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REAUTHORIZING SCHIP: ONLY A STARTING POINT

PAMELA NEWELL*

I. INTRODUCTION

This article focuses on the implementation of State Children's Health Insurance Programs (SCHIP) and the issues surrounding SCHIP. The article will also discuss the organizational lobbying that produced the final legislation.

According to the Children's Defense Fund, nine million children in the United States do not have health insurance.¹ This statistic encouraged Congress to focus on federal-funded SCHIPs when it was up for re-authorization in September 2007.² Lobbyists played a critical role in the passage of the SCHIP amendment.³

Administered by the Center for Medicare and Medicaid Services (CMS), SCHIP benefits became available on 1 October 1997 and provided approximately twenty-five billion dollars in federal matching funds over five years to help states expand health care coverage to uninsured children.⁴

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1. Siobhan Leftwich, *A Call for Universal Health Care for Children*, THE CRISIS, Jul./Aug. 2007, available at http://findarticles.com/p/articles/mi_qa4081/is_200707/ai_n19511744/?tag=content;coll1, citing Children's Defense Fund, Health Coverage for All Children Campaign, Top Ten Facts About Children's Health Coverage in the United States, http://cdf.childrensdefense.org/site/PageServer?pagename=healthy_child_top_ten_facts; see also John K. Iglehart, *Health Policy Report: Insuring All Children - The New Political Imperative*, 357 NEW ENG. J. MED. 70 (2007) (explaining the history and potential reauthorization of the State Children's Health Insurance Program (SCHIP)).

2. Aaron McKethan, Wes Joines & Christina Koster, *SCHIP in North Carolina: Evolution and Reauthorization Challenges and Opportunities*, THE LEWIN GROUP, 1 (March 2007), <http://www.healthwellinc.com/LewinSCHIP07report.pdf>.

3. Emily Cadei, *Health Care Groups Spending Millions on Lobbying*, CQ HEALTHBEAT NEWS (Sept. 17, 2007), <http://www.cq.com/doc/hbnews-2585480?print=true>.

4. Lindsay Renick Mayer, *An Apple a Day Won't Keep the Lobbyists Away*, OPEN SECRETS BLOG (Aug. 1, 2007, 6:00 PM), <http://opensecrets.org/news/2007/08/an-apple-a-day-wont-keep-the-lobbyists-away>.

SCHIP is jointly financed by federal and state governments and is administered by the individual states.⁵ Within very broad federal guidelines, each state can determine the design of the SCHIP program, eligibility groups, and administrative and operating procedures.⁶ SCHIP provides federal matching funds to individual states based on state expenditures under approved SCHIP plans.⁷

II. BACKGROUND

SCHIP is funded through the Social Security Act (SSA), which was passed in 1935.⁸ The purpose of the SSA was to provide benefits for senior citizens (who had previously been employed), victims of industrial accidents, the unemployed, dependent mothers and children, the blind, and the physically handicapped.⁹ Specifically, the Preamble to the SSA defines it as:

An act to provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.¹⁰

The SSA also provided for Medicaid-like financial assistance for citizens on a limited budget.¹¹

SCHIP allocates funds through the Balanced Budget Act of 1997 to assist states with providing insurance to low-income children who are ineligible for Medicaid, but cannot afford private health insurance.¹² The initiative is a partnership between the federal and state govern-

5. *Budget in Brief*, U.S. DEP'T OF HEALTH & HUMAN SERVS., 66-67 (2007), <http://archive.hhs.gov/budget/07budget/2007BudgetInBrief.pdf>.

6. *Id.*

7. *Id.* at 66; see U.S. DEP'T OF AGRIC. FOOD & NUTRITION SERV., *The State Children's Health Insurance Program (SCHIP)*, <http://www.fns.usda.gov/cnd/SCHIP/factsheet.htm> ("Under the law, states are eligible to receive an enhanced federal matching rate drawn from an 'allotment' for state programs approved by the Secretary of Health and Human Services that expand access to targeted, low-income children under SCHIP. Funds are allotted to each participating state according to their number of uninsured and low-income children, accounting for regional cost differences. States have three years to spend a given year's allotment. Allotments for each fiscal year are published in the *Federal Register*").

8. Social Security Act, Pub. L. No. 271, 49 Stat. 620 (1935) (codified as 42 U.S.C. § 1397).

9. *Id.* at 620.

