Insuring the Children

BY JANE HIEBERT-WHITE

With the November 1996 election being hailed as the triumph of the status quo, reform advocates who wish to expand insurance coverage to children were given little hope. Just after the election, Julia James, chief health analyst for the Senate Finance Committee, predicted that the new Congress's top priority would be Medicare reform, since "Medicare played a very significant role in the election." Traditionally Republican states Florida and Arizona went to Clinton in this election largely because of his campaigning on Medicare, said James. "Medicaid and expansion of coverage [to children] will be down the list" of issues to address, she said.

By December, however, interest in expanding health insurance coverage to more children started to heat up. Sen. Tom Daschle, D-SD, after his reelection to the minority leader position the first week of December, signaled that expanding healthcare for children would be one of his top priorities. Sens. Edward Kennedy, D-MA, and John Kerry, D-MA, plan to unveil a proposal to help families purchase insurance for their children with the assistance of grants to the states. The White House has raised the subject in the context of a balanced budget and the administration's Worker's Transition Initiative. This plan would expand coverage to people who are temporarily unemployed, including some 700,000 dependent children. This builds on the passage of the Health Insurance Portability and Accountability Act.

Successful expansion of health insurance coverage for children will require a bipartisan effort. Some Republican members of Congress have expressed interest in the issue, but cost will be a point of concern and negotiation.

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Medicaid Spending Declining

One factor that may affect the debate is new evidence that Medicaid spending has slowed dramatically. Between 1988 and 1992, Medicaid spending increased at a phenomenal average annual rate of 22.4 percent. According to a new study sponsored by the Kaiser Commission on the Future of Medicaid and conducted by the Urban Institute, Medicaid spending slowed to an average of 9.5 percent per year between 1992 and 1995, and preliminary data for 1995-96 spending show Medicaid spending growth at only 3.2 percent.[1]

The 3.2 percent projected growth for 1996 may be artificially low, since it "probably reflects an acceleration of state spending in 1995 because of proposed legislation to restructure Medicaid that would have used 1995 data as the basis for distribution of block grants," note the report's authors, John Holohan and David Liska. Nevertheless, the average spending across 1994-96 is about 6 percent a year, they say, which is much lower than projections the Congressional Budget Office (CBO) released in April 1996. Holohan and Liska project Medicaid spending will grow at 7.4 percent a year over the next six years, compared with the CBO's growth estimate of 9.7 percent. The CBO plans to release its own new estimates for entitlement spending (Medicaid, Medicare, and Social Security) in January 1997.

These findings could have significant ramifications for the policy debate surrounding health insurance for children. Since federal Medicaid expenses are not as high as predicted, policymakers may be more willing to consider expanding the insurance program to include more uninsured children. And they will have less need to radically restructure the program to constrain costs. "Much of the policy debate in the last Congress was fueled by the concern that Medicaid spending was out of control and needed to be reined in," said Jim Tallon, chair of the Kaiser Commission on the Future of Medicaid and president of the United Hospital Fund, in a December 1996 press release. "It now appears this goal can be achieved without major program restructuring," he concluded.

Using the 7.4 percent annual growth rate projected by the Urban Institute researchers, the federal government would spend $59.3 billion less

on Medicaid during 1996-2002, compared with the CBO's estimate. If one uses the lower Urban Institute baseline of 3.2 percent Medicaid spending growth for 1996, federal savings increase to $94.3 billion over the six-year period.

The three main reasons Medicaid spending has slowed, according to the report, are (1) limitations on disproportionate-share hospital payments, (2) slower enrollment growth, and (3) slower growth in spending per Medicaid beneficiary. Several factors contributed to the slowdown. Federal legislation has limited use of provider taxes and donations and placed a ceiling on the disproportionate-share hospital payments. General and medical price inflation have slowed, partly due to an improved economy. And states have implemented a variety of Medicaid cost-containment efforts, including increasing Medicaid enrollment in managed care plans. In 1983 only 3 percent of Medicaid beneficiaries were in managed care plans; by 1995 this had increased to nearly a third of enrollees (11.6 million Medicaid beneficiaries).[2] In Tennessee and Arizona, almost the entire Medicaid population is covered by managed care.

One concern Holohan and Liska raised in their report is the fact that their suggested Medicaid enrollment for the next six years is about 2.7 million lower than the CBO's estimate. "Policymakers need to be concerned about the insurance coverage of those who otherwise would have Medicaid coverage; recent evidence suggests these individuals may not secure private coverage. . . . If employer-sponsored coverage continues to drop as it has recently at the same time Medicaid enrollment slows, the number of uninsured persons could rise precipitously by 2002," conclude Holohan and Liska.

Expanding Medicaid/Declining Private Insurance

In addition to potential increases in the number of uninsured persons, Medicaid and private insurance data show another trend of concern to health policy researchers and public policymakers as they debate expanding insurance coverage to children. From 1987 to 1992, Medicaid coverage of children expanded from 15 percent to 21 percent of all children. Simultaneously, the proportion of children covered by private health insurance fell from 77 percent to 69 percent.[3] Beginning in 1986, the federal government and some states raised the cutoff for Medicaid eligibility by child's age and family income to help cover more children and pregnant women. This raises the question: Did well-meaning expansions in the Medicaid program "crowd out" private insurance coverage?

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The shift of children and pregnant women from private insurance to Medicaid is a concern for several reasons. According to Rick Curtis and his colleagues at the Institute for Health Policy Solutions in Washington, DC, "The substitution of Medicaid for private dollars and private coverage not only represents an inefficient use of scarce public funds but also may have negative effects for beneficiaries."[4] For instance, Medicaid enrollees may face more access-to-care barriers than privately insured persons; a shift to Medicaid will reduce a person's continuity of care with his or her provider; and Medicaid carries a stigma of welfare for many people. On the positive side, Medicaid covers more out-of-pocket costs than the typical private insurance plan, without any premium expenses.

