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Are American Children Being Lured Into Socialized Medicine?

by Naomi Lopez
June 24, 1998

Executive Summary

There is no question that nearly all Americans think children should have access to quality health care. But according to a recent survey, only about one in five believe the federal government is the payer most responsible for children's health care. Most people believe the responsibility for that care rest with the children's parents.

Yet many Americans are unaware that the Clinton Administration's "Kids First" back-up plan is being implemented across the country. Fewer than one-third of Americans report hearing about a new federal program that takes a giant step toward nationalizing health care for children and overriding this parental responsibility.

Today a bevy of health care providers, private foundations, government officials, and political activists are successfully setting up universal health care for children. Their success is found in nationwide school-based health centers, Medicaid expansions, and the new $48 billion federal health care program for children. The new federal program attempts to bring middle-income children into Medicaid, the government health care program that already covers one-quarter of American children.

While current efforts to expand government health care programs for children may be well intentioned, these programs have serious unintended consequences. Experience has shown that expanding government health care programs encourages families to drop their private health insurance, reduces health care choices, infringes upon parental rights, and threatens medical privacy.

The dangers of a nationalized health care system for children -- which could serve as the precursor to a socialized health care system for all Americans -- should be publicly debated before all children are placed under a single government health care roof.

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Introduction

Many Americans assume that efforts to create a government-financed health
system in the United States were halted in 1994, along with President Clinton
failure to establish universal health care. Just the opposite is true. Efforts to e
government health care programs are stronger than ever; they are just not as

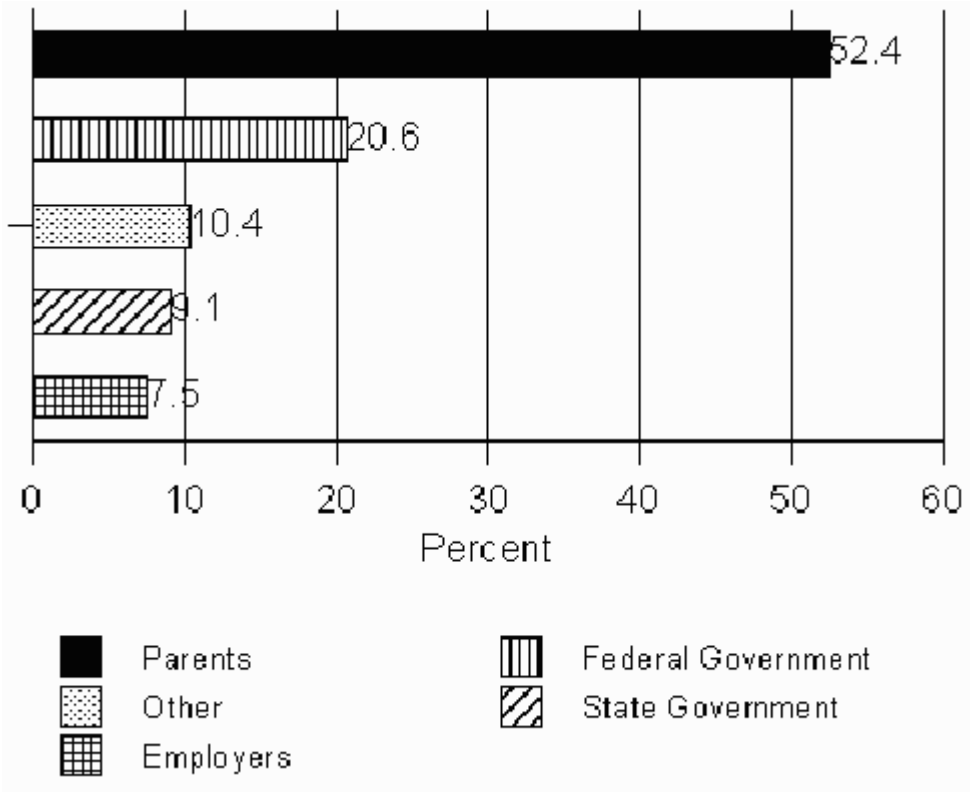
In fact, Clinton Health Care Task Force documents -- made public through co
order -- reveal that "if they [the Clinton Administration] are unsuccessful in g
the Clinton-style, universal health care, that they should take a kids first appr
which would be used as the first step to phase in the full Clinton-style health
plan."(1) The Association of American Physicians and Surgeons reports:

> *[Clinton Health Care] Task Force documents showed, "Kids First" is really a precursor to the new system. It could be implemented through Medicaid or another plan.*(2)

Since the defeat of universal health care legislation in 1994, President Clinton
publicly stated that, rather than re-attempting to pass universal coverage in or
stroke, he will promote universal health care incrementally -- one group at a t

That strategy is working. The goal of government-sponsored children's health
has gained bipartisan support and is being actively, but quietly, pursued at the
and state levels by a bevy of health care providers, private foundations, gover
officials, and political activists. Their success is found in the more than 900 s
based health centers now operating in more than forty states across the countr
provide, among other services, psychological and reproductive counseling to
children.(4) Their success is also seen in the State Children's Health Insurance
Program (SCHIP), a new federal program that expands government health ca
children.

Figure 1.
Who Should Be Responsible for
Children's Health Care?



Source: Harvard University, The Robert Wood Johnson Foundation, and the University of Maryland, "Attitudes Toward Children's Health Care Issues," November 1997. The survey question was worded "Who, if anyone, do you think should be most responsible for paying to make sure that children get this right [to health care and health insurance]?" The survey margin of error is plus or minus 3 percentage points.

