December 2007

SCHIP:
Don't Just Sink it, Reform it

POLICY STUDY

No. 07-6

by

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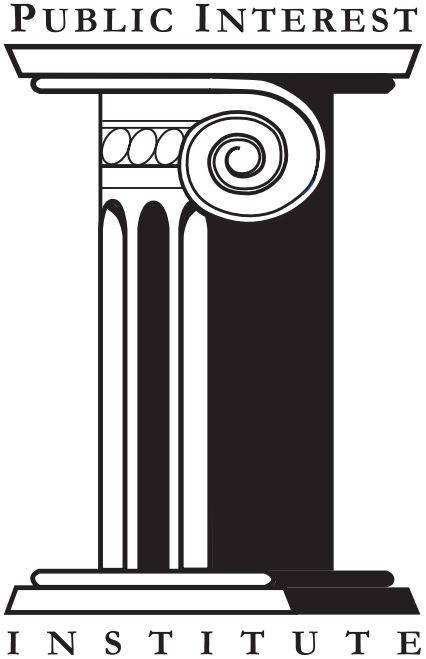

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Dr. Don Racheter,
President

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SCHIP: Don't Just Sink it, Reform it

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EXECUTIVE SUMMARY

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 the 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 level[2] 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 cases, 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 income 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.[5]

This study will examine the SCHIP program and answer the following questions: What is the purpose of SCHIP? How effective has the program been? Is an expansion of SCHIP in the interest of American citizens? If a SCHIP expansion is not in the interest of U.S. citizens, what healthcare reform steps can be taken to improve healthcare in the United States?

This study finds that considerable expansion of the SCHIP program would not be advisable for several reasons, and such an expansion could actually harm healthcare administration in the United States. Grounds for the rejection of expanding SCHIP include the following:

1) The paradigm of SCHIP is flawed and, perhaps, unconstitutional.
2) Massive SCHIP expansion, such as the CHIPRA proposal vetoed by President Bush, would alter the program profoundly in a manner incongruous with its original purpose.
3) A more prudent step would be to freeze federal block grants to states at current levels and allow them to allocate dollars to the program individually as they see fit.

" ... expansion of the SCHIP program would not be advisable for several reasons, and such an expansion could actually harm healthcare administration in the United States."

SCHIP:

"Jointly funded by states and the federal government, Congress alone has allocated nearly $40 billion to SCHIP since 1997. "

INTRODUCTION

On October 3, 2007, President George W. Bush vetoed the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2007 [H.R.976. ENR].[6] The Act would have expanded the State Children's Health Insurance Program by $35 billion over five years, with the majority of the tax dollars coming from a $0.61 per pack increase in the federal cigarette tax.[7]

SCHIP was enacted in the 1997 Balanced Budget Act and was created with the intention of offering health insurance to children from families of modest means that were too well-off to qualify for Medicaid. Jointly funded by states and the federal government, Congress alone has allocated nearly $40 billion to SCHIP since 1997. In 2006, the program covered approximately 6.6 million children.[8]

The proposed legislation would fund government coverage for as many as 4 million children. The House of Representatives failed to override President Bush's veto, falling 14 votes shy of the two-thirds majority required to overturn a presidential veto. The Bush administration had sought a more modest expansion of the program, proposing an additional $5 billion in new money.[9]

Providing children from poorer families with health insurance would seem to many an appropriate and compassionate step. Because of this, many have excoriated President Bush for vetoing CHIPRA. Senate Majority Leader Harry Reid called Bush's veto "heartless."[10] Speaker of the House Nancy Pelosi condemned Bush for using "his cruel veto pen to say 'I forbid 10 million children from getting the health benefits they deserve.'"[11]

Others contend that CHIPRA is an unwarranted expansion of SCHIP that would further change the program's essential mission of providing insurance to poor children. President Bush, speaking to a gathering shortly after vetoing the legislation, said he thought the government should "focus on the poor children rather than expand the program beyond its initial intent," pointing out that approximately 500,000 children eligible for the program are still currently uninsured.[12]

