

## *Sinking SCHIP*

### *A First Step toward Stopping the Growth of Government Health Programs*

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#### **Executive Summary**

Federal lawmakers are considering legislation that could result in millions more middle-income families obtaining health insurance from government. Unfortunately, the debate over expansion of the State Children's Health Insurance Program is divorced from the reality of who truly needs assistance and the forces that are making health insurance increasingly unaffordable.

SCHIP and its larger sibling Medicaid currently enroll many people who do not need government assistance, including some families of four earning up to \$72,000 per year. That is a direct result of federal funding rules that reward

states for making more Americans dependent on government for their health care.

Rather than expand SCHIP, Congress should (1) make private health insurance more affordable by allowing consumers and employers to purchase less expensive policies from other states, and (2) fold federal Medicaid and SCHIP funding into block grants that no longer encourage states to open taxpayer-financed health care to non-needy families. With more Americans able to afford private insurance and no incentive for states to expand government programs beyond the truly needy, federal and state governments could reduce spending on those programs.

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**Maintaining SCHIP would force taxpayers to finance health insurance for many families who are capable of obtaining it themselves.**

## Introduction

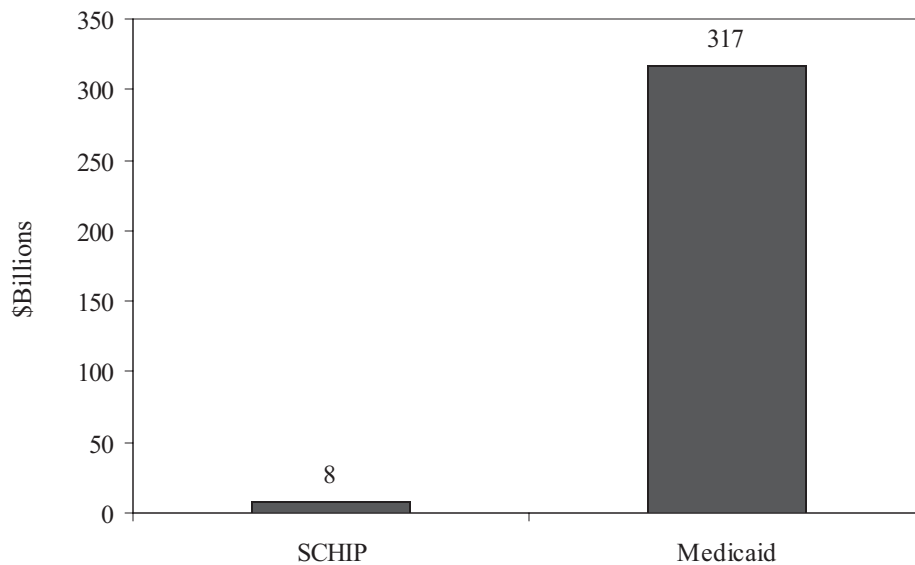
Federal lawmakers are considering legislation that could result in millions more middle-income families obtaining health insurance from government. Congress created the State Children's Health Insurance Program in 1997. That program provides federal grants to states that provide federally defined health insurance coverage to eligible children.<sup>1</sup> In 2006, SCHIP spent approximately \$8 billion to cover 7.4 million individuals.<sup>2</sup> SCHIP's original goal was to provide health insurance to children whose family income is too high to qualify for Medicaid yet too low to afford private health insurance. Medicaid is the much larger federal-state health insurance program targeted presumably at the poorest Americans. Medicaid spends far more than SCHIP (see Figure 1) and covers 60.9 million people.<sup>3</sup>

SCHIP has grown well beyond its original purpose. The program currently enrolls 6.6 million children,<sup>4</sup> many from families that are neither needy nor even low-income. The

Congressional Budget Office estimates that maintaining existing SCHIP benefits for the next five years would require an additional \$8 billion of federal funding above and beyond existing funding levels.<sup>5</sup> President Bush has proposed increasing spending by \$5 billion over five years.<sup>6</sup> Democrats in Congress have proposed increasing federal SCHIP spending by as much as \$60 billion over five years,<sup>7</sup> which would allow states to open SCHIP to far more non-needy families.

