

# Children and National Health Care Reform

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**T**he Summer/Fall 1993 issue of *The Future of Children* examined how to make the overall process of reforming the health care system work for the benefit of children. That earlier issue discussed the ways in which a health care benefits package might be tailored for children, the effects of managed care on children and pregnant women, ways to reform the private health insurance market, how to pay for children's health care, the impact of alternative health care funding arrangements on families with children, and other topics.

Just days after the publication of the journal issue on health care reform, the Clinton Administration officially unveiled its plan to overhaul the nation's health care system. Coming, as it does, on top of a whirlwind of activity in the health care arena, the administration's strong commitment to health care reform has focused congressional and public attention on the issue. In addition to the Clinton Administration's bill, the Health Security Act (H.R. 3600/S. 1757), introduced by Sen. George J. Mitchell (D-ME) and Rep. Richard A. Gephardt (D-MO), there are several other major national health care reform bills currently pending in Congress. This article, based on a review by Sara Rosenbaum of the Center for Health Policy Research at The George Washington University, of six bills introduced during the first session of the 103rd Congress, concentrates on issues of particular importance to children. Principal features of the six bills are summarized in Table 1. This overview compares the proposals on 11 major issues and highlights the degree to which each bill would achieve three basic objectives: universality of coverage and access to health care; equity in the treatment of children regardless of income or resi-

dence; and care that is comprehensive and of good quality.

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## Coverage

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A basic issue in national health care reform is the nature and extent of the coverage envisioned under a proposal. As the accompanying table indicates, all of the bills would extend coverage for children, but the similarities end there. Only the President's proposal and the McDermott/Wellstone bill unconditionally guarantee coverage for all eligible persons. The Thomas/Chafee bill conditionally guarantees coverage if sufficient savings are achieved through reductions in Medicare and Medicaid and through other cost containment measures to underwrite subsidies for lower-income persons. The measures sponsored by Cooper/Breaux, Michel/Lott, and Stearns/Nickles attempt to make coverage more affordable but do not guarantee coverage.

Beyond the issue of guaranteed coverage are the eligibility criteria used to determine coverage: legal residency status,

*Sara Rosenbaum's analysis was funded by the Nathan Cummings Foundation, the Pew Charitable Trusts, the David and Lucile Packard Foundation's Center for the Future of Children, and the Henry J. Kaiser Family Foundation.*

state residence, membership in a unified purchasing pool, and place of residence.

*U.S. citizenship or legal residency status:* Of the six measures reviewed here, four (the President's bill, McDermott/Wellstone, Thomas/Chafee, and Cooper/Breaux) contain legal residence requirements. Cooper/Breaux limits the legal residence test to employees only. The three other measures require legal residence for all other persons as well; however, the McDermott/Wellstone measure allows the American Health Security Board to override this exclusion if it is in the public interest to do so. Legal residency requirements will leave many undocumented immigrants without health insurance. Children of undocumented immigrants who are themselves legal residents technically would be covered as individuals under several proposals; however, enrolling them in the system could be quite messy.

*State residency:* Because all six measures are state administered, all contain a state residency test. For children in families that move for work-related or other reasons (such as children of migrant workers), a state residency test may pose barriers to coverage, particularly if these children are required to reside in each state for a period of time before being permitted to register for health coverage in that state.

*Unified coverage:* Mechanisms for creating unified systems of coverage are important to achieve equity in coverage, payment levels, and benefits and to eliminate the current problems associated with separate types of public and private coverage depending on family income. The McDermott/Wellstone plan achieves this unity by extending identical, government-sponsored coverage to all eligible persons and by incorporating Medicare, Medicaid, and other public programs into a single system.

The other plans rely on insurance purchasing pools to achieve a more unified health care system. The President's

bill uses very large health insurance purchasing pools known as regional health alliances. Enrollment in alliances is compulsory for all persons not receiving Medicare who reside in families with a family member who is employed in a firm with 5,000 full-time workers or fewer. The other bills call for far smaller purchasing pools comprised of small employers and non-working and publicly subsidized individuals. Several bills make membership in a purchasing pool voluntary. Small pools increase the likelihood that children in poorer families with more health problems and fewer resources may be segregated into less-well-financed purchasing arrangements.

