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ISSUE BRIEF

Health Insurance Family Style: Public Approaches to Reaching the Uninsured

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A discussion featuring

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Public Approaches to Reaching the Uninsured

Overview—This issue brief explores existing and potential opportunities to further expand the availability of health coverage for the uninsured and the underinsured, given the current economy and the resulting state budget shortfalls. It also considers the implications of the Health Insurance Flexibility and Accountability initiative recently announced by the Centers for Medicare and Medicaid Services and the legislative options for health care reform being debated in Washington, including tax-credit incentives and additional federal funding for public coverage expansions through Medicaid and the State Children’s Health Insurance Program.

The Forum session will explore state, federal, and academic perspectives on public coverage expansions and the variety of paths available to support such expansions. The meeting will also address the cost implications of the differing perspectives in the context of the shifting economy. This is expected to lead to a discussion among presenters and participants of the future of and priorities for public financing of health insurance coverage.

Throughout the nearly eight decades of the health coverage debate in this country, the nation’s attitude toward the necessity and value of health insurance coverage has been directly influenced by the state of the economy. For example, options for universal coverage tend to be raised most often during periods of economic downturn and rapidly rising health care costs. The level of awareness of the number of uninsured, most recently estimated at 39 million,¹ has also influenced the debate. However, repeated discussions of broad-based expansion or reform of public health financing programs have consistently resulted in incremental policy movements and carefully measured financial investments.

Today, in the face of a slowing economy and a return to double-digit increases in premiums, questions arise about whether further extension of broad-based health coverage is possible and, if so, what the most appropriate and politically viable solutions to the problem of the uninsured might be. While there is little reason to believe that the current administration and the Congress will now embrace universal coverage, there does seem to be bipartisan recognition of the uninsured as a legitimate concern that should be addressed.

EXISTING COVERAGE OPPORTUNITIES

Covering the uninsured is both a political and a logistical challenge. However, while there is room for improvement within the federal Medicaid and State Children’s Health Insurance Program (SCHIP) statutes, they do contain several existing, although somewhat underutilized, options to help states and the federal government work together toward providing a high-quality, cost-effective health care system for most, if not all, low-income individuals.

Existing Medicaid law permits and even encourages states to provide coverage for families and their children at income levels above the poverty line. Many states have taken advantage of this flexibility, but the majority have not. To date, 17 states and the District of Columbia provide Medicaid eligibility for parents with incomes at or above the federal poverty level (FPL)—\$14,634 for a family of three in 2001. While states like Washington, Minnesota, Tennessee,² and New Jersey have expanded coverage up to two and three times the poverty line (between \$29,269 and \$43,890 for a family of three in 2001), the financial incentive has not been significant enough for many states to make such a substantial commitment. (Many states with less generous eligibility standards have actually spent more Medicaid dollars overall, because of the higher proportion of low-income families in the state.) While 94

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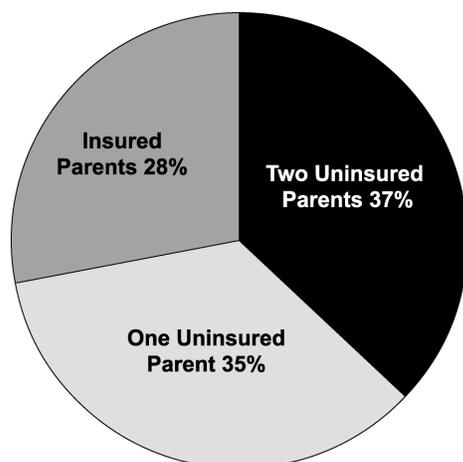
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percent of low-income uninsured children are eligible for Medicaid or SCHIP, most states continue to limit eligibility for adults to the old levels set under the Aid to Families with Dependent Children (AFDC) program, which are often less than 60 percent of the FPL (around \$9,000/year for a family of three in 2001). Thirty-four percent of low-income parents are uninsured, which is substantially higher than the uninsurance rate for children.³ As shown in Figure 1, 72 percent of uninsured children have at least one uninsured parent. In addition, because federal funding is generally not available for childless, nondisabled adults in the absence of a waiver, most states do not provide public coverage for this group, which constitutes 17.5 percent of the nation's nonelderly population. Almost two-thirds of uninsured adults do not have children.⁴

Figure 1
Percent of Low-Income Uninsured Children
by Parents' Insurance Status



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

The arrival of SCHIP in 1997 provided the needed financial incentive and flexibility for states to convince their state legislatures that eligibility expansions, at least for children, would be worth their while. The federal enhanced matching funds provided through SCHIP range from 65 to 87 percent of total expenditures, leaving states to come up with much less than half of the funding for coverage expansions to children of low-income and often working families. As a result, more than 3 million children were enrolled in SCHIP in 2001, and enrollment continues to grow.⁵ And although

the political viability of SCHIP hinged on the fact that the primary purpose was to serve children alone, states and researchers have begun to test the hypothesis that covering low-income parents will actually result in reaching more children.

