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The Proxy War — SCHIP and the Government's Role in Health Care Reform

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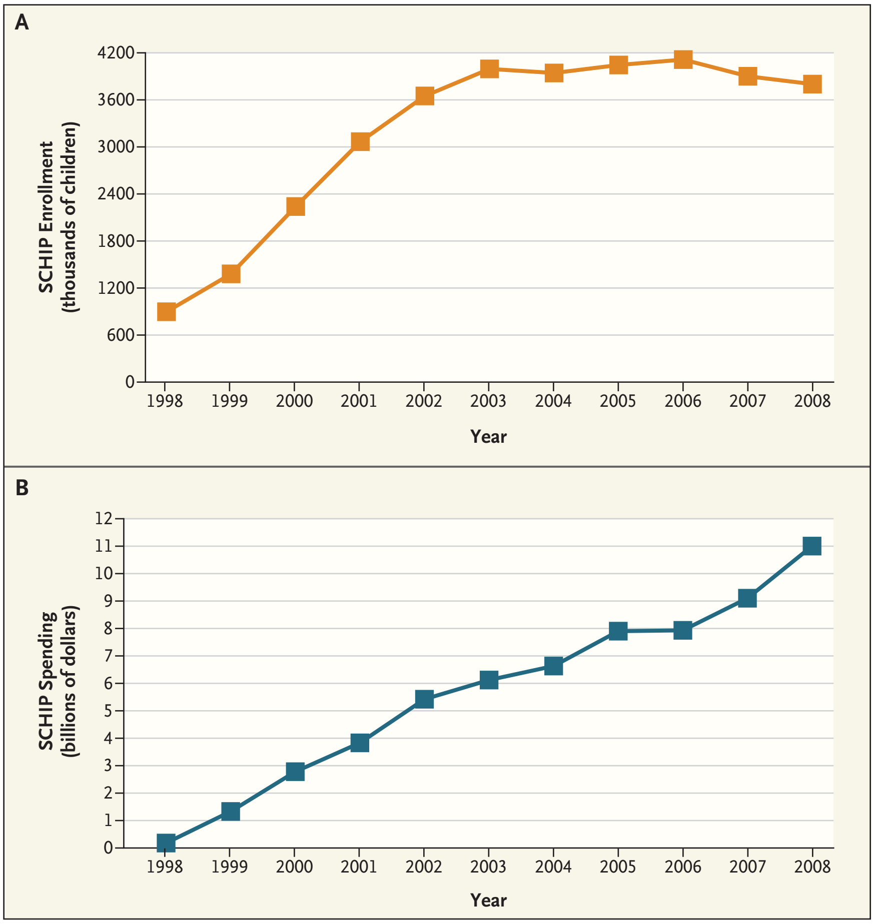
The conflagration over the reauthorization of the State Children's Health Insurance Program (SCHIP) offers a compelling example of Washington's current inability to address even seemingly uncontroversial matters such as improved health care coverage for children. After the House failed to override President George W. Bush's veto of a SCHIP expansion in October, Congressional leaders regrouped to develop a compromise measure that would address Bush's claim that the original bill "moves the health care system in the wrong direction."[1] SCHIP permits coverage of children in families whose incomes (according to evaluation methods developed by the states) are at or below 200% of the federal poverty level. Like the first bill that Congress passed in the fall, the second measure would have provided states with the authority to extend the standard to 300% of the poverty level (with a limit of 350% permitted in New Jersey) while reducing states' flexibility in determining what income counts in eligibility assessments. The bill also moved more aggressively to end SCHIP coverage of parents and other adults, imposed tougher citizenship-documentation requirements, and required states to try harder to avert health insurance crowd-out — the actual or potential tendency of one form of health insurance to substitute for other available coverage.[2]

The second measure passed the House and Senate, only to be vetoed by Bush on December 12; on January 23, 2008, the House failed to override the veto, quashing hope for the time being of reaching several million additional uninsured children. Ironically, the Congressional Budget Office projected that all but 500,000 of the 3.8 million previously uninsured children who would have received coverage by 2012 under the reauthorization in fact would have qualified under SCHIP's previous eligibility standards but would have benefited from the new legislation's expanded enrollment assistance. In other words, the measure truly "put poor children first," as demanded by the President.

Why would the President veto bipartisan legislation that does precisely what he insisted on — namely, aggressively enroll the poorest children? One might blame the poisonous atmosphere that pervades Washington these days, but other important social policy reforms have managed to get through.

One answer lies in a far larger dimension of SCHIP that is basic to any health insurance legislation



SCHIP Enrollment and Spending, 1998 to 2008.

Data are from the Kaiser Commission on Medicaid and the Uninsured, the Government Accountability Office, and the Centers for Medicare and Medicaid Services.