While most Americans think children should have access to quality health care, only 20.6 percent believe the federal government is most responsible fo financing that care, according to a recent survey. The majority (52.4 percent) believe the responsibility for health care rests with the children's parents (see Figure 1).[(5)]

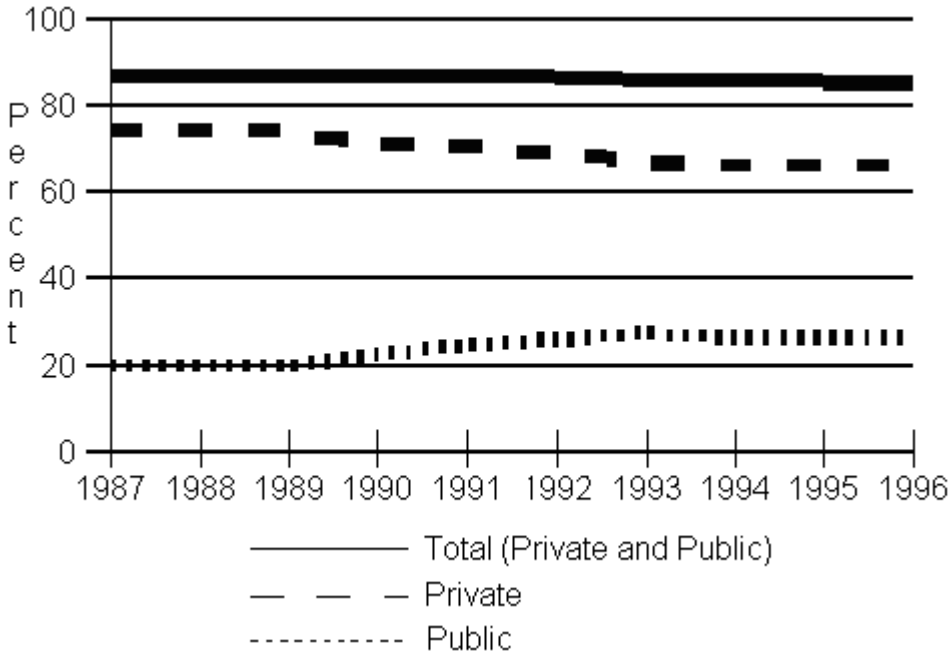
Yet few people realize that more than one-quarter of American children already receive government-sponsored health care. And, fewer than one-third of Americans report hearing about the new $48 billion federal program[(6)] tha takes a giant step toward further nationalizing government-sponsored health care for children across the country, removing this responsibility from parent Undoubtedly, the first major steps toward universal health care for all childre have already been taken.

Is There Really A Children's

Uninsured Crisis?

Rather than addressing the question of "Who lacks health insurance and why' lawmakers recently posed the emotionally charged question, "Are you for or against children's health?" Because sentiment rather than logic too often guides this debate, lawmakers established a new federal health care program for children, even though there is ample evidence that no "crisis" exists. In fact, the overall rate of insured children has remained stable over the past decade (see Figure 2).

Figure 2.
Percent of Children With Health Insurance: 1987-1996



Source: U.S. Bureau of the Census, Housing and Household Economic Statistics Division, unpublished tables based on analyses from the March Current Population Survey as cited in Federal Interagency Forum on Child and Family Statistics, America's Children: Key National Indicators of Well-Being, 1997, Table ECON5, p. 71 and U.S. Bureau of the Census, March 1997, Current Population Survey.

Although welfare advocates and the media portray a health insurance crisis among poor and low-income working families, most uninsured children qualify for (but do not enroll in) existing government programs, or they live i households with moderate to high incomes. It is estimated that between eight and eleven million children lack health insurance.(7) There are about 4.7 million children who are eligible for, but do not participate in, the federal Medicaid program.(8) While some families do not realize their child is eligible, many families choose not to participate because they are concerned about the stigma attached to welfare or they do not have an immediate need for health care services.

Over three million of the uninsured children live in families with incomes more than twice the federal poverty level.(9) A substantial portion of the remaining uninsured children (fewer than one million to less than four millio depending on the estimate) remain so for short periods of time, such as when parent is temporarily unemployed.(10) That is because, in this country, employers rather than employees own health insurance. When a worker is lai off or loses his job, he loses his health insurance. This is the result of current federal tax law whereby employer-provided health insurance is excluded fro taxation, but individually purchased health insurance is not. These difference in tax treatment can effectively double the cost of health insurance for those families who purchase it on their own. For this reason, many people choose t forego purchasing health insurance while between jobs or while temporarily unemployed.

Health policy analyst Robert Goldberg of George Washington University, citing the Department of Health and Human Services, finds that only 13 percent of uninsured children under age 18 lack health insurance because of i reported high cost.(11) In fact, children are the healthiest part of our populatio and the lowest-cost group to insure.(12) The average cost of a health insuranc policy for a child is $900 per year, according to Robert Goldberg.(13) Even so the 105th Congress chose to create a new federal health care program for children, instead of reducing families' overall tax burden to help them pay for their children's health care. This was unfortunate because the new federal program paves the road to socialized medicine, and does so with little public awareness.

Seniors Were Lured Into Socialized Medicine:

Are Children Next?

While current efforts to expand government health care programs for childre may seem like a noble goal, these programs could rapidly evolve into a government-mandated health care program for all children in the United States. The government's Medicare Part A program -- which is a mandatory hospital insurance program that covers the majority of the nation's elderly -- forces seniors to drop their private health insurance and prevents them from seeking medical care privately. A look at the government's Medicare progra illustrates how such an evolution in government health insurance for children might occur.

