Expanding Health Insurance Coverage for Uninsured Children: The Next Step in Health Care Reform?

Anne Rossier Markus, JD, MHS, and Christopher DeGraw, MD, MPH

Series Editor's Note: *This article provides a comprehensive look at many of the health policy issues related to children's health insurance. It was originally written in April 1997 when the outcome of federal legislation was unclear. Even though Congress has recently decided to increase health insurance coverage for children, however, the issues presented in this paper remain critically important. Because this new legislation is expected to provide coverage for fewer than one quarter of the currently uninsured children, it is likely that Congress will revisit these same issues again in the near future. In addition, the information in this article will also be important because a major focus of the current legislation shifts significant responsibility for program development and implementation to the states.*

The authors of this paper, Anne R. Markus, JD, MHS, and Christopher DeGraw, MD, MPH, both from the Center for Health Policy Research at the George Washington University Medical Center, are experts in child health policy. They have also provided a brief addendum, which summarizes the recently passed children's health legislation.

The demise of President Clinton's 1993 proposal for a major overhaul of the US health care system and the failure of congressional alternatives to the Clinton plan have led to subsequent calls for an incremental approach to health care reform. The so-called Kassebaum-Kennedy bill enacted last year took such an approach in its attempt to fine-tune the private health insurance market. Now a number of policy makers, policy analysts, advocates, and others consider the expansion of health insurance coverage to uninsured children to be the logical next step.

In 1997 the political climate at the federal level might be conducive to further incremental health care reforms, although efforts to increase children's coverage might have to compete with other initiatives, such as ensuring coverage for temporarily unemployed workers and their families. According to one survey, 52 percent of voters agreed that expanding health coverage to children should be the next step in health care reform.[1] In his inaugural address President Clinton listed children's coverage as a legislative priority for his second term. While none of the 10 high-priority bills introduced by congressional Republicans at the start of the new Congress dealt with health care reform, Republicans did not discard at the time a bipartisan approach to deal with the issue of children's health insurance. Senate Democrats, on the other hand, introduced a child health bill as one of their top legislative priorities, but when the president and the congressional leaders agreed in February to strive to achieve bipartisanship on five policy areas as part of the effort to balance the budget, children's health was not on the list. In early spring, however, children's advocates gained new hope when a bipartisan child health coverage bill was introduced in the Senate by conservative Republican Orrin Hatch and liberal Democrat Edward Kennedy.

Irrespective of the outcome of current attempts to increase children's coverage, the approaches and policy issues raised will continue to be important. Therefore, this article will review the current state of children's private and public health insurance coverage and discuss a variety of options being considered by the 105th Congress to provide coverage for at least some uninsured children.

Submitted 30 April 1997.

From the Center for Health Policy Research, The George Washington University Medical Center, Washington, DC. Address reprint requests to Anne R. Markus, JD, MHS, Center for Health Policy Research, The George Washington University Medical Center, 2021 K Street, NW, Suite 800, Washington, DC 20006.

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.

Uninsured Children: Is There a Problem?

Since the late 1980s the overall number of children younger than 18 years of age who are without health insurance has increased. According to the US Census Bureau in 1995, 9.8 million children younger than 18 years—13.8 percent of all children—had no health insurance at any time during the year.[2] Moreover, 30 percent of all children younger than 18 years were uninsured for at least 1 month during a 28-month period from 1992 to 1994. Contrary to popular perception, poor children account for only one third of all uninsured children. A closer look reveals disturbing trends.

Since World War II this country has relied on employment as the primary source of health insurance for most workers and their dependents. The vast majority (more than 90 percent) of privately insured persons younger than 65 years still get their coverage as employees or dependents. But the General Accounting Office (GAO) reports that by 1993 more than 29 million employees—almost one fourth of the workforce—could not get employment-based health insurance for their families.[3] While the percentages of both working age adults and children with private coverage have declined, children have experienced the greatest loss. Private coverage of children younger than 18 years of age declined from almost 74 percent in 1989 to only about 66 percent in 1995. The GAO estimates that if the same percentage of children had been covered in 1995 as had been covered in 1989, about 5 million more children would have had private insurance.