Researchers dispute the actual amount of "crowd-out." The percentage drop in employer-sponsored private insurance resulting from expansions in Medicaid ranges from 13 percent to 34 percent.[5] Other reasons for the decline in private insurance coverage include the recession of 1990-91 and "changes in the nature of employment and employers' views about the benefits they need to offer to attract workers," explain David Cutler, an economist at Harvard University, and Jonathan Gruber, an economist at the Massachusetts Institute of Technology.[6] Both are faculty research fellows at the National Bureau of Economic Research.

Without the Medicaid expansions, however, 80 percent of the new enrollees, or 4 million people, would have been uninsured, says Holohan, director of the Urban Institute's Health Policy Center. So while Medicaid expansion has clearly helped some Americans, the concern about shifting a portion of Americans from private insurance to public insurance raises a major question. According to Holohan, "If the nation wants to address the problem of the large number of uninsured, low-income Americans and if Medicaid crowding out is unacceptable, how can coverage be expanded?"

One alternative, suggests Holohan, is to provide employers and/or low-wage individuals with subsidies to purchase employer-sponsored private health insurance. The problem with this solution is that subsidies are costly. They need to be quite high to provide enough incentive to join a private health insurance plan. Also, "it is impossible to limit the subsidies to those who otherwise would have been uninsured," notes Holohan.

In discussions surrounding expansion of insurance coverage for children, the two most plausible options that have emerged are (1) expanding

Medicaid coverage, and (2) providing subsidies to purchase private insurance coverage. Clearly, researchers, policymakers, and advocates considering how to insure the nation's children will have to weigh the trade-offs between the possibility that Medicaid expansions will "crowd-out" private coverage and the high cost of subsidies.

Other Difficult Issues

Beyond cost concerns and trade-offs between public and private insurance, other difficult issues emerge regarding children and health insurance.

Enrollment One problem is getting eligible children enrolled. Only about 60 percent of the uninsured children who were eligible for Medicaid during 1987-92 took advantage of the coverage.[7] "Perhaps the greatest gains in Medicaid effectiveness could come from earlier enrollment of those who are now eligible but not enrolled in the system," suggest economists Cutler and Gruber.

Health Status Some policy analysts argue that expanding health insurance to all children will not necessarily improve their health status. At an October 1996 conference cosponsored by Columbia University and the Robert Wood Johnson Foundation on "First Steps for Children: Strategies for Universal Health Insurance for Our Nation's Youth," Michael Sparer of Columbia University stated, "I am not arguing against universal health insurance. Insurance does count. But lack of insurance isn't the only barrier to health care.

"Lots of systems impact on a child's health, which have to be coordinated—criminal justice, welfare, education" to name a few, continued Sparer. We need to develop "strategies for improving the *health* of the nation's youth," he argued.

Colleen Grogan, an assistant professor at Yale University, challenged Sparer at the conference. "The very question of insurance and health status is misguided. Insurance protects from the high cost of unplanned events. Therefore, we should not only look at whether having insurance improves health," she said. It also reduces financial risk.

Turf Areas In considering the different systems that affect children's health status, some analysts at the children's conference questioned whether the different welfare, healthcare, education, mental health, and criminal justice agencies would be able to join around a rallying point. All of them are battling for a slice of the limited government funding pie.

Children Are Different Children's healthcare systems are very different from those of adults, Neal Halfon, an associate professor at the UCLA Center for Healthier Children, Families, and Communities, noted at the New York children's conference. Schools provide wraparound personal medical care services for children, there are welfare systems for children who are abused, and so on. "It's important to get the *system* issues right," he said. "This is what managed care is all about—coordinating care. Yet we're not developing managed care systems for kids."

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Some Advice for Next Steps

Despite all the difficult issues surrounding children's healthcare and insurance, Harvard professor and historian Theda Skocpol offered some advice at the children's conference. First, "don't call it healthcare reform." Instead, it should build on the new welfare reform legislation. This could be seen as "snatching victory from reform defeat, à la Truman," said Skocpol. "It may make Republicans look better after welfare reform and would show Democrats helping families move from welfare to work." Today, loss of Medicaid healthcare coverage is still a sizable barrier for those who wish to leave welfare.

Second, today's child-care advocates tend to be professional and academic, but not as involved at the grassroots level. "Today's advocates need to mobilize popular support" to improve children's healthcare coverage, said Skocpol. She argued that beyond bipartisan support, children's healthcare needs "transpartisan" support. "We have to have partisans—the PTA, churches—groups that have national offices but also reach well into the communities," said Skocpol. These partisans could "increase civic awareness and connectedness that then pushes states and the federal government to act. . . . And don't exclude the parents," she concluded. □

NOTES

1. John Holohan and David Liska, *Where Is Medicaid Spending Headed?* Urban Institute, Washington, DC, December 1996.
2. Diane Rowland and Kristina Hanson, "Medicaid: Moving to Managed Care," *Health Affairs*, Fall 1996, pp. 150-152.
3. David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, January-February 1997, pp. 194-200.
4. Richard Curtis, Mark Merlis, and Ann Page, "Finding Practical Solutions to Crowding Out,'" *Health Affairs*, January-February 1997, pp. 201-203.
5. John Holohan, "Crowding Out: How Big a Problem?" *Health Affairs*, January-February 1997, pp. 204-206.
6. Cutler and Gruber.
7. Cutler and Gruber.