Executive Summary
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# SCHIP: How Congress Can Avoid Repeating Last Year's Mistakes

*Dennis G. Smith*

Congress may soon debate—again—the reauthorization of the State Children's Health Insurance Program (SCHIP). Congressional leaders have an opportunity to take a fresh approach to the issue, learn from past mistakes, and avoid the serious flaws that emerged in the crafting of last year's legislation.

Extension of the popular program last year should have been simple and quick, but policy took a back seat to politics. Because they left little room or time for serious deliberation about the impact or broader significance of proposed policies, congressional leaders were unable to quell anxieties about controversial elements of the proposed legislation, such as provisions to include higher-income children, coverage of adults, the "crowd out" of private insurance, loopholes that would have allowed noncitizens to become eligible, and the imposition of tax increases. Worse, they resorted to various budget gimmicks that marred their efforts to achieve full reauthorization.

Moreover, the dispute was never about poor children. There is already a $1 trillion commitment to children on Medicaid and SCHIP over the next 10 years.

**Preparing for Next Time.** Congress should hold balanced hearings—with outside policy experts thoroughly examining the policy alternatives—and then begin to mark up legislation through regular order. Last year, legislation went through dramatic changes without the opportunity for Members to digest differing explanations about policy or what was really being accomplished. Leaders seemed determined to spend a pre-set level of money to the extent of rewarding unsound state policies. For the next debate, Congress needs to:

- **Set clear policy first.** During the last SCHIP debate, Congress seemed to pick budget numbers *first* and then back into certain policies. Congress could not spend its target budget increase of $35 billion without expanding eligibility to the middle class or federalizing a greater share of the cost of Medicaid, the huge government health program for the poor and the indigent jointly financed by the federal and state governments. Only 14 percent of enrollment gains (800,000 newly enrolled but previously uninsured out of 5.8 million enrollees) was attributable to the uninsured, low-income children who were eligible for SCHIP.
- **Be clear on eligibility.** Contrary to what some Members said or believed, the legislation did *not* cap eligibility at 300 percent of the federal poverty level (FPL); it would have substituted the lower Medicaid match rate (average of 57

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percent) for eligibility above 300 percent. Even worse for taxpayers, the legislation did not apply the lower match rate if an expansion, *to any income level*, was made through Medicaid. Allowing states to circumvent eligibility caps by expanding Medicaid renders the policy meaningless.

Clarity in determining who should be eligible for SCHIP is also critical in maintaining public support. According to an October 2007 National Public Radio/Kaiser Family Foundation/Harvard School of Public Health survey, only 32 percent of Americans support SCHIP eligibility at $60,000 per year. Greater transparency in policies, not obscured interpretations, is needed.

- **Don't favor wealthier states at the expense of taxpayers in poorer states.** Expanding eligibility to 300 percent of FPL and beyond is likely to be attractive only to a minority of wealthier states. Of the 10 "richest" states, seven (California, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, and New York) have already expanded or are seeking to expand SCHIP eligibility to 300 percent of FPL. Of the 10 poorest states, none has expanded above 250 percent of FPL. Of the 13 states that have expanded to 300 percent of FPL or are seeking to do so, only Missouri and Oklahoma are from the South or Plains states. Congress sacrificed the interests of those lower-income families in favor of wealthier states that want to provide coverage to higher income levels.

  Last year's SCHIP debate appeared to be less about providing affordable health care to low-income children than about bailing out states that had overextended their budgets. Among the states that received nearly $1.3 billion in additional federal funds in 2006 and 2007 because of budget shortfalls, seven (Illinois, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, and Rhode Island) received 79 percent of the funds and covered children at higher income levels, adults, or, in some cases, both.

**Play It Straight with Funding.** Funding should be straightforward, maintain the capped allotments that reflect reasonable growth rates, and have an updated allotment formula. Congress should jettison gimmicks like Express Lane eligibility, which would have allowed non-citizens to slip through, and the Contingency Fund and Performance Bonus, essentially slush funds that would have rewarded states for letting non-citizens join the programs. Under the final version of the Performance Bonus, the federal government would have paid at least an 81 percent match rate for certain additional Medicaid enrollees: The national average is 57 percent. A wealthier state would receive $906.25 per additional enrollee, compared to $725 for a poorer state. The Performance Bonus formula thus provided a disproportionate benefit to wealthier states.

**Conclusion.** Congress can return SCHIP to its original focus on uninsured low-income children by setting a firm cap on eligibility that applies to both SCHIP and Medicaid and by restoring fiscal discipline. Blindly expanding SCHIP up the income scale would eclipse the potential of other more desirable alternatives to expanding health coverage for children in lower- and lower-middle-income families—especially refundable health care tax credits, an option that has already attracted a broad bipartisan and philosophical consensus.

Congress must recognize that expanding public programs into the middle class drives up the cost of private coverage. No longer should Congress ignore the detrimental effects that "crowd out" has on the millions of privately insured families. An expansion of private coverage, including employer-based coverage, through tax credits would revive the states' ailing private health insurance markets by adding young and healthy lives and the resources that would enable them to thrive, thus contributing to a reduction in average health insurance claims costs. This alone would be a tremendous step toward addressing the larger problem of the uninsured in America.

*—Dennis G. Smith is Senior Fellow in the Center for Health Policy Studies at The Heritage Foundation.*

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# SCHIP: How Congress Can Avoid Repeating Last Year's Mistakes

*Dennis G. Smith*

Congress may soon return to reauthorization of the State Children's Health Insurance Program (SCHIP). Extension of the popular program should have been a simple, quick, and bipartisan victory last year, but policy took a back seat to politics and raw emotion, leaving confusion even among proponents on both sides of the aisle. There was little time for serious discussions about important policies.

As a result, congressional leaders were unable to resolve smoldering controversies about the inclusion of higher-income children and adults, the "crowd out" of private health insurance because of public program expansions, or the expansion of eligibility to non-citizens through mechanisms buried in the bill, as well as the imposition of tax increases that were as unnecessary as they were unpopular. Moreover, congressional consideration of the SCHIP legislation was marred by the leadership's insistence on relying on accounting gimmicks that would enable the bills to meet prescribed budgetary rules.

In putting politics before policies, congressional leaders undercut any serious consideration of the underlying issues and obscured key policy questions for Members and taxpayers alike.

Last year's debate was, of course, never about covering poor children. There was never any disagreement about covering the children who meet the statutory definition of a "targeted low-income child." Bills sponsored by Republicans in both the House and the Senate would have provided sufficient funding to

## Talking Points

- Last year's SCHIP debate was about politics, not poor children. $1 trillion is already committed to children on Medicaid and SCHIP over the next 10 years. According to the NPR/Kaiser/Harvard survey, most Americans do not support expansion to children in families making $60,000.
- Eligibility for enrollment in SCHIP was not capped at 300 percent ($61,950 for a family of four) of the federal poverty level. Under the 2007 legislation, states could continue to expand eligibility for government coverage through "income disregards" or even Medicaid.
- Expanding government coverage to higher income levels leads to loss of private coverage, which also drives up the cost of private health insurance for all Americans.
- Performance Bonus and Express Lane eligibility provisions favored wealthier states and states with large non-citizen populations.
- SCHIP should include premium assistance to help families with children get or keep their private health coverage.

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cover the "currently eligible" SCHIP children at a much lower cost to the taxpayer.

There was nonetheless a great deal of confusion and disagreement even among Members who voted for the SCHIP legislation last year. It was a missed opportunity to engage honestly in a critical national discussion about who should be eligible for public assistance and whether there should be such a redistribution of wealth among the various states. The fiscal integrity and program integrity of Medicaid and SCHIP were put at risk by Express Lane eligibility, expansion of presumptive eligibility, and at least eight special-interest earmarks.

