Congressional Budget Office

Testimony

Statement of
Peter R. Orszag
Director

Covering Uninsured Children in the State Children's Health Insurance Program

before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

May 15, 2008

This document is embargoed until it is delivered at 10:00 a.m. (EDT) on Thursday, May 15, 2008. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Pallone, Congressman Deal, and Members of the Subcommittee, it is my pleasure to appear before you today to discuss the State Children's Health Insurance Program (SCHIP). My testimony makes the following main points:

- SCHIP has significantly reduced the number of low-income children who lack health insurance. According to the Congressional Budget Office's (CBO's) estimates, the portion of children in families with income between 100 percent and 200 percent of the poverty level who were uninsured fell by about 25 percent between 1996 (the year before SCHIP was enacted) and 2006. In contrast, the rate of uninsurance among higher-income children remained relatively stable during that period. The difference probably reflects the impact of the SCHIP program.

- The states' outreach efforts and simplified enrollment processes for SCHIP appear to have also increased the share of eligible children who participate in Medicaid—and contributed to a decline in the percentage of children living below the poverty level who are uninsured.

- The enrollment of children in public coverage as a result of SCHIP has not led to a one-for-one reduction in the number of low-income children who are uninsured, however. Almost any increase in government spending or tax expenditures intended to expand health insurance coverage will displace private coverage to some degree. In the specific case of SCHIP, the program provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than alternative coverage. As a result, the program displaces—or "crowds out"—private coverage to some extent. On the basis of a review of available research, CBO has concluded that for every 100 children who gain public coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

- CBO's analysis of the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House of Representatives, suggested that the legislation would result in 5.8 million children gaining coverage under Medicaid or SCHIP in 2012. Of that increase, CBO estimated, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage. In other words, about one-third of the children who would be newly covered under SCHIP and Medicaid would otherwise have had private coverage. That crowd-out rate is probably about as low as feasible for a voluntary program to increase coverage among children, given the size of the proposed expansion. (Policies to reduce the rate below that level would most likely also reduce the number of children enrolled in the program who would otherwise be uninsured.)

- On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a directive to state health officials that imposes certain minimum requirements on states seeking to enroll children in SCHIP whose families have income above 250 percent of the poverty level. CBO's analysis suggests that the directive's impact on enrollment is likely to be modest under current law, given the way CMS appears to be implementing it and, more important, given the funding levels assumed in CBO's baseline. The directive could have a substantially larger impact on enrollment in SCHIP if the Congress expanded the program significantly.

- On May 7, 2008, CMS released a follow-up letter clarifying certain aspects of the August 17 directive. The clarifications issued by CMS are generally consistent with how CBO originally interpreted the August 17 letter; therefore, CBO has not altered its estimates of the policy's impact on the cost and coverage of SCHIP.

Overview of the State Children's Health Insurance Program

The State Children's Health Insurance Program was established by the Balanced Budget Act of 1997 to expand health insurance coverage to uninsured children in families with income that is modest but too high to qualify for Medicaid. SCHIP is financed jointly by the federal government and the states, and it is administered by the states within broad federal guidelines. The Congress provided approximately $40 billion in funding for SCHIP for fiscal years 1998 through 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) extended funding for the program through March 2009.

Eligibility and Enrollment

States have considerable flexibility in designing their eligibility requirements for SCHIP. According to the SCHIP statute, states may cover children living in families with income up to 200 percent of the federal poverty level or 50 percentage points above their Medicaid threshold.[1] States are allowed to disregard certain types of income and expenses in determining eligibility for the program. In 2008, 23 states allow a maximum income equal to 200 percent of the poverty level, 20 states set the limit above 200 percent of the poverty level, and 7 states set it below 200 percent of the poverty level.[2] North Dakota has the lowest threshold, at 140 percent of the poverty level, while New Jersey has the highest, at 350 percent of the poverty level.[3]

1. States are required to maintain the Medicaid threshold (or level of income determining eligibility) that was in place just before SCHIP was enacted. That requirement, for what is termed "maintenance of effort," prevents states from lowering their Medicaid threshold in order to receive a higher matching rate under SCHIP for children who otherwise would have been covered by Medicaid.

2. See Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker, *State Children's Health Insurance Program (SCHIP): A Brief Overview,* CRS Report for Congress RL30473 (Congressional Research Service, March 12, 2008).

3. New Jersey has effectively expanded its threshold to 350 percent of the poverty level by disregarding all income between 200 percent and 350 percent of the poverty level.

Table 1.

