Understanding the State Children's Health Insurance Program Using a Structured Polity Centered Approach

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Introduction

A “structured polity centered approach” as defined by Theda Skocpol is useful for explaining the “origins and transformations of national systems of social provision” such as the State Children's Health Insurance Program (SCHIP) of 1997. SCHIP can be analyzed using Skocpol's approach by taking into consideration the process through which this legislation was conceived, crafted, and implemented with an emphasis on the roles that political parties and special interest groups played in this process and the historical developments that influenced what was possible in the political climate of the late 1990s.

SCHIP succeeded in the aftermath of President Clinton's failed National Health Security Act (NHSA) of 1993 because it was everything the Clinton plan was not. At the time, America was not ready for radical change in the health care delivery system, but the incremental change SCHIP represented ultimately had broad based support even though it was initially opposed by the majority party in Congress. SCHIP was a politically safe solution to covering low income children and incorporated elements of a public plan option, as well as block grants. This legislation built on the earlier success of Medicaid in 1964 and was immediately preceded by the Health Insurance Accountability and Affordability Act (HIPPA) of 1996 which opened the door for incremental approaches to expanding coverage. SCHIP enjoyed strong support from interest groups and policy makers across the political spectrum, paving the way for swift passage and implementation. The present paper argues that SCHIP is a useful model for understanding the polity-centered approach because it was made possible as much by the successes of past policies as it was by the lessons learned from past failures.

Skocpol's polity-centered approach is based on four elements:

> (1) the establishment and transformation of state and party organizations through which politicians pursue policy initiatives; (2) the effects of political institutions and procedures on the identities, goals, and capacities of social groups that become involved in the politics of social policymaking; (3) the 'fit'- or lack thereof- between the goals and capacities of various politically active groups, and the historically changing points of access and leverage allowed by a nation's political institutions; and (4) the ways in which previously established social policies affect subsequent policies. [1]

The present paper examines SCHIP at two points in its development: 1) the initial passage of the legislation in 1997 and 2) the attempted reauthorization that President George W. Bush vetoed in 2007 and President Barack Obama finally signed in 2009. The first and fourth elements of the polity centered approach are most applicable to SCHIP because this legislation was possible largely due to the cooperative balance of power among parties in Congress and between the executive and legislative branches of government, as well as the way previous policies laid a foundation for SCHIP's conception and passage. Because all four elements of Skocpol's model are inter-related, the second and third elements are occasionally interwoven throughout this paper as well.

Initial Passage of SCHIP in 1997

Building on Past Successes

Consistent with the fourth element of the polity centered approach, SCHIP was preceded by a number of other successful legislative initiatives that offered incremental approaches to expanding health care coverage. Originally cosponsored by Senators Edward M. Kennedy (D-MA) and Nancy Kassebaum (R-KS), HIPPA enables workers to keep their health insurance in the event of job loss due to resignation, being locked out of coverage, or being forced to wait for coverage due to pre-existing medical conditions. HIPPA also includes provisions on medical confidentiality and prohibits insurance from being cancelled because of illness.[2] Signed into law

by President Bill Clinton on August 21, 1996, this legislation set a precedent for protecting the health insurance of a targeted population that had not lost coverage through any fault of its own. President Clinton and Senate Democratic Minority Leader Tom Daschle (D-SD) made references to HIPPA in the 1997 State of the Union Address[3] and at a press conference[4] respectively, suggesting that SCHIP could make its way through Congress too.

SCHIP also built on the success of Medicaid which provides government-funded health insurance to the poor and indigent, another targeted population. Signed into law by President Lyndon Johnson in 1964, Medicaid is a means-tested program that is administered by the states. Each state sets different eligibility levels for enrollment and the federal government provides matching funds at different percentages based on a state's income per capita.[5] SCHIP (now known as CHIP) seeks to pick up coverage where Medicaid drops off, offering health insurance for children whose parents do not qualify for Medicaid, but cannot afford private insurance. Like Medicaid, CHIP is jointly financed by the state and federal governments and is administered by the states. Without Medicaid as a starting point for providing health insurance to the poor, SCHIP would never have come to fruition.

