Children's Health Insurance: A Comparison of Major Federal Legislation

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What is the policy context for expanding child health coverage?

At the federal and state level, interest in expanding health coverage for children through new policies is high. Several factors underlie this growing interest:

- Children continue to be the largest group of Americans without health insurance, accounting for one out of every four uninsured persons in 1995.
- The number of uninsured children remains high despite expansions of Medicaid, in substantial part because of a decline in employer-based coverage, a trend which was well under way at the time of passage of Medicaid reforms in the mid-1980s.
- Public opinion polls show widespread support for the enactment of children's health insurance reforms.
- The health insurance reform legislation enacted in 1996 does not address the issue of affordable coverage; while sweeping reforms may not be possible, the current political climate makes enactment of incremental expansions aimed at improving coverage of children more feasible.

The federal legislative proposals reviewed in this comparison table should be read against the health policy context in which they have been introduced. From 1984 to 1990, Congress and the states significantly expanded coverage for children through the Medicaid program. However, by the early 1990s, concern about the cost of Medicaid expansions (which included pregnant women, children, disabled, and elderly populations) had grown. Most states resisted further expansions, and many called for a roll back of federal mandates. Between 1992-1994, national health reform proposals affecting the entire population were the center of the debate. Following the failure of large scale health reform efforts, Congress enacted the Health Insurance Portability and Accountability Act, which provides certain protections in continuity and portability for insured children but does not address affordability. Studies show that the cost of coverage (for employers or families) is one of the most significant barriers to coverage. In addition to Medicaid, more than 30 states offer some type of children's health insurance program which are financed through a combination of public and private funding as well as individual payments. Other states have proposals under consideration in their 1997 legislatures.

What is the status of children's health coverage?

- **Private insurance** covered 66% of children in 1994. This was the lowest level reported in the last 8 years.[1] The vast majority of private coverage is through employer-based plans. As dependent coverage has become less affordable for employers and employees, children were most likely to lose coverage. The percentage of children with private coverage decreased every year between 1987 and 1994. Near-poor children -- most of whom are just above Medicaid eligibility levels -- with family incomes between 101% and 150% of the federal poverty level (FPL) are among those most likely to have no employer-based coverage. Even children whose parents work full time or who have two parents have little protection against the absence of dependent coverage. In 1994, almost 25% of children with a parent working full-time did not have privately funded employment-based health insurance.[2]
- An estimated 10 million children (14%) have **no health insurance**, public or private (see Figure 1). Private insurance for children declined steadily between 1987 and 1994. Children in low-income, working families are most likely to be uninsured -- about one-quarter of children with family incomes below 150% of the federal poverty level (FPL) are uninsured, compared to 9% of those with higher incomes. Older children are more likely than those younger than 6 to be without coverage. An estimated 3 million uninsured children are eligible for, but not enrolled in Medicaid.[3]

- **Medicaid** covers about 25% of all children,[4] but eligibility decreases by age group, with roughly 40% of infants, 30% of children ages 1-6, and 20% of those ages 6-18 currently covered. Medicaid participation levels vary widely by state, depending on eligibility levels, differences in the extent of poverty, and outreach efforts (see Figure 2). For example, in 1994, the percentage of births financed by Medicaid ranged from 16% in Hawaii to 56% in Mississippi.[5] The percentage of non-disabled children under age 18 participating in the program ranges from 12% in Nevada to 39% in West Virginia.[6] More than 60% of Medicaid recipient children had a working parent in 1994, and a majority (54%) did not receive AFDC benefits.

- **State insurance initiatives** are in operation in more than half of states. These initiatives vary widely in scope and operation. Some states expanded Medicaid for children to 150% FPL or higher incomes (e.g., Hawaii, Michigan, New Mexico, Vermont, Washington). Other states subsidize premiums to assist families with uninsured children, sometimes in partnership with private insurance (e.g., Colorado, Connecticut, Massachusetts, New York, Pennsylvania). A Florida model uses a school system as a pooling mechanism for purchasing health insurance for children. And some state (e.g., Minnesota, New Hampshire) combine different approaches. Benefits in such programs may be only preventive, outpatient care or a comprehensive children's package that parallels the Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program.

What is being proposed?

In recent months, Members of Congress and the Clinton Administration have offered a variety of policy options for reducing the number of uninsured children. These range from a Medicare-style entitlement to cover all children who are otherwise uninsured to pilot demonstration programs for states to add coverage for a small number of children.

- **Children's Health Coverage Act** (S.13, Daschle, D-SD) - uses an income-adjusted, state-administered, refundable tax credit approach to subsidize premiums for private health plans, including employer-sponsored plans. The subsidies are primarily targeted to children with family incomes less than 300% FPL.

