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Expanding SCHIP: Not the Best Option for States

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While Washington has been deadlocked over reauthorization of the State Children's Health Insurance Program (SCHIP), many governors and state policymakers have actively supported Congress not only reauthorizing the program but expanding it further to include uninsured children in families with incomes between 200 percent and 300 percent of the Federal Poverty Level (FPL). State lawmakers tend to be supportive of increased SCHIP eligibility largely because they see it as a way to "draw down" additional federal funding for their states.

State lawmakers need to remember that while an expanded SCHIP program might bring their states more federal dollars, those dollars are conditional on state governments spending additional tax money to match. Indeed, to take up Congress's offer of federal funding for expanding SCHIP, the states would collectively have to come up with as much as an additional $1.5 billion in the first year alone; that level of spending would rise in future years. As the SCHIP debate in Congress drags on, state lawmakers need to rethink whether asking Washington to further expand the program up the income scale is the best policy, not only for ensuring health care for children but for the health of state budgets as well.

The Cost to States of Expanding SCHIP Eligibility. Even though SCHIP is a joint federal–state program that, on average, requires states to pay a little more than a third of the program's costs, the debate thus far has focused mainly on the federal cost of expanding eligibility.[1] What have been largely overlooked are the associated cost implications for state budgets. Congress's proposal, which is set to meet another presidential veto,[2] expands the program's target eligibility level from children in families with incomes below 200 percent of the FPL[3] to those with incomes up to 300 percent of the FPL.[4] Should Congress override the President's expected veto, and states begin to draw down federal dollars to expand the program as Congress envisions, states will quickly learn that the additional federal "help" comes at the price of a corresponding increase in state taxing and spending.

In 2006, about 1.5 million children in families between 200 percent and 300 percent of the FPL did not have health insurance coverage.[5] Table 1 shows the theoretical cost to each state of expanding their current SCHIP program to 300 percent of the FPL. This estimate is generated by first multiplying the number of uninsured children in the target population in each state by the current per-child cost of that state's SCHIP program; then, applying the result to the Federal Matching Assistance Percentage (FMAP) for each state. Table 1 reports those results by state and shows that the aggregate theoretical cost to states would be an additional $740 million in the first year of the pro-

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gram expansion—on top of what states are already spending on SCHIP.

In actuality, states would end up covering roughly twice as many children—and at roughly twice the estimated cost—if they expand SCHIP in this fashion. An SCHIP expansion would encourage families in that income range with current private coverage to switch their children to the "lower-cost" or "free" public SCHIP coverage—a phenomenon known as "crowd-out." Indeed, in estimating the

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SCHIP Expansion: Uninsured Population in Target Range with State Coverage Cost, by State in 2008

State	Number of Uninsured Children Between 200% and 300% of Federal Poverty Level (FPL)	Annual Cost to States of Covering Uninsured Children Between 200% and 300% of FPL Through SCHIP Expansion
Alabama	2,165	$ 818,630
Alaska	1,848	1,807,566
Arizona	39,935	16,216,805
Arkansas	16,063	2,893,268
California	256,637	125,033,546
Colorado	22,585	9,770,271
Connecticut	5,967	4,085,008
Delaware	3,936	2,529,274
Florida	119,646	56,855,779
Georgia	40,789	15,398,663
Hawaii	6,229	1,995,772
Idaho	11,431	3,687,183
Illinois	52,403	47,319,909
Indiana	44,576	17,384,640
Iowa	12,641	6,839,792
Kansas	10,425	4,623,696
Kentucky	11,682	4,827,937
Louisiana	18,124	4,049,627
Maine	3,578	2,121,038
Maryland	31,989	21,496,608
Massachusetts	25,595	29,777,223
Michigan	27,524	9,099,434
Minnesota	16,531	30,846,846
Mississippi	16,196	5,451,574
Missouri	28,280	17,911,421
Montana	5,787	2,261,097
Nebraska	6,141	2,863,671
Nevada	21,374	10,156,925
New Hampshire	4,266	2,167,981
New Jersey	54,384	27,637,949
New Mexico	12,838	4,282,757
New York	57,550	35,289,660
North Carolina	27,307	14,991,543
North Dakota	2,698	1,481,202
Ohio	46,694	24,206,170
Oklahoma	15,290	6,034,657
Oregon	12,849	4,579,384
Pennsylvania	44,182	23,073,608
Rhode Island	2,403	2,417,034
South Carolina	19,026	6,184,972
South Dakota	1,969	688,047
Tennessee	16,133	10,986,573
Texas	206,381	72,811,217
Utah	21,767	6,477,859
Vermont	2,040	880,301
Virginia	27,861	17,084,365
Washington	19,151	9,767,010
West Virginia	9,260	2,780,222
Wisconsin	14,369	4,965,926
Wyoming	2,568	1,693,339
Average	**29,621**	**$ 14,772,100**
Total	**1,481,063**	**738,604,978**

