funds to help cover parents and would eliminate the need for states to apply for a time-limited waiver.

³ Matthew Broaddus and Leighton Ku, "More Than 9 Out of 10 Low-Income Uninsured Children Are Now Income-Eligible for Child Health Coverage," Center on Budget and Policy Priorities, forthcoming.

⁴ Peggy Bartels and Pris Boroneic, "BadgerCare: A Case Study of the Elusive New Federalism," *Health Affairs*, 17(6):165-69, Nov./Dec. 1998.

The economic theory behind such a belief is straightforward. Decisions to apply for a health insurance program are made at a family level, generally by the parent(s). In deciding whether to participate, a family must weigh the costs (such as out-of-pocket expenses and time taken off from work to apply) versus the benefits (such as reduced medical care expenses, improved health, and a feeling of security that a family member has insurance). This cost-benefit assessment becomes more appealing if more people in a family can gain coverage through a single application. Covering parents thus ought to increase the probability that the family applies, thereby leading also to greater child enrollment.

To test the effect of broader family coverage on child participation rates, we conducted an analysis to answer a basic question: Have states that undertook broad Medicaid eligibility expansions that included parents increased participation among *children* to a greater degree than states without such parent expansions? We examined Medicaid participation rates among children under six years of age with family incomes below 133 percent of the poverty line, a group that has been eligible for Medicaid in all states since 1990.⁵ If states that instituted broad eligibility expansions that include parents experienced great increases in participation rates among these children, that would suggest that covering parents boosts participation among already-eligible children.

We compared three groups of states:

- *States with broad, early expansions.* (Hawaii, Oregon and Tennessee are in this group.) These states all instituted broad Medicaid expansions in 1994 that include parents. We should expect that these initiatives would have matured by 1998 and thus that data for 1998 would reflect the effects of these initiatives on child enrollment.

TennCare (the Tennessee initiative) subsidized health care for uninsured people with incomes up to 400 percent of the poverty line. Hawaii extended coverage to people with incomes up to 300 percent of the poverty line at first, although it later scaled this back to 100 percent of the poverty line.⁶ Oregon expanded coverage to 100 percent of the poverty line. The expansions in these three states included parents. (They included childless adults as well.)

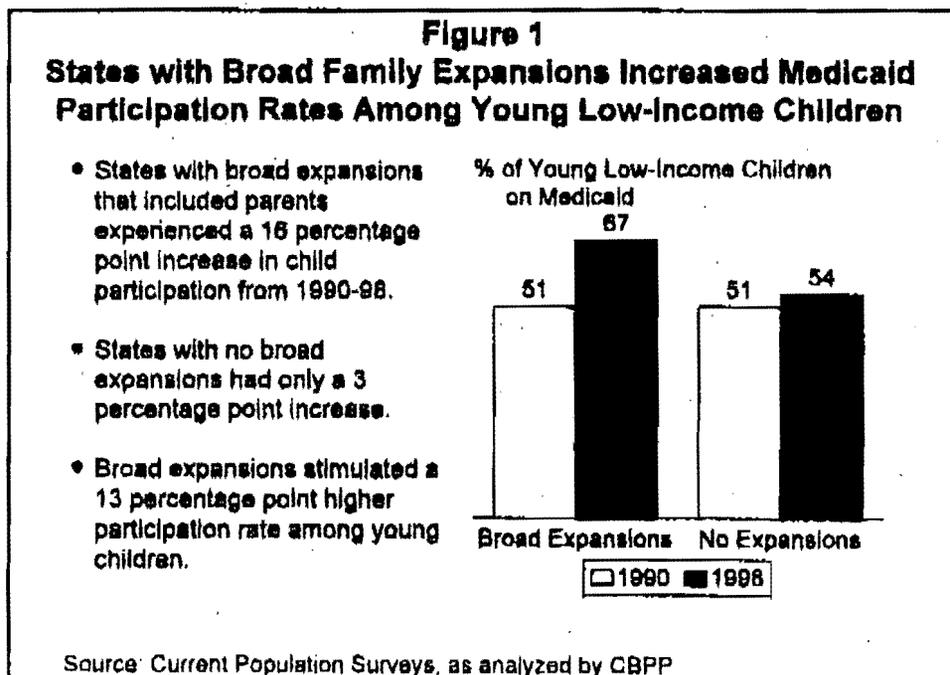
⁵ The Omnibus Budget Reconciliation Act of 1989 required states to implement this expansion by April 1, 1990. Many states exercised options to expand eligibility to children even before then. National Governors Association Center for Policy Research, *MCH Update, State Coverage of Pregnant Women and Children*, Jan. 1990 and Jan. 1991. By 1998, many states had increased income eligibility limits for young children beyond 133 percent of the poverty line, but our analysis is confined to children under that level since they were eligible in all states throughout the period this study covers.

⁶ Although Tennessee froze enrollment of new uninsured applicants during some periods and Hawaii eventually scaled back its eligibility standards, both programs still represent major program expansions, and caseload levels in both states were substantially higher than they had been before these programs began.

- *States with later Medicaid expansions or expansions that occurred outside Medicaid.* (Delaware, Massachusetts, Minnesota, New York, Vermont and Washington are in this group.) These states either implemented expansions later in the 1990-1998 period or created programs separate from Medicaid (such as Washington's Basic Health Plan and Minnesota's MinnesotaCare). Because these expansions were adopted later or outside of Medicaid, we doubted that effects on child participation rates in Medicaid would be detected in 1998. Still, we wanted to separate these states from the states with no expansions at all, since they did institute some policy changes during the study period.
- *States with no broad expansions as of 1998.* (This group includes all other states.) This is the principal comparison group. Several of these states have initiated family expansions since 1998.

Children under six with family incomes below 133 percent of the poverty line have been eligible for Medicaid in all states since 1990. As a result, any changes in the participation rate of these children should not be due to changes in their own eligibility but might have been influenced by changes in the eligibility of other family members. The methodology and other technical aspects of this analysis are discussed in the appendix to this paper.

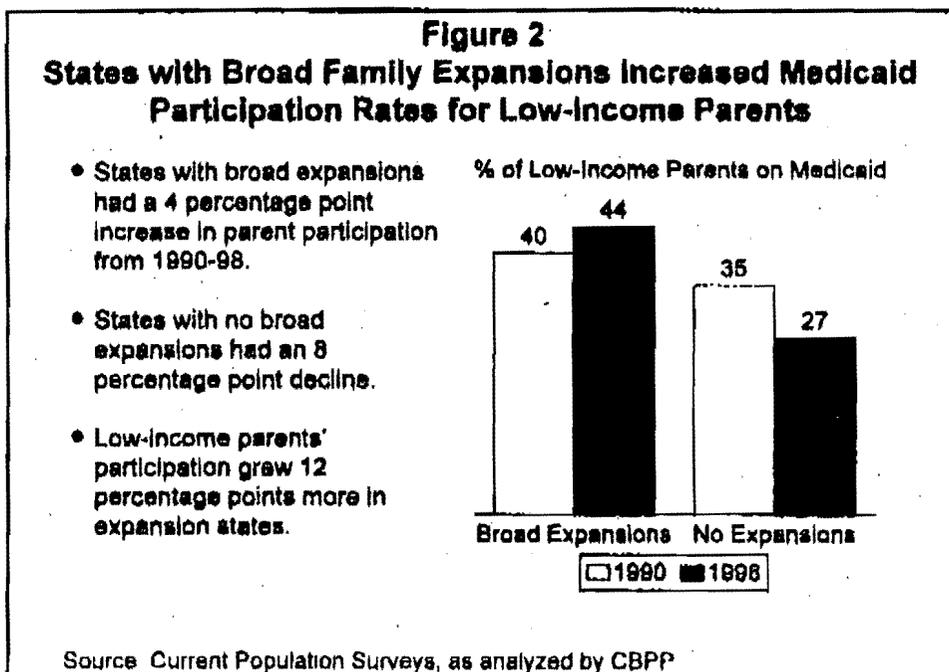
In 1990, before the three states in the first state group had implemented their broad Medicaid expansions, they had a 51 percent participation rate among young low-income children (Figure 1). In other words, 51 percent of the children under six with family incomes below 133 percent of the poverty line were enrolled in Medicaid in these states. This was about the same participation rate as the rate in 1990 in states that did not subsequently adopt a broad expansion.



In 1998, after the broad expansions were in effect in these three expansion states, the child participation rate in these states stood at 67 percent. In the no-expansion states, by contrast, the child participation rate edged up only to 54 percent. In other words, the states with broad, early expansions experienced a 16 percentage point increase in their young child participation rate, while the other states experienced a much-smaller three percentage point increase.⁷

Medicaid participation rates among young children thus grew 13 percentage points more in the early expansion states than in the states without a parent expansion. This difference was statistically significant at a 95 percent confidence level.⁸

Using a similar approach, we also examined changes in Medicaid participation by *parents* with incomes under 133 percent of the poverty line. We did this to verify that changes in parent participation actually occurred in the early-expansion states. As Figure 2 shows, the percentage of low-income parents enrolled in Medicaid increased by four percentage points in the early-expansion states between 1990 and 1998, while declining by eight percentage points in the states with no expansions.



⁷ There was no significant change in the young child participation rate between 1990 and 1998 in the states that had late or non-Medicaid expansions. Some increase in the child participation rate in these states might occur later, but more recent data are not yet available.

⁸ Since these analyses are based on survey samples, the estimates have a margin of error. The 90-percent confidence interval for the difference between these two groups of states in the increase in participation rates for children under six is from 3 percentage points to 23 percentage points.

The decline in Medicaid participation among parents in the states without expansions should not be surprising; it likely is a result of the substantial welfare caseload reductions of recent years. What is striking is that in the early-expansion states, parents' Medicaid enrollment rose despite welfare caseload declines.

The net difference in growth rates for parent participation between the early-expansion states and the no-expansion states is 12 percentage points. This difference is also statistically significant. The 12 percentage-point differential in changes in parent participation closely parallels the 13 percentage-point differential among young children, as described above.

Interpreting These Results

Is it possible that these findings are just a coincidence, caused by factors unrelated to broad Medicaid eligibility expansions that include parents? Perhaps, but the design of this analysis rules out most such possibilities.

First, the early-expansion states and the no-expansion states started out in 1990 with essentially the same child participation rates in Medicaid, as well as with similar parent participation rates. This suggests the states initially were similar in these respects. We measured the 1990-1998 *change* in participation rates to help control for even the small initial differences. We found that children's participation grew faster in the early-expansion states.

Second, the differences in changes in child participation do not appear to be due to variations in the performance of states' economies. The proportion of the population below the poverty line was similar in the early-expansion and no-expansion states in both 1990 and 1998. (The early-expansion states had an average 15 percent poverty rate in both 1990 and 1998, while the no-expansion states had a 15 percent poverty rate in 1990 and 14 percent in 1998). There were no major differences in the trajectories of these states' economies.

Other analyses have shown that Medicaid participation shrank as states' welfare caseloads fell.⁹ This raises the question of whether there were different patterns of welfare caseload declines in the groups of states we compared. Analyses of data from the Census Bureau's Current Population Survey indicate that the number of young low-income children in AFDC or TANF declined about the same amount in the early-expansion states (a 42-percent reduction from 1990 to 1998) and the no-expansion states (a 44-percent reduction). Differences in welfare caseload declines consequently do not explain the variation in the changes in Medicaid participation among young children in these groups of states. Both groups of states experienced large reductions in welfare caseloads.

⁹ Leighton Ku and Brian Bruen, "The Continuing Decline in Medicaid Coverage," The Urban Institute, Dec. 1999. Families USA, "Go Directly to Work, Do Not Collect Health Insurance: Low Income Parents Lose Medicaid," June 2000.

Still another possibility is that the increase in Medicaid participation among young children might be due to additional publicity surrounding the state expansions or other procedural changes, such as simplified applications that may make it easier to enroll, rather than to the family-based eligibility expansions themselves. It is difficult to disentangle these effects, since state reforms that expand Medicaid eligibility often are accompanied by publicity and new procedures. We believe the best evidence that the broad eligibility expansions themselves led to increases in participation among already-eligible children lies in the fact that the net increase in parents' Medicaid participation in the early-expansion states as compared to the no-expansion states (12 percentage points) mirrors the net increase in young children's participation in these states (13 percentage points). This strongly suggests the linkage of parent and child participation. While children were equally eligible in expansion and no-expansion states, there were sharp differences in eligibility criteria for parents across the states, with the expansion states having much higher income eligibility criteria for parents than the states without expansions.

Moreover, efforts to boost children's enrollment in Medicaid were relatively commonplace across states by 1998 and were not peculiar to the expansion states. For example, in 1998, some 40 states had a mail-in application for children in Medicaid, 40 had eliminated assets tests for children and 41 had simplified their applications for children.¹⁰ It seems unlikely that much of the difference in changes in participation rates among young children can be explained by differences between early-expansion and no-expansion states in practices aimed at boosting enrollment among children. (Nevertheless, it stands to reason that state and local agencies should conduct effective outreach and simplify their enrollment procedures; sound policy requires effective implementation.)

While the findings we present here are not as rigorous as those that might be obtained from a randomized experiment, they offer relatively clear evidence that states can increase the rate of enrollment among children by adopting broad expansions that include parents. Simply stated, covering parents helps expand insurance coverage for children.

Insurance Expansions Can Reduce Uninsurance Levels with Minimal Crowd Out

A different policy issue relating to Medicaid expansions is whether such expansions lead to a reduction in the proportion of adults who are uninsured. If increases in Medicaid coverage are achieved by people dropping private coverage and switching to Medicaid, there will be no net decline in the proportion of people who are insured.

Several recent studies have looked at whether states that have broader Medicaid coverage (or similar state-funded insurance programs) have lower uninsurance rates. These studies have found that, on average, states with broader adult eligibility have lower proportions of uninsured

¹⁰ Donna Cohen Ross and Wendy Jacobson, *Free and Low-Cost Health Insurance: Children You Know are Missing Out*, Center on Budget and Policy Priorities, 1999, pp. 146-7.

adults than states without such policies.¹¹ In other words, Medicaid expansions help shrink the ranks of uninsured adults. One of these studies, conducted by Schoen and her colleagues, also found that uninsured adults have more unmet medical needs and lower health care access than adults with Medicaid coverage.

A related area of research involves investigating the "crowd out" problem, or the extent to which Medicaid or SCHIP expansions displace private employer-sponsored insurance. Expanding public insurance would be problematic if all, or a large fraction, of those gaining public coverage simply dropped private, employer-sponsored insurance. It is beyond the scope of this paper to review all of the research concerning crowd out, most of which involves national analyses of the effects of Medicaid child eligibility expansions during the late 1980s and first half of the 1990s. In a recent, comprehensive review of this research, most of the studies indicated that about 10 percent to 20 percent of the gain in Medicaid coverage is offset by a reduction in private coverage.¹² That is, there was an 80 percent to 90 percent net increase in insurance coverage, because most of those who joined the programs were previously uninsured. The number gaining coverage far exceeded the number switching from private insurance, resulting in a substantial net gain in insurance coverage.

Moreover, most studies of this issue examined Medicaid expansions that did not contain anti-crowd-out provisions (such as provisions requiring that people be uninsured before they can enroll). The legislation establishing SCHIP requires states to develop procedures to limit crowd out, and states typically require that children be uninsured prior to enrolling them in separate SCHIP-funded programs. Similarly, the federal government has required states developing demonstration programs like TennCare to include anti-crowd out procedures. Such anti-crowd out policies, which are largely unstudied, ought to reduce further the level of displacement.

Of particular interest here is recent research regarding state programs that expanded family-based coverage. One recent study analyzed TennCare, the largest state insurance expansion of recent years. The study found, using data from the Current Population Survey, that between 1992/93 and 1997/98, the percentage of Tennesseans below 200 percent of the poverty line who had Medicaid coverage climbed from 30 percent to 38 percent, while the percentage of people in that income category who lacked insurance fell from 28 percent to 21 percent. These figures indicate that the increase in Medicaid enrollment was paralleled by a shrinkage in the ranks of the uninsured and suggest that little of the increase in Medicaid enrollment resulted from people switching from private coverage to Medicaid. Although it is a moderately poor state,

¹¹ Cathy Schoen, Barbara Lyons, Diane Rowland, Karen Davis and Elaine Puleo, "Insurance Matters for Low-Income Adults: Results from a Five-State Survey," *Health Affairs*, 16(5): 163-71, September/October 1997; Brenda Spillman, "Adults without Health Insurance: Do State Policies Matter?" *Health Affairs*, 19(4):178-187, July/August 2000.

