Balancing Efficiency and Equity in the Design of Coverage Expansions for Children

Linda J. Blumberg

A n important challenge in designing policy initiatives to address the problem of uninsured children is that the objectives implicit in the programs can conflict. These conflicts necessitate prioritizing multiple objectives and identifying acceptable tradeoffs in order to achieve effective policy design that reflects the nation’s social priorities. This article provides a general discussion of some competing objectives and tradeoffs and presents a framework for evaluating future attempts to design children’s health insurance programs.

The Objectives of Reform

While expanding coverage is the focus of insurance programs for children, financial constraints combined with a general desire for fairness in program implementation complicate the particular elements of a health insurance initiative. Reforms to expand children’s coverage reflect the tradeoffs between two main objectives: target efficiency (directing as many program dollars as possible to currently uninsured children) and horizontal equity (treating children in similar circumstances alike).

Target Efficiency

Given financial constraints, many policymakers hope to direct as many designated program dollars as possible to currently uninsured children, thereby achieving the greatest possible health insurance coverage “bang for the buck.” This objective is known as target efficiency. The intent is to minimize the government dollars spent on children who would have been insured without a new program. Undesired spending on children who could obtain health insurance elsewhere is often referred to as “crowd-out” in the health policy literature, since government spending is considered to be crowding out private spending on health insurance. In other words, the underlying premise is that government should not pay for children’s health insurance if parents can afford to buy it in the private market.

Political motivations also influence policy preferences for target efficiency. Policymakers recognize that new programs will be judged by their measurable effects, particularly by how much they increase the number of insured individuals. A calculation frequently used to analyze new and proposed programs is the federal cost per newly insured person—a measure wholly designed to capture a program’s target efficiency. Although other measures may seem equally important in determining program success—such as stability of coverage, quality of care received, or improved

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to pay for coverage they find difficult to afford—these types of gains are more difficult to measure quantitatively. As a consequence of needing to demonstrate measurable improvements from a new program to justify additional spending, policymakers place a greater emphasis on designing programs that will substantially increase the number of insured children.

**Horizontal Equity**

A second policy objective, horizontal equity, focuses on treating children in similar circumstances alike. This objective is consistent with the desire for fundamental fairness—for example, that all children in families with the same incomes have the same program eligibility status. Beyond simple fairness, however, a program designed to achieve horizontal equity avoids creating perverse incentives. For example, assume that subsidies for a new insurance program for children are limited to children without previous insurance coverage. In such a case, two children could have the same family income and live in the same area, but if one child’s parents purchase employer-based insurance coverage for the child, she is no longer eligible for public coverage. If the other child’s parents have not purchased insurance for him, then that child remains eligible. Parents would have a new incentive to keep their children uninsured for the required length of time—an undesirable policy effect by anyone’s calculation. While there is no evidence on the extent to which such incentives actually lead to this type of undesired response, the incentive still exists.

Another example of undesired incentives created by inequities in policy treatment would be if program eligibility were limited to children of workers (or workers themselves, for that matter) whose employers did not offer private group health insurance. In such a case, workers whose incomes were low enough to qualify for the program would have an incentive to find a job that did not offer employer-sponsored health insurance, even if that job might not be the best fit for their skills. In other words, the effect of the policy on job choice could lead to inefficiencies in the job market.

Workers might make such a choice for a number of reasons. If they enrolled their children in the public plan, workers would save the out-of-pocket contributions to premiums that most employer plans require. These premium contribution requirements are often substantial relative to the small (or even zero) premium contributions that are required for public coverage. In addition, public insurance benefit packages tend to be more generous than packages through private employer plans, so an individual could save substantially on cost sharing (deductibles and coinsurance) through a public plan. Research evidence also suggests that workers pay for a significant share of their employers’ contributions to employer-sponsored health insurance policies through lower wages than they would have if insurance were not offered. Such a phenomenon implies that workers would also experience a wage increase as a consequence of moving from an insurance-offering to a non-insurance-offering employer. This further strengthens a worker’s incentive to seek a non-offering employer if insurance coverage for family members would be available through a public program.

Similarly, when eligibility for subsidies or programs depends on employer behavior, employers may change their own behavior in disadvantageous ways. Take the previous example, in which workers and family members would be eligible for a new public insurance program only if their employer did not offer group coverage. Consider a hypothetical employer who offers employer-sponsored health insurance to her workers. If enough workers would be eligible for public insurance if their employer did not offer private insurance, the workers would have the same incentives described previously to persuade their employer to stop offering coverage. If the employer did stop offering coverage, those eligible for the new program could enroll in public coverage, but there would likely be others working for the same employer who would not be income eligible for public coverage. These workers and their families who are not eligible for public
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coverage and who have just lost their employers’ offer of insurance would have to seek coverage on their own. Consequently, a policy that limited public program eligibility to those without employer offers could lead to a reduction in the employer offer rate and could also potentially leave some families without insurance. An alternative approach would be to subsidize the purchase of employer-sponsored health insurance coverage for low-income children, a policy that could ameliorate the types of perverse incentives described here. (See the article by Curtis and Neuschler in this journal issue.)

