

ing. Currently, the secretary of health and human services does not have sufficient flexibility to test and fine-tune savings strategies on a statewide or regional basis. I believe that the secretary should be given far greater authority, with accountability to the President and Congress — perhaps with the advice of a council of independent experts — to act as a prudent purchaser, test new payment and system reforms, and rapidly spread and implement promising reforms. It is time to

change “business as usual” and to invest in the health care reforms that will benefit the public and patients and put our nation on a sounder economic footing.

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HEALTH CARE 2009

Expanding Coverage for Children — The Democrats’ Power and SCHIP Reauthorization

John K. Iglehart

In the first demonstration of Democratic dominance on health care issues since Barack Obama captured the White House, the new Congress quickly reauthorized the State Children’s Health Insurance Program (SCHIP), enabling the president to sign the measure into law within days after taking office. Though falling short of President Obama’s goal of ensuring that “every child in America has access to affordable health care,” the measure should sustain SCHIP’s current enrollment of about 7 million and expand coverage to an additional 4.1 million children by 2013.

The rapid action underscored Democrats’ intention to reverse or amend many health policies put in place during the Bush administration. Twice in 2007, Democrats failed to override vetoes of similar SCHIP bills by former President George W. Bush, who objected to their financing of the program

through increased federal tobacco taxes and to their going “too far in federalizing health care.” But the newly authorized SCHIP expansion still faces a formidable hurdle. With federal and state governments seeing substantial losses in tax revenue as the recession deepens,¹ many states will find it challenging to stabilize, much less expand, their current SCHIP and Medicaid enrollments, even as more people lose their jobs and their employer-sponsored health insurance.² A large economic stimulus package moving through Congress contains substantial relief for states, including monies to bolster SCHIP and Medicaid programs.

On January 14, eight days after the 111th Congress convened, the House approved a 4.5-year extension of SCHIP by a vote of 289 to 139. The bill attracted 40 Republican votes, reflecting some bipartisan support for expansion of public coverage for the most po-

litically popular uninsured group, children who live in low-income families, most of which have an employed family member. On January 29, the Senate voted 66 to 32 in favor of a similar bill. Only nine Republican senators voted for the measure. Legislators quickly resolved the only issue that separated the House and Senate measures. They eliminated from the final bill a House-approved provision that would essentially have banned the future development of specialty hospitals owned or invested in by physicians who refer patients to these facilities. President Obama signed the bill into law on February 4.

SCHIP was established by the Balanced Budget Act of 1997 as a federal–state program serving children living in families with incomes at or below 200% of the federal poverty level (\$35,200 for a family of three in 2008). SCHIP expanded on coverage provided by Medicaid, a far larger federal–state

program covering some 60 million people (almost half of them children) with incomes below the poverty level (\$17,600 for a family of three in 2008). However, states were granted the flexibility to set their own eligibility levels, and 44 states have since expanded their coverage of children (through either a newly created SCHIP or an expansion of their Medicaid programs) to those with family incomes of 200% of the federal poverty level or higher. New Jersey enrolls children with family incomes up to 350% of the poverty level — the highest threshold of any state.

SCHIP was fashioned as a bipartisan compromise, combining the Democratic preference for expanding public insurance with Republican imperatives that federal funding be capped, that states' participation be voluntary, and that states be allowed to charge premiums and cost-sharing amounts resembling those of private coverage. States' rapid implementation of SCHIP was attributable in part to the lure of federal matching payments more generous than Medicaid's. In 2008, federal SCHIP payment rates to states ranged from 65 to 85% of the total costs of their programs, whereas Medicaid's rates were 50 to 76%. Over the program's first decade, Congress authorized the spending of \$40 billion. The new law authorizes additional spending of \$32.3 billion over the next 4.5 years. Along with ongoing annual federal outlays of about \$5 billion, this additional amount could bring total SCHIP spending (with state matching payments) to about \$57.4 billion between 2009 and 2013.

The new law enables states to enroll children with family incomes of up to 300% of the fed-

eral poverty level (\$52,800 for a family of three) at the more favorable federal-payment matching rate. Coverage at higher income levels is permitted, but the matching rate reverts to the Medicaid level for states electing to enroll children above that income threshold. By a vote of 247 to 179, the House rejected a Republican amendment that would have required states to insure 90% of the children with a family income under 200% of the poverty level before allowing the enrollment of children from higher-income families. The law calls for states to phase out coverage of some 334,616 adults who are currently covered by SCHIP to make room for more low-income children. (Many of these adults are parents of eligible children; their inclusion in the program was meant to encourage them to enroll their children.)

