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The SCHIP Open: Hidden Incentives for States to Spend Federal Funds

By Robert B. Helms

In the federal budget, the State Children's Health Insurance Program (SCHIP) is relatively small compared to its big brothers, Medicare and Medicaid. In FY 2007, SCHIP outlays were expected to make up 0.2 percent of the $2.7 trillion federal budget, compared to 15.9 percent for Medicare and 7 percent for Medicaid. The popular SCHIP, passed by a Republican Congress in 1997 and signed into law by President Bill Clinton, is now scheduled to end on September 30 unless reauthorized by Congress. Both the House and the Senate have recently passed bills to do so and to expand its scope. President George W. Bush has threatened to veto either version of the legislation as too expensive and too expansive.

Washington, D.C., can be a sleepy town in August, with many key players in the policy arena somewhere else trying to avoid thinking about the upcoming political battle, which will eclipse the competitive excitement of the U.S. Open tennis tournament. The clock is running: SCHIP reauthorization must be finished before the end of September. First to serve in this political tournament will be the Democratic leadership, who must find a workable compromise between the divergent bills passed by the House and Senate.[1] The heated tiebreaker will be the attempt to override the president's promised veto.

But not everyone in Washington has left town. Both political parties, candidates for president, and numerous advocacy groups are warming up their serves and volleys in anticipation of the September showdown. The proponents of the House and Senate bills are talking up the benefits of health coverage for more children and the dire consequences of ending a program now covering approximately 7 million children. The bills' opponents are talking about the $35–50 billion in new costs and the increased taxes and cuts in other health programs proposed to pay for the program. Everyone claims to be in favor of more health insurance coverage for children, but there is intense disagreement about how to expand coverage, who should be eligible for the coverage, and how to pay for it.

In the midst of all this preparation, there is one issue that is receiving almost no attention: the effect this legislation will have on the unfunded liabilities of the federal government in future years. These unfunded liabilities—mostly driven by expected shortfalls in funding for Medicare, Medicaid, and Social Security, in that order—are receiving increasing attention from government reports,[2] academic studies,[3] and, even occasionally, from presidential candidates.[4]

The SCHIP Funding Formula

The SCHIP legislation passed in 1997 was essentially a block grant to the states. It specified a limited life span for the program (ten years) and a limited amount of federal funding ($39 billion).[5] Each state received a fixed allocation of this money based on the number of poor children in

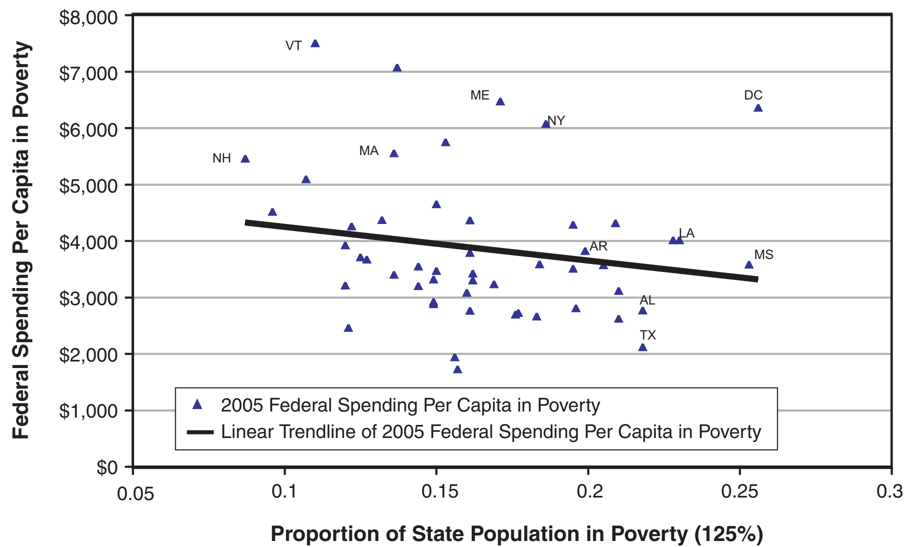
Robert B. Helms (rhelms@aei.org) is a resident scholar at AEI.

the state, the proportion of these who were uninsured, and the relative cost of health care in each state. Allocations to the states in 2007 varied from $5.8 million for Vermont to $791 million for California.[6]

