More than one-half of all uninsured children in 1986 were in families of full-time, full-year workers.

Public and Private Issues in Financing Health Care for Children

Congressional activity on issues of health care access and cost have drawn attention to the number of children who lack health insurance in the United States. In 1986, 81 percent of all children had private or public health insurance. However, 10.6 million were without health insurance, including one-third of all children in families with income below the poverty level.

Almost 87 percent of uninsured children lived in families with one or more workers. More than one-half of uninsured children lived in families of full-time, full-year workers. Children may lack employer-provided health insurance for several reasons: because their parents do not purchase the employer-sponsored plans available to them, because their parents work for employers who do not sponsor health insurance plans, or (infrequently) because available employer plans do not cover dependents.

Congress is now considering legislation to require employers to contribute to health insurance coverage for workers and their dependents. Although mandating employer health insurance would extend coverage to a large number of uninsured children as well as adults, it might also affect product prices, employment levels, workers' earnings, and profits. To guarantee universal coverage, such mandates would have to eliminate the individual option to forgo the purchase of insurance.

Other proposed legislation would expand Medicaid coverage to include more children in families with very low incomes and provide Medicare coverage for home health services provided to children with chronic illnesses. However, concern over the federal budget deficit and the rising cost of health care may limit the expansion of public programs.
Introduction

In 1986, 81 percent of American children had health insurance from a private or public insurance plan. However, approximately 10.6 million did not. These children live in families without access to employer-paid coverage, or in families that do not or cannot purchase group or individual coverage and are ineligible for coverage from a public sector plan. Lack of coverage can impede access to necessary medical care, and, in cases of serious illness, can create financially devastating expenses for families.

Even with insurance coverage, however, families risk incurring high medical expenses. Most health insurance policies do not cover all health care services, and they typically require the insured to share part of the costs. These provisions reduce the cost of insurance by making families more sensitive to the cost of insured health care services and, therefore, presumably more efficient users of health care. However, cost sharing provisions and limits on family coverage can result in large uninsured expenditures among families of children who require extensive health care.

Continuing congressional debate on ways to extend medical insurance coverage and improve access to health care has focused attention on financing health care for children. Proposed legislation would extend private and public sector coverage to children who do not have health insurance. One bill would require employers to cover employees who work more than 17.5 hours per week and their dependent families. Another proposal would expand the Medicaid program—the joint federal/state program which finances care for low-income persons meeting certain eligibility requirements—to cover pregnant women and infants whose family income is below the federal poverty level and who are not covered by private health insurance plans.

A congressional mandate that employers cover the dependent children of participants in their group health insurance plan, or that limits the out-of-pocket costs of insured individuals, would increase employer costs and ultimately offset increases in other forms of employer compensation. Individuals and employers could also face higher taxes if increased federal revenues are necessary to finance expanded public sector coverage.

Increasing coverage of uninsured and underinsured children is also likely to affect the total cost of health care and the distribution of the cost. Currently, much of the cost of treating uninsured children is paid indirectly through higher charges for medical services and various state taxes or surcharges. Providing more coverage and/or limiting out-of-pocket expenses is likely to reduce indirect expenditures but raise direct expenditures. By increasing the number of children who seek care, expanded coverage would probably also increase total health care costs. However, insured children may obtain more preventive care and be less likely to incur expenditures for acute care because of neglected health problems.

Continuing congressional debate on ways to extend medical insurance coverage and improve access to health care has focused attention on financing health care for children.

The United States population spends a greater share of gross domestic product (GDP) on health care than do many U.S. trading partners. In 1985, 10.8 percent of GDP was spent on health care. Projections by the Health Care Financing Administration suggest that by the year 2000 this figure may reach 15 percent. As more resources are devoted to the promotion of health, fewer are available for the production of all other goods and services. This ultimately leads to higher costs in other industries and raises the cost of producing goods and services relative to that in other countries with lower health care costs. For example, health care expenditures in the United Kingdom were 5.7 percent of GDP in 1985. In Canada, health care expenditures were 8.6 percent of GDP.

This Issue Brief reviews the health status of children to provide a context for policymakers' concern about
noncoverage. It discusses how public and private payers, including employers, finance children's health care and describes the characteristics of current insurance coverage. Finally, this Issue Brief considers proposed legislation and policy options for changing children's health care financing.

**Children's Health Care Costs**

Children's health care costs are low compared with other age groups. In 1980, the most recent year for which data are available, total health care spending for children under age 17 reached $18.8 billion, or about 7 percent of national health care spending. Compared with health care spending for adults, a smaller portion of children's health care spending was for inpatient hospital care and proportionally more was spent for physician, dental, and other services (chart 1). By comparison, payments for inpatient hospital care represented 43.7 percent of total health care spending among the population age 17 to 64.

