The State Children’s Health Insurance Program: America’s Political Illness

Jennifer Geffner
In SOSC 491: The Upstate Law Project, students are required to write a policy paper on the topic of their choosing. I chose to write about the State Children’s Health Insurance Program (SCHIP) because I am deeply interested in how the government can help individuals escape the cyclical nature of poverty. This paper is significant because it addresses the normative question of whether it is the federal government’s responsibility to protect low-income children’s health. After exploring both sides of the issue in light of the debate over SCHIP’s reauthorization, I argue that the federal government ought to extend health care coverage to needy children.

When it comes to America’s youth, who is responsible for protecting children’s health, the federal government or individual families? In 1997, Congress addressed this question by authorizing The State Children’s Health Insurance Program (SCHIP) to provide coverage for children living in families too poor to afford private health insurance, but too rich to qualify for Medicaid. Currently, SCHIP provides health insurance to over six million children and adults, but the federal funding for the program expired on September 30, 2007.\(^1\) While both chambers of Congress agreed to reauthorize and expand the program, President George W. Bush threatened to veto any bill that would increase SCHIP’s funding. Bush feared that additional funds would buy health insurance for those already covered by private programs, rather than extend coverage to those in need. On October 3, 2007 and November 16, 2007, President Bush stuck to his word and vetoed the bills that would reauthorize and allot $60 billion to SCHIP.\(^2\) If Congress is not able to override Bush’s veto, millions of children’s health insurance coverage will be in jeopardy.

In debating SCHIP’s reauthorization, lawmakers have revealed that politics have the ability to trump the needs of America’s youth. However, it is not clear whether children’s social welfare should even be a political question. Without health insurance, children are likely to forgo routine medical visits, dental care, immunizations, and treatment for maladies. The far-reaching life and death consequences of receiving proper health care as a child place the debate on funding SCHIP in a distinct category. This paper explores to what extent the

\(^1\) Baumann, Matt and Devon Herrick. *SCHIP Expansion: Robin Hood in Reverse.* (National Center for Policy Analysis: July 31, 2007), 2

federal government should invest in America’s future, its children. To frame the debate, it is necessary to begin by explaining the purpose, structure, and history of SCHIP. Next, the opinions of leading scholars from competing paradigms will be reviewed. This will be followed by a cost-benefit analysis and an argument made in support of expanding SCHIP. Finally, recommendations on how to extend SCHIP’s coverage to maximize its effectiveness will be presented.

Background: The History and Future of SCHIP

The State Children’s Health Insurance Program (SCHIP) was authorized in 1997 to provide health care to low-income, uninsured children.3 Prior to SCHIP’s conception, the United States Government Accountability Office reported that while nineteen million children already received Medicaid benefits, over eleven million children were uninsured because their families were not eligible for Medicaid and could not afford private health insurance.4 Scholars found that without health insurance, children are less likely to receive routine medical care. In a hearing before Congress, John O’Shea of the Heritage Foundation reported that only forty-six percent of uninsured children receive annual check-ups and thirty percent never obtain any type of pediatric care.5 Lawmakers responded to this data in August of 1997 by passing the Balanced Budget Act that created SCHIP, under title XXI of the Social Security Act.6

SCHIP is a federal-state partnership that provides states the opportunity to reduce the number of uninsured children living with families whose incomes are too high to qualify for Medicaid (above 133 percent of the Federal Poverty Line), yet too low to purchase health insurance.7 SCHIP is similar to Medicaid in that the federal government appropriates the program funds and offers each state a matching rate.8 Unlike Medicaid’s matching rate of 50 percent, SCHIP’s matching rate ranges between 65 and 83 percent to encourage states to establish a program.9 SCHIP also differs from Medicaid in that it is not a limitless entitlement program.10 Rather in 1997, Congress allotted $40 billion to be rationed among states’ children’s health insurance program over the course of ten years.11 Each fiscal year, states receive at least $2

7 Congressional Budget Office, VII
8 United States General Accounting Office MEDICAID AND SCHIP Comparisons of Outreach, Enrollment Practices, and Benefits, April 14, 2000, p. 3
9 Allen, Kathryn. State Experiences in Implementing SCHIP and Considerations For Reauthorization, Testimony before the Committee on Finance in the US Senate, March 12, 2007, 5
10 Cook, Allison and Genevieve Kenney. “Coverage Patterns among SCHIP-Eligible Children and Their Parents.” (The Urban Institute: No. 15, February 2007), 1
11 Hill, Ian and Holly Stockdale, and Bigette Courtot. Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis. (The Urban Institute: Series A, No. A-65, June 2004), 1
million for their programs and the Department of Health and Human Services determines how much additional money each program receives through a complex formula known as Current Population Survey (CPS). Based on data from the Bureau of Census, CPS accounts for how much health insurance costs in the state, how many uninsured children under age nineteen live in the state, and how many of these children reside with low-income families. Once federal money is allocated, states must use their federal funds within three years. If states do not use their federal appropriations within this timeframe, then the excess funds are redistributed to the states that express a need for additional funding. States must use redistributed funds within one year or else these funds revert to the Department of Treasury.

