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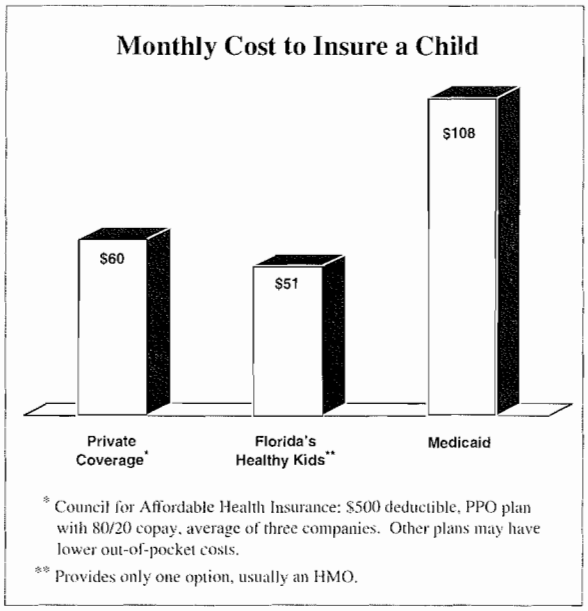
10 Guidelines for Insuring Children

The 1997 budget agreement includes a provision giving the states $24 billion over five years to provide health insurance to uninsured children from low-income families — basically those in families with incomes below 200 percent of the poverty level, not eligible for Medicaid, not enrolled in a health plan or covered by health insurance. In addition, states must contribute about 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 to the federal government's contribution over the five years.

While demographic, economic and political differences mean that programs will vary from state to state, state legislators should implement a program that would maximize the number of children insured with the available amount of money. As the figure shows, there are wide variations in the cost of coverage. The following guidelines should be helpful in adopting the most cost-effective legislation.



1. Use private, not public, insurance. The federal legislation permits states 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 direct purchase of health care services, outreach and administration.

Though representatives of the Health Care Financing Administration (HCFA), the federal agency that oversees implementation of the program, have argued that states would benefit by expanding Medicaid, the flexibility to adjust benefits given to states that adopt a private insurance approach will permit them to cover more children with the same amount of money.

2. Give parents a choice. States and private organizations are already expanding health insurance for children outside of the Medicaid program. 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.

For example, 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 includes 40,000 children. The average cost of each child covered is $51 per month excluding administrative costs, but because premiums are subsidized on a sliding scale, most pay much less. In Florida, local authorities take bids from insurers and health plans and choose the lowest bidder as the sole insurer. While proponents say this practice ensures a lower bid from the provider who can enroll all of the children, it also limits competition.

A better approach would let families choose among qualified insurers and health plans and require families to pay more out of pocket if they choose an expensive plan. This approach would allow parents to choose from a range of available health insurance products such as HMOs, PPOs, Point of Service plans, traditional fee-for-service insurance and Medical Savings Accounts — just as seniors can do under the recently passed Medicare+Choice program.

In fact, a Medical Savings Account option would maximize families' choices by giving them more control over the money, while minimizing the cost.

3. Empower families. Sellers are more responsive when consumers control the money. Therefore, parents should be financially empowered to choose their health plan themselves. Several approaches would work:

(1) Direct transfer of funds. The Medicare+Choice program permits seniors to leave Medicare and choose

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private health coverage instead. If a senior makes this choice, Medicare transfers the senior's allotment of funds directly to the insurer. Similarly, a low-income family could choose a plan and the state could transfer the annual premium to the insurer.

(2) Refundable tax credit. Low-income families could be offered a refundable tax credit to apply toward the purchase of their children's health coverage. The credit would cover most or all of the cost of the insurance and the parents would pay the difference. Families would receive the full benefit of the credit, regardless of how small their income tax obligation was.

(3) Vouchers. Alternatively, parents could receive a voucher for the amount of the health insurance subsidy and apply that voucher towards the purchase of a child's health insurance policy.

4. Encourage family coverage. While health insurance is good for children from low-income families, it would be better if the whole family had coverage. States should find ways to coordinate their new funds for children's health insurance with existing funds set aside for low-income families. In that way, insurers and health plans offering children's coverage could insure the whole family at once.

5. Let insurers, not the state, do the outreach. Currently, there are about three million Medicaid-eligible children who are not enrolled in the program, and HCFA is unsure how to find and enroll them. The new program can avoid this problem. If insurers are selling the plans, they will have a financial incentive to undertake the outreach efforts. They can advertise, meet with school officials, conduct school health fairs, attend PTA or church meetings or find other ways of getting information to low-income families and their children.

6. Reward responsible behavior. Children must be uninsured to be eligible for the program. This means that qualified, low-income parents who sacrificed to insure their children will be penalized and that they will have to let their children's insurance lapse, forcing them to be uninsured, if they want to join the program. Since the legislation does not say how long children must be uninsured, states should impose only a minimal waiting period.

7. Let states rather than insurers determine eligibility. A family's eligibility for the program should probably be left to state officials, such as those working in welfare offices. An eligible family could take a certificate of eligibility to an insurer who would issue the policy and arrange payment for any premium amount not covered by the state.

8. Vary subsidy according to income. Varying the amount of subsidy with two or three tiers — providing the most help to those most in need — encourages the lowest-income families to join the program and extends the state's money. States might still want to require all families to pay some portion of the premium, as Florida's program does, or to make a small copayment.

9. Limit plan migration. Permitting people to shift from one health insurance plan to another causes a number of problems. One problem is "adverse selection," in which one plan has a disproportionately high number of poor health risks and thus higher premiums. The easier it is for people to shift from one plan to another, the easier it is to game the system, which leads to adverse selection. While the legislation stipulates that low-income families be allowed to change their children's health plans, they should be required to give a half-year's or year's prior notice of withdrawal.

10. Guarantee portability and access. Health insurance policies created under the legislation should be "portable." That is, a child whose family moves but remains in a geographical area the insurer serves should be permitted to continue with that policy to ensure continuity of coverage.

In addition, the legislation requires "guaranteed issue," which means that insurers must accept all applicants regardless of their health risk. With adults, this provision creates adverse selection problems. If people can get health insurance when they are sick, why would they buy it when they are healthy? However, since children ages 6 to 12 are the healthiest segment of the population, the threat of adverse selection should be minimal.

Conclusion. The goal of the uninsured children's program is to insure as many people as possible. Medicaid has largely failed because it is too expensive and inefficient. It is time to give private insurance the chance to do what Medicaid could not.

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.