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# The New Child Health Insurance Program: A Carefully Crafted Compromise

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**Alan Weil**
**The Urban Institute**

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**Alan Weil**

**The Urban Institute**
**2100 M Street, NW**
**Washington, D.C. 20037**

**The New Child Health Insurance Program:**
**A Carefully Crafted Compromise**

The new State Children's Health Insurance Program (S-CHIP) represents a compromise crafted and enacted in record time for a program of its size. The compromise came together due to three events. First, liberals and conservatives were in agreement that comprehensive health proposals were not politically viable, but also agreed that inaction in the health arena was not acceptable, thereby opening the door to incremental coverage expansions. Second, in the aftermath of a national debate over welfare reform, attention was focused on the group that would bear many of the consequences of policy changes but could not be considered at fault for their circumstances: children. And finally, a last minute revision to budget projections created an opening for new spending in the context of the balanced budget act.

This paper explores the major policy compromises embodied in the S-CHIP program that made it acceptable, even if not ideal, to people from a range of political and institutional perspectives. It focuses on two areas: the relative control of the federal and state governments over the program, and the design of the program in relation to the private, employer-based health insurance market. This paper argues that rapid enactment of S-CHIP was possible because it reflects a workable approach to federalism. That is, the federal government set sufficient parameters and controls on the program to assure accountability, while the states received a combination of incentives and flexibility to allow program design to meet local needs. This balance made S-CHIP acceptable to Congress and the President, leading to its enactment, and it made the program of sufficient value to the states that they have embraced it and taken significant steps to implement it.

The full design of the S-CHIP program is described in more detail elsewhere.[1] In general, the program makes available to states matching funds for the purpose of expanding health insurance coverage to children in families with income below 200 percent of the federal poverty line. States electing to participate in the program may expand eligibility under their Medicaid programs, expand or create a separate program for children, or combine these two approaches. States that expand Medicaid must operate their S-CHIP programs under the same rules as apply to Medicaid in general. States that operate separate programs have greater flexibility, but still must operate under federal rules that require a reasonably comprehensive benefit package and place limits on family premium and copayment requirements.

[1] See, for example, S. Rosenbaum, et al., "The Children's Hour: The State Children's Health Insurance Program," *Health Affairs* (Jan/Feb 1998): 75-89; C. Mann and J. Guyer, *Overview of the New Child Health Block Grant* (Washington: Center on Budget and Policy Priorities, August 1997).

## Federal/State Relations

Two features characterize the relationship between the federal government and the states in the new S-CHIP program. First, the program is a closed-ended matching program. Second, many controversial program design issues are left to the states.

### *The Need to Change State Incentives*

When thinking about the structure of S-CHIP, it is important to keep in mind that all children eligible for the new program could have been covered by states under Medicaid. That is, through a combination of expanding eligibility through existing federal options or Section 1902(r)(2) provisions, every state could have (and some states did) expanded coverage under Medicaid to all or some children in families with incomes up to or above 200% of the federal poverty level, even if S-CHIP had never been enacted.

In order for S-CHIP to be successful in providing health insurance to currently uninsured children it must present states with a more favorable decision-making calculus than already exists in the Medicaid program. Three features of S-CHIP do this. First, the match rate in S-CHIP is higher than it is in Medicaid. Each state contributes 30% less to earn a matching dollar in S-CHIP than it does in Medicaid, thereby increasing the financial incentive for states to participate. Thus, with the new S-CHIP program in place, states are more likely to choose to expand insurance coverage of low-income children than they were prior to adoption of the program.

Second, the federal government is offering states a greater degree of flexibility in program design under S-CHIP than states have under Medicaid. The ability to design the program to meet the state's preferences makes the program more attractive, creating the possibility that states will be more willing to expand their levels of coverage for children under S-CHIP than they would have been willing to under Medicaid.

Third, the federal government has created political pressure for states to cover more children. A new, highly visible and politically popular program at the federal level creates attention at the local level. Politicians at the state level who decline to participate in the program can be accused of leaving behind a generous offer of federal money for an important purpose. While the power of this critique varies according to the political views of the audience, it is a criticism most politicians would presumably rather avoid.

