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WHAT TO DO ABOUT UNINSURED CHILDREN

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INTRODUCTION

Americans of all political persuasions are understandably concerned about the fact that millions of children lack the protection of health insurance. To be sure, many of these children do have access to a reasonable level of health services when serious illness or injury strikes. But it is nonetheless deeply disturbing that many children and their parents lack the normal range of health care services and the financial security that comes with adequate insurance.

If this problem is to be solved, however, two things are needed. The first is that leading lawmakers should not permit the plight of uninsured children to be reduced to a political weapon, as Medicare was in the last Congress and during the most recent election cycle. Unfortunately, there are signs that some organizations may see it as just that. For example, John Sweeney, President of the AFL–CIO, declared at last year's annual conference of the American Public Health Association, "If they [conservatives] don't come around, we'll use children's health the way we used Medicare, and that's a promise and a commitment."[1]

The second thing that must happen is for lawmakers interested in a genuine solution to understand the root cause of the uninsurance problem, and to propose actions that begin to deal with that root cause rather than apply Band-Aids to the symptoms. In so doing, they also must ponder the long-term effects of proposals they make to deal with uninsured children, lest these proposals produce damaging side effects or eventual results that run counter to their goals. Unfortunately, some of the proposals now being discussed would create new problems without effectively addressing the problem.

Congress must recognize that the phenomenon of uninsured children, and of other uninsured Americans, is the direct result of the fact that the health insurance—if any—of most families with children typically is employment-based. The underlying problem with this situation is that it

1 "AFL–CIO President Joins with APHA to Demand Coverage for All Children," Bureau of National Affairs, *Health Care Policy Report*, November 19, 1996.

HOW EMPLOYER-BASED INSURANCE BOOSTS UNINSURANCE

There is a direct link between the tax-advantaged system of employer-based health insurance and the high level of uninsurance, especially among children.

Under the employment-based system, a worker gets tax benefits, but only by giving up ownership and control of the family's health insurance. This triggers incentives and dynamics that exacerbate uninsurance. Three examples:

- Because the employer, not the worker, owns the health plan, every time the worker changes jobs, his or her insurance must change or may be lost. The common result: uninsurance.
- In industries in which there tends to be a high turnover of employees, such as the service sector, there is little or no incentive for the employer to "invest" in the health of the worker's children, or even in the long-term health of the employee. The common result: uninsurance among children.
- In employment-based coverage, the insurer works for the employer, not the employee. The common result: insurance that tends to be indifferent to the needs of the patient, and is focused instead on cutting costs.

prevents working families from choosing and owning their health insurance—unlike the way they select the providers of their life insurance, homeowner's insurance, and automobile insurance. With employment-based health care insurance, employers choose and own the plan. To be sure, that part of the employee's compensation earmarked for a health insurance fringe benefit is tax-free to the employee. But there is a stiff price associated with this benefit: families lose control of the benefits. Consequently, the cost-control objectives of the employer often will run counter to the goals of the family. For example, employers experiencing a relatively high turnover of staff have little incentive to "invest" in the health of the children of those employees, which is one reason dependent coverage is less prevalent in the low-skill service sector. Furthermore, because the insurance is employment-based, a job change means a change or interruption in coverage, and possibly the loss of protection. These and other consequences of employer-owned insurance lead directly to high levels of uninsurance among children.

It is deeply troubling that many children in the United States lack access to a dependable, predictable system of health care. But action to deal with the problems must seek to address the underlying cause, not just the symptoms. Fortunately, there are steps Congress can take, mainly by using existing programs and resources, that can begin to deal systematically with the problem. Specifically, Congress should:

- Make it easier for families to own and control their health insurance by reforming the tax treatment of health insurance and spending. Congress should provide immediate help in the form of a tax deduction for children's medical expenses for families without health coverage for children. This deduction should be made available as "above-the-line" so it is available to families that do not itemize their tax return. Congress also should introduce refundable tax credits for health care purchases for lower-income, working families and consider converting the deduction over time into a credit.
- Allow states more flexibility in using existing federal Medicaid funds. Most states already have expanded coverage to uninsured women and children beyond the federal minimum requirements by making use of federal waivers and options. In addition, there are numerous public-private partnerships and solely privately funded programs that provide health coverage to thousands of children in communities across the country and serve as models for

community-based solutions. Allowing states more flexibility with existing Medicaid funds could enhance existing programs and allow new ones to develop.

Tax relief and Medicaid flexibility are incremental, targeted responses to the problem of uninsured children that avoid the onerous regulations and expense of new federal grant programs. More important, these limited measures will begin to shift the debate over health care reform in this country away from one that historically has centered around how the government can "fix" what is wrong with the system with new taxes, regulation, and mandates on private business and insurers and toward how the government can create new health care choices for people who lack them today.

WHO ARE THE UNINSURED?

