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COVERING UNINSURED CHILDREN: THE IMPACT OF THE AUGUST 17th CHIP DIRECTIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

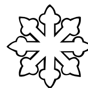
OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

APRIL 9, 2008



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COVERING UNINSURED CHILDREN: THE IMPACT OF THE AUGUST 17th CHIP DIRECTIVE

WEDNESDAY, APRIL 9, 2008

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:30 p.m., in room SD–215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Present: Senators Baucus, Lincoln, Wyden, Stabenow, Salazar, Grassley, and Hatch.

Also present: Democratic staff: Bill Dauster, Deputy Staff Director and General Counsel; and David Schwartz, Health Counsel. Republican staff: Becky Shipp, Health Policy Advisor; Jocelyn Moore, Legislative Assistant; and Patricia DeLoatche, Legislative Health Assistant.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Senator Rockefeller, the chairman of the subcommittee, was momentarily detained. He will be here very soon and asked me to begin the hearing, and I will do so. As soon as he arrives, then he will certainly take over.

The poet Maya Angelou wrote: "Children's talent to endure stems from their ignorance of alternatives." For better or worse, we grownups have often known alternatives. We seek a better future for our kids, and that is what the State Children's Health Insurance Program, CHIP, is all about.

I am pleased that the Subcommittee on Health Care has convened this hearing to talk about CHIP. The CHIP program provides access to health care for poor kids. At 11 years, CHIP is a relatively young program. Despite its youth, CHIP has achieved great success. It has cut the number of kids without health insurance by over one-third and has given millions of kids a better future.

Kids without health insurance often do not get the care they need. Kids who do not get medical care are more likely to miss school or to do poorly in school. This makes it harder for these kids to get good jobs if, and when, they finish school.

The effects of kids going without health care are significant and far-reaching. After 10 successful years of providing poor kids with health insurance, CHIP came up for reauthorization last year. There was a great deal of interest and excitement at the opportunity to expand on the success of the program.

I made reauthorization of the program the committee's top health care priority last year and was glad to work with colleagues from both sides of the aisle, and Senators Grassley, Rockefeller, Hatch and I together crafted a bill that would strengthen and renew this vital program and we brought it to the committee. I can tell you here parenthetically, I do not ever remember working as hard on any subject as we did then. Senators Rockefeller, Hatch, myself, and Senator Grassley were time and time again in my office, and the staffs, the same. Boy, we worked hard to get the result that we finally got.

We then went to the Senate floor. Then we negotiated with the House. The whole time, we were fighting to cover more kids. We sought to give millions of kids a better future.

Congress agreed that it wanted to cover more kids. Congress passed two reauthorization bills that had strong support from both parties. Unfortunately, the President did not agree. The President apparently did not feel that expanding access to health care for poor kids was the right goal. He, therefore, vetoed both of the reauthorization bills that Congress sent him.

Rather than let this important program lapse, Congress extended the program as it currently exists through March of next year. But our fight to cover more kids is not over. Senators Grassley, Rockefeller, Hatch, and I, and many other members of the Congress continue to care a great deal about the future success of CHIP.

We remain committed to reauthorize the program in a way that will increase the number of kids covered. We still seek to give millions of kids a better future. That commitment is at the heart of my concerns about the letter that CMS sent to the States on August 17, 2007. The so-called CHIP directive will limit enrollment, and that is the wrong direction. It will limit States' ability to provide their poor kids with access to health care, and that is the wrong approach.

The restrictive nature of the policies in the directive will leave States little flexibility to expand CHIP coverage in the ways Congress intended when it created the program in 1997 or in ways that CMS has approved since then. Quite simply, proposing hurdles to CHIP coverage means that fewer kids will get the health care that they need. It denies millions of kids that better future.

Now, some may think that the August 17th directive will not have much of an impact. For them, let me tell you about the situation in my home State of Montana. Folks in Montana would like to expand CHIP eligibility as a way to provide more kids with access to health care. There is a ballot initiative under development that would raise CHIP eligibility to 250 percent of poverty. That would be an expansion from Montana's current level of 185 percent of poverty. Such an increase would add nearly 30,000 kids to the rolls in Montana. Last month, Montana's CHIP enrollment was just over 16,000. Montana is poised to almost double its CHIP enrollment. Montana is poised to dramatically decrease the number

of uninsured Montana kids. Montana is poised to give thousands of kids a better future.

But the August 17th directive has Montanans nervous. Montanans are worried that the directive will prevent the expansion. Montanans are nervous that the administration will keep almost 30,000 kids in our State uninsured. I cannot understand why the administration issued the CHIP directive. There are questions about the process by which it was issued, and there are also questions about which data are right. I just want to know why covering more kids, whether it is 30,000 Montana kids or kids anywhere in the country, is not a good idea.

I hope that this hearing can help us to understand the CHIP directive. I believe that we should help our poor kids by providing them access to health care. A clear majority of Congress believes that, and the clear majority of American people believe that. The CHIP directive goes in the wrong direction. It restricts coverage when we should insure as many kids as we can. We need to provide—not prevent—access to health care.

So let us try to figure out how we can get back to the idea of covering more kids. Let us try to get back to the idea of giving millions of kids a better future because, as we all should know, there really should be no alternative.

Our illustrious subcommittee chairman has arrived.

Senator ROCKEFELLER. Thank you, Senator Baucus.

I need a few minutes to get organized. Why don't you go ahead, Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you. The subject matter of this hearing is perfectly legitimate and appropriate, and I am glad to discuss the issues that need to be discussed. I am a little disappointed in the detraction from the bipartisan way that we approach most things on this committee. I am not going to dwell on that, except to say it is disappointing. I know it is not characteristic of everything this committee does.

That being said, I am supportive of the efforts of any member of Congress—particularly members of this committee—to have questions answered. I am hopeful that this hearing will result in members getting answers to questions that they have about the State Health Official letter that was sent by the Centers for Medicare and Medicaid Services on August 17th last year.

I do not have fundamental disagreements with the goal of the August 17th directive. While I do have some questions about how the policy would work, I think the intent of the letter is laudable. Before a State can expand to cover kids with higher incomes, they have to cover their poor kids first. It makes absolutely no sense to me that a State that is not covering poor kids should expand their program to cover higher-income kids. States should be covering their lower-income kids first. Now, that is just common sense to me. Beyond just being common sense, we also know that coverage of higher-income kids leads to what we call crowd-out for kids with private insurance.

Now, think about that for a second. If we do not require States to cover their low-income kids first, a State can cover higher-income kids while lower-income kids still go without coverage. Such a State would be devoting resources then to finding and covering those higher-income kids, and then another higher-income kid could lose private coverage through the crowd-out effect.

When tax dollars are spent to provide coverage to someone who was already covered, that does not make any sense either. It is not an effective use then of scare Federal dollars. Letting that continue makes no sense whatsoever. I am pleased that this hearing includes witnesses then who will testify on the underlying issue at the core of the August 17th directive, that is, the issue of "crowd-out."

Crowd-out occurs when families give up, or do not take, private health insurance in lieu of enrolling in public coverage. As we learned from the excellent report from the Congressional Budget Office, crowd-out is a particularly acute problem in the SCHIP program because crowd-out occurs more frequently at higher income levels.

The report also concludes that, "in general, expanding the program to children in higher-income families is likely to generate more than an offsetting reduction in private coverage than expanding the programs to more children in low-income families."

CBO estimates that "the reduction in private coverage among children is between a quarter and a half of the increase in public coverage resulting from SCHIP. In other words, for every 100 children who enroll as a result of SCHIP, there is a corresponding reduction in private coverage of between 20 and 50 children."

This high incidence of crowd-out is problematic for many reasons. It makes it more difficult for employers to offer health insurance coverage, and it inappropriately uses tax dollars to fund coverage that could have been provided by, or from, an employer.

Concern about crowd-out is not a new issue, and it is certainly not a new subject of a directive letter from an administration. I have here, Mr. Chairman, a "Dear State Official" letter sent out February 13, 1998 by, obviously, the Clinton administration. I would like to read some excerpts from this letter. The purpose of this letter is "to provide guidance on the standards that the Department of Health and Human Services will use to evaluate State strategies to prevent this type of substitution of coverage."

The letter also states, quoting again from the 1998 letter, "The crowd-out concerns increase at higher levels of poverty and the Department will be applying greater scrutiny in these cases." And an additional quote: "After a reasonable period of time the Department will review States' procedure to limit substitution. If this review shows that they have not adequately addressed substitution, the Department may require States to alter their plans." That is from that 1998 letter.

Therefore, under the criteria established during the Clinton administration, it is appropriate for issues of crowd-out to be addressed by the administration, and States were put on notice that they could expect further efforts to address crowd-out should current policies and procedures prove inadequate.

I hope this will be a constructive and informative hearing. I hope that members will not be drawn into protracted discussion about what did or did not happen last year during consideration of SCHIP. I worked on that. I am sorry we did not get a bill to the President for signature, or even the overriding of a veto, but we did not, so going back on that will not be productive. I hope that members will focus on moving forward in a positive, bipartisan manner to cover eligible but uninsured kids.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Grassley. I want to respond on that crowd-out, but not now. We will wait until we get into the discussion.

Senator GRASSLEY. I am going to have to leave in 15 minutes, so, if you want me to hear something, I would appreciate hearing it from you right now, or I will listen on television.

Senator ROCKEFELLER. I have a 35-minute speech.

Senator GRASSLEY. All right. Then I will wait and talk to you privately.

Senator ROCKEFELLER. All right.

Senator HATCH. Could I leave while you give your 35-minute speech? [Laughter.]

Senator ROCKEFELLER. No. No. No.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator ROCKEFELLER. I am very grateful, obviously, to each of our witnesses and those who will follow, but I would especially like to thank Mr. and Mrs. Novak, who are here, who came all the way from Lebanon, OH. CHIP was created for people like the Novaks, hardworking Americans who cannot afford health insurance for their children. I thank them for coming here to share their family's experience, which they will do.

When it comes to reducing the number of uninsured children, States are on the front lines of delivering comprehensive and affordable health care. They know what works best in their individual States and have developed innovative, and for the most part laudable, proposals for guaranteeing coverage for children.

A cornerstone of the Children's Health Insurance Program has always been State flexibility. In a time of growing economic uncertainty—putting it mildly—we should be making it easier, not harder, for States to cover these working families who are in need of assistance.

This is particularly true since many employers may be reducing private coverage because of those same declining economic circumstances. That is why I am so frustrated with the administration's August 17th directive that has placed an unattainable mandate on States, a flat-out unattainable mandate on the States, knowingly so.

In my judgment, its aim is simple: to make it virtually impossible to provide greater access to health insurance for children. This is repugnant. To be blunt, the August 17th directive is a solution to a problem that does not exist except in the minds of Washington bureaucrats or those who are ideologically inclined.

It is clear to this Senator, and a great many others on this committee, that the real genesis for the directive can be found in last year's CHIP reauthorization negotiations. When the Bush administration realized it was not going to get its way because both Houses had passed this bill, because of the overwhelming bipartisan majority, they resorted to the only options left open to them, and that was the veto, which is a very clear option, and an administrative fiat which would take effect, the veto notwithstanding.

With the stroke of a pen and for less than $100 in postage, the administration has unleashed a tidal wave of financial uncertainty that will be measured in the loss of billions of dollars in State aid, and hundreds of thousands of children will be denied access to health insurance.

Now, how one lives with that, I am not sure. But they decided that they could, and they put out the August 17th directive. That is not right. It is not fair. It represents the worst kind of partisanship there is in Washington, and it is no wonder that the American people, who overwhelmingly believe that we should be applying health insurance to children who do not have it, think so little of government.

No other voluntary Federal—I will say this slowly: no other voluntary Federal means-tested program has enrollment of 95 percent as some kind of a formula. None other. This one alone.

Participation in the Food Stamp program is approximately 50 percent, roughly 30 percent below the participation rate for CHIP. Only in Medicare Part B, where seniors are automatically enrolled unless they specifically opt out by their own choice, is there a higher than 95 percent participation rate, and that is 95.5 percent.

My State of West Virginia has proposed an initiative to cover uninsured children up to 300 percent of the Federal Poverty Level, which is $52,800 a year for a family of three. The State phased in coverage at 220 percent of the Federal Poverty Level, FPL, in January of 2007, but has not taken any further steps to implement the planned expansion, which they cannot afford because of the August 17th directive.

The August 17th CHIP directive will mean that my State will not be able to move forward with this expanded coverage, and approximately 4,000 more children will remain uninsured. This committee will hear testimony today from a number of witnesses. Some will discuss the deeply personal impact that this directive has had on families across the country. The administration will attempt to explain why it believes it has the legal authority to issue this regulation, and I will be quoting law, which I have never done before, so I am kind of looking forward to that.

CBO and CRS will testify as well, along with the National Academy of State Health Policy and The Heritage Foundation, and I look forward to hearing from all the witnesses.

I now look forward to hearing from Senator Hatch.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Well, thank you, Mr. Chairman.

The State Children's Health Insurance Program, CHIP, is one of the few programs that many of us on both sides of the aisle put

in the category of motherhood and apple pie. In 1997, Senator Kennedy, the late Senator Chafee, and you and I were able to put together a health care bill that provided care to children of the working poor, basically, people who worked, but just did not earn enough money to get family health insurance. Today, 6 million children have health coverage because of the CHIP program.

The Balanced Budget Act of 1997 created CHIP and it became the glue that put that deal together. Republicans could not vote against it because it had the balanced budget aspect, and the Democrats could not vote against it because we had CHIP in there. But this is a new title 21 of the Social Security Act.

Now, this program provides States with Federal matching funds to cover uninsured low-income children in families with incomes that are above the Medicaid eligibility levels, in other words, children of the working poor, by and large.

When designing their CHIP programs, States may expand their State Medicaid programs, create separate State programs, or use a combination approach. All 50 States and the District of Columbia have CHIP programs.

Chairman Rockefeller, when I was chairman of this subcommittee, I think you will agree that we had two well-balanced and thoughtful hearings on the CHIP program. Let me be clear: I strongly believe that you as chairman, and others, have every right to get answers to your questions regarding the August 17th CHIP guidance letter. In fact, I have some questions about it as well.

However, I do agree with the thrust of the letter. Low-income uninsured children below 200 percent of poverty should have health coverage before State CHIP programs are allowed to raise their CHIP income eligibility levels over 250 percent of the Federal Poverty Level.

Two hundred percent of the Federal Poverty Level is $42,400, the last time I checked. For a poor family of four, 250 percent of the Federal Poverty Level would be $53,000.

Now, I want to turn to the CMS guidance letter on CHIP that went to State health officials last August. First and foremost, when we were writing the original CHIP legislation back in 1997, we all agreed that the purpose of the CHIP program was to cover low-income uninsured children. I still believe that providing coverage of these children has to be our first priority.

Mr. Chairman, after spending way too much time with you last year—I know you agree with that—as you recall, during last year's deliberations, we found that, while 6 million children were covered by the CHIP program, another 6 million low-income children who were either eligible for CHIP or Medicaid were still uninsured. It is my feeling that these 6 million low-income uninsured children should receive health care coverage first before States expand their CHIP income eligibility levels any higher. Again, I know you agree with that.

In my opinion, CMS attempts to achieve this goal through its August 17th, 2007 guidance letter. Do I believe that some of the parameters laid out in this letter make it difficult for States to achieve this goal? I have to admit that I do. I hope our witnesses will shed some light on some of the issues that have been raised. For example, the 95-percent threshold for States and the five cri-

teria that States must meet on crowd-out. But in the end, do I believe that we need to provide this coverage in a way that is coordinated with other sources of health benefits coverage, as stated in the CMS letter? Of course I do.

I firmly believe that families, especially those with higher incomes who have other health care options, should be encouraged to pursue them. I also believe that Congress must do everything possible to discourage crowd-out, especially when there are low-income uninsured children who have no other private coverage options.

Again, the number-one goal of the August 17th CMS guidance letter was to provide health care coverage to poor, uninsured children first, something that I strongly support.

One of the most compelling points that has been made over and over again is that the incidence of crowd-out increases from 25 percent to 50 percent when higher-income families are covered by CHIP. So it is my hope that today's hearing will explore ways to lower crowd-out and at the same time increase the number of low-income uninsured children who are covered by CHIP.

Now, I look forward to hearing the testimony of today's witnesses, and am especially interested in all of your views here today on how this guidance will impact crowd-out.

I know several of our witnesses today, especially Mr. Peterson and Ms. Owcharenko, made special arrangements to be with us today. I want you to please know that we are very appreciative of that, and we greatly appreciate your efforts to be here today.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Hatch.

And I have to apologize because I failed to recognize that Ms. Cindy Mann, who is executive director of the Center for Children and Families, Health Policy Institute, Georgetown University, Washington, DC, is also going to be testifying, and I apologize to her.

I think we should hear, first, from Mr. Dennis Smith, who is the Director for Medicaid and State Operations, Centers for Medicare and Medicaid Services.

STATEMENT OF DENNIS SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. SMITH. Thank you, Mr. Chairman, for inviting me today. Again, it is a great pleasure to appear with the Finance Committee. I do look back with great fondness on my time with the Finance Committee, and specifically their work 10 years ago with your leadership, the leadership of Senator Hatch, and others to create SCHIP, which has been, I think, an outstanding success.

We have added now 7 million children in 2007 who were enrolled, at least for some point in time, in the SCHIP program. Moreover, another 10 million children have been added to Medicaid, compared to what the enrollment numbers were 10 years ago. This is done while the number of children in the United States living in families below 200 percent of poverty has actually declined, so the number of children has gone down while we have added to the ranks of Medicaid and SCHIP.

As mentioned, SCHIP was a great bipartisan compromise. In addition to defining whom the special enhanced match rate is for, Congress created a special match rate, which now averages 70 percent nationally compared to the 57 percent match rate of Medicaid. Congress wanted to create an incentive to make certain States would take up the SCHIP program, and time has certainly proven that to be the case.

The Congress appropriated $40 billion over 10 years within the initial program reauthorization, but SCHIP was never designed, nor funded, to serve all 78 million children in the United States at all income levels. In addition to the discussions on income eligibility, Congress identified at that time and discussed the issue of crowd-out, or the substitution of new public coverage for existing coverage.

Ultimately, the SCHIP legislation did not adopt specific Federal standards for preventing substitution, but it did require States to prevent crowd-out and provided a mechanism through the State plan review process for the Secretary to protect the Federal interest in preserving existing sources of coverage.

Initially in the first few years, as States took off very quickly, there were a handful of States that also went to higher income levels. After June of 2001, basically no State expanded coverage above the definition of the target low-income child until, again, in 2006.

After this 5-year period from 2001 to 2006 in which no State raised its Medicaid or SCHIP eligibility level above 250 percent, there were clearly new interests or pressures among additional States to expand eligibility beyond the statutory definition.

Over time, it became apparent that further action was necessary to remind States of their obligation for preventing crowd-out. An essential question of the original debate—for whom is the enhanced matched rate intended—reappeared for the Federal Government over the past 2 years and is now with us today. We certainly believe we had both the authority and the obligation to act on this matter of crowd-out.

On the SCHIP, the crowd-out data has certainly appeared to have occurred. As 16 million children have been added to Medicaid and SCHIP over the past decade, the percentage of children in families between 100 and 200 percent of the Federal poverty level with private insurance has declined. In 1997, according to the 2006 National Health Interview Survey, 55 percent of children in families with income at this level had private insurance; by 2006, the percentage had declined to 36 percent.

At a minimum, we believe that we should not accept substitution as inevitable and simply be indifferent to potential ways to reduce it. I posed a number of questions in my testimony which I think are important, to talk about crowd-out, and, with the jurisdiction of the Finance Committee certainly over the Social Security Act and the Internal Revenue Code, it is uniquely positioned to be having that discussion, and again, who that 70 percent match rate is for.

The 95-percent threshold that we set in the State Health Official (SHO) letter of last August, we believed that that was aggressive but, in fact, achievable. In our discussions with the States, currently there are 16 States and the District of Columbia above 250

percent of the Federal Poverty Level. Based on our discussions with them, at least nine of those States, based on their data and the guidance that we have provided, will in fact meet that 95-percent threshold. So, we believe it is aggressive but achievable.

Finally, I think it is also important to remember there are also options for States. States can extend—thanks to the leadership of Senator Grassley, particularly in the Deficit Reduction Act that created a new eligibility group for families up to 300 percent of the Federal Poverty Level—coverage to children with disabilities, for example, in Medicaid. The State of New York, I think, is a very appropriate example to discuss.

Again, as you realize, in New York there is no upper income limit on children at income levels from New York. Families in New York today, and last year before the SCHIP SHO letter came out, were buying into the State program. The State per-member, per-month is about $154 on average per month. So with the family contribution for private coverage, the additional amount is about $1,800, a little over $1,800 in New York, the difference between family coverage and single coverage.

That works out to about $152 on average. So, if the State alone were to provide just its State contribution which would have been provided by bringing those families in to SCHIP, that State's share, if a family had two people, the State would be paying roughly the same amount of money using only State dollars to buy the same amount of coverage, and the family share itself would drop to about $46.

So there are options for the States to consider, I believe. Certainly our work in the SHO letter, the intent is not to prevent. Again, States can go to higher income levels if we are able to protect the integrity of the program to cover those low-income children first before States expand to higher income levels.

Thank you, Mr. Chairman. I look forward to your questions.

Senator ROCKEFELLER. Thank you.

[The prepared statement of Mr. Smith appears in the appendix.]

Senator ROCKEFELLER. Dr. Orszag?

STATEMENT OF DR. PETER ORSZAG, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. ORSZAG. Thank you very much, Mr. Chairman, Senator Hatch, members of the subcommittee.

I am going to be brief, and I will make three main points. First, SCHIP has significantly reduced the number of children who are uninsured in the United States. If you look, for example, between 100 and 200 percent of poverty, that uninsurance rate fell by about 25 percent between 1996 and 2006. That is the population that was most affected by the introduction of SCHIP, and that is where uninsurance rates fell the most. At higher income levels, that uninsurance rate remained roughly stable. There was also some reduction in uninsurance rates below 100 percent of poverty, likely attributed to the increased take-up of Medicaid that was associated with outreach efforts and other steps that were introduced as part of SCHIP. So, that is the first point.

The second point is, the enrollment of children in public coverage did not correspond to a one-for-one reduction in the number of un-

insured kids, however, because some of the newly enrolled children did have coverage or would have had coverage even in the absence of the public program. Let me emphasize, almost any effort to expand government spending or to provide a tax expenditure to expand coverage will inevitably involve displacing private coverage to some degree. In the case of SCHIP, the program provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than alternative coverage, and therefore may be more attractive to them. Our estimates suggest that, as has already been said, of every 100 kids added to the program, somewhere between 25 and 50 would otherwise have had private coverage.

My final point has to do with the August 17th directive. Let me make a few subpoints there. First, it is important to look at the distribution of children covered under the program. Survey and administrative data suggest that something like 80 percent of enrollees are under 200 percent of poverty, about 15 percent are between 200 and 250 percent, and perhaps 5 percent or so of beneficiaries under SCHIP are currently above 250 percent of the poverty threshold. So that provides some indication that, at least with regard to current enrollees, the directive may not have an overwhelming effect because it is such a small share of beneficiaries.

Second, and perhaps more importantly, our official baseline involves very constrained funding levels for the program under which the number of enrollees would actually decline over time. Against that official baseline, the directive has little effect. Against an alternative approach or against an expansion of the program if the program were expanded, however, the directive could have a much more significant effect. As States had the ability to expand their programs, the directive would have more “kick” to it, as it were.

Finally, let me just comment very briefly on two aspects of the test itself, or the directive itself. With regard to the 95-percent test, which I know Mr. Peterson will talk about in more detail, my understanding is that Mr. Smith and CMS intend to apply that test using a methodology that is consistent with administration estimates of the number of uninsured children in the United States.

CBO has already written a letter to this committee, to Senator Baucus, in July of 2007 in which we stated that we regarded the more conventional estimates of the number of uninsured children as “more appropriate for considering policies aimed at enrolling more eligible children in those programs,” that is to say, Medicaid and SCHIP. But be that as it may, we also have to just take the methodology as given.

The second point that I want to make is, with regard to the specific provisions to reduce crowd-out, there is new research suggesting that it is not clear that things like increased cost sharing and expanded waiting periods actually reduce crowd-out rates. So, I would just urge a little bit of caution in jumping to the conclusion that some of the provisions that are proposed to reduce crowd-out rates will actually succeed in doing so, given that the existing research is raising questions about whether they are effective.

Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Dr. Orszag.

[The prepared statement of Dr. Orszag appears in the appendix.]
Senator ROCKEFELLER. Mr. Peterson?

STATEMENT OF CHRIS L. PETERSON, SPECIALIST IN HEALTH CARE FINANCING, DOMESTIC SOCIAL POLICY DIVISION, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Mr. PETERSON. Chairman Rockefeller, Senator Hatch.

Senator ROCKEFELLER. I apologize. Dr. Orszag is Director of the Congressional Budget Office. Dennis Smith, we already know, is from CMS. And you, sir, are a specialist in Health Care Financing, Democratic Social Policy Division, Congressional Research Service.

Mr. PETERSON. Domestic Social Policy, not Democratic. [Laughter.] I will leave that alone.

Senator ROCKEFELLER. It must be the season. [Laughter.] My apologies.

Mr. PETERSON. Thank you.

The August 17th letter being discussed today lists six requirements for States seeking to enroll children with income above 250 percent of poverty. Four of these require States to make substantive changes to their SCHIP programs or to comply with new administrative mandates. The other two require States to assure they meet certain program impact measurements. My testimony focuses exclusively on one of those two, what I will call the 95-percent test, which has been alluded to earlier.

This test is that the State must make assurances that it has "enrolled at least 95 percent of children below 200 percent of poverty who are eligible for CHIP or Medicaid." The policy goal of the test appears to be that States should ensure adequate coverage of eligible low-income children before permitting coverage of higher-income children. Although this may be a desirable goal, sound program evaluation also requires the use of measurement standards that are clear and valid.

If the standards are clear, then States would know generally what methods and sources of data are or are not acceptable. It would also help ensure a transparent, equitable review process with less potential for arbitrary approvals or disapprovals. However, such standards have not yet been made clear by CMS.

Nevertheless, CRS has provided two examples in the written testimony of attempts States might make to demonstrate they are meeting the 95-percent test. Although it is unclear whether CMS would approve them, or indeed whether they should, these analyses are based on the Census Bureau's Current Population Survey, the only source of data providing State-level estimates for all 50 States on children's health insurance and family income.

The CPS estimates of uninsurance among low-income kids are currently used to determine States' SCHIP allotment. Although the published estimates indicate that no State covers 95 percent, if one factors in the survey's margins of error, as in Table 1 of my testimony, 18 States could claim that the 95 percent level has been reached, including 8 of the 17 currently affected States.

Even so, there are fundamental concerns with the CPS's insurance estimates beyond the typical margins of error. For example, the CPS is known to under-count Medicaid and CHIP enrollment by several million people. Moreover, CMS said in the letter that the

95-percent test is to be calculated among low-income children who are eligible for CHIP or Medicaid.

Now, no national survey asks respondents whether they are eligible for Medicaid or CHIP. For example, the CPS does not ask noncitizens whether they are in the country legally, which is a factor in determining one's eligibility. Thus, to estimate how many uninsured children are eligible for public coverage, analysts have to make adjustments to the data. Not surprisingly, different adjustments yield different results.

For meeting the 95-percent test, CMS correctly noted that with data adjustments for individuals' immigration status and the Medicaid under-count, "a number of States are likely to meet the 95-percent threshold." So, as shown in Table 2 of my testimony, CRS did an analysis to adjust for these two factors as a State might do. The results were that nearly every State appeared to have enrolled more than 100 percent of eligible low-income children. Obviously, this result lacks face validity, although it is not clear whether CMS would accept or reject such a result.

Although additional—and arguably justifiable—adjustments could be made until every State is between 95 percent and 100 percent, all these adjustments raise questions about the final validity of such results.

I hope my testimony has been useful in framing some of the issues about whether the 95-percent test is a valid absolute standard and, if it is appropriate, about the transparency and clarity that should be provided to States having to perform such tests, especially given the existing data and methods.

Thank you.

Senator ROCKEFELLER. Thank you very much. Again, my apologies.

[The prepared statement of Mr. Peterson appears in the appendix.]

Senator ROCKEFELLER. I would like to start off with a question for Dr. Orszag.

Dr. ORSZAG. All right.

Senator ROCKEFELLER. The title of my question is "fuzzy math."

Dr. ORSZAG. Not mine, right?

Senator ROCKEFELLER. Not on your part.

Dr. ORSZAG. All right.

Senator ROCKEFELLER. The purpose of the question is to point out how the administration uses data inconsistently in order to fit whatever point they want to make. If I recall correctly, did CBO not issue a letter to Congress explaining why the administration's estimates were not an appropriate measure of the number of eligible, but unenrolled, children? What were some of the problems with those estimates?

Dr. ORSZAG. This refers to the July 2007 letter that we did send. I think perhaps the biggest issue involved the concept behind the figure. In particular, take two kids, one of them is insured for the first half of the year, and the second of whom is insured for the second half of the year.

Under the administration's approach, both of those kids are sort of counted as fully covered for the whole year, even though one might think that, since they are each uninsured half the year, that

there would be some policy interest, perhaps, in picking those kids up during the uninsured period. That is a big difference between the more traditional estimates in the literature and the roughly one million estimate that the administration issued. There are also some other methodological differences. So the ever-insured versus insured-during-a-month is a big conceptual difference and, in our judgment, for the purposes of evaluating programs like SCHIP and Medicaid, the figures that are at a point in time or are interpreted at a point in time are more appropriate.

Senator ROCKEFELLER. Thank you.

Now, to follow up with a point that Mr. Peterson made, the administration is claiming that States can, in fact, meet the 95-percent participation rate standard, citing estimates that many States have participation rates in excess of 95 percent.

I would like, before I complete the question, to make a point there. There is no way on earth—and I was a Governor for 8 years—that I could possibly conceive of getting 95 percent of West Virginians below the level of 200 percent of poverty signed up for this program. It just cannot happen. We have tried every single approach. This came in after I was Governor, obviously, but we tried everything. School Lunch programs, all the ways we could outreach. You cannot do it.

Some of them may not want it because their parents may be afraid of what they are getting into, because a lot of people are afraid of health care and often turn down opportunities for health care for fear that, although they have enough bad news in their life, they may have to take a chance on something new. So, I just want to sort of stipulate that.

Are you familiar with the methodology that CMS is using, and do you find their methodology reasonable, and do you find any methodology to be credible that produces a participation rate in excess of 100 percent? That does seem to be a galactic goal.

Dr. ORSZAG. Are you asking me?

Senator ROCKEFELLER. I am asking you.

Dr. ORSZAG. As CBO has already said, our view is that, for the purposes of evaluating programs like SCHIP and Medicaid, that more traditional estimates, which would not in general generate results anywhere close to 95 percent for the majority of States, would be more appropriate. That having been said, we are in the position of, for purposes of evaluating the impact of the directive, having to simply look at what the administration is intending to do.

It reminds me of the joke about the guy who won a lottery by picking the number 36. Someone said, why did you pick 36? He said, well, I have six grandkids and their average age is seven, and six times seven is 36. I do not know what to do with that, other than to say he won the lottery. [Laughter.]

Similarly, if the administration is going to apply a standard, however defined, in which the 95-percent test in general does not bind, we have to predict basically what the administration intends to do and how it will be applied. It is not up to us to evaluate whether it is or is not a reasonable interpretation.

Senator ROCKEFELLER. I thank you, sir. My time is up.

Senator Hatch is not here. Senator Wyden is.

Senator WYDEN. Here is Senator Hatch.

Senator ROCKEFELLER. Senator Hatch comes first. Good timing, sir.

Senator HATCH. I apologize for slipping out on everybody. I want to apologize for the noisy phone.

Mr. Smith, let me just start with you. Would you like to respond to Dr. Orszag's comments regarding the five strategies to reduce crowd-out included in the guidance letter? How did CMS develop these five strategies and determine their effectiveness? And I will ask an additional question. Are there other areas that CMS could consider to reduce the crowd-out?

Mr. SMITH. Thank you, Senator Hatch. A couple of things. One, to first stress that we believe we have the authority to act, even without doing the August 17th letter. We could have simply disapproved it and moved on from there.

We believed it would have been more beneficial, though, to States to actually issue the guidance for what we would be expecting and to evaluate how we would act, and furthermore giving States a year to come into compliance, to give them time to make adjustments, to do things, as we have been discussing, to be able to demonstrate they meet the 95-percent level, for example.

The 95-percent threshold. Again, we talked about the Medicaid under-count. That Medicaid under-count is not a trivial amount. The CPS data for the last year and the most recent ever-enrolled data counted 20.7 million kids in Medicaid. They do not even count SCHIP. They do not have an indicator for SCHIP.

Our administrative data, two sources of the administrative data backed both by the statistical enrollment data and by the statistical information survey, show we have 36 million kids in the most recent count. So, there is a difference of 16 million right off the bat.

Why we believed 95 percent was achievable also was the work that the Urban Institute did for us last summer. Again, those researchers did, I think, the most rigorous research that has been done, looking at these numbers and where they came from. They not only took CPS data, but our data. They looked at specific States, a sample of them. I think they have the most sophisticated simulation model that anybody has been able to use.

So again, we based it on what we believed to be good, solid research and data. The difference between ever-enrolled and a point in time, people can say, well, we should have picked point in time rather than ever-enrolled. I think CRS actually produced a paper last year, again saying the Urban Institute study was invalid, using ever-enrolled.

We believed ever-enrolled was the right one to do, because, again, the obligation is for the State to do outreach to find that child. So the State, from our perspective, if they went and found the child, did their job. They went and enrolled that child. They did the outreach work. Meeting the ever-enrolled target, I thought, was the most important one.

In terms of the other criteria on uninsurance, the States that we have talked about, making certain there had not been a decline in private insurance, again, the States in our sample in these first 17 States, more than half of those States are indicating that that is not an issue for them, that they can demonstrate that that decline has not occurred in their State.

The issue of cost sharing, I think, again, is very important. Have you created an incentive that the difference between the costs of private insurance and public insurance is so vast, are you actually creating an incentive to drop the care?

I mentioned in my New York example, again, $154 a month for a family at 400 percent of poverty, and many families are already signing up. They already believed that that was a good deal. So the issue is, does that 70 percent, or in this case in New York, did the Federal dollars start replacing those dollars for something someone already believed was a good investment?

The period of uninsurance. That clearly has been probably the most controversial. The waiting period, again, was based on—in 1998 the Clinton administration had identified that as a strategy. I think that strategy had been used by individual States as well. At least five States, at least some point in time, have used a period of uninsurance of 12 months.

That is not meant to be punitive, it was meant to be preventative, again to say, if you have private insurance—and what we are talking about also, Senator, is group insurance. We are not talking about coverage purchased in the individual market, which tends to be even higher yet, from group insurance. Those crowd-out provisions are about group insurance.

We believe that, if you have that available to you, families typically pay a somewhat higher percentage of the cost of family coverage rather than the single coverage of the employer. But again, we believed that those higher income levels—again, we are talking about families making in excess of $53,000, now—are reasonable criteria to, again, protect, who is that enhanced match rate for?

