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THE ADMINISTRATION'S DUBIOUS CLAIMS ABOUT THE EMERGING CHILDREN'S HEALTH INSURANCE LEGISLATION

Myth and Reality

by Robert Greenstein

Congress is considering legislation to reauthorize the State Children's Health Insurance Program (SCHIP), a successful federal health program enjoying bipartisan support that, together with Medicaid, has reduced the proportion and the number of low-income children who are insured by about one third since 1997. On July 19, the Senate Finance Committee approved bipartisan legislation by a 17-4 vote, and two House committees are expected to act shortly thereafter.

The Bush Administration, however, is characterizing the children's health insurance legislation being developed in Congress as a big-government approach that would pave the way for socialized medicine, do little for low-income children, and primarily shift people with good incomes from private health care coverage to government health insurance at taxpayers' expense. These characterizations were evident on June 27 at White House events featuring the President, HHS Secretary Mike Leavitt, and White House National Economic Council director Al Hubbard, and again on July 10 and July 14 when the White House announced it would veto the emerging SCHIP legislation. Secretary Leavitt has repeated these claims in media interviews, as have the Administration's regional HHS directors and some Members of Congress.

KEY FINDINGS

Various Administration claims regarding the emerging SCHIP legislation do not reflect reality:

- *Claim*: It would advance a "Washington-run, government-owned" health plan designed to pave the way for a single-payer system.

  Reality: SCHIP and Medicaid are not single-payer systems, and most SCHIP (and Medicaid) beneficiaries receive coverage through *private* managed care plans with which their state SCHIP and Medicaid programs contract. The AMA and the trade associations for the private insurance companies and the drug companies — hardly supporters of "government run" health care — support expanding SCHIP to cover more uninsured low-income children.

- *Claim*: The bill would primarily shift already-insured people "with good incomes" from private to government coverage.

  Reality: The legislation being developed on Capitol Hill is targeted at low-income children who otherwise would be uninsured, as the CBO analysis of the Senate Finance Committee bill clearly shows.

- *Claim*: SCHIP expansions will be inefficient since they will "crowd out" private coverage.

  Reality: The CBO figures show "crowd-out" would be modest under the Senate bill, and the economist whose study on SCHIP crowd-out is touted by the Administration has found that expanding programs like SCHIP is considerably *more* efficient as a way to cover the uninsured than alternatives like tax credits.

Senate Finance Committee Bill Illustrates Fallacies Of Administration Accusations

On July 13, the bipartisan leadership of the Senate Finance Committee unveiled new SCHIP legislation. The Administration greeted the legislation with a promise to veto it, accompanied by a repetition of the charges it has been making against the emerging SCHIP bills. Yet the Congressional Budget Office's analysis of the Finance Committee legislation illustrates that most of these charges simply do not apply.

The White House has been characterizing the emerging bills as doing little to assist low-income children and as primarily being focused on dramatically expanding the SCHIP eligibility criteria to cover middle-income families that already have private coverage. The information in CBO's analysis of the Finance Committee bill does not square with these assertions. To the contrary, CBO finds that the bill would be heavily focused on low-income children who otherwise would be uninsured.

- CBO finds that by 2012, some 4 million children who otherwise would be uninsured would have health care coverage under the bill.
- CBO estimates that 2.7 million of these children are children who would be eligible for the program *under the current eligibility criteria* that states have set. Another 800,000 children are SCHIP children who are projected to lose their coverage and become uninsured, because states will have insufficient federal funding to sustain their existing SCHIP programs.
- This means CBO estimates that 3.5 million of the 4 million children who would obtain coverage rather than be uninsured — or *at least 85 percent* of them — are children with incomes below the current eligibility limits that states have set.
- Only 600,000 of these 4 million children are children who would be made eligible as a result of their state broadening the SCHIP eligibility criteria, and in any event, these are children who would be uninsured if their state did *not* take such action. (The numbers do not add precisely due to rounding effects.)
- CBO also finds that under the bill, a total of 6.1 million more children would be covered through SCHIP and Medicaid by 2012 — the 4 million children just mentioned, who would otherwise be uninsured, and 2.1 million additional children, who otherwise would have some form of private coverage. In other words, only about one-third (34 percent) of the children gaining SCHIP or Medicaid coverage under the bill would be children who otherwise would have private coverage.

