

HEALTH POLICY REPORT

Insuring All Children — The New Political Imperative

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Efforts by the 110th Congress, which is commanded by Democrats eager to reduce the record number of people without health insurance, coupled with other federal and state initiatives,¹⁻³ have thrust health care reform into the political limelight for the first time in 12 years. Not since 1994, when the comprehensive proposal of the administration of President Bill Clinton was rejected, has the erosion of private insurance coverage and the continuing rise in health care expenditures aroused such intense interest among policymakers. Adding an impetus to this renewed interest are other proposals that have been unveiled by an unusual collection of private interests — big business, organized labor, health plans, health care providers, and consumers — which have coalesced around a belief that new steps must be taken to expand coverage and slow the growth of expenditures.⁴⁻⁷ In his 2007 State of the Union address, President George W. Bush introduced his own proposal, which is based on a restructuring of tax incentives designed to encourage people to purchase private health insurance.⁸ Two weeks later, however, when the administration's 2008 budget was released, it called for marked reductions in the growth of the two largest public insurance programs — Medicare and Medicaid — underscoring the divide between Democrats and Republicans over the role government should play in extending coverage to people without health insurance.

The United States relies on voluntary, employer-sponsored health insurance as its preferred way of providing employees and their dependents with financial protection against illness. In 2005, 68.2% of all workers were covered by private insurance, 59.5% of which was employer-sponsored. Of the total U.S. population with coverage of any type, 27.5% relied on government-sponsored insurance.⁹ As private insurance has become less affordable and fewer businesses even offer it, the number of employees with such coverage has declined over the past 5 years. A record 46.6 million people were

uninsured in 2005 — 15.9% of the population — about two thirds of whom were adults with incomes below 200% of the federal poverty level,^{9,10} which in 2007 is \$20,650 for a family of four. Children lost private coverage, too, but most of these losses were offset by expansions in public insurance.¹¹ Because Democrats and Republicans remain divided over how best to expand coverage, there is no expectation that the new groundswell of interest will translate quickly into the enactment of major reforms. But politicians vying to succeed President Bush already recognize that to be viable, a candidate must propose ways to address what has become a major concern among an increasing number of Americans: the availability of affordable insurance.^{12,13}

Although broader efforts at reform will await the results of the 2008 election, there is strong bipartisan sentiment — reinforced by the need for Congress to reauthorize the State Children's Health Insurance Program (SCHIP) — that legislation designed to expand coverage should focus on children this year. In this report, I discuss the evolution and track record of SCHIP and the future prospects for extending the program, the legal mandate of which expires on September 30, 2007.

EVOLUTION AND STATUS OF SCHIP

When Congress, as part of the Balanced Budget Act of 1997, enacted SCHIP, the program derived largely from a compromise negotiated by two senators, Republican Orrin Hatch of Utah and Democrat Edward M. Kennedy of Massachusetts. Although Hatch and Kennedy hold disparate views on the role of government in health care, they have a long history of reaching accommodations over their differences. Reflecting Democratic dogma, the compromise expanded the scope of public insurance, but it also acknowledged Republican preferences in a Congress the party then controlled.

For example, the measure capped federal funding, made participation by states voluntary, and permitted states to charge premiums and cost-sharing amounts so that the program would closely resemble private coverage.¹⁴ In addition, the compromise granted states greater latitude to determine who should be eligible for SCHIP, to limit covered benefits in ways not allowed under Medicaid,¹⁵ and to create program structures that matched their needs.

Within a few years, persuaded that expanding coverage to the children of the working poor was sound public policy and lured by federal matching payments that are more generous than those of Medicaid, every state, the District of Columbia, and five U.S. territories had created some version of SCHIP. In 2006, SCHIP payment rates to states ranged from 65 to 83% of the total costs of the states' programs, whereas the equivalent Medicaid payment rates were 50 to 76%. Eighteen states and the District of Columbia created new programs, 17 states expanded their Medicaid programs, and 21 states opted for a combination of these two approaches.

SCHIP built on coverage provided by Medicaid, which is the backbone of public insurance for children. In 2005, 76% of the children covered by Medicaid lived in families with incomes below the poverty level, whereas a similar percentage of children covered by SCHIP (80%) lived in families with incomes of 100 to 199% of the poverty level.¹⁶ In 2007, the federal government defined 200% of the poverty level for a family of four as \$41,300.