Of the total population of approximately 80 million children in the United States, about 45 percent receive taxpayer-funded health benefits. For Congress to expand dependence on public assistance even more, aggravating the current problems with entitlement spending, would have profound implications for the future of our health insurance system and a significant impact on America's social, economic, and political systems. One cannot escape these effects if more than half of America's children start out relying on government assistance.

**Preparing for Next Time.** Before legislation is sent back to the floor, the House and Senate should hold *balanced* hearings—with outside policy experts who would thoroughly examine the alternatives as well as the pitfalls of last year's versions of the legislation. Only then should they begin to mark up legislation through regular order.

Last year, the SCHIP legislation went through dramatic changes between committee and floor action, leaving little time for Members of either party to digest differing explanations of policy. Locked into political gamesmanship rather than a commitment to bipartisan problem-solving, the debate lacked serious discussion about the real purpose, goals, and future of SCHIP and Medicaid, two government benefit programs that already carry a combined commitment of $1 trillion in spending on children over the next 10 years.

## Setting a Clear Health Care Policy Is Crucial

During last year's debate, Congress picked budget numbers first, then clumsily backed into certain policies with some strange results. With the number of children enrolled in Medicaid and SCHIP already exceeding the number of children below 200 percent ($41,300 for a family of four in 2007) of the federal poverty level (FPL), Congress could not spend its budget target of $35 billion without expanding SCHIP eligibility into the middle class or federalizing even more of the cost of Medicaid. For several states, Medicaid is already the vehicle of choice for the coverage of children eligible for SCHIP, and policies in last year's legislation were further tilted toward Medicaid expansion.

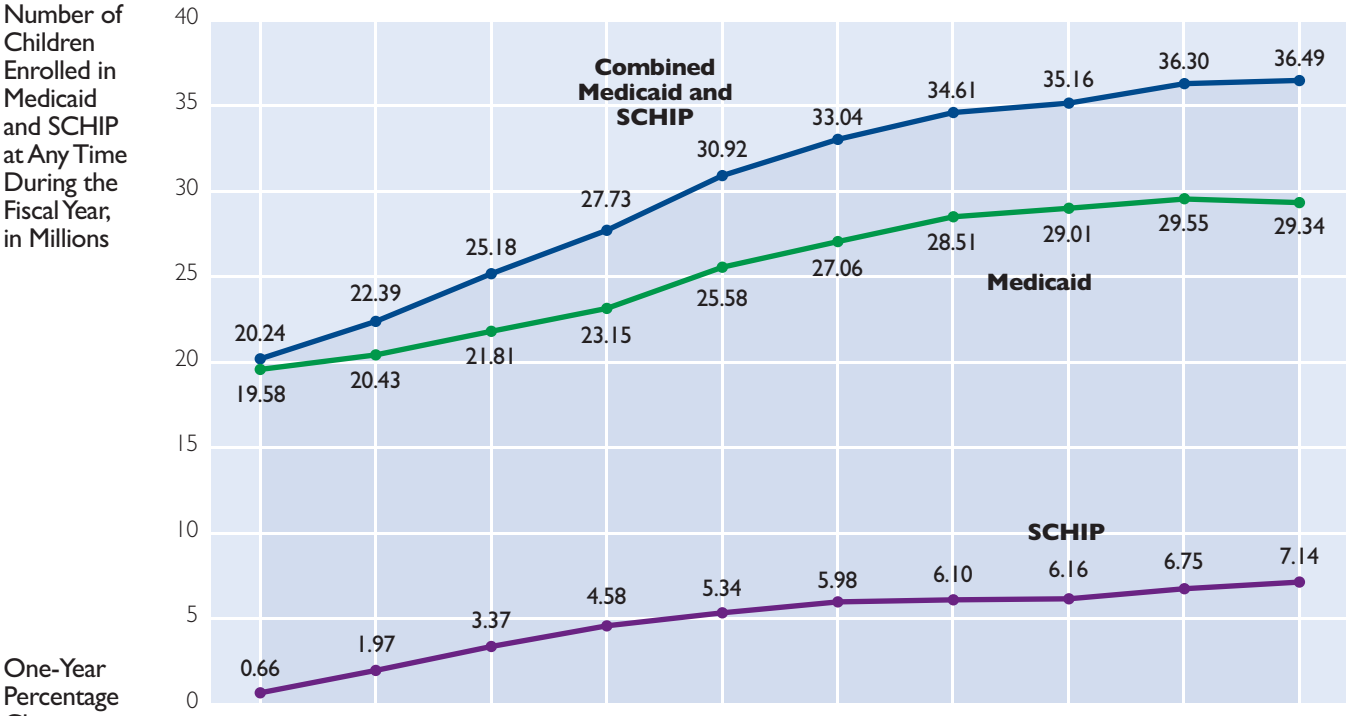
Congress should refocus the program on the population for which it was originally designed—children in low-income working families above Medicaid eligibility—but not on children from higher-income families. This means setting a firm cap on eligibility based on the definition of a targeted low-income child that applies to both SCHIP and Medicaid; closing the income eligibility loopholes that are the source of confusion, tensions, and jealousies among the states; and ending the state practice of expanding eligibility to any income level through a "backdoor" approach, including through Medicaid.

A glance back at last year's debate shows the need for clarity about how states were using SCHIP and about their policy goals. If one examines the growth in SCHIP and Medicaid enrollment—and the Congressional Budget Office (CBO) score tracking additional expansions—then one must conclude that last year's legislation was only marginally about the children for whom SCHIP was created.

**Eligibility for SCHIP.** During last year's debate, nothing was more muddled than the question of who was supposed to benefit from the program.

During the original SCHIP debate in 1997, the goal of insuring 10 million children was widely shared. In federal fiscal year (FY) 1998, the number of "ever enrolled" children in Medicaid was 19.6 million, and the number "ever enrolled" in SCHIP was 660,000, for a combined total of 20.3 million children covered by Medicaid and SCHIP. In FY 2007, the number of children "ever enrolled" in Medicaid had increased to 29.3 million, and the number enrolled in SCHIP had increased to 7.1 million, for a combined total of 36.5 million children—

## Medicaid and SCHIP Have Grown Steadily Since 1998




| One-Year Percentage Changes | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|---|---|
| Combined Medicaid and SCHIP | | 10.8% | 12.5% | 10.1% | 11.5% | 6.9% | 4.8% | 1.6% | 3.2% | 0.5% |
| Medicaid | | 4.3% | 6.8% | 6.1% | 10.4% | 5.9% | 5.4% | 1.8% | 1.9% | –0.7% |
| SCHIP | | 198.5% | 71.1% | 35.9% | 16.6% | 12.0% | 2.0% | 1.0% | 9.6% | 5.8% |

**Source:** Centers for Medicare and Medicaid Services. SEDS and MSIS data compiled by Family and Children Health Programs Group, February 2008.

Chart 1 • B 2180 heritage.org

children, or nearly 80 percent, from the 1998 levels.[1] (See Chart 1.)

Yet, since 2007, as has been widely reported and as Representative Frank Pallone (D–NJ), chairman of the House Energy and Commerce Committee's Subcommittee on Health, declared, "Nine million children in this country have no health insurance." "In a country as wealthy and compassionate as ours," he continued, "no child should be left behind without health insurance, let alone 9 million."[2]

In other words, Congress started with the goal of covering 10 million children, added 16 million, and was somehow left with 9 million children still without health insurance 10 years later.

Has the number of poor children increased in the United States? No. The number of children in families with incomes below 200 percent of FPL actually *declined* slightly from 30.6 million in 1997 to 30.2 million in 2006.[3] The growth in the total number of children occurred among the higher-income

1. Centers for Medicare and Medicaid Services, SEDS Source: CMS-64EC (2-07-08) and SEDS and MSIS Data 1999–2005 compiled by Family and Children Health Programs Group, February 2008.
2. Representative Frank Pallone, Jr., opening statement in hearing, *Covering the Uninsured Through the Eyes of a Child*, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, February 14, 2007, p. 1.
3. U.S. Census Bureau, Current Population Survey, "Annual Social and Economic Supplement 2007," Table Creator for Ages 00–18 Below 200% FPL.

families, not the lower-income families, after the enactment of welfare reform in 1996 and the implementation of pro-growth economic policies. The combined total of children on Medicaid and SCHIP (36 million) now exceeds the number of children living below 200 percent of FPL (30.2 million).

