



Does Congress' bipartisan SCHIP bill move towards a federal government take-over of the country's health care system?

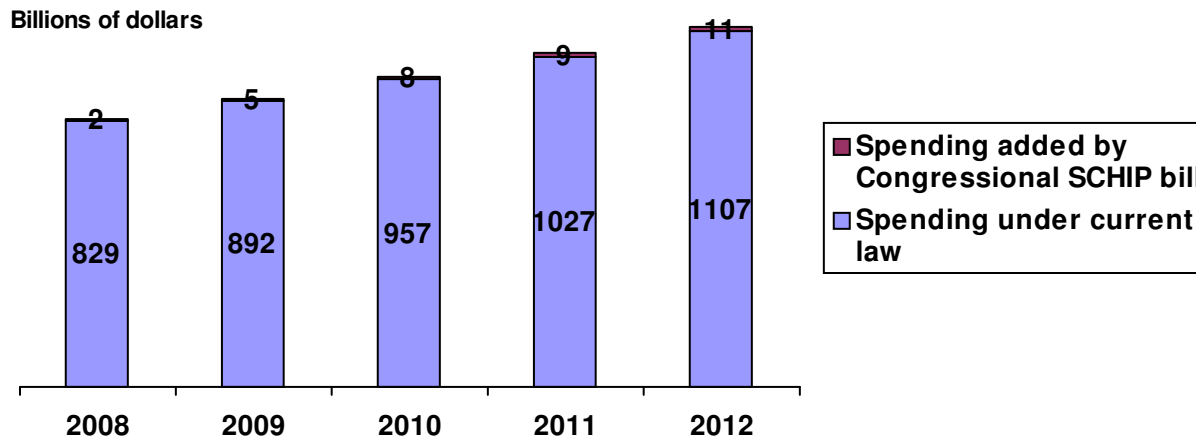
As the battle between President Bush and Congress persists over legislation to provide health coverage for low-income children, the debate continues to raise serious questions about the role of government, income eligibility requirements, and the impact of the Children's Health Insurance Program Reauthorization Act (CHIPRA) on private sector coverage. This issue brief tries to identify the facts about each of these issues.

Does CHIPRA dangerously expand government's role?

In vetoing CHIPRA earlier this month, President Bush continued to argue that the legislation was “an incremental step” toward the “goal of government-run health care for every American.”¹ Others likewise describe the legislation as a “chip off the old, socialized-medicine block.”² A wide body of research-based data confirm that these claims are inaccurate. Here are the facts:

- ***SCHIP uses the private sector to deliver care.*** Most SCHIP children receive coverage through private health plans³ and obtain care from private physicians.⁴
- ***SCHIP is not a federal entitlement.*** Unlike Medicare and Medicaid, SCHIP is a capped federal block grant,⁵ without any individual entitlement.⁶
- ***SCHIP benefits are modeled after the private sector, without rigid federal requirements.*** Unlike Medicare and Medicaid, SCHIP has no federally-specified benefits package.⁷ Covered benefits are frequently modeled after standard commercial policies.⁸
- ***SCHIP promotes freedom of choice.*** Unlike employer-based coverage, which frequently offers workers a single insurance policy, without any coverage options,⁹ SCHIP generally allows families to choose from among multiple, competing private health plans.¹⁰ CHIPRA would expand those options since, for the first time, states would gain the flexibility to permit parents to use SCHIP dollars to enroll their children in dependent coverage at work.
- ***CHIPRA would have a trivial effect on total government health care spending.*** CHIPRA would increase federal health care spending by seven-tenths of 1 percent¹¹ – hardly a massive expansion (Figure 1).

Figure 1. Projected federal health care spending under current law and spending added by CHIPRA: 2008-2012



Source: CBO, 2007; CMS, 2007.

Will CHIPRA erode employer-based coverage?

According to the President, one reason for his veto was that, under the Congressional bill, “millions of children would move out of private health insurance and onto a government program.”¹² In the words of one former White House aide, the legislation would have “huge impacts on private health insurance markets” with “incentives for businesses to accelerate the trend of dropping private health coverage”¹³ – so-called “crowd-out.”