How Seniors Were Lured into Socialized Medicine

Initially, Medicare was created with the promise that it would not interfere with seniors' right to use private health insurance.(14) But after Medicare was passed in 1965, the federal government garnered enough power over the

private market to force private insurers to drop seniors. As a result, private health insurance carriers no longer offer primary hospital insurance to seniors (15) Today, seniors have no alternative but to join the government-sponsored Medicare program.

Moreover, many Americans are unaware that Medicare was created to serve a a stepping stone to socialized medicine for all Americans. Twenty-five years ago, health policy analyst Howard Berliner revealed that:

> *...Medicare was designed to eventually be expanded into a comprehensive and compulsory national health insurance system. ...[H]ealth insurance for the aged was a strategy to get a 'foot in the door.' It was hoped that the small Medicare program would eventually be expanded to include everyone in the country.(16)*

Today, legal barriers prevent seniors from voluntarily opting out of the government's Medicare program. A recent judicial decision has ruled that seniors who are eligible for Medicare do not have a constitutional right to pay privately for their own Medicare-covered health services.(17) Seniors are legally forced to participate in the Medicare program or face severe financial penalties, even if they have recognized religious or philosophical objections t the program.(18)

Furthermore, the Medicare program is fraught with fraud and abuse in excess of $54 million per day, and subjects doctors and Medicare patients to over 45,000 pages of government regulations.(19) The real tragedy of the situation is that seniors cannot opt out of the program and have lost their legal right to purchase health care services with their own money. Meanwhile, health care rationing and reduced health care choice may be compromising the quality of health care that seniors receive. (20)

One has to wonder how Medicare was initially created and evolved into such restrictive government program without greater public debate. Economist Charlotte Twight explains:

> *For more than 50 years before the 1965 enactment of Medicare, the American people repeatedly rejected the idea of government-mandated health insurance. Yet advocates of such federal power inside and outside government did not take no for an answer. Year after year they kept coming back -- pursuing incremental strategies, misrepresenting their proposals, even distributing propaganda paid for with government money in apparent violation of existing law.(21)*

Many of the same tactics that were used to force seniors into socialized medicine are being employed today. But this time the efforts are targeted at

children.

How Children Are Being Lured into Socialized Medicine

Government-sponsored health care for children may already be traveling down the similar, dangerous path as Medicare. The government Medicaid program, which provides medical assistance to low-income families, is rapidl evolving into a middle-class entitlement program that could soon replace private insurance for our nation's children.

The federal Medicaid program is financed by combined federal and state funds. According to the National Governors' Association, over the past decad the vast majority of states have expanded Medicaid eligibility for pregnant women and children beyond the federally established mandate.(22) Consequently, more children have become enrolled in the Medicaid program. The Kaiser Commission on the Future of Medicaid reports:

> *Prior to 1986, Medicaid primarily served children who received AFDC [Aid to Families with Dependent Children] welfare assistance. Today, children qualify for Medicaid based on their age and income. As a result, Medicaid plays an essentially important role for young children, covering 33% of infants and 29% of children age one to five. . .. In 1995, 17.1 million children -- one quarter of all children under age 18 -- had Medicaid coverage.(23)*

Since then, states have further expanded their Medicaid programs and most states do not require asset tests to determine eligibility. Some states have offered Medicaid coverage to children in families with incomes between 300 and 400 percent of the poverty level.(24)

Expanding Socialized Medicine Through Public Schools

The Clinton Health Care Task Force advocated delivering health care throug the public schools. The basic infrastructure for expanding school-based healt care is already well-entrenched across the nation. School clinics have long delivered first-aid and emergency care, as well as documented immunization But that has been changing.

School-based health centers have expanded their missions, adding a broad array of services such as psychological and reproductive counseling.

In 1985, there were only about 40 school-based health centers operating in th United States.(25) By 1993, 40 states used federal block grant funds or state general funds to support school-based health clinics, according to a Robert Wood Johnson Foundation survey.(26) Today, there are over 900 hundred

school-based health centers operating in all but seven states, according to a su
by Making the Grade, a Robert Wood Johnson Foundation affiliate (see Table

Table 1. School-Based Health Centers

by Rank and State: 1995-1996

Alpha			*Rank*		
Rank	State	# Centers	Rank	State	Ce
32	Alabama	5	1	New York	
42	Alaska	1	2	Florida	
11	Arizona	33	3	Texas	
24	Arkansas	9	4	Connecticut	
7	California	37	5	Pennsylvania	
14	Colorado	28	6	Maryland	
4	Connecticut	50	7	California	
18	Delaware	17	8	Massachusetts	
42	District of Columbia	1	9	Michigan	
2	Florida	66	9	Oregon	
22	Georgia	12	11	Arizona	
38	Hawaii	2	12	New Mexico	
45	Idaho	0	13	North Carolina	
16	Illinois	19	14	Colorado	
20	Indiana	15	14	West Virginia	
38	Iowa	2	16	Illinois	
35	Kansas	3	17	Minnesota	
25	Kentucky	8	18	Delaware	
19	Louisiana	16	19	Louisiana	
25	Maine	8	20	Indiana	