The question is this: How could 16 million children be added to the rolls and 9 million remain uninsured? It seems implausible that increasing enrollment and spending $40 billion on SCHIP and even more on Medicaid would have resulted in a net reduction of only 1 million in the number of uninsured children. There could have been various reasons, including "crowd-out" of private coverage from public program expansion, a continuing decline in private coverage, counting Medicaid children who were already enrolled as "uninsured," allowing higher-income children to be enrolled through special "income disregards," counting children from higher-income families, changing the length of time used in measuring the number of uninsured, deficient data, and counting non-citizens among the uninsured in the same way that citizens are counted.

The most plausible explanation is, of course, that there were not 9 million uninsured *low-income* children. Representative Pallone may have recognized this. Later in the debate, he stated that, "If we are going to find the approximately 6 million children who are eligible for SCHIP or Medicaid, but who are not enrolled, we would need at least $50 billion over the next five years."[4] To add 9 million children to SCHIP, Congress would then have to expand SCHIP coverage to higher income levels and somehow make non-citizens eligible. As shown below, proponents of expanding SCHIP conceded that they would not cover even 6 million uninsured children eligible for SCHIP and Medicaid.

Nearly 40 percent of the uninsured children live in families with incomes above 200 percent of FPL, including 27 percent living in families with income above 250 percent of FPL.[5] Also included in the 9 million figure are 1.5 million children who are ineligible because they are not American citizens.[6]

By September 2007, the goal of enrolling 9 million had quietly been cut by more than half, and congressional leaders spoke in favor of adding coverage for just 4 million children by 2012. Representative John Dingell (D–MI), chairman of the House Committee on Energy and Commerce, explained that the SCHIP reauthorization legislation (H.R. 976) then under consideration "gives $35 billion to strengthen and improve children's health coverage. It protects 6 million children today covered by SCHIP. It adds an additional 4 million."[7] House Majority Leader Steny Hoyer (D–MD) echoed this understanding: "Let's be clear; this fiscally responsible legislation will ensure that some 10 million children will receive health insurance coverage. That's approximately 4 million more than are covered under the [State] Children's Health Insurance Program today."[8]

**Deciphering CBO Numbers.** During last year's debate, much of the CBO score remained a mystery throughout the legislative process. The CBO presented enrollment figures only for FY 2012 and combined spending from different sections of the legislation in such a way that the effects of individual parts could not be clearly understood. This prevented a comparison of viable alternatives. The next time SCHIP is considered, congressional leaders should make sure that the CBO provides year-by-year enrollment figures, explains "take up" rates, identifies states that would expand eligibility, and disaggregates funding provisions so that Members understand how the legislation is channeling the spending.

Consider the question of who is counted among the 4 million children. The CBO score was critical to understanding that last's year's legislation, H.R.

4. Pallone, opening statement, p. 2.
5. U.S. Census Bureau, Current Population Survey, "Annual Social and Economic Supplement 2007."
6. Kenneth Finegold and Linda Giannarelli, "TRIM3 Simulations of Full-year Uninsured Children and Their Eligibility for Medicaid and SCHIP," Urban Institute, June 14, 2007, Table 10.
7. *Congressional Record*, September 25, 2007, p. H10878.
8. *Congressional Record*, September 25, 2007, p. H10880.

## The Effects of H.R. 3963 on the Insured and Uninsured

*According to the Congressional Budget Office, H.R. 3963 would add 3.9 million people to SCHIP and Medicaid. The CBO also estimates 2 million people will forfeit their private insurance.*

| | Reduction in the Uninsured | | | Reduction in Private Coverage | | |
|---|---|---|---|---|---|---|
| | Medicaid | SCHIP | Total | Medicaid | SCHIP | Total |
| Maintain Current Program | – | 700,000 | 700,000 | – | 400,000 | 400,000 |
| Additional Enrollment with Existing Eligibility | 1.9 million | 800,000 | 2.7 million | 500,000 | 500,000 | 1 million |
| Expansion of Eligibility to New Populations | – | 500,000 | 500,000 | – | 500,000 | 500,000 |
| Total All Groups | 1.9 million | 2 million | 3.9 million | 500,000 | 1.4 million | 2 million |

**Source:** Congressional Budget Office's estimates of changes in SCHIP and Medicaid enrollment of children under the Children's Health Insurance Program Reauthorization Act of 2007, October 24, 2007.

Table 1 • B 2180 heritage.org

3963, was only marginally about uninsured children currently eligible for SCHIP. The CBO projected that by 2012, the legislation would reduce the number of uninsured individuals (some adults would still be on SCHIP) by 3.9 million.[9] (See Table 1.) But only 800,000 were the result of additional enrollment within existing SCHIP eligibility groups.

The CBO further estimated that H.R. 3963 would also be used to enroll 2 million individuals who would forfeit *private* coverage for enrollment into Medicaid or SCHIP. (See Table 1.)

Only about one-quarter of the total enrollment increase projected by the CBO (1.5 million of 5.8 million people[10]) was attributed to uninsured, low-income children currently eligible for SCHIP. This included 700,000 already enrolled children that the CBO projected would lose coverage under the current baseline. So only 14 percent (800,000 newly enrolled, previously uninsured of 5.8 million total) would have gained coverage. The balance of enrollment was due to Medicaid, "crowd out" of private insurance, and SCHIP expansion into higher income levels of the population.

Members of Congress may not have been aware that, in terms of increasing coverage for people currently eligible for SCHIP, they could have achieved the same results for a fraction of the cost. The CBO estimated that a Senate alternative, the Kids First Act, sponsored by Senator Trent Lott (R–MS), would have increased the enrollment of currently eligible but uninsured children by 700,000 at a net cost of $8 billion, compared to 800,000 at a stunning cost of $32.1 billion under H.R. 3963,[11] the last version of the SCHIP legislation.

Table 2 compares only the costs that were applicable to both bills. H.R. 3963 contained another $3.3 billion in spending that Kids First did not include and that therefore has been omitted. Kids First would have saved $2.5 billion in Medicaid costs because the CBO assumes in its budget baseline, under current law, that states experiencing "shortfalls" in SCHIP funding would move populations into Medicaid. Adding funds to SCHIP would prevent that from happening and would thereby reduce Medicaid spending relative to the baseline, thus "saving" money. Under H.R. 3963, Medicaid spending would have increased by $5.7 billion. Because of the SCHIP–Medicaid baseline interaction just described, the impact on Medicaid spending, then, presumably would really be $8.2 billion ($8.2 billion – $2.5 billion = $5.7 billion). In addi-

9. Congressional Budget Office, letter to John Dingell, Chairman, House Committee on Energy and Commerce, "CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the Children's Health Insurance Program Reauthorization Act of 2007," October 24, 2007.
10. *Ibid.* Figures differ slightly because of rounding.
11. Congressional Budget Office, "Preliminary CBO Estimate of the Kids First Act," August 1, 2007, and Congressional Budget Office, letter to John Dingell, October 24, 2007.

## Comparing the Costs of Two Health Care Programs

*Shown below are the projected changes in direct spending for fiscal years 2008–2012 under the Kids First Act of 2007 and H.R. 3963.*

| Provisions | Kids First Act | H. R. 3963 |
|---|---|---|
| SCHIP Outlays | $9.5 billion | $23.6 billion |
| Medicaid Interactions | –$2.5 billion | $5.7 billion |
| Performance Bonus Payments | n/a | $2.5 billion |
| Outreach | $1 billion | $300 million |
| **Total** | **$8 billion** | **$32.1 billion** |

**Source:** Congressional Budget Office. "Preliminary CBO Estimate of the Kids First Act," August 1, 2007, and H.R. 3963.

