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LOTT-McCONNELL SCHIP PROPOSAL WOULD FAIL TO MAKE PROGRESS IN COVERING UNINSURED CHILDREN

Proposal also Includes Risky Provisions that Preempt State Health Insurance Laws

by Edwin Park and Matt Broaddus

This week, the Senate is considering the “Children’s Health Insurance Program Reauthorization Act of 2007,” bipartisan children’s health legislation approved on July 19 by the Senate Finance Committee on a 17-4 vote. According to Congressional Budget Office estimates, this legislation would provide health insurance to 4 million uninsured children by 2012.

Senator Trent Lott, the Senate Minority Whip and Senator Mitch McConnell, the Senate Minority Leader, have offered alternative SCHIP reauthorization legislation, which also includes provisions to preempt existing state insurance laws and expand Health Savings Accounts (HSAs). Debate on the Lott-McConnell proposal began on August 1.

In contrast to the bipartisan Senate Finance Committee bill, the substitute plan that Senators Lott and McConnell would offer would fail to make progress in reducing the number of uninsured low-income children. The substitute plan also contains provisions that would result in increases in health insurance premiums for small businesses with older and sicker workers (while leading to lower premiums for small firms with healthier workforces). Finally, it would weaken existing employer-based coverage, because its tax provisions would have the effect of encouraging some employers to no longer offer health insurance. This analysis explains why the proposal would have these effects.

KEY FINDINGS

- As an alternative to bipartisan Senate legislation that would provide coverage to 4 million uninsured children, Senate Minority Whip Lott and Senate Minority Leader McConnell have introduced a SCHIP plan that would fail to make progress in reducing the number of uninsured low-income children.
- By 2012, one-third of the states would face funding shortfalls under the plan. Although the proposal includes sufficient *overall* funding to maintain all states’ current SCHIP programs, it would distribute these funds inefficiently across states and then let substantial sums revert to the Treasury unspent even as many states were experiencing shortfalls and being forced to cut back their programs.
- The proposal sharply restricts existing state flexibility in covering children and lacks new tools or financial incentives for states to enroll children who are eligible but uninsured.
- The plan also would preempt various state laws designed to keep insurance affordable for small businesses that have less healthy workforces and to ensure that insurance companies cover certain important health care services.
- Provisions in the bill to modify or expand Health Savings Accounts would do little to help the uninsured afford coverage, but be likely to weaken employer-based coverage by encouraging some employers to stop offering insurance to their workers.

The SCHIP Provisions

The SCHIP provisions included in the Lott-McConnell amendment would fail to make progress in covering more uninsured children.

The Congressional Budget Office estimates that 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 the number of children and pregnant women enrolled in an average month would fall well below today's level. CBO also estimates that the bipartisan Senate Finance Committee bill would avert these shortfalls and thereby prevent 800,000 children from losing their SCHIP coverage and becoming uninsured by 2012. (The Senate Finance Committee bill also would cover an additional 3.2 million children who would otherwise be uninsured, for a total of 4 million uninsured children gaining coverage by 2012.)

Preliminary CBO estimates show, however, that under the Lott-McConnell proposal, only a net of 700,000 children who would otherwise be uninsured would be covered in 2012. In other words, the overall coverage gains under the Lott-McConnell proposal are less than the gains just from ensuring that states can maintain their current children's enrollment in SCHIP (without making any progress in covering more uninsured children). The plan would fall short of that threshold by approximately 100,000 children.²

The Lott-McConnell amendment produces these disappointing children's coverage results because of the following elements of the proposal:

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

The proposal would provide an additional \$13.9 billion over five years above current SCHIP funding levels, enough in the aggregate to address the SCHIP shortfalls *if* perfectly targeted. Because some of these funds would be inefficiently distributed among states, however, the proposal would leave federal funding shortfalls in an estimated *one-third of the states* by 2012. These states would be at risk of having to institute cuts in their SCHIP programs and reduce the number of children they cover.³

- The proposal would use a formula to allocate SCHIP funds among the states under which a portion of the bill's \$13.9 billion in additional SCHIP funding would be directed to states that

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. It is likely that a new estimate of the shortfall would be larger today, due to higher SCHIP spending projections reported by states in the most recent SCHIP expenditure data from May 2007.

² Congressional Budget Office, "Preliminary CBO Estimate of Changes in SCHIP and Medicaid Enrollment under the Kids First Act of 2007," August 1, 2007.

