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Class Competition and American Health Care: Debating the State Children's Health Insurance Program

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*Janet L. Dolgin**

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I. INTRODUCTION¹

In February 2009, two weeks after becoming President, Barack Obama signed a bill reauthorizing and expanding the State Children's Health Insurance Program (SCHIP).² "The way I see it,"

1. This Article was written in 2008, during the last months of the Bush presidency. At that time, the Article suggested that the nation had reached a "tipping point" and that health care reform might soon become real. The Article is going to press in early 2010. It now seems likely that Congress will pass, and the President will sign, significant health reform legislation in 2010. This Article assumes that that will happen, but obviously the details of the new system of health care coverage and delivery cannot be ascertained with certainty at this point. Even with the hope of health care reform on the horizon, the Article describes a set of assumptions about class, health, and personhood that are deeply engrained in the American psyche.

2. Children's Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong. (2009).

explained Obama at the signing ceremony, “providing coverage to 11 million children [through SCHIP] is a down payment on my commitment to cover every single American.”³

The new law signaled a dramatic shift in health care policy from that of the previous administration and signaled a far more sweeping set of reforms, which were entertained by Congress in 2009 and early 2010.⁴ In 2007 and 2008, Congress failed to override presidential vetoes of two bills that would have expanded SCHIP, a state–federal program providing health care coverage for low-income children.⁵ The story of the nation’s failure to expand SCHIP in the last years of the Bush administration reveals as much about the nation’s response to health care delivery during most of the twentieth century and the first few years of the twenty-first century as does the reauthorization and expansion of the program in early 2009. Even more, the failed effort to reauthorize SCHIP in 2007 and 2008 illuminates the nation’s broader reluctance over many decades to develop a health care system providing universal or near-universal coverage. This Article analyzes the SCHIP story, drawing insights from it about the key role played by a peculiar, American form of class competition in the nation’s more general reluctance over many decades to affect universal health care.

A wide compendium of analyses, developed by economists, political scientists, sociologists, legal and public health scholars, and others, offers explanations of the historic failure of the United States to create universal⁶ health coverage.⁷ The explanations are various and complicated.⁸ No one explanation, however compelling, is complete.

3. Noam N. Levey, *Obama Signs Child Health-Care Bill*, CHI. TRIB., Feb. 5, 2009, at C10.

4. As this paper goes to press, the Senate voted sixty to thirty-nine to begin full debate on sweeping health care legislative reform. (Sixty votes were needed for debate to begin.) David M. Herszenhorn & Robert Pear, *Health Care Overhaul Bill Passes Crucial Senate Test*, N.Y. TIMES, Nov. 22, 2009, at A1.

5. See Part III.B.1.

6. Universal health care coverage is not necessarily synonymous with one-payer coverage. More specifically, a system of health care could provide coverage to all or most people in the U.S. without relying on the government as a payer.

7. See, e.g., COLIN GORDON, *DEAD ON ARRIVAL: THE POLITICS OF HEALTH CARE IN TWENTIETH-CENTURY AMERICA* 1 (2003) (describing existing explanations as “profoundly unsatisfying”).

8. Vicki Kemper, *What’s Blocking Health Care Reform?*, COMMON CAUSE MAG., Winter 1992. Kemper comments, in describing opinions about “why” health care reform has not happened:

[D]octors blame lawyers and the government for the current mess. Health care purchasers point to insurance companies that cover only the healthy, while insurers single out greedy doctors and hospitals and

The explanation delineated in this Article is not intended to replace existing explanations, but rather to supplement them. The Article contends that Americans consistently rejected efforts to develop universal health care coverage because of a form of class competition that is intense and unremitting but, at the same time, largely “below the social radar.”⁹

More particularly, because class status is significant—and often determinative of one’s identity and options—in the United States, yet far less self-conscious than identities grounded in race, ethnicity, or religion, the struggle faced by individuals to sustain—or perhaps even advance in—class status is complicated, discomforting, and opaque. It is intertwined with many dimensions of social existence, including health and illness.

Specifically, this Article suggests that various indicia of good health—signs such as weight, dental condition, and general physical prowess—serve as powerful markers of social class. The process through which people’s apparent health status leads to assumptions about their class status is more often unself-conscious than explicit, but people in the United States clearly do rely on such markers to categorize others. People without significant financial resources and without health care coverage are at risk for exhibiting the more obvious indicia of poor health. They are thus less likely to appear “middle-class” than those with extensive resources and those with health care coverage. In the struggle to sustain class status—a struggle even more central to the American psyche at present than the struggle to rise in class status—people are concerned about losing their class position to those whom they rank below themselves on the social ladder but who, at the same time, enjoy government benefits not available to the middle class. Competition about health care coverage is especially intense because it is perceived as more than just another social welfare

unrealistic consumers. Outside analysts frame the problem as a lack of consensus; public interest groups define it as a lack of political courage; and everybody talks about how complicated the issue is.

Id.

9. The United States is among the three countries in the world with the highest levels of inequality. ‘*More Inequality*’ in *Rich Nations*, BBC NEWS, Oct. 21, 2008, <http://news.bbc.co.uk/2/hi/business/7681435.stm>. Mexico has the greatest levels of income inequality: Turkey is second, and the United States is third. *Id.* In the U.S., economic inequality predates the 2008 economic downturn. In 2006, Paul Krugman reported that the “gap between the nation’s CEOs and average workers is now ten times greater than it was a generation ago.” Krugman, *Great Wealth Transfer*, *supra* note 281. Moreover, the gap between the richest people and the poorest grew dramatically between 1973 and 2005. *Id.*

benefit. Indicia of health (understood to follow from increased access to health care) provide significant, though often unmentioned, signs of class status.

This Article shows that opposition to universal health care coverage in the United States has a special meaning to groups of people living above the poverty level but below a level identifying them as “well-off.” Within this broad economic group, people worry about losing their place in the nation’s class hierarchy to those whose class status and apparent class status¹⁰ (as suggested, for instance, by various indicia of health or illness) would improve were health care coverage to become available to everyone.

For many in the middle class, especially in the lower strata of the middle class, sustaining class status is difficult. And insofar as class status is a comparative, rather than an absolute, measure, they assess their success in preserving class status by looking at other groups just above and, more importantly, just below their own. Much of this sort of assessment of class status is not explicit or even conscious. But such assessments and the conclusions at which people arrive as a result of them are powerful motivators of political preferences and of responses to governmental programs. This Article focuses on one example to demonstrate the complicated social, political, and psychological processes that mold responses to health care coverage provided by the government.

The example relates to efforts in 2007 and early 2008 to renew and expand SCHIP. That program was created in 1997 with funding for ten years.¹¹ In 2007, Congress twice attempted to renew and expand the program. President Bush vetoed both bills, and Congress failed to override either veto.¹² This Article examines the complicated responses to Congress’ efforts to renew and expand SCHIP in the last years of George W. Bush’s presidency and suggests that, at least in significant part, Congress’ failure in that regard followed from social responses grounded in implicit forms of class competition. It further suggests that the same forms of class competition have been significant in stymieing more general efforts to expand health care coverage.

10. Levels of concerns have skyrocketed since the fall 2008 economic downturn. Moira Herbst, *The Coming Pink Slip Epidemic*, BUS. WK., Oct. 21, 2008, http://www.businessweek.com/bwdaily/dnflash/content/oct2008/db20081020_022663.htm. Few industries are immune from the consequences of the contracting credit markets that followed the disappearance of the housing bubble in mid-2008. *Id.*

11. Balanced Budget Act of 1997, H.R. 2155, 105th Cong. (1997). See Part III.A.1 (describing the history of SCHIP).

12. See Part III.B.1.

That the nation finally began seriously to entertain a more universal system of health care coverage in the first year of the Obama administration suggests, in part, the extent to which the high cost and inadequate delivery of the old system had become undeniable. Even so, the debate about health care reform reflects the voices of those who *fear* that more universal health care coverage will undermine *their* presumptively fragile place in the nation's socio-economic hierarchy.

The Article begins in Part II with a summary of the nation's failure, over nearly eight decades of trying, to create a health care system providing broad access to care. It then reviews several political and economic explanations for that failure. Next, Part II describes disparities in health and in health care in the United States as compared with other nations.

Parts III provides background information. It describes the SCHIP program and unsuccessful efforts in 2007 and 2008 to renew and expand the program. The story of these efforts illustrates the Article's central claim—that implicit class competition played a significant part in undermining efforts to create a system of universal health care coverage in the United States. Part IV links opposition to SCHIP's expansion with class competition by examining a wide set of responses—especially negative responses—to the proposed expansion of SCHIP. These responses illustrate the intensity of class competition—for both health care access and, less openly, for signs of health presumably provided by access to health care—underlying opposition to SCHIP's expansion.

Finally, Part V, again invoking the failed efforts to expand SCHIP in 2007 and 2008 as an illustration, suggests that, the nation's opposition to universal health care notwithstanding, the United States has been moving for several years toward the sort of moment referred to as a “tipping point”¹³—and thus toward the sort of significant health care reform that became manifest in 2009.¹⁴ That seemed to be the case before the economic downturn

13. See generally MALCOLM GLADWELL, *THE TIPPING POINT: HOW LITTLE THINGS CAN MAKE A BIG DIFFERENCE* (2000) (popularizing the notion of a tipping point in many social arenas).

14. The economic disruptions that rocked the nation, beginning in the second half of 2008, may pose either a stumbling block to such reform or an impetus. This second, and more felicitous, possibility could follow from recognition that health care constitutes a vital, significant, and active dimension of the nation's economy.

of 2008 and was, ironically perhaps, even more the case after the start of the Great Recession.¹⁵

II. WITHOUT ACCESS TO HEALTH CARE: THE AMERICAN CASE

Section A of this Part reviews the history of failed efforts to create a national system of health care coverage during the twentieth century. Then, Section B summarizes some differences in health and in health care between the United States and other nations.

A. An Overview of the American Health Care "System": The History of Efforts to Create More Universal Health Care Coverage

The United States has long spent more per capita for health care than any other nation.¹⁶ Yet, uniquely among wealthy nations, it failed, especially during the last decades of the twentieth century and the first decade of this century, to provide health care coverage for a significant portion of the population.¹⁷

The American people acknowledge the need for an accessible, reliable health care system.¹⁸ Many Americans do not believe they have it.¹⁹ However, they are, and have long been, ambivalent about

15. Despite the dismal economic picture facing the U.S. and much of the world, the health care industry is comparatively unscathed. *See, e.g.,* Herbst, *supra* note 10 (describing the health care and energy industries as two "bright spots on the jobs horizon"). The successful reauthorization and expansion of SCHIP in 2009 provides some evidence that broad reform in the nation's system of health care delivery may be forthcoming. Children's Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong. (2009).

16. THE COMMONWEALTH FUND, EXECUTIVE SUMMARY: WHY NOT THE BEST? 10 (2008), available at <http://www.commonwealthfund.org> (search "Entire Site" for "Why Not the Best?"; then follow "[PDF] Executive Summary -- Why Not the Best?" hyperlink) [hereinafter WHY NOT THE BEST?] (noting that the U.S. spends twice as much as other industrialized countries for health care). Despite the money that the United States spends on health care, it ranks poorly on virtually all rankings of health care and health among the nations of the world. *Id.* at 9.

17. GORDON, *supra* note 7, at 1.

18. Kemper, *supra* note 8. *See also* Paul Krugman, *Can It Happen Here?*, N.Y. TIMES, Aug. 11, 2008, at A17 (describing the "history of the pursuit of universal health care in America" to be "one of missed chances").

19. Over a decade and a half ago, Pennsylvania Democrat Harris Wofford ran ads in his campaign for the U.S. Senate that declared: "[I]f criminals have a right to a lawyer, sick Americans have a right to see a doctor." Kemper, *supra* note 8. Wofford won the election. Polls revealed that a third of those who voted for Wofford did so solely because of his position on health care reform. *Id.* At that time, polls showed that ninety percent of people in the U.S. thought that the

“bringing the poor into mainstream health care,”²⁰ and they are even more ambivalent about bringing the near-poor into that system.

At least seven twentieth-century U.S. presidents²¹ attempted to reform the nation’s health care system.²² Several proposed developing a comprehensive system of national health care coverage.²³ Only President Lyndon Johnson enjoyed some success at reforming the U.S. health care system.²⁴ During the same years, the United States successfully erected a variety of other social welfare programs.²⁵ Moreover, other nations created health care systems providing universal or near-universal health coverage.²⁶

Many commentators have studied the history of the nation’s failure to affect more universal health care coverage.²⁷ Some

health care system was in need of “fundamental change” or “complete rebuilding.” *Id.*

20. Sidney D. Watson, *Jonathan Engel, Poor People’s Medicine: Medicaid and American Charity Care Since 1965*, and Ronald J. Angel, Laura Lein, & Jane Henrici, *Poor Families in America’s Health Care Crisis*, 32 J. HEALTH POL. POL’Y & L. 1053, 1056 (2007) (book review).

21. These include Calvin Coolidge, Kemper, *supra* note 8; Franklin Roosevelt, GORDON, *supra* note 7, at 269; Harry Truman, *id.* at 270–71; Lyndon Johnson, Wendy K. Mariner, *The Health Care Mess: How We Got into It and What It Will Take to Get Out*, 10 DEPAUL J. HEALTH CARE L. 543, 555 (2007) (book review); Richard Nixon, PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 394–96 (1982); Jimmy Carter, *id.* at 411; and Bill Clinton, GORDON, *supra* note 7, at 41–44.

22. Kemper, *supra* note 8 (Kemper’s article was a *Common Cause* cover story only shortly before the articulation and defeat of the Clinton health care plan).

23. *Id.*

24. During President Johnson’s administration, Congress enacted laws creating the Medicare and Medicaid systems. President Johnson:

[W]as able to push an astonishing range of health and civil rights legislation through Congress in the late 1960’s. The momentum for expanding Medicare and Medicaid into a more universal health insurance system was lost, however, as the Vietnam war began to absorb Johnson’s attention and a rising share of the federal budget.

Mariner, *supra* note 21, at 555.

25. GORDON, *supra* note 7, at 1.

26. *Id.* at 147 (commenting that by the 1960s, “virtually every first- and second-world country,” except South Africa and the United States, had a national health insurance system).

27. See, e.g., PAUL FARMER, *PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR* (2005) [hereinafter FARMER, *PATHOLOGIES OF POWER*]; (considering the causes and consequences of disparities in health in many countries, including the United States); GORDON, *supra* note 7, at 7 (noting radical scholars’ explanation that the failure of the United States to develop a system providing national health care coverage

analysts have focused on shifting political affiliations²⁸ or have referred to the faith of the American people in "private solutions."²⁹ Others have focused on economic factors.³⁰ Many special interest groups have thrived in the system that now exists; some of these have strenuously opposed reform. Likewise, business, especially small business, in its role as employer, has sometimes opposed health care reform, largely for fear that reform would place added burdens for health care coverage on employers.³¹

Several times in the twentieth century, Congress entertained proposals to expand health care coverage. Few became law.³² As early as the 1920s, most countries in Western Europe had more or less comprehensive national health care coverage.³³ During that decade, President Calvin Coolidge was the first of several twentieth-century U.S. presidents to propose that the government spend more on health care or that the nation develop a comprehensive system of national health care coverage.³⁴

reflects the politics of class in the nation); Vincente Navarro, *Race of Class Versus Race and Class: Mortality Differential in the United States*, 336 LANCET 1238 (1990).

28. Paul Starr's classic book, *The Social Transformation of American Medicine*, documents much of this history. The irony in that history is startling. For instance, in the first few decades of the twentieth century, a group of academics and some others (the American Association for Labor Legislation) proposed a model bill to provide health coverage to the working class. The bill was opposed by the American Federation of Labor as "an unnecessary, paternalistic reform that would create a system of state supervision of the people's health." STARR, *supra* note 21, at 249.

29. GORDON, *supra* note 7, at 3.

30. See generally *id.* (analyzing political and economic factors that have contributed to the nation's failure to develop a system of more universal health care coverage).

31. *Id.* at 284 (noting responses of business and labor to the Clinton health plan; "business," Gordon reports, "bailed out as soon as it became clear that mandates and cost control could not be reconciled"); Kemper, *supra* note 8.

32. The creation of the Medicare and Medicaid programs during President Johnson's administration is the most important exception to the nation's general failure to strengthen health care delivery. Medicaid was promulgated as Title XIX of the Social Security Act, and Medicare was promulgated as Title XVIII of the Social Security Act.

33. Kemper, *supra* note 8.

34. President Roosevelt refrained from pursuing a national health care insurance system in 1932, 1938, and in subsequent years. He was concerned about opposition from the medical establishment and Democrats in southern states. GORDON, *supra* note 7, at 269. Colin Gordon describes Truman as having "cast his health net widely," but it was "shredded" by Congress. *Id.* at 270. Only President Johnson enjoyed some success in reforming American health care

Rick Mayes contends that the critical point—the point at which a national health system might have been put in place, but was not—was during the Roosevelt administration.³⁵ The widespread economic misfortune resulting from the depression opened a “window of opportunity” for reformist change.³⁶ As originally envisioned, the social security package was to include unemployment insurance, insurance for the elderly, and health insurance.³⁷ The first two became the centerpieces of President Roosevelt’s social security program. The third was abandoned, largely because of fear that the virulent opposition of the American Medical Association (AMA) to national health insurance would have precluded passage of that part of the program and, even more, might have imperiled passage of the entire program.³⁸ The abandonment of national health coverage at that critical, transitional moment meant—as is reflected in the historical record—that Americans, increasingly comfortable with a social security program that provided unemployment insurance and income insurance for the elderly, would spend decades debating the need for and the feasibility of national health care coverage.

Most of the post-Roosevelt proposals for developing national health insurance during the twentieth century were similarly and successfully opposed by the medical establishment and by other interest groups. None of the proposals was actualized.³⁹ Vicki Kemper, in a 1992 analysis that continues to offer valuable insights, identified “special interest groups with a vested interest in the status quo” as the “biggest culprit” among those factors that

coverage. Mariner, *supra* note 21, at 555. Paul Starr reported that the Nixon administration contemplated “some kind of national health insurance” but saw the “more immediate problem” to be how to train more doctors and how to move away from care provided by hospitals. STARR, *supra* note 21, at 394–96. Starr further noted that as a candidate, Jimmy Carter committed himself to create a program of national health care coverage but that he was successfully opposed in that effort by his own economic advisors. *Id.* at 411. Colin Gordon described the proposed, but never actualized, Clinton Health Plan to have included “an employer mandate, a system of regional insurance purchasing cooperatives, a standardized health plan, income tax reform, and global spending caps.” GORDON, *supra* note 7, at 41–43.

35. RICK MAYES, *UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH INSURANCE* 17–19 (2004).

36. *Id.* at 19. Mayes’ contention may bear relevance in the context of the current economic downturn.

37. *Id.* at 17.

38. *Id.* at 19–21.

