Perspectives on Health Reform

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Expanding SCHIP: A Downpayment on Health Reform

By Sherry Glied, Ph.D.

While the process of reforming the nation's health care system will likely be a long and difficult one, we can soon make an important downpayment on reform. In reauthorizing the State Children's Health Insurance Program (SCHIP), Congress could encourage states to ensure universal coverage for children—a change that could serve as the foundation for more comprehensive health system reforms later on.

The Obama administration is committed to changing the nation's health care system, but much needs to be done and there are many plausible directions forward. Progress on meaningful health care reform, therefore, is likely to come slowly. By exploiting opportunities to take early and rapid action, the new president, together with the new Congress, can help build a foundation for reforms that may take longer to accomplish. An excellent such opportunity is the upcoming reauthorization of the State Children's Health Insurance Program (SCHIP), legislation that could be modified to incentivize the states to make coverage for children universal.

Enhancing the Program

The SCHIP program, which provides insurance coverage to about 4.4 million American children—typically in families with incomes below 200 percent of the federal poverty level (FPL)—is set to expire on March 31, 2009.[1] Legislative efforts in the 110th Congress to extend the program to families with incomes up to 300 percent FPL[2] were vetoed by President Bush, and Congress was unable to override the veto. But the 111th Congress is now eager to pass this legislation, which would enable states to expand coverage to more children, and Barack Obama has indicated that he would be pleased to sign such a bill.

SCHIP reauthorization could do much more, however, than is currently under consideration. Instead of simply expanding SCHIP, Congress could offer states the option of receiving an enhanced, countercyclical payment—one that

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promises them an infusion of money in bad budgetary times—if they developed and implemented plans to secure the *universal* coverage of children.

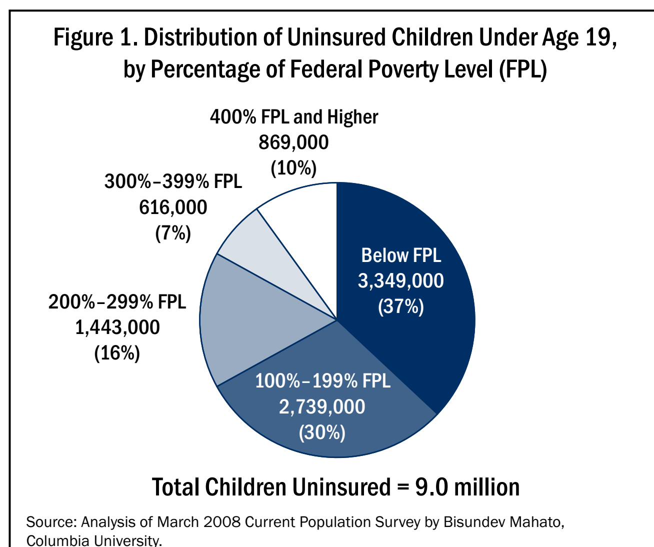
Under such legislation, the federal government would require that state plans include insurance purchasing arrangements—exchanges, connectors, or public program options—whereby all children, those in Medicaid and SCHIP and all others, could obtain coverage. The plans would need to include mechanisms for effective enforcement of a mandate, on parents or systems, for automatic enrollment and notification of all children. For example, states could document that they routinely collect data on coverage from public payers, insurance carriers, and employers.

Moreover, the plans would be required to incorporate reporting on population health outcomes and provider processes. In that way, governments could move toward purchasing outcomes—as opposed to merely paying for the delivery of services. Upon approval of their plans by the Centers for Medicare and Medicaid Services, states would begin to receive enhanced payments, conditional on meeting predefined periodic enrollment targets.

Covering All Children . . .

An effort to encourage states to move toward universal coverage of children would meet three important public policy goals. First, "going universal" would provide coverage to millions of children who would otherwise remain uninsured (Figure 1).

Figure 1. Distribution of Uninsured Children Under Age 19, by Percentage of Federal Poverty Level (FPL)



Source: Analysis of March 2008 Current Population Survey by Bisundev Mahato, Columbia University.

