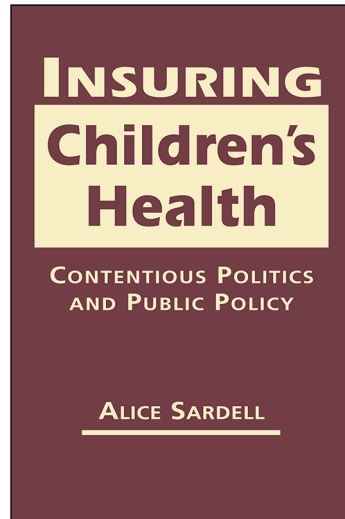


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**Insuring
Children's Health:
Contentious Politics
and Public Policy**

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1

Policy Frameworks and Children's Health

The policy processes that led to the expansion of US children's health insurance were imbued with tragedy, drama, and irony. Tragedy occurred with the death of Deamonte Driver, a twelve-year-old Maryland boy who died on February 25, 2007, after surgery for a brain infection that originated in an abscessed tooth that had not been treated. This tragedy brought media attention and a swift response from members of Congress—first a hearing and then legislation expanding publicly funded dental-care coverage for children. But behind this story is another very important story that helped make the congressional response to the tragedy of Deamonte's death possible.

That is the story of the Children's Dental Health Project, an advocacy group created a decade earlier by a "policy entrepreneur" concerned about the enormity of the problem of lack of access to dental care for low-income children. A dramatic, sometimes tragic event occurs and the media and elected officials respond; this response is a very common phenomenon in US public policymaking. But these dramas are not the most important part of the process of creating policy. Instead it is the policy research, the dissemination and discussion of that research, and the development of relationships between outside advocates and elected and appointed officials over time that establish the ideas that become policy responses to dramatic events. Through this book, I tell the story of the individuals and groups that were critical to

increasing health insurance coverage for US children from the 1980s through 2009.

I begin that story with two other politically dramatic events—presidential vetoes that highlight the ideological conflict that attended the discussion of the expansion of federal health insurance coverage for children when the State Children's Health Insurance Program (SCHIP), created in 1997, was due to be reauthorized. On October 3, 2007, and then again on December 12, President George W. Bush vetoed an expansion and reauthorization of SCHIP that had been passed by large majorities in Congress. Bush opposed the legislation even though many business groups, including insurance and pharmaceutical companies, supported it, as did key Republican health leaders in the Senate and, according to polls, more than two-thirds of the US population.

When SCHIP was created, conservative Republicans controlled Congress. Republican support reflected the fact that SCHIP was not an "entitlement program," as is Medicaid, but rather a federal block grant to the states. So it is ironic that a Republican president twice vetoed a children's health insurance program that at its inception was hailed by Republican governors and Republican congressional leaders as a victory for state autonomy in health policy.

The United States has a much higher infant mortality rate and a lower rate of childhood immunization than other wealthy, postindustrial nations. Assuring that children in the United States have health insurance coverage would appear to be a noncontroversial, consensual, and even a popular issue, the latter confirmed by public opinion polls. Yet the policy history of children's health insurance is marked by drama and controversy. Both its supporters and opponents have viewed it in terms of the larger issue of universal coverage, and its fate has been linked to major electoral change. SCHIP was not reauthorized until Barack Obama became president. On February 4, 2009, during his third week in office, President Obama signed the same legislation, with minor changes, that Bush had vetoed.

In this book, I examine the political debates and dramas surrounding this issue. I explain how a child health "policy community" emerged in the 1980s and focused on the expansion of Medicaid eligibility for pregnant women and children, how children's health insurance moved to the top of the policy agenda in the late 1990s, then how a liberal Democratic senator and a conservative Republican senator partnered with the premier children's advocacy group to push a new children's health insurance initiative through a Republican Congress.

I also discuss how the policy process itself shaped the characteristics of SCHIP.

I then focus on the new set of issues raised when SCHIP came up for reauthorization ten years later: whether parents of eligible children, pregnant women, and legal immigrant children should be included in the program; the services that should be mandated by the federal government; the cost of the program; and how high income levels for eligibility should go. Legislative provisions that would expand SCHIP in several ways led President Bush and other conservative Republicans to oppose the program for ideological reasons. One Republican senator (Tom Coburn, OK) called it “part of an effort to bring everyone into a socialized health care system” (Pear 2007).

SCHIP is significant as a policy, and its policy history is a significant case for analysis. SCHIP was the first major piece of federal legislation to establish a separate health insurance program for children; it has helped to reduce inequality in access to health care. The Balanced Budget and Revenue Reconciliation Acts of 1997, which authorized the program, allocated the largest amount of federal money to children's health since the passage of Medicaid three decades earlier (Pear 1997c). As a consequence of the implementation of the SCHIP legislation, the proportion of low-income uninsured children had decreased by one-third between 1997 and 2005 (Mann 2007) while the proportion of uninsured adults increased.

Good health is critical to the ability of children to develop and to learn. An argument made as early as the 1980s—that investment in children's health care will reduce future health costs—is increasingly salient as we face enormously high health-care costs and compelling health-care problems such as childhood obesity and rising rates of mental illness in children and adolescents. In addition, there is growing scientific evidence that many adult health conditions originate in childhood (Halfon, DuPlessis, and Inkelas 2007).

The 1997 enactment of SCHIP and its 2009 reauthorization illuminate important aspects of the broader debate about the US health-care system. SCHIP was created after the failure of the Clinton administration's health reform plan. For congressional Democrats and some advocates for universal coverage, it was viewed as an incremental step in achieving broader coverage. For state governors, particularly Republican governors, the structure of SCHIP was a victory for the states within the federal and state health policy relationship.

