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# HEALTH INSURANCE FOR CHILDREN

## Declines in Employment- Based Coverage Leave Millions Uninsured; State and Private Programs Offer New Approaches

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# Health Insurance for Children: Declines in Employment-Based Coverage Leave Millions Uninsured; State and Private Programs Offer New Approaches

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss recent changes in health insurance coverage and the effect of these changes on children. Without health insurance, many families face difficulties getting preventive and basic health care for their children. Children without health insurance are less likely to have routine medical and dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses. Recognizing the importance of health insurance for children, Members of the House and Senate and the administration have proposed expanding children's health insurance coverage—either through grants to the states, refundable tax credits, vouchers, or other means.

My remarks today will focus on three points: (1) recent trends in children's health insurance coverage, particularly in employment-based coverage; (2) the increasing role of Medicaid in insuring children and possible interactions with private insurance; and (3) some small-scale but innovative state and private efforts to provide coverage for uninsured children. These remarks summarize findings from previous GAO work, based on our analysis of the Bureau of the Census March Current Population Surveys for health insurance coverage in 1989 and 1995 and information from the Census on trends in coverage from 1987 through 1995; other public and private surveys, such as a survey conducted by KPMG Peat Marwick on employer health insurance; interviews with experts, insurance company executives, and benefits consultants; current research on health insurance issues; and case studies of state and private programs that insure children. (A list of GAO products related to this issue appears at the end of this statement.)

In summary, we found that while most children have health insurance, almost 10 million children lack insurance. Between 1989 and 1995, the percentage of children with private coverage declined significantly—part of an overall decline in coverage of dependents through family health insurance policies. Increases in the cost of providing health insurance have prompted many employers to take steps that discourage or limit dependent coverage, such as raising premiums or providing incentive payments to employees who refuse family coverage. This erosion in employer support for health insurance has contributed to the increasing number of children in working families without private health insurance.

As these reductions in private coverage were occurring, Medicaid eligibility for children expanded. These expansions helped to cushion the effect of the loss of private coverage, but they also may have contributed to some further reductions in private coverage. Families respond to the availability of public coverage differently. While some families may have been induced to drop private coverage to gain Medicaid for their children, others may not have taken advantage of the program. Indeed, almost 3 million Medicaid-eligible children remain uninsured.

A number of states, in conjunction with local governments, and private entities have developed children's insurance programs that differ significantly from Medicaid. Some of these public/private efforts may prove instructive in developing future strategies for insuring children. For example, by targeting their outreach efforts, the programs have been able to identify uninsured children—some of whom are eligible for Medicaid. In addition, the programs have developed service packages based on preventive care and required parents to assume some of the insurance cost through premium contributions and copayments for specific services. Such strategies have helped to stretch program dollars and provide needed health care to more children.

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## **The Decline in Private Health Insurance Coverage Hit Children Harder as Employer Financial Support Decreased**

Between 1989 and 1995, private family insurance coverage declined for both children and working-age adults. Most of the decline was for the dependents of workers—most dramatically for children. During this period, the percentage of children with private health insurance dropped from 74 percent to 66 percent. Had this decrease not occurred, nearly 5 million more children would have had private health insurance.

Eroding employer financial support for providing health insurance to employees' families has contributed to the overall decline in private insurance coverage. The vast majority of privately insured children are covered under their parents' employment-based health care plans.<sup>1</sup> But as health insurance premiums reached 10 percent of employers' payroll costs, many employers began to reconsider the amount of employee insurance—particularly family coverage—that they would support. The health insurance cost to employers for a worker who does not elect family coverage is less than half the cost of family coverage. As a result, firms are considering a variety of ways to control the cost of coverage—particularly family coverage.

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<sup>1</sup>For information on the structure of the private market for individual coverage, see *Private Health Insurance: Millions Relying on the Individual Market Face Cost and Coverage Trade-Offs* (GAO/HEHS-97-8, Nov. 25, 1996).