Without a concomitant increase in public coverage to offset decreases in private health insurance, even more chiidren would be uninsured today. The GAO points out that one reason the percentage increase in uninsured children between 1987 and 1995 was not greater, given the drop in private coverage, was that Medicaid eligibility expansions during that period enabled more low-income children to enroll in Medicaid.[4] By 1995 nearly 1 out of every 4 children was covered by Medicaid, 23.2 percent of all children, or 16.5 million.

Currently federal law requires state Medicaid programs to provide coverage for children younger than 6 years whose family incomes are up to 133 percent of the federal poverty level. Furthermore, states are required to phase in coverage of children born after 30 September 1983 who have reached age 6 years and whose family income is below 100 percent of the poverty level. By 2002 all children younger than 18 years with family incomes below the poverty level will have mandatory coverage. In addition, states have the option to expand coverage to 185 percent of the poverty level for infants younger than 1 year of age.

Thus, for the most part, uninsured children are primarily the children of working parents who fall into the gap between Medicaid eligibility and private insurance that is either not available or not affordable.

State and Federal Expansions of Children's Coverage

Before considering current proposals to expand health insurance coverage for children, it is helpful to look at the context of recent activities at both the federal and state levels. In addition to the mandatory and optional expansions of Medicaid eligibility noted above, a number of states have taken advantage of other provisions of Medicaid law to further expand Medicaid coverage to more children of the working poor. Section 1902(r)(2) effectively gives states the option of liberalizing financial eligibility levels for pregnant women and children, with no upper limit, by disregarding greater amounts of income and resources when determining eligibility for those two groups. Section 1115 research and demonstration waivers, currently being implemented in a number of states, give states additional flexibility.

Other states are choosing to develop their own state-funded programs of children's coverage.[5] In contrast to expanding Medicaid, such programs give these states more flexibility to determine eligibility and benefits, but at the expense of foregoing federal Medicaid matching funds. Still other states are combining Medicaid expansions and state-funded programs in an attempt to create seamless insurance coverage for children from poor and low-income working families.

Although the recently enacted Health Insurance Portability and Accountability Act of 1996 (Kassebaum-Kennedy bill) is expected to increase the continued availability of private health insurance coverage for certain children, it only modestly addresses the issues of affordability. The full extent of the effects of this new law is still to be determined.

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.

Congress Considers the Next Step

In response to the lack of universality in coverage of children, the patchwork of Medicaid expansions and state programs, and the continued high numbers of uninsured and underinsured children, a number of proposals are surfacing in the 105th Congress to address health insurance issues for children. By early spring 1997 at least eight bills or proposals had been announced or introduced by members of Congress and the administration, with more expected.[6]

In their strategies to address the unaffordability of health insurance coverage for children from low-income families, the proposals range from creating a new federal entitlement to health insurance for all children to a voluntary pilot program of limited scope. Several employ incentives to encourage states to develop their own children's insurance programs. Others rely on the tax code for implementation. The strategies differ in the degree to which the federal government or the states are responsible for decision making and implementation and in their reliance on government programs or marketplace solutions. Reflecting the prevailing political climate, most of the proposals to date are incremental in nature, voluntary, and likely to provide coverage for only a limited number of uninsured children.

As a review of specific bills is likely to be quickly outdated, the various policy approaches represented in these bills are discussed below, and some of the underlying policy issues are examined in the following section. Among the strategies included in the current proposals are the following.

Medicaid Outreach

With one third of uninsured children eligible for but not enrolled in Medicaid, several proposals call for intensified outreach efforts on the part of the federal and state governments to find and enroll these children. Mechanisms are usually unspecified.

Because the Medicaid program already exists, and children are currently eligible, this first step would appear to be logical. The Medicaid program, however, has historically incurred high costs to state and federal budgets, and this approach could be more difficult politically than it would seem at first glance. In addition, the reasons why currently eligible children do not take advantage of the program are unknown, which makes it difficult to design a successful outreach strategy.