— namely, the legislative architecture of the reform plan, its structural and operational approach. Viewed from this vantage point, the SCHIP battle turns out not to have been about family-income assistance levels or the mechanism for financing coverage subsidies (although both the Medicare managed-care industry and the tobacco companies weighed in noisily on the latter question). Instead, the issue became the role of government in organizing and overseeing the health care marketplace (see graphs). SCHIP uses the power of government to form insured groups, select qualified plans, oversee plan operations, and measure results. It is this architecture to which the President was referring when he said that the legislation would move the health care system in the wrong direction.

In the end, the SCHIP battle became a proxy war over the duties that government should assume in national health care reform. As SCHIP's reach has grown, the program has wandered into an enormous ideological divide over whether government should be permitted to act as a group sponsor and monitor of plan accountability. The use of government as purchaser and market overseer itself represents a crucial policy and political compromise between advocates of pure public insurance models and proponents of full market deregulation. Certain recent high-profile legislative reforms — Medicare Advantage, Medicare Part D, and the Massachusetts Connector Authority, for example — are evidence of the potential for architectural compromise. Given the need for a compromise providing a robust approach to managing an enterprise as vast as the purchasing of personal health care services, these hybrid systems appear to offer a means of breaking the policy logjam.

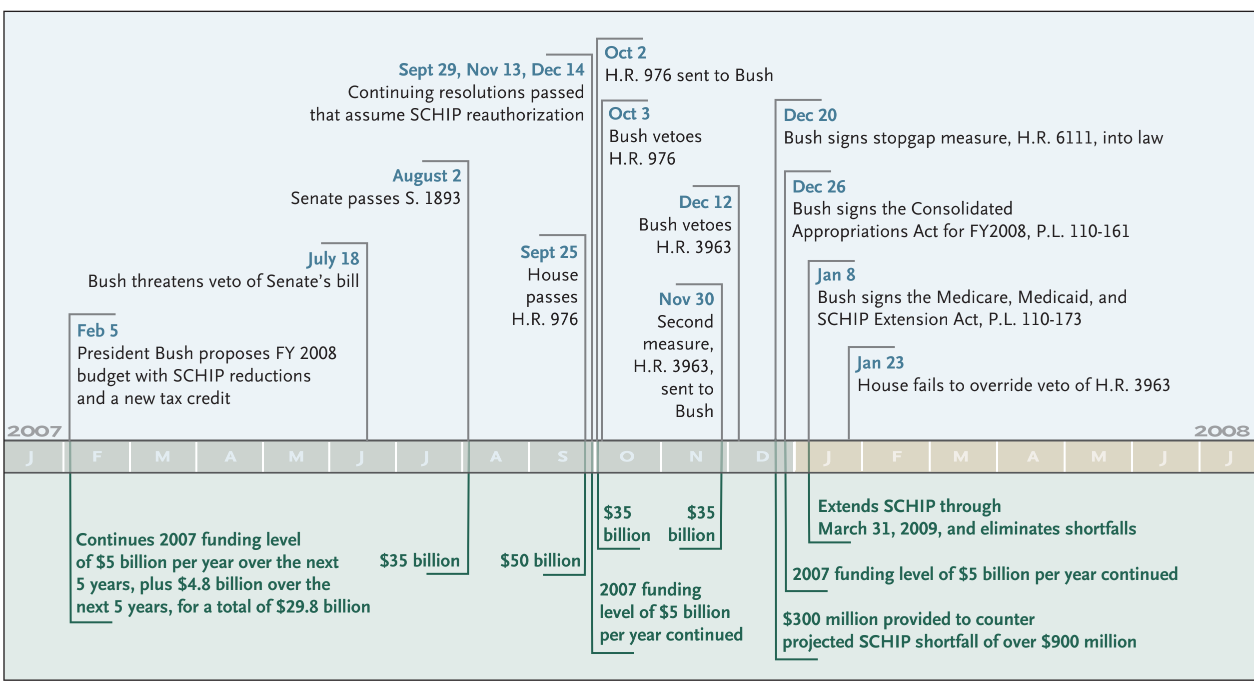
But it was such a solution that the administration sought to halt in the case of SCHIP, precisely because of its implications for broader future reforms. The effort to stop SCHIP was aided by the toxic atmosphere in Washington and the administration's labeling of SCHIP as a middle-class boondoggle. This allegation was made believable, according to one prominent Republican polling expert, because some families receiving assistance in certain states, such as New Jersey, had incomes that, though modest by regional standards, far exceeded the national median. The veto "played well in the South" for the administration, according to this expert; the maximum annual income of eligible New Jersey families seemed absurdly high to focus groups in poorer (and Republican) parts of the country, whose own SCHIP programs were far less generous. Reactions in these strongholds were powerful enough to reassure Republican House members that their support for the President's veto would not damage their chances in the 2008 elections.

