

Georgetown Journal on Poverty Law and Policy
Fall, 2008

"The First Wealth Is Health": The Nexus of Health, Poverty, and the Law

Article

***703 SLOUCHING TOWARD HEALTH REFORM: INSIGHTS FROM THE BATTLE OVER SCHIP**

Sara Rosenbaum [FN1]

Copyright © 2009 by Georgetown Journal on Poverty Law and Policy; Sara Rosenbaum

INTRODUCTION

By the end of 2007, the year that marked its tenth anniversary, the State Children's Health Insurance Program (SCHIP) legislative reauthorization lay in a shambles, the about-to-be victim of a second successful presidential veto. [FN1] President Bush's action swiftly became the subject of a blizzard of speeches, articles, and editorials [FN2] decrying the depths to which the nation's political process had fallen. As of spring 2008, the program soldiers on as a result of legislation that temporarily extends its life until April 2009. [FN3] In private *704 conversations, [FN4] however, a number of consumer and patient advocates suggest that it is time to move on, eyeing federal SCHIP program funding as simply a small part of the all-important budgetary "baseline" that defines federal health care spending [FN5] and serves as the federal health care expenditure starting point for the broader cost estimation process that drives national health reform. [FN6]

It is not impossible, of course, that sometime during the 2008 presidential election season Democratic leaders will push SCHIP reauthorization to the front of the legislative line once more. But a third attempt will be one of pure positioning; even in the best of times, presidential and congressional relations tend to be strained during presidential election years, and no one would ever describe the relationship between President George W. Bush and the 110th Congress as the best of times.

The question, of course, is how a program that was enacted in a little blaze of bipartisanship, [FN7] and that has made an undeniable contribution to the wellbeing of children, [FN8] could have so miserably run aground in the legislative process. In fact, the SCHIP reauthorization story raises many of the themes that will emerge in the broader national health care reform debate that is an expected follow-on to the 2008 presidential election. This article explores this storyline through the lens of this modest piece of legislation whose renewal simply should have breezed through Congress. The story begins with an overview of SCHIP and considers the policy and political themes that were raised by its reauthorization. It concludes *705 with some observations about the import of the SCHIP story for national health reform.

I. AN OVERVIEW OF SCHIP

SCHIP was enacted as part of the Balanced Budget Act of 1997 (BBA). [FN9] A "budget reconciliation"

bill, the BBA is one of a long line of omnibus measures that periodically make their way through Congress as a result of the Budget and Impoundment Control Act of 1974, [FN10] which governs the federal legislative budget and spending process. [FN11] Budget reconciliation is an enforcement tool whose purpose is to bring both tax policy and mandatory spending (such as Social Security, Medicare and Medicaid) into alignment with the underlying assumptions of the annual congressional budget. [FN12] Typically, reconciliation bills make cuts in permanent legislative authorities whose expenditures are automatic and not subject to the annual appropriations process; [FN13] reconciliation bills also can reduce the amount of “income foregone” by curtailing or repealing federal tax law provisions that give favorable treatment to certain types of individual or corporate income. [FN14] Over the years, a number of budget reconciliation bills also have contained provisions to broaden (or in the case of SCHIP, establish for the first time) mandatory spending. Indeed, many of the most important changes in Medicaid to extend coverage to additional categories of children and adults or to broaden program benefits have been provisions contained in budget reconciliation measures. [FN15]

At first blush, SCHIP appears to be a small, simple, and non-controversial program. In fact however, the enactment of SCHIP was quite controversial, coming only one year after the passage of welfare reform and the failure to eliminate Medicaid as an individual entitlement in eligible persons and reenact *706 the law as a block grant to states stripped of its individual coverage guarantees. [FN16] From a conceptual standpoint, SCHIP's greatest harm to Medicaid was its very existence. A policy curiosity, SCHIP was designed to assist a group of children whose coverage already was a state Medicaid option in 1997. [FN17] In other words, SCHIP was a legislative redundancy, and a costly one at that. The legislation allocated nearly forty billion dollars [FN18] that might have been used to address other pressing needs such as adequate housing, child care, education reforms, or coverage of young adults who, under Medicaid's historic principles, lose coverage at age twenty-one (or younger, depending on the state) unless they have a disability, are pregnant, or are parents. [FN19]

This conceptual framing of SCHIP as a policy alternative to Medicaid is borne out in its legislative text. It immediately becomes apparent, upon reading the statute, that, from a structural viewpoint, SCHIP is intended to operate as a legislative vehicle for introducing into the Social Security Act a statutory alternative to a defined benefit legal health care entitlement for the poor, beginning with children. Thus, despite the accolades lavished upon it, [FN20] SCHIP was, at the time, understood by those closest to the process as a means for launching a legislative “incision attack” on the far larger Medicaid program, a beachhead of sorts from which more aggressive structural blows might be mounted. [FN21]

*707 SCHIP's existence as the “anti-Medicaid” law leaps off the legislative page. Whereas Medicaid entitles eligible children to health insurance coverage, [FN22] SCHIP specifically denies the entitlement status of its benefits. [FN23] Whereas Medicaid offers specific and comprehensive coverage with virtually no cost sharing or premiums, [FN24] SCHIP's “benchmark” coverage design (that, with limited exceptions, is pegged to available private health plans) [FN25] rests on the commercial market at any given moment and thus is subject to the strictures and limitations that characterize traditional insurance design, many of which are at their most visible when the patient is a child with developmental disabilities. [FN26] Whereas Medicaid entitles states to open-ended federal financial assistance to extend medical assistance and administer their state plans, without reference to any time limits, [FN27] SCHIP entitles states [FN28] only to aggregate, annual fixed federal allotments; the original legislation authorized funding over a defined 10-year term. [FN29] Finally, whereas Medicaid is a permanent legislative authority, SCHIP must be periodically reauthorized, [FN30] with the program's existence and performance continually subject to prevailing political winds, as was the case in 2007.

SCHIP's tradeoffs read like a political playbook for a team dedicated to ending entitlements for the poor, if

not all at once (as block granting Medicaid in 1996 would have done), then at least one step at a time. The legislation gave states the broad flexibility to limit enrollment and the scope and depth of coverage; [FN31] in exchange, states accepted aggregate annual limits on the level of federal financial support. [FN32] Put another way, SCHIP gave both governmental partners explicit permission to ration public resources where coverage of children was concerned. *708 Seen from this perspective, although SCHIP turns out to have benefited children in important ways, it can be understood as a victory, not for the new ground it broke in child health policy, but for using the cause of children to advance the politics of policy retrenchment for the poor.

In brief, SCHIP entitles states to a fixed, annual, aggregate sum of money, [FN33] toward the provision of “child health assistance” [FN34] to “targeted low-income” children. [FN35] At the same time that SCHIP entitles states to funding, it also specifies that it creates no legal entitlement in any individual. [FN36] Thus, states can establish, and have established, waiting lists of eligible children when either actual or perceived [FN37] funding levels have fallen short. [FN38] Congress has revisited the legislation to address the problem of annual funding shortfalls, which began in earnest as state programs began to grow; [FN39] at the same time, lawmakers have never eliminated the annual aggregate federal cap on available funding. [FN40]

Federal SCHIP funding is allocated to states based on a formula that takes into account the size of the low-income child population, the number of low-income children without health insurance, state wealth, and a state's overall “cost factor.” [FN41] In a manner similar to Medicaid, states are entitled to federal SCHIP contributions (up to their annual aggregate limit) only in connection with approved and documented child health expenditures. [FN42] The actual federal contribution for each dollar of expenditure is set at an “enhanced” level in relation to the federal Medicaid payment formula. In other words, under SCHIP, a state is entitled to recover a greater proportion of its total spending on enrolled children (up to its aggregate annual allotment) than it would receive were its spending in furtherance of Medicaid coverage for the same group of children. [FN43] For example, a state with a fifty percent federal Medicaid payment rate would *709 receive approximately a sixty-five percent federal payment for expenditures on coverage of “targeted low-income” children under its approved SCHIP plan. [FN44] In effect, the law incentivizes coverage of near-poor children (i.e., children ineligible for assistance under the basic state Medicaid plan) at a level that is more generous than that available for coverage of the poorest children. Since coverage of the poorest children is mandatory under Medicaid, [FN45] SCHIP is designed to incentivize higher levels of coverage. But of course, this favored level of federal funding is set against a backdrop of aggregate federal spending caps and other limitations on the federal contribution toward state expenditures, such as expenditures on outreach or administration costs. [FN46]

A “targeted low-income child” is defined as an uninsured child whose family income is at or below two hundred percent of the federal poverty level or whose family income is no more than fifty percentage points above the state's applicable Medicaid income level. [FN47] The term “targeted low-income child” is intended to assure that SCHIP funds are used interstitially-- that is, to reach children who, in the vernacular, fall “between the cracks” of Medicaid at the low-income end and private health insurance (overwhelmingly through employer-sponsored health benefit plans) at the high-income end. [FN48] Thus, targeted low-income children must have no other source of health insurance coverage through health insurance or a group health plan; even an inadequate plan containing extensive exclusions and limitations that effectively disinsure low-income children would be sufficient to bar receipt of SCHIP, even if a child's extensive medical needs had effectively exhausted coverage. Medicaid, on the other hand, contains no similar exclusion; [FN49] indeed reconciliation legislation enacted in 2006 contained provisions permitting states to extend Medicaid's reach in the case of seriously disabled near-poor children who would not otherwise qualify for Medicaid but whose families have exhausted their private coverage. [FN50]

