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THE FALSE "PUBLIC VERSUS PRIVATE" CHOICE FOR CHILDREN'S HEALTH COVERAGE

by Judith Solomon

As Congress considers the reauthorization of the State Children's Health Insurance Program (SCHIP), groups like the Heritage Foundation are making a strong push to change the way coverage is provided to eligible low-income children.[1] They claim Congress must choose between "government-run health care" and private coverage.

But this is a false choice: *most Medicaid and SCHIP beneficiaries already receive their coverage through private health plans that contract with their states.* The real issue is that Medicaid and SCHIP have established standards to ensure that children who receive coverage through private plans receive the health care they need and that public funds are spent effectively. Proposals by the Heritage Foundation and other groups would essentially eliminate those standards and protections. The choice Congress faces, therefore, is whether to maintain measures designed to ensure value and accountability for public funds.

A related issue involves what is known as "crowd out." Those who push to convert SCHIP into a program that subsidizes individuals to purchase coverage in the private insurance market, with few standards or protections, argue that SCHIP is substituting for employer-based coverage. They cite a recent Congressional Budget Office study which estimated that 25 percent to 50 percent of children covered through SCHIP would otherwise have some form of private coverage, and say this demonstrates the need to overhaul SCHIP as they propose.

This criticism, as well, poses a false choice, as it overlooks the fact that under the fragmented U.S. health insurance system, virtually *any* effort to use government funds to help cover the uninsured will result in some substitution of one type of health-care coverage for another. This is a basic point CBO made when issuing its study. The real choice for Congress is what types of coverage expansions are more efficient and effective than others. And on this front, SCHIP scores well. Analysis by Jonathan Gruber of M.I.T. — a leading health economist who has conducted a good part of the work on SCHIP crowd-out on which the CBO analysis rests. and whose work on crowd-out the Heritage Foundation repeatedly cites — has found that despite crowd-out, "public insurance expansions like SCHIP remain the *most cost-effective means of expanding health insurance coverage*" (emphasis

[1] See Nina Owcharenko, "The Future of SCHIP: Family Freedom or Government Control?" Heritage Foundation Web Memo, May 21, 2007.

added). Gruber's work shows that expanding SCHIP is far more cost-effective than proposals such as health tax credits and deductions.

Most Medicaid and SCHIP Beneficiaries Are Enrolled in Private Plans

Almost two-thirds of Medicaid beneficiaries are enrolled in a Medicaid managed care program.[2] In 2004, 73 percent of children enrolled in Medicaid received most or all of their health care services through a managed care plan.[3] Similarly, most children covered with SCHIP funds are enrolled in managed care, regardless of whether their state provides SCHIP-funded coverage through a separate SCHIP program or a Medicaid expansion program. In 2005, all but two separate state SCHIP programs (North Carolina and West Virginia) contracted with a managed care company or other entity to deliver all or some SCHIP services.[4]

In most states, families whose children are eligible for publicly funded coverage have the choice of a privately operated managed care plan. These plans often include both large, commercial health plans like Blue Cross plans that also cover people enrolled in other types of insurance and managed care organizations that limit their business to Medicaid and SCHIP beneficiaries. The Balanced Budget Act (BBA) of 1997 established safeguards to ensure that Medicaid beneficiaries enrolled in managed care receive the services that the managed care companies have contracted to provide. The BBA also established requirements for states to assess the quality of services provided.[5] While SCHIP rules on the delivery of services through managed care are not as specific as those in the BBA, they require states both to ensure that health plans deliver the services they contract for and to safeguard against fraud and abuse.[6]

Most states contract with managed care organizations on a risk-based, capitated basis, meaning that the organization is paid a fixed monthly amount to provide a defined package of services for each enrollee. This approach is attractive to states because expenditures are predictable: state costs vary only with the number of beneficiaries. Increasingly, states also are taking advantage of their power as purchasers of managed care services to increase quality, efficiency, and accountability in

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[2] Centers for Medicare and Medicaid Services, 2006 Medicaid Managed Care Enrollment Report.