Senator HATCH. My time is up. That was a very good answer, but you took up all my time. [Laughter.]

Mr. SMITH. Is that why it was a good answer?

Senator HATCH. Sure. I would love to hear you.

Mr. PETERSON. Could I just respond? Because he mentioned our memo. The CRS did not, on that memo, say they did the right, best thing here. What we said, and Peter alluded to this, we were asked to explain some of these differences. Look, the administration is saying 1.1 million, we are hearing 6 million. What is going on here? In our memo, we simply explained why these differences occur. Peter alluded to one, and that is that we are talking about different time periods, different lengths of uninsurance.

In addition, and as I alluded to in my testimony, if you make different adjustments to the data, you are going to get different results. That is also what occurred. The 6 million number you hear is adjusting a little bit for the Medicaid under-count, but the 1.1 million comes from eliminating the Medicaid under-count.

That means you are turning, in the data, Medicaid coverage on for everybody until you match the administrative totals. The result of that is you get nearly 100-percent coverage, which, Senator Rockefeller, you mentioned that, even though this might be possible on paper, it may be unrealistic to think that this is really occurring on the ground.

Senator ROCKEFELLER. Thank you, sir.

Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Smith, as much as anybody, I believe in a strong role for the private sector in American health care. I have legislation with seven Democrats and seven Republicans to do that. Until we have reform, I am just very concerned that vulnerable kids are going to fall between the cracks, and that is going to happen particularly with this waiting period that you all have imposed.

So what I want to do is sort of unpack how this might work in the real world. I know, Dr. Orszag, you have done a lot of research into economic incentives as they relate to the uninsured. I think my first question to you is, what is going to happen during this waiting period, because it would seem to me that this could result in a cost shift so that kids who might otherwise have been covered with the Children's Health Insurance Program could end up going to hospital emergency rooms.

In other words, where do they go during that 1-year waiting period? I am sure that you may not have exhaustive analyses of this, but based on your research in this area, what happens to the kids in those families during that 1-year waiting period?

Dr. ORSZAG. Well, not based on any specific research, but it will be the case that some of those kids will wind up in emergency rooms because they are not covered otherwise in the meantime.

Senator WYDEN. I appreciate that answer. I would like to follow up with you on the research, because I will tell you, Mr. Smith, as sure as the night follows the day, those kids are going to get sick. They are going to have nowhere to turn, and I believe they are going to go to hospital emergency rooms. That is one of the reasons that your policy is so flawed and why I strongly support you, Chairman Rockefeller, in your efforts to turn it around.

One other question for you, Dr. Orszag, and then I will be happy to go to the folks at CRS. Tell me a bit more about your research on—I think I copied it down right—increased cost sharing does not increase the crowd-out rates.

Dr. ORSZAG. It does not reduce it.

Senator WYDEN. It does not reduce it.

Dr. ORSZAG. Yes. Much of the best work that has been done on crowd-out has been done by an MIT professor by the name of Jonathan Gruber. His most recent evidence on this question does suggest that increased cost sharing does not reduce the crowd-out rate. The reason is, when you have more cost sharing you discourage enrollment. You are discouraging it for two types of people, the people who would otherwise be uninsured and the people who would otherwise have private coverage.

It is really the ratio between those two and whether you are affecting one more than the other that will affect the crowd-out rate. Again, his evidence suggests that you are not having any significant effect in terms of reducing crowd-out rates by imposing more cost sharing. What you are doing instead is reducing enrollment rates in the program.

Senator WYDEN. Another area that I am going to want to explore with you further, and I will do in a couple of minutes because I think in this area, again, the administration is looking at a flawed policy. You can hurt poor people because they are going to have these extra costs, and it does not look to me like you are doing much to promote the private sector's role in health care either. So,

we are going to want to ask you some more questions about that as well.

Let me turn to the gentleman from the Congressional Research Service. I probably use you all in health care as much as anybody, so you ought to have the last word.

Mr. PETERSON. I would just want to comment on your first question. The folks at the Agency for Healthcare Research and Quality did a paper where they said, let us just imagine that SCHIP went away. Of course, that is just a little bit beyond the pale. But the point was to illustrate that at least a portion of those Federal dollars would still get paid in some way, as you are suggesting. So these kids are no longer in the program, in an SCHIP program, because of the waiting period, but that does not mean that those Federal dollars are not spent in some way that may be less efficient in terms of their care as well.

Senator WYDEN. Well, it sounds like you are being too logical, and heaven forbid that logic break out. That, of course, is something by Federal law that is required. By Federal law, hospitals are required to take people who show up at the doors. For the reasons I have outlined, as a result of this administration's policy, which I think is contrary to the good work of Senator Rockefeller and Senator Hatch—this has been a bipartisan approach from the very beginning. It is the only way we ever get anything important done in health. I hope that the two of you can once again prevail on this point.

Dr. Orszag, did you want to add anything?

Dr. ORSZAG. I just wanted to add very briefly that, while there will be those cases, I do not want to leave the impression that Federal costs are the same. Basically there would be some hospital visits and other extreme cases, but when you cover fewer kids under SCHIP, Federal costs are lower than they otherwise would be.

Senator WYDEN. Fair enough.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Wyden.

Now I believe it is Senator Stabenow.

Senator STABENOW. Thank you, Mr. Chairman. First, also, thank you to you and Senator Hatch, Senator Baucus, and Senator Grassley for the really excellent work that has been done on SCHIP.

We have been talking a lot about words like "crowd-out," all kinds of words. I would like to just bring this down to home. What this policy does, Mr. Smith, is say to a mom with two children who makes $33,000 a year, that the State would not have the option of helping them without going through all this directive and waiting a year—a year—in a child's life before being able to get health care.

So I think we need to bring it down to, first of all, the real numbers about what this means. We also know that for that mom and two kids, it is reasonable—probably conservative—to say that, if she were going to go out and buy this insurance in the private sector, just an individual policy, she would spend at least $1,000 a month. If she has a special needs child, as I know our witnesses have, $1,500, $1,800 a month. So, let us say conservatively $1,000 a month. That is $12,000 a year that you deduct from the $33,000 income. So that is what we are talking about.

We are talking about basically taking more than a third of the income coming in from a mom with two children. Based on our Federal Poverty Level numbers, 200 percent of poverty is $32,454, so anything above that $32,454. That is the situation that a mom with two kids finds herself in.

Let me go to, Senator Wyden was talked briefly about use of emergency rooms. Let me just share a real-world experience for us in Michigan, with a lot of employer-based health care. Employer-based health care has gone down, not because families want it to go down, it is going down because of the cost of health care, because of global competition, because of a number of things.

More and more families are using the emergency room. When they use the emergency room they get treated, as they should, by the hospital, and then those costs get rolled over onto employers who see their rates go up and then more of them drop people from insurance, not because they want to but because they are in a terrible situation.

So one of the things that I would like an answer to, you had here as one of your criteria that States must certify that coverage levels under employer-sponsored health insurance have not fallen by more than 2 percentage points over the previous 2 years, when in fact employer-based coverage has fallen by 5 percent nationally, more than that, certainly, in my home State where employers, for years, have done the right thing.

At the same time, uninsured children, the percentages, have gone up in the last decade. So my question is, what is the rationale for creating a provision that says, if there is a decline in employer-based health insurance because of the economy, that a State cannot step in to help the children who have been affected by that decline?

Mr. SMITH. Thank you, Senator. A couple of different things, if I may. Again, in your example of the mom with two kids, if she is below 250 percent of poverty, then the policies do not affect her. If she is above 250 percent of poverty and she had private individual insurance, it does not affect her either. The crowd-out is about private insurance through the employer market.

In terms of what we were trying to look at, how do the States, looking at that indicator that you made reference to in terms of private insurance not declining, again, we have looked at it from a couple of different perspectives. We do believe States do have some impact on the private market.

I think that you have examples. Governor Schwarzenegger, for example, in health care reform last year talked about the MediCAL rates being so low that it was contributing to the cost of private insurance on everybody else, I think around 17 percent. Everyone with private insurance was paying that additional amount because MediCAL was so low. You have other States, New York on the opposite end, where health care is so high it is also having an impact.

So we do believe that States have an impact on their market for the cost of health insurance, cost of health insurance being a prime driver in terms of whether or not insurance will be taken up. Again, this was a criterion that we looked at. In the 17 States that are involved, as I said, a majority are saying that has no impact. Private insurance has not gone down in those States, so we have not believed that to be a factor.

Senator STABENOW. So what are you saying to States like mine where, in fact, private insurance has gone down and our State is attempting to address that? It is actually looking to CMS for approval to be able to do something to help that. We really have not answered the question in terms of why the decline in employer-based insurance is relevant to this situation. I mean, if the employer-based insurance is going down, you are saying it is because they have a Children's Health Insurance Plan in their State?

Mr. SMITH. Again, what we were trying to look at as an indicator, this impacts the relationship between public coverage and private coverage. I think there is a relationship. Our criteria that we placed in there were, again, to help the States to explain to us what was going on in their market. The States that are currently at 250 percent or above seem to indicate at this point that that is not going to be an issue for them.

Senator STABENOW. I would just say—and I am sorry I have gone over. I am sorry, Mr. Chairman. I just want to say for the record, though, that I think it is also important to note that the congressionally mandated 10-State evaluation of Children's Health Insurance, while it found that 28 percent of the newly enrolled children had had coverage before, half of them had lost private insurance coverage for involuntary reasons. In other words, the parent lost their job or they became divorced, or et cetera, et cetera.

Mr. Chairman, I will stop at this point. I find this to be a very unfortunate discussion in terms of a very unfortunate directive with no input before it happened, no ability for us to discuss something that makes sense for families, and it is very, very disturbing to me. Thank you.

Senator ROCKEFELLER. Thank you, Senator Stabenow.

And now, Senator Lincoln.

Senator LINCOLN. Thank you, Mr. Chairman. And thank you for bringing us together. As Senator Stabenow has mentioned, I think a lot of us are very concerned and troubled. With all the hard work that we have tried to put into bringing about a bipartisan resolution to the CHIP extension and the tremendous opportunity we have to cover more of our hardworking American families and their children, it just gets more and more frustrating when we continue to see the number of uninsured growing in our country.

We know how desperate our Nation is to get its arms around these uninsured and put them into a place where we can get a better handle on providing them a better quality of health care and better access, and certainly making sure that they can be insured. So, it is frustrating to us all, I think, to see us stymied in this way.

Mr. Smith, I understand this is your last week at CMS. Is that correct?

Mr. SMITH. Yes, Senator.

Senator LINCOLN. Well, you have been there since 2001, so that is quite a stint you have had there. I am sorry. I came in late, Mr. Chairman. That might have already been brought up. But thank you for your service there.

Senator ROCKEFELLER. There was a nuanced comment.

Senator LINCOLN. All right. [Laughter.]

On the statutory authority, Mr. Smith, I just was curious because there was quote from you in the *New York Times* on the Au-

gust 17th directive, to the effect that you were saying, to be consistent and logical, you have to apply the criteria to Medicaid and SCHIP, or to CHIP. Is that a correct statement? I guess if it is, is it true that CMS is applying this same directive to Medicaid, I guess, essentially placing a cap on an entitlement program? Is that the intent of the comment?

Mr. SMITH. My comment, Senator, was from a policy perspective. Again, Medicaid being for the lowest-income of all, SCHIP came along and was built on top of Medicaid. Logically, it does not make sense—to me, anyway—to put Medicaid back on top of SCHIP. So from a policy perspective, it does seem to be consistent to apply the policies evenly.

As well, going back to the original discussion and compromise of SCHIP, I think in large part we were trying to strike a balance so States were not necessarily tilted to Medicaid or a separate SCHIP one way or another, even though you do deal with the entitlement of Medicaid. There are some reasons some States went Medicaid, some States went to SCHIP itself. But I think at the time we were at least trying to, policy-wise, not try to tilt the balance one way or another.

Senator LINCOLN. So what I am hearing you say, I am assuming, is that you do not believe that placing a cap on Medicaid is a statutorily——

Mr. SMITH. Medicaid has its own distinct rules in title 19 that do distinguish it in some respects from a separate SCHIP.

Senator LINCOLN. Well, I am operating under the assumption that it does require congressional approval to put caps on Medicaid as a mandatory program. Would you agree with me on that?

Mr. SMITH. To put in an upper income limit on Medicaid, the statute works—I mean, there is an interaction between SCHIP and Medicaid. If you are SCHIP-level, you cannot be Medicaid. There is the definition of an optional target low-income child within Medicaid, so we carried over part of the definition of the target low-income child to the Medicaid side.

As I said, from a policy perspective, if you allow Medicaid to go higher, or again with no cap at all on eligibility, then you have created a pathway around what I believe the intent was, again, the enhanced match of SCHIP, which was supposed to be for a specific population. So, if you allow Medicaid to go around SCHIP, then in effect you are going around that relationship.

Senator LINCOLN. I am not sure you and I agree on that, but I am not sure exactly what you are saying. So, I may come back to it. [Laughter.]

Let me see here. I had another question for you.

With Secretary Leavitt's admission that HHS did not have the authority to stop proposed expansion, he sent a letter to Senator Grassley saying that, under those current relations, we have no authority to disapprove them, and that is solely based on income disregards.

The Secretary indicated that he wanted to change the policy, but he acknowledged that the law gives States great flexibility to define income. Is that what you are trying to say to me? I mean, in light of those statements, I guess—I do not know. I am confused here. It seems like just a few weeks short of that, or maybe a few

weeks later, CMS discovered it really could reject States' requests to cover children above 250 percent of the Federal Poverty Level. So was there confusion there?

Mr. SMITH. I hope not, but if there is, I will try to explain. I think that the discussion at the time and the inquiry at the time was specifically about the Secretary's authority to disapprove a plan amendment just based on the Secretary's authority. The response was, because family income was left to the States and there had not been regulations promulgated limiting that, that the overall authority had been delegated to the States. Again, history had told us, States in fact had already been approved at those higher income levels.

As I mentioned in response to another question, we could have made potentially a different policy choice of simply taking the theory that the Secretary could have disapproved it and simply disapproved it based on income, taking a theory that, again, the Secretary had the authority to enforce on substitution and simply use that authority, but we believed that this issue was so important that, in fact, we should go and put out a guidance out there for the States and for the Congress to be able to look at this issue of substitution.

Senator LINCOLN. Do you think that was because we were not clear enough about the intent of what we wanted to happen?

Mr. SMITH. Well, again, I think there were a number of members who were very clear that said the Secretary has absolute authority to stop it at 200 or 250 percent of poverty. There were members who said that very absolutely to us, and this was all sort of a moot issue because the Secretary had the authority to act in that way. We thought a better approach was the approach that we took.

Senator LINCOLN. Well, thanks again for your service. We appreciate that.

Mr. SMITH. Thank you very much, Senator.

Senator LINCOLN. Good luck in your next endeavor.

Mr. SMITH. That is very kind of you, Senator.

Senator LINCOLN. Can I ask Dr. Orszag one question, please? No, I will wait.

Senator ROCKEFELLER. Do you want to get to 10 minutes, or 15 minutes?

Senator LINCOLN. No, I will wait. Thank you, Mr. Chairman.

Senator ROCKEFELLER. You can come right back.

Senator LINCOLN. I will come back.

Senator ROCKEFELLER. Just do not go. There are just the two of us here.

That was called a signing statement, the answer. When you pass law, you give it to the President, then he interprets what he is going to do with the law that is the law. So, you got a very good example of that, in my judgment.

I was going to use the same quote. Then I was going to do a further thing, which is to say that the purpose of this question, I would say, Mr. Smith, is again to highlight the fact that the administration does not have the administrative authority to limit CHIP coverage to children at or below 250 percent of poverty. I really do question—more than question—the legality of the policy.

Federal law does not authorize CMS—in spite of your words, which were also nuanced but came to no hard conclusion, in my mind—to effectively impose an income eligibility cap on CHIP or Medicaid, nor does it require States wanting to cover children at levels higher than 250 percent, or to use 100-percent State-only funds, to do so.

I also question the process. Such a dramatic policy change should have been handled through the formal rulemaking process. Now, this will seem to some like bureaucratic talk, but it is what makes the government work and which holds everybody accountable. There was no public notice. There were no comments. It was just a unilateral, subregulatory fatwa, just a decision that was made. I think it is very interesting that HHS is coming to Congress seeking legislative permission to expand this August 17th proposal to States wanting to cover children at levels higher than 200 percent of poverty, when you did not come to Congress the first time around.

This little bit about crowd-out. Nobody ever talks about crowd-out except when Medicaid and the CHIP program are discussed. In fact, to sort of angle at Dr. Orszag, in the Medicare Prescription Drug Part D matter, crowd-out comes as high as 72 percent. But not a word was said. I have never heard a word about crowd-out except on this subject of children and Medicaid, CHIP and Medicaid.

Now, do you believe that the August 17th guideline has the force of law or is it interpretive? Let me tell you why I am asking that question. The Justice Department just argued on your behalf in the *State of New Jersey v. U.S. Department of Health and Human Services* case, and they came to the conclusion that "the language of the State Health Organization letter itself demonstrates that CMS does not intend the policy guidelines to have the force of law." The high court is saying something.

Could you respond to that?

Mr. SMITH. Yes, Mr. Chairman. Again, certainly I am very familiar with the lawsuits themselves and have participated in the description of what our authority is. You do correctly state how we have characterized our authority in that manner, that this is guidance to the States. It is saying this is what you can expect from us in terms of how we will act when you put a matter before us.

So the Justice Department's—I do not know the legal term—declaration or position, certainly that is my understanding as well as what the authority for these letters—and again, numerous administrations have used this type of guidance to the States. But that authority is what has been described in the Justice Department memo. But again, I think the importance of that, as I said, we could have also chosen a route to simply disapprove it and let that go to the courts as well. Any time the Secretary disapproves a State plan amendment on either Medicaid or SCHIP, the States have a right to appeal that decision, and appeal it to the courts as well.

Senator ROCKEFELLER. Let me just close here, because my time is out. I thought that was not a very compelling answer. In other words, the law is the law. The Federal court rules, that is the law. You are saying, yes, that is the law, but there are these other cir-

cumstances which mitigate somehow that law. I cannot live with that.

President Bush himself has given his statement early on that he did not think this was the right thing to do. I do not have it in front of me to quote.

So my final question is, given that CMS already has issued detailed regulations on how States must address the crowd-out issue, why did CMS decide to disregard the Administrative Procedures Act and issue a new policy without modifying its existing relations and going through appropriate public notice and rulemaking procedures, which is what we do in a democracy?

Mr. SMITH. Yes, Mr. Chairman. Again, we already had a regulation in place regarding the substitution of private coverage. The guidance itself underneath was trying to fill in the blanks further, to say where the Federal Government had previously said, States, it is your responsibility but we are not setting out any particular criteria—that regulation was already there.

As I said, we could have taken the position, we will just rely on that alone and disapprove State plan amendments without doing anything else. We thought it important to do something else in addition to being able to tell the States in advance, this is what we will be looking at for you to fulfill your obligation.

Senator ROCKEFELLER. So going around the Administrative Procedures Act was not that important?

Mr. SMITH. Senator, again——

Senator ROCKEFELLER. I mean, I am trying to put words in your mouth. [Laughter.] Frankly, you deserve it because you have fundamentally not answered any question that has been asked of you, in my humble judgment. And Orrin Hatch can attack me right after I finish my questions, because he is next up. But I really believe it. I think this happens sometimes when either you do or do not believe in what CMS was doing.

If you do not believe in it but you have to uphold it, just like when you are before Congress, when you can testify before Congress, this is not your testimony, this is testimony which has been vetted, your original statement, by OMB. That is the law. I mean, so-called, the law. It is always practice. So, you are not free to give your own opinion. I hope that that was clear to me, because I want to see your better angels on your shoulder.

But I am finished. I call on Senator Hatch.

Senator HATCH. Well, thank you again, Mr. Chairman. As if I would ever jump on you. But if I do, you will know it. [Laughter.]

Mr. Smith, let me just say, a little later we are going to hear testimony from Paula Novak about her family's struggles to cover their child who was born with Down Syndrome. I have a great deal of sympathy for families struggling with children with disabilities, which is why I have worked so hard over the past years with my friends, Senators Grassley and Kennedy, to pass the Family Opportunity Act, or the FOA. The FOA would allow families with disabled children, making up to 300 percent of poverty, to buy into Medicaid, as I view it. We successfully included the FOA in the Deficit Reduction Act.

Now, has the State of Ohio offered to take up the FOA?

Mr. SMITH. No, Senator, it has not.

Senator HATCH. All right.

But do you believe that anything in the August 17th directive would give you the authority to disallow a State plan amendment to expand Medicaid through the FOA?

Mr. SMITH. The FOA stands on its own, and it would not apply to the FOA.

Senator HATCH. All right.

Mr. Peterson, how reliable is the data available through the Census Bureau's Current Population Survey, or CPS, with regard to the number of uninsured, low-income children who are eligible for CHIP coverage?

Mr. PETERSON. Well, as I mentioned in my testimony, the data do not actually tell you who is eligible. You have to make adjustments. I think one of the points in my testimony is that these data can be used to give you a sense of where things are. That is one issue, versus trying to tie public dollars or some sort of threshold that affects what States can do on the ground.

Senator HATCH. Is there a State-to-State survey that basically under-counts Medicaid and SCHIP enrollment by several million individuals? Would you agree with that?

Mr. PETERSON. Yes.

Senator HATCH. All right.

Now, as I understand it—and you tell me if I am wrong—I do not think there is a survey which collects national data on Medicaid- or CHIP-eligible individuals, is there?

Mr. PETERSON. Not on eligibility, no.

Senator HATCH. All right.

Now, is there one reliable data source that will help States determine whether or not they have covered 95 percent of their low-income children?

Mr. PETERSON. It would have to be data that goes through certain adjustments.

Senator HATCH. As a result, it may raise the CHIP income eligibility level.

Mr. PETERSON. I am sorry?

Senator HATCH. Where, as a result, it may raise their income eligibility up a level.

Mr. PETERSON. So are you saying that you are trying to tie the results?

Senator HATCH. What I am saying is, do you have any reliable data source that will help the States to determine whether or not they have hit the 95 percent of low-income children and, as a result, may raise their CHIP income eligibility levels? I may not have stated it very well.

Mr. PETERSON. Yes. It might be the kind of thing where you can do it on paper, which was what we tried to demonstrate. But that raises the fundamental questions of, is this really happening on the ground?

Senator HATCH. All right. So, therefore, as far as the 95-percent threshold, you believe that CMS got it right, once data adjustments are made for individuals' immigration and documentation status and the Medicaid under-count. Am I correct in that assertion?

Mr. PETERSON. We do not say they got it right.

Senator HATCH. What do you say? [Laughter.]

Mr. PETERSON. We were merely trying to demonstrate what can or cannot be done with this data. I tried to say in my testimony, this gets back to laying down standards that are clear and measures that are valid.

Senator HATCH. Yes.

Mr. PETERSON. And that has not been made clear in their guidance.

Senator HATCH. All right.

Dr. Orszag, we appreciate you always. You always give intelligent testimony. I may not always agree with it, but you do a good job, is all I can say.

In your testimony for today's hearing and CBO's report on the CHIP program, the point is raised that the CHIP program provides a source of coverage that is less expensive and offers a broader range of benefits than other types of private health coverage.

Now, if I read it correctly, you concluded that SCHIP coverage replaces or crowds out private health coverage, and that for every 100 children who have received health coverage through CHIP, there is a reduction in private coverage of between 25 to 50 children.

Dr. ORSZAG. Correct.

Senator HATCH. Now, could you talk about this maybe in just a little bit more detail? Is it possible that the reduction in private health insurance can be even higher if the CHIP eligibility level goes beyond 300 percent of the Federal Poverty Level?

Dr. ORSZAG. As you move up the income distribution, this problem becomes more severe simply because a larger share of those children have private coverage, so the potential substitution is a more salient factor.

Again, I want to emphasize, any expansion in public insurance, whether it is the prescription drug benefit or it is trying to cover more kids, is going to displace private coverage in the United States to some degree, unless you impose mandates and other things.

So to some degree this is an inevitable problem, and the question is how well you manage the various trade-offs. That really is up to you all to evaluate whether the effects are worth what you are paying for.

Senator HATCH. All right. It is obvious that you and your staff have had the opportunity to review the CMS CHIP guidance letter of August 17, 2007. Do you believe that the goals of this guidance letter are realistic? Would crowd-out be reduced if States were required to cover 95 percent of their uninsured children at 200 percent of poverty and below before raising the income eligibility for the CHIP program over 250 percent of poverty?

Dr. ORSZAG. Well, that really, again, depends on how the 95-percent threshold is evaluated.

Senator HATCH. It is my understanding—and maybe I am wrong, but I think it is so—that crowd-out numbers only go up if higher income children who typically have a choice between public and private coverage decide to receive their health coverage through a public health program like CHIP as opposed to private coverage. Am I right in thinking that?

Dr. ORSZAG. Yes, that is correct. The difficulty I am having in answering the question is simply that there is ambiguity about whether the 95-percent threshold or test will actually bind to any significant degree or not because of the way that it is apparently being interpreted, and, according to Mr. Peterson's numbers, many States are well above 100 percent.

So, 95 percent is an easy thing to meet, and therefore it does not have any significant effect. There are other interpretations of the 95-percent test where it would have a bigger effect and then it would limit the enrollment of kids above 250 percent to a much more significant degree.

Senator HATCH. Well, you state in your testimony that "the administration's CHIP guidance will have a modest impact on enrollment due to the way that the administration is implementing it." Does CBO have any suggestions for the administration on how this guidance could have a larger impact on enrollment?

Dr. ORSZAG. Again, I do not really feel like it is up to us to tell the administration how to——

Senator HATCH. I do not want you to do that. I just want you to tell us. [Laughter.]

Dr. ORSZAG. And they are not listening. Everyone close their ears.

Senator HATCH. No, they are not listening at all, I can tell you. [Laughter.]

Dr. ORSZAG. I do want to emphasize, again, that the statement that the effect would be modest, given the way the administration appears to be implementing the directive, depends very sensitively on that being evaluated relative to our official baseline in which the funding levels are constrained.

If you were to significantly expand the program so that States had the opportunity to do a lot more, the directive, even the way the administration is interpreting it, could have a much more significant effect. I would rather stay away from making normative statements about how the administration should interpret its own statements.

Senator HATCH. I think the chairman is going to let me ask a couple other questions, even though my time is up. It is very gracious of him.

Senator ROCKEFELLER. I thought I raised one finger.

Senator HATCH. You thought you what?

Senator ROCKEFELLER. Raised one finger.

Senator HATCH. You raised one finger?

Senator ROCKEFELLER. Right. One question.

Senator HATCH. Just one finger?

Senator ROCKEFELLER. One finger.

Senator HATCH. I only have five more. My goodness. Let me just ask you one more.

I read with great interest your comments on the effect of CHIP on private coverage. Now, you state that, even in the majority of States where CHIP covers only children, the program could reduce private coverage among adults as well as children.

Could you please explain how private health coverage would be reduced for both adults and children, and why is there limited in-

formation on how CHIP has impacted employers' decisions on whether or not to offer health coverage?

Dr. ORSZAG. First, to answer the second question, there just has been very limited analytical and data survey work done on that question. But the way that this could arise is if, take a firm that had disproportionate numbers of low-income workers. If the firm decided for whatever reason that because of the availability of more public insurance it was not going to offer a plan or it was going to have very high cost-sharing requirements on the plan, it is possible that some parents will say, I will not take coverage through that firm, or it may not be offered in the first place because my children will be able to sign up for SCHIP, and the parents, or the adults, may be uninsured as a result.

The evidence to date—and it is very limited—suggests that most of the effect is not through employer dropping, which is where that channel would be most salient, but rather through households, families deciding that SCHIP was a better deal for them, was a more attractive package for them than some alternative private coverage would be, to the extent that this occurs at all. So we do point out that it is not known, but the limited evidence that we have suggests that that is not the major thing going on.

Senator HATCH. Well, thank you.

Mr. Chairman, I took more time than I should have, but I appreciate the answers.

Senator ROCKEFELLER. Thank you for your forbearance.

Senator Lincoln?

Senator LINCOLN. Just quickly, from my previous question to Director Smith, I was trying really hard to follow you through that maze in your answer. So I think maybe if I just simply ask you, do you think CMS has the authority to place a cap on Medicaid, yes or no, maybe that will make it black or white for me.

Mr. SMITH. To place an income cap on Medicaid?

Senator LINCOLN. Yes.

Mr. SMITH. We do not have that authority. The issue, though, is for whom is the enhanced match rate, not what is the relationship between a Medicaid expansion versus a separate SCHIP. What are the relationships between the two of those? Medicaid itself, title 19, does not have a specific income threshold, but there is a relationship between Medicaid and SCHIP through the optional targeted low-income child issue.

Senator LINCOLN. As long as I know that what your answer is to whether or not you have the authority to place an income cap on Medicaid, and I am taking it as, no, you do not feel like CMS has that authority.

Mr. SMITH. That is correct.

Senator LINCOLN. All right. Great. Thank you. It takes a little while to get things straight for me.

Dr. Orszag, this is kind of along the lines of what you have been talking about and Senator Stabenow brought up. When you talk about that displacement, or I guess on the State's ability to control the trends in employer-based coverage, you may estimate that the availability of SCHIP coverage may affect the provisions of the ESI in a State. You said that there are declines. I mean, I think there are. Maybe you will disagree with me on that.

But there are overall declines in the employer-sponsored insurance for both children and adults. But that has nothing to do with SCHIP, I do not think. I guess I am asking you, is that not because of the rising cost of health care? Maybe it is transition in the workplace, and other things like that. But do you believe that States exercise significant control over ESI in their States, or is that all a product of other larger market forces in health care? I mean, to that effect, I guess, the answer you gave earlier, it seems as if that is very minimal in terms of the shift of those who will leave private insurance to go to SCHIP. I mean, those numbers were relatively minimal, were they not?

Dr. ORSZAG. Again, I think most of the crowd-out that does occur appears not to be because employers are dropping coverage, but rather because families are deciding that the public coverage is a better alternative for them, whether because of lower cost sharing or because of expanded benefits, and I would agree that——

Senator LINCOLN. What about continuity?

Dr. ORSZAG. The whole package, as it were. I would agree that most of what is happening in the employer-sponsored insurance world, which is a very important topic, is driven by other forces than the one that we are talking about today.

Senator LINCOLN. Great. Thank you.

Thank you, Mr. Chairman, for your indulgence.

Senator ROCKEFELLER. Thank you, Senator Lincoln.

One final question, Dr. Orszag, for you, and then we will go on to the next panel.

You are not, I hope, suggesting that because we offer very generous subsidies to private plans, many of which have dropped private coverage anyway, that crowd-out was non-existent in Medicare Part D.

Dr. ORSZAG. I do not think I came anywhere close to suggesting that. Again, I am going to repeat it: crowd-out is an issue that arises whenever you expand public insurance, and the creation of Medicare Part D did involve significant crowding-out of preexisting private coverage. In other words, you are buying out the base to some significant degree.

Senator ROCKEFELLER. Some range?

Dr. ORSZAG. I would put it in about the same range as the SCHIP program, so somewhere between a quarter and a half, depending on how you do the calculation.

Senator ROCKEFELLER. All right.

I would just end by saying it is just very interesting to me that we never heard this argument when Medicare Part D was being discussed. It is kind of a large program, and it never comes up. Except somehow when we get to children, we get absolutely zealous on crowd-out. I tend to agree with Dr. Gruber of MIT.

Mr. Peterson, you were going to say something, and I did not call on you. You wanted to say something?

Mr. PETERSON. Well, I was just going to respond, Senator, just to explain to help out, because that seems to be what we often do as CRS staff, trying to explain these things as best as we can. CMS has said that they have no ability legally to restrict how States count income either for under Medicaid or separate SCHIP programs, and I think you would find that the statute and the regula-

tions bear that out. So it does seem schizophrenic on the one hand, where SCHIP says 200 percent of poverty plus 50 percentage points, but then States can count income however they want. So, that is where that tension comes in.

That is why this guidance did not use income, per se, as the criteria for limiting eligibility. It was the crowd-out provisions. Then back to Senator Lincoln's question on Medicaid. What I was going to tell her was that the crowd-out provisions that are in the SCHIP statute do not apply to Medicaid, so it would appear that Medicaid expansion SCHIP programs would not be subject to the August 17th letter based on the current regulations. I can just read it to you; I happen to have printed it off. This is under the substitution of coverage in the regulations. It says, "The requirements in this subpart apply to separate child health programs," not Medicaid.

Senator ROCKEFELLER. A question I did not ask. There was a question of Ohio. How does what you say apply to Ohio?

Mr. PETERSON. Well, I would like to hear Mr. Smith's take on this, but Ohio is a Medicaid expansion State, so it would appear that these regulations regarding substitution of coverage would not apply to such a State.

Senator ROCKEFELLER. Mr. Smith?

Mr. SMITH. Senator, the disapproval for Ohio was for a different reason not related to substitution. That is correct.

Senator ROCKEFELLER. For a different reason?

Mr. SMITH. The Ohio plan amendment itself was asking for a different match rate than what was applicable, so it was disapproved for that reason rather than substitution.

Senator ROCKEFELLER. All right.

I thank all of you very, very much. It is always a pleasure to appear before the Finance Committee, and I know that, so you do not have to thank us. [Laughter.] But we thank you for your expertise that you have built up over the years and that you have to work very hard at every day.

Are you like Alan Greenspan? Do you work off four computers at the same time, Dr. Orszag?

Dr. ORSZAG. I believe I have three screens in my office.

Senator ROCKEFELLER. Three screens in your office.

Dr. ORSZAG. Yes.

Senator ROCKEFELLER. Simultaneously running?

Dr. ORSZAG. There you go.

Senator HATCH. Mr. Chairman?

Senator ROCKEFELLER. Yes?

Senator HATCH. I understand Mr. Smith is leaving the administration at the end of this week. Is that correct?

Mr. SMITH. Yes, Senator.

Senator HATCH. Well, if that is so, we want to thank you for the hard work you have done and the good service you have given to our country, and I just want to express my gratitude to you as well. Even though you are one hard-nosed dude. [Laughter.]

Mr. SMITH. You are very kind, Senator. I appreciate it, again, and recall my time with the Finance Committee and serving with the both of you with great affection. I appreciate your very kind remarks.

Senator HATCH. Well, you have served well here. I just want to thank you for your service.

Mr. SMITH. Thank you.

Senator ROCKEFELLER. I join Senator Hatch.

Mr. SMITH. Thank you, Mr. Chairman.

Senator HATCH. We thank you other two for your service, too. [Laughter.] We sometimes even agree with you, you know. [Laughter.]

Senator ROCKEFELLER. All right.

Now, the next panel, the last panel, and there are not many of us here, but for those of us who are here——

Mrs. Paula Novak from Lebanon, OH, whom I spoke about earlier. Mr. Alan Weil, executive director, National Academy for State Health Policy based in Washington. Nina Owcharenko, senior policy analyst at The Heritage Foundation. And the person I forgot to introduce, Ms. Cindy Mann, executive director of the Center for Children and Families, Health Policy Institute, Georgetown University.

Mrs. Novak, because we walked over here together, I want to call on you first.