A 34 percent "crowd-out rate" is modest and is an indication that the bill effectively targets low-income uninsured children. As CBO director Peter Orszag and other health care experts have pointed out, it is virtually impossible under the fragmented U.S. health insurance system to provide resources to shrink the number of uninsured people without having a significant share of the resources go to subsidize people who already are covered. Indeed, an analysis of the tax deduction and tax credit proposals that the Bush Administration made last year — conducted by Jonathan Gruber of M.I.T., the very expert whose work on SCHIP crowd-out has been cited extensively by Secretary Leavitt and conservative activists in recent weeks — found that *77 percent* of the benefits under those proposals would go to people who already were insured. (Gruber also found that the Administration tax proposals would produce *no* net reduction in the number of Americans without insurance because they would induce a significant number of employers to drop coverage.)

Finally, in many cases where a family with access to private coverage enrolls its child in SCHIP or Medicaid instead, that action by the family may be beneficial for the child. In many such cases, the private coverage available to the family may either have significant gaps in coverage or feature high deductibles and co-payments that low-income families have difficulty affording. Research has shown that when faced with high co-payments, many low-income families delay or fail to obtain health care services they or their children need. In such circumstances, a switch to SCHIP or Medicaid coverage can be important for a child's health.

As explained below and in the box on page 2, which examines the new Senate Finance Committee bill, the principal charges being leveled against the emerging Senate and House SCHIP legislation reflect distortions, misuse of data, and false claims.

This is unfortunate. Policymakers will differ on what steps should to take in the area of health care policy, and debate on such issues is necessary and important. But progress in covering the millions of American children who are uninsured — and more broadly, in addressing the twin problems of escalating health costs and the growing numbers of uninsured people, including adults as well as children — will come only if policymakers begin dialogue with a recognition and acceptance of basic facts and an absence (or at least a minimum) of distortion.

Below we consider some of the principal distortions as articulated by Secretary Leavitt and Mr. Hubbard at their June 27 White House press conference and reiterated since. (These statements followed a similar, if less detailed, pronouncement by the President on these matters.)

Administration Claim #1: The SCHIP legislation is being designed as a vehicle to advance "a Washington-run, government-owned [health] plan, where government makes the choices, where government sets the prices, where government then taxes people to pay the bill."

At the press conference,[1] Secretary Leavitt claimed there are two competing philosophies on how to cover the uninsured, and that the emerging SCHIP legislation reflects the philosophy of "a Washington-run, government-owned plan, where government makes the choices, where government sets the prices, where government then taxes people to pay the bill." In a subsequent interview with the *New York Times*, Hubbard declared that the emerging Congressional SCHIP legislation would move the nation toward "a single-payer system with rationing and price controls."[2]

At the press conference Hubbard also stressed the importance of using private insurance companies, rather than federally funded health care programs, in order to preserve "the important doctor-patient relationship that exists in the private sector." The implication was that programs like Medicaid and SCHIP rely on doctors who are government bureaucrats and lack relationships with patients.

These charges are groundless. SCHIP is a ten-year-old program up for reauthorization that does not operate through a single-payer system or anything remotely like it. Both SCHIP and the Medicaid program use private doctors and private health care plans. Moreover, it is the states, not Washington, that set the income limits, contract with providers and set provider reimbursement rates, and determine most of the particulars of the health care benefit packages in these programs.

- "Government doctors" and "government health plans" do *not* deliver the services in SCHIP or Medicaid. It is *private* doctors and *private* health plans that do, as under private insurance.

[1] The transcript of the press conference is available at hhtp://www.whitehouse.gov/news/releases/2007/006120070627-16.html.

[2] Robert Pear, "Battle Takes Shape Over Expansion of Children's Insurance," *New York Times*, July 9, 2007.

