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Health Issues

Stay Focused on SCHIP

By Grace-Marie Turner
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Congress and the White House are poised for a showdown over reauthorization of the State Children's Health Insurance Program before the program expires on September 30, with both houses having passed legislation that the president has vowed to veto.

While President Bush and majorities in both houses of Congress support reauthorization of SCHIP, each offers a very different approach. The president wants Congress to focus on the original intent of the program – to provide coverage for children whose families make too much for them to qualify for Medicaid but too little to afford private coverage. The administration released a directive to state officials in August clarifying existing law and directing the states to focus on core populations the program is designed to serve.¹

The House passed its SCHIP bill by a nearly party-line vote of 225-204 on August 1 that includes greatly-expanded eligibility for SCHIP and other major provisions not directly related to the program. Eighteen Senate Republicans joined 48 Democrats

and two Independents in approving a somewhat more modest SCHIP bill by a veto-proof 68-31 vote on August 3. Members will attempt to reconcile the significant differences between the House and Senate versions, but Senate Republican Whip Trent Lott has said if the final conference report “gives one iota beyond” the provisions in the Senate bill, Republicans will withdraw their support.

That means that in order to override a presidential veto, House conferees would have to give up all of their legislative provisions and adopt the Senate bill and then convince at least 64 members who voted against the House bill to support the compromise – a highly unlikely outcome.

As a result, it would be wise to begin consideration of measures that focus on SCHIP and on fixing problems with the 10-year old program to move the debate forward toward reauthorization legislation that is more likely to be successful. Expanding access to health insurance coverage, through SCHIP or other means, is a very different, more complex, and much more expensive agenda than

reauthorization of this existing program. Mixing reauthorization and expansion is confusing the public, and we are at risk that policy decisions about the future of our health sector could be made without a full conversation about the implications. Therefore, the legislative debate over expansion of SCHIP should be separated from the debate over reauthorization.

Here is our nine-point plan for reauthorization of SCHIP²:

Focus on the lower-income children most in need. An estimated two-thirds of uninsured children³ are eligible for either SCHIP or Medicaid under current law. Congress would be wise to create new incentives for the states to find and enroll these children – and keep them enrolled – before expanding the program to children in families earning 400 percent of poverty and above.

Avoid crowd out. The Congressional Budget Office estimates that at least one child would lose private insurance for every two new children enrolled in SCHIP if the program were expanded into these higher-income categories.⁴ The CBO says that 89 percent of children in families with incomes between 300 and 400 percent of poverty already have private health insurance and 77 percent of children in families earning 200 to 300 percent of poverty have private coverage.⁵ It makes little sense to substitute public dollars for private dollars for already-insured children when resources are needed to provide health coverage to those without any health insurance. Further, expanding coverage to children in higher-income categories inevitably will focus state energies on the expansion populations rather than on lower-income children with fewer options to obtain coverage.

Give more flexibility to states. Research has demonstrated that parents and children are more likely to get needed health care if the family is insured.⁶ SCHIP subsidies could be used to allow

parents to purchase the health coverage they believe is best for their children, including adding them to policies that may be offered at their workplaces, making it more likely that the parents will adopt the private coverage and insure their children as well. The Senate bill provides more flexibility for this premium assistance and could be a starting point for compromise.

Avoid new taxes. The added federal cigarette taxes (61 cents a pack in the Senate bill and 45 cents in the House bill) and a new tax on health insurance in the House bill would be unnecessary if the legislation were to focus on capping access to SCHIP at 200 percent of poverty.⁷

Correct the funding formulas. In order to encourage states to participate in SCHIP when it was first created, Congress provided a higher federal funds matching rate for SCHIP than for Medicaid. It makes little sense for the federal government to offer states a higher match rate to put higher-income children on SCHIP than to enroll lower income children in Medicaid. The average federal match for SCHIP is 69 percent and 57 percent for Medicaid. Congress would be well-advised to reconcile these upside-down funding formulas to rationalize the incentives.

Keep SCHIP as a capped funding allocation to the states to avoid creating another entitlement program. The House bill would permanently reauthorize SCHIP and change the funding formulas for states, risking creating another entitlement program where there are unlimited calls on federal funds to match state spending. Entitlement programs pose a sizeable future threat to taxpayers. Creating a new open-ended entitlement without a full public debate would be a mistake.

Treat all states alike. An estimated 14 states currently have adults enrolled in SCHIP, and at least seven states have enrolled people at or above 300 percent of the federal poverty level.⁸ Both bills

have provisions that would allow for some grandfathering of these measures, but that would mean states would be treated differently depending upon their success in winning early waiver requests or enacting income eligibility expansions. This inequity will not stand over time, and the sooner it is corrected, the more stable the program will be.

Maintain discipline. Congress has begun passing separate legislation to bail out states that have overspent their SCHIP allocations. This rewards states that have done a poor job of managing their allocations and punishes states that have been more fiscally responsible. In order for Congress, and not the states, to make federal spending decisions,

Congress needs to notify the states that the federal SCHIP funding allocations will be enforced.

Focus on SCHIP. If Congress concentrates its energy on updating and focusing the 10-year-old SCHIP program to do a better job of meeting its original intent, the program can be reauthorized and Congress then can have a more open debate about other health reform priorities.

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ENDNOTES

¹ Letter from Dennis Smith, Director, Center for Medicaid and State Operations, Center for Medicare & Medicaid Services (CMS), to State Health Officials, August 17, 2007, at www.cms.hhs.gov/smdl/downloads/SHO081707.pdf.

² Much of this paper originally appeared as a post on the new *Health Affairs* blog on August 16, 2007 at <http://healthaffairs.org/blog/2007/0816/schip-september-showdown/>.

³ Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* 26 (November 30, 2006): w22-w30, online at <http://content.healthaffairs.org/cgi/content/abstract/26/1/w22?etoc>.

⁴ Congressional Budget Office, "Estimated of Changes in SCHIP and Medicaid Enrollment of Children Under H. R. 3162, the Children's Health and Medicare Protection Act of 2007, as Ordered Reported by the Committee on Ways and Means on July 27, 2007," July 27, 2007, at www.cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf.

⁵ Congressional Budget Office, "The State Children's Health Insurance Program," May 2007 at <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf>.

⁶ Centers for Disease Control and Prevention. *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2005*. National Center for Health Statistics, DHHS Publication (PHS) 2006-1569, 2006. http://www.cdc.gov/nchs/data/series/sr_10/sr10_231.pdf.

⁷ A Comparative Effectiveness Research program would be funded in its first three years by a transfer of money (or rather, spending authority, with no actual cash to back it up) from the Medicare Hospital Insurance Trust Fund. In later years, the funding would come from a new tax on private health insurance policies and Medicare Part B coverage set by a formula. The tax would start out at about \$2 per insured life (or about \$8 a year for a family of four). The fee would rise over time. Source: IRET Congressional Advisory No. 226, "SCHIP Reauthorization: Renew or Expand?" by Stephen Entin, Institute for Research on the Economics of Taxation, August 1, 2007, Washington, D.C. <http://www.galen.org/fileuploads/ADVS-226.pdf>.

⁸ "States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization," Kathryn G. Allen, March 1, 2007. GAO-07-558T <http://www.gao.gov/new.items/d07558t.pdf>.

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