Beyond Incrementalism? SCHIP And The Politics Of Health Reform

If the past decade has proved anything in American health policy, it is that incremental solutions are not enough.

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ABSTRACT: When Congress enacted the State Children’s Health Insurance Program (SCHIP) in 1997, it was heralded as a model of bipartisan, incremental health policy. However, despite the program’s achievements in the ensuing decade, SCHIP’s reauthorization triggered political conflict, and efforts to expand the program stalemated in 2007. The 2008 elections broke that stalemate, and in 2009 the new Congress passed, and President Barack Obama signed, legislation reauthorizing SCHIP. Now that attention is turning to comprehensive health reform, what lessons can reformers learn from SCHIP’s political adventures? [Health Affairs 28, no. 3 (2009): w399–w410 (published online 17 March 2009; 10.1377/hlthaff.28.3.w399)]

When Congress enacted the State Children’s Health Insurance Program (SCHIP) in 1997, it was hailed as a triumph of incremental health reform and bipartisanship. During SCHIP’s first decade, the program enjoyed great success in helping reduce the uninsurance rate among low-income children. Moreover, the SCHIP model—tackling the uninsured one group at a time, building political consensus on incremental goals while avoiding the ideological polarization triggered by more ambitious proposals, and leveraging the opportunities created by American federalism—appeared to provide a promising template for health reform that could be extended beyond children to other populations.

Despite SCHIP’s success and promise, in 2007 this exemplar of incrementalism became the object of intense political conflict, as efforts to reauthorize SCHIP stalled. However, the 2008 election broke the stalemate, and in early 2009 the new Congress passed, and President Barack Obama signed, legislation reauthorizing SCHIP. Now that attention is turning to comprehensive health re-
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form, what can reformers learn from SCHIP’s political adventures? This paper explores SCHIP’s evolution from enactment to reauthorization, and it identifies lessons for national health reform.

Incrementalism In Vogue

In 2009, reformers are debating the perennial question of whether to pursue incremental or comprehensive health reform. In 1997, incrementalism was the obvious choice. SCHIP rose from the ashes of the Clinton administration’s failed Health Security Act. Congressional leaders had scarcely pronounced the Clinton plan dead in September 1994 when proposals to expand health insurance for low-income children emerged. Those initiatives built on the federal Medicaid expansions of the 1980s for children and pregnant women and on ongoing state efforts to further expand children’s insurance coverage.

During 1995, expanding children’s health insurance took a backseat as the newly elected Republican congressional majority pursued legislation to turn Medicaid into a system of block grants and make major cuts in Medicare spending. But President Bill Clinton vetoed those measures, and policymakers soon returned to bipartisan incrementalism. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA, cosponsored by Sen. Ted Kennedy, D-MA, and Sen. Nancy Kassebaum, R-KS). After HIPAA, expanding insurance coverage for children became the next item on the incremental agenda.

Senator Kennedy again found a partner across the aisle—this time Sen. Orrin Hatch (R-UT)—with whom to cosponsor legislation.

Congress enacted SCHIP as part of the 1997 Balanced Budget Act (BBA), less than a year after Senator Kennedy introduced his bill. As Congress and the Obama administration consider how to move forward quickly and successfully on health reform legislation, it is worth considering what made SCHIP’s rapid political journey possible.

SCHIP became law “in record time” largely because it was everything the 1993 Clinton health reform plan was not; it clearly embodied lessons learned from the administration’s health reform debacle. Like Medicare, itself conceived in the aftermath of national health insurance’s defeat, SCHIP eschewed universal coverage in favor of demographic incrementalism focused on a sympathetic population. SCHIP thus targeted children of low-income, working families for coverage—a cause popular with the public. Unlike the Clinton plan, it left insured Americans and the existing employer-sponsored insurance system largely alone. SCHIP sought to fill in a coverage gap rather than to reengineer the entire system of coverage for all Americans.
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SCHIP also did not seek to transform the health care delivery system, control national health spending, or impose employer mandates and strict insurance regulations. In other words, it avoided all of the controversial policies that threatened the status quo and thereby doomed the Clinton plan.