[3] Data from the 2004 Medicaid Statistical Information System (MSIS), Centers for Medicare and Medicaid Services. This figure includes the 52 percent of children who are enrolled in health maintenance organizations (HMOs) and the 21 percent who are enrolled in primary care case management programs (PCCMs), which coordinate a child's primary care and related services.

[4] Neva Kaye, Cynthia Pernice, and Ann Cullen, "Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs," National Academy for State Health Policy, September 2006. In designing their SCHIP programs, states have a choice of establishing a separate state SCHIP program, expanding Medicaid, or doing both. In 2005, 18 states had separate programs, 11 had Medicaid expansions, and 21 had a combination of the two.

[5] Section 1932 of the Social Security Act. The BBA requires that health plans provide Medicaid beneficiaries with easily understood information about health care providers, covered services, and appeals and grievances. Health plans must demonstrate they have adequate provider capacity to insure beneficiaries in all areas of the state and that beneficiaries have access to emergency services.

[6] 42 CFR §457.490; 42 CFR §§457.940 to 457.955.

their Medicaid and SCHIP programs.[7] For example, some states are working with Medicaid managed care plans to develop initiatives to improve parent education, care coordination, and other services that can promote the healthy development of children. Other states have worked to improve the quality of care for children with asthma and other special health care needs.[8]

The Issue Is Whether to Retain State Standards and Accountability

The Heritage Foundation and other groups have proposed a sharp break from the current approach, which fosters the involvement of private health plans but also protects children and ensures that public funds are spent efficiently and effectively.

These groups would provide families with a voucher or possibly a tax credit, which families would use to help purchase insurance through their employer or in the individual market, pay cost-sharing charges, and/or save for their child's future health care needs.[9] There would be no standards regarding the cost, benefits, or cost-sharing associated with the private coverage that families would buy. Low-income children could end up in coverage with high out-of-pocket charges and/or inadequate benefits, in contrast with the current system under which public funds are used to provide children with comprehensive coverage through SCHIP or Medicaid, generally through a private managed-care plan.

Moreover, although the Heritage proposal is put forward under the rubric of "premium assistance," its approach is quite different from the premium assistance programs that operate in Medicaid and SCHIP. Under those programs, states use Medicaid or SCHIP funds to help families purchase private health coverage,[10] but with three important protections:[11]

- The coverage must include the benefits covered under the state's Medicaid or SCHIP program. If a benefit is not covered by the private plan, the state provides "wraparound" coverage so the beneficiary is able to obtain the covered benefit if it is medically necessary.

- Beneficiaries must not face larger co-payments and other charges than they would face in the regular program.[12]

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[7] Melanie Bella *et al.*, "Seeking Higher Value in Medicaid: A National Scan of State Purchasers," Center for Health Care Strategies, November 2006.

[8] See, e.g., Purvi Kobawala Smith, "Enhancing Child Development Services in Medicaid Managed Care," Center for Health Care Strategies, October 2005; Patricia J. Barta, "Improving Asthma Care for Children: Best Practices in Medicaid Managed Care," Center for Health Care Strategies, July 2006.

[9] Nina Owcharenko, "Reforming SCHIP: Using Premium Assistance to Expand Coverage," Heritage Foundation Web Memo, May 22, 2007.

[10] Typically, the subsidies are used to help purchase employer-sponsored coverage, but some states allow families to use the subsidies to purchase coverage in the individual health insurance market.

[11] Some states have received waivers for premium assistance programs that do not include all three of these protections. See Joan Alker, "Premium Assistance Programs: How are they Financed and do States Save Money?" Kaiser Commission on Medicaid and the Uninsured, October 2005.

[12] In Medicaid, children in families with income below 150 percent of the poverty line are not charged premiums. There is no cost-sharing for children in families with income below the poverty line; for higher-income children, the total of

- The purchase of private coverage must be cost-effective for the state. In other words, subsidizing the private coverage cannot be more expensive than providing coverage through Medicaid or SCHIP.

