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SCHIP Reauthorization: Congress Should Beware of Creating a New Entitlement

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This year's expected reauthorization of the State Children's Health Insurance Program (SCHIP) has sparked congressional interest in expanding the program. On this issue, Members of Congress should follow some simple advice: When in a hole, put down the shovel and stop digging.

The federal government already spends one-fifth of all tax revenues on healthcare entitlements, namely Medicare and Medicaid. Spending on these programs will consume more than half of revenues by 2050, according to the baseline projections by the Congressional Budget Office (CBO). Also by that year, total federal revenues will have risen to 23.7 percent of GDP, nearly 3 percentage points higher than the record set in 2000.[1] As taxes rise to the highest level in the nation's history, fewer and fewer dollars will be available for spending on other national priorities.

In fiscal year 2007, SCHIP will cost taxpayers more than $11.5 billion; those costs could increase fivefold if the program is expanded as some have suggested.[2] Although SCHIP is not yet a full-fledged healthcare entitlement, expanding the program would move it significantly in that direction. Congress ought to focus on addressing the entitlement spending problem it has already created. Expanding yet another federal healthcare program would be reckless, risky, and irresponsible.

SCHIP's Original Design. SCHIP was created in 1997 to provide health insurance for children in low-income families. Medicaid provided coverage for children and adults with incomes below the poverty line; SCHIP targeted children in families whose earnings were too high to qualify for Medicaid but less than 200 percent of the federal poverty level (FPL), or approximately $40,000 for a family of four. In 2006, 31 million children were enrolled in Medicaid, and 6.7 million children were enrolled in SCHIP.[3]

Like Medicaid, SCHIP is jointly funded by the federal and state governments. Each state's federal allotment depends on a formula including, among other factors, the number of low-income children and healthcare costs in the state. States have wide discretion in designing their SCHIP programs: They can make SCHIP an extension of Medicaid, design a stand-alone program, or use some combination of the two. Eleven states chose the first option and typically model their benefits plans directly after their Medicaid plans, while states that elect to create separate programs frequently model their plans after state government employees' healthcare plans.

One problem with SCHIP's design is that it crowds out private insurance by offering coverage to children who would otherwise be covered by private insurance. Some estimates find that for every 100 SCHIP enrollees, private coverage is reduced for 60 children.[4] This means the program has difficulty targeting

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the truly uninsured as resources are directed to those who would otherwise have private insurance. By crowding out private insurance, SCHIP represents one big step toward government-run national health insurance. For these reasons, further SCHIP expansion should be viewed with great skepticism.

SCHIP's Expansion. As occurred with many other federal programs, SCHIP has already grown far beyond its original scope. Even though Congress first targeted SCHIP to cover near-poor children, some states now cover adults, and many states have obtained waivers to cover children in families above 200 percent of the FPL. With expanding scope comes huge cost increases. While federal funding for SCHIP was originally capped at $40 billion over a 10-year period, Congress has granted an additional $676 million in new federal spending for state bailouts through 2026.[5] Several states began to demand bailouts after overextending their programs beyond the federal statute's original intent. Fourteen states experienced SCHIP shortfalls totaling $720 million in 2007.[6] The CBO projects that 43 states will experience shortfalls totaling $8.9 billion by 2017.[7]

Congress is considering several proposals to expand the federal scope of SCHIP along the line of states that have utilized waivers to vastly expand their coverage.[8] However, states that would like to expand their programs ought to do so on their own dime. There is no justification for federalizing the existing state SCHIP expansions and no reason to ask the taxpayers in states with more restrained SCHIP programs to bear additional costs.

Some proposals would increase eligibility by covering children in families with incomes up to 300 percent or even 400 percent of the FPL. In 2007, that would mean income of $61,940 or $82,600, respectively, for a family of four. Such eligibility expansion would encroach solidly into middle income territory. Raising the threshold to 300 percent of the FPL would result in 14 states extending coverage to families with median incomes; a 400 percent threshold would result in 42 states covering families with median incomes.[9] As families with earnings at the exact middle of the income distribution of the state, median-income earners are by definition not poor. Covering them under SCHIP would go well beyond the original objective of helping truly low-income families, effectively creating a new middle-class entitlement of government-run healthcare.