In addition to possessing a unique financing structure, SCHIP functions under broad federal guidelines that decentralize the program to maximize state preferences. With regards to eligibility requirements, the federal government prescribes two regulations. The federal government first stipulates that an individual may qualify for SCHIP if he or she is under age nineteen. However, being under age nineteen is not sufficient to receive SCHIP benefits. A child must also meet a second requirement: his or her family’s income can be no more than 50 percent above the state’s Medicaid threshold. Initially, states could only cover children living with families below 200 percent above the federal poverty line (FPL). However, Congress changed this criterion in 2001 to account for each state’s varying conditions of poverty. Consequently, seven states have been able to cover children in families with incomes of 300 percent of the FPL and New Jersey has surpassed this mark by covering children in families with incomes up to 350 percent of the FPL. In addition, fourteen states have been able to extend coverage to pregnant women and the parents of children eligible for SCHIP because these states have proven in a Social Security 1115 waiver that covering adults is cost-effective. Given the breadth of federal eligibility requirements, states have the potential to extend coverage in a manner that best suits the needs of their constituents.

Besides providing the state with broad eligibility requirements, the federal government also permits each state to determine the shape of its children’s health insurance program. While all plans are subject to the approval of the Secretary of Health and Human Services, each state can chose among three SCHIP plans that the federal government offers: an extended Medicaid program, a separate children’s health program, or a hybrid of the two. As of January 2007, ten states plus the District of Columbia chose to expand their Medicaid program. Under this option, children’s

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12 Congressional Budget Office, 5
13 ibid.
14 General Accounting Office, 4
15 General Accounting Office, 5
16 Congressional Budget Office, 7
17 Allen, 16
18 Panaritis, Maria. “NJ Sues over Health Insurance Cuts.” (The Philadelphia Inquirer: October 2, 2007), B06
19 ibid.
20 Government Accountability Office, 5-6
21 Ibid.
health insurance plans must adhere to Medicaid’s eligibility rules and benefits.\textsuperscript{22} This plan is advantageous for the beneficiaries because Medicaid does not permit cost sharing and provides services that might not be offered by a separate children’s health program.\textsuperscript{23} Furthermore, an expanded Medicaid program is advantageous for the state because the state is eligible for the Medicaid matching rate even after the state exhausts its federal funds for SCHIP.\textsuperscript{24} Comparatively, eighteen states established separate children’s health programs. Although this option does not permit states to obtain federal matching after they exhaust their SCHIP funds, states have more control over determining eligibility requirements, the size of their program, and the benefits of their plan.\textsuperscript{25} Because states do not adhere to Medicaid’s standards, states also have the right to introduce a minimal cost-sharing plan.\textsuperscript{26} Despite the advantages of both plans, twenty-one states chose to develop a unique, hybrid plan.

Despite states’ ability to tailor SCHIP to fit their specific needs, SCHIP was not immediately successful. From 1997 to 2001, states struggled to establish their programs. In its first year of operation, SCHIP only enrolled 660,000 people across the nation, which was a small percentage of the population eligible for benefits.\textsuperscript{27} Accordingly, states annual spending of federal funds was lower than their annual allotment. In 1998, states only spent $0.12 billion of their allotted $4.24 billion.\textsuperscript{28} In response to this data, states actively publicized SCHIP and restructured the program by accepting applications via mail, reducing proof of income requirements, covering beneficiaries for a continuous 12-month period, and simultaneously vetting applications for Medicaid and SCHIP.\textsuperscript{29} These methods of reform proved successful for SCHIP, as enrollment grew by 90 percent between 1999 and 2000, and the number of children covered under Medicaid increased as well.\textsuperscript{30}

By fiscal year 2002, SCHIP’s success was no longer a question of whether the program had the ability to provide coverage, but rather a question of whether SCHIP had the funds necessary to sustain itself. In 2002, states covered 5.4 million people and began spending more money than the federal government allocated.\textsuperscript{31} Even though the program experienced substantial growth from 1999-2001, Congress reduced SCHIP’s funding in 2002 from $4.25 billion to $3.12 billion because of budgetary problems that arose from the Iraq war.\textsuperscript{32} This cut in federal funding did not slow SCHIP’s growth. Rather, the Congressional Budget Office (CBO) reports that since 2002, SCHIP’s spending and enrollment has increased at a rate of 10 percent each