In fact, research is beginning to substantiate this theory. A recent study by the Center on Budget and Policy Priorities found that family-based Medicaid expansions that include parents have increased Medicaid enrollment among children who were eligible but previously not enrolled. For example, three states (Oregon, Tennessee, and Hawaii) that implemented broad parent expansions in 1994 achieved a 16 percent increase in Medicaid participation among low-income children, compared to 3 percent for states that did not institute broad expansions. In addition, in the early-expansion states, parents' Medicaid enrollment rose despite welfare caseload declines during that time period.⁶ As noted by Leighton Ku and Matthew Broaddus,

In deciding whether to participate [in health insurance] a family must weigh the costs (such as out-of-pocket expenses and time taken off 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.⁷

Finally, one study also determined that children are more likely to receive preventive care when their parents are enrolled in public health insurance programs.⁸

As discussed below, using the demonstration authority established under Section 1115 of the Social Security Act to access SCHIP enhanced matching funds is perhaps the most financially desirable means for states to maximize federal funding for coverage of adults. It should be noted, however, that states also have flexibility, by amending their state Medicaid or SCHIP plans, to expand coverage and work with employer-subsidized group health plans without the lengthy process and complicated budget requirements associated with applying for a waiver.

Medicaid—Section 1931

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as the welfare reform law, replaced the AFDC program with a new, more limited program called Temporary Assistance for Needy Families (TANF). The new law "delinked" eligibility for AFDC (now TANF) from automatic eligibility for Medicaid. Consequently, eligibility for Medicaid in this context is no longer

limited to families receiving welfare benefits and those with incomes well below the poverty line. Under Section 1931 of the Social Security Act, enacted in PRWORA, states now provide coverage to all families with dependent children, as long as they meet the basic eligibility requirements. States can modify the “deprivation requirements” that generally limited AFDC-related Medicaid eligibility to single-parent families or two-parent families whose principal wage earner was not working full time.⁹ Because they have flexibility to set their own standards related to hours of work and income levels and to take into account overall family circumstances, states have the ability to cover two-parent families to the same extent as single-parent families.

Section 1931 also gives states several options for expanding eligibility levels for Medicaid coverage of families. They can do this by utilizing “less restrictive methodologies” for deciding how to count certain types of income and resources in determining eligibility. For example, states may raise their income and resource standards by the amount of the increase in the consumer price index each year.¹⁰ States may also use more generous income deductions or disregards—like disregarding the value of a car, not counting interest income, or eliminating the assets test for families. Although states are not required to do so, many have elected to use the same income and resource methodologies as those in their TANF programs to help facilitate enrollment in both programs. Nearly half of the states have used 1931 in some manner to improve or expand the availability of Medicaid coverage for families and more are considering amending their state plans to do so.

Working with Employers—HIPPs and SCHIPs

Health Insurance Premium Payment (HIPP) programs. Another major area of interest among the states is to expand coverage while conserving public funds by subsidizing private group health plan coverage offered through employers. The interest in this combination of public and private financing of coverage has increased significantly since the advent of SCHIP. Section 1906 of the Medicaid statute enables states to use HIPP programs to pay the contribution necessary to enroll Medicaid-eligible individuals in employer-sponsored private health insurance, as long as doing so is cost-effective (compared to the cost of providing regular Medicaid coverage). Because enrollees must receive all of the benefits covered under the state’s Medicaid plan, states usually issue a Medicaid card that can be used to access services not covered under the employer plan.

Most states are operating HIPP programs, but they are usually limited to individuals with very high-cost conditions, such as cancer and HIV/AIDS. Only a few states (Iowa, Texas, Pennsylvania, and Virginia) use HIPP programs to screen all Medicaid eligibles for access to employer-sponsored coverage. Even when used in this broader way, enrollment has remained very small, representing only 1 percent of states’ total Medicaid program enrollment.¹¹

There are several reasons for these small enrollment numbers. First, because of the nature of low-wage jobs, most Medicaid-eligible individuals do not have access to health coverage through their employers. Further, it is difficult for states to identify the target population because their Medicaid agencies do not generally have relationships with employers, causing information-sharing to be problematic. Nonetheless, for states and for a significant number of individuals who would not otherwise have access to health insurance coverage, HIPP programs present a real opportunity. For example, as is the case in Iowa, many of those being reached are the working parents of Medicaid-eligible children who are not otherwise eligible for Medicaid themselves and who cannot afford the premiums for private health insurance.

Iowa has perhaps had the greatest success with the HIPP option, eliciting a positive enrollment response ever since the program’s implementation in 1991 and saving an estimated \$3.30 in Medicaid benefits for every \$1.00 the state spends on premium assistance. (In 2000, the state estimated the savings achieved at \$19 million.) In 1991, only two state staff were allocated to manage the HIPP unit; today, Iowa has 17 employees staffing it.

Iowa’s enrollment success is due to a screening process that refers Medicaid applicants who are identified as having access to employer coverage to the HIPP unit in the state. The HIPP unit then evaluates the employer coverage and, if it is cost-effective, enrolls the individual or family in the program, regardless of their insurance status. Because HIPP is a Medicaid program, no period of uninsurance is required for enrollment. Enrollees are expected to present their employer plan identification cards and their Medicaid cards when visiting providers. The providers bill the private plan first, then Medicaid for deductibles and coinsurance. Medicaid-eligible enrollees may receive wraparound services from Medicaid providers, who are reimbursed directly from the state.¹² As of May 2001, 9,645 individuals were enrolled (6,502 Medicaid-eligible individuals and 3,143 non-Medicaid-eligible family members).¹³

The state works with employers to provide comprehensive group coverage for all the members of a family in order to keep them in the same health plan and so that they can use the same providers. In addition, since families can access insurance through their employer, they are more likely to retain coverage if they become ineligible for Medicaid. And because HIPP extends coverage to otherwise ineligible family members, there are more people receiving coverage overall. At this point, HIPP programs provide a good example of cooperation with employers and the private market; historically, however, small enrollment numbers show that these programs alone cannot realistically be expected to have a major impact on coverage rates.

