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How Governors Can Help Children to Get Private Health Insurance

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Some 10 million children in the United States are not covered by health insurance. Fortunately, Congress has provided the state governors with a way to help uninsured children to receive coverage through superior private health plans. The governors need to act on this opportunity.

In 1997, as part of the Balanced Budget Act, Congress enacted the State Children's Health Initiative Program (S–CHIP), which is intended to help uninsured children to get coverage by providing $48 billion in taxpayer funds to states over a period of 10 years. The best way to expand health insurance coverage to low-income children is to give real choices and incentives to families, and S–CHIP contains legislative language that allows states to employ private options. Congressional conferees explicitly encouraged the states to "consider such innovative means as vouchers and tax credits."

Too many state officials have looked to alleviate the problem of uninsured children, however, by enrolling them in the troubled Medicaid program. The answer is not to co-mingle S–CHIP dollars with Medicaid funds. The Medicaid money comes with myriad federal regulations that limit a state's ability to design programs to make a difference in the lives of children and their families. Although Medicaid expansion may be an expedient option, it locks a state into a far more expensive set of benefits than is necessary for children, increasing cost pressures in the Medicaid program. Putting S–CHIP funds into Medicaid programs and then having to live by Medicaid restrictions is like throwing good money after bad. States no longer have to do this.

S–CHIP allows governors to experiment with alternatives. Under Section 2103(a) of the Balanced Budget Act, the scope of health insurance coverage required to meet the terms of S–CHIP shall consist of (1) benchmark coverage or (2) benchmark-equivalent coverage. Section (b) spells out the three acceptable benchmark benefit packages. The first is the Children's Health Insurance Coverage (equivalent to the Federal Employees Health Benefits Program), which means the standard Blue Cross/Blue Shield preferred provider option service plan. Second is a health benefits coverage plan that is "offered and generally available to State employees in the State involved." Third is coverage offered by a health maintenance organization that has the largest insured commercial, non-Medicaid enrollment in the state in question.

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It is in the second option that states can find significant flexibility. In a February 9, 1999, letter to Texas Governor George W. Bush, House Commerce Committee Chairman Thomas J. Bliley (R–VA) notes that a state is not limited to *existing* employee health plans. A state is free to create a new state employee health plan so long as it is "offered and generally available to State employees." Therefore, a state has the power to design a cost-effective plan to meet its needs. And there is no minimum enrollment requirement that such a plan must satisfy to be used as a benchmark plan.

Federal approval of a state health plan used as a benchmark package under Section 2103(b) is not required. So long as a state uses one of the options set forth under Section 2103(b) as its benchmark, its use is de facto approved. The Secretary of Health and Human Services' scope of review is focused simply on compliance with Section 2103(a). In other words, a state that uses a benchmark benefit package as described in Section 2103(b) must satisfy the Secretary that the health benefits coverage to be offered to eligible children is "equivalent," as required under Section 2103(a)(1) to the benefits coverage in the benchmark benefit package.

After satisfying this requirement, a state then is free to create a benchmark plan that gives personal choice, responsibility, and ownership of health care plans where it rightfully belongs—in the hands of families. Offering tax credits or vouchers to assist low-income families to purchase private health insurance best serves the needs of individual families.

Tax credits and vouchers are a superior vehicle to Medicaid enrollment. First, by giving a single mother (for example) the means to purchase health insurance for herself and her children, she can buy coverage that includes the entire family under one plan. This eliminates the common problem of a mother's being under one plan while Medicaid covers her kids. Not only is this more simple, it also allows family members to see the same doctor. Second, using vouchers helps states to strengthen their welfare-to-work programs. Very often, a single mother is discouraged from returning to work if it means giving up Medicaid coverage for herself, her children, or both. Vouchers offer the alternative of private coverage. Moreover, if a state were able to make funds available to employers in the form of vouchers to offset the cost of a low-income family's joining a private plan, then employers would have the incentive to offer them coverage. This would remove a major barrier to a single mother's returning to the workforce.

States have real opportunities to experiment with federal dollars under the S–CHIP program. By establishing a new state employee health benefit plan to serve as the required benchmark under Section 2103(b) of the S–CHIP law, a state can take full advantage of the flexibility afforded by the law's language. By using that leeway to create a system of tax credits and/or vouchers for low-income families to obtain private coverage, a state can make real progress toward reducing the number of uninsured families at no additional cost to the taxpayer.

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See also *The State Children's Health Insurance Program (S–CHIP) Implementation Guide*, developed by House Commerce Committee chairman Thomas J. Bliley (R–VA). Contact the committee at (202) 225-2927.