\textsuperscript{22} Congressional Budget Office, 13
\textsuperscript{23} Government Accountability Office, 14-15
\textsuperscript{24} Hill, Ian and Amy Lutzky. \textit{Getting In and Not Getting In and Why}. (The Urban Institute, Occasional Paer Number 66), 1-2
\textsuperscript{25} Government Accountability Office, 16-17
\textsuperscript{26} Allen, 12
\textsuperscript{27} Committee on Child Health Financing, Implementation Principles and Strategies for the State Children’s Health Insurance Program. Pediatrics Vol. 107 No. 5 May 2001 pp. 1214-1220
\textsuperscript{28} Allen, 27
\textsuperscript{29} Hill and Stockdale, 1
\textsuperscript{30} Ibid, 31
\textsuperscript{31} Allen, 9
\textsuperscript{32} Congressional Budget Office, 26
year. Consequently, more states have exhausted their federal appropriations and have relied on the pool of redistributed funds. While only twelve states depended on redistributed funds prior to 2002, forty states expressed a need for these funds subsequent to the federal budgetary cuts. As a result, the funds available for reallocation shrunk from $2.82 billion in 1999 to $0.17 billion in 2003. If SCHIP was to meet the needs of the people, the program would require additional monetary support.

At various times in SCHIP’s history, lawmakers have recognized SCHIP’s fast-paced growth and consequent need for supplementary funding. In 2000, Congress passed the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA), which aimed to prevent redistributed federal funds from reverting to the US Treasury. BIPA permitted states to retain half of their unused funds and extended the time in which redistributed funds from 1998 and 2001 had to be used. Regardless of Congressional attempts to provide additional monetary support for SCHIP, states annual funding continued to exceed the federal appropriation. In 2005, Congress acted on states behalf once again by passing the Deficit Reduction Act, which provided SCHIP an additional $283 million to cover states’ expected losses in fiscal year 2006. However, this federal aid to states’ programs does not appear to be enough. In January of 2007, CBO reported that thirty-five states will exhaust their funds by the end of this fiscal year and of these states, eleven would require an additional $646 million to avoid a deficit. CBO further predicted that, SCHIP, as a whole, would need an additional $14 billion over the next five years just to sustain its existing programs. Considering that SCHIP currently provides coverage to over four million children each day and six million children each year, the shortfalls in funding SCHIP are problematic.

With SCHIP slated for reauthorization in 2007, lawmakers sought not only to reaccredit the program, but also to increase SCHIP’s federal appropriations. Today, states are not just struggling to finance their existing programs, but states are also not covering all those who are eligible for SCHIP. A study completed by the Urban Institute in February of 2007 reported that 13.3 million children are eligible for SCHIP, but of these children, only 3.9 million receive SCHIP benefits, 6.6 million have employer-sponsored insurance, and 2 million are uninsured. In response to these findings, Congress introduced bill H.R. 976, “The State Children’s Health Insurance Program

33 Congressional Budget Office, 25
34 Hill and Luzky, 1
35 Allen, 28
36 Government Accountability Office, 12
37 Allen, 29
38 Congressional Budget Office, 34
39 Kenney, Genevieve and Allison Cook. Coverage Patterns among SCHIP-Eligible Children and their Parents. February 2007, the Urban Institute, 3
40 Congressional Budget Office, 15
41 Kenney, Genevieve. The Children’s Health Insurance Program in Action: A state’ perspective on CHIP, before the committee on Finance,1
42 Kenney and Cook, 3
Reauthorization Act of 2007,” which called for an additional $35 billion to be allocated to SCHIP over the next five years.\(^{43}\) By bringing SCHIP’s total federal allotment to $60 billion, Congress would expand the number of children covered by SCHIP by four million.\(^{44}\) The passage of H.R. 976 specifically targets the children of low to middle-income families by prohibiting SCHIP from covering children in families above 300 percent of the FPL.\(^{45}\) Additionally, the bill intends to protect the federal budget from strain by increasing the tax on tobacco products by as much as 150 percent.\(^{46}\) In July and August of 2007, H.R. 976 passed in the House of Representatives and Senate with a respective vote of 265 to 159 and 67 to 29.\(^{47}\) Despite the bill’s bipartisan support, President George W. Bush vetoed H.R. 976 on October 3, 2007. Consequently, SCHIP was neither reauthorized nor expanded. Yet, because of the passage of a stopgap resolution, funding for SCHIP will continue until November 16, 2007.\(^{48}\)