Expanding SCHIP or even maintaining current enrollment levels would force taxpayers to finance health insurance for many families who are capable of obtaining it themselves. A better strategy for providing health care to those in need would use deregulation to make private health insurance more affordable for middle- and low-income families, thereby allowing government health programs to focus on those patients who most need assistance. This paper proposes a two-part strategy for improving health care access: (1) block-granting federal Medicaid and SCHIP funding to encourage states to rededicate those programs to the truly needy and

**Figure 1**  
**Total Spending (2006): SCHIP vs. Medicaid**



Source: U.S. Congressional Budget Office, "Detailed Projections for Medicare, Medicaid, and State Children's Health Insurance Program," March 6, 2007, pp. 8-9, [http://www.cbo.gov/ftpdocs/78xx/doc7861/m\\_m\\_schip.pdf](http://www.cbo.gov/ftpdocs/78xx/doc7861/m_m_schip.pdf); and author's calculations.

(2) using competitive federalism to make private health insurance affordable for more low-wage earners.

## Medicaid & SCHIP

Medicaid and SCHIP provide necessary medical services to millions of people. At the same time, these programs have significant downsides. For example, there are indications that Medicaid and SCHIP err on the side of providing too much assistance. That is, they induce many people to become dependent on government for medical care and in some cases trap enrollees in dependence. Medicaid and SCHIP weaken private health care markets by crowding out private health insurance and driving up prices for private purchasers. Expanding SCHIP or Medicaid would exacerbate these problems.

### Covering People Who Don't Need Charity

Medicaid and SCHIP have grown beyond their original purposes and well beyond what is necessary to provide health insurance to needy Americans. Many Medicaid enrollees are elderly nursing home residents who could have obtained private long-term care insurance. Economists Jeffrey Brown of the University of Illinois and Amy Finkelstein of the Massachusetts Institute of Technology estimate that Medicaid's loose eligibility rules discourage 66 percent to 90 percent of seniors from purchasing such insurance.<sup>8</sup> Indeed, a cottage industry of Medicaid estate planners exists to help middle-class seniors spend Medicaid funds, rather than their own resources, on their nursing home care.<sup>9</sup> Other Medicaid enrollees come from non-elderly families that could obtain health insurance on their own. More than one out of every five people eligible for Medicaid actually has private health insurance,<sup>10</sup> suggesting that Medicaid's eligibility criteria are overly broad.

Likewise, SCHIP has grown well beyond its original purpose of providing health insurance to children unable to obtain pri-

mate insurance but too affluent to qualify for Medicaid. When Congress created SCHIP in 1996, more than 60 percent of eligible children already had private health insurance.<sup>11</sup> In 2005, about 55 percent of SCHIP-eligible children had private health insurance.<sup>12</sup> Depending on the state, SCHIP now provides health insurance to children in families earning up to 350 percent of the federal poverty level (FPL) or more.<sup>13</sup> For a family of four, that is the equivalent of nearly \$72,000 per year.<sup>14</sup> New York wants to increase its SCHIP eligibility cutoff to 400 percent of the FPL,<sup>15</sup> or roughly \$82,000 per year for a family of four.<sup>16</sup> Nationwide, an estimated 89 percent of children in families earning between 300 percent and 400 percent of the FPL already have private coverage.<sup>17</sup> As a basis for comparison, median family income for all families in 2005 was just over \$56,000.<sup>18</sup> That suggests that if all states raised their eligibility cutoff to New York's proposed level, well over half of all families could enroll their children in a government health program. Finally, SCHIP also enrolls some 670,000 *adults*.<sup>19</sup>

