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MARTINEZ BILL WOULD WEAKEN CHILDREN'S HEALTH COVERAGE

Bill Would Lead to Cuts in SCHIP While Creating Poorly Designed Tax Credit

by Edwin Park, Judith Solomon and Matt Broaddus

Senator Mel Martinez (R-FL) has introduced legislation (S. 2193) intended to rally opponents of bipartisan children's health legislation recently vetoed by President Bush, a revised version of which was passed by the House on October 25 and the Senate on November 1. The Martinez bill also has been introduced in the House, as H.R. 3888, by Representative Marilyn Musgrave (R-CO) and is cosponsored by House Minority Leader John Boehner (R-OH) and House Minority Whip Roy Blunt (R-MO).

In contrast to the bipartisan SCHIP legislation, which the Congressional Budget Office estimates would cover nearly 4 million uninsured children by 2012, the Martinez plan provides less federal funding than states need simply to sustain their existing SCHIP programs. It also overturns procedures that have governed SCHIP since its inception, under which SCHIP funds allocated to states that do not use them are redistributed to states that can use them to cover uninsured children. The Martinez plan would instead return to the Treasury all funds not used by states to which they were initially allocated. This would lead over time to further reductions in SCHIP coverage.

In addition, the plan would prohibit outright the coverage of children whose families have incomes above 250 percent of the poverty line, and would establish requirements that few states could meet as a

KEY FINDINGS

- Legislation introduced by Senator Mel Martinez as an alternative to the bipartisan SCHIP legislation the President vetoed would provide insufficient SCHIP funds to maintain existing SCHIP programs. The bill also would prohibit the redistribution of unspent SCHIP funds from states that do not use them to states that need additional funds to avert cutbacks, leading to further reductions in SCHIP coverage. By 2012, an estimated 27 states would face SCHIP funding shortfalls.
- Unlike the vetoed legislation, the Martinez bill provides states with no new tools or financial incentives to enroll poor children who are eligible but uninsured.
- The bill scales back SCHIP coverage for children between 200 and 300 percent of the poverty line and substitutes a tax credit that families in this income range could use to purchase insurance for their children, primarily in the individual health insurance market.
- Analysis by Urban Institute health experts finds that the bill's tax credit "would involve significant financial burdens for families with healthy children and even larger burdens for families whose children have health problems," would reach fewer insured children than an SCHIP expansion, and could result in children with even minor health problems being denied coverage outright, denied coverage for the health conditions they have, or charged very high amounts.
- The tax credit could be exploited by unscrupulous insurers who deceptively market children's coverage that contains very large gaps. That is what happened when Congress enacted a similar tax credit in 1990 for coverage of low- and moderate-income children. Abuse was so substantial that Congress found it necessary to repeal that tax credit in 1993.

precondition for being permitted to cover children over 200 percent of the poverty line (\$34,300 for a family of three). Most states now providing SCHIP coverage to children over 200 percent of the poverty line would have to terminate it.

Finally, the plan would create a refundable tax credit that families with incomes between 200 and 300 percent of the poverty line could use to purchase health insurance for children, primarily in the individual health insurance market. The tax credit would be too small to make coverage affordable for many children, except for coverage with large gaps. Families whose children have medical conditions would find it particularly difficult to find affordable coverage for their children with the tax credit, if they could find coverage at all.

This analysis is principally divided into two parts — first, a discussion of the Martinez bill’s SCHIP provisions, and then a discussion of its tax credit proposal.

The Bill’s SCHIP Provisions

According to Congressional Budget Office estimates, if SCHIP funding remains frozen at the current level of \$5 billion per year, states will face a federal funding shortfall of \$13.4 billion over the next five years (fiscal years 2008-2012).¹ CBO estimates that by 2012, some 35 states would have insufficient federal funding to maintain their current programs and that the number of children enrolled in an average month would fall far below today’s level.

CBO also estimates that the bipartisan SCHIP reauthorization legislation vetoed by the President would entirely avert these shortfalls and thereby prevent 700,000 children from losing SCHIP coverage and becoming uninsured by 2012, and also cover an additional 3.1 million children who otherwise would be uninsured, for a total coverage gain by 2012 of 3.8 million children. The revised version of the vetoed bill that the House of Representatives approved October 25 and the Senate passed November 1 would result in a slightly higher coverage gain of 3.9 million children, according to CBO.

