

THE MCCAIN HEALTH PLAN & CHILDREN'S COVERAGE

BY HARBAGE CONSULTING, LLC

Republican presidential nominee and Senator John McCain's (R-AZ) health plan is based on the promotion of the individual market over employer-sponsored health insurance. This would be a major shift from today's system. This paper looks at the impact of the McCain health plan on America's children, and proposes changes to the McCain plan that could help protect children. More specifically, this paper discusses several key concerns that would need to be addressed by the McCain campaign for the plan to better serve children.

- **The McCain tax credit will weaken families' ability to afford coverage for children.** The McCain plan's health coverage tax credit is insufficient to make coverage affordable and does not keep pace with growth in the cost of health care premiums. In 2008, the average premium for family coverage was \$12,680, which would leave families with premiums of \$7,680 after the \$5,000 tax credit. Because the tax credit is a fixed amount not set to rise with medical inflation, this shortfall will be approximately \$13,400 by 2014. Additionally, the "one-size-fits-all" premium does not change with family size, thus penalizing large families. Nor does it change for families living in states with higher than average premiums.
- **The 19 million children currently with employer coverage could be barred from insurance due to pre-existing conditions.** As McCain seeks to move children and families into the individual market, this same individual market makes it notoriously difficult for individuals with pre-existing conditions to get coverage. Children who need insurance most — those who are sick today — could be charged much more for insurance, if they are offered insurance coverage at all.
- **Tens of millions of children will lose patient protections.** By allowing insurance to be sold across state lines, millions of children will lose the protection of having guaranteed benefits. Under the McCain plan, 55 million children will likely lose the protection for mandated coverage for well care visits, 18 million will likely lose autism care, and 16 million children will likely lose lead poisoning treatment.
- **Funding for public insurance programs for low-income children will be reduced.** Although the federal government plays a critical role in offering millions of children coverage through public programs, Sen. McCain recently announced that he would reduce Medicaid spending, with estimates showing possible cuts of \$419 billion over ten years.¹ In response, states will be forced to cut children and families from the public insurance program. Also, Sen. McCain has voted against and said that he supports President Bush's vetoes of legislation that would have expanded the State Children's Health Insurance Program (SCHIP).



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I. INTRODUCTION

A recent poll by Kaiser Family Foundation found that health care continues to be one of the top four issues in the 2008 election, with 16 percent of Americans identifying it as their number one campaign issue.² Children’s health issues have also come to the fore this year, as Congress and President Bush failed to agree on the future of the successful State Children’s Health Insurance Program (SCHIP).

Health coverage is particularly important for children given their developmental needs. Children with insurance are more likely to have usual sources of care and less likely to have unmet health care needs. With 11 percent of Americans under 18 (roughly 8 million children) without health coverage in 2007,³ children’s health care is an important part of the health reform debate. This paper will review the status of children’s coverage leading up to the election, present an analysis of the health proposal of Sen. John McCain and the implications it holds for children’s health coverage, as well as options to improve the McCain plan to better serve children.

II. BACKGROUND

SEN. MCCAIN’S HEALTH REFORM PLAN

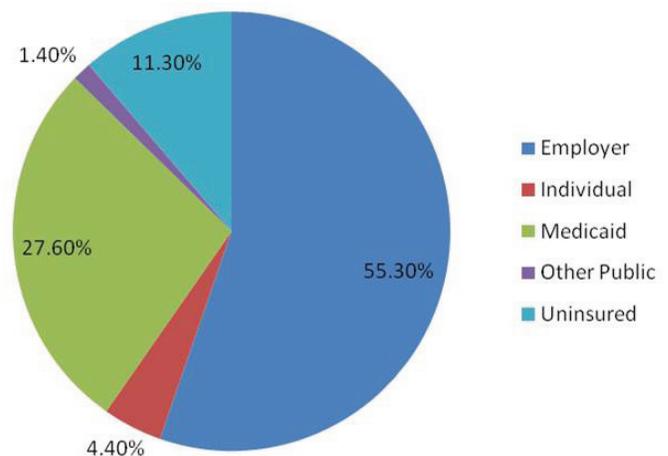
Sen. McCain has proposed a laissez-faire approach to health reform that would make drastic changes in our system. The centerpiece of his plan is to put families “in charge of their health care dollars” and to give them “more control over care.” This would serve essentially to dismantle the current employer-sponsored insurance (ESI) health care system, through which 62 percent of Americans younger than 65 receive coverage. By ending the long-standing tax exemption for ESI and replacing it with a tax credit, millions of American families would be on their own to purchase coverage in the individual market.