- **Healthy Children's Pilot Program Act** (S. 435, same provisions substituted as Title I of S.24, Specter, R-PA) - establishes a new trust fund and authorizes, but does not mandate, federal spending. The bill would provide "grants to states" for pilot programs using vouchers to subsidize employer and private insurance premiums for children in families with income below 235% FPL.

- **Healthy Start Act** (H.R. 560, Stark, D-CA) - creates a new entitlement modeled on Medicare, with expansion of benefits to meet the unique needs of children and pregnant women (financing similar to Medicare, i.e., payroll taxes).

- **Children Health Insurance Act** (H.R. 561, Stark, D-CA) - would provide income-adjusted, refundable tax credits to aid families in purchase of private coverage for children.

- **Child Health Insurance and Lower Deficit Act** (S.525/526, Hatch, R-UT and Kennedy, D-MA; H.R. 1263, Pallone, D-NJ and Roukema, R-NJ) - would establish a "state grant program" (in the form of mandatory federal spending and requiring state contributions) to assist families in purchase of child health insurance. Vouchers or direct payments, as well as direct service contracts with Community Health Centers, could be used. Program would be funded through tobacco tax increases.

- **Child Health Insurance Act** (H.R. 1363/1364 Johnson, R-CT and Matsui, D-HI) - uses same approach S. 525/526, except states may choose Medicaid EPSDT or Federal Employee Health Benefit Plan (FEHBP) as basis for benefits package.

- **Children's Health Insurance Provides Security (CHIPS)** (Chafee, R-RI and Rockefeller, D-WV) - modifies Medicaid (an entitlement program) to encourage enrollment of eligible children and pregnant women with family income below 150% FPL. Proposal would give enhanced federal financial participation for coverage expansion groups to those states which cover all children under age 19 with family income below 100% FPL and guarantee annual enrollment periods for children. The bill also includes a grant program for enrollment initiatives.

- **Child health insurance components of President's FY 98 Budget** (transmitted to Congress but not yet introduced as legislation) - proposes a three-pronged initiative to reduce the number of uninsured children that includes: a program of "grants to states" (in the form of mandatory federal spending and requiring state contributions) to assist families in purchase of coverage; short term assistance to unemployed families; and an initiative to identify and enroll Medicaid-eligible children.

- **Proposal to expand MCH Block Grant** (not yet introduced, Gramm, R-TX) - uses cuts in the Earned Income Tax Credit (EITC) and Medicaid savings (based on state flexibility provisions adopted by the National Governors' Association) to expand the Maternal and Child Health (MCH) Block Grant program (through discretionary funding) to insure more children.

These proposals generally seek to fill the gap between Medicaid and current private health insurance coverage levels. Most use approaches that are income adjusted, giving preference or higher subsidies to the poorest families. Several include mechanisms (e.g., penalties for employers or families) aimed at preventing further deterioration in employer-based coverage.

With the exception of those demonstration projects which give states full discretion to define benefits (i.e., President Clinton's grants to states), most proposals define a benefit package that would include comprehensive benefits (e.g., based on the Medicaid EPSDT package or the FEHBP). Several proposals would make insurance reforms beyond those contained in the 1996 Health Insurance Portability and Accountability Act, such as requirements for guaranteed issue of child health policies on those plans participating in voucher or tax credit programs.

Approaches to allocation of federal funds varies. Some would guarantee funding either by expanding individual entitlements (e.g., H.R. 560 and S. 674) or by establishing mandatory federal spending that functions as an "entitlement" to states (e.g., S. 525/526 and President Clinton's proposal). Other proposals use discretionary funding streams, requiring annual appropriations (e.g., Senator Gramm's proposal). In most cases, under mandatory or discretionary spending, states are required to match federal spending.

Several proposals would amend aspects of Medicaid. S. 674 is focused on Medicaid enhancements to enroll more near-poor children and to guarantee an annual enrollment period. The Clinton proposal would permit states to adopt annual enrollment periods for children in Medicaid and seeks to promote enrollment of eligible children. S. 561 would provide cost- sharing assistance through 100% federal Medicaid financing, and S. 13 includes a maintenance of effort provision requiring states to maintain the children's eligibility levels in effect on 7/1/96. Those proposals using private insurance expansions explicitly exclude Medicaid-eligible children from participation in these programs, but most do not require eligibility determination.

References

1. U.S. General Accounting Office. See *Uninsured and Children on Medicaid* (GAO/HEHS-95-83R, Feb. 14, 1995); *Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion* (GAO/HEHS-95-175, July 19, 1995); *Medicaid and Children's Insurance* (GAO/HEHS-96-50R, Oct. 20, 1995); and *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate* (GAO/HEHS-96-129, June 17, 1996).