Many of these opponents cite the "crowding out" affect SCHIP has on private insurance, and suggest that CHIPRA is merely a ploy to extend government subsidized healthcare to the middle class. Republican Congressman Thaddeus McCotter writes that under the House plan "over 2 million people will be crowded out of their existing private health insurance [plans]." McCotter maintains that such

a SCHIP expansion would foster "a bureaucratic-centered healthcare system and other insidious forms of government dependence."[13]

Complaints have also been raised about the anti-progressive nature of CHIPRA. One writer points out that by expanding SCHIP to include middle- and upper-income wage earners and paying for it by passing a massive tax increase on smokers (who tend to be lower-income wage earners), proponents of the bill are essentially "proposing to tax the poor to pay for the healthcare of the middle class."[14]

The purpose of this study is to examine the SCHIP program and answer the following questions: What is the purpose of SCHIP and how effective has the program been? Is an expansion of SCHIP, similar to that proposed in the Children's Health Insurance Program Reauthorization Act, in the interest of American citizens? If a SCHIP expansion is not in the interest of U.S. citizens, what healthcare reform steps can be taken to improve the U.S. healthcare system?

SCHIP: UNDERSTANDING HOW IT WORKS

A) BACKGROUND

The 1997 Balanced Budget Act was signed into law by President William Jefferson Clinton on August 5, 1997. Section-4901 of Title IV created the State Children's Health Insurance Program. Jointly funded by states and the federal government, Congress alone allocated nearly $40 billion dollars to the program, making it "the single largest investment in health care for children since the enactment of Medicaid in 1965."[15]

All fifty states (as well as the District of Columbia) currently have SCHIP in some form or another, and in 2006 the program covered approximately 6.6 million children at some point throughout the year. Although SCHIP provides insurance coverage for children from families whose incomes are too high to qualify for Medicaid, states have discretion in determining what that level is.

Although the SCHIP statute requires that qualifying families have income less than 200 percent of the poverty level (or 50 percentage points above the Medicaid threshold), states can (and do) apply to have this requirement waived. According to a 2006 report issued by the non-partisan Congressional Budget Office (CBO), "26 states set their eligibility thresholds at 200 percent of the federal poverty level, 15 states had thresholds above 200 percent of the poverty level, and 9 had thresholds below." The highest threshold was set at 350 percent of the poverty level

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" ... proponents of the bill are essentially 'proposing to tax the poor to pay for the healthcare of the middle class.'"

SCHIP:

" For example, in Iowa citizens are allowed to deduct 20 percent of their overall income to qualify for SCHIP. This means that in 2007, an Iowa family of three making $42,900 would be eligible for government assistance."

(New Jersey); the lowest at 140 percent (North Dakota).[16] The threshold in Iowa is 200 percent of the poverty level.[17]

However, how states determine eligibility for SCHIP is not as simple as computing a family's income and determining if it falls within the expanded poverty threshold. States are allowed to use devices — deductions and "disregards" — to essentially increase eligibility levels. The processes used to adjust income are intricate and extremely variable, but the results are often the same: states allow generous deductions to lower the assessable incomes of people who would otherwise be considered too wealthy to qualify for services. For example, in Iowa citizens are allowed to deduct 20 percent of their overall income to qualify for SCHIP. This means that in 2007, an Iowa family of three making $42,900 would be eligible for government assistance.[18]

States also possess considerable latitude in determining how the program is administered and who receives benefits. For example, aside from establishing poverty thresholds, states can opt to expand health insurance coverage to include adults as well as children. In 2006, approximately 670,000 adults received health insurance coverage by obtaining provision exemptions.[19]

States also decide if SCHIP is administered through the Medicaid system, a separate government-run program, or a combination of both. In 2006, 18 states created a separate program, 11 states used Medicaid, and 21 states used an integrated approach.[20] Iowa uses a combined approach, although previous studies have shown that the separate state administered program ("Hawk-I") provides a significantly higher percentage of the coverage than the M-SCHIP.[21]

Under the Medicaid based approach ("M-SCHIP") states are required to provide benefits identical to those received by Medicaid enrollees. However, states that implement their own programs can select from several "benchmark" plans (or their equivalent) or any other federally approved plan. But as is the case with Medicaid, cost sharing measures, such as co-payments and premiums, are either tightly regulated or prohibited, particularly in the lower-income levels. At any income level, cost sharing cannot surpass 5 percent of family income, although the United States spends in excess of 16 percent of its GDP on healthcare.[22]