The McCain plan would also encourage the expansion of the individual market by allowing insurance companies to sell coverage across state lines. This, in essence, would allow insurers to

operate from the state with regulations they wish to follow. The stated goal of McCain’s plan is to provide families with more options through increased competition, but analyses of the individual market show it to be a very difficult place for many Americans families – including the parents of the 26 percent of children with chronic conditions – to obtain or afford coverage. Sen. McCain has acknowledged this shortfall in his plan, and has pledged to work with states to expand high-risk insurance pools. These pools provide coverage for individuals who are considered “medically uninsurable” in the individual market due to a preexisting medical condition, but the pools are considered to have significant limitations.

The McCain plan does not achieve, nor strive for, coverage of all children. A preliminary analysis finds that the McCain plan would cover less than 5 percent of the total uninsured population over the next ten years,⁵ of which only a fraction are children. Indeed, the McCain plan will likely result in a loss of coverage for children due to a reduced role for Medicaid and SCHIP, the driving forces of recent expansions of children’s coverage. Sen. McCain has recently announced that he would reduce Medicaid spending. In addition, Sen. McCain has expressed support for allowing states to give families the option of purchasing private health insurance with Medicaid funds.⁶

CHART 1: MOST AMERICANS UNDER AGE 19 RECEIVE COVERAGE THROUGH EMPLOYERS OR THE GOVERNMENT,



SOURCE: KAISER FAMILY FOUNDATION STATE HEALTH FACTS, “HEALTH INSURANCE COVERAGE OF CHILDREN, 0-18, 2007. AVAILABLE AT [HTTP://WWW.STATEHEALTHFACTS.KFF.ORG/COMPAREBAR.JSP?IND=127&CAT=3](http://www.statehealthfacts.kff.org/comparebar.jsp?IND=127&CAT=3).

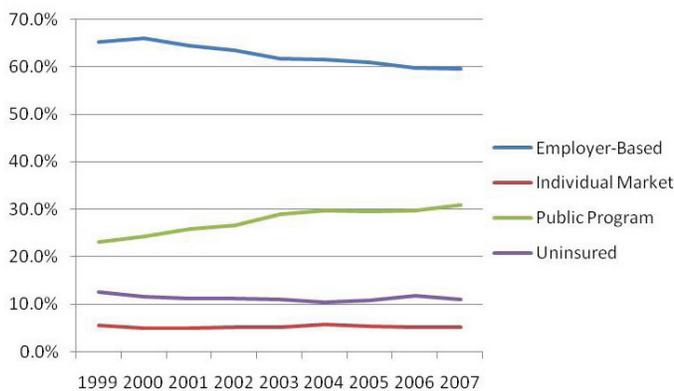
CHILDREN AND HEALTH COVERAGE

The percent of uninsured children fell from 11.6 percent in 2000 to 11 percent in 2007, resulting in 236,000 additional children with insurance.⁷ Despite the overall upward trend of insurance among all children, however, low-income and minority children were still the most likely to be uninsured.⁸

Although ESI remains the primary way children (and most Americans) receive health insurance, it has been on the decline. Where 59.5 percent of children younger than 19 had ESI in 2007, that represents a six-percentage point drop from the 64.5 percent of children who had ESI in 2000.⁹ As Chart 2 shows, the growth of public programs is primarily responsible for recent gains in children’s coverage. Medicaid and SCHIP programs are credited with reducing the number of low-income uninsured children by one-third between 1997 and 2007.¹⁰

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CHART 2: TRENDS IN CHILDREN’S COVERAGE, 1999-2007



SOURCE: U.S. CENSUS BUREAU, AUGUST 2008.