*Children living apart from their families:* Students, children living in foster care and other out-of-home arrangements, and children residing in institutions live apart from their families. They would be covered as individuals under the McDermott/Wellstone plan and would be subject to special coverage rules under the President's plan.

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## Benefits

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Of the six bills, only the President's bill and the McDermott/Wellstone bill guarantee coverage for a specific benefit package. Both bills extend first-dollar coverage for preventive services, as well as coverage for vision and dental care.

The McDermott/Wellstone bill is particularly notable for its coverage of benefits used by children with disabilities. Mandatory benefits include items and services specified in a child's individualized treatment plan under Part B or H of the Individuals with Disabilities Education Act (IDEA). Also covered as mandatory benefits are services furnished by school health clinics and other "community-based primary health care" services.

Unlike the McDermott/Wellstone bill, however, the President's bill does not include either long-term care or rehabilita-

Table 1

<b>Summary of Pending Major Health Care Reform Legislation</b>			
<b>Issue</b>	<b>American Health Security Act of 1993 H.R. 1200/S. 491 McDermott/Wellstone</b>	<b>Health Security Act H.R. 3600/S. 1757 President Clinton/ Gephardt/Mitchell</b>	<b>Health Equity and Access Reform Today Act of 1993 H.R. 3704/S. 1770 Thomas/Chafee</b>
Coverage/ Approach	Universal, mandatory coverage of all citizens and legal residents by 1995 through a "Canadian-style" single-payer system of federal-government-sponsored health insurance administered by states.	Universal, mandatory coverage by 1998 of all citizens and legal residents who do not receive Medicare through a system of subsidized private group health insurance administered by states and purchasing alliances. Financed through a combination of individual, employer, and federal payments, and state contributions for low-income persons and small employers.	Universal, mandatory coverage by 2005 of all citizens and legal residents who do not receive Medicare through use of a system of subsidized private group health insurance administered by states and purchasing alliances. Financed through a combination of individual premiums, voluntary employer premiums, and federal and state contributions for low-income persons and small employers.
Benefits/ Cost Sharing	Comprehensive, explicitly defined benefit package providing primary, acute, and long-term care benefits, with no cost sharing.	Explicitly defined benefit package consisting of primary and acute benefits, with specific permissible cost-sharing levels. Health insurance benefits supplemented with services for persons with developmental, chronic, and long-term care illnesses and conditions through continuation of Medicaid and a new long-term care block grant.	Broadly described benefit package; legislation indicates several categories of items and service coverage, with an emphasis on primary and acute care benefits. Cost sharing permitted.
Financing	Both insurance coverage and other reforms financed through a combination of new taxes, consolidation of Medicare and federal Medicaid expenditures, state contributions, and premiums for long-term care.	Insurance coverage financed through mandatory employer contribution, individual premiums, state and federal contributions, reductions in Medicare and Medicaid spending, taxes on large corporations, and sin taxes. Other provisions financed through special taxes on insurers and general revenues.	Insurance and other reforms financed through individual contributions, voluntary employer contributions, and Medicare and Medicaid spending reductions. Other reforms financed through general revenues.
Cost Containment	Enforceable federal budget accompanied by the elimination of private insurance and government spending controls over pricing.	Enforceable federal budget for insurance premiums paid by employers, individuals, and the federal and state government, supplemented with reforms designed to increase price competition among private insurers. Limitations on the deductibility of private insurance premiums to spur competition, accompanied by Medicaid and Medicare spending reductions.	Increased price competition among insurers through market reforms, limits on the deductibility of health insurance to spur competition, caps on Medicaid spending, Medicare cuts, and Medicaid spending reductions.
Administration	Federal and state administration.	Federal and state administration, with use of mandatory regional and employer purchasing cooperatives.	Federal and state administration, with use of small employer and individual purchasing cooperatives.
Medicare	Consolidated with new insurance plan.	Retained, but with state option to consolidate with new insurance plan.	Retained.
Medicaid	Consolidated with new insurance plan.	Partly consolidated into new system with respect to those Medicaid benefits now covered by the health benefit plans. Medicaid benefits not covered by health plans generally still available to Medicaid-eligible persons.	Consolidated with health plans at state option. Medicaid benefits not covered by health plans still available to Medicaid-eligible persons.
Access to Care	A defined portion of health budget allocated to resource development for underserved.	Requests funding for resource development for underserved.	Requests funding for new resource development for underserved.