2. Rosenbaum S, Borzi PC, DeGraw C, Wehr E, and Blake S. Health Insurance Coverage for Children: Background and Options for Reform. *Providing Universal Health Insurance Coverage to Children: Four Perspectives*, The Robert Wood Johnson Foundation, Princeton, NJ, 1996.

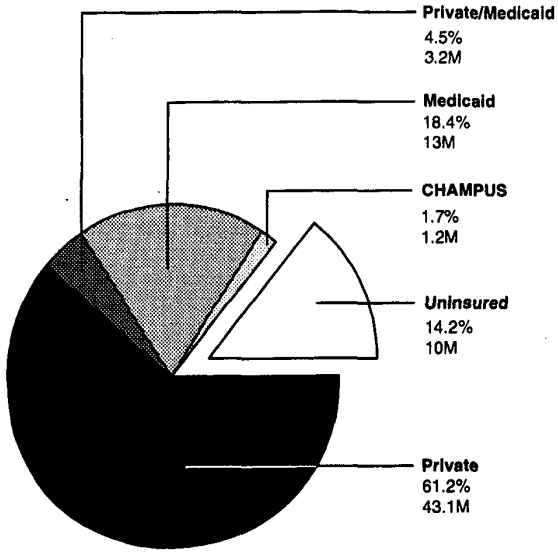
3. GAO, June 1996, op cit.

4. Liska D, Obermaier-Marlo K, Shah A and Salganicoff A. *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1988-1994.* (2nd edition) Kaiser Commission on the Future of Medicaid, Washington, DC, 1996. These are Urban Institute estimates based on HCFA 2082 and Current Population Survey data for 1994. Note that the GAO (June 1996, op cit) estimated that only 23% of children were covered by Medicaid in 1994.

5. National Governors' Association. *MCH Update*, Summer 1996. States not reporting include: Colorado, Georgia, Maine, New Jersey, North Carolina, and Rhode Island, as well as the District of Columbia.

6. Liska D et al. op cit. Note that 48% of children in the District of Columbia are Medicaid beneficiaries.

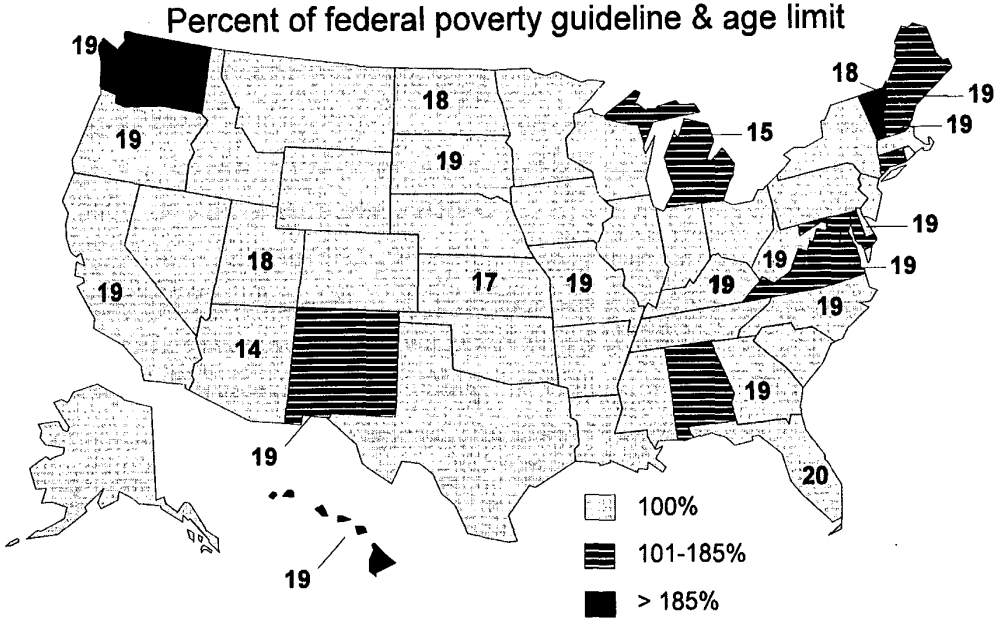
Figure 1: In 1994, 14.2 Percent of Children Were Uninsured



Note: M=million. Uninsured children are children who were reported to have no insurance coverage at all for the entire year. Children reported as having health insurance coverage may have been uninsured for some part of the year. Children with more than one source of coverage reported may have had duplicate coverage at the same time or may have had different types of coverage at different times of the year. CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. The Census Bureau includes other types of public coverage in the CHAMPUS coverage category, such as health coverage through the Indian Health Service or state-funded programs. For this figure, more than one source of coverage is shown only for children who have both private insurance and Medicaid coverage. Children with Medicare are included with the Medicaid group. Children with both private insurance and CHAMPUS coverage will be shown in the group with private insurance coverage. Children with Medicaid (or Medicare) and CHAMPUS insurance will be shown in the section for Medicaid.