³ 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.

would not need the funds, even as other states with greater funding needs were given insufficient funds to maintain their current caseloads.

- Such mistargeting is not uncommon under formula-driven block grants, but the proposal would magnify the adverse effects of the mistargeting by changing current law to *prohibit* the redistribution of unspent funds from states that leave funds unused to states that need them. Currently, funds provided to a state that remain unspent after three years are redistributed to other states. The proposal would reduce the period of availability to two years, starting with the 2008 allotments, but prohibit the redistribution of the funds that remain after the two-year period. As a result, the proposal would result in an estimated *\$1.2 billion in unspent funds expiring and reverting to the U.S. Treasury* over the next five years, even as numerous states were at risk of having to cut their programs due to a lack of adequate federal funding.
- The net result of these features of the proposal would be an estimated total federal funding shortfall of \$6.1 billion over the next five years, according to our estimates. By 2012, some 18 states would have inadequate federal SCHIP funding to sustain their current programs. The shortfall would reach \$1.7 billion in 2012 alone.

2. The proposal sharply restricts existing state flexibility in covering children and parents.

Throughout the SCHIP program's history, states have enjoyed flexibility to provide SCHIP coverage to children in modest-income families — that is, families with incomes above 200 percent of the poverty line (now about \$34,300 for a family of three). Currently, 23 states and the District of Columbia cover children above 200 percent of the poverty line or are in the process of implementing such an expansion.

Eleven additional states use their flexibility under SCHIP on how to measure income to disregard income used for certain purposes — such as child care costs — and as a result, enable some children with gross incomes above 200 percent of the poverty line to qualify.

The Lott-McConnell proposal would effectively prohibit all these states from continuing to cover SCHIP-eligible children in families with gross incomes above 200 percent of the poverty line. Under the proposal, “income disregards” would be eliminated. In addition, states would only be able to claim the lower federal Medicaid matching rate (which averages 57 percent, compared to the federal SCHIP matching rate, which averages 70 percent) for children in families with incomes above 200 percent of the poverty line who are already enrolled. And states would be prohibited from using *any* SCHIP funds for *new* children who have gross incomes above 200 percent of the poverty line, including children who qualify under their state's current SCHIP income limits. As a result, as children who are currently enrolled cycle out of the program (as they age out, their incomes rise, or they become ineligible for other reasons), states would not be permitted to replace them with newly eligible children. This means that coverage of children with gross incomes above 200 percent of the poverty line in these 34 states and the District of Columbia would be entirely eliminated over time.

This would create a risk that substantial numbers of children in these states who would otherwise be eligible and enrolled in SCHIP would end up without health insurance. In fact, the CBO estimates indicate that about 200,000 children who would otherwise be covered through SCHIP in 2012 would instead be uninsured, due to these restrictions.

The proposal also would effectively prohibit the relatively small number of states that now do so from continuing to use SCHIP funds to provide health insurance to low-income *parents* of children who are enrolled in Medicaid or SCHIP. (These states provide such coverage under waivers approved by the federal government — in most cases, by the Bush Administration.) As with the proposal’s treatment of children, states would be able to claim the lower Medicaid matching rate for parents who are already enrolled, but not be able to use any SCHIP funds for new parents.. As parents who are currently enrolled leave the program, states would be barred from replacing them with newly eligible parents. Over time, all coverage of low-income parents through SCHIP would end.

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. In response to a question posed during the Senate Finance Committee’s consideration of SCHIP legislation on July 19, Congressional Budget Office 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.” As a consequence, not only would SCHIP coverage of parents be eliminated in these states, leaving many uninsured low-income parents uninsured, but some of the eligible children of these parents likely would end up unenrolled, and uninsured, as well. (The Senate Finance Committee bill also contains provisions to restrict parent enrollment, by barring any new waivers from being granted to states to cover parents and by reducing the federal matching rate for parent coverage in states that already have waivers to cover parents under SCHIP. The Finance Committee bill’s parent provisions are less severe, however, than those in the Lott-McConnell proposal.⁴)

3. The proposal contains no new tools or financial incentives for states to enroll more of the eligible but uninsured children.

Peer-reviewed academic studies have estimated that there are between 5 million and 6 million low-income children who are eligible for Medicaid or SCHIP but are not enrolled and are uninsured. (The Congressional Budget Office concurs that this is the best estimate.⁵) Both the bipartisan children’s health legislation approved by the Senate Finance Committee and the health legislation now being considered in the House include new tools to help states find and enroll more of these eligible, uninsured low-income children.