Typically, a program's reauthorization is a routine matter because it is viewed as “distributive”: having benefits for some groups, but few

costs for others.¹ This was not the case with SCHIP reauthorization. There was wide bipartisan support for the program during the years of its implementation and when it was due to be reauthorized in 2007; a broad coalition of both health industry groups and consumer advocates was supportive. Yet the program's reauthorization was filled with partisan and ideological conflict.

The effort to expand SCHIP had stimulated a historical ideological controversy about the relative roles of the public and the private sectors in the US health-care system that has reoccurred several times since the late nineteenth century (see Sardell 1988: ch. 2). Thus, to supporters of expanding public health insurance coverage, SCHIP expansion was a positive first step; to opponents of expanding coverage, SCHIP was a "Trojan horse" that would bring forth a system of universal public health insurance. This long-standing ideological debate over the US health-care system occurred within the context of the increased ideological polarization between the Democratic and Republican parties.

Children and childhood have special meaning within the context of US social policy. Babies and children, especially young children, are viewed as both vulnerable and innocent. They are "constructed" as unformed and malleable; they are not yet what they will become. They are thus more "fixable" than adults (Sardell 1991) and have a "dual status" as existing in both the present and the future (Mayall 1998). Children are therefore outside of the paradigm of the moral distinction between the "worthy" and the "unworthy" and the powerful notions of "us" and "them" that have historically been central to US social policy (Katz 1983; Morone 2003). Yet the case of children's health insurance also reinforces the central importance of framing strategies in successful policy enactment, particularly when the target populations are those without political resources of their own. Children's innocence and our moral obligation to the vulnerable was not enough; children's health insurance was framed as a "cost-effective" program for the children of "hard-working parents."

In addition to explaining SCHIP as a product of the politics of US children's policy and the politics of health insurance policy, I also provide lessons about the politics of US social policy more generally. An analysis of the policy processes related to the expansion of health insurance coverage for US children *over time* provides important insights into the dynamics of the policy process itself. Relationships between and among policy actors in and outside of government, advocacy strategies, and the linkages between a series of policy events are all clarified by using a longitudinal lens. A comparison of the creation of SCHIP in

1997 and the reauthorization process in 2007–2009 enables me to analyze changes in the child health policy community over time, the way in which the issue of children's health coverage was framed at the program's creation and then ten years later, and the intersection of policy activity by advocates with changes in the larger political environment.

Insuring Children's Health is the first book in which policy theories and frameworks are used to analyze the politics of children's health insurance over time. The analysis of federal policymaking on "children's issues" and the potential for mobilizing around such issues other than health care has received attention from political scientists (Skocpol 1992; Gormley 1995; Cohen 2001; Skocpol and Dickert 2001; Imig 1996, 2001, 2006; Crowley 2003). Since children themselves are not political actors and have no political resources, a key strategy in political advocacy for children is "framing." William T. Gormley Jr. (2012) examines the framing strategies of various policy actors at both the national and state levels across several policy domains, including child health. But to date, there have been only a few scholarly articles focusing exclusively on the national politics of children's health policy (Sardell 1991; Sardell and Johnson 1998; Brandon, Chaudry, and Sardell 2001; Rosenbaum and Sonosky 2001; Oberlander and Lyons 2009).

There is health policy literature that has examined the implementation of SCHIP in terms of programmatic issues such as enrollment barriers and the substitution of public for private insurance. (I will be referring to this literature in Chapters 4 and 6.) Scholars have also analyzed the contemporary child health system and made important proposals for improvement (see, for example, Grason and Guyer 1995; Stein 1997; Halfon, DuPlessis, and Inkelas 2007; Rosenbaum 2008). Although these are critical contributions to the policy discussion of how to improve the health of US children, they do not examine the policy processes through which these proposals are presented and considered, adopted, or rejected, nor do they examine the roles of various actors, their interactions, and the broader political and social environment in which these interactions occur.

In contrast, there are several major studies of the political processes that produced Medicare policy (Marmor 2000; Jacobs 1993; Himelfarb 1995; Oberlander 2003) that failed to produce national health insurance in the United States (Jacobs 1993; Skocpol 1997; Hacker 2002; Quadagno 2005), and that resulted in the creation of the Affordable Care Act (Starr 2011; McDonough 2011; Altman and Shactman 2011). The politics of the Medicaid program are intimately connected to chil-

dren's health insurance, although children are only one of the constituency groups served by Medicaid. The majority of publicly insured children are enrolled in Medicaid, and the origins of SCHIP/CHIP are rooted in the federal politics of Medicaid. Stevens and Stevens (1974), Smith (2002), Grogan and Patashnik (2003), Olson (2010), and Thompson (2012) present comprehensive, important discussions of the policy history of Medicaid.² Frank Thompson applies his rich analysis of the challenges of program administration within the complex federal health care system to SCHIP as well as Medicaid.

In this first chapter, I discuss the theoretical frameworks used to illuminate the very fluid and complicated policy processes that led to the creation and expansion of a federal children's health insurance program in the United States and briefly outline the way that interviews were conducted with participants in these processes. I will then place these events within a larger historical and ideological context by outlining the politics of federal funding for maternal and child health programs from the early twentieth century through the 1970s.

