Health Policy Online
Timely Analyses of Current Trends and Policy Options
THE URBAN INSTITUTE No. 17, OCTOBER 2007

Can a Child Health Insurance Tax Credit Serve as an Effective Substitute for SCHIP Expansion?

Linda J. Blumberg and Genevieve M. Kenney

As the State Children's Health Insurance Program (SCHIP) has come up for reauthorization, the coverage of children with incomes above 200 percent of the federal poverty level (FPL) has become a contentious issue (Hederman 2007; Herrick and Baumann 2007). Today, Senator Mel Martinez proposed providing refundable tax credits to families with incomes between 200 and 300 percent of the FPL (Wall Street Journal 2007). Under the proposal, families would receive a credit of $1,400 per child that could be used to purchase health insurance policies in the private market. A variant on this approach has been recently proposed by the Heritage Foundation (Butler and Owcharenko 2007).

In contrast, the conference bill, H.R. 976, which the House and Senate passed earlier this year and the president vetoed, would allow states to continue enrolling children with incomes between 200 and 300 percent of the FPL in SCHIP coverage. Coverage through SCHIP under the conference bill, consistent with current program guidelines, would provide benefits to enrollees that are equivalent to benchmark plans in each state, such as comprehensive employer-based plans,[1] and would limit family cost-sharing requirements. The Congressional Budget Office (CBO) projects that the bill would result in 3.8 million children gaining coverage who would otherwise have been uninsured, some of whom would be in the 200 to 300 percent FPL income bracket (CBO 2007).

To date, an estimated 92 percent of SCHIP enrollees have family incomes below 200 percent of the FPL, according to a Congressional Research Service study from earlier this year (Peterson and Herz 2007), and almost all the rest have incomes between 200 and 300 percent of the FPL (Guyer 2007). In recent years, an increasing number of states have expanded eligibility under SCHIP in order to address growing affordability problems facing moderate-income families (Cohen-Ross, Cox, and Marks 2007; Georgetown Center for Children and Families 2007a). According to the most recent estimates available, 1.4 million children with incomes between 200 and 300 percent of the FPL are uninsured (Urban Institute tabulations of the 2007 Current Population Survey). As of May 2007, 18 states had eligibility thresholds under SCHIP that were above 200 percent of the FPL (8 between 200 and 250, 9 between 251 and 300, and 1 [New Jersey] above 300), with almost all of these families paying premiums to enroll their children.

In this analysis, we compare the financial burdens associated with covering children under SCHIP and under a refundable tax credit proposal similar to that suggested by Senator

[1] SCHIP guidelines permit states to choose from three benchmark options when designing benefits for their programs. The three benchmark options are a state employee health plan, the Blue Cross Blue Shield standard option plan offered to federal employees and the HMO plan with the greatest enrollment in the state. See CMS "State Children's Health Insurance Program Summary," 2005. The conference bill also requires benchmark dental coverage and, for states that offer mental health coverage, parity with medical and surgical benefits in terms of restrictions on those benefits. See Georgetown Center for Children and Families. "Summary of the Children's Health Insurance Program Reauthorization Act of 2007 (2007b)."

Martinez, providing a $1,400 per child subsidy. This is not a comprehensive evaluation of either proposal since it only focuses on the implied family financial burdens for those between 200 and 300 percent of the FPL. Among the other issues we do not examine are the differential administrative costs associated with a tax credit as opposed to SCHIP;[2] ensuring a guaranteed source for purchasing private insurance; determining an appropriate set of benefits and cost-sharing requirements; a mechanism for broadly spreading the costs of high medical need children; and protections against marketing fraud by insurers[3].

For illustrative purposes, we use prototypical two-parent/two-child families residing in Georgia at 215 percent of the FPL ($44,400 in 2007). We chose Georgia because it is one of the states that currently cover some children over 200 percent of the FPL (state eligibility goes up to 235 percent of the FPL). We chose 215 percent of the FPL as it is roughly the midpoint of this income range. Under the conference bill Congress passed, uninsured children with family incomes between 200 and 235 percent of the FPL in Georgia who do not have access to employer coverage would continue to be eligible for SCHIP; however, they apparently would no longer be eligible under the Martinez proposal.