Figure 2

Medicaid Eligibility for Children > 6



Federal requirement is 13 years; state expansions above 13 shown by upper age limit.

Source: U.S. General Accounting Office. Health Insurance for Children Private Insurance Coverage Continues to Deteriorate. June 1996.

Children's Health Insurance: A Comparison of Major Federal Legislation (As of May 1, 1997)

	Current Law and Status	Children's Health Coverage Act of 1997 (S. 13, Daschle)	Healthy Children's Pilot Program Act of 1997 (S.435, Specter)	Healthy Start Act of 1997 (H.R. 560, Stark)	Children Health Insurance Act of 1997 (H.R. 561, Stark)	Child Health Insurance and Lower Deficit Act (S.525/526, Hatch-Kennedy; H.R.1263, Pallone-Roukema; *H.R. 1363/1364, Johnson-Matsui*)	Children's Health Insurance Provides Security (CHIPS) Act of 1997 (S. 674, Chafee-Rockefeller)	President Clinton's Children's Health Proposal	Proposal by Senator Gramm
I. Status		• Introduced 1/21/97; referred to Finance Committee.	• Introduced 3/13/97; referred to Labor and Human Resources Committee. • Added to S. 24, as new Title I.	• Introduced 2/4/97; referred to Ways and Means Committee and Commerce Committee.	• Introduced 2/4/97; referred to Ways and Means, Education and the Workforce, and Commerce Committees.	• S. 525/526 introduced 4/8/97; S.525 referred to Labor and Human Resources Committee; S.526 referred to Finance Committee. • H.R.1263 introduced 4/9/97; H.R.1263 referred to Commerce Committee, as well as Committees on Ways and Means, and on Education and the Workforce. • *H.R.1363/1364 introduced 4/17/97; H.R.1363 referred to Committees on Commerce, and on Education and the Workforce; H.R.1364 referred to Committees on Commerce, on Ways and Means, and on Education and the Workforce.*	• Introduced 4/30/97; S. 674 referred to the Finance Committee.	• Presented to Congress 2/6/97 in FY 98 Budget Proposal. Legislative language transmitted to Congress 4/14/97. Principles only. No bill has been introduced.	• Proposal released 4/19/97. No bill introduced as of 5/1/97.

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II. General Approach * *Estimates of the number of children affected are based on calculations by the office of the Member of Congress issuing the proposal.*	• Approximately 10 million (14%) of all U.S. children under 18 have no coverage. • There is no universal system of health coverage for children, only various voluntary mechanisms. • The main sources of health insurance for children are employer-based, individually purchased, and Medicaid coverage. • Most uninsured children live in working families with incomes <250% FPL. • One-third of uninsured children are eligible for	• No estimates available on number of children assisted. • Proposes to reduce the number of uninsured children through federal tax subsidy to assist families with purchase of insurance on a voluntary basis for uninsured children who are ineligible for Medicaid and do not have primary coverage in another plan. • Subsidies go to the insurer rather than to families. • Subsidies could be used to purchase available employer coverage where available or a state certified health plan.	• No estimate on the number of children assisted. • Phased-in coverage beginning with children under 6 in FY 1999 and extending to children under 18 in 2002. • Voucher program would be financed through a children's trust fund valued at $10 billion over the FY 1998-2002 time period.	• No estimate on the number of children assisted. • Proposes to establish a mandatory federal program for all uninsured pregnant women (through their 60th postpartum day) and children who are ineligible for another qualified health plan (defined as any employee health plan or other health plan providing substantially equivalent benefits furnished under the bill). • Measure would extend to any uninsured child or pregnant women with no similar coverage with premium	• No estimate on the number of children assisted. • Proposes to reduce the number of uninsured children through a combination of refundable tax credits to assist families in purchasing health insurance on a voluntary basis for children and expansion of Medicaid to cover children with family incomes up to 150% of FPL. • Refundable tax credits would provide 95% subsidy for income (AGI) up to an "applicable dollar amount" ($15,000, plus $5000 for each additional qualifying	• An estimated 5 million children potentially eligible for assistance. • Proposes to reduce the number of uninsured children through grants to states to assist families purchase coverage on a voluntary basis for uninsured children not eligible for Medicaid or group health coverage. • State subsidies to purchase coverage under a certified plan. Mechanism could be: 1) premium subsidies to insurers, employers, or individuals, or 2) contracts with direct service providers (i.e., Community Health Centers-CHC). • Proposes to assist	• An estimated 5 million children assisted. • Builds on current Medicaid program. • Proposes state option for 12-month Medicaid enrollment to children under age 19 who are already eligible for program. • Augments Medicaid federal medical assistance percentage (FMAP) for certain groups of pregnant women and children in those states that have: - covered all children under age 19 with family income <100% FPL; and - guaranteed 12-month enrollment	• An estimated 5.7 million children potentially covered through various mechanisms. • Proposes to reduce the number of uninsured children through a three-part initiative, including: - federal payments to states of $750 million annually to assist families purchase coverage for children on a voluntary basis; - short term assistance to unemployed families; and - an initiative to identify and enroll Medicaid-eligible children.	• An estimated 3.2 million uninsured children assisted. • Proposes to assist uninsured children in families with income <200% FPL through $3.75 billion in grants to states(through the Title V MCH Block Grant program), funded mainly through cuts in the Earned Income Tax Credit (EITC). • Proposal would lift the cap on MSAs for families with income <200% FPL. • Proposal includes Medicaid