The Conflict between Target Efficiency and Horizontal Equity

The dilemma when designing policy initiatives to increase children’s health insurance coverage is that the objectives of target efficiency and horizontal equity cannot be perfectly met simultaneously. Prioritizing target efficiency by designing a program that narrowly defines eligible populations as particular pockets of the uninsured prioritizes target efficiency but results in inequities, which was the case in the example of the two children, one with and one without employer-based coverage. The highly targeted program rules reward only the parents who have not made the financial effort to insure their child. Another potential inequity could occur if the benefit package available through a public program were more generous than the package through a privately purchased policy.

Conversely, if horizontal equity were prioritized, fewer uninsured children could be covered within a given budget. In the example used above, a policymaker focusing on horizontal equity might design a program to make all children in families with incomes below some percentage of the federal poverty level (FPL) eligible for fully subsidized health insurance coverage, regardless of prior insurance status. This design would solve the equity concerns, but the program would cost more than a carefully targeted program because more children would be eligible. In addition, a significant share of the children eligible for the program may have had prior insurance coverage, thereby reducing the apparent target efficiency of the program.

Of course, how well a program achieves target efficiency depends on how the target population is defined. If the target population is defined as uninsured children below a certain percentage of the FPL, then it would be considerably more difficult to achieve both target efficiency and horizontal equity than if the target population is defined as all children below a certain percentage of poverty. The first definition is more closely associated with the idea of generating as much new insurance coverage as possible for a given budget. The latter, however, is more consistent with the notion that even low-income children with private insurance are vulnerable to losing their coverage, and public policy ought to provide a stable source of insurance regardless of current status.

Carefully defining the target population by income can improve policymakers’ ability to balance target efficiency and horizontal equity. As Table 1 illustrates, children in families with income levels typically associated with the Medicaid program (that is, usually under 100% of the FPL), are less likely to have employer-sponsored health insurance than are higher-income children. If all children in the lowest income ranges with low levels of private insurance coverage were made eligible for a public insurance program, then displacement of previous insurance would not be of great concern and all children at that income level could be treated the same. However, children in the higher income groups, including those typically associated with the State Children’s Health Insurance Program (SCHIP) program (that is, usually from families at 100% to 200% of the FPL, as detailed in the article by Wysen, Pernice, and Riley in this journal issue), are more likely to have employer-sponsored health insurance. As a result, the balance between horizontal equity and target efficiency becomes more and more difficult as policymakers attempt to design mechanisms for reaching the higher-income uninsured.

Different Approaches to Prioritizing Efficiency and Equity

Medicaid and SCHIP have taken different approaches to prioritizing the competing objectives of target efficiency and horizontal equity. The Medicaid program for chil-
children originally limited eligibility to those with extremely low incomes; it was target efficient but had serious equity problems. Over its history, however, the Medicaid program has evolved to an approach that better balances the two goals. SCHIP has focused most explicitly on target efficiency. The approaches of the two programs are discussed in detail below.

**Medicaid**

Until the mid-1980s, Medicaid eligibility for children focused on children in families whose income and family structure qualified them for cash assistance through Aid to Families with Dependent Children (AFDC). AFDC was the precursor to the current welfare program, Temporary Assistance for Needy Families (TANF). Because AFDC income-eligibility levels varied considerably by state, this approach engendered interstate equity issues: Children with the same family incomes living in different states were treated differently. In addition, children in two-parent families had considerably more difficulty qualifying for Medicaid coverage, because the AFDC eligibility rules favored single-parent families. Enrollment in Medicaid was not conditioned on prior insurance status, and participation among the AFDC eligible population was high.7

As the Medicaid program evolved in the late 1980s and the 1990s, eligibility rules for children became more disconnected from eligibility for AFDC. For example, states were required to expand coverage to children in two-parent families and to those with higher family incomes.8 As of April 1990, all state Medicaid programs were required to phase in coverage for children up to age six in families with incomes up to 133% of the FPL. Children born after September 30, 1983, in families with incomes up to 100% of the FPL were eligible starting in July 1991. States could also choose to cover infants in families with incomes up to 185% of the FPL.