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tion, the $2.5 billion in Performance Bonus payments would come from SCHIP funds, but they would be used for increases in Medicaid enrollment. If it were good policy, which it is not, Congress could have considered other policies for increasing Medicaid enrollment that would have cost less.

It is also interesting that Kids First would have provided more funding for outreach ($1 billion) than would have been provided under H.R. 3963 ($300 million). On the surface, this suggests that part of the increase in spending in H.R. 3963 (both for SCHIP and for Medicaid) was not attributed to finding *new* eligible but not enrolled children; rather, the federal government would spend more money keeping the *same* children enrolled. But it is unclear whether this is the case, because the CBO tables combine the effects of different provisions of H.R. 3963.

Congress should also ask what percentage of low-income children will still be uninsured if these new enrollment levels in SCHIP and Medicaid are achieved. Given the criticism of the Bush Administration's August 17, 2007, directive that states should demonstrate that they have achieved a 95 percent coverage rate for low-income children before approving state requests to expand to higher income levels,[12] Congress and the public should know whether the substantial increase in spending would achieve this policy goal.

Finally, Congress should ask the CBO to fully explain its Medicaid enrollment estimates. CBO estimated that in 2012, the average monthly net Medicaid enrollment would increase by 2.3 million individuals within current eligibility groups. As Chart 1 illustrates, Medicaid enrollment has slowed in recent years because of the success and maturity of SCHIP. Between 2004 and 2007, the average annual increase in the number of children ever enrolled in Medicaid for the three-year period was less than 300,000. There is a finite number of children who are currently eligible for Medicaid. Old models that assume that for every child enrolled in SCHIP, one or more will also be enrolled in Medicaid cannot be sustained indefinitely. Given that the number of "ever enrolled" is a substantially higher figure than "average monthly enrollment," the CBO appears to credit H.R. 3963 with an aggressive enrollment rate. Congress should seek a clear understanding of which new policies would achieve such results and whether the same results could be achieved at a lower cost to the taxpayers.

**Confusion over Eligibility.** Eligibility policy was just as murky. During consideration of the SCHIP legislation, Congress was aware of a request from the state government of New York to expand eligibility to 400 percent of FPL ($82,600 for a family of four in 2007). Congressional leaders who favored SCHIP expansion inserted language into the first SCHIP bill, H.R. 976, to protect the ability of New York and New Jersey (350 percent of FPL; $72,275 for a family of four in 2007) to claim the SCHIP-enhanced match rate for their citizens while limiting other states to claiming the enhanced match for up to 300 percent of FPL ($61,950 for a family of four in 2007). With the addition of this language, the bill was passed by both the House and the Senate.

H.R. 976 was subsequently vetoed by President George W. Bush, and the veto was sustained on October 18, 2007. A new SCHIP bill, H.R. 3963, was introduced in the House on October 25. House and Senate SCHIP supporters had broadened dis-

12. Centers for Medicare and Medicaid Services, SHO No. 07-001, August 17, 2007.

## Expanding Dependence: An Example from the 2007 SCHIP Debate

A colloquy between Representatives John Dingell (D–MI) and Michael Burgess (R–TX) shows how, through "income disregards," the states could have continued to expand eligibility even above 300 percent of FPL:[1]

**Mr. Burgess:** "Mr. Chairman, under the changes that have been made in regards to the income disregards in the bill, could a state in its current practice still allow a family to exclude from income $500 a year for child care expenses?"

**Mr. Dingell:** "The answer to the question is yes."

**Mr. Burgess:** "I thank the Chairman. Could a state allow a family to exclude from income $20,000 a year for housing expenses?"

**Mr. Dingell:** "That would be a matter to be determined by the state in which the transaction and the events occurred."

**Mr. Burgess:** "I am not a lawyer, but if I were a lawyer and ask for a 'yes' or 'no' answer I would assume that's a 'yes.'"

**Mr. Dingell:** "Well it's a 'yes' if the state so decides. It's a 'no' if they [*sic*] decide not."

**Mr. Burgess:** "Further then, if the Chair will indulge me, could a state allow for a family to exclude from income $10,000 for transportation expenses?"

**Mr. Dingell:** "Again, the response is that that is up to the state, and there is nothing in the legislation to preclude that."

**Mr. Burgess:** "So the answer would be a 'yes' if to transportation expenses. If the Chairman would, then, could a state allow a family to exclude from income $10,000 a year for clothing expenses?"

**Mr. Dingell:** "Again, the answer is if that is so determined by the states, the answer is yes."

**Mr. Burgess:** "So the state income disregards, now, are up to $40,500, if I am doing my math correctly?"

1.*Congressional Record*, October 25, 2007, pp. H12074–H12075.

cussions to a small group of House Republican members in hopes of picking up additional votes that would make SCHIP veto-proof. A cap on income eligibility was one of the key discussion points that congressional leaders believed might win sufficient support from Republicans.

This time, the House and Senate negotiators dropped the explicit income-eligibility exception for New York State, so Representative Pallone assured Members that "if you go over 300 percent, okay, other than those that are already grandfathered into the program, you're no longer going to be able to cover those kids at that $82,000 or the other levels they suggested."[13] Representative Gene Green (D–TX) echoed his comments: "The bill is clear on family income. Only the lowest-income children are covered with a prohibition on coverage of children above 300 percent. You can't go above 300 percent."[14]

However, H.R. 3963 did *not* cap eligibility at 300 percent of FPL; it would merely have provided the lower Medicaid match rate if a state expanded eligibility above 300 percent. As the legislation was written, states could also adopt "disregards" so that families with gross incomes above 300 percent of FPL could still qualify for the enhanced match rate. These disregards, as explained further below, are used to subtract

13. *Congressional Record*, October 25, 2007, p. H12073.
14. *Ibid.*

income or expenses from a family's gross income in order to let them qualify for assistance.[15]

**Welfare Reform in Reverse.** The House colloquy cited here shows that the income-eligibility "cap" on SCHIP eligibility was a fiction. Through the magic of so-called income disregards, a family of four making $102,450 could subtract $40,500 and appear on paper to meet the eligibility cutoff of 300 percent of FPL. Historically, income- and work-related disregards have been used in welfare programs as incentives for people to return to work and escape dependence on government. In the SCHIP debate, however, the world was turned upside down to allow families at higher income levels to appear to be low-income and thereby become eligible for public assistance.

Even worse, the legislation did not apply the lower match rate to an expansion through Medicaid. Section 115 of H.R. 3963 provided open-ended funding to a state at the enhanced SCHIP match rate at any income level. An eligibility cap should be applied equally if a state chooses to run its SCHIP program as a Medicaid expansion. Allowing states to circumvent eligibility caps by expanding Medicaid would render the policy meaningless.

Clarity in determining who should be eligible for SCHIP is critical in terms of public support as well. Most Americans do not support expanding SCHIP to the levels promoted by H.R. 3963. According to an October 2007 National Public Radio/Kaiser Family Foundation/Harvard School of Public Health Survey, "66 percent of Americans say they support having families of four who make $40,000 per year (roughly two times the poverty level) be eligible but support drops substantially—to 32 percent—at $60,000."[16] Given such sentiment, important SCHIP policy should be clear in order to assure that Members of Congress and the public alike are fully informed.

## Congress Should Not Favor Wealthy States

Offering the enhanced SCHIP match rate for families higher up on the income scale is likely to be attractive only to a minority of states, of which all but two are outside of the South and Plains. Of the 13 states that have expanded to 300 percent or that have pending requests to do so, only two (Missouri and Oklahoma) are from the South or Plains states. Missouri offsets the public cost of expansion to this higher income level by requiring the maximum cost-sharing allowable under federal law: 5 percent of the family's income ($3,097.50 for a family of four with income of $61,950). Tennessee had already learned hard lessons about overextending public benefits to the middle class and has *lowered* eligibility for children post-SCHIP.