¹² Lisa Dubay, "Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says," Kaiser Project on Incremental Health Reform, Menlo Park: Kaiser Family Foundation, October 1999.

Tennessee now has one of the lowest percentages of uninsured people of any state in the nation.¹³

Further buttressing this conclusion, the research found that TennCare led to substantial increases in Medicaid coverage without any statistically significant change in private insurance coverage for low-income Tennesseans, indicating there was no significant crowd out.¹⁴ One possible reason for these favorable results is that TennCare had anti-crowd-out rules, requiring that applicants be uninsured before they could join and that families with incomes above the poverty line pay a portion of the TennCare premiums on a sliding-scale basis.

These new findings are consistent with an earlier study of MinnesotaCare, which found that only seven percent of enrollees said they gave up private insurance to join the program: three percent dropped employer-sponsored coverage while four percent dropped nongroup insurance policies.¹⁵ On the other hand, there have been anecdotal reports of crowd-out in Rhode Island's family-based expansion to its RItCare program.¹⁶ To address these concerns, the state plans to modify its eligibility policies to bar adults who are offered employer-sponsored coverage from RItCare and to subsidize the purchase of employer-sponsored coverage instead.¹⁷

Broad State Expansions Can Improve Health Care Access for Adults and Children

The most important question is: Do eligibility expansions that include parents help uninsured people gain better access to health care and improve health care utilization? This question is more complex than it might seem since Medicaid (or SCHIP) eligibility expansions are typically accomplished through the use of managed care plans. While most would expect that

¹³ Leighton Ku, Marilyn Ellwood, Sheila Hoag, Barbara Ormond and Judith Wooldridge, "The Evolution of Medicaid Managed Care Systems and Eligibility Expansions in Section 1115 Projects," Report to the Health Care Financing Administration from the Urban Institute and Mathematica Policy Research, May 2000, forthcoming in *Health Care Financing Review*. Also see Christopher Conover and Heater Davies, *The Role of TennCare in Health Policy for Low-Income People in Tennessee*, The Urban Institute, February 2000.

¹⁴ For Tennesseans with incomes between 200 and 400 percent of the poverty line, the rate of nongroup insurance coverage fell. However, the reduction in nongroup coverage was not significantly different from the broader trend of falling nongroup coverage for the nation as a whole. This may have been part of a broader national trend, caused by the general increase in the cost of nongroup insurance policies, rather than a result of the Medicaid expansion.

¹⁵ Kathleen Call, et al., "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," *Journal of the American Medical Association*, 278(14): 1191-95, October 8, 1997.

¹⁶ One HMO indicated that many of the people it gained under RItCare had previously been covered under its commercial policies. Christopher Rowland, "House Passes Bill to Stem RItCare's Huge Deficit" *Providence Journal*, June 28, 2000.

¹⁷ These changes have been approved by the state legislature but require a waiver that must be approved by HCFA.

Table 1: Effects of TennCare on Adults' Health Care Use

Selected Health Measures for Adults	Newly Covered Adults	Uninsured Adults
Percent of women with Pap smear in past year	73.4%	51.4%
Percent who had blood pressure measured in past year	92.2%	74.1%
Percent who needed to see a doctor but did not	33.6%	63.8%
Percent who needed to see a specialist but did not	9.9%	30.5%
Percent who took prescription at lower level than recommended	11.3%	21.9%
Percent with usual source of health care	92.3%	71.0%
Percent who always visit the same provider	69.1%	55.4%
Percent who paid more than \$100 out-of-pocket for care in last year	11.9%	23.2%

Source: Moreno and Hoag 2000

insurance would increase health care use, the type of insurance offered might affect access or utilization.

A important new study of TennCare by Lorenzo Moreno and Sheila Hoag of Mathematica Policy Research highlights the value of coverage expansions for adults and children alike.¹⁸ The researchers compared adults and children who are covered by the TennCare expansions but would be ineligible under traditional Medicaid eligibility rules with similar low-income uninsured Tennesseans, using rigorous analysis of survey data. Since TennCare was open to both parents and childless adults, the report does not distinguish between parents and childless adults.

The table below recaps a number of the most important findings for adults. All results shown are significant at the 95 percent confidence level and include statistical adjustments for other differences between the newly covered and the uninsured. The differences shown here consequently are attributable to the effects of insurance, not to other underlying differences between these groups.¹⁹

¹⁸ Lorenzo Moreno and Sheila Hoag, "Covering the Uninsured Through TennCare: Does It Make a Difference?" Report to the Health Care Financing Administration from Mathematica Policy Research, Inc., March 24, 2000. A similar study of Hawaii's QUEST program has been conducted, but results are not yet available for dissemination.

¹⁹ The researchers used multivariate statistical models to control for differences in income, employment, health status, education, and other factors that might affect health care use. The authors tested for selection bias (i.e., they tested for the possibility that TennCare recipients had other, unmeasured baseline differences from the uninsured individuals to whom they were compared) and found no evidence this was a problem.

The study indicates that Medicaid expansions for low- and moderate-income adults can:

- Increase the use of preventive health services, such as Pap smears and blood pressure checks.
- Reduce the level of unmet medical needs. (People are better able to see a doctor if they feel sick or are in need of medical care.)
- Improve the ability of covered individuals to use prescription drugs. (Even if they are able to see a doctor, families lacking insurance often are unable to afford the medications prescribed for them or may try to scrimp by reducing the amount of medication to save money, which may render the treatment ineffective.)
- Assure that people have a doctor or clinic where they know they can go for care. (Insurance expansions help bring adults close to the *Healthy People 2000* goal that 95 percent of Americans have a usual source of care.)
- Improve the continuity of people's health care through seeing the same provider. (Uninsured people often receive fragmented care from multiple providers.)
- Reduce out-of-pocket expenses for medical care despite the fact that some of the TennCare families had to pay premiums, deductibles or copayments.

The study shows that children benefit from insurance expansions in a similar fashion. Table 2 summarizes the findings relating to children.

Table 2: Effects of TennCare on Children's Health Care Use

Selected Health Measures for Children	Newly Covered Children	Uninsured Children
Percent with well-child visits on schedule	82.8%	51.3%
Percent of children three or older with a dental check-up in past year	71.2%	54.8%
Percent who needed to see a doctor but did not	5.5%	31.9%
Percent who needed dental care but did not get it	14.9%	29.8%
Percent with usual place of health care	98.3%	73.7%
Percent who always see the same provider	57.3%	39.4%
Percent who paid more than \$100 out-of-pocket for care in last year	4.9%	11.6%

Source: Moreno and Hoag 2000

In short, both adults and children gain when provided insurance coverage. These data show that insurance expansions can be particularly helpful for adults, since they tend to have greater medical needs than children and to experience greater difficulty in securing care when uninsured. For example, 65 percent of the uninsured adults in the study did not get medical care when they thought they needed it, as compared to 32 percent of the uninsured children. Similarly, about twice as many uninsured adults as uninsured children had out-of-pocket medical expenses exceeding \$100 in the preceding year. Both adults and children benefit when offered insurance, but the burdens of being insured often are more serious for adults.

Findings from Oregon

New research on the effects of Oregon's broad Medicaid expansion — the Oregon Health Plan, which, like TennCare, was launched in 1994 — also is significant. The Oregon initiative extended Medicaid eligibility to uninsured adults and children up to 100 percent of the poverty line. Like TennCare, OHP also involved a shift to mandatory managed care. A distinctive element of Oregon's program was the development of a prioritized list of medical conditions and treatments, which were used to define the benefit package, although in practice there have been very few cases where care was denied because someone needed a low-priority service.

Researchers from Health Economics Research, Inc. have completed preliminary studies comparing OHP recipients with uninsured food stamp recipients.²⁰ Compared to the uninsured food stamp recipients, adult OHP recipients were:

- More like to have a usual source of health care and to have seen a physician or dentist;
- More likely to have had a blood pressure check-up and more likely to be able to use prescription drugs; and
- Less likely to have an unmet medical need for specialty medical care or for prescription drugs.

The researchers found similar positive results for children from the insurance expansions in OHP.

In another part of this study, the researchers compared OHP recipients to privately-insured food stamp recipients. They found no noteworthy differences in health care access or

²⁰ Janet Mitchell, Susan Haber, Galina Khatuskyy and Suzanne Donoghue, "Impact of the Oregon Health Plan on Access and Satisfaction of Low-Income Adults," Health Economics Research, Inc. Draft manuscript, January 2000. Janet Mitchell, Susan Haber, Galina Khatuskyy and Suzanne Donoghue, "Children in the Oregon Health Plan: How Have They Fared?" Health Economics Research, Inc. Results presented at Association of Public Policy and Management Conference in Washington, DC, November 1999.

utilization between these two groups. Although OHP recipients were enrolled in managed care plans and subject to rationing under OHP, their health care utilization was similar to that of the group with private insurance. The form of insurance did not matter as much as having any insurance at all.

Conclusions

The research summarized in this report points to three key findings:

- Broad eligibility expansions that include parents can stimulate moderately higher enrollment rates among children.
- Broad Medicaid expansions that include parents can increase overall insurance coverage, with minimal displacement of private health insurance coverage.
- Covering adults can help people obtain better access to health care services, including preventive services, and help reduce unmet medical needs. This also applies to expansions of coverage for children.

These results are based on the experiences of a handful of pioneering states that implemented family-based expansions earlier in the decade and of the hundreds of thousands of people who gained coverage as a consequence. By contrast, some health reform proposals, such as health care tax credits, are based largely on theoretical analyses, with little real-world experience to provide guidance about how to design such programs, administer them or how many people might gain coverage. The Medicaid-based family coverage expansions stand out as road-tested examples of state policy innovations. We are not claiming that programs like TennCare or OHP were ideal; the states had difficulties implementing the new policies, and the programs were sometimes controversial. New programs often have initial problems, but their experiences are instructive and help teach other states how to avoid predictable pitfalls through careful planning and implementation.

Census data indicate that in 1998, there were 7.1 million uninsured parents in families with incomes below 200 percent of the poverty line, and that one-third of all low-income parents — 34 percent — were uninsured. To a large extent, this is because there are substantial gaps in both employer-based health insurance and Medicaid coverage for low-income working parents. Low-wage workers often are in jobs that do not offer insurance. In 1996, only 43 percent of workers earning \$7 or less per hour (at that time, slightly more than 100 percent of the poverty line for a family of three with one full-time worker) were offered employer-based insurance, and many workers could not afford to purchase insurance even when offered it.²¹ Indeed, working

²¹ Philip Cooper and Barbara Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance:

(continued...)

parents with incomes below the poverty line are twice as likely to be uninsured as poor, nonworking parents.²²

Although most states now provide Medicaid or SCHIP coverage to children with incomes up to 200 percent of the poverty line, eligibility is far less generous for the parents of these children. One-third of the states now cover parents with incomes at or above the poverty line (including those where legislation has been passed but the program has not yet been implemented); the other two-thirds of the states are well below that level. Indeed, the median state Medicaid income eligibility limit for parents is about 60 percent of the poverty line.

The proportion of Americans who lack health insurance has been rising in recent years. Analyses indicate that a major factor in the increasing proportion of people without insurance has been welfare caseload declines, which have lowered Medicaid participation.²³ One of the major functions of family-based Medicaid expansions in states that have instituted them is to help address the loss of insurance coverage that has been an unintended consequence of welfare reform. Helping poor families attain self-sufficiency entails enabling low-wage working parents to secure health insurance rather than going without insurance or having to go on welfare or sink deeper into poverty to obtain it.

Seventeen states have launched initiatives for family-based health insurance expansions that include parents. In most cases, these expansions were financed as Medicaid expansions, with federal matching funds used to augment state funding. Through guidance issued on July 31, 2000, the Department of Health and Human Services has further expanded the range of options for states by indicating that under certain circumstances, it will approve waivers under which SCHIP funds can be applied for parent coverage. The new FamilyCare legislative proposal would enable states to provide family coverage to a much-greater degree, as it would allocate a substantial amount of new federal funding that would be available at an enhanced matching rate for this purpose. It also would permit substantial state flexibility in the use of these funds.

Given the strength of the economy and the presence of sizeable federal and state budget surpluses, there is a window of opportunity for states and the federal government to invest in family health through family-based insurance expansions. The research discussed here indicates that there are practical and tested ways to extend coverage to parents that shrink the ranks of the uninsured and lead to increases in enrollment among children, with the result that access to health care is improved for large numbers of low-income working families.

²¹ (...continued)

1987 and 1996," *Health Affairs*, 16(6): 142-49, November/December 1997.

²² Jocelyn Guyer and Cindy Mann, "Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance," Center on Budget and Policy Priorities, March 1, 1999.

²³ John Holahan and Johnny Kim, "Why Does the Number of Uninsured Americans Continue to Grow," *Health Affairs*, 19(4):188-94, July/August 2000.

How States Can Undertake Family Coverage Expansions

1. **Medicaid options created by the 1996 welfare law.** The 1996 Personal Responsibility and Work Opportunity Reconciliation Act permits states to adopt "less restrictive" methods of computing income or assets in determining the eligibility of families with children. For, example, a state can opt to disregard the amount of income between its previous Medicaid income eligibility limit for families and 100 percent of the poverty line, thus effectively moving the income limit up to the poverty line. These expansions can cover families with children, but not single adults nor childless couples. This new authority has opened the door for a new wave of family-based expansions because these changes do not require special HCFA approval nor budget neutrality.
2. **Demonstration project waivers.** Until this new Medicaid option was created, the main way states could cover parents was by using special demonstration project waivers, under which HCFA may permit major changes in Medicaid programs. Three important conditions apply: (a) the project must be budget-neutral – that is, it must cost no more to the federal government than the program would otherwise cost; (b) the waiver typically has a five-year time limit, although it may be renewed; and (c) it must be approved by HCFA, which may impose additional requirements that it judges appropriate given the agency's oversight function. These waivers may be combined with parent expansions permitted under the welfare law or under SCHIP expansions, to further customize their programs, such as adding anti-crowd out rules or sliding-scale premiums.
3. **SCHIP.** On July 31, 2000, HCFA issued guidance about how states may apply for demonstration project waivers to modify their SCHIP programs. The guidance explains how states may use SCHIP funds (at the higher federal matching rate that accompanies such funds) for parent expansions under certain circumstances. The key requirement is that the state must show that it has already made substantial efforts to cover low-income children: it must cover children under age 19 up to 200 percent of the poverty line and must have implemented a number of procedures that make it easier for children to enroll, such as mail-in joint Medicaid/SCHIP applications, 12-month continuous eligibility, elimination of asset tests, or presumptive eligibility for children. States may use regular Medicaid funding to cover parents up to 100 percent of the poverty line and use SCHIP funds to finance eligibility for those at higher levels.
4. **State-funded expansions.** In the early 1990s, the states of Washington and Minnesota expanded eligibility to parents or childless adults using state funds, without federal matching. Although the states now use Medicaid or SCHIP funds to provide coverage for children and pregnant women, they continue to use state funds to assist parents and childless adults. Earlier this year, New Jersey enacted legislation to expand Medicaid for parents with incomes up to 133 percent of the poverty line. The legislation also provides for use of state funds (including tobacco settlement funds) to cover childless adults up to 100 percent of the poverty line and parents between 133 percent and 200 percent of the poverty line.

Appendix

Methodology and Technical Discussion of Effects of Broad Expansions on Young Children's Medicaid Enrollment

Methods. To measure the effects of broad Medicaid expansions on the enrollment of children under six in Medicaid, we used data from the Current Population Survey (CPS), the nationally representative Census survey used most often to track insurance trends. For each of the three group of states described in the main body of this paper, we estimated the percentage of children under six with family incomes below 133 percent of the poverty line for whom Medicaid coverage was reported in 1990 and 1998.²⁴ We also measured the percentage of parents with incomes below 133 percent of the poverty line who reported Medicaid coverage in these years.

