WebMemo
Published by The Heritage Foundation
No. 1630
September 20, 2007

Why Families Should Be Concerned about SCHIP

Connie Marshner

Congress is at a crossroads in the debate over the State Children's Health Insurance Program (SCHIP), which is set to expire at the end of this month. Competing bills passed by the House and Senate would expand the program, at great expense to taxpayers, to include more children from higher income families, but the President has threatened to veto bills that embody this approach. Often drowned out in the policy debate is how SCHIP touches many issues relevant to families: the recognition of unborn children as recipients of medical services, undercutting existing and superior family coverage, transforming the middle class into recipients of government health care, government control over citizens' private health care decisions, and the impact of significant tax increases. Congress should keep SCHIP focused on uninsured children from low-income families and broaden the options available to middle-income families whose children are uninsured.

Changing the Status of the Unborn. In 2002, the Department of Health and Human Services issued a regulation making an "unborn child" eligible to receive services under SCHIP. It explicitly recognized the existence of human life before birth, thus emphasizing the importance of pre-natal health care.[1] After all, children who receive proper prenatal care are born healthier and suffer fewer health problems than children who are born sickly. Presently, states have the option of offering this kind of coverage, and 11 states now recognize the unborn in their SCHIP programs.

The current policy on the unborn is only that—a policy, not law: It exists at the pleasure of the Secretary of Health and Human Services. While, under a pro-life president, this "unborn child" policy would likely continue, under a non-pro-life president, it would probably not.

If the policy were enacted into law, however, it would be more permanent. This was the intention of a proposed amendment to the Senate's SCHIP legislation. It was defeated during floor debate.[2]

The Senate bill, as passed, leaves the current situation intact: It does not command the "unborn child" language, but it does permit it as a state option. The language in the House-passed bill, meanwhile, gives states the option to cover "pregnant women" (the status quo in the law) but is silent on the unborn.

Focusing on pregnant women, rather than the unborn, raises an additional issue. If an unborn child is a client of a state's SCHIP program, at some definitive point it becomes a "child under the age of 18," one of the clients for whom SCHIP was created. But what becomes of a pregnant client when she ceases to be pregnant? If the woman has been covered during the pregnancy, she may harbor an

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/wm1630.cfm

Produced by the Domestic Policy Studies Department

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

The Heritage Foundation
LEADERSHIP FOR AMERICA

expectation that government health insurance will continue to be available to her.

Undercutting Family Coverage. Under current law, states may use SCHIP funds to pay the additional cost of adding children to a parent's existing health insurance policy, a practice known as "premium support."

Premium support is family-friendly. In the case where one parent's employer offers coverage (a situation that applies to half of the children living in families that earn between 100 percent and 200 percent of the federal poverty level and 77 percent of children in families that earn between 200 percent and 300 percent of the federal poverty level[3]), parents may prefer to have the children on the same policy. With only one policy, parents have only one set of rules to memorize and only one set of forms to fill out no matter which family member saw a doctor. It may even mean that one clinic or family practice can treat the whole family. For families with two working parents and two schedules to juggle, the time savings can be significant.

Unfortunately, premium support is rarely employed because of the extensive red tape that the government imposes on it. The result is that few families use premium support to obtain health insurance for their children. Premium support could be streamlined by an amendment that would simplify the basis upon which it is calculated and administered, but no such amendment was offered in the House or Senate.

Similarly, the government could give parents health care vouchers or tax credits to enable them to buy health insurance for their children, making the purchase of such coverage more affordable. Though Members of Congress have proposed these options, they are not embodied in either chamber's SCHIP legislation.

Government Health Care for the Middle Class. The original mission of SCHIP was to help low-income working families who need a little extra help to insure their children. SCHIP was not intended to be a replacement for private health insurance for the working poor, but assistance toward it. It was not a program for adults or the unemployed or families in middle- or high-income groups.

Under both the House and Senate bills, that would change. The Senate's version of SCHIP would allow the Administration to grant waivers for states to cover families at 400 percent of the federal poverty level—$82,600 in annual earnings for a family of four. The Bush Administration has recently denied New York's request to expand its SCHIP program to cover children in families up to that income level, but the Senate legislation would allow such a waiver if a more liberal political Administration decided to grant it.

In the House bill, there is no explicit income eligibility limit, and the states are strongly encouraged to enroll as many families as possible through a special bonus program to boost enrollment. If eligibility is set at 400 percent of the federal poverty level, approximately 70,000 American families would be eligible for SCHIP—a program originally designed as a form of welfare assistance for low-income persons—while also being subject to the Alternative Minimum Tax (AMT), which is intended to target rich individuals and families.[4]

Expanding SCHIP coverage to more and more children will separate family coverage from child coverage because of the need for different doctors and providers. This is unnecessary: Children could be more easily added to their parents' insurance plan. The Congressional Budget Office reports that 50 percent of children whose families earn between 100 percent and 200 percent of the federal poverty

1. Note that the language of existing policy does not focus on "pregnant women"; it focuses on "unborn children," a significant break with previous policy in this area.
2. Senator Wayne Allard (R–CO) offered an amendment to the Senate bill to clarify the term "unborn child" and allow states to extend eligibility for assistance under SCHIP. The Allard amendment was defeated 50 to 49.
3. Congressional Budget Office, "The State Children's Health Insurance Program," Publication No. 2970, p. 12.
4. Rea S. Hederman, Jr., "Expanding SCHIP into AMT Territory: SCHIP Plan Would Extend Welfare to Wealthy Families," Heritage Foundation *WebMemo* No. 1546, July 9, 2007, at *www.heritage.org/Research/HealthCare/wm1546.cfm*.

level have private health insurance, and of those between 200 percent and 300 percent of the federal poverty level, 77 percent of children have private health insurance.[5] A growing body of professional literature shows that when government health insurance expands, up to 60 percent of existing private coverage is "crowded out." That means that for every 100 persons covered under a government program expansion, 60 people have lost, or given up, private health insurance coverage.[6] This malignant crowd-out effect amplifies as government coverage expands up the income scale.