It is tempting to pinpoint July 18, 2007, as the day that the first sign of real trouble for SCHIP emerged (see timeline). On that day, the President announced, even before the Senate Finance Committee had considered the legislation, that he would veto any measure that followed the broad outlines of a consensus proposed by chairman Max Baucus (D-MT) and ranking minority member Charles Grassley (R-IA), which would have extended SCHIP's allowable coverage to 300% of the federal poverty level.[3] But the opening salvo in this proxy war actually occurred early in 2007, when the White House unveiled a fiscal year 2008 budget calling for reductions in federal SCHIP spending over 5 years. The President coupled the reductions with a new system of individual tax breaks for people without employer-sponsored coverage and new limits on the aggregate value of tax benefits for people with access to such coverage. In keeping with his support for association health plans[4] — private entrepreneurial ventures that essentially create purchasing clubs, with the purported objective of providing a wide choice of health plans for members, while avoiding state insurance regulation — the President refrained from making any recommendation that would suggest a role for the government in overseeing health insurance arrangements.

The White House proposal went nowhere, and the House and Senate both produced legislation that built on the existing SCHIP program, which permits state governments to assume the role of health care purchasers in identifying, selecting, and overseeing children's health insurance products that meet broad criteria. As of 2007, nearly all state SCHIP programs used this purchasing approach, and the continuation of SCHIP's architecture (and implicit rejection of the President's architecture), coupled with funding expansions, set the stage for a legislative fight and two vetoes of a key children's health care measure.

The administration's war over efforts to move the health care system in the "wrong direction" has not been limited to vetoes. On August 17, 2007, the Department of Health and Human Services issued a letter to state SCHIP administrators to "clarify" existing statutory and regulatory requirements related to the extension of SCHIP to children with family incomes above 250% of the federal poverty level.[5]

This letter announced that the Centers for Medicare and Medicaid Services (CMS), which administers SCHIP, would deny federal funding to states that exceeded the 250% mark unless they could make certain assurances: that they were enrolling at least 95% of children with family incomes below



Timeline of Action on SCHIP.

Information is from the Library of Congress, whitehouse.gov, Families USA, the American Network of Community Options and Resources, the Congressional Budget Office, and the Congressional Research Service.

200% of the federal poverty level (an achievement that experts in voluntary health insurance systems consider impossible); that the proportion of children covered by private employers had not dropped by more than 2 percentage points over the previous 5 years (although the federal Employee Retirement Income Security Act [ERISA] prohibits states from regulating private, employer-sponsored group health benefit plans); and that they were in compliance with certain anti–crowd-out practices, the most astounding of which, from a public health point of view, is the imposition of a 12-month waiting period before permitting uninsured children of any family-income level to enroll in SCHIP.

The Georgetown University Center for Children and Families reported in September 2007 that children in 18 states and the District of Columbia would be affected by the CMS ruling, which gave states 12 months to comply or lose funding. By the end of 2007, several states had announced that they would be scrapping planned expansions of SCHIP to 300% of the poverty level — changes that affect thousands of children and families.

In sum, what the administration could not achieve through legislation it has sought to achieve by fiat, including administrative directives that appear to run afoul of other federal laws, such as ERISA. So determined does the administration appear to be to halt the growth of a health insurance architecture it opposes — at least in the case of working families and children not covered through the Federal Employees Health Benefits Plan — that it will flout the law and punish thousands of children in order to achieve its goals.

The President's own tax plan — which is not income-related — underscores the reality that the issue with regard to SCHIP was never the level of family income that would qualify children for a subsidy. Bush's tax proposal also suggests that the real concern is not health insurance crowd-out: estimates show that his tax-credit plan would have a far greater crowd-out effect than any proposed expansion of SCHIP and would result in a net gain of only 3 million insured people. The administration's policy recommendations related to non–means-tested tax subsidies and its support for association health plans lead to the conclusion that the real issue is the role of government in a reformed health care system. The war is over ideology, not money.

Americans have always had greater social tolerance for individual financial support when it is given in the form of tax assistance (which is commonly perceived as letting people keep more of their own money) than when it comes as direct subsidization. The ease with which opponents of direct financing were able to bring down SCHIP simply by translating into actual dollars financial support that is pegged to the federal poverty guidelines does suggest, however, that preventing the same results in broader reform means paying close attention to the political implications of the structure of the individual-subsidy transfer.

But no matter how a subsidy is structured, the matter of system architecture remains front and center. The precedents set by Medicare in the creation of its Advantage and Part D drug coverage plan, as well as by state reforms such as that of Massachusetts, demonstrate the existence of a broad consensus regarding responsible approaches to building a legislative architecture for health care reform. We can only hope that the next president and Congress will follow that consensus.

No potential conflict of interest relevant to this article was reported.

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