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This monograph examines alternatives for expanding health insurance coverage for children. The underlying assumption is that "big government" approaches to comprehensive health insurance are politically infeasible but that incremental expansions will still receive considerable attention in the upcoming year. Employer-sponsored coverage for children has been declining, and the arguments for making investments in children's health are fairly compelling. Interest in expanding health insurance for children has increased in recent months, most notably with the Clinton administration's proposal for increasing participation in Medicaid together with grants to states to support state child care initiatives, the "Children's Health Care Initiative" of Senators Kennedy and Kerry, the "Children's Health Care Coverage Act" of Senator Daschle and Representative Gephardt, and the "Child Health Insurance and Lower Deficit Act" of Senators Hatch and Kennedy.

Despite recent expansions of Medicaid, substantial gaps remain in health insurance coverage of pregnant women and children. About 10 percent of all pregnant women and children lack health insurance. About the same percentage of poor pregnant women and children (11 percent) lack coverage. The percentage of pregnant women and children without health insurance is

higher for the near poor (about 17 percent) than for the poor because of gaps in Medicaid. Similarly, coverage of older children is lower than for young children. Medicaid coverage also varies substantially across states; where Medicaid coverage is high, the proportion of uninsured is low and vice versa.

Employer-sponsored coverage has declined for low-income children in recent years. These declines affect all income groups. For the poor and near poor, Medicaid has been available as an alternative. Among those whose incomes are too high to qualify for Medicaid, the decline in employer-sponsored coverage has resulted in greater numbers of uninsured Americans. Continued declines in employer-sponsored coverage will mean more pregnant women and children will lack health insurance unless Medicaid coverage is extended to higher income levels or an alternative to Medicaid is enacted.

The argument for expanding health insurance for children rests upon evidence that insurance coverage improves access and increases utilization of basic health services. Most of the research on the impact of insurance coverage on access to care has focused on adults, but several recent studies provide evidence that insurance coverage matters for children. Using data from the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), Spillman (1992) found that uninsured children were 14 percent less likely to use medical services than insured children. Among those who used medical services, uninsured children had 15 percent fewer visits than insured children. Evidence from Marquis and Long (1994/1995), using data from the 1987 National Medical Expenditure Survey (NMES), found that uninsured children received 70 percent of the outpatient visits received by similar children with insurance and about 75 percent to 85 percent of the inpatient days. Children without health insurance are also less likely to have a usual source of care, are less likely to be immunized and to receive well-baby or well-child care, and are more likely to be hospitalized for conditions that are avoidable (Kasper 1987; Rosenbach 1985; Short and Leftkowitz 1991; Leftkowitz and Short 1989).

It is also argued that health insurance for pregnant women and children would represent a good investment (Carnegie 1994; National Commission 1993). That is, insurance would lead to ear-

lier prenatal care, which, in turn, would result in improved birth outcomes, more immunizations that would prevent illness, and earlier identification of health care problems that may prevent physical or intellectual impairment.[1] By increasing access to health care, health insurance could result in greater success in school and, eventually, increased productivity. It can also be argued that while adults may voluntarily choose to remain uninsured, children are themselves not responsible for decisions about their coverage. Thus, there is a need for society in general to ensure that children have health insurance.

This monograph sets the stage for consideration of alternatives with a discussion of the current coverage of pregnant women and children and the estimated costs of extending coverage to all or selected groups of children. It also explores the trends in the coverage and looks at the variations in states' use of Medicaid benefits. Data are provided for the numbers of people insured through Medicaid, employers, and other insurance and for the numbers of uninsured pregnant women and children at various income levels.

A number of possible ways in which insurance coverage of children could be expanded are discussed. All but one of the approaches considered build on the current system. The first set of alternatives provides subsidies to families through vouchers or tax credits. The second presents various ways of expanding current Medicaid coverage of children. A number of other, less likely alternatives are also discussed. These include mandates on families to provide health insurance to children through private insurance. Another set of approaches would build on the employer-based system through mandates to require coverage and subsidies to help pay for them. The next set of alternatives extends the current Medicare program to pregnant women and children; these could be voluntary, or coupled with a mandate to purchase coverage. The last approach considered is a new federal-state program for children.

This monograph is not intended to be comprehensive. Approaches such as universal "single payer" systems or direct block grants to hospitals and community health centers are not considered. Single payer approaches are not considered because these imply more comprehensive systems, of which children are

only one of several covered groups. These are beyond the scope of the monograph. Direct financing approaches—i.e., support of maternal and child health programs—are also not considered because our focus is on expanding insurance arrangements and not on supporting the direct delivery of services.

It is assumed that the benefit package should include preventive services, including well-baby care and immunizations. Basic acute care (including physician services, hospitalization, diagnostic services, acute dental care, and prescription drugs) would presumably also be covered. Ideally, preventive services, well-baby care, and basic primary care would be provided without cost-sharing. Other care, including specialist's services and hospitalization, might be subject to income-related deductibles. Clearly, there is a major tradeoff between the amount of cost-sharing and the cost of expanding health insurance to all children.

CURRENT INSURANCE COVERAGE OF PREGNANT WOMEN AND CHILDREN

Table 1 displays current insurance coverage for pregnant women and children with the latter categorized by age: 1 to 5, 6 to 12, and 13 to 18 (March 1994 Current Population Survey). These age groups are significant because the Medicaid program currently has different policies toward each of these groups. Similarly, we present insurance coverage by income levels that correspond to Medicaid policy. For example, Medicaid has expanded coverage to pregnant women and to children under age 6 up to 133 percent of the poverty line. States may, at their own option, extend coverage to pregnant women and infants up to 185 percent of the federal poverty line with federal matching payments. States are now required to cover children between ages 6 through 13 up to the federal poverty line. Children ages 14 to 18 up to 100 percent of the federal poverty level are scheduled to be phased in by the year 2002.

Another provision of Medicaid (Sec. 1902(r)(2)) permits states to cover pregnant women and children without regard to income. No state fully exploits this flexibility, but some use this provision to sig-

Table 1
Insurance Coverage of Pregnant Women and Children, 1994

Poverty Level	Total (millions)	Employer Sponsored	Medicaid	Private and Other	Uninsured
All Pregnant Women and Children Through Age 18					
0-99%	17.9	16.5%	70.6%	1.7%	11.1%
100-133%	5.8	39.2	41.4	3.4	16.1
134-185%	8.1	59.0	17.4	5.0	18.7
186-299%	16.0	76.2	5.0	5.8	13.0
300%+	28.0	89.4	1.3	4.6	4.8
All	75.8	62.4	23.2	4.1	10.4
Pregnant Women and Infants					
0-99%	2.0	14.5%	76.0%	1.3%	8.3%
100-133%	0.5	34.1	53.0	1.7	11.1
134-185%	0.8	58.2	27.9	4.5	9.4
186-299%	1.4	73.4	8.4	5.6	12.6
300%+	2.3	87.9	0.8	5.2	6.1
All	7.0	56.6	30.9	3.8	8.7
Children Ages 1 to 5					
0-99%	5.7	14.0%	78.5%	1.4%	6.1%
100-133%	1.8	39.3	49.1	1.8	9.9
134-185%	2.2	56.7	24.7	3.2	15.4
186-299%	4.1	75.9	6.9	5.1	12.1
300%+	6.4	88.4	1.9	5.0	4.8
All	20.2	57.2	31.0	3.5	8.3
Children Ages 6 to 12					
0-99%	6.0	17.5%	71.3%	1.4%	9.9%
100-133%	2.1	41.2	38.3	2.7	17.8
134-185%	2.9	61.5	13.8	5.4	19.4
186-299%	6.0	78.2	4.2	5.3	12.3
300%+	9.8	90.1	1.2	4.0	4.7
All	26.8	64.3	21.7	3.8	10.2
Children Ages 13 to 18					
0-99%	4.2	19.6%	56.4%	2.9%	21.1%
100-133%	1.5	37.6	32.9	6.9	22.6
134-185%	2.2	58.2	11.1	6.6	24.2
186-299%	4.5	74.9	3.2	6.9	15.0
300%+	9.5	89.8	1.0	4.7	4.5
All	21.9	66.6	15.3	5.1	13.0

Source: Urban Institute tabulations from the March Current Population Survey, 1995.
Note: Percentages may not sum to 100 because of rounding. The population excludes the elderly, the institutionalized and families with an active military member. 'Other' coverage groups include the non-elderly covered through Medicare, VA, CHAMPUS, and military health.

nificantly extend coverage to pregnant women and children. For example, Minnesota extends coverage to pregnant women and infants up to 275 percent of poverty, while Washington provides coverage to pregnant women and children under 19 up to 200 percent of poverty.