Insurer and Individual Mandates

One category of mandates would require insurers to offer child-only policies tailored to children's health care needs. Insurers could be required to offer policies in the group (ie, large or small employers) or the individual markets or both. Insurers could have to comply with a number of reforms, such as being prohibited from excluding a child from coverage based on a preexisting medical condition (eg, congenital heart defect).

Under an individual mandate, which could be imposed alone or in combination with a mandate on insurers, families would have to buy insurance for their children. This approach is usually paired with premium subsidies to make coverage more affordable for low-income families.

A straight insurance mandate alone, requiring insurers to make children's policies available, is politically palatable because it does not involve any direct cost to the federal government and relies on limited government intervention. Such an approach might not accomplish the policy goal of greatly expanding coverage, however, because insurers could price a child-only policy above the marginal cost traditionally estimated for including dependents in family coverage.[7]

Likewise, an individual mandate has its advantages and disadvantages. In theory, such a mandate would result in universal coverage of all children; and because it relies on the private sector to provide insurance, it would be in step with the current political climate. Most of the costs associated with the mandate should not show up as an item in the federal budget because most of the cost burden would be shifted to individuals. On the other hand, increasing reliance on the individual insurance market might make such mandated policies unaffordable for families, since unlike employment-based and other groups, individuals do not have sufficient clout to bargain down prices. Thus, additional regulation of the insurance market and adequate premium subsidies for lower-income families are necessary to ensure access to affordable insurance products. Finally, creating a system of subsidies could create a new administrative burden, depending on how it is implemented.

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.

Federal Grants for State Programs

Following a block-grant strategy, the federal government would allocate lump sums to states to design their own insurance programs for children. Minimum federal standards could be set with which each state would have to comply to participate in the program and receive federal funds. Within this framework states would generally retain flexibility to set income eligibility levels, the sliding scale for premium subsidies, the level of benefits covered, and certification requirements for insurers that offer policies for children.

The block-grant approach has been popular in Congress since the Reagan years. Last year, Congress adopted block grants as part of the welfare reform law, and block granting the Medicaid program was seriously considered 2 years ago. The approach avoids creating a new entitlement and grants states flexibility to administer programs tailored to the specific needs of their own populations. In addition, it builds on initiatives being taken by a number of states to create their own children's programs. Because spending would be discretionary at the federal level, however, block-grant financing could fluctuate in response to budgetary constraints. Individuals, therefore, would not have the assurance of guaranteed coverage, and waiting lists could result. Also, as happened with Medicaid, 50 new state programs might emerge, creating inequities in children's health care coverage depending on the state in which the children happen to reside.

Insurance Subsidies

A number of proposals under consideration would provide federal dollars for subsidies to allow low-income families to buy private insurance for their children.

The shape and form of a subsidy can vary; vouchers, tax credits, tax deductions, and medical savings accounts are common examples. A voucher is a written statement that enables holders to shop for a given service or good and buy it on a pay-as-you-go basis. The classic example of a voucher is the food stamp program. In the case of health insurance, the voucher is applied against the premium when due.

A tax credit is a dollar-for-dollar reduction in the amount of tax that a taxpayer owes to the government. It can be refundable, that is, even if an eligible low-income person owes no tax, the credit can be claimed by filing a tax return. Depending on how the credit is structured, the tax credit can be claimed at the end of the tax year, or it can be advanced throughout the year on a prorated basis. A tax deduction is an item that may be deducted from the gross amount of income subject to taxation. By reducing the amount subject to tax, a tax deduction will usually reduce the amount of tax owed.

Finally, a medical savings account is an individual- or employer-based tax-free account used to pay medical expenditures. Typically, such an account is set up in conjunction with a catastrophic insurance policy. Funds deposited into the account are used to cover the amount of the deductible and are generally limited to that amount. Unused funds at the end of the year can be either accumulated to pay for future medical expenses or withdrawn without penalty.

