CBO TESTIMONY

Statement of
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on
Proposals to Expand
Health Coverage for Children

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

April 8, 1997

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Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss issues that the Congressional Budget Office (CBO) would consider in evaluating proposals to expand health insurance coverage for children. Despite recent expansions of the Medicaid program, about 14 percent of U.S. children are uninsured at any point in time. Many more low-income children are uninsured at some time during the year, because shifts between insured and uninsured status are constantly occurring. Because of the number of children involved and the changing composition of the insured population, a policy that would substantially reduce the number of uninsured children could be both expensive and complicated to design.

Policymakers are considering three broad approaches to increase health insurance coverage for children:

- Enrolling more children in Medicaid, both by expanding eligibility and by extending outreach to uninsured children who are eligible but not enrolled;

- Providing direct subsidies to low-income families with uninsured children to help them pay for insurance; and

- Providing refundable tax credits to low-income families who purchase health insurance for their children.

The costs of such proposals would depend on the number of children who are uninsured, the extent to which they and children who would otherwise have private insurance would participate in a subsidized program, and the average cost per child.

HOW MANY CHILDREN ARE UNINSURED?

According to widely quoted estimates, about 10.5 million children through the age of 18, or 14 percent, are uninsured. At least 3 million of them are thought to be eligible for Medicaid. Most proposals to expand health insurance for children have been developed in the context of those numbers, and they assume that those figures would form the basis for determining the potential costs and coverage effects of alternative options. But the underlying situation is actually far more complex than those numbers suggest.

Although some children remain uninsured for the entire year, many more lack coverage for only part of the year. An estimate made at a point in time—which the 10.5 million figure most closely represents—counts all of the first group but only part of the second.[1] But policymakers may be primarily concerned with children who are uninsured for a year or more, which would be a smaller number than the point-in-

1. CBO analysts believe that the estimate of 10.5 million children, which comes from the March 1996 Current Population Survey, is closer to a point-in-time estimate than an estimate of all children who were uninsured for the whole of 1995. For a discussion of methodological issues, see the appendix to this testimony.

time estimate. Alternatively, policies might focus on all children who are ever uninsured, which would be a considerably larger number than the point-in-time estimate. For example, a preliminary analysis conducted by CBO indicates that in 1993, about 13.5 percent of children were uninsured at any one point during the year, but 6.5 percent were uninsured for the entire year, while a further 15.5 percent were uninsured for part of the year. Those estimates indicate how children's insurance status can change over time.

Changes in insurance status are especially prevalent among children in low-income families (those with family income less than 200 percent of the poverty level). Such children are much more likely than others to be uninsured. CBO's estimates suggest that at any point in time, more than one-fifth of low-income children lack coverage, and they account for almost three-quarters of all uninsured children.

Moreover, in tracking children for more than a year, the probability that a child will experience a spell without health insurance rises considerably. For example, more than 40 percent of children in low-income families at the end of 1993 lacked insurance coverage at some time in the preceding two years.[2] However, some of them were uninsured for relatively short periods (four months or less). The

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2. Those estimates should be interpreted carefully because the family income, as well as the insurance status, of those children probably fluctuated over the two-year period. In addition, unemployment rates were high in 1993, probably resulting in more children being uninsured than in a more typical year.

situation may well have improved with the expansions of Medicaid coverage for poor children under age 19 that are being phased in through 2002. Those expansions may have reduced both the likelihood that poor children will become uninsured and the length of time that those uninsured children lack coverage.

Within the low-income population, children in poor families (with family income less than the poverty level) and in near-poor families (with family income between 100 percent and 200 percent of the poverty level) have similar probabilities of being uninsured, but they have different patterns of insurance coverage. Relatively few poor children have employment-based insurance at any point in time, but more than 80 percent are eligible for Medicaid. (That proportion will rise even higher as Medicaid coverage for poor children under age 19 continues to be phased in.) By contrast, more than half of all near-poor children have employment-based coverage, and a much lower proportion are eligible for Medicaid.

Because they account for the large majority of uninsured children, low-income families are the focus of efforts to expand insurance coverage for children. But the volatility of their insurance status and the fact that many children above the poverty level have private coverage at least some of the time raise difficult questions about how best to design an expansion policy.

HOW MANY CHILDREN WOULD PARTICIPATE IN A SUBSIDIZED PROGRAM?

Participation in any form of subsidized health insurance program for children would come from three groups of children: those who would otherwise be uninsured, the target group of the expansion; those who would otherwise have private coverage; and, in the case of subsidy or tax credit proposals, those who are eligible for Medicaid. The amount of federal assistance that low-income families would be eligible to receive would affect the amount of participation by each group.