IMPORTANCE OF COVERAGE

Insurance is the primary way in which Americans access health care, and it is especially important for children, whose access to health services for regular check-ups promotes healthy development. A large and consistent body of literature has found that, compared with insured children, uninsured children are more likely to be in poorer health, lack a usual source of care, delay care, and have unmet health care needs.¹¹ Regular access to this type of care also facilitates the identification and treatment of special health needs early in a child’s life, giving them a better chance of growing up healthy. Furthermore, the lack of health insurance or significant gaps in health insurance can expose families to financial risk, increase state administrative costs, and impose other hidden costs on the health care market.¹³

III. KEY CONSIDERATIONS IN THE MCCAIN PLAN

In this section, we consider four key issues that may impact access to affordable health coverage and health care for children in health reform under Sen. McCain.

FAMILY TAX CREDIT WILL WEAKEN FAMILIES’ ABILITY TO PURCHASE COVERAGE FOR CHILDREN.

The centerpiece of the McCain health plan is a tax credit to support families in purchasing health insurance. However, this tax credit is biased against children and may do little to extend coverage to uninsured children, as it will increasingly leave health insurance priced out of reach for most families.

BACKGROUND

The average cost of health insurance in America has been sharply increasing, with ESI family premiums doubling between 2000 and 2008 to reach \$12,680 annually.¹⁶ Although children tend to be less expensive to insure than adults, overall price pressures have likely been a major contributor to the decline in ESI dependent coverage. The costs of chronic disease contribute to the high cost of health insurance – average per capita

spending is more than five times greater for those with at least one chronic condition compared to those without.¹⁷

THE MCCAIN PLAN: ON TAX CREDITS

Today, most Americans receive a tax break from the government for the cost of ESI. The McCain plan replaces the income tax exemption with a refundable tax credit, worth \$2,500 for an individual and \$5,000 for a family, with which to purchase coverage in the private group or individual market.

By making changes in the tax code, research shows that McCain would contribute to already eroding employer-sponsored family coverage for working adults and their children.¹⁸ McCain would continue tax exclusions for employer health contributions, but not those for the employees. It is possible that this lesser tax preference may not be enough incentive for employers to continue offering health benefits. As employee health benefits consume a growing portion of employer costs,¹⁹ employers may stop offering dependent coverage, reduce their contribution and shift costs onto employees, or some may quit offering health benefits altogether. In fact, the stated goal of the McCain health reform plan is to encourage individuals and families to seek out and purchase coverage on the individual market. On April 29, 2008, Sen. McCain said, “Americans need new choices beyond those offered in employment-based coverage.”²⁰

MCCAIN IMPACT: TAX CREDIT REDUCES INSURANCE AFFORDABILITY FOR MOST FAMILIES

Where the current tax exemption increases with rising health insurance costs, the McCain credit is a fixed amount that does not take into account the actual cost of coverage for American families, resulting in:

- **Insufficient support for the purchase of family insurance.** The value of the tax credit is insufficient for a family of any size. The \$5,000-per-family tax credit is far below the \$12,680 average cost of a private family insurance plan purchased through an employer.²¹
- **Reduced support over time.** Unlike the current tax subsidies that keep pace with the

growth in insurance premiums (approximately 7 percent annually),²² Sen. McCain’s tax credit would only be adjusted at the rate of inflation (about two percent annually). This means that the effectiveness of the tax credit will be reduced overtime as premiums continue to increase. By 2014, the average premium will be approximately \$18,400, leaving a shortfall of \$13,400.

- **Failure to recognize family size.** Foremost, the “one-size-fits-all” design of the family tax credit is inherently biased against families with children. Children are generally less expensive to insure than adults, but each child raises the cost of the family’s insurance plan. Despite this, the value of the McCain tax credit will not change for a couple even after they have a child and face higher insurance costs. A family will get the same \$5,000 tax credit regardless of the number of children they have. Based on this design, families are penalized for every child.
- **Inadequate support for higher-cost states.** **Health insurance costs vary from state to state.** In 2006, the most recent year for which state-level data is available, the total premium cost for family ESI coverage ranged by more than \$3,000 between some states. Under the McCain plan, families in states with higher premiums would face higher costs, but not receive additional tax credit support.