The requirement that a child be totally without other health insurance coverage as a condition of qualifying for SCHIP is intended to prevent “health insurance crowdout,” a phenomenon that is associated with any incremental approach to health insurance coverage and that involves the substitution of one form of *710 coverage for another. [FN51] Despite the fact that the children receiving SCHIP or Medicaid have only limited access to private health benefits, [FN52] the politics of an era seeking to limit dramatically the role of government in social policy compelled the addition of this “anti-crowdout” provision. [FN53] The constant harping on crowdout has had the effect of pressuring policymakers to further limit the role of government in assuring comprehensive health insurance coverage of children somehow would impede the operation of markets, even in the face of evidence of the sizable failure of a voluntary market approach to coverage--in particular, dependent coverage--in the case of low and moderate income workers and their families. [FN54] The anti-crowdout requirement in SCHIP was effectuated through a statutory provision requiring states' plans to indicate the steps they would take to assure that children had access to other coverage (termed “creditable coverage”) to which they were entitled. [FN55]

As is true in the case of Medicaid, the term “child health assistance” under SCHIP is expressed as a list of specified benefit classes [FN56] that reflect many of the same benefit classes as are found in the definition of “medical assistance.” [FN57] But unlike Medicaid, the SCHIP statute does not require that all classes of services be made available to children in an amount, duration, and scope necessary to ameliorate physical and mental conditions and assure developmental health. By contrast, SCHIP specifies only that a state's coverage design need to be equal to that offered in a “benchmark” or “benchmark equivalent” plan. [FN58] This requirement means that states can fulfill their SCHIP coverage requirements by purchasing commercial health insurance products that generally are less generous than Medicaid. [FN59]

As a practical matter, today both Medicaid and state SCHIP agencies administer their plans for children and families through the purchase of privately *711 marketed health benefit plans that are selected and overseen by the state agency. Both Medicaid and SCHIP agencies spend a good deal of time developing the purchasing specifications used to guide product purchase and oversight. [FN60] The crucial difference, however, lies in the federal standards that govern this purchasing. Medicaid agencies can include in their contracts all of the classes of benefits and services that are covered under their state plans or that fall into the individual federal legal entitlement. [FN61] Alternatively, states can provide certain items and services on an extra-contractual basis--as supplemental insurance benefits. [FN62] But nothing about Medicaid's health benefit plan purchasing provisions alters the basic Medicaid entitlement to defined benefits. The use of private health benefit services plans (known as managed care under Medicaid) constitutes a state plan contractual and administration option under federal law, [FN63] not a substantive alteration in the definition of medical assistance.

As a non-entitlement program, SCHIP is fundamentally different. The definition of “child health assistance” operates simply as an expression of the range of items, benefits and services that qualify for federal financing; it is not a definition of legal entitlements. As a result, SCHIP programs need only satisfy the requirements of “benchmark coverage” [FN64] (as well as a series of limits on the application of premiums and cost sharing), [FN65] and essentially act as group purchasers of private health insurance products on behalf of enrolled children. With the exception of a limited number of broad service classes and specified preventive services, SCHIP coverage is expressed only in terms of actuarial value rather than defined benefits. [FN66]

Thus, with its application of commercial benchmarks (or their actuarial equivalent) as the measure of coverage rather than defined benefits, SCHIP represents an enormous step away from the highly structured benefit entitlement that characterizes Medicaid coverage of children. The impact of this difference *712 can best be seen

in the case of children with special health care needs, who experience the physical, mental, or developmental activity limits, impairments, and health conditions that elevate their use of health care above the norms for children. [FN67] In marked contrast to Medicaid, [FN68] SCHIP contains virtually no statutory minimums other than a handful of broad benefit classes and certain specified preventive services. [FN69] Unless prohibited by contract, a state SCHIP plan, like other commercial insurers, typically would exclude the types of treatments and services associated with long-term and disabling pediatric developmental conditions. [FN70] With respect to children whose enrollment is paid for by Medicaid, the federal coverage requirements would mean that either the insurer or the state agency would be required to pay for medically necessary covered treatment. [FN71]

In sum, in its non-entitlement, fixed-financing, market-responsive approach to coverage, SCHIP represented a basic policy alternative to Medicaid, moving federal child health policy away from the core principles of entitlement and financing that had controlled for more than thirty years. Advocates for this policy alternative sought to incentivize this approach through state flexibility and enhanced federal contribution rates. In its non-Medicaid character, SCHIP was fundamentally a political statement rather than a policy advance.

At the same time, defenders of Medicaid exacted major concessions that were built into SCHIP's statutory structure as a bulwark against the possibility that SCHIP's sponsors would seek to grow its funding over time in order to permit all Medicaid-enrolled children to be slid into a non-entitlement statute. First, SCHIP requires that participating states maintain their pre-existing Medicaid coverage levels for children. [FN72] Thus, a state that in 1997 extended Medicaid to children with family incomes at 150% of the federal poverty level would not be allowed to move children over the federal Medicaid minimum into SCHIP and secure enhanced SCHIP funding and relaxed coverage rules.

*713 Second, in keeping with its anti-crowd-out emphasis, the statute requires that states screen children for Medicaid eligibility prior to enrolling them in SCHIP. [FN73] This provision, as discussed *infra*, has proven to be a huge boon for Medicaid enrollment of children because of the high number of Medicaid-eligible children who were found and enrolled as a result of SCHIP outreach. [FN74] Put another way, as SCHIP grew, Medicaid grew even more. The “bootstrapping” effect of SCHIP on Medicaid also meant that the potential for SCHIP to reach only near-poor children was blunted; the screen-and-enroll requirement assured that the poorest, Medicaid-eligible children would benefit as well.

Third, the legislation was structured to give states a crucial choice. A state can administer SCHIP as a separate program; at its option, however, the state also may administer SCHIP as a Medicaid expansion, in which case, all of Medicaid's rules apply. [FN75] Thus, rather than establishing wholly separate SCHIP programs, states may essentially administer SCHIP, either for all children or a sub-group (e.g., children with family incomes up to 150% of the federal poverty level) as a Medicaid expansion, receiving payment at the enhanced SCHIP rate for eligible children until the enhanced funds are exhausted, then, as a result of Medicaid's federal requirements and standards, reverting to open-ended financing at the federal Medicaid contribution rate if and when the actual number of children exceeds the enrollment cap. In other words, because Medicaid expansion states must administer SCHIP in accordance with federal Medicaid law, they can avoid queuing, the federal aggregate payment cap, and other limits on federal payments that apply to SCHIP but not to Medicaid. [FN76] The tradeoff is that in these states, children whose coverage is achieved via a Medicaid expansion are entitled to all Medicaid protections related to enrollment and coverage.

This effort to turn SCHIP from a Medicaid onslaught into a favorable means of bolstering state Medicaid programs was further strengthened by an early decision by the Clinton Administration to give states broad lee-

way when implementing SCHIP's "anti-crowd-out" provisions, which could have blunted the salutary effects of the program by forcing states to impose restrictions on coverage, such as lengthy waiting periods for children whose families sought assistance. [FN77] Instead, however, the Administration promulgated regulations that afforded states considerable leeway to implement the anti-crowd-out provision, including outright elimination of a waiting period if justified by the state. [FN78] This policy has been reinforced by research showing that long waiting periods have little or no *714 effect on SCHIP's crowd-out effects. [FN79] Current state practice is to avoid long waiting periods. Indeed, an amicus brief filed in a case brought by the state of New Jersey and other states to challenge the Bush Administration's 2007 efforts to reduce the coverage of children (discussed *infra*) [FN80] notes that of the 37 states that have implemented waiting periods, Alaska is the only state to implement a twelve-month waiting period with respect to children covered under a SCHIP-Medicaid expansion. [FN81]

II. SCHIP'S TEN-YEAR PERFORMANCE AND THE 2007 SCHIP DONEYBROOK

A. What SCHIP Accomplished

By 2007, it was clear not only that SCHIP's potential to damage Medicaid's child health coverage provisions had been blunted, but also that by taking the entitlement bogeymen off the table, SCHIP incentivized coverage expansions while also assuring that the lowest-income children benefited from the investment in near poor children. States that wanted to do so could administer SCHIP as a Medicaid expansion, either in part or in whole, and thereby gain the benefit of open-ended entitlement funding as well as other financial benefits available only through Medicaid. States that sought to assist children while eschewing the eternally complicated politics of Medicaid could do so by establishing separately administered SCHIP programs that operated exclusively by SCHIP's more flexible, non-entitlement rules. To be sure, separately administered SCHIP states risked hitting their aggregate funding caps and the terrible problem of waiting lists of needy children; but as implementation gained steam, Congress showed a propensity to come through (even if at the last minute) with supplemental funding to bail out states that had overreached in their generosity toward children. [FN82]

The impact of SCHIP on extending the reach of public financing for children *715 can best be seen in Figure 1 above, which shows the growth of both Medicaid and SCHIP enrollment in the years following SCHIP's enactment. The popularity of SCHIP, along with its screening and enrollment requirements, coupled with the steadily increasing importance of public insurance for children as employer coverage eroded, [FN83] led to a major increase in the reach of both Medicaid and SCHIP for children. As Figure 1 shows, over the decade, the number of children enrolled in Medicaid grew by over eight million, while enrollment in SCHIP exceeded six million. [FN84]

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

SCHIP's biggest contribution--and, ultimately, its greatest vulnerability--was to shine a spotlight on the powerful good that government could do by subsidizing coverage and actively organizing and overseeing a market of *716 participating health plans. SCHIP essentially made insuring children a politically attractive thing for government to do. Most fundamentally, SCHIP's combination of incentives and requirements reduced the proportion of low-income children without health insurance by over 60%, from 23% in 1997 to 14% in 2005, as Figure 2 above shows.

