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The House SCHIP Bill: Cutting Medicare, Undercutting Private Coverage, and Expanding Dependency

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Congress is debating the future health care of millions of Americans, and its decisions will affect families and children, Medicare beneficiaries, and taxpayers for years to come. The 465-page bill favored by House leadership, The Children's Health and Medicare Protection Act (H.R. 3162), greatly expands dependency of millions of Americans on government health care, undermines private health plans, reduces choice for Medicare beneficiaries, and saddles taxpayers with a permanent new entitlement.

The pretext for this massive legislative effort is the need to reauthorize the State Children's Health Insurance Program (SCHIP) by September 30, 2007. The program covers about 6.7 million children whose families are low-income but not poor enough to qualify for Medicaid.[1]

Instead of expanding government dependency, Congress should stake out an entirely different policy. SCHIP reauthorization should restore the original intent of the law by reaffirming sensible age and income eligibility parameters. Beyond that, Congress should take decisive steps to address the barriers to affordability, namely the unfair, regressive, and inequitable tax treatment of health insurance and its impact on access to affordable coverage for millions of Americans. Finally, Congress should not deny seniors the opportunity to pick the plans of their choice in the Medicare Advantage program or cause millions of seniors to lose their Medicare Advantage coverage.

What the House Bill Does:

Crowds Out Private Health Coverage. The House bill undermines private insurance. Rather than designing subsidies in an innovative way to encourage private health insurance among families, the bill's sponsors displace it. Recent studies indicate that people with private insurance will likely drop eligible dependents in favor of welfare-style health coverage—a phenomenon economists refer to as "crowd out." According to CBO estimates, the House bill would move nearly 1.9 million people off private insurance and onto taxpayer-supported health care.[2]

The legislation embodies a bias against private health coverage and in favor of government coverage. For example, in addition to regular SCHIP payments, the bill would offer "bonus payments" to states for SCHIP and Medicaid enrollment *over* specified "baseline" levels. As enrollment above designated levels increases, the bonuses get exponentially larger.[3] These bonus payments are conditioned upon the states' implementing several provisions, each designed to maximize and expedite enrollment above the baseline. The inclusion of

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such conditions, of course, would encourage state officials to actively seek and enroll persons in the government-health programs, regardless of current insurance status.[4]

Expands Government Health Coverage to Middle-Income Adults and Fosters Greater Dependency on Government. The authors of the House bill repudiate the original intent of the program: SCHIP is no longer limited to low-income persons or to children. House sponsors achieve this expansion by simply redefining both "low-income" and "children." Under the bill, eligibility for government coverage would be extended to families with incomes up to 400 percent above the federal poverty level (FPL)—$82,600 for a family of four—hardly considered low-income by any reasonable standard. The House policy is transparently absurd: 89 percent of all children between 300 percent and 400 percent of the FPL are enrolled in private health insurance; 77 percent of all children between 200 percent and 300 percent of the FPL are enrolled in private health insurance; and 50 percent of all children between 100 percent and 200 percent of the FPL are enrolled in private health insurance.[5]

As another attempt to expand welfare dependency, the House bill would allow persons up to age 21 to be recognized as "children" for purposes of the law. Under certain provisions, program funds may be used to cover non-pregnant, childless adults.[6]

Devastates Medicare Beneficiaries' Freedom of Choice. Currently all Medicare beneficiaries are free to enroll in Medicare Advantage, the program of private health plans created under the Medicare Modernization Act of 2003. The new Medicare program serves more than 8.3 million seniors; the majority of its enrolless are the urban poor, seniors in rural areas of the country, and minorities.[7] The Medicare Advantage program provides this diverse population of seniors with additional health benefits beyond those available in the traditional Medicare package, including better access to specialized health care and care management, lower cost-sharing, more preventative services, and prescription drugs. Ninety-five percent of seniors in the program report no difficulty in getting the care they need.[8]

A key achievement of the Medicare Advantage program is better care management through enhanced coordination of care for patients with chronic illnesses. Given the rapid increase in incidents of chronic disease nationwide, such as diabetes, it is remarkable that Members of the House of Representatives would insist on adopting provisions