Before endorsing any proposal to provide health coverage for America's children, lawmakers and their constituents first must find answers to some basic questions. Who are the uninsured? Why are people uninsured, and why are the numbers growing? What are federal government, state governments, and private entities currently doing to address this problem? And what are the long-term implications of proposed reforms? Only after these questions are answered can new solutions be considered.

The ranks of the uninsured are growing, and there are distinct patterns.

- By analyzing the 1996 Current Population Survey data from the U. S. Bureau of the Census, the Employee Benefit Research Institute (EBRI) found that, in 1995, there were approximately 40.3 million non-elderly Americans (or 17.4 percent) without any form of health coverage, public or private. This was up from an uninsured rate of 15.2 percent in 1988. These data correspond with declines in employment-based health insurance—63.8 percent of the population was covered by such insurance in 1995, down from 69.5 percent covered in 1988.[2]

- There are approximately 70.1 million children in the United States. According to the EBRI, 9.8 million of them were uninsured for the entire year in 1995. Data compiled by the Congressional Budget Office (CBO), based on the Bureau of the Census's Survey of Income and Program Participation (SIPP) (which tracks the transitions in health coverage for children over time), indicate that, in 1993, 15.5 percent of children were uninsured for some part of the year while 6.5 percent of children were uninsured throughout the year.[3]

- Employer-based coverage has eroded for children. The figure fell from 66.7 percent covered as dependents in 1987 to 58.6 percent in 1995.[4]

- Although there was a decline in private health benefits, there was a significant increase in Medicaid coverage, rising from 15.5 to 23.2 percent of all children in the same period. Therefore, the total number of uninsured children only increased from 13.1 percent in 1987 to 13.8 percent in 1995.[5]

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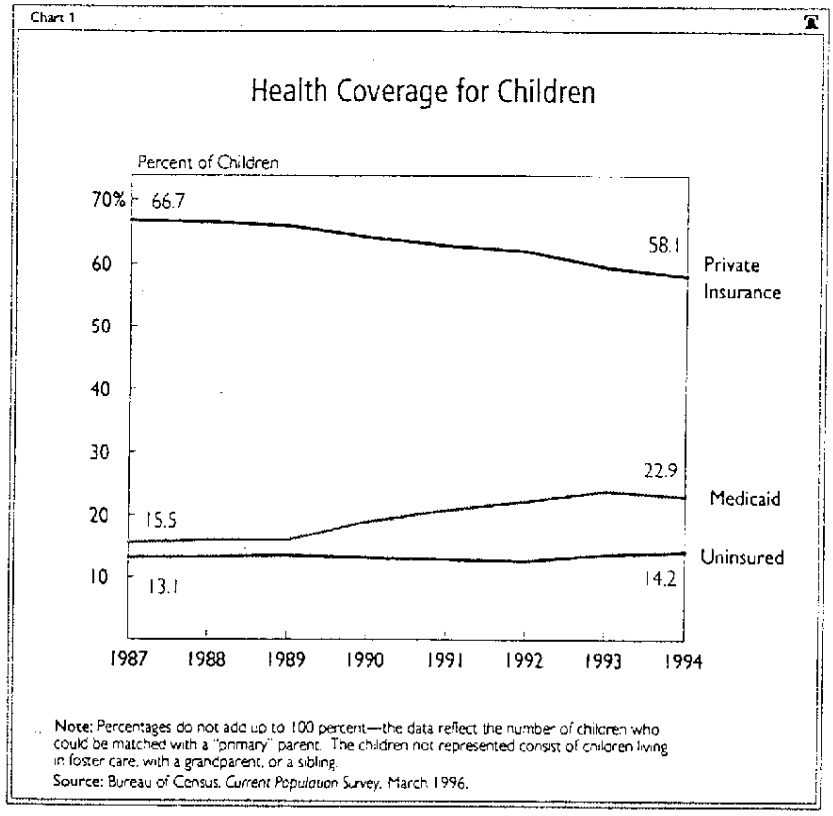
2 Employee Benefit Research Institute, "Sources and Health Insurance and Characteristics of the Uninsured," *Issue Brief* No. 179, November 1996.

3 Written Testimony of Linda Bilheimer, Congressional Budget Office, before the House Ways and Means Health Subcommittee, Proposals to Expand Health Coverage for Children, April 8, 1997, p. 23. *Note:* the CBO interprets Current Population Survey data as a point-in-time estimate of uninsured children rather than a full-year estimate.

