# Resolved: That the State Children's Health Insurance Program (SCHIP) should be significantly expanded.

---

## State Children's Health Insurance Program

**From Wikipedia, the free encyclopedia**

The **State Children's Health Insurance Program** (SCHIP) is a United States federal government program that gives funds to states in order to provide health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. At its creation in 1997, SCHIP was the largest expansion of health insurance coverage for children in the U.S. since Medicaid began in the 1960s. The statutory authority for SCHIP is under title XXI of the Social Security Act. It was initially sponsored by Senator Ted Kennedy in a partnership with Senator Orrin Hatch[1] in concert with First Lady Hillary Rodham Clinton during the Clinton administration.[2]

States are given flexibility in designing their SCHIP eligibility requirements and polices within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults. SCHIP covered 6.6 million children and 671,0000 adults at some point during Federal fiscal year 2006, and every state has an approved plan. However, the program is already facing funding shortfalls in several states.[4] Attempts to expand funding for the program have met with political controversy amidst studies that debate the program's fiscal impacts. Two proposals passed by the Congress in 2007 to reauthorize and expand SCHIP from an average of $5 billion yearly to approximately $12 billion yearly over the next five years were vetoed by President George W. Bush.[5][6][7] At the end of 2007, President Bush signed an extension of the program to cover current enrollment levels through March 2009.[8]

Despite SCHIP, the number of uninsured children continues to rise, particularly among families that cannot qualify for SCHIP. An October 2007 study by the Vimo Research Group found that 68.7 percent of newly uninsured children were in families whose incomes were 200 percent of the federal poverty level or higher….

### Federal dollars with state administration

Like Medicaid, SCHIP is a partnership between federal and state governments. The programs are run by the individual states according to requirements set by the federal Centers for Medicare and Medicaid Services. States may design their SCHIP programs as an independent program separate from Medicaid (separate child health programs), use SCHIP funds to expand their Medicaid program (SCHIP Medicaid expansion programs), or combine these approaches (SCHIP combination programs). States receive enhanced federal funds for their SCHIP programs at a rate above the regular Medicaid match.

States with separate child health programs follow the regulations described in Section 42 of the Code of Federal Regulations, Section 457. Separate child health programs have much more flexibility than Medicaid programs. Separate programs can impose cost sharing, tailor their benefit packages, and employ a great deal of flexibility in eligibility and enrollment matters. The limits to this flexibility are described in the regulations, and states must describe their program characteristics in their SCHIP state plans. Out of 50 state governors, 43 support SCHIP renewal.[16]

In Ohio, SCHIP funds are used to expand eligibility for the state's Medicaid program. Thus all Medicaid rules and regulations (including cost sharing and benefits) apply. Children from birth through age 18 who live in families with incomes above the Medicaid thresholds in 1996 and up to 200% of the federal poverty level are eligible for the SCHIP Medicaid expansion program. In 2004, the maximum annual

income needed for a family of four to fall within 100% of the federal poverty guidelines was $18,850, while 200% of the poverty guidelines was $37,700.

Other states have similar SCHIP guidelines, with some states being more generous or restrictive in the number of children they allow into the program. SCHIP Medicaid expansion programs typically use the same names for the expansion and Medicaid programs. Separate child health programs typically have different names for their programs. A few states also call the SCHIP program by the term "Children's Health Insurance Program" (CHIP).

**Debate over impacts**

SCHIP has cost the federal government $40 billion over its first 10 years, and the debate over its fiscal impacts reflects the larger debate in the U.S. over the government's role in health care.

In 2007, researchers from Brigham Young University and Arizona State found that children who drop out of SCHIP cost states more money because they shift away from routine care to more frequent emergency care situations.[17] The conclusion of the study is that an attempt to cut the costs of a state healthcare program could create a false savings because other government organizations pick up the tab for the children who lose insurance coverage and later need care.