The second column of Table 1 shows that 62.4 percent of all pregnant women and children under age 19 are covered by employers. Slightly more than 55 percent of pregnant women and children under age 6 are covered by employers while more than 60 percent of children ages 6 through 18 are covered by employers. Among poor (0-99 percent of poverty) pregnant women and children up to age 18, 16.5 percent have employer-sponsored coverage. Their limited participation in the workforce means they are much less likely to have employer-sponsored coverage than other workers. As income increases, the likelihood of employer-sponsored coverage grows for all age groups.

The third column of Table 1 shows the importance of Medicaid in covering low-income pregnant women and children.[2] Medicaid covers 70.6 percent of all poor pregnant women and children under age 19. The program covers 76 percent of poor pregnant women and infants and 78.5 percent of poor children ages 1 through 5. Not surprisingly, Medicaid coverage declines to 56.4 percent for poor children ages 13 to 18. Medicaid covers a significant percentage of near-poor (100 percent to 185 percent of poverty) pregnant women and children up to age 18, but clearly the program's importance declines as income increases.

Coverage through private and other government policies—e.g., Medicare—is relatively small for this group. Private and "other" coverage is greatest for near-poor children ages 13 to 18, possibly because of the lower likelihood of Medicaid coverage to this group. In part, this is because these children are less likely to be poor, but private and "other" coverage is also higher at each income level than for younger children.

As a result of the combination of employer-sponsored coverage and Medicaid coverage of pregnant women and children, the number of uninsured pregnant women and children is relatively low. Only 10.4 percent of all pregnant women and children are uninsured.[3] Only 8.7 percent of all pregnant women and infants lack health insurance, and only 8.3 percent of pregnant women

and infants below poverty lack health insurance. The percentage of poor children ages 1 through 5 without insurance is only 6.1 percent. The percentage of children ages 1 through 5 who are uninsured rises to over 15 percent for those between 134 percent and 185 percent of poverty. For those above 300 percent of poverty, the percentage of uninsured drops to 4.8 percent because of the increase in importance of employer-sponsored coverage.

For children ages 6 through 12, the percentage who are uninsured increases because Medicaid becomes somewhat less important. Of poor children ages 6 through 12, 9.9 percent lack health insurance, despite the requirement that states cover these children in Medicaid. About 19 percent of near-poor (between 100 percent and 185 percent of poverty) children ages 6 to 12 are uninsured. Above 185 percent of poverty, the percentage who are uninsured once again declines because of the increasing role of employer-sponsored coverage.

About one-fifth of children between the ages of 13 and 18 who are poor lack health insurance. Employers cover few children below poverty, and this age group is still an optional group in Medicaid. Again, because of the more limited role of Medicaid, about 23 percent of children between the ages of 13 to 18 in families with incomes between 100 and 185 percent of poverty lack health insurance. Even at higher income levels, the percentage of this group who are uninsured is higher than for other children.

In comparison with Table 1, Table 2 shows that the insurance coverage of children is substantially greater than for adult Americans. For example, 18.1 percent of all adults and 34.6 percent of poor adults are uninsured. Of all females with children, 13.4 percent are uninsured, whereas 17.9 percent of females without children lack health insurance. Of those below poverty, 16.4 percent of females with children lack health insurance while 42.4 percent of females without children lack health insurance. The coverage of females with children is substantially greater than coverage of females without children because they are more likely to be eligible for Medicaid. Because Medicaid covers fewer females without children, a substantially higher percent are uninsured. The same pattern follows for males except that the percentage of uninsured males in all categories is higher because there is even less Medicaid coverage. For example, 52.2 percent

Table 2
Insurance Coverage of Adults by Sex and Income, 1994

Poverty Level	Total (millions)	Employer Sponsored	Medicaid	Private and Other	Uninsured
All Adults					
0-99%	17.9	18.7%	38.1%	8.7%	34.6%
100-133%	8.1	33.6	17.5	11.8	37.0
134-185%	13.1	49.5	6.7	9.9	34.0
186-299%	29.7	67.7	2.2	8.7	21.5
300%+	83.0	85.0	0.4	5.7	8.9
All	151.9	68.0	6.6	7.3	18.1
Males with Children					
0-99%	3.1	17.8%	37.2%	7.0%	38.0%
100-133%	1.9	38.0	17.3	8.4	36.3
134-185%	3.1	57.3	4.8	7.6	30.2
186-299%	7.4	74.4	2.0	6.5	17.1
300%+	16.6	88.7	0.3	4.7	6.4
All	32.0	72.6	5.7	5.8	15.9
Males without Children					
0-99%	4.2	19.7%	15.2%	12.9%	52.2%
100-133%	2.0	25.4	11.9	16.5	46.2
134-185%	3.3	35.1	6.9	13.4	44.7
186-299%	7.8	55.4	2.2	10.9	31.5
300%+	27.0	80.3	0.4	6.6	12.7
All	44.3	64.4	3.1	8.9	23.7
Females with Children (excluding pregnant women)					
0-99%	6.5	16.7%	63.5%	3.4%	16.4%
100-133%	2.5	40.0	25.1	5.8	29.1
134-185%	3.6	57.6	9.4	5.9	27.0
186-299%	7.8	76.0	2.9	6.1	15.1
300%+	15.9	89.5	0.5	4.4	5.7
All	36.3	67.0	14.8	4.8	13.4
Females without Children (excluding pregnant women)					
0-99%	4.2	21.4%	22.4%	13.9%	42.4%
100-133%	1.8	29.1	13.3	18.8	38.7
134-185%	3.1	47.5	5.2	13.1	34.3
186-299%	6.8	65.0	1.4	11.4	22.1
300%+	23.5	84.7	0.3	6.4	8.6
All	39.4	69.1	3.8	9.2	17.9

Source: Urban Institute tabulations from the March Current Population Survey, 1995.
Note: Percentages may not sum to 100 because of rounding. The population excludes the elderly, the institutionalized and families with an active military member. 'Other' coverage groups include the nonelderly covered through Medicare, VA, CHAMPUS, and military health.

there is even less Medicaid coverage. For example, 52.2 percent of poor men without children are uninsured.

Table 3
Trends in Health Insurance Coverage, 1988–1993:
By Pregnancy Status and Age
(Persons in Thousands)

Health Coverage	Total	Pregnant Women	Others, by Age				
			0–10	11–17	18–34	35–54	55–64
1988							
Number	**211,584**	**3,475**	**39,385**	**23,226**	**64,604**	**59,518**	**21,377**
Employer	67%	61%	65%	67%	62%	75%	65%
Medicaid	9	23	18	13	6	4	4
Other	2	1	1	2	1	2	7
Nongroup	7	5	3	6	9	7	11
Uninsured	15	11	12	13	21	12	11
1993							
Number	**225,764**	**3,455**	**42,924**	**25,557**	**63,282**	**69,861**	**20,685**
Employer	61%	57%	58%	60%	55%	69%	64%
Medicaid	12	29	28	17	9	6	5
Other	2	1	1	2	1	2	7
Nongroup	8	5	3	6	11	8	11
Uninsured	17	8	11	16	24	16	14
Change in Coverage, 1988-93							
Employer	-6%*	-3%*	-8%*	-7%*	-7%*	-6%*	-1%
Medicaid	4*	6*	9*	4*	4*	2*	0
Other	0	0	0	0	0	0	-1*
Nongroup	0*	1	-1*	0	1*	1*	-1
Uninsured	2*	-3*	-1*	3*	3*	3*	2*

Source: Urban Institute tabulations from the March 1989 and 1994 Current Population Surveys.
Notes: Percentages may not sum to 100 due to rounding. Medicaid enrollment reflects corrections by the Urban Institute's TRIM2 model. The population excludes the elderly, the institutionalized, and families with an active military member. 'Other' coverage group includes nonelderly covered through Medicare, CHAMPUS, VA, and military health.
* Indicates differences are statistically significant at the .05 level.

TRENDS IN HEALTH INSURANCE COVERAGE OF PREGNANT WOMEN AND CHILDREN

It is instructive to examine recent trends in coverage of pregnant women and children. In a recent article, we presented data from the Current Population Survey (CPS) on changes in coverage between 1988 and 1993 by age, income, and other factors (Holahan, Winterbottom, Rajan 1995). The data in Table 3 show that employer-sponsored coverage fell for all age groups, but particularly for children and young adults. For example, employer-sponsored coverage fell by 3 percentage points for pregnant women, 8 percentage points for children up to age 10, and 7 percentage points for children ages 11 through 17. Medicaid expansions more than offset the decline in employer-sponsored coverage for pregnant women and children through age 10, but only partially offset the loss in employer-sponsored coverage for children ages 11 through 17. As a result, the number of uninsured pregnant women and children through age 10 actually fell, while the percentage of uninsured children ages 11 through 17 increased by 3 percentage points. Insurance coverage also fell in each of the older age groups, because of the decline in employer-sponsored coverage.