Eligibility for Federal Assistance

In designing a proposal to increase children's health insurance, policymakers would have to decide who would be eligible for different levels of financial support and how long they could remain eligible without a reassessment of their financial status. Eligibility criteria might include recent health insurance status and current Medicaid eligibility, as well as family income.

Many proposals call for subsidizing uninsured children in families with income below a specified level and using a sliding scale of financial assistance for higher-income families. Proposals that would expand Medicaid, however, would

probably be fully subsidized for all new participants, although they might include small premium contributions or cost-sharing requirements.

Designing a sliding scale of financial assistance to help families buy insurance for their children would involve several policy trade-offs. On the one hand, the higher the income level at which families could receive full subsidies, and the more slowly that assistance decreased as income rose, the more costly the subsidies would be. On the other hand, low subsidy rates would reduce the cost of the proposal, but they would also discourage participation. Moreover, if families who earned too much for full subsidies lost assistance quickly as their income rose, they would face high marginal tax rates (the tax rate on each additional dollar of income).

Some proposals would guarantee that low-income children remained eligible for assistance for up to one year once they enrolled in the program, regardless of whether their family's income or access to employer-sponsored coverage changed. Such a policy could stabilize insurance coverage for low-income children and help them enroll in managed care plans. But extended eligibility could also prove costly given the large number of children who are uninsured at some time during a year. It would mean that some low-income children who would otherwise experience a relatively short spell without insurance could enroll in the program and receive federal support for a full year. To avoid that outcome, proposals could restrict

eligibility only to children who had been uninsured for some minimum period of time. Such a restriction could reduce the number of eligible children significantly, at least in the short run. But as discussed later, such a policy would be difficult to enforce, and its effectiveness would probably erode over time.

Participation by Children Who Would Otherwise Be Uninsured

The rate of participation in a new health insurance program by low-income families with uninsured children would depend in part on whether the program involved Medicaid expansions, subsidies, or tax credits. Both families' attitudes toward the program and the costs they would face would affect their participation.

Expansions of Medicaid. Efforts to use the Medicaid program to increase insurance coverage would probably focus on enrolling uninsured children who are already eligible, although some proposals would also broaden eligibility. Enrolling more children who are now eligible would require major new outreach efforts. Some families choose not to participate in Medicaid in part because of the perceived stigma associated with the program. Others may not participate because they know they have conditional coverage: if their children become sick, they can enroll in Medicaid immediately. Both of those perceptions could be difficult for an outreach program to overcome. Still other families may not enroll because they do not know they are

eligible, which is more likely to be the case if they do not receive cash welfare benefits.

The combination of attitudes toward Medicaid and lack of awareness of eligibility produces surprisingly low Medicaid participation rates among eligible children who do not receive cash welfare benefits. CBO estimates that at any time during the year fewer than 60 percent of children who do not receive cash benefits, do not have private insurance, and are eligible for Medicaid are enrolled in the program. However, short periods of Medicaid eligibility may also contribute to that result. Most uninsured children who qualify for Medicaid but do not participate appear to be eligible for only a few months. Proposals that would allow a one-year minimum period of eligibility, although costly, would increase participation by such children.

Subsidies or Tax Credits. Subsidies or tax credits for the purchase of health insurance would probably have to be large to increase children's coverage substantially. Uninsured children are usually in low-income families, and such families appear to be less responsive to subsidies than are higher-income families. A recent study by researchers at RAND, for example, suggests that subsidies of as

much as 60 percent of the premium would cause only one-quarter of uninsured working families to buy insurance.[3]

Assuming that families had to pay only a small portion of the premium, subsidies to purchase private insurance might overcome any perceived stigma of Medicaid and thus produce higher participation rates. But extensive outreach would still be needed to inform low-income families of their options. Participation in subsidy programs might also be higher than otherwise if the procedures for determining eligibility and enrolling in health plans were streamlined and coordinated.

Although tax credits would also be free of stigma, they would probably produce lower participation rates than direct subsidies that had the same monetary value. Low-income families could experience cash flow problems if they had to pay insurance premiums during the year but only received the tax credit at the end of the tax year. Moreover, even if the credit was made available at the time a family purchased a health plan, the family would still face the possibility of having to repay part of the credit amount at the end of the tax year if its income rose during the year. Such uncertainty might discourage some families from participating. Having to deal

3. M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics*, vol. 14, no. 1 (May 1995), pp. 47-63.

with the tax system could also pose a challenge for some low-income families, many of whom would not ordinarily file a tax return.

