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CBO ESTIMATES SHOW HOUSE BILL WOULD PROVIDE HEALTH INSURANCE TO 5 MILLION UNINSURED CHILDREN

by Edwin Park

Congressional Budget Office estimates show that by 2012, a total of 5 million children who otherwise would be uninsured would have health care coverage under children's health legislation that the House is considering this week.¹ The coverage gains under this legislation are about 1 million higher than under the bipartisan bill the Senate Finance Committee approved on July 19 by a 17-4 vote.

The CBO estimates show that 3.8 million of these children are uninsured children who already would be eligible for SCHIP (the State Children's Health Insurance Program) or Medicaid under the *current* eligibility rules that states have set for these programs.² Another 800,000 are SCHIP children who otherwise would lose their coverage in coming years and end up uninsured because states would (under the "budget baseline" that CBO employs) receive insufficient federal SCHIP funding to sustain their existing programs.³

- CBO consequently estimates that a total of about 4.6 million of these 5 million children — or 90 percent of them — are children who have incomes below the current eligibility limits that states have set.

KEY FINDINGS

- **Claims that the House SCHIP bill would vastly expand public health programs, by providing coverage to large numbers of middle-class children who already have private coverage, are incorrect.**
- **According to CBO, the bill would provide SCHIP or Medicaid coverage to 5 million uninsured children by 2012. Some 4.6 million (90 percent) of these children would have incomes *below* states' current eligibility limits. (Only about 500,000 of them would become eligible for public coverage as a result of state actions to broaden their programs.)**
- **The bill would provide coverage to the large majority of uninsured children whose incomes are low enough to qualify for Medicaid (generally, below the poverty line). Some 3.1 million of these children would gain coverage under the bill.**

¹ Preliminary CBO estimates of the original House legislation unveiled on July 24 found that 4.9 million uninsured children would have gained coverage by 2012.

² Congressional Budget Office, "Preliminary CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children under H.R. 3162, The Children's Health and Medicare Protection Act of 2007," August 1, 2007.

³ The "baseline" assumes SCHIP funding will remain frozen at \$5 billion annually for the next five years even as health care costs continue to increase, a scenario that CBO has determined would cause the number of children covered under SCHIP to decline significantly as states faced federal funding shortfalls under their SCHIP programs. See Congressional Budget Office, "Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program," February 23, 2007 and Edwin Park, "CBO Estimates That States Will Face Federal SCHIP Shortfalls of \$13.4 Billion Over Next Five Years," Center on Budget and Policy Priorities, February 26, 2007.

- Only about 500,000 of the 5 million children who otherwise would be uninsured are children who would gain eligibility as a result of actions their states would take to broaden their SCHIP eligibility criteria or adopt new SCHIP and Medicaid coverage options. (All of these figures represent CBO's estimates of the number of children who would be covered in an average month in 2012.⁴)

Key elements of the House bill would make the SCHIP program permanent and create a more predictable but flexible financing system for states. States with inadequate federal funding and higher-than-expected SCHIP enrollment could qualify for some additional funds. The legislation also would provide fiscal incentives to states that *both* adopt simplified enrollment and retention practices *and* enroll more of the uninsured children who are already eligible for Medicaid or SCHIP.

The House bill produces greater coverage gains than the Senate Finance Committee bill because it provides the full \$50 billion over five years that the congressional budget resolution permits (if fully offset), rather than the \$35 billion under the Senate bill provides, and because it accords states new options to cover older children and legal immigrant children during their first five years in the United States. (States already have the option to cover legal children after that time.)

How the Bill Would be Paid For

The costs of the House bill are financed in part through a reduction in overpayments that Congress' expert advisory body on Medicare and the Congressional Budget Office have found are being made to private insurance companies participating in Medicare, changes to the reimbursement rates for other Medicare providers, and by an increase in the rebates that drug manufacturers are required to pay to the Medicaid program. The remaining financing for the bill comes from an increase in federal tobacco taxes of 45 cents-a-pack (which is smaller than the 61-cents-a-pack increase the Senate Finance Committee approved). The House Ways and Means Committee approved this increase in tobacco taxes on July 26.

Differences with the Senate Bill

The House bill differs from the Senate bill in that it does not limit the existing SCHIP coverage of low-income *parents* of children who are enrolled in SCHIP or Medicaid, and thus does not lead to some children losing coverage as a consequence. (Various studies have found that jointly covering children and their parents results in a larger share of the eligible children signing up and receiving health care services. In response to a question posed last week during the Senate Finance Committee's consideration of the SCHIP legislation, CBO director Peter Orszag explained that "restricting eligibility to parents does have an effect on take up among children.... for every 3 or 4 parents you lose, you might lose 1 or 2 kids, for example.")

As these CBO figures indicate, the House legislation would make somewhat greater progress than the Senate bill in covering uninsured children. The CBO estimates also show that the House bill would reach a large number of the *lowest-income* uninsured children; some 3.1 million children who are eligible for Medicaid but would otherwise be uninsured would gain coverage under the legislation. (By comparison, CBO estimates that the Senate bill would enroll an additional 1.7

⁴ These CBO figures may not precisely add due to rounding effects.

million of these Medicaid-eligible children.) Most of these 3.1 million children likely would be children who live below the poverty line.