Premium Assistance in SCHIP. To date, seven states¹⁴ have received approval from the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration, or HCFA) to develop “premium assistance programs,” that is, to use SCHIP funds to enroll eligible children (and in some cases, their parents) in private coverage offered by employers. Prior to the release of guidance on Section 1115 demonstrations under SCHIP on July 31, 2000, “family coverage waivers”¹⁵ that include a premium assistance component were the main vehicle for states to expand coverage to parents. However, states have not had much success with premium assistance in SCHIP, in part because states with separate SCHIP programs do not generally have an easy way to administer the required supplementation of employer plans. In addition, the proposed SCHIP regulations included fairly strict federal requirements regarding the proportion of funding that must be provided by the employer. (The “cost-effectiveness test” for family coverage indicates that the costs of covering the family may not be greater than the public program costs of covering the children only, which inherently requires a substantial employer contribution.) Consequently, some states have had difficulty recruiting employers to participate in premium assistance programs. In an attempt to help states use this option, the final SCHIP regulations removed the specific requirement for an employer contribution and included some additional flexibility with regard to substitution prevention.¹⁶ These changes to the regulations, along with new flexibility permitted under the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative recently announced by CMS (and described more fully below), may give the Department of Health and Human Services (DHHS) an opportunity to move forward in establishing partnerships with employers and providing expanded access to health coverage.

Thus far, Massachusetts is the only state that has had considerable success in establishing a premium assistance program in combination with a Section 1115 demonstration that blends Medicaid and SCHIP funds, although its 10,000 enrollees represent only a small portion of the state’s overall Medicaid and SCHIP program. New Jersey, Maryland, and Rhode Island have recently established premium assistance programs and hope to emulate Massachusetts’s success under their own 1115 waiver expansions. As discussed below, the new HIFA initiative strongly encourages states to pursue premium assistance programs and suggests a great deal of additional flexibility by removing specific requirements for preventing substitution of private coverage and by removing the cost-effectiveness test.

While premium assistance is a cost-effective way for states to expand coverage, the effect these types of arrangements can have can be considered both positive and negative. Although researchers have long been interested in measuring the level of “crowding out of private coverage” associated with Medicaid, no specific prevention mechanism had ever been required and the topic has remained a source of contention. The debate escalated as the SCHIP legislation was being drafted, since the new program focused on working families who would have higher incomes than Medicaid generally reached. There was concern that families would drop private coverage in order to enroll in the lower cost SCHIP program. The concern resulted in specific administration policies requiring every state to at least monitor for crowd-out and approving some states’ proposals to require a 12-month period of uninsurance before an individual could be enrolled in SCHIP.

In addition, in the case of family coverage using premium assistance through employers, there is a continued concern that employers will reduce or discontinue their health benefits because of the availability of public funds. Analysts note that some working families would not want to enroll in public coverage through Medicaid or SCHIP but would accept help in enrolling in private coverage provided through their employer. And, while premium assistance is not intended to encourage employers to reduce or discontinue coverage because of the availability of public coverage, the potential is there. This has increasingly become a concern as states have expanded eligibility for their programs well into the “full-time worker” range. States have had to carefully structure their programs to maintain the expectation that employers will continue to make a significant contribution toward health coverage for their employees.

Section 1115 Demonstrations

Based on guidance released by DHHS on July 31, 2000, several states began requesting approval to conduct Section 1115 demonstrations in their SCHIP programs in order to test the hypothesis that covering parents will lead to increased child enrollment. The Section 1115 demonstration authority enables states to get enhanced matching funds for directly enrolling parents of SCHIP or Medicaid children, regardless of whether they have employer-sponsored insurance. To date, four states (New Jersey, Rhode Island, Wisconsin, and Minnesota) have received approval and corresponding enhanced matching funds to provide coverage to the parents of children enrolled in SCHIP. However, because Wisconsin's, Minnesota's, and Rhode Island's proposals effectively provide additional federal funding for the states to continue existing parent coverage through Medicaid, New Jersey is the only state thus far that is using its SCHIP dollars to expand coverage to parents and that will be able to show quantitative results on the effects of the demonstration on child enrollment rates.

New Jersey's SCHIP demonstration, NJ Family Care, expanded coverage to parents of Medicaid- and SCHIP-eligible children in families with incomes up to 200 percent of the FPL, pregnant women with incomes between 185 and 200 percent of the FPL, single adults and childless couples up to 100 percent of the FPL, as well as legal immigrants who are permanent residents of the United States (using state-only funds). The state also received approval to establish a premium assistance program, which New Jersey has entitled the Premium Support Program. NJ Family Care is designed for "uninsured people whose employers either don't offer health insurance or it is unaffordable."¹⁷ So far, the response from uninsured New Jerseyans has been overwhelming for the state. The announcement of the new program, which made coverage available to an estimated 45,000 childless adults up to 100 percent of the FPL and another 80,000 parents up to 200 percent of the FPL,¹⁸ caused such a rush of applications that the state has been struggling to keep up with the eligibility determination process and has faced a considerable backlog and budget shortfalls. The state recently had to temporarily stop enrollment of single adults due to lack of funding.