4 EBRI, "Sources and Health Insurance and Characteristics of the Uninsured."

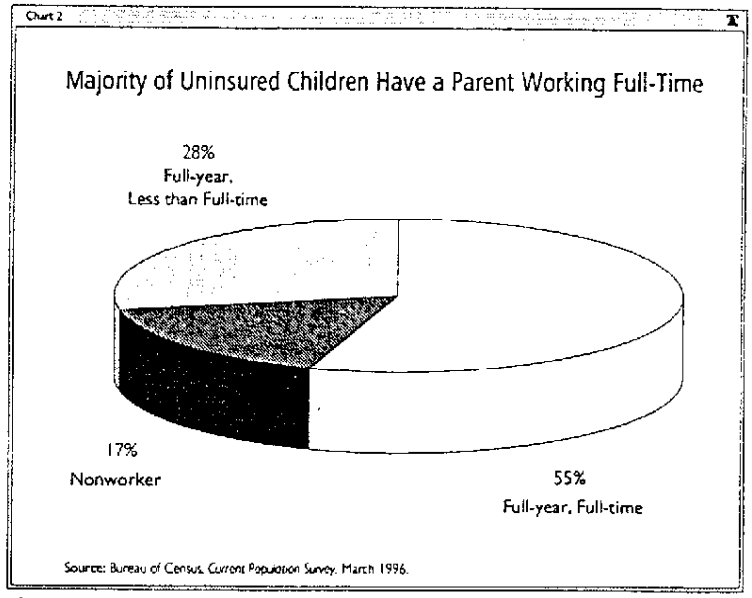
5 *Ibid.*

- According to the U.S. General Accounting Office (GAO), there were approximately 2.9 million uninsured children in 1994 who met federal guidelines for Medicaid eligibility but were not enrolled. Of these children, 80.4 percent had working parents.[6]



- Approximately 60 percent of uninsured individuals live in households that have annual incomes under $33,000 annually, or 200 percent of the federal poverty level (for a family of four) in 1997. Seventy percent of uninsured children live in households with annual incomes under 200 percent of poverty. Almost two-thirds (63.4 percent) of uninsured children live in two-parent families. Fifty-five percent of uninsured children in 1995 lived in households in which at least one parent was working full-time, year round; and 28 percent in households in which at least one parent was working full-time, but for less than a full year.[7]

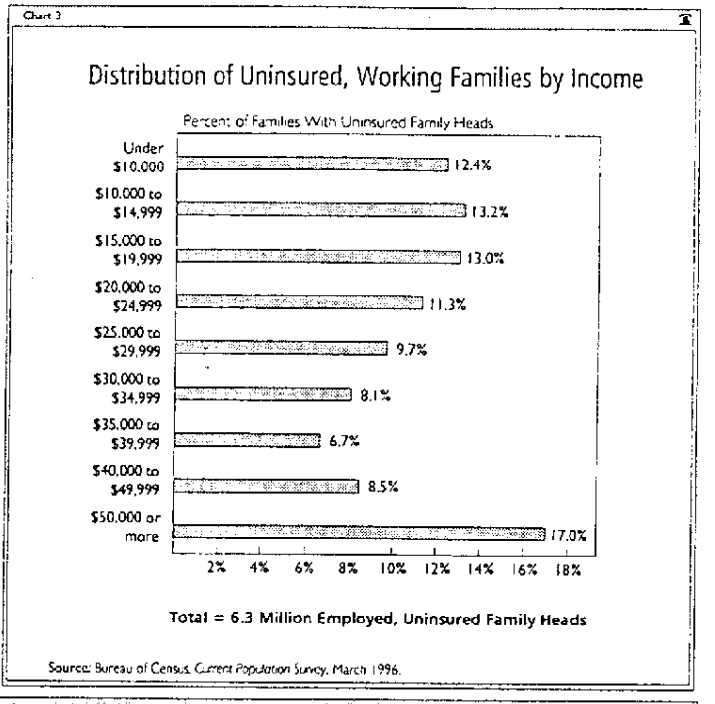
- In 1995, 11 states had populations with 20 percent or more uninsured adults and children. The state with the largest percentage of uninsured was New Mexico, with 28.4 percent of its population without public or private health coverage. (New Mexico also had the highest rate of Medicaid coverage outside the District of Columbia.) The states with the highest level of uninsured generally are located in the southeastern and southwestern parts of the United States. These areas also typically contain the states with the highest numbers of non-citizen and racial minority residents: approximately 42.5 percent of non-citizens and uninsured. Separated by race, 23 percent of the black population, 35 percent of the Hispanic population, and 13 percent of the white



6 U.S. General Accounting Office, "Health Insurance For Children: Private Insurance Coverage Continues to Deteriorate, GAO/HEHS 96–129," June 1996, p. 3.