In Table 4, we divide the population by income—above and below 200 percent of poverty. The results show that the drop in employer-sponsored coverage for pregnant women and children was greater for those below 200 percent of poverty (7 percentage points) than for those above (5 percentage points). Medicaid expansions more than offset (by 12 percentage points) the drop in employer-sponsored coverage for children and pregnant women below 200 percent of poverty. The result was a 4 percentage point drop in the uninsured rate for low-income children and pregnant women. There was a 3 percentage point increase in the uninsured rate for higher- income pregnant women and children, primarily because Medicaid is not important for these groups.

Table 4
Trends in Health Insurance Coverage, 1988–1993: By Income, Pregnancy Status, and Age
(Persons in Thousands)

Poverty / Health Coverage	Total	Income Below 200 Percent of Poverty: Pregnant Women and Children	Income Below 200 Percent of Poverty: Adults 18–34	Income Below 200 Percent of Poverty: Adults 35–64	Income 200 Percent or Greater: Pregnant Women and Children	Income 200 Percent or Greater: Adults 18–34	Income 200 Percent or Greater: Adults 35–64
1988							
Number	**211,584**	**27,954**	**19,886**	**17,728**	**38,131**	**44,717**	**63,167**
Employer	67%	37%	31%	32%	87%	76%	83%
Medicaid	9	38	18	17	1	1	0
Other	2	1	2	8	1	1	2
Nongroup	7	4	11	11	5	9	7
Uninsured	15	20	39	32	7	14	7
1993							
Number	**225,764**	**32,627**	**22,147**	**20,868**	**39,309**	**41,135**	**69,678**
Employer	61%	30%	26%	29%	82%	70%	79%
Medicaid	12	50	25	20	3	1	1
Other	2	1	2	6	1	1	2
Nongroup	8	3	10	9	5	11	8
Uninsured	17	16	39	35	9	16	9
Change in Coverage, 1988-93							
Employer	-6%*	-7%*	-6%*	-3%*	-5%*	-6%*	-4%*
Medicaid	4*	12*	7*	4*	1*	0*	0*
Other	0	0	0	-2*	0	0	0
Nongroup	0*	-1*	-1*	-2*	0	3*	1*
Uninsured	2*	-4*	0	3*	3*	3*	3*

Source: Urban Institute tabulations from the March 1989 and 1994 Current Population Surveys.
Notes: Percentages may not sum to 100 due to rounding. Medicaid enrollment reflects corrections by the Urban Institute's TRIM2 model. The population excludes the elderly, the institutionalized, and families with an active military member. 'Other' coverage group includes nonelderly covered

Variations Among States in Coverage of Pregnant Women and Children

Table 5 shows variations among states in insurance coverage of children under age 19 in families with incomes below 200 percent of poverty (Winterbottom, Liska, Obermaier 1995). Because of small sample sizes, the precision of these estimates is

Table 5
Health Insurance Coverage of the Nonelderly by Age and by Family Income, 1990–1992: Children Under 19, Below 200 Percent of Poverty
(Persons in thousands, standard errors in parentheses)

	Number	Employer Sponsored	Medicaid	Other Coverage	Uninsured
United States	**30,590**	**31.5%**	**45.2%**	**5.4%**	**18.0%**
		(0.58)	(0.62)	(0.28)	(0.48)
New England	**1,097**	**33.6%**	**48.4%**	**5.4%**	**12.7%**
		(2.46)	(2.60)	(1.18)	(1.73)
Connecticut	236	36.0%	45.8%	6.7%	11.6%
		(7.46)	(7.75)	(3.88)	(4.97)
Maine	152	40.7%	40.9%	5.5%	12.9%
		(5.28)	(5.28)	(2.46)	(3.60)
Massachusetts	486	26.8%	56.7%	4.0%	12.5%
		(3.06)	(3.43)	(1.36)	(2.29)
New Hampshire	92	41.6%	24.7%	10.3%	23.4%
		(7.19)	(6.28)	(4.44)	(6.17)
Rhode Island	79	42.4%	47.5%	3.7%	6.5%
		(7.19)	(7.26)	(2.73)	(3.58)
Vermont	53	37.5%	47.6%	5.5%	9.4%
		(6.48)	(6.69)	(3.06)	(3.91)
Middle Atlantic	**3,960**	**33.4%**	**51.6%**	**4.2%**	**10.7%**
		(1.46)	(1.54)	(0.62)	(0.95)
New Jersey	614	31.8%	50.1%	4.7%	13.4%
		(3.20)	(3.43)	(1.45)	(2.34)
New York	2,170	31.2%	54.3%	4.2%	10.4%
		(1.94)	(2.08)	(0.84)	(1.28)
Pennsylvania	1,176	38.5%	47.5%	4.2%	9.9%
		(2.93)	(3.01)	(1.20)	(1.80)
South Atlantic	**5,180**	**29.5%**	**42.9%**	**5.8%**	**21.8%**
		(1.42)	(1.54)	(0.73)	(1.29)
Delaware	74	46.1%	31.8%	7.5%	14.6%
		(6.05)	(5.65)	(3.19)	(4.29)
District of Columbia	86	17.3%	62.7%	1.4%	18.6%
		(4.26)	(5.45)	(1.31)	(4.39)
Florida	1,617	21.9%	44.8%	6.6%	26.7%
		(2.13)	(2.56)	(1.28)	(2.27)
Georgia	866	31.6%	42.7%	4.4%	21.3%
		(4.59)	(4.89)	(2.03)	(4.04)
Maryland	436	32.0%	49.7%	4.2%	14.1%
		(6.00)	(6.43)	(2.58)	(4.48)
North Carolina	749	33.0%	43.5%	5.3%	18.2%
		(2.62)	(2.76)	(1.25)	(2.15)
South Carolina	507	37.6%	35.4%	5.5%	21.5%
		(4.22)	(4.17)	(1.99)	(3.58)
Virginia	593	32.6%	34.8%	8.8%	23.9%
		(4.94)	(5.02)	(2.99)	(4.50)
West Virginia	252	31.9%	49.3%	3.9%	14.9%
		(4.61)	(4.95)	(1.91)	(3.53)

(continued)

Table 5 (continued)
Health Insurance Coverage of the Nonelderly by Age and by Family Income, 1990–1992: Children Under 19, Below 200 Percent of Poverty
(Persons in thousands, standard errors in parentheses)

	Number	Employer Sponsored	Medicaid	Other Coverage	Uninsured
East South Central	**2,300**	**32.3%**	**42.1%**	**5.1%**	**20.5%**
		(2.22)	(2.34)	(1.04)	(1.92)
Alabama	602	35.3%	32.2%	3.5%	29.0%
		(4.55)	(4.45)	(1.74)	(4.32)
Kentucky	458	33.5%	45.0%	5.5%	16.0%
		(4.95)	(5.22)	(2.39)	(3.85)
Mississippi	527	27.3%	44.8%	6.7%	21.2%
		(3.44)	(3.84)	(1.93)	(3.15)
Tennessee	713	32.7%	46.7%	5.0%	15.7%
		(4.33)	(4.61)	(2.00)	(3.36)
West South Central	**4,017**	**27.3%**	**41.1%**	**4.6%**	**27.0%**
	(1.65)	(1.83)	(0.77)	(1.65)	
Arkansas	363	27.5%	38.5%	5.2%	28.7%
		(4.15)	(4.53)	(2.07)	(4.21)
Louisiana	686	21.2%	49.4%	4.3%	25.2%
		(3.86)	(4.72)	(1.91)	(4.10)
Oklahoma	457	31.9%	34.9%	6.3%	26.9%
		(4.46)	(4.56)	(2.33)	(4.24)
Texas	2,511	28.1%	40.4%	4.2%	27.3%
		(2.19)	(2.40)	(0.98)	(2.18)
East North Central	**4,964**	**36.6%**	**47.1%**	**5.3%**	**11.1%**
		(1.49)	(1.54)	(0.69)	(0.97)
Illinois	1,428	31.4%	52.3%	5.3%	11.0%
		(2.58)	(2.78)	(1.24)	(1.74)
Indiana	690	45.4%	30.4%	7.9%	16.4%
		(5.39)	(4.98)	(2.91)	(4.00)
Michigan	1,089	33.3%	51.2%	4.5%	11.0%
		(2.66)	(2.82)	(1.16)	(1.77)
Ohio	1,263	38.3%	48.5%	5.5%	7.7%
		(2.72)	(2.79)	(1.27)	(1.49)
Wisconsin	495	41.8%	42.5%	2.9%	12.8%
		(5.36)	(5.37)	(1.83)	(3.63)
West North Central	**2,126**	**34.2%**	**35.5%**	**12.3%**	**18.0%**
		(2.29)	(2.31)	(1.58)	(1.85)
Iowa	323	45.9%	29.4%	13.8%	10.8%
		(5.27)	(4.82)	(3.65)	(3.28)
Kansas	294	43.8%	30.3%	7.1%	18.8%
		(5.12)	(4.74)	(2.66)	(4.03)
Minnesota	468	24.9%	40.8%	18.6%	15.7%
		(4.99)	(5.67)	(4.49)	(4.19)
Missouri	697	29.7%	38.4%	7.9%	24.0%
		(4.72)	(5.03)	(2.78)	(4.42)
Nebraska	178	37.1%	36.9%	12.6%	13.5%
		(5.05)	(5.05)	(3.47)	(3.57)