President Bush is not opposed to the reauthorization of SCHIP. However, he is opposed to expanding the program by $35 billion.\(^{49}\) Bush fears that an expansion of SCHIP would induce a crowd-out effect where people would leave their private carriers to obtain SCHIP benefits.\(^{50}\) In a public address, Bush stated that an expansion of SCHIP would be “an incremental step toward [the Democrat’s] goal of government-run health care for every-American.”\(^{51}\) This claim is based on various studies that report “for every 100 SCHIP enrollees, private coverage is reduced for 60 children.”\(^{52}\) To prevent crowding out, Bush would like to reauthorize SCHIP and expand it by only $5 billion. Because Congress currently lacks the votes to override Bush’s veto, compromise on SCHIP seems likely.\(^{53}\) Some potential areas of the program that Congress could redefine to maintain the SCHIP without a substantial increase in federal funding include: the target population, eligibility requirements, Social Security 1115 waivers, the federal matching rate, rules for redistributing funds, and the benefits of the program.\(^{54}\)

If the federal government does not reauthorize SCHIP and appropriate the program money, then the health insurance of over six million children and adults’ may be in jeopardy. States may have no choice but to either abandon or independently fund SCHIP. Without federal funding, some states fear that

\(^{43}\) 2007 Bill Tracking H.R. 976, 110th Congress, 1st Session, United States of America
\(^{44}\) ibid.
\(^{45}\) ibid.
\(^{46}\) Joint Committee on Taxation, Senate Committee on Finance Description of the Revenue provisions for markup of the state childrens’ health insurance program July 17, 2007, 3
\(^{47}\) 2007 Bill Tracking H.R. 976, 110th Congress, 1st Session, Congressional Research Service
\(^{48}\) Sean Lengell, SCHIP’s on Table, President tells Hill. The Washington Times, October 7, 2007, A01
\(^{49}\) Bryant, Jane. “The Kids Aren’t All Right.” (Newsweek: October 29, 2007)
\(^{50}\) Kenney and Cook, 3
\(^{51}\) ibid.
\(^{53}\) 2007 Bill Tracking H.R. 976, 110th Congress, 1st Session, Congressional Research Service
\(^{54}\) Congressional Budget Office, 14-17
their operating budgets will not be able to sustain their existing children’s health insurance programs. Seven states, led by Governor Corzine of New Jersey, have already expressed their concern by filing a lawsuit against the U.S. Department of Health and Human Services over SCHIP’s loss of federal funding.\textsuperscript{55} States, however, have a history of coping with federal budgetary cuts made to their children’s health insurance programs. The history of SCHIP in Florida, Texas, and North Carolina, particularly demonstrate state’s resilience. When federal appropriations for SCHIP were reduced in 2002, Florida was able to maintain its program by capping the size of its program through implementing waiting lists and eliminating outreach programs.\textsuperscript{56} Texas also adjusted its program in response to the federal budgetary cuts of 2002; however, Texas assumed a different strategy. Texas altered the eligibility requirements and reduced the benefits offered by its children’s health insurance program. This move curbed the growth and costs of Texas’s program and provided coverage to those with the greatest need.\textsuperscript{57} North Carolina’s program also proved to be uniquely resourceful in 2004 when it overenrolled children due to an accounting error.\textsuperscript{58} To reduce the size and costs of its program, North Carolina moved children under the age of five from SCHIP, into Medicaid.\textsuperscript{59} While the cases of Florida, Texas, and North Carolina demonstrate states’ adaptability, states have always relied on federal funding to some extent. It is unknown how states’ programs will respond without a federal-state partnership.

In its ten-year history, SCHIP has established itself as a thriving program, enrolling over six million uninsured, low-income Americans. The program’s financial history, however, has always been a topic of debate for policy makers. While lawmakers agree that SCHIP needs to be reauthorized, to what extent the federal government should increase its expenditures on children’s health care remains a point of contention. Before this issue is analyzed, it is necessary to review how leading scholars assess SCHIP’s potential expansion.

Literature Review

In addressing whether SCHIP should be expanded, scholars are divided on two salient issues: whether SCHIP properly targets low-income children and whether SCHIP is effective in terms of the cost and quality of care provided. From this litmus test, scholars can be categorized into one of two competing schools of thought, “welfare traditionalists” and “welfare activists.”