The Heritage approach, in contrast, would allow public funds to be used to purchase coverage that is inadequate or unaffordable; the approach provides no guarantee that children will receive the benefits they need and could leave families with steep out-of-pocket costs. Nor would there by any requirement that the private coverage not cost the government *more* than regular Medicaid or SCHIP does.[13]

Furthermore, past history suggests a health tax credit or voucher could lead to fraudulent and abusive marketing of health insurance products. In 1990, Congress established a refundable tax credit for the premium costs of health insurance for low-income children, with few standards involved. As explained below, what ensued was abuse so serious — with many families sold extremely flimsy policies for their children — that Congress repealed the tax credit in 1993.

Approach Would Allow Use of Public Funds for Inadequate, Inaccessible Coverage

Under the Heritage proposal, states would give families a "standard contribution" equal to the average amount that SCHIP spends on a child each year (estimated by Heritage to be about $1,220) to help purchase coverage for the child.[14] This amount would not be enough, however, for most families to purchase coverage in the private insurance market.

Heritage speaks of families using this "standard contribution" to help them purchase family coverage. In 2006, however, the average premium for family coverage in an employer-sponsored plan was $11,480 per year, and the average family's share of the premium was $2,973. Moreover, many of these plans have a deductible that must be met before coverage kicks in, and most have co-payments or coinsurance charges that require families to pay a share of the cost of covered health-care services.[15] In most cases, the "standard contribution" would fall well short of the sum of the premium and additional out-of-pocket costs that families would face under employer-sponsored plans.

Families also could try to use their "standard contribution" to purchase coverage in the individual health insurance market. In fact, for most low-income families, this would be their main option, since most such families do not have access to employer-sponsored insurance. (In 2005, only 14

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premiums and cost-sharing charges cannot exceed 5 percent of family income. SCHIP rules also vary based on family income, but as in Medicaid, total premiums and cost-sharing cannot exceed 5 percent of family income.

[13] It may be noted that the Medicare Payment Advisory Commission (MedPAC), Congress' expert advisory body on Medicare payments, has found that in Medicare, the federal government is paying 12 percent more, on average, to private plans than it would cost to serve the same beneficiaries in the regular Medicare program.

[14] Heritage suggests this approach could be coupled with changes in the tax treatment of health insurance that would provide low-income families with a health care tax credit to supplement the SCHIP contribution. Owcharenko, "Reforming SCHIP."

[15] "Employer Health Benefits 2006 Annual Survey," Kaiser Family Foundation and the Health Education and Research Trust, September 2006.

percent of families with income between 100 and 199 percent of the poverty line and only 8 percent of families with income between 200 and 400 percent of the poverty line declined an offer of employer-sponsored insurance.[16]) However, coverage in the individual market is even less likely to be affordable for the family or cost-effective for the state, because there is no employer contribution to offset part of the premium. In addition, an estimated 25 percent to 40 percent of the cost of coverage in the individual market goes to administrative costs.[17]

While premiums in the individual market vary based on a state's insurance laws and an individual's age and health status, one study found the average premium for 18-to-24 year olds was $1,549 in 2002.[18] Many plans in the individual market also carry high deductibles and co-payments, bringing total out-of-pocket costs to quite high levels. A recent study found that nearly half of the families with incomes below 200 percent of the poverty line who were enrolled in private, non-group health plans had total out-of-pocket expenses exceeding 5 percent of their income.[19] For low-income families that also must cover other basic expenses like rent and utilities, food, and child care, such out-of-pocket medical expenses can result in decisions to forgo needed health care services or to forgo coverage altogether.[20] (Note: The premiums for individual market coverage also do not take into account the fact that plans in the individual market may not cover various benefits, such as dental care and eyeglasses, that the vast majority of state SCHIP programs cover.[21])

In addition, some families may be unable to purchase coverage in the individual market at any price. In most states, insurers can turn down applicants with health problems.[22] When coverage is provided, it may exclude coverage for treatment of existing health conditions.[23]

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[16] 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.

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

[18] David Auerbach and Sabina Ohri, "Price and the Demand for Nongroup Health Insurance," *Inquiry* 43: 122-134 (Summer 2006). The study did not provide cost estimates for children.