Currently, Georgia families with incomes between 200 and 235 percent of the FPL pay premiums to enroll their children in SCHIP that range from $28 to $35 per month per child (with a family maximum of $70 per month). Children have a comprehensive benefit package that includes dental and vision care and no copayments or deductibles are charged. Families have a choice of two or three managed care plans (depending on the county in which they live).

Analysis

We assume that child-only coverage would be purchased using the tax credit in the private individual market, as child-only policies are not available through employers and roughly 80 percent of uninsured children between 200 and 300 percent of the FPL do not have a parent with private coverage on whose policy they might be added (Urban Institute tabulations of the 2007 Current Population Survey). Private individual insurance premiums for child-only policies were obtained from http://ehealthinsurance.com for 6-year-olds living in the Atlanta metropolitan area. While a range of options were available, we chose the PPO plan closest to SCHIP of the private options provided in terms of benefits and cost-sharing (some of the other offered plans had lower premiums, but these would leave people with higher out-of-pocket liabilities). Even so, the individual market plan has substantially higher cost-sharing requirements and benefit limitations, which would leave a family vulnerable to high out-of-pocket costs in the event of a child's illness or injury. For example, the policy has a $500 deductible per child with 20 percent coinsurance after the deductible, subject to a $2,000 out-of-pocket maximum per child. The deductible does not apply to the out-of-pocket maximum, and there is a separate deductible of $100 per child for prescription drugs. It is unclear from the information on ehealthinsurance.com whether copayments apply to the out-of-pocket maximum or not (they often do not in such policies), but copayments are $25 per physician office visit and $15 to $100 per prescription, depending on the drug category. There is a $3,000 lifetime maximum benefit on mental health services, and a $3 million lifetime maximum on benefits overall. There is no coverage for dental or eyeglasses, unlike current SCHIP coverage in Georgia.

[2] See, for example, GAO (2007).
[3] See, for example, House Ways and Means Committee (1993) on experiences with the Bentsen child tax credit.

The annual premium for this plan is approximately $2,420 per child, or $4,840 for a two-child family. As in most states, premiums in the Georgia individual insurance market may be much higher for children with health problems, making these premiums a lower bound. The proposed refundable tax credit that families could use to offset the costs of this private plan would be $1,400 per child, leaving the family to pay about $2,040 in premiums to cover both children with this policy. This amounts to 4.6 percent of gross income and 5.1 percent of after-tax income for the family at 215 percent of the FPL, prior to any utilization.

For a family with healthy children, we assume that a typical year would entail three physician office visits per child plus one prescription per child. Since the cost of this care falls within the deductible of each policy, the family bears all of it.[4] Adding the consequent out-of-pocket costs would raise the family's financial burden to 6.6 percent of income (or 7.4 percent of the monthly family budget) as shown in Figure 1. If, however, the children were considered healthy at the time that the insurance was purchased but later developed illnesses or new health problems (e.g., that involved many physician visits, multiple prescription drugs, and possibly a hospital stay), the family's expenses would be substantially higher under this policy. For example, if each child incurs expenses that bring them to half of the out-of-pocket maximum (covered expenditures of $5,500 apiece),[5] the family financial burden would be over 11 percent of their gross income or 12.6 percent of after-tax income, not counting expenses (such as dental care) not covered under the policy at all. If, instead, the children have medical conditions prior to application for insurance in the individual market, their premiums would likely be much higher than those used here, or they may be unable to purchase a policy at any price.

The Georgia SCHIP premium, by contrast, for these prototypical families at 215 percent of the FPL is $31 per child per month (for children under 6 years of age, no premiums are charged). The premiums required to cover both children (assumed to be over six) in our prototypical family under SCHIP thus amounts to 1.7 percent of gross income, 1.9 percent of after-tax income. As indicated above, the coverage under SCHIP is comprehensive, requiring no deductibles or copayments of any kind, and there are no lifetime maximums on benefits, regardless of type of service. Thus, the total financial exposure for medical care for both children is the SCHIP premium alone, which was $744 in 2007.