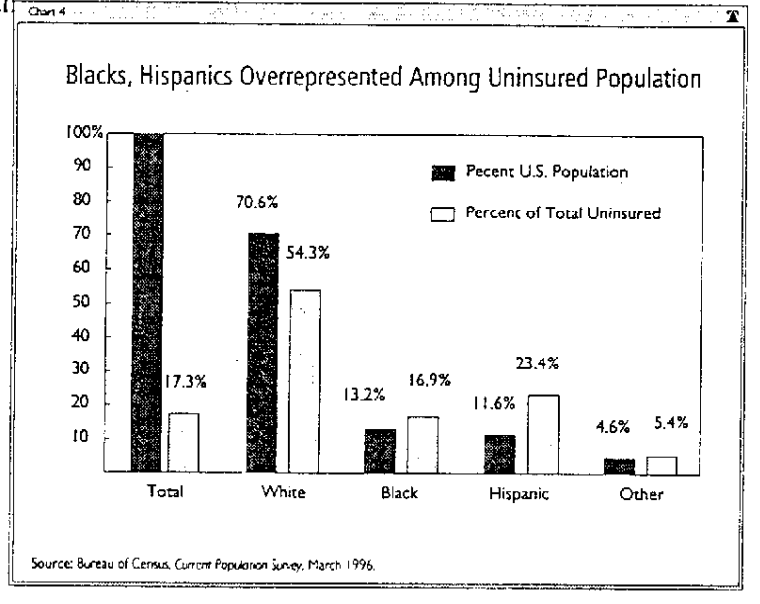
7 EBRI, "Characteristics of Uninsured Children," *Notes* No. 1, January 1997.

population went without health insurance in 1995. Of the total number of uninsured, 16 percent were non-citizens. Again, separated by race, of the total number of uninsured, 17 percent were black, 23 percent Hispanic, and 54 percent white.[8]



WHY ARE PEOPLE UNINSURED?

Health insurance coverage—and, commensurably, the lack thereof—is predominantly a function of employment. The major reason that children lack health care coverage, even though 83 percent have parents who work, is that the parent works for a company that does not offer a health insurance plan that covers dependents or does so at an out-of-pocket cost that is too high for the employee. This statistic is testament to the limitations of the current employer-based health care system. If an individual's employer does not provide health benefits, or provides coverage but participation is too costly for the employee, workers are left with the option of purchasing coverage on their own. But this option involves a large tax penalty.

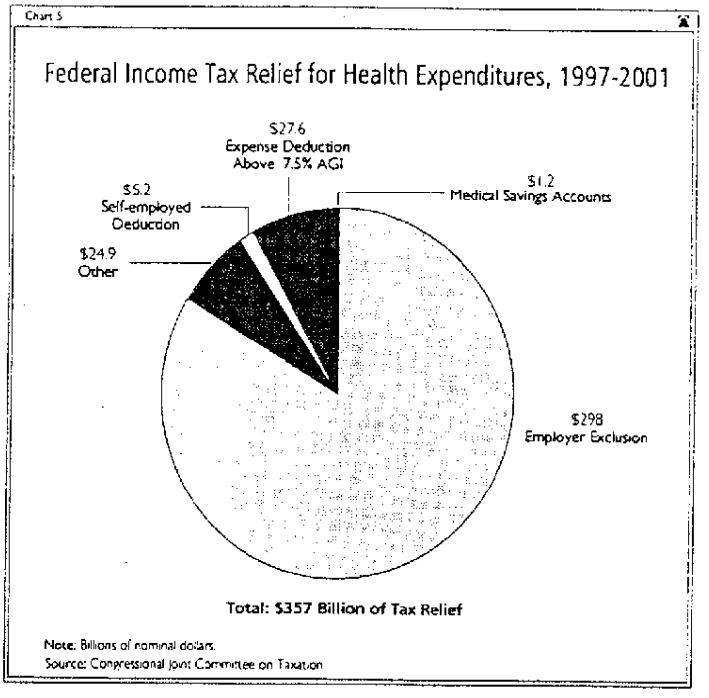


The Tax Treatment of Health Care

The federal government currently provides restricted tax relief in the following ways for the purchase of health insurance: a tax deduction for those who have annual personal health expenditures that exceed 7.5 percent of adjusted gross income; a tax deduction as a business expense of the cost of benefits for businesses that provide health insurance to their employees; a deduction for the self-employed for the cost of health insurance (currently at 30 percent, but rising to 80 percent by the year 2006); and finally, and most important, a tax exclusion from employee income and payroll taxes for the cost of employer-provided health benefits. The Congressional Joint Committee on Taxation (JCT) estimates this federal tax relief alone represents approximately $52 billion in 1997 in foregone federal income tax revenues. According to the JCT, the tax exclusion for employer contributions for health insurance is the second-largest tax benefit available to Americans after the tax break for employer-sponsored pension contributions, and is estimated to be worth $298 billion between 1997 and 2001.[9] (Figures represent foregone income tax revenue only; foregone payroll

8 EBRI, "Sources and Health Insurance and Characteristics of the Uninsured."

tax revenues are not included.)



Individuals who work in jobs without employer-sponsored health benefits are not eligible for this relief, however. Typically, their only option is to purchase health insurance individually with after-tax income. Yet, because individual health policies commonly cost as much as $6,000 annually for a family of four, the lack of adequate tax relief or other assistance from the federal government means a family's purchase of coverage for itself is no option at all.