Enrollment in the State Children's Health Insurance Program, 1998 to 2006

Fiscal Year	Number of Children (Thousands)	Percentage Change from Previous Year	Number of Adults (Thousands)	Percentage Change from Previous Year
1998	660	n.a.	0	n.a.
1999	2,014	205	0	n.a.
2000	3,358	67	0	n.a.
2001	4,603	37	234	n.a.
2002	5,354	16	374	60
2003	5,985	12	484	29
2004	6,103	2	646	33
2005	6,114	0	639	-1
2006	6,745	9	671	5
2007[a]	7,145	6	587	-13

Source: Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Notes: n.a. = not applicable.

The figures for the number of people enrolled reflect enrollment at any time during the year. The number of people enrolled in an average month would be about 60 percent of the above totals. There was a change in reporting between 2004 and 2005. Prior to 2005, in states with a combination program, children enrolled in both the Medicaid expansion and the separate program during a given year were counted twice. Starting in 2005, however, those children were counted only in the program where they were last enrolled.

a. Preliminary.

A number of states have used waivers of statutory provisions to expand coverage under SCHIP to adults. About 80 percent of the adults who were enrolled in SCHIP in 2007 were parents, 19 percent were childless adults, and 1 percent were pregnant women. Covering parents may help increase participation among children because parents who are eligible may be more likely to enroll their children also.

The number of children enrolled in SCHIP at any time during the year increased from 660,000 in 1998 to 7.1 million in 2007 (see Table 1). As states first implemented their programs, enrollment grew very rapidly, reaching almost 6 million children by 2003. Since then, enrollment has grown more slowly as states' programs have matured and some states have enacted policies to restrict enrollment in response to budgetary pressures. About 587,000 adults were enrolled at some point during 2007.

Benefits

States can provide SCHIP coverage by expanding Medicaid to include children not eligible for that program, creating a separate program under SCHIP, or using a combination of the two approaches. In 2008, 8 states are using an expansion under Medicaid, 18 states operate a separate program, and 24 states are using a combination

approach.[4] States that provide SCHIP coverage by expanding Medicaid must provide the same benefits that are available under their Medicaid program and follow all other requirements of that program. States that create a separate program under SCHIP are subject to certain minimum standards, including providing a benefit package that is based on one of several specified "benchmark" insurance plans or an alternative that is actuarially equivalent or otherwise approved by the federal government.

The Financing of SCHIP

The statute that established SCHIP set national funding levels for each year from 1998 to 2007. In addition, it specified a formula for determining each state's share of the federal funding, a matching rate for federal reimbursement of SCHIP spending, and a mechanism for redistributing states' unused SCHIP funds.

The annual funding levels specified in the original SCHIP legislation were as follows: for 1998 through 2001, roughly $4.2 billion annually; for 2002 through 2004, about $3.2 billion per year; for 2005 and 2006, $4 billion per year; and for 2007, $5 billion. MMSEA provided $5 billion for 2008 and that same amount for 2009 (which is available to the states through March 2009) and up to $1.6 billion in additional funds for 2008 and $275 million in additional funds in 2009 to be used for states that exhaust their federal funds.

Each year, federal funding for SCHIP is allocated among states on the basis of a formula that takes into account the number of children in low-income families in each state, the number of such children who are uninsured, and wages in the health services sector in the state relative to the national average. States must provide matching funds for expenditures from their federal allotments and have up to three years to spend those allotments. Funds that are not spent within three years are redistributed to states that have exhausted their allotments and are made available to those states for an additional year.

To encourage states to participate in SCHIP, the federal government pays a higher share of their spending on SCHIP than it pays for Medicaid. The federal government's matching rate for SCHIP varies among states from 65 percent to 83 percent; the federal matching rate for Medicaid varies from 50 percent to 76 percent.[5] The national average matching rate for SCHIP is 70 percent and for Medicaid, 57 percent. Although federal funding is made available on a matching basis for both programs, the nature of the programs differs significantly because SCHIP is a grant program in which federal spending is capped in advance whereas Medicaid is an entitlement program with no predetermined limit on spending.

---

4. See Herz, Peterson, and Baumrucker, *State Children's Health Insurance Program: A Brief Overview.*

5. SCHIP's formula for determining the matching rate is based on the state's federal medical assistance percentage (FMAP), as used in the Medicaid program, and equals FMAP + 0.3 * (100 - FMAP), with an upper limit of 85 percent.

Rules for the redistribution of unused funds have been amended a number of times, both by extending and shortening the periods during which unspent funds are available. Because states were initially slow in spending their allotments, the Congress allowed the states to retain some of their allotments longer than three years. In contrast, because recent spending has outpaced federal funding, the National Institutes of Health Reform Act of 2006 (Public Law 109-482) required that a portion of unspent 2005 allotments be redistributed in 2007 instead of 2008.