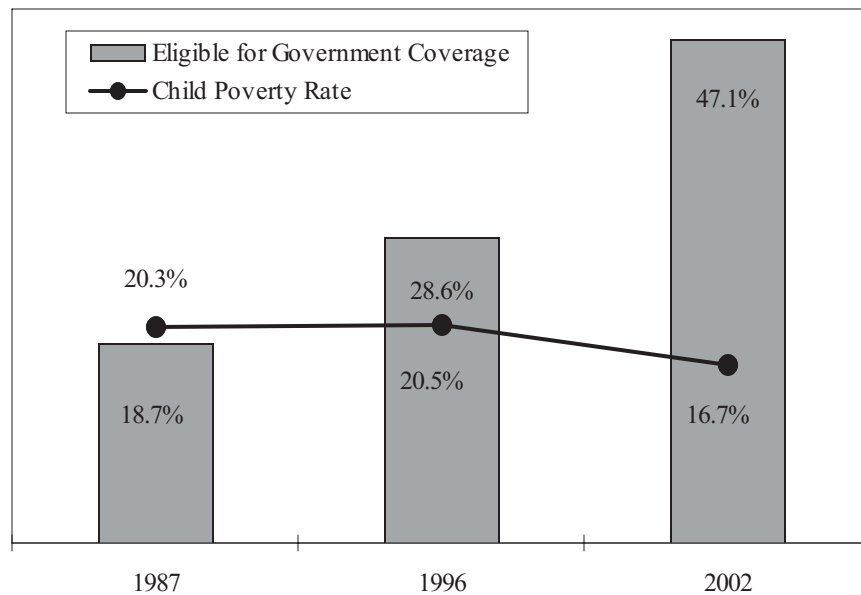
As a result of past Medicaid and SCHIP expansions, the share of children eligible for those programs rose from less than one fifth in 1987 to nearly one half in 2002.<sup>20</sup> That is, despite the fact that the share of children living in poverty actually fell over the same period (see Figure 2).<sup>21</sup> Medicaid and SCHIP eligibility criteria are broader than what would be necessary to cover only those who truly need assistance.

### A Deeper Low-Wage Trap

A frequently overlooked downside of Medicaid and SCHIP is that government programs targeting those below a given income threshold create disincentives for beneficiaries to increase their earnings. As a low-income family's earnings rise, the family pays higher taxes and loses Medicaid, SCHIP, and other government benefits. The combination of higher taxes and lost subsidies means that when a family increases its earnings by \$100, its total income rises by only a small fraction of that amount. In many instances, a family

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**Figure 2**  
**Percent of Children Eligible for Government Health Insurance vs. Living in Poverty**



Sources: Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, “The Impact of SCHIP on Insurance Coverage of Children,” *Inquiry*, 42, no. 3 (Fall 2005): 232; U.S. Census Bureau, “Historical Poverty Tables: Table 3. Poverty Status of People, by Age, Race, and Hispanic Origin: 1959 to 2005,” September 06, 2006, <http://www.census.gov/hhes/www/poverty/histpov/hstpov3.html>.

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that increases its earnings can end up with less income overall.

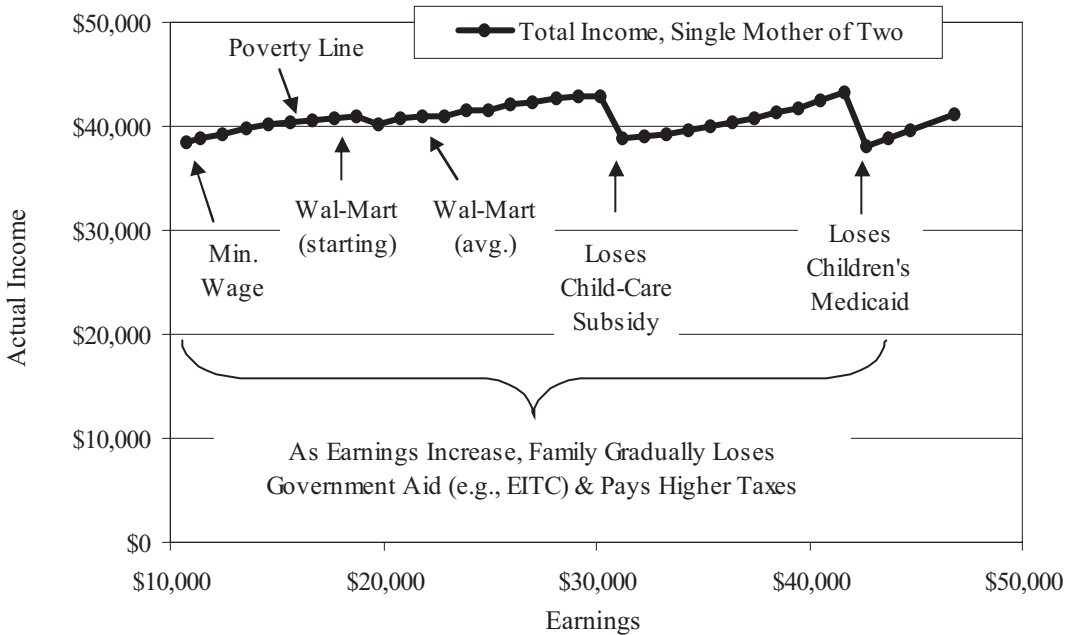
For example, a low-income single mother of two in New Mexico is eligible for a number of income-related subsidies from the federal and state governments. These include the Earned Income Tax Credit, cash assistance, Food Stamps, WIC,<sup>22</sup> housing subsidies, child care subsidies, and Medicaid.<sup>23</sup> Figure 3 shows what happens if that hypothetical mother increases her earnings. The combination of progressively higher taxes and the progressive loss of government subsidies means that even if she increases her *earnings* from about \$15,000 to \$45,000, her net *income* remains the same at about \$40,000.<sup>24</sup> Of the \$30,000 she adds to her earnings, she loses \$4,000 to taxes and \$26,000 to reduced benefits. As a result of programs such as SCHIP, low-income families in New Mexico and other states face marginal effective tax rates that can exceed 100 percent. Such fami-