The SCHIP provisions in the Martinez bill stands in sharp contrast to those in the bipartisan bill. The Martinez bill would neither fully close the looming shortfalls nor help states cover more uninsured children. The bill’s SCHIP provisions are identical to those in legislation (H.R. 3176) introduced earlier this year by Reps. Jim Barton (R-TX) and Nathan Deal (R-GA). A discussion of the bill’s key SCHIP provisions follows.

1. The plan would not provide states with sufficient funding to maintain existing SCHIP programs.

The Martinez bill would provide \$11.5 billion in additional SCHIP funding over the next five years (above the current \$5 billion annual funding level). This is about \$2 billion less than the \$13.4 billion CBO has estimated is needed to allow states to sustain their existing SCHIP programs. The

¹ See Congressional Budget Office, “Fact Sheet for CBO’s March 2007 Baseline: State Children’s Health Insurance Program,” February 23, 2007 and Edwin Park, “CBO Estimates That States Will Face Federal SCHIP Shortfalls of \$13.4 Billion Over Next Five Years,” Center on Budget and Policy Priorities, February 26, 2007. Because of substantially higher SCHIP spending projections reported by states in the most recent SCHIP expenditure data from August 2007, the total federal funding shortfall would be significantly larger than what CBO previously estimated in March 2007.

bill would also use a new formula for allocating SCHIP funds among the states, under which a large portion of these funds would be directed to states that likely would not be able to fully use them, while other states with greater funding needs were given insufficient funds to maintain their current caseloads. Aggravating this problem, the bill also would institute a sharp change in the SCHIP law by barring any reallocation of federal SCHIP funds from the states not fully using their allotments to states that need more funds to avert cuts; the unused funds would revert to the Treasury instead. This would cause the SCHIP cutbacks to be significantly deeper.

- Currently, funds provided to a state that remain unspent after three years are redistributed to other states. The Martinez plan would end this, requiring unused funds to revert to the Treasury rather than being redistributed to other states. An estimated \$2 billion in unspent funds would revert to the U.S. Treasury over the next five years, even as many states were being driven to cut their programs and thereby increase the number of uninsured children because of inadequate funding.
- The combined result would be an estimated total federal SCHIP funding shortfall of \$12.2 billion over the next five years. Some 27 states would have insufficient federal SCHIP funding by 2012 to sustain their current programs, with the shortfall reaching \$3.6 billion that year alone, an amount equal to the projected annual cost of covering 2.3 million children on a monthly basis.²

2. The plan would sharply restrict state flexibility in covering children and force many states to lower their SCHIP income limits substantially.

The Martinez bill would strictly limit SCHIP eligibility to 250 percent of the poverty line and terminate coverage above that level. In addition, states would be barred from covering children with incomes between *200 percent and 250 percent* of the poverty line — between \$34,300 and \$42,900 for a family of three — unless their Medicaid and SCHIP programs covered at least 90 percent of the eligible children below 200 percent of the poverty line.

No means-tested federal program reaches 90 percent of all of the individuals or families eligible for it, and no state meets this threshold for Medicaid and SCHIP. Reaching a 90 percent threshold is particularly difficult in a health care program, since a significant number of low-income parents do not enroll their children until the children first become ill or otherwise need costly treatments.

As a result, up to 24 states (including the District of Columbia) would be forced to scale back their current SCHIP eligibility levels and remove children from the program. Many of these children could become uninsured.