39. Kemper, *supra* note 8.

have hindered national health care in the United States.⁴⁰ In the decade before Kemper's article appeared, political action committees, which represented groups ranging from the AMA to pharmaceutical companies, contributed over \$60 million to candidates running for Congress.⁴¹

At about the same time, however, a set of sweeping changes altered the structure of institutionalized medicine as it had existed since at least the middle of the nineteenth century.⁴² With astonishing speed, beginning in the late 1970s, medicine as big business replaced medicine as a cottage industry.⁴³ By the 1980s, Wall Street understood how much money could be made from the business of health care.⁴⁴ Increasingly, during the decades that followed this transformation, health care workers,⁴⁵ and in particular physicians, lost significant control over their work.⁴⁶

The transformation of medicine from cottage industry to big business has had even more disastrous consequences for the provision of health care, generally, in the United States. One recent book describes some of these consequences:

The result is a chaotic system that has shifted its focus from saving lives to saving dollars, one that discourages preventive medicine and rewards overtesting and overmedicating; a system that allows insurers to reject those most likely to require medical attention and keep only the healthiest; a system where six times as many people die from medical mistakes as from HIV/AIDS; a system that forces doctors to spend as much time negotiating with insurers over referrals and fees as they do treating patients.⁴⁷

In the early years of this century, the enormity of the problems ingrained in the convoluted system—or, more accurately,

40. *Id.*

41. *Id.* In addition, Kemper notes that about forty-two percent of the money contributed went to members of congressional committees concerned with legislation about health-related matters. *Id.*

42. STARR, *supra* note 21, at 379–419.

43. *Id.* at 381–405.

44. DONALD L. BARLETT & JAMES B. STEELE, CRITICAL CONDITION: HOW HEALTH CARE IN AMERICA BECAME BIG BUSINESS—AND BAD MEDICINE 76–77, 88 (2006) (describing the creation of a health care department at a New York investment house and describing “how profit became policy”).

45. *Id.* at 109–21 (describing consequences for physicians and nurses of Wall Street's take-over of medicine).

46. *Id.* at 113, 129, 163, 180–81 (describing physicians' loss of control and authority).

47. *Id.* at 4.

discordant set of systems—that has constituted American health care has become glaring. More and more voices from various sides of the political spectrum, from within government and from without, urged that serious attention be paid to the construction of a more effective, more equitable—or at least more cost-efficient—system of health care.⁴⁸ One of the most striking shifts was a startling reevaluation among doctors about national health coverage. In stark contrast with the unmoving opposition of the medical establishment to national health coverage for most of the last century, individual physicians and physician groups began to clamor for reformist ends.

Even the AMA began to soften its position, beginning in the 1990s when it came forward with a proposal of its own for reforming health care.⁴⁹ More recently, the position of individual American physicians has shifted. One 2007 survey revealed a significant increase in physician approval of a system of national health care insurance from forty-nine percent five years before to fifty-nine percent in 2007.⁵⁰ And in the fall of 2009, the AMA openly favored passage of health care reform.⁵¹ Although physicians, as a group, have lost some of their clout as big business has absorbed medicine, the new responses of doctors to national

48. Physicians, traditionally among the most strident opponents of a system of national health care coverage, have done an about-face. Now a majority of U.S. physicians supports national insurance. Catherine Arnst, *Most Docs Favor National Health Insurance*, BUS. WK., Mar. 31, 2008, http://businessweek.com/technology/content/mar2008/tc20080331_551691.htm. In late 2007, the American College of Physicians (with about 125,000 members) gave its support to a program of national insurance. *Id.*

49. *Id.* At the center of that plan was protection against malpractice suits and against the imposition of cost controls. Even that minimalist suggestion carries significance in comparison to the response of the American Medical Association (AMA) to the suggestion during the Kennedy administration that the government protect health insurance for people over sixty-five. The AMA adamantly opposed the suggestion, referring to it as “socialized medicine.” Kemper, *supra* note 8. Vicki Kemper reports that the AMA responded to President Kennedy’s suggestion by, among other things, hiring Ronald Reagan (then a Hollywood actor). *Id.* Reagan prepared a phonograph record on which he explained to doctors’ spouses that if they did not oppose Medicare we would all “spend our sunset years telling our children and children’s children what it was like in America when men were free.” *Id.*

50. Arnst, *supra* note 48 (reporting on survey results, published in the *Annals of Internal Medicine*, that show that in a historical shift most U.S. physicians now claim to support the creation of a system of national health insurance). The American College of Physicians has noted approval of a single-payer system of national health care coverage. The AMA has not endorsed a single-payer system. *Id.*

51. *AMA Hails House Passage of Health Reform Bill (H.R. 3962)*, MANAGED CARE BUS. WK., Nov. 29, 2009, at 133.

health care coverage have constituted an important piece in the new opportunity for change—a new critical moment that emerged in 2009.⁵²

That said, a myriad of factors still militates against acceptance of universal or near-universal health care coverage in the United States among many groups in the nation. Special interests groups, even if the medical establishment is not among them, continued to lobby for the status quo (or something equivalent) during the first year of the Obama presidency.⁵³ And beyond this lies class competition, concretized through a set of deeply ingrained presumptions about socio-economic status and even about health and health disparities. These assumptions long constituted a peculiar—because generally invisible—stumbling block to the nation's development of a system of universal and comprehensive health care coverage.⁵⁴

B. Disparities in Health and in Health Care

Clearly, the nation's system of health care—or, more accurately, its lack of a coherent system—has precluded good health care and good health for many people. This Section delineates some serious limitations of the system that have existed for the last several decades. Health care costs significantly more per capita in the U.S. than in any other nation.⁵⁵ And yet, life expectancy is lower and infant mortality higher in the U.S. than in

52. See, e.g., Stephen Morrissey et al., Editorial, *Health of the Nation—Coverage for All Americans*, 359 NEW ENG. J. MED. 855 (2008) (noting details of then-candidate Barack Obama's health care reform plan, but noting difficulties in the path of genuine health care reform). Indeed, this editorial pronounced a “challenge” to “all the major stakeholders in our health care system”: “create together a system that will provide high quality, affordable health care for all Americans during the next administration. The time is right for reform. The opportunity is here, and the need is clear.” *Id.*

53. See Katharine Q. Seelye, *The Prudence of Mixing Eggnog and Advocacy*, N.Y. TIMES, Nov. 22, 2009, at A28 (“All sides in the health care debate have already spent a combined \$170 million on television advertising so far this year—the most ever spent on single-issue advocacy commercials in one calendar year.”).

54. Part IV of this Article reviews such attitudes and suggests some of their consequences.

55. See Uwe Reinhardt et al., *U.S. Health Care Spending in An International Context*, 23 HEALTH AFF. 10 (2004) (noting that the U.S. spends more than any other country belonging to the Organization for Economic Cooperation and Development “by a huge margin”; for instance, Canada, with a health care delivery comparable to that in the U.S., spent fifty-seven percent as much per capita for health care as did the U.S. in 2001).

most industrialized countries.⁵⁶ Indeed, healthy life expectancy in the United States—a measure of years of good health that a newborn child can expect—is below that of twenty-six other nations.⁵⁷

Moreover, disparities in access to health care are significant and widespread.⁵⁸ In 2006, almost sixteen percent of the U.S. population was uninsured.⁵⁹ Overall, children fared better than adults (largely because of Medicaid and SCHIP),⁶⁰ but almost twenty percent of children living in poverty had no health care coverage.⁶¹

Even people with insurance do not necessarily have adequate coverage. Fourteen percent of U.S. adults were underinsured in 2007.⁶² A comparative framework is useful for understanding the

56. Relying on U.S. Census Bureau data, forty-three countries have higher life expectancies than the U.S., and forty countries have lower infant mortality rates. UNITED HEALTH FOUND., *AMERICA'S HEALTH RANKINGS: A CALL TO ACTION FOR PEOPLE & THEIR COMMUNITIES* 9 (2007), http://www.borderhealth.org/files/res_1246.pdf [hereinafter UNITED HEALTH FOUND., HEALTH RANKINGS].

57. *America's Health Rankings: 2006 Key Findings*, CHANNEL 3000, Dec. 5, 2006, <http://www.channel3000.com/health/10465801/detail.html>. A girl born in the U.S. in 2008 can expect seventy-one years of active health; a girl born in Japan in the same year can expect seventy-eight years of active health. *Id.*

58. UNITED HEALTH FOUND., HEALTH RANKINGS, *supra* note 56, at 16.

59. Stephen B. Thomas & Sandra Crouse Quinn, *Poverty and Elimination of Urban Health Disparities: Challenge and Opportunity*, in REDUCING THE IMPACT OF POVERTY ON HEALTH AND HUMAN DEVELOPMENT: SCIENTIFIC APPROACHES 111, 113 (Stephen G. Kaler & Owen M. Rennert eds., 2008) (citing CARMEN DENAVAS-WALT ET AL., *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006* (2007), <http://www.census.gov/prod/2007pubs/p60-233.pdf>).

60. COMMONWEALTH FUND, *WHY NOT THE BEST?: RESULTS FROM THE NATIONAL SCORECARD ON U.S. HEALTH SYSTEM PERFORMANCE, 2008* at 28–29 (2008), <http://www.commonwealthfund.org> (search “Entire Site” for “Why Not the Best?”; then follow “Why Not the Best? Results From the National Scorecard on U.S. Health System Performance, 2008” hyperlink; then follow “Embargoed Fund Report” hyperlink) [hereinafter HEALTH SYSTEM SCORECARD].

61. Thomas & Quinn, *supra* note 59, at 114 (citing U.S. CENSUS BUREAU, *CURRENT POPULATION SURVEY, 2006 ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT* (2006), <http://www.census.gov/apsd/techdoc/cps/cpsmar06.pdf>). Even half way through the original SCHIP authorization (2002), it was clear that not all children eligible for Medicaid or SCHIP were enrolled in one of the programs. There are multiple reasons for this gap, including parents without adequate knowledge of the programs, various administrative hurdles, and parents reluctant to enroll their children in public health programs because of negative opinions about “welfare.” Lisa Dubay et al., *Five Things Everyone Should Know About SCHIP*, NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES (The Urban Inst., Wash., D.C.), Oct. 2002, at 7–8, *available at* http://www.urban.org/UploadedPDF/310570_A55.pdf.

62. HEALTH SYSTEM SCORECARD, *supra* note 60, at 29. In that year, the greatest increase in the percent of uninsured or underinsured people in the U.S.

consequences: in 2007, thirty-seven percent of adults in the U.S. reported that they did not receive needed care because of the cost of that care; in the Netherlands, five percent of adults reported going without care in 2007 because of financial concerns.⁶³

Americans are more likely than Europeans to suffer from coronary disease, diabetes, chronic lung disease, arthritis, and cancer.⁶⁴ A study sponsored by the United Nations Children's Fund (UNICEF), comparing children's health in the United States to that in twenty-one comparatively "rich" countries, ranked the U.S. near the bottom—second to last.⁶⁵ Among more specific findings, the U.S. exhibited a high percentage of low birth-weight neonates and only an average rate of childhood immunization.⁶⁶

Furthermore, health disparities in the United States, even within individual states, are startling.⁶⁷ Relying on U.S. census data for the years 1980 through 2000, Gopal Singh and Mohammad Siahpush described a "large and growing" disparity in life expectancy between higher-income and lower-income people.⁶⁸ The researchers reported that in the years near the start of the study's time frame (1980–1982), the poorest people could expect to live 2.8 years less than the richest people (73 years as compared with 75.8 years). During the years at the end of the study's time frame (1998–2000), the difference had increased to 4.5 years.⁶⁹

In short, the nation's system of health care coverage has not served a significant segment of the adult and pediatric populations. Millions of people have had no health care coverage.⁷⁰ Others have had inadequate coverage.⁷¹ None of this is a secret. Yet, for many

occurred among those with incomes at or above 200 percent of the federal poverty level (FPL). *Id.*

63. *Id.*

64. UNITED HEALTH FOUND., HEALTH RANKINGS, *supra* note 56, at 9–10.

65. *Id.*

66. *Id.* at 10.

67. *Id.* at 5–7.

68. *Disparity Increases in Life Expectancies of Higher-, Lower-Income U.S. Residents, Study Finds*, KAISER HEALTH NEWS, Mar. 25, 2008, <http://www.kaiserhealthnews.org/daily-reports/2008/march/25/dr00051125.aspx>.

69. Robert Pear, *Gap in Life Expectancy Widens for the Nation*, N.Y. TIMES, Mar. 23, 2008, at A19.

70. See, e.g., Paul Krugman, *Health Care Excuses*, N.Y. TIMES, Nov. 9, 2007, at A27.

71. Sidney D. Watson, *Health Voices, Unhealthy Silence: Advocacy and Health Policy for the Poor*; Colleen M. Grogan & Michael K. Gusmano, 29 J. LEGAL MED. 263, 263 (2008) (book review) (reporting that those who get care through Medicaid are often "relegat[ed] . . . to a patchwork of under funded and

decades, the nation has not managed to construct an effective system of health care coverage.

III. A CASE STUDY: THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

The SCHIP story includes the effort to construct an adequate health care system (at least for a certain group of children), and it includes the near evisceration of that effort's success. More specifically, responses to congressional efforts to review and expand SCHIP in 2007 and 2008 suggest some of the underlying beliefs and assumptions that long precluded universal or near-universal health care coverage in the United States. This Part presents the SCHIP story, ten years after the program's creation. Parts IV and V refer to that story to illustrate the role of class competition in limiting support for universal health care coverage more generally.

Section A.1 of this Part outlines SCHIP generally, and then, Section A.2 provides details about states' structuring of specific SCHIP programs. This Section notes differences between states' SCHIP programs and their Medicaid programs. Such differences instantiate this Article's central thesis—that class competition underlies the failure of the United States to develop a system of comprehensive health care coverage during eight decades of trying. Section B of this Part describes the two bills that would have reauthorized and expanded SCHIP and then describes an effort by the federal government to limit SCHIP's expansion, even before President Bush vetoed the two SCHIP reauthorization bills.

A. The Scope of the SCHIP Program

SCHIP was created as part of the Balanced Budget Act of 1997.⁷² Established as Title XXI of the Social Security Act, the

overcrowded community health clinics, hospital emergency rooms, and a variety of community-based, not-for-profit providers"). Watson adds that "Medicaid enrollees still lack access to mainstream medical care and Medicaid has become the primary funding source supporting and maintaining America's second tier of medical care." *Id.*

72. Balanced Budget Act of 1997, H.R. 2015, 105th Cong. (1997). Congress intended for the Balanced Budget Act to balance the federal budget by 2002. It was estimated by the Congressional Budget Office in 1997 that the Act would result in gross savings of \$127 billion. CONGRESSIONAL BUDGET OFFICE, CBO MEMORANDUM: BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997, at 1 (1997), <http://www.cbo.gov/ftpdocs/3xx/doc302/bba-97.pdf>.

program was funded through a block grant of about \$40 billion in federal money for its first ten years (1998 through 2007).⁷³ SCHIP provided a new mechanism for expanding Medicaid⁷⁴ (or Medicaid-like) coverage to children⁷⁵ whose parents earned too much to be eligible for Medicaid but who were unlikely to be able easily to afford private health insurance.⁷⁶ In 2008, about seventy-five percent of families with children enrolled in Medicaid or

The Act provided for savings from making changes in, and slowing the growth of, Medicaid, auctioning licenses to use portions of the electromagnetic spectrum, and an excise tax on tobacco. *Id.* The savings were to be partly offset by the children's health insurance initiatives. *Id.*

73. Dubay et al., *supra* note 61, at 3.

74. Medicaid requires states to provide coverage to children under six in families earning 133% or less of the FPL and to cover children between six and eighteen in families earning 100% or less of the FPL. Rebecca Eskin & Usha Ranji, *Children's Coverage and SCHIP Reauthorization: Background Brief*, KAISER FAMILY FOUND., <http://kaiseredu.org/> (search "Children's Coverage and SCHIP Reauthorization"; then follow "Children's Coverage and SCHIP Reauthorization" hyperlink). Medicaid programs are required to provide for periodic screening, diagnoses, and treatment services for anyone under twenty-one. This must include vision, dental, and hearing services, among other things. *Id.*

75. In a few states, some adults have also been covered through SCHIP programs. In 2007, about half of the states that covered adults (fourteen in total) covered parents only. Two of the fourteen covered only pregnant women. Coverage for adults depends on states getting waivers. GOV'T ACCOUNTABILITY OFFICE, STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PROGRAM STRUCTURE, ENROLLMENT AND EXPENDITURE EXPERIENCES, AND OUTREACH APPROACHES FOR STATES THAT COVER ADULTS 4-5 (2007), <http://www.gao.gov/new.items/d0850.pdf>. Section 1115 waivers allow the Secretary of Health and Human Services to waive limitations imposed by the Social Security Act without amending the statute. See KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., MEDICAID SECTION 1115 WAIVERS: CURRENT ISSUES (2005), <http://www.kff.org/medicaid/upload/Medicaid-Section-1115-Waivers-Current-Issues-pdf.pdf>.

76. Rosenbaum et al. noted that "SCHIP was used not to extend [Medicaid] coverage to children who lie beyond the furthest economic reaches of Medicaid (there are none) but instead, to extend coverage to low income children through a mechanism that avoids Medicaid requirements while retaining the state's entitlement to federal funding." Sara Rosenbaum et al., *Devolution of Authority and Public Health Insurance Design: National SCHIP Study Reveals an Impact on Low-Income Children*, 1 HOUS. J. HEALTH L. & POL'Y 33, 34-35 (2001) [hereinafter Rosenbaum, *SCHIP Study Reveals Impact*] (citing Social Security Act § 1902(r)(2)(A)-(B), 42 U.S.C. § 1396a(r)(2)(A)-(B) (Supp. IV 1998)). The authors report that since 1988 federal law has permitted states to include the population of children now covered by SCHIP in their Medicaid programs. *Id.* at 38 (citing Social Security Act § 1902(r)(2), 42 U.S.C. § 1396(r)(2)(A)-(B) (Supp. IV 1998)).

SCHIP included at least one worker.⁷⁷ And many of these working parents did not receive health care coverage through their employers, or, if they did, the plans did not pay for dependants or provided for dependant coverage only at significant cost.⁷⁸

Many members of the public who voiced opposition to the expansion of SCHIP in 2007 acknowledged the social value of providing health care coverage for very poor people but frowned upon providing health care coverage for somewhat less poor people.⁷⁹ Part IV of this Article explores the assumptions underlying such responses. This Section concentrates on describing the SCHIP program.

1. How SCHIP Works

Medicaid is the nation's largest insurer.⁸⁰ SCHIP, though much smaller, follows the Medicaid model by relying on combined federal and state funding.⁸¹ Unlike Medicaid, however, SCHIP does not provide individual entitlements; rather, it provides block

77. DONNA COHEN ROSS ET AL., KAISER HEALTH COMM'N ON MEDICAID AND THE UNINSURED, DETERMINING INCOME ELIGIBILITY IN CHILDREN'S HEALTH COVERAGE PROGRAMS: HOW STATES USE DISREGARDS IN CHILDREN'S MEDICAID AND SCHIP 1 (2008), <http://www.kff.org/medicaid/upload/7776.pdf>.

78. *Id.*

79. See Part IV.C.2.

80. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 5-6 (2006) [hereinafter Rosenbaum, *Medicaid at Forty*]. In 2005, states and the federal government covered 6 million children in SCHIP and 4 million at any point in time during the year. In contrast, 28 million children were enrolled in Medicaid during the same year. KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., A DECADE OF SCHIP EXPERIENCE AND ISSUES FOR REAUTHORIZATION 1 (2007), www.kff.org/medicaid/upload/7574-2.pdf [hereinafter DECADE OF SCHIP EXPERIENCE].