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General Approach (continued)	Medicaid but not enrolled. • States have an option to extend Medicaid to all uninsured children. Five states cover children under age 18 or 19 in near-poor families with incomes up to 185% FPL or higher.	• The health insurance credit would subsidize 10% to 90% of the premium, depending on family income (modified AGI plus tax exempt interest and social security benefits), not to exceed $75,000 AGI. The refundable individual credits (for families with income over 300% of FPL but less than $75,000 AGI) would equal 10% of the premium. • Proposes to reduce the number of uninsured women through a program of grants to states for pregnancy related care, with grants appropriated on a "such sums" basis.		liabilities collected through federal tax system.	child). Credits would phase out over next $10,000 AGI in excess of applicable dollar amount. • Proposes to make private insurance for children more available by mandating provision of children's health insurance coverage by health insurers and employee health benefit plans.	pregnant women through a program of grants to states. • Federal financing of $20 billion over 5 years, with state contributions equal to 40% of the state's Medicaid share, but not less than 10% of state's total spending for assistance under this program. • Program would be financed through a 43 cent increase in tobacco taxes. • *In H.R. 1363/1364, provisions generally the same as S. 525/ 526, with one major exception: states could set benefits package based on Medicaid or Federal Employee Health Benefits Plan.*	period for all children under age 19. • Enhanced FMAP available to expand optional coverage for: - pregnant women, infants, and children under age 6 with family income between 133-150% FPL; and - children ages 6 to 19 with family income between 100-150% FPL. • Proposes $25 million of an outreach grant program to enroll more eligible children in Medicaid, with grants to states, localities, and non-profit entities. Grants may be administered by MCH Bureau-DHHS.		reforms proposed by the NGA.

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III. Coverage Rules	• In 1994 among U.S. children: - 14% or 10 million children were uninsured in 1994 - 61% of children had private coverage - 18% of children had only Medicaid coverage. • In 1994, the percentage of uninsured children varied by income, with: - 22% of children with family income below 100% FPL; - 25% with family income 100-150% FPL; and - 9% of those with higher income being uninsured.	**Children** • Provides tax subsidies up to 90% of the average market premium for children under age 19 who: - are not eligible for Medicaid; - are citizens or qualified aliens; - live in families <200% FPL whose employer does not contribute at least 80% of the premium or between 200-300% FPL whose employer does not contribute at least 50%. • Subsidies phased out at $75,000 AGI. **Pregnant women** • Provides grants to states to insure women with income <300% FPL.	• Similar to S. 24 but phased in by age of child, beginning with implementation date: < age 6 in FY 1999 < age 9 in FY 2000 < age 13 in FY 2001 < age 18 in FY 2002.	**Children** • Provides coverage to children under 18 years old who: - are citizens, U.S. nationals, or permanent resident aliens; and - are not covered under a "qualified health plan" (i.e., private insurance policy, employer-sponsored plan, or federal or state program). **Pregnant women** • Provides coverage to pregnant women who: - are U.S. citizens, nationals, or permanent resident aliens; and - are not covered by a "qualified health plan."	• Provides refundable tax credit for up to 95% of the cost of a premium for a qualifying dependent, using an advance payment structure. • Qualifying dependents are dependent children under 21 years old who: - are American citizens or permanent resident aliens; - are claimed as dependents for tax purposes; - are not eligible for Medicaid; and - reside in states that have reduced their 1/1/97 Medicaid coverage standard.	**Children** • Children under 18 years old who are: - uninsured; - are citizens or qualified aliens; - are not eligible for Medicaid; and - were not covered under a group health plan during the preceding 6 month period *(est. 5 million)*. • Eligibility is to be determined by each participating state. Poorest children must be served first. **Pregnant women** • States have the option to spend up to 5% of total program budget for coverage of preventive and primary care services for pregnant women.	**Children** • Uses outreach grants and enhanced Medicaid FFP to encourage states to enroll all children under 19 years old who qualify for Medicaid, including: - children under age 19 eligible under current options (Sections 1902(l)(1)(D) or 1902(r)(2)); and - under new options children under age 6 with family income between 133-150% FPL, and ages 6 to 19 with family income between 100-150% FPL (*est. 5 million total*). **Pregnant women** • Same incentives to cover pregnant women 133-150% FPL in Medicaid.	• Uses several mechanisms to increase coverage for some groups of children, including: - programs to cover children whose parents are in-between jobs *(est. 700,000)*; - Federal payments to states to design programs for uninsured children *(est. 1 million)*; - unspecified efforts to enroll more eligible children in Medicaid *(est. 3 million)*; - new Medicaid option for states to use annual coverage periods for children; affects those who may lose eligibility due to change in family status *(est. 1 million)*.	N/A