Children's health care concerns policymakers not because of cost but because of its potential impact on children's well-being. Adequate prenatal care and early childhood services, such as immunizations, may reduce the incidence of infant death, childhood illness, and impaired mental and physical growth (U.S. Congress, 1988a). Adequate access to routine health care services for children may reduce costly health expenditures later in life (Starfield, 1985). As in the case of adults, children without health insurance use significantly fewer health care services than children with private or public coverage. Uninsured children had 40 percent fewer visits to physicians than either publicly or privately insured children (Garfinkel, Corder, and Dobson, 1986).

**Infant Mortality**

In 1985, the United States ranked 17th among industrialized countries in infant mortality, with a rate of 10.6 infant deaths per 1,000 live births, or about 40,030 infant deaths. By comparison, the country with the lowest infant mortality rate, Japan, had 5.5 infant deaths per 1,000 live births. If the United States had experienced the same infant mortality rate as Japan, about 19,350 fewer infant deaths would have occurred in 1985 (U.S. Congress, 1988b).

Although the infant mortality rate in the United States declined over the past 20 years, the rate of decline has slowed in the 1980s. From 1981 to 1984, the annual rate of decline averaged 3.3 percent, compared with an average annual rate of decline of 4.2 percent between 1968 and 1985 (U.S. Congress, 1988a). Between 1984 and 1985, the rate of decline slowed to less than 2 percent.

Research suggests a number of reasons for the relatively high infant mortality rate in the United States. For example, teenage and low-income mothers are more likely to bear low birth weight babies at higher

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**Chart I**

**Distribution of Medical Care Expenses by Type for People under Age 17 and Age 17-64, 1980**

<table>
<thead>
<tr>
<th>Category</th>
<th>Under 17</th>
<th>17-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient</td>
<td>32.5%</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>23.5%</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>23.0%</td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>11.6%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5.7%</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>3.8%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Under 17</th>
<th>17-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient</td>
<td>43.7%</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>12.9%</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>24.0%</td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6.8%</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>4.8%</td>
<td></td>
</tr>
</tbody>
</table>

risk of infant mortality. Financial, educational, and attitudinal barriers may prevent these women from obtaining prenatal and maternity care.

Studies repeatedly conclude that prenatal care is cost effective, reducing the risk of premature birth and low birth weight (U.S. Congress, 1988a; Institute of Medicine, 1985). Nationally, neonatal intensive care has been estimated to cost $2.5 billion annually (U.S. General Accounting Office, 1987). For an individual infant, the cost of neonatal intensive care may exceed $100,000.

Few children incur high health care costs. About 0.6 percent of the population age 17 or under, or 421,000 children, incurred out-of-pocket costs that exceeded 10 percent of family income in 1980.

Public and private insurance coverage reduce financial barriers to prenatal and maternity care. The Pregnancy Discrimination Act of 1978 requires private employer-sponsored health plans covering more than 15 employees to cover maternity care for employees, and, if family coverage is provided, for their dependent spouses. The act does not cover nonemployer plans or plans offered by employers with 15 or fewer workers, although some states have mandated maternity coverage in their insurance regulations. (Various issues related to state insurance regulations are discussed in a later section.) Nationwide, an estimated 9 percent of the 41 million women of childbearing age (15–44) who are covered by private health insurance are not covered for maternity care (Allen Guttmacher Institute, 1987).

Employer-sponsored health plans are not required to cover maternity care for dependent daughters. In 1985, 35 percent of employer plans did not cover nonspouse dependents for maternity care, leaving an estimated 2.7 million teenagers without insurance coverage for this service (Allen Guttmacher Institute, 1987).

Medicaid will finance prenatal care services for all women with income that would qualify them for Aid to Families with Dependent Children (AFDC). Twenty-nine states have opted to cover all pregnant women below the federal poverty line. However, although Medicaid coverage reduces the financial barrier for pregnant women, it does not guarantee access since some providers are unwilling to treat Medicaid recipients. A General Accounting Office survey of women in 32 metropolitan areas found that privately insured women obtained prenatal care earlier and more frequently than either Medicaid recipients or uninsured women (U.S. General Accounting Office, 1987).

In 1985, about 555,000 women not covered by public or private insurance for maternity care bore children (Allen Guttmacher Institute, 1987). Lack of coverage for maternity care may indirectly increase employers' costs. An estimated 25 percent of all uncompensated hospital charges comes from uninsured obstetrical care (Sloan, Valvona, and Mullner, 1986). Presumably, providers increase charges to insured patients to recover at least part of the costs of providing uncompensated care.

High Cost Illnesses among Children

Few children incur high health care costs. About 0.6 percent of the population age 17 or under, or 421,000 children, incurred out-of-pocket costs that exceeded 10 percent of family income in 1980 (American Academy of Pediatrics, 1987). However, children with chronic health conditions generally use more health services than children without such conditions and may generate high expenditures.

Estimates of the number of children with chronic conditions vary. The National Health Interview Survey estimates 3 million children living in the community have some chronic condition that limits their activities (U.S. Department of Health and Human Services).