81. Medicaid has always been and remains a much more ambitious program than SCHIP. Medicaid (2004) covers over 50 million people (about half are children). SCHIP (2004) covers about 4 million children. Moreover, Medicaid funding is many times that of SCHIP funding (\$300 billion as compared with \$6 billion in 2004). KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., HEALTH COVERAGE FOR LOW-INCOME POPULATIONS: A COMPARISON OF MEDICAID AND SCHIP 1 (2006), <http://www.kff.org/medicaid/upload/7488.pdf> [hereinafter COMPARISON OF MEDICAID AND SCHIP].

The federal government has been paying a somewhat larger share of the cost of SCHIP than of Medicaid. SCHIP matching rates ranged from sixty-five percent to over eighty-three percent in 2002. In that year, Medicaid matching rates ranged from fifty percent to over seventy-six percent. EVELYNE P. BAUMRUCKER & PETER KRAUT, SCHIP FINANCING ISSUES IN THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP): ISSUES AND ANALYSIS 4 (Arthur B. Rose ed., 2004) [hereinafter SCHIP FINANCING ISSUES].

grants to the states.⁸² In effect, it provides states, not individuals, with capped entitlements.⁸³ The difference is an important one.⁸⁴ Programs that provide entitlements create legal rights.⁸⁵ Medicaid and Medicare extend entitlements to both states and eligible individuals.⁸⁶ That is, individuals deemed eligible for Medicaid have a right, pursuant to the authorizing legislation, to participate in the program.⁸⁷ The same is not typically the case for those deemed eligible for SCHIP programs. States that set up separate SCHIP programs, instead of expanding existing Medicaid programs, may follow the Medicaid model in structuring benefits as legal entitlements under state law, or they may create state programs, offered as either capped entitlements or as discretionary

82. SCHIP FINANCING ISSUES, *supra* note 81, at 1, 3. The distribution of SCHIP funds to states depends on a formula. *Id.*

Rosenbaum et al. note that SCHIP reflects congressional policy not to develop new entitlement programs. Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 35–36 n.9. (noting that 42 U.S.C. § 1397bb(b)(4) (Supp. IV 1998) states, “Nothing in this subchapter shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan”).

83. SCHIP’s original legislation provided states with matching federal funds up to an annual allotment. If not used within a three-year period, funds that have not been used are given to states that spent their own allotments. Funds not used in this way are returned to the U.S. Treasury. COURTNEY M. PERLINO, AM. PUB. HEALTH ASSOC., REAUTHORIZATION OF THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP): A KEY STEP TO COVERING ALL KIDS 2 (2007), <http://www.apha.org/NR/rdonlyres/F892B8E8-0033-42CE-92E2-A5834E44E4AE/0/SCHIPReauthorizationIssueBrief.pdf>. In 2006, \$1 billion in federal SCHIP funds were returned to the U.S. Treasury even though many uninsured children, eligible for SCHIP, were not included in the program. COMPARISON OF MEDICAID AND SCHIP, *supra* note 81, at 2.

84. See Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 44. Most states that designed SCHIP programs separately from their Medicaid programs have precluded beneficiaries from having legal entitlements. Rosenbaum et al. report:

Of the thirty-three states employing either enabling or appropriations legislation in the design of a separate SCHIP program, twenty-four states deny the existence of even a restricted legal entitlement, while only nine states extend the limited protection of a capped entitlement to children. Moreover, by eschewing the creation of even a capped entitlement, the majority of states with separate SCHIP programs in effect retain discretion over the actual level of expenditures undertaken during a year, regardless of authorized funding levels or the guarantee of federal allotments. In these states, enrollment could be frozen legally despite the fact that funds remain available to assist eligible children.

Id. at 52–53. The states’ responses seem to mirror congressional “signals” on the issue. *Id.* at 53.

85. See *id.* at 41–42.

86. *Id.*

87. *Id.*

benefits.⁸⁸ If a state offers SCHIP as a discretionary benefit, then the state can limit costs by capping SCHIP enrollment.⁸⁹ Eligible beneficiaries in states not merging their Medicaid and SCHIP programs have no continuing, legal right to coverage for health care under SCHIP unless that right is specifically provided by the state.⁹⁰ In sum, even children who meet SCHIP's eligibility requirements are not guaranteed continuing coverage.

As originally designed, SCHIP was to be available to children whose parents earned too much to be eligible for Medicaid but not more than or, depending on the state, not much more than 200% of the federal poverty level (FPL).⁹¹ For 2008, the FPL was set at \$10,400 for one person and at \$21,200 for a family of four.⁹² Federal law gave states the option of covering children at higher income levels.⁹³ In general, SCHIP proved successful in its first decade. In 2008, despite fiscal pressures that resulted in tightened state generosity and flexibility, every state and the District of

88. *Id.* at 46. Entitlement under federal law may be precluded in the case of states that set up separate SCHIP programs rather than programs integrated with existing Medicaid programs. See Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 36 n.9 (citing 42 U.S.C. § 1397bb(b)(4) (Supp. IV 1998) ("Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.")).

89. COMPARISON OF MEDICAID AND SCHIP, *supra* note 81, at 2. However, the federal government provides a greater part of SCHIP than of Medicaid funding. *Id.*

90. This third option gives states the greatest amount of flexibility. Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 46.

91. See Statehealthfacts.org, Income Eligibility Levels for Children's Regular Medicaid and Children's CHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), December 2009, <http://www.statehealthfacts.org/comparetable.jsp?ind=203&cat=4> (last visited Mar. 15, 2010).

The Omnibus Budget Reconciliation Act (OBRA) of 1981, 42 U.S.C. § 9902(2) (2006), required the Secretary of Health and Human Services (HHS) to update the federal poverty guidelines at least one time each year. Annual Update of the HHS Poverty Guidelines, 73 Fed. Reg. 3971 (Jan. 23, 2008). The update involves "increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers." *Id.*

92. *Id.* These income levels apply to the forty-eight contiguous states and to the District of Columbia. Somewhat higher levels were set, separately, for Alaska and Hawaii. The HHS poverty guidelines do not define "income" or "family." That task is left to particular programs that rely on the guidelines. *Id.*

93. In July 2006, twenty-six states' SCHIP programs covered children in families with incomes up to 200% of the FPL. Fifteen states allowed children in higher income families to receive SCHIP coverage, and twenty states had income-eligibility limits for SCHIP participation below 200% of the FPL. PERLINO, *supra* note 83, at 3.

Columbia operated SCHIP programs with eligibility levels that were, on average, higher than two times the FPL.⁹⁴

SCHIP's first ten years can be deemed successful. Outreach programs⁹⁵ raised awareness among SCHIP-eligible families about the program's service.⁹⁶ SCHIP reduced the number of children in the U.S. without health care coverage⁹⁷ and resulted in improved health among children enrolled in the program.⁹⁸ It reduced ethnic and racial disparities in access to health care, provided more children with a regular source of health care, and resulted in improved school performance for children enrolled in the program.⁹⁹ Its benefits were clearest for neonates and very young children.¹⁰⁰

By the early years of the twenty-first century, however, states faced significant budget deficits.¹⁰¹ SCHIP programs were not immune from cuts. A few states froze enrollment; others terminated outreach programs or tightened enrollment procedures so that it became harder to enroll in SCHIP; others increased cost-sharing obligations.¹⁰² Fiscal pressures continued to threaten SCHIP enrollment levels and the types of care the program

94. DONNA COHEN ROSS ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, DETERMINING INCOME ELIGIBILITY IN CHILDREN'S HEALTH COVERAGE PROGRAMS: HOW STATES USE DISREGARDS IN CHILDREN'S MEDICAID AND SCHIP (2008), <http://www.kff.org/medicaid/upload/7776.pdf>; Alexandra E. Shields et al., *Trends in Private Insurance, Medicaid/State Children's Health Insurance Program, and the Healthcare Safety Net: Implications for Vulnerable Populations and Health Disparities* 137, 144 n.j., in *REDUCING THE IMPACT OF POVERTY ON HEALTH AND HUMAN DEVELOPMENT: SCIENTIFIC APPROACHES* (Stephen G. Kaler & Owen M. Rennert eds., 2008).

95. Susan R. Williams & Margo L. Rosenbach, *Evolution of State Outreach Efforts Under SCHIP*, 28 HEALTH CARE FIN. REV. 95 (2007).

96. *Id.*

97. PERLINO, *supra* note 83, at 3 (noting that in the first five years of the twenty-first century, SCHIP and Medicaid "more than made up for the declines in employer-sponsored coverage, which could have left thousands of children uninsured").

98. *Id.*

99. Stephen H. Gorin & Cynthia Moniz, *Why Does President Bush Oppose the Expansion of SCHIP?*, 32 HEALTH & SOC. WORK 243, 243 (2007).

100. *Id.*

101. Ian Hill et al., *Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis*, NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES (The Urban Inst., Wash., D.C.), June 2004, at 1, available at http://www.urban.org/UploadedPDF/311015_A-65.pdf (reporting a combined state budget deficit in 2004 of \$78.4 billion).

102. *Id.* at 2.

provides.¹⁰³ By 2007, funding for SCHIP was not adequate even to continue covering children then enrolled in the program.¹⁰⁴

The program's reauthorization, in the first weeks of the Obama administration, eased many of these pressures. The reauthorization provided almost \$33 billion to be spent over four and a half years and promised to expand SCHIP coverage to an additional four million children in families earning up to three times the FPL.¹⁰⁵

2. States' SCHIP Programs

This Section focuses on states' readiness to separate SCHIP from Medicaid programs and on the implications of that separation for poor children and their families. The legislation that created SCHIP in 1997 gave states three broad options: (1) to expand existing Medicaid programs to include children from families with somewhat higher incomes than those eligible for Medicaid; (2) to develop distinct SCHIP programs; or (3) to create SCHIP programs by combining the state's existing Medicaid program with new features.¹⁰⁶

The second and third options provided for SCHIP programs that operated separately, in whole (when the second option was selected) or in part (when the third option was selected), from Medicaid programs. These options gave states more flexibility than the first option—expanding existing Medicaid programs to include

103. Shields et al., *supra* note 94, at 137, 144.

104. PERLINO, *supra* note 83, at 1. In 2007, fourteen states expected shortfalls in SCHIP funding for the year. *Id.* at 2. The fourteen states are listed as Alaska, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Rhode Island, and Wisconsin. *Id.* (citing E. PARK & M. BROADDUS, CTR. ON BUDGET & POLICY PRIORITIES, FOURTEEN STATES FACE SCHIP SHORTFALLS THIS YEAR TALLING [sic] OVER \$700 MILLION (2007)).

The fifteen-month reauthorization bill signed by President Bush in December 2007 will allow a number of states that would have used up their SCHIP funds in 2008 to continue current enrollment levels through the year. Shields et al., *supra* note 94, at 144 n.k.

105. *Obama Signs SCHIP Legislation, Says Bill is "First Step" Toward Universal Health Coverage*, KAISER HEALTH NEWS, Feb. 5, 2009, <http://www.kaiserhealthnews.org/Daily-Reports/2009/February/05/dr00056811.aspx>. New Jersey and New York are permitted to include children in families earning more than three times the FPL. *Id.*

106. 42 U.S.C. §§ 1397aa(a), ee(c)(2) (2006). In 2007, eleven states and the District of Columbia operated programs that added SCHIP as an extension of the state's Medicaid program; eighteen states operated separate SCHIP programs; and twenty-one states relied on a combination approach. DECADE OF SCHIP EXPERIENCE, *supra* note 80, at 1.

SCHIP-eligible children.¹⁰⁷ As a result, states with separate SCHIP programs have enjoyed greater latitude than have those that combined SCHIP with Medicaid, especially with regard to setting SCHIP eligibility levels, designing benefits, and arranging for health care for SCHIP children through managed care organizations.¹⁰⁸

Twenty-six states structured and operated SCHIP separately from Medicaid¹⁰⁹ and entered into contracts with managed care organizations for provision of both Medicaid and SCHIP coverage.¹¹⁰ The majority of those states (fifteen of twenty-six states) entered into separate arrangements for children eligible through SCHIP and those eligible through Medicaid.¹¹¹

These separate arrangements have generally treated the two communities of children (one very poor and one somewhat less poor) differently.¹¹² The differences are troubling. Moreover, they illustrate this Article's central thesis, that a complicated form of class competition, stemming from the opacity of class relationships in the United States, underlies the development of the nation's system of health care.

It is especially noteworthy that children covered under separate SCHIP programs are likely to have had *less comprehensive coverage* than children covered by Medicaid.¹¹³ Under Medicaid children must receive "early and periodic screening, diagnosis, and treatment services (EPSDT)."¹¹⁴ EPSDT benefits include

107. See *infra* notes 112–13 and accompanying text (providing an accounting of states with SCHIP programs combined with Medicaid programs or run separately).

108. Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 39.

109. *Id.* (noting the number of states selecting each broad option).

110. In 2000, twenty-six of the states with separate SCHIP programs had entered into contracts with managed care organizations. Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 52.

111. *Id.* at 52.

112. Moreover, in cases in which states entered into arrangements with managed care organizations for SCHIP children, those arrangements:

[E]stablish distinct duties and specifications from the state's Medicaid contracts not only for coverage but also for access, provider network capabilities, network composition, and other benchmarks relevant to pediatric care. Therefore, the separate SCHIP contracts appear to differ from the Medicaid contracts in more than just benefit design; they actually set different performance standards for contractors.

Id. at 52.

113. The difference was made smaller as a result of the Deficit Reduction Act of 2005. Pub. L. No. 109-171, § 5007, 120 Stat. 4, 34–36 (2006).

114. EPSDT services were first made available to children under twenty-one in 1967 and were expanded in 1989. Rosenbaum, *Medicaid at Forty*, *supra* note

preventive services for children as well as a variety of other services that are not always offered under SCHIP programs, including mental health care, physical therapy, dental care, and vision care.¹¹⁵ Even more, Medicaid programs are required to provide for almost all eligible children,¹¹⁶ with required forms of medical assistance defined pursuant to federal law.¹¹⁷ Separate SCHIP programs do not offer comparable benefits.¹¹⁸ In addition, states have more room under SCHIP than under Medicaid to enforce cost-sharing requirements.¹¹⁹

80, at 19 (citing Pub. L. 90-248, 81 Stat. 929 (codified as amended at 42 U.S.C. § 1396d(a)(4) (2000))).

115. COMPARISON OF MEDICAID AND SCHIP, *supra* note 81, at 3.

116. There is an exception for children whose Medicaid participation stems from their “medically needy spend-down status.” Rosenbaum, *Medicaid at Forty*, *supra* note 80, at 19. Rosenbaum reports that almost all eligible children are “categorically needy individuals who meet preset financial eligibility rules.” *Id.* at n.97 (citing Sara Rosenbaum, et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMED. L. 1, 22 (2004)).

117. *Id.* at 19.

118. PERLINO, *supra* note 83, at 3. *See also* COMPARISON OF MEDICAID AND SCHIP, *supra* note 81.

Before the Deficit Reduction Act of 2005 (DRA), 42 U.S.C. § 1396 (2006), Medicaid provided a wide set of mandatory services and some optional services. *See* COMPARISON OF MEDICAID AND SCHIP, *supra* note 81, at 3. Under the DRA, states may substitute “benchmark coverage” (similar to SCHIP coverage in many respects) for Medicaid children and “optional adults.” *Id.* However, it would seem that states cannot give up Medicaid’s EPSDT for children (EPSDT). *Id.* DRA contains a “savings clause” for EPSDT. The Act requires that state coverage “provide[] for wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).” Rosenbaum, *Medicaid at Forty*, *supra* note 80, at 41. Rosenbaum suggests that legislative history, Congressional Budget Office (CBO) cost estimates attached to the legislation, and statements from the administration suggest an intention to preserve EPSDT coverage for children under nineteen. *Id.* at 41–42. However, she notes that the “savings clause” language is “vague” and thus open to various judicial interpretations. *Id.* at 42.

119. Eskin & Ranji, *supra* note 74.

Sidney Watson notes that the DRA, 42 U.S.C. § 1396 (2006), works “to transform Medicaid in the direction of consumer-directed health care through increased patient cost-sharing, limited-benefit packages benchmarked to private insurance coverage, and high-deductible Medicaid plans linked to Health Savings Accounts.” Sidney Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 404 (2007). The DRA further allows states to impose cost-sharing on Medicaid recipients. However, mandatory children and pregnant women are protected from cost-sharing, except for copayments for drugs defined as non-preferred. COMPARISON OF MEDICAID AND SCHIP, *supra* note 81, at 4. SCHIP allows cost-

In effect, the majority of states structured their SCHIP programs so as to create two distinct public health care systems for children: Medicaid for very poor children and SCHIP for somewhat less poor children. For the most part, very poor children receive greater benefits. However, that difference may reflect an unself-conscious apprehension about benefitting a group that is in competition with the middle-class for class status rather than a more beneficent calculation of comparative need.

This story, and the assumptions and motives that undergirded its development, are complicated—sometimes even contradictory. Therefore, even as states hesitate to benefit children covered by SCHIP as adequately as they benefit Medicaid children, and thus help ensure that the class status of SCHIP children remains stationary, states have also worked (again, unself-consciously, one presumes) to ensure that Medicaid children stay at the bottom of the class system. So, for instance, the separation of Medicaid and SCHIP children into what Sara Rosenbaum calls “separate legal bins”¹²⁰ has far-reaching social consequences for health, health care, and status.¹²¹ The separation of Medicaid and SCHIP children suggests—to the children, to their families, and to policy-makers—an essential dissimilarity between children in the poorest

sharing (including the payment of premiums and copayments); however, cost-sharing cannot be greater than five percent of a family’s yearly income. *Id.* The Kaiser report notes that cost-sharing can work as a barrier to healthcare, especially for very low-income families. *Id.* A study of SCHIP programs in Washington, Minnesota, and Hawaii showed that participation dropped significantly (from fifty-seven to eighteen percent) with a rise in premiums from one to five percent of family income. PERLINO, *supra* note 83, at 8. *See also* Gayle R. Byck, *A Comparison of the Socioeconomic and Health Status Characteristics of Uninsured, State Children’s Health Insurance Program-Eligible Children in the United States with Those of Other Groups of Insured Children: Implications for Policy*, 106 PEDIATRICS 14, 18 (2000) (noting that working poor people are discouraged by even low premium rates from participating in state-subsidized health coverage plans). Byck notes further that SCHIP-eligible parents of healthy children may be “especially discourag[ed]” by premiums from enrolling their children in SCHIP. *Id.* at 18.

DRA also required those enrolling in Medicaid to show proof of citizenship (to keep and to retain coverage). The provision does not apply to SCHIP children in states that have not structured SCHIP as an extension of the Medicaid program. DECADE OF SCHIP EXPERIENCE, *supra* note 80, at 4.

The 2009 reauthorization and expansion of SCHIP does away with a five-year waiting period for immigrants and makes it easier for SCHIP applicants to prove legal immigration status. *Obama Signs SCHIP Legislation*, *supra* note 105.

120. Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 56.