For example, the Senate bill includes a ten-state “Express Lane” demonstration project to allow SCHIP and Medicaid agencies to use income information collected by other benefit programs to streamline the enrollment process. (The House bill includes a similar option, which would be made available to all states.) Both the Senate Finance Committee bill and the House bill also provide financial incentives for states to increase enrollment among eligible low-income children, particularly poor uninsured children who are eligible for Medicaid. (The Senate Finance bill provides bonus payments to states that succeed in raising Medicaid enrollment above certain target levels.) These incentives are a primary reason that CBO estimates the Finance Committee bill would lead to 4

⁴ The Finance Committee bill would lower the matching rate for parents enrolled through SCHIP under existing waivers, starting in 2011. 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.

⁵ Letter from Peter Orszag to Senator Max Baucus, Chairman of the Senate Finance Committee, Congressional Budget Office, July 24, 2007.

million uninsured children gaining coverage, 1.7 million of whom would be uninsured children who are eligible for Medicaid, many of whom live below the poverty line.

The Lott-McConnell proposal, by contrast, would not provide any new enrollment tools or financial incentives for states. The proposal would merely provide a modest amount of outreach funding — \$400 million over five years — to states and other organizations to enroll children who are eligible for SCHIP but are uninsured. This outreach funding appears to ignore uninsured children who are eligible for *Medicaid*, even though two-thirds of the eligible but uninsured low-income children are children who are eligible for Medicaid and these are the poorest uninsured children in the United States.

Provisions Related to Preemption of State Insurance Laws

The Lott-McConnell proposal also incorporates highly controversial elements of small business health legislation sponsored by Senator Michael Enzi last year (S. 1955) that would:

- preempt state insurance laws that limit the amount by which insurers may vary the health insurance premiums they charge to small businesses, based on workers' health status and other risk factors;
- preempt state insurance laws related to the benefits that insurers must offer in the individual and small group markets; and
- establish Association Health Plans.

1. The proposal would preempt state rating rules and likely drive up premiums for many small businesses with older and sicker workers.

A number of states have enacted rules that limit by how much insurers may increase health insurance premiums for small businesses, based on their workers' health status and other factors such as firm size, geographic location, age and gender. The bill would establish a new federal rating standard that would essentially preempt the rating rules in many states, particularly states in which insurers are not permitted to vary premiums charged to small businesses based on workers' health status, or are permitted to vary premiums only moderately based on such factors.

As a result, many small businesses — particularly those that are located in states with more stringent rating rules and have a disproportionate number of older and sicker workers — could see their premiums rise significantly. Some small employers may be hit with premium increases of such magnitude that they could be priced out of the market entirely and many of their workers could become uninsured. This is one of the key reasons why this provision (and similar provisions) are opposed by numerous governors, state insurance commissioners and state attorneys-general.

2. The proposal would preempt state insurance laws related to the benefits that insurers must offer in the individual, small group, and large group markets.

A number of states require that insurers cover certain benefits, such as breast and colorectal cancer screening, maternity care, home health care, mental health services, blood lead screening and

diabetes supplies. The bill would effectively preempt these state laws by allowing insurers to offer health insurance in a state even if they are *not* otherwise in compliance with that state's benefits rules, as long as the insurers offer a plan similar to a plan offered to state employees in one of the five most populous states (California, New York, Texas, Florida and Illinois). In analyzing an earlier version of this provision, the Congressional Budget Office noted that "some individuals might find it more difficult to purchase coverage for conditions or services that previously had been mandated under their state laws, and which were included in their health insurance plan only because of the state requirement."⁶

3. The proposal would establish Association Health Plans, which are likely to provoke adverse selection in the small group market.

The bill would permit the creation of association health plans, called Small Business Health Plans, under which small businesses may pool together to provide health insurance. These plans would generally be exempt from state regulation, include rating rules and benefits standards. There would be significant risk that these plans would attract firms with healthier workers, on average, because the plans could offer those firms health insurance at lower cost (by not having to comply with state rating rules or benefits standards). As the association health plans drew more and more firms with healthy workers, premiums for small group coverage outside these association plans would necessarily rise.

Health Savings Account Provisions

The Lott-McConnell proposal includes several provisions that would modify or expand HSAs. The most troublesome provision would permit the tax-free withdrawal of HSA funds to pay the premium cost of purchasing a HSA-qualified high-deductible health insurance plan if the coverage is obtained in the individual market. This proposal, which likely would be costly, essentially allows a tax deduction for contributions made to HSAs that are then used for the premium costs of buying insurance in the individual market. It would be similar in effect to a HSA tax deduction proposal the Bush Administration made last year.