TENS OF MILLIONS OF CHILDREN COULD BE BARRED FROM INSURANCE DUE TO PREEXISTING CONDITIONS.

McCain’s stated goal in replacing the current tax exemption with a tax credit is to move Americans from employer-sponsored insurance into the individual market. However, Americans currently face significant challenges in obtaining and affording coverage in the individual market – especially if they have a pre-existing health condition, as increasing numbers of children do.

BACKGROUND

There are 74.4 million children living in the United States,²⁴ and the population under 18 is expected to surpass 78 million in 2015.²⁵ While

children are less likely than adults to have chronic diseases, the number of children facing poor health status is rising, and more and more children are at risk for developing a chronic disease in their lifetimes.

A 2007 report showed that 26 percent of children had at least one chronic disease, and 6 percent had two or more chronic conditions,²⁶ for a total of 19 million children. And evidence suggests this number will increase:

- The percent of children whose activity is limited by their chronic condition increased to 7.3 percent of children under 18 in 2006 compared to 6.6 percent in 1997.²⁷
- Asthma is the most common chronic disease among children, and the percentage of children with the disease increased by more than 4 percent each year from 1980 to 1996.²⁸ This is a disease that disproportionately affects low-income and minority children.
- As shown in Table 1, overweight rates have more than doubled for all age groups. Overweight children and teens are 60 percent more likely to have risk factors for cardiovascular disease, and are more likely to be at risk for developing asthma and diabetes.³⁰

TABLE 1. PREVALENCE OF OVERWEIGHT AMONG CHILDREN AND ADOLESCENTS INCREASING OVER TIME

Ages	1976-1980	2003-2004	Percent Increase
2-5 years	5.0%	13.9%	178%
6-7 years	6.5%	18.8%	189%
12-19 years	5.0%	17.4%	248%

SOURCE: Centers for Disease Control and Prevention, "Childhood Overweight," available at <http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/index.htm>.

In short, even children who don't have a chronic condition today are more likely than ever before to develop a chronic disease in their lifetime. For example, if current lifestyle trends continue, one in three children will one day develop diabetes.

**THE MCCAIN PLAN:
ON AMERICANS WITH PREEXISTING CONDITIONS**

The McCain health plan would encourage the expansion of the individual market. Sen. McCain acknowledges that Americans with pre-existing conditions often have trouble securing coverage in that market where insurers can choose to deny coverage altogether due to a pre-existing medical condition, or may exclude coverage of that condition for a period of time, often up to a year or more.³¹ Thus, he has proposed a Guaranteed Access Plan to expand and offer some federal funding for state high-risk pools. These pools have traditionally provided access to insurance for "medically uninsurable" patients. Sen. McCain has suggested that as much as \$20 billion in federal funding could be available for this effort.

**MCCAIN IMPACT:
EMPHASIS ON INDIVIDUAL MARKET COULD IMPAIR
ACCESS TO CARE FOR CHILDREN WITH CHRONIC
CONDITIONS**

The McCain plan does not address the individual market practices, which make coverage unavailable and unaffordable for those with pre-existing conditions. For example, most states allow individual market insurers to use information on an applicant's health status to determine coverage offers and set premium rates, a process known as health underwriting. Studies have shown that the result is 89 percent of those seeking coverage on the individual market are turned down or simply give up.³² This means that under the McCain plan, 19 million children with pre-existing conditions could be left uncovered, including those with conditions which can be costly to manage or even fatal, such as diabetes, asthma, autism, and cancer.

In addition, critics have questioned whether McCain's pledge of \$20 billion in federal funding for high-risk pools will be sufficient to help the number of Americans who may find themselves uninsurable under his reform plan.³³ Even if uninsurable children were able to access coverage for high risk pools, existing state programs often provide less than adequate coverage. Most high-risk pools have higher than standard premiums, limited benefits, waiting periods, and, often, policies that exclude the pre-existing conditions that made it impossible to obtain coverage in the private market.³⁴

TENS OF MILLIONS OF CHILDREN WILL LOSE CONSUMER PROTECTIONS.

McCain's plan to expand the individual market includes a proposal to allow insurers to sell policies across state lines, a practice currently prohibited. This would lead to the erosion of current state-enforced consumer protection laws, and could leave families vulnerable.

