Backgrounder

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Fixing SCHIP and Expanding Children's Health Care Coverage

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The large number of uninsured children is universally acknowledged as a serious problem, but policymakers have inappropriately fixated on expanding the State Children's Health Insurance Program (SCHIP) as the sole solution. Rather than expanding the role of SCHIP, Congress should consider efforts to cover children in the broader context of health reform by refocusing SCHIP to help children in low-income working families, as originally intended, and promoting policy prescriptions that reach beyond SCHIP and improve the health care system for all Americans, including children.

In the context of the upcoming SCHIP reauthorization, lawmakers should resist efforts to rubber-stamp its reauthorization or to use SCHIP as a vehicle to establish what amounts to a universal entitlement for children. Instead, policymakers could help to refocus SCHIP and advance new ways to address the needs of children that empower families and strengthen access to private health care coverage. Specifically, Congress should:

- **Establish a responsible system of program financing.** Congress should maintain the current block grant structure for SCHIP while prioritizing funds to states that demonstrate fiscal prudence and stay within the original context of the law by targeting lower-income uninsured children. Congress should also limit states' ability to secure additional federal taxpayer money to cover their budget shortfalls.

Talking Points

- The lack of health care coverage among children is a serious problem, but the State Children's Health Insurance Program is not the only solution, and certainly not the best.
- Policymakers should resist efforts to use SCHIP to effect narrow and incremental expansion of the government's role in the delivery of health care. Such approaches would move SCHIP closer to becoming an entitlement, increase the fiscal burden on the states and taxpayers, and crowd out existing private coverage for working families.
- Instead, policymakers should consider refocusing SCHIP to help children in low-income working families, as originally intended, and promoting alternatives that improve the overall health care system and strengthen access to private coverage for all Americans, including children.
- In the context of SCHIP reauthorization, policymakers should establish a responsible system of program financing, set rational eligibility rules, broaden flexibility in health benefit design, and promote private coverage alternatives.

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- **Set rational eligibility rules.** SCHIP was designed to help children in lower-income working families at or below 200 percent of the federal poverty level (FPL). States should retain flexibility to experiment but keep within their budgets and federally established income eligibility thresholds. SCHIP should not be used as a mechanism to establish a welfare program for middle-class or upper-middle-class families.
- **Broaden flexibility in health benefit design.** Unlike Medicaid, which targets truly low-income children, SCHIP was intended to target children in families that earn too much to qualify for Medicaid. Therefore, the SCHIP benefit package should resemble private coverage more closely than Medicaid. To help families make the transition into private coverage, SCHIP coverage options should reflect the broadest array of insurance products available in the private market.
- **Promote private coverage alternatives.** SCHIP should allow greater opportunities to take advantage of private-sector health insurance options. One way to do this would be to liberalize administrative rules to facilitate premium assistance at the state level and expand the availability of premium assistance through SCHIP. Policymakers also should look beyond SCHIP for ways to facilitate private insurance coverage for working families: for example, by providing a refundable federal health care tax credit to facilitate private-sector family coverage; allowing the purchase of insurance across state lines; creating state-based health insurance exchange mechanisms that facilitate the purchase of individual, portable health care coverage; and transforming existing subsidies for uncompensated care into direct financial assistance to help families purchase private coverage.

A Clash of Visions on Children's Health Coverage

The lack of health insurance coverage among children reflects today's patchwork health care system in which individuals, families, and children slip through the cracks of the current structure. While arguably the most politically attractive group, children actually have one of the lowest uninsurance rates relative to other age groups. The U.S. Census estimates that 11 percent of children were uninsured in 2005, compared to 31 percent of adults between the ages of 18 and 24.[1] Policymakers would be wise to consider proposals that benefit children as well as other in-need populations by addressing the core problems of the health care system instead of further compartmentalizing groups and perpetuating this patchwork system.