DHHS is also considering approval of a SCHIP parent coverage proposal from California. In an effort to cover a greater portion of its large population of uninsured, the state is similarly seeking additional federal funding to expand the breadth of its program to parents with net incomes up to 200 percent of the FPL. The proposal has been pending in the Office of the

Secretary since March, and Secretary Tommy Thompson recently told the *Los Angeles Times* that "the state's application is strong, [and] I've been looking favorably on it."¹⁹ In the meantime, there appears to be a greater movement in California to expand coverage beyond the realm of Medicaid and SCHIP. In fact, the Santa Clara Valley Health and Hospital System recently received backing from the David and Lucille Packard Foundation and the California HealthCare Foundation to pursue a campaign for "universal" health coverage in Santa Clara County.²⁰ The goal of the Children's Health Initiative (CHI) is to cover the county's estimated 70,000 uninsured children under age 19. The "Healthy Kids" program covers undocumented immigrant children and uninsured children who do not qualify for Medi-Cal or Healthy Families, California's SCHIP program, with incomes up to 300 percent of the FPL (\$43,890 for a family of three in 2001). The program is administered by the Santa Clara Family Health Plan and is funded through a combination of tobacco settlement and tax funds, money from the City of San Jose, funding from the Santa Clara Family Health Plan, and a variety of donations from private sources.²¹ The initiative has reached 15,000 children in seven months of operation.²² Interestingly, whereas some of the private funding for the initiative had been coming from the miraculously successful "dot com" companies of Silicon Valley, Santa Clara County officials are now attributing some of the recent enrollment success to economic uncertainty in the valley. According to CHI officials, "Many people who have been laid off cannot afford the COBRA payments necessary to keep their health insurance benefits, so they are turning to the initiative for temporary help."²³

To date, two states have received approval by the Bush administration for significant SCHIP or Medicaid demonstrations. Minnesota will receive SCHIP funds for coverage of parents with incomes up to 200 percent of the FPL. New York received approval for an amendment to its current Medicaid Section 1115 demonstration to expand coverage to childless adults with incomes at or below the poverty level and to phase in coverage of uninsured parents with incomes up to 150 percent of the FPL by 2002. DHHS is also considering minor Section 1115 demonstration proposals from New Mexico, Ohio, and Rhode Island.²⁴

The Health Insurance Flexibility and Accountability Demonstration Initiative

The Bush administration has outlined three areas of priority for addressing the problem of the uninsured:

flexibility through waivers, tax-credit incentives, and enhanced support for community health centers. On August 4, 2001, DHHS announced the HIFA demonstration initiative, a new approach to Section 1115 waivers under Medicaid and SCHIP. The HIFA initiative, which is targeted at populations with incomes below 200 percent of the federal poverty level, is intended to encourage states to find new approaches to increase the number of individuals with health insurance, within current-level Medicaid and SCHIP resources²⁵

Eligibility. The August 4 guidance outlines program and budget parameters for qualifying HIFA proposals and provides three new eligibility definitions:

- *Mandatory populations*—Eligibility groups that states are required to cover under the Medicaid statute. These include infants under age one up to 185 percent of the FPL, children under age 6 and pregnant women up to 133 percent of the FPL, and children between ages 6 and 17 up to 100 percent of the FPL.
- *Optional populations*—Eligibility groups that can be covered by amending a state Medicaid or SCHIP plan, without a waiver. Groups are considered optional if they can be included, regardless of whether a state elects the option. Optional populations include children covered in Medicaid with incomes above the mandatory levels described above, children covered under SCHIP, and parents covered under Medicaid or SCHIP.
- *Expansion populations*—Any individuals who cannot be covered under Medicaid or SCHIP in absence of a Section 1115 demonstration, including childless nondisabled adults under Medicaid or SCHIP, pregnant women above age 19 in SCHIP, and parents outside of family coverage in SCHIP.

States have flexibility to set eligibility levels for expansions, however if a state proposes to expand coverage above 200 percent of the FPL, it must demonstrate that it already has a high rate of enrollment below 200 percent of the FPL and that covering individuals above 200 percent will not encourage them to drop private coverage in favor of enrolling in the demonstration.

Benefits. HIFA gives states new authority to modify the benefit package for optional and expansion populations. For optional Medicaid and SCHIP populations, the state may choose one of the SCHIP benchmark benefit packages,²⁶ which include a category of “Secretary approved coverage,” essentially allowing the state to propose any benefit package as long as it includes a list

of basic services.²⁷ For the expansion populations, states have even greater flexibility to establish limits on the types of providers and the types of services that are available. The guidance notes that costs of expanding coverage must be budget neutral²⁸ and therefore presumably offset by savings achieved through providing a more limited benefit package.

Cost Sharing. The third area of state flexibility and potential savings is through cost sharing. With the exception to the nominal levels for mandatory populations and a 5 percent cap on cost sharing for optional Medicaid and SCHIP children, there are no specific limitations on cost sharing under HIFA.

