Advocates Call SCHIP Enrollment Data Misleading

BY ALICIA AULT
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The federal government's portrayal of enrollment growth in the State Children's Health Insurance Program in 2007 is disingenuous and somewhat misleading, advocates for children's programs said.

According to the Centers for Medicare and Medicaid Services, 7.1 million children were enrolled in the program (SCHIP) in 2007, up from 6.7 million in 2006.

"While we are pleased that SCHIP continues to grow, we must do more to reach those at the lowest income levels who still need this coverage," Mike Leavitt, Health and Human Services secretary, said in a statement. "Toward that end, we will continue to work with Congress on the reauthorization of this vital program."

That comment is "disingenuous," Dr. Steve Wegner, chairman of the child health funding committee at the American Academy of Pediatrics, said in an interview. He noted that President Bush vetoed a compromise agreement to reauthorize SCHIP not once, but twice, in 2007.

"The administration did everything possible to stand in the way of the reauthorization," Jenny Sullivan, a health policy analyst with Families USA, said in an interview.

SCHIP was finally given a reprieve, with Congress passing, and the president signing, a funding extension through March 2009. But the program still has not been formally reauthorized. And, said Ms. Sullivan and Dr. Wegner, many millions more children would have been covered in 2007 if the reauthorization had been approved when it was first taken up early in the year.

CMS spokeswoman Mary Kahn said that it was not accurate to imply that the Bush administration did not want to continue the SCHIP program. The administration did, however, want to fund it at a lower level, she said in an interview.

Also in the HHS statement, Kerry Weems, CMS acting administrator, said, "We continue to work with states to [ensure] that as many eligible, uninsured children as possible are enrolled in SCHIP and Medicaid."

Dr. Wegner took exception to that statement as well, noting that a CMS directive issued in August 2007 has effectively prevented states from expanding eligibility. The CMS said it would limit states' ability to expand coverage to children in families who had incomes at 250% of the poverty level or above. Ms. Sullivan said that the directive had, in many cases, reversed expansion plans previously approved by the CMS.

Twenty-three states are expected to be affected by the directive, according to the Kaiser Family Foundation. Nine already cover children in families with incomes above 250%, and 13 states had received approval to expand eligibility at or above that level. In addition, Washington was covering children at the 250% level and had gotten approval to raise that cap.

The directive is consistent with the administration's belief that every effort should be made to enroll 95% of children eligible at the lowest income levels before expanding it to those who are in higher-income families, said Ms. Kahn.

The increase in SCHIP enrollment was not unusually high for the program, said Ms. Sullivan. And, she said, U.S. Census Bureau figures indicate that the overall number of uninsured children actually increased in the last 2 years.

'We must do more to reach those at the lowest income levels who still need this coverage.'

MR. LEAVITT

There are approximately 9 million uninsured children in the United States, according to a Families USA analysis. Both Ms. Sullivan and Dr. Wegner said they expect that number to grow in the current year.

A much larger number of children are covered under traditional Medicaid programs—about 28 million in 2005, according to Kaiser—but their coverage is also being threatened because of a series of CMS regulations taking effect this year. Rep. John Dingell (D-Mich.) and Rep. Tim Murphy (R-Penn.) introduced a bill in March (H.R. 5613) that would place a 1-year moratorium on seven of those regulations.

Looking ahead into next year, the picture grows even dimmer. For fiscal 2009, President Bush proposed increasing SCHIP funding by $19.7 billion (added to the current baseline of $25 billion) through 2013. That is much less than the $35 billion that was authorized in the two legislative packages vetoed by the President last year. ■

Medicare Advantage Pay Eyed Once More for Fee Fix

BY ALICIA AULT
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WASHINGTON — With Congress scrambling to avert a physician fee cut in July, it appears once again that Medicare Advantage is being eyed as funding source by Democrats but as sacrosanct by Republicans, setting the stage for several months of political wrangling.

It also may portend a repeat of last year's battle, one that ended with President Bush refusing to sign a legislative package that restored physician reimbursement but slashed Medicare Advantage payments.

The debate played out at a March hearing of the House Ways and Means Committee's Subcommittee on Health where recommendations from the Medicare Payment Advisory Commission's (MedPAC) recent report to Congress were discussed, including a bid for Congress to increase physician fees by 1.5% in 2008 and 2009.

MedPAC said it supported Medicare Advantage (MA) plans—which let beneficiaries receive coverage from private plans such as HMOs and PPOs, and from private fee-for-service insurers. MedPAC also made the case that, for the third year in a row, the MA plans are overpaid relative to traditional fee-for-service (FFS) Medicare.

MedPAC Chairman Glenn Hackbarth told the subcommittee that the commission estimates that Medicare has paid the plans $10 billion more than it would have under traditional FFS for each of the last 3 years. Overall, MA plans will be paid 13% more than conventional Medicare providers in 2008, a 1% uptick from 2007.

The profit potential in those plans has fueled a rush into the market and a 101% increase in enrollment from 2006 to 2007, according to MedPAC. Coordinated care, such as HMOs and PPOs, saw an 8% enrollment increase, although those plans still account for the largest group (20%) of beneficiaries in an MA.

MA plans, with their added benefits, are increasingly attractive to beneficiaries, so MedPAC is concerned about the growth of high-cost FFS plans, said Mr. Hackbarth.

The plans are rewarded for their costs, and there is no penalty for poor quality, he said. "Payment policy is a powerful signal of what we value," Mr. Hackbarth said. He added that MedPAC "supports financial neutrality" between payment rates for the FFS and the MA programs. He noted that about half of overpayments to MA plans are going to insurers' bottom lines.

That fact has not been lost on the subcommittee chairman, Pete Stark (D-Calif.), who has held hearings questioning the value and integrity of the MA plans. Republicans defended the MA program, however.

Rep. Dave Camp (R-Mich.) intensely questioned Mr. Hackbarth, eliciting the admission that MA plans had been successful in rural areas. Rep. Sam Johnson (R-Tenn.) added, "my seniors have asked me not to mess with their Medicare Advantage plans." At one point, he accused the MedPAC chairman of saying the government is a more efficient insurer than the private sector. Mr. Hackbarth disagreed and clarified his position. "The problem with this payment system is we are rewarding inefficient private plans," he said. ■