10. Social Security Act, H.R. 7260, 74th Cong. (1935).

11. Social Security Act, Pub. L. No. 271, 49 Stat. 620 (1935) (codified as 42 U.S.C. § 1397).

12. NAT'L CONFERENCE OF STATE LEGISLATURES, *Children's Health Insurance Program (CHIP)*, <http://www.ncsl.org/IssuesResearch/Health/ChildrensHealthInsuranceProgramOverview/ttabi/14510/Default.aspx> (last updated May 2010).

ments that helps provide children with health coverage.¹³ States are required to use funding from SCHIP to cover uninsured children and not replace existing health coverage.¹⁴ All fifty states, five U.S. territories, and the District of Columbia have approved SCHIP plans.¹⁵ In 2007, more than seven million children were enrolled in the program at some point during the fiscal year.¹⁶

III. ISSUES

The top issues surrounding SCHIP re-authorization are funding, mandatory wait periods, and enforcement. Regarding funding, if Congress re-authorized SCHIP in 2009 at the 2007 numbers, the Congressional Budget Office and many analysts predict the federal funds would be frozen at five billion dollars over five years.¹⁷ This would result in a shortfall for SCHIP across the states.¹⁸ It is predicted that these shortfalls will decrease states' participation in the program.¹⁹

Possibly the most problematic issue with SCHIP is the one-year wait period.²⁰ The child will not be eligible for SCHIP unless she has been uninsured for at least one year, depending on the state.²¹ The important question is whether parents will risk leaving their children uninsured for an entire year in order to be eligible for SCHIP.²²

Another contentious question is whether dental care will be provided by SCHIP. Health insurance does not equate to dental coverage.²³ According to the Children's Defense Fund, over nine million children in the United States do not have health insurance, and even those who have Medicaid coverage have a difficult time securing dental care.²⁴ In addition, in Maryland, less than one in three children in the Medicaid program received dental care in 2005.²⁵

13. U.S. DEP'T OF AGRIC. FOOD & NUTRITION SERVS., *The State Children's Health Insurance Program (SCHIP)* (Feb. 2, 2001), <http://www.fns.usda.gov/end/SCHIP/factsheet.htm>.

14. *Id.*

15. *Id.*

16. U.S. DEP'T OF HEALTH & HUMAN SERVS., *The Children's Health Insurance Program*, CTRS. FOR MEDICAID & MEDICARE SERVS. (Jun. 30, 2010, 6:46 AM), <http://www.cms.gov/LowCostHealthInsFamChild/>.

17. McKethan, *supra* note 2, at 11.

18. McKethan, *supra* note 2, at 11.

19. McKethan, *supra* note 2, at 11.

20. Brant McLaughlin, *SCHIP Lobbying to Hit Capitol Hill*, NAT'L ASS'N OF CHILDREN'S Hosps. (2009), http://www.associatedcontent.com/article/384229/schip_lobbying_to_hit_capitol_hill.html?cat=62 (last visited Oct. 30, 2010).

21. *Id.*

22. Donald Nichols & Michael Plotzke, *The Reality of SCHIP and Uninsured: Do SCHIP Mandatory Wait Periods Increase the Uninsured Rolls?*, 11 F. HEALTH ECON. & POL'Y 1, 1 (2008).

23. Leftwich, *supra* note 1, at 1.

24. Leftwich, *supra* note 1, at 1.

25. Leftwich, *supra* note 1, at 1.

A. *Funding*

In 1997, Congress enacted Title XXI under the Social Security Act to establish state insurance programs with matching federal funds.²⁶ States administer the programs as they see fit and choose how to determine eligibility.²⁷ Generally, the children of an uninsured family making less than \$36,200 per year are eligible.²⁸ This helps low-income families who make more than the Medicaid eligibility requirements, but cannot afford private medical insurance.²⁹ For continuous federal funding, Section 2108(a) of the SSA provides that states must assess the operation of the child health plan in each federal fiscal year and report on the results of the assessment.³⁰ In addition, this section provides that the state must assess the progress made in reducing the number of uncovered, low-income children.³¹

The federal matching funds actually exceed the amount spent on Medicaid to encourage state participation.³² This has led to a decline in the number of uninsured children from 13.9% in 1997 to 8.9% in 2005.³³ If a state exceeds its own budget, it may use federal funds to supplement the SCHIP.³⁴ There is no cap on federal matching funds.³⁵ “Each state can receive federal matching funds up to its allotment and can retain federal allocations for a period of three years.”³⁶

