Key Considerations When Estimating the Cost of
Expanding Coverage for Children

In many respects, it would seem easy to estimate the cost of expanding coverage to more children—simply multiply the number of children who will be covered by the per capita cost of serving such children. In practice, however, it can quickly become more complicated, especially given data shortcomings and the reality that estimators must make numerous educated guesses about how the state, private employers, and families will respond to a proposed expansion.

The key elements of a more detailed cost estimate typically include:

1. **Number of uninsured children in expansion range who will be covered.** A state typically will look at the number of uninsured children in the proposed expansion range, relying on Census Bureau data or a state-based survey, and then multiply by the share of eligible uninsured children who are expected to participate. It can be difficult to accurately predict a participation rate, especially because it will be a function of how the expansion is structured (e.g., the participation rate will be lower if premiums are high) and the adequacy of simplification and outreach efforts. As a benchmark, note that the Urban Institute has estimated the participation rate in SCHIP on a nationwide basis at 75 percent.

2. N**umber of already-eligible uninsured children who will enroll.** It is widely agreed that expanding Medicaid or SCHIP results in more already-eligible children signing up for coverage. In recent state expansions, some 50 to 75 percent of new enrollment has occurred among already-eligible children. To take this effect into account, states typically use one of two options: 1) calculating the additional number of children that will enroll if uninsured, already-eligible children the participation rate among already-eligible children increases, or 2) assuming that the new enrollment attributable to the expansion will be matched (or even exceeded) by enrollment among already-eligible children (e.g., assuming that for each 100 new children who enroll, there will be 100 already-eligible children).

3. **The effect of "crowd out".** Estimates also may take into account the extensive research indicating that expanding Medicaid/SCHIP further up the income scale will cause some children to lose private coverage and, instead, to enroll in public coverage. Dr. Lisa Dubay, who has extensively researched crowd out, has used the assumption that 10 percent of children with private coverage in the affected income range will enroll in public programs after an expansion.[1] In some states, however, state-specific studies or program design decisions can be used to argue for a higher or lower "crowd out" rate.

4. **Cost per child.** To generate a cost per child, estimators typically will begin with data from the state's existing Medicaid and SCHIP programs on the total (state and

federal) cost of serving a child, and then make adjustments to reflect various factors, such as: 1) inflation since the year for which the latest data are available; 2) any expected changes in reimbursement rates; 3) and, if applicable, the effect of premiums on the cost of covering children in the expansion range. Some estimators also "discount" the per capita cost of serving children they anticipate will enroll as a result of an expansion, particularly already-eligible children, on the theory that they are likely to be healthier.

5. **Medicaid and SCHIP matching rates.** After estimating the total per capita cost of serving children in SCHIP and Medicaid, estimators multiply these figures by the state's matching rate to generate a true "state" per capita cost of serving such children.

6. **Phasing in of coverage.** It would be a problem to assume that participation rates will reach their expected levels right away. Typically, it takes at least six months and, more frequently, a year for this to occur. So, it is reasonable to assume that expansion costs also will phase-in.

7. **Other issues.** A host of other considerations can emerge when estimating the cost of expansions, such as:

   • The role of income disregards in effectively increasing the universe of children who are eligible for an expansion;

   • The need to use 100 percent state funds for immigrants and/or children above 250 percent of the federal poverty level given the August 17th directive;

   • Adjustments that should be made as a result of the inadequacies of state-level data on the health insurance status of children.

   • The possibility that a state will accrue offsetting savings in other areas, such as if fewer children will need to rely on a state-financed uncompensated care pool.

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[1] Note that the 10 percent assumption reflects the <u>share of children with private coverage</u> who will drop/lose it and enroll in a public program after an expansion. This is a different way of expressing the phenomena of crowd out, which more traditionally is presented as the <u>share of children enrolled in public coverage who otherwise would have had private coverage</u>.