[19] The exact percentage was 46 percent of such families. Yu-Chu Shen and Joshua McFeeters, "Out-of-Pocket Health Spending between Low- and Higher-Income Populations: Who is at Risk of Having High Expenses and High Burdens?" *Medical Care* 44(3) March 2006.

[20] A national survey of adults with private insurance found that 44 percent of those with deductibles over $1,000 reported at least one problem in obtaining access to care. Sara 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. See also, Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.

[21] Separate state SCHIP programs do not have to cover dental care and eyeglasses, but 92 percent of states covered dental care and 97 percent covered eyeglasses in 2005. Kaye, Pernice, and Cullen. In the Oregon premium assistance programs, almost none of the plans in the individual market covered dental care. Janet B. Mitchell, Susan G. Haber, and Sonja Hoover, "Premium Subsidy Programs: Who Enrolls, and How do They Fare?" *Health Affairs*, September/October 2005.

[22] 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.

[23] Karen Pollitz and Richard Sorian, "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs*, web exclusive, October 2002.

Thus, it is doubtful that low-income families, especially those whose children have greater health care needs, could purchase adequate and affordable coverage for their children in the individual market with the "standard contribution" that Heritage recommends. To the extent that families with healthy children did succeed in finding coverage they could afford in the individual market with their government contribution, states likely would be left having to cover less-healthy children whose parents were unable to obtain adequate coverage in the private market. Caring primarily for these sicker children in the public program — while providing a "standard contribution" for healthier children that is based on the average cost of care for *all* children, healthy and unhealthy alike — would drive up overall program costs.

Past History Shows Health Tax Credits Hold Potential for Abuse

While adequate coverage would likely prove difficult to obtain under the Heritage proposal, history suggests that *inadequate* coverage might be all too easy to obtain. As noted above, in 1990, Congress created a modest tax credit tied to the Earned Income Tax Credit (EITC) to help low-income families purchase health insurance for their children, with few standards involved. The tax credit essentially operated in accordance with the Heritage recommendation that a contribution be provided that would be applicable to any policy on the market, without regard to government standards or safeguards.

In response to the creation of this tax credit, a number of insurers began offering flimsy insurance plans for children, with premiums set equal to the amount of the tax credit. As complaints of abuse mounted, the Subcommittee on Oversight of the House Ways and Means Committee found it necessary to conduct a formal investigation of the credit. The investigators found many low-income working families were being sold virtually worthless policies. Some insurers sold policies for children that covered only cancer, heart attacks, strokes, and other diseases that few children have. Other policies had restrictions such as pre-existing condition exclusions and a limit of one outpatient visit per year. The Subcommittee also found that insurance agents used misleading, high-pressure sales tactics.[24] Separate investigations by the Internal Revenue Service provided strong corroborating evidence.

The problems with the credit were so serious that its original sponsor, Senator Lloyd Bentsen (D-TX), led the effort to repeal it.[25] The credit was repealed in 1993.

Giving families a voucher or health tax credit worth a standard amount could result in similar abuse today. The Heritage proposal for a "standard contribution" of about $1,220 per child is roughly equivalent in today's terms (i.e., after adjustment for increases in health care costs) to the maximum value of the tax credit of the early 1990s.[26]

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[24] "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.

[25] Bentsen proposed repeal in 1993 when he was Secretary of the Treasury.

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

Moreover, reports this year by state insurance commissioners, news organizations, and watchdog groups have documented that aggressive marketing plans of private health insurance plans in Medicare has caused some elderly Medicare beneficiaries to sign up for plans that may be inappropriate for them, with the beneficiaries often having little understanding of how the plans work.[27] A survey of state insurance agencies found that 37 of the 43 states responding had received complaints that agents selling private plans in Medicare used confusing or misleading marketing practices. The abuses included such things as the selling of inappropriate plans to Medicare beneficiaries with dementia.[28]

The Confusion over "Crowd-out"

Heritage presents its proposals as a way of keeping SCHIP from "crowding out" private coverage. Heritage cites a recent analysis by the Congressional Budget Office which estimated that 50 percent to 75 percent of children in SCHIP would otherwise have been uninsured, but that SCHIP substituted for private coverage in the other cases.