The uninsured—whether children or adults—do get care, but it is often delayed and obtained in an inefficient and costly manner (e.g., in hospital emergency rooms). Furthermore, surveys show that uninsured children have less access to care than others. One study reports that 54 percent of children without coverage have not made any well-child visits and that 30 percent had no usual sources of care in the past year.[2]

The lack of coverage also affects taxpayers. Researchers at the Urban Institute found that federal, state, and local governments spent $34.6 billion on uncompensated care in 2004.[3] Moreover, other research shows that the uninsured are not the only ones underserved by the system. Enrollees in poorly performing public programs, specifically Medicaid and SCHIP, often cannot get the kind of care they need and thus go to already overburdened hospital emergency rooms.[4]

1. Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," U.S. Department of Commerce, U.S. Census Bureau, August 2006, p. 22, at *www.census.gov/prod/2006pubs/p60-231.pdf* (April 24, 2007).
2. Campaign for Children's Health Care, "No Shelter from the Storm: America's Uninsured Children," September 2006, p. 9, at *www.childrenshealthcampaign.org/tools/reports/Uninsured-Kids-report.PDF* (April 24, 2007).
3. Jack Hadley, Ph.D., and John Holahan, Ph.D., "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured *Issue Update*, May 10, 2004, p. 3, at *www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf* (April 24, 2007).

The conventional approach to addressing the problems of the nation's uninsured children is to focus on program reauthorization, such as SCHIP, and build on it as a model. This narrow approach ignores serious structural changes—a typical Washington response to many public policy issues—and can also be seen as an incremental approach to expanding the role of government in the health care system.[5]

The broader approach looks at the health care system as a whole and establishes coherent and integrated policy prescriptions that address the system's fundamental, core problems. This approach is far more likely to provide longer lasting solutions that will improve the health care system for all Americans, including children.

The Narrow Approach. Two current legislative proposals are excellent examples of the narrow, incremental approach: the Children's Health First Act (S. 895 and H.R. 1535), introduced by Senator Hillary Clinton (D–NY) and Representative John Dingell (D–MI), and S. 1224, introduced by Senators John Rockefeller (D–WV) and Olympia Snowe (R–ME). These bills rely on government-run models and use SCHIP as the foundation to establish greater government control over health care decisions affecting children. They also share a common focus on enrolling more children in SCHIP, increasing funding obligations for SCHIP to accommodate new enrollees, and broadening the scope of eligibility and services in SCHIP.

The Broader Approach. President George W. Bush has outlined a more comprehensive approach that incorporates SCHIP into a larger vision that addresses the fundamental problems facing the health care system.[6] The President's proposal focuses on maximizing existing SCHIP funds to cover low-income children; reforming the federal tax treatment of health insurance to enable families, regardless of job or job status, to receive federal tax assistance to purchase private health insurance; and providing states with greater flexibility to use federal funding to target assistance more effectively to those who need it.

The Status Quo: How SCHIP Works Today

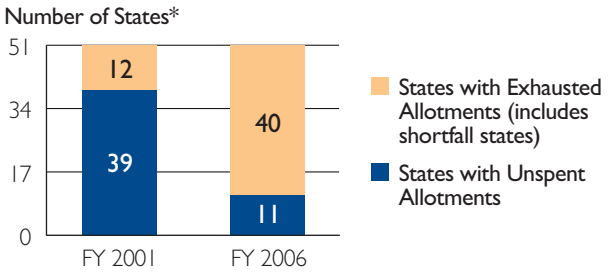
Before reauthorizing SCHIP, Members of Congress should recall that the program was enacted as part of the Balanced Budget Act of 1997[7] to address coverage needs of low-income uninsured children whose families earn too much to qualify for Medicaid but not enough to purchase private coverage on their own.

Financing Structure. Unlike Medicaid, which is an open-ended entitlement, SCHIP was designed as a block grant, meaning that the program is financed through a fixed appropriation. The legislation appropriated $40 billion over 10 years, to be distributed among the states.[8]

These funds are distributed to states based on a formula that accounts for a variety of factors,

Chart 1 B 2029

State SCHIP Spending Trends



* The District of Columbia is counted as a state.

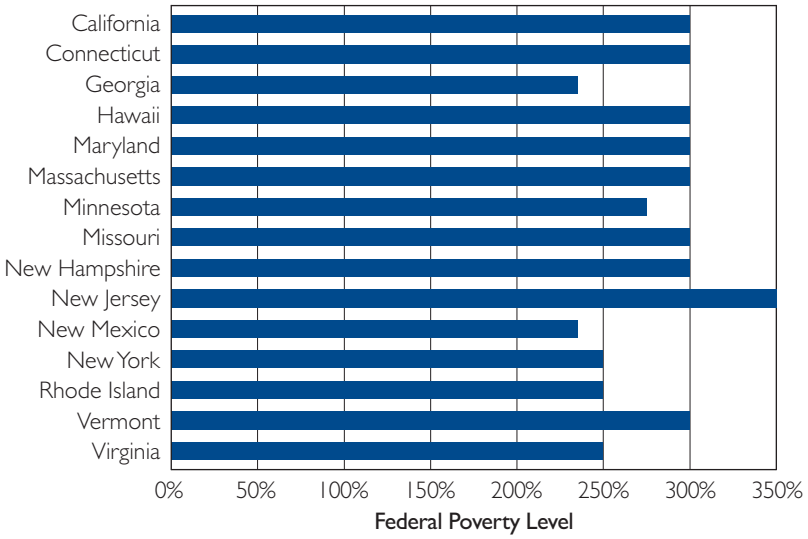
Source: Kathryn G. Allen, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences in Implementing SCHIP and Considerations for Reauthorization," GAO–07–447T, U.S. Government Accountability Office, February 17, 2007, p. 19, at *www.gao.gov/new.items/d07501t.pdf* (April 24, 2007).