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

While not as generous as Medicaid in terms of coverage, SCHIP created a high degree of interest among

health services researchers, the federal and state governments, and policymakers generally, in the effects of coverage on access to health care and the quality of care. A considerable body of research compiled by a government-financed project shows the effects of SCHIP and Medicaid on coverage, health care access, the organization of pediatric health care, and health care quality. [FN85] To be sure, SCHIP raised a number of issues that also have been well chronicled: a perpetual and chronic shortage of funding that worsened as the public response to SCHIP grew, a continuing erosion of employer coverage, increased cost pressures as a result of underlying health care inflation, unstable coverage, continuing differentials in access and quality between the poorest children and less poor children, and coverage limitations that fall with particular *717 hardship on special needs children. [FN86] An additional and key question became whether states would continue to be permitted to apply their allotments to-ward coverage of parents, a strategy that became popular once evidence began to show that family coverage produced higher enrollment rates. [FN87] Finally, concerns emerged regarding the allotment formula itself and whether the formula unfairly advantaged certain states (in this author's experience, federal funds distribution formulas inevitably come under attack within a few years of their introduction). [FN88]

This might seem like a litany of problems. But to a longtime observer of the federal legislative process, none of these issues represented insurmountable challenges. Indeed, they all fell well within the range of experiences one might expect from the implementation of a small but complex program that was designed to be interstitial to far larger and more complicated public and private health insurance laws and practices. It was evident to members of both the House and Senate that with additional funding levels, greater focus on outreach and enrollment of lower-income children, and a series of pragmatic compromises around the use of funds to cover adults and to improve coverage standards for special needs children, the reauthorization of SCHIP could achieve what appeared to be the highly desirable result of improving program performance while encouraging its fundamental goal of near-universal coverage of children. And the legislation that passed in both houses of Congress in the fall of 2007 [FN89] reflected just this assessment, having achieved a pragmatic balance between a more ambitious House bill (covering five million children) and a more narrow Senate measure (covering four million previously-uninsured children). [FN90]

**718 B. The SCHIP War of 2007*

Had matters proceeded routinely, sometime in early fall, the President would have signed the compromise House and Senate measure, which, among other reforms authorized additional federal funding, improved outreach efforts to the lowest-income children, strengthened benefit requirements, revised the state allotment formula, and made other recommended improvements. [FN91] From the earliest days of the 110th Congress, however, it actually was evident that this was not to be a smooth process.

What no one properly anticipated at the beginning of 2007--and what probably should have been anticipated, given the Republican rout of 2006 that had cost the President control of both houses of Congress--was the extent to which SCHIP would become a proxy for a far larger battle over the role of government in health care reform. [FN92] As Congress tipped Democratic and the Bush Administration saw its influence waning, the President, rather than seeking common ground in SCHIP, used the SCHIP reauthorization as the basis of a frontal attack on both SCHIP and the mechanics of group health insurance generally. Rather than outline a pragmatic middle ground for SCHIP, the President, in his FY 2008 Budget, called for \$5 billion in funding, which would have amounted to an actual funding reduction. [FN93] This recommendation to reduce federal SCHIP subsidies was coupled with a far-reaching proposal that would have applied per-capita limits on the tax exclusion for income attributable to employer contributions to employee health benefit plans while making expenditures for individual

and family coverage tax deductible up to a specified amount. [FN94]

From one vantage point, the proposal would have alleviated a long-term shortcoming in federal tax law that provides favorable tax treatment to expenditures on employer-sponsored coverage but not coverage purchased in the individual market. [FN95] From another, however, the President's proposal was understood as ultimately unraveling the employer-sponsored group health insurance system, [FN96] without the additional reforms that would be needed to create *719 an that would put into place an alternative group coverage mechanism of the type created through SCHIP or through Medicare's private health insurance market, known as Medicare Advantage. [FN97] This was not some oversight, but instead part of a much broader strategy to reduce further the role of government in organizing, regulating, and overseeing health insurance markets. [FN98] Put simply, the Administration sought fundamentally to alter the basic architecture of health insurance coverage that has dominated U.S. policy for a half century, [FN99] moving the nation away from group purchasing (whether sponsored by state SCHIP agencies or employers) supplemented by government programs, and toward enrollment in plans sold in the individual market--the least regulated, most costly, and most volatile part of the health insurance industry. [FN100]

The President's broader health reform proposals went nowhere. At the same time, the President was not shy about making his own feelings about SCHIP known. By the middle of June 2007, in advance of Senate consideration of the measure, he informed the Senate Finance Committee [FN101] that he would veto even the more modest measure that the Senate ultimately passed on August 2, 2007 by a vote of 68-31. [FN102] By October, the President had vetoed the first SCHIP reauthorization bill sent to him; by December, he had vetoed a second, even leaner measure, [FN103] leading ultimately to a simple extension of current law to April 2009. [FN104]

The events around the conferencing of a more narrow bill during the fall of 2007 became of intense interest, not only because of the Administration's demands to constrain SCHIP, but also because, sensing the potential for an even more far-reaching victory, the Administration and its supporters insisted that as a condition of compromise, House and Senate negotiators agree not only to a curtailing of SCHIP coverage but also to an elimination of the very Medicaid child health expansion options that already existed at the time of the enactment of SCHIP. [FN105] With these options in place, a state conceivably could elect to *720 withdraw from SCHIP altogether and instead adopt coverage expansions for the very same children as a Medicaid option, relying instead on a somewhat lower, but nonetheless still highly favorable, Medicaid federal contribution rate to its state child health coverage plan. [FN106] The Administration's demands for Medicaid concessions ultimately failed, [FN107] but they underscored the extent to which curbing a broad role for government in the coverage of children, through either Medicaid or SCHIP, was a core aim of the White House's SCHIP political end-game.

The President's October veto message focused heavily on his allegation that the legislation devoted inadequate attention to aggressive enrollment of the poorest children. [FN108] At the same time, the words chosen underscored the fact that something far more complex was afoot; indeed, he expressed his view that the legislation "moved the health system in the wrong direction." [FN109] That more was going on was reinforced by the official cost estimates for the legislation, which showed that it was in fact the lowest-income children who would gain the most from reauthorization, both because of the bill's expanded focus on aggressive outreach and retention and because it is low-income children who are disproportionately uninsured. [FN110]

Despite this evidence, the President continued to insist that the bill favored high-income children, seizing on the dollar value of four hundred percent of the federal poverty level--approximately \$82,500 2007 dollars for a family of four [FN111]--to argue that the bill was simply a boon to affluent families. [FN112] Why he continued

to use this number puzzled many, since raising the federal SCHIP state eligibility option to four hundred percent of the federal poverty level had ceased *721 to be a subject of discussion since the first House/Senate conference. [FN113] But a conversation with a leading Republican pollster sheds light on why the Administration continued to wave this number around like the proverbial bloody flag. [FN114] In fact, the figure offered a convenient political shield for Republican members from poorer Southern and Western states, who needed political shoring up through two rounds of Presidential vetoes of a popular bill. For these members, the figure of \$82,500 was magical, a means of assuring that the battle over SCHIP would devolve back to the regionalism that is a basic characteristic of U.S. politics. The figure implied that the bill favored rich families--even if they were modest income levels by the standards of the nation's East and West coastal regions--and that the measure thus rewarded profligacy on the part of well-heeled families who did not take care of their children. Once it became evident how the dollar figure polled in tight districts, the number became the first words out of everyone's lips. [FN115]

At the same time that it was pursuing an aggressive challenge to the legislative reauthorization of SCHIP, the Administration also concluded that it could use its federal executive powers to drive down SCHIP enrollment--and hence the extent to which SCHIP operates as a Medicaid gateway for very low income children who, as a result of SCHIP screen-and-enroll outreach system, become enrolled in Medicaid. [FN116] On August 17, 2007, the Administration issued what ultimately became an infamous "directive" regarding federal financing of SCHIP. [FN117] Under the directive, states would no longer be able to qualify for federal assistance unless they took certain steps to curb the--as noted previously, virtually non-existent--problem of private health insurance crowd-out among low-income children. [FN118] These steps included a requirement that states achieve coverage of *722 ninety-five percent of all eligible uninsured children below two hundred percent of the federal poverty level (a figure deemed wholly unattainable by experts), [FN119] regulation of the employer-sponsored benefit plan market to prohibit reductions (a legally impossible step in light of the preemption of state regulation of employer sponsored benefit plans under ERISA), [FN120] and imposition of a twelve-month waiting period before SCHIP eligibility could begin (despite evidence that waiting periods had no effect on crowd-out and despite the obvious injury that such waiting periods would inflict on children with special health care needs). [FN121]