Detractors of the program focus on the impact to the private health insurance industry. In a 2007 analysis by the Congressional Budget Office, researchers determined that "for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children." The CBO speculates this is because the state programs offer better benefits at lower cost to enrollees than the private alternatives.[3] A Cato Institute briefing paper estimated the "crowding out" of private insurers by the public program could be as much as 60%.[18]

**HR 976**

In 2007, both houses of Congress passed a bipartisan measure to expand the SCHIP program, H.R. 976. The measure would have expanded coverage to over 4 million more participants by 2012, while phasing out most state expansions in the program that include any adults other than pregnant women. The bill called for a budget increase for five years totaling $35 billion, increasing total SCHIP spending to $60 billion for the five-year period. Despite claims that it also would have increased the eligibility from couples earning up to 200% of the federal poverty level to couples earning 300% of the federal poverty level,[19][20], FactCheck.org has noted that this eligibility was already possible under the old program and was not required by the new bill.[21] The expansion of the SCHIP program was to have been funded by increasing the federal excise tax 6000% on cigars, 700% on rolling tobacco, and 160% on cigarettes, rolling papers, cigarette tubes, snuff, chewing tobacco, and pipe tobacco[22]

On October 3, 2007, President Bush vetoed the bill,[23] stating that he believed it would "federalize health care", expanding the scope of SCHIP much farther than its original intent….

**HR 3963**

Within a week of the failed veto override vote, the House passed a second bill attempting a similar expansion of SCHIP. According to Democrats, the second bill, H.R. 3963, created firmer caps on income eligibility, prevented adults from joining, and banned children of illegal immigrants from receiving benefits. The Senate passed the measure on November 1,2007, but on December 12, 2007, Bush vetoed this bill as well, saying it was "essentially identical" to the earlier legislation.[27]

---

## Democrats' SCHIP bill gets second Bush veto

*The Washington Times, December 13, 2007*

President Bush yesterday vetoed funding for a children's health insurance plan for the second time in less than three months, as House Democrats prepared a third measure aimed at expanding the popular program.

It was the president's seventh veto since taking office in 2001 and the sixth since Democrats took control of Congress in January.

Mr. Bush said he opposed the bill because it was too costly, would cover some adults and children in middle-class families, and would raise the federal cigarette tax. "This bill does not put poor children first, and it moves our country's health care system in the wrong direction," Mr. Bush said in a statement notifying Congress of his decision. "Ultimately, our nation's goal should be to move children who have no health insurance to private coverage, not to move children who already have private health insurance to government coverage."

The measure calls for adding about 4 million children to the 6 million already served by the 10-year-old State Children's Health Insurance Program (**SCHIP**). The expansion would cost an additional $35 billion for the next five years for a total of about $60 billion. The measure included a 61-cent tax increase on a pack of cigarettes to help fund the program's expansion. Mr. Bush initially requested a $5 billion increase but later said he was willing to accept a slightly higher amount.

House Democratic leaders yesterday said they intend to introduce a temporary **SCHIP** bill that would fund the program through fiscal 2008, which ends Sept. 30. Details of the plan were not available yesterday evening because the measure had not been drafted. Democrats hinted that it will be far less expansive than their two previous proposals this year.

House Speaker Nancy Pelosi, California Democrat, said her party is committed to passing a long-term measure that expands **SCHIP** to 10 million children. "Let it be clear that we will persist in this effort," she said.

Congress isn't expected to override the veto. …

---

## Parties square off over health care

*The Arizona Republic, November 23, 2007*

**Health-care poll**
An Oct. 1-11 poll by the nonpartisan Henry J. Kaiser Family Foundation suggested that health care is the second-most-important 2008 presidential-campaign issue among Democrats, Republicans and independents. Here are the top issues as prioritized by all voters:
Iraq war: 44 percent.
Health care: 38 percent.
Economy: 18 percent.
Immigration: 12 percent.
Education: 7 percent.
Taxes: 7 percent.
Social Security: 6 percent.
Terrorism: 6 percent.
The poll had a margin of error of plus or minus 3 percentage points.
The Henry J. Kaiser Family Foundation

---

## Providing Health Insurance to Poor Children in the U.S.

In 1965, President Lyndon Johnson (D, 1963-69) introduced his "Great Society," a set of federal initiatives designed to improve the overall quality of life in the U.S., particularly among the nation's lower-income residents. One of the most celebrated components of the Great Society reforms was Medicaid, a program that provides health insurance to the poor. Funded jointly by state governments and the federal government, Medicaid cost more than $300 billion to run in 2006.

