

OPTION 3: KIDS FIRST COVERAGE

Implementation Start: January 1, 1995

Phase-in: By Population, Beginning with Children

Universal Coverage Achieved by: January 1, 2000

SUMMARY

This proposal phases in universal coverage, minimizes the financial burden of the program at the outset, and covers the most vulnerable of our citizens--children--as quickly as possible. Under this approach, health care reform is phased in by population, beginning with children. Other populations are phased in as follows:

Employer Groups: July, 1997

Individuals: January, 1998

Medicaid: January, 2000

States may be granted a grace period under certain circumstances.

This proposal is designed in two parts which will be implemented simultaneously:

- I. The quick coverage of children--"Kids First"; and,
- II. the development of structures for transitioning to the new system and the phasing in of certain population groups.

Part I, Kids First is really a precursor to the new system. It is intended to be freestanding and administratively simple, with States given broad flexibility in its design so that it can be easily folded into existing/future program structures. The Federal government, States, and the private sector will play a role in its implementation and financing.

Part II of this proposal involves the development of purchasing cooperative (PC) structures and the actual phase-in of all other population groups within the PC system.

PART I - KIDS FIRST

Stage 1 - Kids First: All employers not covering children will be mandated to do so by January 1995.

PROGRAM STRUCTURE

The Federal government, States, and the private sector will play a role in its implementation.

- The **Federal government** will finance the subsidization of the program (including subsidies for individuals and employers), technical assistance to States and State program administration. Additionally, the standard benefit package will be community rated and established at the Federal level; children's coverage will be Federally mandated on States and employers.
- **States** will have the full responsibility for program implementation and administration, including the administration of subsidies, regulation, oversight etc. States will be given very broad authority to implement the mandate, and would not be expected to have the PC structure in place in order to implement Kids First. States could use their Medicaid program, set up another plan, or allow employers the option to "buy-in" to any structure the state developed, including Medicaid.
- **All insurance companies** will be required to offer the children's standard benefit package. **All employers** will be required to pay at least 80% of the bench mark premium.

PROGRAM GOALS

- Provide all children with health care coverage as quickly as possible.
- Keep the approach simple, that is, keep the administrative and program demands of enrolling children as simple as possible. Leave the resources of the State focused on developing PCs and the infrastructure for the new system, including various reforms identified in Part II.

- Provide minimum disruption to current/future program structure and coverage.

ELIGIBILITY FOR KIDS FIRST

The following children will be eligible for Kids First:

- Uninsured children in working families - Employers will be responsible for assuring the coverage of all children either through a private insurance plan or a plan offered by the State.
- Uninsured children in non-working families - States will be required to cover children in non-working families who are currently not eligible for Medicaid.
- Children covered by Medicaid - Children who receive Medicaid benefits because they are categorically eligible or medically needy will remain in Medicaid. For children who fall under any other Medicaid category, states can either enroll them in a new state plan or keep them on Medicaid.

PROGRAM FINANCING

- Several funding streams including employers, government and families will finance Kids First, and it will be administered by States.
- Although States will have the option to establish PCs and to begin phasing in Medicaid or any adult groups in advance of the phase-in dates, no additional Federal funds will be available prior to the dates specified. Additionally, as other groups are phased-in, children in Kids First will be phased into PCs in order of parental coverage, i.e., children receiving coverage through parent's employers will be phased in July 1997, children receiving coverage in State plans and/or Medicaid (non-categorically eligible children) in January 1998, and all categorically eligible children in January 2000.
- The employer mandate will mirror employer/employee premium contribution levels present at full enrollment; e.g., 80/20. (Tax incentive structures will be contingent on decisions made by the Coverage Groups.)
- Subsidies will be available for both the employee and employer portion of the premium and will be Federally financed. (See subsidy discussion.)

- States will be held to a maintenance of effort for their current children's programs; e.g., Medicaid, crippled children's programs, other child health programs, etc..

PROGRAM ADMINISTRATION

- States will have full administrative responsibility for implementation, operation and oversight of the program.
- States will be given maximum flexibility to design and develop a program that meets the needs and complements the existing/future designs of their State health care program.
- States will have the flexibility to fold children into existing Medicaid programs or to develop other plans/PCs.