All three SCHIP versions passed by the House (H.R. 3162, H.R. 976, and H.R. 3963) contained provisions that encouraged states to overspend their allotments and adopt more liberal policies related to eligibility, cost-sharing, and the "crowd out" effect. These provisions also were likely to benefit only a minority of states because most would not expand coverage to higher income levels.

Under the original SCHIP legislation, the federal government provides states an "enhanced" match rate for a "targeted low-income child." (Nationally, the federal government provides 70 percent of SCHIP funding, compared to 57 percent in Medicaid.) This definition would have allowed states to expand eligibility to 200 percent of FPL, or 50 percentage points above a state's Medicaid threshold as of March 31, 1997.[17]

15. Take an example using the 2007 poverty guidelines: A state has set eligibility at 250 percent of FPL, or $4,302.08 per month for a family of four plus "disregards." The Smith family of four applies for benefits with a monthly income of $4,500, which is too high to qualify for SCHIP, but the state also allows a disregard of $90 per working parent and $175 for paid child care. After applying the disregards ($4,500 – $180 – $175 = $4,145), the Smith children now qualify. Disregards also create inequities among families. The Joneses also have two children and the same monthly income of $4,500, but Mom and Dad Jones work different shifts, so one of them is always at home for the children. The Jones children do not qualify because even after the income disregards, their income is $18 too high ($4,500 – $180 = $4,320). The two families start with the same income, and both parents work, but since the Smith children are in paid child care and the Jones children are not, only the Smith children qualify for the benefits.
16. National Public Radio/Kaiser Family Foundation/Harvard School of Public Health, "Public Views on SCHIP Reauthorization: Survey Highlights," October 2007, No. 7704, p. 2.

Sixteen states have exceeded the definition of a "targeted low-income child." These expansions could occur beyond the statutory definition, as explained by the Congressional Research Service: "[B]y using existing flexibility to define what 'counts' as income, any state can raise its effective SCHIP eligibility level above 200 percent of FPL through the use of income disregards."[18]

In other words, SCHIP can be expanded further by redefining who is "poor." By doing so, SCHIP would coax middle-class families into dependence on public assistance.

Under the two bills passed by Congress (H.R. 976 and H.R. 3963) but vetoed by President Bush last year, the enhanced federal match rate would have been provided to states that expand SCHIP eligibility to 300 percent of FPL, and the regular Medicaid match rate would have been provided to states that expand above 300 FPL.[19] There was, however, little discussion about which states would benefit from an expansion of SCHIP.

The expansion of SCHIP (as well as Medicaid) tends to occur in wealthier states, so reauthorization that allowed the enhanced match rate for higher-income families favored those states, resulting in families in lower-income states subsidizing higher-income families in wealthier states.[20] For purposes of state comparisons, the relative wealth of states is based on personal income per capita. Based on 2006 data, Connecticut ranks first in "personal income per capita" at $50,762, while Mississippi ranks last at $27,028—a difference of $23,734.[21] (See Chart 2.)

## States Ranked by Per-Capita Income

**States with the Highest Per-Capita Income, 2006**

| | State | Per-Capita Personal Income |
|---|---|---|
| 1 | Connecticut | $50,762 |
| 2 | New Jersey | $46,763 |
| 3 | Massachusetts | $46,299 |
| 4 | New York | $44,027 |
| 5 | Maryland | $43,788 |
| 6 | Wyoming | $40,655 |
| 7 | New Hampshire | $39,753 |
| 8 | California | $39,626 |
| 9 | Virginia | $39,540 |
| 10 | Colorado | $39,491 |

**States with the Lowest Per-Capita Income, 2006**

| | State | Per-Capita Personal Income |
|---|---|---|
| 41 | Alabama | $30,894 |
| 42 | Montana | $30,790 |
| 43 | New Mexico | $29,929 |
| 44 | Idaho | $29,920 |
| 45 | South Carolina | $29,767 |
| 46 | Kentucky | $29,729 |
| 47 | Utah | $29,406 |
| 48 | Arkansas | $28,473 |
| 49 | West Virginia | $28,206 |
| 50 | Mississippi | $27,028 |

**Source:** Bureau of Economic Analysis, U.S. Department of Commerce, State Personal Income 2007, BEA 08-1.Table 1 A."Per Capita Personal Income, Personal Income, and Population, by State and Region 2006-2007."

Chart 2 • B 2180 heritage.org

17. Differing eligibility levels and match rates for Medicaid and SCHIP have created their own set of inequities and jealousies among the states. For example, 11 states had raised Medicaid eligibility for children prior to the creation of SCHIP. Not wanting limited federal funds to be used simply to "buy out" state efforts, Title XXI includes provisions on Maintenance of Effort. States that had expanded were thereby disadvantaged. Congress subsequently included a provision on these "qualifying" states, which provided a partial buyout of state efforts. H. R. 3963 expanded the buyout even further.
18. Congressional Research Service, "Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and in Agreement," *Report for Congress*, Updated October 3, 2007, p. 4.
19. Under H.R. 976, the enhanced match rate would have been "grandfathered" in at 350 percent of FPL for New Jersey and 400 percent of FPL for New York. Under H.R. 3963, the language for New York was dropped, but the "grandfather" clause for New Jersey was retained. H.R. 3963 could be read to provide the enhanced match rate at any income level if a state adopted additional "disregards" or expanded eligibility through Medicaid.
20. For purposes of defining "richer" and "poorer" states, this paper uses "Personal Income Per Capita" by state according to U.S. Department of Commerce, Bureau of Economic Analysis, State Personal Income 2007, BEA 08-1, Table 1A, "Per Capita Personal Income, Personal Income, and Population, by State and Region 2006–2007."
21. *Ibid.*

Table 3 shows the 16 states that exceed their eligibility thresholds as of April 2008. Ten states have expanded eligibility to 300 percent, and four have pending proposals to do so (California is in both categories, so there is a total of only 13 states).[22]

Of the 10 "richest" states, seven (California, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, and New York) have already expanded or are seeking to expand SCHIP eligibility to 300 percent of FPL. Of the 13 states that have already expanded to 300 percent of FPL or are seeking to do so (California, Connecticut, Hawaii, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, and Vermont), nine rank among the top 20 "richest" states. None of the "poorest" states have expanded to more than 250 percent of FPL.

Expansion of eligibility in "richer" states is sometimes justified because of their higher cost of living. Wealthier states may argue that health insurance, like other goods and services, is more expensive for their citizens. Connecticut, Massachusetts, and New Jersey, for example, can accurately point out that their residents face some of the highest health insurance premiums in the country.

But "affordability" in the cost of health insurance should be viewed as a combination of income and the price of health insurance itself. When expressed as a percentage of income, the amount that Connecticut, Massachusetts, and New Jersey residents actually pay for their health insurance coverage is less than families in poorer states pay. This is illustrated in Table 4 which compares the average median family income for a family of four to the average total family premium for private-sector employer-sponsored health insurance in the 10 highest-income states and the 10 lowest-income states.

In other words, the question is: If a family of four earning a state's median family income paid the

## Expanding SCHIP Thresholds

*Of the 16 states that have exceeded the SCHIP threshold of 200% of the Federal Poverty Level, or 50 percentage points above the 1997 Medicaid levels, 11 have either already expanded or are proposing to expand eligibility to 300% of FPL. Two other states are also proposing the expansions.*

| | Statewide Eligibility Was Expanded to 300% | Proposing to Expand Eligibility to 300% |
|---|---|---|
| **Have Exceeded Thresholds** | | |
| 1. California* | | ✓ |
| 2. Connecticut | ✓ | |
| 3. Georgia | | |
| 4. Hawaii | ✓ | |
| 5. Maryland | ✓ | |
| 6. Massachusetts | ✓ | |
| 7. Missouri | ✓ | |
| 8. New Hampshire | ✓ | |
| 9. New Jersey | ✓ | |
| 10. New York | | ✓ |
| 11. Louisiana | | |
| 12. Pennsylvania | ✓ | |
| 13. Rhode Island | | |
| 14. Vermont | ✓ | |
| 15. West Virginia | | |
| 16. Wisconsin | | |
| **Have Pending Plan Amendments to 300% FPL** | | |
| 1. Ohio | | |
| 2. Oklahoma | | |

* Some counties in California have already expanded eligibility to 300% FPL.