Finally, as mentioned above, the HIFA guidance strongly encourages states to integrate Medicaid and SCHIP funding with private health insurance funding. There will be increased flexibility in establishing premium assistance programs with regard to benefits and cost sharing and states will no longer be required to demonstrate cost effectiveness. Instead, states should monitor the costs and ensure that they are not “significantly” higher than the costs under a direct coverage program. In response to concerns about substitution of private coverage, states will be asked to closely monitor changes in employer contribution levels and be prepared to make changes in their programs if employers begin dropping coverage or providing different contribution levels based on program eligibility.²⁹

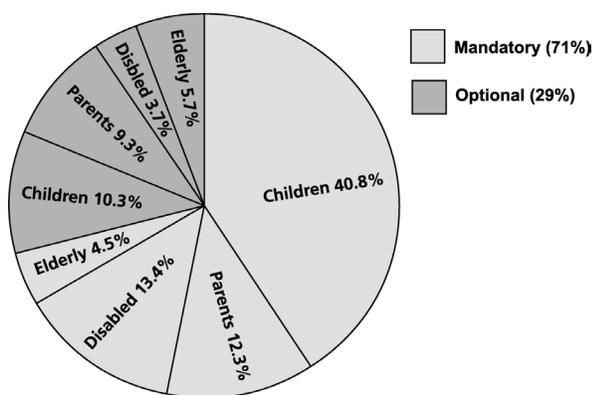
The HIFA demonstration initiative was developed in response to the proposal put forth last spring by the National Governor’s Association (NGA) to restructure the Medicaid program. The NGA proposal included a similar recategorization of population groups and commitment to reducing the number of uninsured but suggested that a significant increase in enhanced federal matching funds should also be available to the states to assist them in this effort. HIFA provides a partial response to the NGA’s proposal but does not include any additional funding beyond providing greater access to SCHIP allotments. Analysis of the NGA proposal conducted by John Holahan of the Urban Institute found that, regardless of whether a state substantially expanded coverage or scaled back eligibility or benefits, the costs of operating the new Medicaid program would become primarily the responsibility of the federal government. States could save money without making any changes to their Medicaid programs just through the increased availability of enhanced matching funds.³⁰

While the NGA has been supportive of the new approach, it remains to be seen what states’ response to

the HIFA initiative will be, in light of the fact that it does not include additional federal funding as an incentive for expansion. Rather, the initiative assumes states will use the savings that result from benefit reductions and additional cost sharing revenues to finance eligibility expansions to additional populations. While states are not explicitly required to reinvest these savings in a health coverage expansion, the stated goal of the initiative is to increase the number of individuals with health insurance coverage, so presumably some sort of effort in that direction will be a condition of approval. And the proposals must be budget neutral, which means the cost to the federal government can be no greater than the costs would be in absence of a waiver.

Concerns have quickly been raised about the structure of the initiative and the significant effect it could have on particularly vulnerable Medicaid and SCHIP beneficiaries. With no maintenance of effort or reinvestment requirement, some states will likely discontinue benefits that are crucial to many of the beneficiaries considered “optional” under the HIFA initiative. About 11.7 million Medicaid beneficiaries—29 percent of the total Medicaid population—fall into this optional category and are at risk of losing benefits and being subject to increased cost sharing (Figure 2). Many individuals in this population still have incomes well below the federal poverty level.³¹

Figure 2
Mandatory and Optional
Medicaid Eligibility Groups, 1998



Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Another concern about the HIFA initiative is that, although recent outreach efforts in SCHIP and Medic-

aid have focused largely on healthy, low-income working parents and their children, the initiative will have significant spill-over effects on the elderly and disabled, who account for 75 percent of the Medicaid expenditures. States may be inclined to derive savings by imposing cost sharing on expensive items and services (for example, prescription drugs) that are disproportionately found in long-term care settings and among the elderly and disabled.³²

Despite the concerns, many agree that the HIFA initiative has come at an opportune moment for states. The increased flexibility gives them the opportunity to find savings at a time when overall Medicaid expenditures are projected to increase markedly (by more than 11 percent in FY 2002).³³ Even with the suggested 200 percent of FPL limit, there is still a great deal of room for expansion, especially for adults, and some states may decide to use the increased flexibility to fill in gaps in coverage that exist between children and their parents.

Community Health Centers

The third element of the Bush administration’s public health agenda is enhanced support for community health centers. Community health centers, which have about 3,000 service sites across the country, comprise a significant piece of the health care safety net for the uninsured and underinsured. It is unlikely that the need for their services and supports will diminish anytime soon. A number of more targeted funding sources are also available, including several block grants, administered by the Health Resources and Services Administration, for services such as mental health, substance abuse, and child development.³⁴ Thompson has made a commitment to “increasing by \$124 million funding for Community Health Centers in FY 2002, for a total of \$1.3 billion, as part of a multi-year initiative to support 1,200 new or expanded health center sites.”³⁵

LEGISLATIVE OPTIONS UNDER CONSIDERATION

In light of the current and growing budget crises among the states, some observers believe that only augmented federal funds will provide the financial incentive needed for state legislatures to authorize further expansions. Partly in response to this concern, a number of new options are being considered within the Congress that may encourage states to continue expanding coverage to the uninsured. In particular, there are a wide range of

legislative proposals for a refundable income tax credit to be used to purchase health insurance, as well as several bills, such as the FamilyCare Act of 2001, that would target additional federal funds to finance public coverage of the uninsured.