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There was a slight decrease in the proportion of workers whose employers sponsored health insurance between 1988 and 1993. The decrease was more pronounced among those working in small firms—13 percent fewer people working for firms with fewer than 10 employees had employers who sponsored coverage. Even if an employer sponsors a plan, it may not cover family members. In 1993, almost one-quarter of the workforce could not get family coverage at work. Over 18 million workers were employed by firms that did not sponsor coverage at all, and more than 5 million workers worked for firms that sponsored coverage for workers, but not family members.

Most employers that offered coverage raised employee premium contributions significantly—especially for family coverage. In large firms with 100 or more employees, average monthly premium contributions increased 79 percent for family coverage compared with 64 percent for single coverage between 1988 and 1993. A Hewitt Associates analysis of benefits offered by a group of major firms with 1,000 or more employees showed that median monthly premium contributions for family indemnity coverage increased 64 percent between 1990 and 1995, whereas median monthly premium contributions for employee-only indemnity coverage increased 47 percent.

In addition to increasing premium contributions, employers are increasingly turning to other options in their benefit design to limit their costs. These options may discourage family coverage but may also result in employers of two-income families sharing in the cost of coverage and avoiding the cost of duplicate coverage. These options include

- providing alternative benefits or incentives to workers who choose employee-only coverage,
- providing financial incentives to employees who obtain family coverage through their spouse,
- refusing to cover a spouse if the spouse has other health insurance,
- imposing a surcharge for working spouses covered as dependents,
- refusing to provide dependent coverage unless the employee is the family's primary wage earner, and
- changing premium structures so that larger families pay higher premiums.

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## **Expanded Medicaid Coverage Offset Much of the Decline in Private Coverage for Children**

Between 1989 and 1995, the number of children in the United States increased by almost 7 million, but the number of children with private health insurance coverage remained virtually unchanged. During this same period, Medicaid eligibility for children expanded so that poor and near-poor children under age 12 became eligible,<sup>2</sup> and enrollment increased by 6 million children. Despite the growth in Medicaid, the number of uninsured children grew by more than 1 million—reaching almost 10 million uninsured children by 1995.

There is considerable debate about the extent to which expanding Medicaid eligibility contributed to the decline in the percentage of children who had private coverage. For example, one study suggests that as much as one-sixth of the overall decline in the proportion of people with private coverage may have occurred because families dropped their insurance to enroll children and pregnant women in Medicaid.<sup>3</sup> However, other studies found a lesser effect or no effect at all.<sup>4</sup>

Regardless, the studies indicate that, at most, one-sixth of the loss in private coverage stems from families' choosing to substitute Medicaid for private coverage. Consequently, had Medicaid eligibility not been expanded, the number of uninsured children would probably have been even greater.

Moreover, Medicaid expansions could have reduced the number of uninsured children even more, but many uninsured children who are eligible for Medicaid do not enroll. In 1994, almost 3 million

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<sup>2</sup>Beginning in 1986, the Congress passed a series of laws that expanded Medicaid eligibility for pregnant women on the basis of family income and eligibility for children on the basis of family income and age. Before these eligibility expansions, most children received Medicaid because they were enrolled in Aid to Families With Dependent Children. Starting in July 1989, states were required to expand coverage for pregnant women and infants with family incomes at or below 75 percent of the federal poverty level. Two subsequent federal laws further expanded mandated eligibility for pregnant women and children. By July 1991, states were required to cover (1) pregnant women, infants, and children up to age 6 with family income at or below 133 percent of the federal poverty level and (2) children 6 years old and older born after September 30, 1983, with family income at or below 100 percent of the federal poverty level.

<sup>3</sup>See David M. Cutler and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?* Working Paper No. 5082 (Cambridge, Mass.: National Bureau of Economic Research, Apr. 1995).