1 Increasing malpractice liability may have led some physicians to cease providing maternity care, especially to women likely to deliver a high risk infant (see, for example, "More Prenatal Care Could Net Savings," Medicine & Health 9 (February 1988). Anecdotal evidence suggests that malpractice liability may have impeded access to maternity care in certain regions (U.S. Congress, 1988a).
1987b). The Survey of Income and Program Participation recently estimated that about 1.9 million noninstitutionalized children have a physical, mental, or emotional disability (U.S. Department of Commerce, 1986). In addition, the 1980 Census reported that about 300,000 children were institutionalized because of severe disabilities.

Data from the National Health Interview Survey show that the prevalence of chronic illness among children increased from 2 percent in 1960 to 5.0 percent in 1986. The survey results may partly reflect better data collection and changes in the survey instrument as well as improved detection of chronic health problems resulting from greater awareness by physicians, parents, and teachers. However, increased survival of low birth weight infants and chronically ill children has also raised the number of disabled children (Newacheck, et al., 1986).

Chronically ill children are more likely to incur medical expenses than healthy children, but they are also more likely to have insurance to cover needed care. Even with insurance coverage, however, disabled children still generate higher uninsured expenses than nondisabled children (Newacheck and McManus, 1986). At the extreme, the situation of "technology dependent" children epitomizes many of the difficult issues involved in financing care for chronically ill children. A

| Number of Children by Family Type and Work Status of Family Head, and Percentage Distribution of Insurance Coverage by Source, for All Children and Children In Families below Poverty, 1986 |
|-----------------|-----------------|----------------|-----------------|-----------------|-----------------|
| Number of children (millions) | Private Insurance | | | Public Insurance | | |
| | Total | Employer coverage | | Total | Medicaid coverage | No coverage |
| | 67.5% | 62.7% | | 16.3% | 14.2% | 19.0% |
| **Total** | 55.7 | | | | | |
| **Two Parent Family** | | | | | | |
| Headed by full-year worker | 40.4 | 81.6 | 77.0 | 7.5 | 5.2 | 31.3 |
| Headed by part-year worker | 38.5 | 84.1 | 79.7 | 5.6 | 5.6 | 12.9 |
| Headed by nonworker | 1.0 | 52.3 | 37.5 | 25.6 | 20.4 | 31.0 |
| **Single Parent Family** | | | | | | |
| Headed by full-year worker | 15.3 | 30.4 | 25.1 | 39.4 | 38.0 | 33.0 |
| Headed by part-year worker | 8.5 | 47.6 | 42.3 | 15.7 | 14.1 | 39.7 |
| Headed by nonworker | 1.8 | 21.6 | 13.3 | 49.8 | 47.5 | 34.2 |
| **Total** | 12.5 | 16.3 | 11.3 | 54.1 | 52.7 | 33.2 |


*Worked or sought work 35 weeks or more during 1986.

*Worked or sought work during the year but for less than 35 weeks.
technology dependent child is defined as one who requires constant or continual medical interventions as well as the use of an assistive device in order to sustain life. The Office of Technology Assessment (OTA) estimates that fewer than 17,000 children are technology dependent (U.S. Congress, 1987a). However, the number of such children is expected to grow as medical technology improves (U.S. Department of Health and Human Services, 1988).

Acquired Immune Deficiency Syndrome (AIDS), though still uncommon among children, is another potential source of high medical costs. Currently, the number of pediatric AIDS cases (under 1,000) is small compared with the number of cases among adults. Thus far, Medicaid has covered an estimated 90 percent of childhood AIDS patients (U.S. Congress, 1988b).

### Current Sources of Children's Health Care Financing

In 1986, 67.5 percent of the nation’s 56 million children under age 18 had private health insurance (table 1). Employer-provided health insurance was an important source of financing for children’s health care, covering 63 percent (nearly 35 million) of children under age 18 as dependents of covered workers. Children living in two parent families (77.0 percent) were more likely to have employer provided coverage than children living in single parent families (25.1 percent). Public programs, especially Medicaid, covered 16.3 percent of all children, including more than three-quarters of the children of nonworking single parents.

In 1986, 67.5 percent of the nation's 56 million children under age 18 had private health insurance.

Children are more likely to be without health insurance than are people age 18 to 64. About 19 percent of children under 18, or 10.6 million children, had no health insurance coverage in 1986 (table 2), compared with 17.3 percent of the total nonelderly population. Almost 87 percent of all children without insurance coverage were in families with at least one member who worked or actively sought work (calculated from table 3). More than one-half of uninsured children were in families whose highest earner was a full-time, full-year worker (working more than 35 hours a week and 35 weeks a year). More than 12 percent of uninsured children were in nonworker families.