States can, however, provide lucrative benefit plans at this reduced (direct) cost. Aside from the normally required Medicaid benefits — "inpatient and outpatient hospital services, emergency room services,

physician services, laboratory and X-ray services, family planning services, dental (medical and surgical) services, well-baby and well child visits, immunizations, prescription medications, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services" — states are able to offer coverage for optometry and non-medical dental services.[23]

B) PROBLEMS OF LEGITIMACY AND STRUCTURE

The first and most obvious question should be to ask if Congress possesses the prerogative to pass tax and spend legislation on healthcare. The U.S. Constitution carefully enumerates the powers bestowed to the federal government. The 10th Amendment states that "powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

It would require a strained reading of the U.S. Constitution to deduce that ambitious federal programs such as SCHIP fell under appropriate enumerated government functions such as issuing patents, coining money, establishing post offices, posting roads, etc. The suggestion that Article I, Sec. 8 — its provision authorizing Congress to "provide for the common Defense and general Welfare" — grants the federal government a sort of blanket authority to act on all matters pertaining to the "general welfare" is feeble, considering that such an interpretation would render the entire section of that document meaningless. However, raising anachronistic constitutional objections to programs enjoying powerful support that provide largesse to broad constituencies is an admittedly quixotic task.

Yet there are practical reasons for, if not eliminating SCHIP, at least curtailing the federal government's role in the program. It is worthwhile to note that SCHIP is a state-administered program. Aside from the wide criteria and benchmarks established in title XXI, the federal government's role in the program is hardly necessary. It might be asked: to what purpose do citizens across the country send dollars to Washington D.C., simply to have Washington D.C. send those dollars back to the states?

The funding model for SCHIP is essentially a flawed and misconceived one. SCHIP dollars are allocated using a formula that gives equal weight to two factors: the total number of children residing in low-income households and the actual number of children that do not have health insurance. The federal government delivers SCHIP dollars in the form of grants. Unlike Medicaid, it does not have an

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SCHIP:

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open-ended dollar stream, but a predetermined set amount.[24]

For budget hawks this is a positive feature. Fiscal conservatives tend to deem fixed grants preferable to open-ended federal entitlements, believing they constrain runaway spending. A grant financing system likely made SCHIP appear more appealing to conservatives in 1997. Yet SCHIP also contains a number of perverse incentives that encourage indulgent overspending.

First, 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.[25]

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.[26]

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 insurance, states can hardly afford not to find creative ways (think: deductions and disregards) 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 exhausted 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."[27]

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 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 with more money. Such actions clearly discourage states from taking the 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.[28]

HOW EFFECTIVE HAS SCHIP BEEN?

As of 2007, the results of SCHIP have been mixed. The non-partisan Congressional Budget Office (CBO) reports that the uninsured rate of children from families with income in the 100-200 percent poverty level range dipped from 22.5 percent in 1996 to 17 percent in 2005. This drop in the rate of uninsured children, though modest, is not insignificant. But as CBO points out, "the increase in public coverage has been partially offset by a reduction in private coverage." Essentially, a considerable number of the children covered under SCHIP come from families that have dropped their children from private plans to enroll them in a "free" government-run program.[29]

There is uniform agreement that increased SCHIP coverage is offset to some degree by a reduction in private coverage, even though Title XXI contains mechanisms intended to control such counteractions. The extent to which SCHIP expansion has "crowded-out" private insurance coverage, however, is a subject of debate. Study results vary according to the models used to measure the offset. The threat, however, is palpable, as studies have shown that "about 60 percent of the children who were eligible for the program were covered by private insurance in the year before the program was enacted."[30]

Economist Jonathan Gruber, perhaps the most established author on crowd-out, has estimated that the reduction rate among children is about 40 percent.[31] Based on the most comprehensive and compelling data available CBO concludes that "the reduction in private coverage among children is most probably between a quarter and a half of the increase in public coverage resulting from SCHIP."[32]