On a related front, the bill also would overturn current rules that enable states to deduct from a family's income certain expenses that a family incurs, such as costs for child care needed for a parent to work. In place of the current state rules in this area, the bill would require that the federal government issue new rules on how to measure a family's income and *mandate* that all states adopt

² These estimates come from the Center on Budget and Policy Priorities' SCHIP expenditure model, which is based on the model developed by the actuaries at the Center for Medicare and Medicaid Services at the U.S. Department of Health and Human Services. The estimates measure how short states would fall of the funding they would need to maintain their current SCHIP programs, with current state participation rates and eligibility criteria.

these rules. To the extent that the new rules (which the federal executive branch would write after enactment of the legislation) limited or denied states the right to deduct costs for items such as child care, even more children would become ineligible and be dropped from SCHIP — even in states with SCHIP income limits *below* 200 percent or 250 percent of the poverty line. (In a number of states, children can have *gross* income somewhat above their state’s SCHIP income limit but qualify because their income falls below the limit when child care or other deductible costs are subtracted.) By outlawing the current state rules and replacing them with new federal rules whose content is unknown, the bill could end up requiring *as many as 35 states* to terminate some children from their SCHIP programs.

The bill also would prohibit states that now do so from continuing to use SCHIP funds to provide health insurance to low-income *parents* of children enrolled in Medicaid or SCHIP. A modest number of states provide coverage to low-income parents under waivers that were approved by the federal government, in most cases by the Bush Administration. States could continue covering parents who are *currently* enrolled, but as these parents cycled out of the program (as their incomes rose or they became ineligible for other reasons), states would be prohibited from replacing them with newly eligible low-income parents. In addition, currently enrolled parents could remain covered only until a state’s existing waiver expired, since waiver renewals would be prohibited.

Various studies have found that covering children and their parents together results in a larger share of the eligible children being enrolled and receiving needed health care services. At a July 19 Congressional hearing, CBO director Peter Orszag explained that “restricting eligibility to parents does have an effect on take up among children... for every 3 or 4 parents you lose, you might lose 1 or 2 kids, for example.”³ (The bipartisan SCHIP legislation the President vetoed — and the revised version of that legislation that Congress has just passed — also restrict parent enrollment in SCHIP, but do so in a much less draconian manner that should not cause the number of uninsured low-income parents to rise markedly.⁴)

3. The plan lacks any new tools or financial incentives for states to enroll more of the eligible but uninsured low-income children.

The bipartisan children’s health legislation the President vetoed contains various new tools to help states find and enroll eligible, uninsured low-income children. For example, the bipartisan bill includes an “Express Lane” option to enable state SCHIP and Medicaid agencies to use other benefit programs, such as the school lunch program, to identify eligible, uninsured children and to use income information that children’s families have provided to those programs to help streamline the enrollment of these children in Medicaid. The vetoed bipartisan bill would also provide strong financial incentives for states to increase enrollment among eligible low-income children, and the revised version of the vetoed that bill the House and Senate recently passed contains even stronger incentives targeted on poor children. These tools and incentives are a primary reason that CBO estimates that the new version of the bipartisan bill would lead to 3.9 million uninsured children

³ Letter from Peter Orszag to Senator Max Baucus, Chairman of the Senate Finance Committee, Congressional Budget Office, July 24, 2007.

⁴ The bipartisan legislation would move the existing waivers covering parents outside of SCHIP in 2010, and starting in 2011, lower the matching rate for parents enrolled through SCHIP under existing waivers. It would set the reduced matching rate halfway between the SCHIP and Medicaid matching rates. States would have to meet certain benchmarks in their *children’s* coverage to qualify for this matching rate.

gaining coverage by 2012, with *1.9 million* (or nearly half) of them being children eligible for Medicaid. Most children eligible for Medicaid live below the poverty line.⁵

The Martinez legislation differs markedly here. It would provide no new enrollment tools or financial incentives for states to enroll low-income children, including poor children. The plan would merely provide for a modest set of outreach grants — \$500 million over five years — to states and other organizations to enroll children who are eligible for SCHIP and Medicaid but are uninsured. (A similar outreach grant provision is included in the vetoed bill.)

4. The Martinez bill would allow SCHIP funds to be diverted to private insurance plans offering inadequate coverage for children and carrying high cost-sharing charges that many low-income families have difficulty affording.

Under current law, states may establish “premium assistance” programs under which states help enroll SCHIP-eligible children in employer-sponsored health insurance by using SCHIP funds to help pay the required premiums for that coverage. States using SCHIP funds for this purpose must ensure that enrolling eligible children in an employer plan would not be more costly than enrolling the children in SCHIP directly. In addition, states using this option must provide supplemental (or “wrap-around”) benefits if the benefits under the employer-based plan have gaps compared to the benefits the child would receive under SCHIP. Finally, a state must ensure that the premiums, deductibles and co-payments a family must pay for a child under an employer plan would not be greater than the maximum amount allowed under the SCHIP program which generally is no more than 5 percent of a family’s annual income.