In fact, crowd-out is combated more effectively by CHIPRA than by the current statute,¹⁴ because of two elements in the Congressional bill:

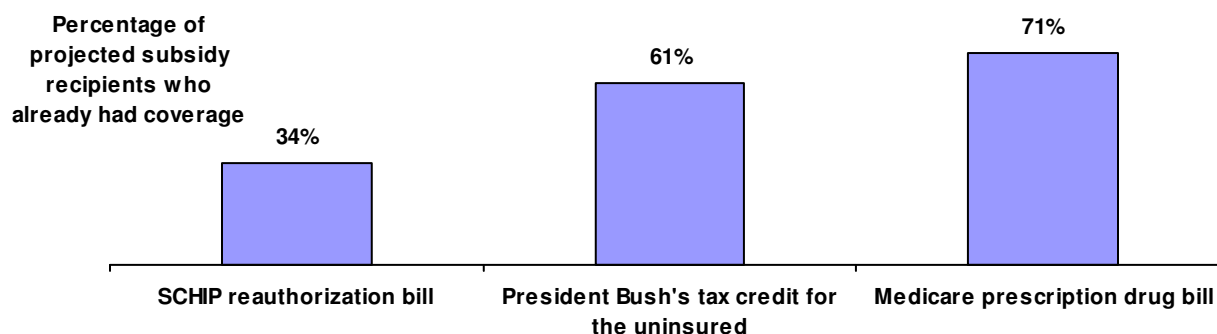
- ***New duties to prevent crowd-out.*** The current SCHIP statute does not limit states’ discretion in this area, other than to say that each state must say what it is doing to prevent crowd-out.¹⁵ Some states do nothing more than monitor whether crowd-out occurs.¹⁶ By contrast, when fully phased in, CHIPRA requires states that exceed 300 percent of FPL to implement HHS-specified best practices for crowd-out prevention.¹⁷
- ***New tools to prevent crowd-out.*** Federal law now makes it difficult to use SCHIP to help families enroll in employer-sponsored dependent coverage.¹⁸ CHIPRA gives states substantial new authority to use SCHIP dollars to pay the cost of dependent coverage at work, thus strengthening rather than displacing employer-based, private insurance.¹⁹

Crowd-out levels under the SCHIP proposal are much lower than under earlier health coverage proposals from the Bush Administration, including legislation supported by members of Congress who now oppose CHIPRA. As noted by one leading conservative thinker, some crowd-out is inevitable with “*any* proposal to help the uninsured.”²⁰ But crowd-out is more modest with the SCHIP bill than earlier policies (Figure 2).

- 34 percent of the 5.8 million children newly covered under the Congressional proposal would otherwise have received private coverage, according to the Congressional Budget Office (CBO).²¹

- The President’s budget for FY 2003 proposed health insurance tax credits to cover uninsured, low-income families. According to the Administration’s own estimates, 61 percent of credit beneficiaries would otherwise have had private coverage.²²
- Based on CBO estimates, approximately 71 percent of Medicare beneficiaries receiving prescription drug coverage under the Medicare Modernization Act of 2003 would have had such coverage, even in the absence of legislation.²³

Figure 2. Crowd-out under CHIPRA is substantially lower than under earlier coverage expansion proposals



Sources: CBO, 2002, 2004, 2007; U.S. Treasury Department, 2002.

Does the SCHIP bill focus on relatively high income children?

The President argues that the Congressional proposal “expands coverage, federal coverage up to families earning \$83,000 a year.”²⁴ Others suggest that, as a result, “government coverage of children becomes an entitlement for all but the wealthiest of citizens.”²⁵ In fact, the SCHIP bill limits rather than expands coverage of higher income children.

The current statute permits states to extend SCHIP to any desired income level – but most children have low incomes. Because states must pay their share of SCHIP costs, no state has ever reached \$83,000 a year for a family of four, or 400 percent FPL. Only New Jersey exceeds 300 percent FPL, going to 350 percent.²⁶ Only New York has even proposed covering children up to the 400 percent FPL level referenced by the President. Altogether, 92 percent of SCHIP children have incomes below 200 percent FPL.²⁷

For the first time, the Congressional proposal imposes statutory limits on states’ ability to cover higher-income children above 300 percent FPL, or \$62,000 for a family of four.