As further qualification, however, CBO adds that studies have focused exclusively on children and have ignored possible reductions in coverage among adults; hence, "the available estimates probably understate the total extent to which SCHIP has reduced private coverage." This means that it is possible, even likely, that for every 100 individuals

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SCHIP:

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enrolled in SCHIP as many as fifty, and perhaps more, are dropped from private coverage.[33]

Federal regulations intended to prevent this replacement, such as waiting periods between the termination of private coverage and the eligibility of public coverage have proved to be unsuccessful. Flush with federal moneys that must be spent, states have little reason to discourage people from receiving government assistance, even if these individuals had previously been covering their children through a private plan; hence, only a single state had a waiting period of longer than six months, and most states have statutes allowing this interval to be waived.[34]

Even beyond the crowd-out affect, there is ample reason to believe that SCHIP has not been exceedingly successful in covering the individuals the program was intended to help. As previously noted, 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.[35]

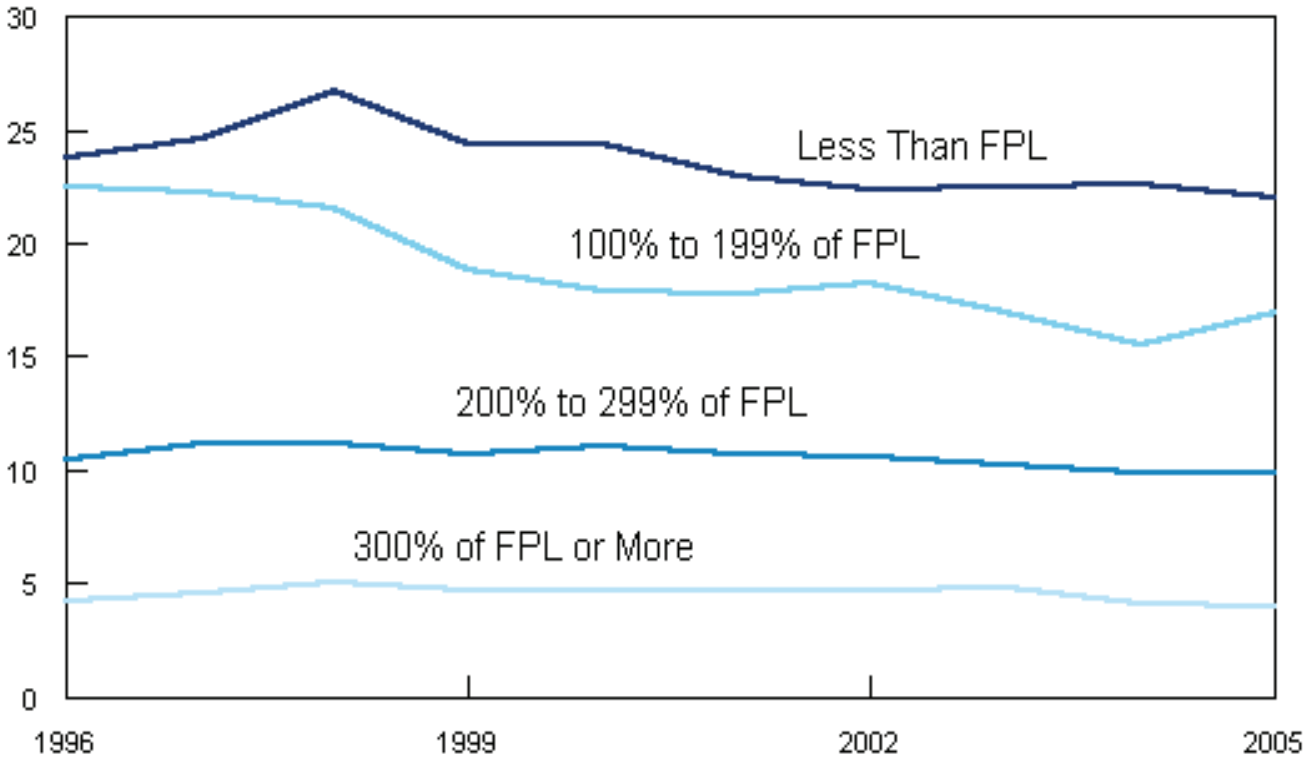
A deluge of federal dollars and the system's flawed incentives have encouraged states to extend welfare to people who do not need it. The Department of Health and Human Services reports that in Wisconsin adults consume nearly three of every four SCHIP dollars spent. New Jersey, on the other hand, has expanded eligibility to families 350 percent above the poverty level, so that a family of four making $72,000 a year is eligible for government healthcare. New York recently voted to expand the SCHIP threshold to families 400 percent above the poverty level, meaning a family of four making $82,600 would be eligible for government coverage.[36]