Medicaid eligibility can be adjusted by individual state governments and can depend on many factors, including age, disability, citizenship status and total financial assets. However, Medicaid coverage is

generally given to anyone whose yearly income falls under the federal poverty level. Calculated each year by the Department of Health and Human Services (HHS), the federal poverty level helps determine which Americans qualify for certain entitlement benefits, such as welfare and Medicaid. In 2007, the poverty level for a single-person household was $10,210. For a four-person family or household, the poverty level was set at $20,650.

Today, Medicaid is a critical component of the U.S. health care system. In 2006, 38.3 million people received their health care through Medicaid. For many years, however, some observers complained that Medicaid failed in a crucial way: Although Medicaid coverage was guaranteed to people living *below* the poverty line, states were not obliged to extend Medicaid to families living just *above* the poverty line. Many health care experts noted that even those families whose total income was as high as 300% of the federal poverty level struggled to acquire health care coverage. Many low-paying jobs do not include health care benefits, and purchasing private health care for a family of four can be prohibitively expensive, even for households earning as much as $60,000, observers of the health care industry say.

In the mid-1990s, Sens. Edward Kennedy (D, Mass.) and Orrin Hatch (R, Utah) attempted to rectify that oversight in the Medicaid program. They co-sponsored a bill that would establish a new federal health care program, **SCHIP**. Like Medicaid, **SCHIP** provides health care coverage to children from lower-income families, and is funded jointly by state governments and the federal government. Unlike Medicaid, it focuses exclusively on children (and, in most states, pregnant mothers) whose families earn too much money to qualify as "poor" under the HHS's guidelines, but not enough money to afford health insurance on their own.

Kennedy and Hatch's **SCHIP** proposal drew broad bipartisan support, and in 1997, President Bill Clinton (D, 1993-2001) officially signed **SCHIP** into law. **SCHIP** began on October 1, 1997. It was given an initial 10-year trial period with a budget of $40 billion; after those 10 years, Congress would have to reauthorize--and rebudget--the program.

Enrollment in the program grew steadily. During its first year of existence, approximately 660,000 children were enrolled in SCHIP. In the 2006 fiscal year, however--the most recent year for which enrollment data are available--**SCHIP** boasted an enrollment of more than 6 million.

Individual states may set the SCHIP eligibility level as high as they choose, providing they receive federal approval to do so. For example, New Jersey has the most generous eligibility level in the country. New Jersey children who are in families that earn as much as 350% of the federal poverty level--$72,275 for a family of four--are given the opportunity to enroll in SCHIP. Meanwhile, North Dakota has the most stringent requirement for SCHIP eligibility, at no more than 140% of the federal poverty level. In other words, a family of four that earns more than $28,910 is not eligible for SCHIP assistance in North Dakota.

**SCHIP Expansion Unnecessary, Opponents Say**

Opponents of **SCHIP** expansion say that while the goals of **SCHIP** are admirable, such a drastic expansion should not be encouraged. Critics say that, by trying to inflate **SCHIP**'s funding, supporters are taking the first step in a plan to establish a government-run health care system in the U.S.--an idea that fiscal conservatives adamantly oppose. Bush has argued that Congress's **SCHIP**-expansion bill would also expand government power, making more people reliant on the government for health care. "Their **SCHIP** plan is an incremental step toward the goal of government-run health care for every American," Bush said in an October 2007 radio address. He continued:

*Government-run health care would deprive Americans of the choice and competition that comes from the private market. It would cause huge increases in government spending. It would result in rationing, inefficiency and long waiting lines.... [I]t is the wrong direction for our country.*

**SCHIP** expansion would lead to an economic phenomenon known as "crowding out," which would substantially weaken the private health care market, opponents say. Easing **SCHIP**'s eligibility level and

raising its funding level would lead to more people "crowding out" of the private health care market by enrolling their children in **SCHIP**--including many families who could otherwise afford to pay for private health care, critics assert. Critics say that, under Congress's proposed **SCHIP** expansion, one out of every three new **SCHIP** participants would be a former private health care customer "crowding out." Private health insurance companies could lose many customers if **SCHIP** is expanded, critics say. Those losses would be felt by the remaining customers in the form of higher costs, opponents assert.