The type of program that a state operates under SCHIP has distinct implications for funding levels. States choosing to implement SCHIP by expanding Medicaid may continue receiving federal matching funds at that program's lower federal matching rate once their SCHIP spending exceeds their available funds. In contrast, states operating a separate program receive federal matching funds (at the enhanced rate) only up to the amount determined by the allocation formula (unless they convert their program to a Medicaid expansion).

Expenditures for SCHIP

Initially, federal spending on SCHIP was well below the annual funding levels, as states implemented their programs (see Table 2). However, since 2002, federal spending has exceeded the annual allotments every year. Because unspent funds from previous years and the redistribution of other states' unspent funds provide additional SCHIP financing for some states, those states have forestalled exhausting their federal funds. Recently, however, some states have had insufficient federal funds available to fully match their SCHIP spending. As a result, the Congress has acted several times to provide additional funding. The Deficit Reduction Act of 2005 (P.L. 109-171) appropriated an extra $283 million in federal funding to support states' SCHIP spending in 2006. The National Institutes of Health Reform Act of 2006 included provisions modifying the redistribution of unspent funds from previous years to provide additional funds in 2007.[6] The U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28) appropriated up to $650 million in additional federal funding. Most recently, MMSEA provided up to $1.6 billion in additional funds for 2008 and $275 million in additional funds for 2009 to cover states' spending through March 2009.

6. The National Institutes of Health Reform Act of 2006 reduced the availability of 2005 allotments in some states from three years to two and a half. Specifically, states forfeited half of their unspent 2005 funds (not exceeding $20 million) if their total available funds as of March 31, 2007, were at least twice their projected spending in 2007. The law also specified that spending in 2007 from redistributed funds on adults who were not pregnant would be reimbursed at Medicaid's lower matching rate.

Table 2.

Allotments and Spending Under the State Children's Health Insurance Program, 1998 to 2007

(Millions of dollars)

Fiscal Year	SCHIP Allotments[a]	Allotments Unspent After 3 Years[b]	Federal Spending	Funds Expiring
1998	4,235	n.a.	122	0
1999	4,247	n.a.	922	0
2000	4,249	n.a.	1,929	0
2001	4,249	2,034	2,672	0
2002	3,115	2,819	3,776	0
2003	3,175	2,206	4,276	0
2004	3,175	1,749	4,645	1,281
2005	4,082	643	5,089	128
2006	4,365 [c]	173	5,452	0
2007	5,040	62	6,000	0
2008[d]	6,000	58	7,094	0

Sources: Congressional Budget Office, Congressional Research Service, the Balanced Budget Act of 1997, the Deficit Reduction Act of 2005, and the Centers for Medicare and Medicaid Services.

a. For both states and territories.

b. In general, states' annual allotments are available for three fiscal years. Any funds unspent after three years become available to other states with projected spending in excess of their allocation plus any available funds from previous years.

c. Includes additional funding from the Deficit Reduction Act of 2005.

d. Projection by the Congressional Budget Office.

The Effect of SCHIP on Children's Health Insurance Coverage

SCHIP has significantly increased the number of children from low-income families who have health insurance, but enrollment in the SCHIP program is greater than the corresponding decrease in the number of uninsured low-income children. SCHIP provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than private coverage; as a result, some people who otherwise would have obtained private health insurance coverage have instead enrolled in SCHIP. Estimates of the extent to which private coverage has declined in response to the program vary, but the available evidence strongly suggests the net effect of the program has been to reduce the number of uninsured children.

Changes in the Number of Uninsured Children

Information on changes in the number of children who are uninsured comes from self-reported data collected in household surveys. The estimates presented here are based on data from the Annual Social and Economic Supplements to the Current Population Survey, conducted by the Census Bureau, which is the most widely cited source of information on insurance coverage. Although the survey is intended to measure the number of people who were uninsured throughout the calendar year, it yields estimates that are similar to other surveys' estimates of the number of people who were uninsured at a particular point in time.[7]

SCHIP should be expected to have had the greatest effect on the extent of insurance coverage among children in families with income between 100 percent and 200 percent of the poverty level because that was the group that had the greatest increase in eligibility for public coverage.[8] According to CBO's analysis, the percentage of children in that income range who were uninsured fell from 23 percent in 1996 (the year before SCHIP was created) to 17 percent in 2006, a reduction of about 25 percent (see Figure 1). The rate of uninsurance was relatively stable among children in families with income over 200 percent of the poverty level. For example, among children whose families had income between 200 percent and 300 percent of the poverty level, the rate of uninsurance remained at about 10 percent from 1996 to 2006.[9]

Among children in families below the poverty level, the rate of uninsurance rose from 24 percent in 1996 to 27 percent in 1998 and then fell to 22 percent in 2006. The increase from 1996 to 1998 in the percentage of such children who were uninsured

---

7. For a discussion of the strengths and limitations of the Current Population Survey and other household surveys for measuring insurance coverage, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003).