States could:

- Develop a State plan for the enrollment of children. A State could opt to allow employers to "buy-in" to the State plan.
 - Use the Medicaid program, or a subset of the administrative functions used to operate the Medicaid program, e.g., the fiscal agent. Also, States could allow the employers to "buy-in" to Medicaid.
 - Contract with health plans, such as HMOs, to serve the children and allow employers to "buy-in" to the State program. Conversely, employers could be allowed to contract directly with the same plans which the State may have certified to serve children.
 - Use the purchasing cooperative or similar structure if available.
 - Require state insurance commissioners to oversee the operation of state plans and private plans to assure comprehensive coverage and access to the newly defined Kids First standard benefits package.
- States may be granted a grace period for the phase-in of children under certain circumstances, e.g., if States can demonstrate that their PC structure will be in place within

six months, they may be allowed to delay the phase-in of Kids First.

- By July 1997, States will be required to develop fully established PCs.

Rationale

- This approach gives States maximum flexibility to design their programs to meet State needs. It allows States which are ready for full PC implementation to proceed, while not penalizing States needing additional time and resources to develop PCs.
- Requiring States to upgrade health benefits offered by private plans to the standard benefit package level will assure that family coverage, currently provided by the employers, will more likely be kept together before the employer the mandate. This will help facilitate an easier phase-in to PCs.
- Studies have shown that when family plans are split, parents tend to opt for plans that will assure continuous coverage for their children. Given this, it is assumed that market forces will keep down the cost of health plans. That is, plans will have incentives to lower prices, with the assumption that they will attract parents, who tend to be young and healthy, later.

Considerations

- Despite the stated goal of simplicity, the program would still require substantial effort on the part of States with the possibility of limited returns, i.e., any structures developed, which are not consistent with the PC structure, will not have a long term pay off and may be very costly to develop.
- States have indicated that many of the administrative structures necessary for full implementation of health care reform will be required in the development of Kids First. They

believe that this will be administratively burdensome and costly.

- Some States have shown a preference for a phase-in approach not predicated on the enrollment of population groups.
- We are exploring administratively simple alternatives to monitor plan operation, to provide oversight of plan financing and to define data and systems requirements for program implementation.

BENEFIT COVERAGE1. Standardized Benefit Package

- In January 1995, all children 0-18 years of age will be covered by a standardized benefit package as defined by the Benefits Workgroup.
- Employers currently covering children will be required to bring their coverage package for children up to the standard benefit package.

Rationale

- Many plans currently covering low-income families are very minimal, often offering little more than catastrophic coverage. Requiring plans to upgrade their coverage to the standard benefit package would improve coverage for children--plans will be required to do so under the employer mandate, anyway. Additionally, insurers may be very willing to offer the children's standard benefit package, with the goal of attracting adults to select them during Part II of this phase-in approach.

Considerations

- Kids First requires that employers already covering children bring their plans up to levels specified in the children's standard benefit package. Under this approach, employers may drop adult coverage if they are required to provide a richer children's benefit--family coverage may be adversely affected.
- Mechanisms to monitor these changes in employer benefit packages need to be explored.
- Data requirements for the development of community rating of children's benefit packages need to be explored.
- It may be difficult for employers to renegotiate contracts with insurers to bring their children's benefit package up to the mandated standard benefit package.

- Federal law will require that any entity offering insurance to offer the standard benefits package.
- The standard benefit package will be community rated.
- Medicaid services not covered in the standard benefit package; (e.g., long-term care, transportation, etc.) will not be included in Kids First--even if the State elects to use Medicaid as the vehicle to cover currently uninsured children.

Rationale

- The standard benefit package is likely to be rich enough to provide services comparable to those in the EPSDT Program (e.g., immunization, well-child visits, screening, other preventative services, etc.).
 - States have generally elected not to include long-term care services in their State-funded uninsured children's programs (e.g., Minnesota Care). These decisions were made to curb costs and with the expectation that children will not use many long-term care services anyway.
2. Supplemental Coverage and Long-Term Care - These benefits have been addressed by the Benefits and the Long Term Care Groups and are not available in Kids First. However, the phase-in of these services will begin in 1997 when the full employer mandate is implemented.

Rationale

- The decision to exclude supplemental coverage and long-term care benefits from Kids First was made on the basis of administrative simplicity and cost.

