Universal Coverage For Children: Alternatives, Key Issues, And Political Opportunities

Is a “children first” approach to universal coverage realistic?

by Stephen Berman

ABSTRACT: This paper describes four alternatives for expanding childhood insurance coverage, discusses key health policy issues, and assesses the political possibilities for enacting universal coverage. Alternatives are (1) a single federal child health program for all children; (2) a hybrid federal child health program (replacing Medicaid and the State Children’s Health Insurance Program [SCHIP]), combined with employer coverage; (3) a new federal wraparound program for the uninsured (that keeps the existing Medicaid program); and (4) expansion of SCHIP. Key policy issues include the type of universal coverage, use of competing commercial health plans, financing, employer and individual mandates, and the definition of benefits. [Health Affairs 26, no. 2 (2007): 394–404; 10.1377/hlthaff.26.2.394]

A well-functioning national health care system should provide everyone with high-quality health care at an affordable cost. A major deficiency of the current U.S. system is its failure to cover all children. Based on data from the Medical Expenditure Panel Survey (MEPS), the American Academy of Pediatrics (AAP) found that twenty-one million children, from birth to age twenty-one, were uninsured for all or part of 2004; nine million were without coverage for the entire year, and twelve million had gaps in their coverage sometime during the year.¹ There is much state-to-state variability in the proportion of children lacking coverage for all or part of the year. This probably reflects both sociodemographic characteristics and the design and implementation of Medicaid and the State Children’s Health Insurance Program (SCHIP) across states. State expansions of Medicaid and SCHIP have allowed a higher proportion of children living in low-income households to obtain insurance coverage. The AAP, using published reports based on data from the Current Population Surveys (CPS), found that the proportion of children under age nineteen who were covered by Medicaid/SCHIP increased from 19.9 percent in 1998 to 26.7 percent in 2005.²

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This paper reviews universal coverage issues for children by presenting four alternatives for increasing coverage, discussing key health policy issues, and assessing the political feasibility of passing universal coverage legislation.

**Alternatives For Increasing Coverage Of Children**

- **Single federal program.** The first alternative is a new federal program that would provide all children with coverage, either without means testing—similar to the age- or disability-related entitlement provided by Medicare—or by requiring a premium contribution based on income. This program would have eligibility and benefits determined nationally but could be funded nationally or jointly by the federal and state governments with state administrative oversight. No bill has yet been introduced in Congress for this type of program.

- **Hybrid federal program.** The second alternative is a new federal program that would cover children who are not covered by employer-sponsored or other private insurance. Uninsured children and children enrolled in Medicaid and SCHIP would transfer into this new program. Again, no bill has yet been introduced in Congress for this type of program.

- **Federal wraparound program.** This program would cover uninsured children who are not enrolled in Medicaid, SCHIP, or employer/other private coverage. This model would provide a “coverage floor” or safety net so that coverage could go into effect whenever other coverage is lost. Examples of this model exist in proposed federal legislation and in state reforms.

  *MediKids.* MediKids: Health Insurance Act of 2005, a federal bill reintroduced in 2005 but not enacted into law, uses this approach. If this plan had been passed, every child born after 2007 would have been automatically enrolled in Medikids, while older children up to age twenty-three would have been enrolled during a five-year phase-in period. Legal immigrant children would have been enrolled when they received their “green cards.” Families below 150 percent of the federal poverty level would have borne no premium contribution, while families with incomes of 150–300 percent of poverty would have had some income-adjusted cost sharing for reduced premiums. Parents above 300 percent of poverty would have been responsible for a small premium equal to one-fourth of the average annual cost per child. These parents would have had to pay their cost share through their income tax filing and payment process. Tax credits would have been available to ensure that no family would be required to pay a premium greater than 5 percent of their adjusted gross income. There would also have been an individual mandate on parents to document that their children had private or public coverage.

