Children's Health Insurance Program: the Dynamics of Federalism and Health Care Policy

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Abstract

On February 4th 2009, President Obama signed into law the reauthorization of the Children Health Insurance Program. The federal government will now spend 30 billion dollars towards the goal of ensuring that more children in the United States are insured. I investigate this particular health care policy and look at the different dynamics that affect the ultimate goal of universal health insurance for children. Because this program allows for state flexibility under broad federal guidelines, one is able to look at individual states, and their particular actions and characteristics, to determine the best approach to insuring the most children. Findings in my research establish that social factors such as diversity of a state's population play an important role in the number of uninsured children in the various states.

Introduction

When the American health care system is being discussed it's often described as being sick or in critical condition. There is general consensus that the current system needs to be reformed but when the issue of what kind of reform is needed, the general consensus turns into dissonance and the deliberation of health care reform turns into debate with minimal results. To understand the broken health care system, think of it as a three-legged stool. Each leg of the stool represents: quality, accessibility, and affordability. In an ideal system, each leg would be equal to all other legs so that the stool could properly function. In our current system, the aspects of accessibility and affordability create for a wobbly stool that is no longer functional. In 2007,

45 million Americans were without insurance at some point and the United States spends 17 percent of its Gross Domestic Product on health care, higher than any other industrialized nation.

The topic of health care politics and policy in the United States is indivisible from the issues of federalism. Local, state and the federal government are active players in the reformation of health care policy and will continue to be predominant decision makers in how to create quality, accessible, and affordable health care. As this is true, it is important to look at how states capitalize on grants and initiatives that the federal government funds as this may give answers to the best possible actions for the future of health care policy-making. Successful actions, as well as those actions that are not as succesful, can give clearer instructions for future health care legislation. Both Medicaid and the States Children Health Insurance Plan (S-CHIP) are federally funded programs that require states to take an active role in health care policy making. States differ in their approaches as well as their successfulness in taking advantage of these programs.

Literature Review

Features of the Health Care System

The United States health care policy relies on pillars of both, centralized and decentralized programs, Medicare and Medicaid. Medicare is a purely federal program with policies being determined by Congress and a federal agency that administers these policies, The Health and Human Services Agency. Medicaid and the S-CHIP are federal to state programs supported by federal conditional grants and delivered by state governments. For these decentralized programs, the federal government sets broad guidelines to the states for general eligibility and coverage standards, but leaves enough room for states to tailor their programs to

best suit their needs. The federal government also has the ability to grant waivers to some regulations for states to allow for experimentation in program design. As a result, state programs vary considerably in eligibility requirements, service coverage, utilization limits, provider payment policies, reliance on managed care, and spending per recipient (Banting and Corbert 2002).

Another important feature of American health care policy is that of incrementalism. To increment policy is to make small changes and modifications to existing policy and this procedure is most commonly used for health care policies for several reasons. It's politically attractive to policymakers because small policy adjustments reduce the impact of negative and political risky consequences of overwhelming change of health care policies. It may be popular, but it does have drawbacks including inhibiting imagination, innovation, and fresh new approaches to problem solving. Policymakers end up creating policies that "satisfy" diverse interests, rather than problem solving the root of the problem (Patel and Rushefsky 2006). Some research has found considerable reason to be pessimistic about the long term success of incremental efforts to promote universal coverage and outline the requirements for a more punctuated approach to rapid policy diffusion (Gray, Lowery, Godwin, and Monogan 2005).

Medicaid

Medicaid was established so that poor people had greater access to health care by providing them with financial assistance to meet their medical needs. The nature of its creation was that of a partnership between levels of government, federal, state, and local, to improve access and quality of health care for the poor. The federal government establishes broad program guidelines, promotes and monitors program development, and provides financial

assistance through matching grants. State governments are given significant control over important aspects of the scope and structure of the program by having discretionary authority over the eligibility standards, the nature and scope of benefits provided, and the different mechanism used to reimburse health care providers (Patel and Rushefsky 2006 (77).

