IRET Congressional Advisory

INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION

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SCHIP REAUTHORIZATION: RENEW OR EXPAND?

The State Children's Health Insurance Program (SCHIP) requires Congressional reauthorization by the end of September. Will it be renewed in its current form, or expanded to cover a much larger population?

Reauthorization, expansion, two different things

SCHIP is a popular program with the public and the Congress. No one is talking about eliminating it, or denying coverage assistance for low income children. However, one side in the SCHIP debate would reauthorize SCHIP with a moderate increase in its funding to reach more of the existing eligible population of low income children. The other side supports a large expansion of the program to bring children of higher income families under its umbrella, and extend eligibility to young adults.

Original intent

SCHIP was originally designed to provide insurance for children in families with incomes up to twice the poverty level. The targeted families had income too high to qualify for Medicaid, but not high enough to make insurance readily affordable.

Many states requested and were granted waivers to expand coverage to children in families with incomes up to 300 percent or 350 percent of poverty. Some states included large numbers of adults in their programs. These states have covered additional populations even though they have not fully enrolled the children in the original target group of poorer families. A number of states overspent their allotments due to their more generous eligibility rules, and have received matching funds from Congress to help cover the over-runs.

Expansion of SCHIP in the Senate and House bills

A simple extension of SCHIP would cost about $5 billion a year, or about $25 billion over five years in the baseline outlays. The Administration has recommended an increase to a bit over $30 billion.

The Senate Finance Committee SCHIP bill would increase coverage to families with incomes up to three times the poverty level. The SCHIP expansion provisions of the bill would require an increase in outlays beyond the baseline of $28.1 billion over five years, and $26.5 billion over ten years. The ten year increase is less than the five year increase because the bill assumes, unrealistically, that the expanded eligibility will sunset at the end of the five years. Counting Medicaid interactions, the additional cost would be $32.8 billion over five years, and $64.9 billion over ten years.

The Congressional Budget Office (CBO) scores the Senate bill as being fully funded over the ten year budget window (2008-2017), but that budget neutrality is achieved by a gimmick in the bill. The tobacco tax increase that is the main source of funding for the bill (see below) is assumed to be permanent, but the expanded income limits on

eligibility for SCHIP are assumed to expire in five years (which will never happen). In reality, the Senate bill is about $50 to $60 billion short of budget neutrality over the 2013-2017 period.

The House SCHIP bill would extend eligibility to children in families with incomes up to four times the poverty level C $82,000 C or higher if the states wish. It would have allowed states to extend the program to "children" through age 25, but that has been amended to age 20 in the House Rule. These are young adults, many of whom are working. They should be seeking coverage in the private sector.

The House SCHIP extension and expansion provisions (Title I of the House bill) would require additional outlays beyond the baseline of $47.4 billion over five years, and $128.7 billion over ten years. (The House SCHIP bill was prepared in two pieces by the Ways and Means Committee and the Energy and Commerce Committee, and deals with Medicare and Medicaid issues as well. For the whole House bill, cuts in the Medicare Advantage program C see below C help to hold the increase in total outlays to $27.5 billion over five years. Outlays would be up $132.6 billion over ten years.)

Both bills would make it a bit harder for states to cover non-pregnant adults under the SCHIP program.

The Senate bill would reauthorize SCHIP for 5 years. It would appropriate specific amounts, annual allotments that the states would have to live within (in theory). The House bill would create a permanent authorization, and set future support for the states by formulas that would be more accommodative of state requests for funding than in the Senate version.

Although there would still have to be annual appropriations under the House bill, the formula approach is a step in the direction of a new entitlement. Entitlement spending is already expected to soar as the baby boom retires, and those outlays are projected to "bust the budget" and absorb the bulk of Federal revenues within a generation. Adding another entitlement-like health program to the Federal funding load is not wise.

"Crowding out" of private coverage, at Federal (i.e. taxpayer) expense

The CBO reports that over 75 percent of children in families with incomes between 200 and 300 percent of poverty (the expanded eligible group in the Senate bill) already have private insurance provided by their families. About 90 percent of children in families with 300 percent to 400 percent of poverty (the House extension) have private coverage already.

The CBO estimates that of every additional 100 children enrolled in SCHIP under the Senate Amendment, between 25 and 50 of them would be switching from private insurance. (Probably more under the House plan.) This "crowding out" of private coverage would shift the cost of the insurance from private wallets to the public purse. Congress may soon regret having made such an expensive promise.

Some of the millions of children transferred to SCHIP would be switched out of their parents' employer-provided plans, and some from their parent's individual insurance plans. Taking millions of children and their older siblings and parents out of the market for individual private health insurance would weaken that market. It would raise premiums. It would make it harder to realize the benefits of correcting the current tax bias in favor of employer-provided health insurance, and to facilitate a switch to individually owned, portable health care policies unattached to one's workplace.