BACKGROUND

States have enacted laws that mandate insurers to offer insurance benefits or cover certain populations, or somehow limit the premiums insurers can charge. Insurance industries in some states are more heavily regulated than others, offering higher levels of consumer protections. Some mandates are specifically aimed at ensuring that children are covered and/or receive certain services through their insurance. These mandates are often targeted at vital medical services for children, or at underserved or at-risk populations.

- **Mandated benefits.** One type of consumer protection takes the form of a mandated benefit, which insurers are required to include in health insurance policies. For example, 31 states require insurers to include well-child care visits in insurance benefit packages.³⁵ Mandated benefits make insurance more comprehensive, although the additional benefits raise the cost of insurance.³⁶
- **Mandated populations.** Another type of insurance consumer protection is mandated coverage of certain child populations. For example, 44 states require insurers to allow children to continue on their parents' insurance through age 18.³⁷
- **Rate protections.** To further protect consumers, some states restrict insurers from charging premiums that vary based on the applicant's health status. This practice, generally known as "community rating," can take different forms, but all serve to protect insurers from taking advantage of the sickest consumers. As of December 2007, 18 states imposed some sort of limits on rating in the individual insurance market, but only two states (New Jersey and New York) require

"pure community rating" where premiums cannot vary at all based on health status, age, or gender.³⁸

THE MCCAIN PLAN: ON CONSUMER PROTECTIONS IN HEALTH CARE

The McCain reform plan states the intention to "improve the quality of health insurance with greater variety to match people's needs, lower prices, and portability." According to the McCain plan, a key mechanism for achieving this is reducing the regulation of insurance by allowing insurers to sell policies across state lines. This will allow insurers to choose which state's regulations they wish to follow, and reduce consumers' ability to hold insurers accountable through their state regulatory bodies.

MCCAIN IMPACT: DECREASING CONSUMER PROTECTIONS THAT HELP CHILDREN RECEIVE THE BENEFITS THEY NEED

A recent analysis of the McCain plan's proposal to allow insurers to sell across state lines suggests that it will "make it harder and more expensive for many Americans to buy quality health coverage."³⁹ Insurers would no longer need to abide by state regulations limiting premium costs for those with medical conditions, and could deny coverage for nearly any reason.

In addition, this policy would limit families' access to policies that have adequate coverage. Millions of children in every state currently benefit from some consumer mandate protections, but some states have more protections than others. The McCain plan would allow insurers to exclude benefits that children and families need.

Table 2 (see page 7) shows some examples of protections that will be lost. See Appendix A for a full list of state child-specific benefit protections and Appendix B for a list of child-specific access mandates.

TABLE 2. MILLIONS OF CHILDREN BENEFIT FROM STATE MANDATES

Condition or Population	Number of Children in States with Benefit Requirement
Well Child Visits	55 Million
Autism Related-Care	18 Million
Lead Poisoning	15 Million
Mandated Access for Dependent Students	17 Million
Mandated Access for Non-custodial Children	8 Million

Many of the mandated benefits are preventive in nature (e.g., newborn hearing and sickle cell screening, early intervention services, well-child care, etc.) and others are intended to diagnose, treat, and manage conditions (e.g., autism-specific mandates, cleft lip and palate treatment, PKU formula, etc.). The purpose of both types of mandated benefits are to ensure that children get the treatment they need to prevent disease and/or manage conditions if they have them. Ultimately the mandates are aimed at improving children’s well-being and health, but McCain’s plan would leave children vulnerable.

For example, California mandates insurers to cover pediatric asthma education, including supplies and medicine for treatment and management. This not only helps improve quality of life for the children, but it can also help reduce health costs. The lack of an asthma management plan is the top indicator of whether California children and teens with active asthma regularly experience symptoms.⁴⁰ Under the McCain plan, it will be possible for these children to be enrolled in a plan from another state that does not require such coverage. This leaves the California children without the coverage that they may need and are guaranteed today. The result could be reduced health status and higher health costs in terms of unnecessary emergency visits.

PUBLIC PROGRAMS FOR LOW-INCOME CHILDREN FACE AN UNCERTAIN FUTURE.