(continued)

Table 5 (continued)
Health Insurance Coverage of the Nonelderly by Age and by Family Income, 1990–1992: Children Under 19, Below 200 Percent of Poverty
(Persons in thousands, standard errors in parentheses)

	Number	Employer Sponsored	Medicaid	Other Coverage	Uninsured
North Dakota	72	35.1%	28.9%	24.7%	11.4%
		(4.92)	(4.67)	(4.45)	(3.27)
South Dakota	93	37.6%	27.3%	13.8%	21.4%
		(4.38)	(4.03)	(3.12)	(3.71)
Mountain	**1,843**	**39.2%**	**32.1%**	**7.0%**	**21.6%**
		(2.10)	(2.01)	(1.10)	(1.77)
Arizona	455	34.8%	39.6%	5.0%	20.6%
		(5.01)	(5.14)	(2.29)	(4.25)
Colorado	352	40.6%	35.0%	7.6%	16.8%
		(5.87)	(5.70)	(3.17)	(4.47)
Idaho	166	41.2%	22.8%	11.5%	24.5%
		(4.25)	(3.62)	(2.75)	(3.71)
Montana	129	35.8%	33.5%	12.3%	18.4%
		(4.31)	(4.25)	(2.96)	(3.49)
Nevada	144	36.3%	25.1%	5.4%	33.3%
		(5.24)	(4.73)	(2.46)	(5.14)
New Mexico	254	27.3%	38.0%	4.2%	30.5%
		(3.90)	(4.25)	(1.76)	(4.03)
Utah	287	57.4%	19.7%	7.5%	15.3%
		(4.32)	(3.47)	(2.30)	(3.15)
Wyoming	57	37.3%	33.1%	8.3%	21.3%
		(5.95)	(5.79)	(3.40)	(5.04)
Pacific	**5,107**	**25.8%**	**53.1%**	**3.3%**	**17.9%**
		(1.46)	(1.67)	(0.59)	(1.28)
Alaska	69	31.7%	42.8%	5.2%	20.4%
		(4.41)	(4.69)	(2.10)	(3.82)
California	4,198	23.2%	55.2%	3.1%	18.4%
		(1.59)	(1.87)	(0.65)	(1.46)
Hawaii	117	43.8%	39.2%	6.6%	10.4%
		(5.91)	(5.81)	(2.96)	(3.64)
Oregon	343	42.5%	36.1%	3.9%	17.6%
		(5.67)	(5.51)	(2.21)	(4.36)
Washington	379	33.1%	50.6%	2.7%	13.7%
		(6.16)	(6.55)	(2.11)	(4.50)

Source: Three-year merged March CPS: 1991, 1992, and 1993.
Notes: We define families as health insurance units. A health insurance unit includes the members of a nuclear family who can be covered under one health policy. Poverty is defined using the federal poverty guidelines from the U.S. Department of Health and Human Services.

weak in smaller states; nonetheless, the variation among states is of interest. The results show that the percentage of children without health insurance varies from 33.3 percent in Nevada to 6.5 percent in Rhode Island. Among larger states, where estimates are more precise, the variation in the percent of uninsured children ranges from 27.3 percent in Texas and 26.7 percent in Florida to 10.4 percent in New York and 9.9 percent in Pennsylvania. The table also reveals that it is variation in both employer-sponsored coverage and Medicaid enrollment that explains the differences among states in the percentage of children without health insurance.

THE COST OF COVERING PREGNANT WOMEN AND CHILDREN

Before examining alternative proposals, we present a "ballpark" estimate of the cost of acute care for noninstitutionalized children. These estimates are based on the 1987 National Medical Expenditure Survey (NMES), adjusted to 1996 using HCFA 64 and 2082 Medicaid expenditure and enrollment data and Congressional Budget Office projections of Medicaid expenditures in 1996. The differences in the relative cost between pregnant women and children in different age groups are based on NMES data, while the absolute levels are adjusted to be consistent with 1994 Medicaid expenditures. The result is an estimate of the cost of covering all children as if they were on Medicaid. (The NMES data allow us to adjust for the differences in demographic characteristics between Medicaid and the rest of the population.) Benchmarking the estimate to Medicaid expenditures may overstate the cost of covering children because of the poor health status of many low-income pregnant women and children. On the other hand, Medicaid provider payment rates have typically been significantly below market levels, which could make Medicaid benchmarked estimates understate the costs of covering all children.

As shown in Table 6, we estimate the cost of covering pregnant women and infants in 1996 to be $3,730, the cost of covering

Table 6
Estimates of the Costs of Covering Pregnant Women and Children, Ages 0 through 18, 1996

	Population (in millions)	Average Medicaid Cost per Enrollee	Estimated Costs (in billions)
All pregnant women and children	7.0	$3,730	$25.9
Children ages 1-5	20.6	$1,342	$27.6
Children ages 6-12	27.3	$670	$18.3
Children ages 13-18	22.3	$840	$18.7
Total	**77.2**		**$90.6**

Notes: Population estimates are drawn from the March 1995 Current Population Survey, corrected for Medicaid underreporting using the Urban Institute's microsimulation model, the Transfer Model (TRIM2). Medicaid per enrollee expenditures come from the Urban Institute's HCFA 2082/HCFA 64 administrative database. Medicaid expenditures for each age group are developed using data from the National Medical Expenditure Survey. To address the issue of small sample size and allocation

children between the ages of 1 to 5 to be $1,342, and so forth. This includes all costs—those borne by insurers and individuals themselves. Using these estimates, we concluded that the cost of covering all children through age 18 in the United States would be approximately $90 billion. This estimate includes all children, even those who are currently insured. The cost of covering all uninsured pregnant women and children under age 19 would be around $10.4 billion. This estimate is an understatement to the extent that the number of uninsured at each point during the year is greater than the number reported by the CPS. Some of the $10.4 billion would offset costs now borne directly by the public sector, by providers, or by the uninsured themselves. However, proposals to extend coverage on a subsidized basis to pregnant women and children would find it difficult to include only the currently uninsured; others who are currently covered are also likely to enroll. Thus, while children are relatively inexpensive to cover on a per person basis, an expansion to cover children has the potential to redistribute a very large amount of money. This problem holds to varying degrees for all of the proposals that will be discussed below.

There are a number of other issues common to each of these proposals. The first is the administrative burden of enrolling potentially large numbers of children in a new program. These include issues of income determination and verification, collection of premiums, and enrolling children in private insurance or managed care plans. The second is the need to establish premium schedules by which low-income families contribute to the costs of coverage. Premiums need to be established in a way that encourages high levels of participation, minimizes incentives for adverse selection, and avoids substantial increases in marginal tax rates on families that could have adverse effects on work incentives. Third, all of these plans carry the risk of at least partially substituting for existing private health insurance coverage. Finally, all will require new revenues, though they vary in how much additional revenue will be required and who will pay. These issues do not suggest that expansions to cover children are not a worthwhile public policy objective, but that it is not a simple matter and careful design of the policy is critical.

ALTERNATIVES FOR EXPANDING COVERAGE

Subsidies to Families

The most prominent approach to expanding coverage is to provide families with subsidies to help them purchase private insurance for their children. Two major proposals have recently been introduced—one by Senator Daschle and Representative Gephardt, the other by Senators Kennedy and Kerry.

The Daschle-Gephardt proposal, the Children's Health Care Coverage Act of 1997, would provide a refundable tax credit equal to 90 percent of the cost of a benchmarked private health insurance premium for children through 12 years of age in families with incomes up to 200 percent of the federal poverty line. The value of the credit would decline on a sliding scale as family income increased up to 300 percent of the federal poverty line. A

10 percent credit would be available for families with incomes up to $75,000.

The credit would only be available to uninsured children who are not eligible for Medicaid and who do not have access to employer-sponsored health insurance. Families would not be eligible for a children's subsidy if the employer had dropped coverage because of the availability of the subsidy. In addition, employers would be prohibited from treating low-income employees differently than other employees. Families with incomes below 200 percent of poverty would be eligible for the credit if the employer's contribution is less than 80 percent of the premium. Families above 200 percent of poverty would be eligible if the employer's contribution is less than 50 percent of the premium. Medicaid enrollees would not be eligible for tax credits, and Medicaid programs would not be permitted to reduce coverage below July 1, 1996, levels.

