
January 14, 2009

CBO ESTIMATES SHOW HOUSE SCHIP BILL WOULD PROVIDE HEALTH INSURANCE TO 4.1 MILLION UNINSURED CHILDREN

by Edwin Park

By 2013, a total of 4.1 million children who would otherwise be uninsured would have health care coverage under children's health insurance legislation the House is scheduled to consider today. These figures come from the Congressional Budget Office. The Senate Finance Committee is scheduled to consider similar legislation on January 15.

The CBO estimates show that 1.6 million of these children are uninsured children who would be eligible for SCHIP or Medicaid under current state eligibility rules but, in the absence of the legislation, would be unenrolled and uninsured.¹ Another 1.8 million are SCHIP children who would otherwise *lose* their coverage in coming years and end up uninsured because states would (under the "budget baseline" that CBO uses) receive insufficient federal SCHIP funding to sustain their existing programs.²

- Thus, CBO estimates that a total of about 3.4 million of the 4.1 million children who would gain coverage — or nearly 83 percent of them — are children with incomes *below the current eligibility limits* that their states have set.
- Only about 700,000 of the 4.1 million children gaining coverage are children who would newly gain eligibility for SCHIP or Medicaid as a result of actions that their states would take to broaden their SCHIP eligibility criteria. (All of these figures represent CBO's estimates of the number of children who would be covered in an average month in 2013, the final year that the bill would be in effect.)

Key elements of the legislation would extend the SCHIP program for 4.5 years and raise SCHIP funding levels so states can *both* sustain existing enrollment by children *and* cover more low-income children. According to CBO, the provisions to maintain and expand children's health coverage would cost \$32.3 billion over five years (2009-2013). These costs would be fully offset, primarily

¹ Congressional Budget Office, "CBO's Preliminary Estimate of Changes in SCHIP and Medicaid Enrollment in Fiscal Year 2013 of Children Under the Children's Health Insurance Program Reauthorization Act of 2009," January 13, 2009.

² 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 and more children become eligible, a scenario that CBO has determined would cause the number of children covered under SCHIP to decline significantly as state SCHIP programs faced federal funding shortfalls.

through an increase in federal tobacco taxes.³ (The bill also includes a Medicare provision affecting certain referrals of patients to so-called specialty hospitals, a measure that produces modest savings of \$300 million over five years, and a Medicaid provision prohibiting new Health Opportunity Account demonstration projects, a measure that saves \$100 million over this period; these provisions offset a small portion of the legislation's cost.)

The SCHIP reauthorization legislation largely mirrors the SCHIP reauthorization bills (H.R. 976 and H.R. 3963) that President Bush vetoed in 2007. As under the vetoed bills, the legislation would, over time, scale back existing SCHIP coverage of low-income parents of children who are enrolled in SCHIP or Medicaid in a small number of states, as well as adults without children, who are covered in a few states. (Various studies have found, however, that covering children and their parents jointly results in more of the eligible children signing up and receiving health care services.⁴)

In addition, the bill would provide financial incentives to states to enroll more uninsured children who already are eligible for Medicaid. CBO estimates show that these provisions would help the bill make significant progress in reaching the lowest-income uninsured children. According to CBO, some 1.4 million children who are eligible for Medicaid but otherwise would be uninsured would gain coverage under the bill. Most of these would likely be children living below the poverty line.

The bill would also add a provision from the original House-passed SCHIP reauthorization bill in 2007 that would permit states, at their option, to cover certain legal immigrant children (and pregnant women) through Medicaid and SCHIP who are otherwise eligible for those programs.⁵ Under current law, states are prohibited from providing federally-funded Medicaid and SCHIP coverage to legal immigrant children for the first five years after entering the United States, though 18 states now provide such coverage at 100 percent state expense.⁶ (The provision is of very modest cost: \$1.3 billion over five years or four percent of the cost of the SCHIP legislation.)

Likely Claims that the Legislation Would Primarily Displace Private Coverage Rather than Cover Uninsured Children Are Inaccurate

Opponents of the vetoed 2007 SCHIP bills, including the Bush Administration, incorrectly claimed at the time that it would not produce much of a gain in coverage, but instead would

³ Congressional Budget Office, "Congressional Budget Office Cost Estimate for H.R. 2, Children's Health Insurance Program Reauthorization Act of 2009," January 13, 2009 and Congressional Budget Office, "CBO's Preliminary Estimate of the Effects on Direct Spending and Revenues of the Children's Health Insurance Program Reauthorization Act of 2009," January 13, 2009.

⁴ Research has shown that reducing coverage of low-parent parents lowers participation among eligible children in public programs. (See Leighton Ku, "Collateral Damage: Children Can Lose Coverage When Their Parents Lose Health Insurance," Center on Budget and Policy Priorities, September 17, 2007.) In response to a question during the Senate Finance Committee's July 2007 mark-up of SCHIP legislation, then-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."

⁵ The provision was also previously passed by the Senate in 2003 as part of the original Senate-passed version of Medicare prescription drug legislation.