Refundable Tax Credit Proposals

At the beginning of the Bush administration, the president outlined a proposal to create a refundable income tax credit for the purchase of individual health insurance coverage for people up to age 65. In addition, several members of Congress have submitted a variety of legislative proposals to provide refundable tax credits. The maximum credits range from \$500 per individual covered by a policy up to \$3,600. Eligibility for the tax credits would be available on a sliding scale to individuals with annual gross incomes up to \$45,000 and families with gross incomes up to \$65,000 per year. Income eligibility would generally be based on the individual's prior year tax return. Several of the proposals could only be used to purchase coverage in the individual market, limiting the tax credit to those not participating in public or employer-sponsored health plans. Others would include individuals eligible for employer-subsidized coverage but would not permit them to use the tax credit to pay for premiums.

Individuals could claim the tax credit for premiums either as part of the normal tax-filing process or receive the credit in advance. The credit would be available at the time of purchase to be applied toward the individual's monthly premium payments. The White House estimated that their proposal could reach approximately 6 million uninsured individuals.³⁶

While bipartisan interest in utilizing tax credits has grown in Congress, some basic concerns must be addressed in order for such an incentive to be viable. Opponents of the tax credit proposals that do not allow the credit to be used to purchase group health plan coverage or supplement the cost of employer-subsidized group coverage note that real progress in lowering the number of uninsured cannot be expected. This is because most of the tax credit proposals are too small to enable low-income families to realistically afford to purchase a full year of private insurance coverage in the individual market. The General Accounting Office has estimated that the average cost of nongroup coverage for a family of four is \$7,352 per year, which would constitute at least 15 percent of the family's annual income at 300 percent of the FPL.³⁷

Analysts also raise the concern that, in the individual market, consumers may have a limited number of insurers

to choose from. Even with the tax credits available, individual insurance carriers have the ability to decline coverage for preexisting conditions and "frequently impose severe limitations and charge higher rates on coverage for expenses related to such conditions."³⁸

While there are some exceptions, it seems that most uninsured low-income adults are not going without insurance because they are simply choosing not to purchase coverage. Rather, the working poor have no insurance because the individual market is not an option for them. They cannot afford even the subsidized coverage that may or may not be offered through their employers. Among uninsured, low-wage workers, most are employed in jobs that do not offer health coverage or offer coverage that the employee cannot reasonably afford. Among full-time workers with incomes below \$20,000 almost half are not offered health insurance by their employers and many decline coverage because they cannot afford the premiums.³⁹ Despite concerns about the tax credit options on the table, the administration has noted that it will make the passage of a tax credit a priority, in absence of additional spending to expand SCHIP. Thompson said recently that these subsidies are "enough to put [the uninsured] over the top" in deciding whether to purchase a policy.⁴⁰

The gaps in the current versions of tax credit proposals and the uncertainty over the availability of funding guarantee continued debate. Some have suggested that the concept of expanding the availability of public coverage through Medicaid and SCHIP could be combined with some form of tax incentive for employers to encourage their participation in Medicaid and SCHIP premium assistance programs. Supporters of such an approach say that a public-private partnership with employers has tremendous potential and could be mutually beneficial to the states and the federal government, as well as to working families.

Leave No Child Behind?

The final area of significant interest in this year's health coverage debate is the possibility of additional funding for public coverage of low-income families. The congressional budget resolution that was adopted in May set aside \$28 billion over the next ten years—about one percent of the surplus that then existed outside of the Social Security and Medicare trust funds—to potentially expand health coverage to the uninsured.⁴¹ Statements made by Thompson, as well as other pieces of legislation that have been introduced in the Congress, indicate that using the \$28 billion to build on Medicaid and SCHIP to extend coverage to parents

would be a promising and popular strategy. This additional funding could provide states with a large financial incentive to capitalize on the enrollment success they have enjoyed over the past four years without enduring what is likely to continue to be a painful waiver negotiation process. In addition, say supporters of this approach, the flexibility and infrastructure already established in states' SCHIP programs would minimize start-up costs and lags in enrollment.

The legislation that has received the most attention thus far is the bipartisan FamilyCare Act of 2001, introduced by Sens. Edward M. Kennedy (D-Mass.) and Olympia Snowe (R-Maine) and co-sponsored by Sens. Susan Collins (R-Maine) and Lincoln Chaffee (R-R.I.), as well as the Democratic members of the Senate Finance Committee. FamilyCare would allow states to expand coverage to parents without rolling back existing Medicaid benefits. In addition, it would allow states adversely affected by the impending decrease in SCHIP funding (the so-called "SCHIP dip") to maintain their current coverage levels and expand coverage to parents as well. FamilyCare would also provide states with flexibility to use the new funds for other activities, such as covering legal immigrants barred from coverage by the welfare reform restrictions.⁴²

However, the actual availability of funds continues to be in question as the debate over the federal surplus heats up. Having a particularly dampening effect are the recent announcements of major declines in the projected budget surplus, which will not leave a great deal of room for major spending bills this year. And Thompson has indicated his concern that the slowing economy and increased budget pressures have decreased the chance that Congress will be able to fund proposals to reduce the number of uninsured and reform Medicare this year.⁴³

THE FORUM SESSION

The Forum session will look at the pros and cons of existing and potential opportunities for expanding public health coverage to the uninsured and underinsured. Presenters will share past experiences with the state-federal policymaking and implementation process and provide their insights into the prospects for the future.

