

# Expanding Coverage for Children

BY JANE HIEBERT-WHITE

**I**n a historic move, the federal government this summer created its biggest new healthcare program in more than a generation. The program, ironically included in the Balanced Budget Act of 1997, establishes a \$24 billion fund to provide healthcare coverage for uninsured children. The measure was approved by large bipartisan margins in the House of Representatives on July 30 and in the Senate a day later. President Bill Clinton signed it into law on August 5.

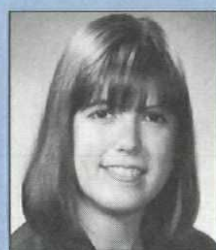
Supporters of the new law hailed its passage as a great victory. Although congressional leaders had earlier planned to spend only \$16 billion on children's healthcare, they eventually agreed—just before Congress's August recess—to appropriate the full amount Clinton had requested. Ron Pollack, executive director of Families USA, a Washington, DC-based consumer group, called approval of the law "the most significant advance in funding for healthcare coverage since the Medicare and Medicaid programs were enacted 32 years ago."

The law establishes a State Children's Health Insurance Program (SCHIP), allowing each of the 50 states to decide how it will use its share of the funds to expand coverage for children. Governors had requested great flexibility in making these decisions, and the new law gives it to them. But the states will need to move quickly in setting up their funding plans, because the first installment—\$5 billion—becomes available October 1.

This column examines, on one hand, some of the options states may consider, and, on the other, the numbers and characteristics of America's uninsured children. Because the estimates of children needing coverage vary greatly, the latter topic is especially controversial.

## STATE OPTIONS FOR COVERAGE

SCHIP authorizes the states to spend the \$24 billion over a period of five years, starting in fiscal year 1998 (which begins on October 1, 1997).



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The program's goal is to provide healthcare coverage for the children of struggling parents at the lower levels of the income ladder. To be eligible, children must in most cases be currently ineligible for Medicaid and must belong to families with incomes less than 200 percent of the federal poverty rate. Congress did allow some exceptions for states like Minnesota, Vermont, and Hawaii, which, under their current Medicaid programs, already cover children in families with higher income levels.

In SCHIP's first three years, funding will vary according to the number of uninsured children in each state. The money will be distributed through a 30 percent increase in the federal "match." For example, in a state whose Medicaid funding is currently split 50-50 between the state and the federal government, the federal portion would climb to 65 percent while the state's would fall to 35 percent.

The options states may choose in designing programs are:

- Expanding current Medicaid coverage to include uninsured children
- Enrolling uninsured children in existing state child health insurance programs (in Florida, Pennsylvania, and New York)
- Providing coverage for uninsured children that equals one of several designated "benchmark" benefits packages. These benchmark packages are: the plan offered by whichever health maintenance organization (HMO) has the state's largest non-Medicaid enrollment; the state's own employee health plan; and the standard Blue Cross/Blue Shield preferred provider organization (PPO) program offered by the Federal Employee Health Benefits Program (FEHBP). A state may also choose to purchase healthcare services for children directly from hospitals and physicians, but this option is restricted to no more than 10 percent of the funding.

Under each of these options, the benefits provided must include hospital inpatient and outpatient care; laboratory and x-ray services; well-baby



and well-child care, such as immunizations; and physicians' surgical and medical services. In addition, nearly all eligible children would receive some mental health coverage, since the FEHBP Blue Cross/Blue Shield PPO and most of the largest HMO and state employee health plans currently include mental health coverage.

Although state officials are pleased to have SCHIP, the suddenness of the program's creation and the variety of its options have many scrambling to figure out what they need to do. According to Robert Mollica, deputy director of the National Academy for State Health Policymakers (NASHP), "States are eager to get under way, but are awaiting word from HCFA (the Health Care Financing Administration) as to what they have to do by when." He said in a phone interview that state legislators and policymakers attending NASHP's annual meeting in early August were focused on "trying to figure out what their benefit package might be, how to develop actuarially equivalent benefits, and so forth." Mollica noted that "some folks are leaning toward expanding Medicaid, while others want to develop something more focused—especially those that already have kids' plans."

Mollica also said that some state officials "are nervous about declining funding over time and cautious about doing something early on with the funding, only to have it cut back in the out years."

The new law will not penalize states that are unprepared to spend the money when it becomes available on October 1. Nevertheless, there does appear to be a sense of urgency among state health policy leaders, who want to demonstrate their responsiveness for constituents. The new law requires states to maintain their current Medicaid spending levels, thus ensuring that the new federal money is not used to replace state funding.

SCHIP will be partly funded by an increase in federal cigarette taxes, expected to yield \$8 billion. The remainder of the program's \$24 billion price tag will be paid from general revenues.

According to the American Hospital Association, the healthcare facilities most likely to benefit from the program are those—inner-city teaching hospitals, public hospitals, and rural hospitals—that currently provide care for large numbers of uninsured children.<sup>1</sup>

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## ESTIMATING THE NUMBER OF ELIGIBLE CHILDREN

Estimates of the number of uninsured children in the United States vary widely. Kenneth E. Thorpe, using data from the March 1996 Current Population Survey, estimates that, in 1995, 10.5 million were uninsured, 13.8 million were covered by Medicaid, 45.8 million had employer-sponsored insurance, and 4.7 million had other coverage.<sup>2</sup> Thorpe, who was deputy assistant secretary for health policy at the U.S. Department of Health and Human Services before joining Tulane University as director of its Institute for Health Services Research, also found that nearly 25 percent of the children uninsured in 1995 were members of families that had incomes of more than 200 percent of the federal poverty rate—SCHIP's eligibility level.