With SCHIP, states have flexibility in determining which children are eligible.³⁷ States may choose to expand their Medicaid programs, establish separate child health programs, or create a combination of both.³⁸ States which establish a separate child health program may offer one of four benefit options:

States choosing a new children’s health insurance program may offer one of the following benchmark plans: the standard Blue Cross/Blue Shield Preferred Provider Option offered by the Federal Employees Health Benefit Program; a health benefit plan offered by the state to its employees; or the HMO benefit plan with the largest commercial

26. McKethan, *supra* note 2, at 1.

27. McKethan, *supra* note 2, at 1.

28. McLaughlin, *supra* note 20.

29. Nichols & Plotzke, *supra* note 22, at 1.

30. State Children’s Health Insurance Program, Social Security Act § 2108(a) (codified as amended at 42 U.S.C. § 1397hh (2009)).

31. *Id.*

32. McKethan, *supra* note 2, at 2.

33. McKethan, *supra* note 2, at 18.

34. McKethan, *supra* note 2, at 2.

35. McKethan, *supra* note 2, at 1.

36. McKethan, *supra* note 2, at 1-2.

37. U.S. DEP’T OF AGRIC. FOOD & NUTRITION SERVS., *The State Children’s Health Insurance Program (SCHIP)* (Feb. 2, 2001), <http://www.fns.usda.gov/cnd/SCHIP/factsheet.htm>.

38. *Id.*

enrollment in the state. A state may also choose to offer the “equivalent” of one of the benchmark plans.³⁹

States can require families to pay some out-of-pocket costs.⁴⁰ If a state expands its Medicaid program, then existing Medicaid cost-sharing limits apply.⁴¹ For enrolled children, cost-sharing cannot be charged for well-child and well-baby visits.⁴² In addition, states cannot require cost-sharing charges that total more than 5% of a family’s total income for the length of a child’s eligibility period in the state.⁴³

B. *Mandatory Wait Periods*

Health insurance rates below the cost of private health plans leads to “crowd-out.”⁴⁴ “Crowd-out” occurs when families take their children out of private health plans and enroll them in SCHIP.⁴⁵ The issue here is whether it is beneficial to “crowd-out” when the child must spend some time uninsured before becoming eligible for SCHIP as a consequence of a mandatory waiting period.⁴⁶

States can require a waitlist of up to twelve months, although the average waiting period is six months.⁴⁷ In a 2008 study, researchers discovered that “as the length of the mandatory waiting periods increase, families will be less likely to insure their children.”⁴⁸ However, when the price of private insurance increases, parents are more likely to risk their children being uninsured for a longer period.⁴⁹ States may decide to decrease the cost of SCHIP by requiring longer mandatory wait periods.⁵⁰

39. *Id.*

40. U.S. DEP’T OF HEALTH & HUMAN SERVS., *CHIP Dental Coverage: Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.hhs.gov/CHIPDentalCoverage/> (last visited Nov. 1, 2010). (Out-of-pocket expenses are defined as cash paid by the party receiving services, which are not reimbursed).

41. *Id.* (Co-payments are generally allowed to align Medicaid programs with private insurance plans by requiring recipients to pay the difference. Expanding State Medicaid programs limit cost-sharing pursuant to the Deficit Reduction Act of 2005 (DRA), available at <http://www1.cms.gov/DeficitReductionAct/Downloads/Costsharing.pdf>).

42. *Id.* (This includes routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealant and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry).

43. *Id.*

44. Nichols & Plotzke, *supra* note 22, at 1.

45. Nichols & Plotzke, *supra* note 22, at 1.

46. Nichols & Plotzke, *supra* note 22, at 1; see also Andrew M. Grossman & Greg D’Angelo, *SCHIP and “Crowd-Out”: How Public Program Expansion Reduces Private Coverage*, WebMemo No. 1518, CTR. FOR HEALTH POL’Y STUDIES, (June 21, 2007), <http://www.allhealth.org/briefingmaterials/schipandcrowdout-heritage-852.pdf>.