A number of states now operate these “premium assistance” programs as part of their SCHIP (and, in some cases, Medicaid) programs. The vetoed bipartisan SCHIP legislation contains provisions that would make the premium assistance option easier and more attractive for states to use, while maintaining the safeguards for beneficiaries. The revised version of the legislation recently approved by the House and Senate adds additional financial incentives for states to elect this option.

The Martinez bill, in contrast, would replace the current state option in this area with a *mandate* that all states not only operate a premium assistance option for children whose families have access to employer-based coverage but also provide “alternative coverage options” under which SCHIP funds would be used to enroll children primarily in coverage that private insurance companies offer in the individual health insurance market. Under both the premium assistance and the private coverage alternatives, the current requirements that the private coverage have adequate benefits and affordable cost sharing — and not cost the government more than it would cost to enroll the child in SCHIP — would essentially be dropped. For the first time, SCHIP funds could be used to enroll children in private coverage that provides greatly scaled-back health coverage, charges deductibles and co-payments that low-income families may not be able to afford, and may cost the federal government more than it would to enroll the children directly in SCHIP.

Enrollment in these private coverage options would be voluntary for parents. But some low-income parents are likely to have difficulty understanding the differences between the benefits and cost-sharing requirements under a private coverage option and the state SCHIP program, especially

⁵ Edwin Park and Judith Solomon, “New SCHIP Legislation Makes Significant Changes from Vetoed Bill to Focus More Heavily on Low-Income Children,” Center on Budget and Policy Priorities, October 25, 2007.

if the private plans market their products aggressively. Significant numbers of low-income children could end up in health plans with fewer benefits and substantially higher cost-sharing charges. Subsidizing private coverage in this manner also could be more costly in some cases.

The Proposed Tax Credit

The Martinez bill would provide a refundable tax credit of \$1,400 per child for families with incomes between 200 percent and 300 percent of the poverty line, which those families could use to help them purchase health insurance for their children in the individual market or through their employer. The tax credit is apparently intended in part as a substitute for existing SCHIP coverage of children in this income range. As explained above, most states would no longer be permitted to cover children above 200 percent of the poverty line through SCHIP.

The proposed substitution of the tax credit for SCHIP coverage raises serious questions, particularly in light of the tax credit's design.

1. Coverage would remain unaffordable for many families in this income range.

The refundable tax credit of \$1,400 per child generally would not be sufficient to purchase adequate coverage in the private insurance market.

- Most families in this income range that are uninsured do not have access to coverage through an employer. Only 8 percent of families with income between 200 and 400 percent of the poverty line have declined an offer of employer-sponsored insurance,⁶ and Urban Institute researchers have estimated that approximately 80 percent of the uninsured children between 200 percent and 300 percent of the poverty line live in a family where their parent does not have access to an employer-based plan that covers children.⁷
- As a result, the vast majority of uninsured children who would be eligible for the tax credit could use it only to purchase coverage in the individual health insurance market. But meaningful coverage in the individual market is unlikely to be affordable for such families with a tax credit of this size, since there would be no employer contribution to offset part of the premium costs. For example, the average premium for family coverage in an employer-sponsored plan, including the employer's share, is estimated to be \$12,100 in 2007.⁸ (Coverage just for children is generally not offered now, so a comparable figure for its cost is not available.) Moreover, coverage in the individual market tends to cost *more* than comparable coverage provided through an employer because the administrative costs are higher in the individual market.⁹

⁶ Lisa Clemans-Cope, Bowen Garrett, and Catherine Hoffman, "Changes in Employees' Health Insurance Coverage, 2001-2005," Kaiser Commission on Medicaid and the Uninsured, October 2006.

⁷ Linda Blumberg and Genevieve Kenney, "Can a Child Health Insurance Tax Credit Serve as an Effective Substitute for SCHIP Expansion?," Urban Institute, October 2007.