Opponents say that **SCHIP** does not need to be expanded because it is already big enough as it is. They note that 42 states as well as Washington, D.C., allow families that earn twice the federal poverty level to enroll in the program, and eight of those states allow families earning three times the poverty level to join **SCHIP**. Opponents say that Congress is trying to transform a health care program for lower-income Americans into an entitlement for middle-income families. Bush has alleged that the **SCHIP**-expansion bill would cover some families of four that earn as much as $83,000 a year. "That doesn't sound poor to me," he said. Expanding **SCHIP** would inevitably shift the program's focus away from its original goal, which was providing free health care to needy children, critics contend.

Critics of **SCHIP** expansion have also criticized the proposed 61-cent tax increase on cigarettes. Many opponents, including Bush, say they oppose tax hikes as a matter of principle. Other opponents, meanwhile, question whether a cigarette-tax increase would even be an effective way of funding **SCHIP** expansion. Researchers from the Heritage Foundation, a conservative think tank, say that "Congress will somehow need to recruit new smokers" if they want to meet their lofty funding goals for **SCHIP**. "In just five years, Congress will need over nine million new smokers," the researchers write. "While unrealistic, this scenario is apparently what Congress envisions in its **SCHIP** proposals."

Proponents of **SCHIP** expansion often claim that **SCHIP** has garnered broad, bipartisan support over the years, but that is not exactly the case, opponents say. Support for **SCHIP** as well as **SCHIP** expansion is not nearly as unanimous as proponents would lead people to believe, critics maintain. In fact, they note, Congress's **SCHIP**-expansion bills were largely drafted without Republican input. Amos Snead, the press secretary for House Minority Whip Roy Blunt (R, Mo.), says sarcastically that, rather than draw up plans to expand **SCHIP** by themselves, House Democrats "could actually call [Republicans] or include us in a conference."

If Democrats had contacted their Republican counterparts, **SCHIP** opponents say they could have suggested several possible ways to alleviate the country's health care problems without throwing money into a government-run entitlement program. For example, many prominent Republicans--including Bush and former New York City Mayor Rudolph Giuliani--have proposed giving families a $15,000 tax credit with which to purchase health insurance from a private provider. Another common suggestion made by **SCHIP**-expansion critics is to allow Americans to buy private coverage from outside their home state. Opponents of **SCHIP** expansion say that, by opening up the interstate health care market, competition between private providers would increase, reducing the cost of health coverage and allowing lower-income people to afford health care.

Finally, many **SCHIP** critics say that Democrats are simply trying to exploit the issue of children's health insurance as a ploy to gain voter sympathy. Democrats have portrayed opponents of **SCHIP** expansion as heartless monsters who are callously turning their backs on lower-income children, critics allege. "It is preposterous for people to suggest that the president of the United States doesn't care about children, that he wants children to suffer," says Dana Perino, the White House press secretary. Opponents maintain that Democrats and other **SCHIP**-expansion supporters have portrayed themselves as the good guys in a battle for the well-being of lower-income children. However, those critics assert, the proposed **SCHIP** expansion would wind up hurting those children in the long run.

**Children Benefit from SCHIP Expansion, Supporters Say**

Proponents of **SCHIP** expansion point to the millions of children who are without health insurance as proof that Bush should raise **SCHIP**'s budget considerably. According to the Congressional Budget Office, a nonpartisan federal agency, Congress's plan to expand **SCHIP** would allow an additional 6 million children to sign up for free health care by 2012, the year **SCHIP** would once again be up for renewal. Meanwhile, supporters maintain, Bush's comparatively meager expansion plan would result in just 100,000 new enrollments between 2007 and 2012.