Welfare traditionalists are those who oppose any further expansion of SCHIP. These scholars often assume a conservative theoretical framework and belong to the epistemic communities of The Heritage Foundation and American Enterprise Institute. Welfare traditionalists answer the litmus test with the following analysis. First, Welfare traditionalists claim that an expansion of SCHIP would target

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\item \textsuperscript{55} Panaritis, B06
\item \textsuperscript{56} Hill, 5
\item \textsuperscript{57} Hill, 4
\item \textsuperscript{58} Government Accountability Office, 44
\item \textsuperscript{59} Government Accountability Office, 49
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children of the upper and middle classes who may already have private health insurance.\textsuperscript{60} Subsequently, this camp opposes SCHIP’s expansion on the basis that the program would go beyond its intended scope.\textsuperscript{61} Moreover, welfare traditionalists advance that increasing the program’s federal allocations is economically viable only if the federal government substantially increases taxes. For the welfare traditionalist, raising taxes in response to an expansion of SCHIP is unwarranted because there is no pressing need to purchase health insurance for families that could afford private carriers.\textsuperscript{62} In light of these arguments, welfare traditionalists propose that while SCHIP should be reauthorized, coverage should be provided only to those below 200 percent of the FPL.\textsuperscript{63} Some welfare expansionists further recommend that families between 200 and 300 percent of the FPL receive a tax incentive to obtain private health insurance for their children.\textsuperscript{64} Contrary to the welfare traditionalist, the welfare activist champions SCHIP’s expansion. Typically, many of these scholars assume a liberal mindset and work for

The Urban Institute or Brookings Institute. Welfare activists proclaim that the majority of people who would benefit from SCHIP’s expansion would be low-income, uninsured children.\textsuperscript{65} Consequently, welfare activists believe that SCHIP’s expansion aligns with the program’s initial goal of providing coverage to those who cannot afford health insurance and do not qualify for Medicaid.\textsuperscript{66} Furthermore, this camp of scholars believes that an expanded SCHIP would be cost and quality effective. Welfare activists argue that an expanded SCHIP would alleviate low-income families from the burden of paying a large percent of their income to obtain health insurance.\textsuperscript{67} Because an expansion of SCHIP would help narrow the gap between the most and least well off, welfare activists argue that it is not problematic to increase taxes to compensate for SCHIP’s added expenditures.\textsuperscript{68} Subsequently, these scholars advocate that SCHIP should be expanded. Exactly how far SCHIP should go in its extension of coverage, however, is controversial within this camp.\textsuperscript{69}

For leading scholars, there is no clear answer as to whether the federal government should substantially

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  \item \textsuperscript{60} Miller, Thomas. “Making a Difference in Differences fro the Health Inequalities of Individuals.” American Enterprise Institute. September 11, 2007.
  \item \textsuperscript{62} Winfree, Paul and Greg D’Angelo. “SCHIP and ‘Crowd-Out’” The Heritage Foundation, September 19, 2007. WebMemo #1627
  \item \textsuperscript{63} Foster, JD. “The Phantom Economic Benefits of SCHIP Expansion” The Heritage Foundation. July 16, 2007. No. 1557
  \item \textsuperscript{64} ibid.
  \item \textsuperscript{65} Kenney, Genevieve. “Medicaid and SCHIP Participation Rates: Implications for New CMS Directive” The Urban Institute, September 16, 2007, No.16
  \item \textsuperscript{66} Dorn, Stan. “Eligible, but Not Enrolled” The Urban Institute, September 24, 2007
  \item \textsuperscript{67} Winston, Pamela and Rosa Maria Castanada. “Assessing Federalism: Research Report” The Urban Institute: June 4, 2007.
  \item \textsuperscript{68} Kenney, 16
  \item \textsuperscript{69} Blumberg, Linda. “Can the President’s Health Care Tax Proposal Serve as an Effective Substitute for SCHIP Expansion?” The Urban Institute, October 11 2007
\end{itemize}
increment SCHIP’s funding. While proponents of SCHIP’s growth assert that the program would target low-income children and would be effective in terms of the quality and cost of the care provided, opponents claim the converse. Given the importance of receiving health care as a child, this debate requires a resolution.

Analysis: Finding a Cure to America’s Political Illness

For policy makers, “The State Children’s Health Insurance Program Reauthorization Act of 2007,” has exhumed the question of whether it is in the federal government’s purview to extend health coverage to the children of low to middle class families. Currently, policy makers have two options before them. Either they can accept the status quo by reauthorizing the program, or they can further extend SCHIP’s coverage by increasing the program’s federal funding. Although scholars are divided, this debate can be resolved by addressing who would benefit from an extension of SCHIP’s coverage, how the program’s expansion would be financed, and what would be the consequences and implications be if the federal government did not expand SCHIP. From analyzing these issue areas, it will become clear that the federal government should increase its expenditures on SCHIP to further cover for the children of the less well off.