121. Rosenbaum et al. do consider the social consequences of developing a SCHIP program structured and defined separately from the state’s Medicaid program. *Id.* at 37–40.

families and children in near-poor families. The resulting isolation of Medicaid children, contend Rosenbaum and co-authors, suggests that those children are not—and perhaps even that they should not be—considered part of the mainstream.¹²²

Placing children, according to family income, in different health care programs almost expressly relegates each group to a different rung on the nation's socio-economic hierarchy. That placement, by informing children, more or less openly, about their “place” in society, signals a powerful class message that can have significant consequences for the long-term health of the children involved and for their families.¹²³ A similar message informed, though often tacitly, much of the debate about the reauthorization and proposed expansion of SCHIP in late 2007.

B. Efforts to Reauthorize SCHIP in 2007 and 2008

Pursuant to the original legislation, SCHIP was slated to expire on September 30, 2007.¹²⁴ In the period just before that date, the cost of private insurance had increased, and businesses were rescinding health care coverage for employees.¹²⁵ As a result, more and more people in the United States were left without health coverage.¹²⁶

State governments began to respond to the increasing need for health coverage. Governors overwhelmingly supported SCHIP's expansion.¹²⁷ By 2007, eighteen states had extended SCHIP eligibility to children in families earning more than 200% of the FPL.¹²⁸ That notwithstanding, ninety percent of children enrolled in SCHIP were from families with incomes lower than 200% of the FPL.¹²⁹

122. *Id.* at 57–58. This may, in turn, “fuel policy makers’ perceptions that Medicaid is not a worthy program.” *Id.* at 56. In short, the separation of SCHIP from Medicaid programs may reinforce understandings of Medicaid children as part of a distinct class group.

123. *See* Part IV.A.

124. SCHIP FINANCING ISSUES, *supra* note 81, at 3; Robert Pear, *Rules May Limit Health Program Aiding Children*, N.Y. TIMES, Aug. 21, 2007, at A1 [hereinafter Pear, *Rules May Limit Health Program*].

125. *See* Part III.B.1.

126. John K. Iglehart, *The Fate of SCHIP—Surrogate Marker for Health Care Ideology?*, 357 NEW ENG. J. MED. 2104, 2104.

127. *Id.*

128. *Id.* (reporting that sixteen of these eighteen states had raised eligibility levels to at least 250% of the FPL).

129. *Id.* at 2105 (citing data for 2005).

1. Expanding SCHIP

Twice in the few months before SCHIP's slated expiration, Congress, with bipartisan support, passed a bill—the Children's Health Insurance Program Reauthorization Act (CHIPRA)—reauthorizing and expanding the program.¹³⁰ Both bills proposed a new tax on tobacco to fund SCHIP's expansion.¹³¹ The first bill (referred to here as CHIPRA I) was passed by Congress in late September 2007; it was soon vetoed by then-President Bush.¹³² As a practical matter, the bill provided about twice the funding that President Bush was willing, at that time, to allocate to the SCHIP program. Moreover, the bill extended SCHIP coverage to children in families earning about twice the income level favored by President Bush.¹³³ After the President vetoed CHIPRA I, Congress passed another bill (CHIPRA II) that responded to some, but not all, of the administration's concerns.¹³⁴ In particular, CHIPRA II responded to concerns about coverage of unauthorized immigrant children,¹³⁵ children deemed middle class, and some adults covered under SCHIP.¹³⁶ Among other things, the bill placed stricter limits on the ability of states to include in SCHIP children from families with incomes higher than 300% of the FPL.¹³⁷ Again, President

130. Children's Health Insurance Program Reauthorization Act of 2007, H.R. 976, 110th Cong. (2007); Children's Health Insurance Program Reauthorization Act of 2007, H.R. 3963, 110th Cong. (2007).

131. Both SCHIP bills would have increased the federal excise tax on cigarettes by sixty-one cents (to one dollar) with a proportionate increase in the federal tax on various other forms of tobacco. *See also* Iglehart, *supra* note 126, at 2106; *How North Carolina's Members of Congress Voted on Major Roll Call Votes Last Week*, THE VIRGINIAN-PILOT (Norfolk, Va.), Jan. 27, 2008, at Y7.

132. H.R. 976 was presented to President Bush on October 2, 2007 and vetoed on October 3, 2007. H.R. 976.

133. Ricardo Alonso-Zaldivar, *President Threatens to Veto Revised Child Healthcare Bill*, L.A. TIMES, Oct. 26, 2007, at A11 (noting that the first SCHIP reauthorization bill would have provided \$60 billion for the SCHIP program over a five-year period; President Bush had originally agreed to an allocation of \$30 billion for the same period; in addition, President Bush was willing to extend SCHIP-eligibility to children in families making twice the FPL). By the time he vetoed CHIPRA I, Bush was apparently ready to provide for \$45 billion in funding and for coverage of children in families making up to three times the FPL. *Id.* Bush opposed funding the expansion through an increase in the tobacco tax. *Id.*

134. H.R. 3963.

135. CHIPRA II provided for verification of citizenship. Alonso-Zaldivar, *supra* note 133.

136. *SCHIP: Senate Approves SCHIP Legislation; Negotiations with House GOP to Continue*, Health Care Daily (BNA) (Nov. 2, 2007).

137. H.R. 3963, § 114. An exception (described in Sec. 114(a)) would have, in fact, applied only to New Jersey. Editorial, *Denying Children*, N.Y. TIMES,

Bush issued a veto, and again Congress failed to override the veto.¹³⁸

The SCHIP program was then temporarily reauthorized until March 31, 2009, but it was not expanded.¹³⁹ Congress expected that the reauthorization would provide adequate funds to maintain existing SCHIP enrollment levels.¹⁴⁰ The program finally was reauthorized and expanded only after the 2009 presidential election.¹⁴¹

Disagreements about whom SCHIP should cover lay at the center of the debate about the two CHIPRA bills. Opponents of the reauthorization bills were particularly critical of the proposed expansion of SCHIP to cover children in families earning up to 300% or more of the FPL.¹⁴² Yet, the presumption that an expansion of SCHIP was unnecessary or frivolous was belied by the data.¹⁴³ A 2007 issue paper of the Kaiser Commission on Medicaid and the Uninsured reported that 900,000 uninsured children in the United States were not eligible for public insurance.¹⁴⁴ Most lived in families earning between 200% and 299% of the FPL.¹⁴⁵ In most states, these families earned too much to be eligible for Medicaid or SCHIP. Health coverage provided by

Oct. 26, 2007, at A24. CHIPRA II provided for any adults covered by SCHIP to be transitioned from the program within a year. (CHIPRA I provided for this change to occur within two years.) *Negotiations with House GOP to Continue*, *supra* note 136.

138. H.R. 3963 was passed by both chambers of Congress on November 1, 2007. It was vetoed on December 12, 2007; the veto was sustained on January 23, 2008. H.R. 3963.

139. Medicare, Medicaid and SCHIP Extension Act of 2007, H.R. 2499, 110th Cong. (2007). See John Dinan, *The State of American Federalism 2007–2008*, 38 PUBLIUS 381 (2008).

140. KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP): REAUTHORIZATION HISTORY (2009), www.kff.org/medicaid/upload/7743-02.pdf. The Medicare, Medicaid and SCHIP Extension Act of 2007 added funds to existing appropriation levels (\$5 billion per year) in order to maintain existing enrollment levels. *Id.* at 2. Specifically, the reauthorization act appropriated an additional \$1.6 billion for 2008 and \$.275 billion for that part of 2009 included in the reauthorization. *Id.*

141. H.R. 2, 111th Cong. (2009).

142. See Part IV.C.2.c.

143. See JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHARACTERISTICS OF THE UNINSURED: WHO IS ELIGIBLE FOR PUBLIC COVERAGE AND WHO NEEDS HELP AFFORDING COVERAGE? (2007), www.kff.org/uninsured/upload/7613.pdf [hereinafter HOLAHAN, CHARACTERISTICS OF UNINSURED].

144. *Id.* at 6.

145. *Id.*

employers tends to be limited at these income levels.¹⁴⁶ Children in such families fell “into the gap between the reach of public coverage and availability of affordable private coverage.”¹⁴⁷ The Kaiser report concluded that most families earning between 300% and 399% of the FPL could afford health coverage but qualified that conclusion by noting that people with a history of poor health, who might well have to pay more for coverage, would be less likely to be able to afford it.¹⁴⁸ In fact, between 2006 and 2007, a significant increase in the number of uninsured children in the United States reflected the loss of health care coverage suffered by middle-class families generally.¹⁴⁹

The successful reauthorization of SCHIP in 2009, during the first weeks of the Obama presidency, promised SCHIP coverage for 11 million children by 2013.¹⁵⁰

2. CMS Policy: The August 2007 Directive

In August 2007, before Congress passed CHIPRA I, Michael Leavitt, then-Secretary of Health and Human Services (HHS) explained the administration’s concern: “SCHIP is being proposed in the spirit of the expansion of health coverage. But that isn’t the reality. For every 10 people that go on a publicly funded plan, six of them leave a private plan.”¹⁵¹ Whether or not Secretary Leavitt

146. *Id.*

147. *Id.* at 7.

148. *Id.* at 11–12.

149. JOHN HOLAHAN & ALLISON COOK, KAISER COMM’N ON MEDICAID AND THE UNINSURED, WHAT HAPPENED TO THE INSURANCE COVERAGE OF CHILDREN AND ADULTS IN 2006? 5 (2007), www.kff.org/uninsured/upload/7694.pdf (reporting that almost half of the increase in the number of uninsured children in the year in question involved children from families earning between 200% and 399% of the FPL).

150. Robert Pear, *Obama Signs Children’s Health Insurance Bill*, N.Y. TIMES, Feb. 5, 2009 [hereinafter Pear, *Obama Signs Children’s Health Insurance Bill*].

151. *States Increasingly Expanding SCHIP Coverage to Middle-Class Families*, KAISER HEALTH NEWS, Apr. 30, 2007, <http://www.kaiserhealthnews.org/daily-reports/2007/april/30/dr00044579.aspx>. Secretary Leavitt explained that were other states to follow a model proposed in New York, almost three-fourths of the children in the nation would be covered by “public assistance.” *Id.* The New York plan to which Secretary Leavitt referred had extended SCHIP eligibility to families of four earning up to \$82,600 a year (400% of the FPL in 2007). The plan assessed subsidies according to a sliding scale. *Id.* New York’s plan was subject to federal approval. In September 2007, the Bush administration rejected New York’s plan. Daniel C. Vock, *Bush Skirts Congress with Medicaid Cuts*, STATELINE.ORG, Feb. 5, 2008, www.stateline.org/live/printable/story?contentId=278154.

was correct about the numbers—and there is evidence that he was not¹⁵²—“crowd-out,” as the phenomenon he described has been labeled, was among the central concerns to which President Bush referred in explaining his vetoes of CHIPRA I and II.¹⁵³

So, in August 2007, focusing on states that had already requested SCHIP expansions and presumably anticipating Congress’s efforts to expand SCHIP, Dennis Smith, director of the Center for Medicaid and State Operations (CMS), issued the so-called “August Directive” (the “Directive”).¹⁵⁴ The Directive, addressed to “State Health Official[s],” explained that, in the administration’s view, extending SCHIP coverage levels would result in the program becoming a “substitute for private coverage.”¹⁵⁵ In short, the administration was unwilling to expand public funding for children’s health coverage to include “middle-class”¹⁵⁶ children. At the time, only one state (New Jersey) provided coverage through SCHIP for children in families earning up to 350% of the FPL.¹⁵⁷

152. The CBO estimated that more than two-thirds of the children who would have been added to state SCHIP programs if expansion had gone forward would not have had alternative coverage. KAISER COMM’N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007 (CHIPRA): THE REVISED CHIPRA BILL (H.R. 3963) COMPARED TO THE ORIGINAL BILL (H.R. 976) 1 (2007), www.kff.org/medicaid/upload/7714.pdf [hereinafter THE REVISED CHIPRA BILL]. In 2006, the Kaiser Commission on Medicaid and the Uninsured reported an increase of one million uninsured children in the previous two years. HOLAHAN & COOK, *supra* note 149, at 5. In some part, that increase was due to a decline in insurance provided by parents’ employers. *Id.* at 7.

153. See H.R. 976, 110th Cong. (2007) [CHIPRA I] (as vetoed by President Bush on October 3, 2007). President Bush explained that the bill, if signed, would lead to “government coverage . . . displac[ing] private health insurance for many children.” H.R. DOC. NO. 110-62 (2007). See also H.R. 3963, 110 Cong. (2007) [CHIPRA II] (as vetoed by President Bush). In vetoing the bill, President Bush expressed concern that the bill, if enacted into law, “would still result in government health care for approximately 2 million children who already have private health care coverage.” H.R. DOC. NO. 110-80 (2007).

154. Letter from Dennis G. Smith, Dir., Ctr. for Medicaid and State Operations, to State Health Officials (Aug. 17, 2007), available at www.cms.hhs.gov/smdl/downloads/SHO081707.pdf [hereinafter August Directive].

155. Pear, *Rules May Limit Health Program*, *supra* note 124.

156. For this purpose “middle class” refers to families *deemed* middle class by those who opposed SCHIP’s expansion. The families involved would have been those earning up to 250% of the FPL (with states permitted to expand SCHIP-covered families beyond that limit).

157. THE REVISED CHIPRA BILL, *supra* note 152, at 1.

New York had proposed expanding SCHIP coverage to children in families earning up to 400% of the FPL.¹⁵⁸ CMS soon applied the restrictions of the Directive to New York's proposal.¹⁵⁹

158. *Id.* More particularly, the Directive provided that states would not be permitted to cover children in families earning more than 250% of the FPL unless the state could demonstrate that it was already covering ninety-five percent of children in families earning less than that amount. August Directive, *supra* note 154. See also Vock, *supra* note 151. At the time, SCHIP programs in eighteen states, as well as Washington, D.C., covered or were about to cover children in families earning more than 250% of the FPL. *Bush Administration Outlines New SCHIP Standards That Would Keep Program Limited to Low-Income Children*, KAISER HEALTH NEWS, Aug. 21, 2007, <http://www.kaiserhealthnews.org/Daily-Reports/2007/August/21/dr00047003.aspx>. See also Pear, *Rules May Limit Health Program*, *supra* note 124. More specifically, the August 17, 2007, Smith level was addressed to states extending SCHIP to cover children in families with incomes above 250% of the FPL. August Directive, *supra* note 154.

In effect, the Directive's requirement precluded states from covering children in families earning more than 250% of the FPL because virtually no state could show that ninety-five percent of children in families below that income were SCHIP participants. Pear, *Rules May Limit Health Program*, *supra* note 124 (quoting a deputy commissioner in the New York State Health Department, stating, "No state in the nation has a participation rate of 95 percent," and quoting a professor at the Health Policy Institute of Georgetown University, stating, "No state would ever achieve that level of participation under the president's budget proposals").

Only Medicare, among all health care programs, can boast a participation rate as high as ninety-five percent. At sixty-five, people are enrolled automatically in the Medicare programs. *9 Million Children and Counting: The Administration's Attack on Health Coverage for America's Children*, ISSUE BRIEF (Families USA, Wash., D.C.), Feb. 2008, at 3, available at <http://www.familiesusa.org/assets/pdfs/chip-9-million-and-counting.pdf>. SCHIP has had a participation rate of about seventy-five percent, and Medicaid has had a participation rate of about eighty percent. *Id.* The Directive outlined a set of additional hoops through which states would have to jump to obtain permission to expand SCHIP coverage. Among other things, the Bush administration suggested that it would impose "waiting periods" so that children from what the administration apparently viewed as middle-income families could not transfer easily from private health plans to SCHIP. Pear, *Rules May Limit Health Program*, *supra* note 124. More particularly, Smith, director of the Center for Medicaid and State Operations, announced that states would have to show at least a one-year period without coverage before a child could be shifted to SCHIP from private health coverage. Just six months earlier, in February 2007, the Bush administration approved Pennsylvania's extension of SCHIP coverage to children in families earning 300% of the FPL. Pennsylvania agreed to a six-month wait for children (two years of age and older) in such families. *Id.* Smith explained that states would be expected to "amend their SCHIP state plan . . . in accordance with [the Directive] within 12 months" or face "corrective action" from CMS. August Directive, *supra* note 154.

159. *Protecting Children's Health Coverage Act of 2008: Hearing on H.R. 5998 Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 110th Cong. 5-6 (2008) (statement of Morton Rosenberg, specialist

New York was clearly unable to meet the terms of the Directive's provisions.¹⁶⁰ CHIPRA II included a provision that overturned the CMS rule.¹⁶¹ However, President Bush's veto of that bill prevented that provision from becoming law, and the temporary

in American Public Law, Congressional Research Service). New York's proposal was denied by the Acting Administrator of CMS. CMS asserted that New York had "failed to provide assurances that the state had enrolled at least 95 percent of the children in the core targeted low-income child population, those with family incomes below 200 percent of the FPL." *Id.* at 5. The CMS Acting Administrator further opined: "In the absence of such assurances, I cannot conclude that New York is effectively and efficiently using available resources to serve that core population, such that expansion to higher income levels would not divert resources from serving the core population." *Id.* at 5-6. A month later, in October 2007, New York Governor Spitzer and New Jersey Governor Corzine (joined by governors in seven states, including Illinois, Maryland, and Washington) challenged the legality of the CMS letter in federal court. *Id.* at 6. They contended that the CMS rule was more than a clarification of existing federal policy. Thus, they argued, it should have been subject to a formal rulemaking processes. *See* Dinan, *supra* note 139, at 390; *see also* Manav Bhatnagar, *Overcoming Deference to Administrative Regulation: Expanding the State Children's Health Insurance Program (SCHIP)*, 117 YALE L.J. 155, 156 (Supp. 2008).

In New York, it had become clear that a family of four with an income of three times the FPL was unlikely to be able to pay for health care and other expensive necessities. *Id.* at 156.

160. The Directive required that the state prove that it had already enrolled ninety-five percent of children in families earning less than 250% of the FPL. Many deemed the rule draconian, especially in its application to a voluntary program. Bhatnagar, *supra* note 159, at 156 (noting that "[t]he inherent inefficiencies in information dissemination make near-complete awareness [of SCHIP] and enrollment unrealistic"). *See also* New Jersey v. U.S. Dep't of Health & Human Servs., No. 07-4698, 2008 WL 4936933 (D.N.J. Nov. 17, 2008). New Jersey claimed that the Directive superseded the authority of CMS under the Administrative Procedure Act; the CMS had given no notice and did not provide an opportunity for public comment. *Id.*

In August 2008 (a few days before the date set in the directive for states to comply), California announced that its SCHIP program would not comply with the Directive. *California Won't Obey SCHIP Directive, Tells CMS State Law Prevents Changes*, Health Care Daily Rep. (BNA) (Aug. 15, 2008). California's letter to CMS asserted that the state would continue to operate its SCHIP program "in conformance with its CMS-approved Title XXI state plan." Letter from Lesley Cummings, Executive Dir., Cal. Managed Risk Med. Ins. Bd., to Herb B. Kuhn, Deputy Adm'r & Acting Dir., Ctr. for Medicaid & State Operations (Aug. 12, 2008), available at [http://ccf.georgetown.edu/index/cms-files/system-action?file=policy/cms directive/ca - aug 17th response to cms.pdf](http://ccf.georgetown.edu/index/cms-files/system-action?file=policy/cms%20directive/ca%20aug%2017th%20response%20to%20cms.pdf).