  *Massachusetts health reform plan.* The 2006 Massachusetts Health Care Reform Plan combines a wraparound-type model (Commonwealth Care Health Insurance Program) for uninsured low-income adults and some legal immigrant children, with a Medicaid/SCHIP expansion for children whose family incomes are at 200–300 percent of poverty. The Massachusetts plan also mandates that adults (nine-
teen and older) have coverage. Legal immigrant children who have been in the United States for less than five years are not eligible for Medicaid and will be covered at the full state cost. Undocumented immigrants will not be covered but will continue to receive emergency health coverage as federally mandated.

■ A SCHIP expansion with a parental mandate. Raising the income eligibility thresholds for SCHIP would cover most uninsured children. A mandate that parents must have health insurance for their children and a streamlined enrollment process would be needed to ensure full participation. More than half of the nation’s uninsured children are now eligible for public coverage but are not enrolled. Many parents are unaware that their children would qualify for public programs, and others have difficulty navigating complex enrollment procedures.

Expansion of SCHIP plus a mandate could be adopted by states without new federal legislation, but a national program would require a new federal mandate that states expand SCHIP coverage or create a strong financial incentive for states to expand coverage, or both. The financial incentive could include changing the federal match rate or federal-state financing structure to benefit states. However, this alternative would not provide children with an entitlement to health care and would be structured as a federal block grant to states. If the need or cost increases, or both, are greater than projections or if states experience budgetary difficulties, program enrollment freezes or cutbacks could be implemented. Although a SCHIP expansion would reduce the proportion of children without insurance and could provide a pathway to affordable or reasonably priced coverage, it would not, by itself, guarantee universal coverage.

Kids Come First Act. This federal legislative proposal, introduced in 2005 but not passed, takes the SCHIP expansion with a mandate approach. In this bill, SCHIP coverage would be expanded to all children under age twenty-one living in families with incomes at or below 300 percent of poverty. By raising the current SCHIP age limit from eighteen to twenty-one, the bill’s sponsors claim that an additional 5.5 million part- or full-year uninsured young adults (ages 19–21) would become eligible for coverage. Although the program would impose a mandate on the states, the joint financing of SCHIP/Medicaid would be restructured to reduce state spending for children enrolled in Medicaid. The federal government would take full financial responsibility for Medicaid coverage and outreach costs for children living in families at or below the poverty level, while states would continue to pay the enhanced SCHIP match rate (an average of 36 percent) for higher-income children up to 300 percent of poverty.

Other examples. Several states already have used or are planning to use this model to reduce the number of uninsured children. As of 2006, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, Vermont, and West Virginia had expanded their SCHIP eligibility to at least 300 percent of poverty, which will make almost all uninsured children who are citizens eligible for public programs.

Illinois passed All Kids in 2006 to provide all children, regardless of immigra-
tion status, with insurance coverage with a sliding-scale subsidy from state funds for families that do not qualify for SCHIP. Premium assistance is available for children with insurance living in families with incomes below 200 percent of poverty. There is a twelve-month waiting period for children when their parents drop family insurance coverage. Illinois SCHIP includes only children up to 200 percent of poverty, so the state will need to pay for coverage without a federal match for children living in families with higher incomes.

California has four counties that cover children up to 300 percent of poverty. The governors of California, Pennsylvania, Oregon, and Wisconsin have also introduced initiatives to reduce the number of uninsured children in their states.

**Key Health Policy Questions**

Although each of the four alternatives will reduce the numbers of uninsured children, there will be differences with respect to the distribution of the financial burden across private and public sectors, coverage benefits, administrative complexity, and reliance on private competitive market forces. The answers to six key health policy questions will affect the design and implementation of any of these alternatives.