Children living in families with below poverty income are less likely to have health insurance than are nonpoor children. One-third of the 12.5 million children from households with below poverty income were uninsured in 1986. Among these children, children of the working poor were the least likely to have health insurance. More than 43 percent of poor children in two parent families whose highest earner was a full-

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<table>
<thead>
<tr>
<th>Table 2</th>
<th>Number and Percentage of All Uninsured Nonelderly Persons, Total and below Poverty, 1986</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Persons under 65</td>
</tr>
<tr>
<td>No coverage (millions)</td>
<td>Percent of total population</td>
</tr>
<tr>
<td>Total Uninsured</td>
<td>34.8</td>
</tr>
<tr>
<td>Workers</td>
<td>17.5</td>
</tr>
<tr>
<td>Family head</td>
<td>10.4</td>
</tr>
<tr>
<td>Other workers</td>
<td>7.1</td>
</tr>
<tr>
<td>Nonworkers*</td>
<td>17.4</td>
</tr>
<tr>
<td>Children</td>
<td>10.6</td>
</tr>
<tr>
<td>Adults</td>
<td>6.8</td>
</tr>
</tbody>
</table>

* Did not work or seek work during the year.
year worker were without any health insurance; more than one-half of poor children with single parents working full year were without coverage (table 1).

Characteristics of Employer-Sponsored Plans

Cost Sharing—Most employer-sponsored group health insurance plans require families to share the costs of their health care. Cost sharing may take the form of employee contributions as well as copayment or deductible provisions that distribute costs of individual services between employer and family.

Requiring an employee contribution to health insurance reduces the employer’s cost for the plan and may sensitize employees to the value of health care as a benefit. When the employer contributes to the added cost of family coverage, employees with families receive higher total compensation than employees without families. Employer payments for family health insurance coverage reduce the employer’s budget for other employee benefits or cash compensation, in effect creating a benefit for workers with families that is subsidized by single workers. For the employer, this raises the issue of balancing employee well-being and productivity with equitable compensation.

Some workers do not elect coverage for their children when an employee contribution to family coverage is required. Budget constraints may discourage the purchase of health insurance among low-wage workers. However, available evidence indicates that some workers with higher wages also choose not to purchase coverage for their dependents (Chollet, 1987b).

Cost sharing from deductibles and copayments can create uninsured expenses for families of children covered by employer-sponsored health plans. Most major medical plans sponsored by medium size and large establishments limit participants’ out-of-pocket costs as long as covered expenses are within the plan limit. About three-quarters of plan participants were in plans that limit out-of-pocket expenses to $2,000 or less. However, in 1986, 19 percent of participants in employer-sponsored plans were in plans that did not limit employee liability for uninsured expenses (Employee Benefit Research Institute, 1987b).

Benefit limits may affect some infants who require neonatal intensive care or children who have very high cost chronic illnesses. In 1986, 73 percent of employees who participated in medium size and large employer

3 Data are not available on how many participants in health plans that cover dependent children have copayments and deductibles, but there is no reason to believe that cost sharing provisions are distributed differently among these participants than among plan participants in general.
health plans had a lifetime maximum on benefits payable for covered services. However, 63 percent of these employees participated in plans with maximum benefits of $250,000 or more.

Uninsured Services—Virtually all employer health plans cover the cost of acute health care services associated with a major illness, such as hospital room and board, physicians' services, and surgical charges. Coverage of prescription drugs is also a common feature of employer plans; 97 percent of participants in plans sponsored by medium size and large establishments had some prescription drug coverage in 1986.

However, as a means of controlling health plan costs, many employer plans do not pay for all health services that children might use. Home health services are provided to 66 percent of participants in plans, dental care is provided to 71 percent of participants, and drug abuse treatment is available to 66 percent of plan participants (U.S. Department of Labor, 1987). Some services are offered by a minority of plans in medium size and large establishments: vision care is provided to 40 percent of plan participants, hearing care to 20 percent, and physical examinations to 18 percent.

Both employer group health plans and Medicaid programs have increased their enrollment in health maintenance organizations (HMOs) in recent years.

Health Maintenance Organizations—Both employer group health plans and Medicaid programs have increased their enrollment in health maintenance organizations (HMOs) in recent years. In exchange for a fixed prepaid premium, federally qualified HMOs are required to cover acute medical care without limits. Coverage for other types of health services used by children, such as mental health, prescription drugs, dental care, or therapy and rehabilitation services, may be limited. Federal regulation also limits cost sharing in federally qualified HMOs. States may impose other requirements on HMOs to the extent that such laws do not interfere with HMOs' operations as providers of prepaid health care. State regulations are generally similar to federal requirements for covered services and limited cost sharing, although there are some state-by-state variations.

HMOs require that members receive care only from providers with whom the HMO has contracted and that members obtain prior authorization before receiving certain services. Children, and in particular those with chronic conditions, may require frequent referrals for specialists' services. While HMOs managed care may serve these children well, incentives to limit care in HMOs may affect them adversely.

State Mandated Coverage—Many states require coverage of certain services affecting children in employer-provided and individually purchased policies. In 1987, 48 states mandated that insurers cover newborn children on the originally insured person's plan, 18 mandated maternity coverage, 3 mandated coverage for preventive care of newborns and infants, and 1 mandated prenatal care (Blue Cross and Blue Shield Association, 1988).

