SCHIP Is No Panacea for Coverage Needs

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The State Children’s Health Insurance Plan (SCHIP), a federal/state venture, was enacted in 1997 to provide health insurance to lower-income children between the ages of 0 and 18 who do not qualify for Medicaid and do not otherwise have access to health insurance.¹ It arose in part as a response to the failed Clinton health plan of the early 1990s: While a complicated scheme to cover all Americans failed, the need to increase coverage, even if only through partial measures, remained.² Children were logical targets as most legislators could at least agree that children need health care in order to give them a better start and help prevent future, more expensive problems.³ Society does not presently hold children responsible for their own poverty or lack thereof, though it may blame the parents.⁴ As it was incontestable that low-income children needed another source of health care apart from private insurance,⁵ SCHIP was enacted as a way to expand health insurance to children without creating another entitlement such as Medicaid.

All 50 states ultimately implemented SCHIP. From its enactment, total SCHIP enrollment grew until it reached a peak of 3,951,000 in June 2003.⁶ At that time, most states were starting to react to budget crises that ultimately led many to cut funding for public programs, raise their eligibility standards, or increase their fee schedules – particularly with respect to non-entitlement programs such as SCHIP.⁷ By June 2004, SCHIP enrollment had dropped by more than 70,000 children.⁸ In the following months, however, enrollment began to grow again. By December 2004, the date for which the most recent data is available, 3,950,000 children were enrolled in the program nationwide, nearly returning to the program’s previous June 2003 high.⁹

² For example, in 1997, nearly one out of every seven children were uninsured. The vast majority of these children – 90 percent – lived in a household with at least one working adult. Nevertheless, private coverage was either not available or was unaffordable. See Children’s Health: Hearing on S. 525 Before the S. Comm. on Labor, 105th Cong. (1997) (statement of Donna E. Shalala, Secretary, U.S. Dep’t of Health and Human Services).
³ See, e.g., supra note 2.
⁴ See, e.g., supra note 2.
⁵ See, e.g., supra note 2.
⁸ SMITH & ROUSSEAU, supra note 6, at 1. Note that the decline in SCHIP enrollment was due not only to changes in eligibility and other measures specific to the program, but also because the incomes of some families dropped so significantly due to job loss that their children qualified for and enrolled in Medicaid rather than SCHIP. Cf. COHEN ROSS & COX, supra note 7, at 1-2.
⁹ SMITH & ROUSSEAU, supra note 6, at 3.
The *New York Times* recently ran an article trumpeting the success of SCHIP in keeping children covered, even in light of the rise in the number of uninsured Americans over the last few years. Reporting on a recent Kaiser Foundation publication, the article noted that, while nearly 46 million Americans were uninsured at the start of 2005, “[t]he number of American children without health care coverage has been slowly but steadily declining over the past several years.”

The article attributed this success to SCHIP and its implementations in various states. As the states’ budget crises have eased, some states have been expanding their SCHIP programs or rolling back cuts made in recent years. Notably, Illinois recently enacted a law intended to provide health insurance to all 250,000 children in the state who presently lack it. Other states, such as Texas, have rolled back cuts or more restrictive measures enacted in 2003.

The *New York Times* article, by comparing the state of children’s health coverage with that of their adult counterparts under age 65, implied that public coverage for all should be considered as a solution to the growing problems of rising health costs and decreasing private coverage. The number of uninsured children dropped by 350,000 between 2000 and 2004. The number of uninsured adults, on the other hand, rose by 6.3 million during the same period. The existence of SCHIP and Medicaid accounted for the difference between the two numbers. As the article quoted Governor Jennifer Granholm of Michigan, “[W]e [don’t] want to be a nation where you go to Dunkin’ Donuts to put a quarter in a jar for Aunt Linda’s mastectomy. We need a national solution for competitiveness and moral reasons. And Washington is utterly silent.”

Governor Granholm is correct. A national solution is required. While unequivocally better than nothing, even federal/state solutions such as that offered by SCHIP, or Medicaid, are inadequate. While these programs provide minimum eligibility guarantees, whether one is covered or remains uncovered above those minimums is often a matter of accident, based solely on where one lives. A child living in Vermont in a three-person household with a family income of $47,000 qualifies for public health coverage. The same child in Texas, or in fact in most other states, would not qualify.

Much worse, though, are the discrepancies in equal access to care engendered by a multi-tiered system such as the one we have. It is true that, at least on paper, children enrolled in SCHIP

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12 *Id.*
13 *Id.*
17 Kaiser Comm. on Medicaid & the Uninsured, *supra* note 11.
18 *Id.*
19 *Id.*
have access to a reasonable array of standard health care services, including generalist and specialist physician visits, laboratory services, and both inpatient and outpatient hospitals services.23 Because of cutbacks made during the recent budget crisis, however, such children may not have access to other services, including, for example, dental and mental health coverage.24 They may be required to make premium payments or copayments that they may not be able to afford.25 They may not be able to enroll for coverage at all, despite meeting eligibility requirements, due to enrollment freezes.26 And even if they are able to enroll and can afford any premiums and copayments that may have been instituted, and the care they need is covered, they may yet not be able to find a health care provider who is willing to accept them as a patient, due to cuts or freezes made in provider reimbursement.27 Some providers are not willing to accept further SCHIP and Medicaid patients, if doing so would mean foregoing substantial higher revenues afforded by privately insured patients and Medicare patients.28 Such actions are bolstered, for example, by a reported recent trend of building freestanding outpatient surgical centers and other facilities for higher-paying patients apart from hospitals in which care for lower-income patients is centered, thus helping physicians practice outside the hospital environments and avoid having to treat poorly paying patients and further segregating care for patients based on insurance status.29

It is true that SCHIP has provided health coverage for literally millions of children who otherwise would likely have remained uninsured.30 As such, it has been a boon for this population. However, we cannot stake covering the uninsured on partial solutions such as targeted expansions of programs such as SCHIP. Such programs, with their non-entitlement status and limited reach to a population that has traditionally lacked political power, will always risk substantial cuts in the face of declining revenues and the desire to cater to more wealthy and influential populations.31 What we need, instead, is a genuine health coverage baseline for all Americans. A significant source of Medicare’s success, to take one prominent example, has been its nondiscrimination among all economic classes of seniors in the benefits it provides and the premiums it charges.32 We should seek to replicate this success among all Americans.

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23 42 U.S.C. § 1397cc(c) (West 2005).
25 COHEN ROSS & COX, supra note 7, at 17 - 18.
26 Id. at 4 – 5.
28 Id.
29 Id.
30 See, e.g., SMITH & ROUSSEAU, supra note 24, at 1.
31 Present efforts in Congress to cut billions from Medicaid, for example, despite ever-increasing need, while at the same time contemplating billions in tax cuts for the economically better-off are one such example. See, e.g., Carl Hulse, Divisions Over Money Await Congress in Year-End Push, NEW YORK TIMES, Dec. 6, 2005.
32 The Bush Administration successfully sought to alter Medicare to institute a differing premium and benefit structure for certain services provided by the program as part of the 2003 Medicare prescription drug act. See, e.g., 42 U.S.C. § 1395w-114(a)(1) (West 2005). It remains to be seen whether these changes will alter the traditional solidarity seniors have shown in supporting the program.