

## **Children's Health First Act**

It is a disgrace that in the wealthiest country in the world, nearly nine million children lack health coverage. Nearly two thirds of those without coverage are in low-income families and more than half are in working families. These children are significantly less likely to visit a doctor when they are sick and receive the care they need to stay healthy.

Children are inexpensive to insure. It costs less than \$3.50 a day – less than the cost of a Starbucks Frappuccino – to provide a child with health coverage. For the cost of one MRI machine, 1,640 children could be insured for a full year.

The short-term investment in children's health pays off in long-term results. Children without health insurance are less likely to receive care for health problems, putting them at greater risk for hospitalization or even death. Children in good health have a better mastery of the skills needed to succeed in school. The lack of health insurance has also been linked to obesity, a rising epidemic.

The Children's Health First Act, introduced by Representative John D. Dingell and Senator Hillary Rodham Clinton, would make quality, affordable healthcare coverage available for all children. The bill would provide States with the incentives and resources to expand existing State programs for children. It would also provide States the tools and resources to identify and enroll the six million children who are eligible for existing State programs, but are not enrolled. In addition, it would provide new incentives to shore up employer-sponsored coverage for children.

### **Incentives to Expand Children's Health Coverage**

The bill creates Federal funding incentives to States that expand children's health coverage in families up to 400 percent of the Federal poverty level (which is \$70,000 for a family of three) through the State Children's Health Insurance Program (SCHIP). There are increased Federal payments for States that expand coverage below that cap as well.

In order to receive these new funds, States must make quantifiable efforts to insure children who are currently eligible for coverage in public programs but have been left out. For example, States must permit children to enroll in the public coverage programs for twelve months, an allowance currently afforded to private coverage programs. States will also be required to expedite the enrollment of qualifying children by eliminating waiting lists and enrollment caps in their programs.

### **Affordable Options for Employers and Children to Buy into SCHIP**

States can allow employers or families to purchase quality affordable coverage for children, so long as States cover children in families up to 200 percent of the Federal poverty level (which is \$35,000 a year for a family of three). Employers or families would be responsible for paying the full cost of the premium for the child being covered. In 2007, the cost of covering a child in the SCHIP was approximately \$1,220 a year.

### **Protecting Employer-Sponsored Coverage**

States can provide financial assistance to ensure that employers can continue covering children in their family policies. States can provide this help to employers if States reach the goal of covering children in families up to 400 percent of the Federal poverty level (which is \$70,000 for a family of three).

Specifically, States can pay the employer a subsidy of up to 50 percent of the cost the State incurs to insure the child. The Federal Government would partner with the State in providing this subsidy. The coverage offered by the employer would need to be similar to the benchmark benefit packages that States offer under their SCHIP programs. In the event that the employer package does not provide benefits equal to the SCHIP benchmark packages, then States would need to fill in any gaps in benefits or cost-sharing.

### **Ensuring A Fair Federal Partnership**

Starting in 2008, State funding would be based upon the 2007 State spending in SCHIP indexed each year by the per capita increase in national health expenditures and a State's child population growth.

States that increase enrollment of children in excess of ordinary population growth would receive adequate funding per each new child covered. This should encourage States to identify and enroll the six million children that qualify for public programs but are not currently enrolled. It should also ensure that States have the funding necessary to provide health services.

States would have two years to spend each year's Federal funding amount. Unspent funds would be redistributed proportionately from States that did not spend all their money to States that did not have enough money. State funding amounts would be rebased every two years on the previous year's spending in order to more accurately reflect what was spent by each State.

### **Other Program Improvements and State Flexibility**

States would have a number of new coverage options under the Children's Health First Act. States would have the option to offer affordable coverage to children up to age 25. States would also have the option to offer coverage to children of State employees in families who otherwise meet the income requirements. In addition, States could also offer coverage to legal immigrant children and would have new incentives to offer coverage to pregnant women.

The Children's Health First Act would provide States with greater flexibility in administering citizenship and identity documentation requirements and modify two of the existing State benchmark plans to ensure the best possible coverage for children.