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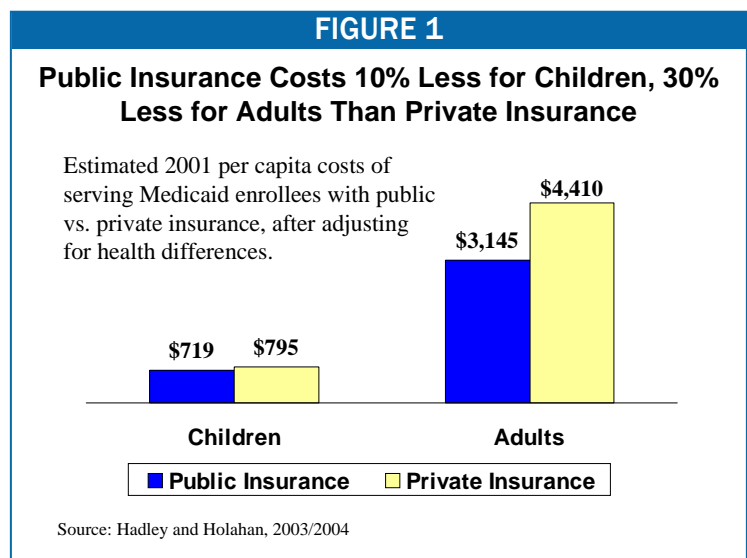
## COMPARING PUBLIC AND PRIVATE HEALTH INSURANCE FOR CHILDREN

By Leighton Ku

In considering the pending reauthorization of the State Children's Health Insurance Program (SCHIP), some have recommended that Congress use federal funds to subsidize purchasing private health insurance rather than expanding public health insurance, like Medicaid or SCHIP.<sup>1</sup> Some may reflexively assume that private health insurance is more efficient or more effective than public insurance. However, the available evidence indicates that public health coverage is less expensive than private insurance and provides comparable, and in some cases better, access to health care for children.

**Health Care Costs.** Economists Jack Hadley and John Holahan of the Urban Institute have shown that, after accounting for the fact that children and adults covered by Medicaid have a higher incidence of health problems and thus tend to require more care, it is less expensive to provide health care with Medicaid than private insurance (Figure 1). They found public insurance was about 10 percent less expensive for children and about 30 percent less expensive for adults.<sup>2</sup>

In addition to having higher medical costs, private health insurance has administrative costs that, on average, are about twice those of public insurance — 14 percent for private coverage as compared to 7 percent for Medicaid.<sup>3</sup> Finally, private



<sup>1</sup> For example, Nina Owcharenko, "Fixing SCHIP and Expanding Children's Health Care Coverage," Heritage Foundation, May 2, 2007.

<sup>2</sup> Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, 40(4): 323-42, Winter 2003/2004.

<sup>3</sup> In 2005, administrative costs (including marketing, profits and reserves) of private health insurance averaged 14 percent of total private health insurance costs, compared to 7 percent for administrative costs in Medicaid (including administrative

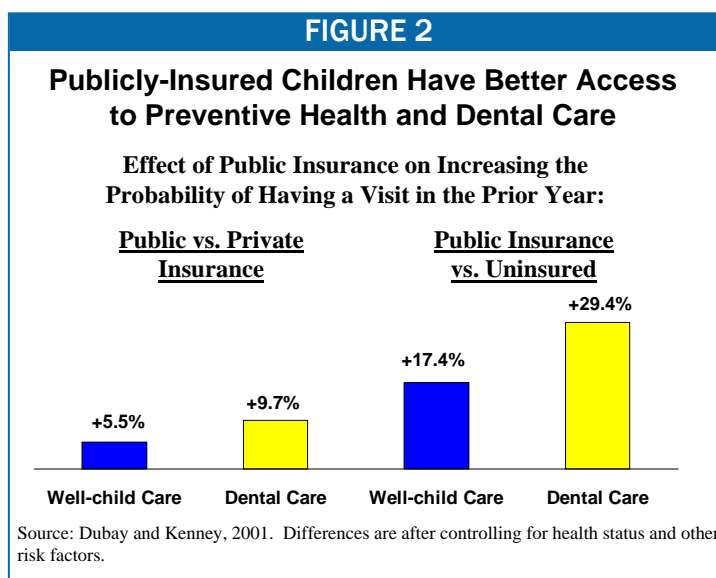
health insurance premiums have risen faster than per capita Medicaid costs in the last few years, which suggests that the differences found above (which are based on data from a few years ago) likely have widened further.<sup>4</sup>

**Health Care Access.** One reason that public insurance costs less than private insurance is that payment rates for health care providers are typically lower. As a result, publicly-insured children sometimes have problems getting timely access to physicians or dentists. While Medicaid and SCHIP are imperfect, private health insurance also has shortcomings and giving children private insurance instead of public coverage might not improve their access to care.