### *Capped, Matching Financing*

An essential component of the S-CHIP program is its capped, matching financing structure. That is, funds are only available to states that spend some of their own funds, while the total amount of federal funds available to each state is capped. This structure creates incentives for state participation but limits federal budget exposure.

This financing structure is a compromise between two alternatives that are familiar in the health arena. One alternative is the open-ended matching design of Medicaid. In Medicaid, increased state spending, whether through expanded eligibility, higher payment rates, or more covered services, allows states to draw down additional federal matching payments and leads automatically to higher federal spending. The other alternative is the block grant structure, as proposed in the Medigrant legislation that passed Congress but was vetoed by President Clinton in 1996. In a block grant, federal payments are fixed without regard to state-level expenditures, although some maintenance of prior state effort may be required in order to receive the grant.

The matching structure provides two advantages. First, matching funds create an incentive for states to participate in the program at a higher level than they would have if they were required to pay for the program solely with state dollars. In economic terms, the "price" of the program to the state is reduced, so demand (i.e., state willingness to participate) increases. Since the match rate is more favorable than in Medicaid, for fiscal reasons alone one can expect that states will be more interested in expansions under S-CHIP than they would be under Medicaid.

Second, the matching program design allows the federal government to leverage its expenditures with state dollars. That is, the program costs the federal government less than it would if the federal government were to fully fund the program. For example, if every state participates in S-CHIP to the maximum extent permitted, the $4.2 billion federal appropriation for 1998 will yield total spending on children's health of just over $6 billion.[2]

The matching structure is particularly important in this program because of its relationship to Medicaid. If the program were funded entirely by the federal government, there would be a tremendous financial incentive for states to find ways to move their Medicaid enrollees into the new program. If the match rate for S-CHIP were less favorable than for Medicaid, states would have little reason to participate in the new program. As designed, the S-CHIP match rate is somewhat higher than in Medicaid, creating an incentive to shift costs into that program, but with limitations since the federal S-CHIP allocation for each state is capped.

Just as important in the compromise as the matching design is that the federal budgetary exposure is capped. The statute that created the program sets forth funding levels for the first ten years, and specific amounts are authorized for the first five years. This stands in contrast to a program like Medicaid where a combination of state policy choices and external factors such as medical inflation or economic downturn can lead to unpredictable federal program costs. Funding caps are possible in S-CHIP because the program entitles states to funds, but does not entitle individuals to services. By capping the allocations to states, the federal government has set an upper bound on its potential costs.

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[2] F. Ullman, B. Bruen, and J. Holahan, *The State Children's Health Insurance Program: A Look at the Numbers* (Washington: The Urban Institute, March 1998).

The federal funding cap is important in the current budgetary environment. While a new program can be authorized on the basis of projected costs, politically it was important to define this program in a way that made it clear costs would be fully predictable.

Advocates for expanding Medicaid or replacing Medicaid with a block grant each have their arguments for why open-ended matching programs or block grants are the better program design. Yet, these positions each have their strong detractors. In the context of a rapidly-developed compromise, the capped, matching program emerged as a reasonable vehicle for meeting the objectives of people with diverging views.

***State-Directed Program Design***

One of the most striking features of the S-CHIP compromise is the degree to which important program design decisions are left to the states. S-CHIP reflects an interesting political balance that strives to give federal policy-makers confidence that program dollars will go to provide needed health insurance to low-income children while state policy-makers have room to design a program that meets local needs.

A good deal of attention has been paid to the fact that, under S-CHIP, states have the choice of expanding Medicaid eligibility or creating or expanding a separate program.[3] This important decision embodies a number of other choices: whether the program should provide an entitlement of services to individuals, whether it should provide an extremely comprehensive benefit packages, and whether potential enrollees should be charged premiums.

The relative merits of each of these choices have been explored elsewhere and need not be repeated here. What is relevant from the perspective of this paper is that there are strongly held views on both sides of each of these issues. Rather than battle over each of these provisions and risk failure of the entire proposal, Congress and the President chose to leave these and other decisions to the states.