Key Questions

The session will feature a discussion of the following questions between the presenters and participants:

- What are the most promising options for states in extending their programs to reach out to the unin-

sured while at the same time being mindful of budget limitations?

- How successful can partnerships with employers and the private insurance market be? Is there an approach or combination of approaches that might work best?
- How will the announcement of the HIFA initiative affect states' plans for future expansion or reforms in their Medicaid and SCHIP programs? Will open-ended Section 1115 demonstrations essentially overtake states' existing Medicaid and SCHIP programs?
- To what extent are concerns about substitution of private (employer) coverage immediate and what impact do these concerns have on policymakers in considering expansions to broader groups at higher income levels?
- Given the reduced likelihood that the Congress will pass a major spending bill this year, what administrative options can be pursued to further the goal of reducing the number of uninsured?

Speakers

Richard Curtis will discuss states' experiences with developing and implementing premium assistance programs in SCHIP and Medicaid and provide his perspective on the implications of the various tax-credit proposals being considered in the Congress. Curtis is the president of the Institute for Health Policy Solutions, an independent nonprofit organization founded in 1992. He has an extensive background in developing strategies for restructuring the health insurance market and developing approaches to cover uninsured workers and children. Curtis is also the founding executive director of the National Academy for State Health Policy.

Dennis Smith will discuss the administration's priorities in implementing the HIFA demonstration initiative and how the initiative is intended to assist in reducing the number of uninsured. Smith is the Director of the Center for Medicaid and State Operations (CMSO) at the Centers for Medicare and Medicaid Services. As director of CMSO, Smith has responsibility for administering the jointly funded federal-state Medicaid and SCHIP programs. Previously, he was director of the Virginia Department of Medical Assistance Services and directed the development of the state's SCHIP premium assistance program.

Michelle Walsky will share her past and present experiences with developing and implementing a

comprehensive Section 1115 demonstration to utilize SCHIP funds to expand coverage to parents, single adults, and legal immigrants. She will also discuss her experience with developing a partnership with employers as New Jersey implemented its Premium Support Program. Walsky is the chief of operations at the New Jersey Division of Medical Assistance and Health Services and currently oversees all of the operations related to SCHIP and Medicaid beneficiaries, including the NJ FamilyCare program.

Gordon Bonnyman will discuss the potential impact of the new proposals on low-income families and provide insights based on experiences with the TennCare program in Tennessee. Bonnyman has practiced poverty law since 1973 and is currently the managing attorney of the Tennessee Justice Center, Inc., a public interest law firm in Nashville. He has been heavily involved, as an advocate for consumers, in the design and implementation of TennCare, Tennessee's Medicaid managed care program, and has served on the Citizen's TennCare Review Commission since 1994.

ENDNOTES

1. This figure reflects the new adjusted Current Population survey data for federal fiscal year (FFY) 1999.
2. Tennessee's TennCare includes uninsured people of all incomes, although the state subsidy is limited to families with incomes up to 400% of the FPL.
3. Leighton Ku and Matthew Broaddus, "The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms," Center on Budget and Policy Priorities, Washington, D.C., September 5, 2000, 3.
4. Lisa Dubay, Genevieve Kenney, and Stephen Zuckerman, "Extending Medicaid to Parents: An Incremental Strategy for Reducing the Number of Uninsured," No. B-20, Series B, Assessing the New Federalism, Urban Institute, Washington, D.C., June 2000, 5.
5. Health Care Financing Administration, "Aggregate Enrollment Statistics for the SCHIP Program, 50 States and the District of Columbia, FY 2000"; accessed August 24, 2001, at <http://www.hcfa.gov/children.htm>. There were 3,333,879 children ever enrolled in SCHIP during FFY 2000.
6. Ku and Broaddus, "Importance of Family-Based Insurance Expansions," 6-7.
7. Ku and Broaddus, "Importance of Family-Based Insurance Expansions," 4.
8. Elizabeth Gifford, Robert Weech-Maldonado, and Pamela Farley Short, "Encouraging Preventive Health Services for Young Children: The Effect of Expanding Coverage to Parents," Pennsylvania State University presentation at the Academy for Health Services Research and Health Policy Conference, Atlanta, Georgia, June 12, 2001.
9. States previously had to request an "AFDC-U" waiver in order to drop the 100-hour rule, which limited coverage of two-parent families to cases in which the principal wage earner is working less than 100 hours a month or one parent is incapacitated. A final regulation converting the waiver authority into a Medicaid state plan amendment was published on August 7, 1998.
10. They may also use more restrictive eligibility standards but may not set them below the levels in effect in May 1988.
11. Sharon Silow-Carroll, Stephen E. Anthony, and Jack A. Meyer, "State and Local Initiatives to Enhance Health Coverage for the Working Uninsured," Commonwealth Fund Task Force on the Future of Health Insurance, New York, November 2000, 20.
12. Silow-Carroll, Anthony, and Meyer, "State and Local Initiatives," 21.
13. Kaye Kellis, Iowa HIPP unit, telephone conversation with author, June 21, 2001.
14. As of August 1, 2001, Massachusetts, Wisconsin, Mississippi, Maryland, Virginia, New Jersey, and Wyoming had received approval to use SCHIP funds to conduct premium assistance programs, either through a state plan amendment, a Section 1115 waiver or a combination of the two.
15. Section 2105(c)(3) of title XXI, the SCHIP statute, provides for a "Waiver for Purchase of Family Coverage" under which states may receive enhanced matching funds for the purchase of family coverage under a group health plan if the coverage (a) is cost-effective and (b) does not otherwise substitute for health insurance coverage that would be provided to targeted low-income children but for the purchase of family coverage.
16. Health Care Financing Administration, "Implementing Regulations for the State Children's Health Insurance Program; Final Rule," 42 CFR 457.810, Department of Health and Human Services, January 11, 2001, 2684.
17. NJ FamilyCare, "Health Insurance on the Job: How the Premium Support Program Works for You," promotional materials; accessed August 24, 2001, at <http://www.premiumsupport.org>.
18. NJ FamilyCare Fact Sheet, accessed May 8, 2001, at www.state.nj.us/humanservices/familycare.html.
19. Robert A. Rosenblatt, "Scarce Funds Imperil Bush Health Goals," *Los Angeles Times*, August 24, 2001.
20. Santa Clara County has received funding to provide a third tier of eligibility predominantly for undocumented immigrants with incomes up to 300 percent of the FPL. While not "universal" per se, the proposal will extend coverage to