**Sources:** SCHIP, August 8, 2007, PowerPoint Slide 32; Oklahoma Health Care Authority, "Insuring Oklahoma's Children," June 2007, PowerPoint Slide 36; Powell Goldstein POGO Alert, "CMS Disapproves New York SCHIP Plan Amendments Enforcing New Crowd-Out Guidance," September 11, 2007; Statement by Gov. Ted Strickland (OH), U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, February 26, 2008. p. 6.

Table 3 • B 2180 heritage.org

22. Minnesota had expanded Medicaid eligibility to 275 percent of FPL prior to creation of SCHIP and therefore could raise eligibility to 325 percent of FPL under current law. It has not done so. New Mexico, Tennessee, and Washington are above 200 of FPL but had expanded Medicaid prior to SCHIP, so they have not exceeded their eligibility thresholds. In 2007, Louisiana and Wisconsin submitted requests to expand to 300 percent of FPL, but they lowered their thresholds to 250 percent after the August 16, 2007, directive from the Centers for Medicare and Medicaid Services, which instructed states to demonstrate that they had covered 95 percent of low-income children before expanding eligibility above 250 percent of FPL.

average health insurance premium in that state, what is the cost as a percentage of the family's income?[23]

For the purposes of illustration, this paper recognizes that the employee ultimately pays the full cost of insurance as he forfeits the full wages necessary to purchase it. According to the federal Agency on Healthcare Research and Quality (AHRQ), the average total (employer and employee shares) family premium per enrolled private-sector employee was $11,381 in 2006.[24]

In comparing the states by median family income of a family of four in 2006, New Jersey was the highest at $94,441 and New Mexico the lowest at $52,034, a difference of $42,407.[25] Paying the average total family premium cost a family in New Jersey $12,233 compared to $11,279 for a family in New Mexico, a difference of $945. However, as a percentage of income, the family in New Mexico would have spent 21.7 percent of its income on coverage, while the family in New Jersey would have spent 13 percent of its income on coverage. It is therefore no great mystery as to why the rate of non-insurance is greater in New Mexico than in New Jersey.

The average cost of health insurance among the 10 states with the highest median family income for a family of four is $11,775, while the average cost in the 10 states with the lowest median family income is $10,076, a difference of just $1,069. But the difference in the median income for a family of four between the 10 "richest" states and the 10 "poorest" states in 2006 was $29,389.

If the cost of group health insurance is broadly comparable across the country[26] while median family income varies as much as $40,000, why would taxpayers in "poorer" states be asked to subsidize higher-income populations in the six wealthiest states?

## Spending on Health Insurance Premiums as Percentage of Family Income

*Families in high-income states tend to pay higher premiums for health insurance, but the proportions of their incomes that go to those premiums are less than those of families in poorer states.*

### Top 10 States in Median Family Income in 2006

| | State | Median Family Income for a Family of Four | Average Total Family Premium | Premium as Percentage of Income |
|---|---|---|---|---|
| 1. | New Jersey | $94,441 | $12,233 | 13.0% |
| 2. | Maryland | $94,017 | $11,272 | 12.0% |
| 3. | Connecticut | $93,821 | $12,416 | 13.2% |
| 4. | Massachusetts | $89,347 | $12,290 | 13.8% |
| 5. | New Hampshire | $87,396 | $12,686 | 14.5% |
| 6. | Hawaii | $84,472 | $9,426 | 11.2% |
| 7. | Minnesota | $81,477 | $11,395 | 14.0% |
| 8. | Virginia | $78,413 | $11,497 | 14.7% |
| 9. | Delaware | $78,321 | $12,601 | 16.1% |
| 10. | Rhode Island | $78,189 | $11,934 | 15.3% |

### Bottom 10 States in Median Family Income in 2006

| | State | Median Family Income for a Family of Four | Average Total Family Premium | Premium as Percentage of Income |
|---|---|---|---|---|
| 41. | Louisiana | $60,161 | $10,796 | 17.9% |
| 42. | Tennessee | $60,143 | $9,996 | 16.6% |
| 43. | Texas | $59,808 | $11,690 | 19.5% |
| 44. | South Carolina | $59,663 | $10,956 | 18.4% |
| 45. | Idaho | $58,066 | $10,775 | 18.6% |
| 46. | West Virginia | $55,920 | $11,282 | 20.2% |
| 47. | Oklahoma | $55,031 | $10,592 | 19.2% |
| 48. | Mississippi | $52,992 | $9,769 | 18.4% |
| 49. | Arkansas | $52,185 | $9,928 | 19.0% |
| 50. | New Mexico | $52,034 | $11,279 | 21.7% |

**Source:** U. S. Bureau of Economic Analysis, U.S. Census Bureau, and Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends 2006 Medical Expenditure Panel Survey–Insurance Component, Table 11.D.1 (2006).

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23. A family of four is used because eligibility for SCHIP and Medicaid is generally based on family income as a percentage of the federal poverty level. The federal poverty level varies by family size. A family of four is generally used as the unit of reference to the poverty level.
24. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2006 Medical Expenditure Panel Survey—Insurance Component, "Average Total Family Premium (in Dollars) per Enrolled Employee at Private-Sector Establishments that Offer Health Insurance by Firm Size and State: United States, 2006," Table IID.1, 2006.
25. U.S. Census Bureau, Housing and Household Economic Statistics Division, "Income-Median Family Income in the Past 12 Months by Family Size," Data Set: 2006 American Community Survey, Table B19119.

Let us look closer at two states, New York and Vermont, as examples for why Congress should examine what is really occurring with these cross subsidies. New York became a lightening rod during last year's SCHIP debate as it submitted a state plan amendment to expand eligibility to 400 percent of FPL ($82,600 for a family of four), but New York was already allowing families at *any* income level to "buy in" to its children's health program. The average cost of health plans available through the state is $154 per member per month, or $1,848 per year. For two children, the annual cost would be $3,696. New York's share of SCHIP expenditures is 35 percent, which would mean paying out $1,293 per year for two children on behalf of one family. If the state contributed just this amount without any federal funds being involved, the family's cost would be reduced to $2,403. Is it not reasonable to expect that a family making $82,600 can afford a premium of less than $7 per day?

In the case of Vermont, the state currently requires its families with income up to 300 percent of FPL ($61,950 for family of four) to pay a maximum of $80 per month, regardless of family size, in premiums. This is 1.5 percent of family income. There are no other types of cost-sharing such as deductibles or copayments involved. Last year, the state decided to cut this modest premium in half. In effect, Vermont intends to give back to these families, who were already paying the current premium, a subsidy of $480 per year.

If health care coverage is already affordable for individuals and families, federal taxpayers should not be required to pay for additional subsidies to cover them. Such a congressional policy sends a demoralizing message to working families who use their own resources to purchase private insurance for their children. This suggests that the real—but thus far tacit—assumption in the recent debate about expanding SCHIP was not about "affordable" health insurance for "poor" children, but rather about increasing dependence on government and the redistribution of income through this venue of public assistance.

The New York and Vermont examples expose the grave risks associated with getting America's middle class hooked on public assistance. Health benefits become tools for political control of the financing and delivery of care. While some families (those to whom eligibility has been expanded) would benefit, other families would be worse off because the cost for them in a shrinking private market with fewer younger and healthier members of the insurance pool would likely increase, resulting in another round of employers and families dropping or forfeiting private coverage.