Government subsidies of health insurance premiums can be made to employers or individuals. Subsidies to low-income persons would bring some equity to a system that favors employer-based coverage at the expense of individually purchased insurance. Subsidies are also perceived as a politically feasible option because their main enforcement mechanism is the tax code, which implies less government intervention in the marketplace. Finally, they maintain individual choice. Subsidies can be expensive, however. New revenues would be needed to finance monitoring and enforcement activities as well as the subsidy itself. Furthermore, subsidies might not reach the people that they are intended to reach if, for example, they are set at very low income levels, they are not marketed to the public, or as in the case of tax deductions, they tend to benefit primarily people who itemize their taxes. Increasing awareness about the availability of subsidies and providing adequate funding for the subsidies would become important in such a voluntary system.

In fact, using the tax code to subsidize children's health insurance coverage is a policy that has a recent track record. The Health Insurance Earned Income Tax Credit, enacted in 1990 and repealed in 1993, gave eligible families a refundable tax credit for purchasing health insurance that included coverage for a qualifying child who satisfied certain relationship, residence, and age requirements. Only a small fraction of eligible

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.

taxpayers claimed the credit, however. Reasons cited for its poor success include a lack of public awareness, a structure that made the credit unavailable at the time families needed to pay their premiums, and a total credit that was considered too small to be useful.

Medical savings accounts have been touted as compatible with a market-based approach, which emphasizes individual responsibility and a limited government role. It is believed medical savings accounts will induce consumers to become more cost conscious and better able to make informed decisions about their care and provide them with greater flexibility. Medical savings accounts tend to favor middle- and upper-income taxpayers, can exacerbate risk segmentation in the private market, and would require a new administrative structure to oversee the program. Despite the establishment of a pilot program in the Health Insurance Portability and Accountability Act passed in 1996, this approach remains largely untested.

Expanding Medicaid Eligibility or Offering a Medicaid Buy-in

Medicaid, a joint federal and state program in place for more than 30 years, could be used as a floor upon which to build additional coverage for insured children. The existing program could be expanded by raising the income eligibility levels, or it could be opened up to families with higher incomes in the form of a buy-in, giving them the option to purchase Medicaid benefits for a premium according to a sliding scale and some cost sharing based on income. This policy option could be convenient, because it builds on a program that has been tested for decades, and as noted earlier, there is a precedent of previous Medicaid expansions. Rising health care costs, the relatively generous Medicaid benefits package, and the open-ended entitlement nature of the program, however, have been cited as reasons some might oppose further Medicaid expansions. Finally, the low level of provider participation could impair access to care for children in the program.

New Mandatory Federal Insurance Program

A new mandatory federal insurance program resembling Medicare for seniors but tailored to children's needs has been proposed. All children younger than a given age would be entitled to a federally defined package of benefits. Administration of the program could rest either at the federal or the state level. Financing could come from a combination of sources, including general revenues, payroll taxes, and individual premiums. The main advantages of such an approach would be its universality, guaranteed access to a comprehensive package of defined benefits, and relatively low administrative costs. Weaknesses include the creation of a new entitlement with an on-budget commitment to a new population and the possible negative impact of a new program on the cost of coverage for other groups, such as workers. At the present time, even proponents of such an approach concede it is unlikely to be successful politically.

One strategy conspicuously absent from current proposals is an employer mandate to provide health insurance for employees. Part of the 1993 Clinton health plan, and recently rescinded from health care reform plans in at least two states (Massachusetts and Washington), such an approach is considered unlikely to have much political currency at the present time.

Policy Issues

Any attempt to fill in the gap in children's health insurance between publicly provided and employer-based coverage raises a number of policy issues.

Voluntary Versus Mandatory

While a voluntary approach is politically more feasible than a mandatory one, the latter is likely to be more effective in meeting the goal of insuring all children. A study of the Washington State Basic Health Plan, a voluntary public health insurance program for low-income families, found that higher premiums, among other factors, provided a disincentive to enroll.[8] In addition, the authors note that "people with more tenuous connections to the mainstream (the less educated, those who do not speak English) are less likely to find their way to the trailhead of the voluntary path, whatever level of premium subsidy." The study concluded that while voluntary insurance programs have an important role in increasing financial access for low-income families, internal program design features have a substantial effect on how many and which families participate.