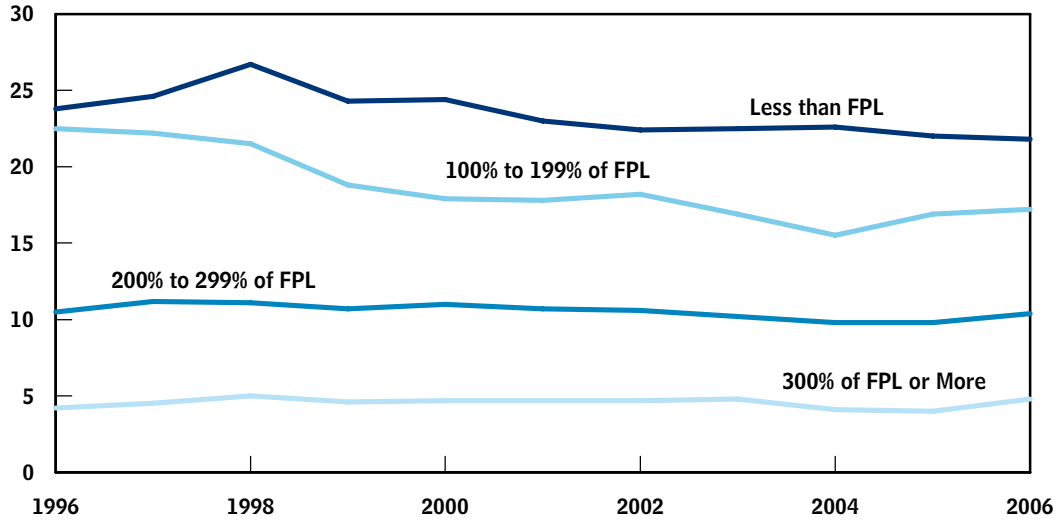
8. One recent study found that the rate of eligibility of children in families with income between 100 percent and 200 percent of the poverty level increased 70 percentage points from 1996 to 2002—compared with an increase of about 30 percentage points among children in families with income between 200 percent and 300 percent of the poverty level, an increase of 10 percentage points among those below the poverty level, and an increase of 8 percentage points among those between 300 percent and 400 percent of the poverty level. See Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* Working Paper No. W12858 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

9. In its analysis, CBO accounted for the fact that a "confirmation" question was added to the Current Population Survey beginning with the interviews that collected data for 1999. The new question asked people who did not report having any of several types of insurance coverage whether, in fact, they were uninsured. CBO compared estimates of uninsurance rates with and without the data from the confirmation question and used those two sets of estimates to create an adjustment factor (separately for each income group) that it applied to the estimates for years prior to 1999 to make them comparable with estimates for later years.

Figure 1.

Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level, 1996 to 2006

(Percent)



Source: Congressional Budget Office based on data from the Current Population Survey for 1996 to 2006.

Note: FPL = federal poverty level.

was accompanied by a drop in Medicaid coverage, which some analysts have cited as an unintended consequence of the welfare reform law that was enacted in 1996.[10]

The decline in the percentage of such children who were uninsured after 1998 was accompanied by an increase in Medicaid coverage. In general, SCHIP did not make more children in families below the poverty level eligible for public coverage because most were already eligible for Medicaid. However, the percentage of children eligible for Medicaid who participated in that program increased, which some analysts have attributed partly to states' outreach efforts for SCHIP (because applicants for SCHIP were enrolled in Medicaid if they were found to be eligible for that program) and the simplified application procedures that states adopted for both SCHIP and Medicaid.[11]

10. See, for example, Karl Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs,* vol. 20, no. 1 (January/February 2001), pp. 97–111.

11. See Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002," *Health Affairs*, vol. 23, no. 5 (September/October 2004), pp. 39–50.

Those changes in the percentage of children who were uninsured do not yield an estimate of the impact of SCHIP because there are many other factors—such as changes in employment levels, family income, and health insurance premiums—that affect children's health insurance coverage. Nevertheless, the fact that the greatest reduction in the percentage of children who were uninsured occurred among those who had the greatest increase in eligibility for public coverage after SCHIP was established strongly suggests that the program has reduced the number of children in low-income families who are uninsured. As discussed below, however, estimating the effect of SCHIP on children's health insurance coverage requires a more sophisticated analysis that controls for other factors that influence coverage and accounts for the program's effects on the number of people with private insurance.