Policy Frameworks

The policy frameworks that are most useful in understanding the dynamics of new program creation, as well as program expansion, in the US context are John Kingdon's policy streams model (1995) and Mark A. Peterson's discussion (1997) of how "policy legacies" shape current policy actions. The advocacy coalition framework developed by Paul Sabatier (1988) refines the critical but general concept of policy networks. Anne Schneider and Helen Ingram's work (1993) on the social construction of target populations and the related interdisciplinary literature on "framing" are also central to understanding the policy process for a population such as children.

Kingdon's Model of the Policy Process

Kingdon's policy streams model provides a comprehensive and dynamic theoretical framework for analyzing the US policy process. Included in his model are the way that issues are defined (or "framed"), the role of ideas and values in the policy process, and the activities and interrelationships of a wide variety of public and private actors. Kingdon's focus is the question of why particular issues get on the governmental agenda at specific points in time; but it is also helpful in concep-

tualizing the process of policy formulation (see Zahariadis 1996; Sardell and Johnson 1998). My analysis of the creation of the State Children's Health Insurance Program (presented in Chapter 3) draws on Kingdon's framework as well as others to be discussed later.

The strength and usefulness of this framework is its conceptualization of three different "streams" of policy-relevant activity that can go on simultaneously, in contrast to a linear model of a series of policy stages. The three streams are the "problem stream," the "policy stream," and the "politics stream."

The "problem stream" is the process by which problems are identified as important to remedy through governmental action. The most significant actors in the process of problem identification and definition are "visible" actors such as legislators, cabinet members, and executives (e.g., the president). There are several ways that problems can gain attention. These include "indicators," which are routine data collected and analyzed by governmental and nongovernmental policy actors; ongoing "feedback" about the operation of existing programs; and "focusing events." Examples of focusing events are a bridge collapse, a plane crash, or long lines at gas stations during an oil shortage. Often groups that have been trying to focus attention on a problem (or a solution) can take advantage of the interest that the media, the general public, and policymakers give to such a "crisis."

The "policy stream" consists of the interaction and recombination of policy ideas, some of which emerge as viable and some of which do not survive, within a specific policy arena. The creation, exchange, and evaluation of these ideas are conducted by the members of the "policy community," specialists in a given policy area who interact with one another from various institutional positions in and outside of government. These specialists can be staff of Congress, executive branch agencies or interest groups, academics, or employees of independent policy organizations or "think tanks." The third stream, the "politics stream," describes the characteristics of the nation's politics at a particular point in time, including which parties or factions within parties control the White House and Congress.

Kingdon argues that a subject is most likely to rise on the decision agenda when these three separate streams—problems, policies, and politics—come together. When this happens, a "window of opportunity" opens for action on a given problem. Such an opportunity may be seized by "policy entrepreneurs"—those individuals *inside or outside* of government who are willing to invest resources such as energy, money, time, and reputation to achieve a particular policy outcome.

Policy entrepreneurs play a central role in Kingdon's theory about how subjects get on the governmental agenda. They work to get recognition for a problem, defining it in the way that will be most effective. They are persistent in putting forward new ideas both within the policy community and outside of it, including introducing bills, holding hearings, giving speeches, and issuing studies and reports—a process that Kingdon calls “softening up.” After the softening up process, successful entrepreneurs may be able to use an opportunity in the problem stream (interest by powerful actors) or a shift in the political stream (e.g., a new administration) to integrate problems, proposals, and politics.

Following Kingdon, policy developments in child health are conceptualized as the interaction of the activities of entrepreneurs within a policy network supportive of expansions of health-care access with changes in the larger political environment. In the case of children's health insurance, activity within the policy community and significant events in Kingdon's “political stream” explain agenda-building and policy formulation. Over time, children's advocates have both responded to and attempted to influence the broader policy agenda.

In Chapter 2, I describe the emergence of a child health policy community during the 1980s that shared a set of beliefs about the nature of appropriate child health services and the necessity for providing them to large numbers of uninsured and underserved children. Several of the institutions within this policy network engaged in activities that aimed to diffuse these beliefs to political actors outside the policy community—that is, to other policymakers and to the general public. There were several policy entrepreneurs whose activities were critical to this effort, including the Children's Defense Fund (CDF) founder Marian Wright Edelman, Governor Richard W. Riley of South Carolina, Congressman George E. Miller (D-CA), and Senator Lawton Chiles (D-FL). One consequence of this focus on children was the expansion of Medicaid eligibility for pregnant women and children and other changes in Medicaid that resulted in an increase in coverage for these populations. Key policy entrepreneurs in that effort were Sara Rosenbaum, the Health Policy Director of CDF; Congressman Henry Waxman (D-CA); and Senator Lloyd Bentsen (D-TX).

In Chapter 3, I chronicle the way in which events in the policy stream interacted with those within the political stream to create the State Children's Health Insurance Program in 1997. While children's health advocates had proposed expansions of insurance coverage for children *before* the introduction of President Clinton's plan for health

system “reform” in September 1993, it was the failure of Congress to enact the Clinton plan that provided the impetus for Democratic legislative leaders to move children’s health insurance higher on their domestic agenda. Policy entrepreneurs were again critical in the actual enactment of a children’s health insurance program. The political dynamic that moved a children’s health insurance program through the legislative process was the entrepreneurial activity,³ in both policy and political terms (Peterson 1993), of two highly respected senators, Edward Kennedy (D-MA) and Orrin Hatch (R-UT), in partnership with CDF, the “premier” children’s advocacy group on the national scene.