- ***Enhanced SCHIP federal matching funds are longer be available above 300 percent FPL***, except for New Jersey and New York, which the legislation “grandfathers in.” For the other 48 states, only the lower, Medicaid matching rate is available.²⁸
- ***Crowd-out prevention is required.*** When the bill is phased in, no state – including the two “grandfathered” states – may receive any federal funds for children above 300 percent FPL unless the state implements HHS-specified “best practices” to prevent SCHIP from “crowding out” employer-based coverage, as noted above.
- ***Low-income children must be covered first.*** When phased-in, the bill forbids going above 300 percent FPL except for states that already reach or exceed very high levels of coverage for poor and near-poor children.²⁹

CHIPRA gives states powerful incentives to focus on low-income children. New incentive payments are limited to children who qualified under prior law, and the largest incentives apply to the poorest children.³⁰

Most children reached by the bill are low income. Because of the above-described features of the legislation, CBO found that 74 percent of children newly receiving coverage would already qualify under current law;³¹ two-thirds of the states cap SCHIP eligibility at 200 percent FPL or less.³² As a result, 7 out of 10 children newly receiving coverage would have incomes at or below 200 percent of FPL,³³ and fully 99.5 percent would have incomes below 300 percent FPL.³⁴

Conclusion

Both the President and his allies who oppose CHIPRA say that they support the goal of the SCHIP program but want to avoid three problems: laying the groundwork for socialized medicine; crowding-out private coverage; and helping high-income rather than low-income. In truth, CHIPRA does none of these things. Moreover, CHIPRA makes these concerns a lower risk than they are under the existing SCHIP statute. CHIPRA would strengthen this bipartisan and cost-effective program with an impressive record of success, ensuring that low-income children do not go without health care because their families are unable to afford coverage. The characterizations of CHIPRA made by the legislation's opponents are clearly inaccurate.

¹ President's Radio Address, October 6, 2007, available at <http://www.whitehouse.gov/news/releases/2007/10/20071006.html>.

² U.S. Rep. Steve King (R-IA), "SCHIP expansion: One step closer to socialized health care," *Des Moines Register*, September 27, 2007.

³ In 2005, among the 50 states implementing SCHIP, only 3 states provided just Medicare-style, fee-for-service coverage. 38 states (including DC) offered private HMO coverage (in most cases, along with other modes of coverage); 5 states provided coverage through primary care case managers (in some states, along with other modes of coverage); and 4 states used other private contractors to deliver services. N. Kaye, et al., *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*, National Academy for State Health Policy, September 2006; CMS, *Medicaid Managed Care Enrollment Report as of June 30, 2005*.

⁴ A survey conducted by the American Academy of Pediatrics found that 89.2 percent and 88.6 percent of pediatricians participated in Medicaid and SCHIP, respectively, with 67.2 percent and 68.9 percent accepting, without restrictions, new patients covered by these programs. B.K. Yudkowsky, S.S. Tang, A. M. Siston, *Pediatrician Participation in Medicaid/SCHIP, Survey of Fellows of the American Academy of Pediatrics, 2000*. Even for Medicaid coverage of both children and adults, 69.5 percent of all physician care (measured by dollar of reimbursement) is provided in solo or group practices or HMOs, entirely outside institutional settings such as community health centers, academic medical centers, and hospitals. P. Cunningham and J. May, *Medicaid Patients Increasingly Concentrated Among Physicians*, Center for Studying Health System Change, August 2006.

⁵ The specific amounts for 2008-2012 are set forth in Section 101 of the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA), the Congressional bill reauthorizing SCHIP.

⁶ 42 USC 1397bb(b)(4).

⁷ 42 Code of Federal Regulations Part 457, Subpart D. The only required services are well-child and well-baby care, emergency service, and immunizations. Section 501 of CHIPRA would add dental care to the list.

⁸ That was the finding of an analysis of several case study states, prepared as part of the Congressionally mandated evaluation of SCHIP. J. Wooldridge, I. Hill, M. Harrington, G. Kenney, C. Hawkes, and J. Haley, *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program*, prepared by Mathematica Policy Research, Inc., and The Urban Institute for HHS, Assistant Secretary for Planning and Evaluation, February 26, 2003. Moreover, the actuarial value benchmarks that SCHIP coverage is required to meet are expressly based on employer-sponsored insurance. 42 USC 1397cc(b).

⁹ In 2005, only 30.5 percent of private firms offered their workers a choice between two or more health plans. At the same time, 56.3 of private employees worked for companies offering such a choice. The explanation for these

apparently contradictory numbers is that a large number of employees work for a relatively small number of very large companies that offer health insurance choices to their workers. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, Tables I.A.2.d and I.B.2.c, *2005 Medical Expenditure Panel Survey-Insurance Component*, available at

http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2005/tia2d.pdf and http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2005/tib2c.pdf.

¹⁰ Woolridge, et al., op cit. Supplementing this case study report, a national survey found that, for comprehensive benefit plans, only 8 percent of states implementing SCHIP via Medicaid expansion and 20 percent of those using separate SCHIP programs contracted with just one plan per geographic area; the rest contracted with competing plans. Kaye, et al., op cit.