⁸ Kaiser Family Foundation and the Health Education and Research Trust, "Employer Health Benefits 2007 Annual Survey," September 2007.

⁹ Jon Gabel, et al., "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs* web exclusive, April 17, 2002.

- For this and other reasons, studies show that most people who try to purchase coverage for themselves or their families in the individual market end up *not* buying it. The Commonwealth Fund Biennial Health Insurance Survey, a national survey conducted from late 2005 through early 2006, found that nine of every ten adults who attempted to purchase coverage in the individual market — and 95 percent of *low-income* people who tried to buy such coverage — ended up without it. (Some 72 percent of low-income people who tried to purchase coverage in the individual market found it difficult or impossible to find coverage they could afford; others were refused coverage outright because of pre-existing health conditions.¹⁰)
- The problems would be most severe for children with conditions like asthma or diabetes. In most states, companies selling insurance in the individual market can vary premiums substantially based on a family member's health. For children with medical problems, insurers in most states can charge very high amounts, refuse coverage for these children's medical conditions, or refuse to sell the families insurance altogether.¹¹ A Commonwealth Fund survey found that one of every three individuals in poorer health who sought coverage in the individual market was rejected outright or charged a higher premium for their pre-existing conditions.¹²

2. Health insurance purchased in the individual market typically imposes substantial deductibles and co-payments and covers fewer benefits.

Families that actually manage to purchase coverage for their children in the individual market often would face high out-of-pocket costs for deductibles, co-payments, and expenses that their health plans do not cover. These costs are generally much higher than the costs faced by people with employer-sponsored insurance or public coverage through Medicaid or SCHIP.

- A recent study that compared health plans offered through the individual market, employer-based plans, and public health insurance programs found that individual-market coverage provides the least financial protection for beneficiaries. (Public coverage provides the most.) Regardless of their income level, families with individual-market insurance were more likely to face out-of-pocket expenses that exceeded \$2,000 a year and constituted more than 5 percent of family income. The problem was most severe for low-income people: nearly half with individual-market coverage paid more than 5 percent of their income for out-of-pocket expenses, on top of what they paid for premiums, presumably because their plans usually had high deductibles and/or high co-payments.¹³

¹⁰ Sara R. Collins et al., "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," The Commonwealth Fund, September 2006.

¹¹ For a further discussion of problems in the individual health insurance market, see Mila Kofman and Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Georgetown University Health Policy Institute, April 2006 and Edwin Park, "Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Coverage," Center on Budget and Policy Priorities, Revised April 6, 2004.

¹² Collins, et al., *op cit*.

¹³ Yu-Chu Shen and Joshua McFeeters, "Out-of-Pocket Health Spending Between Low- and Higher-Income Populations," *Medical Care*, 44:3, March 2006.

- Another study found that families with incomes between 200 and 299 percent of the poverty line who purchased insurance in the individual market spent *21 percent* of their income on medical costs, including premiums and cost-sharing, an amount far above what most analysts consider affordable for families in this income range. The authors of the study suggest these percentages would be even higher if the data were not skewed by the fact that only relatively healthy people were able to purchase individual-market coverage in the first place.¹⁴
- In the same vein, a California study found that individual-market insurance paid just over half — 55 percent — of beneficiaries’ medical costs, well below the 83 percent of medical costs paid by policies in the small-employer group market.¹⁵

These figures are cause for concern. An extensive body of research shows that people often cope with high cost-sharing in their health plans by *going without necessary health-care services*. The Commonwealth Fund survey cited above found that more than one-third of all people with individual-market insurance had deductibles of \$1,000 or more and that close to half of this high-deductible group did without at least one needed medical service such as filling a prescription, seeing a specialist when needed, taking a test recommended by a doctor, or seeing a doctor for a health problem.

Moreover, low-income people with chronic health conditions are the most vulnerable to forgoing needed health care due to deductible and co-payment charges, since they have the most difficulty affording such charges.¹⁶ The proposed tax credit, which could be used only for the premium costs of health insurance and *not* for deductibles or co-payments, would be of little help here.