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.

Incremental Versus Comprehensive

Although it is generally conceded that comprehensive health care reform is politically unfeasible in the current political climate, policy makers must be aware that from a policy perspective, an incremental approach is likely to bring some disruption to the existing system. For instance, "without universal coverage, there is a risk that increasing access will result in higher premiums overall [because] sicker people, who have been excluded from the system, are most likely to become covered [and] younger and healthier persons (and the businesses that employ them) may tend not to purchase coverage as the price for them rises."[9] In another scenario, a new publicly financed program might attract children currently insured through their parents' employers, which in turn could reduce the size of the remaining employee risk pool and increase overall premiums.

Additionally, a new publicly financed program for children might tempt employers to drop dependent coverage for those children eligible for the new program, resulting in so-called "crowd out" by employers. A similar phenomenon could occur if states that have expanded Medicaid to insure additional uninsured children subsequently drop Medicaid coverage for those children who also become eligible for a new federal program, even if the benefits of the new program were less favorable for the children (but less expensive for the state) than under Medicaid.

Benefits Package

The design of the benefits package is a critical element of any proposal to increase children's access to care. Private coverage tends to be less generous than the benefits package offered by Medicaid. As a result, children with needs beyond those commonly covered in a standard benefit package might require additional coverage that includes appropriate services for children who have chronic illnesses and disabilities. Preventive and primary care services at little or no cost for low-income families are essential to promote children's health and development. One such prevention-oriented package often touted as a model is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) package currently available to Medicaid-eligible children. With EPSDT children younger than 21 years are eligible to receive regular screening to assess their medical, developmental, vision, hearing, and dental health, as well as necessary laboratory tests and medically necessary treatment if screening tests reveal a medical condition. Comprehensive benefits do not come without a price attached, however.

Financing

Whereas the cost of insuring a child can be modest compared with the cost of insuring an adult, the number of uninsured children is so great that any proposal to guarantee coverage would likely cost billions in new spending, a sticking point in the current era of fiscal conservatism and efforts to balance the federal budget.

Few proposals to date are specific about the source of new revenue to pay for children's coverage, but an increase in tobacco taxes, such as recently enacted in Massachusetts to help pay for health care reforms, is getting serious consideration. A poll released by the American Cancer Society early this year showed that 73 percent of Americans support an increase in the federal tobacco tax "to pay for health care for all children who need it."[10] Furthermore, studies showing that increased tobacco taxes deter teenage smokers give the idea even more political appeal. A tobacco tax increase has some drawbacks, however. As a consumption tax, it tends to be regressive, affecting low-income people disproportionately. In addition, because of its built-in incentive toward smoking cessation, revenues obtained from the tax might dwindle in the future, thereby decreasing continued funding for a new children's health insurance program.

Health Insurance and Access to Care

Numerous studies have shown that for children, access to health insurance improves access to care. Children with insurance receive more annual physician visits than children without health insurance, and they are also more likely to receive adequate preventive services, including immunizations and primary care, and have a regular source of continuing care.[11] Insured children are also less likely to use emergency departments as a usual source of care.[12] Finally, they are more likely to be seen by a physician when they suffer from symptoms that warrant office visits.[13]

Although the presence of health insurance clearly helps alleviate the financial barrier that is involved in obtaining care, access to health insur-

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.

ance cannot always be equated with access to care because of other nonfinancial barriers that impede the process of seeking care. Several studies suggest that such variables as residence, ethnicity, and family circumstances might play more powerful roles than insurance in the use or nonuse of services.[12,14] This finding implies that guaranteeing insurance coverage for children must be combined with persistent outreach and continued attention to improving the quality, availability, and appropriateness of services and providers to meet the health care needs of children in all areas of the country.