6	Maryland	38	21	Mississippi	
8	Massachusetts	36	22	Georgia	
9	Michigan	34	23	Tennessee	
17	Minnesota	18	24	Arkansas	
21	Mississippi	14	25	Kentucky	
32	Missouri	5	25	Maine	
45	Montana	0	25	New Jersey	
45	Nebraska	0	25	Ohio	
45	Nevada	0	25	Virginia	
42	New Hampshire	1	25	Washington	
25	New Jersey	8	31	Oklahoma	
12	New Mexico	32	32	Alabama	
1	New York	149	32	Missouri	
13	North Carolina	30	32	Wisconsin	
45	North Dakota	0	35	Kansas	
25	Ohio	8	35	Rhode Island	
31	Oklahoma	7	35	South Carolina	
9	Oregon	34	38	Hawaii	
5	Pennsylvania	39	38	Iowa	
35	Rhode Island	3	38	Utah	
35	South Carolina	3	38	Vermont	
45	South Dakota	0	42	Alaska	
23	Tennessee	10	42	District of Columbia	
3	Texas	60	42	New Hampshire	
38	Utah	2	45	Idaho	
38	Vermont	2	45	Montana	
25	Virginia	8	45	Nebraska	
25	Washington	8	45	Nevada	

14	West Virginia	28	45	North Dakota	
32	Wisconsin	5	45	South Dakota	
45	Wyoming	0	45	Wyoming	

Source: Making the Grade, "National Survey of State School-Based Initiatives: School Year 1995-96," George Washington University, Washington, D.C., 1997.

With the number of school-based health clinics rapidly increasing, it is no sur that the amount of money that federal and state governments are contributing school-based health care is also increasing. During 1994, 25 states appropriat more than $22 million in state revenues for school-based health clinics -- an i of 140 percent from the $9.2 million spent in 1992.(28)

The cornerstone of government funding for school-based health care is Medic Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). U EPSDT, Medicaid pays for preventive health services and medical services to improve health care functions.(29) Additionally, EPSDT covers non-health se such as translation, outreach, and transportation.

Over half of all states have established Medicaid mechanisms that permit the deliver health care services in public schools.(30) A report on Missouri's expe in creating school-based programs provides an example of how Medicaid is b expanded to pay for school-based health care:

"*Over the past three years, the Independence School District has generated n than $2 million from creative use of Medicaid financing, primarily through th Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) ar administrative case management (ACM) provisions. . . Since 1967, the Title X the Social Security Act, which established the Medicaid program, had require states to operate EPSDT programs to provide preventive health services to al Medicaid-eligible children under the age 21. The Omnibus Budget Reconcilia Act of 1989 sought to increase the effectiveness of this program and improve health of poor children by requiring states to increase the percentage of eligi children accessing the EPSDT program from 30 percent to 80 percent by FY To do this, states were required to take a more active role in improving acces children to preventive health services and in assuring that once screened, chi were provided with the full range of health and mental health treatments nee address diagnosed problems*."(31)

The Pennsylvania legislature has examined how Medicaid's EPSDT program affecting school-age children in Pennsylvania. In their report "Findings of Fa Report," the Pennsylvania House of Representatives Committee on Educatior reports:

"*[Pennsylvania] Executive Branch officials have manipulated existing state programs and the Medicaid program in order to use the public school system*

means of fully exploiting the EPSDT program. These practices, which are no required by federal law, have caused the cost of the EPSDT program to skyrocket. In 1996, DPW [Pennsylvania Department of Welfare] expanded th targeted enrollment of EPSDT to 900,000 children by December 1997. This manipulation of the EPSDT program has required taxpayers to bear the burden of paying for a host of subjectively determined services which are mo in the behavioral and education realm than the traditional medical arena. This, in turn, raises concerns that too many students are being inappropriate labeled as emotionally disturbed or mentally disturbed or disabled in order t qualify them for the EPSDT program."(32)

In addition to Medicaid, schools also utilize funds provided by the federally funded Centers for Disease Control, according to the General Accounting Office.(33) Other sources of federal support include the Preventive Health Block Grant; Drug Free Schools and Communities Act; and the Social Security Block Grant.(34) States are also relying on private foundation grant programs, federal grants from the Maternal and Child Health Bureau, the Individuals with Disabilities Education Act, and Goals 2000 for Education to fund school-based clinics.(35)

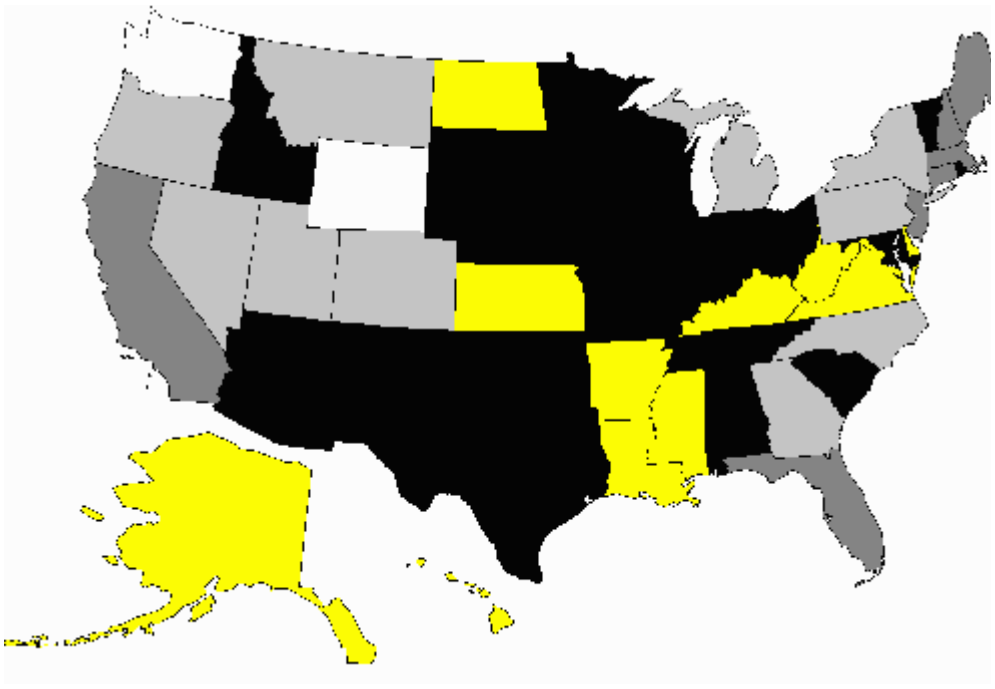
It is not difficult to envision how a children's health care system, delivered through the public school system and/or through the Medicaid program, coul serve as precursor to a nationalized health care system as outlined in the Clinton Health Care Task Force back-up plan. The American public should closely scrutinize any further government intrusion into children's health care or children's health care will face a fate similar to the Medicare program.