The matching rates that the federal government provides depend on state's per capita income with poorer states receiving higher rates than their wealthier counterparts. The lowest percent of the matching fund is 50 percent, while the highest rate is 73 percent, and the average federal matching rate is 58 percent. The federal government funds some of the cost but it is up to the states to deliver the health care. States must provide a wide range of services including: hospital inpatient and outpatient care, physician services, and laboratory and x-ray services. Each state has the option of covering prescription drugs, dental services, physical therapy, prosthetic devices, and other medical care services. The Medicaid program also covers institutional and community-based long-term care services. Medicaid is an essential pillar of America's health care plan because the Medicaid population considerably less healthy than the average person and these people would have a great difficulty obtaining conventional health insurance, and even if they could, their premiums would be extremely high (Holahan, Weil, and Wiener 2003).

S-CHIP

The State Children's Health Insurance Program (S-CHIP) was a result of title XXI of the Social Security Act under the 1997 Balanced Budget Act. It was an incremental change to target children who were uninsured after President Clinton was unable to pass universal health care. This program epitomizes the balance between state and federal governments and their role in

health care policy. Under the program, like under Medicaid, the federal government provides matching funds to assist states in providing health insurance coverage for uninsured children. The S-CHIP was enacted to address the gap in health insurance coverage for low income children who were not poor enough to qualify for Medicaid. The state has three options in utilizing these matching funds from the federal government.

One option is for the expansion of the Medicaid program to cover more children. The state can build on existing institutional structures and make very few program modifications. Another option for states is to fund an alternative new insurance program with the S-CHIP funds, separate from the Medicaid program. Since some states had an insurance program already in place to address insuring children, they can use the funds to sustain their own programs. This option also allows the state to forgo some of the federal requirements of the Medicaid program, such as the mandatory benefits and limits on cost sharing. The final option for a state is to use a combination of the first two approaches.

On average, the federal government pays 70 percent of the program while the state governments pick up the rest. Unlike Medicaid, these enhanced federal matching payments are limited by national and state specific allotments, or annual limits on federal funding. The S-CHIP has a system to redistribute federal allotments from state that did not spend the full amount to others that may need higher amounts. The states may use up to 10 percent of their annual allotments on outreach, administration, and other activities (Lambrew 2007).

The primary difference between Medicaid and S-CHIP is how it is funded by the federal government. For the Medicaid program, the federal government allows an open ended entitlement to matching grants for the states, while the S-CHIP program has a capped allotment

by federal legislation. Rather than guaranteeing unlimited resources to children depending on eligibility guidelines, the federal government matches state spending, on average of about 70 percent, on health care services to children who are eligible, up to a fixed capped allocation (Shea 2007).

A federally funded evaluation in 2003 found SCHIP to be successful in nearly all of the areas examined. SCHIP currently provides health coverage to 4 million low-income children and since its creation in 1997 it has been attributed with helping to reduce the uninsured U.S. children's rate from 23 percent to 15 percent (Krisberg 2007).

Because of the success of the program, and the fact that reauthorization of the program was coming in 2007, there were political fights about the program. The fights over the program came from three different areas. The first was who should S-CHIP cover? There were more children that were eligible for coverage but who were not signed up and some states were allowing parents of children who were eligible to be included in the reach of coverage provided by S-CHIP. Another question was, what coverage should be offered? Finally, the most important was how to finance S-CHIP for the next ten years?

President Bush vetoed the expansion of S-CHIP bill in 2007 and then offered the extension of the S-CHIP at previous funding for 18 months, or four months past the election of a new President. Michael Levitt *Secretary of the U.S. Department of Health and Human Services* offered this explanation, "But the administration will not support a gradual government takeover of the health care market, and neither will the American people. If the world has learned anything from the 20th century, it is that free markets beat governments at delivering value and

controlling costs. The government's proper role is helping the market meet the needs of citizens by organizing the marketplace for fair, efficient competition (Leavitt 2007)."