4. John S. O'Shea, M.D., "More Medicaid Means Less Quality Health Care," Heritage Foundation *WebMemo* No. 1402, March 21, 2007, at *www.heritage.org/Research/HealthCare/upload/wm_1402.pdf*.
5. Editorial, "Hillary Care Installment Plan," *The Wall Street Journal*, April 24, 2007, p. A18, at *www.opinionjournal.com/editorial/feature.html?id=110009981* (April 27, 2007).
6. See The White House, "Strengthening Health Care," at *www.whitehouse.gov/infocus/healthcare* (April 24, 2007).
7. Public Law 105–33.

including a state's number of low-income uninsured children and differences in health care costs from state to state. States receive a fixed, annual allocation based on this formula and have three years to spend their allocation. At the end of the three-year period, the Department of Health and Human Services may recover and redistribute any unused funds. As an enticement, states receive an enhanced Medicaid matching rate ranging between 65 percent and 85 percent.

Chart 2 B 2029

States with SCHIP Eligibility Above 200 Percent of Federal Poverty Level



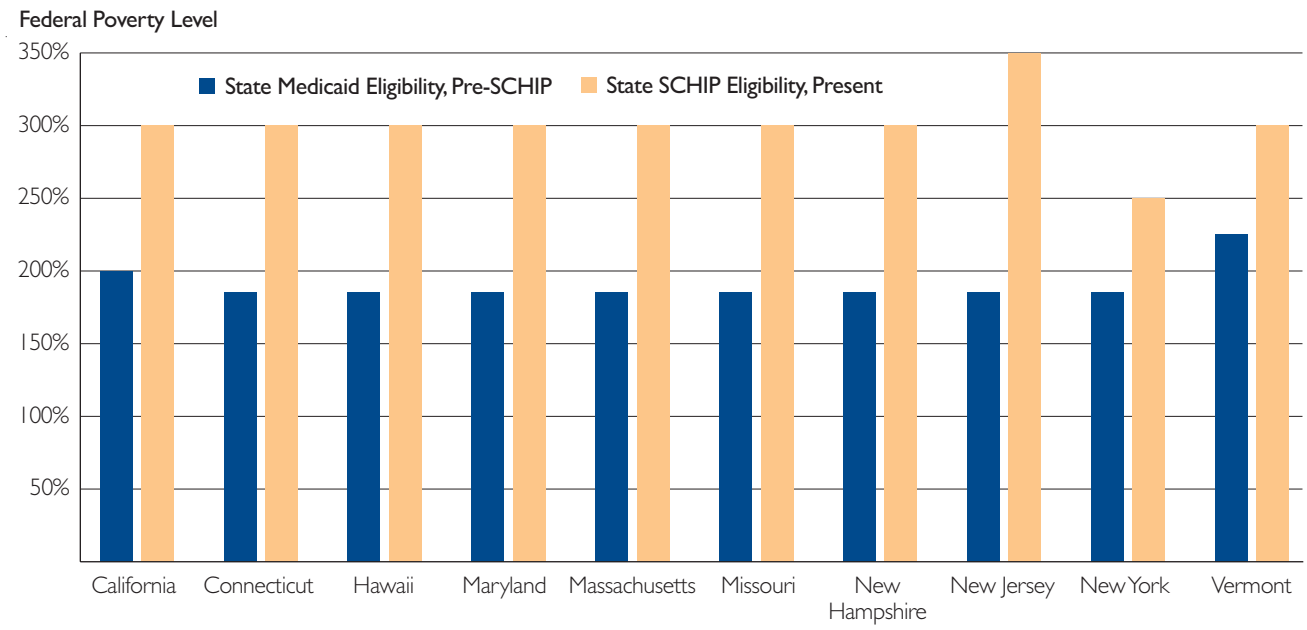
Source: Data provided by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, October 5, 2006.

