PERSONALLY SPEAKING

Number 39 October 2007

WIDENING COVERAGE UNDER STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Edward J. O'Boyle, Ph.D.
Mayo Research Institute

The Congress of the United States is in the final stages of preparing legislation that would widen the coverage of SCHIP (State Children's Health Insurance Program) to provide protection for children not covered under the present program. President Bush has threatened to veto the bill while Congress stands ready with enough votes to override that veto. A review of some of the relevant sources of information might be instructive as to whether widening the coverage is advisable.

Congress claims that by raising the income threshold that qualifies for SCHIP protection to 400 percent of the poverty threshold approximately 9 million presently uninsured children under age 18 would qualify. The uninsured are defined as persons who are not covered by private insurance, Medicaid, state-sponsored or other government-sponsored health plans, or military plans.

There are 8,661,000 uninsured children under age 18. This estimate, according to the Census Bureau, overstates the number of uninsured children because health insurance coverage is underreported. A few of the children under age 18 no doubt would not qualify because their family income is higher than the 400-percent-of-poverty threshold. For a family of four with two related children under 18 the SCHIP income threshold would be $81,776 ($20,444 x 4). See Table 1 for the 2006 federal poverty thresholds by number of children under age 18 and family size. The data source in this report is: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, August 2007.

For those reasons, Mayo Research Institute estimates that no more than 7.5 to 8 million children would qualify at a SCHIP income threshold set at 400 percent of the poverty threshold. Our estimate assumes that at the SCHIP threshold no family otherwise paying for insurance out-of-pocket would drop coverage for their children in order to reduce their insurance premium knowing that those children then would qualify for SCHIP.

If, however, we assume that already insured families paying for that coverage out-of-pocket drop their coverage to qualify for SCHIP, the number of potentially eligible children would increase substantially above the 9 million the Congressional backers of an expanded SCHIP cite in their public statements. This assumption is based on what is called the "crowd out" effect.

Table 1.
POVERTY THRESHOLDS IN 2006 FOR FAMILIES WITH RELATED CHILDREN UNDER AGE 18 BY FAMILY SIZE

Family Size	Poverty Threshold
Two persons (one under 18)	$ 13,896
Three persons (one)	16,227
Four persons (two)	20,444
Five persons (two)	24,662
Six persons (three)	27,788
Seven persons (three)	32,182
Eight persons (four)	35,342
Nine persons or more (four)	42,945

Table 2 shows the number and percent of children potentially eligible under the 400-percent SCHIP threshold, along with four other thresholds. Under the 400-percent-of - poverty-threshold there are a total of 51,925,000 children potentially eligible for SCHIP. They represent 70.4 percent of all children in the United States below 18 years of age. Clearly, there is a huge pool of children potentially eligible for SCHIP under the "crowd out" effect. That number could be nearly 6 times greater than the 9 million assumed under the proposed legislation.

Table 2.
CHILDREN UNDER AGE 18 POTENTIALLY ELIGIBLE FOR SCHIP BY SCHIP THRESHOLD

SCHIP Threshold Percent of Poverty	Number Potentially Eligible	Percent of Under 18 Population
100	12,827,000	17.4
200	28,757,000	39.0
250	36,283,000	49.2
300	42,285,000	57.4
400	51,925,000	70.4

Table 3 displays the same information for families with related children under age 18. Thus 26,421,000 families or 66.4 percent of all families potentially are eligible for SCHIP under the most extreme "crowd-out" conditions.

There are several problems with the current bill; we call attention to only two. First, the bill does not differentiate children in families with the usual health care expenses from other families with children who are experiencing catastrophic expenses. There is, in other words, no distinction drawn on the basis of the severity of health-care needs.

Table 3.
FAMILIES WITH CHILDREN UNDER AGE 18 POTENTIALLY ELIGIBLE FOR SCHIP BY SCHIP THRESHOLD

SCHIP Threshold Percent of Poverty	Number Potentially Eligible	Percent of All Families with Children Under 18
100	5,822,000	14.6
200	13,627,000	34.3
250	17,592,000	44.2
300	20,903,000	52.5
400	26,421,000	66.4

Second, the bill does not establish clearly why 400 percent of the poverty threshold identifies families all of whom need public assistance to pay the health care expenses of their children. Where is the supporting evidence that shows conclusively that setting the threshold at 400 percent includes everyone who is needy and excludes everyone else? Or does that threshold really have little to do with need and everything to do with eventually providing universal coverage under a single-payer (federal or federal/state) program?

Two additional comments come to mind. First, the proposed legislation calls for financing the expansion of SCHIP by raising the federal cigarette tax from the present $.37 cents per pack to perhaps $1. Why should all of the burden of funding SCHIP fall on smokers? If one finds the increased cigarette tax acceptable, will it produce sufficient revenues to handle a large "crowd-out" effect?

Second, experience with both Medicare and Medicaid has shown that there is a "back-door" arrangement for financing these public programs. Reimbursement of expenses for services rendered by hospitals, clinics, physicians and other health-care providers is denied or cut drastically below the charges submitted for those services. No doubt, some providers acting strictly in their own self-interest inflate their charges. However, notice what happens to providers who otherwise are honest. They are forced to choose between (a) providing service knowing they will be paid less than what they are owed in justice, (b) providing service but becoming dishonest as a way of coping with the injustice of cutbacks in reimbursement, or (c) refusing service to those who are covered by reduced-reimbursement programs.

The result is health care decisions being made behind-the-scene by gatekeepers and bean counters, reduced access to care because some providers no longer make themselves available for consultation with their professional colleagues knowing they will not be reimbursed adequately, hospitals that increasingly find difficulty in making ends meet because they cannot refuse service to any uninsured person who shows up in the emergency department and is unable to pay, and physicians fully certified across a range of subspecialties turning away from their subspecialty areas and turning in the direction of

patients who are willing to pay for such aesthetic procedures as botox, restylane, laser hair removal, treatment of age spots and spider webs.

SCHIP at 400 percent of poverty very likely will make these problems even worse. That's what happens when a surge in demand is not matched on the supply side.

Edward J. O'Boyle is Senior Research Associate with Mayo Research Institute. Since completing his doctorate in economics from Saint Louis University more than 35 years ago, Dr. O'Boyle has specialized in economic research and analysis increasingly from the perspective of the human person engaged in everyday activities both as a unique individual and as a community member. In January 2004 the Association for Social Economics conferred on Dr. O'Boyle its prestigious Thomas Divine Award for lifetime contributions to social economics and the social economy. He taught economics at a state university in Louisiana for 30 years prior to his retirement in 2007.

Mayo Research Institute   1217 Dean Chapel Road   West Monroe, Louisiana 71291
318-396-5779   edoboyle@earthlink.net