In keeping with Medicaid's federalist approach, each state had to spend some state money in order to qualify for the federal matching funds. The net cost of the program for the state was determined by the per-capita income formula used in the Medicaid program, a formula designed to give poorer states higher federal matching rates than wealthier ones. In Medicaid, these matching rates vary from 50 percent (no state, regardless of how wealthy it is, gets less) to 76 percent in Mississippi, the poorest state. SCHIP gives each state an "enhanced" matching rate that adds on to the percentage paid under Medicaid, so the SCHIP matching rates vary from 65 percent in the wealthiest states to 83 percent in Mississippi.[7]

FIGURE 1

FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY, 2005



SOURCE: Calculations based on Centers for Medicare and Medicaid Services (CMS) Medicaid and Census Bureau data, 2005. CMS data obtained from CMS-64, "Financial Management Report for FY 2005," available at www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp (accessed August 22, 2007). For more detail on calculations, see Robert B. Helms, "The Medicaid Commission Report: A Dissent," *Health Policy Outlook* no. 2 (January 2007), available at www.aei.org/publication25434/.

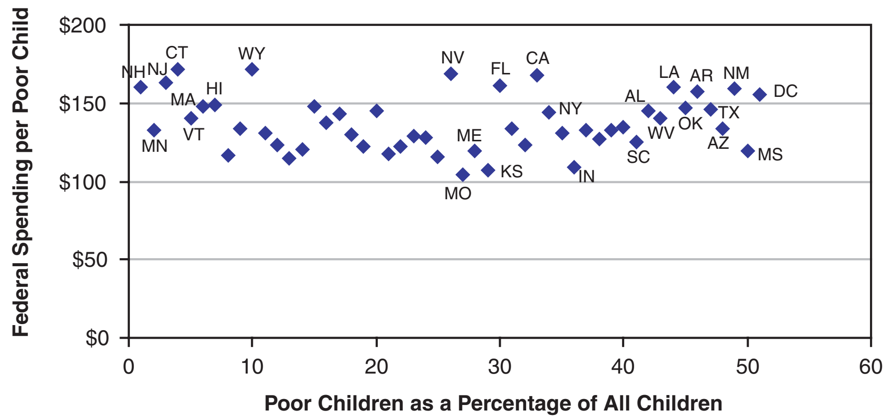
Under existing law, however, there is a big difference in how federal dollars are reimbursed to the states in Medicaid and SCHIP—a difference that is about to change if either of the proposed bills becomes law. Medicaid is an open-ended entitlement, which means that as long as a state is willing to spend more state funds to pay for qualified benefits for eligible recipients, the federal government is obliged to match the state's expenditures at the state's matching rate. While the per-capita formula was originally intended to send more funds to the poorer states, it has not worked out that way. In FY 2005, nine states got half the federal Medicaid funds, with three of these states being wealthy enough to receive the minimum matching rate. As illustrated in figure 1, the higher the poverty rate in a state, the fewer federal funds that state receives per capita. The "Katrina states"—Louisiana, Mississippi, Alabama, and Texas—have higher poverty rates but lower federal payments, while a group of mostly northeastern states with lower poverty rates gets approximately twice the amount of federal funds per person in poverty.

A similar figure can be drawn to show the allocation of federal SCHIP payments to the states on a per capita basis (see figure 2). Since the target population for the program is poor children, the federal allotments in FY 2005 to the states and the District of Columbia were divided by the number of children in each state who were from families at or below 200 percent of the federal poverty level (FPL), shown on the vertical axis. The per-capita federal SCHIP payments range from a low of $104 per poor child in Missouri to a high of $172 per poor child in Connecticut and Wyoming, with an average of $137. On the horizontal axis, the states are arrayed by the percentage of the state's total number of children who were at or below 200 percent of the FPL. The District of Columbia has the highest proportion of all children in poverty (56 percent), while New Hampshire has the lowest (2 percent).

The pattern of federal SCHIP payments in figure 2 does not show the negative relationship shown for Medicaid payments in figure 1. That there is some dispersion among the states at all levels of childhood poverty reflects the federalist approach of both Medicaid and SCHIP in allowing states flexibility in how much they spend on their programs. In addition, it also reflects

FIGURE 2

FEDERAL SCHIP ALLOTMENTS PER CHILD IN POVERTY VERSUS PERCENT OF STATE'S CHILDREN IN POVERTY, 2005



SOURCE: Calculations based on SCHIP data from CMS and population data from U.S. Census Bureau, "2006 Annual Social and Economic Supplement," *Current Population Survey*, August 2006.
NOTE: "Poor children" are those living below 200 percent of the FPL.

differences in the number of uninsured in each state and differences in the cost of health care. SCHIP does not show the strong regional differences that we see in Medicaid (figure 1). This is primarily due to the fixed federal funding established in SCHIP, which takes away the incentive for states to keep expanding their programs using federal dollars. Under Medicaid, any state with the taxing authority or political desire to expand can keep drawing down federal matching funds as long as it is willing to devote more state funds to its program. The upper cap on SCHIP federal funding, however, prevents the wealthier states from expanding their programs relative to poorer states, as they have done under Medicaid.