SCHIP additionally preserved a prominent role for states and exploited the political appeal of fiscal federalism that combined federal matching funds with state administration. In so doing, SCHIP built on an existing program, Medicaid, and didn’t introduce anything like the Clinton plan’s ill-fated and unfamiliar Health Alliances. The Clinton plan advanced an unprecedented synthesis between liberal ends (universalism) and conservative means (competition) that required the creation of new institutions; SCHIP alternatively pursued incremental ends through incremental means within familiar institutions.

Moreover, Congress, not the White House, drove the SCHIP legislation. The plan’s details emerged from legislative negotiations rather than from a presidential task force. With Senator Hatch’s support, SCHIP had bipartisan sponsorship that the Clinton plan never enjoyed. And because SCHIP covered a relatively inexpensive population, it required far less revenue than universal coverage (raising cigarette taxes provided funds for the federal share), thereby avoiding thornier financing dilemmas and leaving the health financing status quo intact. In sum, policymakers designed SCHIP to minimize disruption in the health care system, not to transform it.

SCHIP’s modest scope, focus on children, and incremental financing triggered very different politics than the Clinton Health Security Act had. In 1993–94 the Clinton administration confronted fierce, organized opposition from such stakeholders as the insurance industry and small business, and it failed to mobilize sustained support from the fragmented constituencies favoring health reform. In contrast, SCHIP benefited from both the absence of overwhelming stakeholder opposition and the support of a broad coalition of groups that favored expanding children’s insurance.

Finally, SCHIP passed because it embraced the politics of compromise. Some advocacy groups and members of Congress favored creating SCHIP strictly on the Medicaid model, with eligible children receiving a legal entitlement to services. Many governors instead favored establishing a new program that gave states greater flexibility and fiscal control than Medicaid allowed. The Republican congressional majority, which had just unsuccessfully attempted to block-grant Medicaid, also opposed creating a new entitlement program and wanted to limit federal budgetary exposure.

Consequently, Congress enacted SCHIP as a block grant with the federal gov-
ernment providing participating states with capped, matching funds (at enhanced rates relative to the federal match that states received for Medicaid) to help pay for children's health insurance. States could choose whether to use the new federal funds to expand children's health insurance under their existing Medicaid programs or establish a new, separate program, or both. States were also granted, relative to Medicaid, greater flexibility to set benefit packages and impose cost sharing.

Compromises were also made to ensure that SCHIP did not “crowd out” existing insurance coverage. The legislation authorizing SCHIP required states to implement anti-crowd-out provisions to ensure that the program covered uninsured children and did not substitute for private insurance. Other provisions were aimed at heading off the prospect that states, lured by SCHIP's higher match rate, would use new federal SCHIP money to replace existing state funds dedicated to children's health insurance. The legislation consequently prohibited Medicaid-eligible children from enrolling in SCHIP. States were also required to screen and enroll children for Medicaid and maintain existing Medicaid eligibility levels as well as spending on certain state child health coverage programs.

The 1997 SCHIP law thus blended numerous concerns and compromises, balancing the often competing agendas of states, federal policymakers, child health advocates, liberals, and conservatives into one program.

**A Decade Of SCHIP Operation**

The political compromises embodied in the SCHIP statute enabled states to build rapidly on Medicaid's foundation. With an enhanced match rate and flexibility in program design, and buoyed by economic good times, all states implemented programs within two years. States raised income eligibility levels for children quickly and substantially: forty states raised levels to 200 percent of the federal poverty level higher by 2000, up from six states before SCHIP's enactment.

SCHIP filled in gaps between Medicaid and private insurance. “Screen and enroll” requirements raised state administrative concerns at the program's outset but were important to assuring that poorer children retained Medicaid's comprehensive coverage. States accordingly continued to finance this coverage, despite lower Medicaid matching rates.