State-mandated insurance benefits are controversial. While they appear to address perceived gaps in insurance coverage, insurers, employers, and organized labor contend that they raise insurance costs and reduce plan flexibility. As a result, they claim, state mandates raise costs for employers who offer coverage, discourage health insurance as an employee benefit, and contribute to the high cost of individual coverage.

Massachusetts recently enacted legislation that would provide access to health insurance coverage to all state residents who are currently without coverage. Beginning in 1992, employers with more than five employees will pay a payroll tax of 12 percent on the first $14,000 of earnings of employees who work at least 30 hours a week after 90 days, or 20 hours a week after 180 days (90 days if the part-time employee is the head of a household). The maximum tax will be $1,680 per employee. However, employers will be able to deduct from the payroll tax the costs of offering a package of insurance benefits to employees. Since Massachusetts
employers will be required to spend up to $1,680 per eligible employee whether or not they buy insurance, those who do not at present cover their employees will have an incentive to do so. To earn the deduction, the insurance must cover a minimum set of services, including hospitalization, physician services, and routine and preventive care services for children. However, there are no restrictions on employee contributions, cost sharing, or plan maximums, and employers are not required to cover dependents. If the cost of single coverage in 1992 is less than the payroll tax, employers may decide to contribute toward family coverage.

Since Massachusetts employers will be required to spend up to $1,680 per eligible employee whether or not they buy insurance, those who do not at present cover their employees will have an incentive to do so.

In addition to the payroll tax, beginning in 1990 the Massachusetts statute will add a surtax of 0.12 percent to employers' contributions for unemployment insurance. This will subsidize insurance for unemployed workers. Revenues from the two new taxes, participant premiums, and state funds will be used to fund a new insurance pool for those who remain uninsured, including dependents not covered by employer plans. The state will purchase coverage from a number of insurance carriers, giving persons who do not have access to employer-based coverage, Medicare, or Medicaid an option to purchase insurance. People who are insured through the state pool will contribute to the premiums according to their income. The state will pay from general revenues any shortfall in the cost of the pool. Estimated cost to the state for this legislation, which includes incentives to hospitals and contributions to an interim uncompensated care risk pool, ranges from $622 million to $1.3 billion, over the four years until full implementation in 1992. State officials have not estimated what the full state government, individual, and employer costs will be once the program is fully implemented.

Medicaid

Medicaid, an important source of health insurance coverage for people who are very poor, is the largest single public source of health care financing for children. In fiscal year 1986 Medicaid spent $8 billion on health care for children under 21. Nevertheless, because of Medicaid's complex rules and eligibility restrictions, 4 million children living in families with income below the federal poverty level are without health insurance from this program or any other source.

Medicaid programs are administered by the states, which determine eligibility standards and services covered within guidelines set by the federal government. The characteristics of state Medicaid programs vary broadly. The federal government shares with the states the costs of covered services to people eligible under federal guidelines, although states may also opt to fund services for additional people. Recent federal legislation has required states to include more pregnant women and infants. Coverage of older children varies among states, but eligible children up to age 18 must be covered; some states continue coverage up to age 21.

Eligibility for Medicaid is tied to eligibility for income support programs, chiefly AFDC and the Supplemental Security Income (SSI) program. To obtain cash assistance from AFDC, individuals must establish economic need and meet requirements regarding family structure. States set the level of income for AFDC eligibility at levels below the federal poverty level. For example, in 1987 annual income eligibility levels for a family of three ranged from $1,416 in Alabama (15.2 percent of poverty) to $8,398 in Alaska (77.3 percent of poverty). The average AFDC eligibility level was $4,616, or 49.3 percent of poverty (National Governors' Association, 1987).

States can opt to cover all children below AFDC income limits; however, 17 states restrict eligibility to children who meet specific requirements concerning family structure (Rosenbaum, et al., 1988). Single mothers receiving AFDC and their children are eligible for
Medicaid in all states, and 33 states have made Medicaid available to children in two parent families with incomes below AFDC limits. Families who lose eligibility for AFDC because a newly employed parent’s earnings exceed AFDC income limits continue to be covered by Medicaid for a transition period.

Disabled children can qualify for SSI, depending on their parents’ income. Unlike AFDC, SSI qualifying income levels are set by the federal government. In most states, receipt of SSI confers Medicaid eligibility automatically, but 14 states use a more restrictive income standard to establish Medicaid eligibility among SSI recipients. Children who are institutionalized or hospitalized for more than 30 days are considered no longer to have their parents’ income available to them and become eligible for SSI in their own name. (Until the Omnibus Budget Reconciliation Act of 1981 [OBRA, P.L. 97-35] established a home- and community-based waiver program, a child could not be discharged home without losing Medicaid eligibility even if his or her medical care could be delivered more cost effectively there.) Waivers are granted on a case-by-case basis to states that certify that their waiver program will cost no more than services provided in an institutional setting.