1. This would do little to help the uninsured afford coverage.

The vast majority of the uninsured would receive little or no benefit. As many as 55 percent of the uninsured could not benefit from this tax preference because they do not earn enough to owe federal income tax. Most of the remaining uninsured individuals — more than six of every seven — are in the 10 percent or 15 percent tax bracket and thus would receive only a 10 percent or 15 percent subsidy on the cost of their health insurance.

This provision would primarily benefit higher-income individuals who are already purchasing health insurance in the individual market, by giving them a tax break on their premiums. This makes the proposal a highly inefficient use of federal resources.

2. The HSA proposal would be likely to weaken employer-based coverage by encouraging some employers to no longer offer health insurance to their workers.

⁶ Letter from Donald Marron to Senator Edward Kennedy, Congressional Budget Office, May 9, 2006.

A wide body of health economics research has concluded that tax incentives for the purchase of health insurance in the individual market, such as this proposal, would be likely to encourage some employers to stop offering health insurance to their employees (or not to offer it in the first place). Since individuals could use this tax subsidy to purchase high-deductible health insurance (attached to a HSA) on their own, some employers would conclude they did not need to provide coverage. Small employers, many of whose workforces consist to a substantial degree of low-income workers and who are the employers least likely to offer health insurance, would be the firms most likely to take such a step.

The loss of employer-based coverage would create serious problems for many workers, especially those in poorer health. In most states, companies that sell insurance in the individual market vary their premium charges substantially based on a person's health as well as other "risk factors" like age and gender. For individuals with medical problems, insurers often charge very high amounts, refuse coverage for these individuals' medical conditions, or refuse to sell them insurance altogether. An analysis of the Administration's HSA tax deduction proposal from last year, conducted by Jonathan Gruber of M.I.T., one of the nation's leading health economists, found the proposal would *increase* the number of uninsured by an estimated 1.5 million people, because the gains in coverage in the individual market would be more than outweighed by reductions in employer-sponsored insurance.⁷

3. The HSA proposal could provoke adverse selection in employer-sponsored health insurance.

The proposal also could drive up the cost of employer-based coverage by provoking a process known as "adverse selection." Healthier employees would be the ones most likely to find that with the help of the HSA-related tax break, they could purchase a policy in the individual market. (Healthier individuals are the people most likely to find a high-deductible health insurance plan attached to a HSA to be attractive; since they do not expect to use much in the way of health care, the high deductible and resulting higher out-of-pocket costs are generally of less concern to them.) If significant numbers of healthy individuals opted out of employer-sponsored insurance, however, the pool of workers remaining in employer plans would become sicker, on average. That, in turn, would drive up the cost of the employer-sponsored plans, raising premiums for workers remaining in those plans and inducing still more of the healthy workers to abandon the plans.

Adverse selection could ultimately lead to a vicious cycle in which growing numbers of healthier workers dropped employer-sponsored insurance, and those who remained in such coverage became an increasingly less healthy group. This could cause premiums for employer-based coverage to escalate substantially.

Conclusion

The Lott-McConnell proposal is seriously flawed. It poorly targets the SCHIP funds that it provides and would cause substantial funds to revert unspent to the Treasury even as some states were being compelled to cut back their programs due to a lack of adequate federal resources. It would restrict state flexibility in covering children and require many states to make their eligibility

⁷ Jonathan Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," Center on Budget and Policy Priorities, February 15, 2006.

criteria considerably more restrictive and thereby to disqualify many children (and some parents) who now are covered. It also would fail to provide tools or financial incentives to help states reach and enroll the substantial numbers of low-income children who are eligible for SCHIP or Medicaid but remain uninsured.

In addition, it includes risky provisions that would likely drive up premiums for small businesses with older and sicker workers and weaken employer-sponsored insurance overall. As a result, unlike the bipartisan Senate Finance Committee bill, which would preserve coverage for 800,000 children on SCHIP who otherwise would become uninsured due to federal funding shortfalls — and which also would cover an additional 3.2 million uninsured children by 2012 — the Lott-McConnell plan would fail even to reach the same overall coverage level as merely allowing states to maintain their existing SCHIP programs. It would represent a step backward rather than a step forward in covering the nation's low-income children.