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The Future of SCHIP: Family Freedom or Government Control?

Nina Owcharenko

The reauthorization of the State Children's Health Insurance Program (SCHIP) has brought the issue of health care coverage, especially for children, to the forefront. Recent proposals by House Energy and Commerce Committee Chairman John Dingell (D-MI) and Senator Hillary Clinton (D-NY) and by Senators John Rockefeller (D-WV) and Olympia Snowe (R-ME) would expand the role of government in the delivery of health care by allowing more of America's children to qualify for government-run health care. This would be a big mistake, chipping away at private coverage and placing a great burden on taxpayers. A better solution would be to address the displacement of private coverage and growing dependence on the government for health care. Reform should embrace the advantages of the private sector and empower families to make their own health care decisions.

Expanding the Government's Role. The Children's Health First Act (Dingell/Clinton, H.R. 1535 and S. 895) and the Children's Health Insurance Program Reauthorization Act (Rockefeller/Snowe, S. 1224) share a similar philosophy and approach to expanding coverage through SCHIP. Underlying the bills are three broad policies:

- **Radically expanding eligibility and enrollment.** Both bills would expand SCHIP income eligibility levels beyond the current 200 percent of the federal poverty line (FPL) threshold ($40,000 annual income for a family of four). Dingell/Clinton would expand eligibility to 400 percent of the FPL ($82,600), while Rockefeller/Snowe would expand eligibility to 300 percent of the FPL, ($61,950) and give states that already provide benefits to families at or above 300 percent of the FPL the ability to raise the SCHIP threshold another 50 percent.

  In addition, both bills would allow states to expand coverage to new populations, such as legal immigrants, pregnant women, and children of state employees.[1] These expansions would dramatically change the course and purpose of SCHIP, transforming it from a targeted program for uninsured children from lower-income families to a government-run health care plan for the middle class.

  The bills also focus on maximizing enrollment by conditioning additional federal funding on increased outreach. These efforts would diminish the unique, block grant approach of SCHIP, where expansions are balanced by fiscal constraints, and replace it with a pseudo-entitlement, where eligibility guarantees access.
- **Further extending benefit mandates.** Both bills would change the benefit structure of SCHIP. For example, the bills would expand the application of Early, Periodic, Screening, Diagnosis, and

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(202) 546-4400 • heritage.org

Treatment (EPSDT) services in SCHIP, establishing a virtually unlimited benefits package for SCHIP enrollees. These bills would also raise the standard requirement for the state employees' health plan benchmark option.[2] Because SCHIP primarily targets working families, not the truly indigent, the SCHIP benefit package was intended to more closely resemble private coverage rather than Medicaid, the program for the truly poor. These proposed benefit changes are a departure from the original intent of SCHIP and would put the program on a path to one-size-fits-all government-mandated benefits.

In addition, while both proposals attempt to address and integrate access to employer-based coverage, they ignore critical administrative reforms that currently make this option costly and complex. [3]

- **Significantly increasing federal obligations.** Significant increases in federal and state spending on SCHIP will be necessary to fund these changes. These proposals aim to provide enough assistance to maintain current eligibility levels, to accommodate the "eligible but not enrolled" population, and to support the new expansion populations. Rockefeller/Snowe, for example, would more than double federal obligations to the program by authorizing over $58 billion over five years.

  The original structure of SCHIP was based on a fixed appropriation of $40 billion over 10 years. This was done to provide federal assistance to the states without creating another open-ended entitlement. Neither of these proposals appears to retain this measured approach. Instead, funding would most likely be based on maximizing enrollment rather than fiscal prudence.

The Dangers of Expanding SCHIP. The policy implications of expanding SCHIP eligibility, benefits, and financing are significant. In addition to ultimately creating a pathway to a government-based health care system, these proposals would:

- **Expand dependency on government for the delivery of health care services.** A growing number of children are dependent on the government for health care. In 1998, about 28 percent of children were enrolled in Medicaid or SCHIP.[4] By 2005, that number had skyrocketed to 45 percent.[5] If SCHIP were to raise its eligibility threshold to 400 percent of the FPL, as suggested under Dingell/Clinton, over *71 percent* of children would be eligible for one of these programs.[6]

  Moreover, efforts to expand SCHIP further up the income scale and to adults point the way toward future expansions of government-run health care. The result would be that more individuals would lose their ability to make personal care decisions, leaving them to depend on government to determine access and treatment.

- **Displace private coverage options.** There is no doubt that public program expansions reduce the availability of and enrollment in private coverage. A recent analysis by the Congressional Budget Office (CBO) found that increases in SCHIP coverage reduce private coverage of children by 25 to 50 percent.[7] Moreover, as CBO also explains, most estimates probably understate the "crowd out" effect because they focus

1. The Dingell/Clinton bill goes further by creating a new "buy-in" option for non-eligible populations.
2. Dingell/Clinton also raises the actuarial equivalence test for additional benchmark plan services from 75 percent to 100 percent.
3. Dingell/Clinton also establishes a new employer subsidy scheme to persuade employers to keep coverage, but that coverage must contain benefits comparable to those in SCHIP.
4. Centers for Medicare and Medicaid Services, "The State Children's Health Insurance Program," Presentation, March 5, 2007, p. 19.
5. *Ibid*, p. 20.
6. The Honorable Michael Leavitt, Secretary, U.S. Department of Health and Human Services, Remarks at the American Enterprise Institute, April 24, 2007, at *www.hhs.gov/news/speech/2007/sp20070424a.html*.
7. Congressional Budget Office, "The State Children's Health Insurance Program," May 2007, p. 12, at *www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf*.

solely on children's coverage and do not consider the effects on family and other adult coverage.[8]