- Indeed, most Medicaid and SCHIP beneficiaries receive coverage through private plans that contract with their states. Almost two-thirds of all Medicaid beneficiaries are enrolled in a Medicaid managed care plan, the vast bulk of which are private plans. This is particularly the case among children enrolled in Medicaid; 73 percent of the children enrolled in Medicaid received most or all of their health care services through a managed care plan.[3] These percentages are even higher in state SCHIP programs that operate separately from Medicaid; all but two states with such programs contract with a managed care company or other private entity to provide many or all SCHIP services.[4]

- In most states, children covered through Medicaid or SCHIP either have the choice of a privately operated managed care plan or are required to enroll in such a plan.

These are not the conclusions one would draw from the comments of the President and his senior officials. Nor would one know from their comments that the American Medical Association, America's Health Insurance Plans (the trade association that lobbies for private insurance companies) and the Pharmaceutical Research and Manufacturers of America (the trade association that lobbies for the pharmaceutical companies), all support extending SCHIP to more uninsured children. AMA, AHIP, and PhRMA are hardly supporters of a single-payer system or socialized medicine.

Administration Claim #2: The legislation would primarily shift already-insured people with good incomes and private coverage to public coverage at taxpayer expense.

At the White House press conference, Leavitt portrayed the debate over the SCHIP bill as being, in part, about "whether SCHIP should be used as the vehicle to shift millions of people who have good incomes and private insurance to publicly assisted government insurance."

Leavitt asserted that only 1.7 million uninsured children are eligible for SCHIP at any point during the year and that covering all of them immediately would cost in the range of $10 billion over five years. He asserted that the only way Congress could spend $50 billion over five years (the amount allowed for the SCHIP bill under the congressional budget resolution) would be for Congress to launch a dramatic expansion of SCHIP, such as to cover people up to 400 percent of the poverty line. And since the majority of people between the current SCHIP income limits and 400 percent of the poverty line already have private insurance, Leavitt concluded, the goal of the legislation obviously is to convert these people to being recipients of government health insurance.

Leavitt's math, however, was deeply flawed. For example, he ignored the nearly 4 million low-income children who are eligible for *Medicaid* but are unenrolled and uninsured. Reaching these children — the poorest uninsured children in the United States — is one of the central goals of the

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[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] The two states that do not are North Carolina and West Virginia. 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.

Despite Higher Income limits, Most Children SCHIP Insures Have Low Incomes

Some 16 states set income limits for SCHIP above 200 percent of the poverty line in 2006,* in recognition of the fact that insurance can be unaffordable for families with incomes somewhat above that level (especially if the family does not have access to employer-based coverage or the cost of such coverage is beyond its means).** Even so, the Congressional Research Service has estimated, based on data from the states, that *91 percent* of the children covered through SCHIP in 2006 had incomes *below* 200 percent of the poverty line.***

As these figures suggest, the proportion of children eligible for SCHIP who actually enroll in the program appears to be substantially lower among children above 200 percent of the poverty line, in part because families in this income category are more likely to have access to employer-based insurance. (In addition, states that have raised their income limits above 200 percent of poverty generally charge higher premiums to families at these income levels.)****

* See Donna Cohen Ross and Laura Cox, "Resuming the Path to Health Coverage for Children and Families," Kaiser Commission on Medicaid and the Uninsured, January 2007.

** See Linda J. Blumberg, John Holahan, Jack Hadley, and Katherine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage," *Health Affairs*, June 4, 2007.

*** See Cindy Mann and Michael Odeh, "SCHIP Reauthorization: Can the Nation Move Forward without Going Backward?," Center for Children and Families, Georgetown University Health Policy Institute, June 2007, based on data from Chris Peterson and Elicia Herz, "Estimates of SCHIP Enrollees At or Below 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees," Congressional Research Service, March 13, 2007.

