

The Battle over SCHIP

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Reauthorization of the State Children's Health Insurance Program (SCHIP), which was considered a routine matter until recently because of the program's success in expanding coverage to

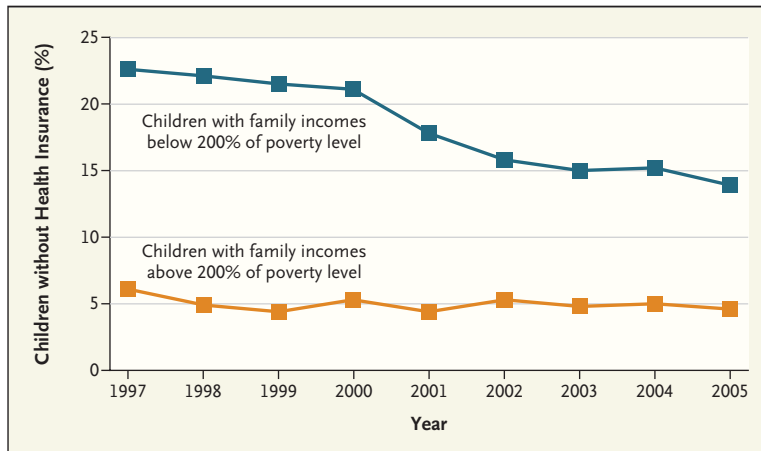
children of the working poor, has become embroiled in a larger struggle over ideologies that divide the political parties. The immediate battle to reauthorize SCHIP, for which the legal mandate expires on September 30, will resume this fall as Democrats, who command the House and Senate by slender margins, seek to stand up to President Bush, who has said he would veto the SCHIP bills approved by the two chambers because they authorize too much spending and go "too far in federalizing health care."

In the last days before Congress broke for its summer respite, the Senate defied Bush's threatened veto and underscored

the bipartisan popularity of SCHIP by reauthorizing the program for 5 years on a vote of 68 to 31. House Democrats approved a more expansive version by a vote of 225 to 204, but only 5 Republicans supported it. Because the House-approved bill would also repeal an impending reduction in Medicare payments to physicians, broaden prevention benefits to Medicare beneficiaries, and increase support for selected hospitals (as well as eliminate the higher Medicare payments to private plans, as compared with fee for service), it attracted the support of the American Medical Association and allied physician organizations, as well as the formidable elderly lob-

by (AARP). This support adds muscle to the efforts of Democrats to overcome the administration's opposition but also complicates the process.

SCHIP was created in 1997 as a bipartisan effort to provide insurance coverage for children living in families with too much income to qualify for Medicaid but not enough to afford private insurance (see line graph).¹ An estimated 91% of children who are insured by SCHIP come from families with incomes below 200% of the federal poverty level, or \$41,300 for a family of four in 2007. Before the enactment of SCHIP, only 11 states covered children in families with incomes of 185% of the poverty level or higher. By 2006, 42 states covered children with family incomes of 200% of the poverty level, including 7 states (in which the cost of living is particularly high) that



Percentage of Children without Health Insurance, According to Family Income Level (1997–2005).

Data are from Ku L. Medicaid: improving health, saving lives. Center on Budget and Policy Priorities analysis of National Health Interview Survey Data, August 2005.

set income thresholds for SCHIP eligibility at 300% of the poverty level. In recent letters that underscored the strong state support for SCHIP, 43 governors urged Bush and congressional leaders to come together on behalf of reauthorization of the program before its expiration date.

The administration countered with a new salvo that will affect states that seek to cover children with family incomes at 250% of the federal poverty level — \$51,625 for a family of four. Some 16 states had been granted federal approval to expand to or beyond that level. The new policy will require states to demonstrate that they have “enrolled at least 95% of children in the state below 200% of the federal poverty level” before accepting children with higher family incomes. No state currently even approaches that percentage of enrolled children with family incomes below 200% of poverty. The new policy was explained to state health officials in a letter released August 17 and signed by Dennis G. Smith, director of the federal Center for Med-

icaid and State Operations. Smith wrote that the administration will apply the policy to new applications from states that seek to expand their SCHIPs, and he expects states to adopt the policy within a year.