Kingdon notes that program reauthorization is a time when the policy “window” routinely opens (1995). The SCHIP reauthorization process, which began in 2006, was used by different policy communities to move their specific issues higher on the policy agenda. (Another metaphor for these policy communities and the “window of opportunity” is the theater. The policy agenda is the stage; policy communities work on a multitude of issues “offstage” while preparing for their time “onstage.”) These policy communities included those concerned about expanding health coverage for pregnant women, coverage for legal immigrants, and increasing access to dental care for low-income children. The reauthorization of SCHIP did not occur until 2009, after a shift in the political stream. Although reauthorization and expansion had broad support across a coalition of professional and business groups as well as the support of a majority of members of Congress, the program was not reauthorized until there was a new president.

While immensely useful as a general framework for organizing information about the policy process, Kingdon’s model needs to be integrated with other conceptual frameworks. The work of Mark Peterson focuses on another critical dimension of policymaking: the ways in which prior policy events influence policymaking at later points in time.

Policy Legacies

Building on the work of Paul Pierson (1992 and see Pierson 2000) and others, Peterson argues that analyzing policy decisions and outcomes only in terms of actors and power arrangements at one point in time is not sufficient to understand the personal, ideological, and institutional dynamics of the event. Rather, it is necessary to examine how prior policy events have shaped the political environment. These policy legacies are “created by previous policy debate, action, and implementation” (Peterson 1997: 1080).

Peterson describes the way that policy legacies enter the policy process via “social learning” by policy actors. He identifies two kinds of social learning, “substantive learning” and “situational learning.” Substantive learning is about the policy itself: it “incorporates the results of practice, experimentation, observation, analysis . . . argued on the basis of facts” (1997: 1087). (Although, as he points out—citing Deborah Stone’s classic *Policy Paradox* [2012]—there is no actual objective policy analysis because all “facts” are shaped by the ideological prism of the analyst.)

Situational learning, in contrast, involves lessons about which policies are viable in a specific political environment. Different types of policy actors (“experts,” “organized interests,” “politicians”) will differ in the degree to which they use each of these types of learning. Whether substantive or situational learning will be viewed as most important in a specific policy situation is also related to the “scope of the policy,” from policy implementation by bureaucrats (more substantive) to the formulation of legislation that could involve major structural change (more situational).

The policy legacies that shaped the enactment and structure of SCHIP included substantive learning about the unique characteristics of children’s health and health services, the increasing numbers of uninsured children, and prior state attempts to deal with this problem. SCHIP policy entrepreneurs acted on the basis of situational learning about politically viable health policy proposals in the period after the failure of the Clinton plan for health-care reform and the 1994 election. There were two sets of policy legacies here, one about the failure of universal health insurance and another about conflict related to state versus federal power within the Medicaid program.

While several distinct policy legacies influenced the timing and structure of SCHIP in 1997, the debate over SCHIP reauthorization in 2007 featured the phenomenon of “policy foreshadowing.” President Bush and some conservative members of Congress opposed SCHIP reauthorization because they believed that expanding coverage to children in higher-income families would breach a boundary between the public and private health sectors and negatively influence the outcome of future health policy decisions for the entire US population.

Policy Communities: “Advocacy Coalitions”

Kingdon notes that the degree of cohesion or fragmentation of policy communities varies (Kingdon 1995: 118). However, he is not specific

about the internal structure of such communities or their boundaries. Paul A. Sabatier's model (1988) of the internal structures of policy communities or subsystems incorporates the effect of specialization, professionalization, and the increased use of policy research in US (particularly federal) policymaking during the past several decades (see Peterson 1995).

Sabatier posits a concept of "advocacy coalitions" whose interactions within various policy domains helps to explain policy change. These advocacy coalitions are defined as networks of individuals from different institutional positions both in and outside of government "who share a particular belief system—i.e., a set of basic values, causal assumptions, and problem perceptions—and who show a non-trivial degree of coordinated activity over time" (Sabatier 1988: 139). The "core" of the belief systems of members of such coalitions include "deep core" assumptions about the nature of human society, notions about justice, priorities of various values, and so on. The next level of beliefs, "the near core," is more concrete and includes such values as the role of the market versus that of government in a particular policy area, and the distribution of authority among levels of government. Advocacy coalitions seek to realize their policy goals by controlling political resources (governmental agencies may be a part of advocacy coalitions) and through debate about policy ideas with representatives of other coalitions. In any specific policy area during the period studied, there may be competing advocacy coalitions with very different core belief systems or there may be one dominant advocacy coalition and one or several minority coalitions. The dominant coalition may be fragmented at various junctures (Sabatier 1988: 142–148).

In the years since Sabatier first developed the advocacy coalition concept, numerous case studies have applied it and suggested refinements and Sabatier and his colleagues have discussed these refinements (Sabatier and Jenkins-Smith 1999; Sabatier and Weible 2007). While such discussions have clarified the necessity of clearly delineating the boundaries of the policy subsystems and studying them over time (seven to ten years is suggested), the core notion of analyzing the interaction of policy actors with shared belief systems is a useful one. The policy network concerned with children's health insurance can be delineated, and I trace its emergence, existence, and internal conflicts for more than twenty years.

Most policy communities in the United States include interest groups whose constituents (large corporations, small businesses, teachers, the elderly) have political resources—money, expertise, numbers

and votes, along with organizational and research skills. Potential constituencies with few political resources often remain underrepresented in the policy process. Children—or at least preadolescent children—do not have any political resources. Gilbert Steiner, who examined children's advocacy in the 1970s, rather acidly said, "As political actors children are useless and dependent" (Steiner 1976: 143). Thus the policy community concerned about children's health will consist of groups representing children, rather than children themselves.⁴ One would also expect the child health policy community or communities to be less stable than most policy communities, precisely because children themselves lack political resources.