Tobacco tax increase: poor way to fund a welfare program

To finance the expansion of SCHIP, the Senate bill would raise the current 39 cent-a-pack cigarette

tax by 61 cents, to an even $1. It would increase the top tax on cigars from 5 cents to $10. The House bill would raise the cigarette tax by 45 cents a pack, to 84 cents, and the maximum tax on cigars to $1.

As we said in an earlier paper (IRET Congressional Advisory 221, March 22, 2007), there is no legitimate rationale for using an increase in the federal tobacco tax to help fund an expansion of SCHIP. Neither tax would raise the full amount of the estimated revenues due to increased smuggling and reductions in smoking. The tax is regressive, constituting a higher percentage of income for lower income families than higher income families. Lower income individuals are more likely to be smokers than higher income individuals. If both parents smoke, the tax could take back a third to a half of the benefits of SCHIP for one of the family's children.

Medicare Advantage cuts: a blow to the elderly and to competition

The House bill would cover part of the cost of the SCHIP expansion to higher-income families by trimming the federal payment for Medicare Advantage plans. The cuts could reduce enrollment in such plans by more than half.

Medicare Advantage plans are an alternative source of Medicare coverage for several million elderly citizens. Instead of the traditional Medicare fee-for-service coverage, retirees may designate a private insurer offering plans with additional benefits or lower co-payments. The plan premiums are then paid by Medicare.

Medicare Advantage brings an element of competition and choice into Medicare. The private plans compete for customers, which holds down costs. The savings are split between the enrollees and the plans. The plans enable retirees to obtain services beyond those offered by regular Medicare without having to buy expensive medigap coverage (or to make do with a smaller medigap plan). For this reason, Medicare Advantage plans have been disproportionally favored by lower income retirees.

In hard-to-service rural and poor urban areas, Medicare pays the Medicare Advantage plans a bit more than the average fee-for-service amount to cover the higher costs of setting up health care networks. The House bill would trim that added payment, making many of the plans uneconomical in those parts of the country, and shutting them down. This is not "leveling the playing field." These plans offer additional benefits compared to ordinary Medicare, and are not being "over-paid" for delivering the same coverage.

Center for Comparative Effectiveness Research

The House bill would create a Center for Comparative Effectiveness Research and a Health Care Comparative Effectiveness Research Trust Fund to fund it. The Committee bill description states that the Center would study the "outcomes, effectiveness, and appropriateness of health care services."

Having the Federal government research which treatments are best may seem like a good idea, but it could lead to some undesirable outcomes. Privacy concerns aside, would the government use the information to decide which treatments or medicines it would or would not authorize and pay for under Medicare or Medicaid, or at the VA? Other nations have set up such "cost-benefit" programs to control their health care budgets by essentially rationing care. Medical treatments should be set by doctors and patients, not by Federal guidelines.

Insurance policy tax: poor way to control insurance costs

The Comparative Effectiveness Research program would be funded in its first three years by a transfer of money (or rather, spending authority, with no actual cash to back it up) from the Medicare

Hospital Insurance Trust Fund. In later years, the funding would come from a new tax on private health insurance policies and Medicare Part B coverage set by a formula. The tax would start out at about $2 per insured life (or about $8 a year for a family of four). The fee would rise over time.

One of the concerns driving the expansion of SCHIP is that health insurance is becoming more expensive. Taxing health insurance premiums and Medicare coverage to fund research into health care is an odd way to lower health costs. The tax would start small (as did the airport tax), but it would certainly be a nuisance for insurers and the Centers for Medicare Services to calculate and comply with. Penalizing private insurance would (at least minimally) increase the number of uninsured adults and children. That is one way to drum up business for SCHIP and Medicaid, and is akin to the off-duty fireman indulging in a touch of arson to justify a bigger budget for the fire department.

Conclusion

SCHIP reauthorization does not require SCHIP expansion to reach higher income families, young adults, or parents. Any additional money made available to the program should be used to increase enrollment of those children in low income families who are currently eligible but who have not been signed up. Money should not be diverted to support insurance for higher-income families, most of whom already provide health insurance for their children.

The federal food stamp program targets low income families and individuals. So does federal support for housing. Middle- and high-income households are responsible for buying their own food and shelter without federal assistance or federal intervention in their choices of what to eat or where to live. The government should not treat health care spending any differently.

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Note: Nothing here is to be construed as necessarily reflecting the views of IRET or as an attempt to aid or hinder the passage of any bill before the Congress.