IS A SCHIP EXPANSION IN THE NATIONAL INTEREST?

Despite its questionable efficiency, the Bush administration has expressed its willingness to reauthorize SCHIP, which is set to expire in 2007. The Democrat-controlled Congress, however, wants to raise SCHIP eligibility thresholds from 200 percent of the poverty level to 300 percent, tacking an additional $35 billion on to the program over the next five years.

Such an expansion, however, would be misconceived for several reasons. First, the actual cost of the program would be substantially more

Figure 1. **Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level (FPL).**



(Source: Congressional Budget Office based on data from the Current Population Survey for 1996 to 2005.)

than implied. Essentially, the authors of the bill use what is basically a budget trick to disguise the long-term costs of the program. As written, annual SCHIP spending would rise precipitously over the next five years, until peaking at $13.75 billion in FY 2011. Beginning in 2012, however, funds are scheduled to plummet to $1.75 billion for the first and second halves of that fiscal year. Of course, in FY 2012 SCHIP funds will not be allowed to fall — they will rise and continue to rise, leaving the program in debt that CBO estimates may eclipse $40 billion. The only thing this not-so-subtle ruse demonstrates is how frivolous and toothless the House's newly installed "PAY-GO" rules actually are.[37]

Second, such a massive expansion of SCHIP would result in only a minimal increase in the total number of covered children, while significantly eroding private health insurance coverage. According to CBO analysis, 77 percent of children in families between 200 percent and 300 percent of the poverty level already have health insurance, while nearly nine out of ten children from families between 300 percent and 400 percent of the poverty level are covered (see Figure-1).[38]

The crowd-out phenomena has already been covered in detail. However, CBO points out that the rate of replacement

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"Put simply, a SCHIP expansion would result in a slight increase in the net total of children receiving healthcare, but the costs would be great (aside from the $60 billion price tag). "

of private insurance for public insurance would likely increase if the program was expanded to cover children from families with higher income: "Such an expansion to higher income would probably involve greater crowd-out of private coverage than has occurred to date because such children have greater access to private insurance."[39]

Put simply, a SCHIP expansion would result in a slight increase in the net total of children receiving healthcare, but the costs would be great (aside from the $60 billion price tag). While the government faces a budget train wreck (re: Social Security and Medicare), it would essentially be assuming control over a significant portion of an industry that accounts for 16 percent of the nation's GDP and is growing rapidly.

To this many people may answer: so what? Are not more children covered? To some, all that matters is that more children have health insurance — who covers them, be it the government or a private insurer, and how much it may cost (it's not their money) matters little. That the coverage may be poorer and may eventually result in significantly higher healthcare costs either goes unnoticed or is inconsequential to them.

The larger issue here, as well, is the politics of healthcare. Liberals have long championed a government-run single-payer system similar to that of Canada; a SCHIP expansion would be a substantial step toward this goal.

How one feels about government annexation of the healthcare industry likely depends largely on one's political philosophy. But the probable consequences of such a takeover are not difficult to conceive: the number of uninsured would plunge (healthcare would be "free" after all); the average waiting time to see a physician (even for critical care) would rise sharply, while one-on-one time with one's physician and the quality of care received would plummet; the cost of healthcare would increase even more rapidly. Most importantly, you would have virtually no control over your healthcare.

A MORE EFFECTIVE SOLUTION

The cure to our healthcare woes is to address the cause of the rising healthcare costs in the United States. The healthcare system, of course, relies on an arrangement that partly isolates consumers from market forces: "A" (patient) receives a service from "B" (Doctor) who charges "C" (insurer). Because "A" will bear little or no cost of the service, there is little or no reason to decline or conserve the service. On the other hand, "B" has every reason to offer services.