Children's Participation in SCHIP

The number of children who participate in SCHIP depends in part on low-income parents' awareness and understanding of the program, their attitudes toward public insurance programs and health insurance in general, and the ease of the application process. Nearly all states have promoted SCHIP through mass media campaigns, and most have used community-based efforts such as educational sessions and home visits.[12] States have also implemented simpler enrollment procedures for SCHIP than those used for Medicaid (although some have also adopted simpler enrollment procedures for Medicaid). For example, most states do not require a face-to-face interview for a parent to apply for SCHIP or to renew coverage but instead use simple mail-in application forms, and most do not impose an asset test (that is, basing eligibility on the amount of assets a family owns). Most states have a 12-month renewal period, which enables children to remain enrolled in SCHIP for a year unless their family reports a change in income or other circumstances.[13] Since 2001, though, some states have reduced their outreach efforts and retracted certain simplified enrollment procedures in response to fiscal pressures.[14]

According to one study, 29 percent of the children who were eligible for SCHIP in 2005 on the basis of their family's income participated in the program.[15] Half of the eligible children were covered by employment-based health insurance, 6 percent had other coverage, and 15 percent were uninsured. According to that study's estimates, the uninsured children who were eligible for SCHIP accounted for over a fifth of all

12. Margo Rosenbach and others, *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* (report submitted by Mathematica Policy Research, Inc., to the Centers for Medicare and Medicaid Services, March 2003).

13. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006* (January 9, 2007), available at www.kff.org/medicaid/7608a.cfm.

14. Ibid.

15. Genevieve Kenney and Allison Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents, Health Policy Online, no. 15* (Washington, D.C.: Urban Institute, February 2007).

uninsured children in 2005. Other studies have estimated that between 60 percent and 75 percent of all uninsured children are eligible for either Medicaid or SCHIP.[16]

Although all of those studies were based on rigorous statistical methods, they have important limitations because they relied on data collected in household surveys to determine children's health insurance coverage and to identify children who were eligible for SCHIP or Medicaid. Coverage in public programs such as Medicaid is underreported in such surveys, but the implications of that underreporting for the estimated number of people who are uninsured is unclear. There is some evidence that many people who are enrolled in Medicaid but who do not report having coverage under the program may report having private coverage instead.[17] There is also evidence that some SCHIP enrollees report having private nongroup insurance, which is not surprising in that many states design their programs to resemble private insurance.[18] Additional research is needed to fully understand the implications of the underreporting.

Another potential problem is that survey data on such things as types of income and expenses that may be disregarded for determining eligibility are also subject to misreporting. In addition, some major surveys (such as the Current Population Survey) collect data on annual income but no information on fluctuations during the year, which would be relevant for determining eligibility for SCHIP.

The Effect of SCHIP on Private Coverage

Determining the extent to which enrollment in SCHIP is offset by reductions in private coverage is important for evaluating the overall effects of the program and for assessing the extent to which government spending on the program has reduced the number of children who are uninsured. The crowding out of private coverage can occur through various mechanisms. For example, some parents who would have otherwise had family coverage through their employer might decline it for their children—or might decline coverage altogether—if their children are eligible for SCHIP. In addition, previously unemployed parents might be more likely to decline coverage at a new job if their children are enrolled in SCHIP. To the extent that SCHIP makes private coverage less important for some families, the program might also increase the likelihood that low-income parents take jobs that offer higher cash wages rather than

16. See Selden, Hudson, and Banthin, "Tracking Changes in Eligibility and Coverage Among Children"; and Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs,* Web Exclusive, November 30, 2006.

17. See Kathleen Thiede Call and others, "Uncovering the Missing Medicaid Cases and Assessing Their Bias for Estimates of the Uninsured," *Inquiry,* vol. 38, no. 4 (Winter 2001/2002), pp. 396–408.

18. See Joel C. Cantor and others, "The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market," *Health Services Research,* vol. 42, no. 4 (August 2007), pp. 1739–1757; and Anthony T. Lo Sasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics,* vol. 23, no. 5 (2004), pp. 1059–1082.

health insurance. Thus, even in the majority of states where SCHIP covers only children, the program could reduce private coverage among adults as well as children.

SCHIP can also reduce private coverage by influencing the actions of employers. If employers of low-wage workers believe that SCHIP makes health insurance less important in attracting high-quality employees, some might reduce their contribution to the premiums for family coverage, reduce the level of benefits offered, stop offering family coverage, or stop offering insurance altogether. Such actions could lead to less private coverage among families that are eligible for SCHIP as well as for those that are not.

Families that substitute SCHIP for private coverage are generally better off because the cost (to the enrollees) is lower and the package of benefits may be more extensive. However, to the extent that employers respond to SCHIP by increasing premiums, reducing benefits, or declining to offer coverage, other families could be worse off.