1. CBO, "Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program," February 23, 2007, at *www.cbo.gov/budget/factsheets/2007b/schip.pdf.*
2. Congressional Budget Office, "Estimated of Changes in SCHIP and Medicaid Enrollment of Children Under H. R. 3162, the Children's Health and Medicare Protection Act of 2007, as Ordered Reported by the Committee on Ways and Means on July 27, 2007," July 27, 2007, at *www.cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf.*
3. The performance bonus for the first tier above baseline Medicaid enrollment is an amount equal to the number of enrollees multiplied by 35 percent; if enrollment reaches the second tier, the bonus percentage jumps to 90 percent. Performance bonus percentages for first and second tier SCHIP enrollment are 5 percent and 75 percent, respectively.
4. See Title I, Sect. 111. Bonus payments are awarded for Medicaid and SCHIP enrollment above the established baseline. In order to qualify for bonus payments, states must implement some combination of four of the following specified criteria: continuous eligibility, "liberalization of asset requirements," elimination of the in-person interview requirement, use of a joint application for Medicaid and CHIP, use of automatic administrative renewal, presumptive eligibility, and/or implementation of an administrative "Express Lane."
5. See page 12 of Congressional Budget Office, "The State Children's Health Insurance Program," Pub. No. 2970, May 2007, at *www.cbo.gov/ftdocs/80xx/doc8092105-10-schip.pdf.*
6. See Title I, Sect. 111 "but is under 19 years of age (or, at the option of a State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age, not to exceed 25 years of age, as the State may elect)." Subsequent action amended the language lowering the eligibility limit to age 21.
7. Centers for Medicare and Medicaid Services, "Medicare Advantage in 2007," April 20, 2007, at *www.cms.hhs.gov/hillnotifications/downloads/MedicareAdvantagein2007.pdf.*
8. *Ibid*, p.16.

that would directly undercut a program focused on this growing problem, especially among vulnerable and low-income senior populations.

The House bill would devastate the Medicare Advantage program, cutting the projected enrollment in half by 2012. The bill's sponsors propose to partially finance their broader legislative agenda of government expansion by "equalizing" payments between Medicare Advantage plans and the traditional fee-for-service Medicare, even though Medicare Advantage plans have richer benefit offerings. The latest estimates from the CBO indicate that such "equalization" would amount to about $50 billion in cuts over the next five years and $157 billion through 2017.[9] Lowering costs in this way would directly hurt seniors by depriving them of the benefits they have chosen. The vast majority of that reduction "would be reflected as reduced benefits or increased costs to the plan's participants."[10] The CBO further indicates that such measures would render Medicare Advantage less attractive to seniors, encourage a number of them to return to the traditional Medicare fee-for-service program, and discourage enrollment by otherwise potential participants.

Creates Another Permanent Program. Unlike the original SCHIP legislation, the House bill requires no future reauthorization, thereby transforming it into a permanent government program. Moreover, the bill would change SCHIP from its current block grant status to the equivalent of a full-blown entitlement. Instead of allotting specific, designated, formula-determined block funding to the states, H.R. 3162 provides an escalating allotment that increases as government coverage is expanded and enrollment increases. As Secretary of Health and Human Services Michael Leavitt warned, "Now is not the time to be adding to these massive unfunded liabilities by taking a program that is working and turning it into a program with excessive Federal funding."[11]

Increases Government Spending. The CBO estimates that the House bill, if enacted, would effect a major change in direct government spending of more than $58 billion over 10 years.[12] In order to secure part of that funding, the House sponsors would impose a substantial increase in the per-pack cigarette tax. Using the tobacco tax as a funding source may be politically popular, but economic research indicates it is regressive, insufficient, and unsustainable as a reliable, long-term financing option.[13]

As noted, financing the House bill would also mean reductions in Medicare, focused mainly on those health plans that provide care management. More than 75 percent of Medicare's high-cost beneficiaries have one or more chronic conditions. Currently, the Medicare Advantage program alone promotes highly coordinated care—by far the most efficient and effective means whereby those with chronic conditions can be treated.[14] In the absence of such coordinated care (currently delivered through integrated and efficient private health plans) patients are relegated to inconsistent, piecemeal medical treatment under the old-fashioned

9. Congressional Budget Office, "Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, for the Rules Committee, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007," July 27, 2007, at *www.cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf*.

10. Congressional Budget Office, "Medicare Advantage: Private Health Plans in Medicare," *Economic and Budget Issue Brief*, June 28. 2007, at *www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf*.

11. Letter from Michael O. Leavitt, Secretary of Health and Human Services, to Rep. Charles B. Rangel (D-), Chairman of the Committee on Ways and Means, U.S. House of Representatives, July 26, 2007, p. 1 (enclosure).

12. Congressional Budget Office, "Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007," July 27, 2007, at *www.cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf*.

13. See page 1 of Michelle C. Bucci and William W. Beach, "22 Million New Smokers Needed: Funding SCHIP Expansion with a Tobacco Tax," Heritage Foundation *WebMemo* No.1548, July 11, 2007, at *www.heritage.org/Research/HealthCare/upload/wm_1548.pdf*.