Insurers that provide coverage to any government program would be required to offer policies to children. The benefit package would have to satisfy guidelines set forth by the Secretary of Health and Human Services. The Secretary would determine the "average cost" of coverage to which subsidies would be linked. The states would be required to establish group purchasing mechanisms. Insurers would not be required to offer individual policies but would be required to participate in state-established group markets.

The Kennedy-Kerry bill, the Children's Health Initiative, would provide subsidies to children up to age 19 in low-income families. Subsidies would be available on a sliding-scale basis. Families with incomes below 185 percent of the federal poverty line would receive the full subsidy. Subsidies would decline at incomes above 185 percent of the federal poverty line, and children in families with incomes above 300 percent of the federal poverty line would be ineligible.

Any contributions by employers would directly reduce the amount of the subsidy. Employers would not be permitted to treat families eligible for vouchers differently than other employees, and states would not be allowed to cut back on optional Medicaid coverage for children now in place. The plan envisions that states that

are currently covering optional groups could receive higher matching payments.

The subsidy would be tied to the average cost of a plan providing a comprehensive benefit package with minimal cost-sharing. The subsidies could be used to purchase insurance through any group purchasing mechanism. Because of potential problems in the private insurance market, there would be a default insurance pool. Insurers would compete by offering policies through the pool, and the cost of the subsidies would be tied to one of the plans in the pool.

The Kennedy-Kerry and Daschle-Gephardt proposals would extend private insurance coverage by providing subsidies for children in families with incomes up to 300 percent of poverty. Currently, 4.3 million uninsured pregnant women and children below 300 percent of poverty are not eligible for Medicaid. The subsidies would be targeted directly to these individuals. If perfectly targeted, the proposals would be a relatively low-cost way of reducing the number of uninsured pregnant women and children. But perfect targeting is difficult. In addition to the 4.3 million pregnant women and children currently uninsured, another 1.5 million below 300 percent of poverty with private insurance policies would be potential recipients of these subsidies. Further, 18.6 million pregnant women and children below 300 percent currently have employer-sponsored coverage. These children could become recipients of the subsidies if provisions to keep employees from dropping their current coverage are not effective. Finally, a large number of individuals currently on Medicaid could become recipients of the tax credits if the federal government could not enforce provisions keeping states from dropping optional Medicaid coverage.

These proposals are attractive in many ways, but they present a large number of problems. The first is that they would provide substantially less than full coverage. The subsidies under these two proposals are so generous that participation rates at lower income levels should be high. Yet we know that over 10 percent of those below poverty who are eligible for Medicaid do not participate. As subsidies are phased out (above 185 percent of poverty in Kennedy-Kerry and above 200 percent of poverty in the Daschle-Gephardt proposal), participation rates are likely to

decline. Recent evidence (Marquis and Long 1995) suggests that subsidies have to be quite high before individuals will purchase health insurance. Marquis and Long concluded that "even a 60 percent subsidy will only induce about 1/4 of working families that do not have insurance coverage (and this makes up the majority of uninsured) to purchase insurance."

Participation rates are inevitably linked with selection. Participants are likely to be those for whom coverage is very valuable—families with children with serious health problems. Thus, in the income ranges over 185 percent of poverty, there is likely to be significant adverse selection, and the cost per additional enrollee will be high. At income levels where subsidies are very generous, participation rates are likely to be higher, and there will be less selection and lower costs per enrollee.

The second issue is the potential crowding out of privately purchased or employer-sponsored coverage. The evidence on crowding out has largely been based on studies of Medicaid expansions to very low-income populations. The Daschle-Gephardt and Kennedy-Kerry proposals would extend subsidies to families with incomes up to 300 percent of poverty or more. Over 70 percent of the children in families between 186 percent and 300 percent have employer-sponsored coverage, and another 5 to 6 percent have private coverage. There is virtually no evidence on the extent of possible crowding out in these income ranges, but there is clearly reason for concern.

To prevent employers from dropping coverage, the Daschle-Gephardt proposal would make employees ineligible for tax credits for the purchase of health insurance for their children if their employer had dropped coverage. Many employers are already dropping coverage or increasing employee contributions in order to reduce their overall wage compensation costs. If these firms cannot be distinguished from those that drop coverage because of the availability of the subsidies, employees in these firms would be unfairly penalized. Penalizing employees whose employers drop coverage treats these employees differently than employees in firms that never offered coverage in the first place.

The Kennedy-Kerry proposal has no explicit provisions to discourage employers from dropping coverage. The proposal's proponents appear to believe that employers are unlikely to drop

coverage since high-wage workers would have to purchase health insurance with after-tax payments, rather than receive the current tax benefit in the form of employer-sponsored health insurance.

Both proposals are faced with the fact that many Medicaid programs cover large numbers of low-income children as optional groups. States are required to cover children through the age of 13 who are below the poverty level, but many states go further and cover children at higher income levels as well as older children. Both proposals would prohibit states from cutting back on optional groups. Otherwise, states with such optional coverage could drop coverage, and the former recipients could obtain a federal tax credit allowing them to purchase health insurance. The Kennedy-Kerry proposal offers to pay a higher Medicaid match than in the current law for optional coverage groups. It is difficult to see how a state could be required to continue covering these groups, essentially making them mandatory for the states that have chosen to cover them. A higher federal matching rate would not provide as much fiscal gain as a state would receive from simply dropping optional coverage and permitting individuals to take advantage of the federal tax credit. It would be hard for the federal government to treat neighboring states so differently simply because of their past coverage decisions.

The next issue is the impact on marginal tax rates and work incentives. Under the Kennedy-Kerry bill, full subsidies are available to those up to 185 percent of poverty. The share of the cost borne by the family increases rather sharply between 185 percent and 300 percent of poverty. The Daschle-Gephardt proposal is similar, phasing out most subsidies between 200 percent and 300 percent of poverty but retaining some tax credits for families with incomes as high as $75,000. There is, therefore, no impact on marginal tax rates on income levels up to 185 percent (or 200 percent) of the federal poverty line, the range most relevant for those concerned with moving individuals from welfare to work and out of poverty. The impact on marginal tax rates is fairly significant above these levels, however.

The final problem lies in administration. The capacity to address all of the questions of income determination would have to be established. This would have to be done for all the 4.3 mil-

lion uninsured children plus an unknown number of additional enrollees who drop or lose individual, employer, or Medicaid coverage.

Under the Kennedy-Kerry proposal, income determination would be done by the states and, presumably, administered at the local or county level. New entities might be established to administer the program, including determining incomes and, therefore, the value of the vouchers to be given to families applying for them. Income determinations would have to be made quickly so that individuals could buy insurance in a timely way. Income would have to be redetermined periodically to assure that individuals have sufficiently high vouchers to allow them to purchase insurance when they suffer income declines and to assure that families are not receiving overly generous vouchers if they have had income increases. Needless to say, this would be a large increase in administrative responsibility for state and local governments.

The Daschle-Gephardt proposal would use a refundable tax credit to be administered by both the states and the Internal Revenue Service (IRS). The model is the federal earned-income tax credit. Currently, 15.3 million Americans receive earned-income tax credits, but very few—about 1.2 percent—receive their credits by increasing their withholding. Rather, they receive their credits when they file tax returns at the end of the year. Health insurance needs to be available in the beginning of the year. Therefore, the Daschle-Gephardt proposal would have the states make the initial income determinations. States would then collect premiums from the individual and send them to insurers. States would inform insurers of the amount of the credit, and they would reduce their payroll taxes by the amount of the credits they received. The Social Security and/or Medicare trust funds would collect lost revenues from the Treasury. The IRS would be responsible for settling with individual taxpayers, either by assessing additional amounts if the individual had underreported income to the state or by sending a refund if the state had overestimated income and given too low a credit. All of this adds substantially to the administrative burdens of state government and of the IRS.

States would also be faced with the problem of assuring adequate participation of insurers and assuring families access to insurance at reasonable premiums. Premiums for individual insurance are substantially higher than those for employer-based insurance, particularly among larger firms, since the individual market is relatively inefficient—e.g., high administrative and marketing costs and greater risk. The individual insurance market would need substantial reform that few states have been able to achieve.

These problems can be partially addressed through the development of regional or statewide purchasing cooperatives. Individuals eligible for coverage would have the option of purchasing insurance through these cooperatives. Plans offering policies through the cooperatives would have to follow certain insurance rules, including guaranteed issue and renewability, limits on preexisting condition exclusions, and some kind of modified age-based community rating. Pools can bring down the administrative costs of insurance and limit discriminatory insurance practices. However, if insurers are able to avoid the insurance market reforms that apply to the cooperative when marketing outside of pools, there is a real possibility of adverse selection. Moreover, purchasing cooperatives are in their relative infancy and are currently available in only a limited number of states.