Research shows that publicly-insured children have access to health care that is generally equivalent to that of privately-insured children and much better than access for uninsured children. For some services, such as preventive health visits or dental care, publicly-insured children have better access than similar low-income children with private insurance (Figure 2).<sup>5</sup>

**Benefits and Standards.** All children covered by Medicaid and SCHIP receive relatively comprehensive health benefits, including preventive and primary medical care, inpatient and outpatient care, laboratory and x-ray services, prescription drugs, and immunizations. Almost all publicly-insured children have coverage for dental, vision and mental health care. (Medicaid standards are more rigorous and require that these services be available for children. They are not required in SCHIP, but most states do cover them.) In comparison, private health insurance benefits vary widely and are typically less comprehensive. Many private plans do not offer dental or vision care, services that are important for children, and some low-cost private plans do not even offer basic services like prescription drugs or preventive care.

The only standards that govern private health insurance are state insurance rules. These vary from state to state, and the state rules usually do not apply to many private insurance plans, such as self-insured health plans. One example of differences between standards for public and private health insurance was noted by Sara Rosenbaum of George Washington University and Paul Wise of Stanford: Medicaid



costs of managed care plans). Aaron Cailtin, et al. "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, 26(1):142-51, Jan./Feb. 2007.

<sup>4</sup> Leighton Ku, "Medicaid Costs Are Growing More Slowly Than Costs for Medicare or Private Insurance," Center on Budget and Policy Priorities, Nov. 13, 2006.

<sup>5</sup> Lisa Dubay and Genevieve Kenney, "Health Care Access and use Among Low-income Children: Who Fares Best?" *Health Affairs*, 20(1):112-21, Jan./Feb. 2001. Karen Duderstadt, et al. "The Impact of Public Insurance Expansions on Children's Access and Use of Care," *Pediatrics*, 118(4):1676-82, Oct. 2006. Leighton Ku, Mark Lin and Matthew Broaddus, *Improving Children's Health*, Center on Budget and Policy Priorities, Jan. 2007.

requires that all Centers for Disease Control and Prevention (CDC) recommended pediatric vaccines be covered for children, while *no* state's insurance rules sets forth such a standard.<sup>6</sup> Public plans use stronger standards to ensure that appropriate and recommended services are available for children.

**Cost-sharing and Deductibles.** To assure that insured low-income families can afford medical care, both Medicaid and SCHIP establish limits on cost-sharing. The maximum in both programs is five percent of a family's income. (More rigorous limits apply for children with lower incomes, particularly those below the poverty line.) In contrast, private plans — particularly low-cost private plans — often impose high levels of cost-sharing that can render health care unaffordable for low-income families. A substantial body of research shows that low-income families are often unable to afford care when cost-sharing is high and consequently may go without care or delay care until health problems become more severe and more expensive to treat.<sup>7</sup>

For example, in 2006, the average annual deductible in a private plan for a family was \$1,034 for the family and \$710 per family member.<sup>8</sup> Private insurance will not cover medical bills until the deductible is met. For many children, the deductibles exceed typical annual medical expenditures, so the private plans may offer little or no financial help for children's medical bills that families incur. In 2004, the median annual medical expenditure for a typical privately-insured child was \$427 per year (including amounts paid by both insurers and families), a level below the average deductible.<sup>9</sup> Even after deductibles are met, private plans often require high copayments or coinsurance, making subsequent care less affordable for children with more serious health needs.

By requiring high cost-sharing to limit their medical outlays, private insurers can reduce the monthly premiums, making them appear to be more affordable. But high deductibles and copayments may leave many families unable to afford needed care for their children.

**Conclusions.** Contrary to a common assumption that private health insurance is more efficient or effective, evidence indicates that public health coverage is less expensive than private insurance and more affordable for families. Public coverage provides access to care that is usually as good as, and sometimes better than, private health insurance. Whether care is offered under public or private insurance, a blend of private and public hospitals, clinics, physicians and others deliver the actual health care that patients receive.

Policies that propose to use federal funding for tax credits to purchase private insurance for children or for loosely-designed premium assistance are likely to be less effective in strengthening low-income children's coverage and access to health care than policies that build and improve upon the current child health programs.

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<sup>6</sup> Sara Rosenbaum and Paul Wise, "Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT," *Health Affairs*, 26(2): 382-93, Mar./Apr. 2007.

<sup>7</sup> Leighton Ku, "The Effect Of Increased Cost-Sharing In Medicaid: A Summary Of Research Findings," Center on Budget and Policy Priorities, Revised Jul. 7, 2005.

<sup>8</sup> Kaiser Family Foundation and the Health Education and Research Trust, *Employer Health Benefits 2006 Annual Survey*, Sept. 2006. These are the average deductibles for an employer-sponsored preferred provider organization plan. Some health plans do not count certain services such as preventive care or prescription drugs against the deductible.

<sup>9</sup> CBPP analysis of the 2004 Medical Expenditure Panel Survey. The average medical expense for a privately-insured child was \$1,314 per year. The average is greater than the median because a minority of children have high medical expenses.