Indeed, supporters say that guaranteeing health care for underprivileged children should be considered a moral imperative. "To be a great nation, we have to take care of the health of our children," says House Speaker Nancy Pelosi (D, Calif.). "It should almost go without saying, but it doesn't. There is every passionate, humanitarian, motherly, fatherly and family reason to [support] this legislation."

Supporters say that another good reason for expanding **SCHIP** is that it is in the country's best interest to ensure that as many of its youngest citizens grow up as healthy as possible, since they will be joining the American workforce within the next decade or two. **SCHIP** expansion "would bring the country huge returns later on, when we baby boomers have retired and need a healthy workforce to pay into our Social Security fund," writes Cynthia Tucker, the editorial page editor for the *Atlanta Journal-Constitution.*

**SCHIP** expansion is a highly popular idea among both Democratic and Republican politicians, as well as among ordinary Americans, proponents assert. Many prominent Republican governors--including Arnold Schwarzenegger (Calif.), Tim Pawlenty (Minn.) and Sonny Perdue (Ga.)--have endorsed **SCHIP** expansion, supporters argue. Public opinion polls consistently show that a majority of Americans--as many as 7 in 10, according to one *Washington Post*-ABC News poll--favor increased funding for **SCHIP**, proponents note. Sens. Grassley and Hatch say that, in the face of such broad support, "it's disappointing, even a little unbelievable" that Bush opposes **SCHIP** expansion so strongly.

Many supporters say that Bush's decision to veto the **SCHIP**-expansion bill is even more appalling in light of the U.S.'s ongoing war with Iraq, launched in March 2003. They argue that, even if **SCHIP**'s budget were doubled, the program would still cost a mere fraction of what the Iraq war is costing and would have far more positive results. "This is all a matter of priorities: the cost of Iraq, $333 million a day; the cost of **SCHIP**, $19 million a day," says Sen. Kennedy. "This is probably the most inexplicable veto in the history of the country."

Proponents further allege that many of Bush's allegations about **SCHIP** are misleading at best. Most notably, they cite Bush's claim that "Congress's plan would...transform a program for poor children into one that covers children in some households with incomes up to $83,000." The $83,000 figure Bush cites is from New York State's request to extend **SCHIP** eligibility to families earning 400% of the federal poverty level, supporters note. Bush denied that request; indeed, he or any future president could deny any state's request to raise the **SCHIP** eligibility level to an amount viewed as too high, proponents say. Advocates of **SCHIP** expansion say that Congress's plan in no way mandates that the government provide health care to any family earning $83,000 a year.

Besides, advocates assert, the vast majority of **SCHIP**'s budget already goes to families that truly need it, and there is no reason to expect that to change. According to the *New England Journal of Medicine*, an estimated 91% of children insured by **SCHIP** come from families earning less than 200% of the federal poverty level. Supporters say that, by increasing **SCHIP**'s funding, the program will better accomplish its stated goal of providing health care coverage to children whose families earn too much money to qualify for Medicaid, but not enough to afford private care.

Proponents acknowledge that a "crowd out" effect will likely take hold if **SCHIP** is expanded. Supporters generally agree with economists' predictions that under Congress's proposed expansion plan, one out of three new **SCHIP** beneficiaries will be "crowding out" of private coverage in favor of free, government-provided health care. However, proponents contend, a certain level of "crowd out" is to be expected and tolerated. The 4 million previously uninsured children who will be added to **SCHIP** by 2012 more than

makes up for the possibility that 2 million children will be "crowding out" from private health care, supporters say.

Advocates also maintain that opponents of **SCHIP** expansion are applying labels such as "government-run health care" and "socialized medicine" as a way of scaring ordinary Americans. "Of course, **SCHIP** has nothing to do with socialism," says New York Gov. Eliot Spitzer (D). "[I]nstead of engaging on the merits, the right wing has pulled socialism from their parade of horribles in order to frighten the public." It is morally wrong for opponents to try to scare Americans into thinking that **SCHIP** expansion, which would greatly help underprivileged children throughout the U.S., represents a move toward socialism, supporters argue.