We then measured the change in child and parent participation rates between 1990 and 1998 for each of the three groups of states. We also compared the net difference in the changes in participation rates across these groups of states, comparing the changes in states with early expansions to the changes in states with no expansions and also comparing these states to states with late or non-Medicaid expansions. This assessment of the net difference in trends is sometimes called a "difference in difference" or "pre/post comparison group" design and is considered a relatively rigorous evaluation approach.

Since the CPS is a sample survey, we used statistical methods the Census Bureau recommends to compute standard errors.²⁵ The standard errors are higher for the early- and late-expansion states than for the no-expansion states, since the population size is smaller in the two groups of expansion states.

There are some pitfalls to the use of the CPS, but the design of this analysis compensates for most of them. First, the CPS undercounts the number of people participating in Medicaid, as compared to administrative data.²⁶ Second, there was a change in CPS questions in 1994 that slightly altered the reporting of children's health insurance, primarily affecting reporting about children whose health insurance was provided by a nonresident. Since this is a "difference in

²⁴ We used gross income in determining low-income status and did not account for factors such as income disregards or assets tests used in computing Medicaid eligibility; there are no data on states' use of disregards and assets test in 1990. Because we did not have such data for 1990, we did not make such adjustments in either year. Discrepancies in income or assets rules ought to affect the number of children in both the numerator and denominator in roughly equal amounts and probably would have minimal effect on changes in participation rates.

²⁵ Census Bureau and Bureau of Labor Statistics, "Source and Accuracy of the Data for the March 1999 Current Population Survey Microdata File," (www.bls.census.gov/ads/1999/ssracc.htm). See the authors for more technical detail, if desired.

²⁶ See Ku and Bruen, *op cit*.

difference" analysis, however, these problems should cancel each other out, because this change should affect early-expansion states and no-expansion states equally. Even if Medicaid enrollment is undercounted, the comparison across states should still be valid.

Results for children. Table A-1 presents the findings for the early-expansion states (Hawaii, Oregon and Tennessee), the later and non-Medicaid-expansion states, and the states with no broad expansions. In 1990, before there were expansions of eligibility for parents, both the early-expansion and the no-expansion states had a 51 percent participation rate for young low-income children. States with later or non-Medicaid expansions started out with a higher participation rate, 63 percent, indicating they differed at the outset. By 1998, the percentage of young children on Medicaid was 67 percent in the early-expansion states, 65 percent in the late-expansion states, and 54 percent in the no-expansion states. The changes in child participation rates between 1990 and 1998 were 16, 2 and 3 percentage points, respectively.

As seen in Table A-2, the key finding is that young child participation rates grew 13 percentage points more in the early-expansion states than in states with no expansions (16 percentage point growth in early-expansion states minus 3 percentage point growth in no-expansion states = 13 percentage point net difference). The net difference was statistically significant at the 95 percent confidence level. (There was no significant difference in the change in participation for young children in the no-expansion states as compared to the late-expansion states.)

Results for parents. Table A-1 presents similar data about participation by low-income parents. The key finding with regard to parents is that while early-expansion states appeared to have an increase in parents' participation rates from 40 percent to 44 percent, the no-expansion states experienced a decline of 8 percentage points, and the late-expansion states saw a 5-percentage point drop in parent participation rates.²⁷

As shown in Table A-2, the net difference in the change in participation rates for the early-expansion as compared to the no-expansion states was 12 percentage points, which was statistically significant. Although most states in the country experienced a reduction in Medicaid participation among low-income parents between 1990 and 1998, the early-expansion states exhibited a quite different pattern, one of modest growth in the proportion of low-income parents enrolled. It seems reasonable to interpret the general reduction in parent participation in other states as being related to reductions in welfare caseloads, which broadly affected Medicaid participation in the late 1990s. The different pattern in the early-expansion states suggests that the broadened parent eligibility criteria that these states adopted both helped to offset some of the effects on Medicaid coverage for parents of the welfare caseload reductions and resulted in more working poor parents being reached and enrolled.

²⁷ The change from 40 percent to 44 percent participation for parents in the early-expansion states was not statistically significant, due to the small sample sizes. However, the key finding — the 12 percentage point difference in changes for early-expansion vs. no-expansion states — was significant at a 95-percent confidence level.

Table A-1: Changes in Medicaid Participation Rates of Children Under 6 and Parents with Family Incomes Below 133 Percent of the Poverty Line, 1990 to 1998

	1990	1998	Percentage-Point Change 1990-1998
States with Early, Broad Expansions (Tennessee, Hawaii, Oregon)			
<u>% Young Children on Medicaid</u>	50.9%	67.2%	16.3%
Standard error	4.1%	3.9%	5.7%
<u>% Parents on Medicaid</u>	39.6%	43.8%	4.1%
Standard error	3.3%	3.3%	4.6%
States with Later or Non-Medicaid Expansion (Minnesota, Washington, Delaware, Massachusetts, Vermont, New York)			
<u>% Young Children on Medicaid</u>	62.9%	65.1%	2.2%
Standard error	2.3%	2.3%	3.3%
<u>% Parents on Medicaid</u>	50.0%	44.7%	-5.3%
Standard error	1.9%	1.8%	2.6%
States with No Broad Expansions by 1998 (All other states)			
<u>% Young Children on Medicaid</u>	50.8%	53.9%	3.2%
Standard error	0.9%	0.9%	1.3%
<u>% Parents on Medicaid</u>	34.9%	26.8%	-8.1%
Standard error	0.7%	0.6%	0.9%

Table A-2: Comparison of Net Differences in Changes in Participation Rates for the Three State Groups from 1990 to 1998

	Percentage-Point Difference	Standard Error (in percentage points)	Significance
Early vs. No-Expansion States			
Difference in Growth Rate for Children	13.1%	5.9%	*
Difference in Growth Rate for Parents	12.3%	4.7%	*
Late vs. No-Expansion States			
Difference in Growth Rate for Children	-1.0%	3.5%	n.s.
Difference in Growth Rate for Parents	2.8%	2.8%	n.s.

Source: March 1991 and 1999 Current Population Surveys, as analyzed by the Center on Budget and Policy Priorities.

* Difference in growth rates is significant with 95 percent confidence.

Parents' and young children's participation rates in Medicaid grew significantly more between 1990 and 1998 in states with early, broad family-based expansions than in states without such expansions. Since children under six with incomes below 133 percent of the poverty line were eligible for Medicaid in all states throughout this period, this indicates that factors unrelated to children's eligibility Medicaid — and in particular, the expanded coverage for parents — are responsible for the increased Medicaid participation among young children in these states.

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January 11, 2000

Clinton Proposes Funds Increase For Children's Health Insurance

By SHAILAGH MURRAY

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON -- The Clinton administration will propose spending \$2.7 billion over five years on new initiatives to get more underprivileged children enrolled in a national health-insurance program.

The initiatives are expected to be announced Tuesday to coincide with the release of a Department of Health and Human Services study showing that two million children are now enrolled in the Children's Health Insurance Program, or CHIP, a figure that more than doubled in a year. However, other studies have shown that as many as 7.5 million children are eligible for CHIP, which covers children whose family incomes are too high to qualify them for Medicaid but too low to afford private insurance.

While politically popular -- and a major component of Vice President Al Gore's health policy -- the program has struggled to attract enrollment. Part of this is inexperience. The government doesn't typically market social services, although it has been aggressively promoting CHIP, such as through public-transportation ads. But now that many welfare offices have scaled back operations, it is more difficult to capture parents whose children might be eligible.

And some states have erected enrollment barriers, such as requiring in-person interviews at inconvenient times. There are also bureaucratic barriers. A recent Urban Institute study found that 60%, or almost four million, of uninsured children are enrolled in school-lunch programs. But federal law prohibits these programs from

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sharing enrollment information.

The extra funding the administration is seeking in its fiscal 2001 budget plan would help overhaul enrollment practices, including allowing states to use school-lunch programs to find candidates. It would also expand recruitment to new sites like daycare centers and help states simplify enrollment procedures for CHIP and Medicaid. Finally, it would allow Medicaid and CHIP to be expanded to everyone up to age 20.

"All of that's helpful," said Ron Pollack of Families USA, a health-care advocacy group. But he points out that according to the U.S. Census, of the 43 million people without health **insurance**, 11 million are under 18. "That's a lot of kids we still have to reach," he said.

Meanwhile, a White House official said President Clinton will seek more money for his "lands legacy" program, aimed at acquiring, preserving and restoring environmentally sensitive lands and coastal resources. He also will offer a plan for a permanent funding source for the effort, said Roger Ballentine, deputy assistant to the president for environmental initiatives. The administration got \$651 million for the effort last year.

--John D. McKinnon contributed to this article.

Write to Shailagh Murray at shailagh.murray@wsj.com

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Health Insurance Coverage
File