In tackling the current debate on SCHIP, it is necessary to begin by addressing who would benefit from SCHIP’s growth. An expansion of SCHIP may extend coverage to children who already have private health insurance. If Congress’s current proposal is enacted, then only children below 300 percent of the FPL would be eligible for SCHIP. Prime facie, this policy prescription may seem problematic. The CBO reports, “77 percent of children between 200 and 300 percent of the FPL already have health insurance.” This data has caused some scholars like Nicola Moore of the Heritage Foundation to fear that children insured by private carriers will drop their plans to obtain coverage through SCHIP. Moore writes, “Covering [median-income earners] 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 health care.” When SCHIP was authorized in 1997, it was not intended to compete with private insurance companies. Rather, the goal of SCHIP was to provide for America’s low-income, uninsured children because this demographic did not have the means to provide for themselves. The middle class does not explicitly meet this criterion, for families between 200 and 300 percent of the FPL can afford private health insurance. Thus, if the program were extended to median-income earners, then SCHIP may be in direct competition with private carriers and might induce a crowd-out effect. Consequently, an expansion of SCHIP would be detrimental not only to insurance companies, who would lose 60

71 Franc
72 Moore, No. 1540
73 Miller
customers for every 100 people enrolled in SCHIP, but it would also channel federal aid away from where it is needed most: children who are the least well-off.\textsuperscript{74}

Although an expansion of SCHIP might benefit some who are able to afford private health insurance, this is not problematic for three reasons. First, SCHIP would continue to primarily target the least well-off. The Congressional Research Service indicates that if SCHIP were expanded, 78 percent of the children covered by SCHIP would be below 200 percent of the FPL.\textsuperscript{75} Since the majority of SCHIP’s funding would be allotted to the children with the greatest need, welfare activists are not justified in their claim that an expansion of SCHIP improperly targets the least well off. Additionally, Congress’s proposal to change income eligibility requirements could be perceived as a necessary, corrective measure.\textsuperscript{76} Because states currently have the ability to cover individuals who are no more than 50 percentage points above their Medicaid threshold, some states have extended coverage to what is arguably the upper-middle class.\textsuperscript{77} This runs counter to the objective of SCHIP. By mandating that states only cover children in families that are below 300 percent of the FPL, Congress would prohibit wealthier families from obtaining coverage through SCHIP and thus prevent the program’s initial goal from being perverted.

Second, SCHIP’s growth would not extend beyond the program’s intended scope. While SCHIP was explicitly authorized to provide for low-income, uninsured children, the program was implicitly created to meet the pressing needs of America’s youth.\textsuperscript{78} As the costs of private insurance rise, making it difficult for middle class families to obtain health insurance, the children of median-income earners have expressed dire need for affordable health care.\textsuperscript{79} Thus, an expansion of SCHIP is not a move towards government-run health care, but rather a logical extension of the program’s goal to fill the gap between the ability to obtain health insurance and the need for affordable health care. At the point where families must make the rational choice between protecting their children’s health and saving a large percentage of their earnings to cover basic living expenses, it seems necessary that the federal government intervene. In expanding SCHIP, policy makers would help bridge the gap between wealthy and poor by permitting lower-middle class families who obtain SCHIP instead of private insurance to retain more of their income and consequently enjoy a higher standard of living.

Third, it is not problematic for SCHIP to with private carriers because this competition will be beneficial to society at large. It is important to note

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\item \textsuperscript{74} Kenney and Cook, 3
\item \textsuperscript{75} Kenney, Genevieve, Allison Cook, and Jennifer Pelletier. “SCHIP Reauthorization: How Will Low Income Kids Benefit under House and Senate Bills” September 2007, The Urban Institute
\item \textsuperscript{76} Winfree, Web Memo
\item \textsuperscript{78} Government Accountability Office, 1-5
\item \textsuperscript{79} Winfree, Web Memo
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that SCHIP is not likely to eliminate private insurance companies. Families below 300 percent of the FPL are not mandated to drop their private carriers for SCHIP benefits. Instead, families of this income bracket would be given the choice between receiving coverage under a social welfare program and purchasing private health insurance. Therefore, what would result from an expanded children’s health insurance program is a competitive market, where rational actors can select the cheapest program that offers the greatest benefits. In differentiating SCHIP from private insurance companies, there is a trade-off between the minimal cost-sharing requirements of SCHIP and the perception of receiving better quality and access to care under a private carrier. As the government becomes a viable competitor in the health insurance industry, private carriers will have incentive to reassess the costs and benefits of their plans, if they want to maintain control of the market. As a result, the price of private insurance may significantly decline and the benefits offered by private carriers may improve as well. Thus, the development of a competitive health insurance market would drive innovation and progress.