---

## The House SCHIP Bill: Cutting Medicare, Undercutting Private Coverage, and Expanding Dependency

by Cheryl Smith and Robert E. Moffit, Ph.D., The Heritage Foundation, August 1, 2007

…Instead of expanding government dependency, Congress should stake out an entirely different policy. SCHIP reauthorization should restore the original intent of the law by reaffirming sensible age and income eligibility parameters. Beyond that, Congress should take decisive steps to address the barriers to affordability, namely the unfair, regressive, and inequitable tax treatment of health insurance and its impact on access to affordable coverage for millions of Americans. Finally, Congress should not deny seniors the opportunity to pick the plans of their choice in the Medicare Advantage program or cause millions of seniors to lose their Medicare Advantage coverage.

**What the House Bill Does**
**Crowds Out Private Health Coverage.** The House bill undermines private insurance. Rather than designing subsidies in an innovative way to encourage private health insurance among families, the bill's sponsors displace it. Recent studies indicate that people with private insurance will likely drop eligible dependents in favor of welfare-style health coverage—a phenomenon economists refer to as "crowd out." According to CBO estimates, the House bill would move nearly 1.9 million people off private insurance and onto taxpayer-supported health care.[2]

The legislation embodies a bias against private health coverage and in favor of government coverage. For example, in addition to regular SCHIP payments, the bill would offer "bonus payments" to states for SCHIP and Medicaid enrollment *over* specified "baseline" levels. As enrollment above designated levels increases, the bonuses get exponentially larger.[3] These bonus payments are conditioned upon the states' implementing several provisions, each designed to maximize and expedite enrollment above the baseline. The inclusion of such conditions, of course, would encourage state officials to actively seek and enroll persons in the government-health programs, regardless of current insurance status.[4]

**Expands Government Health Coverage to Middle-Income Adults and Fosters Greater Dependency on Government.** The authors of the House bill repudiate the original intent of the program: SCHIP is no longer limited to low-income persons or to children. House sponsors achieve this expansion by simply redefining both "low-income" and "children." Under the bill, eligibility for government coverage would be extended to families with incomes up to 400 percent above the federal poverty level (FPL)—$82,600 for a family of four—hardly considered low-income by any reasonable standard.[5] The House policy is transparently absurd: 89 percent of all children between 300 percent and 400 percent of the FPL are enrolled in private health insurance; 77 percent of all children between 200 percent and 300 percent of the FPL are enrolled in private health insurance; and 50 percent of all children between 100 percent and 200 percent of the FPL are enrolled in private health insurance.[6]

As another attempt to expand welfare dependency, the House bill would allow persons up to age 21 to be recognized as "children" for purposes of the law. Under certain provisions, program funds may be used to cover non-pregnant, childless adults.[7]

**Devastates Medicare Beneficiaries' Freedom of Choice.** Currently all Medicare beneficiaries are free to enroll in Medicare Advantage, the program of private health plans created under the Medicare Modernization Act of 2003. The new Medicare program serves more than 8.3 million seniors; the majority of its enrolless are the urban poor, seniors in rural areas of the country, and minorities.[8] The Medicare Advantage program provides this diverse population of seniors with additional health benefits beyond those available in the traditional Medicare package, including better access to specialized health care and care management, lower cost-sharing, more preventative services, and prescription drugs. Ninety-five percent of seniors in the program report no difficulty in getting the care they need.

A key achievement of the Medicare Advantage program is better care management through enhanced coordination of care for patients with chronic illnesses. Given the rapid increase in incidents of chronic disease nationwide, such as diabetes, it is remarkable that Members of the House of Representatives would insist on adopting provisions that would directly undercut a program focused on this growing problem, especially among vulnerable and low-income senior populations.