Over the years, some states have spent more of their allotments than others, creating a tension between the states that have depleted their federal allotments and those that have not. In general, the redistribution process rewards states that have overspent their allotments at the expense of slower-spending states. As a result, each state has a strong incentive to spend its allotment to avoid losing it. In fiscal year (FY) 2001, 38 states and the District of Columbia had unspent allotments, while 12 had spent their original allotments.[9] In FY 2006, only 11 states had unspent allotments, compared to 39 states and the District of Columbia that had exhausted their allotments, and 12 of these states faced shortfalls.[10]

Federal bailouts to shortfall states—those states that have overspent their original allotments—are not a new phenomenon, but it was less obvious in the past when the pool of unspent funds was larger. In FY 2001, over $2 billion in unused funds was available for redistribution, compared to $173 million in FY 2006.[11] Today, an estimated 14 states are facing shortfalls and are pressuring Congress to bail them out.[12] Besides some possible flaws in the basic formula, SCHIP's overall funding structure encourages states to leverage the enhanced SCHIP match, exceed their original allotments, and go beyond the original scope of the program.[13]

8. Annual appropriations were about $4.2 billion for FY 1998–FY 2001, $3.2 billion for FY 2002–FY 2004, $4.1 billion for FY 2005–FY 2006, and $5 billion for FY 2007. Elicia J. Herz, Bernadette Fernandez, and Chris L. Peterson, "State Children's Health Insurance Program (SCHIP): A Brief Overview," Congressional Research Service *Report for Congress*, August 4, 2005, p. 5.
9. Kathryn G. Allen, Director, Health Care, U.S. Government Accountability Office, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences in Implementing SCHIP and Considerations for Reauthorization," statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, February 15, 2007, GAO–07–447T, p. 29, at *www.gao.gov/new.items/d07501t.pdf* (April 24, 2007).
10. *Ibid.*
11. Chris Peterson, "Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee," Congressional Research Service, July 25, 2006, p. 1, at *www.senate.gov/~finance/hearings/testimony/2005test/072506cptest.pdf* (April 24, 2007).
12. $650 million in bailout funding was included in the FY 2007 emergency supplemental appropriations conference agreement but, as of this writing, is pending the President's signature or veto.

Chart 3 B 2029



Source: Data provided by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, October 5, 2006.

Eligibility and Enrollment. The original legislation clearly defined the populations eligible for SCHIP. The program targets low-income, uninsured children and defines low-income children as those whose family income is at or below 200 percent of the FPL (approximately $40,000 for a family of four in 2007).[14] For states where Medicaid eligibility at the time of enactment was near 200 percent of the FPL, the law allowed them to expand SCHIP eligibility to 50 percent above their Medicaid levels.[15]

Today, 25 states and the District of Columbia have set SCHIP eligibility at 200 percent of the FPL, and nine states have set eligibility below 200 percent.[16] Fifteen states have expanded eligibility for children above 200 percent, and nine of the 15 have set it at or above 300 percent of the FPL. Moreover, 10 of the 15 states above 200 percent of the FPL have exceeded the 50 percent pre-Medicaid threshold set in the law.[17]

Fifteen states have used SCHIP funds to cover adults: Of these 15 states, 12 cover parents, seven cover pregnant women, and seven cover childless adults.[18]

Federal waivers have played a role in these expansions. Many states have used the broad terms of

13. Nina Owcharenko, "The Truth About SCHIP Shortfalls," Heritage Foundation *WebMemo* No. 1381, March 5, 2007, at *www.heritage.org/Research/HealthCare/wm1381.cfm*.
14. 42 U.S. Code § 1397jj.
15. *Ibid*.
16. Data provided by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, October 5, 2006.
17. *Ibid*.
18. Arkansas, Arizona, Colorado, Idaho, Illinois, Michigan, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Utah, Virginia, and Wisconsin. Allen, "Children's Health Insurance," p. 22.

Section 1115 waivers to expand coverage up the income scale and to various categories of adults. While waivers are an important tool for states, giving them the ability to develop innovative approaches to address the unique needs of their populations, greater oversight and parameters may be needed to ensure that states are not exceeding or exploiting the fundamental goal of the program and, especially, its fixed funding structure.