Implications

The tax credit Senator Martinez proposes would involve significant financial burdens for families with healthy children and even larger burdens for families whose children have health problems. Since both experience and the economic literature are clear that higher family premium payments reduce enrollment, the tax credit proposal is likely to reach fewer uninsured children than would an SCHIP expansion.[6] The central problem with the tax credit proposal is

[4] The average cost for a child's physician office visit is estimated at $132 and the average prescription drug cost for a child is estimated at $59, based upon data from the Medical Expenditure Panel Survey-Household Component, inflated to 2007 dollars using the projected rate of growth in per capita private health insurance expenditures.
[5] The first $500 per child would be paid by the parents to cover the deductible, and they would pay $1000 in co-insurance per child on the next $5000 in covered expenditures.
[6]. L. J. Blumberg, L. M. Nichols, and J. S. Banthin, "Worker Decisions to Purchase Health Insurance." *International Journal of Health Care Finance and Economics* 1, no. 3–4 (2004): 305–26;

that, to take advantage of it, most families with uninsured children will need to purchase policies in the nongroup market. While this analysis has focused exclusively on one state, the individual private insurance market in Georgia is like that in many states. Barring any legislative language that would prevent insurers from using current common practices, children with even minor health problems may be denied coverage outright or may be offered coverage at much higher premiums than shown here. Alternatively, insurers are permitted to offer policies that permanently eliminate coverage for particular health conditions, body parts, or body systems. This means that a child with asthma may have his respiratory system excluded from a policy; a child with allergies may only be offered a policy that does not cover prescription drugs.

There are extensive limitations and complexities inherent in most states' individual insurance markets. As a consequence, a tax-credit approach similar to those the Heritage Foundation and Senator Martinez suggest will only lead to guaranteed access to adequate and affordable health insurance coverage for children if a number of major additional policy changes are implemented as well. In contrast, over 10 years, SCHIP has successfully addressed affordability and accessibility issues associated with insuring low- and modest-income children, regardless of health status, medical need, or geographic differences in health care costs.

References

Butler, S., and N. Owcharenko. 2007. "SCHIP Plus a Tax Credit: A Compromise Health Insurance Plan for Kids." The Heritage Foundation. Web Memo No. 1652.

Centers for Medicare and Medicaid Services. 2007. "Georgia Title XXI Program & Title XXI Amendment Fact Sheet." http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/GACurrentFactsheet.pdf.

———. 2005. "State Children's Health Insurance Program Summary." http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp

Cohen-Ross, D., L. Cox, and C. Marks. 2007. "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." Kaiser Commission on Medicaid and the Uninsured.

Congressional Budget Office. 2007. "CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the House Amendments to the Senate Amendments to H.R. 976, the Children's Health Insurance Program Reauthorization Act of 2007." Washington, DC: CBO.

M. E. Chernew, K. D. Frick, and C. McLaughlin, "The Demand for Health Insurance Coverage by Low-Income Workers," *Health Services Research* 32, no. 4 (1997): 453–70; G. Kenney, J. Hadley, and F. Blavin, "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43, no. 4 (2007): 345–61; J. Hadley, J. Reschovsky, P. Cunningham, G. Kenney, and L. Dubay, "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43, no. 4 (2007): 362–77.

Ehealthinsurance.com. Health Insurance, Medical Insurance, Individual Health Insurance Quotes. http://www.ehealthinsurance.com.

GAO. 2007. *Trade Adjustment Assistance: Changes to Funding Allocation and Eligibility Requirements Could Enhance States' Ability to Provide Benefits and Services*. GAO-07-702. Washington, DC: GAO.

Georgetown Center for Children and Families. 2007a. "Children's Health Coverage: States Moving Forward." Washington, DC: Georgetown Center for Children and Families.