**** See Ross and Cox, *op cit*., and unpublished survey information on SCHIP premium requirements as of July 2006 from the Center on Budget and Policy Priorities.

emerging legislation. (It also was one of the key goals President Bush set for himself for his second term. In his 2004 reelection campaign, he declared "In a new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for government health insurance programs. We will not allow a lack of attention, or information, to stand between these children and the health care they need."[5] Moreover, in its fiscal year 2006 budget, the Administration proposed increases in outreach funding to reach "as many Medicaid and SCHIP eligible children as possible."[6])

Immediately covering all of the low-income children who are eligible for SCHIP or Medicaid but are uninsured would cost close to $40 billion over five years. In addition, CBO has reported it will cost $8 billion more over five years just to continue covering the same number of children that the SCHIP program serves today. This $8 billion is needed because CBO's budget "baseline" assumes SCHIP funding will remain frozen in coming years at the 2007 level, without any adjustment for increases in health care costs. As a result, the number of low-income children insured through SCHIP drops sharply under the budget baseline, a problem CBO says will cost $8 billion to fix.[7]

[5] See "President Bush Accepts the Nomination at the 2004 Convention" (a transcript of the President's Address to the 2004 Republican Convention) available at http://www.gop.com/News/Read.aspx?ID=5054.

[6] Office of Management and Budget, Budget for Fiscal Year 2006, February 2005.

[7] 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.

Leavitt also overlooked a key conclusion that most program experts and CBO have reached — that to enroll a substantial portion of the children who are eligible for Medicaid or SCHIP but are uninsured, the federal government also will have to provide some additional federal financial support to states. After all, it is the states that will have to identify and enroll these children, and states will then bear a significant share of the costs of insuring them. CBO has reportedly informed the Congressional committees writing the legislation that if Congress wants to reach a sizeable share of the eligible uninsured children, it will need to incorporate additional financial support for states into the legislation.

For these reasons, the estimates that CBO has provided to Congress suggest that if Congress were to design effective measures to cover most of the uninsured children with incomes below the programs' *current* income limits, that alone would likely cost more than $50 billion over five years. The bill that the Senate Finance Committee unveiled July 13, which is targeted heavily on uninsured children who are eligible under the current income limits, rather than on children at higher income levels, would reach about *half* of those children and cost $35 billion over five years. (See the box on page 2 for more discussion of the Finance Committee bill.)

As this discussion indicates, claims that under the emerging legislation, the bulk of the new funds would go to cover the costs of raising SCHIP income limits and adding new beneficiaries at higher income levels are simply not correct.

Administration Claim #3: SCHIP expansions will be very inefficient because they will "crowd out" private coverage.

A key argument that Secretary Leavitt and others have used to criticize the emerging SCHIP legislation — and to promote their alternative proposals for tax deductions or credits — is that expanding Medicaid and SCHIP will primarily displace or "crowd-out" existing coverage obtained in the private insurance market, rather than insuring more children, while their proposal will avoid this problem.

In making this argument, the Administration has ignored a critical point that CBO director Peter Orszag and leading researchers on the crowd-out issue have consistently emphasized: under the fragmented U.S. health insurance system, virtually *any* effort to use government funds to help cover the uninsured, including efforts that work through tax deductions or credits, will result in some crowd-out — i.e., some substitution of one type of health-care coverage for another — or in the use of government funds to subsidize coverage that people would have had anyway.[8]

The relevant question thus is not whether *some* crowd-out or substitution will occur if efforts are made to reduce the number of uninsured children, since some crowd-out or substitution is inevitable. The relevant question is what types of coverage expansion initiatives are the most efficient and effective and would have the smallest such effects.

SCHIP scores well, rather than poorly, on this front. Jonathan Gruber of M.I.T., the eminent health economist who conducted the study on SCHIP crowd-out that Secretary Leavitt singled out

[8] Peter Orszag, Conference Call on the State Children's Health Insurance Program, May 10, 2007 (audio file available at www.cbo.gov/audio/38944207).

in a *Washington Times* op-ed on July 9,[9] has noted that despite the significant "crowd-out" effects he has found to be associated with SCHIP, expanding programs like SCHIP is the most efficient way to cover the uninsured.[10] 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."[11]

Gruber found, for example, that the substitution effects under proposals that the Administration made last year to provide tax deductions and credits for the purchase of insurance in the individual market would dwarf the effects under an SCHIP expansion. Gruber found that *77 percent* of the benefits under the tax deduction and tax credit proposals the Administration made last year would go to people who already were insured. He also found that a primary effect of these tax proposals would be to lead people who already have insurance to switch to from one form of coverage to another, rather than to reduce the number of uninsured. Indeed, he estimated that because the Administration's proposals would induce a significant number of employers to drop coverage, the proposals would produce *no* reduction in the overall number of uninsured people even though they would cost nearly $12 billion a year.[12]

Finally, it should be recognized that some of the crowd-out that occurs when low-income families enroll their children in Medicaid or SCHIP rather than in private insurance occurs because the private insurance available to the family has substantial gaps in coverage or requires large deductibles and co-payments that the family has difficulty affording and that may result in the family failing to access health care services its children need. In such cases, switching the child to SCHIP or Medicaid coverage can be beneficial for the child's health.