The Senate-approved bill or some variation thereof stands a far better chance of becoming law than does the House measure because it drew broad bipartisan support, is less expensive, and would outlaw the enrollment of additional poor adults, focusing most of the money on children in families with incomes of less than 200% of the poverty level. (The latter provision is favored by the administration.) Four senior senators, all of whom are members of the Senate Finance Committee, which has jurisdiction over SCHIP, are chief sponsors of the bill. Two are Democrats — Max Baucus of Montana, who chairs the Finance Committee, and Jay Rockefeller of West Virginia. The other two senators are Charles Grassley of Iowa, the committee’s ranking Republican, and Orrin Hatch (R-UT). The measure au-

thorizes new expenditures of \$35 billion over the next 5 years, which when added to the current annual expenditure of \$5 billion makes for a total of \$60 billion, enabling states to cover an estimated 3.2 million additional children and reducing by a third the number of uninsured children. In 2005, SCHIP provided coverage to 6.6 million children at one point or another during the year. The bill would be funded through an increase of 61 cents in the federal excise tax on cigarettes, raising that tax to \$1 per pack.

Despite entreaties to the president by Republican governors and senators, Bush declined to support the measure, asserting that the reauthorization of SCHIP at a substantially higher level of spending would “crowd out” private insurance in favor of public coverage and lead down a path to socialized medicine. In a strongly worded “statement of administration policy” released several days before the Senate vote, Bush said, “A competitive private market for health insurance is better policy than a government-run system that would mean lower quality, longer lines, and fewer options for patients and their doctors.” According to America’s Health Insurance Plans, however, more than 70% of children whose coverage is through SCHIP are part of private plans. Bush’s 2008 budget proposed the addition of only \$4.8 billion over the next 5 years, an amount that would fall well short of the monies needed to maintain the existing SCHIP case-loads.

A number of Republican senators were stunned by the seeming intransigence of Bush to support a bill that had been crafted carefully by senior legislators of

both parties and was destined to be approved by a large bipartisan margin. Reflecting this dismay, Senators Grassley and Hatch said in a joint news release dated July 12 that “it’s disappointing, even a little unbelievable, to hear talk about administration officials wanting a veto of a legislative proposal” that has drawn broad bipartisan support.

Grassley and Hatch urged Bush to abandon his efforts to link the renewal of SCHIP, a small program within a medical economy of more than \$2 trillion, to his 6-month-old proposal designed to transform the entire system of employer-based health insurance.² Bush proposed to replace the long-standing tax break granted to employer-based health insurance with a new tax deduction designed to help people pay for private coverage regardless of whether it is purchased by an employer or an individual. In their statement, the senators said, “It’s not realistic — given the lack of bipartisan support for the president’s plan — to think that can be accomplished by next week or even before the current children’s health care program runs out in September.”

A new analysis of these proposals, prepared by a researcher who believes that the U.S. tax code could be revised to extend health coverage to large numbers of the uninsured, concludes that Bush’s proposals would not achieve their stated goals. “Neither element of the Bush administration’s plan . . . would make a significant reduction in the number of uninsured,” according to Stan Dorn of the Urban Institute.³

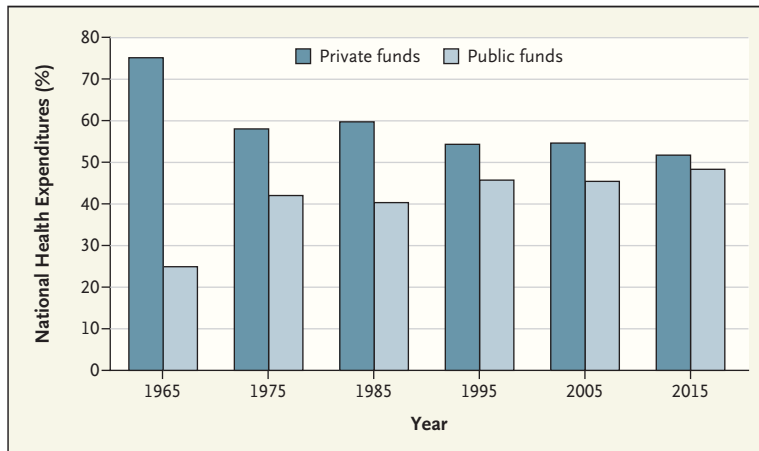
House Democrats, confident that average voters will favor a party seen as aggressively seek-

ing broader coverage for poor children, pursued a far more partisan approach than their Senate colleagues. Led by House Speaker Nancy Pelosi of California, the Democrats stitched together a 700-page bill designed to attract an amalgam of interests that speak for physicians and allied providers, hospitals, the elderly, and many other groups.⁴ But even with the support of an extraordinary coalition, there is little likelihood that, in the end, anything like the House-passed bill will become law. The evidence for such a conclusion lies in the strong opposition of House Republicans to the measure and the power of the presidential veto. Of 199 House Republicans who voted, all but 5 opposed the bill, as compared with 220 Democrats who favored it and 10 who were opposed.