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IV. Premium Assistance		• Premium subsidies, in the form of a tax credit available for children born after 12/31/84 who are citizens or qualified aliens and have family income below 300% FPL. • Sliding scale for subsidies based on income: < 200% FPL=90% 200-<225% FPL=80% 225-<250% FPL=60% 250-<275% FPL=40% 275-<300% FPL=20% and > 300% FPL=10% via a refundable tax credit. • Individuals pay same "reasonable" premiums compared to average premium set by DHHS and states.	• Vouchers are used to subsidize premium costs. • The amount of voucher is the lesser of: - annual premium paid by family for coverage of eligible child - voucher percentage based on income. • Families with incomes below 185% FPL will receive a voucher to cover the full cost of the premium. • Families with incomes between 185% and 235% FPL will receive a voucher to partially cover the premium according to a sliding scale.	•Individuals must pay premium for new Title XXI in the form of a tax imposed in an amount equal to premium liability. • Low income individuals are exempt from premium tax.	• Provides for full tax credit (95% of premium cost) available if family income is not greater than $15,000 plus $5,000 for each qualifying child. • Partial tax credit available for families with incomes not exceeding $10,000 more than the above amount. • Health insurance policies must be "reasonably priced," that is, premiums and other costs may not exceed 150% of average price for similar coverage offered in the state.	• Premium subsidies available for those who qualify based on eligibility levels determined by states, with priority to children in low income families and children with disabilities. • Subsidy may be applied to purchase of child-only coverage from companies contracting with the state or to the employee share of coverage offered by an employer. • States determine family contribution to premium . • For families with incomes below 185% FPL, premium contribution must be nominal (i.e., no greater than 5%).	N/A	• Temporary assistance for unemployed program is a "premium assistance" program. • State programs set up under federal grants may or may not use subsidy approach.	N/A

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V. Benefit Structure	• Medicaid's EPSDT program covers comprehensive benefits for children, including: preventive, primary, developmental, and long term care services. • Employer plans vary in scope of benefits, with most including preventive, primary, and inpatient services and few covering developmental, or long term care services. • State programs and private insurance plans vary in scope of benefits; most have preventive and primary care, but many do not include inpatient or long term care services.	• Benefits not specified. Benefits to be determined by states, based on DHHS definition of comprehensive coverage to include preventive, basic and catastrophic benefits. • Benefits can be offered through a family or a "child-only" policy.	• Benefits not specified. State pilot programs would use voucher to enable children to enroll in health plans that provide coverage for preventive, primary, and acute care.	• Core benefits as available under Part A and Part B of Medicare. • Adds "Well Child Care Benefit," including: - newborn and well baby care; - well-child services such as routine office visits, routine immunizations, routine lab tests and preventive dental care; and - EPSDT services. •Adds a benefit for prescription drugs and biologicals under new Title XXI. • DHHS, with AAP, will establish a schedule for Well Child Care Benefits.	• Core benefits as available under Part A and Part B of Medicare. • Adds "Well Child Care Benefit," including: - newborn and well baby care; - well-child services such as routine office visits, immunizations, routine lab tests, and preventive dental care; and - EPSDT services. • Adds a benefit for prescription drugs and biologicals under new Title XXI.	• Benefits are the same as those state provides under Medicaid (with comprehensive EPSDT benefit package). • Families can choose a "direct service" benefits through a Community Health Center (CHC). States contract directly with CHC to provide benefits. Services not available at the CHC provided through a network of providers or wrap-around insurance. • *In H.R. 1363/1364 qualifying policies' coverage is either:* *- equivalent to Medicaid benefits; or* *- comparable to benefit offered in the Federal Employees' Health Benefits.*	• Benefits for new optional groups are the same as those traditionally provided under Medicaid (with comprehensive EPSDT benefit package).	• Benefits not specified under program for unemployed families - must be generally equivalent to BC/BS Standard Option Plan available through FEHBP. • Benefits not specified under grants to states program. States determine benefits package based on state program approach.	N/A