The expansions in eligibility do focus on low-income children, many of whom do not have access to employer-sponsored health insurance, thereby increasing target efficiency. The more a program includes children with a low probability of having private health insurance without government assistance (that is, lower-income chil-

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**Table 1**

**Distribution of Coverage for Children (Ages 0 to 18) by Family Income Relative to the Federal Poverty Level**

<table>
<thead>
<tr>
<th>Family income relative to the FPL</th>
<th>Employer-sponsored health insurance</th>
<th>Medicaid, SCHIP</th>
<th>Other public insurancea</th>
<th>Private nongroup insurance</th>
<th>No insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100%</td>
<td>21.6%</td>
<td>47.8%</td>
<td>1.4%</td>
<td>3.4%</td>
<td>25.8%</td>
</tr>
<tr>
<td>100%–149%</td>
<td>44.6%</td>
<td>31.4%</td>
<td>1.8%</td>
<td>3.4%</td>
<td>18.8%</td>
</tr>
<tr>
<td>150%–199%</td>
<td>63.3%</td>
<td>16.2%</td>
<td>2.3%</td>
<td>4.1%</td>
<td>14.0%</td>
</tr>
<tr>
<td>200%–299%</td>
<td>76.6%</td>
<td>6.5%</td>
<td>1.9%</td>
<td>4.9%</td>
<td>10.1%</td>
</tr>
<tr>
<td>300%–399%</td>
<td>86.6%</td>
<td>2.7%</td>
<td>1.1%</td>
<td>4.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>400% and over</td>
<td>91.0%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>3.9%</td>
<td>2.8%b</td>
</tr>
</tbody>
</table>

aIncludes Medicare, Champus, and other federal programs.

bColumns may not add precisely to 100% due to rounding.

Balancing Efficiency and Equity

The changes to the Medicaid program increased interstate equity by providing a federal minimum-income eligibility threshold for children in all states. In addition, now that the expansions are fully phased in, inequities across children of different ages within a state have been reduced. All children under age 18 in families with incomes up to 100% of the FPL are now eligible. Variations in eligibility criteria persist, however, as some states exceed minimum standards while others do not. (See article by Wysen, Pernice, and Riley.)

Consequently, the Medicaid expansions for children appear to have struck a balance with reasonable levels of target efficiency and improvements in horizontal equity. Participation levels for the program may have been adversely affected, however, by a narrow targeting of the expansion program to children that generally excluded their parents. In addition, administrative barriers such as lack of familiarity with eligibility rules and onerous application procedures have probably contributed to lower-than-desired participation rates.

SCHIP

Target efficiency was a high political priority among those who drafted the SCHIP legislation. Because income-eligibility levels for SCHIP are higher than those for the traditional Medicaid program, policymakers worked to avoid spending federal dollars largely on those who would have had private insurance without the new program. This goal was explicitly laid out in the legislation, with eligibility for SCHIP limited to uninsured children. In contrast, eligibility under Medicaid is not based on a child’s insurance status. States that have chosen to expand Medicaid under SCHIP cannot exclude children according to prior insurance status (unless they receive a waiver to do so), while SCHIP programs that are run as independent programs must have some type of strategy in place to prevent crowd-out.

States placing different emphases on these mechanisms are likely to have varying success with excluding the previously uninsured. Little evidence currently exists regarding what works to minimize crowd-out and what does not. One finding is that many states have lower participation rates in their SCHIP programs than in their Medicaid programs. These rates are probably partly due to the newness of the SCHIP programs, both because it takes time to educate people that programs exist and because enrollment processes often do not run smoothly in the early implementation stage. But another contributing factor may be administrative barriers designed to exclude those with prior coverage. Such administrative mechanisms can discourage not only the privately insured, but all potential applicants.

SCHIP was designed to provide considerable flexibility to the states, even if some inequities result. Program eligibility rules as well as administrative choices vary considerably across the states because of differences in political preferences, in ability to finance coverage expansions, and in the generosity of the Medicaid programs from which each SCHIP builds. However, significant differences in generosity of programs across states have resulted.

In addition, the federal matching rate for SCHIP-eligible children is higher than the rate for Medicaid-eligible children, which could contribute to horizontal inequities. State governments receive higher federal payments for enrolling SCHIP-eligible children than for enrolling Medicaid-eligible children, even though the SCHIP children come from higher-income families than do Medicaid children. Consequently, states seeking to reduce the number of uninsured children have a greater incentive to enroll children in SCHIP than in a Medicaid program. Although current evidence on participation rates does not seem to indicate that states favor SCHIP enrollment over Medicaid enrollment, the incentive to do so over time is troubling. If states do in fact begin to sacrifice resources from Medicaid outreach and enrollment in order to increase resources allocated to SCHIP outreach and enrollment, this could lead to a redistribution of public spending from lower-income to somewhat higher-income children.