This is one of the consequences of the "crowd out" of private coverage that accompanies public program expansion. As the CBO explained in recent congressional testimony:

> Families that substitute SCHIP for private coverage are generally better off because the cost (to the enrollees) is lower and the package of benefits may be more extensive. However, to the extent that employers respond to SCHIP by increasing premiums, reducing benefits, or declining to offer coverage, other families could be worse off.[27]

There is general recognition that, since the cost of health insurance has increased considerably faster than wages have increased, both the strain on family budgets and the strain on the national economy demand solutions. At the same time, the presidential

26. In the individual or "non-group" market, premium costs are generally much lower, and there appears to be a much greater variation in premiums from state to state. The American Health Insurance Plan's Center for Policy and Research report, "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007, shows in Table 4, "Individual Market, Average Annual Premiums By State—Family Coverage, 2006–2007," that the average annual premium for the nation was $5,799 but that the average premiums ranged from $3,087 in Wisconsin to $16,897 in Massachusetts. States with premiums above the national average may wish to examine the underlying causes of the higher premiums.

27. Peter R. Orszag, Director, Congressional Budget Office, "Covering Uninsured Children in the State Children's Health Insurance Program," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, May 15, 2008, p. 11.

candidates tacitly assume that there is plenty of money in the health care sector of the economy because their various proposals include "savings from reducing inefficiencies in the system."[28]

No one credibly argues that American health care suffers from a lack of money, even though there is general agreement that health insurance should be more "affordable" for lower-income persons. Beyond that, even if one assumes that families in New Jersey who are paying 13 percent of median family income for the average premium may be paying "too much," it does not logically follow that the right answer is to enroll them in SCHIP or some other public program. In any case, SCHIP expansion does not make health care more affordable; it merely *redistributes the costs* and, in the process, creates new inequities among working families.

The states and the federal government should not expand SCHIP to higher-income levels. Instead, they should convert the assistance provided to families at lower income levels into subsidies for the private health insurance market. One routine objection to health savings accounts (HSAs) is that they entice healthy members out of the health insurance pools. Yet that is precisely what Medicaid and SCHIP have accomplished. Returning tens of millions of healthy individuals to the private health insurance market would reverse the negative effects of "crowd out" from public program expansion and help lower the cost of health insurance for everyone. Public policies should put more people into the insurance pools, not take them out.

As shown in Table 4, the costs of health insurance in the group markets across the country are generally comparable. Contrary to what some in Congress suggest, there is no need to create some type of federal government entity to regulate the costs of health insurance; expanding the insurance pool itself will help to lower the cost, especially if states, as regulators of health insurance, open markets and encourage greater competition—including competition across state lines.

There are, and likely always will be, individuals and families who need help paying for health insurance, but fairness requires a more equitable approach than letting wealthier states bankroll families at any income level with federal dollars. States should provide individuals with access to affordable private health insurance through properly redesigned insurance markets that are not smothered by unnecessary regulation, while federal financial assistance should reduce their reliance on current means-tested programs like Medicaid and SCHIP.

While Congress should demand that states adopt policies that prevent "crowd out," it should also encourage the use of premium assistance within Medicaid and SCHIP. To address the real problems faced by middle-class families who are struggling with the cost of health insurance, Congress may wish to look beyond SCHIP and provide these families with a health care tax credit. This would not only enable families who do not get health insurance through their workplace to buy it, but also allow everyone to keep it by expanding the insurance pool.

Congress may wish to consider a tax credit for families with income at least as low as 150 percent of FPL ($30,975 for a family of four in 2007) that allows them to buy their own health insurance. This would also provide relief to all states by diverting families from public assistance provided through Medicaid and SCHIP.

## Play It Straight with SCHIP Funding

All three versions of last year's SCHIP legislation were designed to spend a pre-set level of money. The result: The money was rewarding unsound policymaking at the state level. Again, such policies tend to benefit a minority of wealthier states that need it the least.

In the next debate, Congress should jettison the kind of funding gimmicks embodied in last year's bills that caused so much confusion and that, if enacted, would have been additional vehicles for manipulation by state officials. Specifically, Congress should return financing to true allotments and drop the Contingency Fund, which removes Congress from financial decision-making, and the Performance Bonus, which provided SCHIP dollars

28. Brookings Institution, Opportunity 08, "Candidate Issue Index: Health Care," February 22, 2008; updated May 13, 2008.

for increased Medicaid caseloads. Congress should also eliminate Express Lane eligibility, which would give new authority to different local agencies to determine eligibility and thereby weaken program integrity; eliminate the expansion of presumptive eligibility, which increases the potential for abuse by providers; eliminate the special-interest earmarks for specific states and providers; and refrain from creating a budget cliff in 2013. Funding should be straightforward, maintaining the capped allotments that reflect reasonable growth rates, and include an updated allotment formula.

Congress missed an opportunity last year to show real support for premium assistance. While appearing to promote premium assistance, Congress actually took a big step backwards. The provisions on premium assistance would have provided states with less flexibility than they currently possess and would have hobbled efforts to employ the premium-assistance strategy.

**Prevent State Bailouts.** The preservation of state allotments would preserve the vital policy link with the bipartisan origins of SCHIP. The central features of the bipartisan compromise that created SCHIP were the enhanced federal match rates and program flexibility balanced by capped allotments. The federal government provided the states with a higher match rate and greater discretion to set policies than they had under Medicaid—with the assumption that states would use their flexibility to set sound policies because funding was subject to capped allotments.

For a time, the allotments, with redistribution of unexpended allotments to shortfall states, were generally successful. Then, rather than fixing the allotment formulas, Congress abandoned fiscal discipline and began to bail out shortfall states in each of the past three years (in the Deficit Reduction Act of 2005, the National Institutes of Health Reform Act of 2006, and the Medicare, Medicaid, and SCHIP Extension Act of 2007) with little regard for why the shortfalls occurred.

Although there was sufficient funding in the aggregate, individual states have faced shortfalls. Some of these shortages were appropriately attributed to flaws in the allocation formula, but a large part of the shortfall was caused by the states that had expanded their SCHIP program to include children at higher income levels and, in some cases, adults. In FY 2006, states faced a $454 million shortfall, which was covered by the federal government through redistribution of unexpended funds and supplemental appropriations.[29] In 2007, states faced shortfalls of $813 million, which were also eventually covered by the federal government through redistribution of unexpended funds and supplemental appropriations.[30]

Among the states that received nearly $1.3 billion in additional federal funds in 2006 and 2007 because of budget shortfalls, seven (Illinois, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, and Rhode Island) received 79 percent of the funds and were covering children at higher income levels, adults, or, in some cases, both. The forecast for FY 2008 shows shortfalls of $1.2 billion, which are again covered by additional funding.[31]

These states could forecast their shortfalls in 2006, 2007, and 2008, but instead of modifying their programs, they pressured Congress—i.e., the American taxpayer—for additional funding.

Last year, Congress purposefully set the new allotment levels far beyond projected need in order to disguise funding for the Contingency Fund and Performance Bonus payments, neither of which existed in the original Title XXI legislation. As previously discussed, individual states have overspent their budgets in recent years, and Congress has provided supplemental appropriations to cover the shortfalls.

To avoid the need for congressional review and action in the future should shortfalls occur again even after substantial increases in funding, the various versions of SCHIP reauthorization included a Contingency Fund. The idea of a Contingency

29. *Federal Register*, Vol. 71, No. 77 (April 21, 2006), p. 20705.

30. *Federal Register*, Vol. 73, No. 101 (May 23, 2008), p. 30120.

31. *Ibid.*, p. 30127.

Fund, however, is inconsistent with the original design of capped allotments and would send states the clear message that they are free to overspend because more money will always be available. This also relieves Congress of its appropriate oversight and decision-making obligations. By setting federal spending on autopilot, Congress abdicates its responsibilities and commits the federal government to fund any decisions made by the states. This creates a dangerous imbalance in the federal–state partnership. Therefore, the Contingency Fund should be dropped.