Children in families that have large health expenses but whose incomes exceed AFDC or SSI eligibility levels may receive Medicaid if their state is one of the 38 that have elected to operate a “medically needy” program. States may opt to cover families with incomes of up to 133 1/3 percent of the AFDC eligibility standard as medically needy. Families with higher incomes may subtract their medical expenses from their total income to reach the 133 1/3 percent level. Medicaid coverage is also granted to children receiving foster care under Title IV-Part E of the Social Security Act.

Apart from categorical coverage of AFDC and SSI recipients, states must cover prenatal and maternity care for pregnant women who meet AFDC financial eligibility criteria, even if they do not yet have children. States must cover children born after September 30, 1983, up to age 7 in families that meet AFDC financial eligibility criteria, even if they are otherwise ineligible for AFDC because they are institutionalized, living in foster homes, or are from intact families. Thirty-six states have opted to provide coverage for children in such families up to age 21.

States may now establish a separate income eligibility threshold at any level up to the federal poverty level for pregnant women and for infants up to age one or two. The Omnibus Budget Reconciliation Act of 1987 (OBRA-87, P.L. 100-203) gave states the option of covering pregnant women and infants in families with incomes of up to 185 percent of the poverty level, although states may charge a premium of 10 percent of the amount of the family’s income that exceeds 150 percent of poverty.

State Medicaid programs are required to cover most acute care services for children. However, they may limit the frequency and duration of certain basic services that are required to be covered. Eleven states have limited the duration of hospital stays for which they will pay. Twelve states also limit the number of ambulatory care visits paid by Medicaid (U.S. Department of Health and Human Services, 1987a). These limits may particularly affect children with chronic health conditions requiring frequent medical interventions. Other services often needed by children that may be excluded or limited at a state’s discretion include prescription drugs, emergency services, nursing home care, and home health care services. Medicaid programs are required to cover eligible children up to age 21 for certain routine checkups and immunizations. Although states may impose nominal cost sharing requirements on adult recipients of Medicaid services, they cannot require cost sharing for services provided to children under age 18 or for pregnancy-related services.

Eligibility for Medicaid does not in itself guarantee that low-income children will have access to health care. States have been striving to control their Medicaid

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4 Proposed legislation (H.R. 2470), reported out of conference committee and expected to be enacted this year, would require states to cover all pregnant women and children under one year of age with family income less than the federal poverty level. States with lower income standards for Medicaid eligibility would begin phasing in higher income standards in 1989.

5 In the Early and Periodic Screening, Diagnosis, and Testing program (EPSDT).
Expenditures by limiting payment to providers. Medicaid payments to physicians historically have been lower than the amounts Medicare or private insurers pay for the same service. As a result, some physicians refuse to treat Medicaid beneficiaries. Although the OTA concluded that while there was insufficient evidence to conclude that Medicaid physician payment rates created an access problem for children served by Medicaid, under some circumstances Medicaid patients may not receive their first choice of provider (U.S. Congress, 1988a).

Other Sources of Public Coverage

In addition to Medicaid, federal block grants, Medicare, and a variety of smaller programs finance children's health care. States have broad discretion to use funds provided through the Maternal and Child Health (MCH) block grant program. Some states use these funds to finance community-based clinics in low-income areas, which may serve some uninsured children. Other states use block grants to provide special services for chronically ill and disabled children. However, funds available through block grants are limited, and relatively few uninsured children actually receive health services through MCH programs (Rosenbaum, et al. 1988).

Medicare covers acute care services for people afflicted with end stage renal disease (ESRD), i.e., irreversible kidney failure, requiring either dialysis or a kidney transplant to maintain life. Nearly 2,000 children currently qualify for Medicare coverage on this basis (U.S. Congress 1988b).

Other federal programs provide health care to children as a part of a larger mission to serve specific groups. These include the Indian Health Service, which provides services to about 300,000 Native American children. Children who are dependents of active or retired military families may receive health care financed through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Migrant Health Centers, Community Health Centers, Project Head Start, and other federally funded programs also provide health services to children (U.S. Congress, 1988a).

Policy Options to Change the Financing of Children's Health Care

Congress is currently considering alternative proposals to address the financing of children's health care. Some legislation seeks to increase children's coverage by expanding employer-based health insurance coverage. Another approach would extend public coverage through the expansion of Medicaid and Medicare.

Options Directed at Employers

The potential for expanding children's coverage under employer plans appeals to some public policymakers in part because it would involve less direct public expenditure than a government-based approach. Furthermore, since most uninsured children live in households with either full- or part-time workers, expanded employer coverage could affect a large percentage of uncovered children. Only 12 percent of children without health insurance live in nonworker households.

However, expanding employer-based coverage would raise employer costs. Employers might respond by reducing employment, constraining wages, and/or raising the prices of their products. Higher start-up costs might make it more difficult for new firms to enter the market. Since most of the currently uninsured are low-wage workers or their families, they would be the most likely to gain coverage under an employer mandate. At the same time, low-wage earners are more likely to be adversely affected by reduced employment opportunities, lower wages, and higher prices.