lies have almost no financial incentive to achieve self-sufficiency, because increasing their earnings often has zero effect on their actual income.

Expanding SCHIP would magnify those powerful disincentives to increase family earnings and would ensnare even more families in what economists call the “low-wage trap”<sup>25</sup> created by such programs.

That low-wage trap would be deepened further because Medicaid and SCHIP increase health care prices for private purchasers. For example, Medicaid price controls increase the cost of prescription drugs for private payers by an estimated 13 percent.<sup>26</sup> Government purchasing through Medicaid and SCHIP also can increase prices for private purchasers through what is commonly believed to be “cost shifting,” but may be more accurately described as crowding out private purchasers.<sup>27</sup> Thus expanding SCHIP (and Medicaid) not only would induce greater dependence on government, it

**Figure 3**  
**New Mexico's Low-Wage Trap (2002)**



Source: U.S. Department of Health and Human Services' marriage calculator, and author's calculations.

would make financial independence more difficult even for those who do not enroll.

**Poor Fiscal Sense**

Expanding SCHIP also would be fiscally unwise. First, expanding coverage may not be the best way to improve the health of targeted children. Although policymakers expect that expanding Medicaid and SCHIP will improve children's health, economists have found no evidence that these programs are a cost-effective way of doing so. Economists Helen Levy and David Meltzer write:

It is clear that expanding health insurance is not the only way to improve health. . . . Policies could also be aimed at factors that may fundamentally contribute to poor health, such as poverty and low levels of education. *There is no evidence* at this time that money aimed at improving health would be better spent on expanding insurance coverage than on any of these other possibilities.<sup>28</sup>

In a survey of economic studies examining factors that contribute to longevity, the *New York Times* reported that education appears to have the greatest impact, while "factors that are popularly believed to be crucial—money and health insurance, for example, pale in comparison."<sup>29</sup> According to RAND Corporation health economist James Smith, health insurance "is vastly overrated in the policy debate" over how to increase life expectancy.<sup>30</sup>

One reason that Medicaid and SCHIP may not be cost-effective vehicles for improving health is that expanding those programs reduces private health insurance coverage. Families often substitute Medicaid and SCHIP for private coverage. Similarly, employers often cut or eliminate health benefits when their workers become eligible for those programs. It is well-established that Medicaid and SCHIP "crowd out" private health insurance.<sup>31</sup>

Crowd-out makes expansion of public programs a costly way of increasing the number of people with health insurance. A recent

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study by economists Jonathan Gruber (MIT) and Kosali Simon (Cornell University) estimates that as a result of crowd-out, “the number of privately insured falls by about 60 percent as much as the number of publicly insured rises.”<sup>32</sup>

To illustrate, suppose that Congress and the states were to enroll 10 million additional people in Medicaid or SCHIP. As a result, the number of people with private health insurance would decline by about 6 million. Though taxpayers would be financing health care for an additional 10 million people, the number of uninsured would fall only by 4 million. In other words, Medicaid and SCHIP cover four uninsured people for the price of 10. Crowd-out is more likely to occur when lawmakers open these programs to higher-income families, because those families are more likely to have private health insurance already.<sup>33</sup>