Leavitt offers a viewpoint on the principle of "Crowd-Out." That principle state's that as more people are insured by government policies, the more likely people will drop their private insurance, such as employee based, because the government policies are likely to be less expensive, and apply for those government policies. This leads to the government policies being underfunded because of the increase in people it tries to cover. A study of this principle and its application to S-CHIP found that the program does not create a significant amount of crowd-out for the states (Bansak 2005).

The State's Role

The federal government has increased its role in setting health care policy but with the increase role of state governments, with the expansion of Medicaid and the introduction of the SCHIP program, the states have become a center focus of health care policymaking (Lief Palley 2007). Each state has to confront societal problems, political demands, and constitutional demands that differ from any other state and resulting policy reflects these pressures that are placed on state governments. There has been previous research in how states allocate resources and why state's prioritizes these issues that need funding, finding that interest groups and public opinion play a strong role in determining the services that will be provided to meet state needs (Jacoby 2001).

I look at how some states are effective in reducing the numbers of children without health insurance through the application of the S-CHIP bill. With the S-CHIP program, the states have flexibility in administering eligibility guidelines, choosing the structure whether it's the previous

Medicaid infrastructure or a new creation. The state also has discretion in the benefits it offers under the S-CHIP if it's separated from Medicaid. Finally, to look at the political, social, and economic features of the American states may give clearer detail to the most successful route policymakers can take to ensure that all children are insured in this nation.

Methods and Analysis

For my analysis, I used the state data set provided by Carlson and Hyde (2005). The data set provides numerous variables that can be used as independent variables. Independent variables that I will be looking to use will come from three different areas-social, economic, and political. The unit of analysis in the data is the American states. My dependent variable is the amount of children uninsured in each state and I found this data for this variable from the Census Bureau (Census Bureau, 2008).

The data from the Census Bureau is in Microsoft Excel format and was imported into SPSS program and added to the state data set. These variables include distinctions between the years of 2005-2007 as well as a variable that uses an average of the three years for the data. Other distinctions in my added variables include: types of government health insurance, types of private health insurance, and the population of children in each state.

(table 1 about here)

Table 1 shows all fifty states and the percent of children that are uninsured in each state for the years of 2005-2007. The first column of the table is the data for my dependent variable, the average percent of children uninsured for the years 2005-2007. The data is important to my project because it offers a first glance at the relations between the states and amount of children

uninsured for each state. Florida, Texas, and Arizona have the highest rates of uninsured children while states like Iowa, Minnesota, and Wisconsin have some of lowest percents of children uninsured.

(figure 1 about here)

Figure 1 looks deeper into the relationship between states and the amount of uninsured children. This particular graph uses the percent of respondents in a 2000 exit poll who respond "Conservative" to ideology, to examine whether or not the conservativeness of a state is a strong influence on the amount of children uninsured in a state. The correlation is moderate and positive with a Pearson's Correlation of .335 and the graph shows the states of Florida, New, Mexico, and Texas with high rates of conservativeness as well as high rates of uninsured children. The graph also shows conservative states, Alabama, Kansas, and North Dakota with relatively low percent of children uninsured while relatively liberal states, such as Florida and New Mexico, with high rates of uninsured children.

(figure 2 about here)

Figure 2 shows the same dependent variable, the average percent of children under the age of 18 not covered by health insurance through the years, 2005-2007, and an independent variable of diversity index. I use this variable to look at social factors that might describe the relationship between the states and uninsured children better than political variables that Figure 1 shows. The relationship between the two variables is strong and positive with a Pearson's Correlation of .508. The states of Florida, Texas, Arizona, and New Mexico have a high diversity index, as well as high rates of uninsured children. This graph also shows that states that have a low diversity index, Vermont, Maine, New Hampshire, West Virginia, and Iowa, have

very low rates of uninsured children. Social variables, especially those that deal with ethnicity, seem to explain uninsured rates clearly, as the more diversity in a state, the higher rates of uninsured children there will be with the exception of the outlier of Hawaii.