STATEMENT OF PAULA NOVAK, LEBANON, OHIO

Mrs. NOVAK. Thank you. Good afternoon, Chairman Rockefeller, Ranking Member Hatch, and other members of the subcommittee. My name is Paula Novak. My husband Jeff and I have three children: Cole, Avery, and Seth. We live in Lebanon, OH. Today I represent my family and many others like ours that are self-employed, hardworking, and yet struggle to maintain adequate health care coverage. This becomes particularly true when one person in the family has a chronic illness——

Senator ROCKEFELLER. Just take your time and be comfortable.

Mrs. NOVAK [continuing]. —or disability. In our situation, our youngest son Seth, who is 4 years old, was born with Down Syndrome and struggles with related health and developmental issues. I want to share with you the effects the August 17th directive is having on Seth and the rest of my family.

At this time last year, Ohio was moving to expand its Medicaid SCHIP program to include children like Seth. The expansion was stopped, however, by the August 17th directive and now Seth, as well as his sister and brother, are uninsured. My husband Jeff is self-employed in the construction industry. He works hard, specializing in church construction and remodeling. I do some work for the business, though unpaid, but mostly I am needed at home to care for our children, and particularly our son Seth.

Jeff and I and our two older children have been sporadically covered through private insurance that we purchase ourselves. In January of 2004, our family was covered by Anthem Blue Cross for about $535 per month. Seth was born January 8, 2004. Medicaid covered Seth's birth because we did not have a maternity rider on our policy.

During that same month, the insurance policy came up for renewal and the premium jumped to $800 per month. Jeff was not working in early 2004 due to surgery, so we had to drop the policy. Since we had very little income at that time, we qualified for Med-

icaid. When Jeff returned to work, the business began to produce better income and our Medicaid coverage ended. We were able to pick up a policy with Medical Mutual of Ohio for $444 per month, but they declined to cover Seth because of his Down Syndrome.

At that time I checked with the top 10 insurance companies and dozens of agents, trying to find coverage that would include Seth. But I was told Seth is deemed as "uninsurable" and the only possibility to cover Seth would be to go through open enrollment. Open enrollment is a requirement of the Ohio law that the insurance companies will, once a year, take a limited number of individuals regardless of preexisting conditions. I attempted to enroll Seth during the open enrollment and was quoted premiums ranging from $1,200 to $1,800 per month just for Seth. We cannot afford this additional premium on our current income.

Seth has been uninsured since August of 2007, when his Medicaid coverage ended. He has now been deemed disabled, but the catch here is that our spend-down per month was calculated to be $2,687 which must be spent before Medicaid can help. This amount is even more unreasonable than the price quoted for the private insurance for Seth under open enrollment.

Our entire family is uninsured. We were forced to drop the Medical Mutual policy coverage for myself, my husband, and our two older children in January when our carrier raised the premium from about $450 to almost $600 per month. The policy also had a high deductible and we could not afford the cost of the insurance, plus that out-of-pocket requirement.

Our adjusted gross income for 2006 was about 250 percent of the Federal Poverty Level and it appears that our 2007 gross income will be approximately the same. We were so privileged to be able to participate in the signing of Governor Strickland's budget in Ohio which included the expansion of Medicaid eligibility to children with family incomes up to 300 percent of the Federal Poverty Level.

Under the expansion, Seth would have been able to have the health coverage he so critically needs. Not only Seth, but my other two children would have been able to be covered under this expansion. In a country as prosperous as America, it is just not acceptable that they do not have access to affordable health coverage. Because of the requirements placed on the States by the August 17th directive, Ohio has been unable to implement the expansion of the plan to help children like Seth. We are proud that Ohio made a commitment to cover Seth and children like him, but were deeply troubled by the Federal Government's efforts to block that decision in Ohio.

Just as an example, please let me tell you the needed care that Seth has missed due to his lack of coverage. Seth had open-heart surgery in 2007 and missed his 1-year cardiology follow-up. Seth has missed appointments for eye exams, thyroid exams, ENT visits to replace tubes in his ears, genetic doctor appointments to track his growth and development, fittings for his orthotics, and very importantly, because Seth is still non-verbal, visits to a speech therapist. As the parents of three uninsured children, I implore you to overturn the August 17th directive and allow States such as Ohio

to continue the good they set out to do with the Medicaid expansion.

By virtue of his birth, Seth is not entitled to special privileges; however, he is entitled to equal privileges which can be provided by the proposed Medicaid expansion. We are ready and willing to contribute to Seth's health care, but the $1,200 premium or the $2,600 spend-down are simply out of reach for us. We ask you to help us to help Seth by not adding lack of health care to the already substantial challenges he must face.

I thank you for your time.

Senator ROCKEFELLER. Thank you, Mrs. Novak.

[The prepared statement of Mrs. Novak appears in the appendix.]

Senator ROCKEFELLER. Mr. Weil?

STATEMENT OF ALAN WEIL, EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY, WASHINGTON, DC

Mr. WEIL. Mr. Chairman, Ranking Member Hatch, my name is Alan Weil. I am the executive director of the National Academy for State Health Policy, a nonprofit, nonpartisan organization that works with State officials to develop and implement effective health policy. Thank you for the opportunity to appear before you today to discuss the August 17th directive and its implications for States.

My organization has served as the unofficial home of the Nation's SCHIP directors since the program's enactment. At their request, we convened a work group to discuss the directive. While my testimony is informed by the Nation's SCHIP directors, I do not speak on their behalf.

The August 17th directive was issued without notice and comment, without consultation with States, and was not part of a formal rulemaking process. Although States have sought additional information, CMS has not responded in writing to the many questions that have arisen. This makes it difficult to determine the precise effect of the guidance.

I will focus on four particular concerns. First, States that want to cover children with family income above 250 percent of the Federal Poverty Level must demonstrate that they have enrolled in SCHIP or Medicaid 95 percent of eligible children from families with income below 200 percent of the Federal Poverty Level. States are trying hard to reach and enroll eligible uninsured children, but there is no rational basis for the 95-percent threshold, and CMS has not offered one.

That level far exceeds the actual experience of other means-tested programs. There are no reliable data available to determine whether or not States are complying. While CMS has indicated that they will negotiate with States over which data they may use, this is vague and potentially arbitrary as a means for determining compliance.

But perhaps even more important is that States have found that higher eligibility levels are an effective means for attracting lower-income children into the program. For example, while the Illinois All Kids program has no upper income threshold, 70 percent of the

166,000 children enrolled during the first year of the program were previously eligible for SCHIP or Medicaid. Broadening eligibility reinforces the message that health insurance programs are not tied to welfare and that they are designed for working families. If States follow the CMS directive, they will actually be working against the stated goal of enrolling low-income children.

Second, the CMS directive requires that children with family incomes above 250 percent of poverty go without health insurance for a minimum of 1 year before they can enroll in SCHIP. States already use waiting periods, but generally for 3 or 6 months. There is no evidence that a 1-year waiting period reduces crowd-out.

The directive runs counter to clear lessons from research showing the importance of continuous coverage for children's health. Waiting periods are difficult to administer and always include exceptions for circumstances out of the family's control, something the directive does not mention.

Third, States will not be permitted to expand coverage if employer-sponsored insurance among low-income children has declined by more than 2 percent over the past 5 years. But erosion of employer-based coverage is a broad trend affecting adults and children at all income levels, and it is a trend that States cannot control. The directive essentially says that the larger a problem the State faces, the fewer options it will have to respond.

Fourth, CMS directs States to adopt cost-sharing provisions like those of private insurance plans, but there is no meaningful market for child-only insurance coverage. The only way States can be confident they are complying with this provision is to impose the maximum cost sharing of 5 percent of income, which States have found poses a substantial barrier to enrollment and receipt of necessary services.

Now, while the primary harm of the directive will fall on children, States will bear a heavy burden as well. The policy changes in the directive will require States to make major changes, including seeking legislative approval, initiating formal rulemaking, reprogramming eligibility systems, redesigning application forms, training eligibility workers, and communicating all of this information to families and community organizations that support the enrollment process.

Many of the topics addressed in the directive are likely to be modified when SCHIP is reauthorized. States will have to modify their systems yet again only a few months after they have made changes to conform to the directive. If nothing else, this will be a tremendous waste of resources on administration when we need all available dollars to go toward meeting the health care needs of children.

Ultimately, the CMS directive reflects a fundamental misunderstanding of the interplay between two important program goals. Provisions designed to reduce crowd-out through barriers to enrollment run directly counter to the goal of maximizing enrollment among eligible children. It is simply impossible to simultaneously say that we want every single eligible lower-income family to enroll, but we do not want anyone to enroll if their income is just a few thousand dollars a year higher.

In addition, rates of employer-sponsored insurance, the cost of living, and median salaries vary greatly around the Nation. SCHIP builds upon a variable base of Medicaid coverage. Thus, the risk of crowd-out and the income level at which crowd-out is likely to occur varies significantly from State to State. The August 17th directive imposes a single set of policies on a diverse Nation. Given our diversity, there is no single national policy that will yield maximum enrollment of eligible children and minimum levels of crowd-out.

The CMS directive is poorly crafted because it was written and issued without any input from the States who run the program. The directive includes provisions that are unattainable, outside the control of States, and poorly suited for achieving the purported goals of targeting resources and minimizing crowd-out. Review and modification of the directive, in consultation with States, is warranted prior to its implementation.

Senator ROCKEFELLER. Thank you, sir. Actually, I am a little angry at you because you answered the question I was going to ask you. [Laughter.]

Mr. WEIL. I apologize.

Senator ROCKEFELLER. No. It is entirely acceptable.

[The prepared statement of Mr. Weil appears in the appendix.]

Senator ROCKEFELLER. Ms. Owcharenko?

STATEMENT OF NINA OWCHARENKO, SENIOR POLICY ANALYST, THE HERITAGE FOUNDATION, WASHINGTON, DC

Ms. OWCHARENKO. Thank you, Chairman Rockefeller, Senator Hatch, for having me today to discuss children's health care coverage.

The State Child Health Insurance Program describes the purpose of the program as assisting low-income uninsured children. Although there is some disagreement over its interpretation, "low-income children" is defined as those children whose family income is at or below 200 percent of poverty. Moreover, in an effort to keep the program focused on uninsured children, the statute includes provisions to ensure that the program does not substitute for coverage under a group health plan and to inform parents through outreach efforts of possible availability of private coverage options.

In August of 2007, the Centers for Medicare and Medicaid released a directive to States on SCHIP and helped clarify and reinforce the existing law. The directive keeps the program focused on its core population, low-income uninsured children, and pays particular attention to the impact SCHIP expansions have on existing private coverage.

Many low-income children have private health insurance. The Congressional Budget Office estimates that 50 percent of children between 100 and 200 percent of poverty have private coverage, and 77 percent of children between 200 and 300 percent of poverty have private coverage. Thus, it is critical to take the extent of private coverage into account when considering expanding public programs such as SCHIP beyond the 200-percent threshold. There are wide and varying degrees of estimates on the impact of public program expansions and the availability of enrolling in private coverage.

Economists Jonathan Gruber and Kosali Simon looked at public programs in general and found "the number of privately insured falls by about 60 percent as much as the number of publicly insured rises." Gruber and Simon also conclude that this crowd-out phenomenon is far more dramatic when considering the entire family. The Congressional Budget Office, as has already been discussed, reviewed literature and estimates a 25- to 50-percent reduction in private coverage due to SCHIP expansions.

Since their estimates only considered children and not parents, CBO, like Gruber and Simon, points out that these estimates probably underestimate the total extent to which SCHIP has reduced private coverage. The Heritage Foundation's Center for Data Analysis conducted an econometric analysis based on a modified and extended version of the methodology developed by Gruber. This analysis concluded that, for every 100 newly eligible children and families with incomes between 200 and 400 percent of poverty, 54 to 60 percent of children will lose private coverage.

The directive is not aimed at all States, but those States that expanded eligibility to 250 percent of poverty. Ironically, many of the affected States at or above 200 percent of poverty have received additional Federal funding after over-spending their allotments, which raises questions about whether these States already have expanded beyond capacity.

The administrative directive requires that States that want to expand SCHIP above 200 percent of poverty must meet certain requirements to ensure the basic goals of the program are being met, preserving SCHIP for the core population that it is intended to serve, and by deterring further erosion of private coverage.

Meaningful cost sharing standards and standard waiting periods, for example, can help protect SCHIP as a safety net program for low-income uninsured children and ensure that the program's design does not create incentives for families to drop their existing private coverage.

Policymakers need to balance access to public coverage with the need to preserve private coverage. Instead of focusing solely on SCHIP as a vehicle for covering children, policymakers should broaden their efforts to make private coverage more available for working families.

Offering a Federal tax credit, for example, would give working families the ability to get and keep private health insurance. A dual approach that protects SCHIP for its intended population and a tax credit for others has a long history and broad support.

The administration's SCHIP directive helps to preserve SCHIP as a safety net program for low-income uninsured children. Efforts to undermine these directives will lead to further erosion of private health insurance coverage and over-burdened public programs. In order to address the coverage needs of children, policymakers should look beyond the public program expansion and consider solutions that will bolster, not unravel, the foundations of America's private health insurance system.

Thank you.

Senator ROCKEFELLER. Thank you.

[The prepared statement of Ms. Owcharenko appears in the appendix.]

Senator ROCKEFELLER. Ms. Mann?

STATEMENT OF CINDY MANN, EXECUTIVE DIRECTOR, CENTER FOR CHILDREN AND FAMILIES, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Ms. MANN. Thank you, Senator Rockefeller, Ranking Member Hatch. I am Cindy Mann. I am the director of the Center for Children and Families at Georgetown University's Health Policy Institute, and a research professor there.

I am going to focus my remarks this afternoon on two points: first, the impact that the directive is already having and is expected to have on children's coverage; and second, the extent to which the directive represents back-door rulemaking that reverses longstanding Federal law and practice.

The directive has actually already taken a significant toll on children's coverage at a time when the number of uninsured children is rising and families are facing new hardships due to the downturn in the economy. I could not be nearly as eloquent or compelling, of course, as Paula Novak has been, but let me try to put the experience of her children into a broader context.

The directive potentially affects children in every single State. Currently, it affects children in at least 23 States. This includes 10 States, like Ohio, that had enacted plans to cover uninsured children but whose plans had not made it through the CMS approval process before the directive was issued, so they are subject to the directive.

Tens of thousands of children in these States have lost out on coverage that their State had planned to offer them. For example, according to State projections, about 26,000 children have lost the opportunity for coverage in Oklahoma, Ohio, and Louisiana, just three of those affected States. Each of these States has had to roll back their coverage plans because of the directive.

Fourteen of the 23 States—there is one State in common—that are affected already cover children above this income range under federally approved plans, plans that have been in effect in some cases for a decade. These States have until this August to either show that they can meet the conditions of the directive or they must stop enrolling children in this income range. CMS has said that States in this group that do not meet the requirements do not have to disenroll children. That will do little, however, to avert the shut-down of coverage among children in this income range.

For example, according to State estimates, the combination of ban on new enrollment and turnover in the program will result in the loss of 97 percent of the kids in this income range covered now in New Hampshire, and 84 percent of the children covered in this income range in the State of New Jersey within just 2 years of the directive going into effect. The loss of coverage or the opportunity for coverage moves the Nation exactly in the wrong direction at a time when more children need affordable coverage.

Let me turn to the second point now, which is to describe how much of a 180-degree turn this policy makes with respect to longstanding Federal policy and practice.

The directive requires States to meet two conditions before they can expand coverage, and we have heard much about both of these: they must meet the 95-percent requirement and they must show that employer coverage for low-income children has not declined by more than 2 percentage points. If they meet those requirements, they must impose that 12-month waiting period we have heard talked about, and they must impose new cost-sharing requirements, likely the maximum permitted by law, 5 percent of income.

Compare those policies to the policy and the law before this directive was issued. There was no one-size-fits-all federally imposed precondition before a State could cover uninsured children. States could decide the appropriate income level to cover children in their States given differences in cost of living, differences in the cost of health care, and other relevant factors. States also had the flexibility to design their crowd-out policies. Most had waiting periods, but before the August 17th directive, out of 38 States that had waiting periods, 36 of them had waiting periods of 6 months or less.

States also had the flexibility to design cost sharing. As States go up the income scale, they all impose some form of cost sharing, but no State has the kind of premiums that would be required, apparently, by this directive. In other words, in each of the four most basic components of CHIP—income eligibility, eligibility criteria, crowd-out policies, and cost-sharing—the directive imposes far-reaching new rules and it did so through a letter, not a proposed regulation, not prompted by any new congressional enactment.

When the CHIP extension bill was enacted last December, Congress provided States with sufficient CHIP funding to allow them to keep their programs and their coverage plans intact until March 2009. The directive, however, is undermining that goal. Through back-door policymaking, it is unraveling coverage commitments that States have made to their children relying on longstanding Federal rules. The directive raises many complicated and important questions. Whatever your view of these policies may be, it seems indisputable that they ought to be decided in the light of day on the basis of sound data and good analysis.

A moratorium would move these questions into CHIP reauthorization where they belong, and meanwhile protect children like Seth from losing out on the coverage that they need.

Thank you.

Senator ROCKEFELLER. Thank you very much, Ms. Mann.

[The prepared statement of Ms. Mann appears in the appendix.]

Senator ROCKEFELLER. I want to ask a question of you, but I want to start out and try to stipulate something, as they say. Is it not true, because we have been doing so much discussion around here about 250, 300 percent of poverty, et cetera. Is it not true that 91 percent of all of the children on CHIP are at 200 percent or below of poverty?

Ms. MANN. That certainly was the data in 2006. There is some new data that CRS just released that shows it is about 12 percent in the latest data, Senator. The vast majority——

Senator ROCKEFELLER. So down by——

Ms. MANN. No. The children above 200 percent. It has gone up somewhat slightly.

Senator ROCKEFELLER. All right.

Ms. MANN. But the overwhelming majority of the children covered by the CHIP program have incomes below 200 percent of poverty.

Senator ROCKEFELLER. So this is really the background for this discussion, is it not?

Ms. MANN. That is correct. And it is also true that many of the children between 200 and 300 percent of poverty have access to private health insurance, but so many of them are in exactly the kind of situations that the Novaks find themselves in. They are self-employed, they work for small firms, they work for firms that do not offer affordable health care coverage. They may not be the majority of the children in that income range, but they are uninsured children who do not have affordable options.

Senator ROCKEFELLER. Right.

Now, the August 17th directive. I am going to get to Mrs. Novak. But it does get down to the question about impact on children with special needs care. In a country called America, we tend to want to have an obligation towards those folks, particularly when they are children. You can argue about the whole question of the last 6 months of life and all of that. We are not talking about that, we are talking about children, in this case, a very young child. Because of the 12-month waiting period which has been already spoken about, will States, because of that requirement, have to terminate their coverage in some, or most, cases? I want that as a baseline answer.

Ms. MANN. The 12-month requirement, as I understand it from CMS—and as Mr. Weil said, there are many questions that have yet to be answered—applies if a State is given approval to cover children in this income range, which is a big question-mark given the 95-percent and the ESI requirements. Then they would have to apply a 12-month waiting period. They would clearly have to apply it to a newly eligible child trying to enroll in the program.

They would have to wait 12 months before they could get on the program, like the three Novak children. It is not clear whether they would have to apply it also to the children who are currently enrolled, whether they would disenroll those children for purposes of the waiting period. That has been one of the questions that is not answered.

Senator ROCKEFELLER. Is it not also true that CMS has been doing a great deal of one-on-one negotiation with States, so that the parameters of whatever a State is, and how this applies to them, or a Medicaid waiver, or whatever, it is often done simply by negotiating between CMS folks and the Governor of the State, which to me would be a highly destabilizing way of trying to put together a coherent program.

Ms. MANN. That is correct, Senator.

Senator ROCKEFELLER. And what is the effect of that?

Ms. MANN. The effect of not having even-handed, transparent rules is, States cannot plan, States do not know what the rules are, States are worried that they might not be the favored State in getting the better deal or the same deal as a neighboring State. Families are left in the lurch and do not know at all what the rules of

the game are and how, and whether, they can expect to have the coverage that their State has enacted for them to have.

Senator ROCKEFELLER. I have a little bit of time, but I will go to Senator Hatch now and come back. Go ahead.

Senator HATCH. Thank you. Thank you, Mr. Chairman.

I have to tell all of you, I really appreciate working with Senator Rockefeller. He is a person of great conviction and someone who has great feeling.

Senator ROCKEFELLER. We met every day, as I recall, at the end of the day, you, Chuck Grassley, Max Baucus, and myself, for almost 5 to 6 months for 2 hours, every day, to reach a compromise, a bipartisan compromise on this program.

Senator HATCH. That is right. And I feel badly that we were not able to find the correct compromise. I do not think the House was completely at fault with some of their criticism because they were trying to push Medicaid kids above 300 percent of poverty and get the best match, the better match, which that program grants. That was probably the thing that stuck us from getting a major expansion of this bill. At least, that is my interpretation of it. I think I am pretty accurate.

But let me go to you, Mr. Weil, and just ask you a couple of questions. As I noted in my question to Dennis Smith, I have great sympathy for the disabled. I am one of the prime authors of the Americans With Disabilities Act, and I have worked hard to address their struggles through the passage of the Family Opportunities Act as well.

Now, the FOA gets families making up to 300 percent of poverty with disabled children, including children with Down Syndrome, the option of buying into Medicaid for their coverage. Now, my question is this, because I am concerned about Mrs. Novak and what she goes through. But if Ohio had taken up the FOA option, would Mrs. Novak's son Seth have coverage?

Mr. WEIL. Senator Hatch, I am not sufficiently expert on the FOA to answer that question, though I get the impression the answer is probably yes.

Senator HATCH. I think it is yes.

Mr. WEIL. However, we should be clear that it would apply only to one of her three children.

Senator HATCH. Right.

Mr. WEIL. And that she describes the current state of the Medicaid program with a spend-down requirement where families that have high costs are forced to spend a significant amount of their resources—as she describes, an untenable amount—before they are actually eligible for any benefits from the program.

Senator HATCH. It is a big problem. We have to work on this in this coming—I do not think we are going to get an awful lot done this year, but in the coming years we have to work on this. I dedicate myself to doing so. I am sure Senator Rockefeller will as well.

Ms. Owcharenko? Is that the correct way to pronounce it?

Ms. OWCHARENKO. That is correct.

Senator HATCH. I know you have made significant adjustments to your schedule to be with us today. I want you to know how much we all appreciate your willingness to testify before the hearing today.

You testified before our subcommittee back in 2006 on the CHIP program. I wanted to get your additional insights on what you believe we can do to ensure that low-income uninsured children are covered before expanding CHIP eligibility to higher-income families and, in addition, how do you believe that Congress and CMS should address crowd-out? What is your reaction to the CMS guidance letter of August 2007?

Ms. OWCHARENKO. I guess I will start with the last question first. The guidance, I think, is only part of the answer. It is very difficult to continue to build walls on one side without doing other things to help encourage the participation in the private market. That is why it is important to develop policies such as tax credits and looking at insurance reform for situations like the Novak's—who are actually buying in the non-group market—to really look at, how do we arrive at a comprehensive approach to providing health care coverage? I think that is the one challenge, that obviously their focus is only on the SCHIP program, but I think that it begs a larger debate on the overall efforts of trying to preserve the private health insurance market.

Senator HATCH. All right.

Mr. Weil, the Congressional Research Service has testified that using administrative data factoring in the Medicaid under-count and adjusted for immigrant status, nearly every State could meet the 95-percent test. Now, since it appears that CMS has affirmatively acknowledged such adjustments, when would the States—or should they have cause to complain about having to meet a test that they are virtually certain to meet?

Mr. WEIL. Well, it sort of seems as if they want to have it both ways. On the one hand, the criticism is that States should not expand eligibility until they accomplish this very challenging task of reaching the eligible, but unenrolled. Oh, but by the way, you already did it, so please go ahead. I think we hear different things at different times.

No, I do not think there is a lot of complaint if you are told that you can only pass "go" if you meet a certain test and you have already met the test. But I think that the goal here ought to be a meaningful and comprehensible and defensible mechanism for gauging States' progress, both in terms of what the threshold should be and in the data used to determine whether or not States have met the threshold.

Senator, I am sorry. The only thing I would add is, what we hear from States is that basically CMS sits down with them one-on-one and says, well, you show us what data you think would make it clear that you have met the 95-percent standard, and that is not a good basis on which to determine whether or not States can expand coverage. So I believe there could be an answer to this question, but a letter drafted and sent out with nothing more than the verbal assurance of some folks at CMS that we can get you there, it is not a good basis for making public policy.

Senator HATCH. Well, all right. I do not think I gave you enough time on the answer to that question I gave you. If you want more time, I would be happy to do that. I interrupted you.

Ms. OWCHARENKO. No, no. That is fine. One of the things I would like to point out on the crowd-out issue that has not come up in

the discussion is more of the other consequences of the crowd-out effect. We have to look, and I think Dr. Orszag alluded to it, at the pressures of allowing more people to enroll in the SCHIP program. It is going to put significant financial pressures on the future of the SCHIP program as well.

I think policymakers need to be aware of the amount of funding that would be needed in order to accommodate much of these efforts. I think that sometimes gets lost in the issue of simply, do we want private coverage protected. We also have to look at the long-term costs that that will have on the public programs, in particular SCHIP, but also the entitlement program of Medicaid and the struggles that the country is facing in funding those liabilities.

Senator HATCH. All right.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Hatch.

Mrs. Novak, first of all, again, thank you for coming. Thank you for your courage. Thank you for speaking about profoundly personal matters before essentially strangers, and to the world at large, really. So, I really thank you for that.

One thing I was not entirely clear of in your testimony is whether Seth is, at this moment, healthy. I understand the longer-term problem. I understand the operation. But at this moment?

Mrs. NOVAK. At this moment, he is fairly healthy. He struggles with chronic sinus and ear infections, which are a result of the fact that he does not have the tubes in his ears. But on the whole, he is basically healthy, yes.

Senator ROCKEFELLER. So that just takes me right to the question, in his case or in either of the other children's case, if they get sick in a major way or in a minor way, sick enough so that you cannot take care as a good mother, what are you going to do?

Mrs. NOVAK. You tell me. I do not know. We are going to be in a lot of trouble.

Senator ROCKEFELLER. I accept that and believe that. But there are emergency rooms. If you lived in West Virginia, which you come close to doing but do not quite make, it is a long way to a hospital. A lot of folks in our State can be afraid of hospitals. They are very big buildings that they have not been in before, so they do not go. That would apply to an ER.

I can remember sitting with a mother of a girl who had dyslexia in the—I will not name the hospital; it is a local hospital—for 6 hours. I did not try to pull any rank. I was just a citizen. I never do that. Six hours. If that is a heart attack, the person is not going to survive. So really the only answer that you could give me, is it not, is that you would have to go to an emergency room?

Mrs. NOVAK. Yes. Yes, you are right. The other problem with that is, a lot of Seth's conditions cannot be treated in an emergency room.

Senator ROCKEFELLER. Could you explain that for a moment?

Mrs. NOVAK. I am sorry?

Senator ROCKEFELLER. Could you explain that?

Mrs. NOVAK. Yes. Because there are a lot of issues to do with developmental things with Seth. I cannot get Seth's physical or occupational therapy at an emergency room. I cannot have Seth come in and have tubes put immediately in his ears in an emergency

room. So for Seth, an emergency room is not a viable answer except in an emergency.

Senator ROCKEFELLER. So your first answer is the correct answer: I do not know what I would do, what I could do.

Mrs. NOVAK. Exactly. No. No.

Senator ROCKEFELLER. I am just trying to put myself in your position and think of the strain that brings every day. Children catch colds like crazy, and then you catch them. So that is very, very disturbing.

Let me ask a somewhat blunt question. What do you think this situation with Seth not having insurance, or your children, and I think you implied you and your husband also, how does that affect, in your mind, his long-term prognosis?

Mrs. NOVAK. Oh, it is incredibly detrimental to his long-term prognosis. Just take the instance of just the tubes in his ears, that he cannot hear, which impacts incredibly his speech. He is nonverbal, so long-term that is just going to have an incredible impact. The fact that he needs the orthotics on his feet and the ability for him to just be able to walk and move is an incredible impact. Those are just two of his issues.

Senator ROCKEFELLER. Thank you.

Mrs. NOVAK. Thank you.

Senator ROCKEFELLER. I have a question for you, Ms. Owcharenko, if I can find it here. That is, back when we were doing—you have very definite views from The Heritage Foundation about crowd-out on Medicaid and CHIP, and you have expressed them very clearly. My staff tells me that similar reports on Medicare prescription drug crowd-out were not done by The Heritage Foundation. That gets to my point, that people always get to crowd-out when it gets to the most vulnerable part. Is that true? If so, why?

Ms. OWCHARENKO. There was not an econometric model done, but Heritage Foundation was very outspoken on the concern of what the effects of putting in a universal Part D benefit into the prescription drug piece, what that would do to access to existing private employer-based coverage.

So I think we have documented that quite well, that there was significant concern that, by putting in the Part D benefit—and by the way The Heritage Foundation was very concerned with the direction that that legislation went for the cost and the reliability to the program—but we certainly highlighted the concerns that employer coverage would probably drop because of the adding of the universal entitlement into Part D. So I would be happy to share some of the documentation from my colleagues on that issue.

Senator ROCKEFELLER. I am over my time, but I will have some more questions. It also strikes me sometimes that, when it comes to children or the particularly vulnerable, that we get very picky about our health care policy. For example, one of our sins that was previously committed when we started the program, and the reason that I think the program that Orrin Hatch and I worked on was vetoed by the President was because we had a cigarette tax as a way to pay for it.

Now, the Democrats have committed themselves to being responsible fiscally, which I have to say that in some loneliness, I must

say at my caucus, that there are some things where you just have to spend a little bit more money because there are people involved, at stake. This is too obvious a comparison, but we do that so easily when we go to war. We become so picky about that, so defensive about that, so negative about that when it has to do with American people; trade adjustment assistance, or in this case children without health insurance. Would you agree with that?

Ms. OWCHARENKO. I think that I have been consistent in my writing on the SCHIP program, and actually on the TAA program as well, where Heritage was a strong voice in supporting a tax credit proposal to give those TAA workers some sort of assistance to help them buy private health insurance. I would also say that I am very sympathetic——

Senator ROCKEFELLER. What is "some sort of assistance"?

Ms. OWCHARENKO. It was a tax credit, a TAA tax credit, to enable the——

Senator ROCKEFELLER. Oh. The TAA, you are talking about. All right.

Ms. OWCHARENKO. Tax credit.

Senator ROCKEFELLER. All right.

Ms. OWCHARENKO. But I would also say that I think that one of the issues that I have been trying to introduce to this is that covering children is not a silo of looking into SCHIP, but it really should be looked at as health care coverage as a whole. Those people who have private health insurance today are also at risk of losing it tomorrow and joining the ranks of the uninsured. We need to make sure that the policies that are we are looking at are broader in scope than I think just looking at SCHIP.

Senator ROCKEFELLER. Now, you mentioned Dr. Gruber, and I mentioned Dr. Gruber. When I mentioned him, after we identified he had come from MIT and therefore could tell only the truth, that the amount of crowd-out was vitiated, it was sort of equal as between what private companies did and what people did. It was kind of a wash-out. I think you took a different view.

Ms. OWCHARENKO. Yes. Mine actually was a quote. I would have to say you would have to ask Dr. Gruber his explanation of that, but the crowd-out effect was substantial. I think it is consistent with what CBO has also testified, between 25 and 60 percent of crowd-out. Now, his was on general public program expansions, which include not only SCHIP, but Medicaid as well.

Senator ROCKEFELLER. All right.

Senator Hatch?

Senator HATCH. I want to thank you all for being here. Mrs. Novak, I commend you. Down Syndrome children are beautiful kids, and those who really spend an effort in helping them are always benefitted. There have to be some ways, even within the current lacking system, to be able to get—for your child, for your son—there are child organizations and others.

Now, I would like to solve it where we take care of these problems. Senator Rockefeller is a great champion for children as well. We have worked on a lot of programs to try to help, and let us hope we can solve this problem on CHIP so that folks like you can have the confidence that your children will be given the very best care that they can possibly have under the circumstances.

These are not easy questions and answers because, let us face it, our country is going to be bankrupt if we do not find some way of getting spending under control. There are no simple, easy answers. We have both struggled with these problems the whole time we have been here, and in my case that is 31 years. We have passed a lot of very important legislation, and it has been very important for families and has helped families.

But we still have not come up with a way of solving what really would be universal health care, to me, without government mandates, one-size-fits-all government mandated health care. To others, the government is the only answer to universal health care. But sooner or later, we are going to have to come up with some sort of an answer that will work. Unfortunately, we have liberals fighting the conservatives all the time, and we do not really get to a point where we can really solve these problems.

That was the miracle of CHIP that I indicated at the beginning of our discussion, that CHIP was brought up in the back room right here. All the members of the Finance Committee were here, very few staff. We then would agree on what we could agree on and what we could not agree on and we would go on from there. Well, there was an amendment brought up that failed that was in the nature of helping people, and when that failed, I grabbed the floor and brought up CHIP. Jay weighed in. Al D'Amato shot out of his chair and started screaming, "It's the right thing to do. It's just right." Then Frank Murkowski stood up, and I did not expect him to stand up on this occasion, but he did and he said, "It's right and we ought to do this." Finally, we put it in the bill before we went out there.

Now, I have to tell you, there were some who hated having CHIP in the bill. Others on Jay's side hated having the balanced budget the way we were doing it. But it was the glue that brought everybody together, and it has worked amazingly well. It was basically a block grant where the Federal Government and the States have had to work together. The States have kept a hammer lock on it as far as making it work right. The Federal Government has been a principal source of funding and also making sure that it works right.

Our problem is that we have not covered all the kids, and we have to do that. There is a big desire here to keep entitlement programs going so fast, so furious, and so expensively, that in the process we have not been able to resolve these problems, the anywhere from 3 to 6 million kids who really should be covered by CHIP.

But we are going to keep working on it, and Jay, I, and others will see if we can come to some conclusions here that will get this up and running for all children. If we had that going right, I think we could pretty well solve your child's problem, and your problem as well as far as children are concerned.

But the way CHIP came about, we had two families from Provo, UT come in. Each family had six children, each husband and wife worked. Neither family made more than $20,000 a year. This was back in 1996. They worked but they could not afford to purchase health insurance. That is how the idea of CHIP came about. Others had been working on some sort of idea as to how we could put this

together, and finally it did come together, I think in a pretty darned good way. It could not have come together without the help of Senator Rockefeller and others who worked so hard on this.

But we would like to have it work right. We would like to have the Federal Government as a full partner. We would like the States to be a full partner—at least I would. We would like to be able to get over this hurdle that has stopped us this year, and last year, really, from getting CHIP done in a way that would cover the appropriate kids that should be covered by it.

But I have appreciated, Mr. Chairman, this hearing. I have appreciated the knowledge we have gained from this hearing and the people who have testified, and hopefully we will find some ways of solving your problem. Thanks, Mr. Chairman.

Senator ROCKEFELLER. I am just going to ask one final question of Ms. Mann. What do you suggest we do to make this work for low-income children?