individuals who would otherwise have no possibility of getting coverage through Medicaid/SCHIP.

21. For more information on the CHI, see Peter Long, "A First Glance at the Childrne's Health Initiative in Santa Clara County, California," prepared for the Kaiser Commission on Medicaid and the Uninsured, UCLA School of Public Policy, Los Angeles, August 2001.

22. "Kids' Insurance Program Proves a Healthy Success," *San Jose Mercury News*; accessed July 31, 2001, at <http://www.mercurycenter.com>.

23. "Kids' Insurance."

24. Health Care Financing Administration, "State Children's Health Insurance Program (SCHIP) Pending Section 1115 Demonstration Proposals," Department of Health and Human Services; accessed May 1, 2001, at <http://www.hcfa.gov/children.htm>.

25. Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability Demonstration Initiative," Department of Health and Human Services, August 4, 2001; accessed August 20, 2001, at <http://www.hcfa.gov/medicaid/hifademo.htm>.

26. Section 2103 of the SCHIP statute provides that states may offer any one of the following benefit packages: the health insurance plan that is offered by the HMO with the largest commercial, non-Medicaid enrollment in the state; the standard federal employees health benefit plan (FEHBP); the state employee benefit plan; a benefit package whose value is actuarially equivalent to one of the above; or coverage that is approved by the secretary.

27. The basic services must include inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and age-appropriate immunizations.

28. Budget neutrality requires states to assure that demonstration projects do not increase federal expenditures beyond what would have been spent under current law program requirements, in absence of a waiver. For further discussion of the HIFA budget neutrality requirements, see "HIFA Demonstration," section VII, 4-6.

29. CMS, "HIFA Demonstration," section VII, 3-4.

30. John Holahan, "Restructuring Medicaid Financing: Implications of the NGA Proposal," background paper prepared for the Kaiser Commission on Medicaid and the Uninsured, Urban Institute, June 2001, 14.

31. Edwin Park and Leighton Ku, "Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost Sharing for Low-Income Beneficiaries," Center on Budget and Policy Priorities, Washington, D.C., August 15, 2001, 3.

32. Park and Ku, "Administration."

33. "As Rising Drug Costs Boost State Spending on Medicaid, States Take Action to Encourage Use of Generic Drugs," *Kaiser Daily Health Policy Report*; accessed, August 29, 2001, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=6536.

34. For further information on issues surrounding the safety net, see Richard E. Hegner, "The Health Care Safety Net in a Time of Fiscal Pressures," background paper, National Health Policy Forum, Washington, D.C., April 2001.

35. Department of Health and Human Services, "The First 100 Days: Department of Health and Human Services," press release, April 27, 2001; accessed August 1, 2001, at <http://www.hhs.gov/news/press/2001pres>.

36. Mark McClellan, "Invest in Health Care: Refundable Tax Credit for the Purchase of Health Insurance," presented at a meeting of the Institute for Health Policy Solutions, Washington, D.C., May 18, 2001, briefing book pages 23-24.

37. Iris J. Lav and Joel Friedman, "Tax Credits for Individuals to Buy Health Insurance Won't Help Many Uninsured Families," Center on Budget and Policy Priorities, Washington, D.C., February 15, 2001, 3.

38. Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Institute for Health Care Research and Policy, Georgetown University, and K.A. Thomas and Associates, Washington, D.C., 3.

39. Lisa Duchon et al., "Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century," Commonwealth Fund, Washington, D.C., January 2000.

40. Rosenblatt, "Scarce Funds."

41. Jocelyn Guyer, "Congress Has a \$28 Billion Opportunity to Expand Coverage for Low-Income Working Families with Children," Center on Budget and Policy Priorities, Washington, D.C., July 18, 2001. The reserve funds make \$8 billion available in 2002, \$10 billion each in 2003 and 2004, with distribution at the Budget Committee chairman's discretion.

42. Park and Ku, "Administration," 8. The federal welfare reform law generally prohibits states from using Medicaid or SCHIP funds to provide coverage to legal immigrants to entered the United States after August 22, 1996, for their first five years of residence.

43. Robert A. Rosenblatt, "Scarce Funds Imperil Bush Health Goals," *Los Angeles Times*, August 24, 2001.