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Redesigning SCHIP to Strengthen Private Health Insurance for Working Families

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The best way to ensure adequate, dependable health care for all children is to strengthen private insurance coverage and make it more affordable for lower-income working families. The reauthorization of the State Children's Health Insurance Program (SCHIP) presents Congress with an opportunity to move in that direction. Unfortunately, the approach taken by the Senate Finance Committee—which focuses only on expanding the traditional program—will displace private insurance with government-sponsored health care coverage.

Instead, lawmakers should address the underlying problems in the health care system that make private insurance unaffordable for so many families. Congress should take the following steps in designing an alternative SCHIP reauthorization proposal: Include budget-neutral tax reform designed to help lower-income families pay for dependent coverage; use SCHIP funds to help families enroll in private coverage; and encourage an affordable and competitive private health insurance market at the state level.

What the Senate Finance Bill Would Do. Senate Finance Committee Chairman Max Baucus's (D–MT) reauthorization bill may be less expensive and expansive than other proposals offered in the Senate and House, but it still lacks the steps needed to protect and strengthen existing private coverage. Based on certain provisions in the Senate bill, the Bush Administration has signaled its intention to veto it.[1] The Baucus bill would have the following consequences:

- **Expanded Dependency on Government-Run Health Care.** SCHIP was originally designed as a program to assist uninsured children in lower-income families at or below 200 percent of the federal poverty line (FPL). Supporters of the Senate bill claim that it restores SCHIP to its original intent. However, the bill would allow states to cover children at 300 percent of the FPL and, in some cases, at even higher levels.[2] While the bill includes new prohibitions on states extending coverage to adults, it also provides numerous exceptions. For example, states could continue to cover parents so long as the state adheres to new rules. The federal share of SCHIP funding would be lower for those states, but would still be higher than the federal share of funding for Medicaid.[3]
- **The Displacement of Private Coverage by Public Coverage.** Citing numbers from the Congressional Budget Office (CBO), Department of Health and Human Services Secretary Michael Leavitt notes that by 2012, a total of 3.3 million persons would be enrolled in SCHIP if the Senate bill becomes law. He adds:

> [A]n additional 1.6 million individuals (or approximately 33 percent of the total) who

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were previously covered under private insurance would be enrolled in SCHIP. Billions of dollars for health insurance coverage would be shifted from the private sector to the public sector and from state government to the federal government with little actual gains in insurance coverage for children. In addition, expansions to new populations (those previously not eligible for SCHIP) are offset by the estimated reductions in private coverage.[4]

These CBO numbers are consistent with independent findings in professional literature on the subject—such as a recent study by Jonathan Gruber and Kosali Simon[5] on the loss of private health coverage through public program expansion.[6]

Supporters claim the bill would improve premium assistance—the one aspect within SCHIP that could expand private coverage. However, the effect would be neutralized, because the provisions do not remove the program's most onerous and problematic feature, the "wrap-around" requirement. This feature requires states to fill in the cost-sharing and benefits differences between SCHIP and private plans covered by premium assistance. The SCHIP program also focuses exclusively on employer-based coverage, and so, is biased against the possibility of a family obtaining coverage in the private, individual market.[7]

- **Increased Spending and Taxes.** Reauthorizing SCHIP at its current funding level would cost $25 billion over the next five years.[8] The Baucus bill would add $35 billion to that amount, which is lower than the $50 billion increase provided for in the Senate budget reconciliation, but is drastically larger than the $5 billion increase requested by President Bush.[9] To fund the expansion, the Senate bill includes a hike in the regressive tobacco tax,[10] as well as some creative cost accounting. The major accounting gimmick requires states to cut millions of children from the program in the final year, and assumes that the next Congress will provide additional funding to prevent such a politically unpopular event from occurring. Congress's track record of forcing taxpayers to bail out states that routinely overextend SCHIP coverage illustrates the likely result.[11]