In its current form, the SCHIP reauthorization would provide a substantial state-specific federal match for state dollars used to cover children with family incomes up to 300 percent FPL. Currently, 23 states set their income eligibility levels for Medicaid and SCHIP at 200 percent FPL, while seven states have lower income limits and 21 states (including the District of Columbia) have higher income limits (Figure 2). All told, about 1.1 million uninsured children have incomes between their state's current SCHIP eligibility level and this new level, and estimates based on prior experience suggest that about two-thirds of this group would enroll in SCHIP under a program expansion.[3]

This enrollment would leave about 8.4 million, out of the 9.0 million children uninsured today, without coverage. Of the group remaining uninsured, 6.5 million would have been eligible for public coverage (Medicaid or SCHIP) before the expansion, 0.4 million would be newly eligible for public coverage under the expansion but not expected to take it up, and a final 1.5 million would be in families with incomes above 300 percent FPL. But the requirement to "go universal" would lead states to develop new administrative and marketing strategies aimed at enrolling all public program–eligible children who are not covered. It would lead higher-income parents to prioritize coverage for their children, to take up employer-sponsored insurance where it is available, or to seek coverage through new purchasing mechanisms where it is not.

Health insurance makes a real difference for children. Research shows that continuous insurance coverage, such as that provided through the SCHIP expansions, reduces hospital admissions and improves health outcomes.[4] Universal coverage of children would be an essential step in investing in the health and well-being of future generations.

. . . With Minimal Disruption

Second, going universal would demonstrate that meaningful health care reform could be accomplished without upending the existing system. Mandating coverage for children was one of the elements of Mr. Obama's campaign platform, and it is a goal that is achievable.

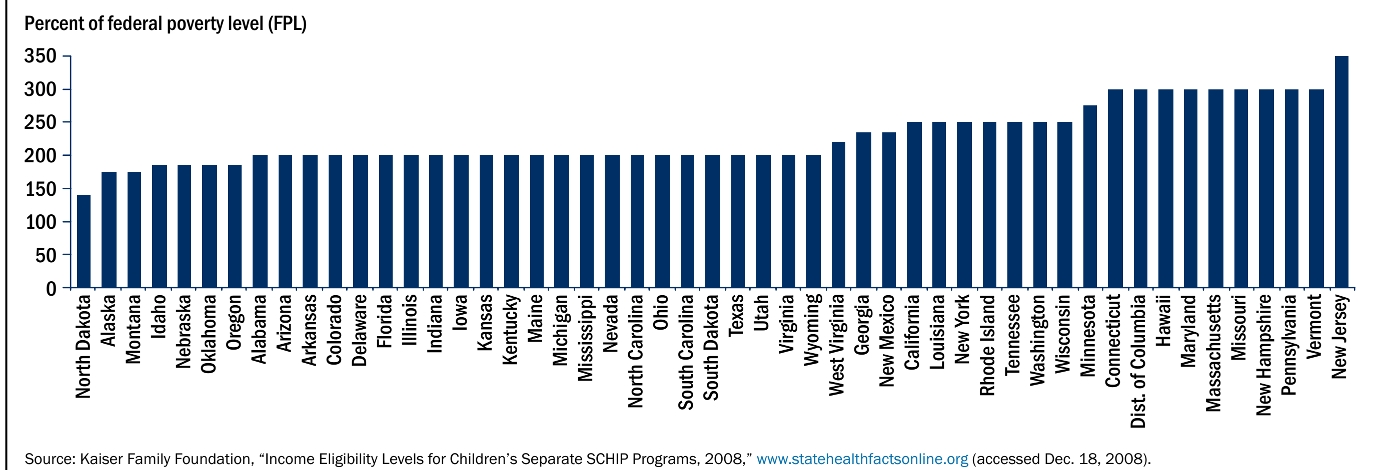


Figure 2. States' Medicaid/SCHIP Income Eligibility Levels for Children

Source: Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs, 2008," www.statehealthfactsonline.org (accessed Dec. 18, 2008).

Indeed, spurred by the prior success of the SCHIP program and the accomplishment of universal coverage in Massachusetts, many states have already drawn up plans to expand coverage for children and even to move to universal coverage. The souring economy has led them to put these plans on hold, but there is a sizeable group of states—Maine, Minnesota, New York, Oregon, Pennsylvania, Vermont, Washington, and others—whose programs are nearly ready to go. With a quick federal start, it is not unrealistic to imagine that as many as 10 states could boast of universal (or near-universal) coverage of children within two to three years.

Efforts to expand coverage more broadly would benefit tremendously from such early initiatives. Indeed, gradually expanding coverage from a limited regional base has been the mechanism for moving to universal coverage in other nations (notably Canada).

Acting Locally

Third, going universal in the states would enable the development and refinement of the new institutional infrastructure essential to expanding health coverage. While discussions of health care reform tend to center on the federal government, existing federal entities are not always well placed to create the institutions required for multipayer insurance expansions such as insurance exchanges, enrollment facilitation organizations, and mandate enforcement mechanisms.