⁶ Data from the National Immigration Law Center, October 2008.

primarily lead children who now have *private* insurance to be switched to *public* programs.⁷ House Republican Leader John Boehner and House Republican Whip Eric Cantor have begun in recent days to make similar arguments.⁸

As with the vetoed bills in 2007, CBO's estimates of the impacts of the legislation show that such criticisms are not valid.⁹ The figures indicate that the legislation would primarily assist children who otherwise would be uninsured, not children who otherwise would have private coverage.

- CBO estimates that out of a total of 6.5 million additional children who would gain SCHIP or Medicaid coverage under the bill by 2013, some 4.1 million would (as noted) otherwise be uninsured. The other 2.4 million children would otherwise have had some form of private coverage. As CBO has previously explained during consideration of SCHIP reauthorization in 2007, a significant share of these 2.4 million children are children who would be *uninsured* when they enrolled in SCHIP (rather than children who previously had private coverage and dropped it prior to enrolling in SCHIP). CBO includes in the 2.4 million figure all uninsured children enrolling in SCHIP as a result of the legislation who are uninsured when they sign up but would be expected (in the absence of the legislation) to purchase private coverage *eventually*.¹⁰
- In other words, 63 percent of the children who would gain SCHIP or Medicaid coverage under the bill (4.1 million out of 6.5 million) would be children who would otherwise be uninsured in 2013. And substantially fewer than 37 percent would be children who otherwise would have some form of private coverage at the time they enrolled in SCHIP.
- As leading health experts have previously explained — including then-CBO director Peter Orszag in 2007 — 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 in the range of one-third — similar to the crowd-out effect that CBO estimates the SCHIP legislation would have — is regarded by many experts as modest.
- For example, in describing the crowd-out levels under the House-passed version of SCHIP reauthorization legislation in 2007, which also had a crowd-out effect of about one-third, then-CBO director Orszag stated that he “has not seen another plan that adds 5 million kids to SCHIP with a 33 percent crowd-out rate. This is pretty much as good as it is going to get”¹¹ (except for approaches that would impose mandates on employers, individuals, or states).

⁷ See, for example, “The President’s Comments on Congress’ SCHIP Plan,” Center on Budget and Policy Priorities, September 20, 2007 and Robert Greenstein, “The Administration’s Dubious Claims about the Emerging Children’s Health Insurance Legislation: Myths and Realities,” Revised July 20, 2007.

⁸ See Letter to President-Elect Barack Obama and Speaker Nancy Pelosi from House Republican Leader John Boehner and House Republican Whip Eric Cantor, January 9, 2009.

⁹ See, for example, Edwin Park, “CBO Estimates Show SCHIP Agreement Would Provide Health Insurance to 3.8 Million Uninsured Children,” Center on Budget and Policy Priorities, Revised September 25, 2007.

¹⁰ See Leighton Ku, “‘Crowd-Out’ Is Not the Same as Voluntarily Dropping Private Health Insurance for Public Program Coverage,” Center on Budget and Policy Priorities, September 27, 2007.

¹¹ “SCHIP: Governors, Health Officials, Seek Withdrawal of CMS Rules Targeting ‘Crowd-Out’ by SCHIP,” *BNA Health Care Daily*, August 31, 2007.

Moreover, analyses of various tax-based approaches that have been promoted as alternatives by opponents of the SCHIP legislation have found that, under those approaches, the large majority of the tax benefits generally would go to people who already are insured. For example, an analysis of the health-insurance tax proposals that the Bush Administration included in its fiscal year 2007 budget found that 77 percent of the benefits under those proposals would go to people who already have insurance. That is more than double the “crowd-out percentage” under the SCHIP legislation. (This analysis was conducted by noted health economist Jonathan Gruber of M.I.T., whose work on SCHIP crowd-out was frequently touted in 2007 by HHS Secretary Mike Leavitt¹² and other opponents of the vetoed SCHIP bills. Gruber’s analysis also found that the net result of the Bush health tax proposals would be to modestly *increase* the ranks of the uninsured because a number of employers would respond by dropping coverage.¹³)

Professor Gruber has explained that although public programs suffer from crowd-out effects, they constitute the most efficient way to cover more of the uninsured.¹⁴ He wrote in 2007 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 [individuals] without providing much new coverage.”¹⁵

It should also be recognized that in a substantial number of the cases where a low-income family with access to private insurance instead enrolls its children in Medicaid or SCHIP, the decision to do so may be beneficial to the child’s health. In many such cases, the private insurance available to the family may contain significant gaps in coverage 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 need.

¹² See, for example, Mike Leavitt, “Reforming Health Care,” *Washington Times*, July 9, 2007.

¹³ Jonathan Gruber, “The Cost and Coverage Impact of the President’s Health Insurance Budget Proposals,” Center on Budget and Policy Priorities, February 15, 2006.

¹⁴ Jonathan Gruber, “Tax Policy for Health Insurance,” Working Paper 10977, National Bureau of Economic Research, December 2004. See also Jonathan Gruber, “Covering the Uninsured in the U.S.,” Working Paper 13758, National Bureau of Economic Research, January 2008.

¹⁵ Letter from Jonathan Gruber to Representative John Dingell, Chairman of the House Energy and Commerce Committee, March 2007.