1. 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/upload/wm_1627.pdf*.
2. Alex Wayne, "Supporters of Child Insurance Bill Fear Deadlock, Back Less Ambitious Plan," *Congressional Quarterly*, November 30, 2007. For a statement of Administration policy, see: *www.whitehouse.gov/omb/legislative/sap/110-1/hr3963sap-s.pdf*.
3. Eligibility based on a family of four. See "The 2007 HHS Poverty Guidelines," U.S. Department of Health and Human Services, January 24, 2007, at *http://aspe.hhs.gov/poverty/07poverty.shtml*.
4. While disagreement remains over how best to assist children in families below 200 percent of the FPL—and whether the existing SCHIP design and rules need to be reformed—that has not been the principle focus of the debate in Congress, nor is it one of the major points of disagreement that have produced the present deadlock.
5. Heritage Foundation calculations based on 2006 Current Population Survey.

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federal costs of such an expansion, the Congressional Budget Office (CBO) assumes that for every two children that gain coverage through the expansion, one will have previously been uninsured and one will have previously had private coverage—a 50 percent crowd-out rate.[6]

A recent Heritage analysis replicated the best study to date of the crowd-out effects of public health care programs, but with the added feature of disaggregating the results by family income to capture differences in the propensity of families with different incomes to substitute public coverage for private coverage when that is an option. The analysis found that among families with incomes in the range of 200 percent to 300 percent of the FPL, the crowd-out effect is between 44 percent and 51 percent.[7]

The results reported in Table 2 are generated using the same data and methodology as those reported in Table 1, except that in Table 2 the number of children gaining SCHIP coverage through an expansion includes both the number of uninsured children *and* the number of children who would move from private coverage to SCHIP coverage. Thus, Table 2 gives a more realistic picture of the likely scope and cost of expanding SCHIP to 300 percent of the FPL in any given state.

For example, Table 1 shows that Illinois has 52,403 uninsured children in the population targeted by the SCHIP expansion. Covering these children with SCHIP should theoretically cost Illinois about $47 million per year. However, after accounting for the crowd-out effect, the total number of newly enrolled children would likely range between 93,557 and 106,945, thus making the first-year cost to Illinois between about $84 million and $97 million.

Thus, according to a more realistic projection that adjusts for crowd-out effects, the states in the aggregate would end up enrolling about 2.7 million to 3 million more children in SCHIP as part of the proposed expansion—about twice the estimated 1.5 million uninsured children in the targeted population. Furthermore, despite federal match rates that are more generous than Medicaid, the proposed expansion would collectively add at least $1.3 billion to $1.5 billion annually to state government budgets. Also, expanding SCHIP eligibility would become even costlier over time as program costs continue to increase.

Health Care Already Challenges State Budgets. The National Governors Association and the National Association of State Budget Officers recently reported that state finance officers are deeply concerned about the growth of health care spending. According to the report, "Medicaid spending is approximately 22 percent of total state spending while all health care accounts for about 32 percent of total state spending and is the single largest portion of total state spending."[8] The Government Accountability Office also has warned that fiscal difficulties for state governments, driven by rapidly rising health care costs, will present serious challenges within the next decade.[9]

The current challenges faced by state governments are a pressing reason why policymakers should not ignore the impact that new initiatives might have on state budgets. While SCHIP is a smaller federal–state program than Medicaid, and the federal government pays a greater share of its cost, an SCHIP expansion would still require states to come up with a substantial amount of additional money in order to leverage federal dollars to cover the uninsured.

