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CONFERENCE CHECKLIST ON KIDCARE: COMPARING THE HOUSE AND SENATE BILLS

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INTRODUCTION

Budget negotiators in Congress face the difficult task of reconciling legislation passed by the House and Senate to expand health coverage for uninsured children. Given the $16 billion to $24 billion in federal funding agreed to in the budget (the Senate-approved $.20 cigarette tax would add $8 billion in new revenues to a child health program), budget conferees must make critical decisions about how these funds will be spent by the states. These decisions will have far-reaching implications because the legislation being considered represents a significant expansion of the government's role as funder and administrator of health care in this country.

The degree to which the government dictates the type and scope of health coverage for uninsured children is the defining difference between the House and Senate bills, and is one that lawmakers should weigh heavily before casting a vote. The House bill would provide states with the flexibility to design health services for children that build on the approach already being taken by many states. The Senate bill would set up a rigid system that is reminiscent of the Clinton Administration's health reform plan, which Congress rejected in 1994.

Neither the House nor the Senate budget bill proposes what most uninsured American families need: individual tax relief for health costs. Neither proposal, in other words, addresses fundamental inequities created by the current tax treatment of health care purchases, which favors health coverage purchased by an employer with a generous tax subsidy yet typically gives no tax relief for health care bought by a family. Uninsurance and health care cost inflation both are direct results of this absurd and regressive tax policy. The best way to address the problems of the uninsured is to provide a refundable tax credit

to low-income families that do not receive family or dependent coverage through their place of work. This would enable low-income working families to purchase health policies that meet their children's needs without government-prescribed benefits or state health care purchasing alliances. In addition, tax relief should be combined with Medicaid flexibility to enable states to use the substantial federal resources they currently receive through this $100-billion-per-year program more effectively.[1]

Considering the options presented to conferees, however, the House bill is far superior to the Senate's. The House and Senate bills may appear to present states with similar options—both give states the choice of expanding Medicaid coverage or receiving federal funds in a capped block grant—but the similarity ends there. The Senate bill is laden with requirements on states that choose to receive a block grant—most notably, requirements that they use funds only for health insurance with federally prescribed benefits—that make the task of covering uninsured children needlessly expensive and bureaucratic.

WHAT IS WRONG WITH THE SENATE BILL

By defining and mandating generous standardized benefits and centralizing health care purchasing authority within state governments, the Senate bill puts in place (albeit in more limited form) key features of President Bill Clinton's 1994 proposal for comprehensive health care reform. Two things were central to that ill-fated Health Security Act: health insurance purchasing alliances (quasi-governmental entities responsible for collecting premiums and contracting with health plans) and government-prescribed comprehensive benefits for all Americans. As if suffering from collective amnesia regarding one of the most dramatic attempts in recent history to impose government dictates on the private market and individual choice, and despite bipartisan objection from the country's governors, the Senate has approved requirements on states that move decisively in the direction of the Clinton plan. Moreover, it has approved these changes with little or no debate: Both the standardized benefits requirement and mental health coverage parity were adopted by unanimous consent.

By proposing onerous federal mandates and limiting state flexibility in defining benefits and health care delivery structure, the Senate bill undermines the potential success of block grant programs. The Robert Wood Johnson Foundation's Alpha Center looked at state programs for expanding coverage to children and concluded that "Overall, the key lesson for state and federal officials designing programs to expand health insurance coverage for children is that the programs need enough flexibility to adjust subsidies, benefits, contracting and enrollment procedures as they evaluate what works best for the target population...."[2]

For years, many governors have sought relief from burdensome federal mandates on how they spend their Medicaid dollars. They have applied for waivers and have advocated Medicaid block grants, arguing that they could cover more low-income uninsured residents at less cost by exercising greater control over the type and scope of health coverage. Although both the House and Senate made only minor changes in the Medicaid program,

1 For more information on this subject, see Carrie J. Gavora, "What to Do About Uninsured Children," Heritage Foundation *F.Y.I.* No. 139, April 22, 1997.

2 Anne Gauthier and Stephen Schrodel, *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform* (Washington, D.C.: The Alpha Center, May 1997), p. iii. This study was produced as part of the Robert Wood Johnson Foundation's program on State Initiatives in Health Care Reform.

the House bill does take an important step toward giving the governors what they so desperately want: flexible use of block grant funds to expand health coverage for uninsured children in a more efficient and coordinated manner. These funds could be used to complement programs and services already offered by states and communities throughout the country.