Expansions would further endanger today's prevalence of private coverage. In 2005, 53 percent of individuals with annual incomes between 150 and 199 percent of the FPL had private coverage; 69 percent with incomes between 200 and 299 percent of the FPL had private coverage; and 87.6 percent above 300 percent of the FPL had private coverage.[9] Further, CBO estimates that 77 percent of children living in families with incomes between 200 and 300 percent of the FPL have private coverage, as do 89 percent of children in families with incomes between 300 and 400 percent of FPL, and proposals to expand public coverage would likely impact these high levels of private-sector coverage.[10]

- **Increase the burden on taxpayers.** Expanding SCHIP would place new burdens on federal and state taxpayers.[11] The extent of these new obligations would depend on the scope of expansion. To maintain the program in its current form, $8 billion in new federal spending over five years will be necessary.[12] The House and Senate budget agreements far exceed this amount and set aside a reserve fund of $50 billion over five years for SCHIP reauthorization. But, the Center for Budget and Policy Priorities suggests that the $50 billion will still not be enough, estimating that "the additional federal cost of immediately enrolling the roughly 6 million eligible uninsured children easily exceeds $50 billion over five years."[13]

Moreover, if recent pleas from so-called shortfall states—states that have exceeded their federal SCHIP allotments—for another federal bailout of their SCHIP programs are any indication, states will likely continue to turn to the federal government for additional funding above and beyond original allotments. [14]

Designing an Alternative. Members of Congress should devise an alternative to counter the heavy-handed government solutions offered in Dingell/Clinton and Rockefeller/Snowe. This alternative should provide a consumer-driven, market-based solution that reinforces private coverage and puts families in control of their health care decisions. There are three key components to such an alternative:

- **Provide a meaningful health care tax credit to low-income families.** Federal policymakers should reform the tax treatment of health insurance to target federal tax relief to those who need it most. Today's tax code discriminates against lower-income workers, increasing the demand for expansions of government-run health care programs. Federal policymakers should provide the lower-income families targeted by the SCHIP expansion proposals with a refundable, advanceable, and assignable tax credit to assist them in obtaining private coverage.
- **Convert SCHIP to a defined contribution model.** Policymakers should also work to convert SCHIP from a defined benefit to a defined contribution model. Chairman Dingell and Sen-

8. *Ibid.*
9. Private coverage includes employer-based coverage and the direct purchase of coverage. These numbers are based on Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Employee Benefit Research Institute, *Issue Brief* No. 298, October 2006, p. 14 at *www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20061.pdf*.
10. See Congressional Budget Office, "The State Children's Health Insurance Program," p. 12.
11. Ironically, under proposals like Dingell/Clinton, some of the same families struggling under the Alternative Minimum Tax (AMT) could qualify for SCHIP coverage. See Mike Franc, "States' Addiction to Welfare Corrupts Federalists System," Heritage Foundation *Commentary*, March 3, 2007, at *www.heritage.org/Press/Commentary/ed030307a.cfm*.
12. Congressional Budget Office, p. 14.
13. Edwin Park and Robert Greenstein, "Options Exist for Offsetting the Cost of Extending Health Care Coverage to More Low-Income Children," Center on Budget and Policy Priorities, April 12, 2007, at *www.cbpp.org/3-8-07health.htm*.
14. See Nina Owcharenko, "The Truth about SCHIP Shortfalls," Heritage Foundation *WebMemo* No. 1381, March 5, 2007, at *www.heritage.org/Research/HealthCare/wm1381.cfm*.

ator Clinton estimate that SCHIP spends an average of $1,220 per child.[15] Under a defined contribution model, families would be able to use that money to enroll their children in private coverage. This would reinforce the private health care market—which the majority of workers prefer[16]—and help to unify families under a private insurance plan of their own choice. Moreover, this contribution could supplement a federal health care tax credit, as described above.

- **Encourage state-based experimentation on health reform.** Congress should encourage and facilitate innovation for health care reform at the state level. Too many overlook the role states play in regulating their insurance markets and how this affects the affordability and availability of coverage. Members of Congress should adopt a federalism approach for health care, much as they did with welfare reform. In addition, policymakers should consider ideas such as the President's Affordable Options[17] concept and health insurance exchanges[18] to promote and facilitate the private health care coverage options for families.

Conclusion. The SCHIP proposals put forth by Chairman Dingell and Senator Clinton and Senators John Rockefeller and Snowe would be a step toward establishing a government-run health care system. These incremental approaches would increase dependency on the government for the delivery of health care, chip away at private coverage, and burden taxpayers.

Policymakers must decide whether to place more of the health care system under government control or to preserve and improve the private sector system. Federal policymakers should enact a low-income health care tax credit, convert SCHIP to a defined contribution program, and encourage market-based reforms at the state level. The alternative—ever-larger expansions of government health care—would further stifle private coverage and reduce Americans' ability to exercise choice in health care.

—Nina Owcharenko is Senior Health Policy Analyst in the Center for Health Policy Studies at The Heritage Foundation.

15. See House Committee on Energy and Commerce, "Children's Health First Act, Legislative Summary," at *http://energycommerce.house.gov/chfa/031407%20Kids%20Bill%20Summary.Final.pdf*.
16. Jennifer N. Edwards *et al.*, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey," *Issue Brief*, Commonwealth Fund, August 2002, p. 7, at *www.commonwealthfund.org/usr_doc/edwards_erosion.pdf?section=4039*.
17. See The White House, "Strengthening Health Care," at *www.whitehouse.gov/infocus/healthcare*.
18. See Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *www.heritage.org/Research/HealthCare/wm1230.cfm*.