Medicaid, a vast federal–state program, included among the 60.4 million people it covered in 2005 some 28 million children — 8 of every 10 publicly insured children.¹⁷

Over the decade from 1997 to 2007, 42 states made rapid strides in expanding public coverage for children in families of modest means. Beyond their efforts, community-based organizations, foundations — the Robert Wood Johnson Foundation invested \$150 million — and, in California, even insurance brokers and tax consultants were enlisted in the cause of enrolling uninsured children in SCHIP.¹⁸ Before enactment of SCHIP, only 11 states covered children in families with incomes of 185% of the poverty level or higher. By 2006, 42 states covered children with family incomes of 200% of the poverty level, including 7 states that set income thresholds for SCHIP eligibility at 300% of the poverty level. New Jersey, where the cost of living is particularly high, topped all jurisdictions, enrolling children who live in families with incomes of up to 350% of the defined level of poverty.

Combined, the efforts made through implementation of SCHIP and the continued enrollment growth of Medicaid led to a significant decline in the number of uninsured children from 15.4% (11.1 million) in 1998 to 11.2% (8.3 million) in 2005, according to data from *Current Population Surveys* (Table 1).¹⁹ In 2005, 33.5 million children were enrolled in two programs at one time or another: 28 million in Medicaid and 5.5 million in SCHIP. Also enrolled in SCHIP were 639,000 adults, most

Table 1. Health Insurance Coverage of Children, 2001 through 2005.*

| Year | No Coverage | Medicaid and SCHIP | Employer-Sponsored Insurance | Individually Purchased Insurance | Medicare | Military Health Care |
|---|-------------|--------------------|------------------------------|----------------------------------|----------|----------------------|
| <i>percent of U.S. children (no. in millions)</i> | | | | | | |
| 2005 | 11.2 (8.3) | 26.7 | 60.5 | 5.5 | 0.7 | 3.1 |
| 2004 | 10.8 (7.9) | 27.0 | 61.0 | 5.8 | 0.7 | 2.8 |
| 2003 | 11.4 (8.4) | 26.4 | 61.2 | 5.3 | 0.7 | 2.7 |
| 2002 | 11.6 (8.5) | 23.9 | 63.0 | 5.3 | 0.7 | 2.9 |
| 2001 | 11.7 (8.5) | 22.7 | 63.9 | 5.0 | 0.6 | 3.3 |
| 2000† | 11.9 (8.6) | 20.9 | 65.6 | 5.0 | 0.7 | 3.5 |
| 1999 | 12.8 (9.3) | 20.3 | 64.8 | 5.6 | 0.5 | 2.9 |
| 1998 | 15.4 (11.1) | 19.8 | 63.3 | 5.1 | 0.5 | 3.1 |

* Data are from *Current Population Surveys* (in Rosenbaum¹⁹). Percentages do not sum to 100 because some people have more than one type of coverage.

† Because in 2000 the U.S. Census Bureau changed how it determines who is uninsured, data for earlier years are not fully comparable to more recent estimates.

of whom were parents of children eligible for the program.²⁰ But since 2005, the number of uninsured children has begun to rise again, with rates highest in the South (18.2% of all children living in that region) and West (18.1%) and lowest in the Midwest (11.9%) and Northeast (12.3%). Some 9 million children remain uninsured, including 6 million who are eligible for but not enrolled in either SCHIP (2 million) or Medicaid (4 million).²¹⁻²³

EFFECT OF SCHIP ON ACCESS AND QUALITY

In 1999, Congress directed the Department of Health and Human Services (DHHS) to conduct an independent comprehensive study of SCHIP. The evaluation, conducted by Mathematica Policy Research and the Urban Institute, closely examined the programs of 10 states: California, Colorado, Florida, Illinois, Louisiana, Missouri, North Carolina, New Jersey, New York, and Texas. The evaluation — glowing in its conclusions — characterized the programs as “successful in nearly all of the areas examined. . . . SCHIP programs were found to provide health coverage to the population SCHIP was intended to serve, particularly to children who would otherwise have been uninsured. The programs availed enrollees of needed primary and other health care services, leaving enrollees with fewer unmet needs than they would have had in the absence of SCHIP.”²⁴