The compromise on the individual entitlement is of particular interest, since whether or not a program is an entitlement does not permit shades of grey – it either is or is not. If states were denied the opportunity to construct their S-CHIP programs with enrollment and budget caps – in other words not as entitlements – they would not be able to create programs with a clearly defined budget. This would leave states in the position of bearing all of the financial risk for increased enrollment or costs, since federal outlays are capped. This is not a program design that states would have accepted.

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[3] See, for example, A. Weil, *The New Children's Health Insurance Program: Should States Expand Medicaid?,"* (Washington: The Urban Institute, October 1997); C. Mann, *Why Not Medicaid? Using Child Health Funds to Expand Coverage Through the Medicaid Program* (Washington: Center on Budget and Policy Priorities, November 1997); U.S. House Committee on Commerce, *State Children's Health Insurance Program (S-CHIP) Implementation Guide* (Washington: November 1997).

At the same time, if states could not structure their programs as entitlements, the option to implement S-CHIP by expanding Medicaid would have no meaning. If this option were not available, states would have been forced to design programs for S-CHIP that are separate from Medicaid and bear the costs of inefficiency and potentially poor coordination such a program design entails. Yet, states that choose this option must keep in mind that, under S-CHIP, the federal government is not willing to share the budgetary risk inherent in entitlement programs, as the federal outlays are capped.

The course of S-CHIP implementation shows that most states have preferred an approach that relies primarily upon expanding Medicaid. This is presumably not what some share of the program's advocates would have predicted. It suggests in part that flexibility in program design is of less importance, at least in some states, than financial incentives. It also suggests that, despite frequent criticisms of the Medicaid program, when put to the test it appears to be a more desirable route for expanding insurance coverage than constructing something new. The implication is that, had the Medicaid expansion route not been an option in S-CHIP, many fewer states might have participated.

The compromise in program design areas other than the entitlement is more traditional. In general, the federal government set standards that the states must follow to assure that certain federal goals were met, but states are left with some flexibility beyond those standards. For example, states may establish the benefit package, but the minimum standard is of a rather comprehensive package of services. States may charge enrollees premiums and may require copayments for services, but the size of these payments is restricted by the federal law.

Another portion of the S-CHIP compromise that is easy to overlook is that actual program operation is left entirely to the states, with limited oversight by the federal government. This may seem an obvious provision of the law, but it is worth noting that just a few years ago there was significant debate over whether the federal or state governments should actually administer programs that provide health insurance. For example, during debates over comprehensive health care reform in 1993, options included Medicare for all and a federally-administered single payer system. In S-CHIP, the federal government retains a significant oversight role, while program design and administration occurs at the state level.

The federal government's decision to leave important design decisions to the states could have simply created paralysis at the state level. That is, states could have found the difficult choices surrounding entitlements and cost-sharing so contentious that they could not coalesce around a single plan to submit to the federal government. Yet, despite the protracted debates in some states over how to design the CHIP program, compromise emerged in every state where the debate was over design (as opposed to over whether or not to participate in the program at all). This is an interesting lesson for federalism. At least in this instance, when provided with a strong financial incentive, even difficult ideological and practical disputes at the state level could be overcome when the federal government provided the proper combination of guidance and flexibility.

**Relation to Employer-Sponsored Coverage**

One of the great challenges in designing a health insurance program for low-income people is how such a program should relate to the voluntary, employer-based system that covers most Americans. For, while 14.3% of children with incomes below 200% of the federal poverty line are uninsured, an even larger portion, 34.2%, have insurance through their employer.[4] This section discusses how the S-CHIP program approached the complexity of the relationship between employer-sponsored coverage and publicly-financed coverage.

***The Risk of Substitution***

Any effort to reduce the number of Americans without health insurance that is an overlay on a voluntary, private insurance-based market will face significant administrative and design challenges. The target population for such an effort is the large group of people whose income is too high to make them eligible for public health benefits, such as Medicaid, but not high enough to afford coverage on their own. Of this group, many have employer-sponsored coverage available. The public policy challenge is to design a subsidy for this population in a way that maximizes the number of people who use the subsidy to buy new coverage while minimizing the number of private dollars, from employers and families, that are withdrawn due to the value of the subsidy.