Extending Medicaid Coverage

A second approach to extending coverage to children is to expand current Medicaid coverage. One option is to extend current coverage to children ages 14 through 18 below the poverty line on an accelerated basis. Current law will extend coverage to these children by the year 2002. In principle, they could be covered sooner. The other related approach is to extend coverage to children with higher incomes. For example, states could be required to cover all pregnant women and children through age 6 or, alternatively, through age 18 up to 185 percent of poverty. States would have the option of covering children with higher levels of income and could permit families to buy into Medicaid, regardless of income. States could, for example, charge premiums for pregnant women and children above the poverty line and

require those above, say, 300 percent of poverty to pay the full premium. Medicaid could be expanded in a variety of ways—with mandates requiring coverage of different age and/or income groups, with options for broader coverage, and with variations on income-related premium schedules.

The advantage of extending Medicaid coverage is that the program is currently "up and running" and today covers over 21 million poor and near-poor children. Federal and state administrative and financial roles have been established. Procedures for enrolling beneficiaries, including making income determinations, paying providers, and monitoring and regulating quality of care, have been established. A Medicaid expansion would increase incentives for parents in poor families to enter the workforce, since they would not lose health insurance because they could remain in Medicaid. Expansions of Medicaid may also be a relatively low-cost way of extending coverage. Despite some recent arguments, states have generally done an effective job of controlling expenditures on a per capita basis (Holahan et al. September 1995).

There are also a number of problems with expanding Medicaid. The first problem with expanding Medicaid in the current environment is that states are very opposed to even the current mandates. Medicaid is one of the largest items in state budgets and one of the fastest growing. A large part of the 1995-1996 debate over Medicaid can be directly linked to state objections to the mandates that have been imposed since the mid-1980s. The Medigrant proposal passed by the Republican Congress in 1995 would essentially have ended Medicaid and replaced it with block grants to the states. The Clinton administration proposal would have retained the Medicaid entitlement but would have given states enormous flexibility in establishing policies for coverage, benefit packages, managed care, provider payment, and so forth. The National Governors' Association proposal would have ended the phase-in of coverage of children ages 13 to 18 as well as reduced state financial requirements. Expansions of Medicaid are inconsistent with the direction that the public policy debate has taken in the past year.

The second problem is that expansions of Medicaid only expand eligibility; enrollment in Medicaid would remain volun-

tary. There has been a long-standing stigma attached to Medicaid coverage because of its relation to welfare programs. Access to care in Medicaid has also been limited in comparison to private plans. For these reasons, not all low-income families who are eligible enroll in Medicaid. For example, about 2 million children who are eligible do not have Medicaid coverage (Urban Institute estimates). The Clinton administration has proposed to launch an effort to increase participation rates. Nonetheless, any Medicaid expansions to higher income levels would still leave the nation short of universal coverage.

A third problem is the fact that with the flexibility states now have, Medicaid benefits are, and have been for a long time, highly variable across states. Table 5 showed that Medicaid coverage of poor and near-poor children under age 19 (in 1990 through 1992) varied from 62.7 percent in the District of Columbia and 56.7 percent in Massachusetts to under 25 percent in Idaho and Utah. Spending on children varies from $789 per beneficiary in Idaho to $2,344 in Maryland (Liska et al. 1996). The variation in spending reflects differences in benefits and payment policies. A mandate to cover more children would have small effects on states that now have broad coverage. States with narrow coverage would face much higher costs in complying with a mandate. Variations in other aspects of Medicaid—e.g., benefits and provider payments—would be retained even under the current program structure and presumably would be much greater if Medicaid reforms allowed states even greater administrative discretion.

A fourth problem is establishing a premium schedule by which individuals would buy into Medicaid. Subsidies must be large for lower-income people in order to encourage participation. If subsidies are to be phased out slowly to avoid large increases in marginal tax rates, which could have adverse effects on work incentives, the results would be a large number of families with subsidies and a high level of income at which all subsidies are phased out. The result would be that even middle-income individuals would be receiving some Medicaid subsidies and the costs of the program would be high. One alternative is to phase out subsidies more quickly, but then marginal tax rates, with their resulting disincentive effects, are higher. Another alternative is less generous subsi-

dies to begin with, but then the cost to lower-income individuals could be prohibitive.

A fifth issue is whether federal financing arrangements should be changed if coverage of children is to be expanded. In the recent block grant debate, higher-income states supported reducing state matching requirements. In principle, the federal share of costs of covering children could be increased in all states. There is a large federal or national stake in the coverage of children. Individuals everywhere have a strong stake in how children are treated in every other state. Because individuals become mobile as they grow older, investment in children in one state could reap benefits for residents of other states. In addition, children may not fare as well as the elderly in the battle over scarce resources in times of state fiscal stress. This would argue for increasing federal matching payments to ease the cost to states of expanding coverage for children. Increases in matching payments could be designed so that the marginal cost of expanding coverage to states would be relatively small. Of course, this would mean a greater cost to the federal government, particularly if higher federal matching payments apply to children already enrolled.

The final issue is that extending Medicaid coverage to larger numbers of individuals will increase the risk of "crowding out" private coverage. It has been argued that a large amount of the Medicaid expansions to pregnant women and children have crowded out private coverage (Cutler and Gruber 1995). However, the size of the crowd-out is the subject of considerable debate (Dubay and Kenney 1995; Shore-Sheppard 1995). Most of the expansion of Medicaid has been to individuals below poverty, who are much less likely to work and, even if they do work, to have access to health insurance. However, expansions of Medicaid to individuals up to 200 percent or 300 percent of poverty could result in a more serious problem of crowding out private coverage. Whether crowding out would be greater than under the subsidy approaches would depend on the relative costs to families of coverage and the value they place on private versus Medicaid coverage. A significant share of the additional federal and state tax costs would simply replace private employer and individual payments. This does not imply new costs to the nation but could

significantly alter the distribution of "who pays" for health care. If participation is lower under Medicaid (e.g., because of stigma), there could be less crowding out than most other alternatives.

Mandates

Mandates on Families—Some of the problems with the subsidy proposals discussed above could be addressed by mandating that families provide health insurance for their children. This would be coupled with either direct subsidies—e.g., vouchers—or tax credits to assist low-income families with the cost of insurance. A mandate would probably be necessary to achieve universal coverage, given the evidence on low responses to subsidies. It would also avoid many of the selection issues. With a mandate, all would be required to obtain coverage, and the average cost per enrollee would be lower.

The first problem with a mandate on families to provide coverage for their children is that there are high and very visible costs to families. While these would exist under a subsidy arrangement, individuals have the option of accepting the subsidy and purchasing insurance. Under a mandate, there is no choice.

Because there would be more participation, there would be more potential for crowding out of existing coverage. The mandate could ignore the possibility of crowding out and provide subsidies based on income independent of current coverage. Ignoring the crowding-out problem essentially shifts more of the cost to government and away from firms and low-wage workers. Alternatively, it could create "walls" and provide strong disincentives to employers to drop coverage and prohibit states from dropping optional Medicaid coverage. Creating walls reduces the cost to the government, but it creates equity problems. Individuals are treated differently, depending on whether employers currently offer coverage. Those whose employers currently provide coverage are ineligible, even if all or part of the cost of health insurance is shifted back to them in the form of lower wages. Meanwhile, employees who do not currently have health insurance would be fully eligible for tax credits or vouchers.

The administrative issues discussed in the previous section apply with a mandate but are more extensive. Since there would be universal coverage, the problems of income determination and reconciliation are greater. Moreover, enforcing the mandate would be a problem. The problems with the individual insurance market and with the development of group purchasing cooperatives also become more important.

Employer Mandates—Another alternative would be mandates on employers to offer and pay for a large share of the cost of health insurance for children (National Commission 1993; AAP 1990). This would necessarily be coupled with a back-up mandate on families to accept this coverage and pay their required share or obtain alternative coverage meeting the same standards. Two broad types of employer mandates have been proposed. One would be a pure mandate on employers to provide coverage. Pure mandates usually have provisions for subsidies for small, low-wage firms and for low-income individuals. An alternative is a "play or pay" type of employer mandate. Employers would be required to provide insurance to their employees or pay a tax. Employees of firms that chose to pay the tax would join a public plan and pay their required share of the premium.