The Future of Increased Children's Coverage

As this article is written, the outlook for expansion of children's health care coverage at the federal level in 1997 is anything but clear. Whatever the outcome in Congress, any expansion of children's coverage in the near future is likely to be incremental. It will be important to learn from the current debate and from the various expansions of coverage being undertaken by the states so that we can continue to work toward full coverage and access to care for all children.

Addendum

As this article goes to press, Congressional leaders and President Clinton have reached an agreement on a new $24 billion block grant program for children's health insurance as part of the 1997 budget reconciliation package, which was signed into law August 5. Under the State Children's Health Insurance Program (SCHIP)—touted by all sides as the biggest step forward for children's coverage since Medicaid—states will have broad latitude to expand Medicaid, develop new child health insurance programs, or combine both approaches to cover additional children, with relatively few prescriptions from the federal government. Of the available funding, 90% must be used for health insurance, which must cover inpatient and outpatient care, physician services, laboratory and x-ray studies, and well-child care and immunizations. The remaining 10% of funds can be used for administration, outreach, or direct services. Coverage must be equivalent to standard plans available at the state or federal level. Eligible children are those who are not currently eligible for Medicaid and who also live in families whose income is less than 200% of the poverty level (or higher for those states that already have expanded coverage). States that opt to participate in SCHIP are mandated to cover more uninsured, low-income children. As the states begin to plan and implement coverage expansions under SCHIP, the involvement of health professionals and other children's advocates will be critical to ensure that this mandate is met.

References

1. Kaiser Family Foundation, Harvard University, and Princeton Survey Research Associates. Post-election survey of voters' 1997 health care agenda. Menlo Park, Calif: Kaiser Family Foundations, January 1997.
2. Housing and Household Economic Statistics Division. News release. Suitland, Md: US Bureau of the Census, Department of Commerce, April 8, 1997.
3. Employment-based health insurance: costs increase and family coverage decreases. GAO/HEHS 97-35. Washington, DC: US General Accounting Office, Health, Education, and Human Services Division, February 1997.
4. Children's health insurance 1995. GAO/HEHS 97-68R. Washington, DC: US General Accounting Office, Health, Education, and Human Services Division, February 1997.
5. DeGraw C, Park MJ, Hudman JA. State initiatives to provide medical coverage for uninsured children. Future Child 1995;5:223-31.
6. Johnson K, DeGraw C, Sonosky C, Markus A, Rosenbaum S. Children's health insurance: a comparison of major federal legislation. Washington, DC: Center for Health Policy Research, the George Washington University Medical Center, 1 May 1997.
7. Budetti PP. Health reform for the 21st century? It may have to wait until the 21st century. JAMA 1997;277:193-8.
8. Madden CW, Cheadle A, Diehr P, Martin DP, Patrick DL, Skillman SM. Voluntary public health insurance for low-income families: the decision to enroll. J Health Polit Policy Law 1995;20:955-72.
9. Feder J, Levitt L. Steps toward universal coverage. Health Aff Millwood 1995;14:140-9.
10. Health care access. Poll finds support for increased taxes. Am Health Line 1997;January:29.
11. Newacheck PW, Hughes DC, Stoddard JJ. Children's access to primary care: differences by race, income, and insurance status. Pediatrics 1996;97:26-32.
12. Halfon N, Newacheck PW, Wood DL, St. Peter RF. Routine emergency department use for sick care by children in the United States. Pediatrics 1996;98:28-34.
13. Kogan MD, Alexander GR, Teitelbaum MA, Jack BW, Kotelchuck M, Pappas G. The effect of gaps in health insurance on continuity of a regular source of care among preschool-aged children in the United States. JAMA 1995;274:1429-35.
14. Marquis MS, Long SH. Reconsidering the effect of Medicaid on health care services use. Health Serv Res 1996;30:791-808.

J Am Board Fam Pract: first published as 10.3122/jabfm.10.5.363 on 1 September 1997. Downloaded from http://www.jabfm.org/ on 28 May 2025 by guest. Protected by copyright.