Under SCHIP today, the federal matching rates are a multiple of the Medicaid matching rates, so the range extends from 65 percent in the wealthiest states to a high of 83 percent in Mississippi. The federal government is not obliged to send additional matching funds to a state once that state has exhausted its fixed allocation. Since some states do not spend their full allocation, other states can use these funds to expand their programs, but the total amount of the federal obligation was fixed by the initial legislation.

This situation will change under either the Senate or House bill. Three major provisions of the proposed bills combine to change SCHIP into another open-ended entitlement like Medicare and Medicaid:

Expanded Eligibility. The original SCHIP legislation restricted eligibility to children in families that were at 200 percent of the FPL or below. Later changes in the program allowed states to increase the income standard so that today twenty-three states cover children in families with incomes above 200 percent of the FPL. These expansions range from 235 percent in Georgia and New Mexico to 350 percent in New Jersey. Eight states have extended their coverage to 300 percent of the FPL.[8] The Senate bill expands eligibility to children in families up to 300 percent of the FPL. The House bill has no upper limit on income eligibility, leaving it up to the states to expand it to the level they desire. The Congressional Budget Office (CBO) estimates that average monthly enrollment of children in 2012 would increase by 6.2 million under the Senate bill and by 7.3 million under the House bill.[9] The CBO also estimates that the net "budget effects" (estimated expenditures minus estimated revenues) over the next ten years will be $71 billion for the Senate bill and $129 billion for the House bill.[10]

Enhanced State Matching Rates. Both bills maintain the current policy of providing larger federal matching rates to each state than are currently provided under Medicaid. This can be expected to have two effects: First, there will be an incentive for states to transfer eligible children out of the Medicaid program and into SCHIP. The CBO estimates that either the Senate or House bill would have the effect of transferring 600,000 children from Medicaid to SCHIP as states seek to substitute federal for state outlays. Second, the enhanced federal matching rates will give states a stronger incentive to expand coverage to higher-income children and other newly eligible categories, a desirable result from the point of view of those who support expanded government entitlements.

No Upper Limit on Federal Funding. Unlike today's SCHIP, the proposed bills have no ending date for the program and no upper limit on federal government obligations. Like Medicare and Medicaid, the federal government will be obliged to pay the matching rate for any authorized SCHIP expenditures made by the various

states. The states can be expected to respond as they have under Medicaid: those states that can afford larger programs can be expected to expand their programs relatively more than the poorer states.[11] This has the effect of exacerbating the distribution of federal funds away from the states with the most poor children and increasing the amount of unfunded liabilities faced by the federal government in coming years.

SCHIPping Away at Limited Government

The history of health policy in the United States has seen an almost century-long political battle between those who wish to establish an open-ended entitlement to health care for the entire population funded through federal taxation and those who support a more limited role for government.[12] So far, the entitlement approach has been adopted for Medicare and Medicaid. Federal tax policy provides a generous tax subsidy for employer-sponsored health insurance, which causes many people with private insurance to view their coverage as an open-ended entitlement.[13] Health policy has taken a different tack over the last decade with the passage of SCHIP in 1997 and the Medicare Modernization Act in 2003. The former authorized a fixed amount of federal funding, while the latter established a system of competitive market competition to provide a drug benefit for Medicare.

The current political dispute over the future of SCHIP again presents Congress with the classic choice between an open-ended federal entitlement and a more limited approach. The debate is more about the extent of this coverage, how it is to be paid for, and how the states should run the program than it is about health coverage for children. Everyone claims to be in favor of health insurance coverage for children—even President Bush. What is receiving almost no attention in this debate is the effect expanding SCHIP will have on the behavior of states. The history of Medicaid reveals that the combination of open-ended federal entitlements and generous federal matching rates creates strong incentives for all states to expand eligibility and covered benefits. It also tells us that this incentive is stronger in wealthier states than it is in poorer states. The results are rapid growth in total federal outlays and an increasing flow of federal funds away from states with greater poverty toward states with less poverty.