For those reasons, the tax credit in the Martinez bill is not well designed to help children between 200 percent and 300 percent of poverty secure adequate, affordable coverage. In a recent analysis of the Martinez tax credit, Linda Blumberg and Genevieve Kenney, health care experts at the Urban Institute, conclude:

“The tax credit Senator Martinez proposes would involve significant financial burdens for families with healthy children and even larger burdens for families whose children have health problems The central problem with the tax credit proposal is that, to take advantage of it, most families with uninsured children will need to purchase coverage in the nongroup [i.e., the individual] market Barring any legislative language that would prevent insurers from using current common practices, children with even minor health problems may be denied coverage outright or may be offered coverage at much higher premiums than shown here. Alternatively, insurers are permitted to offer policies that permanently eliminate coverage for particular health conditions, body parts, or body systems. This means that a child with asthma may have his

¹⁴ Linda J. Blumberg et al., “Setting a Standard of Affordability for Health Insurance Coverage,” *Health Affairs* web exclusive, June 4, 2007. These findings were based on an analysis of MEPS data for 2001 to 2003.

¹⁵ “Health Insurance: Can Californians Afford It?” California HealthCare Foundation, June 2007.

¹⁶ The research on the impact of cost-sharing on low-income people is summarized in Leighton Ku and Victoria Wachino, “The Effects of Increased Cost-Sharing in Medicaid: A Summary of Research Findings,” Center on Budget and Policy Priorities, July 7, 2005; and Julie Hudman and Molly O’Malley, “Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations,” Kaiser Commission on Medicaid and the Uninsured, March 2003.

respiratory system excluded from a policy; a child with allergies may only be offered a policy that does not cover prescription drugs.”¹⁷

For children who would be pushed off SCHIP and whose families would have to use the tax credit in the individual market instead, the Martinez bill thus would be deleterious.

3. Past history shows that a children’s health insurance tax credit of this nature holds potential for substantial marketing abuses.

In 1990, Congress created a modest tax credit (tied to the Earned Income Tax Credit) to help low- and moderate-income families purchase health insurance for their children. This children’s health insurance tax credit operated in a fashion similar to the approach taken by the Martinez bill: a modest tax credit was provided that could be used to purchase children’s coverage in the individual insurance market, without meaningful government standards or safeguards.¹⁸

Once this tax credit was created, a number of insurers began to offer extremely scaled-back insurance plans for children, with premiums set exactly equal to the amount of the tax credit, and to use high-pressure sales tactics to market their plans. Substantial numbers of lower- and moderate-income families enrolled their children in these individual market plans, only to find that the plans often provided flimsy coverage that offered little protection against substantial health care costs. Complaints of abuse mounted, prompting both the Subcommittee on Oversight of the House Ways and Means Committee and the Internal Revenue Service to undertake investigations.

The investigations found that many low-income working families were being sold nearly worthless policies. For example, some insurers sold policies that barred coverage for all pre-existing conditions or contained limits such as *one* outpatient visit per year. The investigations found widespread use by insurance agents of misleading sales tactics.¹⁹

The problems with the tax credit grew so serious that in 1993, its original sponsor, Lloyd Bentsen, led the effort to undo the damage and eliminate it.²⁰ The children’s health insurance credit was repealed in 1993, and widely regarded as a failure.

The Martinez bill provisions that would establish a tax credit for the purchase of children’s coverage could result in similar abuse today. The Martinez proposal for a tax credit of about \$1,400

¹⁷ Blumberg and Kenney, *op cit*.

¹⁸ The only standard is that the Martinez tax credit could not be used to purchase non-health insurance plans such as liability, disability and worker’s compensation insurance; limited health plans covering only vision and dental benefits; and health insurance covering only certain diseases and illnesses.

¹⁹ “Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit,” Subcommittee on Oversight of the Committee on Ways and Means, U.S. House of Representatives, June 1, 1993. See also Hearing before the Subcommittee on Oversight of the Committee on Ways and Means, U.S. House of Representatives, “Abusive Insurance Sales and Marketing Techniques Involving the Earned Income Tax Credit,” March 4, 1993.