Benefit Design. States have some autonomy in designing their SCHIP programs. A state can expand the existing Medicaid program, set up a separate program, or use a combination of the two. States have adopted all three approaches: 10 states and the District of Columbia have a Medicaid expansion, 18 states have a separate program, and 22 states use combination approaches.[19]

If a state expands its existing Medicaid program to meet SCHIP requirements, Medicaid rules and benefits must apply. A different set of rules and benefit standards are established for states that set up a separate program. Specifically, a state can meet the benefit standards by:

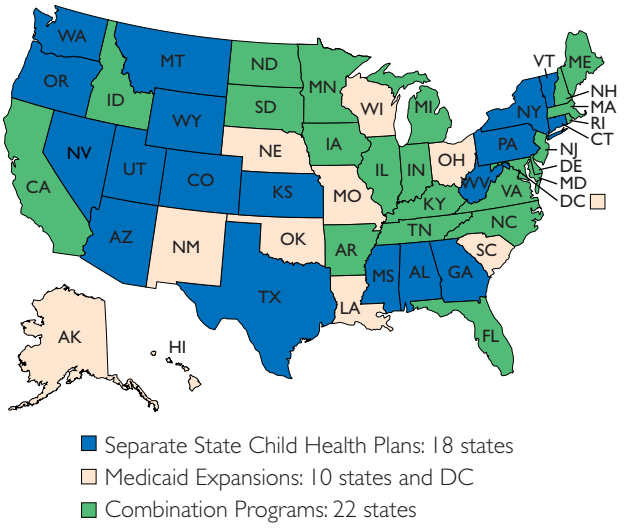
- Designating one of the "benchmark" benefit packages listed in law,[20]
- Developing an actuarial equivalent plan to a benchmark,
- Assigning an existing comprehensive state-based program, or
- Receiving approval from the Secretary of Health and Human Services for an alternative approach.

Under a separate SCHIP structure, states can also require cost-sharing (e.g., premiums or co-pays).[21] As noted, the goal of SCHIP was to provide assistance to children whose families earn too much to qualify for Medicaid but not enough to afford private coverage. Thus, implementing cost-sharing requirements helps to differentiate SCHIP from Medicaid, which is intended to service the truly poor, and cost-sharing better prepares these working families for eventual transition into private coverage.

Regrettably, some states have weakened this distinction by removing or diluting any cost-sharing requirements. In FY 2005, 11 states required no cost-sharing, 14 charged only premiums, and nine charged only co-pays.[22] Furthermore, the range in premiums and co-pays varied significantly.[23]

Map 1 B 2029

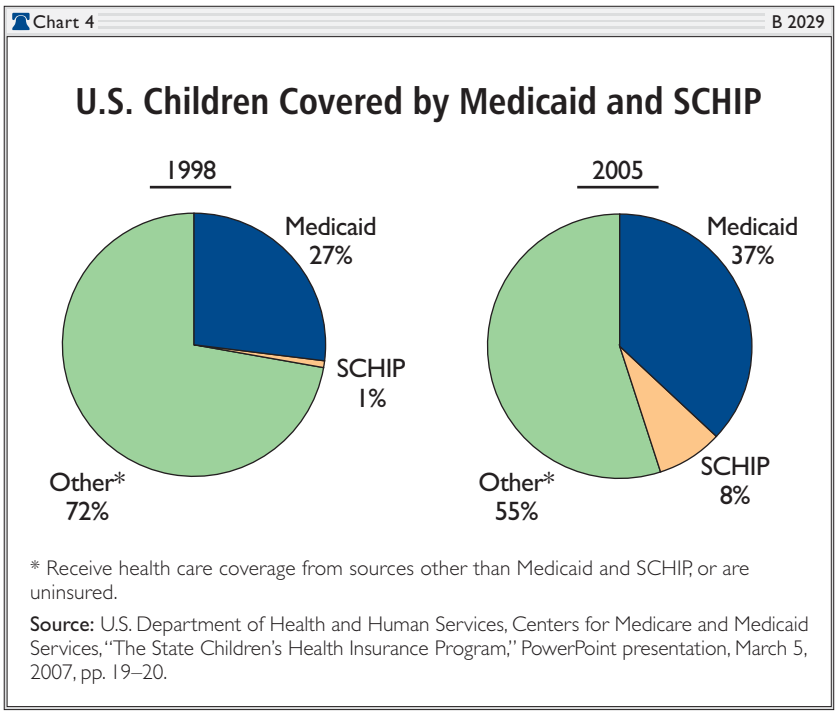
State Children's Health Insurance Program Plan Activity as of January 18, 2007



Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "The State Children's Health Insurance Program," PowerPoint presentation, March 5, 2007, p. 6.

19. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "The State Children's Health Insurance Program," PowerPoint presentation, March 5, 2007, p. 6.
20. Benchmark options include the standard BlueCross BlueShield preferred provider option in the Federal Employees Health Benefits Program, a state employee health benefit plan, and the largest HMO in the state.
21. As noted, SCHIP Medicaid expansions must follow Medicaid cost-sharing rules.
22. Allen, "Children's Health Insurance," p. 18.
23. *Ibid.*, p. 19. See also Donna Cohen Ross, Laura Cox, and Caryn Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," Henry J. Kaiser Family Foundation, January 2007, pp. 59–62, at *www.kff.org/medicaid/upload/7608.pdf* (April 24, 2007).

Passage of the Deficit Reduction Act of 2006 raises further questions about SCHIP's benefit package. It gives states greater flexibility to design their Medicaid benefit packages and cost-sharing requirements to resemble SCHIP more closely. While these changes are good for Medicaid, this further reduces the distinction between the two programs. New thinking on SCHIP's coverage options and cost-sharing is in order, such as adding new coverage options and cost-sharing standards that better reflect the private sector and prepare families for private coverage.



Premium Assistance. States can leverage the private coverage option for enrollees through premium assistance, but the level of bureaucracy involved in implementing this option makes it unattractive and not cost-effective for many states. "Premium assistance" typically means that an SCHIP child enrolls in the parent's employer-based coverage and SCHIP pays a share of the child's premium. However, to do this, a state must determine whether the employer's benefit package matches the SCHIP benchmark and provide a "wraparound" to fill in benefit and cost-sharing differences. Today, only 12 states offer a premium assistance option.[24]

The obstacles to premium assistance illustrate the backward thinking about SCHIP. SCHIP's proponents often view government-controlled SCHIP coverage for children as preferable to empowering families to purchase their own coverage from the private market where the vast majority of Americans get their coverage. In addition, there seems to be a sense that private coverage is not a viable option for low-income families, yet an estimated 10.4 million children below 200 percent of the FPL have private coverage.[25] Broadening the applicability of SCHIP premium assistance would be a valuable and attractive tool in helping SCHIP children to obtain private coverage with their families.

Expanding SCHIP: Building on a Flawed Status Quo

The reauthorization of SCHIP provides a vehicle for policymakers to address the obstacles to children's coverage, but SCHIP is not the only solution. Nor is it the ideal setting to address the needs of working families. Policymakers should be cautious and consider the implications of proposals that focus solely on SCHIP as the "solution."

Entitlement Creep. The government already provides health care for a staggering number of children, and efforts focused on enrolling all eligible children in these programs will only increase this dependence on the government. In 2005, an estimated 45 percent of all children were covered by Medicaid or SCHIP, compared to 28 percent in 1998.[26] Recent research suggests that a significant number of uninsured children are eligible but not enrolled in SCHIP or Medicaid.[27] Those who sup-

24. U.S. Department of Health and Human Services, "The State Children's Health Insurance Program," p. 14.
25. *Ibid.*, p. 22.
26. *Ibid.*, pp. 18 and 19.

port expanded government control over the delivery of health care reference such research and argue that policymakers should fund and facilitate greater outreach for enrollment.

However, establishing a policy of enrolling all eligible children goes far beyond the program's original intent and is in reality a thinly veiled attempt to convert SCHIP into a new entitlement. Establishing a federal goal of enrolling all eligible children would move SCHIP closer to an entitlement and make it the primary source of coverage for more children instead of a safety net for those who cannot secure coverage in the private sector. American taxpayers are already saddled with massive financial obligations for Medicare and Medicaid. They cannot afford another health care entitlement program.

Unfunded State Mandate. Policymakers should also consider the fiscal realities of the existing SCHIP program. Like Medicaid, it is based on a state–federal matching system in which both the states and the federal government contribute to the program. States are already struggling to maintain their budgets, and Medicaid has become the largest budget item, surpassing the traditional state obligations of education and transportation.[28] Efforts to enroll more children in the SCHIP program would undoubtedly impose an even larger burden on state budgets.