Expanding SCHIP also makes poor fiscal sense because spending on Medicaid and SCHIP is already on an unsustainable path. Cato Institute senior fellow Jagadeesh Gokhale estimates that maintaining existing Medicaid growth rates would require implausibly high tax rates in the future. According to Gokhale, “Limiting Medicaid spending growth is . . . an essential component of putting the federal budget on a sustainable course without imposing crushing tax burdens on younger and future generations.”<sup>34</sup>

Nevertheless, lawmakers appear ready to let the poorest Americans carry the burden of a SCHIP expansion. Congress is considering financing a SCHIP expansion with a 156-percent increase in the federal cigarette tax, from 39 cents to \$1 per pack.<sup>35</sup> According to Harvard economist Kip Viscusi:

Cigarette taxes fall predominantly on the very poor. The usual concerns about regressive taxes involve those that are regressive in percentage terms, that is, the poor pay a higher percentage of their income in taxes than do the wealthy. Cigarette taxes are actually so regressive that the poor pay a much

higher absolute level of taxes than do the wealthy. In 1990, people who made under \$10,000 per year paid almost twice as much in cigarette taxes as those who made \$50,000 and above.<sup>36</sup>

An increase in the cigarette tax would force the poorest Americans to subsidize health insurance for families earning up to \$82,000 per year.

Moreover, a higher federal cigarette tax would lead to more violent crime. Tax Foundation chief economist Patrick Fleenor has documented that high cigarette taxes fuel black market activity, including truck hijackings and other armed robberies. In 2003, Fleenor wrote:

Today, 200 cases of cigarettes in a modest-sized transport truck would have a retail value in New York City of around \$1 million and would be [a] tempting target for thieves.<sup>37</sup>

Increasing the federal cigarette tax would create an even greater incentive for armed thieves to rob retailers and hijack cigarette trucks.

## Why Do Medicaid and SCHIP Cover Non-Needy Families?

Medicaid and SCHIP cover many non-needy families as a result of the incentives that the federal government creates for state governments. Overall, 57 percent of Medicaid spending comes from the federal treasury, with 43 percent coming from states.<sup>38</sup> Much as it did under the old Aid to Families with Dependent Children cash assistance program, the federal government “matches” every dollar a state puts toward its Medicaid program with at least one dollar from the federal treasury. The federal Medicaid “match” is completely open-ended. States can therefore double their money without limit by increasing Medicaid enrollment and benefits.<sup>39</sup> Poorer states such

as Mississippi can even quadruple their money without limit.

Medicaid even creates opportunities for states to push even more of their Medicaid costs onto taxpayers in other states than federal law would seem to permit. For example, the federal government is supposed to finance only half of California's Medicaid program. A recent proposal by Gov. Arnold Schwarzenegger (R), however, would bend Medicaid's rules so that taxpayers in other states would finance three-fourths of Schwarzenegger's proposed new spending.<sup>40</sup>

Since states pay only a fraction of the cost of expanding Medicaid to non-needy families, the Medicaid "match" encourages such expansions. Like the former AFDC program, Medicaid's funding mechanism creates a "pay-for-dependence" incentive, rewarding states that increase the number of Americans dependent on government. The states' open-ended entitlement to federal dollars—or more precisely, to the earnings of taxpayers in other states—likewise increases the damage that Medicaid does to private markets.

As with Medicaid, the federal government matches state outlays for SCHIP, though at higher rates. Overall, 69 percent of SCHIP spending comes from the federal treasury, with 31 percent coming from the states.<sup>41</sup> At a minimum, the federal SCHIP "match" allows states to triple their money. In some cases, states with a high proportion of low-income uninsured children can nearly quintuple their SCHIP outlays.<sup>42</sup> Unlike Medicaid, the federal government caps its contribution to each state's SCHIP program at a pre-determined amount, which ostensibly denies states an open-ended entitlement to the earnings of taxpayers in other states.

Nevertheless, the cap on federal SCHIP allotments is not as binding as it might appear. States such as Georgia sometimes spend all of their allotted SCHIP funds before the end of the fiscal year. The CBO estimates that 11 states will do so in 2007.<sup>43</sup> Typically, those states then petition the federal government for additional funding.<sup>44</sup> So far, Congress has twice bailed out such

states,<sup>45</sup> effectively rewarding states that commit to spend more federal dollars than they have been allotted.