Lessons From the Past

Consistent with the fourth element of the polity centered approach, President Clinton learned from his missteps during debate of the NHSA, ensuring that the same errors were not repeated during consideration of SCHIP. The NHSA was the most substantive attempt to expand access to health insurance in America since Johnson passed Medicaid and Medicare. Under the NHSA, all Americans would have received a health insurance security card that guaranteed comprehensive preventative and catastrophic coverage. Every citizen would have received the same benefits as employees of Fortune 500 companies regardless of family medical history or ability to pay. In addition, Medicare would have covered the cost of prescription drugs for the

first time, expanding the scope of Johnson's achievements into the late twentieth century.[6] When the NHSA failed to pass Congress in 1994, Senate Finance Committee chairman Daniel Patrick Moynihan (D-NY) tried to convince First Lady Hillary Rodham Clinton[1] to put health care on hold, but she would not hear of it. Hillary and the president believed that "the government would never get control of the federal budget deficit unless health care costs went down."[7] SCHIP offered a way for the Clintons to make some strides in health policy even if the change was incremental and targeted to a subset of the population. The third element of the polity centered approach is relevant here because SCHIP was a "good fit" with the goals of the White House.

SCHIP differed from the NHSA in four important ways which contributed to its passage. First, the NHSA was drafted by Hillary's Health Care Task Force before it ever reached Congress, whereas with SCHIP the Clintons expressed support for children's health legislation, but allowed Congress to write it. In the case of the NHSA, this lack of collaboration between the executive and legislative branches of government connects to the first element of the polity centered approach because it shifted the balance of power so that the White House was giving Congress a directive and Congress was required to interpret legislation that was not its own. As a result, over twenty different proposals were introduced across eleven committees. Each committee drafted its own version of the president's plan, making it difficult for any one bill to be approved.[8] In contrast, President Clinton never sent SCHIP-related legislation to Congress. On February 6, 1997, Clinton presented a children's health proposal to Congress as part of his FY 1998 federal budget proposal, but he let the House and Senate negotiate the details. Clinton's initiative had three parts including 1) federal payments to states of $750 million annually to assist families with coverage for children on a voluntary basis; 2) short-term assistance to unemployed families; and 3) an initiative to identify and enroll Medicaid-eligible children.[9] Only

[1] To eliminate confusion, First Lady Hillary Clinton will be referred to as "Hillary" in this paper and President Bill Clinton will be referred to as "Clinton."

seven versions of the SCHIP bill were debated and they were not significantly different from each other.[10] By handing Congress the reins, Clinton eventually galloped down his desired path: a health-related bill that had broad-based support.

Second, the NHSA was broad in scope and sought to provide for the health care needs of all Americans,"[11] while SCHIP was incremental and sought to address the specific problem of uninsurance for low income children which had appeal across the ideological spectrum. Since children are viewed as innocent and not responsible for their economic fate, they are considered deserving of government protection, similar to how disabled veterans are viewed with political empathy. Congressional Republicans and Democrats disagreed on the appropriate policy response for this problem, but there was bipartisan consensus that all children should have health insurance.[12] By taking an incremental approach to expanding health coverage, Democrats hoped to pave the way for covering all Americans, not just children.

Third, SCHIP leveraged the power of federalism more effectively than the NHSA. The latter oversaw the distribution of health coverage through a National Health Board and was primarily administered at the federal level.[13] In contrast, Republicans demanded state discretion over state eligibility for SCHIP and the quality of health insurance that was to be provided. Therefore, states were given considerable flexibility in program design and implementation,[14] making it easier for SCHIP to gain grassroots support. This ties in with the first element of the polity centered approach since federalism is by definition the distribution of power between the federal and state governments which is part of the "organization of state and party organizations."

