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The State Children's Health Insurance Program: High Stakes for American Families

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Congress is at a crossroads in the debate over the State Children's Health Insurance Program (SCHIP). One road gives government more control over the health care of American families. The other strengthens private sector options and increases parental choice and responsibility.

Congress is now reviewing and debating changes to the program. Over the past 10 years, the program has increased dependence on government, undermined parental responsibility, and increased the burden on taxpayers. With SCHIP requiring reauthorization in 2007, some Members of Congress are seeking to accelerate these trends. Members must recognize that SCHIP, as it is structured today, is not serving the bests interests of children, their families, or taxpayers.

The Beginning of SCHIP. In the early 1990s, when President and First Lady (now Senator) Clinton proposed a form of national health insurance, Americans wisely rejected the idea that the government should control the financing and delivery of medical care. Recovering from this temporary setback, many advocates of government-controlled health insurance thought it best to pursue an incremental strategy of progressively expanding the government's share of health insurance coverage. They enthusiastically supported the enactment of SCHIP as a key component of the Balanced Budget Act of 1997.

SCHIP was originally designed to offer coverage for uninsured children in low-income families that earn no more than twice the federal poverty level (FPL). The program provided federal matching funds as block grants to states, with total federal expenditures capped at $40 billion over 10 years.

Increasing Dependency on Government. The dynamics of the program set in motion an expansion that has continued for the past 10 years. In 1998, 28 percent of American children were enrolled in either Medicaid or SCHIP.[1] The percentage of all children in SCHIP jumped to 45 percent (or 6.2 million children) by 2005.[2] The program is encompassing persons who are not poor, and in certain cases, are grown adults.

State policies have encouraged the trend of adult enrollees. Almost 10 percent of SCHIP enrollees are adults, according to the Government Accounting Office.[3] In Minnesota, for example, 87 percent of those enrolled in 2005 were adults, as were 66 percent of those enrolled in Wisconsin.[4]

Nor are the state officials sticking to the original eligibility ceiling of 200 percent of the FPL. New Jersey's SCHIP program covers children whose parents earn up to 350 percent of the FPL—an amount more than $72,000 per year.[5] The original framers did not intend the legislation to cover middle-class families. It is increasingly clear that many Members of Congress want expansion into higher income

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families largely because they favor government health insurance over private health insurance as a matter of policy.

Transferring Family Responsibilities to the Government. In many ways, SCHIP has eroded a responsibility traditionally reserved to parents.

Division of Families and Loss of Private Coverage. In many cases, SCHIP gives children health coverage totally separate from their parents' health coverage. In practice, that translates to different office locations, different office hours, different doctors, different paperwork—all of which make life more difficult, especially for lower-income families who are likely to have scheduling and transportation problems. The goal should be to help unite families' coverage under one private plan, not spread their coverage throughout a hodgepodge that increases dependency on the government.

While some Members of Congress suggest that private coverage is unattainable for lower-income, working families, the facts tell a very different story. According to the Congressional Budget Office (CBO), 50 percent of children whose families earn between 100 percent and 200 percent of the FPL have private health coverage. That number skyrockets to 77 percent for children whose families earn between 200 percent and 300 percent of the FPL.[6] In addition, many of the working poor have private health insurance available to them through their workplace. In fact, 60 percent of people covered by SCHIP expansions already had private coverage available to them.[7] Based on the most recent research, any expansion of program coverage into middle- and upper middle-class families could accelerate the displacement of private coverage.[8]

The data also suggest that the very availability of SCHIP to low-income workers may cause them to decline private insurance for both themselves and their children.[9] In other words, once their children become eligible for SCHIP, working parents may decide to abandon their own health insurance. In the event of catastrophic illness, those adults would be dependent on taxpayers to pick up the bill (either directly or indirectly) or be forced into a crushing debt.