Within the child health policy community there was one dominant advocacy coalition that worked on increasing access to care through insurance coverage and then a competing advocacy coalition that was influential in shaping policy related to the *delivery of child health services* rather than children's health insurance. But there were also some changes in the composition of the dominant advocacy coalition over time and internal conflict over the structure of the State Children's Health Insurance Program. These will be described in Chapters 2 and 3.

It is precisely because children are "resource-less" that both outside groups and inside supportive policymakers must use wise "framing" strategies to build support for the allocation of actual (as opposed to symbolic) benefits for children. An analysis of how children's health issues were framed is thus critical to understanding the nature of the policy process in relation to children's health insurance.

"Framing" Health Insurance for Children

Political scientists have long written about the presentation of policy arguments in a manner that evokes specific values and societal beliefs (Stone [1988] 2012) and about the process by which certain policy ideas are "organized out" of political discourse by being labeled as outside of the US ideological spectrum (Schattschneider 1960; Bachrach and Baratz 1970; Cobb and Elder 1983; Rochefort and Cobb 1994; Cobb and Ross 1997). "Framing" refers to the specific way that political actors present an issue or a policy to an audience, often attempting to link the policy or issue to deeply held common values. Framing is a process of "value recruitment," "efforts of political persuaders to influence the connections individuals make between broad social values and particular political issues" (Nelson, Wittmer, and Shortle 2010: 13). Thus, the works of Schattschneider, Stone, Cobb

and Elder, Cobb and Ross, and Bachrach and Baratz are all expositions on framing broadly defined.⁵

Recent political science scholarship that analyzes framing explores the effects of framing on public opinion, often by doing laboratory experiments looking at the impact of various framing strategies on different audiences. It seeks to understand the conditions that make presenting an issue, policy, or event in a certain way more or less effective in shaping public opinion. These are “framing effects” (see Nelson, Wittmer, and Shortle 2010; Gormley 2010). While most of this research examines how the frames created by elected officials and the media are received by the public, there has been some work on how interest groups create frames (Chong and Druckman 2007).

It can be suggested that within a policy network, one set of policy actors uses frames to influence the views, and possibly the behavior, of other elite actors. Members of Congress and their staffs frame issues for each other, and interest groups certainly attempt to frame their arguments in a way that will make members of Congress or agency officials sympathetic to their cause. The goal here was to understand how children’s health insurance was framed within the “elite discourse” over time.

In this book, I discuss the framing of the expansion of Medicaid eligibility for pregnant women and children in the 1980s, the framing of the children’s health insurance bill proposed by senators Kennedy and Hatch in 1997, and the way that both supporters and opponents framed the expansion and reauthorization of SCHIP in 2007. I show that the frames used by advocates of expanding Medicaid eligibility in the 1980s functioned as a form of “substantive policy learning” and were used again during the debates over both the creation and reauthorization of SCHIP.

Framing in the political debate over the reauthorization of children’s health insurance was “emphasis framing” in which “competing frames emphasize different messages” about what is at stake in the policy debate (Schaffner and Sellers 2010). Supporters of expanding the program emphasized the long-term economic value of providing health insurance coverage to large numbers of children, while opponents of expansion—such as the Bush administration—countered with the concept of an expanded SCHIP as a “Trojan horse” ushering in the demise of the “free-market” aspects of the US health-care system.

Schneider and Ingram (1993) discuss one aspect of the embedded historical framing of different kinds of groups over time, the “social construction of target populations.” Both the power of specific types of

groups and the way that they are constructed and viewed are important in agenda setting and policy outcomes. Children, along with mothers, are in Schneider and Ingram's matrix "dependent groups"—positively constructed but politically weak. Such "dependent groups" may be offered symbolic policies that express concern but do not allocate resources (Schneider and Ingram 1993).

Children are positively constructed within US political culture because of both their vulnerability and their "innocence." In fact, David S. Gutterman argues that *children represent innocence* and shows that the rhetorical response to the 9/11 attacks often used children as a representation of the innocence of the whole nation (Gutterman 2002). Children are innocent in two important ways. First, they are malleable, as adults may not be. They are, in a sense, a "new frontier" where we as a society can begin again and succeed in solving our social problems. "It's easier to build successful children than repair men and women," said the governor of Kentucky and cochair of a National Governors Association (NGA) campaign on children's issues in 1986. Second, children are "innocent" because they have not made the choice to do things that the mainstream culture would consider antisocial—for example, taking illegal drugs or receiving public assistance. (The framing of children as both innocent and dependent on parental decisionmaking is the basis of "The Dream Act," which would have legalized the status of young adults brought to the United States as children by immigrant parents who were undocumented or overstayed their visas.) Even among those with an individualistic view of the origins of poverty and drug addiction, children can be seen as the innocent victims of the actions of adults.

Americans are and have been relatively comfortable supporting government-funded programs for children. A report done for the Democratic Party in 1987 found far more support for social and economic programs that benefited children than for those that assisted adults (Dionne 1987). Public opinion polls conducted between 1990 and 1995 found that majorities of respondents across demographic groups and ideological positions believed that children's health should be prioritized as a government effort. Polls conducted by First Focus in 2010 and 2011 found that large majorities of voters chose children's coverage as their priority for health coverage reform and children's programs as those most important to be protected from federal budget cuts.