Medicaid and SCHIP, public health coverage programs, have played an integral role in expanding access to coverage and health care for America’s

most vulnerable children – the disabled and low-income. Despite their importance, Sen. McCain has announced that he will significantly cut Medicaid spending.

BACKGROUND

Public insurance programs, like Medicaid and SCHIP, cover 26.4 percent, or more than one-quarter, of all children younger than 19, and 50.4 percent of all low-income children younger than 19.⁴¹ With eligibility expansions over the past decade, Medicaid and SCHIP have reduced the number of low-income uninsured children by one-third,⁴² and have helped mitigate the effects of declining employer-sponsored coverage for children.⁴³ As the nation heads towards an economic downturn, families may find it harder to retain their insurance, and states will be strained by increased demand for public coverage. For instance, with each one-percentage point increase in the unemployment rate, an estimated 600,000 children would be otherwise uninsured were it not for public programs.⁴⁴

Public programs have improved the health of the country’s poorest and most vulnerable children, and have done so in a less costly and more efficient way than private insurance. Enrollment in Medicaid and SCHIP has been associated with an increased likelihood of having a usual source of care, a decrease in emergency department visits, improved health status, and reduced problems among asthmatic children.⁴⁵

Research has shown that Medicaid is a cost-effective way of covering children. Total medical spending for a low-income child with private coverage is 37 percent higher than for children with Medicaid.⁴⁶

Nevertheless, Medicaid and SCHIP programs face certain challenges, most notably the enrollment of eligible children. An estimated seven of every ten uninsured children are eligible for Medicaid or SCHIP but are not enrolled.⁴⁷ This suggests these programs could cover more uninsured children, but as state officials consider options regarding outreach activities, simplifying the enrollment processes, and strategies to improve retention, they often face budget and financing issues, such as the uncertainty of future federal SCHIP funding.

THE MCCAIN PLAN: ON PUBLIC PROGRAMS

Consistent with his history of supporting cuts to Medicaid funding (including \$10 billion in 2005), Sen. McCain recently announced that he would cut \$1.3 trillion over ten years from the Medicare and Medicaid programs.⁴⁸ Assuming those cuts are allocated to Medicare and Medicaid based on the size of the programs, the proportional cut to Medicaid would be \$419 billion over ten years.⁴⁹ An analysis of the proposed cuts shows that Medicaid spending would not meet increases in inflation or enrollment. The federal funding shortfall would cause states to reduced enrollment or benefits, or both. Enrollment cuts could disproportionately affect children, many of whom are not in the mandatory populations that states are required to cover.

In addition, Sen. McCain has shown a lack of support for maintaining the SCHIP program. In 2007, Sen. McCain voted against the original SCHIP reauthorization bill (H.R. 976), and supported President Bush's veto of that legislation.⁵⁰ On the Senate floor, Sen. McCain expressed disappointment that "SCHIP coverage has been extended to middle-income children," or children in families of four with incomes between \$42,400 and \$53,000 a year.⁵¹ Sen. McCain's health reform plan does not mention the SCHIP program.

In interviews on the topic of public coverage programs, Sen. McCain has indicated he would promote increased state flexibility for Medicaid programs. In particular, the candidate supports increasing the role of private insurance plans in providing coverage to eligible families.⁵² This could weaken the financial stability of the programs to the extent private insurance options are used by healthier families.⁵³

MCCAIN IMPACT: INCREASING UNCERTAINTY FOR STATES SEEKING TO EXPAND COVERAGE AND ACCESS FOR LOW-INCOME CHILDREN

Despite Medicaid and SCHIP's central role in supporting coverage for children, the states would have little choice under the McCain plan other than to reduce the size and scope of their Medicaid programs in response to federal budget cuts.

His Medicaid cuts also target many low-income children. While the federal government requires states to cover certain populations under Medicaid, 29 states and the District of Columbia used an option to extend Medicaid eligibility to children above the FPL.⁵⁴ As an optional population, these children could likely be targeted for Medicaid enrollment cuts first.

Without strong federal funding support, states will have greater difficulty providing children's coverage, much less expanding coverage. If states begin to enact policies to restrict enrollment for budget reasons, the decade-long success of Medicaid and SCHIP could begin to unravel, leaving increasing numbers of children uninsured.

