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# Promises And Illusions Of The Reauthorization Of The State Children's Health Insurance Program

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## Citation

O Nnamuchi. *Promises And Illusions Of The Reauthorization Of The State Children's Health Insurance Program*. The Internet Journal of Law, Healthcare and Ethics. 2008 Volume 5 Number 2.

## Abstract

For proponents of universal health care, the signing into law of the bill expanding the State Children's Health Insurance Program (SCHIP) by President Barack Obama on February 4, 2009 seems to have infused new life to their long-awaited dream. The SCHIP reauthorizing Act, twice vetoed by President George W. Bush, guarantees continued insurance coverage through 2013 to about 7 million poor children and allows additional 4 million to enroll in the program. Considering that there is an estimated 47 million uninsured in the United States, the addition might seem insubstantial, but freeing these children from the predicament associated with lack of access to medical care is unquestionably a major achievement in the life of the new administration. Nonetheless, as we jubilate over the passage and signing of the bill, it would be beneficial to caution ourselves as to what the expansion actually represents.

First, we need to note that regardless of the amount of positive spin filtering down from Washington, the new SCHIP bears little or no correlation to universal health care. The modest support received from Republicans in both chambers of the legislature (forty in the House and nine Senators), more than anything else, speaks to the shared recognition of the unique status of those to whom coverage would be extended. Indeed, the inability of children to provide for themselves appears to have been the clincher. But there was another helpful factor – the source of funding. The cost of the expansion, estimated at \$33 billion, will be met from hiking the federal tax on tobacco products as opposed to general taxation against which a vast majority of Republican legislators were adamantly opposed. Even at that, downplaying political differences in attending to the needs of a uniquely vulnerable segment of the population is one thing; it is quite a different story when the subject shifts to coverage for able-bodied adults.

The second concern relates to immigrant care. Under the previous law, children of legal immigrants are ineligible to receive benefits until the expiration of five years from the date of their residence in this country, meaning that for many of these children whose parents cannot afford private insurance, the only available source of medical care is hospital emergency rooms. The Emergency Medical Treatment and Active Labor Act (EMTALA), passed in 1986, requires affected hospitals to provide appropriate care to anyone suffering from an emergency medical condition regardless of residency status or ability to pay. Long wait and overcrowding at hospital emergency rooms throughout the nation is one of the more visible, but unintended, consequences of this “anti-dumping” statute. Experts believe that denial of insurance to immigrant children, known to be more susceptible to illnesses and communicable diseases, constitutes a public health blunder not only in terms of likely morbidities or mortalities in the general population but also in terms of increased cost of treating the children. Numerous studies show that timely preventive and screening services is more cost effective than emergency care. Moreover, with respect to children of illegal immigrants, one can easily argue that allowing them access to publicly funded health care is tantamount to rewarding illegality. But there is no similarly plausible argument regarding children of aliens who have been granted legal privileges to reside in this country permanently.

The final issue is the so-called “crowding out” fear, whether, as charged by opponents, the expansion would motivate cancellation of existing private insurance in favor of SCHIP, thereby unnecessarily increasing cost. This worry, at least from an operational perspective, is unfounded. Those intending to milk the system would quickly discover that there are safeguards in place to weed out such schemes. Because states are rewarded with bonus payments for

enrolling lowest-income children, it is likely that every state would design its program in such a way as to accord preferential treatment to such children, meaning that relatively well-off children would be enrolled only if spots are left. The truth is that parents who, having survived strict eligibility verification process, drop private (in most cases, inadequate) insurance would be those already laboring under the burden of high deductibles and copayments. The introduction of SCHIP, in 1997, by then President Clinton and a Republican-controlled Congress was meant to address exactly this kind of situation: families with income too high to qualify for Medicaid and yet too poor to afford private insurance for their children.

In conclusion, I return to the question to which I earlier alluded; that is, whether the smooth sailing of the legislation through Congress evidences the inevitability of universal health care. Not surprisingly, many people think so. But they are wrong. A 2008 Rasmussen poll found deeply rooted ideological and political schism on the subject. Least

opposed, according to the poll, are Democrats – at 26 percent, compared with 35 percent of Independents and 59 percent of Republicans. Translating these numbers to congressional representation signals a tough battle looming ahead. In the meantime, however, it may be wise to concentrate efforts on existing programs on which there is a wealth of support. To better attend to the needs of those for whose benefit they were established, institutions and programs such as community health centers, veterans hospitals, Medicare and Medicaid need unflinching support from the President, Congress and all stakeholders in terms of resource allocation and demand for good stewardship on the part of administrators and service providers. Ultimately, the central lesson of SCHIP expansion might be that by improving upon those elements of the health care system which we have accepted as consistent with our values, we take significant strides toward improving the overall health of the population, even if universal coverage remains elusive.

## **References**

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