Fourth, the NHSA was an independent initiative that came from the White House, whereas Clinton and congressional Democrats tactfully incorporated SCHIP into a much larger

piece of bi-partisan legislation- the Balanced Budget Act (BBA) of 1997 which was also the materialization of a key campaign promise on Clinton's part to balance the federal budget. Bipartisanship cannot be emphasized enough as being central to SCHIP's success. After the congressional elections in November 1996, Clinton lost his Democratic majorities in the House and Senate, making bipartisanship even more essential than before. In Clinton's 1997 State of the Union Address, he made a plea for cooperation across the aisle, saying that "the people of this nation asked us to be partners, not partisans."[15] He also noted that "10 million children still lack health insurance and 80 percent of them have working parents who paid taxes."[16] The president promised that the BBA would extend health coverage for up to 5 million of those children.[17] Clinton insisted on including health insurance for some low-income children as his price for the BBA that granted Republicans their priorities of tax and spending cuts as well as a balanced budget. The final SCHIP bill addressed Republican concerns about government spending by being completely funded through projected spending cuts in Medicare and Medicaid as well as cuts in discretionary programs; therefore, a tax increase was not needed to pay for the legislation. To acquiesce the majority party, Democrats agreed to a block grant program through which states would have discretion in how to use SCHIP funds. Furthermore, Republicans insisted that SCHIP not become a new entitlement. [18] The BBA was important to both Democrats and Republicans, so by including SCHIP in that legislation, Clinton encouraged collaboration and successful passage of the two initiatives. This bipartisanship or balance of power between parties relates to the first element in Skocpol's model.

A Democratic Priority Across Different Branches of Government

Health reform was also a priority for congressional Democrats, who like the president, saw children as a politically palatable group to cover using public resources. At a press conference on January 9, 1997, Senator Daschle said that "expanding health care to children will

be our [the Democrats'] [19] number-one health priority this year."[20] Daschle's bill, The Children's Health Coverage Act (S. 13) used an income-adjusted, state-administered, refundable tax credit approach to subsidize premiums for private health plans, including those sponsored by employers.[21] When asked if Clinton intended to push this initiative, Daschle replied "Yes, the president has been very supportive and the White House is working with us."[22] As the first element of Skocpol's model suggests, in these early stages of policy formation, alignment between the goals of the executive and legislative branches was key to SCHIP's success.

The SCHIP Debate in Congress: A Bipartisan Goal with Partisan Policy Alternatives

Daschle's bill was the least ambitious of the SCHIP-related bills that followed. Most of these bills were discussed simultaneously and varied in their level of federal involvement, their sources of funding, and treatment of federalism. Yet, they all shared a sincere effort to accomplish the bipartisan goal of expanding health coverage for children in a bipartisan fashion. Only the Child Health Insurance and Lower Deficit Act (S. 525/S.526), otherwise known as the "Child Bill," will be discussed here because it was the most controversial SCHIP bill to be considered and is most useful for explaining the polity centered approach. Consistent with the first element of Skocpol's model, this bill offers fertile ground to show why a bipartisan piece of legislation might lose support as a result of party alliances. The Child Bill also provides insight into the hurdles that SCHIP went through before it became law. These hurdles made SCHIP stronger and enabled its final passage.

The Child Bill which eventually took the form of the "Kennedy-Hatch Amendment" was cosponsored by Edward M. Kennedy (D-MA) and Senator Orrin Hatch (R-UT) and introduced at a hearing of the Senate Labor and Human Resources Committee on April 18, 1997. As Kennedy, the committee's Ranking Member explained, the Child Bill "provides grants to the states to

contract private insurers to provide coverage for uninsured children, subsidies to be available to families [in the form of vouchers and direct service contracts with community health centers] who cannot purchase this coverage on their own."[23] The Child Bill included mandatory federal spending as well as required contributions by participating states and was to be financed by an increase in the cigarette tax of 43 cents per pack.[24] Kennedy called on the cigarette industry to support this legislation citing an industry spokesperson as admitting in *The Washington Post* that "even a 50 cent per pack increase in the price of cigarettes would barely make a dent in the industry."[25] The House version of the Child Bill (H.R. 1363/HR. 1364), co-sponsored by Representatives Nancy Johnson (R-CT) and Okada Matsui (D-HI) was identical to the Senate version except that it allowed states to use Medicaid or the Federal Employee Health Benefit Plan as the basis for benefits packages.[26]