47. See Nichols & Plotzke, *supra* note 22, at 2.

48. Nichols & Plotzke, *supra* note 22, at 6.

49. Nichols & Plotzke, *supra* note 22, at 6.

50. Nichols & Plotzke, *supra* note 22, at 7.

Furthermore, some states have chosen to limit their SCHIP costs by establishing enrollment caps or enrollment freezes.⁵¹ An enrollment cap occurs when a state establishes a certain number of SCHIP eligibility slots.⁵² Children unable to enroll due to the full SCHIP slots are placed on a waitlist.⁵³ As children leave the program, the waitlisted children are enrolled.⁵⁴ On the contrary, an enrollment freeze happens when the state disallows enrollment after a certain date.⁵⁵ Children would not be able to enroll until the next enrollment period.⁵⁶

Federal law requires states with waitlists to inform citizens: (a) whether an enrollment cap or an enrollment freeze is in effect; (b) of procedures regarding enrolling when there is a waitlist; (c) how families will be informed that they have been enrolled; and (d) the conditions in which enrollment will re-open.⁵⁷

C. Dental Care

Under SCHIP, dental services are optional.⁵⁸ In Maryland, a twelve year-old uninsured boy died of meningitis that originated as a tooth infection, which had spread to his brain.⁵⁹ The boy's family qualified for Medicaid, but found that many dentists were reluctant to treat Medicaid patients because of low reimbursement rates and the amount of paperwork involved in processing Medicaid claims.⁶⁰ Studies show that children living in poverty have twice as many dental problems than other children.⁶¹

The boy's death spurred Congress to include a mandatory dental health component in SCHIP.⁶² This allows states to cover routine preventive and diagnostic dental services, including, *inter alia*, oral exami-

51. Cynthia Pernice & David Bergman, *State Experience with Enrollment Caps in Separate SCHIP Programs*, NAT'L ACAD. FOR ST. HEALTH POL'Y, 2 (Feb. 2004), http://www.nashp.org/sites/default/files/SCHIP_enrollment_caps.pdf.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. U.S. DEP'T OF HEALTH & HUMAN SERVS., *Oral Health in America: A Report of the Surgeon General*, NAT'L INST. OF DENTAL & CRANIOFACIAL RESEARCH, 255 (2000) [hereinafter, *Nat'l Inst. Of Dental & Craniofacial Research*], <http://silk.nih.gov/public/hck1ocv.www.surgeon.fullrpt.pdf>.

59. Leftwich, *supra* note 1.

60. John Iglehart, *Dental Coverage in SCHIP: The Legacy of Deamonte Driver*, HEALTH AFFAIRS BLOG (Jan. 30, 2009, 6:11 PM), <http://healthaffairs.org/blog/2009/01/30/dental-coverage-in-schip-the-legacy-of-deamonte-driver/>; see U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 58, at 254-55.

61. NAT'L INST. OF DENTAL & CRANIOFACIAL RESEARCH, *supra* note 58, at 252.

62. Iglehart, *supra* note 60.

nations, topical fluoride applications, sealants, and x-rays.⁶³ This fundamental component is not offered through Medicaid for more than fifty percent of eligible children.⁶⁴ SCHIP is designed to complement dental Medicaid services.⁶⁵

States may use SCHIP for oral health services initiatives.⁶⁶ “For example, California has opted to increase dental service utilization among low-income, and uninsured children up to five years old by creating a health service initiative. California’s oral health service initiative includes case management, oral health education, innovative preventive services and mobile vans that will provide dental services.”⁶⁷

Despite these SCHIP issues, companies, corporations, grassroots activists, and lobbyists have strongly advocated for the re-authorization of SCHIP.⁶⁸

D. Organizational Efforts

The Senate tapped a higher tax on tobacco to pay for the SCHIP expansion by adding sixty-one cents to every pack of cigarettes.⁶⁹ Tobacco companies, such as the Cigar Association of America and Reynolds America, lobbied furiously against the tax increase, spending \$3.5 million in campaign and commission donations in 2006.⁷⁰ Most of their contributions went to Republicans.⁷¹ Tobacco companies admitted that the issues were tough: “it’s inevitably portrayed as kids versus tobacco.”⁷² In fact, one citizen stated that “a vote against SCHIP is a vote for tobacco profiteers over kids.”⁷³

63. U.S. DEP’T OF HEALTH & HUMAN SERVS., *CHIP Dental Coverage: Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.hhs.gov/CHIPDentalCoverage/> (last visited Nov. 1, 2010).

64. NAT’L INST. OF DENTAL & CRANIOFACIAL RESEARCH, *supra* note 58, at 253.

65. NAT’L INST. OF DENTAL & CRANIOFACIAL RESEARCH, *supra* note 58, at 255.

66. U.S. DEP’T OF HEALTH & HUMAN SERVS., *CHIP Dental Coverage: Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.hhs.gov/CHIPDentalCoverage/> (last visited Nov. 1, 2010).