The House bill would devastate the Medicare Advantage program, cutting the projected enrollment in half by 2012. The bill's sponsors propose to partially finance their broader legislative agenda of government expansion by "equalizing" payments between Medicare Advantage plans and the traditional fee-for-service Medicare, even though Medicare Advantage plans have richer benefit offerings. The latest estimates from the CBO indicate that such "equalization" would amount to about $50 billion in cuts over the next five years and $157 billion through 2017.[10] Lowering costs in this way would directly hurt seniors by depriving them of the benefits they have chosen…

**Creates Another Permanent Program**. Unlike the original SCHIP legislation, the House bill requires no future reauthorization, thereby transforming it into a permanent government program. Moreover, the bill would change SCHIP from its current block grant status to the equivalent of a full-blown entitlement. Instead of allotting specific, designated, formula-determined block funding to the states, H.R. 3162 provides an escalating allotment that increases as government coverage is expanded and enrollment increases. As Secretary of Health and Human Services Michael Leavitt warned, "Now is not the time to be adding to these massive unfunded liabilities by taking a program that is working and turning it into a program with excessive Federal funding."[12]

**Increases Government Spending**. The CBO estimates that the House bill, if enacted, would effect a major change in direct government spending of more than $58 billion over 10 years.[13] In order to secure part of that funding, the House sponsors would impose a substantial increase in the per-pack cigarette tax. Using the tobacco tax as a funding source may be politically popular, but economic research indicates it is regressive, insufficient, and unsustainable as a reliable, long-term financing option.[14]

As noted, financing the House bill would also mean reductions in Medicare, focused mainly on those health plans that provide care management. More than 75 percent of Medicare's high-cost beneficiaries have one or more chronic conditions. Currently, the Medicare Advantage program alone promotes highly coordinated care—by far the most efficient and effective means whereby those with chronic conditions can be treated.[15] In the absence of such coordinated care (currently delivered through integrated and efficient private health plans) patients are relegated to inconsistent, piecemeal medical treatment under the old-fashioned Medicare fee-for-service system—a relic of a bygone era of health care delivery…

**What Congress Should Do**

**1. Facilitate affordability and individual choice in the private markets**. To borrow a phrase from the medical milieu, Congress should treat the disease, not the symptom. Congress should address the root issues plaguing health care coverage by focusing on the way families and individuals pay for coverage.

Studies indicate that most uninsured workers who decline coverage cite high costs as the primary reason.[16] These persons need help. Rather than shepherding middle-income and even upper-middle-income families onto the equivalent of a federal welfare program, Congress should provide direct tax

relief to individuals and families—o r refundable tax credit or vouchers to low-income families—enabling them to choose the type of coverage that best suits their needs. Congress should also allow the states to use SCHIP funds to enhance premium assistance for low-income families; moreover, Congress should dispense with the regulatory obstacles that limit the effectiveness of such assistance. Finally, Congress should support innovative efforts to reform health insurance markets already underway at the state level….

## CBO ESTIMATES SHOW LARGE GAINS IN CHILDREN'S HEALTH COVERAGE UNDER SENATE SCHIP BILL

By Edwin Park, Center on Budget and Policy Priorities, August 7, 2007

Congressional Budget Office estimates show that 4 million children who otherwise would be uninsured would have health care coverage by 2012 under the bipartisan children's health legislation that the Senate Finance Committee approved on July 19 by a 17-4 vote. CBO estimates that 2.7 million of these children are uninsured children who would already be eligible for the program under the current eligibility limits that states have set in the State Children's Health Insurance Program (SCHIP) and Medicaid, and another 800,000 are SCHIP children who would otherwise lose their coverage in coming years and end up uninsured under the "budget baseline" (because states would have insufficient federal SCHIP funding to sustain their existing programs).

- As a result, CBO estimates that 3.5 million of these 4 million children — at least 85 percent of them — are children with incomes below the current eligibility limits that states have set.
- Only about 600,000 of the 4 million children who would otherwise be uninsured are children who would gain SCHIP eligibility as a result of actions by states to broaden the program's eligibility criteria. (All of these figures represent CBO's estimates of the number of children covered in an average month in 2012.)

Key elements of the bill that the Finance Committee approved would extend the SCHIP program for five years and raise SCHIP funding levels both to enable states to sustain existing children's enrollment and to cover more children. The legislation also would provide financial incentives to states to enroll uninsured children who are already eligible for Medicaid or SCHIP. According to CBO, the various provisions to maintain and expand children's health coverage would cost $35 billion over five years, with these costs fully offset by an increase in federal tobacco taxes.