The Minimum Health Benefits for All Workers Act (S. 1265), introduced by Senators Edward M. Kennedy...
most employers to provide health insurance benefits for workers employed 17.5 hours per week or more and for their dependents who are not covered by another plan. Nearly 23 million people could potentially be covered by the insurance mandated by this bill, including 8.3 million children (Chollet, 1987a).

The bill specifies minimum required benefits, including prenatal and well-baby care, but would allow employers to offer substitute plans that are at least “actuarially equivalent” (i.e., that provide benefits net of employee paid premiums, deductibles, and copayments that are at least equal to those required in the bill) as long as the equivalent plan does not exclude coverage for prenatal and well-baby care. The bill does not specifically require employers to provide coverage for routine physical examinations and preventive care, and parents would still be responsible for the costs of these services for their children.

Employers would be required to contribute at least 80 percent of the minimum plan premium for individual and family coverage. However, employers would be required to pay the full minimum plan premium for workers earning less than $4.19 an hour in 1988 (125 percent of the current minimum wage). In 1985, 8.3 million uninsured workers (50.4 percent of all uninsured workers) reported average annual earnings less than 125 percent of the federal minimum wage (Employee Benefit Research Institute, 1987a).

The proposed minimum insurance plan limits maximum annual deductibles to $250 per individual and $500 per family, maximum coinsurance to 20 percent of provider charges, and total family out-of-pocket cost to $3,000. The bill has been approved by the Senate Labor and Human Resources Committee and may be voted on by the full Senate later this year. Hearings have also been held on a House companion bill, H.R. 2508, sponsored by Reps. Henry A. Waxman (D-CA) and William L. Clay (D-MO).

The Congressional Budget Office (CBO) estimates that the purchase of new policies for workers or dependents required by S. 1265 would cost employers an additional $22 billion, or about $900 per employee, representing an average 12 percent increase in the affected employees' wages. The effective increase in compensation would vary with the worker's wage, adding about 20 percent to the cost of compensation for workers who are paid the minimum wage and about 10 percent for workers paid $4.30 an hour (U.S. Congress, 1987b). Employees newly eligible for health insurance would spend an estimated $3.3 billion in premiums. The expansion of existing policies to cover new benefits mandated by the bill would cost an additional $2.0 billion.

These estimates are based on assumed annual premiums for the minimum insurance plan of $708 for individuals and $1,798 for families. One survey suggests that in 1986 employers spent an average of $1,985 per employee for medical, dental, prescription drugs, vision and hearing, and administration expenses for all covered plan participants (A. Foster Higgins, 1987). Other studies estimate that the bill might cost employers and workers from $35 billion (Robert R. Nathan, Inc., 1988) to $55 billion (Robbins and Robbins, 1987).

The effect of mandated employer coverage on the federal budget deficit would be twofold. On the one hand, a portion of workers' earnings that could have been taxable income would now be tax exempt. Lost federal revenue is estimated to range from $5.6 billion to $6.2 billion. On the other hand, because private health insurance would become the primary payer for approximately 6.7 million employed or dependent federal health program beneficiaries, federal outlays for health care would be reduced. This could reduce federal expenditures by $5.1 to $5.7 billion (Blum, 1988).

Estimated revenue effects are sensitive to a number of different assumptions. The range of these estimates depends on how effectively federal secondary payer provisions would be enforced and the amount of total employee compensation that would be shifted to health insurance from taxable income relative to currently nontaxable benefits. The estimated effect on the budget would also be significantly affected by the cost of a provision mandating mental health benefits in the minimum benefit plans. The mental health benefit provision was added to the bill by the Senate Committee on Labor and Human Resources. The House version of the bill does not contain this provision, which some believe would also significantly increase estimated aggregate employer costs (Blum, 1988).
H.R. 3766, an alternative to mandated employer coverage introduced by Rep. Martin O. Sabo (D-MN), would require employers with more than 10 employees to offer health plans to workers and their dependents but would not require an employer contribution. The plans would be required to limit out-of-pocket payments to $3,000 annually and provide unlimited lifetime benefits. Workers would not be able to exclude their dependents from their insurance plan to reduce the premiums. The bill would also require states to administer risk pools to purchase coverage for the remaining uninsured and for smaller employers. The bill would give states the option to set up a program of subsidies for low-income families to buy health insurance, with federal funds supplementing the state subsidy. In addition, the bill would allow states to establish catastrophic insurance programs for persons whose medical expenses exceed a specified portion of income, with the federal government contributing 75 percent of the cost.

Another bill, S. 968, would mandate that employer-provided health insurance cover a specified set of pediatric preventive care services. Sponsored by Sen. John Chafee (R-RI), this bill would deny a tax deduction to employer plans that do not cover, or impose any employee cost-sharing on, pediatric preventive care services. No hearings have been scheduled on the measure.