(figure 3 about here)

Figure 3 looks at the economic variable, percent of person in state in poverty, and its relationship with the rates of uninsured children in each state. The relationship is strong and positive with a Pearson's Correlation of .422. Even though it is a strong and positive relation, there are exceptions as the southwest states; Nevada, Arizona, and Colorado have higher rates of uninsured children than other states with the same amount of percent of persons in state in poverty. This graph reinforces those social factors, such as diversity caused from an immigrated work-force, cause higher rates of uninsured children for the states.

(table 2 about here)

Table 2 has political, social, and economical variables and their corresponding correlations in relation with the percent of children uninsured for each state. Of note, is that the percent of women in state legislature has no significant effect on the rates of uninsured children. The social variables have the strongest correlations, reinforcing that social features of a state play a large role in the amounts of children uninsured. Specifically, the data shows that the Hispanic race has the most difficulty in obtaining health insurance for children because the correlation with the variable of Percent Black is not significant, while Percent Hispanic has the strongest correlation with a .660. Percent of Persons in state in Poverty is a significant correlation, but it's the only economic variable that is significant, and that particular relation may be better explained by social variables.

(table 3 about here)

Table 3 represents partial correlations that control for the variable Diversity Index while testing the relationship between the percent of children uninsured in each state with political, social, and economic variables. I included this test because I wanted to see the effect that variables had on the amount of children uninsured while controlling for a strong variable, the diversity index, because this variable might be an underlying power in other variables. The partial correlation of percent of persons in state in poverty shows this effect because the correlation is smaller when controlling for diversity index, .340, than what it is in a normal bi-variate correlation, .422. The variable of percent population change has the same effect happening as the correlation is smaller when controlling for diversity index.

Conclusion

My first analysis, the bivariate correlations, finds that social characteristics of a state have the strongest correlation with my dependent variable, the average percent of children uninsured in each state. Variable that were significant included: Diversity, Hispanic, and Population Change. These variables had strong positive relations with the dependent variable. The political characteristics of a state were significant with the variables Republican, Independent, Liberal, and Conservative having significance. The pearson's correlation were not as strong as the social characteristics, however. The economic characteristics in my bivariate correlations were the weakest as only person's in poverty as a variable was significant. This variable did have a strong and positive correlation but other variables representing economic factors of a state were found to have no significance. Because the social characteristics were so strong in correlation, I

determined that an analysis of partial correlations might give a better picture of the relationships between the variables.

The partial correlations controlled the diversity index variable when testing the variables from my bivariate correlations. When controlling for diversity index, the relationship of political characteristics of a state and my dependent variable changed. The correlations were all stronger than they were with my bivariate testing and the democratic variable became significant. The liberal and conservative variables became significant at a .01 level while the independent variable became only significant at the .05 level. The biggest change from controlling the diversity index, a social characteristic of a state, was the change in economic characteristics of a state and the percent of children uninsured in each state. The variables of annual pay, bachelor's degree, and personal income became significant after not being significant when bivariate correlations were performed. My research shows empirically that political and economic characteristics play a mixed role in the amount of children uninsured in each state, while, social characteristics of a state have a strong relationship with the amount of children uninsured in each state.