In response to anti-crowd-out requirements, states established waiting periods, imposed premiums and copayments, and developed premium assistance programs. The Congressional Budget Office (CBO) found that SCHIP has substituted for private coverage to some extent, while noting that families who substitute SCHIP for private coverage are generally better off because of lower costs and more extensive benefits. Further noting that any increase in government spending to expand health insurance will displace private coverage to some degree, the CBO concluded, based on its analysis of the research, that “for every 100 children...
“SCHIP’s biggest challenge has been the mismatch between program needs and federal funding subject to state allocations.”

who gain public coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children,” but the net effect of SCHIP has been to reduce the number of uninsured children.12

Today, more than seven million children are enrolled in SCHIP, building on Medicaid’s larger base of twenty-nine million children. Coverage gains under both programs helped reduce the rate of uninsurance among low-income children by one-third from 1997 to 2005, a striking feat considering the decline in employer-sponsored coverage over this period and the fiscal stress that states experienced during the 2001 economic downturn.13 SCHIP’s record on access, quality, and health outcomes compares favorably with that of private insurance and has received high marks in congressionally mandated evaluation studies. However, access to mental health and dental services, as well as broader services needed by children with disabilities, remains of concern.14

SCHIP also broke new ground in establishing a priority to find eligible children and enroll them in public health coverage. Charged with developing strategies to increase the enrollment of eligible children, state officials shed the mentality that has historically ensnared welfare programs. With federal support, states designed welcoming programs, engaged in aggressive mass-media and community-based outreach, and implemented family-friendly enrollment and renewal procedures.15

SCHIP’s new model conferred positive spillover effects on Medicaid, as states simplified application and renewal requirements to align Medicaid with SCHIP.16 As a result, both children in poorer families who qualified for Medicaid and slightly higher-income children who qualified for SCHIP saw improvements in access. However, new documentation requirements included in the Deficit Reduction Act (DRA) to verify citizenship and identity in Medicaid have hampered enrollment and resulted in coverage delays and denials for some children.17

Persistent Problems

Children’s participation in SCHIP and Medicaid is high—a noteworthy accomplishment in voluntary, means-tested programs. However, 8.9 million children remain uninsured, and about two-thirds of these children are eligible for SCHIP or Medicaid. These children live predominantly in working families with incomes below 200 percent of poverty, and although some children were previously enrolled in Medicaid or SCHIP, other parents do not know that their children qualify or how to apply, or have faced enrollment barriers.18

SCHIP’s biggest challenge has been the mismatch between program needs and federal funding subject to annual caps and state allocations. In early years, as states were getting their programs off the ground, SCHIP spending was below to-
tal funding levels. As programs matured, however, national SCHIP spending has exceeded the annual funding levels every year since 2002. Provisions in the law to redistribute SCHIP funds have been complex, made funding uncertain for states, and required repeated legislative fixes.\footnote{In addition, like Medicaid, SCHIP’s reliance on state funds creates challenges during an economic downturn, when the need for public coverage increases as state revenues decline (a predicament exacerbated by state balanced budget requirements). When state budgets are constrained, outreach and enrollment in SCHIP and Medicaid are impeded, and some states have imposed SCHIP enrollment caps.\footnote{These actions can have long-lasting adverse impacts on families and on enrollment.}}

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SCHIP’s focus on children was politically expedient, but it left family coverage unaddressed. Research shows that children’s enrollment, access, and medical service use improves when parents are also covered.\footnote{However, in most states, parental eligibility levels for Medicaid are set well below the poverty level, precluding family enrollment for all but the poorest families.}

Since 2000, the average cost for a family premium has doubled, and the percentage of firms offering health insurance has declined.\footnote{These changes have placed coverage of children in low- and middle-income families increasingly in jeopardy. After a decade of progress, the number of uninsured children climbed in 2005 and 2006 by more than one million, reversing some of the gains made since SCHIP’s enactment. Most of these newly uninsured children were in families with incomes above 200 percent of poverty.}