Little is known about how employers have responded to SCHIP. As discussed below, the limited evidence that is available suggests that SCHIP has not affected employers' decisions on whether to offer coverage but may have caused them to modestly raise employees' premiums for family coverage relative to the premiums for individual coverage. The implication is that most of the reduction in private coverage associated with the existence of SCHIP appears to result from parents choosing to forgo private insurance for their children and instead enroll them in SCHIP, presumably because the parents believe the program offers better benefits or lower costs than private insurance.

The existence of SCHIP may also affect private coverage by increasing enrollment in the Medicaid program—a consequence of the outreach that states have conducted for SCHIP and the simplified application procedures that many have adopted (in some cases, for Medicaid as well as for SCHIP). That increased enrollment in Medicaid has probably been offset to some extent by a reduction in private coverage, for the same reasons that enrollment in SCHIP has probably been partly offset by a reduction in private coverage. The reduction in private coverage associated with the increase in Medicaid coverage is probably smaller than that associated with enrollment in SCHIP, however, because people eligible for Medicaid have lower income and less access to private insurance than people eligible for SCHIP do.

Efforts to Limit the Substitution of SCHIP for Employment-Based Health Insurance. Federal law requires that the states have procedures in place to prevent people from substituting SCHIP for employment-based insurance. The Congress included that provision in the authorizing legislation because of concern about substitution, in part resulting from a study that estimated that an expansion of Medicaid in the late 1980s

and early 1990s caused a decline in private coverage that was about half the size of the increase in Medicaid coverage.[19] Subsequent studies obtained much lower estimates for the effects of Medicaid on private coverage.[20]

The potential for SCHIP to displace employment-based insurance is greater than it was for the expansion of Medicaid because the children eligible for SCHIP are from families with higher income and greater access to private coverage. According to one study, 60 percent of the children who became eligible for SCHIP had private coverage in the year before the program was established.[21]

States have included a variety of features in their programs to try to prevent SCHIP from displacing employment-based insurance. A widely used approach is to impose a waiting period—that is, a specified length of time that children must be uninsured before becoming eligible for SCHIP. In 2006, 35 states had a waiting period, the two most common being six months (imposed by 16 states) and three months (imposed by 11).[22] Only one state had a waiting period that was longer than six months. Many states allow exceptions to the waiting period—when a parent loses private coverage for reasons considered involuntary (by losing his or her job, switching to a job that does not offer family coverage, or becoming disabled, for instance) or when the available insurance is considered too expensive (if the employee's premiums exceed a specified percentage of income, for example, or if the employer contributes less than 50 percent to the cost of coverage).[23] Most states collect insurance information on the application for SCHIP, and some verify that information with employers. Some states try to limit the displacement of employment-based insurance by requiring premiums and copayments within SCHIP.

Estimates of the Effects of SCHIP on Private Coverage. Estimates vary about the extent to which SCHIP has resulted in less private coverage. The available studies, which have focused on the effects of SCHIP on children, use various data sources and methods. On the basis of a review of the available studies, CBO concludes that the reduction in private coverage among children is most probably between a quarter and

19. That estimate included changes in coverage among children, women of childbearing age, and other adults (who were not eligible for Medicaid). Among children, the study found, the reduction in private coverage was equal to 40 percent of the increase in public coverage. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *The Quarterly Journal of Economics,* vol. 111, no. 2 (May 1996), pp. 391–430.

20. See, for example, Linda J. Blumberg, Lisa Dubay, and Stephen A. Norton, "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics,* vol. 19, no. 1 (2000), pp. 33–60.

21. See Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry,* vol. 42, no. 3 (Fall 2005), pp. 232–254.

22. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents.*

23. Rosenbach and others, *Implementation of the State Children's Health Insurance Program.*

a half of the increase in public coverage resulting from SCHIP.[24] That is, for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.[25]

Measuring the extent to which SCHIP is associated with a decline in private coverage is difficult because it requires comparing the insurance coverage of people under current law with an estimate of the coverage they would have had if the program did not exist. Analysts have estimated the reduction in private coverage attributable to SCHIP by using various statistical models to try to remove the effects of other factors that affect private coverage. All studies that have been conducted to date have estimated the reduction in private coverage among children only; they do not capture any possible reduction in private coverage among parents or other adults. Consequently, the available estimates probably understate the total extent to which SCHIP has reduced private coverage.

Some studies have estimated crowd-out by examining the insurance coverage of participants in SCHIP before they enrolled in the program. Such studies classify enrollees who had private insurance prior to being in SCHIP as having potentially substituted SCHIP for private coverage, and they classify those who were uninsured or covered by Medicaid as not having substituted SCHIP for private coverage. One such study found that 28 percent of children enrolled in SCHIP in 10 states had private coverage at some time during the six months before they enrolled in the program.[26] Such studies probably understate the full extent to which SCHIP reduces private coverage because they do not account for the fact that some of the children who were uninsured or enrolled in Medicaid prior to enrolling in SCHIP may have obtained private

24. That range includes estimates obtained under various approaches. Estimates differ under alternative specifications of the statistical models that analysts have used; some specifications yield estimates that are below or above the range cited. That range encompasses the estimates from specifications in the studies that CBO reviewed and considered most reliable.