Schneider and Ingram also relate the different social constructions of target populations to differing policy rationales. The rationales for

policy aimed at powerful, positively constructed groups discuss how fulfilling the needs of those groups will serve important public purposes such as national defense and economic competitiveness, whereas policies benefiting powerless groups are more likely to be justified using social justice-oriented rationales. During the 1980s and 1990s, appeals to social justice and morality were central in the rhetoric of Marian Wright Edelman, the founder of the Children's Defense Fund (CDF). Edelman and CDF, the oldest and most prominent children's advocacy organization, framed their appeals on behalf of public policies that would benefit children in religious and moral language that emphasized children's vulnerability (Marlow 1995). But interestingly, much of the framing used in arguing for the expansion of children's health insurance from the mid-1980s through 2009 was about the economic benefits that such a policy would produce. (CDF used this framing as well.) Such "economic" framing will be discussed at several points in my analysis of the framing of children's health insurance coverage in Chapters 2, 3, and 5.

Framing issues to evoke broadly shared US values was crucial to effective policy advocacy for children's health insurance. These values included the innocence of children, but also positive norms about work and family responsibility and negative values attached to cigarette manufacturers and smoking by youth. Ideological arguments about the boundaries of public health financing were also central to policy debates about children's health insurance because this issue was intertwined with the larger debate about universal health insurance coverage.

The Interview Process

This analysis is based on data from both archival material and interviews with policy actors. Archival data include newspaper and journal accounts, reports published by government agencies and nongovernmental organizations, congressional documents, and congressional office files. I have drawn on data from four different sets of interviews conducted at different points in time.

The first was a set of informant interviews with policy staff at several children's advocacy organizations conducted in the mid-1990s for a project describing the (then) child health policy community; the second was a series of interviews about the agenda-setting process for children's issues in the mid-1980s and the related legislative expansions of Medicaid eligibility for pregnant women and children during the latter

part of that decade. The third and fourth sets of interviews were about the policy processes that resulted in the creation of SCHIP in 1997 and the debate over its reauthorization and expansion in 2006–2009, respectively. Those interviewed were participants in some aspect of the policy process that I was investigating: administration officials, staff of public commissions, congressional committees, or interest groups. In several cases I interviewed different staff members working for the same congressional committee or the same not-for-profit organization (such as the American Academy of Pediatrics) at different points in time.⁶

A snowball sampling technique was used to assure that I had identified all of the key participants in each phase of each policy process. I began with a list of participants involved with each of these legislative events, based on archival material and a set of key informant interviews. I asked each interviewee at the end of each meeting who else they believed I should interview. After a certain number of interviews, I found the same names were being suggested by all of the interviewees. This was a confirmation of the policy community or policy network concept.

The interviews that I conducted were semistructured, with open-ended questions. I used two interview tools or questionnaires for each person interviewed. One was a general set of questions about the policy process that we were discussing; a second questionnaire was about the specific role of their organization, institution, or member of Congress in this process. Often those interviewed used the questions as a guide to telling her/his “own story” and sharing insight into the policy process.

All interviews were conducted in confidentiality, and all but two were tape-recorded with the permission of those interviewed. The questions were submitted to those interviewed in advance of our meeting. I informed all interviewees that I would use their institutional positions, rather than their names, in referencing them, and they agreed to this. The institutional positions that are identified are the positions that those interviewed occupied during the policy process that they were discussing and were not necessarily those occupied at the time that the interview took place. Congressional staff are identified by the part of Congress (House or Senate) and the political party of the member of Congress for whom they were working during the period that they were discussing with me, and by a number (Republican Senate staff #3; Democratic House staff #2). Since I conducted interviews with staff of some interest groups more than once, I have also assigned numbers to identify

different staff members working for the same group (CDF staff #3). Although all of those who worked for interest groups are identified as “staff,” some people had high-level positions in the organizations such as vice president for policy or policy director.

A brief note here about the abbreviations used in this book to refer to the children’s health insurance program: The State Children’s Health Insurance Program was created by federal legislation in August 1997. Twelve years later it was reauthorized by the Children’s Health Insurance Program Reauthorization Act of 2009. Prior to February 4, 2009, when this legislation was signed, the federal children’s health insurance program was usually referred to as SCHIP. Since reauthorization, it has been referred to as CHIP. I will use both SCHIP and CHIP, depending on whether I am discussing program and/or policy activity before or after February 2009.⁷

Boundary-Setting: The History of Federal Child Health Policy

The second part of this chapter will place the emergence of a policy community focused on the expansion of health care for children in the mid-1980s within a larger historical and ideological context. It will outline the politics of federal funding for maternal and child health programs from the early twentieth century through the 1970s.

From the Progressive Era, federally funded child health services were community-based and limited to preventive services such as immunization, parental education, and professional training, and to treatment for a few specified conditions. Children’s health advocates, including public health physicians, faced opposition from private providers to public services that would compete with private medicine.

Child Health Advocacy in the Progressive Era

One of the issues addressed by the social reformers of the Progressive period was the welfare of children, particularly poor children.⁸ Industrialization, migration, immigration, and urbanization produced high rates of infectious disease and death in infants and young children. Children worked in factories, lived in inadequate housing, and suffered from malnutrition (Black 1988; Wilson 1989). Diarrhea was a major cause of infant death, and one of the first efforts made to reduce infant mortality was the creation of infant milk stations to provide inexpensive sterilized

milk in urban working-class areas. In 1908 the New York City Bureau of Child Hygiene was established, the first in the nation. The bureau sent nurses to visit new babies and to teach their mothers how to care for them. It also provided health exams to children in the public schools (Halpern 1988; Wilson 1989). At the national level, activities that focused on child welfare included the first White House conference on children in 1908, the birth of the American Association for the Prevention of Infant Mortality in 1910, and the establishment of the US Children's Bureau in 1912 (Halpern 1988).