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Changing SCHIP from a system of fixed federal funding to a new open-ended entitlement can be expected to intensify both of these trends. If Congress intends to tax poor states so that wealthier states can provide more benefits to more of their populations, then that policy should be stated and discussed explicitly. SCHIP may be a relatively small program today, but it has the potential to increase substantially the unfunded federal liabilities that the United States now faces with Medicare, Medicaid, and Social Security.

AEI research assistant Tal Manor and editorial assistant Evan Sparks worked with Mr. Helms to edit and produce this Health Policy Outlook.

Notes

1. *Children's Health Insurance Program Reauthorization Act of 2007*, S 1893, 110th Cong., 1st sess., available at http://thomas.loc.gov/cgi-bin/query/z?c110:s.1893: (accessed August 22, 2007); and *Children's Health and Medicare Protection Act of 2007*, HR 3162, 110th Cong., 1st sess., available at http://thomas.loc.gov/cgi-bin/query/z?c110:H.R.3162: (accessed August 22, 2007).

2. Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs*, April 2007, available at www.ssa.gov/OACT/TRSUM/trsummary.html (accessed August 23, 2007); and U.S. Government Accountability Office, GAO *Strategic Plan 2007–2012* (Washington, DC: GAO, 2007), available at www.gao.gov/sp/d071sp.pdf (accessed August 23, 2007).

3. Andrew J. Rettenmaier and Thomas R. Saving, *The Diagnosis and Treatment of Medicare* (Washington, DC: AEI Press, 2007) available through www.aei.org/book879/; Joseph Antos and Jagadeesh Gokhale, "Medicare Prescription Drugs: Medical Necessity Meets Fiscal Insanity," *Cato Institute Briefing Paper*, no. 91 (February 2005), available at www.cato.org/pubs/briefs/bp91.pdf (accessed August 23, 2007); and Jagadeesh Gokhale, "Medicaid's Soaring Costs: Time to Step on the Brakes," *Cato Institute Policy Analysis*, no. 597 (July 19, 2007).

4. David S. Broder, "Fred Thompson's Gamble," *Washington Post*, August 16, 2007.

5. Jeanne M. Lambrew, "The State Children's Health Insurance Program: Past, Present, and Future," *Fund Report* 49 (February 9, 2007), available at www.commonwealthfund.org/publications/publications_show.htm?doc_id=449518 (accessed August 23, 2007). Congress added $283 million in the Deficit Reduction Act of 2005 to fill in state shortfalls.

6. Georgetown University Health Policy Institute, Center for Children and Families, "Original SCHIP Allotment by State, 1998–2007," October 18, 2006. Compiled from *Federal Register* notices.

7. U.S. Department of Health and Human Services, Office of the Secretary, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2006 through September 30, 2007," *Federal Register* 70, no. 229 (November 2005): 71856–57.

8. Heritage Foundation, "States with SCHIP Eligibility above 200 Percent of Federal Poverty Level," chart 2, available at www.heritage.org/research/healthcare/images/B2029_chart2-lg.gif (accessed August 22, 2007).

9. The CBO also estimates that 2.1 million and 2.4 million of these increases, respectively, would be crowdout—that is, children who were previously covered by private health insurance. See CBO, "Preliminary CBO Estimate of Changes in SCHIP," July 13, 2007; and CBO, "Preliminary CBO Estimate of Titles I through VI of the Chairman's Mark for the CHIP Reauthorization Act of 2007," July 13, 2007.

10. CBO, "Preliminary CBO Estimate of Changes in SCHIP," July 13, 2007; and CBO, "Preliminary CBO Estimate of Titles I through VI of the Chairman's Mark for the CHIP Reauthorization Act of 2007," July 13, 2007.

11. The incentives work in two ways: there is an incentive for wealthier states to expand their programs when they have the funds and a disincentive for poorer states to cut their programs when in financial trouble. See Robert B. Helms, "The Medicaid Commission Report: A Dissent," *Health Policy Outlook* no. 2 (January 2007), available at www.aei.org/publication25434/.

12. Robert B. Helms, "Health Reform in the US: What Will Shape the Future Debate?" *PharmacoEconomics* 24, supp. 2 (December 2006): 5–14.

13. Robert B. Helms, "The Tax Treatment of Health Insurance," in *Empowering Health Care Consumers through Tax Reform*, ed. Grace-Marie Arnett (Ann Arbor, MI: University of Michigan Press, 1999), 1–25.