- **Should there be a “children first” approach to universal coverage?** There are a number of advantages to adopting an incremental “children first” approach that would initially provide insurance to all children and later expand coverage to other uninsured populations. First, expanding public programs to cover all uninsured children has considerable public support. Second, the expenditures necessary to cover all children are much lower than amounts needed to insure everyone because there are far fewer uninsured children than adults, and caring for adults costs more than twice as much as caring for children. In 2005, of the 46.6 million people who were uninsured throughout the year, only 12.4 million were infants, children, and young adults through age twenty-one. According to the AAP Pediatric Medical Cost Model, the 2004 medical cost (not including dental) to cover each commercially insured child was $109 per month, compared with $252 for each commercially insured adult.

Alternatively, many people consider providing health insurance to children without covering their parents shortsighted, because children need a supportive family to optimize their health and development. When parents are uninsured and fail to receive needed preventive and curative medical care for common conditions such as hypertension and diabetes, poor health might impair their ability to work and result in financial and emotional stress.

- **Should the health care system maintain the current private marketplace?** There is widespread belief that the competition within an open marketplace encourages both efficiency and innovation. Central planning often fails to recognize and accommodate to local differences, leading to a “one-size-fits-all” approach that might not serve many populations well. Advocates for maintaining the private mar-
ketplace believe that this system has encouraged rapid technological advances in medicine as well as much pharmaceutical research and development. Concerns have been raised that a governmental program will bring inferior medicine with underfunded hospitals; denial of high-cost care to patients; and delays in introducing advanced, life-saving technology into practice. Supporters of a multipayer, private health care system also believe that the marketplace will be more effective at forcing the health care system to become more efficient and reduce unnecessary (and perhaps harmful) spending than a federal or federal-state governmental system will be. Many in the business community believe that government is less able to control health care costs than employers are and therefore that employers will end up paying more in taxes to support a governmental program than what they will pay in premiums to maintain the employer-based system. Advocates of a competitive marketplace point to the problems in other government programs such as the military procurement “single-payer” system and the need to avoid the mistakes of this type of model.

An alternative to the current marketplace with competing commercial health plans is a single-payer federal program such as Medicare, in which providers are paid directly by the government. Single-payer advocates say that this federal approach would bring consistency and equity across the states with respect to eligibility, enrollment, benefit design, and cost sharing and that it would remove the difficulties families experience when they move between states or require medical services outside their home state. Having a federal program would also provide a vehicle for increased federal support for system changes such as widespread adoption of health information technology (IT), electronic medical records, and patient or disease registries, as well as the development and implementation of pediatric quality outcome and performance measures, as is now done in Medicare.

Advocates cite studies documenting that large savings to the health system can be realized by shifting to a single-payer model. They claim that a national single-payer system would streamline, reduce, or eliminate many administrative expenses related to marketing, enrollment, and verification; billing and collections; utilization controls; audits; and performance measures. Clinicians and hospitals now require extensive administrative staffs because they work with many different health plans, each with its own administrative policies and requirements. Although many clinicians do not support a single-payer system because of burdensome administrative requirements and low payments associated with both Medicaid and Medicare, my experience suggests that a growing number feel that they and their patients are treated better by public programs than by for-profit health plans.

Achieving some consensus or compromise on a single-payer versus competitive marketplace is critical to moving forward on universal coverage for children and everyone else. A U.S. governmental system could have financing and delivery systems that differ from the traditional British- or Canadian-style single-payer sys-
tems. A federal program for children could use vouchers or other types of subsidies to maintain a private-market health care delivery system using commercial health plans. In addition, it is possible to have increased government regulation of a competitive private health care system, as is done in Germany.

How should a national program of universal coverage to children be financed? In addition to the spending needed to have universal coverage for children, it is important to consider differences in the relative contributions from the federal government, states, employers, and enrollees. The major differences in the four coverage alternatives involve the distribution of spending among these parties.

Distribution of financing. A new federal program would shift most or all fiscal responsibility for children's coverage to the federal government except for a possible family contribution. With the hybrid federal-employer alternative, the federal government, employers, and enrollees would contribute. Because Medicaid and SCHIP would be replaced by a new federal program, there might not be any state contribution (although a continuing state contribution could be built into the first two alternatives). The new federal wraparound alternative would maintain the state, employer, and enrollee contributions associated with employer coverage and Medicaid/SCHIP but would increase federal support for the uninsured. Since this alternative would encourage a shift from Medicaid/SCHIP into the new federal program, over time it would most likely shift to the hybrid alternative. The SCHIP expansion would continue federal, state, employer, and enrollee contributions, although their relative distribution could be modified.