The measure authorizes new SCHIP expenditures of \$50 billion over the next 5 years, for a total of \$75 billion. It would cover an estimated 5 million more children than the current program. The measure, developed without Republican input, would be financed in part through an increase of 45 cents in the federal tax on a pack of cigarettes, bringing the total to 84 cents. The other major source of support to cover the costs of the bill would come from eliminating the differential between the per capita payments Medicare makes to private health plans that enroll its beneficiaries and the average costs of covering similar beneficiaries under the traditional fee-for-service payment model. On average, the Congressional Budget Office estimates, Medicare pays health plans 12% more per beneficiary than its average costs under fee-for-service reimburse-

ment for a similar patient. By eliminating the differential, Medicare would save \$50 billion over the next 5 years. The administration adamantly opposes elimination of the payment differential, asserting that private plans offer more generous benefits and are in a better position to coordinate care than are physicians who are compensated through Medicare’s traditional fee-for-service model.

The most important item for physicians in the House-passed bill would repeal the sizable reductions (10% in 2008 and 5% in 2009) in fee-for-service payments to doctors that Medicare is scheduled to implement on January 1. The measure would replace the cuts with payment increases of 0.5% in both 2008 and 2009. The bill also calls for a 2.5% increase in Medicare’s target for growth in spending for primary care and preventive services and creates separate spending targets for other categories of service, such as diagnostic imaging, major procedures, and tests. From 2004 to 2005, spending per beneficiary for all physicians’ services increased by 7%, but some types of advanced imaging increased by more than 15%. If separate targets are established, physicians who provide services whose percent increase in expenditures from the previous year is at or below the spending target — the percent real (inflation-adjusted) growth of the gross domestic product (GDP) or, in the case of primary care and preventive services, GDP growth plus 2.5% — are not penalized by reductions in payment that result from service categories in which expenditures exceed the target. The bill also would initiate a nationwide demonstration project to test the practice of pro-



Growth of Public Health Expenditures, as Compared with Private Spending, since 1965 and Projected Contributions for 2015.

Data are from the Centers for Medicare and Medicaid Services.

viding a medical home for patients where their personal physician is paid to coordinate care.

The struggle over the reauthorization of SCHIP reflects the recurring discussion over the role that government should play in providing health coverage to the population. Every time, combatants come to the question with fervor, believing their arguments reflect the values of the American people. In a recent survey conducted by the *Wall Street Journal* and NBC, respondents who expressed pessimism about the future were asked to identify the source of their viewpoint; next

to the Iraq war, failures of the health care system drew the most nods.⁵ Whether politicians are able to capture this concern in the form of an expanded SCHIP or reaffirm Bush's belief in the private market as the preferable solution is a question that will be addressed over the course of the coming presidential election campaign and beyond. As long as no political party holds a commanding margin in Congress, this debate will continue without a clear resolution in sight.

However, the growth of public health expenditures has far outstripped private spending since

1965 because, in the absence of affordable private insurance, the federal government has expanded coverage of populations considered appropriate recipients of public support. This trend will only accelerate with the coming retirement of baby boomers (see bar graph). And as it does, there is no question that the role of government will expand along with the fiduciary responsibilities of policymakers, regardless of who is in the White House.

An interview with Professor Sara Rosenbaum, Chair of the Department of Health Policy at the George Washington University School of Public Health and Health Services, can be heard at www.nejm.org.

Mr. Iglehart is a national correspondent for the *Journal*.

1. Iglehart JK. Insuring all children — the new political imperative. *N Engl J Med* 2007; 357:70-6.
2. Reischauer RD. Benefits with risks — Bush's tax-based health care proposals. *N Engl J Med* 2007;356:1393-5.
3. Dorn S. A brief analysis of the Bush administration's tax proposals in the context of SCHIP reauthorization. August 2007. (Accessed August 16, 2007, at <http://www.firstfocus.net/Download/DORN.pdf>.)
4. Pear R. Select hospitals reap a windfall under child bill. *New York Times*. August 12, 2007:A1.
5. Harwood J. America's economic mood: gloomy. *Wall Street Journal*. August 2, 2007: A4.

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Sidelining Safety — The FDA's Inadequate Response to the IOM

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Having been commissioned by the Food and Drug Administration (FDA) to evaluate the U.S. drug-safety system, the Institute of Medicine (IOM) published a report, *The Future of Drug Safety*, in September 2006 identifying weaknesses in the laws, regulations, re-

sources, and practice of ensuring drug safety.¹ Some of the IOM's recommendations were directed toward Congress, which it believed should increase FDA funding and regulatory authority. Some outlined ways in which other federal agencies could work in partnership

with the FDA for the public good. But most of the report outlined deficiencies that the FDA itself — or the Department of Health and Human Services (DHHS), to which it belongs — should correct.

In general, the IOM implored the agency to “embrace a culture