Ms. MANN. Well, if I could make one clarification-for-the-record comment. It has been talked about that every State maybe can make this 95-percent participation rate, and do we care if the numbers are cooked or not as long as everybody gets through the gate. I just want to stress that we have had six States that have not gotten through the gate, including Ohio. This is not a theoretical problem. This is Louisiana, Indiana, Ohio, New York, Wisconsin. They have already had to roll back their plans to cover children. So the notion that every State will get in is not borne out by the activities of CMS relative to State plans over the last few months, and it is just important to be clear on that.

In terms of what we can do, I think there is absolutely no disagreement among all players that the primary objective really is to cover uninsured children and a really important focus is to cover the low-income uninsured children: 7 out of 10 of those kids who are uninsured today are eligible for Medicaid and CHIP. Many of the things that can be done were in the CHIP reauthorization bill that you all worked on in a bipartisan fashion. They provided financing, the bills provided incentives, they provided new tools.

As a result, 87 percent of those newly enrolled kids would have been kids who are already eligible, but unenrolled, the lowest-income kids. We have to very much keep our eye on that ball because that is where so many of the kids are, but we do not have to do that at the expense of the kids like the Novaks. We could do it all. It is not extraordinarily expensive. It has worked so far. We have had a disruption by virtue of this letter that was issued, and hopefully that disruption can be put aside and we can keep moving forward.

Senator ROCKEFELLER. That August 17th letter has caused enormous outrage on the Hill. I am hopeful something will come of that. Does that make me optimistic? Not necessarily, but we have to——

I would, finally, just end up by saying that there is something almost sad about having a hearing like this, there really is. I mean, the generals are talking to the Armed Services and the Foreign Relations Committees. One of the things that is often brought up, and this will sound political and I do not mean it to be that way, but it comes right out of my gut as a former Vista volunteer who

worked with people for 2 years who had no health insurance whatsoever, nobody had a job, what we are spending over there and what a couple of weeks of that could do back here to help Seth and family, and many others.

It is a real mystery that we in America, maybe because of the degradation or sensationalism in the media, are you patriotic or are you not, that we have developed an increasingly concerning habit of ignoring our own people even as we help others, in Iraq or whatever. So whether it be a sad hearing or not, it is a very important hearing. You have all contributed very, very substantially. I am sorry, Mr. Weil, I did not ask you a question. It was nothing personal.

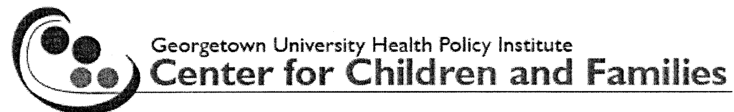
Mr. WEIL. I already answered it, I thought you said.

Senator ROCKEFELLER. That is right, you already answered it. So it was your fault. [Laughter.] But I thank you all. It is 10 minutes after 5, so I think we will just adjourn this, with great appreciation to all of you.

[Whereupon, at 5:11 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD



"Covering Uninsured Children: The Impact of the August 17 CHIP Directive"

Testimony Submitted to the

Subcommittee on Health Care

Committee on Finance

By

Cindy Mann, JD

Research Professor and Executive Director

Center for Children and Families

Georgetown University Health Policy Institute

April 9, 2008

Good afternoon Chairman Baucus, Senator Grassley, Subcommittee Chairman Rockefeller, Senator Hatch and distinguished members of the Subcommittee. Thank you for the invitation to participate in this hearing on the impact of the August 17th directive issued by the Centers for Medicare and Medicaid Services (CMS). I am Cindy Mann, a Research Professor at Georgetown University and the Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute. Soon after enactment of the State Children's Health Insurance Program (SCHIP), I served as the director of the group within the Health Care Financing Administration (now CMS) that oversees the implementation of SCHIP and Medicaid for children and families at the federal level. Since leaving the department in early 2001, I have worked with federal and state policymakers on SCHIP, Medicaid, and private coverage options and have analyzed how federal and state policies and procedures have affected children's coverage.

In my testimony, I will focus on the August 17th directive's impact on children's coverage and describe the extent to which the new policies depart from longstanding federal SCHIP and Medicaid rules and practices. The directive, which was issued as a letter to state SCHIP directors, imposes new and likely insurmountable hurdles for states covering or planning to cover children with family incomes above 250 percent of the federal poverty level (FPL), the equivalent of $44,000 in annual income for a family of three. By August 2008, at least 23 states will be affected by this new policy.

The directive already has taken a significant toll on state efforts to cover children at a time when the number of uninsured children is rising and more families are experiencing hardship due to the downturn in the economy. SCHIP was specifically designed to bridge the gap for families with incomes above Medicaid levels but still too low to afford private health insurance. Many children in families with incomes above 250 percent of the FPL have access to affordable employer-based insurance, but in light of rising health care costs and the evolving job market increasingly some do not. SCHIP has been a remarkably successful program in part because it has always provided states the discretion to decide which families need help purchasing affordable coverage in their

state, within the limits of available funding. SCHIP coverage is not free for families with more moderate incomes, but it is affordable.

The directive abruptly and unilaterally changes SCHIP and Medicaid rules and disrupts longstanding SCHIP programs without any evidence that the policies it mandates will further what we can all agree is the top priority of SCHIP and Medicaid – covering the lowest income children. The members of this Subcommittee and Committee, most notably Senators Baucus, Grassley, Rockefeller and Hatch, crafted a bipartisan SCHIP reauthorization bill last year that addressed these important and complex issues in thoughtful, constructive ways. Later in the year, the Congress enacted a SCHIP extension bill to keep SCHIP coverage and state coverage plans intact until SCHIP could be reauthorized. That goal, however, is being undermined through the backdoor by a set of policy prescriptions that lack support in the research literature or in state experiences and that did not even go through normal rulemaking procedures. A moratorium on the August 17th directive would keep longstanding federal rules and state flexibility in place and avert the loss of coverage until Congress can more thoroughly address these issues in the context of SCHIP reauthorization.

More children need coverage, particularly during this economic downturn.

Over the last decade, the country achieved significant gains covering children even as the uninsured rate for adults rose sharply. Between 1996 and 2006, the percent of low-income children without health insurance dropped by more than one-third, largely as the result of enrollment in Medicaid and SCHIP. The most recent Census Bureau data, however, show that the number of children without health insurance has begun to climb. If children continue to lose coverage at the same rate they lost coverage in 2006, almost 2,000 children a day will join the ranks of the uninsured. Sadly, it is likely that the number of children losing coverage this year will be even higher because of the economic downturn. In light of growing need, this is a time for states and the federal government to deepen, not restrict, their support for children's health coverage programs.

States have responded to this growing need in a variety of ways, including conducting outreach and improving enrollment and renewal procedures. Over the past two years,

many states have also increased their income eligibility levels to reach more uninsured children. The August 17th directive is specifically aimed at stopping or restricting states' ability to cover children with gross family incomes above 250 percent of the FPL. Some 14 states had covered children in this income range before the directive was issued, some since the very beginning of the program. Currently, at least 23 states cover children, or have enacted legislation to cover children, in this income range (Figure 1). Some states have adopted these income eligibility levels because of the higher cost of living in their state, but the growing interest in expanding children's coverage programs in states as diverse as Ohio, Oklahoma, Washington, and West Virginia is probably best explained by the fact that the cost of health insurance has been rising far more rapidly than earnings and fewer families have access to affordable coverage through their jobs. As a result, more moderate-income families may need access to affordable coverage through SCHIP.

SCHIP was specifically designed to reach families whose incomes are too high to qualify for Medicaid and too low to afford private insurance, and in recent years that affordability gap has been widening. Over the past decade, the cost to families of buying into employer-sponsored coverage rose by 103 percent while their earnings grew by only 33 percent (Figure 2). The average total cost of family coverage through a private group health insurance plan is now more than $12,000 a year. A family with moderate income whose employer contributes a substantial portion of that premium cost might be able to afford to purchase that coverage, but if the employer does not make a significant contribution to the cost of the insurance the coverage may be well beyond the family's reach. A $12,000 premium would consume more than one fourth (27 percent) of the total annual income for a family of three at 250 percent of the FPL. Additionally, parents working for firms that do not offer family coverage or who are not eligible for employer-based coverage or who are self-employed face particular challenges affording private insurance for their children. Given rising costs and job market trends, it is not surprising that nearly half of the additional 710,000 children who became uninsured between 2005 and 2006 were in families with more moderate incomes.

States have turned to SCHIP and Medicaid to help address this affordability gap because the programs have a proven track record of providing families with a cost-effective

coverage option for their children. SCHIP does not provide free coverage. Families pay premiums and copayments, but the coverage financed with SCHIP is affordable, and the research has shown that it offers children access to care in an efficient and effective manner.

The directive is unraveling state coverage efforts.

In the face of the growing need for coverage, the August 17th directive moves federal policy in exactly the wrong direction. Instead of providing tools and support for states to remove barriers to coverage, the directive puts new, potentially insurmountable hurdles in the path of states trying to cover uninsured children. In the few months since the directive has been in effect, not one state seeking to expand coverage has had a plan approved by CMS to cover children with gross incomes above 250 percent of the FPL. Instead, tens of thousands of uninsured children have lost out on coverage that their state had determined they needed and had planned to offer. About 26,000 children lost out on coverage in just three of the states that already have been affected by the directive – Louisiana, Ohio, and Oklahoma. Each of these states had enacted state legislation to expand coverage for children with family incomes up to 300 percent of the FPL, and all three states have had to roll back their coverage plans as a result of the directive.

Many more children will lose coverage or the opportunity of coverage as more states become subject to the directive. The 14 states that already have approved plans to cover children in this income range are required by the directive to comply with its terms by August 2008. CMS has said that it will not require these states to disenroll currently enrolled children with incomes above 250 percent of the FPL. This policy, however, will do little to avert the shutdown of coverage among children in this income range in states that have long covered these children. Program turnover is considerable, particularly among children in this income range. Some leave the program because overtime pay or a wage increase permanently or temporarily puts them over the state's income eligibility level; some leave because affordable employer-based coverage becomes available to the family; and some leave because of burdensome or confusing renewal procedures. The rules announced by CMS would not permit states to enroll new applicants or to re-enroll eligible children who once were covered by the program. As a result, Hawaii, New

Jersey, and New Hampshire expect that within two years of when the directive is applied, enrollment of children with incomes above 250 percent of the FPL will fall by 76 percent, 84 percent, and 97 percent, respectively.

The directive unilaterally alters longstanding federal policy.

The August 17, 2007 CMS directive was issued just as Congress was debating SCHIP reauthorization. It was released as a letter to state health officials, not as a proposed regulation. States and other stakeholders had no prior notice of the rule and no opportunity to comment, and the kind of important details about new rules that are normally explained in the context of the regulatory process have yet to be explained in writing.

To appreciate just how much of a change in policy the directive represents, it is useful to compare the directive requirements with longstanding SCHIP rules and practice. The directive imposes two new conditions that have never been applied before as a condition of providing coverage to children with family incomes above 250 percent of the FPL. States must show that they are covering 95 percent of eligible low-income children and that employer-sponsored coverage for low-income children has not declined by more than two percentage points over the prior five years. If a state can meet both of these potentially impossible standards (to date, no state seeking to expand coverage has), the state must charge a certain level of premium (in most cases, equal to the maximum allowed by law) and impose a 12-month waiting period.

These policies dramatically alter longstanding rules. Federal law has always provided states the flexibility to set income eligibility levels, subject to available funding. Even in the first years of SCHIP, states covered children with incomes above 200 percent of the FPL through the discretion granted to states in the 1997 statute to adopt income deductions and disregards. The law neither requires nor authorizes any one-size-fits-all federal preconditions before a state can cover children with more moderate incomes. It also affords states flexibility to set their cost sharing rules, subject to an overall maximum (five percent of income) and to devise state-specific strategies to limit the substitution of public for private coverage.

Consistent with the flexibility accorded states, SCHIP eligibility levels have always varied widely across the states. Most states began their programs with income eligibility levels at or below 200 percent of the FPL, but some states, like New Hampshire, started out covering a broader group of children. (Prior to SCHIP, New Hampshire was already covering children up to 185 percent of the FPL in its Medicaid program.) Its plan to cover children through SCHIP up to 300 percent of the FPL was approved by CMS in September 1998.

Similarly, there is considerable variation across states with respect to the premiums they charge families that enroll their children in SCHIP. Most states charge premiums or other cost sharing, but the amount varies widely across the nation. No state currently sets its premium as high as the five percent maximum level permitted by law.

States also have adopted different policies with respect to crowd out. Most have waiting periods but the waiting periods vary in length and in the exemptions allowed. In general, states have been shortening or dropping their waiting periods – with CMS approval – largely because of the negative impact on coverage and the lack of evidence that these periods of uninsurance are effective in limiting substitution. Before August 17, 2007, only two states imposed a 12-month waiting period in their SCHIP program.

The extent to which the directive represents a sharp departure from longstanding rules is illustrated by considering Pennsylvania's experience. Pennsylvania was the last state (not including the District of Columbia) to expand coverage for children up to 300 percent of the FPL with CMS approval before the directive was issued. It was not required to meet a participation rate requirement or show that its employer-sponsored insurance coverage rates for low-income children had not declined by more than two percentage points over the past five years before gaining approval. The approved plan includes a waiting period for children who previously had employer-based coverage, but the waiting period is for six months, not 12 months, and it exempts children under age two. The approved plan includes premiums for families in the expansion group, but not as high as five percent of family income. It appears, therefore, that the Pennsylvania plan approved just a few months before the directive was issued is no longer approvable under the terms of the directive (Pennsylvania has until August 2008 to comply), and yet neither federal law nor

regulations have been changed since CMS approved this plan. The state reports that over the first year of implementation, 17,000 children gained coverage, including 10,000 low-income children (59 percent of the total) who were previously eligible but unenrolled.

Not only does this new policy differ sharply from longstanding federal rules, it also is markedly different than the provisions adopted in last year's SCHIP reauthorization bills. Both versions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) constrained state flexibility to expand coverage but in ways that are significantly different than the August 17th directive. The first CHIPRA bill lowered the matching rate for coverage above 300 percent of the FPL while the second bill capped eligibility at 300 percent of the FPL, allowing for certain deductions such as for work-related child care expenses. Most significantly, in terms of improving participation rates among low-income children, both bills provided states with new financing, incentives, and policy options to boost enrollment among already eligible but uninsured children, including children eligible for Medicaid – the lowest income uninsured children. According to Congressional Budget Office estimates, 87 percent of the nearly four million children who would have gained coverage under the bill were uninsured children who were already eligible for SCHIP or Medicaid.

The matters addressed by the directive are best addressed in the context of SCHIP reauthorization, and, in the meantime, children's coverage should be protected.

As you know, neither CHIPRA bill became law. The legislation adopted by Congress and signed by the President in December 2007 extends SCHIP funding through March 2009. Congress' intent in enacting this stopgap measure was to maintain current coverage and coverage plans until SCHIP could be reauthorized. The law provides funding sufficient to allow states to keep children's coverage intact and to proceed with their coverage plans until March 2009. The August 17th directive, however, is undermining this goal. In states such as Louisiana, Indiana, Ohio, and Oklahoma, the directive has already taken a considerable toll on state efforts to cover children.

SCHIP has been a remarkably successful program. The strong bipartisan support for CHIPRA demonstrated that most members of the Congress want to strengthen not

weaken SCHIP and Medicaid's ability to cover uninsured children. The sweeping new policies imposed by the CMS directive take the nation down a different road. These far-reaching policies relating to eligibility levels, the interaction between public and private insurance, and the strategies that are effective in improving participation rates among eligible but unenrolled children are important but complicated policy issues that are best addressed within the context of SCHIP reauthorization.

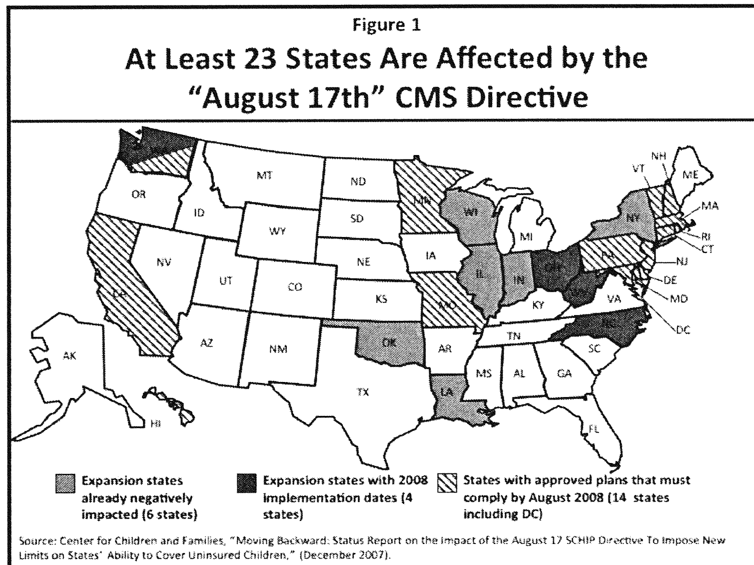


Figure 1
At Least 23 States Are Affected by the "August 17th" CMS Directive
OR
ID
MT
WY
ND
SD
NE
KS
NV
UT
CO
AZ
NM
TX
OK
IA
AR
LA
MS
AL
GA
FL
SC
TN
KY
VA
MI
WI
IL
IN
NY
VT
NH
ME
MA
RI
CT
NJ
DE
MD
DC
AK
HI
Expansion states already negatively impacted (6 states)
Expansion states with 2008 implementation dates (4 states)
States with approved plans that must comply by August 2008 (14 states including DC)
Source: Center for Children and Families, "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children," (December 2007).

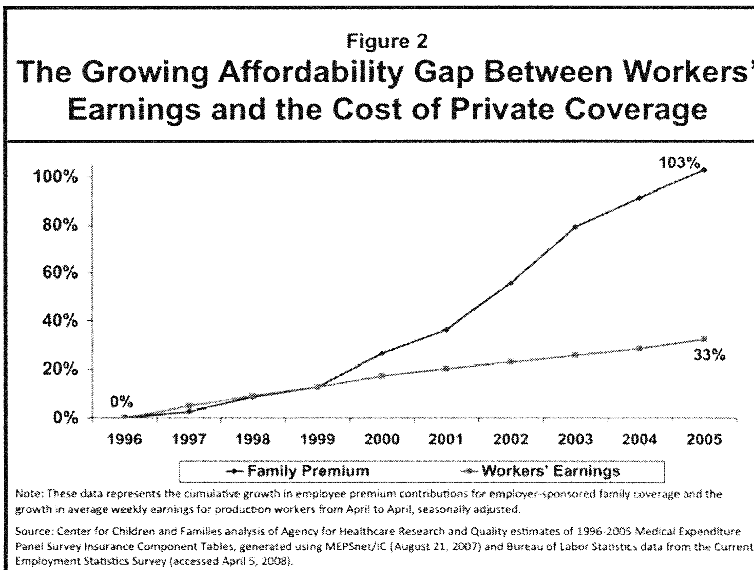


Figure 2
The Growing Affordability Gap Between Workers' Earnings and the Cost of Private Coverage
100%
80%
60%
40%
20%
0%
103%
33%
0%
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
Family Premium
Workers' Earnings
Note: These data represents the cumulative growth in employee premium contributions for employer-sponsored family coverage and the growth in average weekly earnings for production workers from April to April, seasonally adjusted.
Source: Center for Children and Families analysis of Agency for Healthcare Research and Quality estimates of 1996-2005 Medical Expenditure Panel Survey Insurance Component Tables, generated using MEPSnet/IC (August 21, 2007) and Bureau of Labor Statistics data from the Current Employment Statistics Survey (accessed April 5, 2008).

04-09-2008

Testimony on August 17 Directive

Testimony on August 17 Directive before the Subcommittee on Health Care of the U.S. Senate Committee on Finance presented on April 9, 2008, by Paula Novak.

Good Afternoon, Chairman Rockefeller, Ranking Member Hatch, and other members of the Subcommittee. My name is Paula Novak. My husband Jeff and I have three children: Cole, Avery, and Seth. We live in Lebanon, Ohio. Today I represent my family and many others like ours that are self-employed, hard-working and yet struggle to maintain adequate health care coverage. This becomes particularly true when one person in the family has a chronic illness or disability. In our situation, our youngest son, Seth, who is four-years-old, was born with Down Syndrome and struggles with related health and developmental issues.

I want to share with you the effects the August 17 Directive is having on Seth and the rest of my family. This time last year, Ohio was moving to expand its Medicaid/SCHIP program to include children like Seth. The expansion was stopped, however, by the August 17th directive and now Seth, as well as his sister and brother, are uninsured.

My husband Jeff is self-employed in the construction industry. He works hard, specializing in church construction and remodeling. I do some work for the business, though unpaid, but mostly I am needed at home to care for our children and particularly our son, Seth.

Jeff and I and our two older children have been sporadically covered through private insurance that we purchase ourselves. In January 2004, our family was covered by Anthem Blue Cross for about $535 per month. Seth was born January 8, 2004. Medicaid covered Seth's birth because we did not have a maternity rider on our policy. During that same month the insurance policy came up for renewal and the premium jumped to $800 per month. Jeff was not working in early 2004 due to surgery, so we had to drop the policy. Since we had very little income at that time, we qualified for Medicaid. When Jeff returned to work, the business began to produce a better income and our Medicaid coverage ended. We were able to pick up a policy with Medical Mutual of Ohio for $444 per month, but they declined to cover Seth because of his Down Syndrome. At that time I checked with the top ten insurance companies and dozens of agents trying to find coverage that would include Seth but I was told Seth is deemed as "uninsurable" and the only possibility to cover Seth would be to go through "open enrollment."

Open Enrollment is a requirement of the Ohio law that the insurance companies will once a year take a limited number of individuals regardless of preexisting conditions. I attempted to enroll Seth during open enrollment and was quoted premiums ranging from $1,200 to $1,800 per month, just for Seth. We cannot afford this additional premium on our current income.

Seth has been uninsured since August of 2007 when his Medicaid coverage ended. He has now been deemed disabled, but the catch here is that our spend-down per month was calculated to be $2,687.00, which must be spent before Medicaid can help. This amount is even more unreasonable than the price quoted for private insurance for Seth under open enrollment.

Now our entire family is uninsured. We were forced to drop the Medical Mutual policy coverage for myself, my husband, and our two older children in January when our carrier raised the premium from about $450 to almost $600 per month. The policy also had a high deductible and we could not afford the cost of the insurance plus the out of pocket requirements.

Our adjusted gross income for 2006 was about 250 percent of the federal poverty level and it appears that our 2007 gross income will be approximately the same.

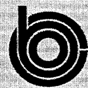
We were so privileged to be able to participate in the signing of Governor Strickland's budget in Ohio which included the expansion of Medicaid eligibility to children with family incomes up to 300 percent of the federal poverty level. Under the expansion, Seth would have been able to have the health coverage he so critically needs. Not only Seth, but my other two children would have been able to be covered under this expansion. In a country as prosperous as America, it is just not acceptable that they do not have access to affordable health coverage.

Because of the requirements placed on States by the August 17th directive, Ohio has been unable to implement the expansion it had planned to help children like Seth. We're proud that Ohio made a commitment to cover Seth and children like him, but we're deeply troubled by the federal government's efforts to block that decision in Ohio.

Just as an example please let me tell you the needed care Seth has missed due to his lack of coverage. Seth had open heart surgery in March 2007 and missed his one year cardiology follow-up. Seth has missed appointments for eye-exams, thyroid exams, ENT visits to replace tubes in his ears, genetic doctor appointments to track his growth and development, fittings for his orthodics, and very importantly because Seth is still non-verbal, visits to his speech therapist.

As the parents of three uninsured children, I implore you to overturn the August 17th directive and allow States such as Ohio to continue the good they set out to do with the Medicaid expansion. By virtue of his birth, Seth is not entitled to special privileges, however he is entitled to equal privileges which can be provided by the proposed Medicaid expansion. We are ready and willing to contribute to Seth's health care, but the $1200 premium or $2600 spend-down are simply out of reach for us. We ask you to help us to help Seth by not adding lack of healthcare to the already substantial challenges he must face.

I thank you for your time and consideration. I would be happy to answer any questions you may have.


Congressional Budget Office

Testimony

Statement of
Peter R. Orszag
Director

Covering Uninsured Children in the State Children's Health Insurance Program

before the
Subcommittee on Health Care
Committee on Finance
United States Senate

April 9, 2008

This document is embargoed until it is delivered at 2:30 p.m. (EDT), on Wednesday, April 9, 2008. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Rockefeller, Senator Hatch, and Members of the Subcommittee, it is my pleasure to appear today to discuss the State Children's Health Insurance Program (SCHIP). My testimony today makes the following main points:

- SCHIP has significantly reduced the number of low-income children who lack health insurance. According to the Congressional Budget Office's (CBO's) estimates, the portion of children in families with income between 100 percent and 200 percent of the poverty level who were uninsured fell by about 25 percent between 1996 (the year before SCHIP was enacted) and 2006. In contrast, the uninsurance rate among higher-income children remained relatively stable during that period. The difference probably reflects the impact of the SCHIP program.

- The states' outreach efforts and simplified enrollment processes for SCHIP appear to have also increased the share of eligible children who participate in Medicaid—and contributed to a decline in the percentage of children below the poverty level who are uninsured.

- The enrollment of children in public coverage as a result of SCHIP has not led to a one-for-one reduction in the number of low-income children who are uninsured, however. Almost any increase in government spending or tax expenditures intended to expand health insurance coverage will displace private coverage to some degree. In the specific case of SCHIP, the program provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than alternative coverage. As a result, the program displaces—or "crowds out"—private coverage to some extent. On the basis of a review of the research literature, CBO has concluded that for every 100 children who gain public coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

- CBO's analysis of the Children's Health Insurance Reauthorization Act of 2007, as passed by the House of Representatives, suggested that the legislation would result in 5.8 million children gaining coverage under Medicaid or SCHIP in 2012. Of that increase, CBO estimated, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage. In other words, about one-third of the children who would be newly covered under SCHIP and Medicaid would otherwise have had private coverage. That crowd-out rate is probably about as low as feasible for a voluntary program to increase coverage among children, given the size of the proposed expansion. (Policies to reduce the rate below that level would most likely also reduce the number of children enrolled in the program who would otherwise be uninsured.)

- On August 17, 2007, the Administration issued a directive to state health officials that imposes certain minimum requirements on states seeking to enroll

children in SCHIP whose families have income above 250 percent of the poverty level. CBO's analysis suggests that the directive's impact on enrollment is likely to be modest under current law, given the way the Administration appears to be implementing it and, more important, given the funding levels assumed in the baseline. The directive could have a substantially larger impact on enrollment in SCHIP if the Congress expanded the program significantly.

Overview of the State Children's Health Insurance Program

The State Children's Health Insurance Program was established by the Balanced Budget Act of 1997 to expand health insurance coverage to uninsured children in families with income that is modest but too high to qualify for Medicaid. SCHIP is financed jointly by the federal government and the states, and it is administered by the states within broad federal guidelines. The Congress provided approximately $40 billion in funding for SCHIP for fiscal years 1998 through 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) continued funding for the program through March 2009.

Eligibility and Enrollment

States have considerable flexibility in designing their eligibility requirements for SCHIP. According to the SCHIP statute, states may cover children living in families with income up to 200 percent of the federal poverty level or 50 percentage points above their Medicaid threshold.[1] States are allowed to disregard certain types of income and expenses in determining eligibility for the program. In 2008, 23 states allow a maximum income equal to 200 percent of the poverty level, 20 states set the limit above 200 percent of the poverty level, and 7 states set it below 200 percent of the poverty level.[2] North Dakota has the lowest threshold, at 140 percent of the poverty level, while New Jersey has the highest, at 350 percent of the poverty level.[3]

A number of states have used waivers of statutory provisions to expand coverage under SCHIP to adults. About 80 percent of the adults who were enrolled in SCHIP in 2007 were parents, 19 percent were childless adults, and 1 percent were

1. States are required to maintain the Medicaid threshold (or level of income determining eligibility) that was in place just before SCHIP was enacted. That requirement, for what is termed "maintenance of effort," prevents states from lowering their Medicaid threshold in order to receive a higher matching rate under SCHIP for children who would have otherwise been covered by Medicaid.

2. See Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker, *State Children's Health Insurance Program (SCHIP): A Brief Overview,* CRS Report for Congress RL30473 (Congressional Research Service, March 12, 2008).

3. New Jersey has effectively expanded its threshold to 350 percent of the poverty level by disregarding all income between 200 percent and 350 percent of the poverty level.

pregnant women. Covering parents may help to increase participation among children, because parents who are eligible may be more likely to enroll their children also.

The number of children enrolled in SCHIP at any time during the year increased from 660,000 in 1998 to 7.1 million in 2007 (see Table 1). As states first implemented their programs, enrollment grew very rapidly reaching almost 6 million children by 2003. Since then, enrollment has grown more slowly as states' programs have matured and some states have enacted policies to restrict enrollment in response to budgetary pressures. About 587,000 adults were enrolled at some time during in 2007.

Benefits

States can provide SCHIP coverage by expanding Medicaid to children not eligible for that program, creating a separate program under SCHIP, or using a combination of the two approaches. In 2008, 8 states are using an expansion under Medicaid, 18 states operate a separate program, and 24 states are using a combination approach.[4] States that provide SCHIP coverage by expanding Medicaid must provide the same benefits that are available under their Medicaid program and follow all other requirements of that program. States that create a separate program under SCHIP are subject to certain minimum standards, including providing a benefit package that is based on one of several specified "benchmark" insurance plans or an alternative that is actuarially equivalent or otherwise approved by the federal government.

The Financing of SCHIP

The statute that established SCHIP set national funding levels for each year from 1998 to 2007. In addition, it specified a formula for determining each state's share of the federal funding, a matching rate for federal reimbursement of SCHIP spending, and a mechanism for redistributing states' unused SCHIP funds.

The annual funding levels specified in the original SCHIP legislation were as follows: for 1998 through 2001, roughly $4.2 billion annually; for 2002 through 2004, about $3.2 billion per year; for 2005 and 2006, $4 billion per year; and for 2007, $5 billion. MMSEA provided $5 billion for 2008 and that same amount for 2009 (which is available to the states through March 2009) and up to $1.6 billion in additional funds for 2008 and $275 million in additional funds in 2009 to be used for states that exhaust their federal funds.

Each year, the federal funding for SCHIP is allocated among states on the basis of a formula that takes into account the number of children in low-income families in

4. See Herz, Peterson, and Baumrucker, *State Children's Health Insurance Program: A Brief Overview.*

Table 1.

Enrollment in the State Children's Health Insurance Program, 1998 to 2006

Fiscal Year	Number of Children (Thousands)	Percentage Change from Previous Year	Number of Adults (Thousands)	Percentage Change from Previous Year
1998	660	n.a.	0	n.a.
1999	2,014	205	0	n.a.
2000	3,358	67	0	n.a.
2001	4,603	37	234	n.a.
2002	5,354	16	374	60
2003	5,985	12	484	29
2004	6,103	2	646	33
2005	6,114	0	639	-1
2006	6,745	9	671	5
2007[a]	7,145	6	587	-13

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Notes: n.a. = not applicable.

The figures for the number of people enrolled reflect enrollment at any time during the year. The number of people enrolled in an average month would be about 60 percent of the above totals. There was a change in reporting between 2004 and 2005. Prior to 2005, in states with a combination program, children enrolled in both the Medicaid expansion and the separate program during a given year were counted twice. Starting in 2005, however, those children were counted only in the program where they were last enrolled.

a. Preliminary.

each state, the number of such children who are uninsured, and wages in the health services sector in the state relative to the national average. States must provide matching funds for expenditures from their federal allotments and have up to three years to spend those allotments. Funds that are not spent within three years are redistributed to states that have exhausted their allotments and are made available to those states for an additional year.

To encourage states to participate in SCHIP, the federal government pays a higher share of their spending on SCHIP than it pays for Medicaid. The federal government's matching rate for SCHIP varies among states from 65 percent to 83 percent; the federal matching rate for Medicaid varies from 50 percent to 76 percent.[5] The national average matching rate for SCHIP is 70 percent and for Medicaid, 57 percent. Although federal spending is made available on a matching basis for both programs, the nature of the programs differs significantly because SCHIP is a

5. SCHIP's formula for the matching rate is based on the state's federal medical assistance percentage (FMAP), as used in the Medicaid program, and equals FMAP + 0.3 * (100 - FMAP), with an upper limit of 85 percent.

grant program in which federal spending is capped in advance whereas Medicaid is an entitlement program with no predetermined limit on spending.

Rules for the redistribution of unused funds have been amended a number of times, both by extending and shortening the periods during which unspent funds are available. Because states were initially slow in spending their allotments, the Congress allowed the states to retain some of their allotments longer than three years. In contrast, because recent spending has outpaced federal funding, the National Institutes of Health Reform Act of 2006 (Public Law 109-482) required that a portion of unspent 2005 allotments be redistributed in 2007 instead of 2008.

The type of program that a state operates under SCHIP has distinct implications for funding levels. States choosing to implement SCHIP by expanding Medicaid may continue receiving federal matching funds at that program's lower federal matching rate once their SCHIP spending exceeds their available funds. In contrast, states operating a separate program receive federal matching funds (at the enhanced rate) only up to the amount determined by the allocation formula (unless they convert their program to a Medicaid expansion).

Expenditures for SCHIP

Initially, federal spending on SCHIP was well below the annual funding levels, as states implemented their programs (see Table 2). However, since 2002, federal spending has exceeded the annual allotments every year. Because unspent funds from previous years and the redistribution of other states' unspent funds provide additional SCHIP financing for some states, those states have forestalled exhausting their federal funds. Recently, however, some states have had insufficient federal funds available to fully match their SCHIP spending. As a result, the Congress has acted several times to provide additional funding. The Deficit Reduction Act of 2005 (P.L. 109-171) appropriated an extra $283 million in federal funding to support states' SCHIP spending in 2006. The National Institutes of Health Reform Act of 2006 included provisions modifying the redistribution of unspent funds from previous years to provide additional funds in 2007.[6] The U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act (P.L. 110-28) appropriated up to $650 million in additional federal funding. Most recently, MMSEA provided up to $1.6 billion in additional funds for 2008 and $275 million in additional funds for 2009 to cover states' spending through March 2009.

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6. The National Institutes of Health Reform Act of 2006 reduced the availability of 2005 allotments in some states from three years to two and a half. Specifically, states forfeited half of their unspent 2005 funds (not exceeding $20 million) if their total available funds as of March 31, 2007, were at least twice their projected spending in 2007. The law also specified that spending in 2007 from redistributed funds on adults who are not pregnant will be reimbursed at Medicaid's lower matching rate.

Table 2.

