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United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

H.R. 5998
Protecting Children's Health Coverage Act of 2008
May 15, 2008 Hearing

Testimony submitted by
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Chairman Dingell; Subcommittee Chairman Pallone; Ranking Member Barton; Ranking Member Deal; Representatives Waxman, Eshoo, Capps, Solis; and distinguished members of the subcommittee thank you for the invitation to participate in this hearing on H.R. 5998-the Protecting Children's Health Coverage Act of 2008. I am Lesley Cummings, Executive Director of the California Managed Risk Medical Insurance Board (MRMIB), the state agency that administers California's State Children's Health Insurance Program (SCHIP) also known at the Healthy Families Program (HFP), as well as several other health programs.

California's SCHIP

In California, SCHIP funding provides coverage to over one million uninsured children and pregnant women through Healthy Families, the state Medicaid program (known as Medi-Cal) and Access for Infants and Mothers Program. California's SCHIP is the largest in the United States and is larger than the combined total of the second and third largest states' SCHIP programs.

The program opened in July 1998 under a state plan approved by CMS. Initially, the program served children with family incomes up to 200% of the federal poverty level (FPL) after application of Medicaid income deductions. In 1999, California expanded coverage to include children with family incomes up to 250% of the FPL (net of income deductions). CMS approved California's state plan amendment for the expansion on November 23, 1999. California's 3 month waiting period for coverage applied to the expansion population as well as the original population and was approved by CMS. In 2006, California chose to implement the option to cover pregnant women using SCHIP funding; this expansion to cover pregnant women was strongly encouraged by the Bush

Administration. As part of that state plan amendment (SPA) approved by CMS on March 28, 2006, pregnant women are covered up to 300% of poverty as are their infants through the second birthday. Governor Schwarzenegger and the legislative leadership are interested in expanding coverage of children to 300% of poverty and have included the expansion as one element of the health care reform proposals that have been under active discussion. In the meantime, California, under a state plan amendment approved by CMS July 10, 2004, already allows 3 counties with local programs serving children up to 300% of poverty to draw down SCHIP funding to match their county funding. Thus, CMS was a partner with California in the design of our SCHIP program, its eligibility levels and crowd out policies. The program, as approved by CMS in the original state plan and in 12 state plan amendments CMS also approved, is in compliance with existing SCHIP law and regulations.

We believe Congress was absolutely correct in designing broad state flexibility into the SCHIP law, recognizing that a "one-size-fits-all" administration structure would not be the best model. This state flexibility has been of enormous value to California in designing and implementing the Healthy Families Program. As a state, California has a higher cost of living than most other states (see chart on page 11 of this document), a lower rate of employer sponsored coverage, and a higher rate of uninsurance. Having the ability to take these issues into consideration has been essential as the state has assessed its approach to children's coverage and universal coverage. And while Governor Schwarzenegger and other California policy makers believe California children should be eligible up to 300% of poverty (net of income deductions), the Healthy Families Program's average child has a family income of 165% of poverty. This

only makes sense given that the lower a family's income, the greater the likelihood that the family will be uninsured.

California is concerned that CMS attempted to make significant changes in SCHIP rules, without sharing the "guidance" with states in advance or providing for a period of public comment prior to issuance. Governor Schwarzenegger wrote to President Bush on August 29, 2007 and Secretary Leavitt on September 17, 2007 asking that they withdraw the CMS directive. The states of New York (joined by Illinois, Maryland and Washington) and New Jersey have filed lawsuits against the federal Department of Health and Human Services (HHS) seeking to prevent HHS from disapproving any state plan amendment using the criteria based on the August 17, 2007 directive. Governor Schwarzenegger also directed the California Attorney General to file an amicus brief in support of New York's lawsuit. The brief was filed on April 18, 2008 jointly with the states of Connecticut, Massachusetts and New Mexico. In addition, a New York advocacy organization has filed a lawsuit against the Secretary of HHS asking for similar relief.

Impact of the Directive on California and Other States

Children in a number of states already have been adversely affected by the application of the August 17 directive's requirements. A Families USA's February 2008 report estimates that the directive has already prevented more than 150,000 children nationally from getting health care in states that have tried to expand SCHIP coverage. According to Georgetown University's Center for Children and Families, four states that enacted legislation expanding their SCHIP programs have been forced to halt or cut

back their coverage expansion plans. Two other states have chosen to finance their expansion with state-only funds and an additional eighteen states are expected to be affected over the next five months, including fourteen that cover children above an "effective" (i.e. gross) income level of 250% of poverty. Tennessee, which like California has traditionally applied Medicaid income disregards when determining income eligibility, has had to change over to a gross income standard in order to receive CMS approval. States must apply income deductions to family income consistent with their Medicaid programs if they want to assure that children will be appropriately enrolled in Medicaid. The requirement to calculate gross income at higher income levels means that states must maintain 2 separate eligibility systems, a costly and confusing situation for states and families.

California is one of the 14 states that CMS has identified as having eligibility at a level that requires program changes consistent with the requirements and assurances of the August 17 letter. CMS has told these 14 states that they must be in compliance within one year or cease covering new children with gross family incomes above 250%. A report commissioned by the California HealthCare Foundation "Assessing California's Ability to Comply with New Federal SCHIP Rules", Harbage Consulting, October 5, 2007, (included as Attachment 1) made a preliminary analysis of California's ability to comply with each of the directive's requirements. According to the August 17 letter a state must comply with **ALL** requirements and assurances to serve children with gross incomes above 250% of poverty.