14. Centers for Medicare and Medicaid Services, "Medicare Advantage in 2007," April 20, 2007, at *www.cms.hhs.gov/hillnotifications/downloads/MedicareAdvantagein2007.pdf*.

Medicare fee-for-service system—a relic of a bygone era of health care delivery.

Finally, the House sponsors propose to eliminate an early warning system for entitlement spending, adopted by Congress in 2003, that would set in motion presidential and congressional actions to cope with the rapidly rising cost of the Medicare entitlement. The future costs of the Medicare entitlement, its share of overall federal spending, and its impact on other budget priorities are national problems widely recognized by liberal and conservative analysts alike as an even greater challenge than that posed by Social Security. Nonetheless, the House sponsors would repeal the so-called Medicare "trigger," which signals that 45 percent of total Medicare spending in specified periods is being financed, not by premiums or dedicated revenues, but by transfers of general revenues. Under current law, the "trigger" requires a Presidential submission of a plan for action, and expedited congressional procedure to cope with skyrocketing Medicare spending.

What Congress Should Do. H.R. 3162 goes well beyond facilitating access to health coverage for low-income children. Rather, it encourges states to game the system by rewarding—with federal taxpayers' dollars—state officials for aggressively enrolling persons in public programs. The bill expands eligibility for assistance far up the income scale—to $82,600 per year—and crowds out private health coverage. Congress should restore SCHIP to its original purpose by focusing assistance on the neediest children who lack another source of health insurance. Beyond that, Congress should pursue very different policies:

1. Facilitate affordability and individual choice in the private markets. To borrow a phrase from the medical milieu, Congress should treat the disease, not the symptom. Congress should address the root issues plaguing health care coverage by focusing on the way families and individuals pay for coverage.

Studies indicate that most uninsured workers who decline coverage cite high costs as the primary reason.[15] These persons need help. Rather than shepherding middle-income and even upper-middle-income families onto the equivalent of a federal welfare program, Congress should provide direct tax relief to individuals and families—o r refundable tax credit or vouchers to low-income families—enabling them to choose the type of coverage that best suits their needs. Congress should also allow the states to use SCHIP funds to enhance premium assistance for low-income families; moreover, Congress should dispense with the regulatory obstacles that limit the effectiveness of such assistance. Finally, Congress should support innovative efforts to reform health insurance markets already underway at the state level.

2. Preserve Seniors' Choice in Medicare. Medicare Advantage enrollees receive extra value for their health care dollar. CBO projections indicate that Medicare Advantage, if left intact by Congress, would experience an increase in health plan enrollment at an average annual rate of about 7 percent for the next decade.[16] Seniors like the program.

Medicare Advantage is a successful program that provides effective, efficient, coordinated care through a new system of private health plans. The House bill would jeopardize the critical care that these health plans provide, particularly to seniors who are vulnerable and those who are suffering with chronic diseases. Medicare Advantage should be preserved, not only for current seniors, but also for the next generation of seniors, the Baby Boomers.

Conclusion. The House SCHIP bill is a detailed legislative prescription for expanded government control over the financing and delivery of health care. If enacted, it would have a profoundly negative effect on millions of Americans for years to come. Running through the legislation are common objectives: the progressive reduction of personal choice in private health care alternatives, crowding out pri-

15. See page 4 of Nina Owcharenko and Robert E. Moffit, Ph.D., "Redesigning SCHIP to Strengthen Private Health Insurance for Working Families," Heritage Foundation *WebMemo* No. 1564, July 23, 2007, at *www.heritage.org/Research/HealthCare/upload/wm_1564.pdf*.

16. Congressional Budget Office, "Medicare Advantage: Private Health Plans in Medicare," *Economic and Budget Issue Brief*, June 28 2007, at *www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf*.

vate coverage among the young, and eliminating or reducing private health plans as viable options for the elderly and disabled in Medicare.

Beyond legislating massive spending, the authors of the bill also wish to eliminate existing legislative "early warnings" that require presidential and congressional action on Medicare's entitlement spending, even though there is a growing consensus among liberals and conservatives alike that the nation is ill served by official refusals to acknowledge the gravity of the entitlement challenge.

Increased dependency on government and metastasizing government control is not the remedy for the very real ills of the American health care system. Innovative tax and regulatory policies would bring about results that would dramatically increase family control over health care dollars. Robust competition would result and drive innovation and quality among health plans and providers. That is a far better policy than the plodding, unimaginative drive toward an inferior, bureaucratically controlled health care system, one 21-year-old child at a time.

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