The evaluation placed less emphasis on the quality of care provided through SCHIP than on the extent of coverage by SCHIP because the law imposed no requirement on states to systematically document the quality dimension of the program. Genevieve Kenney, one of the evaluators, recently wrote that monitoring quality closely “would likely require additional federal resources, technical assistance and the imposition of a mandatory, standardized reporting system that includes a much more comprehensive set of pediatric measures . . . in place of the current voluntary one.”²⁵ Although documentation of access to care and of its quality has been limited overall, a number of studies have reported that SCHIP, like Medicaid, is associated with fewer unmet health care needs among enrolled children, including children with chronic and serious conditions^{26,27}; SCHIP is associated with improved

delivery of continuous care²⁸ and has also led to a reduction in the health care disparities that affect people who belong to ethnic and racial minorities.²⁹ Nevertheless, the most recent data from the National Health Interview Survey show that children in low-income families remain at greater risk for living with a chronic or acute condition and are more likely to be limited by such conditions than are those living in families with higher incomes.³⁰

DEBATE ON THE FUTURE OF SCHIP

The debate over reauthorizing SCHIP will test the resolve of federal and state policymakers to reduce the number of uninsured children largely through the expansion of a public program. The central issue will be to determine how much money Congress should authorize for funding the program during the next 5 years. Democratic leaders are seeking to greatly expand the scope of SCHIP, authorizing funding levels that are about three times those proposed by the Bush administration.

In 1997, Congress authorized expenditures of \$40 billion over the next 10 years, with each state that chose to participate allotted an annual federal payment based in part on the number of uninsured children living within each jurisdiction. Each state could draw on its annual allotment over a period of 3 years. After 3 years, any unused funds could be reallocated to states that had exhausted their original allotments. In 2007, according to the Congressional Research Service, SCHIP expenditures in 14 states (Alaska, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Rhode Island, and Wisconsin) will exceed their federal allotments, resulting in shortfalls in the coverage of the children enrolled.³¹

To maintain, much less expand, SCHIP nationally will require a substantially higher level of federal funding than is currently needed — about \$5 billion a year — and this expansion is clearly the top health legislative goal of Democrats in 2007. Senator Hillary Clinton of New York established the highest bar when, on January 20, she announced her intention to propose legislation that would encourage states to cover children in families with incomes up to four times the federal poverty level, or about \$82,000 a year for a family of four. Surrounded by children in a com-

munity health center, Clinton unveiled her plan while announcing her intention to seek the Democratic nomination for president. Clinton said she and Representative John Dingell (D-MI) would introduce companion bills designed to reauthorize an expanded SCHIP. Dingell chairs the House Committee on Energy and Commerce, which holds jurisdiction over SCHIP and Medicaid.

Six weeks later, Senator Max Baucus (D-MT), chair of the Senate Finance Committee, announced that he would introduce legislation authorizing \$50 billion to fund SCHIP over the next 5 years. Baucus's committee oversees SCHIP and Medicaid. Bipartisan proposals were also introduced by Senators Jay Rockefeller (D-WV) and Olympia J. Snowe (R-ME), and Jeff Bingaman (D-NM) and Richard Lugar (R-IN), both of which would authorize a larger SCHIP than sought by the administration. And in early June, Hatch and Kennedy announced they had reached agreement that favored the enrollment of all children of the working poor in SCHIP programs, giving states the option to cover all legal immigrant children and funding the program through taxes on tobacco.³²

FAVORING A SMALLER SCHIP

The Bush administration will strongly resist efforts by Democrats to expand the scope of SCHIP, preferring instead to tighten the program's original eligibility thresholds to concentrate federal resources on covering children in families with incomes of less than 200% of the poverty level. Its 2008 budget proposed the addition of \$4.8 billion over the next 5 years to the current annual level of \$5.04 billion (for a total of about \$30 billion). According to one analysis, this funding level would provide less than half the money needed by states to maintain their existing SCHIP caseloads, much less cover all children in families with incomes of less than 200% of the poverty level.³³ When a bipartisan delegation of governors met with President Bush on February 26, its members urged the President to provide states with at least enough money to maintain the current enrollment levels of their SCHIPs. In response, according to one newspaper account, "administration officials said states should make better use of the money they already had."³⁴

Before Congress reauthorizes SCHIP, a House-

Senate conference committee will have to craft compromises on funding and other issues on which Democrats and Republicans differ. The task will be made more challenging for Democrats by their pledge to abide by "pay-as-you-go" rules, which they restored in January. Under these rules, legislators must either increase taxes or extract savings from other programs to cover the higher costs of operating SCHIP. Budget resolutions, approved by both the House and Senate this past March, include money earmarked for the expansion of SCHIP, but they do not identify the sources that would be used to cover these additional sums. Budget resolutions, although not binding, serve as spending guides for the House and Senate committees that preside over different federal programs.