IV. OPTIONS TO FURTHER IMPROVE CHILDREN'S COVERAGE UNDER MCCAIN

The McCain plan places children in danger of losing coverage in the group market, reduces their insurance protections, and will reduce public options. There are changes that could be made to the McCain plan in order to help more children secure coverage. While these changes may be significant, they are essential to ensuring that families can obtain coverage for their children. The McCain plan could be improved by:

- **Assuring affordable coverage with a higher tax credit.** The most important change to the McCain plan would be to make the tax credit more child-friendly. For example, the tax credit could be adjusted to account for the number of children in a family so that a family can obtain insurance for all of the children, rather than penalizing families for each child. The tax credit could also be adjusted to account for low-income families who have more difficulty affording coverage; children with special health care needs who often have higher medical bills; and for variation in state insurance costs.
- **Prohibiting children's coverage denials based on pre-existing conditions.** The McCain plan could be changed to account for children with pre-existing conditions who are

likely to be denied coverage. For example, the McCain plan could require guarantee issue or community rating for children, which would require plans to sell coverage to every child applicant, or charge the same amount of premiums to all children. Sen. McCain does not support community rating, yet as Dr. Jonathon Gruber stated, “If McCain doesn’t tax the healthy to pay for pre-existing conditions, as happens under community rating, he has to tax the taxpayer. That means his plan will require huge subsidies he’s not talking about.”⁵⁵

- **Ensuring insurance protections for children.** Access to timely and necessary care is important for children to develop healthfully, and mandatory child protections are one way that states ensure that insurance companies serve children to that purpose. Sen. McCain could further regulate the insurance market and encourage the expansion of common state-mandated benefits, like well-child care visits, and mandated populations, such as students.
- **Expanding and strengthening Medicaid and SCHIP.** Children will be better served if the McCain plan protected and even expanded these important safety net programs. Sen. McCain could encourage enrollment of eligible children, such as the simplification of application and renewal procedures, which may also achieve administrative savings. Promoting outreach activities to help find eligible but uninsured children could help reduce the number of uninsured children through the existing program. However, the McCain plan could also provide new resources to support state efforts to expand Medicaid and SCHIP to cover more uninsured children and strengthen the safety net.

Furthermore, the McCain plan leaves children and families stripped of state protection laws, thrown into the expensive individual insurance market, and vulnerable to uninsurance. There are, however, improvements to the McCain plan that could do more for children’s coverage. The McCain plan could make the tax credit more family-friendly, further strengthen and fund Medicaid and SCHIP, and ensure that consumers are protected so that insurance will be available and affordable for American families.

V. CONCLUSION

The McCain plan proposes a radical shift in America’s health coverage system, but it would do more to disrupt than strengthen children’s coverage. The proposed tax credit is insufficient for families, and biased against children, especially those with special health needs or pre-existing conditions.

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ABOUT FIRST FOCUS

First Focus is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. First Focus brings both traditional and non-traditional leaders together to advocate for federal policies that will improve the lives of America's children. Child health, education, family economics, child welfare, and child safety are the core issue areas in which First Focus promotes bipartisan policy solutions.

While not the only organization working to improve public policies that impact kids, First Focus approaches advocacy in a unique way, bridging the partisan divide to make children a primary focus in federal policymaking. First Focus engages a new generation of academic experts to examine issues affecting children from multiple points of view in an effort to create innovative policy proposals. First Focus convenes cross-sector leaders in key states to influence federal policy and budget debates, and to advocate for federal policies that will ensure a brighter future for the next generation of America's leaders.