67. *Id.*

68. *E.g.*, Jeffrey Young, *Coalition of Interest Groups Backs SCHIP Bill*, THE HILL (Washington, D.C.), Jan. 12, 2009, <http://thehill.com/business-a-lobbying/3850-coalition-of-interest-groups-backs-schip-bill>; *see also* Jeffrey Young, *Health Program Splits Parties*, THE HILL (Washington, D.C.), Feb. 7, 2007, <http://thehill.com/business-a-lobbying/2273-health-program-splits-parties>.

69. Mayer, *supra* note 4.

70. Mayer, *supra* note 4.

71. Mayer, *supra* note 4.

72. Mayer, *supra* note 4.

73. Howard Park, *Guest Post: Is Big Tobacco Stealth-Lobbying Against Children’s Health?*, OURFUTURE.ORG (Oct. 2, 2007, 5:00 PM), <http://www.ourfuture.org/blog-entry/guest-post-big-tobacco-stealth-lobbying-against-childrens-health>.

Organizations against tobacco use also lobbied for the re-authorization of SCHIP.⁷⁴ Campaign for Tobacco-Free Kids spent \$398,000 in lobbying fees in 2006.⁷⁵ Citizens besieged tobacco lobbyists who campaigned against SCHIP, stating that “[t]he same companies that get so many kids sick when they grow up want[] [sic] to keep them from having health insurance when they are growing Rural kids without health insurance are the sort of folks that Big Tobacco wants to grow up and be addicted to its products.”⁷⁶

From the beginning of 2007 until September 2007 (Congress’s time to vote whether to extend SCHIP), health care organizations spent approximately \$227 million solely for lobbying, a 17% increase from 2000.⁷⁷ One-half of the highest spending associations were from health care groups, including Pharmaceutical Research and Manufacturers, the American Medical Association, Amgen, USA Inc., the American Hospital Association, and Pfizer, Inc.⁷⁸ Pharmaceutical companies pushed very hard for the SCHIP re-authorization because “[m]ore children insured means using more drugs.”⁷⁹ Smaller watchdog groups have also significantly participated in SCHIP lobbying, such as the National Alliance for Hispanic Health, MoveOn.org, Americans United, USAction, and the National Catholic School of Justice Lobby.⁸⁰ They are credited for “[r]eal advances in health care[.]”⁸¹

On the other hand, some private health insurance corporations lobbied against the SCHIP expansion to minimize costs.⁸² Many private insurance companies worried that the availability of SCHIP would attract those buying private insurance to the government plan.⁸³ America’s Health Insurance Plans spent \$7.1 million in lobbying efforts in 2006.⁸⁴ One of its arguments against an expansion of SCHIP is that it “could curtail health care for some seniors.”⁸⁵ However, the American Association for Retired Persons (AARP) was the second-highest spender, at \$23.2 million, in support of the re-authorization of

74. Mayer, *supra* note 4.

75. Mayer, *supra* note 4.

76. Park, *supra* note 73.

77. Cadei, *supra* note 3, at 1.

78. Cadei, *supra* note 3, at 1.

79. M. ASIF ISMAIL, *A Record Year for the Pharmaceutical Lobby in '07: Washington's largest lobby racks up another banner year on Capitol Hill*, THE CTR. FOR PUBLIC INTEGRITY (June 24, 2008), <http://projects.publicintegrity.org/rxl/report.aspx?aid=823>.

80. NICO PITNEY, *MoveOn Threatens Republicans With New SCHIP Ads*, HUFFINGTON POST, Oct. 17, 2007, http://www.huffingtonpost.com/2007/10/17/moveon-threatens-republic_n_68799.html.

81. LEE SUSTAR, *The Story Behind Bush's SCHIP Veto*, THE SOCIALIST WORKER, Oct. 26, 2007, at 16, available at http://socialistworker.org/2007-2/650/650_16_SCHIP.shtml.