The advantages often cited for employer mandates are that when coupled with a back-up mandate on individuals to obtain coverage, a mandate would assure universal coverage in a way that is less disruptive to the present insurance arrangements of most Americans (Zedlewski 1991). Moreover, new costs to the government would probably not be as high (depending on the subsidy arrangement) as under alternatives because the bulk of the costs are borne by employers and their workers directly. To the extent that a mandate results in shifting some workers from Medicaid to private plans, it could actually reduce public sector outlays for that program. A further advantage often cited for employer mandates is that they would rely on the private market. Insurance companies would not lose market share to a large public plan, though this is potentially less true under a play or pay approach. There would be a need for substantial insurance market reform to assure access.

Employer mandates were a central feature of the Clinton administration health care reform proposal, which evoked considerable political opposition two years ago (although not exclusively because of the employer mandate). A mandate on employers to provide health insurance for children has many, but not all, of the problems associated with the Clinton proposal. It would be difficult to impose a mandate on employers to provide health insurance for the children of employees without a mandate to cover those employees themselves. Further, a mandate to provide coverage to children creates a variety of administrative problems basic to employer mandates. These include the treatment of families with two workers and potential exemptions for small firms and part-time workers. Both low-wage firms and low-income workers would need subsidies. As discussed above, these are complicated to administer. In addition, employer mandates tend to be highly regressive forms of health care financing. Finally, employer mandates could have adverse effects on labor and product markets. Given these problems, an employer mandate for children is not likely to be given consideration.

Extending Medicare to Pregnant Women and Children

Yet another approach to expanding coverage to pregnant women and children is to expand the Medicare program (Hughes et al. 1995). The model is not Medicare Part A, which is based on payroll contributions, but Medicare Part B, which relies on premiums and general revenues. The basic principle of social insurance—the spreading of risk to all members of society—would apply.

The advantage of expanding Medicare for pregnant women and children is that it would build upon a program that is popular with the elderly and is highly regarded by the public. This model would build on over 30 years of experience in administering a very large public insurance program, one that has established a broad set of policies for paying and regulating providers. It has developed and maintained data systems to support program monitoring and policy analysis. It has a network of private-sector intermediaries to process and adjudicate claims, address

the problems of beneficiaries, and implement Medicare regulations. The program also has low administrative costs and relatively good success with controlling expenditure growth (Moon and Zuckerman 1995). A Medicare approach would also minimize variations across geographic areas in the design of the program. There are at least two ways to build on the Medicare Part B model. In each, Medicaid coverage of pregnant women and children would be eliminated.

The first model is a new Medicare program for pregnant women and children in which enrollment would be voluntary. As with Medicare Part B for the elderly and disabled, large subsidies could be provided to encourage a high level of participation, and some subsidies would be available to all. For budgetary reasons, in the examples below we assume all children would receive some subsidies but those subsidies would not be as generous as those now available in Medicare. For example, parents could be assessed premiums based on their income. Premiums could, for example, be zero for those below poverty and increase with income, up to 75 percent of the actuarial cost, for those above 300 percent of poverty. The balance of the cost would come from general revenues.

A purely voluntary approach would result in less coverage, with participation rates that would be significantly less than 100 percent simply because individuals are not very responsive to subsidies in their decisions to purchase insurance (Marquis and Long 1995). While the voluntary approach would be the least costly to the public and to the taxpayer, a voluntary approach would probably result in some adverse selection into the plan, increasing the average cost per enrollee. Families would retain the most choice under this arrangement, including the choice to keep children uninsured. Families would have the same choices of private plans as they do today but they would now have the choice (as well as the incentives through the subsidies) of enrolling their children in Medicare.

The second model would permit voluntary Medicare enrollment, but it would be coupled with a mandate on families to obtain coverage for their children. Families would be required to obtain coverage for their children either through Medicare or private insurance policies that provide coverage at least as compre-

hensive as Medicare. Premiums would be income related, with subsidies available to families who choose to enroll in Medicare. Subsidies would also be available to those who enroll in private plans, but the value of the subsidy would be linked to the cost of Medicare. Families who chose a more expensive private option would pay any additional cost.

An approach that permitted voluntary Medicare enrollment coupled with a mandate would assure full coverage of children. Subsidies would be available to all families up to, say, 300 percent of poverty. This approach would be more costly to the taxpayer than a purely voluntary approach because participation would be closer to 100 percent. How much additional cost depends on how much adverse selection occurs under the purely voluntary arrangement; that is, because the additional enrollees who participate because of the mandate may be less costly than average, costs will not rise in proportion to the added enrollees.

Expanding Medicare presents a number of problems. Medicare is viewed by some as large and cumbersome and unresponsive to major innovations in the marketplace. For example, it is argued that it is difficult for Medicare to use the threat of exclusion of hospitals and physicians to drive hard bargains the way private managed care plans are currently doing. An alternative view is that Medicare has successfully used its considerable buying power to achieve lower rates of payment than typically achieved by the private sector. Whether private-sector managed care plans are doing better today is a matter of some debate.

This debate raises the related issue of whether a Medicare program for children would be a fee-for-service program as it largely is for the elderly. Would new delivery system changes be required? Would an expansion of Medicare coverage for children build on Medicare's current systems for paying for hospital and physician services? Or would (or should) fee-for-service arrangements be replaced? Would Medicare need to develop capitation arrangements for payments for packages of ambulatory services to pediatricians with an independent system of paying for specialty and hospital care? Or would a Medicare program for children rely on private managed care plans? In this model, Medicare would become the mechanism—i.e., a public sponsor—through which managed care plans competed for contracts to provide cov-

erage for children. A new set of responsibilities would then be required of Medicare that it is only beginning to address for the elderly. Medicare would monitor plan quality, conduct surveys of consumer satisfaction, and provide information to improve family decision-making. Medicare would be the vehicle for spreading risk across different families—i.e., collecting premiums, adding subsidy dollars, and distributing payments to plans, depending on the health status of their enrollees. Medicare would establish a set of risk adjusters for children of different ages and those with different health status. At issue would be whether families could supplement the Medicare premiums to pay for more generous plans with greater access to providers and additional benefits.

Second, expansions of Medicare inevitably lead to higher costs to the taxpayer, even under plans that require families to pay premiums, as long as some subsidies are provided to all children. The tax cost will depend on the generosity of the subsidies offered to lower-income people and the amount of the subsidy offered to high-income families. Any of the approaches that would expand coverage obviously have tax consequences, but the costs of the approach described here—with some subsidies available for all children—would probably mean this approach would be more costly than alternatives.

Third, the current Medicare benefit package is relatively narrow. A program for children would probably need to provide for prescription drugs and include prevention and screening programs similar to Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. There also may not be a strong argument for the system of deductibles and coinsurance in Medicare, given the emphasis on prevention and early access to services often recommended for children's health. The division into Part A and Part B, with different deductibles and coinsurance, would clearly be inappropriate, as it probably is for Medicare itself. The absence of a stop loss is also problematic.

It would be difficult to make changes to the benefit package, cost-sharing provisions, or the Part A/B distinctions without making comparable changes in the rest of the program. Making many of these changes to the current Medicare program for the elderly would increase the costs of a children's Medicare initiative, though they could be at least partially offset if other poli-

cies, such as increasing the age of eligibility and income-related premiums, were adopted for the elderly.

Fourth, as shown in Table 1, most children are currently covered by either employers or by Medicaid. Moving to a heavily subsidized single federal program would probably mean, as with other proposals, that many employers who currently provide coverage or families who contribute to employer-sponsored coverage or purchase private nongroup policies would drop that coverage. Financing could shift from the private sector to the public sector, with a relatively small expansion in total coverage.

How much of a shift occurs depends on whether the program is voluntary or mandatory and how generous the subsidies are. Even under a purely voluntary program, the shift could still be significant if subsidies are generous and only available to children who enroll in Medicare. If subsidies are also made available to those who choose private plans, more families will choose private plans and there will be less substitution of Medicare for private coverage. The availability of subsidies, however, will mean that some substitution of public dollars for employer contributions will take place.

A New Federal-State Program for Children

Another approach would be to develop a new federal-state program for children rather than to rely on the current structure of either Medicaid or Medicare. The new program would replace current Medicaid coverage for pregnant women and children. Under such a program, the federal government would establish essential program rules for enrollment, benefits, provider payment and regulation and so forth, and provide matching grants to states. These would be more generous than the under current federal matching formula. Subsidies would be available to the poor and near-poor but not to everyone, though any family could enroll their children. Subsidies would be made available for all children, say, up to 300 percent of poverty, with no premiums for children in families with incomes below, say, 100 percent to 150 percent of poverty. Those with incomes above 300 percent of poverty could enroll by paying the full premium. This approach avoids the problems of state opposition to federal mandates, the

problems with the stigma of the attachment of Medicaid to welfare, and the problem of variations in Medicaid coverage and benefits.