¹¹ CBO projects that CHIRLA would increase annual federal spending by an average of \$7 billion between FY 2008 and 2012. During that same period, CMS projects that federal health spending will average \$962 billion. CMS, Office of the Actuary, *National Health Expenditure Projections 2006-2016*, February 2007, calculations by S. Dorn, October 2007.

¹² President's Radio Address, op cit.

¹³ Noam Neusner, "Anecdotes Won't Keep America's Kids Healthy," *The Jewish Daily Forward*, October 3, 2007.

¹⁴ It is true that the CMS policy announced in August imposed new anti-crowd out requirements and new limits on coverage of higher-income children, neither of which is found in the SCHIP statute. CMS, *Dear State Health Official letter*, SHO #07-001, August 17, 2007. However, it is not clear whether this policy, which represents a major departure from prior law, will withstand the two lawsuits that have been filed by more than half a dozen states.

¹⁵ 42 U.S.C. 1397bb(b)(3)(C).

¹⁶ N. Kaye, et al., op cit.

¹⁷ CHIPRA, Sec. 116.

¹⁸ The requirements for premium assistance under current law are described at 42 Code of Federal Regulations 457.810.

¹⁹ CHIPRA, Title III.

²⁰ *Statement of Stuart Butler, Ph.D., Vice President, Domestic and Economic Policy Studies, Heritage Foundation*, Testimony Before the House Committee on Ways and Means, Hearing on Health Care Tax Credits to Decrease the Number of Uninsured, February 13, 2002, available at

<http://waysandmeans.house.gov/legacy.asp?file=legacy/fullcomm/107cong/2-13-02/2-13butl.htm>.

²¹ CBO, op cit.

²² According to Assistant Treasury Secretary Weinberger, "15.5 million would receive the credit. Six million of these individuals would have been uninsured for at least part of the year." *Health Care Tax Credits To Decrease The Number Of Uninsured*, Hearing Before The House Committee On Ways And Means, February 13, 2002, available at <http://waysandmeans.house.gov/legacy.asp?file=legacy/fullcomm/107cong/2-13-02/107-58final.htm>.

²³ CBO estimated that MMA would cover prescription drugs for 87 percent of Medicare beneficiaries. CBO, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004. Approximately 25 percent of Medicare beneficiaries lacked prescription drug coverage before enactment of MMA, according to an earlier CBO analysis on which CBO's cost estimate relied. CBO, *Issues in Designing a Prescription Drug Benefit for Medicare*, October 2002.

²⁴ Office of the White House Press Secretary, *President Bush Visits Lancaster Chamber of Commerce and Industry, Discusses S-CHIP*, October 3, 2007, available at <http://www.whitehouse.gov/news/releases/2007/10/20071003-3.html>.

²⁵ "Override overdrive: SCHIP debate bypasses key question," *The Oklahoman*, Editorial, October 10, 2007.

²⁶ D. Cohen Ross, L. Cox, and C. Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*, Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured, January 2007.

²⁷ Peterson, C. and E. Herz, *Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees*, Congressional Research Service, March 13, 2007.

²⁸ CHIPRA, Sec. 114.

²⁹ Beginning in FY 2011, such a state would be required to reach at least the level of coverage for low-income children achieved by the 10th best state as of January 1, 2010. However, a state that falls short can nevertheless

cover higher-income children if the state submits a corrective action plan that, according to CMS, has a reasonable likelihood of reaching the required coverage level for low-income children. CHIPRA, Sec. 116(e).

³⁰ CHIPRA, Sec. 104.

³¹ CBO, *Cost Estimate for H.R. 976, Children's Health Insurance Program Reauthorization Act of 2007*, September 25, 2007, calculations by S. Dorn, October 2007.

³² Cohen Ross, et al., *op cit*.

³³ G.M. Kenney, A. Cook, J. Pelletier, *How Will Low-Income Kids Benefit under House and Senate Bills?* The Urban Institute, September 17, 2007.

³⁴ The latter represents the proportion of SCHIP children, under current law, with incomes above 300 percent FPL. J. Guyer, *Coverage of Uninsured Children in Moderate-Income Families Under SCHIP*, Center for Children and Families, Georgetown University Health Policy Institute, October 2007. That proportion would increase under CHIPLA, since the bulk of new enrollees would be children who qualify under current law, and CMS would retain the authority to deny New York's request to cover children up to 400 percent FPL. Letter from Finance Committee Ranking Member Grassley and Finance Committee Member Roberts to the Honorable Michael O. Leavitt, October 15, 2007.