Source: Kaiser Commission on the Future of Medicaid. *Health reform legislation: A comparison of major proposals*. Menlo Park, CA: The Henry J. Kaiser Family Foundation, January 1994.

Managed Competition Act of 1993 H.R. 3222/S. 1579 Cooper/Breaux			Affordable Health Care Now Act of 1993 H.R. 3080/S. 1533 Michel/Lott			Consumer Choice Health Security Act of 1993 H.R. 3698/S. 1743 Stearns/Nickles		
Expanded, voluntary coverage through group-purchased private insurance for persons not covered by Medicare through a system administered by states and regional purchasing pools. Financed through individual and voluntary employer contributions; state and federal subsidies available for low-income persons and small employers.			Expanded access to private health insurance for persons not covered by Medicare through insurance practice and coverage reforms and through new program of insurance subsidies for Medicaid beneficiaries and other low-income persons.			Requirement for individuals not eligible for Medicare to purchase private health insurance through system administered by federal government and financed by individual premiums and subsidies for low-income persons.		
Details of a benefit package left to a national commission, which is given broad direction to develop coverage rules within certain guidelines that assure coverage of preventive and diagnostic services. Cost sharing permitted.			Broadly defined minimum requirements for standard and catastrophic benefit packages to be offered by employers and to individuals, with authority delegated to the National Association of Insurance Commissioners (NAIC) to develop actuarial coverage standards. Benefits not stated in terms of defined content but rather in terms of actuarial value. Cost sharing permitted.			Broadly defined categories of benefits that must be offered by participating health insurance plans, with authority in the Department of Health and Human Services and in state insurance commissions to develop and enforce coverage standards. Cost sharing permitted.		
Insurance financed through individual and voluntary employer contributions and through Medicare and Medicaid spending reductions. Other reforms financed through general revenues.			Insurance financed through individual and voluntary employer contributions and through Medicare and Medicaid spending reductions. Other reforms financed through general revenues.			Insurance financed through individual contributions and through Medicare and Medicaid spending reductions. Other reforms financed through general revenues.		
Increased emphasis on price competition through insurance market reform, accompanied by limits on the deductibility of private insurance costs. In addition, Medicaid is repealed and replaced with low-income assistance capped program. Medicare spending is reduced, and all federal contributions for state long-term-care Medicaid programs are ended.			Increased emphasis on price competition through market reform. Reductions in Medicaid spending through caps on the cost of acute care and the creation of a new capped health allowance program. Medicare spending reductions also proposed.			Termination of employer Insurance expense deductions and employer exclusion, limitations on the deductibility and favorable tax treatment of individual tax expenditures. Caps on federal payments for Medicaid acute care coverage expenses, other Medicaid spending reductions, and Medicare savings.		
Federal and state administration with use of mandatory purchasing cooperatives for individuals and small firms.			Federal and state administration.			Federal and state administration.		
Retained.			Retained.			Retained.		
Repealed and replaced by low-income assistance program. Responsibility for Medicaid services not covered by health plans relegated entirely to states without federal financial participation.			Revised to give states authority to purchase private insurance for Medical beneficiaries and other low-income persons. Medicaid spending capped.			Medicaid revised to permit states to buy insurance for beneficiaries and low-income persons. Medicaid spending capped.		
A defined portion of health budget allocated to resource development for underserved.			Requests funding for new resource development for underserved.			Requests funding for new resource development.		

tion and associated services for children with birth-related conditions in the guaranteed benefit package. Instead, these benefits are covered through a separate long-term care program for severely disabled children and supplemental Medicaid coverage for services used by low-income children with chronic conditions and disabilities. The other four measures specify no benefit package but, instead, leave to the rule-making process the development of a standard benefit package.