In response to these trends, states took decisive steps to expand children’s coverage, resulting in twenty states with SCHIP income limits raised, or authorized, to 300 percent of poverty or higher in 2007.\footnote{At the time, states anticipated a strong SCHIP reauthorization to support their efforts.}

The Reauthorization Battle

With SCHIP’s original federal funding authorization set to expire 30 September 2007, reauthorization offered Congress an “important opportunity...to acknowledge the success of SCHIP” and address the challenge of inadequate funding by renewing and expanding the program.\footnote{In the 2006 elections, Democrats gained majorities in both the House of Representatives and the Senate for the first time since 1994, and the Democratic leadership identified SCHIP as a legislative priority.}\footnote{Democrats wanted to expand SCHIP to cover more children—a proposal that drew support from key Republicans, including Senators Hatch and Chuck Grassley (R-IA). A broad coalition of interest groups, encompassing Families USA, America’s Health Insurance Plans (AHIP), the American Medical Association (AMA), Pharmaceutical Research and Manufacturers of America (PhRMA), and the Federation of American Hospitals (FAH), as well as many governors, endorsed SCHIP expansion.}\footnote{The political prospects for broadening SCHIP on a bi-}

Politics Of Reform

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partisan basis thus appeared favorable. “If anything looked like a sure thing in the new Congress,” the Washington Post remarked, “it was that lawmakers would renew and probably expand [SCHIP] before it expires.”

As it turned out, SCHIP renewal was anything but a sure thing. The 2007 reauthorization battle is by now a familiar story. In August 2007 both the House and Senate passed legislation to renew and extend SCHIP. The Senate bill, adopted on a 68–31 vote with significant Republican support, called for expanding SCHIP by $35 billion over five years, funded by an increase in the federal cigarette tax of sixty-one cents per pack. The House bill, which called for $50 billion in additional spending to be financed by tobacco taxes as well as cuts in payments to Medicare Advantage (MA) plans, passed largely on party lines, 225–204, with only five Republicans voting in favor and ten Democrats voting against the bill.

The compromise bill that emerged from conference committee largely tracked the Senate version, providing $35 billion in new funding from increasing cigarette taxes and dropping the House Medicare provisions.

In September 2007, the House adopted the conference committee legislation 265–159 (with 45 Republicans voting for it) and the Senate passed the bill 67–29 (with the support of 18 Republicans). President George W. Bush vetoed the legislation. Supporters failed to override the veto in October 2007, falling thirteen votes short in the House of the necessary two-thirds majority. Congress subsequently enacted a second conference committee bill (which would have financed coverage for about four million uninsured children—nearly 90 percent of whom were previously eligible for Medicaid or SCHIP) with additional compromises designed to allay critics’ concerns. But when President Bush repeated his veto in December, efforts to override the veto again fell short in the House. Unable to expand SCHIP, Congress instead ended up extending the program through March 2009 and providing additional federal funding to help states with shortfalls.

Why did SCHIP reauthorization end in stalemate in 2007? The most crucial factor was obviously President Bush’s opposition. Not only did the president twice veto legislation that had bipartisan support, but the administration did not seriously engage in meaningful negotiations with Congress to find a compromise. Indeed, SCHIP advocates found it difficult to locate an official who could authoritatively negotiate with Congress on behalf of the administration.

The Bush administration’s opposition to SCHIP expansion was largely ideological. Administration officials argued that SCHIP expansion would push the U.S. toward “a single-payer health care system with rationing and price controls.” President Bush labeled SCHIP expansion a step “down the path to government-run health care for every American.” The administration apparently saw SCHIP
as a front in a broader ideological struggle over health reform, and it was unwilling to give any ground.\textsuperscript{34}

The failure of SCHIP expansion also reflected partisan and ideological differences over how to expand insurance coverage and the appropriate scope of government programs. The SCHIP debate, in other words, revolved around competing visions of health reform. While Democrats (and some Republicans) wanted to expand coverage to children through SCHIP, conservative Republicans instead favored legislation to expand coverage through tax credits for private insurance (consistent with the Bush administration’s broader health reform strategy to revamp the tax treatment of employer-sponsored insurance).\textsuperscript{35}