The Nature of Medical Services. As with most government health programs, the benefits and services provided through SCHIP are determined by politicians and bureaucrats. Americans want to reduce or eliminate the number of uninsured persons, but they are also wary of greater government involvement in health care. Sixty-two percent of Americans believe that if government takes over more of the health care system, the government will get in the way of the doctor-patient relationship.[10] Fifty-eight percent of Americans believe that if government takes over health care, the individual's choices of doctor, treatment options, hospitals, and access to care will be rationed.[11] Based on the experience of government-run health care in countries

1. Centers for Medicare and Medicaid Services (CMS), "The State Children's Health Insurance Program," Presentation, May 23, 2007, p. 20.
2. *Ibid.*, pp.19–20.
3. Kathryn G. Allen, "Children's Health Insurance. State experiences in implementing SCHIP and considerations for reauthorization," testimony before the U.S. Senate Committee on Finance, February 1, 2007, at *www.senate.gov/~finance/hearings/testimony/2007test/020107katest.pdf,* p. 8.
4. *Ibid,* p. 33.
5. CMS, *op. cit.*, p. 31.
6. "The State Children's Health Insurance Program," Congressional Budget Office, Publication No. 2970, p.12.
7. See Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry,* vol. 42, no. 3 (Fall 2005), pp. 232–254.
8. See Greg D'Angelo and Andrew Grossman, " SCHIP and 'Crowd-Out': How Public Program Expansion Reduces Private Coverage," Heritage Foundation WebMemo No. 1518, June 21, 2007, at *www.heeitage.org/research/healthcare/wm1518.cfm.*
9. CBO, pp. 11, 12.
10. "Health Care America National Survey," April 21–22, 2007, conducted by The Winston Group, p. 3.
11. *Ibid.*

like Britain and Canada, these beliefs are well grounded.[12]

As a matter of policy, parental choice should be primary. Parents are the moral as well as the legal guardians of their children and have ultimate responsibility for their children's well-being. Yet, if children are enrolled in a government health program, the parents' options are set by government officials; these determinations are sometimes made on the basis of ideological or political calculations, not simply medical circumstances. Parents may not be fully aware of the medical services that government officials authorize for their children, and they may even be confused as to what is or is not provided under the government's health care program.

For parents, the crucial issues often revolve around matters relating to sexual behavior and health, which clearly have a moral or ethical dimension. In the case of SCHIP, for example, the enabling legislation stipulates that the federal government shall not pay for abortions using program dollars except in the case of rape, incest, or endangerment of the mother. But for many parents, abortion is not the only issue that merits parental involvement and consent. State officials in Michigan, concerned that the law required SCHIP to fund contraception and sterilization services,[13] amended Michigan's Title XXI State Plan to remove coverage for those services.[14]

In this area of public policy, both clarity of coverage and parental freedom are crucial. Clearly, parents have the right to know what services their children are receiving, and they have a right to withhold consent from such services if they deem them ethically or morally objectionable. Taxpayers also have the right, through their elected representatives, to withhold their tax dollars from funding such procedures. For example, some forms of emergency contraception are, in fact, abortifacients.[15] Many taxpayers and parents might find this procedure objectionable. Furthermore, if parents are to be liable for subsequent medical costs for their children's iatrogenic illnesses, they have a right to know and approve the medical services their children are getting.

Burdening the Taxpayers. SCHIP was intended to help children whose families make too much income to qualify for Medicaid, a traditional welfare program, but not enough to afford private coverage. Since its inception, however, the program has expanded government control over a progressively larger share of the health insurance system.

Current reauthorization proposals in Congress are designed to exacerbate this trend. The Children's Health First Act (Dingell/Clinton, H.R. 1535 and S. 895) would expand SCHIP income eligibility to 400 percent of the FPL, or $82,600 for a family of four. If it becomes law, more than 71 percent of children will be eligible for either SCHIP or Medicaid.[16] Whereas SCHIP was originally a fixed appropriation of $40 billion over 10 years, the estimated cost of current proposals exceeds $50 billion over 5 years.[17]

SCHIP contains perverse incentives for states to expand the program beyond its original mandate.

12. See, in particular, Kevin C. Fleming, M.D., " High-Priced Pain: What To Expect from a Single–Payer Health Care System," Heritage Foundation *Backgrounder* No. 1973, September 22, 2006, at *www.heritage.org/research/healthcare/bg1973.cfm.*

13. Michael O'Dea, "Health Care Reform: Moral Crisis in State Children Health Insurance (S-CHIP)" The Christus Medicus Foundation, March 23, 2000, at *www.christusmedicus.com/S-CHIP/MIChild/SCHPpaperStan_3-2000.pdf*.