82. Mayer, *supra* note 4, at 2.

83. Mayer, *supra* note 4, at 2.

84. Mayer, *supra* note 4, at 2.

85. Mayer, *supra* note 4, at 2.

SCHIP to aid seniors with drug prescription costs and higher premiums.⁸⁶

E. Enforcement

The federal agency charged with overseeing the implementation of SCHIP is the Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS).⁸⁷ According to the Act, states must report several things to the federal government, including: (1) how the money will be spent; (2) what type of programs will be created to maximize SCHIP benefits; (3) amount of matching funds; and (4) statistics regarding the number of uninsured children.⁸⁸ The Act's requirements, however, stop there. DHHS does not have the authority to actually force states to do anything. SCHIP is a funding statute and can only put strings on information that must be provided. Accordingly, states can arbitrarily spend SCHIP funds as long as they report the required components to DHHS.⁸⁹ Thus, there are no teeth to the legislation. There is only the hope that states will use the funds wisely by investing in the welfare of uninsured children.

The answer to the nonexistent enforcement mechanisms are found either in CMS regulations or congressional action. The Federal Advisory Committee Act (FACA) authorized CMS to establish a working group to make recommendations on the implementation of SCHIP.⁹⁰ This "CHIP Working Group" was established on April 3, 2009 and was tasked to:

Develop a model coverage coordination disclosure form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of coverage available under group health plans to employees who have family members who are eligible for premium assistance offered under a State plan under titles XIX or XXI of the Social Security Act (the Act) and to allow for coordination of coverage for enrollees of such plans. The form shall provide the following information in addition to other information as the Working Group determines appropriate: 1) a determination of whether the employee is eligible for coverage under the group health plan, 2) the name and contact information of the plan administrator of the group health plan, 3) the premiums and cost-shar-

86. Mayer, *supra* note 4, at 2.

87. U.S. DEP'T OF HEALTH & HUMAN SERVS., *Office of Legislative Affairs: Overview*, CTMS FOR MEDICARE & MEDICAID SERVS., http://www.cms.hhs.gov/OfficeofLegislation/01_overview.asp (last modified Sept. 8, 2010).

88. See 42 U.S.C. §§ 1397aa(b)(1), 1397gg(a)(1), 1397gg(b)(1), 1397dd(B) (2010).

89. § 1397aa(a)(1); see generally, §1397gg(a)-(d).

90. U.S. DEP'T OF HEALTH & HUMAN SERVS., *Children's Health Insurance Program Working Group*, CTMS FOR MEDICARE & MEDICAID SERVS., https://146.123.140.205/FACA/06_CHIPWorkingGroup.asp (last modified Aug. 23, 2010) [hereinafter *CHIP Working Group*].

ing required under the plan, and 4) any other information relevant to the coverage under the plan.

Identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Act or child health assistance or other health benefits coverage under title XXI of the Act.

Not later than August 5, 2010, submit to the Secretary of Labor and the Secretary of Health and Human Services the model disclosure form as stated above along with a report containing recommendations for appropriate measures for addressing the impediments (as stated above) to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Act.⁹¹

These directions, again, apply to reporting regulations only, focusing on developing forms and providing information.⁹² This is frustrating because that information has already been provided for over a decade.⁹³ CMS should implement regulations which tighten restrictions on SCHIP federal funds. Many federal funding statutes have greater requirements than SCHIP, such as DHHS grants to state, local, and tribal governments,⁹⁴ Department of Justice Programs,⁹⁵ and grants under the Federal Transit Administration.⁹⁶

Although tighter regulations are seemingly not imminent, it would likely be faster and in the best interests of the children needing health care to wait on CMS rather than wait for the legislative process. CMS should look at reports by the Surgeon General, research by scholars, medical associations, reports by the Office of the Inspector General, and databases from health centers to guide it in establishing needed substantive regulations.

For example, the Office of the Inspector General issued a report in September 2007, which provided that the percentage of uninsured children had decreased between 2002 and 2005.⁹⁷ The report also stated that documenting states' progress for SCHIP was very difficult.⁹⁸ In a different report, the Inspector General found that only 1% of children enrolled separately in SCHIPs were also eligible for Medi-

91. *Id.* See also Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, § 311(b)(1)(C), 123 Stat. 8, 68-69 (2009).

92. § 311(b)(1)(C)(i).

93. Mayer, *supra* note 4.

94. See 45 C.F.R. § 92.1 (2010).

95. See 28 C.F.R. § 33.1 (2010).

96. See 49 U.S.C. § 5305 (2010).

97. Daniel R. Levinson, U.S. DEP'T OF HEALTH & HUMAN SERVS., *Assessing States' Progress in Meeting State Children's Health Insurance Program Goals*, OFFICE OF INSPECTOR GEN., 10 (Sept. 2007), <http://oig.hhs.gov/oei/reports/oei-05-07-00330.pdf>.