In addition, many Republicans argued that SCHIP should focus more narrowly on the lower-income children who constituted the program’s original population. They objected to using SCHIP funds to subsidize coverage for adults or for children above 200 percent of poverty (concerns were also raised over ensuring that undocumented immigrants could not enroll in the program). Indeed, in the midst of the reauthorization debate, the Bush administration issued a directive that placed new restrictions on states’ ability to use SCHIP funds to cover children in families above 250 percent of poverty, a directive later deemed by the U.S. Government Accountability Office (GAO) to be in violation of federal law.\textsuperscript{36}

The debate over how and where to draw the line in expanding SCHIP illustrates a broader dilemma in health reform: the higher up the income ladder a government program proposes to go with subsidies to assure broader coverage, the more likely it is to encounter criticism that it will crowd out private insurance and that such subsidies are not necessary for higher-income Americans.

SCHIP expansion also stalled because the congressional Democratic leadership (as well as key Senate Republicans) failed to bridge differences between competing constituencies in the SCHIP debate. Their efforts to secure enough Republican votes in the House to override President Bush’s veto fell short, despite compromises designed to attract support (including limits on adult coverage and new provisions requiring citizenship documentation). Yet there might not have been a workable deal in 2007. With additional concessions to House conservatives, the leadership might have lost the support of liberal groups and Democrats who were already uneasy about earlier compromises. And since prior concessions had not delivered enough Republican votes, there was no guarantee that additional compromises would have decisively changed the vote count.

**SCHIP’s Reversal Of Fortune**

The 2008 elections broke the SCHIP deadlock. In early 2009 Congress quickly passed (66–32 in the Senate, 290–135 in the House) and President Obama signed legislation reauthorizing the program for four and a half years. The legislation (known as the Children’s Health Insurance Program Reauthorization Act, or CHIPRA) provided $32.8 billion in funds (financed through a sixty-two-cent-
“As health policy moves onto more controversial terrain, the partisan divide will grow.”

per-pack increase in the cigarette tax) so that SCHIP—now renamed CHIP—could cover an estimated four million more uninsured children (in addition to the seven million already enrolled). Notably, the legislation authorized states to use federal money to cover legal immigrant children and pregnant women who have been in the country for less than five years; previously they faced a five-year waiting period before they were eligible for Medicaid or SCHIP. The reauthorization also expanded CHIP benefits to include dental services.

SCHIP’s Lessons For Health Reform

Now that SCHIP reauthorization and other incremental health reforms have passed (including increased federal funding for Medicaid to help states cope with the economic emergency), attention is turning to the prospects for comprehensive health reform. What lessons does the SCHIP reauthorization experience hold for the upcoming debate over national health reform?

■ Reasons for hope. Those looking for reasons to be hopeful about comprehensive reform’s political prospects during the Obama administration can take comfort in elements of the reauthorization story. After all, Congress enacted SCHIP reauthorization with sizable majorities (66–32 in the Senate and 290–135 in the House). The speed with which CHIPRA became law and the scope of the program’s expansion underscore the new political environment (a Democratic president and expanded Democratic congressional majorities) for health care reform. SCHIP expansion also attracted strong public approval and drew support from a broad range of stakeholders, including businesses, providers, and the insurance industry. In short, the passage of CHIPRA offered a glimpse of exactly the type of coalition reformers hope to build for universal coverage during the Obama administration.

■ Warning signs. Yet the SCHIP fight also provides ample warning signs about the difficult road ahead. The SCHIP reauthorization debate once again revealed the ideological divide in U.S. health policy. If legislation covering an additional four million children can be derided as “socialized medicine” and provoke resistance to “government-run health care,” then a much larger firestorm surely awaits universal coverage proposals. The SCHIP debate revolved around the same boundary issues that will determine the fate of comprehensive reform in 2009 and beyond: the balance between public and private insurance, who should be eligible for government subsidies and at what income level, whether health care is an individual responsibility or social good. Those issues are far from resolved.