The Child Bill was bipartisan in that it expanded social programs in a fiscally responsible way without expanding the welfare state. The legislation addressed Republican concerns about "big government" in that it was not was not an entitlement, it had a limited reauthorization of five years, and allowed states considerable latitude in establishing their own programs. As Hatch put it, "there's no government takeover, it's fully financed. It's private insurance. It's totally voluntary. There's a minimal federal role to collect and disperse the funds and a simple allocation formula."[27] The bill also had a deficit reduction component of $10 billion for a total of $30 billion until reauthorization. Senator Hatch acknowledged that he and Kennedy were "an odd couple" to be working together considering the differences in their political persuasions, but said they had decided to "set politics aside for the good of the nation." Hatch enthused, "we now have a bipartisan, bicameral proposal…and it is time for the president to climb aboard."[28] The first element of the polity centered approach appeared to be working in favor of this legislation.

The goal of the Child Bill had bipartisan support, but many Republicans did not approve of using a tax, even a cigarette tax, as the means to finance that goal. As Senator Arlen Specter (R-PA) described the opposition's perspective, "when a tax is proposed, however worthy that tax may be…it faces a real problem in the Congress of the United States." Specter suggested using discretionary funds to finance the bill under the assumption that "we have enough resources in America, with a budget of one trillion, 700 million dollars, to take care of America's needs if we prioritize."[29] Yet, Democrats did not want to cut spending from existing social programs in order to fund a new initiative.

The size of the federal government's allocation for SCHIP was also a contentious matter. The Republicans' original budget resolution called for $16 million over ten years, but the cigarette tax in Kennedy and Hatch's bill would have generated an additional $20 million for SCHIP over five years, generating significant partisan conflict.[30] Yielding to Republican pressure, Clinton reversed his earlier support of the Child Bill and lobbied Democratic Senators to oppose it. Yet, Kennedy and other Senate Democrats pressed the president until he agreed to insist upon $24 million for SCHIP's first five years with the increase funded by higher tobacco taxes. Interest groups such as The Children's Defense Fund also played a key role in Clinton's decision to support the cigarette tax. [31]

The Child Bill illustrates how "party organizations" can shape politicians' desires and make it challenging for them to shape social welfare policy. Theda Skocpol herself concluded that "the increased weight of antigovernment conservatives among congressional Republicans [during congressional debate of SCHIP] made more difficult even an incremental expansion of the government's role in providing health care."[32] Yet, despite the obstacles to its passage, SCHIP was a success. In his memoirs, Clinton described SCHIP as "the largest expansion of health insurance since Medicaid was enacted in 1965."[33] Prior to SCHIP, only eight states

provided health insurance to children with family incomes at twice the poverty level, but by 2006 SCHIP provided coverage for 6.1 million children in 41 states and the District of Columbia. Perhaps most impressive is that while children with employer-sponsored health insurance fell from two thirds in 1997 to 59.4 percent in 2005, the rate of uninsurance among children declined during this period because of the expansion of public health insurance via Medicaid and SCHIP.[34]

Attempted Reauthorization of SCHIP in 2007

Part of SCHIP's initial appeal to Republicans lay in the fact that it did not crowd out private insurance, it was not an entitlement like Medicaid, and was somewhat of a pilot program with an authorization of only ten years. In 2007, Democrats sought to reauthorize and expand SCHIP for another ten years, requesting an additional $35 billion in spending increases,[35] but partisan struggles between the Democrat-controlled Congress and Republican President George W. Bush made that impossible. Bush vetoed the legislation in October 2007 saying that it violated the original intent of SCHIP, "taking a program meant to help poor children and turning it into one that covers [middle class] children in households with incomes of up to $83,000 a year."[36] Democrats fell 13 votes short of the two-thirds majority needed to override the veto. After vetoing similar legislation a second time in December 2007, the president finally agreed to reauthorize SCHIP through 2009, but refused to increase funding for it.[37] The first element of the polity centered approach helps explain why Democrats lost the battle for expansion of SCHIP. A lack of synchronicity between the goals of Democrats and Republicans, between states and the federal government, between the Bush Administration and Congress, and within the Democratic Party itself contributed to a struggle for power among state and party organizations.