Legislation Expanding Medicaid and Medicare

Two bills, H.R. 4072, whose chief sponsor was Rep. Henry Waxman (D-CA), and S. 2122, introduced by Sen. Bill Bradley (D-NJ), would require states to cover all pregnant women and infants in families with incomes below the poverty line. Furthermore, S. 2122 contains provisions to phase in coverage of all children below the poverty line up to age four. Current law mandates coverage of such children in families meeting AFDC income guidelines. Both bills seek to increase access to obstetrical services by requiring states to set payments to physicians at levels sufficient to ensure that Medicaid-eligible women receive care as frequently as women in the general population. The conference agreement on the expansion of Medicare benefits to cover catastrophic expenses (H.R. 2470) incorporates key provisions of these bills. If the Medicare legislation is enacted, state Medicaid programs would be required to cover all pregnant women and children under one year of age with family income below the federal poverty line.

A bill introduced by Sen. Chafee (R-RI), S. 1139, would allow states to provide Medicaid coverage to all families with incomes less than the federal poverty standard. In addition, the Chafee bill would allow all people with incomes between 100 percent and 200 percent of poverty to buy Medicaid coverage at a premium not to exceed a fixed percentage of income. The Chafee bill would also allow small employers and people who are uninsurable or who have exhausted their private insurance benefits to buy Medicaid coverage. Hearings on the bill have not been held.

H.R. 3436, a proposal sponsored by Rep. Claude Pepper (D-FL), would expand Medicare coverage of home health services for elderly and disabled Medicare enrollees. It would also grant eligibility for these

Congress has also considered using the Internal Revenue Code to define the characteristics of tax-exempt employer-sponsored health insurance plans.

Congress has also considered using the Internal Revenue Code to define the characteristics of tax-exempt employer-sponsored health insurance plans. H.R. 2300, introduced by Rep. Bill Gradson (R-OH) and Rep. Pete Stark (D-CA), would deny tax deductibility to employer-sponsored health benefit plans that do not limit the annual out-of-pocket liability of covered families to $3,500 ($2,000 for an individual). Plans that cover fewer than 20 employees would be exempt. The bill also would deny tax deductibility to employer plans that exclude employees or family members on the basis of a prior health condition or other measure of health status. The proposal was considered for inclusion in OBRA-'87, but was dropped. However, the bill remains active.
services to disabled children under age 19 who are not usually eligible for Medicare, if they lack the ability to perform two of five specified activities of daily living. The proposal would be financed by eliminating the current ceiling on earnings subject to the 1.45 percent employee contribution allocated to the Medicare Hospital Insurance Trust Fund. This would increase revenues by $2.0 billion in the first year.

◆ Conclusion

Recent proposals to increase the availability of health insurance coverage are a response to gaps in health care financing that are leaving some children and pregnant women without necessary health care. Some policymakers view mandatory employer coverage of all employees and dependents and limitations on employee contributions and out-of-pocket liabilities as a way to extend financial protection against health costs without increasing public expenditures as much as would be done under a new government program. Making coverage mandatory would significantly raise the labor costs among employers who do not already offer coverage. These employers could respond by reducing employment, constraining wages, charging higher prices for products, or sustaining reduced profits. Some workers who have access to employer coverage for themselves and their dependents, if they agree to make the required premium contribution, cannot afford to make this payment or choose not to do so. An individual preferring higher pay to employer financed health insurance would be denied that choice under these proposals.

Congress has shown a willingness to expand Medicaid coverage of pregnant women and infants where it can be argued that increasing access to health services is cost effective. By authorizing waiver programs, Congress has created alternatives to deal with the special problems of children with chronic illness but has not attempted a comprehensive solution. Older children without insurance coverage, however, have not yet been affected by these initiatives to expand public sector coverage. It is possible that Congress will continue to consider extending public coverage on a piecemeal basis to more children and pregnant women below the poverty level.

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Both public and private approaches to expanding insurance coverage among children are constrained by the federal budget deficit and the Gramm-Rudman-Hollings Balanced Budget Act (P.L. 99-177), which requires Congress to seek more revenue before expanding public programs or "tax expenditures" for employer-based programs, and by more general concern over the nation's health care spending. Efforts by Congress to expand children's health insurance coverage without adding to the federal deficit may focus attention on the characteristics of tax qualified employer-provided benefits. The new nondiscrimination rules imposed by the Tax Reform Act of 1986 (P.L. 99-514) provide a precedent for federal involvement in employer-provided health benefits. At least two bills (H.R. 2300 and S. 968) recently introduced in Congress use this principle to limit cost sharing for dependent coverage and mandate preventive care coverage for children. It is possible that similar proposals will be made in the future.

Policymakers are also likely to watch the experience of Massachusetts in extending health insurance to uninsured adults and children by combining mandated employer coverage and publicly subsidized insurance. Because Massachusetts has a relatively unique economic environment and political culture, the law may not be emulated quickly by other states. However, the Massachusetts law may provide guidelines for future policies on both the state and federal level.

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6 These include dressing, bathing, eating, toileting, and transferring in and out of bed or chair.
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