Forty-Eight Billion Dollars for Socializing Children's Health Care

In response to the question, "Are you for or against children's health?" lawmakers passed a ten-year, $48 billion State Children's Health Insurance Program (SCHIP). This new program, passed as part of the Balanced Budget Act of 1997, allocates federal funds to states. Under the SCHIP program, stat have several options for spending the new federal health care dollars. Contingent upon federal approval, states may expand their current Medicaid programs, create a new state child health insurance program, create a combination of both, provide health care services directly such as through the public schools with increased funding from Medicaid, or decline to participat entirely.(36) The program will cover children under the age of 19 whose fami income may exceed 200 percent of the federal poverty level, which is the equivalent of $32,900 for a family of four.

Leading free-market policy experts have voiced strong concern that most states appear to be leaning toward expanding their Medicaid programs (see Figure 3).(37)

Figure 3.
Medicaid Expansion Under the New Federal SCHIP Program



	Option	States
	Medicaid expansion (21)	AL*, AR, DC, ID, IL*, IA, IN, MD, MN, MO*, NE, NM, OH*, OK*, RI*, SC*, SD, TN, TX, VT, WI*
	Medicaid expansion & new state program (7)	CA*, CT*, FL*, MA*, ME, NH, NJ*
	New state health care program (10)	CO*, GA, MI*, MT, NC, NV, NY*, OR, PA*, UT
	Plan includes Medicaid expansion (11) (plan yet to be submitted)	AK, AZ, DE, HI, KS, KY, LA, MS, ND, VA, WV
	Not participating in SCHIP at this time (2)	WA, WY

** State plan approved by the U.S. Department of Health and Human Services (HHS) as of June 9, 1998. Note: Congress extended the deadline for obtainin HHS approval from Sept. 30, 1998 to Sept. 30, 1999. Source: American Legislative Exchange Council, "1998 Health and Human Services Task Forc Legislative Update," May 5, 1998; Brian K. Bruen and Frank Ullman, "Children's Health Insurance Programs: Where States Are, Where They are Headed," Urban Institute New Federalism Issues and Options for States, Series A, no. A-20, May 1998, Figure 1, pp. 3-4; Health Care Finance Administration, "Child Health Insurance Program State Plans," June 9, 199*

and Bureau of National Affairs, "Children's Health Supplemental Spending Law Gives States Extra Year to Submit [S]CHIP Plans to HHS," Health Care Policy Report, vol. 6, no. 18, May 4, 1998.

The Consensus Group, a group of leading health policy analysts from major public policy organizations, warns:

> *Although Medicaid expansion appears to be an expedient option, it locks a state into a far more expensive set of benefits than may be appropriate for [S]CHIP children, exacerbating existing cost pressures in the Medicaid program. Choice also is constrained, even when states contract with private or public health plans to provide coverage for Medicaid beneficiaries.*(38)

Senate Minority leader Tom Daschle (D-SD) praised SCHIP as "the single biggest health achievement since we passed Medicaid in 1965."(39) Unfortunately, this "achievement" may be paving the way for socialized medicine for our nation's children and could ultimately compromise health care quality and freedom in many ways.

The Hidden Dangers of Government Health Care Programs

While efforts to expand health care access and affordability may be well-intentioned, this current trend could have serious unintended consequences. By creating or expanding school-based health clinics and providing government-sponsored health insurance for children, government health care programs could encourage families to drop their private health insurance, reduce health care choices, infringe upon parental rights, and threaten medica privacy.

Eroding Private Health Insurance

One of the greatest dangers of expanding government-funded health program for children is that such programs could reduce the number of privately insured children. Many parents who currently purchase private insurance coverage for their children will switch over to subsidized government care. Health policy expert Robert Goldberg of George Washington University Medical School, explains:

[T]he Congressional Budget Office estimates that half of all new enrollees [ir SCHIP] will be from families who drop private coverage in favor of a federally subsidized entitlement. That's what happened when Medicaid opene in 1987 to pregnant women and their children with incomes 250% of the poverty level. Between 1988 and 1995, the percentage of children covered by private insurance fell to 64% from 72%. At the same time, the percentage of children covered by Medicaid climbed to 23.1% from 15.5%. Studies show

that at least three-fourths of the shift was the result of parents dropping privat coverage for themselves and their children.(40)

Indeed, there is empirical evidence proving that when government health care grows, private health insurance shrinks. Health economists from Harvard University and Massachusetts Institute of Technology examined how Medicaid expansions have affected private coverage between 1987 and 1992. Researchers concluded:

> *Our net result is that the Medicaid expansions led to an effective total of 3.5 million more persons with public coverage and 1.7 million fewer persons with private coverage. . . The decline in private insurance was roughly 50 percent (1.7 million of 3.5 million) of the increase in Medicaid coverage induced by the expansions. . . Our results find evidence of substitution of Medicaid for private insurance.(41)*

In an effort to attract larger numbers of families to participate in the new SCHIP program, states are (unsuccessfully) employing aggressive marketing techniques that target lower-income families. Strategies include using coupons, payments, and gifts in exchange for enrollment.(42) For example, 14 states use coupons to encourage families to enroll their children. The coupon books offer discounts on a variety of children's goods, such as diapers, baby food, and formula. Some states require that a medical provider validate the coupon book before the coupons can be redeemed.(43)

In other words, some states are using tax dollars to lure families into government-sponsored health care in an effort to promote an agenda of universal health care for children, with little or no public debate.