6. Congressional Budget Office, "CBO's Estimate of the Effects on Direct Spending and Revenues of the Children's Health Insurance Program Reauthorization Act of 2007," October 24, 2007, at *www.cbo.gov/ftpdocs/87xx/doc8741/hr976DingellLtr10-24-2007.pdf.*
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/upload/wm_1627.pdf.*
8. *The Fiscal Survey of States,* National Governors Association and National Association of State Budget Officers, June 2007, at *www.nasbo.org/Publications/PDFs/Fiscal%20Survey%20of%20the%20States%20June%202007.pdf.*
9. U.S. Government Accountability Office, *State and Local Governments: Persistent Fiscal Challenges Will Likely Emerge within the Next Decade*, GAO-07-1080SP, July 18, 2007, at *www.gao.gov/new.items/d071080sp.pdf.*

SCHIP Expansion: Projected Enrollment in Target Range with State Coverage Cost, Adjusting for Crowd-Out Effects, by State in 2008

State	SCHIP - 200%–300% FPL Potential New Enrollment with 44%–51% Crowd-Out	Annual Cost to States of Covering Uninsured Children Between 200% and 300% of FPL Through SCHIP Expansion with 44%–51% Crowd-Out
Alabama	3,866–4,418	$ 1,461,839–1,670,673
Alaska	3,300–3,771	3,227,796–3,688,910
Arizona	71,312–81,500	28,958,580–33,095,520
Arkansas	28,684–32,782	5,166,549–5,904,628
California	458,280–523,749	223,274,190–255,170,503
Colorado	40,330–46,092	17,446,912–19,939,329
Connecticut	10,655–12,178	7,294,657–8,336,751
Delaware	7,029–8,033	4,516,560–5,161,783
Florida	213,654–244,176	101,528,177–116,032,202
Georgia	72,837–83,243	27,497,613–31,425,843
Hawaii	11,123–12,712	3,563,878–4,073,003
Idaho	20,412–23,329	6,584,256–7,524,864
Illinois	93,577–106,945	84,499,837–96,571,243
Indiana	79,600–90,971	31,044,000–35,478,857
Iowa	22,573–25,798	12,213,915–13,958,760
Kansas	18,616–21,276	8,256,600–9,436,114
Kentucky	20,861–23,841	8,621,316–9,852,933
Louisiana	32,364–36,988	7,231,476–8,264,544
Maine	6,389–7,302	3,787,569–4,328,650
Maryland	57,123–65,284	38,386,800–43,870,629
Massachusetts	45,705–52,235	53,173,612–60,769,843
Michigan	49,150–56,171	16,248,990–18,570,274
Minnesota*	29,520–33,737	55,083,654–62,952,747
Mississippi	28,921–33,053	9,734,953–11,125,660
Missouri	50,500–57,714	31,984,680–36,553,920
Montana	10,334–11,810	4,037,673–4,614,483
Nebraska	10,966–12,533	$ 5,113,698–5,844,227
Nevada	38,168–43,620	18,137,366–20,728,418
New Hampshire	7,618–8,706	3,871,395–4,424,451
New Jersey	97,114–110,988	49,353,480–56,403,977
New Mexico	22,925–26,200	7,647,780–8,740,320
New York	102,768–117,449	63,017,250–72,019,714
North Carolina	48,762–55,729	26,770,612–30,594,986
North Dakota	4,818–5,506	2,645,004–3,022,861
Ohio	83,382–95,294	43,225,303–49,400,346
Oklahoma	27,304–31,204	10,776,174–12,315,627
Oregon	22,945–26,222	8,177,471–9,345,681
Pennsylvania	78,896–90,167	41,202,871–47,088,995
Rhode Island	4,291–4,904	4,316,131–4,932,721
South Carolina	33,975–38,829	11,044,593–12,622,392
South Dakota	3,516–4,018	1,228,656–1,404,178
Tennessee**	28,809–32,924	19,618,880–22,421,578
Texas	368,537–421,186	130,020,030–148,594,320
Utah	38,870–44,422	11,567,606–13,220,121
Vermont	3,643–4,163	1,571,966–1,796,532
Virginia	49,752–56,859	30,507,795–34,866,051
Washington	34,198–39,084	17,441,089–19,932,673
West Virginia	16,536–18,898	4,964,683–5,673,923
Wisconsin	25,659–29,324	8,867,726–10,134,544
Wyoming	4,586–5,241	3,023,820–3,455,794
Average	**52,895–60,452**	**$ 26,378,749–30,147,142**
Total	**2,644,755–3,022,578**	**1,318,937,461–1,507,357,098**