All measures use a “medical necessity” standard to determine the amount and scope of covered benefits. None of the bills, however, amplifies what is meant by medical necessity in the context of pediatric care or other care, for that matter. This may make it difficult to obtain coverage for treatment services which promote child health and prevent disease and disability. Services at an early, preventable stage of illness rather than after the onset of disease is measurable and more serious are covered under the liberal medical necessity standard in the current Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

All six measures contain provisions curbing discrimination in the coverage of benefits based on preexisting conditions. However, the Cooper/Breaux, Chafee/Thomas, Michel/Lott, and Stearns/Nickles bills permit the application of six-month waiting periods for preexisting conditions except for pregnant women and newborns.

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## Financing

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Financing is likely to be one of the most contentious health care reform issues. Regardless of the immediate source of funds to pay for health care, the costs of health care are borne by the citizens of the United States as a group. The precise set of mechanisms used to finance health care will determine the distribution of the burden in the population as well as provide incentives to purchase coverage in voluntary systems.

Under the McDermott/Wellstone bill, health care is financed entirely through an increase in employer payroll taxes (capped at 8.4% of payroll), a 2.5 percentage point increase in the personal income

tax, and higher sin taxes. Insurance premiums are eliminated. How families with children are affected by this bill depends on the net offset they experience between higher taxes and the elimination of health insurance premiums.

All of the other reform bills impose premiums on families with varying subsidies for low-income families. Under the President’s plan, families receiving either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) have 100% of their premiums paid. Working families would have 80% of their premiums paid by employers with subsidies for employers of low-wage workers. Low-income working families would also receive subsidies to help cover the cost of the remaining 20% of their premiums.

All of the other bills provide subsidies for low-income families, but the amount of assistance is less generous than under the President’s plan. Subsidies for low- and moderate-income families generally phase out more rapidly than under the President’s plan so that, as wages rise, premiums may increase enough to offset much of the wage increase.

Plans such as Cooper/Breaux, Thomas/Chafee, and Michel/Lott, which rely on voluntary purchase of coverage, run the risk of leaving uninsured children in families of moderate means for whom coverage is deemed too costly despite modest subsidies. Plans that rely on an employer mandate (the President’s proposal) or a payroll tax (the McDermott/Wellstone proposal) will cover all eligible children but run the risk of increasing unemployment or depressing wages, particularly among low-wage workers, as employers attempt to recoup higher compensation costs by adjusting their work forces.

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## Cost Sharing

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All of the measures except the McDermott/Wellstone bill use cost sharing. The McDermott bill allows no payment for covered benefits at the point of service. Instead, all health care is financed through the tax system.

The President’s bill exempts prenatal and preventive services from cost sharing and subsidizes cost sharing for low-income

families enrolled in health maintenance organizations (HMOs) or other similar plans. Low-income families that wish to remain in a fee-for-service plan are responsible for all copayments and deductibles.

The McDermott/Wellstone bill, the President's plan, and the Cooper/Breaux plan prohibit providers from billing patients for more than allowed charges. The other measures do not regulate provider billing practices.

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### **Treatment of Children with Chronic Illness and Disability**

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Only the McDermott/Wellstone bill places in one comprehensive benefit package virtually all medical care and services needed by children with chronic illness and disability, regardless of whether services are needed because of an illness or injury or a condition existing at the time of birth. Under the President's bill, certain benefits are covered in the basic benefit package only if needed to treat an illness or injury which occurs after birth. Thus, a child born with cerebral palsy would not be covered for speech therapy because the child's condition existed at birth.

The President's plan moves toward addressing these limitations by supplementing the basic guaranteed benefit package with a long-term care benefit package subsidized out of general revenues for severely disabled children and by continuing Medicaid coverage for low-income children who need care and services not covered by the basic benefit package.

The other measures include no supplemental long-term care program. The Cooper/Breaux bill would entirely repeal the Medicaid program. States would be responsible for long-term care and for services for persons with chronic illnesses and disabilities. The other measures would place flat spending limits on certain items and services used by low-income children such as mental health and rehabilitation services received on an outpatient basis.

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### **Treatment of Providers**

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The measures vary widely in their treatment of providers. The McDermott/Wellstone bill continues unrestricted use of

individual office-based, clinic-based, and institutional providers who would be paid on a fee-for-service basis. The bill also permits formation of comprehensive health service organizations to provide care through participating providers.

The other measures all depend importantly on private managed care plans such as HMO-type provider networks. Children and families would have to pay out of pocket for services received from nonplan providers unless services were emergency in nature or out-of-plan care is authorized by the family's plan.