Though one can see such a system has its snags, there is probably no more practical or efficient pay method for administering healthcare than risk pooling for a costly and catastrophic incident. However, health insurance in the United States today is not insurance in the traditional sense. Insurance originally meant protecting individuals or groups from considerable and unforeseeable costs or circumstances. Negligible costs were not covered, expenses above a pre-determined deductible were.

Most insurance markets still operate this way. The minimum deductible for homeowners insurance usually runs at least $500. Your typical auto insurance plan protects individuals from collision damages or other costly expenses, not expenditures such as oil changes, new brakes, or flat tires.

But the U.S. Tax Code and excessive government red-tape (e.g. excessive mandates and regulation) has rendered the healthcare market dysfunctional. As a result it has created a system that insulates citizens from direct medical costs and removes them from hard healthcare decisions.

The federal government has indirectly prompted this healthcare system that severs individuals from prices and encourages them to over-consume healthcare. For many working adult Americans, the only crucial medical insurance decision they make is determining which comprehensive plan to purchase. Americans are essentially being removed from direct healthcare costs (See Figure-2) and, hence, the decision-making process. As a result, today the United States spends 16 percent of its GDP on healthcare, compared to 5.2 percent in 1962.

Syndicated columnist Robert Samuelson, who writes extensively on healthcare and economics and is hardly a partisan figure, recently wrote that the first step the United States must take to rein in runaway healthcare costs is not a complicated one: "People need to see and feel health costs."[40] Congress could immediately take two decisive steps that would be crucial to this effort.

First, allow consumers to purchase healthcare plans across state lines by repealing the McCarran-Ferguson Act. This would eliminate the quasi-monopolies many insurance companies have within their respective states. Second, permit individuals to purchase healthcare plans with pre-tax dollars the same way businesses can. Employer involvement in healthcare politics was an unintended and unfortunate consequence of government meddling in the

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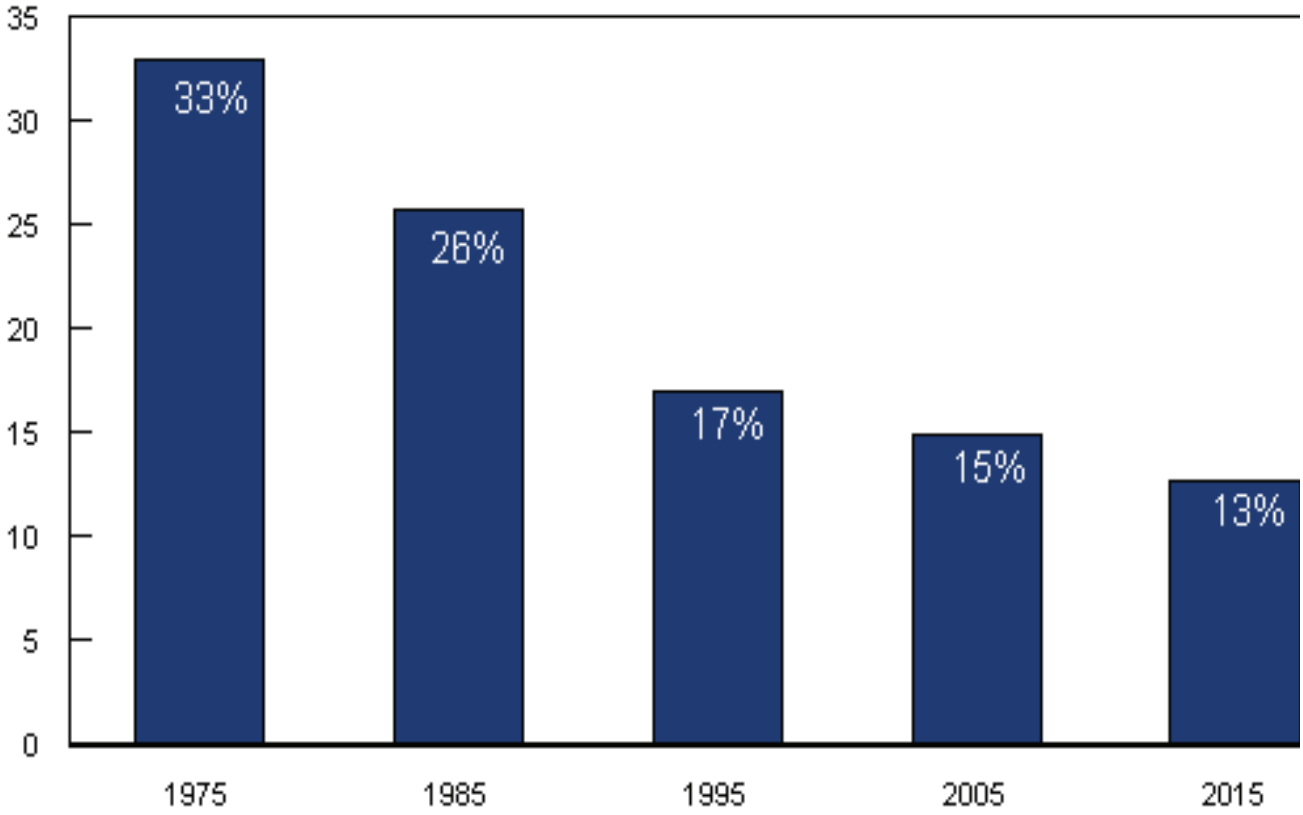
"The federal government has indirectly prompted this healthcare system that severs individuals from prices and encourages them to over-consume healthcare."