The CBO studied the tax treatment of health care in 1994[10] and found four fundamental problems with the U.S. health care system created by current tax policy. According to the CBO, employer-based insurance:

- undermines the portability of health insurance and restricts consumer choice because the insured individual's employer owns the health policy;
- hides the true cost of health care as well as the identity of the person paying for health care by creating the impression that health care is a free fringe benefit, not money otherwise spent on wages or other benefits (other studies indicate that up to 88 percent of the cost of health benefits is actually paid for by lower employee compensation[11]);
- fuels higher health costs because it encourages employees to seek more comprehensive and expensive benefits—the more expensive the benefits, the greater the tax exclusion; and
- is, therefore, very regressive, favoring those with higher incomes, while low-income workers—who are least able to afford coverage on their own—benefit very little.

The Portability Problem. Employer ownership of health insurance is at the heart of the problem of portability of health coverage. A lack of portability contributes to the uninsurance phenomenon because adults and children often become uninsured for a period in which a parent is between jobs and temporarily lacks employer-sponsored coverage. Workers face uninsurance if they lose their job, or they can feel trapped in their current job, because their employer owns their health insurance policy and that coverage will be lost once that worker leaves his place of employment. Public Law 104–191, the Kennedy–Kassebaum Health Insurance Portability and Accountability Act (HIPAA) passed by Congress last year, attempts to legislate insurance portability and end "job lock" by requiring insurers to issue health coverage, regardless of health status (or guarantee issue) to individuals moving from one group plan to another if they change jobs and for persons wishing to purchase an individual policy if they lose their jobs. Although this requirement may provide some level of

9 Congressional Joint Committee on Taxation report, "Estimates of Federal Tax Expenditures for Fiscal Years 1997–2001," JCS–11–96, November 26, 1996.

10 Congressional Budget Office, "The Tax Treatment of Employment Based Health Insurance," March 1994.

11 Analysis performed by Lewin–VHI for The Heritage Foundation. For more information on this subject, see John Liu, "What the CBO Says about the Tax Treatment of Employment-Based Health Insurance," Heritage Foundation *F.Y.I.*, May 25, 1994.

security for workers, it does not provide for true portability because the law only requires a new insurance plan be available for an individual who changes or loses his job—it does not allow that individual to keep the same health plan. Thus, a worker could move from a job that offers dependent coverage to one that does not. True market portability comes from an individual's owning his own health policy.

The Erosion of Employer-Based Insurance. Another problem with employer-sponsored insurance is related to the pattern in recent decades in which the cost of health benefits has been rising faster than total compensation. The employer's response to the growing cost burden of employee health coverage has been either to reduce coverage or to move employees to managed care health plans. The success of this strategy from the employers' point of view is evident. The average annual growth in employer health benefit costs was 18.6 percent in 1988. Eight years later, in 1996, employer health costs rose only 2.5 percent. According to a survey performed by the accounting firm KPMG Peat Marwick, this was the smallest annual increase in health insurance costs since the 1960s and the first time in recent years that the medical consumer price index (CPI) was lower than the overall CPI. This decline has come hand-in-hand with the rapid growth of managed care: Three-quarters of all workers covered by employer-sponsored plans are enrolled in some form of managed care today.[12] The recent stretch of slow-growing health care inflation, however, could be coming to an end: Some experts predict employee health benefits costs will grow 4 percent in 1997 and possibly even 10 percent in 1998,[13] particularly with the rapid consolidation of the health provider industry and with the federal government's move toward regulating the means by which managed care companies attempt to control costs.

But how does the significant decline in the growth of employer-based health costs in the past few years jibe with the fact that Americans have experienced a steady erosion of employer-based health coverage over much of the past decade? Employer-based coverage fell almost 6 percentage points between 1989 and 1993, with only 63.5 percent of the population covered by employer-provided health insurance in 1993.[14] Although there are various hypotheses for this apparent contradiction, the primary reason for the erosion of employer-based health coverage is still its high cost.

Besides the move to managed care, the other method employers have used to hold down their costs, is to shift a greater percentage of health costs to employees, such as requiring employees to pay some or a greater proportion of premiums, especially for family coverage. This, in turn, causes some employees not to enroll themselves and/or their dependents in employer-sponsored plans even when such coverage is available. EBRI statistics indicate that 16 percent of uninsured children have parents with employer-sponsored health plans, although it is unclear whether dependent coverage is not offered or employees are declining coverage for themselves and/or their dependents.[15]

In addition, there are more temporary workers today, and continued growth is expected in transitory service industry jobs. Both these populations of workers are less likely to have health coverage offered through their place of employment. One reason for this practice is the typical unwillingness of insurers to negotiate attractive long-term insurance contracts with employers when the employment group is constantly changing. This encourages insurers frequently to negotiate annual contracts that are experience-rated (that is, premiums are based on the actual claims of the previous year) and optionally renewable. This uncertainty leads many employers in high-turnover firms to forego providing insurance altogether.

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12 Robert Langreth, "Employers' Health Costs Are Stabilizing," *The Wall Street Journal,* October 7, 1996, p. A3.