PRESIDENT'S HEALTH INSURANCE INITIATIVE

Background

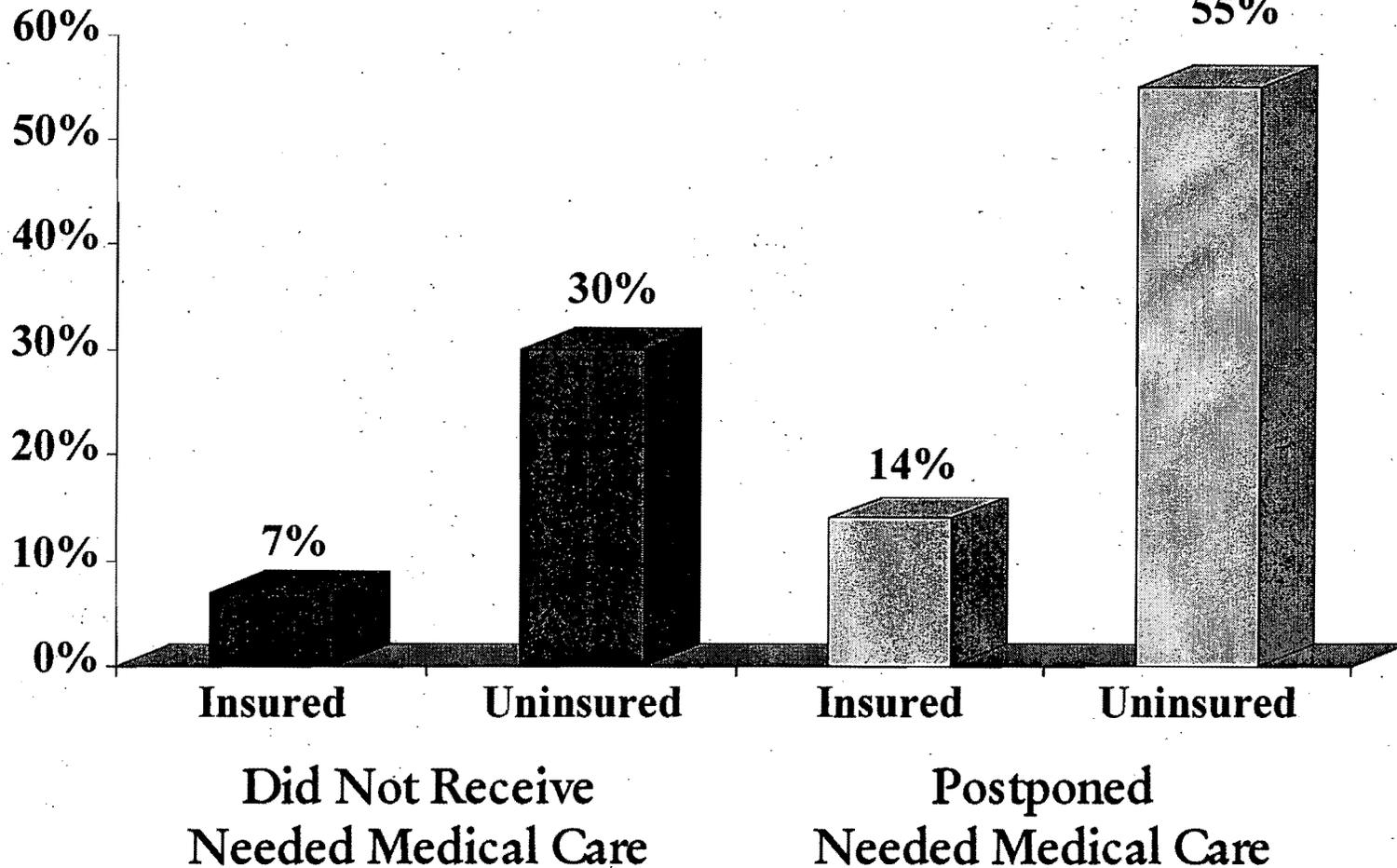
Proposals

February 2000

BACKGROUND

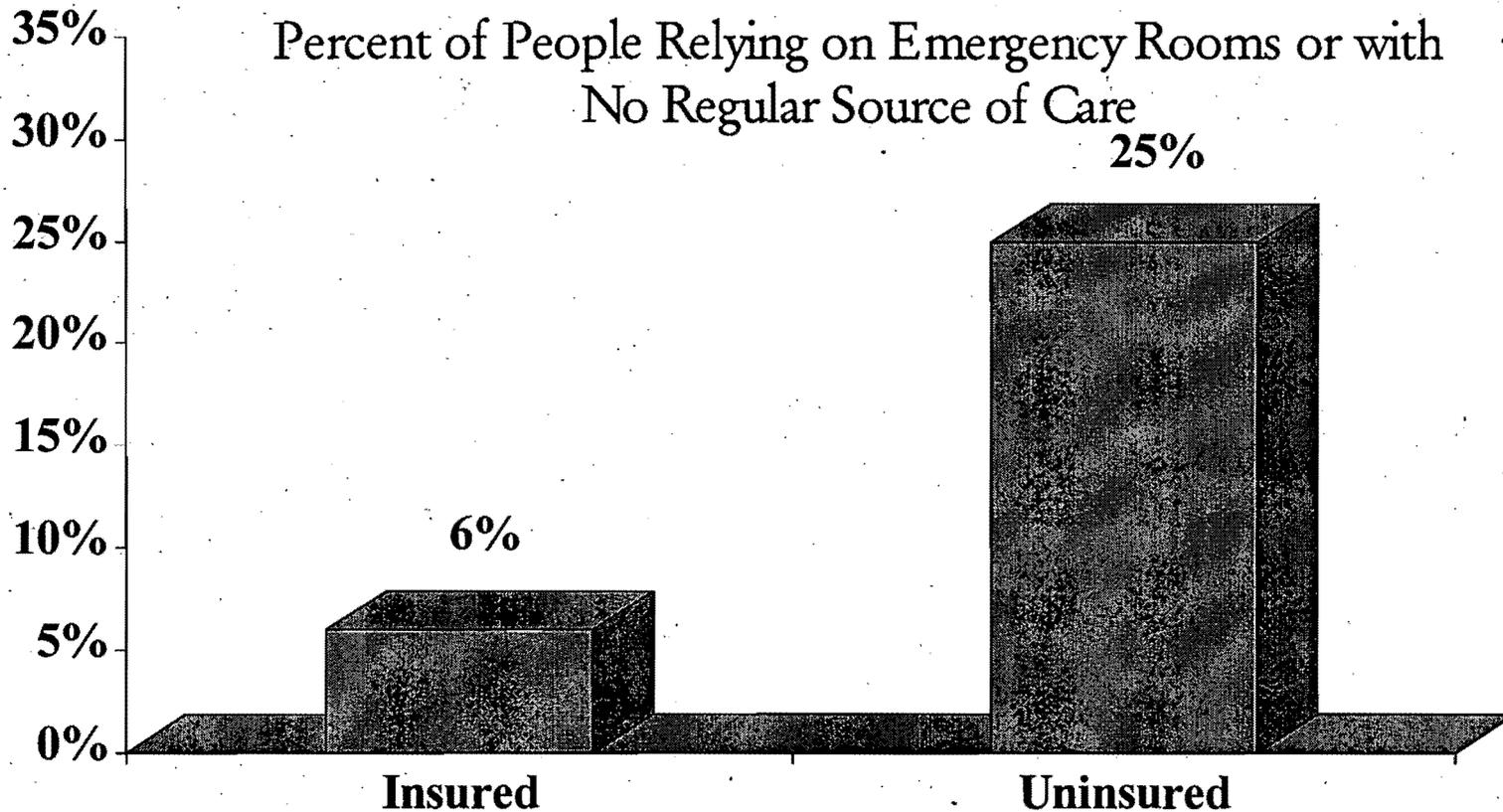
Health Insurance Matters

Uninsured Are More Likely to Postpone or Not Receive Needed Care



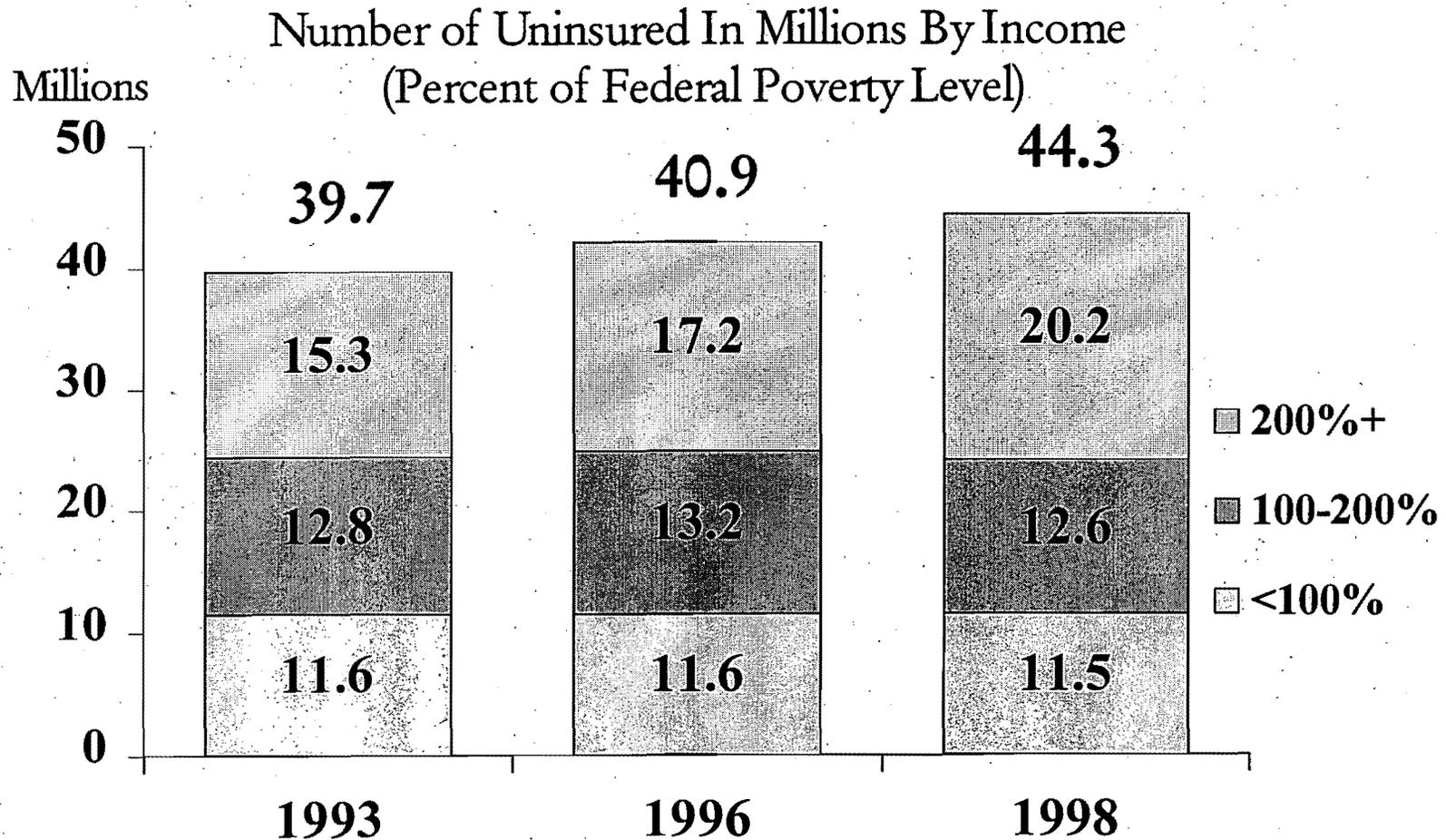
Care for the Uninsured Can Be Costly

*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

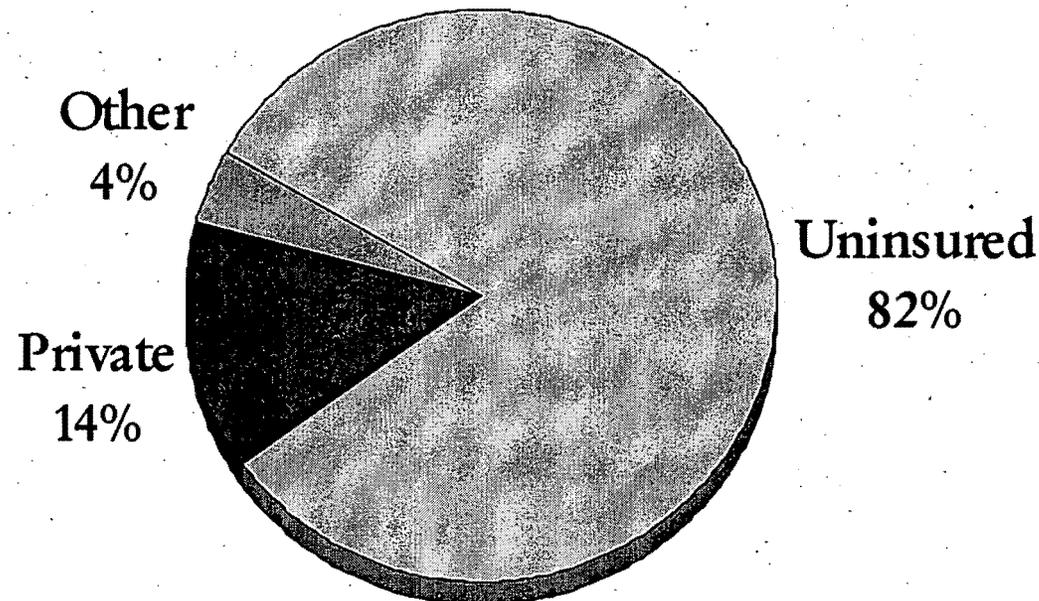
1. Provides Affordable Health Insurance Option for Families
2. Accelerates Enrollment of Uninsured Children Eligible for Medicaid and S-CHIP
3. Expands Health Insurance Options for Americans Facing Unique Barriers to Coverage
4. Strengthens Programs that Provide Health Care Directly to the Uninsured

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



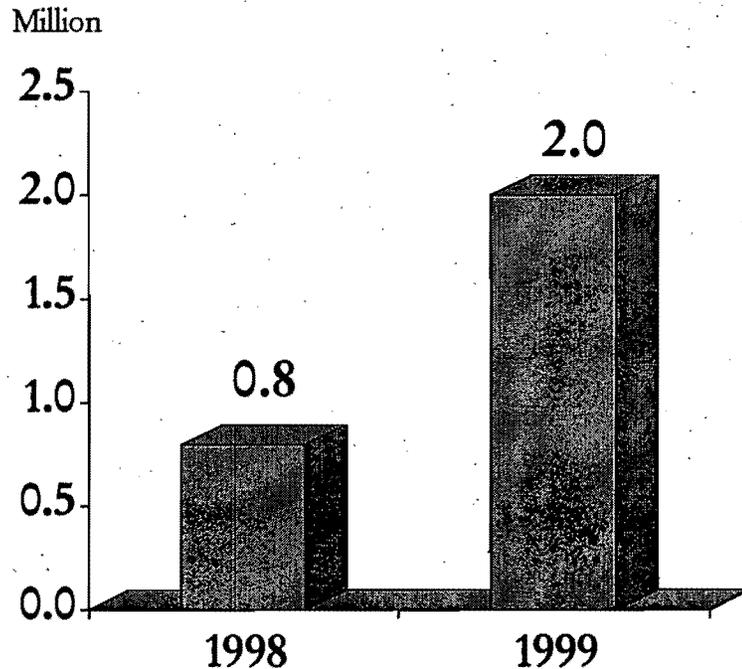
1. Providing Affordable Option for Uninsured Parents

- 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

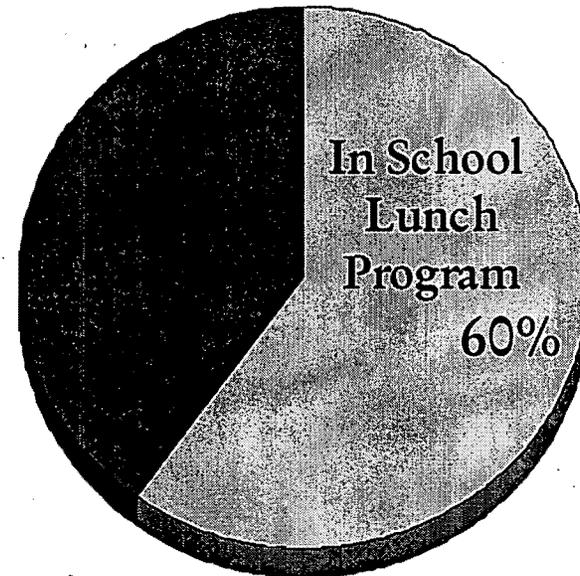
Uninsured Children

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



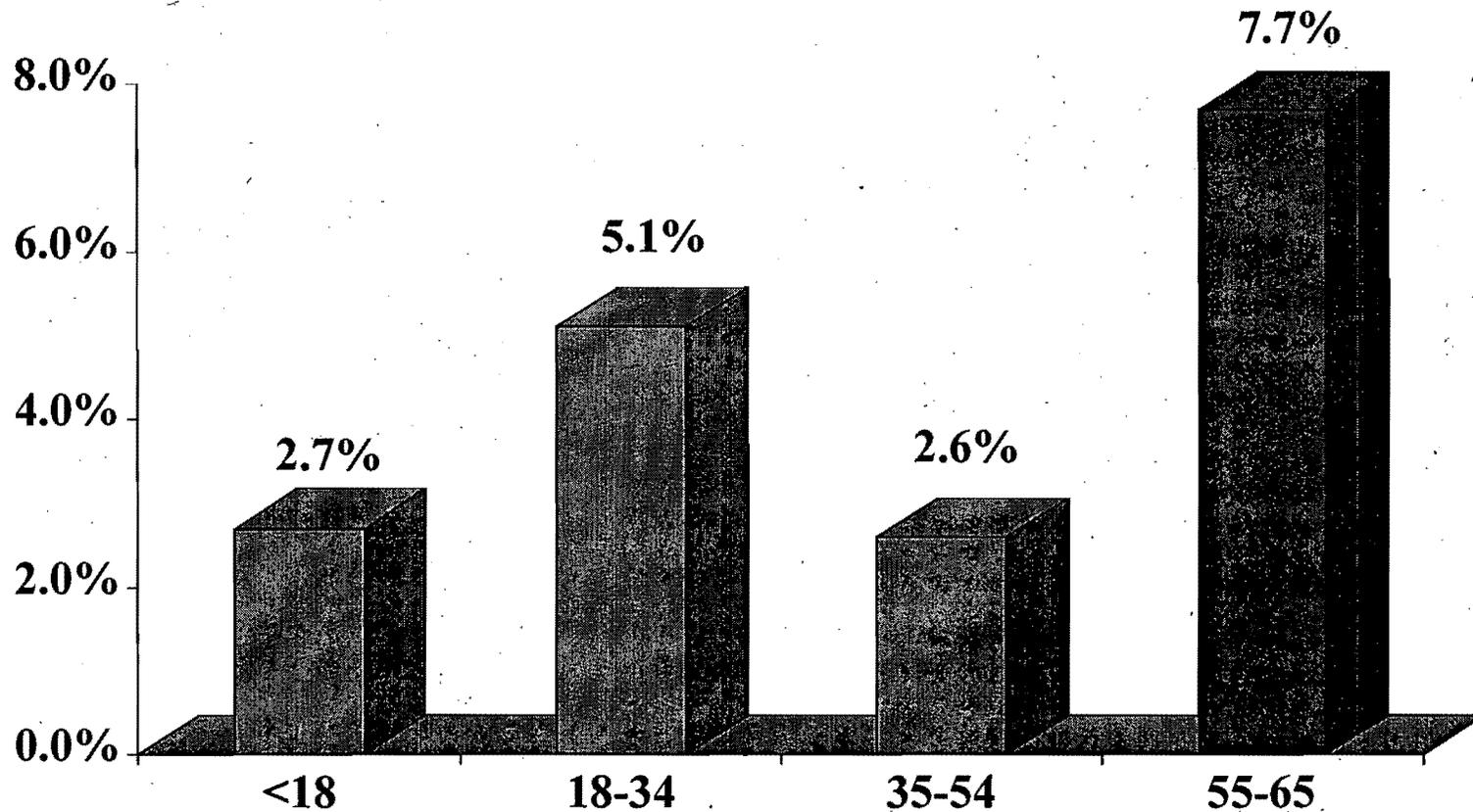
Source: HHS Annual Report on S-CHIP Enrollment, 2000. Kenney GM; Hally JM; Ullman F. (2000). *Most Uninsured Children in Families Served by Government Programs*. Washington, DC: The Urban Institute.

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



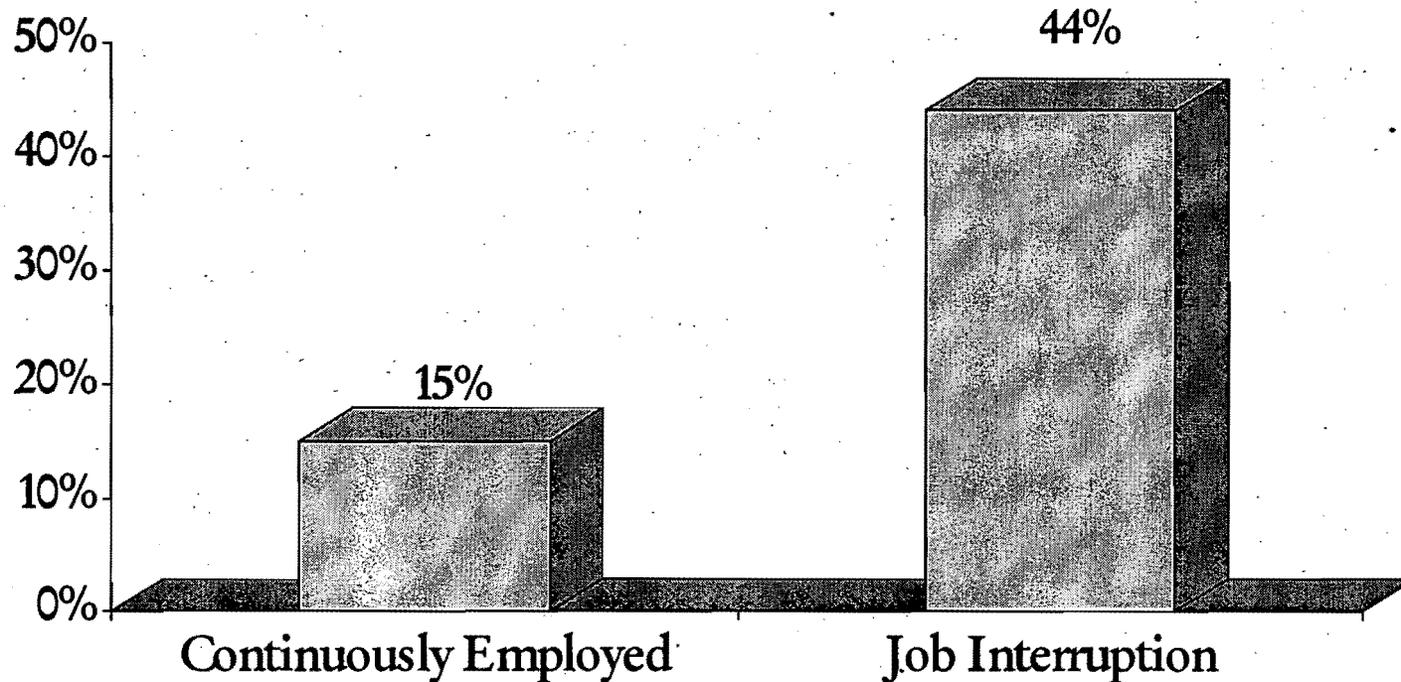
3a. Medicare Buy-In

- 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



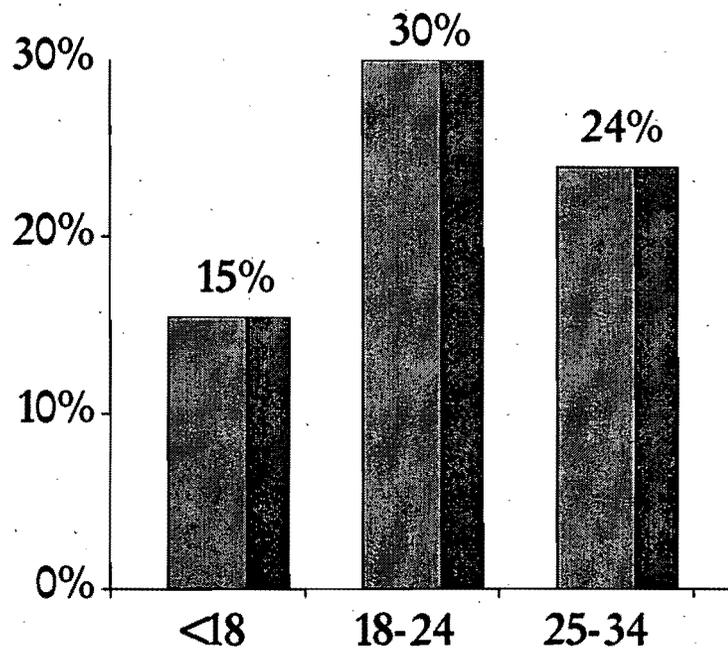
3c. Encouraging Small Business Purchasing Coalitions