Participation by Children Who Would Otherwise Have Private Insurance

In the case of higher-income children, Medicaid expansions, subsidies, and tax credits would all probably result in a significant share of federal payments going to children who would otherwise have private health insurance for at least part of the subsidy period. The participation of such children would raise federal costs beyond what was necessary to cover the uninsured.

Medicaid Expansions. Many researchers have looked at how the Medicaid expansions for children and pregnant women in the late 1980s and the 1990s have affected employment-based health insurance coverage. Private coverage of dependents has fallen as the number of children and pregnant women enrolled in Medicaid has soared. But that fact does not necessarily indicate that families have dropped private coverage to enroll in Medicaid; higher Medicaid enrollment may have resulted because families were losing private coverage.

Studies have reached various conclusions about whether Medicaid "crowds out" private insurance. However, most researchers agree that little crowding out occurs in families with income below the poverty level, although it increases higher up the income scale. Researchers at the Urban Institute, for example, estimated that over the 1988-1992 period, less than 30 percent of the increase in Medicaid coverage for pregnant women with income between 100 percent and 133 percent of the poverty level resulted from the crowding out of employment-based insurance. But the estimate was almost 60 percent for pregnant women with income between 134 percent and 185 percent of the poverty level.[4]

Subsidies or Tax Credits. As noted earlier, any system of subsidies or tax credits would have to be generous to have much impact on coverage. As a result, a large share of subsidy payments would probably go to children who would have been insured in the absence of the program, which could increase costs considerably. The probability of that outcome would rise, the higher the income level at which families were eligible for subsidies. But the probability would be significant even for families with income between 100 percent and 200 percent of the poverty level, who would be among the primary targets of a program to expand insurance; more than half of such families have employer-sponsored coverage.

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4. Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs*, vol. 16, no. 1 (January/February 1997), pp. 185-193. Also see David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, vol. 16, no. 1 (January/February 1997), pp. 194-200; and John Holohan, "Crowding Out: How Big a Problem?" *Health Affairs*, vol. 16, no. 1 (January/February 1997), pp. 204-206.

Low-income workers would have an incentive to drop employment-based coverage for their family and obtain children's coverage through a federally subsidized program if, by so doing, they could increase their money wages. Employers with many low-income workers might be willing to adjust the composition of their workers' compensation packages accordingly.

To avoid such a response, most proposals would prohibit people from claiming subsidies or tax credits for insurance if they had been enrolled in an employer-sponsored plan within the previous year (or some other recent period) or if they were eligible for such coverage. But such provisions could be both costly and difficult to enforce, because verifying eligibility would be problematic. They would also raise questions of fairness. Some families who had chosen not to enroll in an employer-sponsored plan would be eligible for subsidies, whereas families with comparable income who had enrolled in their employer's plan would be ineligible.

Moreover, even if such "firewalls" could be successfully imposed in the short run, in the long run employers and low-income workers would change their behavior in response to the availability of federal funds in ways that the requirements could not prevent. For example, firms might transfer the jobs done by low-income employees to contractual workers who did not receive fringe benefits, and over time, increasing numbers might no longer offer family coverage.

Experience during the short existence of the health insurance tax credit (HITC), established by the Omnibus Budget Reconciliation Act of 1990, provides some insight into the way that families with insurance would probably respond to tax credits or subsidies. The HITC, which existed between 1991 and 1993, allowed taxpayers who qualified for the earned income tax credit (EITC) to claim an additional tax credit if they bought health insurance coverage for their children. The credit was 6 percent for earned income up to $7,125. Taxpayers with earned income between $7,125 and $11,275 could claim the maximum credit of $428, and the credit phased down to zero by an earned income of $21,250.

The credit was small, on average, paying for less than one-quarter of the taxpayer's share of a family health insurance premium. Hence, it was unlikely to provide much incentive for uninsured families to obtain coverage. The income of taxpayers who claimed the credit was 30 percent higher, on average, than that of other EITC recipients. Thus, claimants were primarily in the phaseout range of the credit, and their credit amounts were sufficiently small that it seems likely they would have purchased health insurance anyway.

Interactions Between a Subsidy or Tax Credit Program and Medicaid

The existence of a federally subsidized program of health insurance for children would give states an incentive to shift children out of Medicaid—for which they share responsibility with the federal government—into the new program. For example, states that provide Medicaid coverage to children in higher-income families than required by federal law might lower their income standards. To limit such responses, federal policymakers could consider requiring financial contributions from the states or maintenance of effort with respect to the existing Medicaid program in any proposal to expand health insurance coverage for children through a mechanism other than Medicaid.