In addition, expanding outreach efforts and simplifying the enrollment process would significantly diminish the states' ability to adopt policies to keep the program fiscally manageable. Moreover, if the recent practice among some states of depending on federal bailouts of their SCHIP shortfalls continues, federal taxpayers will also be tasked with covering future shortfalls.[29]

Crowding Out Private Health Care Coverage. Congress should exercise extreme caution when expanding any public health care program. The unintended consequences often include loss of private coverage and reductions in private spending for health care, which is replaced by an increased public spending.

While the empirical research on the extent of the "crowd-out" effect—declines in private coverage caused by expansion of a public program—is mixed, there is absolutely no doubt that it exists. The latest research by economists Jonathan Gruber and Kosali Simon suggests an approximate 60 percent crowd-out effect.[30] Thus, Congress should not undertake SCHIP expansions without understanding the level of damage that such policies can inflict on existing private-sector options, especially for the family as a whole.

Improving SCHIP and Expanding Coverage

Policymakers can help to refocus SCHIP and advance new ways to address the needs of children that are consistent with empowering families and strengthening access to private health care coverage. Policymakers should look at ways to improve SCHIP and expand availability for private coverage for children, preferably while addressing the fundamental shortfalls of the entire health care system.

Establishing a Responsible System of Financing. Specifically, Congress should:

- **Maintain the block grant structure.** Keeping the block grant structure would allow states to continue to receive federal assistance to address the needs of targeted low-income children while limiting their financial dependence on the federal government and protecting taxpayers from funding yet another fiscally unsustainable entitlement program. Congress should reinforce the block grant financing structure. Without it, the existing fiscal abuses will continue and grow much worse.

27. John Holahan, Allison Cook, and Lisa Dubay, "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Kaiser Commission on Medicaid and the Uninsured *Issue Paper*, February 2007, at *www.kff.org/uninsured/upload/7613.pdf* (April 24, 2007).
28. National Governors Association and National Association of State Budget Officers, "The Fiscal Survey of States," December 2006, p. 1, at *www.nasbo.org/Publications/PDFs/Fall%202006%20Fiscal%20Survey%20of%20States.pdf* (April 24, 2007).
29. Owcharenko, "The Truth About SCHIP Shortfalls."
30. Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research *Working Paper* No. 12858, January 2007.

- **Prioritize funding to states that focus on targeted low-income children.** There is great debate as to whether or not the current system for calculating state allocations accurately reflects state dynamics.[31] While states arguably need a more accurate and reliable formula structure, policymakers should incorporate an approach that gives priority attention to states that stay within the federal eligibility thresholds and demonstrate fiscal prudence.
- **Eliminate redistribution of unspent funds among states.** One of the most contentious issues in state allocations is the process of redistributing unspent funds. While well-intentioned, the current policy rewards states for overspending and encourages other states to follow suit or risk losing their allotments. Moreover, simply allowing states to keep these federal funds indefinitely is also not effective. A better approach would allow states to carry over funds for a specific number of years, with any funds still unspent after that time to revert to the U.S. Treasury.
- **Limit states' ability to leverage Medicaid financing.** Under SCHIP, if a state expands Medicaid to accommodate SCHIP enrollees, the state can revert to lower Medicaid matching rates to finance shortfalls or additional coverage. Unlike SCHIP matching funds, which are limited under the block grant, Medicaid matching funds are unlimited. Thus, states that use this technique as a fallback can receive unlimited federal matching through Medicaid. Policymakers should restrict the states' ability to use this financing technique for Medicaid expansions and resist efforts to expand this practice to separate SCHIP plans.

Rational Eligibility Rules. Congress should:

- **Focus on children at or below 200 percent of the FPL.** SCHIP should focus primarily on addressing the coverage needs of children at or below 200 percent of the federal poverty level. Although some states have gone beyond this income target and others are proposing going even further, such expansions risk eroding private coverage options for working families and creating a welfare program for middle-class and upper-class families. Policymakers should resist efforts to expand SCHIP eligibility beyond 200 percent of the FPL.
- **Set parameters on state flexibility.** While the SCHIP law clearly targets children below 200 percent of the FPL, some states have used the waiver process to expand coverage beyond income thresholds and to populations other than children. While federal policymakers should preserve state flexibility, they should establish clear parameters for such flexibility. Specifically, a state requesting a waiver to expand coverage must do so within its original federal allotments, and this funding limitation should be *strictly* enforced at the federal level. In addition, a state requesting to expand coverage to non-children should demonstrate that it has fulfilled its obligation to targeted children. Finally, expanding coverage above the 200 percent FPL threshold should be strictly prohibited. If states wish to expand beyond this income level, they should do so with only state funds.