Most of the child health activists, in both private organizations and government agencies, were women. The League of Women Voters and the Women's Joint Congressional Committee worked with other activists for the passage of the Maternity and Infancy (Sheppard-Towner) Act of 1921, legislation that provided federal matching funds to states to establish prenatal and child health services. Opponents of the legislation included the American Medical Association (AMA), chiropractors, and those opposed to women's suffrage. During the debate, members of Congress made antifeminist remarks and the AMA labeled the act as "socialistic." Women's magazines were very supportive of the legislation, and the potential votes of newly enfranchised women were a major factor in its passage (Black 1988; Wilson 1989).

The Sheppard-Towner Act was the first federal grant-in-aid program in health care. Sheppard-Towner funds were used to establish 3,000 clinics where women physicians and public health nurses examined children and taught their mothers and older sisters (in "little mothers" classes) about infant care, nutrition, and childhood illness (Black 1988). The renewal of Sheppard-Towner (five years after enactment) was actively opposed by the AMA and the Catholic Church. Congress voted to extend the legislation for two years and then to repeal it (Wilson 1989).

Two aspects of child health advocacy in the first part of the twentieth century are noteworthy. First, women physicians who established maternal and child health programs incorporated the values of the female-dominated popular health movement of the nineteenth century by emphasizing the education of mothers, preventive services such as immunization and nutrition counseling, and work in the community, such as "family visitors."

Second, these health activists avoided direct competition with general practitioners by not providing treatment for illness (Black 1988). This was part of the general struggle between public health and academic physicians and private-practice physicians over the boundaries of

public and private medicine during the late nineteenth and early twentieth centuries. This “boundary-setting” also involved means testing, such as was imposed on urban dispensaries in New York State in 1899 (Sardell 1988: ch. 2). The belief that publicly funded medical care should only be provided to the very poor—those proven not to be able to pay for their care—was echoed in the debate over the expansion of SCHIP in 2007, particularly in the discussion of “crowd-out” (the substitution of public coverage for private insurance).

Pediatrics and the Child Welfare Movement

Pediatricians had a special relationship to the child health movement, which was quite different from that of most general practitioners and the AMA. Pediatrics began to develop as a specialty during the second half of the nineteenth century, primarily as a separate academic area.⁹ In contrast to other medical specialties, pediatrics defined itself as providing preventive and primary care and focusing on normal development rather than pathology. Pediatricians worked in the child welfare movement, providing it with greater legitimacy and using it to support their demands for the recognition of pediatrics as a unique medical specialty (see Halpern 1988). Yet by the 1930s, the majority of pediatricians were in private practice, providing services primarily to children in middle-class families.

The child health clinics established in the 1920s offered “well-baby conferences” during which health professionals evaluated children’s development and advised mothers on many aspects of child rearing. Such services were promoted by the Children’s Bureau and national child health organizations, and a demand for them was generated among middle-class as well as working-class mothers. In response, one group of pediatricians campaigned to restrict the use of clinics to families unable to pay for private pediatric care (Halpern 1988). A specialty that was nurtured by a social movement to improve the health of poor mothers and children was privatized.¹⁰

The Depression and World War II

The Sheppard-Towner Act expired just as the Depression began, and states were unable to provide maternal and child health care (Wilson 1989). While proposals for universal health insurance were excluded from the Roosevelt administration’s draft of the Social Security bill because of the opposition of the AMA (Stevens 1971: 188, 190), Sheppard-Towner

was reborn as Title V of the Social Security Act of 1935. Title V was to be administered by the Children's Bureau¹¹ and included funds for maternal and child health services and for identifying and treating conditions that could result in crippling.

Until the beginning of World War II, Title V primarily funded programs for planning, training, and preventive health projects. Little direct medical care was provided, again in observation of the boundaries between public and private medicine. However, during World War II, the Children's Bureau administered a separate program of prenatal and obstetrical care for the wives of servicemen, the Emergency Maternity and Infant Care Program. This was the largest tax-supported medical care program ever funded solely by the federal government (Wilson 1989). Opposition to the expansion of publicly funded medical care was deflected by labeling it as an emergency program and by limiting it to the wives of servicemen in the lowest pay grades. One and a half million women received care under the Emergency Maternity and Infant Care Program, and although maternal and child health programs were again limited to preventive health services after 1949, a precedent had been established for providing federally funded prenatal, obstetrical, and postpartum care (Davis and Schoen 1978; Marieskind 1980).

The Expansion of Child Health Services During the 1960s

During the 1960s, when the role of the federal government in social policy was broadened, low-income women and children became the beneficiaries of more extensive health-care financing and services. In 1965, Medicaid was enacted along with Medicare. Medicaid provided federal funds to the states on a cost-sharing basis to pay for medical services to the poor, primarily provided by the private sector. Medicaid became the major source of public funding for children's health services.

As early as 1966, the Department of Health, Education, and Welfare (DHEW) proposed that state Medicaid agencies take direct responsibility for the provision of preventive health services to low-income families, a responsibility not being fulfilled by private practitioners. This proposal became the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program enacted by Congress as part of the Social Security Amendments of 1967. States were required to screen all Medicaid-eligible children for potentially handicapping conditions and then to arrange treatment. Advocates for the EPSDT program hoped that the program would be structured to bring together all children's health services (Goggin 1987), but this was not done.