Despite possible shifting by the states, however, the net effect of a subsidy or tax credit program would probably be to increase rather than decrease Medicaid enrollment. The reason is that many children applying for a new program would probably be among the 3 million uninsured children who are eligible for Medicaid at any point in time. Proposals would generally bar such children from participating in any new federally subsidized option, requiring them to obtain coverage from Medicaid instead. That requirement would mean that the states and the federal government would share the costs of covering those children.

HOW MUCH WOULD A PROGRAM COST PER PARTICIPANT?

The cost per child of expanding health insurance coverage would depend on which services were covered, the extent to which newly covered children used them, and the cost of administering the program. Because proposals for expanding children's coverage would be voluntary, parents with less healthy children would be more likely to participate. Premiums are generally higher, however, the less healthy the population that is enrolled in a health plan. So if a policy goal is to keep premiums low in order to encourage parents to buy insurance for their children, limiting that type of adverse selection would be a priority in designing the program. Administrative costs would also vary according to the design of the program.

Costs per Child Under a Medicaid Expansion

If Medicaid expansions focused primarily on enrolling uninsured children who were already eligible, those children might actually cost less to insure than current enrollees. Because most poor children who are sick can enroll in Medicaid at any time, those who are eligible but are not enrolled may be healthier and use fewer health services than the ones who are enrolled. If that is indeed the case, states might be able to negotiate lower rates for such children with managed care plans. Whether

children who enrolled under expanded eligibility requirements would be less costly than current enrollees is uncertain, however.

Expanding Medicaid to cover more children would entail relatively low administrative costs because the eligibility, enrollment, and provider contracting systems are already in place. But the additional outreach services that would be needed to enroll children who are now eligible could be costly.

Premiums Under Subsidy or Tax Credit Programs

Premiums for insurance purchased with subsidies or tax credits would depend on the covered benefits and on whether coverage was provided through individual policies or group plans.

Covered Benefits. Depending on the proposal, benefits for children might range from relatively costly packages, offering services similar to Medicaid's, to much leaner benefits, perhaps not even covering hospitalization. Benefit packages with higher cost-sharing requirements would generally be less costly than those with lower ones. But higher cost-sharing requirements would make health care less affordable for low-income families. Alternatively, a proposal that would expand coverage

primarily through health maintenance organizations and other strictly managed health plans could provide comprehensive benefits more affordably.

Coverage Through Individual Policies or Group Plans. Proposals vary with regard to the type of coverage that would be eligible for subsidies or tax credits. Some proposals would subsidize only the purchase of special insurance policies for children. Others would allow families with access to employer-sponsored coverage to use subsidies or tax credits to help pay for that coverage.

The costs of special children's policies would depend on a variety of factors. Premiums might vary, for example, according to the age of the child. In addition, they would vary if policies covering more than one child were permitted. Allowing only single policies would increase the risk of adverse selection because families might choose to enroll only their less healthy children. How children's policies were marketed and purchased would also affect the probabilities of healthier or less healthy children enrolling, as well as the administrative costs of the program. Possibilities for marketing and purchasing include establishing a nonprofit or government organization to coordinate those functions, using the schools to group children together to buy insurance, or requiring insurance companies to sell children's policies in the individual market.

Selling policies through schools would provide a way to group mostly healthy children together to purchase health insurance, thereby reducing adverse selection and helping to keep premiums low. In effect, schools could serve the same grouping function for children that employers do for workers. Moreover, the costs of marketing the program through schools could be relatively low. The disadvantage of a school-based program, however, would be the fragmentation of a family's health insurance coverage that could result; not only parents but, presumably, preschool children would be ineligible, and those children might have to enroll in a different program.

By contrast, requiring families to buy insurance coverage for children in the individual market would reduce the probability that a generally healthy mix of children would enroll, and premiums would be correspondingly higher. Marketing costs would also be high because each family would be negotiating for health insurance on its own. Costs could be reduced, however, if a nonprofit or government organization existed to provide standardized information about health plans and to coordinate their purchase.

If families could use subsidies or tax credits to buy employment-based coverage, they would become part of their employer's group, and the employer would generally cover part of the insurance cost. But because many employers pay 60 percent or less of a family premium, the employee's share might still be more than the

cost of purchasing children's policies for one or two children. The advantage would be that parents as well as children would gain coverage, and they could all enroll in the same health plan.

