



Sinking SCHIP

By Jonathan J. Miltimore

On October 3, 2007, President George W. Bush vetoed the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2007 [H.R.976.ENR].¹ The Act would have changed Title XXI of the Social Security Act by increasing the standard eligibility threshold of the State Children's Health Insurance Program (SCHIP) from 200 percent of the poverty level² to 300 percent. This expansion would increase baseline projections from the current level of \$25 billion over the next five years to about \$60 billion. The bulk of the tax dollars would have come from an increase in the federal cigarette tax.³

By making middle- and even in some case, upper-income families eligible for government-funded healthcare insurance, CHIPRA proposed to cover an additional 4 million uninsured children in the state-administered program. President Bush's veto was sustained by the House of Representatives. The Bush administration had sought to reauthorize the program, proposing \$5 billion in new money.⁴

The goal of CHIPRA is a well-intentioned and obvious one: reduce the number of uninsured children in the United States. Covering children from families with modest incomes that may find it difficult to purchase private health insurance seems like an appropriate and compassionate step, and many have condemned President Bush for vetoing CHIPRA. Others, however, believe CHIPRA is a Trojan horse intended to extend socialized healthcare to the middle-class and is an unwarranted expansion of SCHIP that would fundamentally change the program.

An expansion of the SCHIP program would not be advisable for several reasons, its greatest detriment being that it relies on a funding system that is flawed and misconceived. To begin, the federal government's matching rates for SCHIP are far too high. While the national average matching rate for a SCHIP program is 69 percent, rates in some states exceed 80 percent. Some may think that a policy that involves the federal government providing \$0.69, perhaps even \$0.80, for every dollar a state spends on SCHIP is reasonable. In actuality, a 69 percent "matching rate" means that the federal government bears 69 percent of the total *cost*.⁵

Actual matching rates are considerably higher than \$.80 on the dollar. The vast majority of states receive between \$2.50 and \$4.50 for every \$1.00 they put into SCHIP. In 2005, Mississippi received \$5.23 from the federal government for every \$1.00 it spent.⁶

Such an arrangement encourages states to expand their programs because they bear a disproportionately small amount of the cost. When one state dollar spent can purchase over six dollars of government-financed care, states can hardly afford not to find creative ways to expand healthcare to demographics that may not need the coverage.

Second, states have very little reason to attempt to control costs. For example, one would assume that in a grant program (versus an entitlement program) if states exhaust their federally allocated SCHIP dollars the funding would cease. This is not the case. Instead, in Medicaid-based SCHIP programs, states "automatically receive federal matching payments under the Medicaid program."⁷

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The majority of states (32) use Medicaid expanded coverage for at least part of SCHIP. This means that in these states the federal dollar spigot continues to flow even after they have exhausted their SCHIP funds. States that have opted to establish a separate program under SCHIP might have some incentive to control costs, if it were not for other bad incentives that encourage overspending.

For example, states that have implemented a non-Medicaid expanded program that do not spend all of their funds within three years lose those dollars. Ironically, these unspent funds are redistributed to states that have spent all of their funds. Furthermore, Congress, demonstrating an utter lack of understanding of the term “moral hazard,” has twice rescued states that exhausted their funds by granting them additional monies. Such actions clearly discourage states from taking cost-saving measures they would almost certainly implement if they were spending their own funds, which would not be replaced if exhausted or seized if unspent.⁸

Because they bear only a small percentage of the cost, states often extend coverage to individuals who do not need government assistance. It is estimated that 670,000 adults were covered by SCHIP in 2006. Ironically, while nearly 700,000 adults were receiving government welfare in the State Children’s Health Insurance Program, the Urban Institute estimates that 689,000 children from low-income families (less than 200 percent of the poverty level) are currently uninsured despite being eligible for the program.⁹

In essence, SCHIP represents a microcosm of the worst parts of the U.S. healthcare system. By hiding the costs from those who are purchasing the care, people erroneously believe they are getting something for free. This results in an over-consumption of healthcare resources.

An expansion of SCHIP would not solve America’s healthcare crisis but exacerbate it. Because SCHIP tends to crowd out private insurance, such an expansion would provide only a minimal increase in net coverage, while shuffling millions of middle-income American children already covered into government programs. The expansion would be funded by taxing many of Americans who could least afford it, as cigarette levies are the most regressive taxes in our system. In a cruel stroke, poor and working-class Americans will be subsidizing the healthcare for middle- and upper-middle class citizens.

Instead of extending state financed insurance to citizens that do not need it, Congress should pass legislation giving states more control over their SCHIP dollars to target the truly needy.

Endnotes

- 1) Michael Abramowitz and Jonathan Weisman, “Bush Vetoes Health Measure,” The Washington Post, October 4, 2007, <<http://www.washingtonpost.com/wp-dyn/content/article/2007/10/03/AR2007100300116.html>> (November 1, 2007).
- 2) The federal poverty level for a family of three in 2007 is \$17,170.
- 3) Children’s Health Insurance Program Reauthorization Act of 2007 [H.R.976.ENR], <<http://thomas.loc.gov/cgi-bin/query/D?c110:32::/temp/~c110eHiVjA:>> (November 17, 2007); “Children’s Health Insurance Program Reauthorization Act,” The Kaiser Commission on Medicaid and the Uninsured, October, 2007, p. 4, <<http://www.kff.org/medicaid/upload/7701.pdf>> (November 25, 2007).
- 4) Robert Pear and Sheryl Gay Stolberg, “House Sustains President’s Veto on Child Health,” New York Times, October 19, 2007, <<http://www.nytimes.com/2007/10/19/washington/19health.html>> (October 22, 2007).
- 5) Ibid, p. 2.
- 6) “How Much Does My State Get from the Federal Government When It Spends A Dollar on Medicaid and the State Children’s Health Insurance Program (SCHIP)?” Families USA: The Voice of Healthcare Consumers, March 2004, <http://www.familiesusa.org/assets/pdfs/FMAP_update_Mar_2004280f.pdf> (December 2, 2007).
- 7) Congressional Budget Office, “Section-2, Summary: The State Children’s Health Program,” May 2007, <<http://www.cbo.gov/ftpdoc.cfm?index=8092&type=0&sequence=1>> (Dec 5, 2007).
- 8) SCHIP, vii, p. 6.
- 9) United States Department of Health and Human Services, Fact Sheet, June 28, 2007, <<http://www.hhs.gov/news/facts/schip2.html>> (December 5, 2007).

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