Share of Personal Health Care Expenditures Paid Out of Pocket



(Source: Congressional Budget Office based on the Centers for Medicare and Medicaid Services' data on national health expenditures.)

SCHIP:

"...instead of expanding SCHIP, Congress should give states more control over the program — first by freezing SCHIP allotments and then slowly reducing the federal government's exorbitant matching rate. "

1950s — an attempt to impose wage controls on employees, which simply resulted in employers offering healthcare plans to employees instead of the wages — which needs to be rectified. Such action would make the health insurance market far more competitive and would eventually lower costs substantially.

In addition, instead of expanding SCHIP, Congress should give states more control over the program — first by freezing SCHIP allotments and then slowly reducing the federal government's exorbitant matching rate. It is important to understand that SCHIP would not cease to exist or operate; rather, such a modification would merely prompt states to establish their own funding mechanisms for the program.

States, of course, would be free to expand SCHIP thresholds as they see fit — to 300 percent, 400 percent, or even (if they felt so inclined) to 1,000 percent of the poverty level. The only difference would be that states would not receive the "matching federal funds" at these rates and would be forced to spend their own tax dollars, not those of the other 49 states. In essence, states would be forced to "see and feel health costs." Such a change would likely discourage

states from implementing costly government programs to provide healthcare to citizens who do not need it, and encourage them to focus their efforts on the truly needy.

CONCLUSION

An expansion of SCHIP would not solve America's healthcare crisis but exacerbate it. It 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 Americans who could least afford it. Cigarette smokers tend to be lower-income wage earners that can least afford a 156 percent tax increase. In short, 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.

A massive SCHIP expansion — like CHIPRA — would also leave the program facing a $40 billion budget gap in 2012. With looming budget crises in Social Security and Medicare due to the imminent retirements of droves of baby-boomers, extending government financed healthcare to middle- and upper-class Americans — the vast majority of which already have private healthcare plans — makes little sense.

Instead, Congress should take steps to correct the U.S. Tax Code that would allow individuals to purchase healthcare plans with pre-tax dollars the same as businesses. Congress should also facilitate market competition by permitting individuals to purchase health care plans across state lines.

In the mean time, Congress should consider legislation that would freeze SCHIP allocations (while leaving all other guidelines and benchmarks in place) at their current levels and work at rectifying the flawed funding mechanism that grants states dollars at "bargain rates." By giving states more control over their own dollars and making them "see and feel health costs," states would be encouraged to spend funds more judiciously and redirect their efforts at providing assistance to the truly disadvantaged.