Destroying Choice

Similar to the government Medicare program -- which forces seniors to drop their private health insurance -- these new children's health care programs could ultimately force all American children to participate in government programs by destroying the private market for health insurance or by making it illegal to seek health care services privately. It has happened to seniors' health care and could easily happen to children's now that the framework for government-sponsored medical care for children is becoming entrenched at the federal and state levels.

Infringing on Parental Rights and Medical Privacy

While school-based health clinics are being established with the good intention of providing health care to the uninsured, they will ultimately lead t negative consequences that infringe on parental rights. In fact, a report on hov a Missouri school district implemented school-based health care warned that schools should not consider such programs if their philosophy is that "it is the sole responsibility of parents to attend to the health care needs of children."(4

School-based health centers give public schools broad responsibility and considerable latitude regarding medical treatment and psychological and reproductive counseling of children. A recent *Forbes* feature article revealed one of the most shocking instances that occurred at a school-based health center:

> *In the summer of 1993 Betsy Grice of Owensboro, Ky. [Kentucky] took her 11-year-old daughter to the local elementary school for the checkup she needed before starting sixth grade. Grice was shocked to learn that the doctor intended to give the child a genital examination. Turns out it's required by the Department of Education.*(45)

Unfortunately, this is not an isolated example of the usurpation of parental rights by schools funded by taxpayers and private foundations. For example, the Pennsylvania Legislature learned that 11-year-old girls were being subjected to genital exams as part of "routine" physicals in public school, without specific parental consent and over the objection of the girls themselves.(46) In fact, some schools have designed permission slips to treat students in a way that automatically grants permission if there is no parental response after a specific period of time.

Another concern with school-based health care is the lack of health privacy. I many cases, children are subjected to intrusive psychological testing without parental consent. Psychological testing information and records can then be shared between state government agencies, again without parental consent. For example, State Representative Samuel Rohrer investigated Pennsylvania school-based health centers and found that confidential information becomes the property of private foundations responsible for funding school-based centers.(47) Not only does sensitive information become the property of private foundations, but the foundations also retain the right to license others to use data.(48) Additionally, the results of psychological tests, however subjective, become part of a student's permanent school record, which could then affect future career opportunities.

What Can Be Done To Reverse This Dangerous Trend?

While expanding the Medicaid program may be the simplest approach for states to pursue in providing children's health coverage, it may not be the mos efficient choice. The Consensus Group developed recommendations for the states to provide free-market alternatives under SCHIP. In particular, the group advocates the use of tax credits, vouchers, and pilot programs that provide direct payments to individuals. Such approaches "give families greate control and choice in health insurance coverage and provide a foundation for more stable and efficient market for medical care and health insurance in the United States."(49) Rather than relying on the one-size-fits-all government

approach, these alternatives provide the maximum parental control and allow for the greatest flexibility in helping parents to best meet their children's health care needs.

The Cato Institute recently released a study showing how a universal tax cred policy would enable families to buy insurance on their own, and still receive tax break. In their publication "Restoring Freedom to Health Care: The Case for a Universal Tax Credit for Health Insurance," the author explains how thi policy gives families greater control of their health insurance coverage.(50) Fo example, the tax credit could be used to purchase health insurance, health car services, or to create a family medical savings account (MSA).

To date, one state has adopted a tax-credit policy for covering uninsured children. In April, North Carolina set a national precedent by approving a tax credit for middle-income families, as part of its new health-insurance progran for children. While North Carolina will still use federal funds to cover 71,000 low-income children, it will use only state funds to provide a tax-credit for health insurance to some 400,000 middle-income families.(51) Free-market advocates are heralding this plan, because it empowers families and limits the growth of federal health care programs.

Conclusion

Although efforts to pass a large-scale version of socialized medicine failed in 1994, the "Kids First" back-up plan is successfully being implemented at the federal and state levels. Yet, only about one-third of Americans are aware of the new $48 billion State Children's Health Insurance Program (SCHIP) and even fewer people believe that health care for children should be provided by the federal government. This new program has enormous potential to force al American children into government health care and is the first incremental step toward implementing the same Clinton health care plan that Americans resoundingly rejected in 1994. The American public should know about and debate government's role in providing health care to children before all children are forced under a single government health care roof.

Notes

(Click on the footnote number to return to its reference)

1. Rep. Ernest J. Istook, Jr. (R-OK) as quoted in 20 September 1994, Congressional Record, 103rd Congress, 2nd session, p. H9291.

2. Association of American Physicians and Surgeons, "Clinton Care Through the Kitchen Door," AAPS 52, no. 1 (January 1996): p.1.

3. Bureau of National Affairs, "Clinton Floats Trial Balloons on Expansion o Health Coverage," Health Care Policy Report 5, no. 37 (September 22, 1997) p. 1441.