There are two primary ways by which the Senate bill would inhibit a state's ability to provide basic health care assistance to its uninsured children:

- It requires that block grant funds be used only for health insurance. A state may not use the funds to purchase direct services. As a result, the program would deny funds to successful community-based programs.
- It requires that the insurance coverage purchased by a state provide benefits that are equal to or more generous than those offered under the Federal Employees Health Benefits Program's (FEHBP) BlueCross/BlueShield Standard Option plan. It prohibits child health insurance plans from imposing cost-sharing restrictions on mental health services that are not also imposed on physician and surgical services. As a result, fewer children would be helped for the same number of dollars, and the state would be forced to standardize coverage.

Senate vs. House on Direct Services

The Senate bill would require states to use block grant funds only for insurance with generous prescribed benefits for all enrollees, regardless of the availability of such services in the community. States would not be able to use the money to purchase direct services. The result: Successful community-based programs would be denied funds.

The House bill would give governors far greater latitude in spending block grant funds to purchase services directly at a local community clinic, to augment employer-provided coverage, or to provide additional assistance to programs already operating in their states. The House legislation also would allow states to offer individual tax credits or vouchers to families with uninsured children to purchase private coverage of their choice.

It is important that conferees retain the House language allowing states to use block grant funds to purchase health services directly. Although having insurance coverage is the ideal, the fact that approximately 3 million uninsured children are eligible for Medicaid coverage but are not enrolled should caution lawmakers that creating a new program does not guarantee its use. In most communities, relationships have developed between organizations and institutions that attempt to provide improved health coverage and services to the predominantly low-income populations that need them. Significantly, community-based solutions recognize that the answer to problems associated with uninsurance is not always more money or even health insurance. Some researchers have argued that inconvenient health care (the lack of community-based, easily accessible services) 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.[3]

Take, for example, a rural or inner-city clinic that provides primary health services to low-income uninsured children. Today, this clinic typically receives funds from a variety

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

of sources, including Medicaid, community health center grants, and state assistance. Under the Senate bill, assuming that most states opted to contract with a managed care plan to provide insurance to the target population, this clinic would not have access to block grant funds unless it contracted with such an insurer. There is, however, a large network of clinics and hospitals in this country whose primary mission is to provide a health care safety net for the poor and uninsured. Requiring states to use funds solely for insurance may come at the expense of efforts already being carried out by many of these clinics and hospitals.

Senate vs. House on Benefits

The Senate bill requires that the insurance coverage purchased by a state provide benefits equal to or more generous than those offered under the FEHBP's BlueCross/BlueShield Standard Option plan, including vision and hearing services. In addition, all child health insurance plans would be prohibited from imposing cost-sharing restrictions or other limitations on mental health services that they do not also impose on physician and surgical services. The result: States would have to service fewer children for the same dollars and would be forced to standardize coverage.

The choice for budget conferees is simple: They can approve the Senate provision to standardize benefits, tie the governors' hands, and create the foundations for a new version of the Clinton health plan, or they can choose the course proposed by the House, which recognizes that different children have different health care needs and that successful state and community-based initiatives would be hindered, not enhanced, by inflexible benefit requirements.

The House bill, it should be noted, is by no means skimpy on coverage; it defines core services that must be made available to children, including inpatient and outpatient services and coverage for preventive health and immunizations. But defining the type, amount, duration, and scope of benefits—areas in which federal requirements have frustrated state efforts to make needed Medicaid reforms—is a matter best left to the states.

When looking at state initiatives to cover uninsured children, the tradeoffs inherent in the House and Senate bills become clear. It is estimated that a child-only FEHBP BlueCross/BlueShield Standard Option health benefits package costs approximately $800 per year per child. This figure does not include the mental health parity provision that, it is estimated, adds at least another 5 percent to total premium costs. On average, under the Senate bill, all states accepting a block grant would have to provide this level of coverage for each child enrolled.

The Alpha Center calculated the average cost per child of care already provided through various state-based health care initiatives. These programs cover a variety of health benefits, ranging from limited (primary and preventive care) coverage to basic (including inpatient) coverage to comprehensive (including substance abuse treatment and vision, dental, and hearing care) coverage. The study found that programs offering comprehensive benefits, like Florida's Healthy Kids and Vermont's Dr. Dynasaur program, cost on average between $446 and $612 annually per child. Programs offering more limited, but nonetheless needed, coverage cost as little as $204 annually per child. The study also showed that most states with programs for uninsured children were providing comprehensive coverage without federal mandates or, in many instances, federal Medicaid dollars.[4]

CONCLUSION

Many states that want to expand coverage to include uninsured children choose specifically to implement programs outside the confines of Medicaid so that they will have the flexibility they need to spend limited state funds more wisely. The Alpha Center study indicates that states can cover children at a cost well below the price tag contemplated by the Senate plan. Thus, if Congress wants to provide reasonable coverage to as many children as possible under the new program, it should incorporate the state flexibility embodied in the House bill.

4 Gauthier and Schrodel, *Expanding Children's Coverage,* pp. 18, 24.