* According to the CMS data, Minnesota's 2006 SCHIP PM/PM for chldren is $592, with an FMAP of 65%. However, after excluding parents, the children covered (on a point-in-time basis) consist of about 3,000 unborn children and 30 children under 2 years old in families with incomes between 275%-280% FPL. Thus, the $592 figure actually reflects the PM/PM for pregnant women. In contrast, Minnesota has 60,000 to 70,000 children below 275% FPL enrolled in its Minnesota Care (Medicaid waiver) program. The PM/PM for children in that program is $311 and the match rate is 50%. Thus, the Minnesota calculations in this table are based on using those lower figures to calculate more realistic estimates for the cost of expanding public coverage to uninsured children in Minnesota.

** Tennessee was not operating an SCHIP program in 2006. Therefore, 2007 data were obtained from the state's Cover Kids program at *http://www.covertn.gov/web/cover_kids.html.*

However, these costs can be avoided if Congress pursues a strong alternative to expanding SCHIP eligibility.

SCHIP Plus a Tax Credit: A Better Option for the States. The rising number of uninsured, growing health costs, and budget challenges have understandably put pressure on governors and policymakers. Although expanding SCHIP eligibility might bring additional federal dollars to states, it would not mitigate any of these pressures.

For states, the most promising alternative[10] in Congress to expanding SCHIP eligibility would be to couple a straight SCHIP reauthorization with a child health care tax credit for the same population targeted by proponents of an SCHIP expansion (children in families with incomes between 200 percent and 300 percent of the FPL). If Congress were to provide those families with a federal tax credit to offset the cost of private health insurance, children in those families would get the financial assistance they need to gain or keep quality private health insurance coverage. States would gain increased coverage among middle-income children, but without the need to expand public programs or to spend additional state tax dollars on health care.[11]

Furthermore, instead of simply substituting public programs for private insurance and increasing the cost of covering the uninsured, a tax credit would expand and preserve private insurance through direct tax relief for middle-class families. This alternative would enable states to focus their resources on uninsured children in lower-income families. It would also give states the flexibility to complement the tax credit with other state-based initiatives tailored to their particular circumstances or budget constraints.

Conclusion. State lawmakers should not be so focused on the prospect of more federal money resulting from an SCHIP expansion that they neglect to consider the costs to their states of matching those federal dollars. While an SCHIP expansion would certainly bring additional federal funding, states are likely to find themselves extending coverage to twice the number of children that are currently uninsured due to the crowd-out effects inherent in public program expansions. Because states already face fiscal challenges, a better option would be for Congress to keep SCHIP focused on lower-income children and pass a health care tax credit that could help middle-class families obtain or keep private health insurance.

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10. Senators Mel Martinez (R–FL) and George Voinovich (R–OH) co-sponsored The More Children, More Choices Act of 2007 (S. 2193). Representatives Marilyn Musgrave (R–CO) and Tom Price (R–GA) introduced companion legislation (H.R. 3888) in the House, along with 46 co-sponsors, including House Minority Leader John Boehner (R–OH). Also, a similar bill, the Healthy Kids Act of 2007 (H.R. 2147), was introduced earlier in the year by Representative Rahm Emanuel (D–IL).
11. However, nothing would preclude states from supplementing the size of the credit or providing other forms of assistance. The details of any additional measures would be left to the states.