²⁰ Bentsen proposed repeal in 1993 when he was Secretary of the Treasury.

per child is not much greater in today's terms (i.e., after adjustment for increases in health care costs) than the maximum value of the tax credit of the early 1990s.²¹

Moreover, reports this year by state insurance commissioners, news organizations, and watchdog groups have documented that the aggressive marketing of private health insurance plans in Medicare — where there are substantially *more* standards than there would be under the Martinez tax credit — has caused some elderly Medicare beneficiaries to sign up for plans that are inappropriate for them.²² A survey of state insurance agencies found that 37 of the 43 states responding had received complaints that agents selling private plans in Medicare were using confusing or misleading marketing practices, with the abuses including such practices as selling of inappropriate plans to Medicare beneficiaries whose mental capacities are limited by dementia.²³ The Centers for Medicare and Medicaid Services recently released detailed information on numerous marketing and other beneficiary-protection violations committed by private insurers participating in Medicare.²⁴

State Health Reform Projects

Finally, the Martinez bill contains a new initiative under which states could receive five-year federal grants to support state programs to increase health coverage and access, improve the quality and efficiency of health care, and test alternatives for the delivery of health care services. These grants could be more illusory than real. The bill provides no funding for them; it merely authorizes them. The grants would materialize only if room were found for them in the annual appropriations bills.

To launch significant expansions of health care coverage, states need assurance of stable financing. Without a firm commitment of funding that will continue for a meaningful period of time, it is unlikely that many states would take up the invitation to apply for the grant program. Under the appropriations process, however, any grant funds that materialize will likely be provided for only a year at a time.

The grant program contained in the Martinez bill has another shortcoming as well — the bill includes no standards for the coverage that states could provide with the grants.²⁵ Low-income people who need subsidies to afford health coverage also need protection from high cost-sharing changes, high out-of-pocket costs resulting from inadequate benefit packages, and misleading sales tactics. Without minimum coverage standards, a state could use federal funds authorized for the

²¹ The 1992 tax credit of \$451 would be \$1,023 in 2007, when adjusted for the increase in national per-capita health care expenditures.

²² Robert Pear, "Methods Used by Insurers are Questioned," *New York Times*, May 7, 2007.

²³ Testimony of Sean Dilweg, Insurance Commissioner for the State of Wisconsin, Senate Special Committee on Aging, May 16, 2007.

²⁴ Robert Pear, "Medicare Audits Show Problems in Private Plans," *New York Times*, October 7, 2007. See also Centers for Medicare and Medicaid Services, "Corrective Action Plan (CAP) Detailed Report," September 27, 2007.

²⁵ The bill would merely require the federal entity awarding the grants to devise a menu of options for state proposals that could include expansions of public programs and the creation of purchasing pools as well as tax credit approaches, providing coverage through the individual market and health savings accounts. The entity would also establish some minimum performance measures and goals with respect to coverage, cost and quality.

grant program to provide vouchers for high-deductible health plans in the individual market with few or no standards against flimsy policies, discrimination against less healthy applicants, or deceptive marketing practices. That could leave people, especially those who have medical conditions, without access to appropriate coverage, if they could purchase coverage at all.

Conclusion

The Martinez legislation does not provide sufficient SCHIP funds to allow states to sustain their existing SCHIP programs. It also would force many states to make their SCHIP eligibility criteria considerably more restrictive and disqualify many children who now are covered. In addition, despite the rhetorical emphasis by opponents of the vetoed SCHIP legislation on *poor* children, the Martinez bill fails to provide any new tools or financial incentives to help states reach and enroll them. The bill also would allow SCHIP-eligible children to be transferred to private plans with fewer benefits and higher cost-sharing, even if the costs of the private coverage for these children were greater than that of providing SCHIP coverage directly.

One of the critical features of the bill is a new tax credit for coverage of children between 200 percent and 300 percent of the poverty line. The bill is designed to shift a number of children from SCHIP to the tax credit. But the tax credit is inadequate and poorly designed. And it would be used primarily in the troubled individual health insurance market where insurers can vary premiums based on children's health status and deny coverage entirely to children and other individuals who are sicker.

Unlike the bipartisan SCHIP legislation approved by the Senate and House that would cover nearly 4 million uninsured children by 2012, the more ideologically-driven Martinez plan would likely make little or no net gain in covering uninsured children, and could cause substantial numbers of children who currently have adequate coverage through SCHIP to become uninsured or underinsured.