A follow-up December 2007 ruling by the Administration rejecting Ohio's SCHIP expansion plan [FN122] left no doubt that the Administration viewed its August 17 directive as equally applicable to states in which SCHIP is administered as a Medicaid expansion rather than as a separate program subject to separate legislative rules. The Administration's Ohio letter appeared to do precisely what the SCHIP statute forbids, [FN123] namely, require that a state Medicaid program that had expanded child health coverage via a Medicaid expansion abide by the eligibility criteria that govern a separately administered SCHIP program. Medicaid expressly permits eligibility for children to be set at any income level, [FN124] even levels that surpass limits that would be held to be lawful in the case of a separately administered SCHIP plan. Furthermore, while Medicaid contains a third party liability recovery provision that assures coordination of public and private coverage, [FN125] it contains no anti-crowdout bar to dual coverage in the case of children with limited private benefits.

Thus, in denying Ohio's plan amendment, CMS was essentially attempting to subject the state's Medicaid expansion program to the limits that the federal government had decreed for SCHIP. The federal disapproval of Ohio's proposed expansion plan represented a blatant effort to bootstrap a seemingly unlawful interpretation of the SCHIP statute directly into Medicaid itself. In reaching this conclusion, the Administration offered a tortured explanation as to why the state's proposal was unlawful despite the state legal authority--and duty-- to abide by Medicaid rules if it used its SCHIP funds to adopt a Medicaid expansion. The Administration essentially argued that notwithstanding the plain wording of the SCHIP legislation, which specifies adherence to Medicaid policies

when SCHIP funds are used to expand Medicaid, all conditions applicable to separately administered SCHIP programs are to be applied to Medicaid whenever SCHIP *723 funds are used to extend Medicaid coverage. [FN126] Furthermore, the Administration argued, because Ohio would not receive Medicaid funding at the regular federal contribution rate (rather than the enhanced rate applicable to SCHIP-authorized payments) until the state's federal SCHIP allotment ran out, the state could not qualify for *any* Medicaid financing at its regular federal contribution rate until it had first exhausted its SCHIP allotment, which of course, under the Ohio ruling, the state could not do. [FN127]

In essence, Ohio was punished for participating in SCHIP. If the state had terminated its SCHIP plan and had elected to use only its Medicaid flexibility to cover children, it could have covered all low and moderate income children with comprehensive assistance and would have received federal payments pursuant to federal Medicaid law. But because the state was attempting to use its SCHIP allotment to offset the cost of the expansion, this fact, according to CMS, gave the federal government the power to step in and prohibit the state's expansion. Put another way, under the Administration's interpretation, Ohio would have had to pull out of SCHIP entirely in order to exercise its Medicaid coverage options--options that existed at the time of SCHIP's enactment. [FN128]

With the second failed veto override attempt [FN129] and the systematic efforts by the Administration to undermine the existing statute, Congress effectively declared the battle over, enacting legislation that extends and funds the current SCHIP statute through April 2009. [FN130] As of late summer 2008, the lawsuit to enjoin implementation of the SCHIP directive is pending and SCHIP remains unauthorized.

In a final astounding twist, in August 2008, the Administration quietly informed the state of California, in response to its letter to federal officials informing them that it would not comply with the August 17th directive, that the federal government would not enforce its August 17th directive for the time being. [FN131] What exactly the federal government meant by this response is unclear; what is clear, however, is that its actions to not only stop the legislative reauthorization of SCHIP, but also to roll back existing coverage under its August 2007 directive, amounted to a wildly complex political sham to halt the expansion of a modest public benefit program for children. The Administration's *724 2008 response to California suggests that federal officials never had any intention of enforcing their own directive. Instead, the directive was thrown onto the table as a further legal maneuver to buy the time they needed to work their political magic on a bipartisan SCHIP's reauthorization effort.

III. WHAT DOES THE SCHIP EXPERIENCE MEAN FOR HEALTH CARE REFORM?

It is difficult to know how to interpret the phenomenal events surrounding the demise of SCHIP reauthorization. Was the reauthorization battle just a strange interlude reflecting the super-heated, post-2006 political and ideological climate? Or does the fault lines that emerged during the battle regarding the role of government in subsidizing coverage and organizing the health insurance market represent one that cannot be surmounted? Whatever, the case, beneath the peculiar fury that surrounded the SCHIP reauthorization process, there probably are some lessons for broader reform.

A. It's the Architecture, Stupid

Much of the fight about health reform boils down to what can be thought of as its legislative "architecture:"

how high to subsidize coverage; whether to use markets to effectuate a coverage guarantee, and if so, how to structure the market. It is easy to get so caught up in the political sturm und drang of reform to the point at which one loses sight of the basic architectural choices and potential avenues of compromise.

1. Subsidies

It is easy to harbor the impression from the fight over SCHIP that a major point of contention was how high to push the subsidy in relation to family income. The President--by virtue of the CMS directive--appeared to demand that the subsidy essentially be capped at 250 percent of the federal poverty level, while Congress (at least for awhile) appeared to want to set the limit at 400 percent of the federal poverty level. This perception would be wrong.

National policy today is to subsidize coverage to the highest income levels once the effects of tax subsidies are included. As a result of U.S. tax policy, even the wealthiest Americans have their coverage subsidized if they secure it through an employer based plan given the way in which the tax code functions. Indeed, it was the President who sought to make the current tax approach fairer by extending subsidy arrangements to persons who do not have access to coverage through work, although he would have made American workers alone pay for the change. [FN132] But if lawmakers can find common ground in relation to blending *725 direct and tax-related subsidies (e.g., direct subsidization for those with incomes up to some percentage and the use of a refundable tax credit for remaining individuals) and creating a financing mechanism that does not place the entire burden of financing coverage for the uninsured on the workforce, it is likely that a compromise can be found.

2. The Use of Markets and Market Organization and Ground Rules

It is evident that whoever is elected President in 2008 will espouse a coverage plan that uses the sale of private health insurance products to achieve coverage of the population. [FN133] The question becomes the extent to which the sale will be organized into a group market as well as the degree to which companies that want to sell to a group market will be regulated in terms of access, exclusions, coverage content, consumer protections, and other matters. [FN134] The legislative architecture of the Medicare Part D prescription drug legislation in 2003 [FN135] illustrates one possible approach to compromise: a group coverage market operated on a federal regional basis, with preemption of state regulatory authority and residents of each state entitled to select from among numerous plans. [FN136] Another model would be state-based, following the contours of legislation enacted by Massachusetts in 2006, which establishes a state-regulated group coverage arrangement for persons without access to employer coverage, known as the Connector. [FN137] As with the subsidy issues, there are potential ways to blend the two models, such as the use of federal products for small groups and state regulated products in the individual market. What is evident however, is that the compromise lies in achieving a reasonable level of coverage regulation and thus, the avoidance of reliance on an unstable individual market.

3. Hold onto Medicaid

It is impossible to overstate the impact on the American health care system if the price of reform is the unintended (or intentional) unraveling of Medicaid. *726 Medicaid's reach is vast because the program plays multiple roles as a major financier of health care that is considered uninsurable, particularly health care services used by children and adults with serious and chronic health conditions. [FN138] The 2007 SCHIP debate pulled

back the curtain somewhat on the extent to which the Medicaid program is under attack and the degree to which efforts to broaden its reach add to the political heat surrounding health reform.

Medicaid is, to be sure, a vast entitlement. But much of its costs arise because, as one writer has noted, the program is the workhorse of the American health care system, doing jobs no one else will do and burdened by rampant underlying health care costs that help drive total program spending. [FN139] There is no question that in Medicaid's absence, there simply would be no financing mechanism for both institutional and community-based services for children and adults whose health needs--whether moderate or severe--extend beyond the limits of conventional health insurance products. [FN140] Whether Medicaid continues as a primary insurer for certain population or as a supplemental source of coverage, offering essentially an additional coverage tier for persons with serious and chronic health conditions, remains to be resolved. But what is eminently unworkable is to leave children and adults with chronic illnesses and conditions without a means of coverage for extended health needs. The SCHIP battle underscored the degree to which a serious discussion about how to juxtapose Medicaid within and against other insurance reforms, will be a major aspect of national health reform.

Don't start with children unless the legislative power to act is strong and children are viewed as part of a broader effort

Phasing with children is a popular notion. Senator Obama's health care reform plan would phase in children first. Over the years, politicians and candidates have espoused the notion of phasing in children first; indeed, Senator Barak Obama would mandate coverage of children. [FN141] Starting with children is popular in two respects. First, compared to adults, children are exceedingly low-cost, particularly when one considers the existing Medicaid and SCHIP federal and state expenditure offsets. [FN142] Second, the 1997 enactment of SCHIP itself shows that children can serve as political common ground.