161. *See* Sara Rosenbaum, *Slouching Toward Health Reform: Insights from the Battle over SCHIP*, 15 GEO. J. ON POVERTY L. & POL'Y 703, 724 (2008).

reauthorization bill that Congress ultimately passed did not include a comparable provision.¹⁶²

Even beyond its far-reaching practical consequences, the Directive was significant in that it signaled the intensity and substance of the Bush administration's concern about an expansion of SCHIP. The administration justified the standards outlined in the Directive as an effort to preclude SCHIP from becoming a substitute for private health care.¹⁶³ That claim reflects arguments within the broader debate about the future of health care coverage in the United States. That is clear in HHS Secretary Leavitt's characterization about disagreements regarding the expansion of SCHIP:

[T]here is a widely held aspiration that every American have [sic] access to an affordable basic insurance policy.

But there are two competing philosophies about how that should be accomplished. One is a Washington-run, government-owned plan, where government makes the choices, where government sets the prices, where government then taxes the people to pay the bill. The other is a state-organized private market where consumers choose, where the insurance plans compete, and where innovation then drives the quality up and the cost down.

S-SCHIP and the reauthorization debate is a center court match between the philosophies of government-run health care and organized private health care markets.¹⁶⁴

Secretary Leavitt's linking of the debate about expanding SCHIP to a wider debate about "government-run, government-owned" plans is telling. In fact, many children enrolled in state SCHIP programs were receiving care through the same private

162. Several states sought relief in court. In late 2008, the Southern District of New York held for HHS in a suit brought by the state of New York, challenging the Directive. *New York v. U.S. Dep't of Health & Human Servs.*, No. 07 Civ. 8621, 2008 WL 5211000 (S.D.N.Y. Dec. 15, 2008). The court declined to consider the merits of the state's case because the state's challenge was not ripe in light of the fact that HHS had not applied the requirement of the Directive aimed at showing that expanded SCHIP benefits do not result in "crowd out." In addition, the court noted that New York had not exhausted its administrative claims; and it noted that the case, if ripe and if administrative remedies had been exhausted, should properly be filed in a federal appeals court. *Id.* A similar case, brought by New Jersey, was also dismissed for lack of ripeness. *New Jersey v. H.H.S.*, 2008 WL 4936933.

163. Pear, *Rules May Limit Health Program*, *supra* note 124.

164. Press Briefing, Secretary Michael Levitt, Briefing on Health Care by Senior Administration Officials (June 27, 2006), <http://archive.hhs.gov/news/speech/2007/sp20070627a.html>.

health plans serving people with non-governmental insurance.¹⁶⁵ Either Secretary Leavitt did not know that, which seems unlikely, or his reference to “a Washington-run” plan was intended (whether consciously or not) to mask a different concern—concern about SCHIP itself and thus about funding health care coverage for people who are poor but not very poor.¹⁶⁶

For Secretary Leavitt, representing the Bush administration, the CHIPRA bills threatened a private market in health care with a dangerous government-run system. The next Part focuses on this assumption and others that undergirded opposition to SCHIP’s expansion.

IV. ACCESS TO HEALTH CARE AND CLASS: WHAT THE DEBATE ABOUT EXPANDING SCHIP REVEALS

This Part suggests that opposition to the expansion of SCHIP in 2007 reflected a peculiarly American form of class competition. Section A of this Part provides an introductory discussion of class in the United States in relation to attitudes about national health coverage. Section B concretizes the discussion in Section A through comparisons between the SCHIP and Medicaid programs. Then Section C reviews some of the claims made about SCHIP by those who opposed its expansion.

A. The Opacity of Class in America and Health Disparities

This Section explicitly presents this Article’s central thesis—that opposition to universal health care coverage in the U.S. can be explained, at least in some part, through reference to the nation’s complicated understanding of class and class competition. The nation’s responses to SCHIP and its proposed expansion in 2007 provide evidence of that understanding and of its consequences. More specifically, many who opposed SCHIP’s expansion in 2007 claimed, more or less explicitly, that providing health care coverage to families not deemed truly poor would unfairly tilt the nation’s socio-economic hierarchy. Understanding this view is complicated by Americans’ long-standing—albeit unself-conscious—tendency to mask the reality and social consequences of class.¹⁶⁷

165. KAISER COMM’N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM: LESSONS AND OUTLOOK 4 (2007), <http://www.kff.org/medicaid/upload/7628.pdf>.

166. See Part IV.A.

167. Erika Blacksher, *Healthcare Disparities: The Salience of Social Class*, 17 CAMBRIDGE Q. HEALTHCARE ETHICS 143, 144 (2008) (referring to class in the U.S. as a “suppressed” category).

1. Class Opacity and Poverty

Almost from the nation's start, Americans have assumed, or at least contended, that anyone can avoid poverty through hard work and that, at least most of the time, those who work hard will enjoy social mobility.¹⁶⁸ "[I]f we are industrious," declared Benjamin Franklin in the late eighteenth century,¹⁶⁹ "we shall never starve," and, similarly, "[I]aziness travels so slowly, that Poverty soon overtakes him."¹⁷⁰

In fact, class mobility is far less common than Americans believe.¹⁷¹ That Americans do not have an explicit set of measures for assessing class status has facilitated the common belief that rising from rags to riches is largely a matter of individual effort.¹⁷²

Americans recognize poverty but are uncertain about how to differentiate among those above the poverty level.¹⁷³ In this, they

168. *Id.* at 144.

169. SIMON P. NEWMAN, EMBODIED HISTORY: THE LIVES OF THE POOR IN EARLY PHILADELPHIA 143 (2003); *see also* Janny Scott & David Leonhardt, *Class in America: Shadowy Lines That Still Divide*, N.Y. TIMES, May 15, 2005, § 1, at 1 (describing Franklin as "[t]he original exemplar of American social mobility").

170. NEWMAN, *supra* note 169, at 143.

171. *See* Scott & Leonhardt, *supra* note 169 (noting that earlier studies were flawed in relying, for instance, on children's memory about parental income or on single years of income).

172. NPR/KAISER FAMILY FOUND./HARVARD SCHOOL OF PUB. HEALTH, PUBLIC VIEWS ON SCHIP REAUTHORIZATION: SURVEY HIGHLIGHTS (2007), <http://www.kff.org/kaiserpolls/upload/7704.pdf> [hereinafter PUBLIC VIEWS ON SCHIP]. Katherine S. Newnman and Victor Tan Chen use the term "missing class" to refer to those who are near poor. KATHERINE S. NEWMAN & VICTOR TAN CHEN, THE MISSING CLASS 3 (2007).

173. PUBLIC VIEWS ON SCHIP, *supra* note 172, at 3. The survey data showed that Americans were unsure about how to categorize families making \$40,000 a year (about twice the FPL at that time, for a family of four). *Id.* at 2.

Interestingly, pursuant to the original SCHIP legislation, state SCHIP programs generally covered children in families with incomes up to \$40,000 (using 2007 FPL figures). Survey respondents assessed families of four with incomes of \$30,000 or less a year as poor. *Id.* at 3. Most respondents judged families of four making between \$50,000 and \$60,000 a year as middle-class. *Id.* A survey summary characterized the national response to families of four making \$40,000 a year to lie in a "strange [class] netherworld." *Id.* In significant part, however, discrepant categorizations of \$40,000-a-year families reflected geographic differences. *Id.* (reporting that among respondents living in states with the lowest cost of living, almost half judged a family of four making \$40,000 a year to be middle class; but in higher cost of living states, only twenty-nine percent of respondents described such families as middle class).

Correlative with views of poverty and middle-class status, about sixty-six percent of respondents favored SCHIP being available to children in families of

echo their government, which defines the “federal poverty level” each year but has no clear-cut markers that distinguish among other classes.¹⁷⁴ The consequent division—between those who are very poor and everyone else—has long structured the nation’s understanding of class and personhood.¹⁷⁵ More particularly, almost from the nation’s start, very poor people have been categorized separately from all others because, unlike people in other classes, they have not been deemed candidates for social mobility. They have thus been effectively marginalized socially, as well as economically.¹⁷⁶

Distinguishing class status among everyone above the poverty level—in a society that has assiduously presumed to downplay the significance and consequences of class status—has depended on the elaboration of various indices and symbols of status.¹⁷⁷ None is definitive, but some provide powerful clues. Among the most important markers on which Americans rely in assessing socio-economic status are various signs of good health and ill health.

2. *Illness and Health as Markers of Class*

Among the most important physical signs (signs of health, as it were) on which Americans rely in assessing class status—a process that is usually not self-conscious—are dental condition,¹⁷⁸ posture, weight,¹⁷⁹ and a general appearance of fitness rather than an appearance suggesting lethargy or pain.¹⁸⁰

four making \$40,000 a year, while only fifteen percent favored including children in families of four making \$80,000 a year. *Id.* at 2.

174. See Hanns Kuttner & Matthew S. Rutledge, *Higher Income and Uninsured: Common or Rare?*, 26 HEALTH AFF. 1745 (2007). Kuttner and Rutledge remark: “Although the government has an official definition of who is poor, there is none for who is well-off. The line where higher income begins is subjective.” *Id.* at 1746.

175. See NEWMAN, *supra* note 169. Newman, who studied class in early Philadelphia, reported on the physical signs of poverty. He reports the stunning absence of very poor people from etchings of life in early Philadelphia. *Id.* at 1–3, 14 (describing a series of engravings by William Birch). The few engravings that depicted poor people at all included the near-poor—a group Newman referred to as the “deserving poor.” *Id.* at 14, 147.

176. *Id.* at 14, 147.

177. See, e.g., Jennifer Steinhauer, *When the Joneses Wear Jeans*, N.Y. TIMES, May 29, 2005, § 1, at 1 (noting that the vast majority of Americans (eighty-one percent) claimed they “felt social pressure” to buy expensive goods).

178. See *infra* notes 180–86 and accompanying text.

179. Gary Taubes, *Do We Really Know What Makes Us Healthy?*, N.Y. TIMES, Sept. 16, 2007, § 6, at 52 (reporting that poor people are more likely to

Dental health is a particularly strong indicator of socio-economic status in the U.S. today.¹⁸¹ Dental problems are often visible. For children, lack of dental care is especially worrisome because dental illness during childhood can result in a lifetime of oral health problems.¹⁸² Even more, there is ample evidence that dental disease, which can be painful and which can permanently affect the ability to eat, can interfere with a child's ability to play and learn.¹⁸³ Studies report a statistical relationship between dental (especially periodontal) disease and a variety of other conditions, including weakened immune systems, sinus infections,¹⁸⁴ preterm low-birth weight babies, coronary disease,¹⁸⁵ pulmonary disease,

smoke more, to weigh more than people with more money, and to have hypertension and other coronary risk factors).

180. In addition, though a bit to the side for purposes of this Article, people may focus on a somewhat different set of markers that simultaneously identify those higher on the socio-economic hierarchy and those in better health. With this set of markers, it becomes especially difficult to disentangle cause and effect. The markers in question are associated with health (e.g., eating fruits and vegetables, not smoking, exercising routinely); they are viewed as personal choices. One's choice (to reject plums and carrots for white bread and luncheon meat, for instance) separates those who may be deemed responsible about their health from those deemed irresponsible. Making the "right" life choices is taken to suggest, in the phrase of Philip Alcabes, that one is "[w]orthy in the modern American moral register of health." Philip Alcabes, *What Ails Public Health?*, CHRON. HIGHER EDUC. (Wash., D.C.), Nov. 9, 2007, at B6. Of course, such choices are not equally open to everyone. The choice to eat vegetables, for instance, or the choice to exercise routinely depend on one's resources. Poor people, especially those living in urban areas, cannot afford a diet of fruits and vegetables and are much less likely than people higher in the socio-economic hierarchy to have the space or time to exercise on a routine basis. *Id.*

181. Harold D. Sgan-Cohen & Jonathan Mann, *Health, Oral Health and Poverty*, 138 J. AM. DENTAL ASS'N 1437 (2007) (asserting the existence and importance of "disparities in oral health").

182. Donya C. Arias, *Children's Dental Health Still Often Overlooked, Neglected*, NATION'S HEALTH, Mar. 2008, at 7.

183. Dental problems can even be life-threatening for children. *Oral Coverage and Care for Low-Income Children: The Role of Medicaid and CHIP*, POL'Y BRIEF (Kaiser Comm'n on Medicaid & the Uninsured, Wash., D.C.), Apr. 2009, at 4 [hereinafter *Oral Coverage and Care*] (noting deaths of two children in 2007, one in Maryland and one in Mississippi, because of complications from tooth decay that went untreated); Arias, *supra* note 182 (noting the death of Deamonte Driver, at age twelve, from a tooth infection that was not treated).

184. *Oral Coverage and Care*, *supra* note 183, at 1.

185. See Nalini Ranjit et al., *Socioeconomic Position, Race/Ethnicity, and Inflammation in the Multi-Ethnic Study of Atherosclerosis*, 116 CIRCULATION 2382 (2007) (reporting the relationship between low income and higher concentrations of interleukin-6 in every racial and ethnic group studied; interleukin-6 was used as a marker for inflammation).

and diabetes.¹⁸⁶ It is thus of great concern that dental problems are the “most prevalent unmet health need”¹⁸⁷ among children in the United States today. Less than half of children in families below the FPL are reported to have teeth in “excellent” or “good” condition.¹⁸⁸ In comparison, over eighty percent of children in families earning at least 400% of the FPL are reported to have healthy teeth.¹⁸⁹

Significant obesity is another mark of socio-economic status in the U.S. today. Obesity correlates inversely with wealth.¹⁹⁰ Indeed, in a startling historic irony, being poor and being fat are linked. As food prices go up, people without money are likely to choose cheaper and more calorie-laden foods.¹⁹¹ The most calorie-dense foods—those made with corn syrup—continue to cost less per calorie than other foods.¹⁹² Thus, poor people grow fatter than people with enough resources to buy fruits, vegetables, and other foods not high in calories.

Other conditions, viewed more traditionally as “diseases,” have long been associated with poverty. These include various forms of chronic ill health,¹⁹³ especially in young people, that correlate with susceptibility to infectious disease. Paul Farmer notes that within a global perspective, a variety of infectious diseases may be linked more or less explicitly in people’s imaginations with low socio-economic status.¹⁹⁴ Farmer further asserts that societal awareness of, and organized responses to, a particular disease tend to

186. Sgan-Cohen & Mann, *supra* note 181.

187. Susan A. Fisher-Owens et al., *Giving Policy Some Teeth: Routes to Reducing Disparities in Oral Health*, 27 HEALTH AFF. 404, 405 (2008).

188. Arias, *supra* note 182, at 7.

189. *Id.*

190. Rachel Raskin-Zrihen, *Income a Factor in Teen Obesity*, VALLEJO TIMES-HERALD, Dec. 12, 2008 (reporting that a study from the UCLA Center for Health Policy Research attributes the significantly higher obesity rate among poor adolescents to the prevalence of fast food restaurants and the absence of parks in the neighborhoods in which they live).

191. Hillel W. Cohen & Judith Wylie-Rosett, *Higher Prices, Wider Waistlines*, L.A. TIMES, July 25, 2008, <http://www.latimes.com/news/opinion/la-oe-cohen25-2008jul25,0,2190300.story>.

192. *Id.* (reporting that corn syrup remains cheaper per calorie than most other foods but that the increasingly high cost of oil has encouraged farmers to sell land to “biofuel giants” and is increasing the cost of such foods).

193. Interestingly, chronic childhood conditions occur more often among poor children than among other children. Yet, poor families report children with chronic conditions less often than other families. P.W. Newacheck, *Poverty and Childhood Chronic Illness*, 148 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1143 (1994).

194. Paul Farmer, *Social Inequalities and Emerging Infectious Diseases*, 2 EMERGING INFECTIOUS DISEASES 259 (1996).

correlate with the vulnerability of middle-class and richer people to the disease in question. “[O]ne place for diseases to hide is among poor people,” those “segregated from those whose deaths might be considered more important.”¹⁹⁵

Thus, again, one sees evidence of the “segregated” poor. Social interest in preserving a boundary between very poor people and other people explains some of the opposition to expanding the SCHIP program that was voiced in 2007 and 2008. This emerges concretely in differences, both perceived and actual, between Medicaid and SCHIP programs and in differences among Medicaid-eligible and SCHIP-eligible children.

B. Comparing Groups of Children

This Section reviews such differences. Much of the debate about SCHIP’s expansion in 2007 focused, at least implicitly, around assumed differences between or similarities among Medicaid-eligible children (or Medicaid-eligible plus SCHIP-eligible children) with those who would have become eligible for SCHIP had one of the two reauthorization bills become law¹⁹⁶—and who are now eligible for SCHIP coverage as a result of the reauthorization of the program in 2009.¹⁹⁷ There is a significant literature that compares Medicaid-eligible and SCHIP-eligible children. That is a useful starting point in understanding opposition to the expansion of SCHIP and thus, this Article contends, in understanding opposition to more universal health care coverage in the United States.

Subsection 1 below describes findings about socio-economic distinctions and health disparities between children covered by or eligible for Medicaid programs and children covered by or eligible for SCHIP programs. Then Subsection 2 compares perceptions of the two programs and of the children enrolled in them.

195. *Id.* at 263.

196. As a result of the passage of the Children’s Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong. (2009), the children in question are indeed now eligible for enrollment in SCHIP. The comparison remains a powerful indicator of the extent to which social opposition to universal health care coverage in the United States reflects subtle, yet pervasive, modes of class competition.

197. Children’s Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong. (2009). The SCHIP authorization bill was passed in the Senate by a vote of 66–32 (January 29, 2009) and in the House by a vote of 290–135 (February 4, 2009). Forty Republicans in the House voted for the bill. *Obama Signs SCHIP Expansion Bill as “Down Payment” on Universal Coverage*, 17 Health Care Pol’y Rep. (BNA) 189 (Feb. 9, 2009).

1. Comparing Medicaid-Eligible and SCHIP-Eligible Children

In comparing children covered by Medicaid with those covered by SCHIP, it is important, at the start, to remember that children in families at every rung of the socio-economic hierarchy are dependent on the adults responsible for them. Moreover, most children enrolled in Medicaid or SCHIP programs live in economically fragile circumstances. Even families at the higher income levels among those whose children are eligible for SCHIP may, with fairly small shifts in family income, be re-categorized as eligible for Medicaid.¹⁹⁸

There are, however, differences between the two groups of children with regard to health as well as with regard to income and socio-economic status more broadly. Even more, the perception of such differences undergirded much of the opposition to expanding SCHIP in 2007.

Children covered by Medicaid are more likely to have chronic diseases, such as asthma, and to be at higher risk for developmental delays than those covered by SCHIP.¹⁹⁹ Moreover, children covered by Medicaid are described as being in "fair or poor health" twice as often as those covered by SCHIP.²⁰⁰ These differences suggest that Medicaid-eligible children are less likely to be—and to appear—healthy than those enrolled in SCHIP. In this context, "looking healthy" depends, as described above,²⁰¹ on a set of characteristics that people may also rely on as signals of class status²⁰²—conditions such as dental health, height and weight, and capacity for physical activity. Children with poor teeth, underweight or significantly overweight children, and children with chronic conditions that limit physical activity are likely to appear unhealthy, and they are more likely to appear impoverished than other children.