Administration Claim #4: Private insurance is less expensive and more efficient than "government coverage" through SCHIP and Medicaid.

As noted, the Administration is pushing for a tax deduction or tax credit to be provided in place of most of the funding increase for SCHIP that Congress is discussing. Families would use these tax benefits to purchase coverage on their own. In the June 27 press briefing, Secretary Leavitt portrayed "private" coverage as more efficient and less costly than the "government coverage" that is provided through programs like SCHIP and Medicaid.

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[9] Mike Leavitt, "Opinion: Reforming Health Care," *Washington Times*, July 9, 2007.

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

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

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

Administration SCHIP Numbers and Claims Have Not Been Reliable This Year

The President's budget proposed SCHIP funding totaling only $5 billion over five years above the budget baseline, even though the baseline reflects a five-year freeze at the 2007 funding level with no adjustment for increases in health care costs. In releasing its budget, the Administration claimed its SCHIP proposal would be adequate to maintain current SCHIP enrollment levels, an assertion it has never backed off from.

Yet the Congressional Budget Office, as well as analysts outside the government, have found these claims to be incorrect. CBO estimates it will take $13.4 billion in increased SCHIP funding (above the baseline) just to maintain current enrollment levels. CBO also estimates that under the President's budget, the number of children (and the small number of pregnant women) who are insured through SCHIP in any given month would drop by about 840,000 between 2007 and 2012.*

* Congressional Budget Office, "Additional Information On CBO's Estimate of the Administration's SCHIP Proposals," March 9, 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.

Yet the facts dispute this portrayal. Programs such as Medicaid and SCHIP — and Medicare as well — are able to use their large purchasing power to secure health care services for significantly *less* than it generally costs to deliver such services through private insurance.

- The major study comparing the costs of providing health care through Medicaid to the costs of providing it through private insurance — a study conducted by economists Jack Hadley and John Holahan of the Urban Institute — found that after adjusting for health status, health care costs for adults enrolled in Medicaid were *30 percent lower* than those costs would be under private insurance, and costs for children were *10 percent lower* than under private insurance. The main reason for the difference is that Medicaid pays lower fees to health-care providers. The study also indicated that Medicaid administrative costs were about half of the administrative costs under private insurance.[13] (Such costs in the private non-group health insurance market are very high; as much as 40 percent of the premium cost of individual market insurance may go to administrative costs.[14])

- In Medicare, both the Congressional Budget Office and Congress' own Medicare expert advisory commission have found that when beneficiaries opt to receive coverage through private insurance plans rather than through regular Medicare, the private plans are paid 12 percent more on average.[15] While a part of the overpayments goes to additional benefits that the private companies offer to induce people to sign up, a good part of the overpayments go to higher administrative costs, marketing, and plan profits.

[13] Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?," *Inquiry*, 40(4): 323-42, Winter 2003/2004. See also Leighton Ku, "Comparing Public and Private Health Insurance for Children," Center on Budget and Policy Priorities, May 11, 2007.

[14] Jon Gabel, Kelly Dhont, Heidi Whitmore and Jeremy Pickreign, "Individual Health Insurance: How Much Financial Protection Does It Provide?," *Health Affairs*, Web Exclusive, April 17, 2002.

[15] Medicare Payment Advisory Commission, "Report to the Congress: Promoting Greater Efficiency in Medicare," June 2007 and Peter Orszag, "The Medicare Advantage Program: Enrollment Trends and Budgetary Effects," Testimony before the Senate Finance Committee, Congressional Budget Office, April 11, 2007.