But the enactment of SCHIP serves to underscore another fact: it is too easy to relegate children's coverage to a structurally unsustainable non-entitlement model and, indeed, to use the cover of children to weaken a structurally more ***727** robust form of coverage. SCHIP's non-entitlement, fixed allocation structure [FN143] is the antithesis of Medicaid's open-ended entitlement financing scheme [FN144] that is capable of growing and evolving as the size of the population in need grows, as health care costs increase, and as health care needs become more complex. SCHIP, on the other hand, is punctuated by a history of funding shortfalls, under-financing in relation to need, and fights over what proportion of children in need will be served. Simply put, SCHIP does not offer the type of dynamic financing platform on which to build a sustainable approach to health care financing, and only in the case of the politically weakest population--children--would such a platform even have been suggested. (Note in contrast that the Medicare Part D prescription drug reform rests on open-ended entitlement spending. While market strategies are used to attempt to contain costs, expenditures will automatically rise along with need and the cost of treatment).

Unless the legislative power to act is overwhelming, and unless children's coverage is viewed as part of a broader reform effort, the SCHIP experience underscores the problems with putting children first. It simply is too easy to create a program that is financially too weak to carry out its mission and yet still call it progress. Health reforms for children need to be understood from the beginning as part of a broader effort to extend affordable and appropriate coverage to the entire population, since children on their own have demonstrated a unique lack of the type of political power essential to building a sufficiently robust platform for national health reform.

4. Political Accommodation is One Thing, Political Expediency, Another

SCHIP was a little creature of the politics of its time when it was enacted in 1997. For a number of reasons, some good and others not so good, lawmakers came together to create a modest program that ultimately proved beneficial to low income children.

By contrast, in 2007, political expediency favored deadlock rather than accommodation with influential policymakers believing that their immediate interests were best served by not finding a middle ground. One can only surmise that the theory here was that the program could automatically be extended as it was and no one would be the worse for the gridlock. In reality of course, several million children who might have gotten help but went without coverage did suffer, as well as the children in states that were instructed to roll back coverage in the August 17th 2007 directive. The problem with political expediency is that not only does it accomplish too little, but it is too easy to overlook consequences of expedient conduct--both good and bad.

*728 When and if it ever arrives, national health reform will necessitate a series of grand political compromises around a domestic policy matter that has almost no parallel in U.S. policy and whose resolution carries profound national social and economic consequences. It is important not to fritter away the next great opportunity for health reform on something so modest as reauthorizing SCHIP. Hopefully the 111th Congress will set its aims the next time at a level that is commensurate with the long-term interests of all children and their families.

[FNa1]. Harold and Jane Hirsh Professor of Health Law and Policy and Chair, Department of Health Policy, The George Washington University School of Public Health and Health Services. © 2009, Sara Rosenbaum.

[FN1]. The President's first veto message was delivered to the House of Representatives on Oct. 3, 2007. Message to the House of Representatives from George W. Bush, President of the United States (October 3, 2007), <http://www.whitehouse.gov/news/releases/2007/10/20071003-2.html>. The second message was delivered on December 13, 2007. In his first veto message, the President explained that the legislation would "move health care in this country in the wrong direction" because of the income range of the families aided and the measure's impact on the private health insurance market. The second veto message was a reiteration of the first. The House of Representatives failed to override the second veto on January 23, 2008. For the full reauthorization history, see KAISER COMMISSION ON MEDICAID AND THE UNINSURED, STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP): REAUTHORIZATION HISTORY (2008), <http://www.kff.org/medicaid/upload/7743.pdf>.

[FN2]. Many of these can be seen if one simply Googles "State Children's Health Insurance Program." As of May 3, 2008, 1.2 million entries can be reviewed.

[FN3]. Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492 (2007). The White House Press Statement issued when the measure was signed into law stated in pertinent part that "we can be assured that children will continue to have coverage." Press Release, The White House, Statement by the Press Secretary On Passage of SCHIP Legislation (Dec. 19, 2007) <http://www.whitehouse.gov/news/releases/2007/12/20071219-11.html>. What the Press Statement omitted was the approximately 4 million additional children who also would have received coverage under H.R. 976, the original reauthorization measure. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 1. This statement also made no mention of the Administration's August 17, 2007 directive imposing new limits on

state child health coverage options under current law. Centers for Medicare and Medicaid Services, State Health Official Letter 07-001 (August 17, 2007), available at <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>. One study estimates that nearly half of all children will be affected by the directive. CINDY MANN AND MICHAEL ODEH, GEORGETOWN PUBLIC POLICY INSTITUTE CENTER FOR CHILDREN AND FAMILIES, MOVING BACKWARD: STATUS REPORT ON IMPACT OF THE AUGUST 17TH SCHIP DIRECTIVE TO IMPOSE NEW LIMITS ON STATES' ABILITY TO COVER UNINSURED CHILDREN (2007), <http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/movingbackward1212.pdf>.

[FN4]. Having worked on federal legislative health reform matters for more than 30 years, I (and all of my colleagues) have become accustomed to the cognitive dissonance that frequently characterizes the dichotomy between public battles and private discussions.

[FN5]. For a comprehensive review of the federal budget process and health policy, see Timothy Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555 (2007). For an excellent specific article on the budget process and national health reform, see Timothy Westmoreland, *Can We Get There From Here? Universal Health Insurance and the Congressional Budget Process*, 96 GEO. L.J. 523 (2008).

[FN6]. For a brief background on the role of cost estimation in health reform legislation, see Congressional Budget Office, Background on Cost Estimates, <http://www.cbo.gov/CEBackground.shtml> (last visited August 25, 2008). For a discussion of the significance of baselines, see Timothy Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555, 1569-75 (2007).

[FN7]. Senators Edward Kennedy (D-Mass.) and Orrin Hatch (R-Utah), longtime Senate colleagues, were the two prime sponsors of the original SCHIP legislation. Sara Rosenbaum et al., *The Children's Hour*, HEALTH AFFAIRS, Jan.-Feb. 1998, at 75-89; see also GEORGETOWN CENTER FOR CHILDREN AND FAMILIES, TOO CLOSE TO TURN BACK: COVERING AMERICA'S CHILDREN (2006), available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/too%20close%20to%20turn%20back.pdf>.

[FN8]. See, e.g., JEANNE M. LAMBREW, COMMONWEALTH FUND, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PAST, PRESENT AND FUTURE (2007), available at http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf?section=4039 (last visited October 25, 2008) (detailing program achievements, pp. 6-12, including coverage of an additional 6.1 million children, reductions in the rate of uninsured children, reduction in unmet health needs, an increased rate in the receipt of preventive care, and some evidence of improvements in health itself); Genevieve Kenney and Justin Yee, *SCHIP at a Crossroads: Experiences to Date and Challenges Ahead*, 26 HEALTH AFFAIRS (2007) 356, 359-360 (noting SCHIP's effects on improving access to care and reducing racial and ethnic disparities in health care).

[FN9]. Pub. L. 105-33, 111 Stat. 251 (1997).

[FN10]. Pub. L. 93-344, 88 Stat. 297 (1974) (codified as amended at 2 U.S.C. §§ 601-88 (2004)). The legislation, which has been amended on several occasions, is supplemented by special Senate and House rules governing consideration of the budget. See MARTHA COVEN & RICHARD COGAN, CTR. ON BUDGET & POLICY PRIORITIES, INTRODUCTION TO THE FEDERAL BUDGET PROCESS 5-6 (2007), available at <http://www.cbpp.org/3-7-03bud.pdf>.

[FN11]. A large portion of direct federal outlays are predetermined because they represent mandatory expenditures. Nonetheless, because these expenditures are the result of the legislative process one way or the other, Congress has plenary authority to alter the terms of spending and taxation and frequently does so. *See* Westmoreland, *supra* note 6, at 1565.

[FN12]. For an excellent and simple overview of the Congressional budget process, see COVEN & COGAN, *supra* note 10, at 5-6.

[FN13]. *Id.*

[FN14]. For a discussion of the different types of spending in federal budgeting, see Westmoreland, *supra* note 6, at 1564-69.

[FN15]. The Kaiser Commission on Medicaid and the Uninsured has created a user-friendly interactive "timeline" chart showing these and other legislative reforms. Kaiser Family Foundation, Medicaid: A Timeline of Key Developments, http://www.kff.org/medicaid/medicaid_timeline.cfm (last visited May 3, 2008).

[FN16]. Sara Rosenbaum & Kathleen Maloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and its Impact on Medicaid for Families and Children*, 60 OHIO ST. L.J. 1443, 1443-44 (1999). For an interesting discussion of how close lawmakers came to repealing Medicaid, see Honorable Bob Graham, *Medicaid Reform: Saving an American Success Story*, 23 F. ST. U. L. REV. 917 (1996). Senator Graham was instrumental in saving the program. *See also* Colleen Grogan and Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821 (2003).

[FN17]. Sara Rosenbaum, *SCHIP Reconsidered*, 26 HEALTH AFFAIRS w608, w611 (2007).