If Congress and state officials permit SCHIP eligibility to expand to children living in families at 400 percent of the federal poverty level, fully 71 percent of American children would be eligible for either Medicaid or SCHIP.[7] The next generation of children would grow up knowing or receiving nothing but government health care.

Removing Patient Control Over Health Care. A provision in the House's SCHIP legislation makes an assault on Medicare that would set a very dangerous precedent. Hidden in the House bill is a provision that would threaten the ability of senior citizens to supplement Medicare with their own personal funds.

Medicare is the mandatory government health insurance program for citizens over the age of 65. Why is anything concerning Medicare found in legislation concerning health care for children? That's a good question.

The reason is money.

With the aging of the American population, the financial future of Medicare is shaky. Many believe that price controls are inevitable, followed by the rationing of health care services. Seniors in particular fear that rationing will target end-of-life care.

Under Medicare today, there is an alternative to rationing that does not impact the federal budget or require new taxes. Known as the private fee-for-service option, this alternative permits Medicare recipients to supplement government premiums for health insurance with their own money. It ensures that government bureaucrats cannot impose price controls or rationing on them.

Hidden in a part of the House bill that appears to foster quality controls is language that would effectively eliminate all indemnity private fee-for-service plans as of 2009 and all private fee-for-service plans, including PPOs, as of 2010.

This provision would prevent senior citizens from spending their own money for their own health care. If this provision becomes law, the stage will have been set for government rationing of health care.

Future Tax Increases. When it was enacted in 1997, SCHIP was a limited block grant program. Federal money was given to the states as matching funds to provide health insurance coverage to uninsured children in low-income families. It capped expenditures at $40 billion over 10 years.

An expansion and liberalization of income eligibility, however, would burst through such caps, and so the House and Senate bills finance their legislative handiwork with a strange and regressive tax policy. Congress proposes to pay for SCHIP expansion primarily by increasing taxes on tobacco products, products disproportionately consumed by the low-income population. But this is an unreliable revenue stream: The more lawmakers tax a product like tobacco, the faster consumption, and thus revenue, will fall.

In order to get the tobacco revenue necessary to fund the congressional expansion of SCHIP, Congress would need to recruit 22.4 million new smokers. [8] Barring that, the tobacco tax would only serve as initial funding and would have to be supplemented by higher taxes on individuals and families.

5. See Michael Franc, "States' Addiction to Welfare Corrupts Federalist System," Heritage Foundation *Commentary*, March 3, 2007, at *www.heritage.org/Press/Commentary/ed030307a.cfm*.
6. Andrew M. Grossman and Greg D'Angelo, "SCHIP and 'Crowd-Out': How Public Program Expansion Reduces Private Coverage," Heritage Foundation *WebMemo* No. 1518, June 21, 2007, at *www.heritage.org/Research/HealthCare/wm1518.cfm*.
7. Michael O. Leavitt, Secretary of Health and Human Services, remarks on April 24, 2007, cited in BNA's Medicare Report Banner, Volume 18, Number 17, April 27, 2007, ISSN 1521-4699, page 453.

The expense to future generations would be gargantuan. When the projected costs of an expanded SCHIP and other entitlement programs are combined, the total value of unfunded debts and entitlement obligations that must be paid down the road is equivalent to imposing a $170,000 mortgage on every child in America at birth—but without the house.[9]

Conclusion. SCHIP expires this year, and Congress and the Administration agree on the need to help needy families with children. How to give that help is the argument. The sensible course is to focus on children in low-income families in a fiscally responsible fashion and to expand coverage options for families with children without destroying or crowding out their existing family health coverage.

For middle-class families who need help, Congress could easily combine the reauthorization of the current program with a targeted health care tax credit for children that is focused on children in families with annual incomes between 200 percent and 300 percent of the poverty line (approximately $42,000 to $62,000). This child health care tax credit could be available for individual family coverage or for enrollment in a parent's employer-based health insurance plan.

There is no reason, however, for Congress to indulge in extravagant government expansions that serve primarily to undermine families.

—Connie Marshner is a Visiting Fellow for Domestic Policy Studies at The Heritage Foundation.

8. Michelle C. Bucci and William W. Beach, "22 Million New Smokers Needed: Funding SCHIP Expansion with a Tobacco Tax," Heritage Foundation *WebMemo* No. 1548, July 11, 2007, at *www.heritage.org/Research/HealthCare/wm1548.cfm*.
9. Stuart M. Butler, "Solutions to Our Long-Term Fiscal Challenges," Testimony before the Committee on the Budget, U.S. Senate, January 31, 2007, at *www.heritage.org/Research/Budget/tst013107a.cfm*. Note that this figure includes unfunded obligations for Social Security as well as Medicare and Medicaid.