In the law's most contentious provision, Congress allowed states — at their discretion — to restore Medicaid coverage for otherwise eligible children and pregnant women who have been in the United States legally for 5 years or less. A 1996 law had barred coverage for these groups, and considerable support had built over the years for giving states the option of reviving assistance for these previously covered persons. In provisions opposed by Republicans, the law also expands options for verifying citizenship and identity.

Republicans also opposed the manner in which SCHIP would be financed in 2009 and beyond — through a 61-cent increase in the federal excise tax on tobacco, bringing the tax for a pack of cigarettes to \$1. SCHIP was largely financed through tobacco-tax revenues during its first decade. Al-

though Democrats touted this increase as a way of achieving their "pay-as-you-go" pledge, they also argued that it would reduce children's exposure to secondhand smoke and discourage young people from taking up smoking. Republicans called the increased cigarette levy regressive, asserting that it amounted to a tax on the poor.

Benefits mandated by the SCHIP law are similar to those covered through the standard Blue Cross–Blue Shield plan that many federal employees select or through a package offered to employees of a private company that contracts with a health maintenance organization. However, benefits are less generous than those of Medicaid programs. Under the new SCHIP law, dental services were added as a required benefit in response to mounting evidence that low-income children have very poor access to oral health services.

Although quality of care has been a focus in Medicaid managed care for some time and all states use some form of quality measurement when purchasing insurance products for SCHIP-covered children, there has been no formal policy on the quality of children's health care under Medicaid and SCHIP. A study of the quality of ambulatory care delivered to a random national sample of children showed that children receive indicated care about 46.5% of the time,³ as compared with 55% for adult care.⁴ Having been urged for a decade to devote more attention to improving the quality of children's care,⁵ Congress established extensive new requirements for the Department of Health and Human Services (DHHS). With authorized resources of \$225 million over 5 years,

the new quality provisions represent “the single largest explicit federal investment in pediatric quality to date,” according to Lisa Simpson of Cincinnati Children’s Hospital Medical Center.

Congress directed the DHHS to develop new measures of both the quality of pediatric care and the success of Medicaid and SCHIP in meeting children’s needs. The law stipulates that the measures should be developed with extensive input from pediatric and quality experts and that the DHHS should provide comprehensive information regarding the delivery and outcomes of care, identify disparities in care, improve existing measures of children’s health and update them periodically, and report to Congress on the degree to which states are using the measures. The law also includes funding for demonstration projects to improve the delivery of children’s health care, address childhood obesity, and promote the use of health information technology.

Although many states and the Robert Wood Johnson Foundation have invested substantial sums in reaching out to enroll eligible children in SCHIP, an estimated 5 mil-

lion to 6 million such children remain without coverage. The law therefore offers bonus payments to states that increase their enrollments by a certain amount, makes it easier for states to implement “express lane” eligibility mechanisms, and provides for grants to local governments and community-based organizations for conducting outreach campaigns, especially in rural areas and underserved populations.

The rapidity with which Democrats managed to reauthorize SCHIP should not be taken as a sign that it will be easy to pass broader proposals for expanding coverage to other uninsured populations. Democrats saw the SCHIP measure as unfinished business from the 110th Congress. Moving on to more ambitious reforms will be more difficult, given the rapidly increasing federal deficit, the competing claims for federal resources, and the determination of Republicans to forestall the growth of public insurance. Nevertheless, President Obama believes that a major health care initiative must be “intimately woven into our overall economic recovery plan.” As he has said, health care reform

is “not something that we can put off because we are in an emergency. This is part of the emergency.”

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

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CABG vs. Stenting: Clinical Implications of the SYNTAX Trial

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A video is
available at
NEJM.org

The SYNTAX trial compared coronary-artery bypass grafting (CABG) with percutaneous coronary intervention involving drug-eluting stents for patients with advanced coronary artery disease (results available at NEJM.org). On January 30, 2009, the *Journal* hosted a debate about the clinical implications of the study’s findings that the need for repeat revascularization was significantly lower with CABG, but the risk of stroke was significantly higher. What should the new standard of care be? Watch the video, participate in the poll, and contribute your thoughts at NEJM.org.