The fragile relationship between private and public coverage creates both a policy and a political problem. The policy problem is that every dollar of the public program that replaces a private dollar already being spent is a dollar that fails to achieve the stated program objective of providing health insurance to the uninsured. To the extent that this occurs, the cost of the program to taxpayers relative to the anticipated benefit of reducing the number of people without health insurance will rise. Stated differently, the program is less efficient at achieving its objective than one would prefer. Thus, any steps that can be taken to reduce the likelihood that public dollars will merely replace private dollars should be seriously considered.

The political problem is that this inefficiency subjects the program to serious criticism, as occurred in quite strong terms at the time the S-CHIP program was enacted. There are two possible responses to this criticism. The first is that every public investment to some extent reduces similar, private investment regardless of the domain. Substitution is a phenomenon whether one is examining Social Security, policing services, or funding for higher education. Given this reality, substitution is a phenomenon to be addressed and analyzed and perhaps to be minimized, but it, alone, does not negate the possible positive value of government action.

Second, in S-CHIP, to the extent this substitution occurs, it is mostly a public subsidy to low wage workers who are spending a relatively large share of their wages buying health

[4] Rajan, S., "Publicly Subsidized Health Insurance: A Typology of State Approaches," *Health Affairs* (May/June 1998).

insurance for their families.[5] Other likely beneficiaries are employers of low wage workers who are doing what society asks of them – offering insurance to their employees – while many of their competitors let their employees go without insurance. Certainly the primary goal of S-CHIP is to cover new children, not to subsidize those already covered. Substitution may be less of a political problem when the inefficiencies in the program spill over to a relatively deserving population. Still, this sort of analysis goes only so far in responding to a legitimate point – a program designed to provide health insurance to uninsured low-income children will be judged ineffective if, after spending billions of dollars, the number of uninsured children does not substantially decline.

The extent to which substitution of private coverage for public coverage will occur is a topic of recent scholarly interest, with the few efforts to analyze the extent of this phenomenon reaching varying conclusions. In addition, how one interprets findings with respect to substitution are affected by the political views of the observer. Thus, any attempt to set a single, national eligibility standard for S-CHIP designed to keep the extent of substitution within some politically acceptable bounds would be quite difficult to accomplish.

### *The S-CHIP Approach*

The new program has three features designed to address the policy and political problems associated with substitution: state flexibility in eligibility, a federal requirement that the issue be addressed directly, and a waiver provision for innovative approaches.

State flexibility in establishing eligibility standards may help address the substitution problem. While federal law permits states to use S-CHIP funds to cover children in families with income up to 200% of the federal poverty line, states can adopt lower levels, some states that already had more expansive coverage can go higher than this level, and, it appears that all states can cover more children if they design their eligibility standards along the lines of those used under Section 1902(r)(2).

Locally-tailored eligibility standards may reduce substitution because there is good reason to believe that the nature of the interaction between private and public coverage varies across the country. Employers' willingness to offer coverage likely depends upon competitive forces in local labor markets and the cost of offering coverage, which varies tremendously around the country. Employees are more likely to participate in employer-sponsored insurance when employer contributions are higher, the alternative of relying upon the local safety-net providers is unappealing, when providers are less willing to offer reduced-cost services to the indigent, and when the individual insurance market is a less realistic alternative. While there is no clear evidence establishing the degree to which each of these factors affects employers' decisions to offer coverage, we do know that the percentage of the population covered by employer-sponsored insurance varies tremendously from state to state. This variation suggests that the degree of substitution likely to occur at different income eligibility standards is likely to vary as well.

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[5] J. Holahan, "Crowding Out: How Big a Problem?," *Health Affairs* (Jan/Feb 1997): 204-206.