Estimated costs. The estimated cost in 2005 of a new federal program to cover 89.7 million children through age twenty-one would be approximately $134 billion, based on an AAP actuarial study cost of $113.17 per member per month, with an additional 10 percent administrative cost (which might be conservative). I am unaware of any current cost estimates on MediKids, the federal wraparound alternative. Exhibit 1 presents the AAP's 2002 analysis, based on 1998 MEPS data, with reasonably accurate estimates of future Medicaid/SCHIP enrollment data. The exhibit also includes an estimate of the cost of the hybrid new federal program–employer insurance alternative, using MediKids as the model for the new federal program. The financial estimates for a national SCHIP expansion to 300 percent of poverty depend on whether the expansion will include incentives or mandates to enroll eligible children, whether there will be twelve months of continuous eligibility, and whether there is any restructuring of the federal-state match.14

However, one can raise concerns that all of these types of estimates might overstate additional costs because they fail to consider the offsetting current spending for uninsured children and the potential savings that could be achieved if they are insured, have a regular source of primary care, and can get appropriate access to specialty care. For example, James Todd and colleagues report that a maximum of $5.3 billion in hospital charges could theoretically be saved if uninsured and Medicaid-covered children had the same per capita charges as children with pri-
It is unclear what proportion of this amount could be saved by improving access and care quality for uninsured and Medicaid children. Universal coverage for children might also moderate escalating family coverage premiums in the private sector. Hospitals and other providers seek to recover a portion of spending for uninsured children by charging more for patients with insurance. This cost shift contributes to higher premiums for family employer coverage.

Is an employer mandate or “play-or-pay” approach necessary? Insurance coverage through employers has been steadily eroding in recent years. Five million employees lost coverage from 2000 to 2005, as the proportion of businesses offering it fell from 69 percent to 60 percent. The goal of an employer mandate is to reduce “crowd-out,” the further shifting of children out of employer-based health plans into government-sponsored plans, or at least to maintain an employer contribution through payment when coverage is not offered. An employer mandate would require employers to provide a specified level of family coverage or a defined amount of money to be used to purchase a child or family plan. A variation on the employer mandate is called “play” (provide coverage) or “pay” (pay an assessment when you don’t). Advocates for an employer mandate say that it is more equitable than the status quo because it levels the business playing field. Businesses that now provide some level of family coverage complain that they are at a financial disadvantage with other competing firms that do not provide this level of coverage. Advocates also say that the play-or-pay approach can be fine-tuned to provide certain sizes and types of businesses with varying employee assessment rates.

Opposition to employer mandates is widespread in the business community, especially with small employers. Employers with narrow profit margins that do not

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**EXHIBIT 1**

Estimated Expenditures For A New Federal Wraparound Program Based On The Proposed MediKids Legislation

<table>
<thead>
<tr>
<th>MediKids proposal</th>
<th>Newly covered (millions)</th>
<th>Expenditures ($ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private and public coverage maintained</td>
<td>20.5&lt;sup&gt;b&lt;/sup&gt;</td>
<td>25.1</td>
</tr>
<tr>
<td>Only private coverage maintained&lt;sup&gt;c&lt;/sup&gt;</td>
<td>40.1 (adds 19.6)</td>
<td>44.9 (adds 19.8)</td>
</tr>
<tr>
<td>Private coverage erosion&lt;sup&gt;d&lt;/sup&gt;</td>
<td>29.8 (adds 9.3)</td>
<td>39.3 (adds 14.2)</td>
</tr>
</tbody>
</table>