25. Nearly all studies have estimated the effect of SCHIP on private coverage generally (including both employment-based insurance and private nongroup coverage). Some observers might argue that studies should focus on the effects of the program on employment-based insurance, because federal law requires states to have procedures in place to prevent the substitution of SCHIP for such coverage. However, estimates of the effects of SCHIP are not likely to be affected measurably by whether or not private nongroup insurance is included. According to CBO's analysis of data from the Current Population Survey, only about 6 percent of children in families with income between 100 percent and 200 percent of the poverty level had private nongroup insurance in the year before SCHIP was enacted, while about half had employment-based insurance. Moreover, a recent study found that, although SCHIP reduced coverage of children by employment-based insurance, it had no effect on private nongroup coverage of them. See Lisa Dubay and Genevieve Kenney, *The Impact of SCHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families (*working paper, Washington, D.C.: Urban Institute, May 2007).

26. See Anna Sommers and others, "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs,* vol. 26, no. 2 (March/April 2007), pp. 529–537.

coverage if SCHIP had not been established.[27] Moreover, such studies do not account for the possibility that some of the children who were uninsured prior to enrolling in SCHIP may have lost coverage as a result of parents' or employers' response to the program (such as a decision by employers to drop family coverage or raise the premiums). In addition, in the surveys that are conducted for such studies, some parents might not have reported their children's private coverage before they enrolled in SCHIP out of fear that their children could be dropped from the program if the state authorities learned about that coverage.

There is limited evidence on whether SCHIP has affected employers' decisions about offering health insurance. Only one study has examined that issue, and it analyzed employers' responses to SCHIP only through 2001.[28] It found no evidence that employers stopped offering single or family coverage in response to SCHIP but did find evidence suggesting that employers of low-wage workers reacted to the program by increasing the marginal cost of family coverage (which was defined as the difference between employees' premiums for family coverage and single coverage). For example, the study estimated, a hypothetical employer with 20 percent of its workforce with children eligible for public coverage would increase employees' marginal cost of family coverage by about $120 per year (in 2001 dollars). The estimated increase was larger in states that experienced a higher-than-average increase in eligibility for public coverage following the establishment of SCHIP and larger for employers with a higher percentage of the workforce with children eligible for public coverage.

The study also examined the extent to which employees accepted private insurance that was offered. It found evidence suggesting that SCHIP reduced the percentage of employees who accepted any private coverage, generally, and family coverage, specifically. For example, at a hypothetical employer at which 20 percent of the workforce had children eligible for public coverage, the estimated percentage of employees who accepted any offer of insurance fell by an average of 1 percentage point. Among employees who accepted any coverage, a similar decline occurred in the percentage of workers who accepted family coverage. The estimated declines were greater for employers that had a higher percentage of workers with children eligible for public coverage. Such findings suggest that SCHIP can reduce private coverage of adults as well as children—in other words, that some workers may respond to SCHIP by declining coverage altogether, not merely declining coverage for their children.

---

27. The uninsured population is not a static group but is constantly changing. Some people are uninsured for long periods, while others are uninsured for shorter periods, such as between jobs. See Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?*

28. Thomas Buchmueller and others, "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry,* vol. 42, no. 3 (Fall 2005), pp. 218–231.

Crowd-Out Effects from Expansions of SCHIP. Estimates reported in recent research measure average changes in private coverage since SCHIP has been implemented, which may differ from what would occur if policies were adopted to increase enrollment. For example, policies designed to increase enrollment among children who are currently eligible would involve less reduction in private coverage than would expanding the program to cover children in families with higher income. Such an expansion to those with higher income would probably involve greater crowd-out of private coverage than has occurred to date because such children have greater access to private insurance.[29]

CBO has previously analyzed the effects of H.R. 976, the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House of Representatives. That analysis indicated that the legislation would result in 5.8 million children gaining coverage under Medicaid or SCHIP in 2012. Of that total, CBO estimated, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage. Under H.R. 3963, the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House, the outcome would be the same. Compared with the outcome under current law, the act would result in 5.8 million children gaining coverage under Medicaid or SCHIP, according to CBO's estimates. Again, of that total, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage.

Those estimates suggest that about one-third of the children who would be newly covered under SCHIP and Medicaid would otherwise have had private coverage. For expansions of public coverage of the scale that would occur under those bills, it is unlikely that crowd-out rates could be substantially reduced below one-third.[30] Although it is possible to establish policies that would reduce the extent to which SCHIP displaces private coverage, such policies would probably also reduce the enrollment of people who were not substituting public coverage for private coverage.