Allotments and Spending Under the State Children's Health Insurance Program, 1998 to 2007

(Millions of dollars)

Fiscal Year	SCHIP Allotments[a]	Allotments Unspent After 3 Years[b]	Federal Spending	Funds Expiring
1998	4,235	n.a.	122	0
1999	4,247	n.a.	922	0
2000	4,249	n.a.	1,929	0
2001	4,249	2,034	2,672	0
2002	3,115	2,819	3,776	0
2003	3,175	2,206	4,276	0
2004	3,175	1,749	4,645	1,281
2005	4,082	643	5,089	128
2006	4,365 [c]	173	5,452	0
2007	5,040	62	6,000	0
2008[d]	6,000	58	7,094	0

Sources: Congressional Budget Office, Congressional Research Service, the Balanced Budget Act of 1997, the Deficit Reduction Act of 2005, and the Centers for Medicare & Medicaid Services.

a. For both states and territories.

b. In general, states' annual allotments are available for three fiscal years. Any funds unspent after three years become available to other states with projected spending in excess of their allocation plus any available funds from previous years.

c. Includes additional funding from the Deficit Reduction Act of 2005.

d. Projection by the Congressional Budget Office.

The Effect of SCHIP on Children's Health Insurance Coverage

SCHIP has significantly increased the number of children in low-income families who have health insurance, but the enrollment in the SCHIP program is greater than the corresponding decrease in the number of uninsured low-income children. SCHIP provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than private coverage; as a result, some people who otherwise would have obtained private health insurance coverage have instead enrolled in SCHIP. Estimates of the extent to which private coverage has declined in response to the program vary, but the available evidence strongly suggests the net effect of the program has been to reduce the number of uninsured children.

Changes in the Number of Uninsured Children

Information on changes in the number of children who are uninsured comes from self-reported data collected in household surveys. The estimates presented here are based on data from the Annual Social and Economic Supplements to the Current Population Survey, conducted by the Census Bureau, which is the most widely cited source of information on insurance coverage. Although the survey is intended to measure the number of people who were uninsured throughout the calendar year, it yields estimates that are similar to other surveys' estimates of the number of people who were uninsured at a particular point in time.[7]

SCHIP should be expected to have had the greatest effect on the extent of insurance coverage among children in families with income between 100 percent and 200 percent of the poverty level because that was the group that had the greatest increase in eligibility for public coverage.[8] According to CBO's analysis, the percentage of children in that income range who were uninsured fell from 23 percent in 1996 (the year before SCHIP was created) to 17 percent in 2006, a reduction of about 25 percent (see Figure 1). The uninsurance rate was relatively stable among children in families with income over 200 percent of the poverty level. For example, among children whose families had income between 200 percent and 300 percent of the poverty level, the uninsurance rate remained at about 10 percent from 1996 to 2006.[9]

Among children in families below the poverty level, the uninsurance rate rose from 24 percent in 1996 to 27 percent in 1998 and then fell to 22 percent in 2006. The increase from 1996 to 1998 in the percentage of such children who were uninsured was accompanied by a drop in Medicaid coverage, which some analysts

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7. For a discussion of the strengths and limitations of the Current Population Survey and other household surveys for measuring insurance coverage, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003).

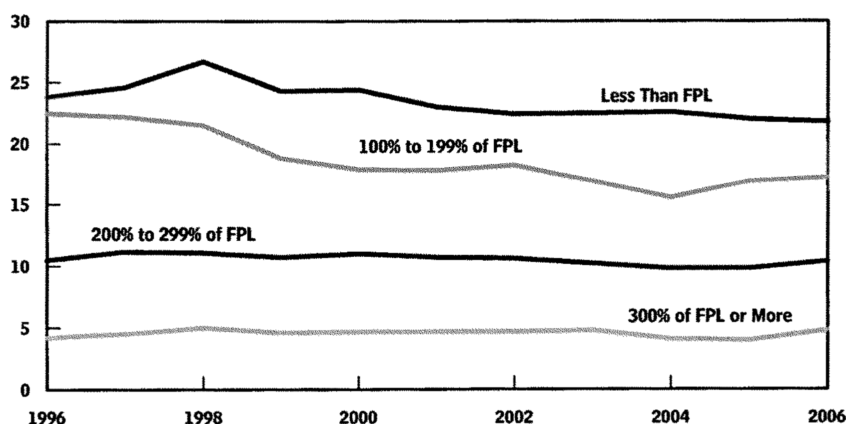
8. One recent study found that the rate of eligibility of children in families with income between 100 percent and 200 percent of the poverty level increased 70 percentage points from 1996 to 2002—compared with an increase of about 30 percentage points among children in families with income between 200 percent and 300 percent of the poverty level, an increase of 10 percentage points among those below the poverty level, and an increase of 8 percentage points among those between 300 percent and 400 percent of the poverty level. See Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* Working Paper No. 12858 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

9. In its analysis, CBO accounted for the fact that a "confirmation" question was added to the Current Population Survey beginning with the interviews that collected data for 1999. The new question asked people who did not report having any of several types of insurance coverage whether, in fact, they were uninsured. CBO compared estimates of uninsurance rates with and without the data from the confirmation question and used those two sets of estimates to create an adjustment factor (separately for each income group) that it applied to the estimates for years prior to 1999 to make them comparable with estimates for later years.

Figure 1.

Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level, 1996 to 2006

(Percent)



Source: Congressional Budget Office based on data from the Current Population Survey for 1996 to 2006.

Note: FPL = federal poverty level.

have cited as an unintended consequence of the welfare reform law that was enacted in 1996.[10] The decline in the percentage of such children who were uninsured after 1998 was accompanied by an increase in Medicaid coverage. In general, SCHIP did not make more children in families below the poverty level eligible for public coverage because most were already eligible for Medicaid. However, the percentage of children eligible for Medicaid who participated in that program increased, which some analysts have attributed partly to states' outreach efforts for SCHIP (because applicants for SCHIP were enrolled in Medicaid if they were found to be eligible for that program) and the simplified application procedures that states adopted for both SCHIP and Medicaid.[11]

10. See, for example, Karl Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs,* vol. 20, no. 1 (January/February 2001), pp. 97–111.

11. See Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002," *Health Affairs*, vol. 23, no. 5 (September/October 2004), pp. 39–50.

Those changes in the percentage of children who were uninsured do not yield an estimate of the impact of SCHIP because there are many other factors—such as changes in employment levels, family income, and health insurance premiums—that affect children's health insurance coverage. Nevertheless, the fact that the greatest reduction in the percentage of children who were uninsured occurred among those who had the greatest increase in eligibility for public coverage after SCHIP was established strongly suggests that the program has reduced the number of children in low-income families who are uninsured. As discussed below, however, estimating the effect of SCHIP on children's health insurance coverage requires a more sophisticated analysis that controls for other factors that influence coverage and accounts for the program's effects on the number of people with private insurance.

Children's Participation in SCHIP

The number of children who participate in SCHIP depends in part on low-income parents' awareness and understanding of the program, their attitudes toward public insurance programs and health insurance generally, and the ease of the application process. Nearly all states have promoted SCHIP through mass media campaigns, and most have used community-based efforts such as educational sessions and home visits.[12] States have also implemented simpler enrollment procedures for SCHIP than those used for Medicaid (although some have also adopted simpler enrollment procedures for Medicaid). For example, most states do not require a face-to-face interview for a parent to apply for SCHIP or to renew coverage but instead use simple mail-in application forms, and most do not impose an asset test (that is, basing eligibility on the amount of assets a family owns). Most states have a 12-month renewal period, which enables children to remain enrolled in SCHIP for a year unless their family reports a change in income or other circumstances.[13] Since 2001, though, some states have reduced their outreach efforts and retracted certain simplified enrollment procedures in response to fiscal pressures.[14]

According to one study, 29 percent of the children who were eligible for SCHIP in 2005 on the basis of their family's income participated in the program.[15] Half of the eligible children had employer-sponsored insurance, 6 percent had other cover-

12. Margo Rosenbach and others, *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* (report submitted by Mathematica Policy Research, Inc., to the Centers for Medicare and Medicaid Services, March 2003).

13. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006* (January 9, 2007), available at www.kff.org/medicaid/7608a.cfm.

14. Ibid.

15. Genevieve Kenney and Allison Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents,* Health Policy Online, no. 15 (Washington, D.C.: Urban Institute, February 2007).

age, and 15 percent were uninsured. By that study's estimates, the uninsured children who were eligible for SCHIP accounted for over a fifth of all uninsured children in 2005. Other studies have estimated that between 60 percent and 75 percent of all uninsured children are eligible for either Medicaid or SCHIP.[16]

Although all of those studies were based on rigorous statistical methods, they have important limitations because they relied on data collected in household surveys to determine children's health insurance coverage and to identify children who were eligible for SCHIP or Medicaid. Coverage in public programs such as Medicaid is underreported in such surveys, but the implications of that underreporting for the estimated number of people who are uninsured is unclear. There is some evidence that many people who are enrolled in Medicaid but who do not report having coverage under the program may report having private coverage instead.[17] There is also evidence that some SCHIP enrollees report having private nongroup insurance, which is not surprising in that many states design their programs to resemble private insurance.[18] Additional research is needed to fully understand the implications of the underreporting.

Another potential problem is that survey data on such things as types of income and expenses that may be disregarded for determining eligibility are also subject to misreporting. In addition, some major surveys (such as the Current Population Survey) collect data on annual income but no information on fluctuations during the year, which would be relevant for determining eligibility for SCHIP.

The Effect of SCHIP on Private Coverage

Determining the extent to which enrollment in SCHIP is offset by reductions in private coverage is important for evaluating the overall effects of the program and for assessing the extent to which government spending on the program has reduced the number of children who are uninsured. The crowding out of private coverage can occur through various mechanisms. For example, some parents who would have otherwise had family coverage through their employer might decline it for their children—or might decline coverage altogether—if their children are eligible for SCHIP. In addition, previously unemployed parents might be more likely to decline coverage at a new job if their children are enrolled in SCHIP. To the

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16. See Selden, Hudson, and Banthin, "Tracking Changes in Eligibility and Coverage Among Children"; and Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs,* Web Exclusive, November 30, 2006.

17. See Kathleen Thiede Call and others, "Uncovering the Missing Medicaid Cases and Assessing Their Bias for Estimates of the Uninsured," *Inquiry,* vol. 38, no. 4 (Winter 2001/2002), pp. 396–408.

18. See Joel C. Cantor and others, "The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market," *Health Services Research,* vol. 42, no. 4 (August 2007), pp. 1739–1757; and Anthony T. Lo Sasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics,* vol. 23, no. 5 (2004), pp. 1059–1082.

extent that SCHIP makes private coverage less important for some families, the program might also increase the likelihood that low-income parents take jobs that offer higher cash wages rather than health insurance. Thus, even in the majority of states where SCHIP covers only children, the program could reduce private coverage among adults as well as children.

SCHIP can also reduce private coverage by influencing the actions of employers. If employers of low-wage workers believe that SCHIP makes health insurance less important in attracting high-quality employees, some might reduce their contribution to the premiums for family coverage, reduce the level of benefits offered, stop offering family coverage, or stop offering insurance altogether. Those actions could lead to less private coverage among families that are eligible for SCHIP as well as ones that are not.

Families that substitute SCHIP for private coverage are generally better off because the cost (to the enrollees) is lower and the package of benefits may be more extensive. However, to the extent that employers respond to SCHIP by increasing premiums, reducing benefits, or declining to offer coverage, other families could be worse off.

Little is known about how employers have responded to SCHIP. As discussed below, the limited evidence that is available suggests that SCHIP has not affected employers' decisions on whether to offer coverage but may have caused them to modestly raise employees' premiums for family coverage relative to the premiums for individual coverage. The implication is that most of the reduction in private coverage associated with SCHIP's existence appears to result from parents choosing to forgo private insurance for their children and instead enroll them in SCHIP, presumably because the parents believe the program offers better benefits or lower costs than private insurance.

The existence of SCHIP may also affect private coverage by increasing enrollment in the Medicaid program—a consequence of the outreach that states have conducted for SCHIP and the simplified application procedures that many have adopted (in some cases, for Medicaid as well as for SCHIP). That increased enrollment in Medicaid has probably been offset to some extent by a reduction in private coverage, for the same reasons that enrollment in SCHIP has probably been partly offset by a reduction in private coverage. The reduction in private coverage associated with the increase in Medicaid coverage is probably smaller than that associated with enrollment in SCHIP, however, because people eligible for Medicaid have lower income and less access to private insurance than people eligible for SCHIP do.

Efforts to Limit the Substitution of SCHIP for Employer-Sponsored Insurance. Federal law requires that the states have procedures in place to prevent people from substituting SCHIP for employer-sponsored insurance. The Congress included that provision in the authorizing legislation because of concern about substitution, in

part resulting from a study that estimated that an expansion of Medicaid in the late 1980s and early 1990s caused a decline in private coverage that was about half the size of the increase in Medicaid coverage.[19] Subsequent studies obtained much lower estimates for the effects of Medicaid on private coverage.[20]

The potential for SCHIP to displace employer-sponsored insurance is greater than it was for the expansion of Medicaid because the children eligible for SCHIP are from families with higher income and greater access to private coverage. According to one study, 60 percent of the children who became eligible for SCHIP had private coverage in the year before the program was established.[21]

States have included a variety of features in their programs to try to prevent SCHIP from displacing employer-sponsored insurance. A widely used approach is to impose a waiting period—that is, a specified length of time that children must be uninsured before becoming eligible for SCHIP. In 2006, 35 states had a waiting period, the two most common being six months (imposed by 16 states) and three months (imposed by 11).[22] Only one state had a waiting period that was longer than six months. Many states allow exceptions to the waiting period—when a parent loses private coverage for reasons considered involuntary (by losing his or her job, switching to a job that does not offer family coverage, or becoming disabled, for instance) or when the available insurance is considered too expensive (if the employee's premiums would exceed a specified percentage of income or if the employer contributes less than 50 percent to the cost of coverage, for example).[23] Most states collect insurance information on the application for SCHIP, and some verify that information with employers. Some states try to limit the displacement of employer-sponsored insurance by requiring premiums and copayments within SCHIP.

Estimates of the Effects of SCHIP on Private Coverage. Estimates vary about the extent to which SCHIP has resulted in less private coverage. The available studies, which have focused on the effects of SCHIP on children, use various data sources

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19. That estimate included changes in coverage among children, women of childbearing age, and other adults (who were not eligible for Medicaid). Among children, the study found, the reduction in private coverage was equal to 40 percent of the increase in public coverage. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *The Quarterly Journal of Economics,* vol. 111, no. 2 (May 1996), pp. 391–430.

20. See, for example, Linda J. Blumberg, Lisa Dubay, and Stephen A. Norton, "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics,* vol. 19, no. 1 (2000), pp. 33–60.

21. See Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry,* vol. 42, no. 3 (Fall 2005), pp. 232–254.

22. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents.*

23. Rosenbach and others, *Implementation of the State Children's Health Insurance Program.*

and methods. On the basis of a review of the available studies, CBO concludes that the reduction in private coverage among children is most probably between a quarter and a half of the increase in public coverage resulting from SCHIP.[24] That is, for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.[25]

Measuring the extent to which SCHIP is associated with a decline in private coverage is difficult because it requires comparing the insurance coverage of people under current law with an estimate of the coverage they would have had if the program did not exist. Analysts have estimated the reduction in private coverage attributable to SCHIP by using various statistical models to try to remove the effects of other factors that affect private coverage. All studies that have been conducted to date have estimated the reduction in private coverage among children only; they do not capture any possible reduction in private coverage among parents or other adults. Consequently, the available estimates probably understate the total extent to which SCHIP has reduced private coverage.

Some studies have estimated crowd-out by examining the insurance coverage of participants in SCHIP before they enrolled in the program. Such studies classify enrollees who had private insurance prior to being in SCHIP as having potentially substituted SCHIP for private coverage, and they classify those who were uninsured or covered by Medicaid as not having substituted SCHIP for private coverage. One such study found that 28 percent of children enrolled in SCHIP in 10 states had private coverage at some time during the six months before they enrolled in the program.[26] Such studies probably understate the full extent to which SCHIP reduces private coverage because they do not account for the fact

24. That range includes estimates obtained under various approaches. Estimates differ under alternative specifications of the statistical models that analysts have used; some specifications yield estimates that are below or above the range cited. That range encompasses the estimates from specifications in the studies that CBO reviewed and considered most reliable.

25. Nearly all studies have estimated the effect of SCHIP on private coverage generally (including both employer-sponsored insurance and private nongroup coverage). Some observers might argue that studies should focus on the effects of the program on employer-sponsored insurance, because federal law requires states to have procedures in place to prevent the substitution of SCHIP for such coverage. However, estimates of the effects of SCHIP are not likely to be affected measurably by whether or not private nongroup insurance is included. According to CBO's analysis of data from the Current Population Survey, only about 6 percent of children in families with income between 100 percent and 200 percent of the poverty level had private nongroup insurance in the year before SCHIP was enacted, while about half had employer-sponsored insurance. Moreover, a recent study found that, although SCHIP reduced coverage of children by employer-sponsored insurance, it had no effect on private nongroup coverage of them. See Lisa Dubay and Genevieve Kenney, *The Impact of SCHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families* (working paper, Washington, D.C.: Urban Institute, May 2007).

26. See Anna Sommers and others, "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs,* vol. 26, no. 2 (March/April 2007), pp. 529–537.

that some of the children who were uninsured or enrolled in Medicaid prior to enrolling in SCHIP may have obtained private coverage if SCHIP had not been established.[27] Moreover, such studies do not account for the possibility that some of the children who were uninsured prior to enrolling in SCHIP may have lost coverage as a result of parents' or employers' response to the program (such as a decision by employers to drop family coverage or raise the premiums). In addition, in the surveys that are conducted for such studies, some parents might not have reported their children's private coverage before they enrolled in SCHIP out of fear that their children could be dropped from the program if the state authorities learned about that coverage.

There is limited evidence on whether SCHIP has affected the health insurance decisions of employers. Only one study has examined that issue, and it analyzed employers' responses to SCHIP only through 2001.[28] It found no evidence that employers stopped offering single or family coverage in response to SCHIP but did find evidence suggesting that employers of low-wage workers reacted to the program by increasing the marginal cost of family coverage (which was defined as the difference between employees' premiums for family coverage and single coverage). For example, the study estimated, a hypothetical employer with 20 percent of its workforce with children eligible for public coverage would increase employees' marginal cost of family coverage by about $120 per year (in 2001 dollars). The estimated increase was larger in states that experienced a higher-than-average increase in eligibility for public coverage following the establishment of SCHIP and larger for employers with a higher percentage of the workforce with children eligible for public coverage.

The study also examined the extent to which employees accepted private insurance that was offered. It found evidence suggesting that SCHIP reduced the percentage of employees who accepted any private coverage, generally, and family coverage, specifically. For example, at a hypothetical employer at which 20 percent of the workforce had children eligible for public coverage, the estimated percentage of employees who accepted any offer of insurance fell by an average of 1 percentage point. Among employees who accepted any coverage, a similar decline occurred in the percentage of workers who accepted family coverage. The estimated declines were greater for employers that had a higher percentage of workers with children eligible for public coverage. Such findings suggest that SCHIP can reduce private coverage of adults as well as children—in other words,

27. The uninsured population is not a static group but is constantly changing. Some people are uninsured for long periods, while others are uninsured for shorter periods, such as between jobs. See Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?*

28. Thomas Buchmueller and others, "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry,* vol. 42, no. 3 (Fall 2005), pp. 218–231.

that some workers may respond to SCHIP by declining coverage altogether, not merely declining coverage for their children.

Crowd-Out Effects from Expansions of SCHIP. The estimates reported in the research literature measure average changes in private coverage since SCHIP has been implemented, which may differ from what would occur if policies were adopted to increase enrollment. For example, policies designed to increase enrollment among children who are currently eligible would involve less reduction in private coverage than would expanding the program to cover children in families with higher income. Such an expansion to those with higher income would probably involve greater crowd-out of private coverage than has occurred to date because such children have greater access to private insurance.[29]

CBO has previously analyzed the effects of H.R. 976, the Children's Health Insurance Reauthorization Act of 2007, as passed by the House of Representatives. That analysis indicated that the legislation would result in 5.8 million children gaining coverage under Medicaid or SCHIP in 2012. Of that total, CBO estimated, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage. Under H.R. 3963, the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House, the outcome would be the same. Compared with the outcome under current law, the act would result in 5.8 million children gaining coverage under Medicaid or SCHIP, according to CBO's estimates. Again, of that total, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage.

Those estimates suggest that about one-third of the children who would be newly covered under SCHIP and Medicaid would otherwise have had private coverage. For expansions of public coverage of the scale that would occur under those bills, it is unlikely that crowd-out rates could be substantially reduced below one-third.[30] Although it is possible to establish policies that would reduce the extent to which SCHIP displaces private coverage, such policies would probably also reduce the enrollment of people who were not substituting public coverage for private coverage.

29. According to CBO's analysis of data from the Current Population Survey, 50 percent of children in families with income between 100 percent and 200 percent of the poverty level had private coverage in 2005. The rate of private coverage was 77 percent among children in families with income between 200 percent and 300 percent of the poverty level, 89 percent among those between 300 percent and 400 percent of the poverty level, and 95 percent among those over 400 percent of the poverty level.

30. Another point of comparison is CBO's estimate for the original SCHIP authorizing statute, the Balanced Budget Act of 1997. At that time, the agency estimated that 40 percent of children covered under SCHIP would otherwise have had private insurance coverage.

Effects of a Recent Directive on Enrollment in SCHIP

According to a letter to state health officials issued by the Administration on August 17, 2007, a state covering children in families with income above 250 percent of the poverty level or proposing to expand coverage to such children is required to have already enrolled at least 95 percent of eligible children in families with income below 200 percent of the poverty level, and private employer-based insurance coverage for children in low-income families in the state may not have decreased by more than 2 percentage points over the prior five-year period. In addition, the directive requires such a state to adopt five strategies for minimizing the substitution of coverage under SCHIP for private coverage. The states must:

- Impose waiting a period of at least one year between the dropping of private coverage and enrollment in SCHIP for children in families with income above 250 percent of the poverty level;
- Impose cost sharing in SCHIP that approximates the cost of private coverage;
- Monitor health insurance status at the time children apply for the program;
- Verify families' insurance status through insurance databases; and
- Prevent employers from changing dependent coverage polices to favor a shift to public coverage.

It is important to note that many details regarding the implementation of the directive have not been specified, and different interpretations of that directive are possible. CBO's analysis suggests that the impact of the directive on enrollment is likely to be modest under funding levels assumed in CBO's baseline projections. According to program and survey data, about 80 percent of enrollment in SCHIP in all states is by families with income below 200 percent of the poverty level; about 15 percent of enrollment, between 200 percent and 250 percent of the poverty level; and less than 5 percent, over 250 percent of the poverty level. CBO assumes that families in the last category—constituting less than 5 percent—are potentially affected by the August 17th directive.

Consistent with those overall findings, administrative data suggest that fewer than 20 states provide SCHIP coverage for children in families with income above 250 percent of the poverty level. Even in those states, the great majority of those covered children are from families with income below 200 percent of the poverty level. (Some states, however, had planned to expand their coverage to families with income above 250 percent of the poverty level but dropped such plans after the directive was issued.)

Given the way that the Administration appears to be implementing the directive, the provision most likely to affect enrollment is the requirement that states impose

at least a one-year waiting period between private coverage and enrollment in SCHIP for children in families with income above 250 percent of the poverty level. Only two states currently have a waiting period as long as one year; many require no waiting period, and the majority of states with waiting periods set them at only three or six months. The requirement for a one-year waiting period would therefore mean that a number of children who currently could obtain coverage either immediately or three to six months after leaving private coverage would have their enrollment delayed or might never enroll in SCHIP, if they obtained private coverage during the waiting period. On the basis of an analysis of current waiting periods, CBO estimates that, under current law, enrollment in SCHIP would be reduced by 0.1 percent as a result of the Administration's action.

The directive could have much greater impact on enrollment in SCHIP if the Congress expanded the program significantly. Under its baseline projections for SCHIP, which assume continued allotments of about $5 billion per year, CBO estimates that enrollment of children in SCHIP will fall from 6.8 million in 2009 to 3.3 million in 2018, as the growth in health care costs per person diminishes the number of children states can cover with a fixed sum of money. However, if the Congress substantially increased SCHIP funding, additional states would probably wish to expand their programs to children in families with income above 250 percent of the poverty level. In that case, the August 17th directive would be a more significant constraint on enrollment.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Peter R. Orszag, Director

June 3, 2008

The Honorable Max S. Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Enclosed you will find my responses to the written questions for the record from members of the Subcommittee on Health of the Senate Committee on Finance regarding my testimony on April 9, 2008. I hope that this information is useful to the subcommittee. If you or your staff have any questions, please feel free to contact me at (202) 226-2700 or Lyle Nelson at (202) 225-2608.

Sincerely,

Peter R. Orszag

Enclosure

cc: Honorable Charles E. Grassley
Ranking Member

Questions from Senator Rockefeller:

Question 1a

As you know, I sent you a letter on March 27 asking for your analysis of crowd-out under CHIP relative to crowd-out under Medicare Part D. In your response you state, "That legislation established the Part D prescription drug benefit in Medicare, which provided federal subsidies to many individuals who already had private prescription drug coverage. However, crowd-out was not a factor because the act explicitly permitted Medicare enrollees with private coverage to enroll in Medicare Part D, and authorized payments to private firms to maintain prescription drug coverage."

Surely you aren't suggesting that because we offered very generous subsidies to private plans—many of which dropped private coverage anyway—that crowd-out was non-existent in Medicare Part D?

Isn't it true that crowd-out was indeed a factor in the Medicare prescription drug benefit? Isn't it also true that the range of Medicare prescription drug crowd-out was consistent with the range of crowd-out under both CHIP reauthorization bills passed last year?

Response

Thank you for the opportunity to clarify that statement. My previous written statement should have indicated that crowd-out was not a prominent part of the public policy debate over Medicare Part D; indeed, as noted in my previous statement, the legislation clearly anticipated a certain amount of crowd-out. Only in the sense of its lack of prominence in the public policy debate was crowd-out "not a factor" with regard to Part D.

CBO's estimate of crowd-out effects resulting from the Medicare drug benefit is consistent with the range of assumptions that CBO uses to analyze proposals regarding SCHIP. Since the drug benefit became available in 2006, the available evidence indicates that only a small percentage of employers have dropped drug coverage for their Medicare-age retirees. For those enrollees it therefore appears that crowd-out has primarily taken the form of substituting public funds for private funds rather than leading individuals to lose their private coverage altogether. Even so, the overall extent of crowd-out that has occurred as a result of enacting the Medicare drug benefit is within the range of 25 to 50 percent that CBO uses when analyzing proposals regarding SCHIP.

Question 1b

With regard to CHIP, it seems that this Administration has used a lot of "fuzzy math."

For example, last year, the Administration issued an analysis of the number of children who are eligible for Medicaid and CHIP, but remain uninsured, that was well-below the commonly cited estimates by researchers in the field.

If I recall correctly, didn't CBO issue a letter to Congress explaining why the Administration's estimates were not an appropriate measure of the number of eligible but unenrolled children? What were some of the problems with those estimates?

Now, the Administration is claiming that states can in fact meet the 95 percent participation rate standard citing estimates that many states have participation rates in excess of 95 percent. Are you familiar with the methodology CMS is using? Do you find their methodology reasonable? Do you find any methodology to be credible that produces a participation rate in excess of 100%, when that seems to be impossibility?

Response

Last year, the Administration estimated that 1.1 million children lack health insurance coverage but are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). That figure is well below other estimates in the research literature, which indicate that there are between 5 million and 6 million such children. On July 24, 2007, CBO sent a letter to Senator Baucus that discussed the reasons for the differences between the two sets of estimates and concluded that the estimates from the research literature are more appropriate for both policy judgments and budget scoring.

A major reason that the Administration's estimate is much lower than other estimates is that it measures the number of children who are uninsured for an *entire year* and eligible for Medicaid or SCHIP. That estimate does not include all uninsured children who are eligible for the programs, however, because substantial numbers of children are uninsured for part of the year and are eligible for public coverage during that period. Consequently, the Administration's estimate understates the number of uninsured children who might participate in Medicaid or SCHIP under policies aimed at expanding enrollment.

The estimates from the research literature are instead based on the number of children who are uninsured and eligible for Medicaid or SCHIP at a particular

point in time. That concept provides a more appropriate measure of the number of children who are uninsured and eligible for public coverage on average over the course of the year. (For example, consider two children, one of whom is uninsured for the first six months of the year and the second of whom is uninsured for the second six months of the year. The Administration's estimates would not count either child as uninsured, because neither was uninsured for the entire year. In any month, however, one of them would be uninsured and potentially eligible for coverage under a public program.)

The directive that was issued by the Centers for Medicare & Medicaid Services (CMS) on August 17, 2007 specified a number of requirements that states must satisfy in order to use SCHIP funds to cover children in families with income above 250 percent of the poverty level, including a requirement that the state enroll at least 95 percent of the children who are eligible for Medicaid or SCHIP and whose family income is below 200 percent of the poverty level. CMS has indicated that most states currently satisfy that requirement. The agency has indicated that states will be given flexibility in the data sources and methods they can use to demonstrate whether they meet the requirement. CMS released a table illustrating one approach that states might use. The estimates in that table, which CMS is apparently allowing states to use as participation rates, indicate that 38 states and the District of Columbia have "participation rates" that exceed 100 percent. Such estimates raise clear credibility questions, since participation rates in a program by definition cannot exceed 100 percent.

CMS has not released a description of the methodology it used to obtain those participation rates. However, some aspects of the methodology are apparent from the tables that the agency has released. Perhaps the most glaring issue that is apparent from those tables is that CMS defined the numerator as the number of children who were enrolled in Medicaid or SCHIP *at any time during the year*. This "ever enrolled" concept includes children who were enrolled for as little as a day. And yet in the denominator of the ratio, CMS included all children in families with income below 200 percent of poverty threshold at a particular point in time. The following example illustrates the problem with this type of calculation. Consider two families, both of which have income below 200 percent of poverty for half the year and income above that threshold for the other half, and both have one child who is enrolled in Medicaid or SCHIP during the period in which income is below 200 percent of poverty but is uninsured during the other half of the year. The numerator of the CMS ratio would include two children as having coverage (since each family had one child enrolled during some part of the year), yet the denominator would include only one child (since during any given month, only one child lived in a family with income below 200 percent of poverty). The "participation rate" for these two families would then be measured by CMS as 200 percent. In reality, the participation rate at any point in time would be 100 percent.

Another problem with CMS's methodology is that the numerator includes all children who were enrolled in Medicaid or SCHIP during the year—including those in families with income over 200 percent of the poverty level. This results in an overestimate of the participation rate among children below 200 percent of the poverty level. Again, consider two families, one with income below 200 percent of the poverty level and one with income slightly above that threshold. If the children in both families were enrolled in Medicaid or SCHIP, CMS would again measure a participation rate above 100 percent.

Question 1c

The Administration has made a big to-do about the need to address crowd-out under Medicaid and CHIP. I have one rather basic question for you, is there significant evidence which shows that the procedures called for under the August 17 directive—such as mandatory waiting periods and cost-sharing—actually reduce crowd-out?

Isn't it true that respected M.I.T. Professor Jonathan Gruber has examined the effectiveness of waiting periods such as those required in the August 17 guidance and found that they do little to reduce crowd-out? In fact, didn't Professor Gruber conclude that "there is certainly no reason to conclude that waiting periods are lowering the crowd-out rate"?

Response

There is limited evidence on whether and to what extent mandatory waiting periods and cost sharing reduce crowd-out in SCHIP. A recent study by Jonathan Gruber and Kosali Simon found that those measures may fail to reduce crowd-out, and indeed if anything they may reduce enrollment in SCHIP at a faster rate among children who would have otherwise been uninsured than among children who would have otherwise had private coverage.[1] Those results are statistically imprecise, however. A study by Anthony Lo Sasso and Tom Buchmueller, using

1. Jonathan Gruber and Kosali Simon, "Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" *Journal of Health Economics*, vol. 27, no. 2 (2008), pp. 201-217.

the same methods as Gruber and Simon but a different data source, found that waiting periods do reduce crowd-out.[2]

There is strong evidence that waiting periods and cost sharing reduce the *number* of children who enroll in SCHIP. The available evidence to date is not sufficient, however, to conclude that such measures reduce crowd-out rates.

Question 1d

Under the Administration's August 17 guidance, states must provide assurance that employer-sponsored insurance of children has not declined by two percentage points over the previous five-year period. However, the availability of employer-sponsored insurance is largely beyond states' control. In West Virginia, for example, we would not be able to meet a two percent threshold if we lost a Weirton Steel or Ravenswood Aluminum or Philips Lighting, or Special Metals.

Can you talk about states' abilities to influence the availability of employer-sponsored coverage of children? What do you believe are the primary factors driving the availability of employer-sponsored coverage of children in a state? How is employer-sponsored coverage affected during an economic downturn?

Response

Changes in economic conditions and health insurance premiums are perhaps the most important factors that can lead to changes in the number of children in a state who are covered by employer-sponsored insurance (ESI). For example, during an economic downturn, a drop in employment levels reduces the number of people who have access to ESI. Moreover, there is evidence that rapidly rising health insurance premiums have reduced the number of people with ESI. Other factors that can affect the number of children covered by ESI in a particular state include changes in family income, changes in the types of jobs people hold, and decisions by employers about whether to offer coverage. In addition, as indicated in my testimony, public insurance programs such as SCHIP reduce the number of children with ESI by crowding out such coverage, but the impact of this crowd-out tends to be substantially less in aggregate than the effect of the broader forces affecting ESI coverage

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2. Anthony T. LoSasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics*, vol. 23, no. 5 (2004), pp. 1059-1082.

Questions from Senator Stabenow:

Question 2a

The August directive includes whether there has been a decline in a state's overall employer-sponsored insurance as part of its guidelines. In your research, is there any rational relationship between a decline in private employer-sponsored coverage and the Children's Health Insurance Program? I am very confused about this relationship. Could there be other factors at play such as rising health care costs and failure to address global competition that are causing an erosion in employer-sponsored coverage?

Response

There is considerable evidence that SCHIP substitutes for, or crowds out, employer-sponsored insurance (ESI). The most reliable estimates currently available suggest that the reduction in private coverage among children is between a quarter and a half of the increase in public coverage resulting from SCHIP. In other words, for every 100 children who enroll in public coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

A number of other factors can reduce the percentage of children who are covered by ESI, such as declining employment levels, increasing health insurance premiums, and declining family incomes. In studies that estimate crowd-out, researchers use statistical models to try to control for these other factors that influence children's health insurance coverage and thus isolate the effect of public coverage on private coverage.

According to data from the Current Population Survey, the share of children who have private coverage fell from 70 percent in 2000 to 65 percent in 2006. Just how much of that decline in ESI coverage has resulted from the various factors discussed above is not known. However, to put those figures in perspective, the share of children enrolled in SCHIP increased from 2.9 percent to 5.3 percent during that period. That 2.4 percentage point increase in the number of children enrolled in SCHIP, according to the crowd-out estimates discussed above, would suggest a reduction in the share of children with ESI coverage due to crowd-out of at most 1.2 percentage points. In other words, most of the reduction in private coverage among children was due to factors other than crowd-out associated with SCHIP.

Question 2b

Dr. Orszag, I would like to just clarify something on what CBO means when it says "crowd out." Does it necessarily mean that a parent has substituted public coverage for private coverage? For example, suppose a recently-divorced unemployed mother enrolls her child in her state's CHIP program. Let's say that later, the mother gets a low-paying job that offers private insurance but she would have to pay a high premium and deductibles for her child. If she does not take the private insurance that is inferior to the CHIP coverage, would you say she has been "crowded out?" Are you considering children who are uninsured when they go into CHIP but who, at some point in the future, may have access to insurance as being "crowd out" children?