13 Ron Winslow, "Health-Care Costs May Be Heading Up Again," *The Wall Street Journal,* January 21, 1997, p. B1.

14 "Sources and Health Insurance and Characteristics of the Uninsured."

15 EBRI, "Sources and Health Insurance and Characteristics of the Uninsured."

Medicaid "Crowding Out." Another explanation for the erosion of employer-based insurance is that Medicaid coverage may be substituting for private coverage. There is a growing body of evidence to suggest that expansions in public programs, such as Medicaid, have led to a phenomenon called "crowding out"—that is, expanded eligibility for publicly financed programs into the working poor population have induced some employers to drop dependent coverage (if dependents are perceived to be eligible for Medicaid). In some cases, the employer may discontinue all employee coverage. In other cases, employees choose to forego coverage provided through their employer because free or subsidized coverage is available to them through Medicaid or other state-sponsored, low-income health care programs.

Medicaid expansions in the early 1990s increased eligibility to a significant number of previously ineligible women and children—nearly two-thirds of whom already had private health insurance—while employer-based coverage for children was declining. David Cutler of Harvard University and Jonathan Gruber of MIT have studied the extent to which increases in Medicaid coverage have been responsible for declines in employer-based coverage. They found that the overall share of the decline in private insurance between 1987 and 1992 resulting from Medicaid expansions was about 15 percent. In addition, they found that 1.5 million children who were not previously eligible were added to the Medicaid rolls during this same period, and that this increase led to a decline in children covered by private insurance of 0.6 million.[16] The extent to which public dollars replace private ones also increases as family income moves above the federal poverty line. Lisa Dubay and Genevieve Kenney of the Urban Institute report that, for pregnant women with incomes under the poverty level, Medicaid expansions accounted for little or no decline in employer-based coverage. For pregnant women with incomes between 100 and 185 percent of poverty, however, Medicaid expansions accounted for a decline of 52 percent in employer coverage.[17]

Public Programs Are Not Fully Utilized. Statistics indicate that almost one-third of the children who are currently without health insurance coverage actually are eligible for Medicaid under federal rules. There are several reasons that such a large number of children are not enrolled. One is that parents are not even aware that the child is eligible. (This is particularly true of working parents whose families are not enrolled in the Aid for Families with Dependent Children [AFDC] program.) Another is the complexities of the enrollment process. In addition, many parents want to avoid the stigma of welfare. This population represents such a large cohort of the uninsured that it is very important for close attention to be paid to the reasons these individuals are not enrolled when evaluating new national programs designed at covering the uninsured.

Problems in the Insurance Market. A number of states have passed insurance reforms aimed at making health insurance more accessible and affordable; yet, in some ways, these reforms only have exacerbated the problem. The most common insurance market reforms are designed to increase access to health insurance for individuals or groups that are costly to insure, or to enable groups to continue coverage they already have. These include requirements that plans be guaranteed renewable, and guaranteed issue, as well as the introduction of community rating. Guarantee renewal requires insurers to renew coverage for groups and/or individuals regardless of the experience of the previous year's claims, often with restrictions placed on the premiums that can be charged. Similarly, guarantee issue requirements force insurers to provide coverage to any

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16 David Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs,* January/February 1997, pp. 196, 198.

17 Cited in Rick Curtis and Ann Page, "Improving Health Care Coverage for Low-Income Children and Pregnant Women: Public & Employer-Financed Coverage Relations," The Institute for Health Policy *Solutions,* December 17, 1996, p.10.

employer group or individual who applies, regardless of health status. Community rating prohibits insurers from charging different premiums for different groups within a given geographic area.

When reforms combine guarantee issue requirements with community rating, the result is a rise in average premium rates (because insurers must accept all comers, including the chronically ill, but they cannot vary premiums based on health status or age). Some healthy individuals, seeing no extra insurance value accompanying the significantly higher premiums under community rating, drop out of the insurance market altogether, triggering spiraling costs by creating a sicker risk pool to insure. Many states, like Kentucky, Vermont, and Washington, have passed some or all of these restrictions on commercial insurance and have experienced dramatic increases in premium rates, particularly in the individual market; many insurers decide to quit issuing policies as a result. For example, Kentucky passed community rating and guarantee issue reforms for the individual market in 1994. Since then, 40 private health insurers have stopped selling individual policies and, in January of this year, the state's health purchasing alliance approved premium rate increases of between 10 and 40 percent for the individual insurers remaining in the market.[18]

With the passage of the Kennedy–Kassebaum health care bill, federal law now requires that individual market insurers guarantee issue to individuals and families leaving group health plans (although premium rates can vary). The Health Insurance Association of America estimates this requirement will increase premium costs in the short term (that is, within a year of enactment) by 10 to 19 percent.[19] The American Academy of Actuaries predicts less significant increases in premium costs—between 2 and 5 percent—for the same provision. They also predict, however, that, due to the number of options that must be exhausted before a person could enter the individual insurance market under this law, no more than 150,000 individuals would utilize this group-to-individual coverage guarantee, and they would pay up to 67 percent more for their coverage than existing policyholders.[20]