1. Letter to the Honorable Max Baucus, Chairman of the Committee on Finance, United States Senate, from the Honorable Michael Leavitt, Secretary of the United States Department of Health and Human Services, July 17, 2007, p. 1.
2. See Title I, Sect. 110, "Description of the Chairman's Mark: The Children's Health Insurance Reauthorization Act of 2007," U.S. Senate Finance Committee, at *finance.senate.gov/sitepages/leg/LEG%202007/Leg%20110%20071307%20Mark.pdf*. For example, New Jersey's level of coverage at 350 percent of the FPL, or $72, 275 for a family of four, would still qualify, as would that of New York, which recently passed legislation to expand coverage to 400 percent of the FLP, or $82,600 for a family of four.
3. See Title I, Sect. 106.
4. Letter to the Honorable Max Baucus, Chairman of the Committee on Finance, United States Senate, from the Honorable Michael Leavitt, Secretary of the United States Department of Health and Human Services, p. 3.
5. Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" NBER Working Paper No. w12858, January 2007.
6. Andrew M. Grossman and Greg D'Angelo, "SCHIP and 'Crowd-Out': How Public Program Expansion Reduces Private Coverage," Heritage Foundation *WebMemo* No. 1518, June 21, 2007, at *www.heritage.org/research/healthcare/upload/wm_1518.pdf*.
7. See Title IV, Sect. 401.
8. Congressional Budget Office, "Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program," February 23, 2007, at *www.cbo.gov/budget/factsheets/2007b/schip.pdf*.
9. In 1997, SCHIP was originally authorized at $40 billion over 10 years, and proposed expansions are increases above the program's baseline.
10. For a description of the impact of the Senate bill's tobacco tax, see Michelle C. Bucci and William W. Beach, "22 Million Smokers Needed: Funding SCHIP Expansion with a Tobacco Tax," Heritage Foundation *WebMemo* No. 1548, July 11, 2007, at *www.heritage.org/research/healthcare/upload/wm_1548.pdf*.

Moreover, the higher spending levels that result in the near future[12] will coincide with dramatically increasing federal expenditures to cope with the rising health costs of retiring Baby Boomers. To make matters worse, liberals in Congress and elsewhere can be expected to push for further expansions, accelerating the displacement of private coverage.

- **More Pressure to Expand the Program.** The bill also sets in motion policy changes that would expand the future size, scope, and cost of SCHIP. Such changes include the seemingly reasonable "outreach" provisions and the "removal of administrative barriers to enrollment." [13] Higher enrollment will naturally lead to calls for spending increases to keep pace with new demand. The bill also gives states broader authority to cover pregnant women (states need only pass a simple plan amendment)[14] and includes numerous loopholes to maintain coverage for those outside the scope of the program. Finally, the bill re-opens and unravels the successful Medicaid reforms found in the Deficit Reduction Act, which include citizenship requirements and benefit mandates.[15]

An Emerging Alternative. Some Members of Congress are considering alternative strategies to address America's health care needs. Senators Richard Burr (R–NC), Tom Coburn (R–OK), Bob Corker (R–TN), Jim DeMint (R–SC), and Mel Martinez (R–FL), along with Representative Jim McCrery (R–LA), have outlined an approach that tackles the broader issue of improving access to, and the affordability of, private health care coverage.[16]

Reforming the broader health care system is a better strategy for meeting the needs of lower-income families and their children. The alternative plan's aim is to ensure that SCHIP remains a targeted safety net program for low-income families while avoiding an expansion that would displace private coverage.

Recommendations. Congress should take a more ambitious approach than the limited SCHIP reauthorization in the Baucus bill—one that directly addresses, not sidesteps, the underlying problems plaguing the health care system.

Congress should take the following steps to strengthen private coverage for all American families:

- **Include Budget-Neutral Tax Reform for Health Insurance.** The current tax treatment of health insurance is highly regressive: It benefits higher-income families more than lower-income families. Furthermore, it discriminates against those individuals who do not have employer-based health insurance. Only individuals who enroll in employer-based coverage receive an unlimited tax break by excluding the value of their health benefits from taxable income.