In 1965, as part of the War on Poverty, the federal government funded a small demonstration project to establish neighborhood health centers with the goal of increasing access to health care and providing a model of comprehensive, community-oriented care. In 1975, these programs received their own separate legislative authority as community health centers (CHCs), but in the same year DHEW shifted funding from a small number of comprehensive centers based on a social medicine model to a larger number of more traditional medical projects. The number of community health centers in medically underserved areas was increased during the Carter administration, and later greatly expanded by both the administration of George W. Bush and the first Obama administration. Most of those served by CHCs are women and children (Sardell 1988, 2012). Also during the 1960s, Congress created a program to fund family planning services and the Women, Infants, and Children program (WIC), which provided nutritious food and nutrition counseling to pregnant and lactating women and children up to age five. Studies indicated that these programs successfully increased access to care for low-income pregnant women and children and helped to reduce mortality and morbidity among children (Starfield 1985).

Retrenchment in Federal Spending for Maternal and Child Services

While the first ten years of the Medicaid program saw expansion in eligibility and benefits, the second decade was, particularly for children's health services, a period of retrenchment. During the latter part of the 1970s, inflation rates were almost as high as increases in program expenditures, so the actual availability of services expanded only slightly. Beginning in 1972, there was a shift within Medicaid away from spending on health services for nondisabled children as a higher proportion of Medicaid funds went to pay for services for the aged, blind, and disabled. In 1972, 18 percent of all Medicaid expenditures paid for services for nondisabled children under 21; in 1987, the proportion was 13 percent (Obergh and Polich 1988).

In the early part of the 1980s, both Medicaid funding and funding for federal grant programs in maternal and child health were cut as part of the Reagan administration's efforts to cut spending on domestic social programs. These cuts threatened the gains made in maternal and child health and stimulated a new focus on children's issues during the 1980s. New children's health advocates emerged, and new policy argu-

ments were made about the morality and cost-effectiveness of the expansion of government funding for children's health services. These events are described in Chapter 2.

Notes

1. This has changed as the intense ideological polarization in Washington has made other program reauthorizations controversial. A case in point is the conflict over the reauthorization of the Violence Against Women Act, another program whose targets—physically and sexually abused individuals—would appear to be universally sympathetic. (See Weisman 2013.)

2. In their books, David Smith, Laura Olson, and Frank Thompson also discuss the enactment and implementation of SCHIP.

3. Oliver and Paul-Shaheen (1997) use their empirical work on comprehensive health-care reform in the states to illustrate a model of policy entrepreneurship that conceptualizes the set of activities in which successful policy entrepreneurs engage as parallel to those of entrepreneurs in a corporate environment. Thus, recruiting others from in or outside of government to work with them as “investors” is necessary, as is gathering broader support from policymakers, interest groups, or the interested public by framing the issue in ways that will attract support (“marketing”).

4. Historically, such groups have been linked to other reform movements, such as the Progressive movement and the women's movement (Skocpol 1992; Imig 2001).

5. In part because scholarly work on this concept is done from several different disciplines including sociology, mass communication, and political science, there is no agreement on a general definition of framing (Schaffner and Sellers 2010).

6. I conducted twenty-seven interviews (between October 1998 and June 1999) with policy actors who participated in or observed the creation of SCHIP: sixteen Senate and House committee staff, ten interest group officials or staff, and one member of the Clinton White House staff. Between November 2000 and August 2001, I did twenty interviews—seven with congressional staff members, three with staff of government commissions, and ten with officials and staff of interest group or advocacy organizations—about efforts to expand Medicaid eligibility to pregnant women and children. (Three of these were phone interviews and were conducted jointly with Kay A. Johnson, the co-investigator of a project analyzing several different child health policy issues, and funded by the Robert Wood Johnson Foundation Investigator Award in Health Policy Research from 1999 to 2003). In October and December 2010, I interviewed three Senate staff members and the staff of five interest or advocacy organizations active on the issue of reauthorizing SCHIP. All of the in-person interviews were conducted in Washington, DC.

7. States have their own names for the children's health insurance programs that receive funding through the federal program: for example, Dr. Dyna-

sur in Vermont, Husky Health in Connecticut, NewMexikids and NewMexi-Teens in New Mexico.

8. This historical discussion is reproduced from my article, "Child Health Policy in the U.S.: The Paradox of Consensus" (1990) by permission of the *Journal of Health Politics, Policy and Law* in which it appeared. It was updated and appeared in *Health Policy and the Disadvantaged*, edited by Lawrence D. Brown (Durham, NC: Duke University Press, 1991).

9. A section on diseases of children was created by the AMA in 1879; the American Pediatric Society was created in 1888 (Wilson 1989).

10. Pediatricians, however, continued to be active on social policy issues. During the 1930s, (male) pediatricians replaced feminist political activists in policy positions in government and private sector organizations concerned with children's health (Black 1988).

11. The Children's Bureau had originally been located in the Department of Labor, but was transferred to the Federal Security Agency in 1946. That agency became the Department of Health, Education, and Welfare (DHEW) in 1953. In 1967, the Children's Bureau lost most of its programs to other bureaus in DHEW. Title V came under the jurisdiction of the Public Health Service (Wilson 1989). In 1980, DHEW became the Department of Health and Human Services (DHHS) after the creation of the Department of Education in 1979.