At the same time, the program would avoid some of the costs associated with the kind of Medicare expansion described above because subsidies would only be available to the poor and near-poor. That is, the program would not provide some subsidy for all children regardless of family income. Moreover, under this approach, it would also not be necessary to expand the benefit package for Medicare beneficiaries.

The problems with this approach are that an entirely new administrative structure would be needed, with the potential of serving over 40 million pregnant women and children (if all below 300 percent of poverty enrolled). It would not have the benefit of the prestige that would come from being linked to the current Medicare program. Finally, most of the governmental (above current Medicaid) costs would be borne by the federal government. Finally, the program would also face the same problems of crowding out of current private coverage described for Medicare and Medicaid. All those below 300 percent of poverty would have some incentive to enroll in this program. Many of the new enrollees would currently have employer-sponsored or privately purchased insurance.

The Child Health Insurance and Lower Deficit Act introduced by Senators Hatch and Kennedy would provide grants to states to set up voluntary programs that would provide subsidies to low-income children. States would have considerable flexibility in setting up these programs, including establishing income eligibility criteria and subsidy schedules. Individuals would not be eligible if they had employer-sponsored coverage within the last six months unless they dropped coverage because of a change in employment. States would be required to contract with insurers to make sure plans are available. They would also be required to ensure that families would contribute no more than 5 percent of the premium if their incomes were below 185 percent of poverty, that there would be no cost-sharing for preventive services, and that families with incomes below 150 percent of poverty would not have to pay more than 20 percent of the cost of services. The

benefit package would be required to be the same as under the current Medicaid program.

Grants would be distributed to states on the basis of their share of uninsured children. The more uninsured children in the state, the higher the share of federal funds. The state would be required to match federal payments, but the state's matching contributions would be less than under Medicaid. The state matching requirements would be 40 percent of current Medicaid levels with a minimum match of 10 percent. For example, a state that has a 50 percent Medicaid match would be required to pay 20 percent of the cost of the new program. A state with a 25 percent match would be required to pay 10 percent.

Unlike the proposal discussed earlier in this section, the Hatch-Kennedy bill would build upon the current Medicaid program rather than replace it. States would be required to maintain the current Medicaid eligibility rules, and children would not be eligible for subsidies under the new program if they were currently eligible for Medicaid. The result is that the proposal would provide more funds to states that have had less Medicaid coverage, all else being equal. If a state had not covered many low-income children, it would be likely to have more uninsured children and would therefore receive more federal funds. Because this program would offer more generous matching payments than does Medicaid, states would be penalized for having broader Medicaid coverage. The program would also provide greater federal support for higher-income children than lower-income children in each state because its subsidies are more generous than those under Medicaid.

A proposal that replaced Medicaid for pregnant women and children (rather than freezing it in place and then building on it) with one that had higher federal matching rates than in the current Medicaid program would avoid this problem. Higher matching rates would apply to all pregnant women and children, not just those who would be newly covered. The program could be designed so that the incremental costs to states would be low, as in the Hatch-Kennedy proposal. But the result would be that federal payments to states would depend on relative per capita incomes, not on how generous a state has been in the past.

CONCLUSIONS

In this monograph, data is presented on the number of uninsured children, on changes in insurance coverage over time, and on variations across states in health insurance coverage of children. The data showed that 10.4 percent of all children lack health insurance but that the number of uninsured is higher for the near-poor and for children over age 6. There are also substantial variations across states primarily because of differences in Medicaid coverage. Large declines in employer-sponsored coverage shown in recent years have been offset thus far by increases in Medicaid. These offsets seem unlikely to continue. We also developed an estimate that the cost of covering currently uninsured pregnant women and children would be about $10.4 billion and the cost of covering all pregnant women and children from all sources is now in the neighborhood of $90 billion. The two figures imply that any policies to expand coverage to the uninsured would have relatively low net new costs to the nation (about $10.4 billion) but could result in a rather large redistribution of spending (a significant share of the $90 billion).

We then examined a number of alternatives for expanding coverage. All have significant problems, particularly in the current political environment, but with the likely continued declines in employer-sponsored coverage, it is difficult to see how these problems can be solved without an increased government role. The major conclusions are as follows.

Subsidies

Subsidies provided directly to the family in the form of vouchers or tax credits to expand health insurance for children offer considerable promise, but they also come with a number of problems. Current proposals (Daschle-Gephardt, Kennedy-Kerry) propose to target vouchers or tax credits directly on the uninsured poor and near-poor. They attempt to assure that their subsidies are not available to those with current employer or Medicaid coverage. If they can successfully target the subsidies, new government costs will be low, and there would be little

crowding out of existing coverage. However, such walls create inequities between employees in firms providing health insurance and employees in firms that do not, as well as between individuals living in states that provide optional Medicaid coverage and those that do not. If these walls cannot be sustained or enforced, there will be a greater cost to the public sector and more crowding out of current coverage. The costs of these proposals would also be high to the extent the subsidies will be used to purchase health insurance in the individual insurance market. These problems can only be mitigated with substantial reforms of that market, together with a development of purchasing cooperatives to reduce the cost of health insurance, efforts which are now in their infancy in most states. These proposals also have high administrative costs of determining incomes, collecting premiums, and end-of-the-year reconciliation.

Expanding Medicaid

An expansion in Medicaid would be the easiest approach for expanding coverage to children. Expansions could be targeted to low-income families. Policies and procedures for addressing a wide range of issues have been established, including eligibility determinations, provider payment and contracting, and quality monitoring. The federal government could require states to cover all children below poverty and phase in older children faster than is now currently envisioned (by 2002). Alternatively, coverage could be required for all children up to 133 percent of poverty, as it is now for children up to age 6, or up to higher income levels. Medicaid expansion faces the problem of state opposition to mandates, the high current variability among states in coverage and benefits, and the difficulties states are having developing managed care products. Any substantial coverage mandates probably should also be accompanied by increases in federal matching contributions for acute care benefits for children.

Mandates with Expansion of Medicare or Medicaid

If there is a national consensus for universal coverage for children, probably the best approach would be through a mandate on parents to provide coverage for their children, coupled with full subsidies for those below poverty. Subsidies would decline as income increases. Subsidies might be available to families with incomes below 250 percent or 300 percent of poverty. To avoid problems in the individual insurance market, a mandate would be coupled with an expansion of Medicare or Medicaid, or enactment of a new federal-state program for children independent of Medicaid. Parents could choose between enrolling their children in Medicare, or Medicaid, or the new childrens' program, depending on which would be used, or use subsidies to purchase private insurance policies meeting established standards.

This approach would achieve universal coverage of children while giving families a choice of private coverage or enrolling in a government program. All of the advantages and disadvantages cited in this monograph for these options would apply. With a Medicare expansion, benefits would be uniform among states. With a Medicaid or state-based program, benefits and program structure could vary. With Medicare, there could be a link to a popular program; with Medicaid, there is the stigma of a welfare, or poor people's, program. A new federal-state program would not have the link to Medicare but would also not have the tie to welfare. With Medicare, there are higher costs because of higher payment rates and stricter regulatory standards as well as the possible need to expand benefits for the elderly. With Medicaid or a new federal-state program, costs of the expansion would almost certainly be lower, but most would probably have to be borne at the federal level. There is likely to be substantially more crowding out of private coverage with a Medicare option than with Medicaid.

Serious consideration of universal coverage of children requires acceptance of mandates and/or taxes, neither of which are popular notions. It also requires acceptance of the fact that a substantial coverage expansion would crowd out some private coverage. How much crowding out depends on the generosity of the subsidies. As subsidies are phased out, they become less generous than employer contributions, which would naturally limit dropping of coverage.

Approaches that would attempt to target subsidies to only those currently without either private insurance or Medicaid would mean lower government costs but would also create serious inequities and most likely could not be sustained. The crowd-out issue is largely an income distribution issue. Subsidies that replace private expenditures largely substitute tax revenues for payments made by low-income individuals, either directly or through lower wages. While proposals that crowd out existing coverage can create difficult political problems, they can also improve the distribution of "who pays" for health care. It is also important to remember that the only way to truly avoid crowding out private coverage is to do little or nothing and thereby accept a large number of uninsured children.

Notes

1. It should be noted that although many observers have made these arguments rhetorically, empirical support to link expanded health insurance with positive health outcomes is quite limited (Kenney and Dubay 1996).

2. The Urban Institute's TRIM2 microsimulation model corrects for the underreporting of Medicaid coverage. As a result, the number of individuals reported as having Medicaid will be higher and the number of uninsured lower than in the unadjusted Current Population Survey.

3. There is still considerable debate over the meaning of uninsured counts on the CPS—do they represent the number of uninsured for a full year, at a point in time, or a combination? Most likely, these are an underestimate of the number of uninsured at a point in time. On the other hand, they probably undercount the number of individuals covered by state programs other than Medicaid.

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