Response

SCHIP can crowd out private coverage in various ways. For example, some parents might drop the family coverage offered through their employer—or might drop their coverage altogether—if their children are eligible for SCHIP. In addition, previously unemployed parents might decline private coverage at a new job if their children are eligible for (or already enrolled in) SCHIP. Moreover, to the extent that SCHIP makes private coverage less important for some low-income families, parents might be more inclined to take jobs that offer higher cash wages rather than health insurance.

In each of these cases, crowd-out occurs only to the extent that SCHIP causes parents to change their decisions regarding their children's insurance coverage or their own employment. For example, consider an unemployed and uninsured parent who enrolls her children in SCHIP and then declines coverage for them when she obtains a job that offers insurance. Such children are "crowded out" only if the parent would have enrolled her children in employment-based insurance in the absence of SCHIP. (Both of your examples would count as crowd-out as long as the mother would have purchased the employer-based coverage for the child in the absence of SCHIP.) Parents who forgo private coverage and enroll their children in SCHIP presumably believe the program offers better benefits or lower costs than private insurance.

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CONGRESSIONAL TESTIMONY

Covering Uninsured Children: The Impact of the August 17 CHIP Directive

Testimony before
Finance Committee Subcommittee on Health
United States Senate

April 9, 2008

Nina Owcharenko
Senior Health Policy Analyst
Center for Health Policy Studies
The Heritage Foundation

My name is Nina Owcharenko. I am Senior Health Care Policy Analyst in the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Keeping SCHIP Focused

The State Children Insurance Program (SCHIP) statue describes the purpose of the program as assisting uninsured, low-income children. Although there is some disagreement over its interpretation, the statue defines "low-income" children as those children whose family income is at or below 200 percent of the poverty line. Moreover, in an effort to keep the program focused on uninsured children, the statue includes provisions to ensure that the program does not substitute for coverage under a group health plan and to inform parents through outreach efforts of the possible availability of private coverage.

In August of 2007, the Centers for Medicare and Medicaid released a directive to state on SCHIP helps clarify and re-enforce existing law. The directive keeps the program focused on its core population—low income uninsured children—and pays particular attention to the impact that SCHIP expansions have on existing private coverage.

Impact of Expansion on Existing Private Coverage

Many low-income children have private health insurance. The Congressional Budget Office estimates that 50 percent of children between 100 and 200 percent of poverty have private coverage,[1] and 77 percent of children between 200 and 300 percent of poverty have private coverage.[2] Thus, it is critical to appreciate these numbers when considering expanding public programs, such as SCHIP, beyond the 200 percent threshold.

There is wide and varying degrees of estimates on the impact that public program expansions has on the availability and enrollment in private coverage. Economists Jonathan Gruber and Kosali Simon, looking at public programs in general, found that "the number of privately insured falls by about 60 percent as much as the number of publicly insured rises."[3] Gruber and Simon also concluded that this "crowd out" phenomenon is far more dramatic when considering the entire family.[4]

The Congressional Budget Office conducted a review of the literature and estimated a 25 to 50 percent reduction in private coverage due to SCHIP.[5] Since their estimates only consider children and not parents, CBO, like Gruber and Simon, points out

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[1]Congressional Budget Office, "The State Children's Health Insurance Program," May 2007, p. 12 at *www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf* (April 8, 2008).
[2]*Ibid.*
[3]Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Heath Insurance?" National Bureau of Economic Research *Working Paper* No. 12858, January 2007, p. 2, at *www.nber.org/papers/w12858* (April 8, 2008).
[4]*Ibid.*, p. 28.
[5]Congressional Budget Office, "The State Children's Health Insurance Program," p. 11.

that these estimates "probably understate the total extent to which SCHIP has reduced private coverage."[6]

The Heritage Foundation's Center for Data Analysis conducted an econometric analysis based on a modified and extended version of the methodology developed by Gruber. This analysis concluded that, for every 100 newly eligible children in families with incomes between 200 and 400 percent of federal poverty, 54 to 60 children would lose private coverage.[7]

Protecting SCHIP and Private Coverage

First, the directive is aimed at those states that have expanded eligibility above 250 percent of poverty. Nineteen states have expanded SCHIP eligibility above the 200 percent threshold, and 11 of those have extended it above 250 percent of poverty. Moreover, of these states at or above 250 percent of poverty, several have received additional federal funding to address "shortfalls" within their programs, which raises questions about whether these states have already expanded beyond capacity.[8]

The Administration directs states that want to expand SCHIP above 250 percent of poverty to meet certain requirements to ensure that the basic goals of the program are being met by preserving SCHIP for the core population that it is intended to service and deterring further erosion of private coverage. Meaningful cost sharing and standard waiting periods, for example, will help protect SCHIP as a safety net program for low-income uninsured children and ensure that the program's design does not create incentives for families to drop their existing private coverage.

Policymakers need to balance access to public coverage without eroding private coverage. Instead of focusing solely on SCHIP as a vehicle for covering kids, policymakers should broaden their efforts to make private coverage more affordable for working families. Offering a federal tax credit to working families is one way to give families the help they need to afford private coverage. A dual approach that protects SCHIP for its intended low-income uninsured populations and a tax credits for others has a long history and broad support.[9]

Conclusion

These SCHIP directives help to preserve SCHIP as a safety net program for low-income, uninsured children. Efforts to undermine these directives will lead to further erosion of the private health insurance market and overburden public programs. In order to address the coverage needs of children, policymakers need to look beyond public

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[6]*Ibid.*, p. 12

[7]Paul L. Winfree and Greg D'Angelo, "SCHIP and 'Crowd Out': The High Cost of Expanding Eligibility," Heritage Foundation *WebMemo* No. 1627, September 20, 2007, at *www.heritage.org/Research/HealthCare/wm1627.cfm.*

[8]For example, six states at or above 250 percent of FPL received additional funding under the Deficit Reduction Act (Public Law 109–171), and eight states are projected to receive additional funding through the Medicare, Medicaid, and SCHIP Extension Act (Public Law 110–173). See and Chris Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," Congressional Research Service, May 8, 2006, and Chris L. Peterson, "FY 2008 Federal SCHIP Financing," Congressional Research Service, January 9, 2008.

[9]See Health Coverage Coalition for the Uninsured, Web site, at *www.coalitionfortheuninsured.org* (April 8, 2008).

program expansion and consider solutions that will bolster—not unravel—the foundation of America's private health insurance system.

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August 17 SCHIP Letter: 95% Enrollment Target for Eligible Low-Income Children

Testimony, Senate Finance Health Subcommittee
April 9, 2008

Chris L. Peterson
Specialist in Health Care Financing
Domestic Social Policy Division

Summary of CRS Testimony

My testimony focuses on the "95% test," one of the six requirements in the August 17 letter pertaining to states seeking to enroll children with "effective" family income above 250% of poverty. This test requires affected states to provide "assurance that the state has enrolled at least 95 percent of the children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid."

Only one source of data is currently available that provides state-level estimates for all 50 states of children's health insurance status and family income: the Census Bureau's Current Population Survey (CPS). The Census Bureau annually publishes the insurance rates of low-income children (i.e., those below 200% of poverty). Although the published estimates indicate that no state covers 95%, if one factors in the survey's margins of error, several states could claim that the 95% level has been reached. Even so, there are fundamental concerns with the CPS's insurance estimates, beyond the typical margins of error. For example, the CPS is known to undercount Medicaid and SCHIP enrollment by several million individuals.

Moreover, the 95% test is to be calculated among low-income children who are eligible for SCHIP or Medicaid. No national survey asks respondents or determines separately whether individuals are eligible for Medicaid or SCHIP. For example, the CPS does not ask respondents about their immigration/documentation status, which is a factor in determining one's eligibility for Medicaid and SCHIP. Thus, analysts have to make adjustments to estimate, for example, how many uninsured children are eligible for public coverage. Such estimates can vary widely, depending on the methodologies used. For example, based on adjusted CPS estimates, the Administration announced that 1.1 million uninsured children were eligible for public coverage. This varied from an estimate of 6.0 million previously published by researchers using a different model.

For meeting the 95% test, CMS correctly noted that with data adjustments for individuals' immigration/documentation status and the Medicaid undercount, "a number of states are likely to meet the 95 percent threshold." This testimony includes an illustration by CRS that makes adjustments for these two factors and produces percentages that exceed 100% for nearly every state. This is a result that lacks face validity, although it is not clear whether CMS would accept or reject such a result. Additional and arguably justifiable adjustments could be made until every state has a rate between 95% and 100%.

The policy goal — in this case, ensuring adequate coverage of eligible low-income children before permitting coverage of higher-income children — may be considered worthwhile. However, sound program evaluation also requires the use of measurement standards that are clear and valid. If the standards are clear, then states would know generally what methods and sources of data are or are not acceptable. Having a clearly stated policy would also help ensure a transparent, equitable review process, with less potential for arbitrary approvals or disapprovals. In addition, clear guidance could protect the validity of the resulting measures, if valid results are possible.

August 17 SCHIP Letter:
95% Enrollment Target for Low-Income Children

Chairman Rockefeller, Ranking Member Hatch, and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Health Care Financing with the Congressional Research Service (CRS). Thank you for the opportunity to testify.

The letter being discussed today, issued by the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007, outlined six requirements for states seeking to enroll children with "effective" family income above 250% of poverty.[1] Four of those require states to make substantive changes to their SCHIP programs or to comply with new, ongoing administrative mandates. The other two requirements are for states to assure they met certain program-impact measurements — (1) the 95% test, "that the State has enrolled at least 95 percent of the children in the State below 200 percent of the FPL[2] who are eligible for either SCHIP or Medicaid," and (2) "that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period." My testimony today focuses exclusively on the 95% test.

My written statement begins with background information on federal sources of data for estimates of those with and without health insurance. This is followed by a description of how such data are used to estimate public program eligibility. Then there is an analysis and illustration of how states might attempt to use available federal data to meet the 95% test. The written statement concludes with an analysis of the implications of the various possible approaches.

Background: Federal Data Sources on the Uninsured

Public and private entities that provide health insurance or pay for health care on behalf of individuals have administrative data for the individuals they cover. For example, the Centers for Medicare and Medicaid Services (CMS) has administrative records on individuals covered in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Because administrative data are based on premiums and/or claims paid, analysts tend to have a relatively high level of confidence in the enrollment counts from administrative data.

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[1]Letter to State Health Officials from Dennis G. Smith, Director of the Center for Medicaid and State Operations of CMS, SHO #07-001, August 17, 2007, available at [http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf].

[2]Federal Poverty Level. The 2008 FPL for a family of three in the lower 48 states is $17,600. Thus, for a single parent with two children, 200% of poverty is roughly $35,000 in annual income. For more information, see http://aspe.hhs.gov/poverty.

However, because uninsurance means the lack of any coverage, there is no administrative data on the uninsured. Thus, estimates of the uninsured generally rely upon surveys of the population. Survey data face challenges different from administrative data. For example, in surveys, individual respondents are asked about a variety of health coverage options and which people in the household were covered by these options, which can lead to response error. The federal government has four surveys with published nationally representative estimates of the uninsured:

- the U.S. Census Bureau's Current Population Survey (CPS);
- the Census Bureau's Survey of Income and Program Participation (SIPP);
- the Medical Expenditure Panel Survey (MEPS) administered by the U.S. Department of Health and Human Services (HHS); and
- HHS's National Health Interview Survey (NHIS).

Each data source differs in how it collects information from individuals, as well as the amount of information it collects related to health insurance status. As a result, the estimates of the number of uninsured produced by these data sources vary widely.[3] Of these four, only the CPS provides state-level estimates for all 50 states of children's health insurance status and family income. Indeed, the Census Bureau annually publishes the insurance status of low-income children (i.e., those below 200% of poverty), which is used in determining states' annual federal SCHIP allotments. These results for 2006, the latest year available, are shown in **Table 1**.

Although the CPS has the largest sample size of the four surveys, when examining a subset of the sample such as children under the age of 19 with family income below 200% of poverty (i.e., "low income"), the sample sizes for certain states can become quite small. In that case, it is particularly prudent to consider state-level estimates in terms of a range of values. While column D of **Table 1** shows the best point estimates, or single values, for the percentage of children covered by health insurance, column E shows the margins of error.[4] The resulting confidence interval produces the lower and upper bounds in columns F and G. The larger the confidence interval in relation to the size of the estimate, the less reliable the estimate. The size of the range depends primarily on the sample size. Column H shows the number of CPS-sampled children in the survey who were considered low income.

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[3]See, for example, CRS Report RL31275, "Health Insurance: Federal Data Sources for Analyses of the Uninsured."

[4]These calculations are based on a 95% confidence interval, a standard statistical threshold. A 95% confidence interval means that if repeated samples were collected under essentially the same conditions and their confidence intervals calculated, in the long run about 95% of those intervals would contain the true number of children with (or without) health insurance.

Although these point estimates indicate that no state covers 95% of low-income children, several states could claim that 95% is reached if they factor in the survey's margin of error. Even so, there are fundamental concerns with the CPS's insurance estimates, beyond the typical margins of error. For example, the CPS is known to undercount Medicaid and SCHIP enrollment by several million individuals.

Table 1. Health Insurance Coverage Among Low-Income Children, by State, CPS Estimates for 2006

State	Total (denominator)	Total insured (numerator)	Insured percentage	Margin of error	Lower bound	Upper bound	Sample size
A	B	C	D = C / B	E	F = D - E	G = D + E	H
U.S.	30,186,000	24,512,000	**81.2%**	1.0%	80.2%	**82.2%**	24,119
Alabama	446,000	382,000	**85.7%**	7.7%	78.0%	**93.3%**	246
Alaska	60,000	51,000	**85.7%**	8.7%	77.1%	**94.4%**	317
Arizona	825,000	612,000	**74.2%**	7.6%	66.6%	**81.8%**	475
Arkansas	400,000	342,000	**85.5%**	6.5%	78.9%	**92.0%**	395
California	4,164,000	3,347,000	**80.4%**	3.1%	77.3%	**83.5%**	2,640
Colorado	427,000	307,000	**72.0%**	10.7%	61.3%	**82.7%**	506
Connecticut	216,000	196,000	**90.8%**	8.3%	82.5%	**99.1%**	358
Delaware	71,000	59,000	**82.7%**	9.5%	73.2%	**92.2%**	319
DC	61,000	55,000	**89.8%**	7.4%	82.4%	**97.2%**	277
Florida	1,688,000	1,188,000	**70.4%**	5.3%	65.1%	**75.7%**	889
Georgia	1,030,000	797,000	**77.4%**	6.1%	71.3%	**83.5%**	576
Hawaii	92,000	81,000	**88.5%**	8.1%	80.4%	**96.5%**	288
Idaho	182,000	152,000	**83.4%**	7.5%	75.9%	**90.8%**	394
Illinois	1,135,000	936,000	**82.5%**	5.4%	77.1%	**87.9%**	669
Indiana	553,000	498,000	**89.9%**	6.0%	83.9%	**95.9%**	328
Iowa	274,000	253,000	**92.6%**	6.3%	86.3%	**98.9%**	464
Kansas	282,000	249,000	**88.2%**	7.4%	80.8%	**95.6%**	328
Kentucky	481,000	417,000	**86.9%**	7.1%	79.7%	**94.0%**	393
Louisiana	503,000	380,000	**75.6%**	8.8%	66.8%	**84.5%**	247
Maine	102,000	92,000	**90.5%**	8.2%	82.3%	**98.7%**	348
Maryland	359,000	281,000	**78.4%**	10.4%	68.0%	**88.8%**	335
Massachusetts	448,000	382,000	**85.1%**	7.8%	77.3%	**92.9%**	279
Michigan	945,000	863,000	**91.3%**	4.3%	87.0%	**95.6%**	610
Minnesota	373,000	307,000	**82.3%**	9.2%	73.1%	**91.5%**	418
Mississippi	438,000	316,000	**72.1%**	8.1%	63.9%	**80.2%**	330
Missouri	592,000	506,000	**85.5%**	6.9%	78.6%	**92.4%**	408
Montana	88,000	66,000	**75.3%**	10.2%	65.1%	**85.5%**	246
Nebraska	159,000	127,000	**80.2%**	9.7%	70.5%	**89.8%**	311
Nevada	267,000	196,000	**73.4%**	10.0%	63.4%	**83.4%**	400
New Hampshire	66,000	57,000	**85.3%**	11.4%	73.8%	**96.7%**	248
New Jersey	594,000	444,000	**74.7%**	8.5%	66.2%	**83.2%**	358
New Mexico	231,000	174,000	**75.1%**	9.8%	65.4%	**84.9%**	314
New York	1,880,000	1,658,000	**88.2%**	3.6%	84.6%	**91.8%**	1,024
North Carolina	1,035,000	848,000	**81.9%**	5.7%	76.3%	**87.6%**	532
North Dakota	55,000	45,000	**81.4%**	9.5%	71.9%	**90.9%**	269
Ohio	1,109,000	1,013,000	**91.4%**	4.0%	87.4%	**95.3%**	682
Oklahoma	469,000	382,000	**81.4%**	7.7%	73.7%	**89.1%**	417

State	Total (denominator)	Total insured (numerator)	Insured percentage	Margin of error	Lower bound	Upper bound	Sample size
A	B	C	D = C / B	E	F = D - E	G = D + E	H
Oregon	347,000	268,000	**77.1%**	10.2%	66.9%	**87.3%**	342
Pennsylvania	1,059,000	931,000	**87.9%**	4.7%	83.2%	**92.6%**	605
Rhode Island	83,000	77,000	**93.8%**	6.5%	87.3%	**100.4%**	332
South Carolina	475,000	422,000	**88.9%**	6.7%	82.2%	**95.6%**	330
South Dakota	77,000	66,000	**85.1%**	7.5%	77.6%	**92.7%**	385
Tennessee	662,000	613,000	**92.5%**	4.8%	87.7%	**97.3%**	348
Texas	3,247,000	2,231,000	**68.7%**	4.1%	64.6%	**72.9%**	1,822
Utah	325,000	252,000	**77.5%**	7.7%	69.9%	**85.2%**	430
Vermont	36,000	32,000	**90.0%**	9.6%	80.5%	**99.6%**	202
Virginia	611,000	487,000	**79.7%**	7.6%	72.1%	**87.4%**	410
Washington	484,000	443,000	**91.6%**	6.1%	85.5%	**97.7%**	320
West Virginia	192,000	176,000	**91.7%**	5.6%	86.1%	**97.3%**	314
Wisconsin	449,000	417,000	**92.9%**	5.7%	87.2%	**98.6%**	397
Wyoming	42,000	39,000	**91.5%**	7.5%	84.0%	**99.0%**	244

Source: CRS analysis of "Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2006," U.S. Census Bureau, available at [http://pubdb3.census.gov/macro/032007/health/h10_000.htm] and of March 2007 Current Population Survey (CPS).
Note: Shaded states are those determined by CMS to be subject to the August 17 letter, per letter to Mr. Barton, January 22, 2008.

Although the CPS provides the most widely cited estimates of uninsurance, it is not primarily a health, health insurance or health care survey. Its primary purpose is to provide employment and income data. The CPS health insurance questions appear at the end of an annual survey supplement. Although the questions are intended to obtain estimates of the number of people uninsured for the *entire* year, most analysts treat the estimates as the number uninsured at a specific point in time during the year. This is because the CPS estimates are substantially higher than the other surveys' full-year uninsured estimates and are more in line with the other surveys' point-in-time estimates, as the Census Bureau has pointed out.[5] Although some have compared these issues to "making sure we know how many deck chairs we have on the Titanic,"[6] they are particularly relevant in the current context, when federal funding or states' ability to expand eligibility are tied to such estimates.

In terms of the SCHIP allotments, use of the CPS has been considered a boon for some states. For example, compared to results in Delaware's own state-sponsored

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[5]On p. 18 of U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, it says, "Compared with other national surveys, the CPS ASEC's estimate of the number of people without health insurance more closely approximates the number of people who were uninsured at a specific point in time during the year than the number of people uninsured for the entire year."

[6]Uwe Reinhardt quoted by Ricardo Alonso-Zaldivar, "Number of Uninsured May Be Overstated, Studies Suggest," *Los Angeles Times*, April 26 2005, p. A-14.

survey, the CPS reported many more low-income children, providing the state with large SCHIP allotments compared to what it was able to spend. As a result, Delaware was projected to have more than three times the federal SCHIP funds necessary to cover its projected spending in FY2007.[7] On the other hand, when the Iowa SCHIP director was asked why the state was projected to exhaust all of its federal SCHIP funds in FY2007, the response began with the following: "The SCHIP funding formula is flawed in that it allocates funds to states based on inaccurate data."[8] The sense of SCHIP directors is that "(s)tates do not consider the CPS to provide an accurate estimate of the number of low-income children or of the number of uninsured low-income children."[9] In addition, Georgia Gov. Sonny Perdue, in testimony last year to this Committee, noted that while the three-year average of CPS data in the SCHIP allotment formula reduces annual variations, it also suppresses estimates of population growth that could lead to higher SCHIP allotments for growing states like his.[10]

In the two bills vetoed by the President that would have reauthorized SCHIP,[11] the CPS was not used for determining SCHIP allotments. There was one test included in the legislation that called for using Census data. Under the legislation, for states continuing SCHIP coverage of parents in FY2010-FY2012, a matching rate above the regular Medicaid matching rate could be possible if a state was able to meet one of three criteria. One of those criteria was that the state had to be a "high-performing state" — that is, "on the basis of the most timely and accurate published estimates of the Bureau of the Census, [the state] ranks in the lowest 1/3 of States in terms of the State's percentage of low-income children without health insurance."[12]

The legislation did not specify the CPS as the source of data for determining a "high-performing state." Instead, it called for the Census Bureau's "most timely and accurate published estimates." This is because, later this year, another Census survey will be providing estimates of uninsurance on a state-by-state basis. The American Community Survey (ACS) has a much larger sample size but does not ask as detailed questions as the CPS. Thus, the legislation left it for the Secretary of HHS, based on the recommendation of the Secretary of Commerce (who oversees the Census Bureau), to

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[7]CRS Congressional Distribution memorandum CD061057, "Status of Federal SCHIP financing among nine states reporting identical lower-and upper-income SCHIP eligibility levels," September 12, 2006, p. 4.

[8]Id., p. 9.

[9]"Perspectives on Reauthorization: SCHIP Directors Weigh In," David Bergman, National Academy for State Health Policy (NASHP), June 2005, p. 5.

[10]Georgia Gov. Sonny Perdue, testimony before the Senate Finance Committee, on behalf of the Southern Governors' Association, February 1, 2007.

[11]H.R. 976 and H.R. 3963, Children's Health Insurance Program Reauthorization Act of 2007, or CHIPRA.

[12]§112 of CHIPRA

decide whether to use the CPS or ACS (or an amalgamation of both) for this purpose.[13] The new health insurance estimates from the ACS will be available this fall, at the same time the CPS health insurance estimates are released. It is also worth noting that the legislation did not put in an absolute percentage for this coverage test, since different surveys can produce different amounts. Instead, the legislation used a test of relative values — that is, comparing a state's result to all the other states, that it ranked in the lowest one-third, regardless of the actual percentage.

Background: Estimates of Children's Eligibility for Medicaid and SCHIP

States have substantial flexibility to determine income eligibility for children in Medicaid and SCHIP. At a minimum, poor children (that is, those below poverty) are eligible in every state for Medicaid, unless they are non-qualified aliens or fail to meet some other eligibility test a state might have. SCHIP exists in every state to cover uninsured low-income children (that is, those below twice the federal poverty level) whose family's income is above the Medicaid thresholds. States' upper-income SCHIP eligibility levels range from 140% of poverty in North Dakota to 350% in New Jersey.

States are permitted to define family income in Medicaid and SCHIP. Nearly every state uses this flexibility to disregard certain amounts and types of income (and in some cases, under Medicaid, the state is legally required to use certain disregards). Although SCHIP statute limits upper-income eligibility to the greater of (1) 200% of poverty, and (2) 50 percentage points above the state's pre-SCHIP Medicaid level, some states have effectively bypassed these limits by disregarding an entire block of percent-of-poverty income. For example, New Jersey's SCHIP program covers children with net family income up to 200% of poverty. But the state excludes all family income between 200% and 350% of poverty. As a result, children with gross family income up to 350% of poverty may be eligible for the state's SCHIP program. With this flexibility, states could effectively expand eligibility to all children of whatever income level they choose.[14]

Although the CPS data provides estimates of the number of children below 200% of poverty, that is not the same as providing estimates of those children who are *eligible* for Medicaid or SCHIP coverage, even in states with upper-income limits of 200% of

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[13]§602 of CHIPRA

[14]See 66 *Federal Register* 2320, January 11, 2001, and 42 CFR 457.10. For additional information on income disregards, see the following CRS Congressional Distribution memoranda, available upon request: *Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees*, by Chris L. Peterson; and *Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income*, by April Grady.

poverty. Two reasons primarily accounts for this discrepancy: (1) the CPS does not provide information on all the reasons why individuals might be ineligible (e.g., for immigration/documentation status), and (2) 200% of poverty, or any particular eligibility level set by the state, is calculated very differently in the CPS than in states.

On the latter point, when looking at family income, the definitions of both "family" and "income" are key. Medicaid and SCHIP programs generally determine family income based on the adult, spouse, and dependent children in the family, while the CPS combines the income of *all* individuals in a household who are related by blood or marriage. In addition, the CPS counts as income items that some or no states include in determining eligibility for Medicaid, SCHIP or other programs. This is not surprising, because the CPS's income data are not intended to indicate eligibility for public programs but to report family's income from all sources. For example, the CPS includes as income educational grants and means-tested benefits such as Temporary Assistance to Needy Family (TANF), items generally not counted as income for public-program eligibility purposes. (Indeed, these items, as well as others, are also excluded from the definition of gross income in the Internal Revenue Code (§§101-139).) Besides these exclusions, almost every state has disregards of certain monthly amounts (usually $90) of earnings, for example.

As a result, to estimate eligibility for Medicaid and SCHIP, researchers must create models that make additional adjustments that account for the differences between the survey data and states' eligibility criteria and administrative enrollment counts. The methods and data used affect the results. This was evident when HHS published findings last year, using a model from the Urban Institute, that there were only 1.1 million uninsured children who were eligible for public coverage.[15] Previous published estimates were that as many as 6.0 million children were eligible but uninsured.[16] However, these results were different, and arguably not even comparable, because of (1) assumptions about the length of uninsurance measured by the CPS, (2) adjustments for the Medicaid undercount, and (3) adjustments, if any, for immigrant/documentation status.[17]

Generally speaking, estimates of program-participation rates often depend heavily on the assumptions used to model who is eligible. Such estimates may be useful to give policymakers a sense of program effectiveness. However, most researchers would be

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[15]Kenneth Finegold and Linda Giannarelli, "TRIM3 Simulations of Full-Year Uninsured Children and their Eligibility for Medicaid and SCHIP," June 14, 2007.

[16]Lisa Dubay et al., "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* Web exclusive, November 30, 2006.

[17]For additional discussion, see CRS Congressional Distribution memorandum, "Description of the varying estimates of uninsured children who were eligible for public coverage," June 21, 2007, available upon request.

extremely uncomfortable using their models of public-program eligibility as the basis for allocating funds or as a determining or limiting factor for program expansions.

Analysis of the August 17 Letter's 95% Test

Although CMS may not be able to directly restrict states' income-counting methods for Medicaid and SCHIP, the August 17 letter has already had the effect of limiting some states' SCHIP expansions to higher-income children. CMS has also determined that the states having to meet the letter's criteria because they currently are "states with eligibility above 250 percent FPL when income disregards are included are California, Connecticut, the District of Columbia, Georgia, Hawaii, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, Pennsylvania, Rhode Island, Tennessee, Vermont, and Washington."[18] This section illustrates how states might attempt to satisfy the 95% test and discusses issues resulting from the lack of guidance from CMS regarding what the standards for this measure are.

As previously discussed, the sole federal data source currently providing estimates of the uninsured for all 50 states is the U.S. Census Bureau's Current Population Survey (CPS), the source of data for the most commonly cited estimates of the uninsured (47 million in 2006). The Census Bureau annually publishes a table of health insurance coverage among low-income children by state, summarized in **Table 1**, with the rows shaded for the 17 states (including the District of Columbia) having to come into compliance with the letter. According to these results, no state reaches 95%.

Rhode Island had the highest rate of coverage among low-income children, 93.8%. Considering the margin of error (at the 95% confidence interval), the percentage could be as low as 87% or as high as 100%, although the latter result strains credulity. Rhode Island's SCHIP upper-income eligibility level is set at 250% of poverty. However, because of other disregards,[19] some enrollees have gross incomes above 250% of poverty. Of the roughly 11,000 SCHIP-enrolled children in Rhode Island in December 2007, 138 children (in 93 households) had gross income above 250% of poverty, most of whom were between 250% and 255% of poverty, and none with gross income above 280% of poverty.[20] Because of these disregards, Rhode Island is listed as

[18]Letter to Rep. Joe Barton, Ranking Member of the House Energy and Commerce Committee, from Dennis G. Smith, Director of CMS's Center for Medicaid and State Operations, January 22, 2008.

[19]Rhode Island's SCHIP program uses common disregards of up to $90 per month earned income per employee, up to $200 a month for child care per child, and up to $50 per month of child support. For a single parent with two children, the maximum disregards (e.g., if the parent spent $400 a month on the two children's child care, or $4,800 per year) would equal 6% of poverty for earned income, 28% of poverty for child care, and 3% of poverty for child support.

[20]Conversation with John Andrews, information systems consultant for the state of Rhode Island, April 2, 2008.

being subject to the August 17 letter. Besides Rhode Island, seven other states listed as being subject to the letter have confidence intervals that exceed 95%. It is unclear whether CMS would sign off on these states meeting the 95% test on this basis.

If a state wanted to increase its percentage further, there are two ways to do so: lower the denominator (in this case, the base population of eligible low-income children) or raise the numerator (that is, the estimated number of eligible low-income children with coverage). CMS has correctly observed that the numbers in **Table 1** reflect two issues that suppress the percentages: (1) the base number of low-income children is too high because it includes ineligible non-qualified aliens, including unauthorized (illegal) aliens, as well as qualifying aliens who have not resided in the country for the five years necessary for full-benefit eligibility; and (2) the numerator is too low because the CPS "undercounts" enrollment in Medicaid and SCHIP.[21] **Tables 2 and 3** show a CRS illustration of how available data could be used to account for these two factors. The results also reflect adjustments to remove from the analysis those covered by private health insurance. Although CMS has not clarified whether it has a preference in this regard for the 95% test, children with private health insurance are ineligible for SCHIP (though still potentially eligible for Medicaid). Regardless of whether the adjusted rates include or exclude those with private health insurance, all affected states would attain rates exceeding 100% in the illustration.

The first adjustment was operationalized for the illustration by excluding non-citizen children who have been in the country for less than five years.[22] Second, the CPS estimates for the number of low-income children with public coverage (Medicaid, SCHIP or Medicare) were replaced with the number of low-income children ever enrolled during FY2006 in Medicaid and SCHIP as reported to CMS by the states. The administrative counts were reduced to account for children who had private coverage as well as Medicaid or SCHIP during the year.[23] The result of these adjustments, as shown in **Table 2**, is that all affected states meet the 95% test, with rates exceeding 100%. The impact of the specific adjustments is shown in the detailed table, **Table 3**, at the end of the written statement.

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[21]Letter to Mr. Barton from Dennis Smith, CMS.

[22]This estimate does not account for non-qualified alien children who have been in the country for more than five years, and thus is still too low of an adjustment. On the other hand, the administrative counts likely include unqualified aliens who received Medicaid emergency services.

[23]This was done by calculating in the CPS the state-level percentages of Medicaid/SCHIP-enrolled low-income children (excluding non-citizens with less than five years of U.S. residency) who also had private coverage.

Table 2. Illustrative Example of Health Coverage among Low-Income Children, Adjusted for Non-citizens' Length of U.S. Residency, Private Coverage, and States' Reported Medicaid/SCHIP Enrollment, 2006

State	Total	Adjusted denominator: Total excluding non-citizens in U.S. < 5 years and private insurance	Adjusted numerator: With Medicaid/ SCHIP, without private insurance	Adjusted/ Illustrative percentage
A	B	C	D	E = D / C
U.S.	30,186,000	19,372,000	31,555,000	163%
Alabama	446,000	311,000	563,000	181%
Alaska	60,000	37,000	86,000	232%
Arizona	825,000	564,000	715,000	127%
Arkansas	400,000	281,000	498,000	177%
California	4,164,000	2,841,000	4,797,000	169%
Colorado	427,000	254,000	381,000	150%
Connecticut	216,000	134,000	209,000	156%
Delaware	71,000	39,000	88,000	227%
DC	61,000	44,000	105,000	237%
Florida	1,688,000	1,056,000	1,740,000	165%
Georgia	1,030,000	724,000	1,283,000	177%
Hawaii	92,000	49,000	95,000	194%
Idaho	182,000	106,000	132,000	125%
Illinois	1,135,000	734,000	1,552,000	212%
Indiana	553,000	324,000	650,000	200%
Iowa	274,000	150,000	217,000	144%
Kansas	282,000	187,000	208,000	111%
Kentucky	481,000	311,000	415,000	134%
Louisiana	503,000	387,000	713,000	184%
Maine	102,000	66,000	146,000	220%
Maryland	359,000	219,000	416,000	190%
Massachusetts	448,000	259,000	616,000	237%
Michigan	945,000	530,000	877,000	165%
Minnesota	373,000	208,000	326,000	157%
Mississippi	438,000	305,000	457,000	150%
Missouri	592,000	323,000	490,000	152%
Montana	88,000	61,000	60,000	99%
Nebraska	159,000	91,000	170,000	186%
Nevada	267,000	137,000	155,000	113%
New Hampshire	66,000	32,000	59,000	187%
New Jersey	594,000	354,000	564,000	159%
New Mexico	231,000	169,000	277,000	164%
New York	1,880,000	1,133,000	2,278,000	201%
North Carolina	1,035,000	692,000	1,017,000	147%
North Dakota	55,000	32,000	35,000	112%
Ohio	1,109,000	673,000	1,042,000	155%
Oklahoma	469,000	324,000	440,000	136%
Oregon	347,000	220,000	294,000	134%
Pennsylvania	1,059,000	653,000	1,090,000	167%
Rhode Island	83,000	47,000	86,000	185%

State	Total	Adjusted denominator: Total excluding non-citizens in U.S. < 5 years and private insurance	Adjusted numerator: With Medicaid/ SCHIP, without private insurance	Adjusted/ Illustrative percentage
A	B	C	D	E = D / C
South Carolina	475,000	**270,000**	**440,000**	**163%**
South Dakota	77,000	**49,000**	**44,000**	**90%**
Tennessee	662,000	**385,000**	**610,000**	**159%**
Texas	3,247,000	**2,376,000**	**3,143,000**	**132%**
Utah	325,000	**171,000**	**197,000**	**115%**
Vermont	36,000	**24,000**	**51,000**	**210%**
Virginia	611,000	**367,000**	**478,000**	**130%**
Washington	484,000	**278,000**	**570,000**	**205%**
West Virginia	192,000	**130,000**	**240,000**	**185%**
Wisconsin	449,000	**240,000**	**437,000**	**182%**
Wyoming	42,000	**23,000**	**53,000**	**235%**

Source: CRS analysis of March 2007 Current Population Survey and of enrollment reports provided by CMS ("Income Report Annual Medicaid 040507.xls," May 10, 2007, and "Income Report Annual 030807.xls," March 8, 2007) from state-reported information in the SCHIP Statistical Enrollment Data System (SEDS).
Notes: Shaded states are those determined by CMS to be subject to the August 17 letter, per letter to Mr. Barton, January 22, 2008. Details of adjustments shown in Table 3.