<sup>4</sup>See Lisa Dubay and Genevieve Kenney, *Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children* (Washington, D.C.: The Urban Institute, Oct. 1995); Lara D. Shore-Sheppard, "Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage," unpublished draft, Nov. 1995; Lara D. Shore-Sheppard, "The Effect of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage," paper presented at the Cornell/Princeton Conference on Reforming Social Insurance Programs, May 1996; and Esel Y. Yazici, "Medicaid Expansions and the Crowding Out of Private Health Insurance," paper presented at the 18th Annual Research Conference of the Association for Public Policy Analysis and Management, Pittsburgh, Pa., Nov. 2, 1996.

Medicaid-eligible children lacked health insurance. Our previous work and that of other researchers points out several reasons families do not enroll their eligible children in the Medicaid program. Some low-income families are unaware that their children may be eligible for Medicaid, and some are stymied by the complexity of the enrollment process. Moreover, some families may not consider health coverage necessary until a child experiences a medical crisis. The stigma associated with participation in a publicly funded health insurance program can also deter some families.

While states have developed Medicaid outreach programs, their past outreach efforts focused more on encouraging use of preventive care by current participants than on encouraging new enrollment. The Health Care Financing Administration and the Health Resources and Services Administration are in the preliminary stages of developing a more aggressive outreach program for potential Medicaid beneficiaries.

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## **States, Localities, and Private Organizations Have Created New Strategies to Insure Children**

While many states expanded Medicaid beyond federal requirements to cover more uninsured children, a few developed innovative programs to offer subsidized coverage apart from Medicaid. By 1996, 9 states had state- and locally funded programs, and 24 states had privately funded programs. While most of these programs are small in scale, they do provide important lessons regarding program design characteristics.

In earlier work that we conducted on six of these state-funded or privately funded programs in five states,<sup>5</sup> we found that while the programs' approaches varied significantly, they shared some common characteristics. In some ways, they differed strikingly from Medicaid.

- Unlike state Medicaid programs, which operate as open-ended entitlements, all the programs capped enrollment to stay within their fixed budgets. The state programs' funding came from state general revenues; dedicated shares of specialized taxes, such as tobacco taxes or health care provider taxes; local tax revenue; and grants and donations from foundations and other private-sector entities. The private programs raised money through private donations, many with considerable support from Blue Cross/Blue Shield organizations.

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<sup>5</sup>We visited the Alabama Caring Program for Children, the Western Pennsylvania Caring Program for Children, Pennsylvania's Children's Health Insurance Program, New York's Child Health Plus Program, the Florida Healthy Kids Program, and MinnesotaCare. MinnesotaCare began as a state-funded program, but Medicaid began to fund children participating in the program as of July 1995 through Minnesota's Medicaid 1115 waiver. The children's portion of MinnesotaCare is still distinct from its Medicaid program, however.

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- All of the programs we visited were designed to augment the existing range of coverage options by covering uninsured children not eligible for Medicaid. Two of the programs allowed children of any income to join, but families with higher incomes were responsible for paying full premium costs.
- All six programs required at least some of the families to share in the costs of coverage through premiums and copayments—with the families' share increasing as income increased. For example, Pennsylvania's Children's Health Insurance Program charged nothing for children in families with income below 185 percent of the federal poverty level and charged \$29 to \$34 per month per child for children in families with income between 185 and 235 percent of the federal poverty level. All programs heavily subsidized premiums for the lowest-income children—ranging from charging families nothing to charging \$10 per child per month for children with family income at or below 130 percent of the federal poverty level. In every program, most children received the maximum subsidy. (See app. I.)
- While all six programs covered basic preventive and outpatient services, some limited other services, such as vision, hearing, dental, and mental health care. Some also limited inpatient care, particularly the privately funded programs. The programs that limited inpatient services sometimes did so anticipating that the children would qualify for Medicaid if they needed more extensive care.
- The programs were developed to be easily administered. Most operated, at least partially, through nonprofit or private insurers, which enabled the programs to use existing provider payment systems and physician networks, guaranteeing patient access to providers.
- Each of the six programs worked extensively to reach families of uninsured children and to promote their knowledge of the program. One program worked through the schools, which allowed it to most easily reach its target group: school-aged children. Other outreach efforts included dedicated hot lines, television and radio ads, bus billboards, posters in local discount stores, fast-food restaurant tray liners, and presentations provided at churches and other community locations. To encourage enrollment, three programs used sports and television personalities as program spokespersons. These outreach efforts served to identify not only children eligible for the six programs but also children eligible for Medicaid, who were then channeled into that program.
- Each of the six programs developed simplified enrollment procedures and took specific steps to avoid the appearance of a welfare program.