Also adding to the cost of health care, and therefore presenting a barrier for the uninsured to purchase coverage—are mandated benefit and provider laws. Over 1,000 such laws have been enacted at the state level, each requiring a specific benefit, procedure, or provider service be covered in every state-regulated insurance policy sold. The costs of these mandates vary from state to state. For example, the GAO estimates that mandated benefit laws account for 12 percent of claims costs in Virginia and 22 percent in Maryland.[21] Last September, with the passage of mandated in-patient coverage for maternity stays and mental health parity legislation, Congress for the first time started down this dangerous path of mandating what benefits Americans must have in their private health plans, further adding to the cost of coverage for everyone.

WHAT STATES AND COMMUNITIES ARE DOING

States and communities already have begun to address the uninsured children issue in a number of ways.

A number of private health insurers and philanthropic organizations have initiated programs to provide outreach and coverage for children. And many states have combined public and private resources to provide access to health insurance and health services for children. Any national

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18 Bureau of National Affairs, "Anthem to Drop Percentage Commissions to Agents for Individual Health Policies," *Health Policy Report,* Vol. 4, December 9, 1996, p. 1875.

19 Health Insurance Association of America, "The Cost of Ending 'Job Lock,'" July 26, 1995, p. 4.

20 Tom Stoiber, Letter to the Editor, *The Wall Street Journal,* April 3, 1996.

21 U.S. General Accounting Office, "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance," GAO/HEHS 96–161, August, 19, 1996.

response to the health care needs of children must recognize these efforts and respect the need and efficacy of individual and community-based solutions.

Community-Based Approaches. In many communities, relationships have developed between organizations and institutions that assist the predominantly low-income populations in need of health care with the aim of improving health coverage and services. Significantly, community-based solutions recognize that the answer to problems associated with uninsurance is not always more money, or even health insurance. In *Market Driven Health Care,* Regina Herzlinger, a Professor of Business at Harvard University, argues that inconvenient health care and a lack of education regarding health needs—not the cost or absence of insurance—are the primary reasons that low-income populations do not receive adequate health care. Herzlinger defines "inconvenience" according to such criteria as how far an individual has to travel to see a doctor, whether the individual has to take time off work for an appointment, and the lack of user-friendly community-based clinics. She cites studies that assess immunization rates among poor urban infants and the use of preventative services by low-income families, reporting that:

> Although well intentioned observers believed that these shortcomings [low immunization rates] were caused by the costs of the services, providing free vaccinations and health insurance did not significantly improve the problem.[22]

Similar findings have come from studies of the health outcomes of Medicaid beneficiaries. The high incidence of infant mortality and low-birthweight babies was a driving factor for Congress when it enacted Medicaid expansions in the late 1980s. But in studies performed by the Urban Institute on the national impact of these expansions, researchers found that expanding Medicaid eligibility had "only a small effect on the timeliness of prenatal care and the incidence of low-birthweight births."[23] Making coverage available evidently does not guarantee that individuals will use it.

These findings suggest that policymakers should use caution when advocating new or expanded broad-based national programs to address the uninsurance problem. In very many cases, the necessary task is to find ways to encourage families to make use of services already available.

State-Based Initiatives. Many states and charitable organizations sponsor children's health programs, many without funding or direction from the federal government. The GAO has profiled state and community programs that are under way to address needs of uninsured children and found that, in 1995, some 14 states had publicly funded programs for uninsured children, with the number of children enrolled in programs ranging from 39 to 99,000 and budgets running from $240,000 to $71.5 million annually. Some 31 states had either publicly or privately funded programs for children in 1995.[24]

These state efforts to expand coverage for children without new federal funding or direction runs counter to the contention that governors and state legislators are somehow unwilling or unable to address the needs of their citizens—a claim that was made throughout the debate over welfare and Medicaid block grants in 1995 and 1996. In fact, Michigan had planned expansions of Medicaid coverage for uninsured children had Congress passed legislation making the program a block grant

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22 Regina Herzlinger, Ph.D., *Market Driven Health Care* (Reading, MA: Addison-Wesley Publishing Company, 1997) p. 24.

23 Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd out Private Coverage?" *Health Affairs,* January/February 1997, p. 185.

24 U.S. General Accounting Office, "Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children," GAO/HEHS 96–35, January 18, 1996, p. 7.

in 1995. Michigan was forced to put that proposal on hold when the federal legislation to restructure the Medicaid program failed in Congress.[25]

Four models have emerged in states and communities to provide health care coverage and services.