- 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

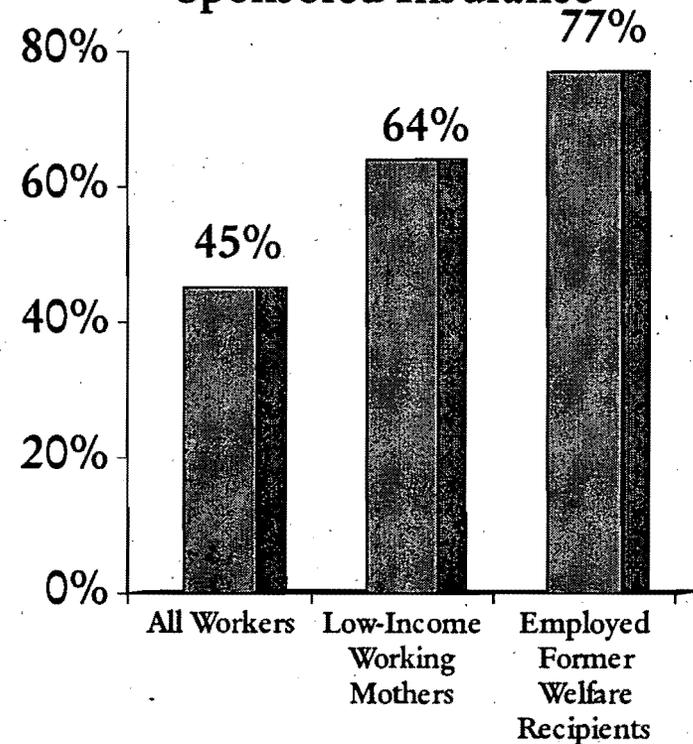
Transitions and Health Insurance

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



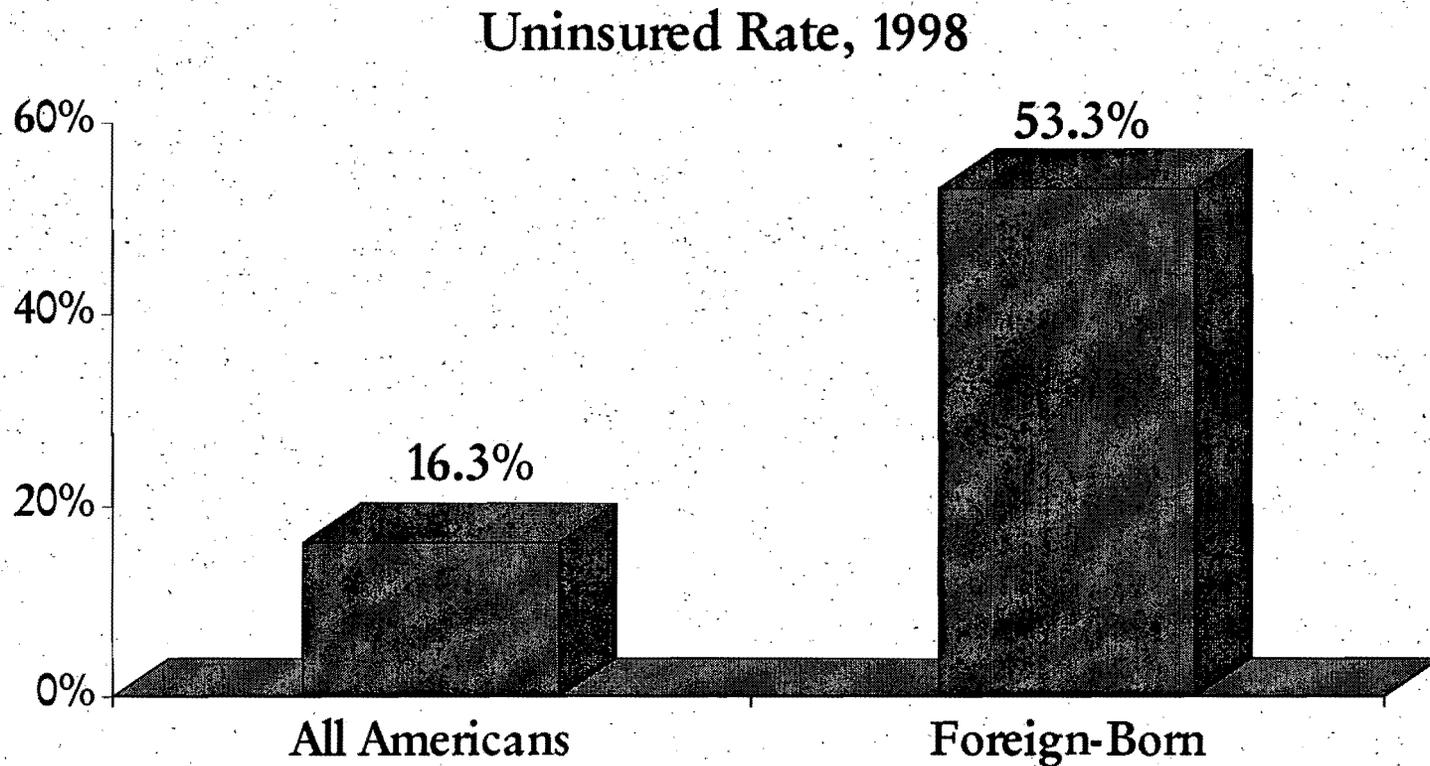
People Without Employer-Sponsored Insurance



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



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

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**REACHING THE UNINSURED:
ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS**

EXECUTIVE SUMMARY

The lack of affordable and accessible health insurance remains a major problem for millions of Americans. Without health insurance, many people forego needed health care and suffer adverse health consequences. This has economic consequences as well. This report evaluates three major policy options to make health insurance more affordable. The key findings are:

- **While there are multiple barriers to coverage, lack of affordability remains the primary reason why 44 million Americans lack health insurance.** Though 82 percent of the uninsured are in working families, 56 percent of the uninsured have incomes of less than 200 percent of poverty. Low-wage jobs are less likely to offer health care coverage—and, when offered, often have unaffordable premiums. However, low-incomes are not the only barrier to coverage. Many Americans with incomes well above poverty—such as people who have lost access to employer-based coverage; the near-elderly and people with chronic illness—have difficulty obtaining quality insurance at a reasonable price.
- **Lack of health insurance has economic and health consequences.** Studies show that people without health insurance are less likely to seek health care, resulting in worse health. For example, uninsured pregnant women who fail to get adequate prenatal care have newborns that are at a 31 percent greater risk of being born with adverse health outcomes. In addition, uninsured people often incur higher-than-necessary costs. One study found that expanding Medicaid led to a 22 percent decrease in avoidable hospitalizations of participants. The costs associated with lack of insurance are passed on to the public at large.
- **Tax deductions will do little to improve coverage.** Studies indicate that extending tax deductibility to individually purchased policies would do very little to expand insurance coverage—considerably less than tax credit or direct subsidy programs would. The simulated plans reviewed in this study suggest that the proportion of participants who would be newly insured under a tax deduction plan would be about one-third the proportion of participants who would be newly insured under a tax credit plan. The proportion of participants who would be newly insured under a tax deduction plan would be about one-tenth the proportion of participants who would be newly insured under a direct provision plan. Because tax deductions disproportionately help people with higher incomes, these plans would benefit predominantly middle and upper-income households who already purchase coverage, but would only modestly improve the affordability of insurance for most uninsured people, and thus lead to very few newly insured.
- **While more effective than deductions, tax credits are not the most efficient way to expand coverage.** In contrast to tax deductions that disproportionately benefit those with higher incomes, tax credits provide the same benefit to all eligible taxpayers who take advantage of them. Thus, they are more likely than deductions to help the low-income

uninsured. To expand coverage to significant numbers of uninsured, tax credits must be refundable, since many uninsured have little to no tax liability, and they must be large enough to cover most of the premium costs for the low-income. However, such large, refundable tax credits could also encourage people who currently have group insurance to switch into the more expensive individual market. Therefore, tax credits are less efficient – the cost per newly insured person is higher than direct provision programs narrowly targeted at the uninsured.

- **Refundable tax credits can complement direct insurance programs and also address the inequity in the current tax treatment of health insurance.** Quality individual health insurance purchased with a refundable tax credit equal in value to the employer deduction could eliminate the current tax advantage enjoyed by those who have employer-provided group insurance. In addition, the Administration has proposed allowing tax credits to be coupled with public program expansions to make such expansions more affordable – i.e. allowing the application of tax credits towards coverage through Medicare, Medicaid or SCHIP buy-ins or through individual health insurance with reforms. However, as stated above, by themselves, tax credits are not the most efficient means of providing affordable insurance to uninsured Americans.
- **Direct provision of health insurance through public programs is the most efficient way of targeting low-income families.** Simulation results indicate that direct provision of health insurance, such as the proposed plan to insure parents of children in SCHIP and Medicaid, effectively reaches the uninsured at a relatively low cost for the benefits provided to the newly insured. The costs are relatively low not only because of lower administrative costs, but also because there is less “crowd-out” of current employer-based coverage in direct insurance programs than in tax credit proposals. The simulation reviewed in this paper suggests that over two-thirds of the participants would be newly insured. This proportion of newly insured participants is between seven and ten times the proportion of newly insured participants for the simulated tax deductions. Thus, this is the best first step in expanding health coverage to the uninsured.

REACHING THE UNINSURED: ALTERNATIVE POLICIES TO EXPAND HEALTH INSURANCE COVERAGE

1. INTRODUCTION

This report documents a serious policy issue—the lack of health insurance for tens of millions of Americans. Without health insurance, many Americans forego needed health care and suffer adverse health consequences. This has economic consequences as well. The lack of insurance is particularly prevalent among low-wage working Americans and their families, because many of their employers do not offer health coverage, and many of these families cannot afford individual insurance coverage. With regular jobs and incomes above the poverty level, however, many of these hard-pressed families do not qualify for existing government insurance programs, such as Medicaid. A number of policy proposals, including alternative tax treatments (such as tax deductions and tax credits) direct provision of health insurance to specific groups in need of coverage, and allowing individuals to “buy-in” to government insurance programs such as Medicare have been suggested to address the rising numbers of the uninsured. Recent studies that have simulated the effects of some of these proposals indicate that certain types of programs may be more efficient and effective than others in increasing health insurance coverage.

2. HEALTH INSURANCE COVERAGE AND THE CONSEQUENCES OF BEING UNINSURED

A. The Scope of the Problem

In 1998, about 1 in 6 Americans—an estimated 44.3 million individuals—went without health insurance for the entire calendar year.¹ Despite a robust economy and low unemployment rates, the number of uninsured increased from about 31 million in 1987.² The lack of coverage is not solely a function of employment status, because over 80 percent of the non-elderly uninsured either work or live in families with a worker.³ Instead, many of these workers find that insurance is either unavailable from their employer or is simply unaffordable. They also find that while they cannot afford insurance, their effort to earn a living makes them ineligible for existing government programs (like Medicaid) that provide insurance for the poorest Americans.⁴

The lack of health insurance in the United States is strongly related to income (Chart 1). In families with income below the poverty line, 43 percent of adults did not have health insurance. In contrast, in families with income greater than 300 percent of poverty, only 9 percent of adults are uninsured. Fifty-six percent of uninsured nonelderly people are in families with incomes below 200 percent of poverty. The source of coverage also varies with income. More than 80 percent of families with incomes over 300 percent of poverty receive health care

¹ Jennifer A. Campbell, *Health Insurance Coverage: 1998*, U.S. Census Bureau, Current Population Reports, P60-208 (Washington: U.S. Government Printing Office, 1999).

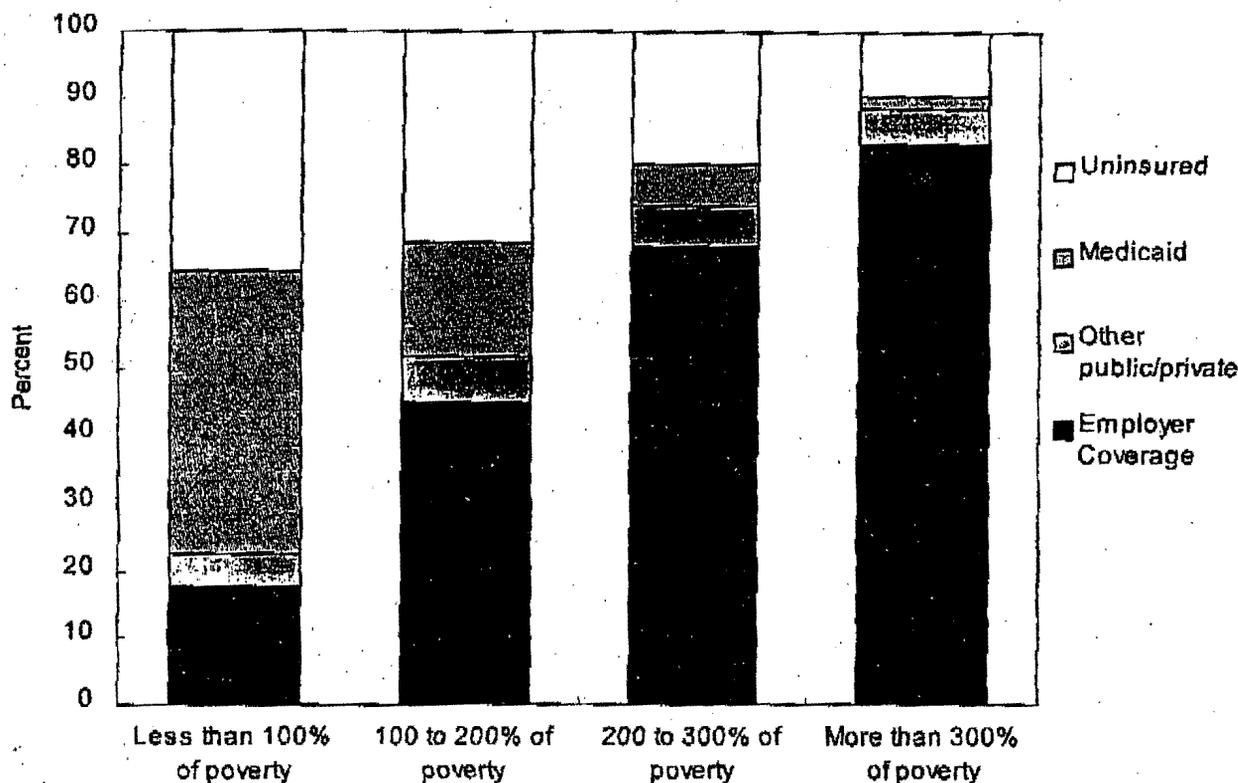
² *Ibid.*

³ Kevin Quinn, *Working without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (New York: The Commonwealth Fund, 2000).

