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The House SCHIP Bill: Enlisting States as Agents of Government Dependency

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States would become instruments for expanding dependency on the federal government under the House-passed Children's Health and Medicare Protection Act (H.R. 3162).[1] Legislation to reauthorize the State Children's Health Insurance Program (SCHIP) is now headed to House–Senate conference.

If enacted in its current form, the House bill would usher in a major expansion of Medicaid, a welfare program, as well as SCHIP, originally designed to provide health care coverage to children in low-income families. H.R. 3162 goes far beyond helping low-income children. The bill actually weakens private health insurance and uses budget gimmicks to encourage states to maximize enrollment. The House bill also makes SCHIP permanent and removes the existing cap on federal SCHIP funding.

Congress should backtrack and instead encourage states to expand access to private plans of families' own choosing. For the sake of taxpayers and the truly needy, Congress must not use states as blunt instruments for transitioning families en masse from private coverage into a state of permanent government dependency.

How States Would Expand Dependency. With H.R. 3162, Congress aims to use states for the purposeful, vigorous recruitment of new government dependents. Several mechanisms in the bill would have the effect of incorporating more individuals, families, and states themselves into the web of federal entitlements.

State Bonus Payments. H.R. 3162 would create "performance bonus payments"—essentially "bounty payments"—for states that exceed specified Medicaid and SCHIP enrollment levels. States qualify for "bounty payments" only if they implement specific outreach and retention practices, such as:

- "liberalization of asset requirements" (eliminating verification of income eligibility);
- doing away with in-person interviews in determining eligibility;
- establishing a process of continuous eligibility;
- implementing a joint application for Medicaid and SCHIP;
- implementing automatic administrative renewal of eligibility; and
- establishing "presumptive" eligibility.

Another option for expediting Medicaid and SCHIP enrollment is through what the sponsors call an Express Lane. By eliminating normal screening requirements, the Express Lane speeds up the process whereby states may grant—but not deny—Medicaid and SCHIP applications.[2]

Special Incentives. To the extent that a state enrolls kids in Medicaid and SCHIP at a rate faster than its population growth, it is, under the terms of the House bill, entitled to "bounties." Inherent in

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the calculation of bounty payments is an incentive for the states to enroll persons at maximum levels. The state's target enrollment level, or baseline, for any given year is determined by the previous year's enrollment, plus a percentage increase to account for population growth. Enrollment levels above the targeted baseline are designated by tiers; the higher the tier, the greater the number by which the targeted baseline enrollment is exceeded.

Bonuses for exceeding the enrollment baseline within the first tier are substantial, but bonuses associated with exceeding the second tier are significantly higher. In other words, the more a state exceeds its targeted baseline, the higher its bounty.[3] The objective is unmistakable: States are given a strong incentive to enroll as many children and qualifying adults as possible. States could find many ways to expand enrollment, including with waivers or by raising the income threshold.

Increased Federal Spending. The Medicaid and SCHIP programs are jointly financed by the federal and state governments. For every dollar a state spends, the federal government is responsible for a matching payment. The federal match for each program differs from state to state, but it is generally between 50 percent and 76 percent for Medicaid and between 65 percent and 83 percent for SCHIP.[4] H.R. 3162 would allow the states to use the bonus payments for their share of the funding. This creates a fiscal no-brainer for states: The more they expand public program enrollment, the greater their bonus grows, and the smaller their funding burden becomes.

The House bill would thus worsen the flaws in existing SCHIP financing. Today, each state's federal allotment is determined by a formula that takes into account several factors, including the number of low-income children in the state, the number of uninsured children in the state, and the cost of health care in the state. States where spending exceeds the budget are called "reallocation" states. States that remain within their specified budgets are "retention" states. Currently, those states that operate within their means (the retention states) are permitted to keep 50 percent of their unspent federal funds, and the other 50 percent is redistributed among the reallocation states. Such an arrangement clearly favors fiscally imprudent states.