- Private initiative–funded through philanthropic organizations and/or health care insurers;
- Private-public–funded initiatives, coordinated with the county or state governments, operated independent of Medicaid;
- State-funded programs that are coordinated with Medicaid; and
- Programs that directly incorporate Medicaid benefit structure and financing.[26]

Private Initiatives. The most noteworthy private-sector initiatives (although some receive partial state funding) to expand access to health coverage for children are the Blue Cross/Blue Shield Caring Programs for Children. These operate through 26 Blue Cross health plans, providing health insurance to 225,000 children across the country. The Caring Programs for Children are predominantly financed through grassroots fundraising, and have the support of businesses, labor unions, and religious groups. Many plans match the contributions made by the community, and all Blue Cross/Blue Shield plans donate administrative services to the program. Benefits and eligibility differ from state to state, and each program is tailored to meet individual community needs and coordinated with other state-based and/or private outreach and service delivery programs.

Among the other large-scale efforts, Kaiser Permanente recently instituted a School Connections program in three Denver, Colorado–area school districts to provide Kaiser health coverage to approximately 1,300 low-income children. Kaiser is subsidizing most of the premium costs, charging participating families only $3 per month per child. They expect the program to cost $1 million annually. Kaiser Permanente also is offering the use of a clinic and its physicians for the privately operated Young and Healthy Program in Pasadena, California. This program utilizes about 160 volunteer doctors to provide comprehensive health services to approximately 7,500 children in the Pasadena area. Children access the program by referrals from school-based clinics and services are funded through foundation and private donation support. This program model has been expanded to four other California counties.

Public-Private Initiatives. Most state-based approaches involved the state government's funding of services through nonprofit entities or private insurers. Most have fixed budgets and require some amount of beneficiary cost-sharing (paying a portion of the premium), and most have varying levels of benefits. For example, Florida created the nonprofit Florida Health Kids Corporation in 1990 to manage its state-, county-, and privately funded insurance program for children. The Healthy Kids program uses schools, health maintenance organizations (HMOs), and contractors to provide administrative services, including application processing, billing, and collection, and to determine eligibility. The Healthy Kids program has grown from a small demonstration program covering only a couple counties to a comprehensive program of health services for children in 14 counties with a budget of $13 million and projected enrollment of 47,520 previously uninsured children in 1997.

Medicaid Initiatives. The federal government will provide over $100 billion in grants to states for Medicaid in fiscal year 1997. With these funds and state matching funds, many states use

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25 The Children's Partnership, "Monitoring the States: A Review of the Past Year's Efforts to Extend Health Coverage to Uninsured Children," *Next Generation Reports,* January 1997, p. 2.

26 The Children's Partnership, "America's Uninsured Children and the Changing Policy Environment," Washington, D.C., February 1996.

federal options and waiver authority to expand coverage for the uninsured. Medicaid expansion (without new federal mandates) is attractive for states because it builds on programs already in place for the traditional Medicaid population. It also allows for more seamless coverage of the near-poor population (those above current federal law minimum-coverage requirements), who tend to go on and off the program due to changing work patterns.

Currently, 40 states have expanded eligibility and service coverage for pregnant women, infants, and some children beyond the federal minimum requirements—states receive federal matching payments for this expanded, optional coverage. In addition, there are currently 15 states that have federally approved comprehensive Medicaid waivers —called "1115 waivers"—to create privately managed care systems for Medicaid beneficiaries and to extend benefits to uninsured children and some adults. Alabama, Delaware, Kentucky, Oregon, Tennessee, and Utah plan to use or already have used savings from moving to managed care to expand coverage to uninsured children and adults. Other states have expanded, or intend to expand, coverage to the uninsured through Medicaid outside managed care programs.

State-Run Block Grants. In addition to programs to expand access to health insurance for children and their families, the federal government funds a number of grant programs specifically targeted for health services or to provide general assistance to communities, including health care assistance. These programs and their fiscal year 1997 funding levels include:

- $802 million for consolidated health center grants (these include community and public housing health center funds);
- $681 million for Maternal and Child Health Block Grants;
- $96 million for the Healthy Start program (a demonstration program directed toward and preventing infant mortality and low-birthweight babies);
- $12.5 million for emergency medical services for children;
- $468 million for the Centers for Disease Control and Prevention's childhood immunization program;
- $524 million for the Vaccines for Children program, funded through Medicaid;
- $70 million for children's mental health services;
- $2.5 billion for Title 20 Social Services Block Grants; and
- $536 million for Community Services Block Grants.

There also are a number of other programs, like the Women, Infants, and Children (WIC) nutrition program, that have health care components to them.

UNDERSTANDING THE IMPLICATIONS OF PROPOSED SOLUTIONS

Unintended Consequences

Any federal action to address the lack of health insurance coverage among children must take full account of the initiatives already under way and address the root causes of the problem. Any action Congress takes will have effects on these initiatives and causes. Unfortunately, policymaking all to often takes place in a vacuum. History provides us with numerous examples of well-intentioned "fixes" to immediate problems that were made with little or no consideration of their long-term impact. These offer ample evidence of the general inability of policymakers to gauge accurately the implications of programs at their inception.