98. *Id.* at 13.

caid.⁹⁹ This report also revealed that SCHIPs became more vulnerable due to lack of documentation.¹⁰⁰

The American Medical Association (AMA) releases one-page issue briefs to medical students and doctors.¹⁰¹ The issue briefs contain frequently asked questions, statistics, and clarifications of the AMA's position on the subject.¹⁰² In a recent issue brief, the AMA declared that it supported the expansion of SCHIP and urged more physicians to accept Medicaid patients.¹⁰³

The School of Public Health and Health Services at George Washington University conducted a study regarding the achievements and challenges for health care centers.¹⁰⁴ The report provided that health centers, which served mostly poor and minority communities, relied heavily on Medicaid payments to function.¹⁰⁵ Interestingly, the report revealed several challenges to the future success of health centers, including: (1) changes in Medicaid reduction payments; (2) implementing Medicare Part D drug benefits; (3) increasing the number of uninsured patients with complex health care needs; (4) improving health center quality; (5) adopting health information technology; (6) responding to an increasingly diverse patient population; and (7) needing more employees in health center workforce.¹⁰⁶

CMS has immense "power [for] a single federal administrative agency to change the course of national health policy."¹⁰⁷ However, CMS has focused mainly on Medicaid regulations.¹⁰⁸ Increasing the confusion about SCHIP requirements, CMS issued a policy directive in 2007 establishing anti-crowd-out policies under SCHIP, but did not take into account how this would affect Medicaid patients.¹⁰⁹ This is

99. OFFICE OF INSPECTOR GEN., *Determining if Children Enrolled in Separate SCHIPs Were Eligible for Medicaid*, U.S. DEP'T OF HEALTH & HUMAN SERVS., 9 (June 2005), <http://oig.hhs.gov/oei/reports/oei-07-03-00220.pdf>.

100. *Id.* at 11.

101. See AM. MED. ASSOC., *Advocacy*, MED. STUDENT SEC., <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/mss-issue-briefs.shtml> (last visited Oct. 31, 2010).

102. *Id.*

103. AM. MED. ASSOC., *Access for Children: The State Children's Health Insurance Program*, MED. STUDENT SEC. ISSUE BRIEF (Oct. 31, 2010), http://www.ama-assn.org/ama1/pub/upload/mm/15/cola_medicaid_brief.pdf.

104. Sara Rosenbaum & Peter Shin, *Health Centers Reauthorization an Overview of Achievements and Challenges*, KAISER COMM'N ON MEDICAID & THE UNINSURED, 1 (Mar. 2006), <http://www.kff.org/uninsured/upload/7471.pdf>.

105. *Id.*

106. *Id.* at 2.

107. Sara Rosenbaum, *CMS' Medicaid Regulations: Implication for Children With Special Health Care Needs*, GEORGETOWN UNIV. HEALTH POL'Y INST. CTR. FOR CHILDREN & FAMILIES, 1 (March 2008), <http://www.americaspromise.org/About-the-Alliance/~media/Files/About/FirstFocusCMS%20Report.ashx>.

108. *Id.*

109. See *id.* at 13.

especially significant due to federal policies aimed at decreasing Medicaid payments in favor of SCHIP funding.¹¹⁰

CMS has developed regulations prohibiting the use of schools to administer SCHIP, which is a problem for special needs students who receive special education.¹¹¹ CMS proposed a regulation to remove foster care, child welfare, and child education from SCHIP programs.¹¹² This regulation would block children from receiving rehabilitative services.¹¹³ CMS has also issued regulations to exclude certain hospital outpatient services.¹¹⁴ Additionally, it proposed regulations which would require administrative review under the Departmental Appeals Board prior to any judicial review.¹¹⁵ This process would be in contravention of normal appellate review.¹¹⁶

However, on 4 February 2009, President Barack Obama issued a Presidential Memorandum ordering CMS to withdraw an August 2007 letter which set forth restrictive eligibility policies. The Memorandum provides:

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a letter to State health officials limiting the flexibility of States to set income eligibility standards for their SCHIP programs. On May 7, 2008, CMS issued a subsequent letter restating the policy set forth in the August 17, 2007, letter.