[FN18]. Rosenbaum et al., *supra* note 7, at 76.

[FN19]. *See* Explanation of Medicaid eligibility categories at CCH Medicare/Medicaid Guide ¶14,211 and specific descriptions of eligibility categories at §§ 14,231-14,271.

[FN20]. For example, at its SCHIP page, Wikipedia offers the same myth repeatedly told about SCHIP, namely, that it represented the largest expansion of health insurance coverage for children in the U.S. since the enactment of Medicaid. Wikipedia, State Children's Health Insurance Program, http://en.wikipedia.org/wiki/State_Children's_Health_Insurance_Program (last visited May 3, 2008). In fact, the Medicaid reforms enacted between 1984 and 1990, which phased in coverage of all low-income children, essentially tripled the program's size. For a complete description of all Medicaid reforms enacted between 1984 and 1990 that relate to coverage expansions for children, *see* CONGRESSIONAL RESEARCH SERVICE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (1993 UPDATE) 35-36 (GPO 1993). In 1980, prior to the period of reform, the number of child Medicaid beneficiaries stood at 9.3 million. *Id.* at table II-20 o. 160. By 1997, 21 million children were enrolled in Medicaid, and by 2004, the number of Medicaid-enrolled children had reached nearly 28 million. JEANNE LAMBREW, THE COMMONWEALTH FUND, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PAST, PRESENT AND FUTURE 7 fig.2, 17 (2007), available at http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf?section=4039.

[FN21]. Efforts by Senators Jay Rockefeller (D. W. Va.) and the late Senator John Chafee (R. Rhode Island), S. 674, 105th Cong. (1st Sess. 1997), to substitute a modified Medicaid coverage expansion option in lieu of a separate SCHIP statute failed. Robert Pear, *Senate Panel Rebuffs Clinton on Child Health Plan*, N.Y. TIMES, June 18, 1997. Senior Congressional staff were not shy during the conferencing of SCHIP about vocalizing the importance of establishing a separate non-entitlement statute under the Act that offered a fundamentally different, non-entitlement approach to financing coverage of low-income populations.

[FN22]. Despite the mounting legal uncertainty that surrounds Medicaid as an enforceable legal right, the law's provisions on coverage of eligible individuals continue to be interpreted as a privately enforceable legal right. See TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT?* 162-78 (2003). For perhaps the most scholarly discussion of the evolution of private enforcement actions under Medicaid, see *Sanchez v. Johnson*, 416 F. 3d 1051 (9th Cir. 2005).

[FN23]. 42 U.S.C. § 1397bb(b)(4) (2008). No state that operates a separately administered SCHIP program (as opposed to using its funds to expand Medicaid) has elected to establish its own SCHIP program as a legal entitlement. See also Sara Rosenbaum et. al., *Devolution of Authority and Public Health Insurance Design: National Study Reveals an Impact on Low Income Children*, 1 HOUS. J. HEALTH L. & POL'Y 33, 49 (2001).

[FN24]. 42 U.S.C. § 1396a(a)(10)(A), (a)(14) (2008).

[FN25]. 42 U.S.C. § 1397cc(2008).

[FN26]. See Sara Rosenbaum & Paul Wise, *Crossing the Medicaid-Private Health Insurance Divide: The Case of EPSDT*, 26 HEALTH AFFAIRS 382, 389-90 (2007).

[FN27]. 42 U.S.C. § 1396 (2008).

[FN28]. 42 U.S.C. § 1397aa(c) (2008).

[FN29]. 42 U.S.C. § 1397dd(a) (2008).

[FN30]. Compare 42 U.S.C. § 1396 (2008) with 42 U.S.C. § 1397aa(c) (2008).

[FN31]. 42 U.S.C. §§ 1397aa-1397cc (2008).

[FN32]. 42 U.S.C. § 1397dd(a) (2008).

[FN33]. *Id.*

[FN34]. The state allotment formula is set forth at 42 U.S.C. § 1397dd(b) (2008).

[FN35]. 42 U.S.C. § 1397cc(a). The term "child health assistance" is defined at 42 U.S.C. § 1397jj(a) (2008).

[FN36]. 42 U.S.C. § 1397bb(b)(4) (2008).

[FN37]. One problem with a program whose funds are subject to the ups and downs of the annual Congressional appropriations process is that states face great uncertainty in designing and administering programs that experience elasticity and growth, as is the case with a need based insurance program such as SCHIP. States simply don't know if their needs will exceed their allotments in any given year and thus may cut back and curtail cover-

age in anticipation of funding shortfalls. Genevieve Kenney and Debbie Chang, *The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges*, HEALTH AFFAIRS, Sept./Oct. 2004, at 51, 57-58. Congress has revisited this problem by amending the law to allow states to carry over funds and to redistribute unused funds. 42 U.S.C. § 1397dd(g) (2008).

[FN38]. Donna Cohen Ross and Laura Cox, Kaiser Commission on Medicaid and the Uninsured, OUT IN THE COLD: ENROLLMENT FREEZES IN SIX STATE CHILDREN'S HEALTH INSURANCE PROGRAMS WITHHOLD COVERAGE FROM ELIGIBLE CHILDREN (December, 2003), available at <http://www.kff.org/medicaid/4159.cfm> (last visited May 3, 2008).

[FN39]. 42 U.S.C. § 1397dd(d) (2008), added by the Deficit Reduction Act of 2005, Pub. L. 109-171 §§ 6101(a) and (b) (2008).

[FN40]. 42 U.S.C. § 1397dd(2008).

[FN41]. 42 U.S.C. § 1397dd(b)(3) (2008).

[FN42]. 42 U.S.C. § 1397aa(b) (2008).

[FN43]. 42 U.S.C. § 1397cc(b) (2008).

[FN44]. Calculations by author using the enhanced federal medical assistance percentage formula described in 42 U.S.C. § 1397ee(a) and (b) (2008).

[FN45]. 42 U.S.C. § 1396a(a)(10)(a)(i) (2008).

[FN46]. 42 U.S.C. § 1397ee(c)(2)(A) (2008).

[FN47]. 42 U.S.C. § 1397jj(b) and (c)(4) (2008).

[FN48]. Children with family incomes at or below twice the federal poverty level have a very low rate of employer sponsored coverage. In 2006, only 13.7% of children living in households with annual incomes at or below \$20,000 had employer-sponsored health insurance, while only slightly more than three percent were covered through individually purchased plans. KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, <http://www.kff.org/uninsured/7451.cfm>. Table 2.

[FN49]. Unlike SCHIP, Medicaid requires state agencies to pursue available "third party liability" but does not prevent dual coverage. 42 U.S.C. § 1396a(a)(25).

[FN50]. 42 U.S.C. § 1396a(cc) (2008), added by § 6062(a)(1)(B) of the Deficit Reduction Act of 2006 (P.L. 109-171).

[FN51]. LISA DUBAY, KAISER FAMILY FOUNDATION, EXPANSIONS IN PUBLIC HEALTH INSURANCE AND CROWD OUT: WHAT THE EVIDENCE SAYS 1-2, available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13305> (last visited May 3, 2008).

[FN52]. 13.5% of poor (family incomes under 100% FPL) children and 36.3% of near-poor children (family incomes 100%-199% FPL) had employer-sponsored coverage in 2006. Kaiser Family Foundation, State Health

Facts Online <http://www.statehealthfacts.org/comparebar.jsp?ind=129&cat=3> (last visited August 26, 2008).

[FN53]. For an excellent essay on the politics of “crowdout” see Judy Feder, *Crowd-out and the Politics of Health Reform*, *National Health Reform and America's Uninsured*, 32 J. LAW, MEDICINE & ETHICS 461 (2004).

[FN54]. As of 2006, only slightly more than 55% of *all* children had employer-sponsored coverage. Kaiser Family Foundation, State Health Facts, <http://www.statehealthfacts.org/comparebar.jsp?ind=127&cat=3> (last visited August 26, 2008). *See also* Kenney & Yee, *supra* note 8, at 359-360 (reporting that so few children enrolled in the program had employer-sponsored coverage to begin with that as a practical matter, crowdout fears abated).

[FN55]. 42 U.S.C. § 1397bb(a)(1) and (2) (2008).

[FN56]. 42 U.S.C. § 1397jj (2008).

[FN57]. *Compare* 42 U.S.C. § 1397jj(a) (2008) (SCHIP) *with* 42 U.S.C. 1396d(a) (2008).

[FN58]. 42 U.S.C. § 1397cc(a) (2008).

[FN59]. Sara Rosenbaum, Anne Markus, & Colleen Sonosky, *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMEDICAL LAW 1, 22, 36-38 (2004) (Figure 3 and accompanying tables).

[FN60]. Much of the Medicaid and SCHIP technical support provided by the Department of Health Policy involves assisting states in developing and designing their purchasing specifications. Technical assistance tools can be found at George Washington University School of Public Health and Health Services, Institutes and Centers, http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/managed_care.cfm (last visited May 4, 2008).

[FN61]. Children's legal entitlement under Medicaid actually extends beyond services covered under a state Medicaid plan and includes all items and services that fall within the federal definition of “medical assistance.” 42 U.S.C. § 1396d(r)(5) (2008).