Of course, enrollment rates exceeding 100% lack face validity. It does not make sense that out of roughly 19 million potentially eligible low-income children there would be nearly 32 million covered by Medicaid or SCHIP. This occurs because, as previously mentioned, the CPS counts as income items that some or no states include in determining eligibility for Medicaid, SCHIP or other programs. As a result, average incomes as reported in the CPS tend to be higher relative to Medicaid/SCHIP eligibility, reducing the number of children considered to be low income in the denominator.

One question not clarified in correspondence from CMS is whether enrollment rates above 100% like those in **Table 2** would be permitted. As proof that states could meet the 95% test, CMS provided in 2007 state-level estimates of enrollment rates for low-income children that exceeded 100% in some cases, perhaps suggesting methods producing such results might be permissible.[24] If not, then starting from enrollment rates exceeding 100%, states could relatively easily make additional adjustments to the data to account for income-counting differences in order to obtain rates between 95% and 100% on paper.

It is possible to raise additional concerns with such calculations. Some of these concerns emanate from mixing survey estimates, used for the population totals, with

[24]For a description and discussion of those CMS estimates, see Genevieve M. Kenney, "Medicaid and SCHIP Participation Rates: Implications for New CMS Directive," Urban Institute's *Health Policy Online*, no. 16, September 2007, at [http://www.urban.org/UploadedPDF/411543_medicaid_schip.pdf].

administrative counts, used for the enrollment totals. For example, the administrative counts used in this illustration include "children who were enrolled in Medicaid and SCHIP for as little as one day over the course of a year." In addition, the survey results and the administrative totals "are inconsistent with one another in terms of time frame (ever enrolled over the course of a year vs. low-income at a point in time)."[25]

Even if it is possible for states to attain such rates with data adjustments, some have expressed concerns that doing so could work against other policy goals or initiatives. For example, if a state is uncertain whether its actual enrollment rate exceeds 95%, giving CMS enrollment rates in excess of that percentage may reduce the willingness of state or federal policymakers to provide additional funding for reaching eligible but uninsured children. States officials have also lamented the resource costs necessary to produce these adjusted estimates, particularly if their validity is questionable and the sole purpose is to provide the appearance of meeting the test. Moreover, it draws resources away from state SCHIP programs' core functions.[26]

It should be noted that, while the CPS may be the only available federal data source of analyses of all 50 states, some states have their own survey data. "Although reliable alternatives to the CPS data exist for many states, this is not the case for all states."[27] Indeed, rather than craft their own survey from scratch, many states opted to pay the Census Bureau to boost their states' sample size in the CPS. Thus, permitting the use of a state's own survey may raise additional questions about an equitable way for states to obtain valid measures for the 95% test. Moreover, such surveys may produce 95% results due to survey differences rather than because the state actually is enrolling that percentage of eligible low-income children.

Conclusion

For meeting the 95% test, CMS correctly noted that, with data adjustments for individuals' immigration/documentation status and the Medicaid/SCHIP undercount, "a number of states are likely to meet the 95 percent threshold." This testimony included an illustration by CRS that makes adjustments for these two factors and produces percentages that exceed 100% for nearly every state, a result that lacks face validity, although it is not clear whether CMS would accept or reject such a result. Additional and arguably justifiable adjustments could be made until every state has a rate between 95% and 100%.

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[25]Id.

[26]CRS conversations with state SCHIP directors.

[27]Bergman, NASHP, p. 6.

The policy goal — in this case, ensuring adequate coverage of eligible low-income children before permitting coverage of higher-income children — may be considered desirable. However, sound program evaluation also requires the use of measurement standards that are clear and valid. If the standards are clear, then states would know generally what methods and sources of data are or are not acceptable. Such standards have not yet been made clear by CMS. Having a clearly stated policy would also help ensure a transparent, equitable review process, with less potential for arbitrary approvals or disapprovals. In addition, clear guidance could protect the validity of the resulting measures, if valid results are possible.

I hope my comments have been helpful. Thank you.

Table 3. Details of Table 2, Health Insurance Coverage among Low-Income Children, by State, Adjusted for Non-citizens' Length of U.S. Residency, Private Coverage, and States' Reported Medicaid/SCHIP Enrollment, 2006

State	Total	Reduction for non-citizens in U.S. less than 5 years	Additional reduction for privately insured	**Denominator: Total excluding non-citizens in U.S. < 5 years and private insurance**	Medicaid enrollees under 200% FPL	SCHIP enrollees under 200% FPL	Total Medicaid/ SCHIP under 200% FPL	Reduction for private insurance	**Numerator: With Medicaid/ SCHIP**	**Percentage with Medicaid/ SCHIP**
A	B	C	D	**E = B x (1-C) x (1-D)**	F	G	H = F + G	I	**J = H x (1-I)**	**L = K / F**
U.S.	30,186,000	2.6%	34.1%	**19,372,000**	29,531,000	6,148,000	35,679,000	11.6%	**31,555,000**	**163%**
Alabama	446,000	0.3%	30.0%	**311,000**	488,000	84,000	572,000	1.5%	**563,000**	**181%**
Alaska	60,000	0.0%	37.8%	**37,000**	88,000	22,000	111,000	22.3%	**86,000**	**232%**
Arizona	825,000	5.1%	28.0%	**564,000**	670,000	97,000	767,000	6.7%	**715,000**	**127%**
Arkansas	400,000	0.3%	29.6%	**281,000**	471,000	90,000	561,000	11.3%	**498,000**	**177%**
California	4,164,000	4.2%	28.7%	**2,841,000**	4,231,000	1,061,000	5,292,000	9.3%	**4,797,000**	**169%**
Colorado	427,000	3.5%	38.5%	**254,000**	359,000	70,000	429,000	11.1%	**381,000**	**150%**
Connecticut	216,000	1.3%	37.1%	**134,000**	234,000	3,000	237,000	11.8%	**209,000**	**156%**
Delaware	71,000	3.5%	43.4%	**39,000**	85,000	11,000	96,000	8.9%	**88,000**	**227%**
DC	61,000	1.0%	26.7%	**44,000**	122,000	6,000	128,000	17.9%	**105,000**	**237%**
Florida	1,688,000	3.4%	35.2%	**1,056,000**	1,668,000	304,000	1,971,000	11.7%	**1,740,000**	**165%**
Georgia	1,030,000	1.8%	28.5%	**724,000**	1,144,000	317,000	1,461,000	12.2%	**1,283,000**	**177%**
Hawaii	92,000	3.0%	45.1%	**49,000**	95,000	22,000	117,000	18.8%	**95,000**	**194%**
Idaho	182,000	0.9%	41.3%	**106,000**	136,000	25,000	160,000	17.5%	**132,000**	**125%**
Illinois	1,135,000	1.2%	34.5%	**734,000**	1,367,000	317,000	1,683,000	7.8%	**1,552,000**	**212%**
Indiana	553,000	0.8%	40.9%	**324,000**	575,000	134,000	709,000	8.3%	**650,000**	**200%**
Iowa	274,000	0.8%	44.7%	**150,000**	220,000	50,000	269,000	19.5%	**217,000**	**144%**
Kansas	282,000	0.5%	33.3%	**187,000**	197,000	49,000	246,000	15.1%	**208,000**	**111%**
Kentucky	481,000	0.9%	34.8%	**311,000**	405,000	65,000	470,000	11.7%	**415,000**	**134%**
Louisiana	503,000	0.6%	22.5%	**387,000**	650,000	142,000	793,000	10.0%	**713,000**	**184%**
Maine	102,000	0.3%	34.4%	**66,000**	137,000	31,000	169,000	13.3%	**146,000**	**220%**
Maryland	359,000	5.4%	35.3%	**219,000**	355,000	119,000	475,000	12.3%	**416,000**	**190%**
Massachusetts	448,000	0.2%	42.1%	**259,000**	520,000	191,000	711,000	13.4%	**616,000**	**237%**
Michigan	945,000	0.9%	43.4%	**530,000**	951,000	119,000	1,070,000	18.1%	**877,000**	**165%**
Minnesota	373,000	7.5%	39.6%	**208,000**	370,000	5,000	375,000	13.0%	**326,000**	**157%**
Mississippi	438,000	0.7%	30.0%	**305,000**	426,000	83,000	510,000	10.4%	**457,000**	**150%**
Missouri	592,000	0.5%	45.2%	**323,000**	550,000	90,000	640,000	23.5%	**490,000**	**152%**
Montana	88,000	0.0%	30.6%	**61,000**	53,000	17,000	70,000	14.3%	**60,000**	**99%**
Nebraska	159,000	1.4%	41.8%	**91,000**	155,000	45,000	200,000	15.3%	**170,000**	**186%**
Nevada	267,000	0.9%	48.3%	**137,000**	147,000	36,000	183,000	15.4%	**155,000**	**113%**

State	Total	Reduction for non-citizens in U.S. less than 5 years	Additional reduction for privately insured	**Denominator: Total excluding non-citizens in U.S. < 5 years and private insurance**	Medicaid enrollees under 200% FPL	SCHIP enrollees under 200% FPL	Total Medicaid/ SCHIP under 200% FPL	Reduction for private insurance	**Numerator: With Medicaid/ SCHIP**	**Percentage with Medicaid/ SCHIP**
A	B	C	D	**E = B x (1-C) x (1-D)**	F	G	H = F + G	I	**J = H x (1-I)**	**L = K / F**
New Hampshire	66,000	0.8%	52.0%	**32,000**	80,000	2,000	82,000	28.0%	**59,000**	**187%**
New Jersey	594,000	8.3%	35.1%	**354,000**	502,000	108,000	610,000	7.6%	**564,000**	**159%**
New Mexico	231,000	4.7%	23.3%	**169,000**	320,000	7,000	327,000	15.5%	**277,000**	**164%**
New York	1,880,000	3.4%	37.6%	**1,133,000**	2,027,000	604,000	2,631,000	13.4%	**2,278,000**	**201%**
North Carolina	1,035,000	2.7%	31.3%	**692,000**	898,000	248,000	1,146,000	11.3%	**1,017,000**	**147%**
North Dakota	55,000	1.2%	41.6%	**32,000**	36,000	6,000	42,000	16.1%	**35,000**	**112%**
Ohio	1,109,000	0.5%	39.0%	**673,000**	1,015,000	219,000	1,234,000	15.5%	**1,042,000**	**155%**
Oklahoma	469,000	0.5%	30.5%	**324,000**	369,000	116,000	485,000	9.4%	**440,000**	**136%**
Oregon	347,000	1.2%	35.8%	**220,000**	278,000	59,000	337,000	12.7%	**294,000**	**134%**
Pennsylvania	1,059,000	0.4%	38.1%	**653,000**	1,014,000	189,000	1,203,000	9.4%	**1,090,000**	**167%**
Rhode Island	83,000	2.3%	42.0%	**47,000**	86,000	22,000	108,000	20.1%	**86,000**	**185%**
South Carolina	475,000	0.9%	42.6%	**270,000**	500,000	69,000	569,000	22.5%	**440,000**	**163%**
South Dakota	77,000	0.5%	36.4%	**49,000**	40,000	15,000	54,000	19.2%	**44,000**	**90%**
Tennessee	662,000	2.1%	40.6%	**385,000**	692,000	0	692,000	11.8%	**610,000**	**159%**
Texas	3,247,000	3.4%	24.2%	**2,376,000**	2,749,000	585,000	3,334,000	5.8%	**3,143,000**	**132%**
Utah	325,000	1.7%	46.6%	**171,000**	176,000	52,000	228,000	13.6%	**197,000**	**115%**
Vermont	36,000	1.0%	31.8%	**24,000**	63,000	0	63,000	19.5%	**51,000**	**210%**
Virginia	611,000	2.8%	38.1%	**367,000**	416,000	138,000	554,000	13.7%	**478,000**	**130%**
Washington	484,000	5.8%	39.0%	**278,000**	659,000	1,000	659,000	13.5%	**570,000**	**205%**
West Virginia	192,000	0.0%	32.4%	**130,000**	236,000	40,000	276,000	12.8%	**240,000**	**185%**
Wisconsin	449,000	5.8%	43.2%	**240,000**	453,000	57,000	510,000	14.2%	**437,000**	**182%**
Wyoming	42,000	2.1%	45.3%	**23,000**	52,000	8,000	60,000	11.7%	**53,000**	**235%**

Source: CRS analysis of March 2007 Current Population Survey and of enrollment reports provided by CMS ("Income Report Annual Medicaid 040507.xls," May 10, 2007, and "Income Report Annual 030807.xls," March 8, 2007) from state-reported information in the SCHIP Statistical Enrollment Data System (SEDS).

Testimony of
Dennis G. Smith
Director
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
Before the Senate Committee on Finance, Health Care Subcommittee

"Covering Uninsured Children: The Impact of the August 17 SCHIP Directive"
April 9, 2008

Chairman Rockefeller, Senator Hatch and distinguished members of the Subcommittee, thank you for inviting me to testify today. The Administration strongly supports the State Children's Health Insurance Program (SCHIP), which has provided health care coverage to millions of low-income children since its creation in 1997. As you know, last year additional funding for the program was provided to ensure stability through March 2009. We look forward to continued work with the Congress to achieve the goal of reauthorization through 2013.

The full picture of Federal commitment to covering uninsured, low-income children includes Medicaid as well as SCHIP. Medicaid is approximately four times larger than SCHIP in terms of enrollment of children and just over six times larger in terms of expenditures for children. Total Federal and state Medicaid spending on children will exceed $400 billion over the next five years and $1 trillion over the next ten years.

SCHIP is a unique combination of incentives and checks and balances. Congress rejected the idea of simply re-creating Medicaid and its complexities when designing SCHIP. Capped appropriations and capped allotments were critical features of the bipartisan compromise enacting SCHIP. States with an approved SCHIP plan are eligible for

Federal matching payments; while states have a great deal of program flexibility (including using Medicaid as their vehicle for administering Title XXI), they must adopt policies to stay within state-specific capped allotments.

Covering Uninsured Low-income Children

When Congress was considering the legislation that became Title XXI more than ten years ago, there was a widely held view that 10 million children in the United States lacked health insurance. It was recognized that many of these children were uninsured but lived in families with sufficient income to afford private or employment-based coverage. Congress realized also that millions of children were eligible for Medicaid but not enrolled. To ensure the initial success of SCHIP and avoid creating a new program that would not be taken up by states, an enhanced match rate was ultimately adopted to provide states sufficient incentive to aggressively find and enroll uninsured low-income children. SCHIP provides a 70 percent federal match rate on an average national basis compared to the 57 percent average match rate for Medicaid.

After considerable debate, the final compromise legislation in 1997 set a general upper limit of income eligibility at the higher of 200 percent of the federal poverty level (FPL) or 50 percentage points above a state's Medicaid level.[1] However, to avoid the complex statutory eligibility rules that are part of the Medicaid program and with the rationale that capped allotments would be a check on the states, Congress did not establish a statutory definition of "family income," allowing states to define and disregard certain income.

[1] Under current FPL guidelines, 200 percent of FPL is $42,400 for a family of four and 250 percent of FPL is $53,000 for a family of four.

Congress appropriated $40 billion over ten years with the initial program authorization, an amount that would support the number of children estimated to be in the target population group. SCHIP was neither designed nor funded to serve all 78 million children in the United States at all income levels.

In addition to the discussions on income eligibility, Congress identified and discussed the issue of "crowd-out," or the substitution of new public coverage for existing coverage. Ultimately, the SCHIP legislation did not adopt specific federal standards for preventing substitution but did require states to prevent crowd-out and provided a mechanism through the state plan review process for the Secretary to protect the Federal interest in preserving existing sources of coverage.

States adopted SCHIP quickly and their programs took shape. Between April 1998 and June 2001, twelve states established SCHIP eligibility levels above 250 percent of the FPL (counting applied disregards) with New Jersey the highest at 350 percent of FPL. Of those 12 states with early expansions to higher income levels than 200 percent of the FPL, eight were "qualifying states," that had increased Medicaid eligibility prior to the creation of SCHIP. When Missouri's SCHIP was approved with an income eligibility level at 300 percent of poverty, the state also adopted cost sharing of up to 5 percent of family income, the limit allowed under federal law. These states demonstrated efforts to prevent crowd-out among higher-income eligible populations.

In June 2001, Georgia was approved to expand its SCHIP eligibility level to 235 percent of FPL. Georgia's use of income disregards effectively allows at least some families with income above 250 percent FPL to qualify their children for SCHIP. After that, no state expanded above 250 percent of FPL on a statewide basis for almost five years.

This stability in the SCHIP was interrupted in 2006 as states again began to expand eligibility, without substantial strategies to prevent crowd-out as had been included by earlier expansion states. In 2006, Hawaii and Massachusetts increased their eligibility levels to 300 percent of FPL. In January 2007, Tennessee created an SCHIP program with an income threshold of 250 percent of FPL. In February and March 2007 respectively, Pennsylvania and the District of Columbia also were approved for eligibility levels at 300 percent of FPL. These more recent requests for increased eligibility levels were combined with little or no cost-sharing and short or no waiting periods.

After this five-year period (2001-2006) in which no state raised its SCHIP eligibility level above 250 percent, there clearly are new interests or pressures among additional states to expand eligibility beyond the statutory definition. It is important to understand those interests or pressures in order to design an appropriate response. For example, the goal of providing affordable coverage does not appear to justify programs that require little or no family participation in the cost of coverage from families with income of $62,000 or higher; this appears to be dictated by other concerns. After Pennsylvania and D.C., there were clear indications that even more states would be proposing to increase their SCHIP eligibility levels. Additionally, several of the approved expansion states had

turned out to be "shortfall" states which created pressure on the Federal government to increase program funding in the context of reauthorization.

In short, over time it became apparent that further action was necessary to remind states of their obligation for preventing "crowd out." A central question of the original debate, "for whom is the enhanced match rate intended?" reappeared for the Federal government over the past two years and is with us today.

Effects of Crowd-Out

Crowd-out, or substitution of public coverage for private coverage, is a public policy concern because it increases public expenditures without necessarily improving access to care or health status. It is also a concern because, as healthy lives are shifted out of private sector insurance pools, there is a detrimental impact on those who remain in the private sector pools. Insurance fundamentally means the sharing of risk. When the pool of healthy insured lives shrinks and the risk cannot be spread as widely as before, the cost will rise for those who remain, triggering another cost increase which is likely to displace yet another group of people – employers, employees or both. It is counter-productive for government policies to drive up the cost of private coverage and thereby result in more people becoming uninsured.

Substitution is an area which demands further attention. As 16 million children have been added to Medicaid and SCHIP over the past decade, the percent of children in families between 100 and 200 percent of FPL with private insurance has declined. In

1997 according to data from the 2006 National Health Interview Survey, 55 percent of children in families with income at this level had private insurance. But by 2006, the percentage had declined to 36 percent. [2]

To the extent that SCHIP makes private coverage less attractive (and less affordable) for some lower-income workers, employers may seek to save money by reducing their contribution to health insurance premiums or by eliminating their contribution altogether. Such concerns were substantiated last year by the Congressional Budget Office (CBO), who after reviewing the volume of research on crowd-out observed that for every 100 uninsured children covered as a result of SCHIP, there is a corresponding reduction in private coverage of 25 to 50 children.[3]

At a minimum, we should not accept substitution as inevitable and be indifferent to potential ways to reduce it. Our current health insurance system relies heavily on employment-based coverage options; erosion of that coverage cannot be taken lightly. How much of the rise in the cost of private health insurance has been caused by the shift of millions of healthy children to the public coverage pool? How many people have lost their health insurance as a result of that shift? Are state policies actually encouraging substitution rather than preventing it? How can private sector risk plans compete against the government pool that provides a 100 percent subsidy? Is public coverage actually

[2]See http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200712.pdf. The data are derived from the Family Core component of the 1997–2007 NHIS, which collects information on all family members in each household. Data analyses for the January – June 2007 NHIS were based on 41,823 persons in the Family Core.

[3] Congressional Budget Office, *The State Children's Health Insurance Program*, May 2007 at VIII-IX, available at http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf.

inflating the cost of covering children and creating an unexpected windfall for health plans given that the government pays a per-member, per-month rate for each child insured whereas private coverage charges a single price to insure two or more children in the same family? Where does further erosion in the private sector really lead us? As a nation, are we prepared to accept the consequences? These are important questions for which the Finance Committee, which has jurisdiction over both the Social Security Act and the Internal Revenue Code, is uniquely positioned.

The August 17, 2007 State Health Officials Letter

From the outset, the goal of SCHIP has been to increase the rate of insurance among our nation's children in low-income families. The statute explicitly reflects this goal, requiring that states "expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."[4] Moreover, the statute calls for state SCHIP programs that "do not substitute for coverage under group health plans."[5]

As noted in the preamble to the original SCHIP regulations, available SCHIP coverage risks replacing employer-provided or other private insurance because it may cost less and provide a broader range of benefits than private insurance. When the SCHIP regulations were initially published, CMS did not require any specific crowd-out prevention procedures. The regulations do require that states adopt "reasonable procedures" to prevent crowd out, leaving flexibility for states to implement policies based on ever-

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[4] 42 USC 1397aa(a)]

[5] 42 USC 1397bb(b)(3)(C)]

evolving research and actual experience.[6] However, the preamble to the final regulations did offer some general guidelines, specifically:

(1) in providing coverage to children in families with incomes at or below 200 percent of FPL, states should have procedures to monitor the occurrence of substitution (crowd-out);

(2) states offering coverage to children in families over 200 percent of FPL should identify in their state child health plans specific strategies to limit substitution if monitoring efforts show unacceptable levels of substitution; and

(3) for coverage above 250 percent of FPL, states must have substitution prevention strategies in place (emphasis added).

These guidelines were reinforced in a 1998 State Health Official (SHO) letter. The February 13, 1998 letter required "States that provide insurance coverage through a children's only and/or a State plan (as opposed to subsidizing employer-sponsored coverage) or expand through Medicaid ...to describe procedures in their State CHIP plans that reduce the potential for substitution. ... After a reasonable period of time, the Department will review States' procedures to limit substitution. If this review shows they have not adequately addressed substitution, the Department may require States to alter their plans."

Another Federal agency within the Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ), listed several strategies to prevent crowd-out at that time as well, including:

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[6] *See* 66 Federal Register at 2602.

- Institute waiting periods (3, 6, or 12 months);
- Limit eligibility to uninsured or under-insured;
- Subsidize employer-based coverage;
- Impose premium contributions for families above 150 percent of the Federal poverty level;
- Set premiums and coverage levels comparable to employer-sponsored coverage; and
- Monitor crowd-out and implement prevention strategies if crowd-out becomes a problem.[7]

Unfortunately, over time and with the benefit of actual program experience, all of this guidance has shown its limitations. Crowd-out remains a significant concern.

States face competing pressures as they design and update their SCHIP programs. Effective crowd-out strategies are checked against pressures to quickly build enrollment. Decision-makers at the state level have faced strong public criticism for "turning back" Federal funds that would then go to other states or be returned to the Federal Treasury. As state budgets continue to face the stress of ever-increasing needs and scarce resources, the pressure to maximize Federal dollars continues to increase.

To ensure that SCHIP stays focused on providing health insurance to the core uninsured targeted low-income populations, while at the same time offering some accommodation to those states wishing to expand SCHIP coverage, CMS issued new policy guidance in August 2007. The August 17, 2007 SHO letter advises state health officials of the types of crowd-out prevention procedures CMS expects states to incorporate into their programs should the state opt to extend SCHIP eligibility above 250 percent of FPL.

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[7] See http://www.ahrq.gov/chip/Content/crowd_out/crowd_out_topics.htm.

From the outset, CMS has been committed to working with states to develop strategies and monitoring tools to prevent crowd-out. We have seen five general strategies that states use to prevent crowd-out: (1) imposing waiting periods between dropping private coverage and SCHIP enrollment; (2) imposing cost sharing in approximation to the cost of private coverage; (3) monitoring health insurance status at the time of application; (4) verifying family insurance status through databases; and (5) preventing employers from changing dependent coverage policies in a manner that provides a shift to public coverage.

As the August 17 SHO letter explained, as we have gained more experience with SCHIP and gathered more information about the impact of state programs, it has become clear that the greatest potential for crowd-out is with the higher income families. In other words, consistent with CBO's conclusions in May 2007, our policies recognize that expanding SCHIP coverage to children in higher income families is more likely to displace private coverage than programs that focus on the core targeted low-income population. For this reason, the August 17 SHO letter indicates that CMS expects states that expand coverage above 250 percent of FPL to adopt all five of the prevailing state strategies for preventing crowd out. CMS also expects such States to provide assurances to CMS related to crowd-out strategies and the effective operation of their program, including an assurance they have enrolled at least 95 percent of children below 200 percent of FPL in the state in either SCHIP or Medicaid.

Tremendous growth in Medicaid and SCHIP enrollment relative to the overall population and to the low-income population specifically, led the Administration to articulate this "95 percent enrollment" goal. The goal is reasonable in light of the statutory purpose of SCHIP and we also believe it is achievable. The Federal government should demand that states reach the poorest of the poor before allowing payment of an enhanced match rate averaging 70 percent nationally to be used for coverage at levels not foreseen by the original authors of SCHIP.

Since issuing the August 17 SHO letter, we have reached out to states to assist in determining their specific rates of coverage. It is unfortunate that some groups hastily responded to the letter by prejudging state compliance based on flawed national data such as the Current Population Survey (CPS), which is widely recognized as undercounting Medicaid participation.[8] Work by the Urban Institute in 2007 actually shows much lower uninsurance rates among Medicaid and SCHIP eligible children than might have been expected based on popular opinion reported at the time.[9] While the Urban Institute study was not unanimously received as good news when released, we believe it clearly demonstrates that states have been far more successful in finding and enrolling eligible children than typically given credit. Indeed, we suspect that an accurate analysis of the data would demonstrate that a number of states are already meeting the 95 percent goal.

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[8] In the most recent CPS data released last year, the Census Bureau reported 20.7 million children ever enrolled in Medicaid and SCHIP during FY 2006, when enrollment reported to the Administration by states for that same period was over 36 million.

[9] "Eligible but Not Enrolled: How SCHIP Reauthorization Can Help," September 24, 2007 [available at http://www.urban.org/publications/411549.html].

As the future of SCHIP is considered, we strongly believe that states should be required to put poor children first before they expand to higher income levels. The 95 percent goal is not only achievable, but should be expected and demanded. The policies articulated in the August 17, 2007 SHO letter do not preclude states from expanding SCHIP coverage, but they are consistent with the Administration's goal of covering low-income children first, and also help ensure that states are taking sufficient steps to preserve existing private sources of coverage at a critical time.

We reaffirm our previously stated position that children currently enrolled in SCHIP should not be affected as we work with states to implement the August 17, 2007 SHO letter. Again, the guidance sets out procedures and assurances that should be in place when states enroll new applicants with family incomes of 250 percent FPL ($53,000 for a family of four). The guidance is not intended to affect enrollment, procedures, or other terms for individuals currently enrolled in state programs.

Conclusion

SCHIP has been highly successful in its original purpose of increasing coverage among uninsured low-income children. That success *does not* mean SCHIP can or will be as successful when populations at higher incomes are involved. We hope that the lessons of the past will guide how we use the fresh opportunity before us, and the Administration looks forward to working with Congress to forge reauthorization in the same bipartisan spirit in which SCHIP was created.

Additional Written Questions for the Record for Dennis Smith
Senate Finance Committee
Health Subcommittee Hearing
"Covering Uninsured Children: The Impact of the August 17 CHIP Directive"
April 9, 2008

1.) Questions From Senator Rockefeller:

a.) On July 31, 2007, Secretary Leavitt sent a letter to Senator Grassley declaring that, "Under current regulations, we have no authority to disapprove amendments solely based on income disregards."

The Secretary indicated that he wanted to change this policy, but acknowledged that "the law gives states great flexibility to define income."

In light of these statements on July 31, 2007, how is it that just a few short weeks later CMS discovered – through your August 17 directive – that you could easily reject states' requests to cover children above 250 percent of the federal poverty level?

What research or evidence basis did you rely upon in crafting the standards for the directive? Has any other researcher or authority suggested that the standards included in the directive are the right ones for measuring participation in public programs or indicating crowd out?

ANSWER: The August 17, 2007 SHO letter outlined a review strategy to ensure compliance with requirements that States operate their SCHIP programs "in an effective and efficient manner that is coordinated with other sources of health benefits coverage" and have procedures to ensure "that the insurance provided under the State child health plan does not substitute for coverage under group health plans." These are existing statutory requirements at sections 2101(a) and 2102(b)(3)(C) of the Social Security Act. Under this review strategy, CMS is examining whether States that seek to expand, or that have expanded, eligibility to higher income levels (above 250 percent of the Federal Poverty Level) can demonstrate that they are effectively serving the core low-income population and have sufficient safeguards to prevent substitution of coverage ("crowd-out" procedures). Under this review strategy, CMS will not approve State plan amendments to expand to such higher income levels unless the State demonstrates that it meets these statutory requirements. CMS is also working with States with existing expansions to higher income levels so that these States will also demonstrate compliance. This review strategy ensures that the extension of SCHIP eligibility to children at higher effective income levels does not interfere with the effective and efficient provision of child health assistance coordinated

with other sources of health benefits coverage to the core SCHIP population of uninsured targeted low income children.

The use of income disregards is a different issue, and the CMS review strategy does not affect the ability of a State to define countable income. The only connection is that extension of eligibility to higher income levels triggers greater scrutiny of the issues of effectively serving the core population and preventing crowd-out. In the preamble to the final SCHIP programmatic regulations, CMS noted that crowd-out was a greater concern at higher income levels than lower income levels, and expressly indicated that States that extended eligibility above 250 percent of the FPL would need to have crowd-out prevention procedures in place, as well as monitoring for crowd-out (see, e.g. 66 FR 2603, Jan. 11, 2001). In that preamble discussion, CMS indicated that it would be working with States to identify appropriate crowd-out strategies.

In 1998, the Agency for Healthcare Research and Quality (AHRQ) listed several strategies to prevent crowd-out[1]. Those strategies included instituting waiting periods, subsidizing employer-based coverage, imposing premium contributions for families above 150 percent of the FPLvel, and setting premiums and coverage at levels comparable to employer-sponsored coverage

Since that time, CMS has developed more experience and information from the operation of SCHIP programs. It has become clear that it is necessary to implement specific strategies to prevent crowd-out for higher income individuals. The SHO letter specifies these strategies.

Furthermore, in its May 2007 report entitled, *The State Children's Health Insurance Program*, the Congressional Budget Office stated that, "in general, expanding the program to children in higher-income families is likely to generate more of an offsetting reduction in private coverage (and therefore less of a net reduction in uninsurance) than expanding the program to more children in low-income families." "According to CBO's analysis of data from the Current Population Survey, 50 percent of children in families with income between 100 percent and 200 percent of the poverty level had private coverage in 2005. The rate of private coverage rose to 77 percent among children between 200 percent and 300 percent of the poverty level, 89 percent among those between 300 percent and 400 percent of the poverty level, and 95 percent among those over 400 percent of the poverty level."

b.) Do you believe the August 17 guidance has the force of law or is it interpretive? And let me tell you why I am asking that question – the Justice Department just argued on your behalf in the *State of New Jersey v. the United States Department of Health and Human Services case* that "The language of

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[1]See http://www.ahrq.gov/chip/Content/crowd_out/crowd_out_topics.htm.

the [State Health Organization] letter itself demonstrates that CMS does not intend the policy guidance to have the force of law."

ANSWER: The August 17, 2007, State Health Official (SHO) letter sets forth a review strategy for CMS to ensure compliance with existing requirements under the SCHIP for the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage. The SHO letter is currently the subject of ongoing litigation and it would not be appropriate to comment on legal issues outside of those proceedings. The Department's overall position in these actions was summarized in a January 10, 2008, letter from the Department of Justice to the United States District Court for the Southern District of New York and our May 9, 2008, brief filed in the United States District Court for the District of New Jersey. As the letter and brief make clear, the SHO letter is a general statement of policy that announces the course which the agency intends to follow in adjudications concerning compliance with requirements already set forth in regulations.

c.) **Given that CMS already has issued detailed regulations on how states must address the crowd-out issue, why did CMS decide to disregard the Administrative Procedures Act and issue a new policy without modifying its existing regulations and going through appropriate public notice and rulemaking procedures?**

ANSWER: The August 17, 2007, State Health Official (SHO) letter sets forth a review strategy and is a general statement of policy. Therefore, we do not believe it requires the engagement of formal rulemaking procedures. Statutory authority for the August 17, 2007, guidance is found in Section 2101(a) and Section 2102(b)(3)(C) of the Social Security Act, and implementing regulations at 42 C.F.R. 457.805.

As CMS has developed more experience and information from the operation of SCHIP programs, it has become clear that the potential for crowd-out is greater for higher income beneficiaries. The August 17, 2007, SHO letter reminds the States of their existing statutory obligations to targeted low-income children, including obligations to find and enroll such children "in an effective and efficient manner that is coordinated with other sources of health benefits coverage" before States consider expanding to higher income levels.

d.) **In its new report on the directive, the National Association of State Health Policy reports that "CMS did not consult states and has not, to date, provided any additional written guidance for all states currently affected or for those states that may want to cover more of their uninsured children in the future." How could CMS issue a major new policy on CHIP without even consulting with the state officials who run the program? Why did CMS not consult with them or other affected parties, such as beneficiaries?**

ANSWER: The Administration respectfully disagrees with the characterization of the August 17, 2007, State Health Official (SHO) letter as "major new policy." The letter reminds the States of their existing statutory obligations to targeted low-income children, including obligations to find and enroll such children "in an effective and efficient manner that is coordinated with other sources of health benefits coverage" before States consider expanding to higher income levels. Moreover, on May 7, 2008, CMS issued further guidance on flexibility in the application of the review strategy outlined in the August 17, 2007, SHO letter.

e.) **How many children currently enrolled in CHIP today will lose coverage because of the August 17 directive? I am not interested in the easy answer indicating that *no children will lose coverage because individual children are grandfathered*. I'm interested in the real answer about the practical effects of this policy. For example, how many Wisconsin children in families above 250% of poverty – who were previously enrolled in CHIP (before application of the August 17 policy) – will lose coverage because the state can no longer afford to cover 100% of their health care costs? Given the economic downturn, this is a very likely scenario.**

I'd like your answer to include the number of children who will lose CHIP coverage forever because they were on the rolls when this August 17 policy went into effect, but went off the rolls for a short time to enroll in their parents' employer-sponsored coverage, and at some point in the future will need to reenroll in CHIP because their parent lost their job during the economic downturn.