Currently, federal SCHIP spending is capped at a level set by Congress. H.R. 3162 would remove the allotment cap; thus, federal SCHIP matches would be limited only by the number of recipients that states enroll. This—in conjunction with the absence of a sunset provision—paves the way for SCHIP to become a full-blown, open-ended, and permanent entitlement.

New Taxpayer Costs. In order to determine true cost, one must consider both the requisite funding of the program itself and residual costs incurred as a result of the program's success or failure. The House sponsors of H.R. 3162 made several critical changes to the legislative language before floor consideration. [5] In the amended version of the bill, they provided for the bonus payments to begin in 2009 and run through 2013, with a total five-year cost of $15 billion. But during the period of 2014–2017, the House sponsors provide no money for the

1. The House bill passed on August 1, 2007 by a vote of 225 to 204.
2. See Title I, Sec. 111 and 112.
3. Under H.R. 3162, for each Medicaid enrollee who is above the targeted level but within the first tier, the state will receive a bonus equal to 35 percent of the projected per capita state Medicaid expenditures; if Medicaid enrollment reaches the second tier, the bonus percentage jumps to 90 percent. Performance bonus percentages for first and second tier SCHIP enrollment are based on 5 percent and 75 percent (respectively) of projected per capita state SCHIP expenditures.
4. Kaiser Family Foundation, "State Health Facts, Federal Matching Rate (FMAP) for SCHIP" at *www.statehealthfacts.org/comparetable.jsp?ind=239&cat=4,* and "Federal Matching Rate (FMAP) for Medicaid and Multiplier," at *www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4*.
5. For example, in the original version, CBO estimated athat the special bonus payments would cost $35.4 billion over ten years. Congressional Budget Office, "Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007," July 27, 2007, at *www.cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf*.

bonus payments. So, not surprisingly, the CBO estimates the total ten-year cost at $15 billion over 10 years,[6] because all of the federal spending would be front-loaded in the first five years.[7]

This is a tricky way of budgeting, especially for health care expansions. The champions of H.R. 3162 in Congress and elsewhere are likely to argue that the bounty payments are a one-time expenditure—that once children are enrolled in the program, additional funds would not be necessary to maintain their enrollment.

But there is a problem. The powerful incentives for the states, at least in the first five years of the reauthorization, are to enroll as many eligible beneficiaries as possible as quickly as possible, tapping into as much of the federal bonus money as possible. The problem arises in 2014, when there is no more bonus money for the states at the very time that the incentives for program expansion have created new financial burdens for the states. With public program enrollment high, and with no more bonus payments to offset their rising Medicaid and SCHIP contributions, states would be left holding the proverbial bag; too many enrollees, not enough money. In other words, the states that were most "successful" in their enrollment efforts, fueled by the extra federal "bonus" cash, would be the states most likely to face the biggest budget shortfalls. Undoubtedly, the situation would intensify political pressure to increase federal spending to cover the high costs of an unprecedented number of enrollees in the public programs.

Conclusion. The House congressional leadership has enacted an SCHIP bill that would expand welfare spending, while enlisting the states as tools of that expansion. H.R. 3162 sets up a cunning bait-and-switch operation: (1) It creates the need for additional federal funds by rewarding states' zealous enrollment efforts with "bounty payments"; and (2) it would answer that urgent funding need by having removed the existing federal SCHIP allotment cap.

Congress should reverse course and demonstrate fiscal integrity by retaining the existing SCHIP allotment capping mechanism. Moreover, Congress should reward effective and efficient program innovation at the state level. Congress can strengthen private coverage options by offering low-income families direct premium assistance or tax credits. Creating a culture of dependence on welfare programs can never be the goal of a free society.

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6. All program spending would take place within a 5-year window from 2009 to 2013, then go to zero for years 2014 to 2017.
7. Congressional Budget Office, "Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, for the Rules Committee," August 1, 2007, at *cbo.gov/ftpdocs/85xx/doc8519/HR3162.pdf*.