⁴ Catherine Hoffman and Alan Schlobohm, *Uninsured in America: A Chart Book*, 2nd ed. Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 2000).

coverage through an employer. For families below the poverty line, meanwhile, Medicaid is the source of coverage for nearly a third of all families.

Chart 1. Health Insurance Coverage of Non-elderly People by Family Income, 1998



Source: US Census Bureau tabulations (August 2000)

Overall, the vast majority of Americans who have health insurance receive it through their employers. The percentage of workers insured through the workplace has generally declined since the late 1970s, with low-wage workers being the hardest hit. This decline is due in part to firms' restricting eligibility to exclude many part-time and temporary workers from health insurance coverage.⁵ The effect of this decline is magnified by the increasing use of temporary workers. The employer-based system means that young adults have a particularly high risk for non-coverage because they are more likely to hold part-time and temporary jobs. Too old to be covered by their parents' plans but too young to be established in jobs providing health insurance, 30 percent of those aged 19 to 29 are uninsured.⁶ Affordable access can also be a problem for the near elderly (those aged 55-64) in the individual insurance market. As health status generally declines with age, insurance may be more important for the near elderly. At the same time, exclusions for pre-existing conditions and high premiums related to expected costs

⁵ Ellen O'Brien and Judith Feder, *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers*, Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

⁶ Kevin Quinn, Cathy Schoen, and Louisa Buatti, *On their Own: Young Adults Living without Health Insurance* (New York: The Commonwealth Fund, 2000). The authors find that 80 percent of adults aged 19 to 29 take up employer-provided insurance, when it is offered, compared with 84 percent of 30-to-64 age group.

can restrict access and affordability for the early retirees who are no longer covered by employment-based health insurance. Employees of small businesses (less than 100 employees) are also less likely to have insurance: one-fourth of small business employees are uninsured, compared to one-eighth of the employees in firms with 100 or more workers. Racial and ethnic minorities are less likely to be insured than whites, because members of minority groups are less likely to have employer-sponsored health insurance coverage, as they are disproportionately likely to work in low-wage jobs. Approximately 12 percent of non-Hispanic whites, 22 percent of blacks, 35 percent of Hispanics, and 21 percent of Asians and Pacific Islanders were uninsured in 1998.⁷

B. An Investment in Health

Because lack of insurance leads to a host of adverse health consequences and higher medical costs, health insurance, although seemingly expensive, may be a good investment for society. Uninsured people experience worse health problems and thus increase the cost of care to society. One study valued the increase in longevity and improved quality of life between 1970 and 1990 at \$77,000, while the increase in medical spending per person was only \$25,000. While much of this increase in longevity and quality of life may be due to non-medical reasons, such as better nutrition or more exercise, if even a third of the improvement is due to medical spending, the investment is worthwhile.⁸ Public investment in health insurance might extend the benefits of longevity and quality of life to more people. In addition, if individuals can be treated routinely, they may maintain better health at a lower cost.

The health effects

Uninsured Americans are more than three times as likely to delay seeking care, and between three and five times less likely to obtain medical/surgical care, dental care, or prescription drugs.⁹ Additionally, people who lack insurance coverage often require medical attention for medical complications that could have been prevented by earlier treatment. Thus, they are often hospitalized for conditions that might have been avoided altogether.¹⁰ Uninsured people are often diagnosed at later stages of diseases, when the chance of recovery is diminished. Moreover, failure to receive routine care has far reaching consequences. For example, uninsured pregnant women receive prenatal care later in their pregnancy and make fewer doctor visits than the privately insured. As a result, their newborn infants are at a 31 percent greater risk of being born with adverse health outcomes, including low birth-weight, which is a major cause of physical disability, mental retardation, and other costly health problems (see Box 1).¹¹

⁷ Hoffman and Schlobohm, *Uninsured in America*.

⁸ David M. Cutler and Elizabeth Richardson, *Your Money and Your Life: The Value of Health and What Affects It*, Working Paper W6895 (Boston: National Bureau of Economic Research, 1999). These values are in constant 1990 dollars.

⁹ *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

¹⁰ Joel S. Weissman, Constantine Gatsonis, and Arnold M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268:17 (1992).

¹¹ *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

Box 1. The Value of Prenatal Care

Prenatal care is currently underused, limiting its ability to cost-effectively improve infant health. Innovations in neonatal care have dramatically increased the life expectancy of low-birth-weight infants, counteracting in part the lack of pre-natal care. But this care has a high price tag. Intensive neonatal care for a low-birth-weight infant can cost more than \$2,000 per day and more than \$100,000 over the course of treating one infant.¹² By increasing prenatal care coverage, we may be able to take advantage of preventive medical care, resulting in healthier infants at lower costs. At a relatively low cost of about \$400-\$500 per woman, prenatal medical screening and appropriate care could reduce the incidence of low-birth-weight by about 20 percent.¹³

Access to prenatal care is often a problem for low-income and uninsured women. Almost 60 percent of uninsured women do not begin prenatal care until after their first trimester. Among uninsured women, almost 70 percent reported difficulty paying for prenatal care. Additionally, a full 15 percent of uninsured mothers were refused prenatal care when looking for a provider. Evidence suggests that increased eligibility for medical care decreased the number of women who went without prenatal care and the number of women who delayed prenatal care beyond the first trimester.¹⁴ To the extent that cheaper prenatal care can substitute for much more expensive neonatal care, the overall costs of achieving improved infant health outcomes might be reduced.

The health benefits of routine preventive care measures are evident in the rapid progress made in treating cardiovascular disease over the last 50 years. Although heart disease remains the leading cause of death for Americans, cardiovascular disease mortality has fallen dramatically.¹⁵ Part of this decline is due to advances in medical technology, but much of it is because of increased prevention. Less than half of the decline in cardiovascular disease mortality can be attributed to medical technological advances for post-heart attack treatment. Better preventive care, rather than responsive medical care, has accounted for most of the decline. Almost a third of the reduction in heart disease was due to reducing risk factors in individuals diagnosed with coronary disease.¹⁶ Access to early diagnosis and medical care is an effective method of treating cardiovascular disease.

The economic cost

Lack of health insurance for the poor may be costly. The uninsured more often obtain care in the emergency room than in a physician's office, and emergency room care is more expensive than office visits. Further, because of inadequate care, the health problems of the uninsured are often more severe and hence more expensive to treat. Evidence indicates that

¹² David M. Cutler and Ellen Meara, *The Technology of Birth: Is It Worth It?*, Working Paper W7390 (Boston: National Bureau of Economic Research, 1999).

¹³ Janet Currie and Jeffrey Grogger, *Medicaid Expansions and Welfare Contractions: Offsetting Effects on Prenatal Care and Infant Health?*, Working Paper W7667 (Boston: National Bureau of Economic Research, 2000).

¹⁴ *Ibid.*

¹⁵ Based on Centers for Disease Control calculations for the entire U.S. population in 1997. Heart disease is estimated to have killed 726,974 people that year.

¹⁶ Calculations based on MG Hunink, L Goldman, AN Tosteson, MA Mittleman, PA Goldman, LW Williams, J Tsevat, and MC Weinstein, "The Recent Decline in Mortality from Coronary Heart Diseases, 1980-1990: The Effect of Secular Trends in Risk Factors and Treatment," *Journal of the American Medical Association* 277.7 (1997).

Medicaid expansions are associated with significant increases in primary care utilization and reductions in expensive avoidable hospitalizations. One recent study found that increases in Medicaid eligibility were associated with a 22 percent decline in avoidable hospitalizations.¹⁷

Lack of insurance creates a public cost. The costs of hospital care for people who cannot pay are often absorbed by providers, passed on to the insured through higher cost health care and health insurance, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs.

3. OVERVIEW OF CURRENT FEDERAL HEALTH INSURANCE POLICIES

There are several ways whereby the Federal government traditionally seeks to improve the public's access to health insurance. One approach is through provisions in the U.S. tax code that lower the price of insurance. A second is by providing free or low-cost health insurance through public programs. A third method is through laws and regulations enhancing access to insurance. This section provides a brief overview of these approaches.

The current tax system encourages health insurance by allowing income exclusions and deductions for health insurance expenses. Employer-provided health insurance has long had a tax preference, originating during World War II when the IRS ruled that increased health benefits were outside the limits of federal wage controls.¹⁸ Eventually, the exemptions were codified by Congress. This status continues today.¹⁹ One study estimates that the tax exemptions (including both the income and payroll tax exemptions) will cost the Federal government approximately \$125.6 billion in lost tax revenues in 2000.²⁰

There are some inequities inherent in the current system. The system provides a tax subsidy that varies directly with the tax rate of the individual or family receiving coverage—the higher the tax rate, the higher the implicit tax subsidy (see Chart 2). For individuals who are in the highest federal income tax bracket, the tax policy reduces the relative “price” of health insurance compared to other goods that must be purchased with after-tax dollars by 39.6 cents on the dollar. In contrast, for those with low incomes—who are in a low tax bracket—the current

¹⁷ Leemore Dafny and Jonathan Gruber, *Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansion and Child Hospitalizations*, Working Paper W7555 (Boston: National Bureau of Economic Research, 2000).

¹⁸ Jon Gabel, “Job-Based Health Insurance, 1997-1998: The Accidental System Under Scrutiny,” *Health Affairs*, Vol 18, No 6 (1999).

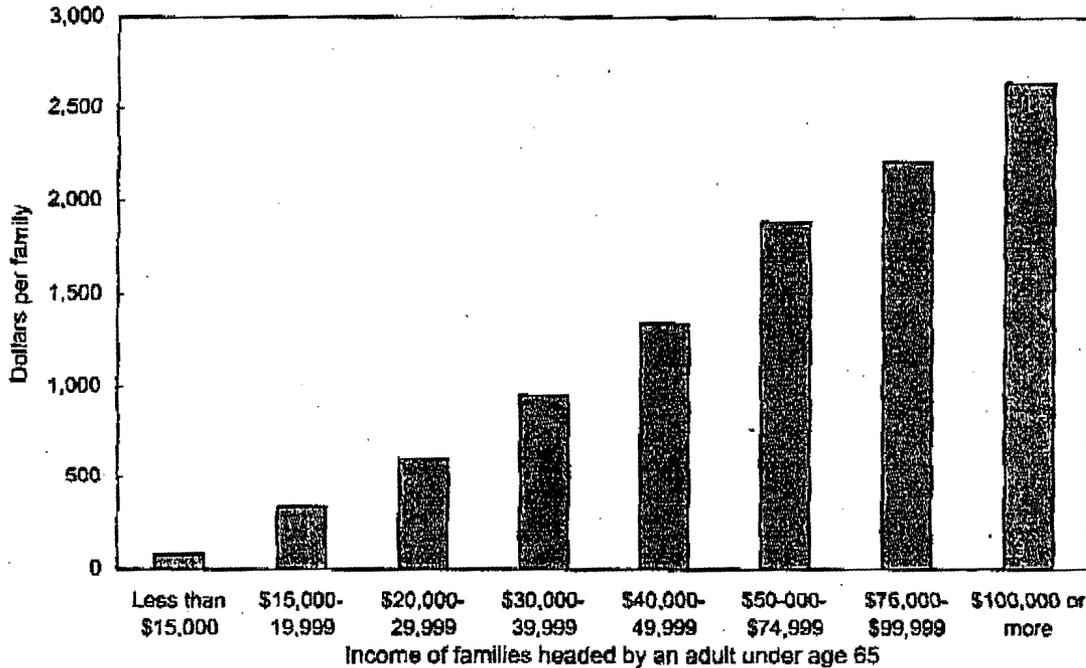
¹⁹ Other tax provisions include: itemized deductions for any medical spending above 7.5 percent of adjusted gross income; flexible spending plans (Section 125) that allow employees' shares of premiums to be made on a pre-tax basis; a phased-in deduction for self-employed workers; and a demonstration of Medical Savings Accounts for some self-employed and workers in small businesses.

²⁰ John Sheils, Paul Hogan, and Randall Haught, *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy: Prepared for The National Coalition on Health Care* (Washington, DC: The Lewin Group, Inc., 1999). This estimate also includes the foregone tax revenue due to the exclusion of income from Social Security and Medicare hospitalization insurance taxes.

tax reduces the relative "price" of health insurance by only 15 cents on the dollar or not at all, if no taxes are owed by the individual.²¹

A second inequity arises for those who do not get health insurance through their workplace, but who purchase insurance in the individual market. Because the exemption only applies to employer-provided group insurance, their subsidy, if any, is much smaller.²²

Chart 2. Average Federal Tax Benefit from Health Insurance Exemption, 2000



Source: John Shells, Paul Hogen and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," October 1999, The Lewin Group, Inc.

Note: Calculations incorporate likelihood of receiving employer-provided health benefits and the value of the tax benefit of employer-provided health insurance

With the introduction in 1965 of Medicare and Medicaid to provide health insurance for elderly and low-income Americans, the government began to provide health insurance directly. Over 32 million elderly and 4 million disabled received basic medical insurance through Medicare Part B in 1998.²³ Medicaid offers federal assistance to States that provide medical care to low-income Americans. Historically, eligibility for Medicaid was linked to eligibility for cash welfare. Beginning in the late 1980s, Medicaid has shifted toward a more general health insurance program that includes low-income working people.²⁴ The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, particularly, allowed Medicaid

²¹ The exclusion from the employer and employee shares of the Social Security tax and state and local income taxes further reduces the after tax price (in the case of high income earners only the Medicare tax would typically apply). However, future Social Security benefits may also be reduced.

²² The tax code includes a phased-in deduction for self-employed individual insurance purchases. See footnote 21.

²³ These statistics for Medicaid, SCHIP and Medicare are based on publicly available estimates by the Health Care Financing Administration.

²⁴ Lara Shore-Sheppard, Thomas Buchmueller, and Gail Jensen, "Medicaid and Crowding out of private insurance; a re-examination using firm level data." *Journal of Health Economics*, 19 (2000), 61-91

coverage to low-income families. Medicaid served over 41 million people in 1998. In 1997, the State Children's Health Insurance Program (SCHIP) was created to target the growing number of uninsured children in families that have too much income to be eligible for Medicaid but too little to afford private insurance. SCHIP provides states with funding to provide health insurance through Medicaid, a non-Medicaid program, or a combination of both. Combined, these programs insure over 74 million Americans – but through strict eligibility rules, leave out many of the uninsured. For example, people age 62 are not eligible for Medicare, and the uninsured parents of children enrolled in SCHIP are not eligible themselves. (The Administration's budget includes a proposed expansion of SCHIP.)

Federal and state governments have enacted policies to improve access and affordability to private health insurance. Two Federal health-care initiatives were designed to make it easier for workers with health-care coverage to maintain that coverage when they are in-between jobs. The health continuation rules enacted under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) enable workers to purchase continued coverage for a limited time when they change jobs or lose eligibility for health insurance. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was designed to extend individuals' ability to maintain private health insurance by limiting exclusions for pre-existing conditions in employer health plans and for workers converting to individually purchased insurance. State regulation of the insurance market is varied. Only eight states require guaranteed issue of all products in the individual insurance market; another five states require guaranteed issue of a standard product only. Fifteen states limit rating in the individual market; two require pure community rating.

4. CONSIDERATIONS IN ASSESSING PROPOSALS TO EXTEND COVERAGE

While the current system of tax incentives and direct provision programs assists millions of Americans in obtaining health insurance, there are many who remain uninsured because they either are ineligible or do not take advantage of them. A number of proposals have been considered to extend coverage to the uninsured. Prior to discussing individual proposals, it is useful to lay out the basic economic issues that are important in assessing the various proposals.

A. Distributional Effects

Different types of subsidies will have different distributional effects. As described in the previous section, expanding tax deductibility for health insurance premiums will provide more benefit to higher-income people. In contrast, a tax credit directly reduces tax payments by the amount of the credit, and is therefore worth *the same to all taxpayers able to take advantage of it*. To take full advantage of a non-refundable tax credit, however, an individual must pay at least as much in taxes as the amount of the credit. Because almost half of the uninsured do not pay any taxes against which either a deduction or credit can be applied, neither tax deductions nor tax credits reduce the cost of health insurance for this group.²⁵ If a tax credit is made *refundable*, however, it will reduce the cost of health insurance to all lower-income individuals, because a refundable credit is payable even to those individuals who do not owe any taxes at all.