4. Bureau of National Affairs, "School-Based Centers Gaining Attention for

Providing Access to Uninsured Kids," Health Care Policy Report 5, no. 32 (August 11, 1997): p. 1273; and Making the Grade, "National Survey of State SBHC Initiatives: School Year 1995-96," (Washington: George Washington University, 1997).

5. Harvard University, The Robert Wood Johnson Foundation, and the University of Maryland, "Attitudes Toward Children's Health Care Issues," November 1997. The survey was funded by the Robert Wood Johnson Foundation. It was designed by the Harvard University School of Public Health, with assistance from the Survey Research Center at the University of Maryland at College Park. Survey analysis was performed at Harvard. The survey of 1501 adults within the continental United States was conducted by telephone by the Survey Research Center, and the survey's margin of error is plus or minus 3 percentage points.

6. Ibid.

7. Alliance for Health Reform, "Outreach to Uninsured Kids," Health Coverage 1998, (May 1998): p. 2.

8. Thomas M. Selden, Jessica S. Banthin, and Joel W. Cohen, "Medicaid's Problem Children: Eligible But Not Enrolled," Health Affairs 17, no. 3, (May/June 1998): pp. 192-200.

9. Employee Benefit Research Institute, 1997 as cited in Alliance for Health Reform, p. 3.

10. Data from the U.S. Census Bureau, Survey of Income and Program Participation indicates that only 4.1 percent of children lacked health insurance for an entire 28-month period during

1992 to 1994. In other words, few children are chronically uninsured.

11. The 13 percent figure is based on 1.3 million [of the 10 million uninsured children under 18] who lack health insurance because of its costs. Robert M. Goldberg, "The Birth of Clintoncare Jr. . . . ," Wall Street Journal, August 5, 1997, p. A18.

12. A survey conducted by the Council for Affordable Health Insurance found the cost of child-only policies for a single child ranges between $58 and $66 per month, depending on geographic region. Council for Affordable Health Insurance, "Is There Really An Uninsured Epidemic?," CAHI Policy Brief 1, no. 1 (April 1, 1997): p. 5.

13. Golberg, p. A18.

14. 42 USC Sec. 1395 states "Nothing in this title shall be construed to authorized any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which Medical service are provided, or over the selection, tenure, or compensation of any officer or

employee of any institution, agency, or person providing health services; or t exercise any supervision or control over the administration or operation of an such institution, agency, or person." Sec. 1395(a) states "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services." Sec. 1395(b) continues "Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services."

15. U.S. District Federal Judge Thomas F. Hogan recently noted "Medicare is in effect, the only primary health insurance available to people over 65. No private health insurance companies offer 'first dollar' insurance to this group; they offer only supplemental insurance (See Pls.' Mot. For Prelim. Inj. at 18.) United Seniors Association, Inc., v. Donna Shalala, Civ. No. 97-3109, April 14, 1998.

16. Howard S. Berliner, "The Origins of Health Insurance for the Aged," International Journal of Health Services 3, no. 3 (1973): pp. 465-473.

17. U.S. District Federal Judge Thomas F. Hogan recently opined "The Court does not pass judgment on Congress' wisdom in passing Section 4507; the Court's role here is solely to determine whether the United States Constitution confers a fundamental right on individuals to contract privately with their physicians. The Court finds that it does not. The Supreme Court has declined to extend the right to autonomous decision-making beyond certain limited contexts involving child rearing and education, family relationships, procreation, marriage, contraception and abortion. See Bowers v. Hardwick, 478 U.S. 186, 190 (1986). This Court is not inclined to create new areas of constitutional protection. See Dronenberg v. Zech, 741 F.2d 1388, 1937 (D.C Cir. 1984) ("If it is an any degree doubtful that the Supreme Court should freely create new constitutional rights, we think it certain that lower courts should not do so.") Therefore, the Court finds that, on this record, Plaintiffs have not demonstrated that they have a constitutional right to contract privately with their physicians." United Seniors Association, Inc., v. Donna Shalala, Civ. No. 97-3109, April 14, 1998.

18. Social Security Administration. The Social Security Operations Manual states that "Some individuals entitled to monthly benefits have asked to waive their HI [Medicare Part A Hospital Insurance] entitlement because of religious or philosophical reasons or because they prefer other health insurance. Policy Individuals entitled to monthly benefits which confer eligibility for HI may not waive HI entitlement. The only way to avoid HI entitlement is through withdrawal of the monthly benefit application. Withdrawal requires repayment of all RSDI [retirement, survivors, and disability insurance] and HI benefit payments made." Social Security Operations Manual Policy no. HI 00801.00

19. Medicare fraud amount derived from Helen Dewar and Barbara Vobejda, "Medicare Waste: 11 Cents per Dollar," Washington Post, April 24, 1998, p. A5. Senator Don Nickles (R-OK) recently remarked that "Medicare's regulatory regime takes up about 45,000 pages." as cited in Association of

American Physicians and Surgeons, "The Medicare Paperwork Burden,"AAPS News 54, no. 5 (May 1998): p. S2.

20. Peter J. Ferrara, "The Next Steps for Medicare Reform," Cato Institute Policy Analysis no. 30, April 29, 1998, pp. 9-10.

21. Charlotte Twight, "Medicare's Origin: The Economics and Politics of Dependency," Cato Journal 16, no. 3 (Winter 1997): pp. 309-338.

22. National Governors' Association, "New Efforts to Provide Health Care Coverage for Uninsured Children - Spring 1997," StateLine, (April 22, 1997) p. 1.