14. Letter from Robert M. Smedes, Deputy Director for Medical Services Administration, Lansing, Michigan, to Ms. Alisa Adamo, Health Care Financing Administration, December 21, 1998.

15. As Dr. James Trussel, Director of the Office of Population Research at Princeton University, explains, "To make an informed choice, women must know that ECPs—like all regular hormonal contraceptives such as the birth control pill, the implant Implanon, the vaginal ring NuvaRing, the Evra patch, and the injectable Depo-Provera,31…may prevent pregnancy by delaying or inhibiting ovulation, inhibiting fertilization, or inhibiting implantation of a fertilized egg in the endometrium." See *ec.princeton.edu/MOA.pdf,* accessed on June 19, 2007.

16. Hon. Michael Leavitt, Secretary, U.S. Department of Health and Human Services, remarks at the American Enterprise Institute, April 24, 2007, at *www.hhs.gov/news/speech/2007/sp20070424a.html.*

17. Edwin Park and Robert Greenstein, "Options Exist for Offsetting the Cost of Extending Health Care Coverage to More Low-Income Children," Center on Budget and Policy Priorities, April 12, 2007, at *www.cbpp.org/3-8-07health.htm*.

States that overspend typically get bailed out by either collecting SCHIP money that was not spent by other states or by receiving federal funds above and beyond the original allotments. States like Maryland, Massachusetts, and New Jersey are repeat "shortfall" states and have set SCHIP income eligibility at or above 300 percent of the FPL. These states are turning middle-class families into welfare recipients at the expense of families in other states and taxpayers.

SCHIP's expansion up the income scale has initiated a major change in the way that many Americans—working adults and children from non-poor families—obtain health insurance. The debate over SCHIP is not simply about the future of one program; it is part of the larger national debate over whether or not the United States will have a health care system controlled by government, accompanied by a dramatic increase in taxes for ordinary Americans.

What Congress Should Do. In designing a new SCHIP policy, Congress should incorporate measures that would lessen dependence on government officials in the financing and delivery of health care for children, respect and enhance the role of parents, and reverse the "mission creep" toward national health insurance. Such an entitlement would inevitably be characterized by central planning, price controls, rationing, and the suppression of personal freedom.

- **Target SCHIP on lower-income, uninsured children.** SCHIP should not be used as the foundation for incremental government health care; it should remain limited in focus and funding to addressing the needs of children who are below 200 percent of the FPL and who do not have access to private health insurance.
- **Empower families to make the health care decisions affecting their children.** Parents, not the government, should decide what is best for their children. A robust system of premium assistance would allow parents to use SCHIP funds to purchase private health care coverage without government micro-management. Most importantly, SCHIP must respect the moral authority of parents, especially when it comes to the provision of controversial health care services. Congress and state policymakers should soundly protect parents' rights, including the rights to know what services are being provided to their children and to consent before those services are rendered.
- **Expand options for individuals and families beyond the narrow confines of the SCHIP program.** The number of uninsured children is just one aspect of the broader malfunctioning of the health care system and the government policies that shape it. The best way to address the needs of children is to address the fundamental problems of the health insurance markets, such as outdated state insurance regulations and the inequitable tax treatment of health insurance. Congress should use the opportunity of SCHIP's reauthorization to tackle the larger problems of the health care system. A powerful injection of consumer choice and robust competition would help make private health insurance more accessible and affordable for all Americans.

Conclusion. Most American taxpayers are willing to provide health insurance for children who do not have it. But in drafting the SCHIP reauthorization, Congress should make it easier, not harder, for individual families to secure the health care they want. The goal should be to unify families through family coverage, whether that coverage is provided through employers or in other ways of the family's choosing.

Government funding for children's health insurance should simplify, rather than complicate, the lives of poor working families; it must build upon, rather than weaken, private health insurance; finally, it must support, rather than undermine, the transmission of fundamental ethical and moral values from parents to children, which is at the heart of family life.

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