Appendix

Table 1. States and the Average Percent of Children Uninsured

State	Average Percent of Children Uninsured 2005-2007	Average Percent of Children Uninsured 2007	Average Percent of Children Uninsured 2006	Average Percent of Children Uninsured 2005
MA	4.73	3	7	4.2
MI	5.3	6.2	4.7	5
IA	5.37	4.8	6.3	5
HI	5.47	4.8	6.3	5.3
WI	5.87	5.8	4.9	6.9
CT	6.3	5.2	6	7.7
AL	6.4	7.3	7.4	4.5
ME	6.4	5.1	6.4	7.7
NH	6.43	6.5	7.5	5.3
WV	6.57	4.6	8.5	6.6
RI	6.83	8.8	4.1	7.6
MN	6.87	6.4	8.3	5.9
KS	7.07	7.7	7.3	6.2
OH	7.3	8.6	5.7	7.6
PA	7.37	7.4	7.3	7.4
WA	7.47	6.8	6.9	8.7
VT	7.57	9.4	8	5.3
IN	7.6	5.2	7.8	9.8
KY	8.13	8	9.7	6.7
TN	8.2	9.1	6.4	9.1
NY	8.33	8.9	8.4	7.7
SD	8.43	8	9.2	8.1
NE	8.47	10	10.1	5.3
AR	8.73	6.2	9.3	10.7
IL	8.73	6.6	9.5	10.1
MO	9	10.4	9.1	7.5
ND	9.03	7.9	10.3	8.9
WY	9.53	9.6	8.2	10.8
MD	9.57	10.5	9.9	8.3
VA	9.6	10.2	10.1	8.5
AK	10.03	11.4	10.3	8.4
DE	10.37	7.5	11.7	11.9
OR	11.37	10.6	13.1	10.4
SC	11.7	14.2	10.7	10.2
GA	11.77	11.5	12.8	11
ID	11.8	11	13	11.4
OK	12.03	12.6	12.5	11
NJ	12.23	12.9	13.3	10.5
LA	12.27	12.5	15.9	8.4
CA	12.3	10.7	12.8	13.4
UT	12.57	10.4	15	12.3
NC	12.6	12.1	14	11.7
CO	13.77	13	14.6	13.7
MT	13.77	12.6	14.5	14.2
MS	14.1	12.1	18.9	11.3
AZ	15.73	13.8	17	16.4
NV	15.8	14.3	18.8	14.3
NM	17.8	15.5	17.9	20
FL	18.73	19.2	18.9	18.1
TX	20.5	21.4	21.2	18.9