The August 17, 2007, letter imposes additional requirements that States must meet in order to cover children under SCHIP plans, including plans that CMS had previously approved. These requirements have limited coverage under several State plans that otherwise would have covered additional, uninsured children. As a result, tens of thousands of children have been denied health care coverage. Unless the August 17, 2007, letter is withdrawn, many more children will be denied coverage.

By this memorandum, I request that you immediately withdraw the August 17, 2007, and May 7, 2008, letters to State health officials and implement SCHIP without the requirements imposed by those letters.¹¹⁷

When he signed the bill reauthorizing SCHIP, President Obama made the following remarks:

We are not a nation that leaves struggling families to fend for themselves. No child in America should be receiving her primary care in

110. McKethan, *supra* note 2, at 1-2.

111. Rosenbaum, *supra* note 107, at 13.

112. Rosenbaum, *supra* note 107, at 15.

113. Rosenbaum, *supra* note 107, at 15.

114. Rosenbaum, *supra* note 107, at 17.

115. Rosenbaum, *supra* note 107, at 17-18.

116. Rosenbaum, *supra* note 107, at 18.

117. Barack Obama, *Presidential Memorandum for the Secretary Of Health And Human Services*, THE WHITE HOUSE (Feb. 4, 2009), <http://edocket.access.gpo.gov/2009/pdf/E9-2721.pdf>.

the emergency room in the middle of the night. No child should be falling behind at school because he can't hear the teacher or see the blackboard. I refuse to accept that millions of our kids fail to reach their full potential because we fail to meet their basic needs. In a decent society, there are certain obligations that are not subject to trade-offs or negotiation – health care for our children is one of those obligations.

That is why we have passed this legislation to continue coverage for seven million children, cover an additional four million children in need, and finally lift the ban on states providing insurance to legal immigrant children if they choose to do so. Since it was created more than ten years ago, the Children's Health Insurance Program has been a lifeline for millions of kids whose parents work full time, and don't qualify for Medicaid, but through no fault of their own don't have – and can't afford – private insurance. For millions of kids who fall into that gap, CHIP has provided care when they're sick and preventative services to help them stay well. This legislation will allow us to continue and build on these successes. But this bill is only a first step. The way I see it, providing coverage to 11 million children through CHIP is a down payment on my commitment to cover every single American. And it is just one component of a much broader effort to finally bring our health care system into the twenty-first century.¹¹⁸

Clearly, President Obama views the SCHIP re-authorization as a first step in universal health care.¹¹⁹ However, he will need to continue guiding CMS's regulations, policies, and proposed regulations through executive orders or presidential memoranda. Once the government can establish effective SCHIP administration, the executive and legislative branches will be able to formulate a universal health care insurance option for all Americans. Until then, all branches should keep CMS's SCHIP policies under a microscope and take note of CMS regulations regarding SCHIP.

III. CONCLUSION

The creation and implementation of SCHIP substantially enhanced medical coverage for millions of children who otherwise would have been uninsured.¹²⁰ After operating for over a decade, obvious concerns must be addressed to ensure the future success of the program. Appropriating federal matching funds combined with state resources proves to be an effective formula for maintaining this program.¹²¹

118. Press Release, Barack Obama, Remarks by President Barack Obama on Children's Health Insurance Program Bill Signing (Feb. 4, 2009) (transcript available at <http://www.whitehouse.gov/the-press-office/remarks-president-barack-obama-childrens-quos-health-insurance-program-bill-signing>).

119. *Id.*

120. See *supra* nn. 12-16 and accompanying text.

121. See *supra* Part I, note 33.

However, the federal funds for SCHIP must be adjusted accordingly to be consistent with the nature of the economy in the future.¹²² More importantly, the issue regarding the one-year wait period should be addressed immediately to reduce parent risks.¹²³ Lastly, dental coverage is a rising concern as it relates to SCHIP.¹²⁴ Although optional in some states, advocates of SCHIP should promote dental health coverage as a mandatory component of the program.¹²⁵ CMS maintains enforcement and implementation of SCHIP.¹²⁶ The President of the United States, along with lobbyists, activists, and advocates of SCHIP must continue to support this federal agency in assuring that no child in America is medically uninsured.¹²⁷

122. *See supra* nn. 49-52 and accompanying text.

123. *See supra* Part II.

124. *See supra* Part III.

125. *See supra* nn. 58-64 and accompanying text.

126. *See supra* Part V, nn 86,109.

127. *See supra* p. 16, notes 120 and 121, and Part IV.