At the same time, some aspects of SCHIP contribute to improved horizontal equity. For example, the higher federal matching rates that the federal government provides to participating states for SCHIP have allowed states with fewer resources to finance more generous expansions
than they would have otherwise been able or willing to do under the Medicaid matching rates. This boost to the more financially constrained states, combined with limits as to how high up the income scale states could subsidize children while still receiving federal matching funds, means that the SCHIP program is likely to improve interstate equity somewhat.20

Some states have also used their flexibility to expand public insurance program eligibility to the parents of Medicaid- and SCHIP-eligible children. Early results suggest that states that include parents are increasing the participation rates of their children.21 Such expansions increase horizontal equity by removing differential treatment by age, but with reduced target efficiency. The added benefit of expansions to parents is that the initial child target population is reached more effectively.22

Overall, SCHIP has placed a greater emphasis on target efficiency than on horizontal equity. Policymakers, recognizing that children between 100% and 200% of the FPL had employer-sponsored health insurance, attempted to legislate the exclusion of those with prior coverage and thus increase target efficiency. Achieving target efficiency within this higher-income group of children is clearly more difficult than within the lower-income Medicaid population. Families eligible for Medicaid are less likely to have employer-sponsored coverage, and thus exclusion mechanisms are less relevant. In the future, as the SCHIP program matures and more effort is made to increase participation rates, the focus on horizontal equity issues may also increase.

Ways to Improve the Balance between Efficiency and Equity

The previous discussion highlights that target efficiency and horizontal equity cannot be perfectly satisfied simultaneously. Both objectives have political and social value, and neither should be ignored. Policymakers should strive to design future programs to better balance these two objectives. Several possible approaches could be tried separately or in combination.

For example, one possible approach would be to define eligible populations very narrowly, and expand coverage incrementally. All children within a small subpopulation (defined, for example, by narrow bands of family income relative to poverty) could be treated equally, thereby limiting costs. The drawback to this approach would be that it requires accepting a slower path to coverage expansion. The benefits would be that it would be viewed as fair, costs would be contained, and program effects could be evaluated prior to widespread implementation.

A second approach to improving the balance between efficiency and equity would be to narrowly define the subsidy or the insurance product being provided. For example, the benefit package of a public insurance product could be limited relative to existing public packages. This approach could lower government spending per enrollee and reduce the attractiveness of the program to those with more generous prior coverage. The challenge would be to carefully tailor a narrow package while retaining significant benefits. Similarly, limited subsidy dollars could be provided to make more children eligible, with each child receiving less assistance.

A third approach would be to design programs to limit eligibility to those receiving coverage through the most efficient sources of coverage and/or providers, such as the most cost-effective managed care organizations or hospitals with the most effective internal utilization controls mechanisms. Such a plan might limit participation significantly among those who already have strong attachments to their providers (those likely to be insured), while reducing program costs.

In the end, policymakers must think realistically: Programs cannot substantially increase coverage, keep costs low, and treat similar individuals the same. In addition, policymakers must determine how much displacement of private insurance spending is acceptable. To make significant progress in reducing the number of uninsured children, policymakers need flexibility in spending public dollars in an increased effort to enroll and retain the many currently eligible, but not enrolled, children. Overemphasis on target efficiency and other administrative barriers have likely hampered these efforts to date. However, target efficiency with little increase in coverage of children is not a satisfying programmatic outcome from anyone’s perspective. Future policies need to tip the scales further in the direction of equity in an effort to boost overall participation.

2. See note 1, Blumberg, et al.


4. These types of effects, resulting from altered financial incentives, have been simulated in models by the author and her colleagues. Depending upon the size and structure of a subsidy, they can be significant.


6. Because the federal government and the states jointly finance Medicaid and SCHIP, each state has some flexibility to tailor programs to meet the specific needs and fiscal capacity of the state. (The federal government has placed various limits on this flexibility over time and across programs, however, such as maximum-income eligibility thresholds and minimum benefit package requirements.) Consequently, eligibility rules and benefit packages vary across states—that is, opportunities for insurance coverage may be quite different for similar children living in different states. A state may have lower program eligibility levels than average because political preferences for public insurance may be limited or because the formulas used to calculate cost sharing with the federal government may not be adequately adjusted for a state’s relative ability to finance insurance for its low-income population. Income and the costs of living vary among states, making strict comparisons of interstate equity difficult.


8. See note 5, Congressional Research Service.


11. A pregnant parent is the exception. See note 7, Dubay, et al.


14. See note 12, Lutzky and Hill.

15. See note 12, Lutzky and Hill.

16. See note 7, Dubay, et al.

17. See note 9, Dubay.


19. See note 18, Ullman, et al.

20. While higher matching rates surely make it easier for all states to do more expansions of coverage than they would otherwise, it is worth noting that, in many cases, higher-income states received larger increases in absolute dollars than did lower-income states under SCHIP. So while equity from the beneficiaries’ perspective was likely improved, this is not necessarily the case from the perspective of state governments.

21. See note 7, Dubay, et al.

22. See note 7, Dubay, et al.