Broadening Flexibility in Health Benefit Design. Congress should:

- **Expand benefit choices beyond traditional benchmarks.** SCHIP requires states to design an SCHIP benefit based on a benchmark plan. These plans tend to set the benchmark very high and do not reflect current private coverage options or trends. Instead of further distancing SCHIP benefits from existing private coverage models, policymakers should encourage states to broaden the coverage options available within SCHIP. For example, consumer-directed products promote value by engaging individuals in their health care decisions. An estimated 4.6 million people were covered by either a health savings account (HSA) plan or a health reimbursement arrangement as of January 2007.[32] Moreover, one survey found that 50 percent of HSA purchasers earned less than $50,000 per year.[33]

31. Peterson, "Federal SCHIP Financing."

- **Require basic cost-sharing in SCHIP.** States can require cost-sharing (e.g., premiums and co-pays) for SCHIP, but many of these cost-sharing requirements are negligible. SCHIP targets children in working families; thus, coverage should help to prepare and mainstream these families into private coverage, and this includes cost-sharing. Policymakers should set some explicit cost-sharing requirements for enrollees based on income and oppose efforts to minimize these standards.

Promoting Private Coverage. To facilitate the availability and affordability of private coverage, Congress should:

- **Liberalize administrative and regulatory rules on premium assistance.** While SCHIP and even Medicaid allow for premium assistance, the rules and regulations make it too administratively difficult and burdensome to be a practical option for states or families. Policymakers should make it easier for families to leverage SCHIP funds to enroll their children in private coverage, whether through an employer or on their own, without the administrative hassles of the existing process. Policymakers should also require states to offer premium assistance as an option to families and enable states to require participation in premium assistance.
- **Expand the premium assistance model.** The current model for premium assistance is designed to help a family pay for its share of a child's premium, but many parents may face other cost-sharing requirements for their children in the private market. Thus, policymakers should expand the SCHIP premium assistance model to allow SCHIP funds to be used for premiums and other cost-sharing requirements (e.g., deductibles, co-pays, and even savings for future health care needs). This will also help to move SCHIP from a defined benefit model to a defined contribution model.
- **Create tax incentives for parents to obtain family coverage in the private market.** The current tax treatment of health insurance discriminates against lower-income workers and families. Thus, for many low-income families, SCHIP is the only affordable option for their children. Policymakers should fix this inequity by building on the President's health care tax proposal. Specifically, they should give parents a tax subsidy (a tax credit or a deduction) to assist them in obtaining private coverage, either through their employers or independently, and should allow parents with SCHIP-eligible children to use SCHIP funds to supplement the tax benefit for family coverage.
- **Improve private-sector coverage options.** Expanding the availability of affordable, private coverage options is important to helping lower-income working families obtain private health insurance. Allowing individuals to purchase coverage from outside their own states, establishing state-based health insurance exchanges, and transforming existing subsidies into direct financial assistance to help families purchase private coverage are three ways to increase the availability and affordability of coverage.[34]

Conclusion

Continuation or—worse—expansion of the SCHIP status quo is unacceptable. It sets the program on a path toward becoming an entitlement, adds additional fiscal burdens on states and federal taxpayers, and even crowds out existing private coverage.

Congress can rectify these problems by creating a responsible system of financing for the program, establishing rational eligibility standards targeted to

32. This number includes individual, small-group, and large-group markets. See American's Health Insurance Plans, Center for Policy and Research, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans," April 2007, at *www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf* (April 24, 2007).
33. eHealthInsurance, "Health Savings Accounts: January 2005–December 2005," May 10, 2006, p. 9, at *www.ehealthinsurance.com/content/ReportNew/2005HSAFullYearReport-05-10-06F.pdf* (April 27, 2007).
34. For more information on the state-based health insurance exchange, see Robert E. Moffit, Ph.D., "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *www.heritage.org/Research/HealthCare/wm1230.cfm*.

children in lower-income families that need the most help, expanding coverage options, and promoting private-sector alternatives for lower-income working families.

SCHIP reauthorization is a historic opportunity for lawmakers to address the health care needs of children. Congress can best address the coverage needs of children by incorporating SCHIP as a component of larger and more sweeping reforms of the health insurance market. Successfully reforming SCHIP would be a major step toward expanding and improving the health care system for children, their parents, and all Americans.

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