In citing this finding, Heritage glosses over an essential point that CBO's director and other leading researchers on crowd-out have emphasized: under the U.S. health care system, virtually any effort to use government funds to help cover the uninsured will result in some substitution of one type of health-care coverage for another, or in the use of a not-insignificant amount of government funds to subsidize coverage that people would have anyway.[29]

Analysis by Jonathan Gruber of M.I.T. — a leading health economist who conducted a good part of the work on SCHIP crowd-out on which the CBO analysis rests — found, for example, that the proposals in the Administration's fiscal year 2007 budget to provide tax deductions and credits for the purchase of insurance in the individual health insurance market would carry large costs but result in *no* net gain in coverage. Gruber found the proposals' primary effect would be to lead people who already are insured to switch from one form of coverage to another. He estimated that while the proposals would increase the number of Americans who have coverage through the individual market by 8.3 million people, they would cause employer-based coverage to decline by fully as much as coverage in the individual market would rise. Although the proposals would ultimately cost nearly $12 billion a year, Gruber found, they would produce no reduction in the number of uninsured.[30]

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[27] Robert Pear, "Methods Used by Insurers are Questioned," New York Times, May 7, 2007.

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

[29] In releasing the CBO report, CBO's Director Peter Orszag noted that some crowding out is inevitable under any proposal to reduce the number of uninsured children, explaining: "The uninsured children exist in many of the same pools as insured children and so any attempt to target uninsured children necessarily has some spill over effects." Remarks of Peter R. Orszag, CBO conference call, May 10, 2007.

[30] In fact, Gruber estimated there would be a net increase of 600,000 in the number of uninsured. Jonathan Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," Center on Budget and Policy Priorities, February 15, 2006.

Similarly, proposals to use SCHIP funds to a much greater degree to help pay premiums for employer-based coverage for children carry the risk of causing a large percentage of the funds to go to subsidize coverage for children who already are insured through their parent's employer and who are not currently consuming any SCHIP funds. To the extent this is the case, there would be large taxpayer costs for little gain in coverage.

Accordingly, the question is not whether some "crowd-out" or "substitution" occurs under efforts to reduce the number of uninsured children, but rather what types of coverage expansion initiatives are more efficient and effective than others. On this front, SCHIP scores well.

Professor Gruber, the economist who has produced some of the highest estimates of crowd-out under SCHIP and is extensively cited by Heritage, has concluded that despite the "crowd-out" effects, expanding programs like SCHIP is the most efficient way to cover the uninsured.[31] Professor Gruber has written that "no public policy can perfectly target the uninsured, and public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage. I have undertaken a number of analyses to compare the public sector costs of public sector expansions such as SCHIP to alternatives such as tax credits. I find that the public sector provides much more insurance coverage at a much lower cost under SCHIP than these alternatives. Tax subsidies mostly operate to 'buy out the base' of insured without providing much new coverage."[32]

Conclusion

Research has shown that children enrolled in SCHIP or Medicaid receive coverage that generally costs less than what is available in the private market, provides a more comprehensive benefit package, and protects them against high out-of-pocket costs.[33] States are able to use their purchasing power to get strong value for public dollars, and through oversight and quality assurance of private plans that participate in the program, states can ensure that children actually get the benefits the state is paying for.

As Congress begins to debate SCHIP reauthorization, the real issue is *not* whether low-income children will receive public or private coverage (or whether they will be locked into "government-run plans" rather than "mainstreamed" into private coverage, as Heritage suggests), since most children insured with SCHIP funds are already enrolled in private plans. Rather, the question is whether public funds will continue to be used to provide these children with high-quality, affordable health care services in a cost-effective manner.

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[31] See Jonathan Gruber, "Tax Policy for Health Insurance, Working Paper 10977, National Bureau of Economic Research, December, 2004.

[32] Letter from Jonathan Gruber to Rep. John Dingell, Chairman of the House Energy and Commerce Committee, March 2007.

[33] See Leighton Ku, "Comparing Public and Private Health Insurance for Children," Center on Budget and Policy Priorities, May 11, 2007.