The Finance Committee bill provides $15 billion less for children's health care coverage than the $50 billion over five years the congressional budget resolution permits if the costs are offset. The legislation consequently would extend health insurance to significantly fewer uninsured low-income children than could be covered with the full $50 billion. The legislation also scales back existing SCHIP coverage of low-income parents of children who are enrolled in SCHIP or Medicaid. Various studies have found that covering children and their parents jointly results in more of the eligible children signing up and receiving health care services.

Nevertheless, as the CBO figures cited above demonstrate, the legislation would make major progress in extending health insurance to uninsured children. Of particular note, CBO estimates that the bill would make significant progress in reaching the lowest-income uninsured children; 1.7 million children who are eligible for Medicaid but otherwise would be uninsured would gain coverage under the legislation. Most of these would likely be children living below the poverty line.

### Claims that the Bill Would Primarily Displace Private Coverage Found to be Inaccurate

Even before the Senate Finance Committee completed its work in crafting the legislation, the Administration and some conservative activists began castigating the bill (and the SCHIP reauthorization bill being drafted in the House) as doing relatively little to cover uninsured low-income children and as being primarily designed to shift middle-income children (and families) "with good incomes" from private insurance to "government coverage."

The CBO figures on the Finance Committee bill show that these charges are without foundation. The figures show the bill would be heavily targeted on children with low incomes and would primarily assist children who would otherwise be uninsured, not children who otherwise would have private coverage.

- CBO estimates that the legislation would increase the number of children enrolled in SCHIP or Medicaid by a total of 6.1 million by 2012. As noted above, CBO estimates that 4 million of these would be children who would otherwise be uninsured.
- In other words, nearly two-thirds (66 percent) of the children who would gain SCHIP or Medicaid coverage under the bill are children who would otherwise be uninsured, not children who would otherwise have private coverage.

CBO estimates that the other 34 percent of the children who would gain SCHIP or Medicaid coverage under the bill otherwise would have some type of private insurance. But as CBO director Peter Orszag and other leading health experts have explained, under the fragmented U.S. health insurance system, virtually any effort to cover more of the uninsured — including efforts that rely on tax deductions or credits for the purchase of insurance in the private market — would result in some crowd-out (i.e., in the substitution of one type of health insurance for another). A crowd-out effect of 34 percent is actually quite modest.

For example, analyses of various tax-based approaches have found that the large majority of the tax benefits generally would go to people who already are insured. Thus, an analysis of the health-insurance tax proposals that the Bush Administration included in the budget it submitted last year, conducted by the very economist (Jonathan Gruber of M.I.T.) whose work on SCHIP crowd-out HHS Secretary Mike Leavitt and conservative activists have been touting in recent weeks, found that 77 percent of the benefits under the Administration's health tax proposals would go to people who already are insured. This is more than double the crowd-out percentage under the Senate Finance Committee bill. (Professor Gruber's analysis of the Administration tax proposals also found that the net result of the proposals would be to modestly increase the ranks of the uninsured, because a number of employers would respond by dropping coverage.)

Professor Gruber, who is widely considered to be one of the nation's leading health economists, has explained that although public programs suffer from crowd-out effects, they still constitute the most efficient way to cover more of the uninsured. He has noted that "no public policy can perfectly target the uninsured, and public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage. I have undertaken a number of analyses to compare the public sector costs of public sector expansions such as SCHIP to alternatives such as tax credits. I find that the public sector provides much more insurance coverage at a much lower cost under SCHIP than these alternatives. Tax subsidies mostly operate to "buy out the base" of insured without providing much new coverage."

It also should be recognized that in a substantial number of the cases in which a family with access to private insurance enrolls its children in Medicaid or SCHIP, that decision may be beneficial to the child's health. In many such cases, particularly among the low-income families targeted by the Senate Finance Committee bill, the private insurance available to the family may contain important gaps in the coverage it provides or may require large deductibles and cost-sharing charges that the family has difficulty affording. Research has shown that when low-income families face large cost-sharing charges, they often go without (or delay obtaining) health care services that they or their children need.