[FN62]. Federal Medicaid regulations give states the option regarding which items and services covered under their state Medicaid plans will be enumerated in contracts with managed care entities. 42 C.F.R. § 438.210.

[FN63]. 42 U.S.C. § 1396b(m) (2008); 42 U.S.C. § 1396u-2 (2008).

[FN64]. Federal law also prohibits the application of pre-existing condition exclusions and limitations. 42 U.S.C. § 1397cc(f)(1) (2008).

[FN65]. 42 U.S.C. § 1397cc(c) (2008). SCHIP historically permitted a more liberal use of cost sharing than allowed under Medicaid, even in the case of near-poor children. *See* Amendments to Medicaid in 2006 as part of the Deficit Reduction Act broaden state cost sharing options. 42 U.S.C. § 1396o(a) (2008) as added by § 6041 of the Deficit Reduction Act (P.L. 109-171)

[FN66]. 42 U.S.C. § 1397cc(b) and (c) (2008).

[FN67]. Rosenbaum & Wise, *supra* note 26, at 384-385.

[FN68]. 42 U.S.C. §§ 1396a(a)(10) (2008); 1396d(a); 1396d(r)

[FN69]. 42 U.S.C. § 1397cc(a)-(c) (2008). Required preventive services are limited to well-baby and well-child care and immunizations. SCHIP products must also cover at least some inpatient and outpatient hospital care, physician services, and laboratory and x-ray services. Services as basic as vision, dental and hearing care are optional as a matter of law. Most states cover these services to some extent. See Neva Kaye et al., National Academy for State Health Policy, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (2006), available at http://www.nashp.org/Files/charting_SCHIP_III.pdf (last visited August 26, 2008).

[FN70]. *Id.*

[FN71]. This tension, between what is typically furnished and what may be necessary and thus part of the Medicaid legal entitlement for children can be seen in *Rosie D v. Romney*, 410 F. Supp 18 (D. Mass. 2007), probably the most extensive litigation regarding the meaning of the pediatric health care legal entitlement ever mounted. The case involved the systematic denial of advanced mental health treatment for Medicaid-eligible children enrolled in the state's managed care plans and the decision provides an in-depth analysis of the transcendent and binding nature of this legal entitlement, even in the case of children who receive most of their care and services through a private benefit plan.

[FN72]. 42 U.S.C. § 1397ee(d) (2008).

[FN73]. 42 U.S.C. § 1397bb(b)(3)(B) (2008).

[FN74]. The impact of the screen and enroll requirement on Medicaid enrollment can be seen in the growth of the underlying Medicaid between 1997 and 2004, as the SCHIP reforms were implemented. See Lambrew, *supra* note 20.

[FN75]. 42 U.S.C. § 1397aa(a)(2) (2008).

[FN76]. Rosenbaum, *supra* note 17.

[FN77]. 42 C.F.R. § 457.60.

[FN78]. 42 C.F.R. § 457.810(a)(1)-(4).

[FN79]. See Cynthia Bansak & Steven Raphael, *The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program*, 26 J. POLICY ANALYSIS & MGMT. 149, 159-60, 167 (2006); Barbara Wolfe & Scott Scrivner, *The Devil May be in the Details: How the Characteristics of SCHIP Programs Affect Take-up*, 24 J. POLICY ANALYSIS & MGMT. 499 (2005); Jonathan Gruber & Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* 14-16 (Nat'l Bureau of Econ. Research, Working Paper No. 12858, 2007).

[FN80]. *New Jersey v. U.S. Department of Health and Human Services*, Civ. Action No. 07-04698.

[FN81]. Brief for Health Policy Scholars as Amici Curiae Supporting Plaintiffs, *New Jersey v. U.S. Department of Health and Human Services* (2008) (Civ. Action No. 07-04698). The brief cites the following research: Donna Cohen Ross & Aleya Horn, Kaiser Comm'n on Medicaid and the Uninsured, *Health Coverage for Children and*

Families in Medicaid & SCHIP: State Efforts Face New Hurdles (2008), at 32 Table 2, available at <http://www.kff.org/medicaid/upload/7740.pdf>. Illinois requires 12-month waiting periods for children covered by its State-funded expansion of children's health insurance. *Id.* The remaining States have implemented waiting periods of between one and six months. *Id.*

[FN82]. 42 U.S.C. §§ 1397dd(h)-(1) (2008) (codifying Congress' efforts through a series of amendments beginning in 2006 and continuing into 2007 to address state funding shortfalls). See P.L. 109-482 § 201(a); Pub. L. 110-173 § 7001; Pub. L. 110-173 § 201(c)(1).

[FN83]. See John Holahan & Allison Cook, *The U.S. Economy And Changes in Health Insurance Coverage, 2000-2006*, 27 HEALTH AFFAIRS w135-w144 (2008).

[FN84]. A portion of the SCHIP growth can be attributed to coverage of adults. A number of states sought and received permission to use a portion of their SCHIP allotments to assist adults, including single persons and parents. Congress prohibited the use of funds for single persons, 42 U.S.C. § 1397ee(c)(1), as part of the Deficit Reduction Act of 2005, § 6102b. Congress also was poised to phase out coverage of adults in the SCHIP reauthorization that was vetoed. See H.R. 976 §112. See also U.S. GOVERNMENT ACCOUNTABILITY OFFICE, STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PROGRAM STRUCTURE, ENROLLMENT AND EXPENDITURE EXPERIENCES, AND OUTREACH APPROACHES FOR STATES THAT COVER ADULTS (Nov. 2007), available at <http://www.gao.gov/htext/d0850.html> (finding that of 4.5 million persons enrolled in SCHIP at any given time period, some 384,000 were adults).

[FN85]. These studies are collected at the Children's Health Insurance Research Initiative (CHIRI), a project of the Agency for Health Care Quality and Research. See Children Health Insurance Research Initiative, <http://www.ahrq.gov/chiri/#Findings> (last visited May 4, 2008).

[FN86]. See John Iglehart, *Insuring all Children--the New Political Imperative*, 357 NEW ENGLAND J. OF MED. 70-76 (2007); LAURA SUMMER & CINDY MANN, COMMONWEALTH FUND INSTABILITY OF PUBLIC HEALTH INSURANCE COVERAGE FOR CHILDREN AND THEIR FAMILIES: CAUSES, CONSEQUENCES, AND REMEDIES (2006); Janet Bronstein et. al., *SCHIP Structure and Children's Use of Care*, 27 HEALTH CARE FINANCING REVIEW 41-51 (2006); CONGRESSIONALLY MANDATED EVALUATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: FINAL REPORT TO CONGRESS (Mathematical Policy Research Ref. No. 8782-130; HHS-100-01-0002, Oct. 26 2005); Jennifer Edwards et al., Do Enrollees in 'Look Alike' Medicaid and SCHIP Programs Really Look Alike? 21 HEALTH AFFAIRS 240-248; Kenney & Yee, *supra* note 8, at 356-369; Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP* 1 J. HEALTH & BIOMEDICAL LAW 1-46 (2004).

[FN87]. See Sara Rosenbaum & Ramona Whittington, *Parental Health insurance Coverage as Child Health Policy* FIRST FOCUS, June 2007, available at <http://www.firstfocus.net/Download/parentalcoverage.pdf> (summarizing studies).

[FN88]. See CHRIS L. PETERSON, LIBRARY OF CONGRESS, CONGRESSIONAL RESEARCH SERVICE, SCHIP FINANCING: FUNDING PROJECTIONS AND STATE REDISTRIBUTION ISSUES (2007).

[FN89]. See H.R. 976, 110th Cong. (2007).

[FN90]. See Kaiser Commission on Medicaid and the Uninsured, State Children's Health Insurance Program:

Reauthorization History, [http:// www.kff.org/medicaid/upload/7743.pdf](http://www.kff.org/medicaid/upload/7743.pdf) (last visited May 4, 2008). *See also* Georgetown Center for Children and Families, SCHIP Timeline, [http:// ccf.georgetown.edu/index/cms-filesystem-action?file=policy/schip% 20reauth/schiptimeline.pdf](http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/schip%20reauth/schiptimeline.pdf) (last visited May 4, 2008).

[FN91]. H.R. 976 §§ 101-506, 110th Cong. (2007).

[FN92]. *See* Sara Rosenbaum, *The Proxy War*, 358 NEW ENGLAND J. MED. 869-72 (2008).

[FN93]. *Id.* *See also* Office of Mgmt. & Budget, Executive Office of the President, THE PRESIDENT'S BUDGET: FISCAL YEAR 2009 (2008), *available at* <http://www.whitehouse.gov/omb/budget/fy2008/hhs.html>.

[FN94]. *Id.* *See also* Rosenbaum, *supra* note 92.

[FN95]. *See* David Blumenthal, *Employer Sponsored Health Insurance in the United States: Origins and Implications*, 358 NEW ENGLAND J. MED. 195-202 (2006). *See also* reference to tax policy and health insurance coverage in Peter Orszag, Congressional Budget Office, Taxes and Health Insurance at 7 (2008), *available at* http://www.cbo.gov/ftpdocs/90xx/doc9009/02.29.2008-Taxes_and_Health_Insurance.pdf.