Given federal funding rules, states have little incentive to tailor Medicaid or SCHIP to cover only the truly needy. Instead, they face rather large incentives to expand those programs to people who do not need assistance.

## Refocus Aid on the Truly Needy

Congress should apply the same solution to SCHIP and Medicaid that it applied to AFDC in 1996. Reforming SCHIP and Medicaid as Congress reformed welfare would reduce dependence on government and encourage states to focus government health care programs on those who truly need assistance.

As with AFDC, Congress should end the federal entitlement to Medicaid benefits and stop funding state Medicaid and SCHIP programs with matching grants. As with AFDC, Congress should replace those matching grants with one block grant that neither increases nor decreases with the size of a state's health care programs. As with AFDC, Congress should place as few restrictions as possible on how states spend their block grants. Congress should give states the flexibility to spend those funds at the state's discretion on a few broad goals, such as:

1. Targeting medical assistance to the truly needy, including the uninsurable;
2. Reducing dependence; and
3. Reducing crowd-out of private effort, including charitable care.

As with AFDC, Congress should freeze the overall amount it transfers to state health care programs at current Medicaid and SCHIP levels. If Congress were to freeze the new block grants at 2007 levels, much as it did with welfare reform, that would produce a savings of \$1.1 trillion over 10 years.<sup>46</sup>

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The most crucial element of the block-grant approach is that states could not obtain additional federal funding by expanding their programs. That feature would discourage states from expanding government aid to individuals who could obtain health insurance on their own. Block grants would allow each state to preserve its Medicaid and SCHIP programs just as they exist today. States that wish to expand their programs could continue to do so. However, states would have to pay for such expansions themselves, rather than have taxpayers in other states shoulder the burden. That would encourage each state to focus its programs on the truly needy. Over time, states would learn from each other's experiments at providing efficient care to those who truly need assistance.

It makes little sense for residents of the 50 states to send their money to Washington, DC, only to have Washington send that money back to the states. Moreover, it is arguably unconstitutional. The U.S. Constitution does not grant Congress the power to provide health care to the needy. Under the Tenth Amendment, such "powers not delegated to the United States by the Constitution . . . are reserved to the states."<sup>47</sup> Converting federal Medicaid and SCHIP funding to block grants would do more than simply limit the growth of government health care programs. Block grants would take a step toward a more sound and constitutional means of providing health care for the needy, where the money never passes through Congress's hands.

Opponents will predict that block grants would reduce access to care and increase the number of uninsured. Opponents of welfare reform made similar predictions, which turned out to be inaccurate. When Congress pared back cash assistance, welfare caseloads plummeted and poverty decreased—often dramatically—in every category. The poverty rate remains lower today than at any point in the 17 years leading up to 1996.<sup>48</sup> Many who opposed welfare reform have since admitted that it accomplished a large measure of good.

There are indications that a block-grant

approach to Medicaid and SCHIP could produce similar results. When the 1996 welfare reform law eliminated Medicaid benefits for noncitizen immigrants, opponents predicted that coverage levels among noncitizen immigrants would drop. Instead, coverage levels *increased* because more noncitizen immigrants obtained private health insurance.<sup>49</sup> That experience supplies evidence that private health insurance coverage expands in response to a reduction in government coverage—sometimes enough to overwhelm the reduction in government coverage.

Medicaid block grants were part of the original 1996 welfare reform law until they were dropped at the insistence of President Clinton. Congress should revive the idea to rededicate government health care spending to those who truly need assistance.

## **Affordable Coverage via Competitive Federalism**

Another reason states have been eager to expand their Medicaid programs has been the rising cost of private health insurance. State health insurance regulations have been a driving force behind that trend.

The average state requires consumers to purchase 38 separate types of coverage.<sup>50</sup> Forty-five states require all consumers, even teetotalers, to purchase coverage for alcoholism treatment. Thirty states require consumers to pay for contraceptive coverage and 13 states require consumers to pay for coverage of in-vitro fertilization—even though many consumers, such as some Catholics, find those services morally objectionable. Those coverage mandates increase the cost of private health insurance by as much as 15 percent.<sup>51</sup> An estimated 25 percent of the uninsured lack coverage due to the cost of mandatory coverage laws.<sup>52</sup> Underwriting restrictions such as "community rating" laws, a type of price control, further increase the cost of private health insurance for many low-income families, and likewise increase the number of uninsured.<sup>53</sup> Such regulations price many low-



income families out of the market for private health insurance. As many as 75 percent of the uninsured could afford to purchase health insurance<sup>54</sup> but find that the available options are not worth the high cost of coverage.