The federal government has historically had a limited role in overseeing private insurance plans—insurance regulation is largely under state authority. While the U.S. Office of Personnel Management does oversee the Federal Employees Health Benefits Program, it is not poised to operate a large insurance exchange for individuals who have no employment connection to the federal government. Similarly, federal experience in enrolling people in health insurance programs is drawn mainly from Medicare, whose beneficiaries gain eligibility through aging into Social Security or through disability determinations. States, by contrast, have had many years of experience in finding beneficiaries and enrolling them into Medicaid and SCHIP, with eligibility increasingly based on income.

Finally, while the federal government has had little experience with the enforcement of insurance or health-related mandates, state insurance departments already administer automobile insurance mandates and local school districts and health departments administer immunization mandates.

Any program of universal coverage with multiple payers and modes of entry would need to be designed around local conditions, which states, at least in the short run, are better positioned to reflect. Over time, states might continue to run separate programs; alternatively, state-based programs could be integrated into a national structure. In either case, states could serve as "laboratories of democracy"—natural locations

for experimenting with the best institutional designs for insurance exchanges and mandates.

A Base for More Comprehensive Reforms

Building the institutions of universal mixed-payer coverage around state-based child health expansions has other advantages as well. Because most children are healthy and those who are not are already disproportionately enrolled in public insurance programs, the direct federal cost of universal coverage for children would be relatively modest. Meanwhile, the federal government could continue to play a critical role by providing regulatory oversight, ensuring that states adhered to their universal coverage plans.

Building an expansion around children also has delivery system advantages. Children mainly use a dedicated network of child health providers; in 2000, 80 percent of primary health care visits for young children were to pediatricians.[5] Few regions are currently experiencing shortages of pediatricians, so the capacity to effect coverage expansions to this population is already in place, making it easier to develop and implement appropriate delivery system reforms.

Political opposition to SCHIP expansions certainly exists: opponents are mainly concerned that such expansions will shift the balance of the system toward public coverage. But the likelihood that most states would move to universal coverage by combining SCHIP expansions with a private insurance mandate might ease this concern, as such a structure would provide a boost to both the public and private insurance markets.

Because Congress hopes to take up the SCHIP bill early in 2009, this legislation offers an opportunity to act quickly, jumpstarting the critical movement toward transformation of the U.S. health care system. Including provisions in this bill that prompt states to go universal for kids would enable the building of new institutional infrastructure. This would complement, rather than crowd out, later and more comprehensive reforms.

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Notes

[1] Kaiser Commission on Medicaid and the Uninsured, "State Children's Health insurance Program (SCHIP): Reauthorization History," Nov. 2008; available at www.kff.org/medicaid/upload/7743.pdf; and Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes as a Percent of Federal Poverty Level, 2008," *State Health Facts,* Jan. 2008, available at www.statehealthfacts.org.

[2] Kaiser Commission on Medicaid and the Uninsured, "Children's Health Insurance Program Reauthorization Act of 2007: The Revised Bill Compared to the Original Bill," Nov. 2007, available at http://www.kff.org/medicaid/upload/7714.pdf.

[3] L. Dubay, J. Guyer, C. Mann et al., "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward," *Health Affairs,* Mar./Apr. 2007 26(2):370–81.

[4] A. Aizer, "Public Health Insurance, Program Take-Up, and Child Health," *Review of Economics and Statistics,* 2007 89(3):400–15; D. Bermudez and L. Baker, "The Relationship Between SCHIP Enrollment and Hospitalizations for Ambulatory Care Sensitive Conditions in California," *Journal of Health Care for the Poor and Underserved,* Feb. 2005 16(1):96–110; M. R. Cousineau, G. D. Stevens, and T. A. Pickering, "Preventable Hospitalizations Among Children in California Counties After Child Health Insurance Expansion Initiatives," *Medical Care,* Feb. 2008 46(2):142–47; M. H. Fox, J. Moore, R. Davis et al., "Changes in Reported Health Status and Unmet Need for Children Enrolling in the Kansas Children's Health Insurance Program," *American Journal of Public Health,* April 2003 93(4):579–82; P. C. Damiano, J. C. Willard, E. T. Momany et al., "The Impact of the Iowa S-SCHIP Program on Access, Health Status, and the Family Environment," *Ambulatory Pediatrics,* Sept./Oct. 2003 3(5):263–69; and A. B. Bindman, A. Chattopadhyay, and G. M. Auerback, "Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions," *Annals of Internal Medicine,* Dec. 16, 2008 149(12):854–60.

[5] S.-F. S. Tang, L. M. Olson, W. L. Cull et al., "From Infants to Teens: Pediatricians Provided Primary Care for More Children, 1991–2000" (poster), American Academy of Pediatrics (2003); available at: www.aap.org/research/PASPoster2003.pdf.

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