Additional funding for SCHIP was necessary because many states were experiencing a fiscal crisis over their programs, but states were not effective in lobbying the federal government for more resources. In order to comply with budget rules, the annual SCHIP allotment dropped from $4.2 billion for FY1998-2001 to only $3.1 billion for FY 2002-2004, and then increased only to $4.1 billion for the next two years. Most states were spending more than their annual SCHIP allotment and increases in rates of medical inflation made the program more expensive. Even Republican governors wrote their senators and congressmen asking for increases in SCHIP funding, prompting the National Governors' Association (NGA) to take a stand, but the NGA could not agree about the size of any increase.[38] The lack of a unified voice on the part of state governments may have hindered Democrats' ability to effectively lobby for expansion of SCHIP. In this case, federalism was not leveraged well.

One of the strengths of the original SCHIP legislation in 1997 is that it represented the bipartisan goal of providing health insurance for low income children who did not qualify for Medicaid; however, in 2007 the parties had different goals for SCHIP. At a press conference on September 20, 2007, ten days before SCHIP was set to expire, Bush expressed concern that Democrats were using the SCHIP expansion as "an incremental step toward the goal of government-run health care for every American." The president said that his goal was "for children who have no health insurance to be able to get private coverage, not for children who already have private health insurance to be able to get government coverage."[39] Bush also worried that Congress' proposal would interfere with the private insurance market. The president was only willing to increase SCHIP by 20 percent, just enough to ensure that children who were currently eligible for the program were covered by it. In contrast, Democrats wanted to expand coverage for children with family incomes above 200 percent of the FPL.[40]

Much of Bush's interpretation of SCHIP and of Democrats' goals for the reauthorization was uninformed, leading to considerable partisan conflict. The nonpartisan website FactCheck.org points out that 70 percent of children who stood to gain coverage under reauthorization had family incomes of roughly $40,000, not up to $83,000 as Bush claimed. FactCheck.org also notes that the number of children who were expected to shift from private to public coverage under an expansion of SCHIP was relatively low, rendering the president's talk of a Democratic initiative for "government-run health care for all" inaccurate.[41] White House spokeswoman Dana Perino accused Democrats of cutting Republicans off from the debate[42] and Democratic House Majority Leader Nancy Pelosi (D-CA) criticized Bush for his refusal to compromise and increase SCHIP funding by more than 20 percent.[43]

Public opinion and interest groups also influenced the debate over SCHIP reauthorization, indicating that the expansion of government programs was not a "good fit" with the political climate in Washington and with Americans across the country. This is consistent with the second and third elements of the polity centered approach. When asked if they favored most of the SCHIP increases going to families earning under $41,000 (as Bush proposed) or if they wanted families earning up to $62,000 to be able to qualify for the program (as Democrats proposed) 52 percent of respondents to an October 17, 2007 Gallup Poll[2] agreed with Bush and only 40 percent agreed with Democrats. A solid majority of 55 percent said they were very or somewhat concerned that an expansion of SCHIP would create an incentive for middle class Americans to drop their private insurance and enroll in the program.[44] This could have been influenced by the president's misinterpretation of SCHIP as discussed above. In addition, the tobacco industry organized a powerful lobby against SCHIP expansion because like the 1997 Child Bill, it was funded through an increase in the tax on cigarettes.[45] The fact that so many

[2] The remainder of the sample had no opinion or refrained from answering the question.

people had reservations about SCHIP may have contributed to the lack of unification among congressional Democrats, making it difficult for the majority party to get enough votes to override Bush's veto.