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## Conclusions

Although most children are still covered by private employment-based insurance, recent erosion of private coverage has left many children without coverage. The Medicaid expansion has cushioned the effect of this erosion on children. However, efforts to expand coverage for children need to be developed in ways that do not supplant existing private coverage. Despite the Medicaid expansion, many uninsured children who are eligible for Medicaid do not enroll. Outreach strategies developed by state and private programs could guide state efforts to reach uninsured children who are eligible for Medicaid but not enrolled. Other innovative state and private strategies, such as sliding-scale premiums and cost sharing for program enrollees, could provide a model for enrolling more uninsured children while controlling costs. However, adopting other strategies, such as limiting services like inpatient care on the premise that other funding may be available, may not provide the range of coverage that children need.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Subcommittee may have.

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## Contributors

For more information on this testimony, please call Michael Gutowski, Assistant Director, on (202) 512-7128. Other major contributors included Sheila K. Avruch and Karen M. Sloan.

# Comparison of Family Cost-Sharing Provisions, October 1996

Program	Income range, as a percentage of federal poverty level	Family premium contribution per month per child by income range	Percentage enrolled by income range	Copayments	Service and amount of copayment
Alabama Caring Program for Children	\$0-12,000 <sup>a</sup>	\$0	100	Yes <sup>b</sup>	Outpatient services-\$5
Florida Healthy Kids Program	0-130	5-10 <sup>c</sup>	68	Yes	Prescription drugs-\$3, eyeglass lenses-\$10, refractions-\$3, nonauthorized emergency room visits-\$25
	131-185	13-30 <sup>c</sup>	15		
	over 185	45-60 <sup>c</sup>	17		
MinnesotaCare	0-150	4	66 <sup>d</sup>	No	None for children or pregnant women; for other adults, prescription drugs-\$3, eyeglasses-\$25, inpatient hospital charges-10%
	151-275	4-98 <sup>e</sup>	34 <sup>d</sup>		
New York's Child Health Plus Program	0-159	0	86	Yes	Prescription drugs-\$1-3, inappropriate emergency room use-\$35
	160-222	2.08	13		
	over 222	35-66.50 <sup>c</sup>	1		
Pennsylvania's Children's Health Insurance Program	0-184	0	95 <sup>f</sup>	Yes	Prescription drugs-\$5
	185-235	28.74-34.39 <sup>c</sup>	5 <sup>f</sup>		
Western Pennsylvania Caring Program for Children	0-184	0	96	Yes	Prescription drugs-\$5
	185-235	20/up to 50 per family	4		

Note: This appendix corresponds with enclosure IV in GAO/HEHS-97-40R and updates table 2 in GAO/HEHS-96-35.

<sup>a</sup>Alabama uses absolute dollar amounts for income eligibility determination.

<sup>b</sup>Preferred doctors may require a \$5 copayment for some services; however, most doctors waive the copayment.

<sup>c</sup>Premium contribution varies by locale or insurer.

<sup>d</sup>Estimated by program officials for 1995.

<sup>e</sup>Premium contribution varies by income level within specified range and family size.