**SOURCE:** See below.

**NOTES:** Estimates were derived using a simulation method based on monthly health insurance coverage data reported in the 1998 full-year consolidated file (HC028) of the Medical Expenditure Panel Survey (MEPS) Household Component. Projections include estimated insurance costs, administration, and operation costs (at 10 percent of insurance cost) and family premium contributions (not including cost sharing). The methodology is more completely described in a report: American Academy of Pediatrics, Budgetary Implications of MediKids: A Preliminary Study (Chicago: AAP, 6 June 2002). The 1998 MEPS data were trended forward to 2007 to match population growth estimates by the Census Bureau.<sup>4</sup>

<sup>4</sup> Eligibility is through age twenty-two.

<sup>5</sup> Includes 8.9 million uninsured for the full year and 11.6 million uninsured for part of the year, with the average period of coverage being 6.9 months per year.

<sup>6</sup> Assumes 100 percent substitution of Medicaid and state programs by MediKids, while keeping employer-sponsored insurance intact. This is similar to the hybrid new federal program–employer-sponsored insurance program.

<sup>7</sup> Assumes substitution of individually purchased coverage and small firms' employer-sponsored insurance (ten employees or fewer) by MediKids, while public coverage remains unchanged.
provide their employees with coverage say that they would go out of business if re-
quired to provide health insurance. This would increase unemployment, dampen
economic growth, and perhaps contribute to a recession. Opponents of an em-
ployer mandate recommend other strategies to lower premiums and increase
employer-sponsored coverage for employees of small companies. These include
having the state negotiate less costly premiums for small businesses; allowing for
low-cost, high-deductible plans (without any mandated benefits); and using state
funds to reduce premium costs by creating reinsurance pools, premium assistance
programs to reduce costs for both small employers and their employees, and other
types of subsidies that could involve tax benefits.

Is an individual mandate necessary to ensure program participation?
One way to ensure participation and universal coverage is to have an individual
mandate that requires parents to have insurance for their children. The implementa-
tion of an individual mandate for everyone (children and adults) should be linked to
community rating without medical underwriting in the individual and small-group
insurance markets. Health plans would not have to be concerned that individuals
and families could wait until someone was ill to enroll in a health plan, so that pre-
miums could be based on age and sex rather than on health status and preexisting
conditions. The first three alternative models have a federal program component
that could include an individual mandate with automatic enrollment at birth or
during a phase-in period. Payment could be made through Internal Revenue Service
tax filing if alternative coverage is not documented. Expansion of SCHIP would be
more complicated, since this approach would continue the eligibility and enroll-
ment policies of the state Medicaid and SCHIP programs and by itself would not ad-
dress how to deal with eligible children whose parents fail to apply or submit the
necessary documentation and remain uninsured.

A mandate could be linked to a subsidy or refundable income-adjusted tax
credit for qualifying low-income families. Concerns with this approach involve
the likelihood that the amount of the government subsidy will be inadequate and
only allow low-income families to buy low-quality plans with high cost-sharing
provisions. The Kids Come First Act includes an individual mandate that requires
parents to insure children under age nineteen.17 Parents would not be required to
spend more than 5 percent of their adjusted gross incomes on health plan premi-
ums for their children. Tax credits would ensure that families purchasing coverage
remain under this 5 percent ceiling. To simplify SCHIP enrollment, there would be
presumptive eligibility, twelve-month continuous eligibility, acceptance of self-
declaration of income, elimination of face-to-face interviews for redetermination
of eligibility, and adoption of express-lane eligibility procedures.

Should universal coverage legislation define a basic benefit package,
and, if so, how? The costs of universal coverage will be influenced to some degree
by the benefits included. Since one of the challenges of having universal coverage for
children will involve containing costs over time, defining the benefits in statute re-
moves an important mechanism for containing escalating costs: the capacity to reduce benefits. For exactly the same reason, needed benefits can be lost during more difficult financial times if the enacting legislation does not specify the benefits, especially Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, which stresses preventive care for all children. To date, programs that have expanded coverage for children, such as SCHIP, have specified either the Medicaid benefit package or a commercial benchmark plan to define benefits. The federal Deficit Reduction Act of 2005 allowed states to use a wraparound benefit package to provide EPSDT services to Medicaid children enrolled in programs that use benchmark coverage to determine benefits.