Considerations

- If States elect to use the standard benefit package to cover children, traditionally eligible for Medicaid by poverty-level groups, these children may receive a less rich benefit package than they would have received under Medicaid.

3. Mental Health - Addressed by Mental Health Group.

SUBSIDIES

- Subsidies will be federally financed.
- Low-income working families and employers will be eligible for subsidies to cover premium costs.
- Deductibles would be waived, however, coinsurance would be allowed.
- Subsidies will be determined using a Federal formula on a national basis and States will use either the current welfare system or a new agency to determine individual and employer eligibility.
- Total family out-of-pocket expenditures for coverage under Kids First would be capped at 2 percent of total family income.
- Subsidies for individuals will be determined on the basis of family income (asset and resource tests currently used in Medicaid will not be applied).

[IMPLICATIONS OF THIS APPROACH AND ADDITIONAL OPTIONS ARE BEING EXPLORED.]

Rationale

- Several approaches were considered regarding employer and individual subsidies. However, not offering subsidies to employers could have a negative economic impact on States and small employers.
- Not offering subsidies to individuals could adversely affect low-income families covered by Kids First.
- Offering employers subsidies may prevent them from attempting to offset the cost of offering children's coverage by laying-off low-wage workers, not hiring additional employees or not hiring employees with children, etc.

- We continue to explore employer and individual subsidy approaches which would be administratively simple and encourage economic development.

Considerations

- Arguments against the provision of employer subsidies in Kids First include the concern that employers not covering children will be preferentially treated over those who already do.
- Subsidy programs are difficult to administer. States have indicated that regardless of how much flexibility they are given to implement a subsidy program, it will be administratively difficult under the short time-lines. Concerns are also raised that changes will need to be made once the subsequent stages of this phase-in are implemented.

MEDICAID INTERFACE WITH KIDS FIRST

- Until the Medicaid program is phased in completely, legislation will be developed to provide States with additional flexibility to administer the Medicaid program so that it may complement Kids First and the smooth transition to the PC and managed competition structure.
 1. Services (Long-Term Care, etc.)
 - To the extent that an employer mandate enrolls otherwise Medicaid-eligible children into private plans or these children are enrolled in a State Kids First, these children would likely lose the comprehensive benefits they now receive under Medicaid; e.g., early and periodic screening, diagnosis, and treatment. Requiring employers to cover these services may be prohibitively expensive.
 2. Groups (Spend-Down, Institutionalized Kids, Medicare/Medicaid Dual Eligible)
 - Enrolling Medicaid-eligible children into the new system first or through employer-provided coverage

could negatively impact the Medicaid eligibility of their parents because, presumably, their children would not be counted as part of the standard filing unit.

- To alleviate these types of eligibility issues, States should be given the flexibility to develop new eligibility policies that would facilitate the implementation of Kids First and the subsequent development of the PC managed competition structure.
3. State Maintenance of Effort
- The Kids First option could allow States to fold Medicaid children into a State children's program. If so, then the State's contribution into the PC system, if based on Medicaid spending during or after this transfer had taken place, would reduce the State's maintenance of effort payments. Adjusting for this lowered Medicaid enrollment in the maintenance of effort calculation could be administratively complex.
 - Conversely, if low-income children are enrolled first into Medicaid, as an easy way to provide them subsidized care in the short-term, this could also complicate the maintenance of effort standard by inflating State Medicaid spending. The extent of this difficulty depends on the base year for determining maintenance of effort.

PART II - PHASE IN OF OTHER POPULATION GROUPS

Stage One: Investment and Preparation

Duration: 2 years and 7 months (43 months)
Start Date: January 1, 1994
Completion: July 1, 1996

The following processes are undertaken simultaneously.

Preliminary Staff Working Paper for Illustrative Purposes Only

Federal Rule-Making

- Interim final rules will be promulgated.
- A lead agency is established or designated to review and respond to public comment.

Model State Legislation and Rules

- The lead agency will develop models of enabling legislation and regulation for States.

Federally-Supported Technical Assistance for States

- Planning grants are provided to States to develop their internal capacity.
- Technical assistance is Federally supported to provide expertise to the States.
- Key implementation tasks are conducted Federally to relieve the States of administrative burdens.
- The development of supporting information systems is undertaken.