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APPENDIX A

SELECT MANDATED BENEFITS BY STATE, 2008
ALPHABETICAL BY CONDITION

Benefit	Benefit Definition	States with a Mandate	Total Children Under 18 with Mandate (unless otherwise noted)
Autism	Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. Mandate provides for evaluation and treatment.	11 states (Colorado, Delaware, Georgia, Iowa, Indiana, Kentucky, Maryland, New Jersey, New York, South Carolina, Tennessee)	17,618,000
Blood Lead Poisoning	Blood lead poisoning is a specific-substance poisoning that may be derived from lead sources such as lead-based paint, folk medicine and imported pottery. Mandate provides for evaluation and treatment.	7 states (California, Delaware, Massachusetts, Missouri, New Jersey, Rhode Island, Wisconsin)	16,418,000
Cleft Lip and Palate	Cleft lip and cleft palate are congenital defects, or birth defects. Treatments vary but may include several different types of services, e.g., surgery. Mandate provides for evaluation and treatment.	14 states (Colorado, Florida, Idaho, Indiana, Louisiana, Maryland, Minnesota, North Carolina, Nebraska, South Carolina, Utah, Virginia, Washington, Wisconsin)	1,094,000 newborns
Early Intervention Services	Provides for reimbursement up to \$5,000 per child from birth to age three, including speech and language therapy, physical therapy, case management, nutrition service plan development and review, nursing services and assistive technologies.	3 states (Colorado, New Hampshire, Rhode Island)	387,000
Newborn Hearing Screening	Testing newborns for hearing related disorders. Mandate provides for evaluation.	17 states (Alaska, Delaware, Florida, Indiana, Massachusetts, Maryland, Missouri, Montana, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, Rhode Island, Texas, Virginia, West Virginia)	1,356,000 newborns
Newborn Sickle Cell Screening	A chronic, usually fatal anemia marked by sickle- shaped red blood cells, occurring most often in people of African descent, and characterized by episodic pain in the joints, fever, leg ulcers. Mandate provides for evaluation.	3 states (Nebraska, Oklahoma, Rhode Island)	91,000 newborns
Pediatric Asthma Education	Asthma is a chronic respiratory disease characterized by reoccurring attacks of labored breathing, chest constriction and/ or coughing. Mandate provides benefits for equipment, supplies, and medication for the diagnosis, treatment and management of asthma and for asthma self-management education.	1 state (California)	9,633,000

PKU/Formula	Inherited metabolic diseases such as phenylketonuria (PKU), which is a genetically determined abnormality caused by a missing enzyme called phenylalanine hydroxylase. Mandate provides for evaluation, education, treatment and supplies like formula or special foods.	32 states (Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Florida, Hawaii, Indiana, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Minnesota, Missouri, Montana, North Dakota, New Hampshire, New Jersey, New Mexico, Nevada, New York, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Washington)	51,555,000
Well Child Care	Provides for reimbursement up to \$5,000 per child from birth to age three, including speech and language therapy, physical therapy, case management, nutrition service plan development and review, nursing services and assistive technologies.	3 states (Colorado, New Hampshire, Rhode Island)	387,000
Wilms' Tumor	Testing newborns for hearing related disorders. Mandate provides for evaluation.	17 states (Alaska, Delaware, Florida, Indiana, Massachusetts, Maryland, Missouri, Montana, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, Rhode Island, Texas, Virginia, West Virginia)	1,356,000 newborns

APPENDIX B

SELECT MANDATES FOR ACCESS TO INSURANCE, 2008

Population	Population Defined	States using that Population	Total Children Protected
Adopted children	Children legally becoming part of a family – whether or not biological to the parent(s).	43 states (Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Maryland, Minnesota, Mississippi, Montana, North Carolina, Nebraska, North Dakota, Nebraska, New Mexico, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming)	43,786 children adopted in 2006
Continuation dependents	A dependent may stay on parents' health insurance coverage through the end of the year in which he or she reaches a certain age by law.	44 states (Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Minnesota, Missouri, Mississippi, Montana, North Carolina, Nebraska, North Dakota, New Hampshire, New Jersey, New Mexico, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia)	3,738,000 18-year-olds
Dependent students	Similar to continuation dependents. A student may stay on parents' health insurance coverage through the end of the year in which they reach a certain age by law – typically through age 22, but some states have moved it to age 30.	30 states (Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Montana, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, West Virginia)	16,938,000 individuals 18-25
Non-custodial children	Even if the parent is not the custodial parent, the child may be covered under the parent's health plan.	11 states (Colorado, Connecticut, Maine, Minnesota, Montana, North Dakota, New Mexico, Oregon, Tennessee, Utah, Wyoming)	7,603,000 children under 18

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