Gayle Byck conducted a study that provides suggestive data. Byck investigated the correlation between socioeconomic status and health status among various groups of children, including uninsured children, children eligible for Medicaid, children eligible for SCHIP, and children covered by private insurance. She reported that SCHIP children differ in both socioeconomic status and in health status from both children covered by Medicaid and

198. See Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 46 (noting that the two populations of children resemble each other with regard to "health status, place of residence, and health needs").

199. *Id.* COMPARISON OF MEDICAID AND SCHIP, *supra* note 81, at 2.

200. *Id.*

201. See Part IV.A.2.

202. *Id.*

from privately-insured children but that the differences are “less significant” between SCHIP-eligible and privately-insured children than between children eligible for SCHIP and those covered by Medicaid.²⁰³

SCHIP children more often live with college-educated (39.4%) and employed adults (91.2%) than do Medicaid-enrolled children (23.0% and 53.9%, respectively). However, SCHIP children live with college-educated and employed adults less than do all privately insured children (66.7% and 96.9%, respectively) and privately-insured/same income children (57.8% and 97.0%, respectively). Parents of SCHIP-eligible children are also disproportionately self-employed or employed in industries (e.g., retail trade) and occupations in which health insurance coverage is less available or affordable.²⁰⁴

In addition, both parents of SCHIP children are more likely to be employed than are both parents of Medicaid children.²⁰⁵ But, both parents of children covered by private insurance are more likely to be employed than are the parents of SCHIP children.²⁰⁶ Byck found that differences in parents’ level of education can have significant implications for children’s health status:

Education may be seen as a predictor of occupational and labor market position; because our health insurance system is primarily employment-based, this has profound implications for health care coverage. Individuals who are better educated may be more open to health education, less inclined to partake in risky behaviors, and may have more skills that enable them to navigate complex health care bureaucracies. Studies have shown that higher levels of educational attainment are associated with lower adult mortality. In addition, low maternal education is associated with lower utilization of health care services for children.²⁰⁷

In sum, Byck reports that Medicaid children are less healthy than children in any of the other groups she studied.²⁰⁸ Her study

203. Byck, *supra* note 119, at 14. The study compared four groups of children: children eligible for SCHIP; children eligible for Medicaid; all privately-insured children; and privately-insured children with the same family income as SCHIP children. *Id.* at 16.

204. *Id.* at 14.

205. *Id.* at 17.

206. *Id.*

207. *Id.* at 19–20.

208. *Id.* at 17–18.

reflects the fact that Medicaid children, on the whole, belong to families so poor, at least as a comparative matter within the nation, that with or without health care, these children continue to bear the psychological and physical stigmata of poverty, including, for instance,²⁰⁹ poor nutrition, dental problems, malnutrition, and obesity. Being enrolled in Medicaid is apparently not enough to render very poor children middle class in appearance. The same is not necessarily the case for SCHIP children, and, even more, it is not the case for children covered by an expanded SCHIP program. That is to say, signs of differences between those deemed middle class and those not—especially those who earn less than the FPL—are less likely to be erased by Medicaid than by SCHIP, or an expanded SCHIP. Correlatively, in a universe competing (however opaquely) for class status, those in the middle class are more likely to assess their own status by reference to SCHIP enrollees than by reference to Medicaid enrollees.

It is important to underline the significance of these findings for this Article's claim that an intense, though often unacknowledged, form of class competition underlies opposition to expanding SCHIP and that, more generally, the same sort of competition has undergirded opposition to programs that would provide universal or near-universal health care coverage. Byck's findings suggest that middle-class people concerned about safeguarding their class status are more likely to focus on and feel threatened by SCHIP than Medicaid. More generally, they are more likely to believe that their class status is rendered vulnerable by improvements in the lives of those just below them in the class hierarchy rather than by similar improvements in the lives of very poor people. The next Subsection considers the concrete implications of these claims in more detail.

2. An Expanded SCHIP: Implications of the Comparisons

As Byck's data suggest, children covered by Medicaid are less likely to be perceived by others as belonging to the middle class than is the case for children covered by SCHIP.²¹⁰ Moreover, differences between perceptions of Medicaid and SCHIP-eligible children—by those not covered by either program, as well as by the children themselves and by their families—would presumably be greater the higher the income level for SCHIP eligibility.²¹¹

209. See Part IV.A.1.

210. See *supra* notes 203–08 and accompanying text.

211. These suggestions call for empirical investigation (which the author expects to conduct). Insofar as, at this point, the suggestions here are inferential,

Gayle Byck concretizes some of the social implications of the comparison among Medicaid-eligible, SCHIP-eligible, and privately-insured children, with the suggestion that SCHIP-eligible children may be reluctant to participate in a program associated with what she refers to as Medicaid's "stigma."²¹² The implications of that claim are far-reaching.²¹³

Medicaid's "stigma" obviously has serious consequences for Medicaid-eligible children. It also seems to carry unfortunate consequences for SCHIP-eligible children. Among other things, SCHIP-eligible families, whose children's health care and health are at stake, may want *to be seen as* different from Medicaid-eligible families. They worry that perceived differences between them and the poorest (Medicaid-eligible) families could be blurred were they to become identified with a public health system associated with the poorest families. Concern about preserving their socio-economic status may explain some part of their reluctance to enroll their children in SCHIP.²¹⁴

Other commentators have noted that some parents have refrained from enrolling their children in both Medicaid and SCHIP because of disdain for "welfare."²¹⁵ The difference between this response and that identified by Byck is subtle but significant. The concern Byck pinpoints is grounded primarily in class competition. In comparison, disdain for "welfare" may reflect a more specific, more openly ideological opposition to public assistance. To say this a bit differently, Byck's reference to the "stigma" of Medicaid suggests that reluctance to participate in SCHIP programs would vanish were SCHIP adequately distinguished from the public health program that serves the very poor—that, in short, SCHIP-eligible families might be more likely to rely on and benefit from the program were it not linked with

the conclusions reached in this Article must be considered tentative until the necessary research has been conducted.

Both CHIPRA I, H.R. 976, 110th Cong. (2007), and CHIPRA II, H.R. 3963, 110th Cong. (2007), would have expanded SCHIP to cover children in families earning at least 300 percent of the FPL.

212. Other commentators have also suggested that Medicaid is stigmatizing. Watson, *supra* note 20, at 1058. One interviewee, for instance, told Jonathan Engel: "[Dealing with Medicaid employees] is difficult because they never trust you and every time you go you have to prove you don't have a car, what your income is, and that you don't have any other bank accounts." *Id.* at 1059 (quoting JONATHAN ENGEL, POOR PEOPLE'S MEDICINE 119 (2006)).

213. Byck, *supra* note 119, at 18. Byck reports that this is the case as well for Medicaid children "at the higher end of the income eligibility spectrum." *Id.*

214. *Id.*

215. Dubay et al., *supra* note 61, at 7–8.

Medicaid. But, at the same time and for similar reasons, Medicaid beneficiaries would likely enjoy better mental and physical health were Medicaid's rules not perceived as humiliating to those attempting to enroll in the program or to those actually participating in it. They would likely enjoy better health if Medicaid were expanded to include people at higher income levels.²¹⁶

C. Explanations Offered by Those Who Opposed SCHIP's Expansion

This Section examines commentary offered by those, including government officials, journal authors, and members of the public, who sided with President Bush in opposing SCHIP's expansion in 2007 and early 2008. Assumptions about class can be found behind most of the explicit claims voiced by those who opposed SCHIP's expansion. Often those assumptions are masked by other, related, concerns.

The responses delineated in this Section show that class competition was at the center of much of the opposition to SCHIP's expansion in 2007 and 2008. Subsection 1 briefly comments on an underlying perception of SCHIP and suggests that that perception has been reinforced by the separation of SCHIP and Medicaid programs within many states. Then Subsection 2 details and examines claims about SCHIP offered by those who opposed the program's expansion.

1. States' Responses to SCHIP

At the time of SCHIP's creation in 1997, states were hesitant to promise continuing, expansive coverage under the program. Even as states developed SCHIP programs, most balked at creating programs with legal entitlements to coverage.²¹⁷ Moreover, despite the flexibility for states built into SCHIP's authorizing legislation, states developed programs that burdened SCHIP participants with bureaucratic requirements and with features resulting in a back-and-forth movement of children between SCHIP and Medicaid as

216. Comparisons between Medicaid and SCHIP-eligible children are particularly significant in light of the fact that many critics of the SCHIP reauthorization bills that President Bush vetoed noted, in explaining their opposition to the bills, particular concern about extending a benefit intended for poor people to people they viewed as middle class. See Part IV.C.2.c.

217. Rosenbaum, *SCHIP Study Reveals Impact*, *supra* note 76, at 36.

family incomes shifted between the eligibility levels of the two programs.²¹⁸

[M]ost state laws creating separate SCHIP programs do not even obligate the state to cover eligible children to the maximum level of available funding. Moreover, rather than using SCHIP to create seamless care systems as children move up the economic ladder by consolidating SCHIP and Medicaid revenues into combined managed care contracts, most states elect to separate children into distinct contractual “bins” by sponsorship status. This practice enables state agencies to design different conditions of participation, standards of coverage and operation, and other contractor requirements for these contractual “bins.” It also potentially permits contractors to participate in one program but not the other. These findings suggest that over time, SCHIP might have a further “isolating effect” on state policies toward the poorest of children and might eventually erode Medicaid’s policy goal to “mainstream” America’s low-income children.²¹⁹

Whatever the justifications that states relied on when structuring SCHIP, most programs work to ensure that SCHIP and Medicaid remain separate. That separation suggests a set of troubling social assumptions about the children eligible for each program, and about their families. The poorest children are distinguished from those who are somewhat less poor. This separation has proved harmful to the children involved. First, shuffling children between the programs as family income shifts, even by small amounts, above or below the level of Medicaid eligibility, creates discontinuity in health benefits. Second, and perhaps even more important, the separation forces children (and their parents) to think of themselves in negative terms. Providing different forms of public health care to very poor children and to children deemed not quite so poor sadly illustrates society’s longstanding failure to acknowledge—even, perhaps to see—the significance of class differences for the nation’s development and for its social structure.²²⁰

218. *Id.*

219. *Id.* at 36–37 (internal citations omitted).

220. Blacksher, *supra* note 167, at 144 (describing “[s]ocial class” in the United States as a “suppressed category”).

2. Why Oppose SCHIP's Expansion?: Public Responses

This Subsection focuses on opinions voiced by those who *opposed* the expansion of SCHIP. It should not, however, be forgotten that a majority of people in the United States and a majority in Congress—though not enough to override President Bush's CHIPRA vetoes—favored the program's expansion.²²¹

Opponents of the effort to expand SCHIP, both within government and among the public, made a set of interconnected claims. Most of these claims fall into at least one of four broad, though overlapping, categories.²²² The first such category,

221. Many others favored or strongly favored passage of the two CHIPRA bills that President Bush vetoed. In October 2007, the Kaiser Family Foundation, National Public Radio, and the Harvard School of Public Health surveyed the public regarding its attitude toward expanding the SCHIP program. NPR/KAISER FAMILY FOUND./HARVARD SCHOOL OF PUB. HEALTH, PUBLIC VIEWS ON SCHIP REAUTHORIZATION (CHARTPACK) (2007), <http://www.kff.org/kaiserpolls/upload/7703.pdf> [hereinafter CHARTPACK]. At that time, twenty percent of those surveyed claimed to know "a lot" about SCHIP and its proposed expansion, and thirty-one percent claimed to know "nothing at all." Others fell somewhere between these two positions. *Id.* After hearing summaries of a few arguments for or against expanding SCHIP, sixty-five percent of those surveyed supported increased funding for SCHIP, and twenty-eight percent opposed increased funding. *Id.* Interestingly, while ninety percent of the survey population supported eligibility for children in families earning \$20,000 a year and fifteen percent supported eligibility for children in families earning \$80,000 a year, when asked if they believed children in families at the FPL should be SCHIP-eligible, eighty-nine percent answered affirmatively, and when asked if they believed children in families at 400% of the FPL should be SCHIP-eligible, thirty-two percent answered affirmatively. In fact, at that time, an income of \$80,000 a year placed a family at about 400% of the FPL. (In 2007, the FPL for a family of four was \$ 20,650. CTRS. FOR MEDICARE & MEDICAID SERV., 2007 POVERTY LEVEL GUIDELINES, <http://www.cms.hhs.gov/MedicaidEligibility/Downloads/POV07ALL.pdf>.) More particularly, forty-nine percent of those surveyed (including Democrats, Republicans, and Independents) "[s]trongly disapprove[d]" of Bush's veto of CHIPRA I. The rest either "[s]omewhat disapprove[d]," "[s]omewhat approve[d]," "[s]trongly approve[d]," or "[did]n't know." CHARTPACK. The study included 1,527 randomly selected people, deemed to constitute a "nationally representative sample." *Id.* Interviews were conducted by telephone between October 8 and October 13, 2007. *Id.*

222. A few SCHIP opponents raised other concerns not encompassed by the four categories considered below. For instance, Representative Robin Hayes (R-NC) explained his vote to uphold President Bush's veto of CHIPRA I by noting that the expansion was to be funded by an increase in the tobacco tax. Robin Hayes, *I Support SCHIP But . . .*, CHARLOTTE OBSERVER, Oct. 29, 2007. Representative Hayes further explained that that tax would be especially burdensome to North Carolina because the state's economy is dependent on the tobacco industry:

As it stands right now, the burden to pay for this particular reform falls squarely on the North Carolina tobacco industry. SCHIP proposes a 61-

considered in Subsection 2(a) of this Section, reflects worry about increased governmental spending. The second category, considered in Subsection 2(b), examines claims bemoaning SCHIP's expansion as a step toward "socialized medicine." A third group of claims, especially important to this Article's thesis, decries the inclusion of "middle-class" children in a public health care program understood as having originally been created to provide coverage for poor children. A fourth category of arguments against the passage of the two CHIPRA bills identifies the bills' apparent focus on providing health care coverage for children as a foil for affecting other goals. The group of CHIPRA opponents making this sort of claim generally contended that the CHIPRA bills fabricated sympathy for children and that that sympathy served as a cover under which proponents hoped to actualize unrelated political ends.²²³ Letters to newspaper editors and comments posted on various blogs about CHIPRA I and II provide a rich source of responses to the two bills and their shared fate. After Congress reauthorized and expanded SCHIP in early 2009, Republican legislators who opposed that result echoed concerns about the program that were widely expressed by SCHIP opponents in 2007 and 2008.²²⁴

a. Concerns About Cost

Much of the debate about expanding SCHIP focused on the potential costs involved. In explaining his veto of CHIPRA I, President Bush declared:

The original purpose of the State Children's Health Insurance Program (SCHIP) was to help children whose families cannot afford private health insurance, but do not qualify for Medicaid, to get the coverage they need. My Administration strongly supports reauthorization of SCHIP.

cent increase on tobacco—a 160 percent increase. This will have grave consequences on the growers, manufacturers and workforce left in the industry, and would be detrimental across the state's economy.

Id.

223. See Part IV.C.2.d.

224. Representative Tom McClintock (R-Calif.) explained that SCHIP's expansion would result in "spiraling costs" for the government, and Representative Steve King (R-Iowa) called the bill a "foundation stone for socialized medicine." Pear, *Obama Signs Children's Health Insurance Bill*, *supra* note 150. Senator Pete Sessions (R-Texas) expressed concern about children giving up private coverage to join the governmental program. *Obama Signs SCHIP Legislation*, *supra* note 105.

That is why I proposed last February a 20 percent increase in funding for the program over 5 years.

This bill would shift SCHIP away from its original purpose and turn it into a program that would cover children from some families of four earning almost \$83,000 a year. In addition, under this bill, government coverage would displace private health insurance for many children. If this bill were enacted, one out of every three children moving onto government coverage would be moving from private coverage. The bill also does not fully fund all its new spending, obscuring the true cost of the bill's expansion of SCHIP, and it raises taxes on working Americans.²²⁵

Justifying the veto of CHIPRA I through reference to the program's costs is shorthand, it would seem, for the contention that *this* cost is not acceptable, though other comparable expenses may be. Indeed, even some of those who supported President Bush's vetoes of CHIPRA I and II found it difficult to accept his contention that he was motivated by concern about spending, *per se*. One Ohio newspaper's editorial staff, though noting that the paper's editorial board was "glad" about the President's October 2007 veto of the first SCHIP reauthorization bill, remarked that President Bush had shown little fiscal constraint about other matters.²²⁶ In particular, he approved other costly bills,²²⁷ even bills aimed at expanding health care benefits, including Medicare Part D²²⁸, which offered a prescription drug benefit to Medicare recipients.²²⁹

225. H.R. DOC. NO. 110-62 (2007). Similarly, President Bush explained his veto of CHIPRA II by noting, among other things, that "[t]he new bill, like the old bill, does not responsibly offset its new and unnecessary spending, and it still raises taxes on working Americans." H.R. DOC. NO. 110-80 (2007).

226. Editorial, *Fiscal Restraint*, LIMA NEWS, Oct. 25, 2007 [hereinafter *Fiscal Restraint*].

227. Indeed, in October 2008, President Bush signed a bill authorizing the Treasury Department to spend at least \$700 billion as part of a "bailout" plan. David M. Herszenhorn, *Bush Signs Bill*, N.Y. TIMES, Oct. 4, 2008, at A1.

228. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066 (2003) (codified as amended at 42 U.S.C. § 1395w-101 (2006)); see David Pratt, *The New Medicare Part D Prescription Drug Benefit*, 17 ALB. L.J. SCI. & TECH. 337, 348 (2007) (noting that "[t]he original estimate of the cost of the new drug benefit, for the 10-year period from 2004 through 2013, was \$400 billion").

229. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended at 42 U.S.C. § 1395w-101 (2006)).

Similarly, many others who expressed opposition to SCHIP's expansion because of its cost seem to have been comfortable with the government's spending comparable, and often much larger, sums of money for other purposes.²³⁰ One blogger explained:

You can't equate the Iraq war with this issue. It is the federal government's job to deploy troops if necessary [sic]. It is NOT the federal government's job to create and expand entitlements. If we were only spending money on the poor instead of defining "poor" to include anyone who we can scare into voting for somethink [sic] they THINK is free, we'd have more than enough money in the federal budget.²³¹

Another CHIPRA opponent who posted comments on a Washington Post blog that focused on the economic implications of expanding SCHIP worried more about whom the added funds would help than about the fact that the funds would be spent: "[The bill] has verbage [sic] in it that would allow illegal aliens access to tax payer funds. . . . U.S. funds for U.S. citizens. Period!"²³²

Indeed, many who opposed the expansion of SCHIP expressed concern about the expansion's cost. The concern, however, was less about fiscal restraint, *per se*, than about a perceived need to preclude spending for the specific purpose of expanding SCHIP. Some, for instance, spoke almost bitterly about a government handout to people viewed as capable of caring for themselves.²³³

Class competition—specifically, concern about sustaining class status—became transparent in explicit comparisons made by some opponents of SCHIP's expansion between their own situation and that of families they presumed would become eligible for SCHIP under the proposed expansion. These CHIPRA critics compared their own hard work and self-sufficiency with a deep irresponsibility that they attributed to those whose children would become eligible for SCHIP under an expanded program. To them, the comparison suggested a fundamental unfairness. One blogger, complimenting President Bush on his veto of CHIPRA I, complained that the program's proposed expansion would have encouraged and rewarded irresponsibility:

230. See *infra* notes 231–32 and accompanying text.

231. Posting of Frank Lawson to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html (Oct. 3, 2007, 17:22 EST).

232. Posting of America needs a wakeup to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html (Oct. 3, 2007, 17:18 EST).

