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CONGRESSIONAL TESTIMONY

Covering Uninsured Children: The Impact of the August 17 CHIP Directive

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Keeping SCHIP Focused

The State Children Insurance Program (SCHIP) statue describes the purpose of the program as assisting uninsured, low-income children. Although there is some disagreement over its interpretation, the statue defines "low-income" children as those children whose family income is at or below 200 percent of the poverty line. Moreover, in an effort to keep the program focused on uninsured children, the statue includes provisions to ensure that the program does not substitute for coverage under a group health plan and to inform parents through outreach efforts of the possible availability of private coverage.

In August of 2007, the Centers for Medicare and Medicaid released a directive to state on SCHIP helps clarify and re-enforce existing law. The directive keeps the program focused on its core population—low income uninsured children—and pays particular attention to the impact that SCHIP expansions have on existing private coverage.

Impact of Expansion on Existing Private Coverage

Many low-income children have private health insurance. The Congressional Budget Office estimates that 50 percent of children between 100 and 200 percent of poverty have private coverage,[1] and 77 percent of children between 200 and 300 percent of poverty have private coverage.[2] Thus, it is critical to appreciate these numbers when considering expanding public programs, such as SCHIP, beyond the 200 percent threshold.

There is wide and varying degrees of estimates on the impact that public program expansions has on the availability and enrollment in private coverage. Economists Jonathan Gruber and Kosali Simon, looking at public programs in general, found that "the number of privately insured falls by about 60 percent as much as the number of publicly insured rises."[3] Gruber and Simon also concluded that this "crowd out" phenomenon is far more dramatic when considering the entire family.[4]

The Congressional Budget Office conducted a review of the literature and estimated a 25 to 50 percent reduction in private coverage due to SCHIP.[5] Since their estimates only consider children and not parents, CBO, like Gruber and Simon, points out that these estimates "probably understate the total extent to which SCHIP has reduced

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[1]Congressional Budget Office, "The State Children's Health Insurance Program," May 2007, p. 12 at *www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf* (April 8, 2008).
[2]*Ibid.*
[3]Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Heath Insurance?" National Bureau of Economic Research *Working Paper* No. 12858, January 2007, p. 2, at *www.nber.org/papers/w12858* (April 8, 2008).
[4]*Ibid.*, p. 28.
[5]Congressional Budget Office, "The State Children's Health Insurance Program," p. 11

private coverage."[6]

The Heritage Foundation's Center for Data Analysis conducted an econometric analysis based on a modified and extended version of the methodology developed by Gruber. This analysis concluded that, for every 100 newly eligible children in families with incomes between 200 and 400 percent of federal poverty, 54 to 60 children would lose private coverage.[7]

Protecting SCHIP and Private Coverage

First, the directive is aimed at those states that have expanded eligibility above 250 percent of poverty. Nineteen states have expanded SCHIP eligibility above the 200 percent threshold, and 11 of those have extended it above 250 percent of poverty. Moreover, of these states at or above 250 percent of poverty, several have received additional federal funding to address "shortfalls" within their programs, which raises questions about whether these states have already expanded beyond capacity.[8]

The Administration directs states that want to expand SCHIP above 250 percent of poverty to meet certain requirements to ensure that the basic goals of the program are being met by preserving SCHIP for the core population that it is intended to service and deterring further erosion of private coverage. Meaningful cost sharing and standard waiting periods, for example, will help protect SCHIP as a safety net program for low-income uninsured children and ensure that the program's design does not create incentives for families to drop their existing private coverage.

Policymakers need to balance access to public coverage without eroding private coverage. Instead of focusing solely on SCHIP as a vehicle for covering kids, policymakers should broaden their efforts to make private coverage more affordable for working families. Offering a federal tax credit to working families is one way to give families the help they need to afford private coverage. A dual approach that protects SCHIP for its intended low-income uninsured populations and a tax credits for others has a long history and broad support.[9]

Conclusion

These SCHIP directives help to preserve SCHIP as a safety net program for low-income, uninsured children. Efforts to undermine these directives will lead to further erosion of the private health insurance market and overburden public programs. In order to address the coverage needs of children, policymakers need to look beyond public

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[6]*Ibid.*, p. 12

[7]Paul L. Winfree and Greg D'Angelo, "SCHIP and 'Crowd Out': The High Cost of Expanding Eligibility," Heritage Foundation *WebMemo* No. 1627, September 20, 2007, at *www.heritage.org/Research/HealthCare/wm1627.cfm.*

[8]For example, six states at or above 250 percent of FPL received additional funding under the Deficit Reduction Act (Public Law 109–171), and eight states are projected to receive additional funding through the Medicare, Medicaid, and SCHIP Extension Act (Public Law 110–173). See and Chris Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," Congressional Research Service, May 8, 2006, and Chris L. Peterson, "FY 2008 Federal SCHIP Financing," Congressional Research Service, January 9, 2008.

[9]See Health Coverage Coalition for the Uninsured, Web site, at *www.coalitionfortheuninsured.org* (April 8, 2008).

program expansion and consider solutions that will bolster—not unravel—the foundation of America's private health insurance system.

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