**Performance Bonus Uses SCHIP to Federalize Cost of Medicaid.** Last year's SCHIP legislation would have created a new Performance Bonus funded with an initial $3 billion appropriation and supplemented with unexpended allotments. Although the specific design went through a number of incarnations in the legislative process, all shared the same central feature: federalizing the cost of Medicaid. Under the final version in H.R. 3963, the federal government would, in effect, pay at least an 81 percent match rate for certain additional Medicaid enrollees—compared to the national average of 57 percent.

Moreover, the Performance Bonus formula provided a disproportionate benefit to wealthier states. As shown in Table 5, a wealthier state with a 50/50 Medicaid match rate would receive $906.25 per additional enrollee, compared to $725 per additional enrollee for a poorer state with a 60/40 Medicaid match rate.

The real purpose of the proposed SCHIP Performance Bonus was to reimburse states for growth in their Medicaid programs. This could result from recruiting "new" enrollees, but it also could reward states for simply "retaining" current enrollees. Because caseloads fluctuate on a monthly basis, a state would not necessarily need to engage in any real outreach efforts to find "new" children; it could still qualify for the bonus by simply keeping the same children on Medicaid for a longer period of time.

## Calculating the Performance Bonus

*In this hypothetical example, we compare how a $2,900 Medicaid cost for a non-disabled child results in different shares paid for by the federal government, based on two Medicaid match rates.*

| | State A<br>Current Medicaid Match Rate:<br>50% Federal, 50% State | State B<br>Current Medicaid Match Rate:<br>60% Federal, 40% State |
|---|---|---|
| Federal Share of Cost | $2,900 × 0.5 = $1,450.00 | $2,900 × 0.6 = $1,740.00 |
| State Share of Cost | $2,900 × 0.5 = $1,450.00 | $2,900 × 0.4 = $1,160.00 |
| Performance Bonus | $1,450 × 0.625 = **$906.25** | $1,160 × 0.625 = **$725.00** |
| Federal Share of Cost | + **$1,450.00** | + **$1,740.00** |
| Total: New Federal Share of Cost | **$2,356.25**<br>(***81.25%*** *of original $2,900)* | **$2,465.00**<br>(***85%*** *of original $2,900)* |

**Source:** Author's calculations based on Section 104 of H.R. 3963.

Table 5 • B 2180 heritage.org

However, in order to qualify for a Performance Bonus payment under Section 104 of H.R. 3963, states would have been required to adopt at least five of eight "enrollment and retention" provisions. A state that did not adopt at least five of these provisions would not qualify for a Performance Bonus regardless of its success in enrolling eligible but previously uninsured children into Medicaid. The requirements were:

- *12-month "continuous eligibility" for both Medicaid and SCHIP children.* This would allow individuals to qualify for a full year regardless of any increase in family income.
- *Liberalization of asset requirements.* States have authority under current law to impose eligibility limitations based on a family's assets as well as income. A state, for example, could insist that even though a family meets the income test, it could be disqualified if the family also had substantial assets that could be used for the cost of insurance or care. This provision would have

required states to eliminate any such asset test for children under their SCHIP and Medicaid programs. Alternatively, the state would have to allow a parent or guardian to make a declaration regarding the family's assets without requiring the family to provide documentation.

- *Elimination of the in-person interview requirement.* States have authority under current law to adopt their own procedures for determining eligibility including requiring, if they so choose, a face-to-face interview with the applicant. This provision would have prevented the state from requiring applicants to appear in person.
- *Use of a simple joint application and information verification process for Medicaid and SCHIP coverage.* As states established their SCHIP programs, they also chose whether to operate their programs as Medicaid expansions or separate programs. They also made decisions about how to "market" SCHIP. States have the authority under current law to design their own SCHIP applications and have made decisions about whether or not their applications included the information needed to perform a determination for Medicaid as well. This provision would require states to use the same application and information verification process for both Medicaid and SCHIP.
- *Automatic renewal.* Under current law, states have the authority to determine their procedures for renewing eligibility. The state would automatically renew a recipient's eligibility "unless the state is provided other information." This was a major shift in personal responsibility from the family to the state and a major break in long-standing public policy that requires individuals to be "re-determined" periodically to know whether the individual still meets eligibility criteria.
- *Presumptive eligibility of children for both Medicaid and SCHIP.* This meant beginning benefits before determining whether the individual is even eligible for the public programs. It would also have allowed ineligible individuals such as non-citizens to receive government benefits.
- *Use of Express Lane agencies.* Under current law, states have the authority to establish their own procedures for taking applications for SCHIP. Under this provision, states would open up the application process to include additional local agencies such as schools and would accept information from such agencies that would not be under direct state control. Express Lane eligibility has been pushed by various advocacy groups since the 1990s. It has blown a big hole in the eligibility determination process that would allow non-citizens to join the programs, threatening the integrity of the nation's largest means-tested program—Medicaid.
- *Premium assistance subsidies.* Under this provision, states that adopted premium assistance for the purchase of employer-based coverage under newly proposed rules in Section 311 of H.R. 3963 would be recognized for purposes of the Performance Bonus. In fact, Section 311 provided states with less flexibility than they currently possess.

These recruitment and retention provisions are not new to SCHIP, and over the course of the past 10 years, states have carefully considered whether to adopt them. Some advocates see these provisions as removing barriers to coverage. Others view them as putting taxpayer dollars at risk. Seven of these eight proposed provisions (all except premium assistance) would have weakened the integrity of the eligibility process because they involve some form of forfeiting information or relinquishing control. In order to qualify for Performance Bonus funds, states would have been required to change their eligibility determination processes for Medicaid as well as SCHIP. Given that the federal government would eventually proscribe procedures through regulation, and given the history of Medicaid litigation related to the eligibility determination processes, these requirements represent greater federalization of the SCHIP program.

Meanwhile, a state that increased Medicaid enrollment through normal "outreach" to needy persons but retained its regular eligibility policies and procedures would *not* qualify for the Performance Bonus. In other words, there would be no bonus unless a state were willing to put the integrity of its Medicaid program at risk. Combining the Performance Bonus with Express Lane increases the

risk of covering ineligible individuals, including non-citizens, by rewarding states with even more federal dollars.

**Throwing Kids Off the Cliff.** In a mockery of fiscally sound budget rules, all three versions of last year's SCHIP legislation contained a budget gimmick: It was designed to avoid the fiscal consequences of facing an honest 10-year score of the cost of the program as estimated by the CBO. By manipulating the manner in which the federal funding would be provided in 2012, under Sections 101 and 108 of H.R. 3963, the projected cost of SCHIP in 2013 dropped by 80 percent. Of course, if this were to happen in real life, all of the children who had been added to the program would lose their coverage. Moreover, even children who are covered under the assumptions of current law, with no change in eligibility, would also lose their coverage.

Unmasking this scheme, Representative Jim McCrery (R–LA) secured data from the CBO that showed SCHIP enrollment dropping by 6.5 million children in the second five-year budget window.[32] This accounting gimmick was particularly offensive to fiscally responsible Members of Congress from both parties who had pledged to take action to restore integrity to the budget process and reduce the federal deficit. In the next debate, Congress should refrain from such practices.

## Conclusion

Congressional leaders seemed determined last year to spend a pre-set level of money to the extent of rewarding unsound policies. SCHIP needs a fresh approach. Congress can return SCHIP to its original focus on uninsured low-income children by setting a firm cap on eligibility that applies to both SCHIP and Medicaid and by restoring fiscal discipline.

Instead of expanding SCHIP, policymakers should promote tax relief for working families to enable them to buy private insurance, including employer coverage, and inject the oxygen of healthy members and resources needed to improve and strengthen private insurance pools. In turn, such action will help to make insurance more affordable for everyone.

*—Dennis G. Smith is Senior Fellow in the Center for Health Policy Studies at The Heritage Foundation.*

32. *Congressional Record*, October 18, 2007, p. H11736.