As with the Senate Finance Bill, Claims that the House Bill Would Primarily Displace Private Coverage Are Not Accurate

Even before the Senate and House bills were unveiled, Administration officials and some conservative activists began to criticize them. These critics have argued that instead of covering significant numbers of uninsured low-income children, the bills would primarily shift children (and families) “with good incomes” from private insurance to “government coverage.”⁵

The CBO estimates of the impacts of the House bill show these criticisms are not valid.⁶ The figures indicate that the bill would be heavily targeted to children with low incomes and would primarily assist children who otherwise would be uninsured, not children who otherwise would have private coverage.

- CBO estimates that the House legislation would increase the overall number of children enrolled in SCHIP or Medicaid by a total of 7.5 million in 2012. As noted above, CBO estimates that 5 million of these would be children who would otherwise be uninsured.
- In other words, two-thirds (66.7 percent) of the children who would gain SCHIP or Medicaid coverage under the bill (5 million out of 7.5 million) would be children who would otherwise be uninsured in 2012, *not* children who would otherwise have private coverage.

Moreover, CBO classifies as children who would shift from “private coverage” to SCHIP or Medicaid 200,000 legal immigrant children who would move from *state-funded* public health insurance programs to Medicaid or SCHIP. Once this is taken into account, the CBO estimates indicate that fewer than 30 percent of children who would gain SCHIP or Medicaid coverage under the bill are children who would otherwise have some type of private health insurance in 2012.

As CBO director Peter Orszag and other leading health experts have explained, under the fragmented U.S. health insurance system, virtually any effort to cover more of the uninsured — including efforts that rely on tax deductions or credits for the purchase of insurance in the private market — would result in some “crowd-out” (i.e., in the substitution of one type of health insurance for another). A crowd-out effect of less than one-third actually is regarded by many experts as modest. For example, in describing the crowd-out levels under the Senate bill (which are similar to those under the House bill), CBO director Peter Orszag observed during Senate Finance Committee consideration of the bill that to reach this many uninsured children, the Senate approach is “pretty much as efficient as you can possibly get” (except for approaches that would impose mandates on employers, individuals, or states).

⁵ For an analysis of these and other Administration claims about the SCHIP bills and why they do not withstand scrutiny, see Robert Greenstein, “The Administration’s Dubious Claims about the Emerging Children’s Health Insurance Legislation: Myths and Realities,” Revised July 20, 2007.

⁶ For an analysis of the CBO estimates of the Senate Finance Committee SCHIP bill, see Edwin Park, “CBO Estimates Show Large Gains in Children’s Health Coverage under Senate SCHIP Bill,” Center on Budget and Policy Priorities, Revised July 20, 2007.

Furthermore, analyses of various tax-based approaches have found that the large majority of the tax benefits under such approaches generally would go to people who already are insured. An analysis of the health-insurance tax proposals that the Bush Administration included in its budget last year, conducted by the very economist (Jonathan Gruber of M.I.T.) whose work on SCHIP crowd-out has been touted in recent weeks by HHS Secretary Mike Leavitt and conservative activists,⁷ found that 77 percent of the benefits under the Administration's health tax proposals would go to people who already are insured. This is more than double the crowd-out percentage under the House and Senate bills. (Professor Gruber's analysis of the Administration tax proposals also found that the net result of the proposals would be to modestly *increase* the ranks of the uninsured, because a number of employers would respond by dropping coverage.⁸)

Professor Gruber, who is widely considered to be one of the nation's leading health economists, has explained that although public programs suffer from significant crowd-out effects, they still constitute the most efficient way to cover more of the uninsured.⁹ He has noted that "no public policy can perfectly target the uninsured, and public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage. I have undertaken a number of analyses to compare the public sector costs of public sector expansions such as SCHIP to alternatives such as tax credits. I find that the public sector provides much more insurance coverage at a much lower cost under SCHIP than these alternatives. Tax subsidies mostly operate to "buy out the base" of insured without providing much new coverage."¹⁰

It should also be recognized that in a substantial number of the cases in which a family with access to private insurance instead enrolls its children in Medicaid or SCHIP, that decision may be beneficial to the child's health. In many such cases, particularly among the low-income families that the House and Senate bills target, the private insurance that is available to the family may contain significant gaps in the coverage it provides or may require large deductibles and cost-sharing charges that the family has difficulty affording. Research has shown that when low-income families face large cost-sharing charges, they often go without (or delay obtaining) health care services that they or their children may need.

⁷ See, for example, Mike Leavitt, "Reforming Health Care," *Washington Times*, July 9, 2007.

⁸ Jonathan Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," Center on Budget and Policy Priorities, February 15, 2006.

⁹ Jonathan Gruber, "Tax Policy for Health Insurance," Working Paper 10977, National Bureau of Economic Research, December 2004.

¹⁰ Letter from Jonathan Gruber to Representative John Dingell, Chairman of the House Energy and Commerce Committee, March 2007.