Moreover, although SCHIP expansion drew bipartisan support, the scope of that support was limited. Only nine of forty-one Republican senators voted for CHIPRA in 2009, while all fifty-seven Democrats voted for it. Indeed, two Repub-
lican supporters of SCHIP reauthorization in 2007, Senators Grassley and Hatch, were angered by changes Democrats made in the legislation and switched their votes to no in 2009. In the House, 99 percent of Democrats voted in 2009 for the reauthorization bill, while 77 percent of Republicans voted against it.

Political differences. Despite broad consensus that the U.S. health care system is broken, there is little agreement on how to fix it. Most Democrats and Republicans come to health reform with different public philosophies, different reform priorities, and different solutions. As health policy moves away from children’s health insurance and onto more controversial terrain, such as whether to impose employer mandates or adopt a new national health plan, that partisan divide will grow.

Even with President Obama’s support for health reform and larger Democratic majorities in the House and Senate, reformers could well need a supermajority of sixty votes to get comprehensive reform legislation past a Senate filibuster. Bipartisanship thus may still be a precondition for successful health reform, at least in the Senate. However, securing actual (rather than rhetorical) support for comprehensive reform will be far more difficult than building a coalition for SCHIP.

Financing. Comprehensive reform also presents a fundamentally different financing challenge. SCHIP navigated PAYGO (pay as you go) budgetary rules because the price tag for expansion was modest and cigarette taxes offered a viable financing mechanism. However, the bill for universal coverage is much more expensive. Consequently, more controversial funding sources must be tapped, or PAYGO rules must be suspended.

Given the enormous political and fiscal barriers to adopting legislation that aims for universal or near-universal coverage, it could be tempting for Congress and the Obama administration to follow the expansion of children’s health insurance with further incremental measures. The political appeal of such a strategy is understandable: maximizing consensus on incremental policies while avoiding harder, more polarizing, and more expensive reforms is a time-tested strategy in U.S. health policy. Indeed, it is the exact political formula that produced SCHIP’s enactment in 1997. Advocates of incrementalism have long recognized that political constraints mean that the alternative to imperfect, limited reforms is, alas, often to do nothing. In that context, incrementalism looks quite appealing—a fallback position seemingly validated by the repeated failure of big-bang reform.

Yet there are real limits to incremental health reform. After all, despite gains in Medicaid and SCHIP, almost nine million children remain uninsured. The insur-
ance system for children, notwithstanding their sympathetic status, is beset by the same problems that plague the rest of the U.S. health care system: fragmentation, inequality, and alarming coverage gaps. It is a sobering reminder of just how far the country has to go in health reform that we have not been able to secure universal coverage even for children.

There are also limits to a health reform strategy premised on demographic incrementalism that insures Americans group by group. Unlike children or the elderly, most uninsured Americans do not fit into sympathetic population subgroups that can be neatly matched to public programs. The SCHIP formula can only take us so far, since “all the ‘good’ (that is, politically attractive) populations are taken.” To make significant progress toward covering all Americans, we will have to adopt insurance expansions that don’t simply target politically attractive populations.

If the past decade has proved anything in American health policy, it is that incrementalism is not enough. A decade of incrementalism and inaction has left us with higher costs and rising numbers of uninsured Americans; absent decisive action, those trends will only worsen in coming years. It is encouraging, then, that both the Obama administration and key players in Congress are now pursuing bolder reforms. Perhaps we are entering a new era where U.S. health policy will finally move beyond incrementalism.

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NOTES
6. Brandon et al., “Launching SCHIP.”
Health Affairs 26, no. 2 (2007): 370–381.


16. Ibid.


34. Iglehart, “The Fate of SCHIP.”


37. CHIPRA also officially changed the program’s name from SCHIP to CHIP.