Many individuals and employers who purchase health insurance cannot avoid the unwanted costs imposed by such regulations. Under each state's licensing laws, every health insurance policy sold in that state must include state-mandated coverage and comply with the state's price controls.

Given the wide variation in health insurance regulation from state to state<sup>55</sup> and the availability of lower-cost policies in some states,<sup>56</sup> many consumers and employers should be able to obtain lower-cost health insurance in other states, just as they purchase many other products from out-of-state. However, state licensing laws act as a barrier to trade, preventing many Americans from obtaining lower-cost health insurance. The burden of these laws falls hardest on low-income individuals; 75 percent of the uninsured have family incomes below 200 percent of the federal poverty level (about \$41,000 per year for a family of four).<sup>57</sup>

## **A Health Insurance Free-Trade Zone**

Congress should sweep away those trade barriers and let individuals and employers purchase health insurance licensed in states other than their own. Article I, Section 8 of the U.S. Constitution grants Congress the power "To regulate Commerce . . . among the several states." That power exists primarily to prevent each state from erecting barriers to commerce from other states.<sup>58</sup> Congress should enact a federal law that prevents states from barring the sale of an insurance product licensed by another state.

Such a law would enable many low-income, uninsured consumers to obtain private health insurance, because it would expand their range of choices to include policies free of unwanted regulatory costs. The

consumer protections required by the licensing state, such as financial solvency requirements, could be incorporated into the insurance contract. That would allow the purchaser to enforce those requirements in the purchaser's home state, with the help of his state's insurance regulators.

This "competitive federalism"<sup>59</sup> approach would improve the quality of health insurance regulation. Giving consumers the freedom to avoid unwanted regulatory costs would force states to offer only the regulatory protections that consumers demand. Otherwise, consumers would take their business—and, importantly, their premium taxes—to a state that provides consumer-friendly regulation. Competition among the states would drive insurance regulation toward an equilibrium—or multiple equilibria—between too much and too little regulation. States would be unlikely to engage in a "race to the bottom" by eliminating important consumer protections: the first people to be injured by such unwise regulatory policies would be the voters in that very state, who would then punish the responsible officials.<sup>60</sup>

Competitive federalism would be a far preferable means of making health insurance affordable to low-income consumers than federal preemption of state regulation.<sup>61</sup> First, competitive federalism preserves each state's power to determine its health insurance regulations. Second, competitive federalism preserves each individual's freedom to choose the protections they demand. Third, and most importantly, competitive federalism would maintain constant pressure on states not to enact costly regulations, because consumers could choose policies licensed by other states.

If Congress were to preempt state health insurance regulations, however, that would effectively federalize the regulation of health insurance.<sup>62</sup> Over time, at the behest of special interests, Congress would enact costly regulation after costly regulation, just as state legislatures have.<sup>63</sup> Those regulations would apply nationwide, meaning that consumers—particularly low-income consumers—would have no escape.

**Costly state regulations price many low-income families out of the market for private health insurance.**

**Letting people purchase health insurance licensed in other states would be a far preferable means of making health insurance affordable to low-income consumers than expanding SCHIP.**

Competitive federalism also would be a far preferable means of making health insurance affordable to low-income consumers than expanding SCHIP. Unlike SCHIP, competitive federalism would require no government spending and no tax increases. It would not pull more families into a low-wage trap. Indeed, competitive federalism would help low-income families avoid dependence on government. Competitive federalism would not increase the cost of privately purchased health care. If anything, by enabling a more competitive health insurance market, it would force insurers to put more downward pressure on health care prices. Finally, because competitive federalism would help more low-income families become independent, it would allow state governments to focus their health care programs on those who truly need assistance.

### **SCHIP's Bootleggers and Baptists**

With so many reasons not to expand SCHIP—including a lack of evidence on cost-effectiveness and the availability of better alternatives for making coverage affordable for low-income families—why is there so much support for expanding means-tested government health insurance to people who don't need charity?