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VI. Cost-sharing		N/A	N/A	• No deductibles, coinsurance or co-payments for well child services and for services for pregnant women.	• No deductibles, coinsurance or co-payments for well child services. • Cost-sharing assistance for qualified children with family income below 150% FPL (100% federally-financed through Medicaid).	• No cost-sharing for preventive services. • Cost-sharing may be required but must be limited to 20% for individuals below 150% FPL (with the exception of cost-sharing that is deemed by DHHS not to be a barrier to care).	• No cost-sharing for services provided to children and pregnant women under Medicaid.	N/A	N/A

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VII. Insurance reforms		• Guaranteed issue of family or "child-only" coverage. • Mandate to offer in group market, but no mandate to participate in individual market for federal contractors only (i.e., FEHBP). • Prohibits pre-existing condition exclusions and discrimination based on health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. • Plans may set limits across the board.	N/A	N/A	• Group health plans must offer qualifying coverage for eligible children whose parent(s) has group health coverage under the plan. • Each insurer that offers health insurance coverage must make health insurance available for purchase for eligible children under age 21. • Excise tax (penalty on insurers) for failure to meet coverage requirements.	• Most insurance reforms enacted in the Health Insurance Portability and Accountability Act (P.L. 104-191) (e.g., limits on preexisting conditions exclusions) apply to policies subsidized under this program. • States have flexibility to establish insurance reforms that are stricter or broader (i.e., provide greater protection or benefit to eligible children), but state must ensure that children have access to policies issued by insurers in the child's area of residence. • Policies must provide access to traditional providers.		• Insurance reforms enacted in the Health Insurance Portability and Accountability Act (P.L. 104-191) (e.g., limits on preexisting conditions exclusions) apply to coverage under the program for temporary assistance to the unemployed. • Proposal would lift the cap on medical savings accounts (MSAs) set at 750,000 health insurance policies in a demonstration project enacted last year in the Health Insurance Portability and and Accountability Act (P.L. 104-191).	N/A

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VIII. Treatment of Medicaid	• Medicaid coverage mandated for: - persons who meet AFDC income rules as of 7/16/96; - children born after 9/31/83 with family income <100% FPL; - <age 6 with income <133% FPL; - infants of mothers covered by Medicaid; - certain others (e.g., SSI , foster care). • Optional groups: - infants with family income <185% FPL; - ages 13 to 21 with income <100% FPL; - other children under liberalized income eligibility criteria (1902(r)(2)). • No cost sharing for children's services.	• DHHS required to establish procedures to identify children in the subsidy program who subsequently become Medicaid eligible (e.g., "spend down children who have high medical costs), so that Medicaid becomes the primary payer. • States are prohibited from decreasing Medicaid eligibility requirements effective 7/1/96 for coverage of children under the program. • To qualify for assistance, child must be found ineligible for Medicaid.	• Family is not eligible for voucher if family is eligible for coverage under Medicaid. • To qualify for assistance, child must be found ineligible for Medicaid.	N/A	• Cost-sharing assistance for qualified children with family income below 150% FPL (100% federally-financed through Medicaid).	• To qualify for assistance, child must be found ineligible for Medicaid. • States must maintain children's Medicaid eligibility rules in place as of 1/1/97 (except for modifications in a Section 1115 waiver application).	• To qualify for assistance, child must be Medicaid eligible. • Augments Medicaid federal medical assistance percentage (FMAP) for certain groups in states that: cover all children under 19 with income <100% FPL; and guarantee 12-month enrollment period for children • Coverage groups for enhanced FMAP: - pregnant women and children under 6 with income 133-150% FPL; and - ages 6-18 with income 100-150% FPL. Enhanced FMAP = ((100-FMAP) x 30%) + FMAP. Total not to exceed 90%.	• Permits states to extend continuous Medicaid coverage for 1 year after eligibility is determined. • Outreach efforts to enroll additional Medicaid-eligible children (mechanism not specified).	N/A