<sup>f</sup>Estimated by program officials for 1996.

# Average Cost Per Child Per Month for Services Covered by Programs, October 1996

Costs/services	Alabama Caring Program for Children	Florida Healthy Kids Program	MinnesotaCare	New York's Child Health Plus Program	Pennsylvania's Children's Health Insurance Program	Western Pennsylvania Caring Program for Children
<b>Average cost per child per month<sup>a</sup></b>	<b>\$20.00</b>	<b>\$49.00</b>	<b>\$60.00</b>	<b>\$56.45<sup>b</sup></b>	<b>\$52.00<sup>c</sup> \$63.00</b>	<b>\$70.62</b>
<b>Services</b>						
Primary and preventive care <sup>d</sup>	•	•	•	•	•	•
Emergency and accident care	•	•	•	•	•	•
Speech therapy		• <sup>e</sup>	•		•	•
Physical and occupational therapy		• <sup>e</sup>	•	•	•	•
Prescription drugs		•	•	•	•	•
Hospitalization and inpatient physician services		•	•		• <sup>e</sup>	• <sup>e</sup>
Mental health care		• <sup>e</sup>	•		• <sup>e</sup>	• <sup>e</sup>
Substance abuse care		• <sup>e</sup>	•	• <sup>e</sup>		
Vision care		• <sup>e</sup>	•		• <sup>e</sup>	• <sup>e</sup>
Hearing care		•	•		•	•
Dental care			•		•	•
Home health care		•	•		•	•
Ambulance services		•	•			•
Durable medical equipment and prosthetic devices		•	•			•
Podiatry		• <sup>e</sup>	•			
Chiropractic services		• <sup>e</sup>	•			• <sup>f</sup>
Family planning		•	•			
Other services	•	• <sup>g</sup>	•	•	•	•

(Table notes on next page)

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**Appendix II**  
**Average Cost Per Child Per Month for**  
**Services Covered by Programs, October**  
**1996**

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Note: This appendix corresponds with enclosure III in HEHS-97-40R and updates figure 3 in GAO/HEHS-96-35.

<sup>a</sup>Average cost reflects the total premium cost, regardless of the funding source, but excludes program administrative costs.

<sup>b</sup>New York planned to add inpatient services and reset premiums to cover these additional services in 1997.

<sup>c</sup>Average cost for fully subsidized children aged 1 through 17 is \$52 per child per month and for partially subsidized children birth through age 5 is \$63 per month.

<sup>d</sup>Primary and preventive care services include well-child visits, immunizations, diagnostic testing, outpatient physician services, and outpatient surgery.

<sup>e</sup>These services have specific limitations.

<sup>f</sup>Chiropractic services are covered if ordered by the primary care physician.

<sup>g</sup>Preventive dental care is offered in some counties.

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**Appendix II**  
**Average Cost Per Child Per Month for**  
**Services Covered by Programs, October**  
**1996**

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# Related GAO Products

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Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases (GAO/HEHS-97-35, Feb. 24, 1997).

Children's Health Insurance Programs, 1996 (GAO/HEHS-97-40R, Dec. 3, 1996).

Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

Medicaid and Uninsured Children, 1994 (GAO/HEHS-96-174R, July 9, 1996).

Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate (GAO/HEHS-96-129, June 17, 1996).

Medicaid: Spending Pressures Spur States Toward Program Restructuring (GAO/T-HEHS-96-75, Jan. 18, 1996).

Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children (GAO/HEHS-96-35, Jan. 18, 1996).

Medicaid and Children's Insurance (GAO/HEHS-96-50R, Oct. 20, 1995).

Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access Care (GAO/HEHS-95-115, Mar. 23, 1995).

Uninsured and Children on Medicaid (GAO/HEHS-95-83R, Feb. 14, 1995).

Tax Policy: Health Insurance Tax Credit Participation Rate Was Low (GAO/GGD-94-99, May 2, 1994).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

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