Administrative Costs Under Subsidy or Tax Credit Programs

The costs of proposals using subsidies or tax credits would also depend on how complex they were to administer. All such proposals would have to develop mechanisms for establishing eligibility, determining subsidy or credit amounts, and giving those subsidies or credits directly to low-income families (perhaps in the form of vouchers) or to health plans and employers. The costs of those functions would vary among proposals.

Proposals that used the schools to administer subsidies, for example, could achieve considerable efficiencies by tying eligibility for the subsidies, as well as their amounts, to eligibility for subsidized meals (as occurs in Florida's Healthy Kids program). Parents could make payments directly to the school system, which could negotiate with health plans. By contrast, if families were able to use subsidies or tax credits to buy employment-based coverage, the agency administering those subsidies or credits might have to deal with thousands of employers, to verify both eligibility and the amount of the premium.

Any proposal using tax credits would have the advantage that the tax system provides a ready means for verifying income. But tax credits would also require low-income families who do not usually file tax returns to do so in order to obtain a credit. Moreover, experience with the EITC suggests that establishing a mechanism that would enable low-income families to receive a tax credit when they purchased health insurance would be difficult; very few families take advantage of the present option to receive their earned income credit in advance.

CONCLUSION

Most uninsured children live in families whose income is below 200 percent of the poverty level. Such children tend to have sporadic health insurance coverage, causing many of them to experience spells without coverage during the year. Thus, the potential target population of uninsured children could be significantly greater than the 10.5 million who lack coverage at any point in time.

Reducing the number of uninsured children significantly would require generous levels of direct subsidies or tax credits, and it would be difficult to prevent low-income children who would otherwise have private coverage from participating in such a generous program. The likelihood of their participation would increase as the income level at which families could qualify for federal assistance rose. As a

result, the cost of a program to expand health insurance coverage for children would probably be considerably higher than the cost of covering only those children who would otherwise be uninsured.

An alternative approach to direct subsidies or tax credits would be to expand Medicaid to cover higher-income children, although that approach would also cause some children who would otherwise have private coverage to enroll in the program. Another way to lower the number of uninsured children would be to induce more children who were already eligible for Medicaid to enroll. However, achieving that outcome would require making major outreach efforts and, possibly, modifying the program to guarantee a minimum period of eligibility.

APPENDIX: ESTIMATING HOW MANY CHILDREN ARE UNINSURED

Because the health insurance status of many children, especially those in low-income families, is so volatile, the question of how many children are uninsured is not easy to answer. The number of children who are uninsured at any point in time, the number who are uninsured for the entire year, and the number who are uninsured sometime during the year differ considerably. Understanding what different estimates of the number of uninsured children actually measure is important in evaluating the costs and effects of proposals to expand coverage for children. But unfortunately, people who respond to the national sample surveys from which analysts derive estimates of insurance status appear to interpret questions about their health insurance in ways that make distinguishing among the different measures difficult. Determining people's potential eligibility for such programs as Medicaid is also difficult, because family incomes fluctuate over time in ways that surveys may not be designed to track.

Analysts at CBO use two national sample surveys from the Bureau of the Census to estimate rates of health coverage: the annual March supplement to the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP). Data from the CPS present a relatively current snapshot of children's health insurance status, whereas the SIPP data illuminate the transitions in insurance status that children experience over time. Because of underreporting of

health insurance coverage, especially of Medicaid, both surveys probably underestimate health insurance coverage to some degree.

The CPS produces timely estimates of insurance coverage each year. The current widely quoted estimates of 10.5 million uninsured children under age 19, of whom at least 3 million are eligible for Medicaid, come from the March 1996 CPS. But analysts disagree on how to interpret those estimates. Some believe that they refer to children who were uninsured throughout 1995, which is the information that the survey intends to obtain. Other analysts, including those at CBO, believe that people's responses to the CPS questions produce estimates that reflect the number of children who were uninsured at a point in time, rather than for the full year.

The SIPP data support that interpretation. Although the SIPP is less timely than the CPS, it is a longitudinal survey that tracks the insurance status of a sample of children over time. Thus, analysts can determine how many children were uninsured for the whole year and how many were uninsured for part of the year. The most recent survey to track respondents for up to 33 months covered 1992 through part of 1994. CBO's preliminary analysis of that survey indicates that in 1993, about 13.5 percent of children were uninsured at any point in time. That estimate corresponds closely to the March 1993 CPS estimate of 13.1 percent. The SIPP data

also indicate that 6.5 percent of children were insured throughout 1993 and a further 15.5 percent were uninsured for some part of the year.