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

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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) 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> (July 31, 2007).
5) 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).
6) Abramowitz; Children's Health Insurance Program Reauthorization Act of 2007. 7) Kaiser Commission.
8) Congressional Budget Office.
9)Pear.
10) Patrick Healy, "G.O.P. Contenders Endorse Health Insurance Veto," New York Times, October 5, 2007, <http://www.nytimes.com/2007/10/05/washington/05insure.html> (October 12, 2007).
11) Press Release, "Pelosi: 'We Remain Committed to Making SCHIP into Law—With or Without the President's Support,'" October 3, 2007, <http://www.speaker.gov/newsroom/pressreleases?id=0353> (November 10, 2007).
12) White House Press Release, "President Bush Visits Lancaster Chamber of Commerce and Industry, Discusses S-CHIP," October 3, 2007, <http://www.whitehouse.gov/news/releases/2007/10/20071003-3.html> (November 14, 2007).
13) Thaddeus McCotter, "S-CHIP and The Politics of Principle," Townhall.com, October 2, 2007, <http://townhall.com/columnists/ThaddeusMcCotter/2007/10/02/s-chip_and_the_politics_of_principle> October 21, 2007).
14) Robert Robb, "Dem Health Plan a Burden on Poor," Arizona Republic, August 1, 2007, <http://www.azcentral.com/arizonarepublic/opinions/articles/0801robb01.html> (October 17, 2001).
15) Congressional Budget Office; The White House Home Page, "The Clinton-Gore Administration: A Record of Progress," <http://clinton5.nara.gov/WH/Accomplishments/eightyears02.html> (November 29, 2007).
16) United States Congressional Budget Office, "The State Children's Health Insurance Program," May 2007, <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf> (November 29, 2007).
17) "Iowa on SCHIP 'Short List,'" Iowa Fiscal Partnership, February 20, 2007, <http://www.iowafiscal.org/2007docs/070220-SCHIP-bgd.pdf> (December 6, 2007).
18) Margo Rosenbach and others, Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations (report submitted by Mathematica Policy Research, Inc., to the Centers for Medicare & Medicaid Services, March 2003), p. 41, <http://www.mathematica-mpr.com/PDFs/impchildhlth.pdf.> (December 2, 2007).
19) SCHIP, vii.
20) Ibid.
21) Elizabeth T. Romany and Peter C. Damiano, "Evaluating the Iowa Medicaid Managed Care Program: Outcome of Care," University of Iowa, January 2003, <http://ppc.uiowa.edu/health/medicaidweb/outcomes.pdf> (December 7, 2007).
22) "Facts on Healthcare Costs," National Coalition on Healthcare, <http://www.nchc.org/facts/cost.shtml> (28 August, 2007).
23) Rosenbach, Implementation of the State Children's Health Insurance Program, p. 51.
24) SCHIP, p. 4.
25) Ibid, p. 2.
26) "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, <http://www.familiesusa.org/assets/pdfs/FMAP_update_Mar_2004280f.pdf> (December 2, 2007).
27) Congressional Budget Office.
28) SCHIP, vii, p. 6.
29) Congressional Budget Office.
30) Ibid.
31) See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics, Vol. 111, No. 2, May 1996, pp. 391–430.
32) SCHIP, p. 11.
33) Ibid, p. 12, (my italics).
34) Ibid, p. 11.
35) United States Department of Health and Human Services, Fact Sheet, June 28, 2007, <http://www.hhs.gov/news/facts/schip2.html> (December 5, 2007).
36) Ibid.
37) H.R.976.ENR, Title-1, Subtitle-A, Sec. 101. For more on budget obfuscation, see: Marsha Blackburn, "Let Their SCHIP Sink," Human Events, October 18, 2007, <http://www.humanevents.com/article.php?id=22903> (December 2, 2007); and also <http://www.heritage.org/Research/Budget/images/wm1576_chart1-lg.gif> (November 15, 2007).
38) SCHIP, p. 12.
39) Ibid.
40) Robert Samuelson, "Rx For Health Care: Pain," Washington Post, December 6, 2007, p. A29, <http://www.washingtonpost.com/wp-dyn/content/article/2007/12/05/AR2007120502235.html> (December 5, 2007).

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