²⁵ Jonathan Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*, Working Paper 7553 (Boston: National Bureau of Economic Research, 2000).

Limiting eligibility for tax credits targets the benefits to specific income groups. Direct government provision of health insurance can also be targeted to specific income levels by eligibility criteria. While Medicare eligibility is not income-related, Medicaid and SCHIP eligibility are.

B. Crowding Out and the "Cost per Newly Insured."

Policies that are designed to extend coverage to those currently uninsured can cause some people who currently have insurance to drop it in favor of government-provided insurance or individually purchased insurance motivated by a tax subsidy. Equivalently, some employers may stop offering coverage (or reduce their contribution) and tell their employees to take advantage of the new government insurance or tax subsidy. *This is known as "crowding out" of existing insurance—when new government subsidized insurance crowds out employer-provided insurance.* It means that government dollars go not just to newly insured; some fraction of the money goes to those who had employer-provided coverage and are now switching to a new government-subsidized plan. If the new subsidy provides a much higher benefit than the value of the tax exclusion, then crowding out can be severe and the cost to the government of each net newly insured person can be pushed up substantially. Moreover, if firms drop coverage, some employees may choose not to purchase individual insurance, leading to a smaller net increase in coverage, or possibly even a net decrease.

Studies of the Medicaid child eligibility expansions of the late 1980s and first half of the 1990s found that about 10 to 20 percent of the increase in Medicaid coverage was due to a reduction in private insurance coverage. Most of these studies examined Medicaid expansions that did not contain anti-crowd-out provisions. Because Medicaid covers mostly low-income people who are less likely to have private insurance, crowding out might be expected to be modest.

To prevent crowding-out, some proposals have excluded eligibility of people who previously had private insurance. However, this penalizes people who had already purchased health insurance in the private market and are not eligible for the new subsidies. The amount of crowding out will likely increase as eligibility for subsidies is extended up the income scale. Crowding out will also likely increase as the generosity of a subsidy increases. Therefore crowding out might be limited by targeting subsidies to the lowest income families, who are unlikely to be covered by health insurance, or by limiting subsidies to relatively modest amounts.

C. Encouraging Participation

Many families do not take advantage of insurance programs that are available to them. For individuals at low-income levels, even modest costs (such as nominal premiums or co-payments) may dramatically decrease enrollment and utilization. This may especially affect families without health-insurance problems, who could risk remaining uninsured to pay for more pressing needs such as food and housing. In addition, a complex application process designed to determine eligibility may have the unintended side effect of dramatically reducing coverage for otherwise qualified individuals. A subsidy that is received only after expenses have been paid may also deter individuals who do not have the funds to pay the insurance premiums up front.

D. Issues with Different Types of Insurance

The type of health insurance that the government subsidizes is important. Traditional employer-based insurance is often called "group" coverage, because a firm's employees form a risk pool of individuals who are all charged the same rate regardless of their individual health status. In contrast, individuals seeking health insurance on their own must purchase insurance in the "non-group" market, where fewer regulatory protections apply. A third option is a public insurance product: either by public provision of insurance, or by a "buy-in" provision. The following are some of the major issues associated with these different types of policies.

Accessibility of insurance

In the non-group market, individuals can face difficulties with access to insurance. Insurers can often vary the benefits package to limit coverage, or exclude individuals with pre-existing conditions from coverage. In many states, insurers can charge different premiums based on the perceived risk of coverage, making health insurance unaffordable for some people. State regulations can address these problems—for example, fifteen states limit rating in the individual market, restricting how much insurers can base premiums on a person's health²⁶—but such solutions can lead to adverse selection problems (discussed below). Small businesses can also face accessibility issues. Insurers recalculate premiums each year based on the experience of the firm. Because firms with fewer employees have a small risk pool, a few serious, costly illnesses among employees could significantly increase premiums in subsequent years. These increases could be passed on to the employees, or the firm could drop health insurance coverage. Larger firms, with larger risk pools are less likely to have such access problems. Publicly-provided insurance provides guaranteed issue to those meeting the criteria established by the government.

Adverse selection

Health insurance is based on the premise that, by offering a single rate to a group of individuals, those people who do not have health expenses in a particular year help pay the costs of those people who do experience health-related expenses—people pool their risks. *Adverse selection occurs when low-risk individuals do not believe they benefit from the risk pooling, and therefore leave the risk pool.* As these relatively healthy people leave the original pool, the average cost per person remaining in the pool will increase. When the costs and therefore the premiums for insurance begin to climb, still more people will elect not to purchase health insurance and there can be a spiral of rising premiums and declining enrollments. This could lead to prohibitively high premiums for those still desiring to purchase health-care insurance.

Adverse selection can affect both the group and the non-group markets. The existing tax subsidy for employment-based group health insurance encourages healthy workers to remain in the group pool, because the subsidy for individually purchased insurance is smaller. If alternative subsidies are available for individual insurance, healthy people may decline employer-based coverage for individual coverage priced to suit them. In response to restrictions on individual

²⁶ Deborah Chollet, "Consumers, Insurers, and Market Behavior," *Journal of Health Politics, Policy, and Law*, 25.1 (2000).

rating, healthy people may also leave the individual market and not carry any health insurance. Even if young, healthy individuals find low-premium policies that reflect their lower risk rather than choosing to drop insurance altogether, higher risk people might still face prohibitively high premiums because the market becomes segmented into different risk pools.

Administrative costs

The administrative expense of selling and billing to many individual policyholders is much larger than when a group of people are represented by a benefits manager. This means that administrative costs are often higher in the non-group than in the group market. Estimates of the amount of premiums paid relative to benefits received suggest that non-group insurance is substantially more expensive than group insurance. *Individuals buying insurance in the non-group market pay on average about \$1.50 in premiums for each \$1 in benefits, a substantially higher ratio than the \$1.15 in premiums paid for \$1 of benefits in the group insurance market.*²⁷ Small businesses also face relatively high administrative costs.²⁸ The administrative cost of Medicare is 3 percent of benefit payments.

5. SIMULATING THE IMPACT OF ALTERNATIVE POLICY PROPOSALS: EXAMPLES FROM THE LITERATURE

Economists have built simulation models that estimate the value and cost of different policy options for extending health insurance coverage. These models include estimates of the effects of some or all of the factors discussed above—such as crowding out and take-up rates. The available simulations suffer from some inevitable limitations. They look at a range of different policies that differ sharply in overall cost and eligibility, and the workings of the models are not terribly transparent. Seemingly small changes in proposals can have a big impact on the estimates. Moreover, some of the simulations present short-term effects, even though the policies are likely to require many years before the full effects on the health insurance market play out. But despite these limitations, the models provide a way to quantitatively compare alternative policy choices that go beyond the more qualitative discussion of issues given above. In this section we will briefly present the simulation results for alternative policies aimed at incrementally expanding coverage.

A. Tax Policies

A simulation model developed by Jonathan Gruber examines the effects of two tax proposals to extend coverage.²⁹

²⁷Mark V. Pauly and Allison M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy and Law*, 25.1 (2000).

²⁸If the credit is available to anyone purchasing private insurance, taxpayers may file tax returns solely for the purpose of claiming the new tax credit. That could be costly for the IRS to administer. A solution to this problem could be to limit the credit to working individuals and families with earnings above a *de minimis* amount. Those people almost all file tax returns, and as noted earlier, 80 percent of the uninsured are employed or married to an employed person. However, the restriction would exclude many early retirees and other working-age people who are out of the work force, but ineligible for Medicaid.

²⁹Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*.

- The first proposal is a refundable tax credit of up to \$1,000 per individual and \$2,000 per family for non-group health insurance.
- The second proposal is a tax deduction for individually purchased health insurance, available whether or not the household itemizes deductions.³⁰ (Unlike the Patients' Bill of Rights proposal, the deduction would not be available to individuals whose employers contribute to their health insurance, regardless of how small the contribution is.³¹)

Each proposal would be fully available to individuals with incomes up to \$45,000 and to families with incomes up to \$75,000, and phased out to zero by incomes of \$60,000 for individuals and \$100,000 for families. The results of these simulations are in the table below.³²

Although Gruber's analysis does take into account the immediate effect of the subsidy on employers' decisions to discontinue coverage or employees opting out of employer plans, it does not take into account the long-run effects. For example, after healthy individuals opt out of their employers' plans to obtain individually purchased health insurance, employers' premiums (especially for small firms) will rise, causing more employers to drop coverage or causing some additional employees to opt out. These second round effects may lead to higher crowding out in the long run.³³

Table 1: Tax Policy Simulation Results (Gruber)

	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
All \$ figures in 1999 dollars		
Total participants (millions)	18.4	6.3
Percent of participants previously uninsured	25.7%	9.2%
Net increase in number of insured people (in millions)	4.03	0.25
Percent decrease in the uninsured population	9.5%	0.6%
Number of currently insured who lose coverage (in millions)	0.69	0.34
Percent of participants with incomes below 200% of poverty	53%	32%
Percent of costs spent on participants with incomes below 200% of poverty	56%	29%
Government cost per participant	\$723	\$138
Government cost per newly insured person	\$3,296	\$3,544
Total government cost (in billions)	\$13.3	\$0.9

³⁰ The deduction would be "above-the-line," which means that it would be available to taxpayers whether or not they itemize deductions.

³¹ The Patients' Bill of Rights would allow a deduction for individuals covered under an employer plan as long as the employer contribution does not exceed 50 percent of the premium.

³² Because there has been limited experience with tax subsidies for health insurance, the estimates of behavioral responses to tax subsidies are based on less solid evidence than that available for simulations of direct subsidies below.

³³ As discussed earlier, this process of adverse selection could in theory cause premiums to spiral up to the point where premiums are unsustainable.

The striking drawback to the tax deduction plan is that the size of the uninsured population falls by less than one percent. (Table 1). Of the 6.3 million participants in this plan, only 580,000 were not previously covered by health insurance. In addition, an estimated 340,000 people who were originally insured under an employer plan become uninsured. Another 300,000 people are dropped from employer plans and move to the individual insurance market. On net, the proposal would increase coverage by 250,000. Thus, though the benefit level to each participant is only \$138, because 91 percent were previously insured, the cost to the government per newly insured participant is \$3,544. Moreover, only 29 percent of the benefits would go to those with incomes below 200 percent of poverty; only 6 percent goes to those in poverty. Thus, though the total cost of this plan is modest, this is not an effective way to extend coverage to the uninsured.

In contrast, the refundable tax credit attracts a much larger number of the uninsured—25.7 percent of the participants (or 4.7 million) were not previously covered by insurance compared to the 9.2 percent for the tax deduction plan—but at a much higher cost. The refundable credit causes some crowding out: over one million people are dropped by firms and purchase individual insurance, and about 3.6 million voluntarily switch from employer-provided insurance to non-group insurance. About 700,000 people who were insured through their employer become uninsured. The net increase in the number of insured people is about 4 million. Because the refundable tax credit is more effective in reaching the uninsured, the government cost per newly insured is slightly smaller under the refundable tax credit than the tax deduction (\$3,296 versus \$3,544), even though the refundable tax credit provides participants with a much higher level of benefits (\$723 versus \$138). This higher level of benefits raises the total cost of the tax credit plan relative to the tax deduction plan, but even if it were designed to have the same overall cost—which would require narrow targeting—the refundable tax credit could be expected to be more cost effective at reaching the uninsured than a tax deduction.

Another set of researchers—sponsored by the Kaiser Family Foundation—also simulated the effects of refundable tax credits and tax deductions.³⁴ The simulation model that they use is different from that of Gruber, and the particular features of the tax proposals that are analyzed are somewhat different from those examined by Gruber.³⁵

- The first proposal is a sliding-scale refundable tax credit covering full policy costs for all families with incomes at or below 150 percent of the federal poverty level with private health insurance (either direct purchase or through employment). The credit would decline with income until it was phased out completely at 500 percent of the federal poverty level (about \$85,000 for a family of four).
- The second proposal is a policy that would allow individuals without access to employer-sponsored insurance to deduct 80 percent of the premium from taxable income on their tax returns.

³⁴ Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance*, The Kaiser Project on Incremental Health Reform (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

³⁵ The Kaiser researchers used their own estimates of behavioral responses to tax subsidies and so their findings would not be directly comparable to the Gruber study even if both studies examined exactly the same tax provisions. Most notably, Gruber assumed a significant number of people would be dropped from their employer-provided group health insurance as a result of the availability of subsidies for non-group insurance.

The simulation incorporates the predicted participation among the eligible population based on historical data from participation in similar plans, the expected costs of the offered plans, and the expected switching of people who were already insured to the more generous full (or near full) subsidy. The table below provides the results of the simulation.

Table 2: Tax Policy Simulation Results (Kaiser)

	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
All \$ figures in 1998 dollars		
Total adult participants (millions)	42.5	6.1
Percent of participants previously uninsured	18%	7%
Number of newly insured (in millions of people)	7.7	.4
Percent of non-elderly adult uninsured who become covered	26%	1%
Percent of participants with incomes below 200% of poverty	46%	21%
Percent of costs spent on participants with incomes below 200% of poverty	73%	14%
Government cost per participant	\$912	\$265
Government cost per newly insured	\$5,156	\$3,953
Total government cost (in billions)	\$38.7	\$1.6

A comparison of the refundable tax credit and the tax deduction using the Kaiser model produces the same general conclusions as those reached using the Gruber model. The refundable tax credit reaches a larger fraction of the uninsured (26 percent) than does the tax deduction (1 percent). It is also much better targeted to the poor than the tax deduction, providing almost 73 percent of its funds to persons below 200 percent of poverty. However, the Kaiser refundable tax credit plan provides a very generous subsidy, so it is expensive and has higher take-up rates. Eighty-two percent of the people who use the subsidy were previously insured.

The Treasury Department analyzed the effects of the tax deduction plan proposed in the Patients' Bill of Rights (PBOR), which provides an above-the-line tax deduction for premiums for non-employer acute care health insurance, or employer health benefits if employer contributions are less than 50 percent of the premium. Because eligibility for the subsidy is extended to the insured whose employer pays less than 50 percent of the premium, many more currently insured individuals would be eligible for this subsidy than the deductions considered in the Gruber and Kaiser simulations, which assume that anyone whose employer contributes at least a dollar is ineligible for a deduction. Further, employers who contribute only a bit more than 50 percent of the premium could reduce their contributions to 49 percent and reduce the after-tax cost to their employees. The PBOR proposal would benefit many people currently covered by employment-based health insurance. According to the 1996 Medical Expenditure Panel survey, 30 percent of family plans have employer contributions of 60 percent or less. Accordingly, the Treasury estimates assume that most of the cost of the deduction would go to currently insured workers whose employers would contribute less than 50 percent of premiums.

Another important difference of the Treasury analysis is that it models a fully phased in policy that has been in effect for 10 years. The Treasury Department estimates that, under this plan, 1.2 million additional people would acquire insurance in 2010, but 600,000 people who were insured through their employer would become uninsured, resulting in a 600,000 net increase in the insured population. The policy would reduce tax revenues by \$11 billion in 2010, so the cost per newly insured person would be about \$18,000.³⁶

Overall, tax deductions provide a very small subsidy for the majority of the uninsured, who are lower-income, and thus do very little to increase coverage. Refundable tax credits provide a bigger subsidy that does not increase with income—indeed they could even be designed to provide the largest subsidy to those with the lowest incomes who are least likely to have insurance coverage. Thus, by targeting the people who are left out of the current system, credits can be more effective, more progressive and less disruptive of the employer health insurance market than tax deductions. However, credit proposals, like the ones simulated above, which have broad eligibility may be quite expensive, because the total cost of the tax credit proposals is high when the subsidy attracts many participants who are already insured. For the same reason, they also present the greatest threat to the market for employment-based health insurance. Therefore, they are considerably less efficient than the direct provision proposals described below.

A final drawback of the refundable tax credit plans evaluated here is that the credits direct people to the individual market which, today, is inaccessible to many individuals because they have pre-existing conditions that render them ineligible for insurance. It also can be unaffordable to many people due to adverse selection. Insurance regulation can help address the accessibility and affordability problems that exist today. Another alternative is to allow refundable tax credits to be used for public group plans such as Medicare, Medicaid, or SCHIP buy-ins.