Whether explicitly or not, state legislatures and governors are likely to establish maximum income eligibility standards for S-CHIP that seek to cover as many new children as possible while minimizing substitution for private coverage. In addition, there is certainly variation around the country in people's political willingness to accept this sort of program inefficiency. That is, in states with a more activist government tradition there is more likely a willingness to accept some substitution for private effort than there is in states where government tends to take a minimalist approach. Thus, state flexibility helps assure that the program is designed in a way that reflects local political willingness to accept substitution.

The effects of making these decisions local is already apparent in how states have approached the S-CHIP program. In Washington, where coverage for children was already extensive prior to enactment of the new program, the state has chosen not to participate in S-CHIP. This decision reflects the view that expanding publicly subsidized coverage to middle income families will bring in relatively few uninsured children compared to the number of already insured children who would switch from private to public coverage. Wyoming, a state with far lower levels of eligibility for children's coverage prior to the enactment of S-CHIP, has also chosen not to participate in the program. The Wyoming political culture supports a far lower level of government intervention and public policy embodies an unwillingness to expend public funds where private funds are at least potentially available to address the social need.

Fortunately for those who see S-CHIP as an opportunity to expand insurance coverage to more children, Washington and Wyoming are the exception, not the rule. However, those two examples reveal how important a role state political culture plays in how states respond to the S-CHIP program. That is, state choices reflect a combination of the political view the state has of government intervention in an area where private activity dominates, and the substantive reality of the relationship between the private, employer-based system and the public system.

The second feature of the law that makes effective handling of this issue more likely is the provision that requires states to adopt provisions in their S-CHIP plans to minimize the occurrence of substitution. This provision has two strengths. First, it acknowledges this as a real and serious issue – one worthy of addressing. Second, it recognizes that there is no single vehicle for addressing this issue. Some states are using program structures such as requiring that applicants be uninsured for a period prior to applying for coverage or requiring that families pay a portion of the premium. These options can reduce substitution, but they can also reduce enrollment of those the state hopes to bring into the program. There is also a phenomenon inherent in S-CHIP that reduces the amount of substitution without any state action being necessary at all. That is the likelihood that, if they have the choice, most people would rather obtain their health insurance coverage through their employer than receive it through a state-run, welfare-like program. This preference may be based upon a stigma associated with welfare, a desire for continuity of coverage as the family increases its earnings and loses eligibility for public coverage, or a perceived or actual sense that quality is likely lower with respect to customer service and the provider network in the public plan. The

federal compromise is to allow states to consider these issues and strike a balance that is appropriate to the goals and politics of each state.

Finally, the law also has a provision for waivers whereby states can use S-CHIP funds to purchase family coverage through an employer if such coverage is cost-effective. While it is difficult to envision how this provision will be employed, the concept behind it is sound.[6] If a state can determine a way to leverage employer-based coverage in a manner that is fiscally neutral to the federal government but that also achieves the objective of covering currently uninsured children, this approach should be encouraged. While greater reliance upon employer-sponsored coverage may desirable, those who are concerned about substitution will want to pay particular attention to how states take advantage of this provision. Presumably a state that permits S-CHIP subsidies to be paid directly to an employer will experience a higher level of substitution since barriers to participation for the currently insured will be low relative to the barriers that exist in a state where an insured person must move into a new, state-sponsored plan in order to receive an S-CHIP subsidy.

Once again, the S-CHIP statute reflects an interesting approach to a difficult set of political and policy problems. Whether intentional or not, the statue reflects the notion that there can be no single, national approach when designing an effective mesh between the private, employer-sponsored component of our health insurance market and the sizable public component. The variation in state approaches reflect a variety of views on these matters that reflects their complexity and political importance. The early lesson of S-CHIP is that states are willing and able to make these choices within the broad parameters of the federal statute.

**What S-CHIP Can Tell Us About Alternative Approaches**

The S-CHIP design is not the only one that has been considered as a vehicle for expanding health insurance coverage to new populations. A wide variety of alternative proposals have been made. Three of these alternatives are worth some exploration in light of the S-CHIP experience: tax credits, Medicaid expansions, and a range of proposals that rely entirely upon federal funding.