Using an existing health plan as a benchmark for establishing a basic benefit package for any new federal program avoids the need to have a political fight over defining benefits in legislation. Using a benchmark plan could be less expensive than current Medicaid or AAP-recommended benefits but might not provide all children—especially those with chronic illnesses—with services that they need. If there needs to be a national benchmark plan, some child advocates would like the Federal Employees Health Benefits (FEHB) program to be used, since the benefits would less likely be eroded in a plan used by Congress and federal employees.

Assessing The Political Possibilities For Passing Universal Coverage Legislation For Children

Is there any realistic likelihood that Congress will enact legislation to provide children—or everyone—with health insurance coverage in the foreseeable future? There have been no serious national attempts at comprehensive health care reform since the mid-1990s. I believe that it is unlikely that Congress will seriously consider any federal universal coverage legislation before the 2008 presidential election. First, the huge budget deficit will make it difficult to pass major expansions in child health coverage, since recent legislation has already made substantial cuts in existing programs for children, including Medicaid. Instead, the main federal focus on child health coverage will involve the reauthorization and funding of the existing SCHIP Title XXI legislation. Second, many politicians probably will defer any national action on health care reform until it becomes evident whether or not the Massachusetts universal coverage experience is successful. However, expanding numbers of uninsured Americans, out-of-control health care cost increases, and serious concerns about medical errors and quality will continue to focus attention on the need to restructure health care in the United States.18

Public opinion. Public sentiment for comprehensive change continues to build. In 2003 Congress established a fourteen-member Citizens Health Care Working Group “to go to the public and give them a chance...to provide a kind of general roadmap to find out where the country ought to head” in health care reform. The working group’s report indicates that most Americans agree that the federal government should guarantee that all Americans have basic coverage and that bene-
fits should be “portable and independent of health status, working status, age and income.” The group found that most Americans believe that “assuring health care is a shared social responsibility” and that financing universal coverage should involve a state and federal contribution through income taxes and “sin taxes” (on tobacco or alcohol), an employer contribution with a possible payroll tax, and enrollee contributions. Although there might be agreement on certain goals, many compromises will have to be worked out in Congress for universal coverage to be enacted.

- **Political feasibility.** Conservatives might be willing to compromise to avoid having the health care system move to a single-payer model, and liberals might be willing to compromise to achieve universal coverage. The United States requires a well-educated workforce to sustain its future economy in a rapidly changing, high-technology world, and many policymakers understand that health care for children and youth is linked to school readiness and academic achievement. Children and youth with unmet health needs have a more difficult time learning, achieving academically, and successfully entering the workforce.

Despite the health and education link, it remains uncertain whether a “children first” approach should be pursued. Such an approach could weaken public pressure for universal coverage by playing one population group against another. Also, there might be a political price to pay for advocating that children deserve health care more than young adults (ages 18–25) do, who have the highest rates of being uninsured, or adults in their thirties with young families, or adults ages 55–64 who want to be covered by Medicare. It might be more politically effective to leverage the influence of all of these constituencies to jointly push for comprehensive reform for universal coverage for all.

- **Realistically, reauthorization of SCHIP could provide the only federal opportunity to reduce the number of uninsured American children.** Although it has the broadest base of congressional support among both Republicans and Democrats, it will not ensure that all children are covered. Therefore, child advocates will have to ask themselves, Can U.S. children get a new national program that will cover all children, or is universal coverage unrealistic? And will strong demands for universal coverage for children undermine efforts to expand SCHIP coverage?

The author acknowledges Benjamin Berman for his assistance in reviewing this manuscript.
NOTES


10. AAP, “Children’s Health Insurance Status.”