Figure 1. Ideology's Effect on Insurance of Children

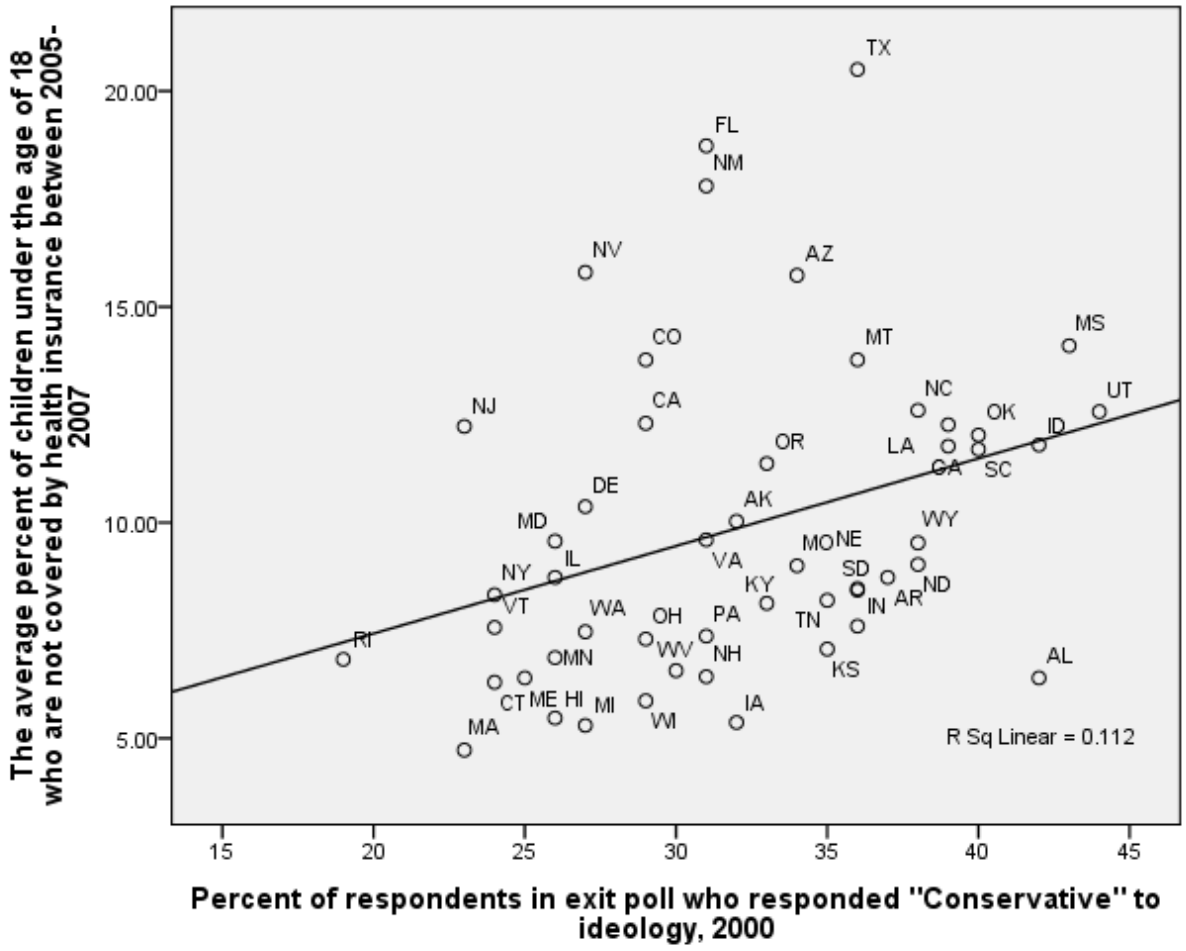

Figure 2. Diversity's Effect on Insurance of Children

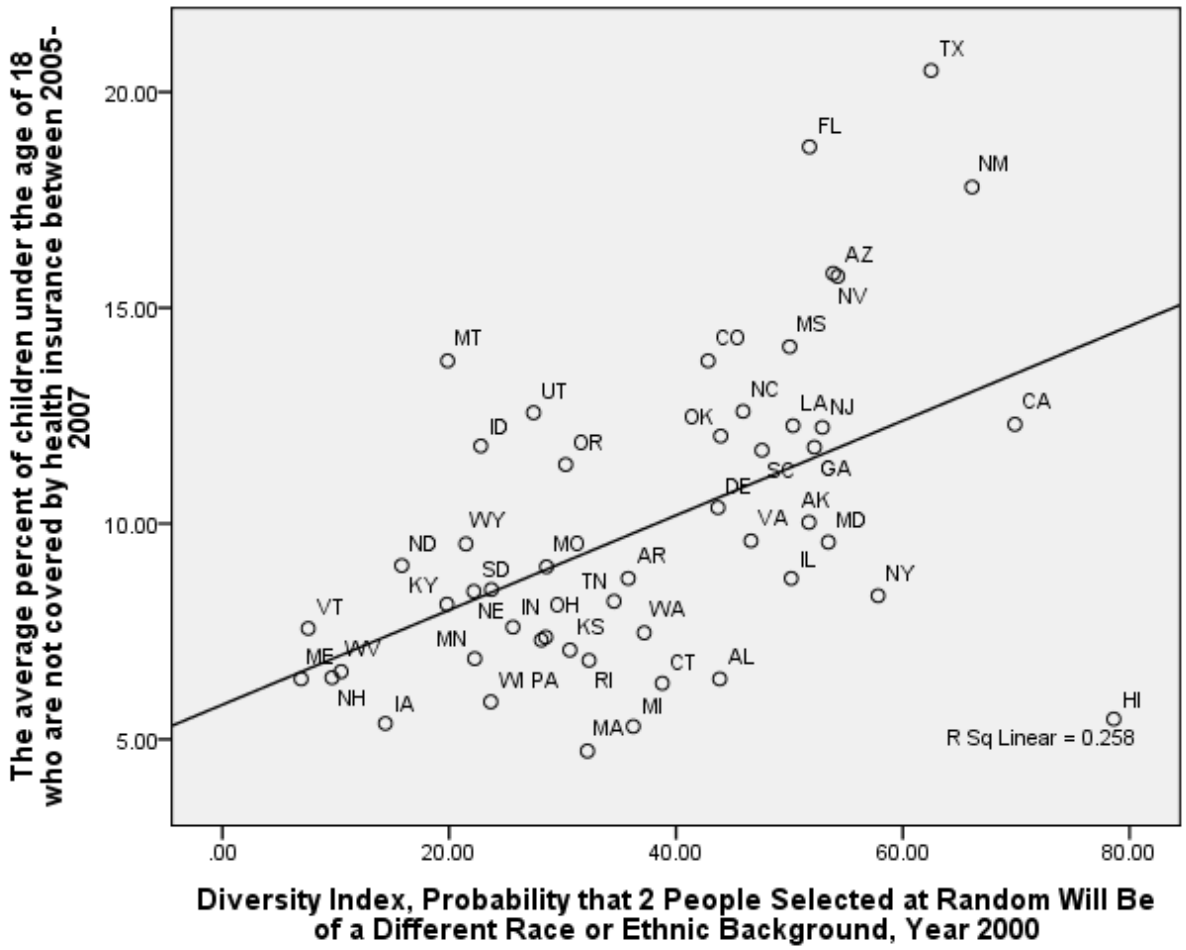

Figure 3. Poverty's Effect on Insurance of Children

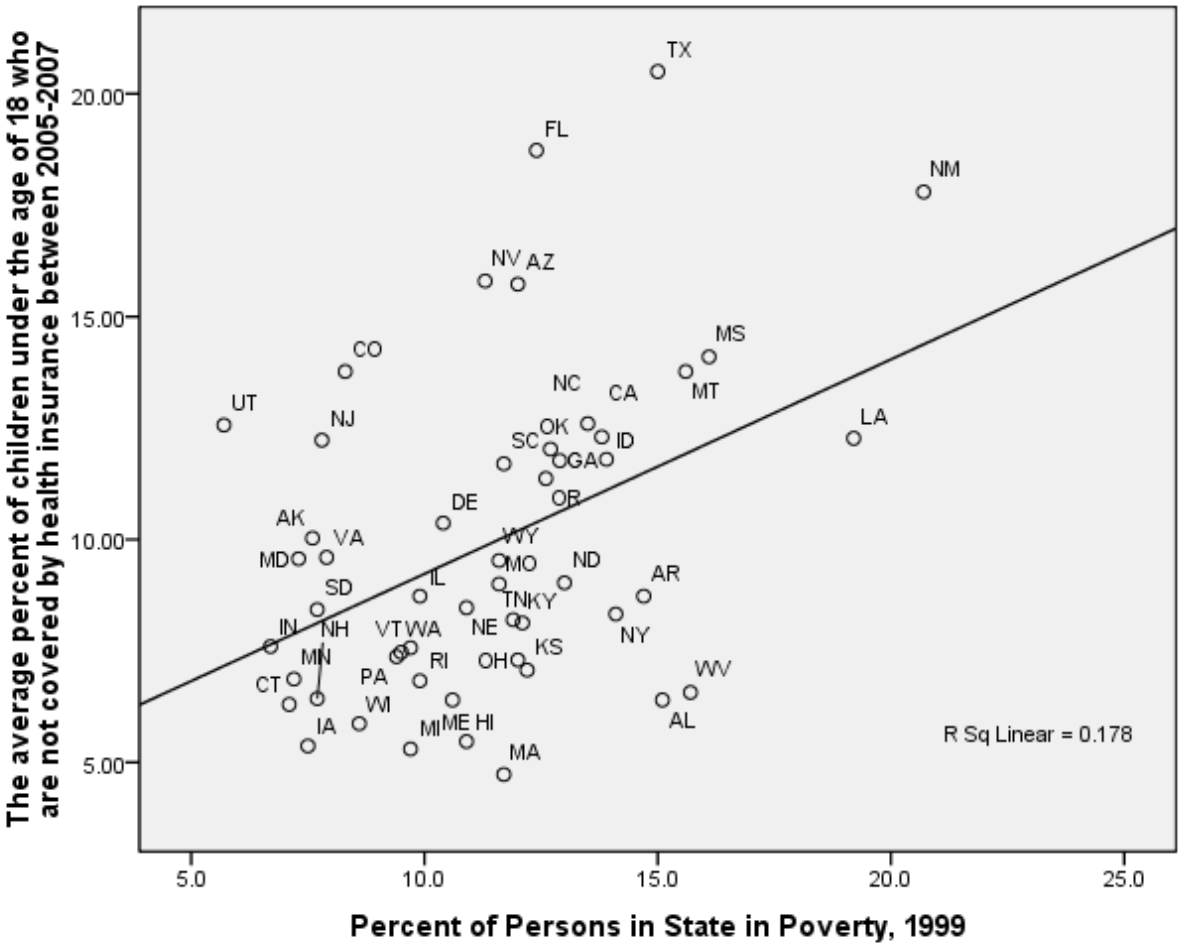

Table 2. Bivariate Correlations between Political, Social, and Economic Variables and Relationship with Insurance Rates of Children

Variable Name	Pearson Correlation
Political	
Percent of Women in State Legislature, 2001	.057
Percent of respondents in exit poll who responded "Democrat" to party identification, 2000	-.038
Percent of respondents in exit poll who responded "Republican" to party identification, 2000	.382**
Percent of respondents in exit poll who responded "Independent" to party identification, 2000	-.367**
Percent of respondents in exit poll who responded "Liberal" to ideology, 2000	-.306*