Overall, the benefits of covering more low-income children by expanding SCHIP outweigh the potential problem of covering some who already have private health insurance. SCHIP’s growth would ultimately minimize the number of uninsured children living in America. According to the Congressional Research Service, over half of America’s uninsured youth lives with families who are between 200 and 300 percent of the Federal Poverty Line. This data suggests that families in this income bracket may not be willing to pay the high out-of-pocket costs for health insurance. If the children of low to middle class families were eligible for SCHIP benefits, then these families could enroll in SCHIP and avoid the choice between retaining a high percentage of their earnings and insuring the livelihood of their children. Genevieve Kenney of the Urban Institute affirms, “Adopting broader Medicaid/SCHIP eligibility policies that encompass higher income children may also raise enrollment among the millions of low-income uninsured children who are eligible … but not enrolled.” By expanding SCHIP on the federal level, policy makers would further decrease the number of uninsured children living in America.

Even if an expansion of SCHIP targets the right demographic, the program’s growth could be opposed if it is not economically sustainable. Under Congress’s current proposal, the federal government’s annual cost of covering an uninsured child would range from $1,612 to $4,008; this amount is over three and half times the average cost of covering a

80 O’Shea, Web Memo
82 Congressional Research Service. SCHIP Original Allotments: Description and Analysis. October 31, 2006
83 Zuckerman, Stephen and Cynthia Perry. “Concerns about parents Dropping Employer Affordability September 2007, The Urban Institute
84 Kenney, 6
child through private insurance. While Congress plans to balance the federal budget by placing a tax on tobacco products, econometric data from the Heritage Foundation predicts that 22 million additional smokers would be needed to offset the funds allotted to SCHIP. Given the federal government’s current campaign to encourage people to quit smoking, it seems ironic and unlikely for Congress’s financial solution to work. Realistically, SCHIP is likely to be financed through income taxes. The CBO estimates that if SCHIP is expanded, the middle-class is likely to pay 66 percent of their income in taxes by 2050. Unless SCHIP mandates a cost-sharing plan, there does not seem to be any viable alternative for securing the funds needed to expand SCHIP.

Although Congress’s proposal to raise tobacco taxes to fund SCHIP is unattainable, it is not problematic to increase income taxes to expand SCHIP. Traditionally, the tax system in America has been adjusted to reflect the state of society. As the cost of health insurance undergoes a fast rate of inflation, health insurance is becoming a commodity exclusively for the rich. In a testimony before the House of Representatives in October of 2007, Leonard Burman of the Urban Institute explained, “Rising health care costs translate into higher health insurance premiums, which prices health insurance out of the reach of more and more workers.” This is adverse to one’s intuitions, considering that the upper class can afford to pay the high out-of-pocket cost of health care, while the lower and middle classes can barely cover their basic living expenses. Instead of continuously pandering to the rich, the American government should raise taxes to provide coverage for the less well off. Thus, an expansion of SCHIP would help reduce the growing disparity between the lives of the rich and the poor.

The third area of analysis, the implications and consequences of maintaining the status quo, also offers good reason to increase SCHIP’s federal appropriations. If federal funding is not significantly increased, then the program is likely to depreciate. Without additional funding, SCHIP will not be able to sustain its current enrollment and programs. This is problematic, given the growing popularity and subsequent demand for SCHIP. The Kaiser Foundation predicts that if SCHIP is not expanded, then, “It will be difficult for states to move forward to address the growing number of uninsured children and some of the 6 million children currently covered could be at risk of joining the ranks of the uninsured.” Given the life and death consequences of obtaining health care as a child, it is in the federal government’s interest to insure the livelihood of the next generation by allotting more money to SCHIP. At first glance, an expansion of SCHIP seems to set the dangerous precedent that the federal government

87 Congressional Budget Office, 15
88 Burman, Web Memo
89 ibid.
90 The Kaiser Commission on Medicaid and Uninsured, 4
will entitle any capped program that continuously runs a deficit. Nina Owcharenko of The Heritage Foundation expresses her concern, writing, “Congress should not provide [states with] another bailout... States know their federal SCHIP contributions and should plan accordingly.”

However, this complaint is unfounded, for the federal government is not implying that states abandon fiscal responsibility. By further extending SCHIP’s coverage, the federal government would demonstrate that it recognizes its responsibility to identify and meet the needs of the American people. Because the children of low to middle class families express dire need for health care, the federal government would further demonstrate its accountability to the American people by expanding SCHIP.

Moreover, it is necessary to expand SCHIP, for proposed alternatives would not be as effective. Some who oppose an expansion of SCHIP have called for the federal government to provide tax credits to middle class families who insure their children through private carriers. Robert Helms of the American Enterprise Institute recommends, “Refundable credits or credits... for lower-income families ... to purchase private health insurance, and offer an important alternative to further expanding government-run health care programs.”