RELATIONSHIP BETWEEN PUBLIC AND PRIVATE COVERAGE

Beyond the funding issue, other questions will also require resolution, among them whether more stringent policies should be adopted to prevent the loss of private coverage that is attributable to the expansion of public insurance and whether states should be allowed to continue enrolling childless adults and the parents of enrolled children, as some states have done under federal waivers granted by the administration. When designing SCHIP, Republicans were concerned that some parents, insured through their employers, might opt to drop such coverage for their children and enroll them in the new federal-state insurance program. The law explicitly required states to implement strategies to prevent this eventuality, such as imposing a mandatory waiting period on families who dropped or lost private coverage before they could enroll their children in SCHIP. The administration's tight 2008 budget proposal for SCHIP, one newspaper reported, was in part an ideological statement — that too much government support could limit the growth of private insurance for the working poor, an alternative that Bush strongly favors.³⁵

The substitution of private coverage for public insurance, known as "crowd out," would raise the cost of SCHIP but would not reduce the number of uninsured children.³⁶ Studies seeking to measure the effect of this phenomenon^{23,24,36-40} have reached various conclusions depending on the

data sources and methods used; thus, no consensus exists on the question. The most recent examination of the effect of “crowd out” may prove to be the most influential with legislators because it was conducted by the nonpartisan Congressional Budget Office (CBO) at the request of the Senate Finance Committee.⁴¹ On the basis of a review of the literature and discussions with the analysts who produced the work, the CBO concluded that

the most reliable estimates currently available suggest that the reduction in private coverage among children is between a quarter and a half of the increase in public coverage resulting from SCHIP. In other words, for every 100 children who enroll as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children. The available evidence, which is quite limited, suggests that the bulk of the reduction in private coverage occurs because parents choose to forego private coverage and enroll their children in SCHIP (because of better benefits, lower costs, or some combination thereof), rather than employers deciding to drop coverage for such children.

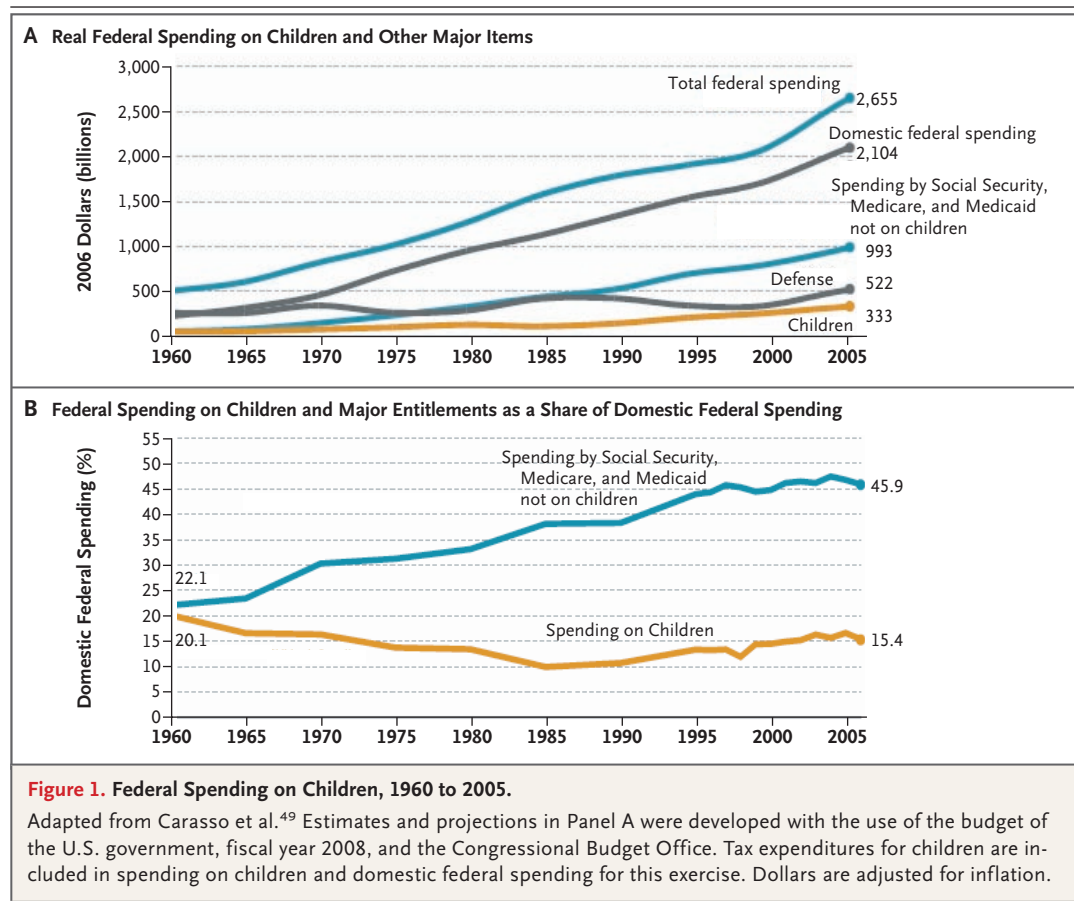
Another issue that will draw fire is whether states should continue to have the flexibility to cover childless adults and parents whose children are enrolled in SCHIP. Until recently, the Bush administration allowed states the flexibility to cover adults under waivers of federal policy issued by DHHS, but it now opposes the enrollment of more adults. The Deficit Reduction Act of 2005 called a halt to the enrollment of more adults in SCHIP but allowed those already participating in the program to remain. Almost a decade ago, Wisconsin was the first state to experiment with enrolling adults when Republican Tommy Thompson was its governor. In a recent interview, I asked Thompson, former secretary of DHHS (2001–2005), about his current view on enrolling adults in SCHIP. He responded, “When I was governor, we found that the chances of enrolling children improved significantly if their parents also could enroll in BadgerCare [Wisconsin’s SCHIP]. If the overriding goal is to reduce the number of low-income children without insurance, then the administration is making a big mistake by opposing the enrollment of their parents in the SCHIP.”