  Policymakers should limit the current, unlimited tax preferences for employer-based coverage and begin to introduce a fairer and simpler system. A variety of budget-neutral strategies could be used to structure a new tax system for health care. For example, the President proposes replacing the tax exclusion for employees with a universal tax deduction for the purchase of private health insurance. A standard, non-refundable tax credit would be another budget-neutral approach to focus tax relief on those who need it most without raising taxes to fund new spending.

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11. Nina Owcharenko, "The Truth About SCHIP Shortfalls," Heritage Foundation *WebMemo* No. 1381, March 5, 2007, at *www.heritage.org/Research/HealthCare/upload/wm_1381.pdf*.
12. As Michael Leavitt, Secretary of the U.S. Department of Health and Human Services, observes, "The Mark would effectively balloon the (state) allotments in 2012 to $16 billion, then plunge them to $3.5 billion in 2013. This is clearly not a credible assumption." Letter to the Honorable Max Baucus, Chairman of the Committee on Finance, United States Senate from the Honorable Michael Leavitt, Secretary of the United States Department of Health and Human Services, p. 2.
13. See Title II, Sect. 201, and Title III, Sect. 302.
14. See Title I, Sect. 107.
15. See Title III, Sect. 301 and Title VI, Sect. 605
16. See Kimberly Strassel, "Socialized Medicine Showdown," *The Wall Street Journal*, June 29, 2007.

- **Allow SCHIP to Supplement Tax Relief for Lower-Income Families.** The cost of health insurance can discourage families, in particular lower-income families, from obtaining coverage for themselves and their children even when it is offered by employers.[17] Almost three-quarters of uninsured workers choose to decline coverage because of high costs.[18] Focusing tax relief on lower-income families would help, but it would offer limited or no help to those families who owe little or nothing in federal income taxes. Premium assistance, however, allows states to use SCHIP funds to help families enroll in private coverage. Unfortunately, a number of administrative and regulatory obstacles limit the effectiveness of premium assistance. Therefore, policymakers should improve and expand upon the premium assistance model by subsidizing lower-income families to purchase the private coverage of their choice—whether through an employer or on their own—without heavy-handed government interference.[19]
- **Promote Health Insurance Reform.** Major efforts are underway in several states to reform health insurance markets. One favored change is to enable individuals and families to own and control their own health insurance policies—like they own and control other types of insurance—and take these policies with them from job to job. Full portability of health insurance, coupled with more affordable health plans, could significantly reduce un-insurance and expand access to coverage for millions of Americans. Congress could adopt legislation that would further this process, including grants for technical assistance to states that wish to reform their health insurance markets, adopt new pooling arrangements, or promote more affordable health insurance coverage.

Conclusion. SCHIP and the broader health care system are at a crossroads. Some want to expand the role of government in the delivery of health care, while others believe in empowering families to obtain private health insurance coverage.

Policymakers should reject the narrow approach, taken by the Senate Finance Committee, to address children's health care through SCHIP expansion. Tackling the fundamental problems in the health care system would have a broader, longer-lasting impact. Congress can accomplish this by reforming the tax treatment of health insurance, expanding the role of SCHIP to subsidize private coverage for lower-income families, and promoting an affordable and competitive private health insurance market at the state level. Every step is critical for changing the status quo and improving access to health care coverage for all Americans, including for lower-income families.

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17. Janet Stokes Trautwein, "The Children's Health Insurance Program in Action: A State's Perspective on CHIP," Testimony before the United States Senate Committee on Finance, April 4, 2007, at *www.nahu.org/legislative/uninsured/JSTFinanceTestimony.pdf.*
18. Paul Fronstin, "Employment-Based Health Benefits: Access and Coverage, 1988-2005," Employee Benefit Research Institute, *Issue Brief* # 303, March 2007.
19. Nina Owcharenko, "Reforming SCHIP: Using Premium Assistance to Expand Coverage," Heritage Foundation *WebMemo* No. 1466, May 22, 2007, at *www.heritage.org/Research/HealthCare/upload/wm_1466.pdf.*