[FN96]. Orszag, *supra* note 95 at 10. Dr. Orszag's presentation illustrates that even as the proposal would have undone employer-sponsored group coverage, it would have resulted in only a 14% reduction in the number of uninsured persons. *Id.* at 14.

[FN97]. 42 U.S.C. §1395w-27a et. seq. (2008).

[FN98]. *See* Rosenbaum, *supra* note 92.

[FN99]. *See* Blumenthal, *supra* note 95.

[FN100]. For an overview of the private health insurance market and the problem of individual coverage and risk underwriting *see* Kaiser Family Foundation, *How Private Health Coverage Works: A Primer* (2008 Update), *available at* <http://www.kff.org/insurance/upload/7766.pdf>; *See also* Karen Pollitz & Richard Sorian, *Perspective: Ensuring Health Security: Is The Individual Market Ready for Prime Time?* HEALTH AFFAIRS W 372-377 (2002).

[FN101]. *See* Rosenbaum, *supra* note 92.

[FN102]. Kaiser Commission on Medicaid and the Uninsured, State Children's Health Insurance program Reauthorization History (Jan. 2008), *available at* <http://www.kff.org/medicaid/upload/7743.pdf>.

[FN103]. *Id.*

[FN104]. *Id.*

[FN105]. Rosenbaum, *supra* note 17. *See also* Author's contemporaneous discussions with Congressional staff [hereinafter *Author Discussions*]. The internal negotiations during the period between the President's veto of the first bill and the second veto. As noted previously, SCHIP essentially allows states to enact expansions already permitted under Medicaid while receiving a somewhat higher federal contribution rate and having to comply with fewer federal Medicaid requirements including coverage entitlement and a broad benefit mandate. Were

SCHIP to not be authorized, states of course could therefore maintain coverage for children in the form of a Medicaid expansion, an approach that could be expected to be even more fiercely resisted by the White House and its supporters because of Medicaid's entitlement nature. Sensing an opening to use SCHIP reauthorization to reach the underlying problem--a broad Medicaid entitlement--Republican opponents insisted that a second effort at SCHIP reauthorization include a repeal of federal Medicaid options. Ultimately this offer was rejected, a slimmed down SCHIP measure was sent to the President, and the President vetoed the bill for the second time. An article that hints on the maneuvering that was going on is Alex Wayne, *Medicaid Issue is the Latest Sticking Point on Children's Health Measure* CONG. QUARTERLY HEALTHBEAT Nov. 19, 2007.

[FN106]. 42 U.S.C. § 1396b (2008). States qualify for federal contributions (known as the federal medical assistance percentage) that are at a rate lower than the enhanced federal medical assistance percentage rate governing SCHIP. Compare 42 U.S.C. §§ 1396b(a)(1) and 1396d(b) (2008) (Medicaid) to the “enhanced FMAP” described in 1396d(b) and set forth in 42 U.S.C. § 1397ee(a) (2008) (SCHIP).

[FN107]. See *Author Discussions*, *supra* note 105.

[FN108]. Message to the House of Representatives from George W. Bush, President of the United States, *supra* note 1.

[FN109]. *Id.*

[FN110]. See Rosenbaum, *supra* note 91, at 869.

[FN111]. United States Department of Health and Human Services, Poverty Guidelines 2007 <http://aspe.hhs.gov/POVERTY/07poverty.shtml> (last visited Aug. 26, 2008).

[FN112]. Message to the House of Representatives from George W. Bush, President of the United States, *supra* note 1.

[FN113]. H.R. 976, 110th Cong. § 116(e) (2007), which limited coverage to 300% of the federal poverty level.

[FN114]. See Rosenbaum, *supra* note 91.

[FN115]. *Id.* A Google search of “SCHIP” and “excessive” turns up over 98,000 hits (search conducted on April 27, 2008) at <http://www.google.com/search?hl=en&q=SCHIP%2C+excessive&btnG=Google+Search>. A sampling of what turns up. A taste of what turns up is this item by Ray Nothstine of an organization called Action Institute, at <http://www.acton.org/commentary/commentary406.php> (last visited April 27, 2008): “Originally established by House Republicans in 1997, SCHIP was meant to insure children of families who do not qualify for Medicaid. The incomes of eligible families generally did not exceed 200 percent of the poverty level. The new version of SCHIP does not stay faithful to the intent of the program. The congressional expansion of SCHIP raises spending \$35 billion over 5 years. Families making more than 400 percent above the poverty line may be eligible for the program. In the state of New York, a family of four earning \$83,000 would qualify. Rampant spending and middle class handouts aren't the only problems. Half of all new children enrolling will be leaving private insurance, shifting ever more of the health care sector from market to government. Part of the needed funding increase will come from an even higher cigarette tax, making the plan even more regressive and unfair.”

[FN116]. Kenney & Yee, *supra* note 8, at 357 (discussing SCHIP's “positive spillover” effects on Medicaid).

[FN117]. Letter SHO 07-001 from Dennis G. Smith, Director of CMS to state health officials (August 17, 2007), available at <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf> (last visited August 26, 2008).

[FN118]. Kenney & Yee, *supra* note 8, at 359.

[FN119]. See discussion of the SCHIP directive in the Amicus Brief, *supra* note 81, 6-7.

[FN120]. *Id.*

[FN121]. *Id.*

[FN122]. Letter from Kerry Weems, Acting CMS Administrator to Cristal A. Thomas, Ohio State Medicaid Director, (December 20, 2007).

[FN123]. 42 U.S.C. § 1397aa(a) (2008). The legislation gives states the option of administering SCHIP as a separate program, a Medicaid expansion, or combination of the two.

[FN124]. 42 U.S.C. § 1396a(r)(2) (2008).

[FN125]. 42 U.S.C. § 1396a(a)(25) (2008).

[FN126]. Letter from Kerry Weems to Cristal A. Thomas, *supra* note 122.

[FN127]. *Id.*

[FN128]. Rosenbaum, *supra* note 17.

[FN129]. The second veto override attempt involved H.R. 3963, a scaled-back version of the legislation vetoed in October. Kaiser Family Foundation, State Children's health Insurance Program Reauthorization History (Jan. 2008), <http://www.kff.org/medicaid/upload/7743.pdf> (last visited August 27, 2008).

[FN130]. P.L. 110-173. See also State Children's Health Insurance Program Reauthorization History, *supra* note 129.

[FN131]. Letter to Herb Kuhn, Deputy Administrator and Acting Director for Center for Medicaid and State Operations, from Lesley Cummings, State of California, MRMIB (August 12, 2008). See also, statement of Cindy Mann, Georgetown Center for Children and Families regarding the Administration's decision (August 15, 2008), available at <http://ccf.georgetown.edu/index/cms-filesystemaction?file=ccf%20news%20clips/cms%20directive%20statement.pdf> (last visited August 26, 2008).

[FN132]. The President's budget proposal, *supra* note 93, makes clear that this extension would have come at the expense of a cap on the value of the subsidy for persons with employer sponsored coverage, which made the proposal anathema, at least when put forth by a Republican President with low approval ratings.

[FN133]. See Obama Plan for a Healthy America, <http://www.barackobama.com/issues/healthcare/> (last visited August 27, 2008); John McCain, Straight Talk on Health Care Reform, <http://www.johnmccain.com/Informing/Issues/19ba2flc-c03f-4ac2-8cd5-5cf2edb527cf.htm> (last visited August 27, 2008).

[FN134]. For a complete discussion of insurance market regulation and issues of benefit structure, plan administration and consumer and patient protection, *see* Rand Rosenblatt et al., *Law and the American Health Care System* (1997) Ch. 2; Rand Rosenblatt et al., *Law and the American Health Care System* (2001-2002 Supplement).

[FN135]. Medicare Prescription Drug Improvement and Modernization Act of 2003 P.L. 110-173.

[FN136]. For a succinct explanation of how the prescription drug benefit plan works *see* Kaiser Family Foundation, Medicare: A Primer, <http://www.kff.org/medicare/upload/7615.pdf>, 7-9 (last visited August 27, 2008).

[FN137]. For a fuller explanation of the Connector, *see* John E. McDonough, et al., *Massachusetts Health Reform Implementation: Major Progress And Future Challenges*, 27 HEALTH AFFAIRS w285 (2008); Cathy Schoen et al., *Building Blocks For Reform: Achieving Universal Coverage With Private And Public Group Health Insurance*, 27 HEALTH AFFAIRS 646 (2008).

[FN138]. Alan Well, *There's Something About Medicaid*, 22 HEALTH AFFAIRS 13 (2003).

[FN139]. *Id.*

[FN140]. *See* text accompanying notes 61-65 *supra* (discussing Medicaid's special design features).

[FN141]. Obama Plan for a Healthy America, *supra* note 133.

[FN142]. *See* Rosenbaum & Wise, *supra* note 26.

[FN143]. *See* Rosenbaum, *supra* note 17, at w608-609.

[FN144]. *Id.*

15 Geo. J. on Poverty L. & Pol'y 703

END OF DOCUMENT