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# Best and Worst Ideas for Insuring Children

The budget agreement passed by Congress and signed by President Clinton includes a provision giving the states $24 billion over five years to extend health insurance to more low-income uninsured children — basically those with family incomes below 200 percent of poverty, not eligible for Medicaid, not enrolled in a health plan or covered by health insurance. The first $5 billion becomes available October 1, 1997. But there is a caveat: States must contribute 70 percent of their Medicaid matching rate. For example, a state whose Medicaid matching rate is 50 percent of the federal contribution must contribute 35 percent under this bill. As a result, state contributions will add perhaps $10 billion over the five years, on top of the federal government's contribution.

States must now determine how to spend these large sums to maximize the number of children with health insurance. The legislation allows them to:

- Expand the existing state Medicaid program.
- Offer coverage under group or individual health plans, with a benefits package actuarially reflecting one of several existing plans (e.g., a standard Blue Cross Blue Shield policy or the Federal Employees Health Benefits Program).

In addition, states may use up to 10 percent of the funds for purchasing health care services directly, outreach and administration.

Some approaches permitted under the legislation would be more effective and cover more children than others. According to some analysts, it is more cost-effective to move uninsured children into private health insurance than to put them in Medicaid due to the way the matching funds process works under the legislation. As a result, state legislatures should carefully consider the available options before acting.

**Worst Idea: Expanding State Medicaid Programs.** In 1986, Congress began a series of Medicaid expansions. As a result, all children under 18 living below the poverty level will be covered under Medicaid by 2002.

**How Much Does Children's Health Insurance Cost in the Private Sector?**
**(Per Child Per Month by Carrier and Geographic Region[1])**

| | Carrier A | Carrier B | Carrier C |
|---|---|---|---|
| East | $61 | $58 | $63 |
| South | $60 | $50 | $59 |
| West | $58 | $67 | $62 |
| Midwest | $58 | $57 | $55 |

[1] Child-only coverage, $500 deductible, PPO plan with copay, 80/20 coinsurance to $5,000.

Source: Council for Affordable Health Insurance.

While the federal government requires these Medicaid expansions, it has allowed states to do more. According to the National Governors Association (NGA):

- By March 1997, 29 states had expanded Medicaid beyond federal guidelines.
- Of those, Tennessee had expanded Medicaid eligibility up to 400 percent of poverty for those 13 and younger, five states had expanded coverage to those with family incomes between 200 and 300 percent of poverty and 15 states had extended the upper age limit to 19.

As a result of both federal and state expansion efforts, Medicaid now covers a larger portion of the population. According to the Employee Benefit Research Institute (EBRI), in 1987, 73.2 percent of children received their health insurance through their parents' private insurance, while 15.5 percent were covered under Medicaid. By 1995, only 66.1 percent had private health insurance, and 23.2 percent were covered under Medicaid. Those without insurance increased from 13.1 to 13.8 percent.

However, making Medicaid bigger doesn't make it better. For years Medicaid has been one of the fastest-growing segments in many state budgets, in part because the program is riddled with fraud and abuse.

As a result, many states have submitted waiver requests to the Department of Health and Human Services to escape Medicaid's costly and burdensome restrictions and to impose tighter controls. What has been the primary state alternative? Health Maintenance Organizations (HMOs).

**Mediocre Idea: Enrolling Children in an HMO.** While Medicaid waivers permit a range of options, most states have used them to put more low-income families into HMOs, and the budget agreement of 1997 encourages states to continue this process.

Currently, about 40 percent of Medicaid enrollees are in HMOs, with some observers predicting an increase to 75 percent by the year 2000.

While this approach provides children and pregnant women with access to more extensive primary and

Dallas Headquarters: 12655 N. Central Expy., Suite 720 • Dallas, TX 75243-1739 • 972-386-6272 • Fax: 972-386-0924 • E-Mail: ncpa@public-policy.org
Washington Office: 727 15th St. N.W., 5th Floor • Washington DC 20005 • 202-628-6671 • Fax 202-628-6474
*For more information: Katy Meaker Menges in Dallas at 972/386-6272 or Joan Kirby in Washington at 202/628-6671*

preventive services — the care most needed by this generally healthy segment of the population — most low-income families have no choice of health care coverage. The state simply assigns them to an HMO. Ironically, state legislatures across the country are simultaneously passing anti-managed care legislation in an effort to prevent HMOs from harming patients or reducing the quality of care.

**Good Idea: Purchasing Private Health Insurance.** A number of states and private organizations are trying to expand health insurance for children outside of the Medicaid program. For example:

- Eight states have implemented programs funded solely by the state.
- And 24 more are working with private organizations such as the Caring Programs for Children in order to provide children with private health insurance.

In most cases, the private programs provide children with private health insurance at subsidized prices — with the subsidy usually coming from state or local governments or private sources.

*Case Study: Florida* — Florida's "Healthy Kids" program provides subsidized private health coverage through the public schools for children from low-income families. It has been expanded from seven to 17 counties and covers 40,000 children. The average cost of each child covered is $51 per month, excluding administrative costs — only slightly less than the average monthly cost of a traditional health insurance policy [see the table] — but because premiums are subsidized on a sliding scale, most pay much less. Total funding for the program in 1997 is $35 million.

*Case Study: Blue Cross Blue Shield* — In about half the states, Blue Cross Blue Shield has established programs that provide low-income children with health insurance at discounted prices. Blue Cross solicits private donations to offset the costs of providing this coverage. Most parents pay a portion of the premium.

While several of these programs turn to the public schools as a pooling mechanism for reaching low-income children and their families, expanding school-based clinics is less desirable. School-based clinics contradict the spirit and letter of the legislation, which is meant to provide children with comprehensive health insurance, not general medical and reproductive services of which their parents might not approve.

**Best Idea: Empowering People to Choose Their Coverage**. Instead of expanding Medicaid or forcing people into HMOs, why not let families use the money to enroll in the private health plan of their choice? These choices should include HMOs, Preferred Provider Organizations (PPOs), Provider Service Networks (PSNs), traditional fee-for-service policies and especially Medical Savings Accounts.

Subject to HHS approval, several funding approaches could be available:

*(1) Direct transfer of funds.* The recently passed "Medicare+Choice" program permits seniors to opt out of traditional Medicare and choose private health coverage instead. If a senior takes this option, Medicare transfers the senior's allotment of funds directly to the insurer. This same process could apply to coverage for uninsured children. Low-income families could choose the plan best suited to their children's needs and the state would transfer the annual premium to the insurer.

*(2) Refundable tax credit.* Low-income families could be offered a dollar-for-dollar refundable tax credit for use toward the purchase of their children's health coverage. The credit would cover most or all of the cost of health insurance; parents would pay the difference, if any. The credit would be refundable, which means that families would receive the full benefit of the credit, regardless of how small their income tax obligation was.

*(3) Vouchers.* Parents could receive a voucher for the amount of the health insurance subsidy and apply that voucher toward the purchase of a child's health insurance policy.

**Conclusion.** The key to a successful expansion of health insurance for poor children is providing low-income families with choice. While many have suggested that up to half of the 10 million currently uninsured children could be covered with the available money, the Congressional Budget Office predicts that only 2.03 million previously uninsured children will obtain coverage. Including the state match money, that works out to about $3,000 per additional child covered — about five times what it would take to buy a child private coverage. Thus, by relying on private sector options, we could easily reach the goal of insuring five million children.

*This Brief Analysis was prepared by Merrill Matthews Jr., NCPA vice president of domestic policy, and Kristin A. Becker, director of the Health and Human Services Task Force, American Legislative Exchange Council.*