Even though this policy prescription offers families’ incentive to obtain private health insurance for their children and greater control over their plans, lower and middle class families would still endure the burden of paying high out-of-pocket costs for health insurance. Under a tax-credit system, it does not follow that families between 200 and 300 percent of the FPL would be more likely to obtain private health insurance. Burman elucidates this point, writing, “Most people would like to have insurance [only] if they can get it at a reasonable price because it protects them from a major financial risk.”

While a tax-credit system does not substantially offset the financial burden entailed by obtaining health insurance, SCHIP does. Subsequently, SCHIP is superior to its leading alternative.

In light of this analysis, the federal government should not only reauthorize SCHIP, but also substantially increase SCHIP’s federal allocations. An expanded children’s health insurance program will primarily benefit children whose families cannot afford private health insurance or who would be financially overstretched if private health insurance was purchased. Even though SCHIP’s growth would probably be financed by income taxes in the long-run, this is not problematic, given the widening disparity between the lives of the rich and the poor. If SCHIP is not reauthorized and expanded, then the program is likely to deteriorate and creating new programs with goals similar to those of SCHIP are not likely to be effective. Thus, SCHIP requires expansion to meet the needs of the children of lower and middle class.

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93 Burman, Web Memo
following section, three recommendations will be provided on how to further extend SCHIP’s coverage and increase enrollment.

**Recommendations**

First, it is recommended that the legislative and the executive branches of the federal government cooperate with one another to reauthorize SCHIP and provide the program with an additional $35 billion over the next five years. States should receive additional levels of funding to sustain their current enrollment and health care plans; states should also have the monetary means necessary to cover more of America’s uninsured, low-income children. To finance SCHIP, the federal government should raise the tax on tobacco products and consider raising income taxes as well. It is also recommended that the federal government help states avoid further shortfalls in funding by creating a counter-cyclical financial plan, where the federal government would increase federal appropriations to SCHIP during times of economic decline.94

Second, it is recommended that states award SCHIP benefits only to the children of families below 300 percent of the FPL. If a state is not covering children at this threshold, then states should either lower or raise their income eligibility requirements. It is important for states to specifically target the children below 300 percent of the FPL, for the most uninsured children reside with families between 200 and 300 percent of the FPL and the children living in families below 200 percent of the FPL are those with the greatest need for public health care.

Third, it is recommended that states increase their outreach efforts and remove barriers to SCHIP enrollment. States should implement community-based campaigns to educate the public about SCHIP and consequently enroll more of America’s uninsured children. Health care should not be forgone because families did not know about SCHIP.95 Furthermore, it is suggested that states reassess SCHIP’s application procedure to ensure that no barriers deter participation. While states have already simplified the application procedure, states could further streamline the process by coordinating enrollment with other public benefit programs.

Since its authorization in 1997, The State Children’s Health Insurance Program has become an integral part of the welfare system, insuring the lives of over six million citizens. While SCHIP is a thriving program, the program currently faces shortfalls in funding and there is still much progress that could be made in reducing the number of uninsured children that live in America. If these three recommendations are enacted en bloc, then states’ children’s health insurance programs will have sufficient funding not only to sustain their current programs, but also to further enroll America’s uninsured, youth.

**Summation**


95 Building on Success of Children’s Coverage Through SCHIP and Medicaid. Center for Children and Families. December 12, 2006
As Congress attempted to reauthorize SCHIP and provide SCHIP with additional monetary support, policy makers have commenced debated on the extent to which the federal government should be responsible for the lives of America’s youth. This debate, however, has been muddled by partisan politics. While Congress passed a bill to reauthorize SCHIP and provide the program with an additional $35 billion, President Bush vetoed this measure to expand SCHIP, fearing that America would take on the shape of a socialist state. Even after policy makers returned to the drawing board to negotiate SCHIP’s expansion, on November 16, 2007, President Bush issued another veto. The fate of America’s youth now lies in the hands of Congressmen to work together to muster enough votes to override Bush’s veto; it is imperative that they do so.

Throughout this paper, it has been argued that President Bush should not prevent SCHIP from flourishing. SCHIP has made great strides in reducing the number of uninsured children and should continue to do so by further extending its coverage. Growth in the program would benefit those in need, be economically sustainable, and be demonstrative of governmental accountability. It is recommended that the federal government cooperate and award SCHIP an additional $35 billion, redefine income eligibility requirements, and encourage states to increase their enrollment. By expanding SCHIP to this extent, SCHIP will not only insure the lives of millions of children, but also ensure America that the next generation will grow up to be healthy and productive members of society.

Works Cited