———. 2007b. "Summary of the Children's Health Insurance Program Reauthorization Act of 2007." Washington, DC: Georgetown Center for Children and Families.

Guyer, J. 2007. "Coverage of Uninsured Children in Moderate-Income Families Under SCHIP." Washington, DC: Georgetown Center for Children and Families.

Hederman, R. 2007. "Expanding SCHIP into AMT Territory: SCHIP Plan Would Extend Welfare to Wealthy Families." The Heritage Foundation. Web Memo No. 1546.

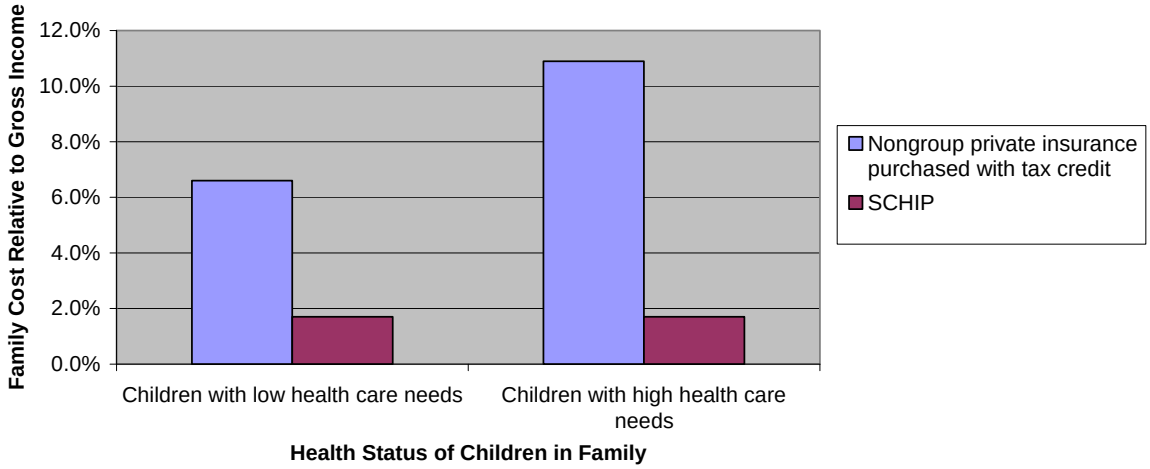
Herrick, D., and M. Baumann. 2007. "SCHIP Expansion: Robin Hood in Reverse." National Center for Policy Analysis. Brief Analysis No. 589.

House Ways and Means Committee, Subcommittee on Oversight. 1993. "Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit." WMCP: 103-14, 103rd Cong., 1st Sess.. Washington, DC: House Ways and Means Committee.

Peterson, C., and E. Herz. 2007. "Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees." Washington, DC: Congressional Research Service.

Wall Street Journal. 2007. "Health-Care Feud Intensifies." October 18, 2007, A8.

Figure 1. Financial Burdens of Obtaining Children's Coverage under SCHIP Conference Bill (H.R. 976) and the Martinez Tax Credit Bill



Source: Urban Institute calculations.
Note: Data are for prototypical two-parent/two-child families at 215 percent of FPL, residing in Georgia. The estimates include the cost of obtaining a child-only health insurance policy that most closely resembles SCHIP in the nongroup market in Georgia based on premiums reported on http://www.ehealthinsurance.com for a healthy child living in the Atlanta Metropolitan Area. Children with low health care needs are defined as those with three physician visits and one prescription per child, and children with high health care needs are defined as those that use enough health services to bring them to half of the out-of-pocket maximum under the plan. Private insurance premiums are lower bounds as they reflect price quotes for healthy children.

Copyright © 2007. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

The authors are grateful for the advice and suggestions of Stan Dorn, John Holahan, Kim Rueben, Len Nichols, and Steve Zuckerman and for the research assistance of Allison Cook, Jennifer Pelletier, and Aaron Lucas. The views expressed are those of the authors and should not be attributed to the Urban Institute, its sponsors, staff, or trustees.