Proposals that seek to increase the number of people with health insurance by providing tax credits to families that purchase coverage will experience substitution of private dollars by public dollars on a scale far greater than will occur in a program such as S-CHIP. For equity reasons, tax credits must be offered on the same terms to those who currently have employer-based coverage as those who newly purchase coverage. For the millions of currently covered families, the tax credit is a pure swap of private for public dollars. Put differently, tax credits are an extremely inefficient policy vehicle when viewed as tax revenues foregone as a ratio to newly insured people.

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[6] See letter to State Health Officials from Sally K. Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, February 13, 1998, for a description of some of these issues. (http://www.hcfa.gov/init/chsub213.htm)

As noted above, substitution is both a policy and a political problem. For tax credit proposals, the policy problem is inherent and cannot be overcome. Thus, the only vehicle for making such a proposal palatable is to win the political battle. This can be done one of two ways. Politicians can deny that the tax credit is an expenditure of public funds, and instead call it "letting people keep their own money." The political dynamics of tax credits are often different from those of expenditures even though they have an identical effect on the treasury. Alternatively, the tax credit can be defended as providing families with "incentives to do the right thing" (i.e., pay for health insurance for their children). In this version, the appeal is to justice as a way to divert attention from the poor target efficiency of the program. While these phrases may resonate politically, it would be ironic if they could carry the day while a far more efficient program, such as S-CHIP, was subject to such attack for being an inefficient method of spending public funds. That is, the tax credit may achieve political victory because of the ideology it represents, but opponents have a strong argument that it is an inefficient design if the objective is to use taxpayer dollars to reduce the number of people without health insurance.

Some have proposed Medicaid expansions as an alternative to S-CHIP. There are two ways to do this: the federal government could offer a better financial match to states that expand coverage, or the federal government could require states to liberalize their Medicaid eligibility rules. Either approach assures a high level of continuing program oversight as currently exists in Medicaid. Only the second of these approaches guarantees that the program will be implemented.

The difficulty of either approach is that, as noted above, states have always been free to expand Medicaid coverage. A better match rate would entice many states, as we now know because many states have chosen exactly that approach under S-CHIP. But we also know that some states would rather design programs separate from Medicaid and it is likely that a Medicaid-only option would be less of an enticement to states than the S-CHIP design. Of course, a federal mandate overcomes this problem because it requires states to participate. However, the strong objections of governors to such a proposal would almost certainly prevent its being enacted in the current political climate.

Finally, some proposals rely entirely upon federal funding. This is particularly the case for tax-based subsidies, since they rely upon the IRS for administration. This approach has some clear advantages: national uniformity and simplicity of administration through a vehicle that is designed to transfer money. However, the experience of the S-CHIP compromise suggests that such a design has two major flaws. First, a program that relies exclusively upon federal funds by definition fails to take advantage of the willingness and ability of states to expend their own funds to address this social problem. As a result, such a program is likely to either meet less of the need than a jointly federal/state program would, because it will have fewer resources, or it will face greater opposition in a fiscally constrained Congress. Second, such programs fail to acknowledge the critical relationship between any subsidy program for low-income children and the quite variant eligibility levels set by states in the Medicaid program. As a result, a single eligibility standard will be overlaid on variant standards with unpredictable and sometimes awkward results for the eligible families.

## Conclusion

As the largest expansion of health insurance coverage since the enactment of Medicaid in 1965, the new S-CHIP program represents a considerable achievement for those interested in incremental progress towards reducing the number of Americans without health insurance. The enactment of the program is even more remarkable given the speed with which it was designed, debated, and enacted. This achievement was made possible by a series of compromises made during a period when health care and federal/state relations were the focus of a great deal of political attention.

The S-CHIP program conforms to no single ideological view, allowing it to be attacked from all sides. It embodies compromises with respect to state/federal relations and with respect to the key issue of making publicly subsidized programs function effectively in the midst of a voluntary, employer-based health insurance system. While S-CHIP may have significant design flaws that will become apparent over time, the general structure of the compromise has already shown that it meets the political tests of today. If it also proves itself as an effective means for achieving complex policy objectives in a country with disparate political views and health care markets, it will provide an interesting lesson or model for resolving future debates over social programs and the devolution of authority for those programs to the states.