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IX. Treatment of employer-based coverage		• Employer-sponsored plans are prohibited from treating eligible employees differently from their other employees with respect to provision of health insurance. • Employers who drop family coverage cause employee's children to be program ineligible for tax benefits for a 12-month period.	N/A	• Administrators of qualifed health plans are required to make an annual report to the IRS, as well as statements to the primary insured individual or the spouse or dependent of a primary insured individual upon request.	• Employer of employees using children health insurance credit makes payments on their behalf. • Employer payment is equal to credit advance amount of employee.	• Financial assistance may be applied to employee share of coverage offered by an employer. • Employers are not required to offer a child-only policy to eligible children. • Employers who drop family coverage must terminate coverage for all their employees.	• Employers who choose to make contributions to employee or dependent coverage may not condition or vary contributions based on an individual's Medicaid eligibility status. • Enforcement of the employer requirement is based on the provisions for group health plans contained in the Health Insurance Portability and Accountability Act (P.L. 104-191, Section 110(e)(2)).	N/A	N/A

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X. Treatment of children with special health care needs		• Prohibits discrimination based on disability and *mental and physical* illnesses. • Prohibits preexisting condition exclusions.	N/A	N/A	N/A	• States must ensure that policies provide access to pediatric *primary and specialty* care providers, including centers of pediatric specialized treatment expertise.	• States must use Medicaid EPSDT comprehensive *benefit package*, including all treatment services medically necessary and covered under Federal Medicaid law, in coverage of all children in optional groups.	N/A	

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XI. State Role	• Multiple approaches to financing children's health insurance. • States administer Medicaid. In general states determine the eligibility process, payment levels, providers, etc. State Medicaid programs use options and waivers to further modify program eligibility categories, benefits, payments, and provider types. • Over 30 states operate child health insurance initiatives such as premium subsidy programs, insurance pools, etc. Some use Medicaid options, private insurance mechanisms, or both.	• State insurance commissioners certify health plans. • States are responsible for collection of premiums and payments to plans. • States to establish and maintain enrollment system, including informing and simple application. • State maintenance of effort in Medicaid required (see above).	• States design and administer pilot voucher programs within federal block grant guidelines. • Maintenance of effort provisions require states to maintain expenditures for state programs designed to provide health coverage for children at less than the level of the preceding fiscal year.	N/A	• States administer programs, including contracts with insurers to offer "child-only" coverage and collection of premiums. • States to establish and maintain enrollment system, including informing and simple application. • States notify health plans when families become eligible. • Grants to states for insurance outreach and information programs targeting child health.	• State participation is voluntary. Participating states contribute at 40% of Medicaid state share but no less than 10% of state spending in subsidy program . • States determine structure including: - eligibility levels (priority to children in low income families and with disabilities); - family contribution to premium cost; - cost sharing (capped at 5% below 185% FPL); and - benefits package. • States administer program through: - contracts to private insurers or CHCs; and - subsidy payments.	• State participation is voluntary. • States must adopt optional coverage for all children <100% FPL and guarantee annual enrollment to qualify for enhanced FMAP. • States (or localities or non-profit entities) may apply for outreach grants.	• Program for unemployed: states select method to administer (e.g., through Medicaid, COBRA, or an independent program). • Federal payments to states to design and administer child health insurance programs; states match federal dollar. • States to play a role in increasing enrollment. • For Medicaid annual enrollment periods for children over age 1, state action would be required in order to adopt proposed new option.	N/A

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XII. Financing	• Federal-state entitlement funding for Medicaid, in which a set federal contribution is made to states for each dollar spent. • Employers have tax deduction for contributing to employee health benefits. Typically, employees make a contribution to health benefit costs. Some employers "self-insure," that is they do not use outside insurer.	N/A	• Financing through a Healthy Children's Trust Fund generated through auction and licensing of spectrum broadcast licenses. • Authorization (funds to be appropriated from the Healthy Children's Trust Fund) set at: $250 million FY 1998; $1.35 million in FY 1999; 2.05 million in FY 2000; $2.7 million in FY 2001; and $3.65 million in FY 2002.	• Similar to Medicare (i.e., payroll taxes). • Additional tax imposed on individuals above 100% FPL to cover the premium cost under new program. • Establishes a Childrens Health Insurance Trust Fund. • Development of new DRGs and weights for provider reimbursement. • Phases in tax on income-adjusted basis for families of covered individuals.	N/A	• 43 cent per pack increase in the federal cigarette tax and similar increase in tax on other tobacco products. • Over 5 years, 2/3 of the revenues raised by the tobacco taxes will be earmarked for this program and 1/3 (an estimated $10 billion) will be used to reduce the federal deficit. • Funds distributed to states based on number of uninsured, eligible children <18 relative to the total number of children in all participating states in the base year.	N/A	N/A	N/A
XIII. Estimated Cost						• $20 billion over five years.	• $25 million per year for outreach program.	• For grants to states, $3.8 billion over 5 years; program for unemployed $9.8 billion over 5 years.	• $3.75 billion over five years.