A new national survey of 24,000 families—conducted by the Washington, DC-based Center for Studying System Change—puts the number of uninsured children at 8.5 million, including 6.7 million uninsured for a full year or longer. This survey, part of the Community Tracking Study funded by the Robert Wood Johnson Foundation, also found (like Thorpe) that close to a quarter of uninsured children belong to families earning more than 200 percent of the poverty rate.<sup>3</sup>

Anyone who delves deeper into the numbers will find some interesting trends regarding those people who lack healthcare coverage. For example, the survey conducted by the Center for Studying Health System Change discovered that 3.2 million of the nation's uninsured children (37 percent) were eligible for Medicaid coverage.

This would seem to indicate that the nation needs to link up eligible children with the coverage they are already entitled to, not new coverage. In creating SCHIP, lawmakers recognized this problem and set aside a portion of the funding for media campaigns to inform people about available benefits. The question is, Will such campaigns be effective?

The center's survey also found that a disproportionate number of uninsured children were Hispanic (29 percent). Among African Americans 14 percent were uninsured. A majority were members of two-parent families (68 percent); many had working parents (78 percent). The survey examined 12 randomly selected metropolitan



areas (each having a population of more than 200,000) to see what demographic variations might be found in them. The analysts discovered that areas with large proportions of uninsured children included Orange County, CA (19.1 percent); Little Rock, AR (18.4 percent); Miami, FL (18.4 percent); and Phoenix (18.3 percent). Areas in which the proportion were small included Lansing, MI (5.5 percent); Seattle (7.2 percent); and Syracuse, NY (7.3 percent). Nationwide 11.9 percent of children are uninsured.

The center's survey asked household respondents why, if their children did not have coverage, that was the case. The largest number (38 percent) said that the parents' employers did not offer insurance; another 22 percent said the parents were unemployed. On the other hand, about 40 percent of respondents said their employers did offer insurance. Some parents said they were ineligible for the insurance, some said the plans covered parents but not children, and some said they had rejected the plans. Among those who rejected coverage, 84 percent said they had done so because the plans cost too much.

Cost is also a factor for parents who, when they are between jobs, do not pick up temporary health insurance for their children, according to Robert D. Reischauer, a former Congressional Budget Office (CBO) director who is now a senior fellow at the Brookings Institution. "Some parents make a choice to take a calculated risk," he said in a conversation. "Kids don't use a lot of healthcare," and any healthcare bills they incur during their parents' period of unemployment could turn out to cost less than several months' worth of premiums under a COBRA insurance extension, Reischauer said.

He noted that, of the 10.5 million uninsured children in Thorpe's estimate, only a portion of that number remain uninsured for a full year or longer. According to analysts for the Center for Studying System Change, of the 8.5 million uninsured children in their estimate, about 6.7 million (79 percent) are uninsured for a full year. Thus the number of children facing long periods of uninsured status is not nearly so large as the figures bandied about during the balanced budget debate.

The CBO's preliminary estimate of the number of children who may become insured under SCHIP is 2.5 million. House Republican staff

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argue that this figure will drop to 1.5 million once the "crowd-out effect" is factored in.<sup>4</sup> Researchers continue to examine how expansions of public programs may encourage people who are already insured under private plans to simply shift to a public plan, especially if the latter's out-of-pocket costs are lower or the benefits are better. "Crowd-out" defeats the purpose of expanding government programs to cover uninsured people; the policy goal is *not* to take on more of the private sector's share.<sup>5</sup> As for the high end of the estimates, the Children's Defense Fund predicts that as many as 5 million uninsured children may be covered by SCHIP.<sup>6</sup>

#### A FOOT IN THE DOOR?

Whether the number of newly insured children is 1.5 million or 5 million, most analysts agree that SCHIP represents a sizable new infusion of money to be used for expanding healthcare coverage. The new program gives the president a victory to offset the defeat of his healthcare reform plan in 1994. And it gives states new authority and flexibility in designing programs to fit their highly varying needs.

Some analysts worry that this flexibility may result in new inequities as some states manage their resources better than others. And some Republicans worry that SCHIP is a foot in the door, a prelude to broader entitlement programs in the future.

For now, we will just have to see what \$24 billion can buy. □

#### NOTES

1. American Hospital Association, "'Kiddie Care' Block Grants Will Insure 2 Million Children," *AHA News*, August 4, 1997.
2. Kenneth E. Thorpe, "Incremental Approaches to Covering Uninsured Children: Design and Policy Issues," *Health Affairs*, July-August 1997, pp. 64-78.
3. Preliminary survey results were released at a June 10, 1997, press briefing. Survey data were collected from July 1996 to February 1997.
4. "Kids' Plan Gets 10-Year Funding, May Cover 1.5 Million Uninsured," *Medicine & Health*, August 4, 1997.
5. For a discussion of "crowd-out," see Jane Hiebert-White, "Insuring the Children," *Health Progress*, January-February 1997, pp. 12-14.
6. Jon Jeter, "Budget Deal Creates Health Care Quandary," *Washington Post*, August 4, 1997, p. 1.