1. Estimates are based on Congressional Budget Office, "Long-Term Budget Outlook" Scenario 2 data, December 2005, at *www.cbo.gov/ftpdocs/69xx/doc6982/12-15-LongTermOutlook.pdf*.
2. For federal estimates, see Chris Peterson, "SCHIP Financing: Projections and State Redistribution Issues," CRS Report for Congress, July 6, 2005, at *www.ahipresearch.org/pdfs/RL32807.pdf* (June 2, 2007). For state estimates, see Elicia J. Herz et al., "State Children's Health Insurance Program (SCHIP): A Brief Overview," CRS Report for Congress, March 23, 3005, at *www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3047303232005.pdf* (June 21, 2007).
3. Congressional Budget Office, "The State Children's Health Insurance Program," Pub. No. 2970, May 2007, p. 2, at *www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf* (June 13, 2007).
4. Andrew Grossman and Greg D'Angelo, "SCHIP and 'Crowd-Out': How Public Program Expansion Reduces Private Coverage," Heritage Foundation *WebMemo* No. 1518, June 27, 2007, at *www.heritage.org/Research/HealthCare/wm1518.cfm*.
5. $283 million in new spending was included in the Deficit Reduction Act of 2006, and $650 million in additional bailout funding was included in the Iraq war supplemental passed in May 2007, $393 million of which was new spending, with the rest coming from Medicaid offsets.
6. Nina Owcharenko, "The Truth About SCHIP Shortfalls," Heritage Foundation *WebMemo* No. 1381, March 25, 2007, at *www.heritage.org/Research/HealthCare/wm1381.cfm*.
7. Congressional Budget Office, p. 13.
8. One bill, HR 1535, has been introduced in the House by John Dingell (D–MI), and two bills, S. 895 and S.1224, have been introduced in the Senate. S.895, sponsored by Hillary Clinton (D–NY), is a companion to HR 1535, and S.1224 is co-sponsored by John Rockefeller (D–WV) and Olympia Snowe (R–ME).
9. Calculations are based on data from 2005 due to the fact that state level median income data is not yet available for 2007. In 2005, 300% of the FPL was $58,050, and 400% of the FPL was $77,400, so the exact number of states that would extend coverage to median income earners may vary slightly for 2007.

A second proposed change would expand SCHIP access by streamlining the enrollment process. This entails creating a one-stop shop for families who are eligible for other government aid (such as free school lunches or the Women, Infants and Children Program) to enroll in SCHIP automatically. Currently, many states budget their federal SCHIP allotments by capping enrollment. Forced expansion of enrollment would undermine a state's ability to control costs and would further burden state and federal taxpayers. According to the Center on Budget and Policy Priorities, the cost of covering all eligible uninsured children under SCHIP would exceed $55 billion over five years.[10]

Unaffordable Entitlements. In reality, these expansion efforts are a thinly veiled attempt to turn SCHIP into an open-ended entitlement.[11] SCHIP already resembles traditional entitlements like Medicaid and Medicare in that the program provides a specified set of benefits (health insurance) to qualifying beneficiaries (children in low-income families). Raising the eligibility threshold or expanding enrollment would broaden the scope of the program and increase the amount of committed federal dollars. Having established the precedent of federal bailouts for state programs, the last clear distinction between SCHIP and common entitlement programs would fade away. Major expansion of eligibility up the income scale would require more coverage that would likely force the elimination of the current block grant structure of SCHIP, requiring an open-ended commitment from the federal government.

It would be irresponsible of Congress to transform SCHIP into an entitlement program. Taxpayers are already confronting huge costs for existing healthcare entitlements. According to the CBO, Medicaid spending is projected to grow from $200 billion this year to more than $3 trillion by 2050—a 1,400 percent increase.[12] Although Medicare does not target the same population as SCHIP, it, too, is placing a huge strain on government finances. The Medicare Trustees report that spending on the program will increase from $440 billion today to $8.5 trillion by 2050.[13]

Ironically, the very children that many in Congress want to insure through SCHIP expansion will also be the ones footing the bill for federal entitlement programs. The total value of unfunded debts and entitlement obligations that must be paid down the road is equivalent to giving a $170,000 mortgage to every child in America but without the house.[14] Rather than increase costs through program expansion, Congress should work to reduce this onerous debt for the millions of children who stand to inherit it.

Conclusion. Since its inception, SCHIP has grown in cost and scope, gradually crowding out part of the private insurance market. Efforts to expand the program would further drive up costs and move it in the direction of an entitlement program with an open-ended commitment from American taxpayers. If state officials wish to expand SCHIP, they ought to do so on their own state's dime rather than asking Congress to collect and redistribute taxes from the rest of the country. Congress must take steps to get its existing healthcare obligations under control rather than make the problem worse through an unwise SCHIP expansion.

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10. Edwin Park, et al. "Clearing Up Confusion on the Costs of Covering Uninsured Children Eligible for Medicaid or SCHIP," Center on Budget and Policy Priorities, March 13, 2007, at *www.cbpp.org/3-13-07health2.htm* (June 12, 2007).
11. Nina Owcharenko, "Children's Health: SCHIP Should Not Become a Welfare Entitlement," Heritage Foundation *WebMemo* No. 1473, May 23, 2007, at *www.heritage.org/Research/HealthCare/wm1473.cfm*.
12. Congressional Budget Office, "The Long-Term Budget Outlook," December 2005, p. 31, at *www.cbo.gov/ftpdocs/69xx/doc6982/12-15-LongTermOutlook.pdf*.
13. 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, April 23, 2007, at *www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf* (April 23, 2007).
14. Stuart M. Butler, "Solutions to Our Long-Term Fiscal Challenges," testimony before the Committee on the Budget, United States Senate, January 31, 2007, at *www.heritage.org/Research/Budget/tst013107a.cfm.* Note: This figure includes unfunded obligations for Social Security as well as Medicare and Medicaid.