Furthermore, policies available in the individual health insurance market often carry high deductibles and cost-sharing charges, which can pose formidable obstacles for low-income families. Policies sold in the individual market also frequently fail to cover, or impose strict limits on, important health care services. In addition, the premiums charged for private coverage in the individual health insurance market are generally quite high for people who have medical conditions, if such people are able to buy such policies at all. In short, such coverage may be inadequate or unaffordable, especially for children who are not in good health, and often is inferior to the coverage Medicaid and SCHIP provide for children.

The Administration's Flawed Alternative

The alternative that the Administration apparently intends to push is to devote substantially less money to SCHIP — an amount sufficiently small that CBO has found states would not be able to continue even to cover the number of children they currently serve — and instead to give tax credits or deductions to families to purchase insurance on their own, particularly in the individual health insurance market. Basic analysis, as well as direct experience with a federal health insurance tax credit for low- and moderate-income children in the early 1990s, indicates that such an approach would likely produce disappointing results and have adverse consequences.

As noted above, most state Medicaid and SCHIP programs contract with private managed care companies to provide coverage for children. Medicaid and SCHIP programs have developed standards that are written into these contracts to ensure that children receive coverage for important services and that funds are effectively spent. The standards are designed to ensure that the government (and hence the taxpayers) receive accountability and value for these funds.

Under the Administration's proposals, by contrast, many families could be sent with government-funded tax credits (and/or tax deductions) into the individual health insurance market, where few standards apply in most states. Studies have consistently shown that insurers in the individual market frequently charge very high premiums, or refuse coverage altogether, to individuals who are not in good health. In addition, as noted above, the insurance available in the individual market often carries high deductibles and co-payments that exceed what many low-income families can afford and also may fail to provide coverage for important health care services.

This means that instead of using public funds to contract with private plans in a manner designed to assure accountability and value — and to provide adequate coverage for low-income children — the Administration is seeking to allow public funds to be used for insurance that could leave substantial numbers of children without coverage for particular services they may need or leave their families with co-payments for care that the families have difficulty affording. (Jonathan Gruber's assessment of the tax credits and deductions the Administration proposed a year ago also suggests that the crowd-out or substitution effects of the Administration's health tax proposals would be much greater than the effects from the SCHIP legislation.)

History provides a sad but instructive example of what can occur under such an approach. In 1990, Congress established a refundable tax credit for the purchase of health insurance for low-income children, with few standards involved. The result was a failure of such a scope that Congress repealed the tax credit in 1993.

The decision to repeal the children's health insurance tax credit came after investigations of the credit were undertaken by the Internal Revenue Service and the Oversight Subcommittee of the House Ways and Means Committee. The investigations found that many low-income families were sold flimsy insurance policies of dubious merit; some insurers sold policies for children that covered only cancer, heart attacks, strokes, and other diseases that few children have. Other policies imposed restrictions such as pre-existing condition exclusions and/or austere limits, such as a limit of one outpatient visit per year. The investigations also uncovered extensive evidence of insurance agents using misleading, high-pressure sales tactics.[16] (Note: Evidence that misleading sales tactics by insurance agents can emerge when the government sends unsuspecting individuals into the health insurance market to buy coverage with a federal subsidy has surfaced again in recent months, with the revelations of misleading marketing practices by agents selling private insurance polices under the Medicare Advantage program.[17])

[16] "Report on Marketing and Abuse and Administrative Problems Involving The Health Insurance Component of the Earned Income Tax Credit," Subcommittee on Oversight of the House Ways and Means Committee, June 1, 1993 and "Abusive Insurance Sales and Marketing Techniques Involving the Earned Income Tax Credit," Hearing before the Subcommittee on Oversight of the House Ways and Means Committee, March 4, 1993

[17] See, for example, "Testimony of Sean Dilweg, Wisconsin Insurance Commissioner, before the United States Special Committee on Aging Regarding Medicare Advantage Marketing and Sales," Testimony before the Senate Special Committee on Aging, May 16, 2007, and David Lipschutz, Paul Precht, and Bonnie Burns, "After the Goldrush: The Marketing of Medicare Advantage and Part D Plans," California Health Advocates and the Medicare Rights Center, January 2007.