233. See, e.g., *infra* notes 236–37 and accompanying text.

I want people to pay for [my] new car. Why shouldn't my desires be fulfilled? Why is it the people who are responsible enough to say "I can't afford kids right now" [are] the ones that are obligated to support people who could [not] care less about being responsible. . . . The people who need government support will have to be forced to undergo some sort of birth control since it seems they can't control themselves.²³⁴

Further, this blogger blamed those unable to pay for health insurance for their plight and then suggested they might prefer leaving the United States for a socialist country.²³⁵

This blogger's pronouncement reflected a theme common to much of the opposition to SCHIP's expansion. Many CHIPRA opponents viewed SCHIP's proposed expansion, unfavorably, as part of a broad process moving the nation toward "socialism."²³⁶

For instance, Representative Todd Tiahrt (R-Kan.) explained in a newspaper opinion piece that "Democrats" were using SCHIP "as a platform to take one giant step toward a national socialized health care system."²³⁷ Representative Tiahrt concluded that he could not support "a reckless \$35 billion spending increase that imposes the eighth tax increase of the year on American families."²³⁸

234. Posting of bob to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html (Oct. 3, 2007, 17:43 EST).

235. *Id.*

236. One commentator noted this trend and considered some of its implications. *Red Herring: Federal Role in Health Care Long, Varied*, LEXINGTON HERALD-LEADER, Oct. 24, 2007 ("We live in the only industrialized nation that would tolerate leaving 16 percent of its people with no health coverage. Yet, Kentucky Republicans in Congress are railing against socialized medicine and drawing imaginary ideological lines in the sand.").

Fear of socialism has deep roots in twentieth-century United States history. See, e.g., HOWARD ZINN, A PEOPLE'S HISTORY OF THE UNITED STATES 373 (1980). During most of the twentieth century, for the American mainstream, the invocation of socialist ideals suggested communism and thus seemed akin to a national heresy.

237. Todd Tiahrt, Opinion, WICHITA EAGLE, Sept. 26, 2007.

238. *Id.* CHIPRA proponents responded to such rhetoric. Senate Grassley of Iowa (ranking minority member of the Senate Finance Committee), who helped craft the CHIPRA bills, explained, in denouncing President Bush's veto of CHIPRA I: "Screaming 'socialized medicine' during a health care debate is like shouting 'fire' in a crowded theater. It is intended to cause hysteria that diverts people from reading the bill, looking at the facts." Iglehart, *supra* note 126, at 2106 (quoting September 26, 2007, speech by Senator Grassley on Senate floor).

Introducing a discussion of CHIRPA I and his veto of the bill at an October 2007 press conference, President Bush declared:

In fact, most SCHIP children are covered by private health plans. However, claims about encroaching socialization were likely grounded as firmly in concern about subsidized coverage for children in families with incomes two or three times the FPL as in concern about the development of a system of government-designed health care.²³⁹ In effect, in the debate about SCHIP's expansion, references to "socialized medicine" often served as covers for concern about intensified class competition. More particularly, such references were grounded in concern that those at the lower edge of the middle class would be able (with SCHIP coverage and perhaps other "benefits") to compete more effectively for a higher place in the socio-economic hierarchy.

One visitor to a blog featuring comments on CHIPRA I elaborated on the fear of socialism by describing some of the presumptive dangers of socialism:

The reason I am against this bill is because it is another example of creeping socialism. Our government is trying to steal our liberties slowly and we are asleep. If we don't stop them now, with this bill and with each bill like this they

[S]ocialized medicine [in other nations] has led to lower standards, longer waits, rationing of care. We've tried, by the way, here in Washington to have a—to have a major effort, put the federal government square in the center of health care in 1994, and the legislation didn't pass. I believe many of the Democrats in Congress who supported that legislation have learned from the experience. So instead of pushing to federalize health care all at once, they're pushing for the same goal through a series of incremental steps. With each step, they want to bring America closer to a nationalized system where the government dictates the medical coverage for every citizen. . . . And we can now see the strategy [of expanding various health-related programs] clearly when you analyze the efforts to expand the State Children's Health Insurance Program—that's the—that's the issue I was going to talk to you about; SCHIP it's called.

George W. Bush, U.S. Pres., Remarks at 2007 Grocery Manufacturers Assoc./Food Growth and Free Trade Conf. (Oct. 31, 2007) (transcript available at http://www.gmabrands.com/news/president_bush_discusses.cfm). And an editorial in the Atlanta Journal-Constitution explained Congress' failure to override the veto as a Republican commitment to "hold[] the line against something called 'socialized medicine.'" Cynthia Tucker, *Our Opinion: GOP Will Suffer if Children Lose Health Coverage*, ATLANTA J.-CONST. Oct. 21, 2007, at 6B.

239. See Gorin & Moniz, *supra* note 99.

will get away with it. Stop going to DC with your hand out. Each time you do you lose a piece of your freedom.²⁴⁰

Such assertions suggest, in effect, that SCHIP's expansion would constitute a public "handout" that would undermine the presumptive "freedom" to make one's own choices and therein design one's own fate. That presumption—that "freedom" eludes only those who are irresponsible and lazy—reflects the conviction that social mobility can be enjoyed by those who work hard and make the right choices.²⁴¹

South Carolina Senator James DeMint (R) struck a similar note in criticizing CHIPRA I for extending health care coverage to families that he deemed middle class.²⁴² He expressed particular concern about the development of a system of "government controlled health"—a system of health care that he described as having "prove[n] disastrous in Europe."²⁴³ In Senator DeMint's view, both "government controlled health" care and state-funded care for middle-class people deprive people of autonomy and choice.²⁴⁴ Interestingly, however, the Senator did not disfavor governmental health care coverage for poor children.²⁴⁵ But those who would have become eligible under the CHIPRA bills were, in Senator DeMint's view, middle class.²⁴⁶ He suggested that such families might be given tax credits, thus allowing them "to purchase health plans for their kids that they choose, rather than being handed a one-size-fits-all Washington-run program."²⁴⁷

In this way, Senator DeMint sought to preserve choice and autonomy—values he seemed to view as quintessentially American—but only for those not burdened by poverty. Middle-class children and their families, he explained in opposing the CHIPRA bills, should enjoy "control of their own health care decisions."²⁴⁸ In contrast, Senator DeMint supposed, poor children

240. Posting of Mia to H.R. 976, The Children's Health Insurance Program Reauthorization Act of 2007, http://www.washingtonwatch.com/bills/show/110_HR_976.html (Oct. 15, 2007, 9:31 EST).

241. These presumptions were reflected in the Horatio Alger myth. *See, e.g.*, STANLEY ARONOWITZ, FALSE PROMISES 141 (1973); Richard Delgado, *The Myth of Upward Mobility*, 68 U. PITT L. REV. 835, 879–80 (2007).

242. Jim DeMint, Opinion, *A Better Way Forward on Health Care for Poor Children*, CHARLESTON POST AND COURIER, Nov. 2, 2007.

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.*

247. *Id.*

248. *Id.*

and their families must sacrifice—or in the nature of their poverty, had already sacrificed—the right to choice and autonomy.

Two essential assumptions underlie Senator DeMint's critique of the proposed expansion of SCHIP. Both are widespread among those who opposed the CHIPRA bills. First is the assumption that poor people are fundamentally different, as people, from people who are not poor. Not only are poor people, in the very nature of poverty, seen as lacking economic, and often political, resources, they are deemed, as a group, not to have developed the spirit of autonomous individuality viewed as characterizing the middle class. Second, and in consequence, is the assumption that those in poverty are deemed incapable of self-help.

These assumptions supported Senator DeMint's conclusion that "government controlled health" constitutes a form of charity and should thus be offered only to those unable to provide for themselves.²⁴⁹ This position harmonizes with a popular American conception of class as including two basic groups, poor people and everyone else,²⁵⁰ and it harmonizes with the institutional decision to separate SCHIP children from Medicaid children.²⁵¹ Moreover, this position undergirded much of the opposition to the expansion of SCHIP in 2007 and 2008.

Others picked up on the theme of SCHIP as charity. Several opponents of plans to expand SCHIP suggested, as did Senator

249. Paul Farmer, who believes health care is a basic human right, has offered a view of "charity medicine" that might be confused with Senator DeMint's view, but which is, in fact, quite different. Farmer wrote:

The approach of charity further presupposed that there will always be those who have and those who have not. This may or may not be true, but, again, there are costs to viewing the problem in this light. In *Pedagogy of the Oppressed*, Paulo Freire writes: "In order to have the continued opportunity to express their 'generosity,' the oppressors must perpetuate injustice as well. An unjust social order is the permanent fount of this 'generosity' . . . Given the twentieth century's marked tendency toward increasing economic inequity in the face of economic growth, the future holds plenty of false charity. All the recent chatter about 'personal responsibility' from 'compassionate conservatives' erases history in a manner embarrassingly expedient for themselves."

FARMER, *PATHOLOGIES OF POWER*, *supra* note 27, at 153–54. Farmer, however, understands the virtues of "charity medicine." His plea is not to eviscerate charity, but to offer charity while remembering and revealing the "causes of excess suffering among the poor." The apparent similarity between Farmer's claims and those of Senator DeMint is quickly belied by Farmer's conclusion that "charity medicine" can succeed only if it refrains from blaming the poor for their poverty. There is, he comments, a world of difference between assuming that the poor are poor because of "innate shortcomings" and assuming that they are the victims of "structural violence." *Id.* at 153–57.

250. See Part IV.A.1.

251. See Part III.A.1.

DeMint, that those who accept charity must also accept an understanding of themselves as very poor *because* they are incompetent. One blogger, focusing on one of President Bush's CHIPRA vetoes, assumed that SCHIP constitutes charity and opined: "Perhaps some of us should take a civics class and learn about America. We all have to labor for what we want. For those who need help there are the charities and state programs."²⁵² In short, in this person's view, only those who are both very poor *and* unable to "labor for what [they] want" should benefit from "charities and state programs." The price for accepting such benefits is the price of absolute social marginality.

b. Must Poor People Sacrifice Liberty and Choice?

That marginality is suggested forcefully in the presumption that poor people, and especially those who deign to accept charity or governmental benefits designed to help those in poverty, should lose the right to enjoy certain privileges.

It should not be surprising that no society is as strongly tied to the notion of autonomous individuality and as absolutely committed to the notion of free choice as is the contemporary United States, and the United States is also not averse to jettisoning other values (including equality) if those values appear to interfere with autonomy and choice.²⁵³ It is, thus, not surprising that segments of society have assumed that governmental health care, if provided at all, should be limited to those in poverty *because* poor people are deemed therein to have shown themselves incapable of appropriating the life choices that would render them middle class. These assumptions, taken as a group, limit the very personhood of people living in poverty.

In consequence—and this is central to the thesis of this Article—those deemed so poor that they are unlikely to improve their class status are situated outside the domain of implicit class competition. This is the very group to which Senator DeMint would offer "government controlled health" care. This is the group, read broadly, that might have been eligible for Medicaid, but not for SCHIP, in 2007 and 2008.²⁵⁴ More particularly, those

252. Posting of Dr. Coles to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html (Oct. 3, 2007, 17:05 EST).

253. See FARMER, *PATHOLOGIES OF POWER*, *supra* note 27, at 163.

254. At that time, the limited resources available to people living below the FPL seem likely to preclude their rising in the class hierarchy even if they received health care coverage from the government. See MICHAEL MARMOT,

who opposed SCHIP's expansion in 2007 and 2008 seem to have assumed that no system of "government controlled health" care (again, to use Senator DeMint's term), created for and offered only to very poor people, would likely have been adequate to have cured health conditions, such as obesity, depression, coronary disease, and diabetes, that disproportionately affect those at the bottom of the nation's socio-economic hierarchy.²⁵⁵ These conditions are likely to remain chronic among people who live in poverty.

c. Expanding SCHIP to Include People Deemed Middle Class

In short, a disturbing message—one generally not voiced openly—was implicit in some of the opposition to the CHIPRA bills. That message, decoded, opposed expanding SCHIP because that expansion might have posed a threat to the class status of those in income brackets just above the income-eligibility level for an expanded SCHIP program.

This message is reflected more or less clearly in a set of responses from people who opposed SCHIP's expansion. For instance, one critic of CHIPRA I complained that expanding SCHIP would offer a "free ride" to one group of people while, at the same time, "the gov[ernment] is taxing" middle-class people more heavily than ever. The specific reference was to new, higher fees for Medicare recipients earning "more than \$80,000" a year.²⁵⁶ Others contended that SCHIP's proposed expansion defied

THE STATUS SYNDROME: HOW SOCIAL STANDING AFFECTS OUR HEALTH AND LONGEVITY 82–103 (2004). Marmot explains:

If we find health to be related to position in the social hierarchy, everywhere from British civil servants to baboons, from Swedish university graduates to average Americans, then is the whole enterprise of understanding health inequalities with a view to doing something about it not doomed? The thrust of the previous chapter was to argue that above the minimum level of resources it is what you have, relative to others in society, that is crucial for health; and what you have relative to others is related to your position in the social hierarchy, it may even define it.

Id. at 83. Later in the book, Marmot suggests that not all hierarchies will have the same effect on health. He notes the possibility, for instance, that even those at the bottom of a social hierarchy might be offered a sense of involvement and thus of autonomy and choice. *Id.* at 127–28.

255. *Id.* at 43, 152 (noting the disproportionate presence of diabetes, heart disease, obesity, and depression among those in "the lower employment grades").

256. Posting of bermil@gmail.com to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_

the American rule that “[w]e all have to labor for what we want.”²⁵⁷ More simply, others concluded that “[t]his program expands SCHIP to cover families who do not need it. Period.”²⁵⁸

Other opponents of the CHIPRA bills suggested even more openly that by making some “middle class” people eligible for SCHIP coverage, the government would undermine the middle class itself. An editorial in an Ohio newspaper, for instance, referred to the proposed expansion of SCHIP as an attempt to recategorize segments of the middle class as “government dependents.”²⁵⁹

Most CHIPRA critics focused more simply on the unfairness of providing public health care to people deemed capable of affording health care or health care coverage. Thus, a visitor to a blog that included comments about CHIPRA I openly compared her own situation to that of people who would have been covered under the terms of the bill²⁶⁰ (and who will in fact be covered under the SCHIP authorization bill passed in 2009).²⁶¹ She wrote:

It is ridiculous that a family can have \$500,000 in property, 4 kids in private school, 3 newer cars, part-time jobs that pay \$45,000 and get benefits. This is not an example of the working poor. This is an example of a family who is better off than I am BUT I am paying my own way.²⁶²

Leaving aside this critic’s assumptions about the expanded reach of SCHIP, this comment, by someone calling herself “Mia,” expresses the concern of many SCHIP opponents who accepted governmental health care coverage for children in families that were truly poor but not for children from somewhat better-off families. It would seem that public health care coverage for

begin_schip_veto_ove.html (Oct. 3, 2007, 17:04 EST) (commenting that seniors may be taxed for Medicare participation and asking “why should other people making \$82,500 or more get a free ride”).

257. Posting of Dr. Coles, *supra* note 252.

258. Posting of Steve to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html (Oct. 3, 2007, 17:22 EST) (commenting that “there are the leftists who lie and claim that children will be without healthcare. Bull. Lies”). (In the original, the words “do not need it,” quoted in the text, are in capital letters).

259. *Fiscal Restraint*, *supra* note 226.

260. The female pronoun is used in reference to this blogger. The name used suggests that the blogger is female. That may, of course, not have been the case.

261. Children’s Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong. (2009).

262. Posting of Mia, *supra* note 240.

children in families significantly less well off than those deemed middle class was not worrisome to Mia. Mia seemed to have believed such families *could not* “pay[] [their] own way.” And perhaps, as well, Mia assumed that such families are so far below her²⁶³ in the social hierarchy that they did not present significant competition as she struggled to maintain her own class status.

One reader of a newspaper article that reported on President Bush’s likely veto of CHIPRA II argued that children in families making 300% of the FPL do not need government help with health coverage. This reader explained:

If you make \$60K a year, you can afford healthcare, even with 4 kids. You might have to drive a van instead of a luxurious SUV, but it can be done. The problem here is those families [sic] priorities. Many of the children currently uninsured are eligible right now, but their irresponsible parents don’t have them signed up.²⁶⁴

The author (“Twreck”)²⁶⁵ focused on the “irresponsib[ility]” of those who would be covered by an expanded SCHIP program, and he made two rather different claims. At first, Twreck described the parents of the children involved as irresponsible in choosing luxuries (e.g., an SUV) over health coverage. Then, Twreck switched frames and commented on what he saw as the irresponsibility of parents whose children were, in fact, eligible for health care coverage. Twreck characterized the parents of such children as irresponsible because, in his view, they failed to enroll their children in the health care programs that were available to them.

Another reader’s comment—this one written as a letter to the editor of a South Carolina newspaper—described the 2007 CHIPRA bills as a “middle-class vote-buying effort.”²⁶⁶ The writer explained that SCHIP was “designed to help those in need, not people who earn more than three times the poverty level income in

263. “Mia” is referred to in the text with the use of a female pronoun. In fact, however, there is no way to know, through reference to a blog name, the gender of one who contributes to a blog.

264. Posting of twreck_11 to Bush: No Child Health Bill with Tobacco Tax Hike, <http://www.chron.com/disp/story.mpl/nation/5259744.html>. (Oct. 31, 2007, 8:55 CST).

265. This blogger referred to himself or herself as “twreck” with a small “t.” This Article uses a capital “T” to make it easier for readers to recognize the term as a name, and it refers to this blogger with a male gender term even though there is no way to know the blogger’s gender. In other such cases, a female gender term may be used.

266. Richard Mahorsky, Letter to the Editor, *Democrats Used Boy to Buy Votes*, COLUMBIA STATE, Oct. 25, 2007.

this country.”²⁶⁷ The same critic then explained that “90 percent of the news media” is “liberal, strongly support the Democratic Party[,] . . . hate our president and do everything possible to smear conservatism.”²⁶⁸ The writer took umbrage at the “use” of an “innocent” child to garner support for legislation presumptively aimed at helping children, but actually, in the author’s view, aimed at squandering government resources in order to win votes.²⁶⁹ In this, the author portrayed children as both innocents in need of protection and as a tool for advancing other (“liberal”) ends.

d. The “Kid Card”

Few of those who opposed the expansion of SCHIP expressly decried providing health care to *children*.²⁷⁰ Rather, they acknowledged children and their needs but then identified other concerns that outweighed the presumptively laudatory goal of ensuring that children have access to health care.