Federal Investment in Rural and Underserved Areas

To develop capacity in rural and underserved areas, targeted investments will be made during the transitional period.

- Investment funds are provided to build capacity and promote the development of community-based health plans where they do not currently exist.
- Provider-workforce initiatives are undertaken to train physicians for underserved areas.

System Reform Initiative

In order to relieve the current health care crisis, national reforms are immediately undertaken in the following categories:

1. Insurance reforms
2. Malpractice reforms
3. Short-term cost controls

4. Administrative simplification
5. Preemption of State anti-managed care laws
6. ERISA Reform to allow states to mandate employer coverage

State Requirements

During this period, States will pass enabling legislation using the Federally established model. Following the passage, States will submit a plan describing the operation of purchasing cooperatives which meet "minimum Federal requirements." The Department of Health and Human Services (HHS), or another designated Federal entity, will have one month to acknowledge the States' adherence to minimum Federal requirements or return the plan for amendment.

Stage Two: Last Minute Things

Duration: One Year
Start Date: July 1996
Completion Date: July 1997

Establishment of Purchasing Cooperatives (PCs)

With Federal "approval," States will establish purchasing cooperatives, conduct negotiations with health plans, and begin enrolling all eligible persons into health plans or fee-for-service plans offered through purchasing cooperatives.

Federal funding to establish PCs will become available on July 1996 to States, contingent upon Federal approval of their plans. (As a stronger incentive, we could opt to provide Federal funding for PCs before July 1996.)

Other Reforms

In addition, the investment and "other reforms" will be continued.

Stage Three: Employer Mandate

Duration: States will have the time between the passage of Federal legislation and date-certain to phase in the employer mandate.

Completion Date: July 1, 1997

Coverage Through the PCs

On July 1, 1997, all employers will be required to purchase health plans for their employees through PCs.

Children receiving coverage through parent's employers will be phased in with their parents.

Federal subsidies to eligible individuals and firms will become available through mechanisms determined by the States.

Stage Four: Individual Mandate

Duration: States will have the time between the passage of Federal legislation and date-certain to phase in the individual mandate.

Completion Date: January 1, 1998

Coverage Through the Purchasing Cooperatives

By January 1, 1998, States will assure coverage of self-insured and unemployed individuals through the PCs.

Children receiving coverage through a State plan and/or Medicaid (non-categorically eligible) will be phased in with their parents.

We are exploring the option of bringing in early retirees with benefits at this time.

Federal subsidies will become available on date-certain to qualifying self-insured unemployed individuals.

Other Reforms

Workmen's Compensation Reform will be required by January 1, 1998.

Stage Five: Medicaid

Duration: States will have the time between the passage of Federal legislation and date-certain to phase in individuals receiving acute Medicaid benefits.

Completion Date: January 1, 2000

Coverage Through the PCs

- By January 1, 2000 States will assure coverage to individuals (under 65) receiving Medicaid benefits through PCs for acute care services. Non acute-care services will be left in tact with Medicaid as a residual program.
- Children receiving coverage through Medicaid (categorically eligible) will be phased in for acute care services.

Aftermath: States Failure to Implement Mandates

As of January 1, 2000 Federal tax credits for the purchase of health insurance will only apply in those States which have established universal coverage through PCs.

The National Health Board (NHB) will be required to monitor the State implementation of each mandates and will be given the authority to grant grace periods based on States' efforts toward implementation.

If States fail to comply with various mandates and have not demonstrated sufficient efforts toward implementation, then the Secretary of HHS or the NHB will have the authority to establish a Federal health care program in that State. The nature of the substitute system will not be specified in legislation to give the Secretary or NHB sufficient flexibility to create a workable system at the time within the constitutional constraints.

It is believed that such Federal programs will not become necessary for the following reasons:

1. Provision of medical security to all State residents;
2. cost control;

3. States must implement the new system to receive financial assistance which will result in the removal of great financial burden for states;
4. relief from short-term cost controls; and
5. other funds or initiatives are tied to implementation.

Other Transitional Issues

Interagency Task Force

In the transition period, the White House will announce the establishment of an interagency task force and lead agencies to perform Federal functions related to implementation.

The National Health Board (NHB)

The interagency task force established by the White House will assume the functions of the NHB until it becomes operational.