I'd also like to know the number of children in states, like West Virginia, that have passed eligibility expansions beyond 250% of poverty that will not be allowed to ever enroll in CHIP because of this new policy.

ANSWER: The August 17, 2007, State Health Official (SHO) letter very specifically indicated that CMS would not expect any impact on current enrollees, and is willing to work with States to ensure this outcome. With respect to Wisconsin specifically, Wisconsin does not currently cover children above 250% of poverty under its SCHIP program, so the State is not impacted by the August 17, 2007, SHO letter.

Children that have changes in circumstances (e.g., access to and enrollment in employer sponsored health insurance), and discontinue SCHIP coverage for a period of time as a result of these changes, will subsequently be considered new applicants. If a State changes its coverage levels or crowd-out measures, such children would be subject to those new standards upon re-applying.

In accordance with the applicable requirements, CMS reviews formal requests for program eligibility changes submitted by the State in the form of State plan amendments. Thus, we do not have information on expansions that have been

authorized but not submitted to CMS for approval. Nor does CMS have enrollment data by income level and data on enrollment in State-only programs.

f.) **In your testimony before this Committee, you indicated that the Ohio state plan amendment denial on December 20, 2007, was not because of the August 17 directive. However, you said something very different when you were asked the same question by the *New York Times*. In a January 4, 2008, *New York Times* story entitled "U.S. Curtailing Bids to Expand Medicaid Rolls" you are quoted as confirming that CMS was, in fact, applying the criteria set for in the August 17 letter to Ohio's planned Medicaid expansion. Can you explain the discrepancy in these two accounts?**

ANSWER: CMS was unable to approve the Ohio Medicaid State plan amendment in question (SPA 07-014) because the State's submission indicated that the State would claim Federal matching funds at a rate other than the rate set forth in the Social Security Act, and, thus, was not consistent with methods of administration for proper and efficient operation of the plan, as required by section 1902(a)(4). As I indicated in my testimony and attempted to convey in my comment to the *New York Times*, there is a relationship between Medicaid and SCHIP and, from a policy perspective, it seems logical and consistent to apply the crowd-out policy evenly to both programs.

2.) <u>Question From Senator Lincoln:</u>

I would like clarification from the Centers for Medicare and Medicaid Services (CMS) on the following questions, in follow up to issues raised at the recent Finance Health Subcommittee Hearing on the August 17 CHIP Directive:

a.) **Does the department believe it has the legal authority to impose the August 17 directive, or the rules in that directive, to Medicaid expansion states?**

ANSWER: The August 17, 2007, SHO letter states that it is applicable to SCHIP state plans and section 1115 waivers that include SCHIP populations. It is not applicable to Medicaid programs.

b.) **If the department believes that it cannot apply the August 17 directive to Medicaid, under what circumstances could a state use Medicaid funds to cover children with gross incomes above 250% of the FPL? Specifically, would a state be permitted to use Medicaid funds to cover children above 250% of FPL if it had available CHIP funds but could not use those CHIP funds for such coverage because of the directive?**

ANSWER: It is conceivable that a State could implement a Medicaid expansion SCHIP program on top of its existing separate SCHIP program (i.e., the lower

income threshold of the newly created Medicaid expansion program would begin where the upper income threshold of the Separate program ends) and provide coverage for targeted, low-income children using available Title XXI funds. If those title XXI funds are exhausted, the State would use title XIX funds for expenditures. As a Medicaid expansion SCHIP program, the State would be required to provide the Medicaid benefit package, including EPSDT, and follow the applicable Medicaid rules.

3.) Questions From Senator Stabenow:

Mr. Smith, CMS recently promulgated a new regulation for Medicaid rehabilitative services option that would cut $2.2 billion from that program over a five year period. You may be aware that both the disability and mental health communities have expressed deep concern to many members of this committee that these funding cuts would be realized through reduced access to services like coaching and community skills training now provided to children with developmental disabilities, and Medicaid recipients with serious mental illnesses.

a.) First, doesn't this CMS policy approach directly contradict President Bush's New Freedom Initiative, which promises "full access to community life" for people with disabilities? Does CMS ever talk to the senior officials who made that pledge on behalf of the Administration?

ANSWER: CMS is fully engaged in the President's New Freedom Initiative and has been an active participant in the New Freedom Commission on Mental Health's comprehensive study of the United States mental health service delivery system. The provision of rehabilitative services to individuals with mental health or substance-related disorders is consistent with the recommendations of the New Freedom Commission on Mental Health. The Commission noted in its report that, "[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs." The Commission challenged States, among others, to expand access to quality mental health care and noted that States are at the very center of mental health system transformation. Thus, while States are not required to provide rehabilitative services for treatment of mental health and substance-related disorders, they are encouraged to do so in the proposed rule.

Furthermore, CMS states in the proposed rule that rehabilitative services include services provided to an eligible individual to address the individual's physical needs, mental health needs, and/or substance related disorder treatment needs. Because rehabilitative services are an optional service for adults, a State has flexibility to determine whether rehabilitative services would be limited to certain rehabilitative services (for example, only physical rehabilitative services) or will

include rehabilitative treatment for mental health or substance-related disorders as well.

b.) Second, aren't we trying to reduce the institutional bias of the Medicaid program? How could CMS implement DRA programs like Money Follows The Person, while reducing access to intensive community-based services at the same time?

ANSWER: CMS assures you that the agency has made important strides in identifying and eliminating barriers to community living. Beyond the implementation of DRA programs, the agency has enabled Medicaid programs to implement systemic changes to better serve individuals with disabilities in the setting of their choosing, including the following examples:

- **Alternatives to Psychiatric Residential Treatment Facilities Demonstration:** These grant programs will help States provide community alternatives to psychiatric residential treatment facilities for children. They will also assist States in their efforts to adopt strategic approaches for improving quality as they work to maintain and improve each child's functional level in the community.
- **Real Choice Systems Change:** These grants support infrastructure changes that will result in effective and enduring improvements in community long-term support systems.
- **Direct Service Worker:** These demonstration grants support strategies to help recruit, train, and retain direct service workers who provide personal assistance to people with disabilities who need help with activities of daily living.
- **Employment Initiatives:** Authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), CMS provides funds to states through the Medicaid Infrastructure Grants (MIG) and Demonstration to Maintain Independence and Employment (DMIE) Program to create systemic change that supports employment for people with disabilities.
- **New Freedom Open Door Forums:** On-going CMS teleconferences to address the commitment made in the *HHS New Freedom Report* to the President for a task force process focused on Medicaid reform actions that could help remove barriers to community living and participation on the part of people with a disability. These extremely well-attended forums have been particularly useful in obtaining input from a broad array of stakeholders, including those who might not otherwise be able to travel to a meeting. In FY 2006, CMS received input from a total of approximately 1,500 individuals participating in four different forums held throughout the year. More information available at http://www.cms.hhs.gov/opendoor/.
- **National Technical Assistance Strategy:** A CMS, national strategy to provide assistance to States, local organizations, and consumer groups involving multiple technical assistance organizations that actively work with States to improve community-based service systems. These activities include initiatives

related to Real Choice Systems Change grants, employment of persons with disabilities, and direct workforce activities.

In the proposed rehabilitative services rule, CMS proposes that rehabilitative services may be provided in a facility, home, or other setting. For example, rehabilitative services may be furnished in freestanding outpatient clinics and to supplement services otherwise available as an integral part of the services of facilities such as schools, community mental health centers, or substance abuse treatment centers. Other settings may include the offices of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings. The State has the authority to determine in which settings a particular service may be provided. The agency's view is that while services may be provided in a variety of settings, the rehabilitative services benefit is not an inpatient benefit. Rehabilitative services do not include room and board in an institutional, community, or home setting.

Mr. Smith, we have heard a great deal of concern about how CMS handles administrative actions regarding both the Medicaid rehabilitative services option and the targeted case management option. The specific allegation is that CMS uses its administrative clout – through processes like waiver applications and plan amendments – to essentially harass states into reducing access to community-based services for people with disabilities and individuals with mental illnesses. The services at issue are typically things like coaching and community-skills building to assist with daily living.

c.) First, if CMS has approved community-based services in prior state plans or waiver applications, do you feel bound by those prior determinations at all? Or can your agency literally make up new service definitions and restrictions – and impose them on states – as you go along?

ANSWER: CMS takes its partnership with the States very seriously, and through its interactions, the agency provides clear, technical assistance to the States on the authorities in which they can provide home and community-based services. At times, this partnership has been threatened by the ambiguity of service definitions. Both Government Accountability Office and HHS Office of the Inspector General reports have confirmed this ambiguity and recommended that services definitions be clarified. The agency sees the reduction of ambiguity in the administration of the Medicaid program as essential to not only preserving the financial integrity of the program, but also the State-Federal partnership. Under these circumstances, the agency has, through legislative or administrative authority and the rulemaking process, sought to clarify these service definitions.

CMS has provided ongoing technical assistance to States to ensure their State Plans and waivers operate under the appropriate authorities. Despite any prior determinations, CMS must ensure all States operate their Medicaid programs in accordance with current laws and regulations.

d.) Second, as an example of harassment, I'm told that CMS now requires community mental health and disability providers to bill for services under the rehabilitation option in 15 minute increments. Is CMS paying for documentation or actual service delivery?

ANSWER: CMS does not require any provider to bill for services under the proposed rehabilitation option in 15 minute increments. Under the proposed rule, a State that opts to provide rehabilitative services must amend its State plan and (1) describe the rehabilitative services proposed to be furnished, (2) specify the provider type and provider qualifications that are reasonably related to each of the rehabilitative services, and (3) specify the methodology under which rehabilitation providers would be paid.

Over the past year, I have been shocked by some of CMS's regulations that will have terrible effects on our most vulnerable children. It is disappointing that in the last days of this administration, you have not worked with Congress to address real challenges facing Medicaid but gone ahead on your own.

What is most surprising to me about this directive is the total lack of public input. CMS has issued these significant and unprecedented requirements by means of a two-and-a-half page directive – basically a letter sent out late on a Friday evening – without an opportunity for comment from experts, health care providers, or the general public. In the Senate, as you know, it basically takes 60 of us to pass a bill.

In the executive branch, this is what the comment period is for – for everyone to have a say in the process.

In its new report on the directive, the National Association of State Health Policy reports that "CMS did not consult states and has not, to date, provided any additional written guidance for all states currently affected or for those states that may want to cover more of their uninsured children in the future."

e.) Can you explain what is the legal authority of CMS to make such a blanket statement without any transparency or public input? I feel this is a blatant disregard of accountability and abusing the public trust.

ANSWER: The August 17, 2007, State Health Official (SHO) letter sets forth a review strategy for CMS to ensure compliance with existing requirements under the State Children's Health Insurance Program (SCHIP) for the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage. The SHO letter is currently the subject of ongoing litigation and it would not be appropriate to comment on legal issues outside of those proceedings. The Department's overall position in these actions was summarized in a January 10, 2008, letter from the Department of Justice to the United States District Court for the Southern District of New York and our May 9,

2008, brief filed in the United States District Court for the District of New Jersey. As the letter and brief make clear, the SHO letter is a general statement of policy that announces the course which the agency intends to follow in adjudications concerning compliance with requirements already set forth in regulations.

When a state is in an economic downturn, shouldn't we be helping instead of hurting states and employers who cannot afford to provide coverage anymore. For example, the erosion of Michigan's employer-based health care coverage and the tightening state economy means that more than ever, children's health care must be a priority. In my opinion, your directive blames the states for decline in employer-sponsored coverage without actually taking into account legitimate reasons.

f.) What is the rationale for the creating a provision that says if a two-percent decline in employer-based coverage happens then the state cannot expand coverage to help the people affected by this decline?

ANSWER: The assurance relating to coverage of children in the target population insured through private, employer-based insurance is not intended to tell States they cannot expand coverage to help the people affected by a decline in employer-based coverage; instead, the assurance is intended to ensure that coverage expansions to higher income populations do not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage and prevent the substitution of SCHIP coverage for coverage under group health plans. The Administration believes it is reasonable to acknowledge that States can influence the behavior of the private market.

4.) Question From Senator Cantwell:

a.) CMS implemented policy on addressing the issue of "crowd-out" in 2001. At that time, CMS, known then as the Health Care Financing Administration, required states to describe their policies to prevent substitution of private coverage under their state CHIP plans. This policy was implemented after a formal rule-making process, including notice and opportunity for public comment.

Importantly, at that time, the agency considered and rejected the concept of issuing specific anti-crowd out procedures to states. This option was rejected because it was determined that the underlying statute provided broad discretion to states to select strategies to prevent substitution, or crowd-out that reflect the unique conditions of each state.

The manner in which the August 17 directive is a stark contrast to this process.

The August 17 directive was sent to states through the mail, with no advanced warning or opportunity for comment. In addition, it completely reverses earlier regulations which gave states discretion to create policies that reflect the conditions of the state. The directive is a substantial policy shift that needs further scrutiny – at the very least through procedures of proposed rule and comment set forth under the Administrative Procedures Act.

Why did CMS not follow the same procedures it did in 2001 to address policy changes for crowd-out? Has CMS's authority, or CMS's interpretation of Administration Procedures Act requirements, changed since 2001 to justify the process under which the August 17 directive was issued?

What stakeholders did CMS consult with prior to making this new policy decision? Which states?

ANSWER: The August 17, 2007, SHO letter sets forth a review strategy and is a general statement of policy. Rather than constituting a new policy decision, it merely serves to further clarify already-existing agency policy. Moreover, as evidenced by our recent approval of a State Plan Amendment in Rhode Island that does not incorporate the suggested 12-month uninsurance period, the review strategy provides inherent flexibility in its application. As such, the guidelines in the letter do not require the engagement of formal rulemaking procedures. Statutory authority for the August 17, 2007, guidance is found in Section 2101(a) and Section 2102(b)(3)(C) of the Social Security Act, and implementing regulations at 42 C.F.R. 457.805.

Statement of Senator Olympia J. Snowe
Senate Finance Committee
Health Subcommittee Hearing – August 17th S-CHIP Directive
April 9, 2008

Thank you, Mr. Chairman for holding this hearing today. As you all know, no issue is more vexing, or compelling, as the challenge of covering the nearly nine million uninsured children in America. Over the past ten years, S-CHIP has been a saving grace for millions families who struggle with the cost of high health insurance coverage.

So it is exceedingly frustrating to me that in terms of reauthorizing the S-CHIP program we have made little progress. *A year ago this month, Senator Rockefeller, Senator Kennedy and I introduced our comprehensive $50 billion S-CHIP reauthorization proposal.* And last summer, through the yeoman efforts of Chairman Baucus, Ranking Member Grassley as well as Sen. Rockefeller and Sen. Hatch, we were able to fashion a bipartisan compromise with the House of Representatives – one that would have represented a *real victory* for hardworking parents and their children.

But instead of taking an opportunity to show the American people that we not only hear their problems about the affordability of health insurance coverage – *but are prepared to actually do something about it* – the best Congress and the Administration could do is maintain the status quo with a long term extension. For many families struggling to obtain health care, if benefits are even *accessible*, the cost is moving further out of their reach. In Maine, the cost of coverage for a family on the individual market ranges from *$1,000 per month for a bare bones policy to more than $3100 per month for a more comprehensive policy.* This is simply untenable for working families in the economic climate we are experiencing today.

While Congress and the Administration dither, in the past year, the financial situation for low and middle income families has grown much worse. Consider that over the last five months, the increase in energy costs alone has effectively translated into a $150 billion tax increase for the American public! The cost of basic groceries is growing too. According to the Bureau of Labor Statistics, a loaf of bread has increased by 20 percent, milk has jumped over 25 percent, and eggs cost 40 percent more over the past year. With so many competing bills – gas, heating oil, groceries, health insurance coverage – families are left with wrenching decisions on where they need to cut back. So the availability of the S-CHIP program can and does make a critical difference.

That's why I'm disappointed in the path this Administration has chosen to take when it comes to reaching more families in need coverage for their children. In the Baucus-Grassley bipartisan compromise, we successfully balanced the necessity for higher eligibility standards in states with a higher cost of living with performance measures aimed at covering lower income children first. But instead of using that compromise as a guide – the Administration came back with a heavy-handed, 95 percent coverage standard which no state currently meets for states with eligibility above 250 percent of poverty. Yet health coverage has grown so expensive in this country that *even above 250 percent of the federal poverty line, many families simply cannot afford it*.

Furthermore, this dramatic change wasn't pursued through the traditional rulemaking process, with proper public notice and comment. Instead, this was accomplished through a "clarification" letter to state health officials. And in January, Robert Pear of the New York Times reported that this policy is now being extended to the Medicaid program citing this letter.

That's why last week I joined Senator Rockefeller in introducing legislation to provide a one year moratoria on this policy – as well as a number of other misguided Medicaid rules issued over the past year such as targeted case management and the rehabilitation rule. In addition, Senator Rockefeller and I have also requested the Government Accountability Office determine if the S-CHIP "clarification" letter is a rule under the Congressional Review Act which should have been reported to the Congress and subjected to review.

Mr. Chairman, these are tough times for working families. According to a report by the Joint Economic Committee, between 700,000 and 1.1 million *additional* children will enroll in Medicaid and S-CHIP each year due to slowing employment growth alone. We are backsliding on some of the progress we have made since the creation of the S-CHIP program. I urge my colleagues on the Committee to consider cosponsoring the Rockefeller-Snowe-Kennedy "Economic Recovery in Health Care Act" and hope we can work collaboratively with the Administration in the coming months on how we can better serve working families.

Thank you, Mr. Chairman.

U. S. Senate Subcommittee on Health Care
Committee on Finance
"Covering Uninsured Children:
The Impact of the August 17th CHIP Directive"
April 9, 2008

Testimony of Alan Weil, JD, MPP
Executive Director
National Academy for State Health Policy (NASHP)

Chairman Baucus, Senator Grassley, Subcommittee Chairman Rockefeller, Senator Hatch, and members of the committee, my name is Alan Weil and I am the Executive Director of the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization dedicated to working with state leaders to identify emerging issues, develop policy solutions and advance state health policy and practice. Since the inception of the State Children's Health Insurance Program (SCHIP) in 1997, NASHP has reported on and supported the work of states to implement and strengthen coverage of low-income children through SCHIP. Thank you for the opportunity to appear before you today to discuss CMS's August 17 SCHIP directive and its implications for states.

At the request of SCHIP directors in states affected by the directive, NASHP convened a workgroup to discuss the August 17 directive. Conference calls were held between January and March 2008 to allow states within the workgroup to discuss the directive, share information, and consider the potential implications of the directive's requirements. My testimony is based upon what we have heard from state officials who work closely with the SCHIP program but I do not purport to speak on behalf of the states.

In my testimony I will make three points. First, because the directive was written and issued without any input from states, it includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd out. Second, the CMS directive usurps Congressional authority with respect to both SCHIP and Medicaid. And third, the directive adds yet another level of uncertainty to states in a manner that impedes state action designed to achieve the statutory goal of reducing the number of children without health insurance.

Lack of Input Yields Flawed Directive

On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) released a letter to state health officials (SHO #07-001) directing significant changes in policy for SCHIP and children's health coverage. This directive was issued without any notice and comment period, without consultation with states, and was not issued as part of a formal rulemaking process. The requirements in the August 17 directive prompted questions and concerns among states, especially among the 24 states that are immediately affected due to current or recently approved eligibility levels. Because the directive was written and issued without any input from states, it includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd-out.

Although states have sought further guidance from CMS to address their concerns, CMS so far has not responded in writing to many of the detailed questions about the directive posed by individual states or to questions compiled from states by NASHP and submitted at the suggestion of CMS. Without further guidance, many states are struggling to determine whether they will be able to come into compliance. In many states, making the policy or eligibility changes that could

be required under the August 17 directive cannot happen overnight. States will need time to implement policy changes (including in some cases seeking legislative approval, rewriting forms, and reprogramming systems), to train workers, and to notify families who are enrolled or may apply of the new rules. Without further guidance from CMS, many states will likely be out of compliance when the guidance goes into effect on August 17, 2008.

As a result of our work with affected states, NASHP has identified four requirements in the August 17 directive as causing the greatest concern among states: 1) the 95 percent participation requirement; 2) the 12-month minimum waiting period; 3) the employer-sponsored insurance requirements; and 4) the cost-sharing requirements. These concerns are also discussed in a NASHP State Policy Briefing on this topic, which is being released today.

1. The 95 Percent Standard is Unattainable

CMS's directive requires states covering children with "effective" family income above 250 percent of the federal poverty level to assure that they have enrolled in SCHIP or Medicaid 95 percent of children from families with income below 200 percent of the federal poverty level.[i] While states share the goal of maximizing enrollment of eligible uninsured children, many are concerned this participation requirement will undermine ongoing efforts to cover more low-income children. They are concerned about the feasibility of measuring participation given the absence of reliable data, and they observe that experience from other programs demonstrates that this standard is unattainable.

Many states already are targeting efforts to cover children with family incomes below 200 percent of poverty. States expend significant resources on outreach to find and enroll these eligible children, and they have instituted a variety of measures to improve enrollment and

retention practices. The vast majority of children with family incomes below 200 percent of the federal poverty level who are eligible for either Medicaid or SCHIP are covered.[ii]

Additionally, a number of states that cover children with family incomes above 250 percent of the federal poverty level have found that increasing eligibility has been instrumental in reaching more eligible low-income children below 200 percent of the federal poverty level. For example, under Illinois' universal children's coverage program, AllKids, approximately 70 percent of the 166,000 children that were enrolled when the program started had been low-income children previously eligible for Medicaid and SCHIP but unenrolled. Establishing higher eligibility levels can reinforce the message that children can qualify even if their parents are working and earning low to moderate incomes.

Another significant challenge states face is the difficulty with measuring participation of low-income children. States cannot easily measure participation rates for SCHIP and Medicaid using available data sources. National surveys, such as the Census Bureau's Current Population Survey (CPS), have very small sample sizes for individual states, and many states view their own state estimates as a more accurate representation of the number of uninsured. In addition, survey respondents in the CPS tend to underreport Medicaid or SCHIP coverage (instead saying they have private coverage or are uninsured). Other surveys, such as the Survey of Income and Program Participation or the National Health Information Survey, do not contain recent enough data or have other limitations for measuring participation rates in SCHIP and Medicaid.

CMS has indicated in phone calls with states that it believes there are data approaches that could be used to demonstrate 95 percent coverage of eligible children, including modifications of the CPS to account for underreporting of Medicaid/SCHIP. If some states can develop methods to document 95 percent participation rates, there still may be concerns about

the policy and political implications of using different data for different purposes within a state and across states. Without consistent data definitions and sources, both state and federal policy makers will be denied the most consistent and valid data possible. In addition, some states worry about the potential long-term impact of showing compliance with the 95 percent standard using data or methods that are not accepted universally. By using less than rigorous data or methods, states could adversely impact future SCHIP funding, depending on the allocation formula used.

The 95 percent requirement appears arbitrary to states. CMS has not provided a rationale for selecting this figure. The participation rates for Medicaid and SCHIP are already higher than for most other voluntary programs targeting low-income Americans. Participation in the federal Food Stamp Program is approximately 50 percent, roughly 30 percent below the participation rate for SCHIP[iii]. Even in a program like Medicare Part B, in which seniors are enrolled automatically unless they opt-out, the participation rate is at 95.5 percent[iv]. Since no state has met this standard under CPS estimates or has yet successfully convinced CMS that it has reached the standard, many states believe it is unrealistic and unattainable.

2. The One Year Waiting Period Contradicts SCHIP Program Goals

CMS's directive requires states to establish – for children with family incomes above 250 percent of the federal poverty level – a minimum one year period of uninsurance before receiving coverage under SCHIP. Although requiring a period of uninsurance, also known as a waiting period, is not a new concept, states have had the flexibility to determine if a waiting period should be used and how long it should be. States have raised a number of concerns about the stringency of the new waiting period requirement related to its length and whether or not exceptions will be allowed.

In accordance with federal policy dating back to 2001,[v] states with SCHIP programs covering children with family income above 200 percent of the federal poverty level are responsible for monitoring, developing, and remaining ready, if necessary, to implement specific crowd-out prevention strategies.[vi] In addition, states with eligibility above 250 percent of the federal poverty level must have anti-crowd out strategies in place. Using the flexibility afforded through SCHIP, along with past experiences implementing strategies to deter crowd-out, states have policies in place that are aimed at reducing the likelihood of crowd-out in SCHIP programs.

According to NASHP's most recent state survey, the most frequently reported means used to deter crowd-out is a waiting period for children previously covered by a private insurance policy.[vii] Although it is unclear at this time how many states will be affected the by August 17 directive, 19 of the 24 states[viii] that either provide or propose to provide coverage to at least some children in families with gross incomes above 250 percent of the federal poverty level already use waiting periods. While the 19 states' waiting periods range from 1 month to 6 months, most states require between a 3- and 6-month waiting period between leaving private coverage and joining SCHIP.[ix] All of the states requiring waiting periods recognize that there may be reasons for losing private coverage that are beyond the family's control, so they allow exceptions to the waiting periods for circumstances such as death of a parent or involuntary loss of employment. By contrast, the August 17 directive does not discuss exceptions and CMS has not indicated whether any exceptions to the standard will be considered.

States are also concerned that the new waiting period could create substantial administrative complexity. For example, states that cover children above 250 percent might be forced to modify or create new applications to address the need for two different standards -- children in families with income above 250 percent of the federal poverty level will have a

longer period of uninsurance than those at lower incomes if states retain shorter periods for these children. States fear that adopting this policy will further fragment the public health coverage system, which already can be complicated for the families it serves. Costly technical systems changes may be needed to process applications and determine eligibility.

States are also concerned about the adverse consequences of a longer waiting period for children's health. Requiring children to remain uninsured for a full year prior to enrolling in public coverage, especially if there are no exceptions, increases the risk to their health and development. Research indicates that children with gaps in health coverage greater than 6 months have the highest rates of unmet needs[x], and that children with gaps in coverage are less likely to report they have a usual source of care other than an emergency room compared with children insured for a full year[xi]. Gaps in coverage may deny children the preventative and diagnostic care that could have lasting implications for their healthy development.

Considering the success to date of SCHIP in providing children with important health coverage and the potential the CMS directive has to reverse some of that success, affected states largely view this waiting period provision as poor public policy. Requiring a standard one-year waiting period will reduce the state flexibility, impose unfunded administrative burdens, and will have potential negative consequences for children's health.

3. Employer-Sponsored Insurance Coverage Erosion is Outside of States' Control

The CMS directive requires that, if states are to cover children with gross family incomes above 250 percent of the federal poverty level, they must show that employer-sponsored insurance (ESI) rates for low-income children have not declined by more than 2 percentage points. States cannot control the rate of ESI erosion.

States recognize the benefits of private insurance coverage. As discussed, most states have requirements for waiting periods following the dropping of private coverage before a child may be covered by SCHIP. Some states also see premium assistance programs as a means to encourage families to utilize employer-sponsored insurance; nine states operated premium assistance programs in SCHIP in 2005.[xii] Bipartisan SCHIP reauthorization legislation proposed to amend the rules to make it easier for states to begin to offer premium assistance for SCHIP enrollees.

Despite their interest in promoting employer-sponsored insurance (ESI), states have no control over private employers' decisions to offer insurance coverage, as employer benefit plans are regulated under federal law. States are unable to provide regulatory or oversight assistance for employees working for employers that choose to self-insure. In 2007, 55 percent of employees with ESI were covered under a self-insured plan.[xiii] And, although states can regulate private insurance companies within their jurisdictions, states cannot change the decisions of individual employers regarding premiums or cost sharing imposed on the employee, or the type of coverage offered.

The erosion in ESI has occurred for both children *and* adults, a phenomenon believed to be driven primarily by factors other than public coverage expansion. ESI rates have declined for reasons outside of a state's control. Rising health care costs and premiums have had a great impact on the ability and inclination of employers to offer coverage to their employees.[xiv] Businesses have responded to rising costs by declining to offer benefits or by requiring more employee cost sharing. This increased cost sharing has forced many families, unable to absorb the increased cost, to drop health coverage. SCHIP and Medicaid have offset the decline in ESI

coverage this decade, but there is no clear evidence that public coverage has caused the erosion.[xv]

Changes in the U.S. economy this decade also have played a role in declining ESI rates. Fewer Americans are now employed in the manufacturing sector, which historically has had high levels of ESI coverage. More Americans are working in service and construction jobs, which are less likely to offer ESI coverage. In addition, between 2000 and 2004, millions more Americans went to work in small firms or became self-employed, and these groups of workers are less likely to have ESI coverage.[xvi] States consider it arbitrary to constrain the options for program design on the basis of factors almost entirely outside of their control.

4. The Cost-Sharing Requirement is Unworkable

For children with gross family income above 250 percent of the federal poverty level, CMS directs states to adopt a cost-sharing requirement that is comparable (within one percent of the family income) to that of a competing plan sold in the state's private insurance market unless the cost requirement of the public plan is set at the federal cap of five percent of family income.[xvii] It appears through its directive, that in addition to the already established cost-sharing maximum, CMS is suggesting there also should be a *minimum* cost-sharing requirement.

Of the states that could be most affected by CMS's directive, 22 of them currently include or have proposed to include cost sharing within their SCHIP programs for children in families with incomes above 250 percent of the federal poverty level.[xviii] States establish cost-sharing provisions with caution, knowing that levels that are too high will deter eligible families from enrolling in the program and needy children from obtaining necessary services. Even if cost-sharing provisions borrowed from private health plans deter crowd-out, they may come at the cost of other critical SCHIP program goals of coverage and access.

States will not be held to the five percent of family income standard if it can prove to CMS that the state's SCHIP cost-sharing requirement is not more favorable by more than one percent of family income when compared to a competing private plan's cost sharing requirement.[xix] Most states find that comparison to be unfeasible, considering the improbability that child-only coverage is being sold currently within each state's private insurance market. If child-only plans are not on the market, states are left to look at privately sold family plans for comparison. A valid comparison of cost sharing between SCHIP coverage and private family coverage is unlikely, due to the higher cost of adult health care services, which is often balanced by higher cost-sharing requirements within private family coverage.

The Directive Usurps Congressional Authority

The CMS directive usurps Congressional authority with respect to both SCHIP and Medicaid. While the directive itself does not mention Medicaid, CMS has indicated that it intends to apply the directive to Medicaid programs.

Medicaid expansion SCHIP programs *must* follow federal Medicaid rules regarding enrollment and cost sharing. Under Medicaid law and rules, states cannot use waiting periods and they are limited to cost-sharing provisions far smaller than 5 percent of family income. The CMS directive requires states to adopt policies that contravene the Medicaid statute. In addition, because some aspects of the directive are literally impossible to achieve, it has the effect of capping SCHIP eligibility at 250 percent of the federal poverty level, which contravenes statutory language and bipartisan compromise legislation passed but vetoed.

The Directive Adds to Uncertainty which Undermines Program Goals

It is a particularly unstable time for SCHIP. Although the Medicare, Medicaid, SCHIP Extension Act has provided SCHIP with additional funding to help prevent state shortfalls in the current fiscal year, SCHIP still has not been reauthorized. While the reauthorization process has dragged on, many states have been unable to adequately plan for future coverage expansions that build on past success in covering eligible children. States, dealing with an economic slowdown, are reluctant to commit significant new state resources without a commitment of federal funding to support any coverage initiatives. Even with the uncertain future of reauthorization, some states have moved forward, which is a testament to state commitment to SCHIP and coverage for low-income children. However, many states that had planned initiatives to cover more uninsured children are putting their plans on hold without more certainty on funding.

The August 17 CMS directive is yet another challenge for states in managing their programs and threatens future coverage expansions. States that currently cover children above 250 percent of the federal poverty level face the prospect of being required to cut back their programs and turn children away who they would have covered in the past. States that have recently approved expansions above the 250 percent threshold have been stopped in their tracks from seeking CMS approval because they have not proven compliance with the CMS directive.

Conclusion

The premise of the SCHIP federal-state partnership is that state flexibility within a capped federal grant will yield exceptional progress toward a critical national goal. Indeed, ten years of experience proves this to be the case.

States are authorized under current law to extend SCHIP coverage to and beyond 250 percent of the federal poverty level. States make this choice because they know that insurance coverage is often unaffordable to families with incomes at this level. While 250 percent of FPL

is approximately median income for a family of four in Arkansas, it is barely half the median in New Jersey. In states with higher median incomes, many families need assistance obtaining health insurance despite the fact that their income would be sufficient to put them squarely in the middle class if they lived in a different state. States share the national goal of deterring crowd out, but they also know that this goal needs to be balanced against other critical program goals such as providing high quality coverage and access to health care services.

The August 17 directive imposes a single set of policies on a diverse nation. The directive is poorly crafted because it was written and issued without any input from states. The directive includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd out. The directive usurps Congressional authority and impedes state actions designed to achieve the statutory goal of reducing the number of children without health insurance. The level of state concerns about the directive suggests that review and modification, in consultation with states, is warranted prior to enforcement of the directive.

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[i] While not defined in the directive, based on state conversations with CMS, the agency's reference to effective income appears to refer to gross income.
[ii] 79 percent of Medicaid-eligible children and 63 percent of SCHIP-eligible children are covered nationwide. From: Cindy Mann, Michael Odeh. *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children* (Washington, DC, Georgetown University Health Policy Institute, Center for Children and Families, December 2007).
[iii] Government Accountability Office. *Means-tested Programs: information on Program Access Can Be An Important Management Tool* (Washington, DC: Government Accountability Office, May 2005)
[iv] D.K.Remler and S.A. Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health*, Volume 93, Number 1, 2003:67-74.
[v] CMS. Federal Register, January 11, 2001 Vol. 66, No. 8., p.2603. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=page+2639-2688.pdf
[vi] Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, September 2006), 43.
[vii] Ibid., 43.

[viii] North Carolina and Ohio have enacted legislation to increase the income eligibility for their SCHIP programs, but are currently undecided regarding their programs' waiting period.
[ix] Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Center for Budget and Policy Priorities: Washington, DC and Kaiser Commission on Medicaid and the Uninsured: Washington, DC, January 2008), 10.
[x] Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (Georgetown University Health Policy Institute: Washington, DC & The Commonwealth Fund: New York, NY, June 2006) 14-15.
[xi] Summer and Mann, 2006, 14-15
[xii] Kaye, Pernice, and Cullen, op. cit.
[xiii] Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2007 Annual Survey* (Menlo Park, CA:2007). http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf
[xiv] Center on Budget and Policy Priorities, "Is Medicaid Responsible for the Erosion of Employer-Based Health Coverage?" September 22, 2006, accessed at http://www.cbpp.org/9-22-06health.htm.
[xv] Ibid
[xvi] John Holahan and Allison Cook. *Health Affairs* 27, no. 2 (2008): w135–w144 (published online 20 February 2008; 10.1377/hlthaff.27.2.w135)]
[xvii] Under SCHIP federal regulation, total cost sharing, including premiums and co-payments, may not exceed 5 percent of family income. For more information see *Charting SCHIP III*
[xviii] Kaye, Pernice, and Cullen, op. cit.
[xix] Center for Medicaid and Medicare State Operations, Health Official Letter (Baltimore, MD: U.S. Department of Health and Human Services, August 2007), SHO #07-001.