An editorial in one Ohio newspaper, published after Congress failed to override Bush’s veto of CHIPRA I, referred openly to efforts to expand SCHIP as a “shameless effort[] to play the Kid Card.”²⁷¹ The editorial explained that the vote was actually about the “proper role and size of government” but that those favoring the bill attempted to present the central issue as concern for children.²⁷²

One visitor to a Washington Post blog exclaimed: “I’m all for kids having health care—but this bill [CHIPRA I] is not the way.”²⁷³ The form of such claims instantiates a long-standing

267. *Id.* The letter was apparently in response to a story about a twelve-year-old boy whose statements were in support of expanding SCHIP. Mr. Mahorsky complained that the “Democrats . . . use[d] and rehearse[d] this boy to make statements that were in favor of their giveaway bill to people with incomes up to 300 percent of the poverty level.” *Id.*

268. *Id.*

269. *Id.*

270. American society and law have long proclaimed deep concern for the best interests of children. That presumptive concern has often, however, masked other interests, including those of adults in structuring familial relationships. Janet L. Dolgin, *Suffer the Children: Nostalgia, Contradiction and the New Reproductive Technologies*, 28 ARIZ. ST. L.J. 473, 473–75 (1996).

271. *Fiscal Restraint*, *supra* note 226.

272. *Id.* The author apparently assumed that few people would openly oppose a program structured to help children.

273. Posting of Policzar to Democrats Begin SCHIP Veto Override Campaign, http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html. (Oct. 3, 2007, 17:01 EST) (emphasis added.) The critic explained further that the bill was “one step to socialist health care,” which “is going to be more expensive than what people have now and be worse!” *Id.*

pattern in the United States: conflicts between public (ideal) values and private (actual) values are expressed through reference to the public ideal which is then qualified in some way.²⁷⁴ People may thus acknowledge a public ideal (e.g., a belief that “children are good” or that “racism is bad”) and then amend it with a more particular claim that limits or even, in fact, eradicates the voiced “ideal.”

Some who opposed the expansion of SCHIP avoided openly opposing governmentally funded health care *for children* by describing SCHIP’s recipients as the “middle class.”²⁷⁵ Or they focused on balancing the cost of providing for the health needs of one vulnerable group (e.g., children) against the needs of another vulnerable group (e.g., the elderly). A Wall Street Journal editorial, for instance, commented on the attempt in the House of Representatives to expand SCHIP coverage at the same time that Congress was providing less funding for Medicare Advantage (Medicare’s managed care plan):²⁷⁶ “Politically, it’s ironic that Democrats are funding free health care for the middle class by dingling poor seniors.”²⁷⁷ This claim displaced SCHIP’s focus on children’s health care with a focus on “health care for the middle-class.”²⁷⁸

V. CLASS COMPETITION AND THE FUTURE OF A NATIONAL HEALTH CARE SYSTEM

The responses reviewed in Part IV, taken together, depict a nation much more sensitive to even small differences in socio-economic rank than people may generally realize. Section A of this Part summarizes the significance of class competition in the United States in light of responses to SCHIP’s expansion described in

274. The prototype of the pattern is: “I am not racist, *but . . .*”

275. Editorial, *The Schip Revelation*, WALL ST. J., Aug. 9, 2007, at A12.

276. *Id.*

277. *Id.* Yet, interestingly, in July 2008, Congress overrode Bush’s veto of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331). Among other things, the bill protects Medicare payments to physicians, reduces funding for Medicare Advantage medical education programs, and requires that pharmacies distributing pharmaceuticals to Medicare Part D recipients be paid promptly. *Medicare: House, Senate Override Bush Veto of Medicare Legislation with Rx Language*, 6 *Pharmaceutical L. & Indus. (BNA)* 826 (July 18, 2008). In the House of Representatives, the vote was 383 to 41. In the Senate, it was 70 to 26. *Id.*

278. The editorial further distanced itself from the subject of providing health care for children by focusing on the comparative advantage of providing health care for the “middle class” and for a group deemed especially vulnerable—poor, elderly people. *The Schip Revelation*, *supra* note 275.

Part IV. It then broadens the discussion with a view toward understanding more general responses to the creation of a system of national health care. Then, Section B suggests a set of factors that coalesced in the first year of the Obama administration to move the nation toward the possibility of change.

A. CHIPRA Bills and Class Competition

Traditionally, people in the U.S. have claimed that hard work, the “right” personal choices, and a good education make for socio-economic success.²⁷⁹ They expect to be socially mobile and assume that their children will be better off than they are.²⁸⁰ Yet, in fact, social and economic mobility are not common.²⁸¹ Class differences are salient and wide. And, on the whole, they have paralleled health disparities.²⁸² Rather than becoming narrower, class differences have grown wider in the United States in the last half century.²⁸³ Even more, as the economic gap between the middle class and the very rich grew dramatically in the last decades of the twentieth century and the first decade of the twenty-first century, the gap between the middle class and the poor did not change.²⁸⁴

The contradiction between the nation’s abiding belief in social mobility and the reality of its fairly static class system sits at the center of the American psyche. On the one hand, people tell themselves and each other that they can and will overcome economic adversity and that mobility is available to anyone who tries hard enough; however, they find themselves faced with a reality in which a pervasive class system limits mobility for most

279. Scott & Leonhardt, *supra* note 169, at 1. The economic downturn of 2008 may openly challenge such assumptions, at least for a time.

280. See Michael A. Fletcher & Jon Cohen, *Hovering Above Poverty, Grasping for Middle Class*, WASH. POST, Aug. 3, 2008, at A1. Fletcher and Cohen report that about eighty percent of low-wage workers in the U.S. believe that they will rise in social class, and fifty-nine percent predict that their children will be better off than they are. *Id.*

281. Scott & Leonhardt, *supra* note 169; see also Paul Krugman, *The Great Wealth Transfer*, ROLLINGSTONE, Nov. 30, 2006, http://www.rollingstone.com/politics/story/12699486/paul_krugman_on_the_great_wealth_transfer [hereinafter Krugman, *Great Wealth Transfer*].

282. See MARMOT, *supra* note 254, at 1 (attempting to show the “remarkable finding” that “among all [groups of] people, the higher the status in the pecking order, the healthier they are likely to be”).

283. Scott & Leonhardt, *supra* note 169.

284. Krugman, *Great Wealth Transfer*, *supra* note 281. Krugman notes: “The real divergence in fortunes is between the great majority of Americans and a very small, extremely wealthy minority.” *Id.*

people.²⁸⁵ Indeed, socio-economic mobility in the U.S. is less than in Canada, and less than in several Scandinavian nations; it is about the same as in France and Britain, two countries with monarchical histories and populations that openly assume that class is important in establishing one's identity and one's place in the larger scheme of things.²⁸⁶

In short, the perseverance of the Horatio Alger myth in the United States, despite significant evidence to the contrary, may instill hope (though that hope is often misplaced), but it also encourages people to focus closely on the symbols and marks of socio-economic difference as they seek evidence that they can, indeed, participate in the myth's promises. The task that people face in assessing their own and others' socio-economic class is complicated by the common myth—virtually official in character—that class status, unlike race or ethnicity, is not an essential part of one's identity within society. Assessing socio-economic class is also complicated due to shifts over time in, and some uncertainty about, the signs of socio-economic success. Even as class differences widen, class position becomes “harder to read.”²⁸⁷ During much of the twentieth century, high status could be discerned from one's religion, political party, race, or even consumption patterns.²⁸⁸ By the start of the twenty-first century, that was less often the case.

Yet, a few transparent signs of class difference have persisted. They appear in the location of one's residence, in family structure (with more affluent people tending to have children within marriage, later in life, and fewer in number than others), and in health disparities.²⁸⁹

If the suppositions informing the central thesis of this Article are correct—that class is crucial and often disguised within the American socio-political order,²⁹⁰ that health disparities follow socio-economic rank,²⁹¹ and that class competition (though often framed in other terms) directs responses to socio-political events²⁹²—then opposition to SCHIP's expansion—opposition forceful enough to preclude the passage of both CHIPRA bills—is not surprising. And the nation's failure to construct a national

285. Krugman, *Great Wealth Transfer*, *supra* note 281; Scott & Leonhardt, *supra* note 169.

286. Scott & Leonhardt, *supra* note 169.

287. *Id.*

288. *Id.*

289. *Id.*

290. See Part IV.A.

291. See MARMOT, *supra* note 254.

292. See Part IV.A.

health care system during the twentieth century seems at least as unsurprising.

B. Is Change Possible?

For a century Americans defeated every important proposal for a national health care system offering universal or near-universal health care. That pattern is reflected in the 2007–2008 defeat of the effort to expand state and federal health care coverage for children from families with only modest incomes. Nevertheless, new options emerged in the first year of the Obama administration. Indeed, the reauthorization and expansion of SCHIP in early 2009²⁹³ suggested future changes. A “tipping point” for health care reform appeared on the horizon.²⁹⁴

First, the economic downturn that rocked the nation beginning in the fall of 2008 provided a peculiarly apt context for dramatic political shifts and economic experiments. More specifically, President Obama made it clear that, in his view, health care reform was essential, *per se*,²⁹⁵ and that it could constitute a basic part of an economic recovery plan.²⁹⁶

Second, the fate of 47 million people without health care coverage, many of whom could not afford private insurance, became emblematic of the nation’s failure to create a health care system adequate to meet the needs of its population.²⁹⁷ Even more, the high costs and comparative ineffectiveness of the nation’s health care system provided forceful arguments for some change.²⁹⁸

293. Children’s Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong. (2009).

294. See, e.g., MALCOLM GLADWELL, *THE TIPPING POINT: HOW LITTLE THINGS CAN MAKE A BIG DIFFERENCE* (2000) (popularizing the notion of a magic point at which significant change occurs).

295. At a December 2008 news conference, President-Elect Obama declared: “Now, some may ask how at this moment of economic challenge we can afford to invest in reforming our health care system. And I ask a different question. I ask, how can we afford not to?” *All Things Considered: Staff Had No Idea of Illinois Scandal* (National Public Radio broadcast Dec. 11, 2008).

296. Noam N. Levey, *Healthcare an ‘Emergency,’ Obama Says*, L.A. Times, Dec. 12, 2008, at A26; Alexandra Marks, *Healthcare: Obama Presses Ahead*, CHRISTIAN SCI. MONITOR, Dec. 12, 2008, at 25.

297. See, e.g., Paul Krugman, *Health Care Excuses*, N.Y. TIMES, Nov. 9, 2007, at A27 (noting that the 47 million people without coverage include different individuals during any period and that about a third of people in the U.S. under sixty-five did not have health care coverage at some point in 2006 or 2007).

298. BARLETT & STEELE, *supra* note 44, at 12–27. Barlett and Steele report, among many other similar facts, that in 2001 the U.S. spent \$4,887 per capita for health care. In contrast, in that year Canada spent \$2,792. Yet the life span in

Third, there is some, though admittedly not overwhelming, evidence that Americans—or at least certain groups within the nation—were becoming more conscious of the class differences that structure their social universe and thus implicate their social and personal identities.²⁹⁹ For instance, in 1990 Vincente Navarro³⁰⁰ focused attention on the significance of class, along with race, in the construction of U.S. society and, in particular, on the significance of inequalities in class status for the development of health disparities.³⁰¹ A large literature about the correlation between health disparities, health care disparities, and socioeconomic inequalities has appeared since that time.³⁰²

Fourth, states have worked on several fronts to expand health care access. Under SCHIP, despite some backsliding in the last five years, states made significant strides in outreach programs and worked to simplify the process of applying for and enrolling in the program.³⁰³ Moreover, in fact, the 111th Congress expanded SCHIP on the model of the CHIPRA bills that were defeated in 2007. And President Obama signed that legislation.³⁰⁴

Yet, expanding SCHIP—and in 2007 and 2008, even that did not happen—is a long step from creating a national health care system. Even more, were one to seek a new public health initiative likely to pass muster with the American people, one offering health care to children in families with modest incomes would be a good candidate. But in 2007–2008, Congress was unable to affect that end. On the other hand, the defeat of the legislation proposing an expansion of SCHIP was not a foregone conclusion.³⁰⁵ Congress

Canada was two and a half years longer than in the United States. *Id.* at 13. Even more, the U.S. in the same year spent 205% more per capita on health care than did Spain. Yet, the life span in Spain was more than two years longer than in the United States. *Id.*

299. The search term “socioeconomic status” (or “socio-economic status”) produced 2,161 citations in the LexisNexis Library for the two-month period that has just passed (January 5, 2010–March 4, 2010). A comparable search for the same days in 1998 produced 220 citations. (Even though there is a larger number of total Lexis citations available for 2010 than for 1998, the difference is suggestive.)

300. Navarro, *supra* note 27, at 1238.

301. *Id.*

302. See, e.g., ICHIRO KAWACHI & BRUCE P. KENNEDY, *THE HEALTH OF NATIONS* (2002); MARMOT, *supra* note 254; R.G. WILKINSON, *MIND THE GAP: HIERARCHIES, HEALTH AND HUMAN EVOLUTION* (2000); Nancy A. Ross et al., *Relation Between Income Inequality and Mortality in Canada and in the United States*, 320 *BRIT. MED. J.* 898 (2000).

303. Eskin & Ranji, *supra* note 74.

304. Pear, *Obama Signs Children's Health Insurance Bill*, *supra* note 150.

305. Iglehart, *supra* note 126.

voted for both bills, though not with large enough margins to override a presidential veto. In addition, a majority of the public and most state governors voiced strong support for an expansion of the SCHIP program.³⁰⁶ Moreover, a survey conducted by the Commonwealth Fund and its Commission on a High Performance Health System reported in August 2008 that thirty-two percent of those queried indicated that the nation's health care system demanded a complete overhaul, and fifty percent indicated that fundamental changes were in order.³⁰⁷

Finally, a fuller awareness of the underlying concerns among those who opposed universal or near-universal health care coverage—concerns such as those documented in this Article—may help in the effort to quell public uneasiness about a major reform of the nation's health care system.³⁰⁸

VI. CONCLUSION

This Article has aimed to explain the failure to reauthorize and expand SCHIP in 2007 and 2008 and, in doing so, to suggest one explanation—grounded in the nation's murky understanding of class—of both the failure during the twentieth century to construct a system of universal or near-universal health care coverage and the volatile debate surrounding health care reform in 2009 and early 2010.³⁰⁹

The story of the defeat of the CHIPRA bills contains important messages about the nation's more general failure to broaden access to health care. The CHIPRA story was built around the concerns of those who opposed the creation of a public system of national health coverage, and, thus, it is unsurprising that the story suggests—if one reads between its lines—some of the deeper assumptions that long stalled the development in the United States

306. *Id.*

307. *Reform Proposals: Reports Find Strong Support for Overhaul of U.S. Health System, Recommends Reforms*, Health Care Daily (BNA) (Aug. 7, 2008) (noting that the Commonwealth Fund surveyed more than 1,000 adults).

308. See, e.g., FARMER, *PATHOLOGIES OF POWER*, *supra* note 27; MARMOT, *supra* note 254; SUSAN STARR SERED & RUSHIKA FERNANDOPULLE, *UNINSURED IN AMERICA* (2005).

309. As this Article goes to press, the Senate is commencing debate on health care overhaul. Richardo Alonso-Zaldivar, *Turbulence Ahead: Senate Opens Health Care Debate*, AP, Nov. 28, 2009. Should a reform package be accepted by Congress and signed by the President, it is likely that the nation's understanding of class and the intense class competition considered in this Article will affect the operation of new programs for delivering health care and the consequences of those programs for children and their families.

of a health care system that would provide everyone with access to health care.

This Article suggests a new explanation for America's long-term failure to develop a national health care system that would provide universal or near-universal coverage. The explanation is intended to supplement, not replace, other explanations. Compared with the people of many other nations, Americans have long been both uncomfortable with and anxious about the effort to maintain class status. In part that is because individuals are perpetually uncertain about their own status and, even more, about the implications of class status generally. That uncertainty does not attend understandings of class status in much of Europe, where class has long been a transparent dimension of social reality.

In part, Americans' discomfort with competing for class status follows from their reluctance openly to acknowledge class status and the competition it spawns. As a result of the uncertainty and intensity that accompany Americans' efforts to discern the implications of class, they are hyper-sensitive to symbols and marks that distinguish gradients in the socio-economic hierarchy. Among those symbols and marks,³¹⁰ the indicia of health status, always present in a way that is not true even of houses, cars, and other expensive possessions, are especially powerful. Poor dental health, extreme obesity, and physical lethargy, even during childhood, adolescence, and middle age, are some of the signals of low socio-economic status. Signs of health and ill health provide particularly powerful indications of class status in the American context because they are written into people's very bodies. This Article has suggested that competition for both access to health care and for the resulting indicia of health undergirded at least some of the opposition to expanding the SCHIP program and the nation's reluctance during many decades to construct a system offering more universal health care coverage.³¹¹

310. Class status in the U.S. is indicated by residential geography and by a host of material items constituting the consumer marketplace. Steinhauer, *supra* note 177. Steinhauer reported that a *New York Times* poll found that over eighty percent of the American public reported feeling "social pressure to buy high-priced goods." *Id.* Even more, Steinhauer reported that Americans were less concerned with copying "the top tier" than with "simply having a fair share of the bounty and a chance to carve out a place for themselves in society." *Id.*

311. An empirical examination of attitudes toward presumed indicia of health and ill health in the United States is in its early stages. The author expects to report on the results of that study in a future Article.

In short, many impediments³¹² to the development of national health care coverage in the United States have been reinforced by an underlying, largely implicit understanding of class status that has encouraged widespread anxiety among people in the United States about sustaining class status. People compete for class position without quite “seeing” that they do so and, equally important, without knowledge that class mobility is more myth than fact.³¹³ The social connotations of health, and the apparent relevance of health care coverage to the sustenance of good health, have made competition for both health care and health status important forms of class competition and important evidence of success or failure in that endeavor.

The economic downturn that began in 2007 presented an impetus for health care reform rather than an incubus. Similarly, the Roosevelt administration’s far-reaching social welfare reform in the 1930s was in part a consequence of economic turmoil. That turmoil facilitated broad policy innovations.³¹⁴ That health care reform was eventually excluded from President Roosevelt’s social welfare package was largely a response by the administration to the fierce opposition among established medical groups.³¹⁵ That opposition has largely disappeared.³¹⁶

And so change is on the horizon. This shift has been facilitated by the growing realization that the cost the nation has paid for curtailing access to health care for millions and millions of people has its own cost—one that can no longer be sustained. By 2009, a critical mass of people in the United States was ready to abandon an almost unrelenting commitment to autonomous individuality for the sake of the health of the communal whole. Finally, the

312. In turn, and sometimes simultaneously, efforts to construct a system of national health coverage in the United States have been undermined by the opposition of special interest groups, including the longstanding antagonism of establishment medicine to universal or near-universal health coverage and the concern of employers about the cost to them of universal health coverage. This was especially of concern in the context of the Clinton plan because that plan relied on the incorporation of private insurance into the system and the shifting of often-surprising political affiliations. See Mariner, *supra* note 21, at 543. But none of these factors seem completely to explain the startling fact that the United States pays more—indeed much more—per capita for health care than any other nation, and yet the U.S. fares badly on almost all comparative assessments of health. See *supra* notes 62–68 and accompanying text.

313. Scott & Leonhardt, *supra* note 169.

314. MAYES, *supra* note 35, at 19.

315. *Id.* at 19–21.

316. Indeed, in late 2009, the AMA hailed passage in the House of Representatives of a bill providing for health care reform. *American Medical Association: AMA Hails House Passage of Health Reform Bill (H.R. 3962)*, AGING & ELDER HEALTH WK., Nov. 29, 2009, at 20.

actualization of a system of near-universal health care is likely, in its turn, significantly to reshape the nation's assumptions about class status—assumptions that for so long reinforced opposition to health care reform.