In addition, the President's bill takes specific steps to ensure families continued access to certain types of services despite their enrollment in network plans. First, all plans must offer a point-of-service option for a higher premium. This option enables families to see any provider with higher cost sharing. Second, the plan allows children with serious illnesses and conditions access to very specialized services at academic health centers and other "centers of excellence." Third, the President's plan requires that, for a five-year period following implementation of health reform, all health plans contract with certain "essential community providers" (such as community and migrant health centers) who are located in medically underserved communities and are particularly accessible to low-income and medically underserved families.

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### **Access to Health Care for Medically Underserved and Vulnerable Populations**

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All of the measures acknowledge the importance of allocating funds to develop health services in communities that, because of poverty or geographic, racial, or cultural isolation, cannot attract or retain sufficient numbers of primary care providers. Only the McDermott/Wellstone bill specifically allocates a portion of the national health budget for service development and support activities. The McDermott/Wellstone bill also specifies certain payment methodologies for providers located in underserved communities in recognition of the higher costs they may incur in caring for medically underserved populations.

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## Treatment of Public Health

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The President's bill, the McDermott/Wellstone bill and the Cooper/Breaux bill include population-based public health activities. However, only McDermott/Wellstone allocates a specific portion of the national health budget to these activities.

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## Treatment of Medicaid

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The bills vary greatly in their treatment of Medicaid, the nation's largest source of public health funding for children. The Cooper/Breaux and McDermott/Wellstone bills eliminate Medicaid entirely. The Cooper/Breaux bill makes states solely responsible for those items and services currently provided by Medicaid but not included in the guaranteed benefit package.

The President's bill eliminates Medicaid for services that would be covered by beneficiaries' health insurance plans. It leaves in place those current Medicaid benefits that would not be covered by the comprehensive benefit package. Thus, all treatment services would continue to be covered for low-income children through both the basic Medicaid plan and through a special new "children's wrap-around" program that would be federally administered and subject to uniform national rules.

The Thomas/Chafee, Michel/Lott, and Stearns/Nickles proposals all maintain separate Medicaid programs for eligible low-income persons through which both basic and long-term benefits would be provided. At their option, states could replace Medicaid with private coverage. Under these bills, children receiving public assistance potentially would remain covered by Medicaid while other low-income children would receive coverage through private plans.

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## State Administration and Cost Controls

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All of the measures depend heavily on state administration. Only in the President's bill and the McDermott/Wellstone bill does the cost control system not differ-

entiate between children whose coverage is publicly subsidized and children whose coverage is not. The McDermott/Wellstone bill achieves this goal by covering all children with government insurance. The President's bill achieves this goal by paying identical health plan enrollment rates for children regardless of family income. Funds from employers, individuals, and the state and federal governments are commingled in a common pool and are subject to uniform premium controls.

The other measures contain direct cost controls only for persons whose insurance is publicly subsidized. While the Cooper/Breaux, Thomas/Chafee, Michel/Lott, and Stearns/Nickles bills limit tax deductibility, plans can raise premiums above this level for privately insured persons. Because public subsidies are limited, as a practical matter children in lower-income families face more stringent health care budget limitations.

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## Quality of Care

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All of the measures address the development of quality-of-care measures and place emphasis on health outcomes measures and on empowering consumers through better disclosure of quality-of-care information.

As this journal goes to press, the issues concerning health care reform are being analyzed and discussed. Predicting the outcomes of this political process is impossible, but it appears likely that none of the bills reviewed in this article will emerge as the consensus health care reform measure without substantial modification. Many of the compromises necessary to achieve health care reform will probably not directly reflect children's issues. Yet, if children are to benefit from health care reform, it will be important to examine the implications for children of specific components of any serious reform proposal and to take appropriate corrective actions to protect their interests.

*For the complete text of Sara Rosenbaum's detailed review of provisions for children in the major national health care reform proposals and for a detailed general summary of the legislation prepared for the Kaiser Commission on Medicaid, contact the Circulation Department at the Center for the Future of Children.*

*In addition to selected members of the editorial advisory board, we sought reviews from a number of other scholars. We wish to thank the following reviewers for their valuable contribution to this journal issue.*

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