In July 2007, the Senate Finance Committee approved its initial version of the bill known as the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2007 (S. 1893). The bill was largely bipartisan with eleven Democrats and six Republicans supporting it. Only four Republicans opposed. Bush threatened to veto the Senate bill before even seeing it. On August 21, 2007, the White House issued new rules that severely limited the power of states to expand SCHIP coverage. Under the new rules, states that allowed children in families with incomes above 250 percent FPL to receive SCHIP would be required to remove those children from their rolls. Following Bush's veto threat, the House passed its own version of the bill, the Children's Health and Medicare Protection Act of 2007 (H.R. 3162) which was far more costly than the Senate version. The House and Senate then reconciled the two versions and passed a new bill on September 17 which included most of the provisions of the more conservative Senate bill. Bush vetoed the reconciled version in December 2007 even though a considerable number of Republicans had voted for it. This bill would have brought the spending total to $60 billion over five years and added 4 million children to the program.[46] Bush finally reauthorized SCHIP for two years in order to prevent the program from being completely eliminated. As White House spokeswoman Dana Perino said in a statement on December 20, 2007, "With this bill, we can be assured that children will continue to have coverage and Democrats won't get to play election year politics with children's health."[47] With Bush's second term in office drawing to a close, it would be up to the next president to decide SCHIP's fate.

Conclusion

The reauthorization of SCHIP was one of President Barack Obama's first official acts in office, fulfilling a key campaign promise to expand eligibility for the Medicaid and SCHIP programs. More broadly, Obama had campaigned on a mandate that all children have health insurance coverage and SCHIP was an important part of achieving that goal.[48] In his remarks at the signing of the reauthorization on February 4, 2009, Obama called SCHIP "a downpayment on my commitment to cover every single American," noting that there are still 45 million children without health insurance in the United States.[49] Under reauthorization, SCHIP came to be known simply as CHIP, the Children's Health Insurance Program. The legislation, known as the CHIP Reauthorization Act of 2009 (H.R. 2) amends Title XXI of the Social Security Act to reauthorize the CHIP program through FY 2013 at increased levels.[50] CHIP is funded through increases in the federal excise tax on tobacco products, raising the tax from $0.61 per pack to $1 per pack (Sec. 701).[51]

As of late 2010, CHIP covers over 7.7 million children across the nation, up from less than 0.7 million when SCHIP was first signed into law.[52] Obama's goal is to cover an additional 4 million children under CHIP, and with the reauthorization many restrictions on eligibility have been lifted. For example, states are now permitted to cover children of legal immigrants if they choose to do so and these immigrants can bypass the normally required five year waiting period for eligibility.[53] Under CHIP, states are allowed to provide pregnancy-related assistance for pregnant women whose income is at least 185 percent of their state's poverty level or at least 200 percent of the poverty level for children under 19 years of age (Sec. 111).[54] Coverage has been expanded to children of families whose incomes exceed 300 percent of the poverty line (Sec. 114).[55] Obama also directed Kathleen Sebelius, his Secretary of Health and Human Services to withdraw an August 17, 2007 letter sent by the Bush administration to state health officials

which had imposed federal income eligibility standards that states must meet in order to cover children under SCHIP plans, including plans that CMS had previously approved. These restrictions were put into place due to the rising cost of private health insurance premiums, but as a result, tens of thousands of children were denied health coverage.[56]

Obama's major health care achievement, the Patient Protection and Affordable Care Act (PPACA), passed in March 2010 has additional provisions for CHIP. According to the Henry J. Kaiser Family Foundation, PPACA requires states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019 and extend funding for CHIP through 2015. States have the option of providing CHIP coverage for children of state employees if certain conditions are met. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100 percent. Furthermore, CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges established under PPACA.[57]

Consistent with the first element of the polity centered approach, Obama used federalism effectively in his treatment of CHIP. By lifting state restrictions on eligibility and expanding the program, he gave some power back to the states while keeping the source of funding in Washington. As a president who had campaigned for "change," CHIP was a "good fit" with Obama's goals and those of the Democratic House and Senate, making CHIP reauthorization smooth and streamlined. CHIP has come a long way since its beginnings in 1997 and Skocpol's model goes to show that even a seemingly partisan piece of legislation can be successful if policy makers learn from past failures and successes, and are willing to put aside partisan differences in the interest of a common goal.

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