---

29. According to CBO's analysis of data from the Current Population Survey, 50 percent of children in families with income between 100 percent and 200 percent of the poverty level had private coverage in 2005. The rate of private coverage was 77 percent among children in families with income between 200 percent and 300 percent of the poverty level, 89 percent among those between 300 percent and 400 percent of the poverty level, and 95 percent among those over 400 percent of the poverty level.

30. Another point of comparison is CBO's estimate for the original SCHIP authorizing statute, the Balanced Budget Act of 1997. At that time, the agency estimated that 40 percent of children covered under SCHIP would otherwise have had private insurance coverage.

Effects of a Recent Directive on Enrollment in SCHIP

According to a letter that the Centers for Medicare and Medicaid Services issued to state health officials on August 17, 2007, a state covering children in families with income above 250 percent of the poverty level or proposing to expand coverage to such children is required to have already enrolled at least 95 percent of eligible children in families with income below 200 percent of the poverty level. In addition, private employment-based insurance coverage for children in low-income families in the state may not have decreased by more than 2 percentage points over the prior five-year period. Further, the directive requires such a state to adopt five strategies for minimizing the substitution of coverage under SCHIP for private coverage. The states must:

- Impose a waiting period of at least one year between the dropping of private coverage and enrollment in SCHIP for children in families with income above 250 percent of the poverty level;
- Impose cost sharing in SCHIP that approximates the cost of private coverage;
- Monitor health insurance status at the time parents apply for coverage for their children under SCHIP;
- Verify families' insurance status through insurance databases; and
- Prevent employers from changing dependent coverage polices to favor a shift to public coverage.

On May 7, 2008, in response to inquiries from the states, CMS released a follow-up letter explaining certain aspects of the August 17 directive. The May 7 letter provides the following clarifications:

- Policies intended to prevent substitution apply only to children entering the program for the first time, not to those already enrolled (unless they leave the program and reapply later);
- States may submit alternatives to the 95 percent coverage test, which CMS will consider and approve if those states present supporting data showing their effectiveness in reducing crowd-out;
- CMS believes most states already meet the 95 percent test and will work with states regarding data sources CMS considers acceptable; and
- The policies stipulated in the August 17 directive do not apply to unborn children.

The clarifications that CMS issued in its letter of May 7 are generally consistent with how CBO originally interpreted the directive of August 17; therefore, CBO has not altered its estimates of the policy's impact on cost and coverage.

CBO's analysis suggests that the impact of the directive on enrollment is likely to be modest under funding levels assumed in CBO's baseline projections. According to program and survey data, about 80 percent of enrollment in SCHIP in all states is by families with income below 200 percent of the poverty level; about 15 percent of enrollment, between 200 percent and 250 percent of the poverty level; and less than 5 percent, over 250 percent of the poverty level. CBO assumes that families in the last category—constituting less than 5 percent—are potentially affected by the August 17 directive.

Consistent with those overall findings, administrative data suggest that fewer than 20 states provide SCHIP coverage for children in families with income above 250 percent of the poverty level. Even in those states, the great majority of those covered children are from families with income below 200 percent of the poverty level. (Some states, however, had planned to expand their coverage to families with income above 250 percent of the poverty level but dropped such plans after the directive was issued.)

Given the way that CMS appears to be implementing the directive, the provision most likely to affect enrollment is the requirement that states impose at least a one-year waiting period between private coverage and enrollment in SCHIP for children in families with income above 250 percent of the poverty level. Only two states currently have a waiting period as long as one year; many require no waiting period; and the majority of states with waiting periods set them at only three or six months. The requirement for a one-year waiting period would therefore mean that a number of children who currently could obtain coverage either immediately or three to six months after leaving private coverage would have their enrollment delayed or might never enroll in SCHIP, if they obtained private coverage during the waiting period. On the basis of an analysis of current waiting periods, CBO estimates that, under current law, enrollment in SCHIP would be reduced by 0.1 percent as a result of CMS's action.

The directive could have much greater impact on enrollment in SCHIP if the Congress expanded the program significantly. Under its baseline projections for SCHIP, which assume continued allotments of about $5 billion per year, CBO estimates that enrollment of children in SCHIP will fall from 6.8 million in 2009 to 3.3 million in 2018, as the growth in health care costs per person diminishes the number of children that states can cover with a fixed sum of money. However, if the Congress substantially increased SCHIP funding, additional states would probably wish to expand their programs to children in families with income above 250 percent of the poverty level. In that case, the directive of August 17 would be a more significant constraint on enrollment.