CONCLUSIONS

The likelihood that Congress will reauthorize SCHIP this year is better than 50-50 but no sure bet, given the challenge that Democrats face in securing the \$50 billion in new resources required to expand the program without adding to the budget deficit.⁴² If no compromise is struck this year, Democratic leaders could decide to continue the program under a stopgap resolution and resume the debate after the 2008 election, in hopes that they will be able to increase their House and Senate majorities.

Another factor in the equation is the stance that the National Governors Association — composed of 28 Democrats and 22 Republicans — will adopt in relation to reauthorizing SCHIP. In 2007, reflecting the bipartisan interest among governors to press for reforms, 38 of them emphasized the need to expand coverage to uninsured persons in their state-of-the-state addresses.⁴³ Nevertheless, governors of both parties who by law, in all states but Vermont, must balance their annual budgets, worry that Democrats, in their zeal to expand the program, may seek to expand SCHIP benefits (the Dingell bill would authorize a new dental benefit), impose quality standards, and mandate greater outreach efforts. All such steps would increase the costs of the program and reduce the flexibility that governors say states must possess to manage their programs effectively.

Although SCHIP enjoys broad political support, there are many advocates of children who believe that its emphasis on medical benefits is far too narrow.^{44,45} A growing body of research asserts that increased investments in early childhood development, disease prevention, and health promotion could greatly improve the long-term prospects of children⁴⁶⁻⁴⁸ and that SCHIP should be expanded to respond to these needs, particularly by addressing the epidemic of obesity among the young. Among many interests, the American Academy of Pediatrics, the Institute of Medicine, and the Robert Wood Johnson Foundation share this view, but there is no early indication that Congress is prepared to expand SCHIP in this fashion. Indeed, given the competing claims for federal and state tax revenues, an expansion of SCHIP that reaches the ambitious goal sought by Democrats would be a modest reversal of a longtime trend in public policy — a political preference that favors other age groups and sectors over children. A recent re-



port by the Urban Institute concluded that children have been a “diminishing national priority” for federal policymakers during the past half century (Fig. 1).⁴⁹ During this period, real (inflation-adjusted) federal spending on children in more than 100 programs (health and nonhealth) grew from \$53 billion in 1960 to \$333 billion in 2006 and rose from 1.9% to 2.6% of the gross domestic product (GDP). By comparison, spending on the large federal entitlement programs — the “non-child” components of Social Security, Medicare, and Medicaid that benefit disabled and elderly people — nearly quadrupled from 2% to 7.6% of the GDP, or from \$58 billion to \$993 billion.

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Mr. Iglehart is a national correspondent for the *Journal*.

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