However, these tax credit plans can be valuable in addressing a different problem—the inequities inherent in the current tax treatment of health insurance. As described above, those currently covered by employer-provided health care receive tax breaks, but those who purchase their own insurance receive very little tax benefit. Therefore, a refundable tax credit that approximately equals the value of the employer deduction would provide equity with the tax advantage currently enjoyed by those who have employer-provided insurance.

B. Direct Government Provision of Health Insurance

The simulation model developed by a Kaiser Family Foundation study is also used to examine the effectiveness of two alternative options that increase the direct provision of health insurance to certain segments of the population.

- The first option is a large-scale plan that would extend government-provided insurance coverage to all uninsured adults with incomes below the poverty level.

³⁶ A significant part of the difference between the Treasury and Gruber estimates is expected increases in health insurance costs. Treasury assumes that insurance costs will roughly double between 1999 and 2010; thus, Gruber's estimate of \$3,544 per newly insured person in 1999 would correspond to about \$7,000 at 2010 levels. Most of the rest of the difference is attributable to the difference in policies estimated.

- The second option is a proposal very similar to the Administration's proposal to extend government-provided health insurance to parents of children who are eligible for the Medicaid and SCHIP programs. Under this plan, adults in families with incomes up to 100 percent of the poverty line would receive health insurance that was completely paid for by the government. Families with incomes above the poverty level but below state-determined eligibility limits (typically 200 percent of poverty³⁷) would pay a premium of 2 or 4 percent of income, depending on whether one or two parents were covered.

Table 3: Direct Provision Simulation Results (Kaiser)

All \$ figures in 1998 dollars	Coverage to all poor adults	Coverage to Parents of Medicaid/SCHIP Children
Total participants (millions)	9.3	3.0
Percent of participants previously uninsured	69%	69%
Number of newly insured people (millions)	6.2	2.1
Percent of non-elderly adult uninsured who become covered	22 %	7%
Percent of participants with incomes below 200% of poverty	100%	93%
Percent of costs spent on participants with incomes below 200% of poverty	100%	94%
Government cost per participant	\$2,484	\$2,271
Government cost per newly insured	\$3,582	\$3,306
Total government cost (in billions)	\$23.0	\$6.7

The results for the two plans are very similar (Table 3), except, of course, for the fact that the broader plan covers many more people and is correspondingly more expensive. The cost per participant is slightly lower in the narrower plan, because some SCHIP parents will contribute a small premium.

The majority of the participants in both plans are newly insured. There is some crowding out evident in this simulation, as 31 percent of those covered were previously covered by some other type of insurance. But that is a very low figure relative to the options considered earlier. *Over two-thirds of the participants in the programs are newly insured.* This is because the eligibility for these programs is targeted to lower-income people, who are less likely to be covered by other insurance, and the programs have a generous enough subsidy to get high participation.

³⁷ State upper income eligibility limits vary from 133 percent of poverty to 350 percent of poverty.

The Office of Management and Budget has estimated the cost of the Administration's FamilyCare proposal, a different proposal with some of the features as the simulation covering parents of children on SCHIP and Medicaid (second column of Table 3), and finds it comparable to the simulation's estimated cost per newly insured person. The Administration proposal is broader, projecting 5 million newly insured people, because it includes provisions for the coverage of immigrants, Medicare buy-in for individuals between 55 and 65, and outreach programs to eligible populations.

6. CONCLUSIONS

This report highlights a number of troubling features of the current state of health insurance in the United States.

- Over 44 million Americans—about 1 in 6—are not covered by health insurance. This lack of health insurance has worsened over the past decade, even as the economy has been booming. *Forty-three percent of adults in households below the poverty line did not have health insurance coverage in 1998.* Minorities are less likely to be covered by insurance than the average.
- For families without health insurance, health problems often go untreated—leading to poorer health outcomes, including a higher likelihood of being hospitalized with conditions that could have been treated out of the hospital or avoided altogether. *Uninsured Americans are more than three times as likely to delay seeking care.* For many uninsured families, major health problems can lead to financial devastation. Health insurance, while seemingly expensive, may be the most cost-effective way to ensure a healthy society. The benefits of prenatal care, often delayed because of a lack of health insurance, for example, are enormous.
- The cost burden of the uninsured falls on the public at large, because ultimately the entire society absorbs the costs of medical treatment for individuals who are unable to pay for medical care.
- The federal tax code provides a very large subsidy for the purchase of employer-based health insurance by not including employer premium contributions in taxable income. But, because the effective subsidy depends on an employee's marginal tax rate, the value of the health benefit to households rises sharply with household income. Low-income households receive little or no tax incentive to participate in health insurance plans—a key reason that so many low-income households do not have coverage.

A number of policy responses to the problem of the uninsured are discussed in this report, using a discussion of the economic issues involved and quantitative estimates from simulation models. The analysis suggests that some approaches are likely to be more effective than others.

- **Tax deductibility is not an effective policy to extend coverage.** Studies indicate that extending tax deductibility to non-group policies would expand medical insurance coverage only modestly, and would do very little to expand insurance coverage to low-income

families. It would provide a tax break to predominately middle- and upper-income households already purchasing such coverage.

- **Refundable tax credits may reach some low-income families, but, to the extent that tax credits encourage the use of non-group insurance, this creates different problems.** Initiatives of this sort can be scaled to provide a reduction in the number of uninsured—at substantial cost to the government. Refundable tax credits are far more effective in targeting low-income families than are new tax deductions, because a refundable tax credit can be used by families at lower-income levels to reduce the cost of insurance. However, serious problems exist in the non-group insurance market. Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. The difficulties can be addressed with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage. Alternatively, tax credits can be used for individuals to buy insurance through small business purchasing groups or public programs that do not have these problems.
- **Direct provision of health insurance, like the SCHIP initiative, would be particularly effective in targeting low-income families.** Research indicates that this type of initiative, while not affecting as many uninsured people as some of the tax credit proposals, is very effective at reaching the lower-income uninsured for a relatively small total cost. Thus, direct provision has an advantage over tax credits in more effectively making health insurance affordable and accessible for many Americans. *Simulations suggest that over two-thirds of expanded direct provision participants would be newly insured.*
- **Serious problems arise in the non-group insurance market.** Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. This means that policies that encourage households to move into this market are problematic. To an extent these difficulties can be overcome with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage.

Reversing the trend of declining insurance coverage among Americans will require a major commitment by the public sector. One common theme in these studies is that there is no silver bullet that will easily or inexpensively resolve the problem of the uninsured in America. Indeed, taken as a whole, these studies suggest that a careful blend of different policies may be required to reach the uninsured effectively. For Americans at moderate income levels, direct provision policies, such as the Administration's proposal to expand SCHIP to cover adult members of families with eligible children, are particularly cost-effective. Although well intentioned, tax changes (even when based on more-efficient refundable credits rather than tax deductions) are not very effective at reaching a high percentage of the uninsured, because the uninsured are predominantly low-income and the poor simply cannot afford insurance even at a reduced cost. However, tax-credit programs, with insurance regulation or for purchase of public insurance, can be useful to families as their incomes rise and they become ineligible for subsidies through direct provision programs. Such a combination of programs might offer an effective way to provide health insurance to those who have been left out of the current health-care system.

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.

**REPLY TO THE REPUBLICAN RESPONSE
TO THE PRESIDENT'S STATE OF THE UNION ADDRESS ON HEALTH CARE**

HEALTH INSURANCE COVERAGE INITIATIVE

CLAIM: "The last time he [the President] proposed a health plan was seven years ago... It would have forced every American into a Washington-run HMO and denied them the right to choose their own doctor."

RESPONSE: **This is patently false, divisive rhetoric designed to thwart any progress towards improving the health care system.** While it is not constructive to start the Health Security debate all over again, it is important to note that the President's 1993 proposal: (1) relied on private employers to cover their employees with private health insurance; and, (2) unlike today's system, would have provided many plan choices, including at least one fee-for-service option that would guarantee that every American could choose their doctor. Today, it is ironic that the Republican leadership raises concerns about a Washington-run HMO when they have aligned themselves with the insurance industry to oppose the Patients' Bill of Rights. We can only hope the Republican rhetoric after the State of the Union on their concern about HMOs signals a change in their position on supporting the passage of a strong, enforceable, Patients' Bill of Rights.

CLAIM: "... [E]ach new proposal we heard about tonight – and there were about 11 of them in health care alone – comes with its own massive bureaucracy."

RESPONSE: **There is no new bureaucracy in the President's plan.** Each targeted proposal builds on existing private as well as public insurance options.

Builds on the very children's health insurance program that Senator Frist claims is a Republican accomplishment. The President's plan simply adds uninsured parents to the health insurance that their children already have – no new applications, no new health plans, no new bureaucracy is needed.

Additional initiatives build on programs currently in place. The other proposals are either tax incentives or are extensions of the currently existing Medicare and Medicaid programs.

Helps make private insurance more affordable. Under the President's plan, states would be able to help working families afford insurance through their jobs when they have the option. Similarly, the tax credit for COBRA continuation coverage and small businesses purchasing insurance through coalitions help people purchase high-quality private health plans.

CLAIM: "And each will cost you, the taxpayer, billions more of your tax dollars – more than \$1,000 for every man, woman, and child."

RESPONSE: **There are no new taxes in the President's proposal.** The President invests part of the on-budget surplus into making health insurance more affordable – he does not raise taxes to do so.

CLAIM: "Already because of Republican efforts, five million more children now have access to health care; if you change jobs, you can now take your health insurance with you; new mothers can leave the hospital when their doctor, not some bureaucrat, says they're ready. And we're doubling research for more and better cures."

RESPONSE: We're pleased that the Republican leadership is now claiming credit for these bipartisan initiatives. Clearly, these laws would not have been enacted without the President's strong advocacy and Democrats' consistent support. However, we are pleased that Republicans are now associating themselves with these successful, bipartisan initiatives. As is illustrated by this statement by Senator Nickles shortly before the passage of S-CHIP (State Children's Health Insurance Program): "No one in their wildest dreams would have said we should have \$36 billion to solve this problem, which I guarantee you is not that big." (The Congress ultimately enacted \$48 billion over 10 years to help provide coverage to the nation's 11 million uninsured children.)

Ironically, the President's current initiative builds on these so-called Republican successes. Senator Frist praises the Kennedy-Kassenbaum insurance reform initiative and the S-CHIP as Republican accomplishments. Yet, he criticizes the President's proposal to build on the state administered, S-CHIP program and extend access to insurance for their parents. This is despite the fact that insuring parents through S-CHIP is one of the highest priorities of nation's Governors, the great majority of whom are Republicans.

MEDICARE

CLAIM: "The answer [to prescription drugs] is not government-dictated price controls that stop life-saving research, or forcing the 65 percent of seniors who now have drug coverage to pay more or give up what they have."

RESPONSE: The President agrees – his plan has no price controls and would not force any senior to give up what they now have. Even the pharmaceutical industry has acknowledged that the President's plan is voluntary and has no price controls. The President's proposed prescription drug benefit simply provides another choice for beneficiaries, and as such, would not force any Medicare beneficiary into the program. It provides an affordable option for millions of beneficiaries, but is also provides billions of dollars of subsidies to employers to encourage them to maintain their private retiree health benefits. These employer subsidies are important because many employers are dropping this coverage at historic and extremely troubling rates. Finally, the plan is administered in exactly the same way that virtually every private insurer manages their drug benefit today. They contract out with private pharmacy benefit managers and / or managed care plans – and the Medicare program would do the same thing.

Most seniors who have drug benefits do not have dependable coverage, but are freely able to retain their current coverage under the President's plan. The number the Republicans cite as reflecting how many seniors have drug coverage includes beneficiaries with managed care and Medigap coverage – which is unstable, unreliable and frequently extremely expensive. It does not take into account that the number of firms offering retiree health plans has declined by 25 percent over the last four years. The truth is that over 3 in 5 Medicare beneficiaries do not have dependable drug coverage. The only way to ensure that older Americans have access to a dependable benefit is to provide a voluntary Medicare benefit that is affordable and accessible to all.

CLAIM: **“But just last year the President said “No” to [the Breaux-Thomas] plan put forth by the “National Bipartisan Commission” – the very commission the President and Congress appointed to save Medicare.**

RESPONSE: **The President did not support the Breaux-Thomas plan considered by the Medicare Commission because it would not “save” Medicare and did not achieve sufficient consensus to be formally recommended by the Medicare Commission.** The reason why seven out of the nine members appointed by the Democrats opposed the Breaux-Thomas plan was that it would: (1) explicitly increase premiums between 10 and 30 percent for those beneficiaries who choose to stay in the traditional fee for service Medicare program; (2) raise the eligibility age for the Medicare program without a proposal to provide an affordable alternative -- inevitably increasing the number of uninsured Americans; (3) fail to moderate the impact of the Balanced Budget Act's Medicare provider reimbursement changes, and in fact assumed savings consistent with their extension into the future; (4) provide an inadequate, means-tested drug benefit that would only be available to those below 135 percent of the poverty line, excluding more than one half of those currently without drug coverage; and (5) did not dedicate one cent from the surplus to extend the life of the Medicare program.

Although he could not support the Breaux-Thomas plan, the President praised the Commission's work and committed to – and did unveil – his own comprehensive reform proposal. The President's proposal to modernize and strengthen Medicare, which was widely praised by health economists and policy experts, would: (1) make the fee for service and managed care programs more competitive through market-based initiatives; (2) modernize the benefits by providing for a voluntary, affordable prescription drug benefit available to all beneficiaries; and (3) dedicate nearly \$400 billion of the on-budget surplus to extend the life of the Trust Fund to 2025 and help pay for the drug benefit.

The President's commitment to Medicare is longstanding and he has a record to prove it. Since 1993, under the President's leadership, Medicare spending growth has been cut by two-thirds and Medicare solvency has been extended from 1999 to 2015. He enacted bipartisan legislation in 1993 and 1997 to improve Medicare, reducing spending growth and adding important new preventive benefits. The President has also taken aggressive action to improve quality and reduce waste and fraud, and worked with the Congress, providers, and others on a bipartisan basis to address reimbursement shortcomings last year.

CLAIM: **"For this to happen, Mr. President, all we need is for you to tell the American people "Yes" to this...plan to fix Medicare, so that people like my fellow Tennessean, Patricia Brown, whom we have honored in the gallery this evening, will have the vital prescription drug coverage she needs.."**

RESPONSE: **Medicare beneficiaries like Mrs. Brown would receive no coverage from the prescription drug benefit included in the Breaux-Thomas plan.** Mrs. Brown – and the tens of million of beneficiaries who have no or unreliable drug coverage – would not be eligible for the drug benefit in the Breaux-Thomas plan. That plan limited coverage to beneficiaries with incomes below 135 percent of the poverty level – only about \$11,000 for a unmarried senior. Mrs. Brown's \$15,000 in income makes her too wealthy to access this benefit. In fact, more than half the uninsured beneficiaries today would receive absolutely no benefit.

CLAIM: **"And tonight, to show you that we are sincere and that we mean business, Republicans take a first step towards making Medicare stronger. To guarantee that seniors can rely on Medicare forever, we will add it to the Social Security lockbox...."**

RESPONSE: **A new lockbox will not extend Medicare solvency for a day – let alone "forever."** To date, the Republican leadership has refused to dedicate one penny of the on-budget surplus to extend the life of the Medicare program. We would hope that the intent of their language is that they are contemplating altering their position and dedicating a portion of the on-budget surplus to Medicare. If they did, we would welcome such a development because, as is the case in the President's proposal, it would have the effect of reducing debt and freeing up resources that can be used to care for the baby boom generation when it retires.

PATIENTS' BILL OF RIGHTS

CLAIM: **"Unlike the President, we see lawsuits as a last resort, not the first."**

RESPONSE: **So do we.** The real news here is that Senator Frist and the Senate Republican leadership, for the first time, are apparently agreeing with Governor Bush and Senator McCain that all Americans in all health plans have the patient protections that they need, including to access to remedies through the courts for who have been harmed or those who have died as a result of arbitrary actions by health plans. We hope and believe this signals the possibility of a long-overdue agreement on a strong, enforceable, Patients' Bill of Rights.

**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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¹³ Data from the March 1999 Current Population Survey as analyzed by DHHS/ASPE.

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