23. The Kaiser Commission on the Future of Medicaid, "Medicaid's Role for Children," Medicaid Facts, May 1997, p. 1.

24. Brian K. Bruen and Frank Ullman, "Children's Health Insurance Program Where States Are, Where They Are Headed," Urban Institute New Federalisr Issues and Options for States, Series A, no. A-20 (May 1998): Figure 1, pp. 3 4.

25. Bureau of National Affairs, "School-Based Centers Gaining Attention for Providing Access to Uninsured Kids," p. 1273.

26. Maternal and Child Health Bureau, "School Health Fact Sheet," October 1994.

27. Bureau of National Affairs, "School-Based Centers Gaining Attention for Providing Access to Uninsured Kids," p. 1273.

28. Ibid, p. 1274.

29. The Center for the Study of Social Policy, "A Strike for Independence: How a Missouri School District Generated Two Million Dollars to Improve the Lives of Children," (Washington: Center for the Study of Social Policy, 1994), p 3.

30. Ibid, p. 10.

31. Ibid, pp. 2-3.

32. Commonwealth of Pennsylvania House of Representatives, Committee oı Education, Select Subcommittee on Education, Select Subcommittee on House Resolution No. 37, Findings of Fact and Report, November 1996, pp. 18-19.

33. U.S. General Accounting Office, Health Care: School-Based Health Centers Can Expand Access for Children, (Washington: GAO, December 1994).

34. Making the Grade, p. 1.

35. Genevieve Young, "FOCUS: The Medicalization of Public Schools," Eagle Forum Education Reporter, no. 132, (January 1997): p.1.

36. Bureau of National Affairs, "Conference Report, Joint Explanatory Statement on Medicare, Medicaid, and Children's Health Provisions of HR 2015 (H. Rept. 105-217)," Health Care Policy Report Special Supplement 5, no. 31, (August 4, 1997). States that participate in SCHIP are required to provide a package of minimum benefits as follows: (1) A plan that is an equivalent to one of the following benchmark plans, (2) FEHBP Blue Cross/Blue Shield PPO option, (3) state employee health plan that is generall available in the state, or (4) the HMO with the highest commercial enrollmen in the state. Also, New York, Florida, and Pennsylvania are permitted to use their current state-only programs' benefit plans as a benchmark plan. A plan with the same actuarial value as a benchmark plan. Under this option, states must cover four basic services: (1) inpatient and outpatient hospital services, (2) physicians' surgical and medical, (3) laboratory and x-ray, and (4) well-baby/well-child care, including immunizations. The new plan must have an aggregate actuarial value at least equivalent to the benchmark plan and it mus assure that the plan's mental health, vision, hearing, and prescription drug benefits have at least 75% of the actuarial value of prescription drug, mental health, vision and/or hearing services in the benchmark plan. In order to participate in the new State Children's Health Insurance Program, states are required to allocate some of their own funds to the program. States must contribute 70% of a state's current matching rate. For example, if a state currently contributes 50% to its total federal/state Medicaid program, the stat would be required to contribute 35% to the SCHIP (70% of the current 50% Medicaid matching rate).

37. American Legislative Exchange Council, "1998 Health and Human Services Task Force Legislative Update," Washington, D.C., May 5, 1998.

38. The Consensus Group, "Giving States and Citizens a Choice," Policy Statement to State Governors, November 25, 1997, p. 2. The Health Policy Consensus Group is a broad-based group of leading health policy analysts from the major market-oriented think tanks. The statement was developed by Grace-Marie Arnett of the Galen Institute; Brad Belt of the Center for Strategic and International Studies; Stephen Entin of the Institute for Researc on the Economics of Taxation; Robert Helms, Ph.D. of the American Enterprise Institute; John Hoff, Esq. a health policy attorney; John Goodman, Ph.D. and Merrill Matthews, Ph.D. of the National Center for Policy Analysis David Kendall of the Progressive Policy Institute; Naomi Lopez of the Institute for SocioEconomic Studies; Marty McGeein of The McGeein Group Robert Moffitt, Ph.D. and Carrie Gavora of the Heritage Foundation; Mark Pauly, Ph.D. of The Wharton School, University of Pennsylvania; and Michael Tanner and Darcy Olsen of the Cato Institute. These views reflect those of these individuals and not necessarily their organizations.

39. Bureau of National Affairs, "Health Care for Uninsured Children Become Reality in Compromised Plan," Health Care Policy Report 5, no. 31, (August

4, 1997): p. 1204.

40. Goldberg, p. A18.

41. David M. Cutler and Jonathon Gruber, "Medicaid and Private Insurance: Evidence and Implications," Health Affairs 16, no. 1 (1997) : 194-200.

42. National Governors' Association Center for Best Practices, "How States Can Increase Enrollment in the State Children's Health Insurance Program," NGA Center for Best Practices Issue Brief , (May 7, 1998), p. 9.

43. Ibid.

44. The Center for the Study of Social Policy, p. 30.

45. Brigid McMenamin, "Trojan Horse Money," Forbes, December 16, 1996, p. 123.

46. Ibid, p. 126.

47. Commonwealth of Pennsylvania House of Representatives, pp. 33-34.

48. Ibid, p. 34.

49. The Consensus Group.

50. Sue A. Blevins, "Restoring Freedom to Health Care: The Case for a Universal Tax Credit for Health Insurance," Cato Institute Policy Analysis nc 290, December 12, 1997.

51. Bureau of National Affairs, "Children's Health Proposal to Include Tax Credits as Part of Overall Package," Health Care Policy Report 6, no. 18 (Ma 4, 1998): pp. 752-753.

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