Support for SCHIP (and Medicaid) expansion comes from an alliance of “bootleggers and Baptists.” Economists often explain support for government policies (e.g., restrictions on alcohol sales) in terms of those who truly believe in the merits of the policy (i.e., Baptists who oppose alcohol consumption) and those who benefit financially from the policy (i.e., the bootleggers who sell illicit alcohol).<sup>64</sup>

The “Baptists” behind SCHIP expansion are those who believe that the way to increase health care quality and access is for government to finance and control the delivery of care. An example would be left-wing advocacy groups such as Families USA.<sup>65</sup> Expanding

SCHIP and Medicaid to enroll more and more Americans serves their goal of eventually enrolling all Americans in government health care programs. This incremental strategy is neither new nor secretive. In 1993, the Clinton administration's Health Care Task Force explicitly considered what it called a “Kids First” strategy for health care reform that would have first enrolled all children, and eventually all adults, in a government-controlled health care system.<sup>66</sup>

The “bootleggers” behind SCHIP expansion include those who stand to gain financially from greater government subsidies for health insurance and health care. They include several lobbying groups: America's Health Insurance Plans, and the insurers it represents;<sup>67</sup> the Pharmaceutical Research and Manufacturers of America and the drug manufacturers it represents; the American Medical Association and the physicians it represents; and the Federation of American Hospitals and the for-profit hospitals it represents.<sup>68</sup> State officials who support SCHIP expansion, such as California's Governor Schwarzenegger<sup>69</sup> and the rest of the National Governors Association,<sup>70</sup> also belong in the bootleggers category because increasing federal SCHIP spending benefits them politically: it enables them to provide new subsidies to voters at a fraction of the cost.

### **Conclusion**

The debate over expansion of the State Children's Health Insurance Program is divorced from the reality of who truly needs assistance and the forces that are making health insurance increasingly unaffordable. Congress should refocus government aid on the truly needy, while allowing markets to reduce their number. Deregulating health insurance via competitive federalism would make coverage affordable for more low-income consumers, thereby reducing the demand for government health care programs. Eliminating the financial incentives that reward states for making more Americans dependent on

Medicaid and SCHIP would encourage states to rededicate government health care programs to the truly needy, including the uninsurable. With more Americans able to afford private insurance, and no incentive for states to expand government programs beyond the truly needy, federal and state governments could even reduce spending on those programs.

## Notes

1. States provide 17–45 percent of the funding for their SCHIP programs. U.S. Congressional Budget Office, “The State Children’s Health Insurance Program,” May 2007, p. viii, <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf>. (Hereinafter SCHIP).
2. U.S. Congressional Budget Office, “Detailed Projections for Medicare, Medicaid, and State Children’s Health Insurance Program,” March 6, 2007, p. 9, [http://www.cbo.gov/ftpdocs/78xx/doc7861/m\\_m\\_schip.pdf](http://www.cbo.gov/ftpdocs/78xx/doc7861/m_m_schip.pdf); and author’s calculations.
3. *Ibid.*, p. 8.
4. SCHIP, p. viii.
5. *Ibid.*, p. 14.
6. Kaiser Family Foundation, “Capitol Hill Watch: Rep. Dingell, Sen. Clinton Introduce Legislation to Expand SCHIP,” *Daily Health Policy Report*, March 14, 2007, [http://www.kaisernet.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=43577](http://www.kaisernet.org/daily_reports/rep_index.cfm?hint=3&DR_ID=43577). See also Robert Pear, “Top Democrats Propose Expanding Health Insurance for Children,” *New York Times*, March 14, 2007, <http://www.nytimes.com/2007/03/14/washington/14health.html>.
7. See, for example, S 895, “The Children’s Health First Act,” introduced March 15, 2007, <http://thomas.loc.gov/cgi-bin/bdquery/D?d110:29:./temp/~bdKjoo:|/bss/d110query.html>.
8. Jeffrey R. Brown and Amy Finkelstein, “The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market,” NBER Working Paper no. 10989, December 2004, pp. 2–3, <http://www.nber.org/papers/w10989>.
9. See Stephen A. Moses, “Aging America’s Achilles’ Heel: Medicaid Long-Term Care,” Cato Institute Policy Analysis no. 549, September 1, 2005, [http://www.cato.org/pub\\_display.php?pub\\_id=4376](http://www.cato.org/pub_display.php?pub_id=4376).
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