Percent of respondents in exit poll who responded "Conservative" to ideology, 2000	.335*
Social	
Diversity Index, Probability that 2 People Selected at Random Will Be of a Different Race or Ethnic Background, Year 2000	.508**
Percent White, Year 2000	-.136
Percent Black, Year 2000	.171
Percent Hispanic, Year 2000	.660**
Percent Population Change from 1990-2000	.630**
Economic	
Percent of Persons in State in Poverty, 1999	.422**
Average Annual Pay, 1999	-.182
Percent of population 25 years and older with bachelor's degree or more, Year 2000	-.164
Personal income per capita, current dollars, 1999	-.211
Gross State Product, millions of current dollars 1999	.208

Table 3. Partial Correlations of Independent Variables in Relationship with Insurance Rates of Children Controlling for Diversity Index

Variable Name	Pearson Correlation
Political	
Percent of Women in State Legislature, 2001	.037
Percent of respondents in exit poll who responded "Democrat" to party identification, 2000	-.379**
Percent of respondents in exit poll who responded "Republican" to party identification, 2000	.539**
Percent of respondents in exit poll who responded "Independent" to party identification, 2000	-.267*
Percent of respondents in exit poll who responded "Liberal" to ideology, 2000	-.397**
Percent of respondents in exit poll who responded "Conservative" to ideology, 2000	.423**
Social	
Percent White, Year 2000	.373**
Percent Black, Year 2000	-.074
Percent Hispanic, Year 2000	.510**
Percent Population Change from 1990-2000	.563**
Economic	
Percent of Persons in State in Poverty, 1999	.340**
Average Annual Pay, 1999	-.453**
Percent of population 25 years and older with bachelor's degree or more, Year 2000	-.256*
Personal income per capita, current dollars, 1999	-.386**
Gross State Product, millions of current dollars 1999	-.042

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