According to the report, California would have difficulty with the following requirements from the directive:

- Assuring that the state has enrolled in Medicaid or SCHIP at least 95% of children with incomes below 200% FPL. CMS invites states to offer data from a variety of sources to make this determination, including the Urban Institute's TRIM model. There is something critical at stake here. Even presuming that states could find data sources that work, by agreeing to the CMS refinement process states would be undercounting the number of uninsured children in the state. The SCHIP funding formula takes the number of uninsured children into consideration. As a result, states would risk a reduction in funding because the count would show fewer uninsured children. And this would be occurring at a time when the national economy is slowing and the number of uninsured in growing.

  The report notes that the Urban Institute's TRIM model suggests California has met the standard and enrolled 135 percent of the children eligible for Medi-Cal and Healthy Families. On its face, this is not credible. It is clear that California has yet to enroll all of its eligible uninsured SCHIP children. A 2005 state survey indicates that California has reached approximately 88 percent of the children at or below 200 percent of poverty but it does not account for the recent economic slowdown which is increasing the number of uninsured in California and nationally.

- Redefining "uninsured children" as those without coverage for a period of one year, would require a fourfold increase in California's waiting period before a child is eligible for SCHIP coverage. California has seen no reason to believe that such a long period of uninsurance is necessary to prevent crowd out. (See Attachment 2). The redefinition of an uninsured child by CMS does not change

the fact that the child is uninsured and will lack access to preventive cost-efficient health care. The impact to families is that they will wait until their child is sicker to seek health care through the emergency room, -- the least cost efficient vehicle for delivering care. Not only will this redefinition of being uninsured have adverse consequences on the health of children nationwide, it will have adverse impacts on the financial health of struggling low-income working families who will potentially be liable for the full costs of the emergency room visits. Also, the one year waiting period will potentially direct hundreds of thousands of children nationwide to seek basic preventive health care in emergency rooms, further stressing these already overtaxed facilities. This not only impacts the children diverted to the hospital settings but reduces access for anybody needing emergency services because of the unnecessary redirection of children's basic health care delivery to hospital emergency departments. CMS originally told states there would be no exceptions to this requirement. On May 7, 2008 CMS released a letter to "clarify" aspects of the August directive. On this issue, the letter indicated that CMS is willing to discuss exceptions with states, although the letter reiterates that one year is still considered the standard. CMS has provided no guidance as to what exceptions would be acceptable.

- Increasing cost-sharing to five percent of family income (the maximum allowed under federal law) unless the state can demonstrate that there is less than a one percent difference between public and private coverage. Requiring a family contribution at five percent of income would increase family premiums by a factor of 14 times in California – thousands of dollars in new family costs. Private insurance cost-sharing has not been developed with the need to be compatible with the needs of low-income families, so it is not clear why a comparison to

private insurance is the appropriate standard. Further, it is unclear how states, in general, or California, in particular, could make this demonstration given the wide range of health insurance products. And implementing it would require that California make significant and costly system changes to track familial premiums and co-payments to ensure that they do not exceed the federal maximum. [Note: In his budget for 2008/9, the Governor has proposed premium and co-payment increases for families with incomes above 150 percent of FPL. These would increase family cost sharing from the present level of around 1.8 percent of family income to between 2.3 to 2.7 percent of family income.]

- Assuring that the number of children in the target population insured through private employers has not decreased by more than two percentage points over a five year period. California, like many states, is experiencing an erosion in employer sponsored coverage and could not even provide this assurance for adults. As health care costs rise, employers are reducing their health benefits nationally and without regard to the existence of public programs. From 2002-2005, California experience a three percent drop in employer sponsored coverage for adults according to the California Employer Health Benefits Survey, 2007.
- Verifying family insurance status through insurance databases. HFP relies on its participating plans to report whether an enrolled child previously had employer sponsored coverage. HFP could implement this requirement, but it would significantly increase administrative costs. According to California's Legislative Analyst, a proposed new system to verify auto insurance in California will cost over $40 million.

Another troubling aspect to CMS's approach with the August 17 letter is that CMS has failed to provide a transparent and consistent standard that will be applied to all states. Instead, CMS apparently plans to negotiate with states on a state-by-state basis concerning each requirement and assurance. The CMS' August 17 letter and its May 7, 2008 follow-up letter invites the SCHIP states to engage in discussions with the agency to better understand the requirements and how they will be put into operation. On February 29, 2008 California had such a discussion with CMS and will be scheduling additional calls in the future. However, states have not received written guidance or direction from CMS on what data sources will be used to measure compliance and what processes will be used for SCHIP states that are not able to meet all of the directive requirements, or on what timeline CMS will proceed.

It is similarly unclear which SCHIP populations would be subject to the requirements. When CMS issued the original August 17 letter, California estimated that it would affect 35,000 enrolled children with gross family incomes above 250% FPL (because of the application of income deductions). In the May 7 letter, CMS specifies that the provisions would not apply to existing enrollees. Nevertheless, they would apply to children who are newly applying at this income level, some 14,000 children per year. We are unclear whether or not CMS would be applying the rules to pregnant women. In our phone conversation, we were told that the August 17 provisions did not apply to them. However, the May 7 letter merely exempts them from the one year of uninsurance requirement.

In a letter to Senators John Rockefeller and Olympia Snowe dated April 17, 2008, the Governmental Accountability Office (GAO) concluded that the August 17th letter is a rule under the Congressional Review Act and "[t]herefore, before it can take effect, it must be submitted to Congress and the Comptroller General." Similarly, in an earlier memorandum to Senator Rockefeller (January 10, 2008), the Congressional Research Service suggested that a reviewing court would likely reach the same conclusion. The American Public Health Services Association and the National Association of State Medicaid Directors wrote to the HHS secretary on April 23, 2008 urging withdrawal of the August 17 directive on that basis and on the basis of deep concerns about the content of the directive.

The enactment of H.R. 5998 would specifically nullify the policies established in the August 17 letter, and subsequent guidance letters. This would stop the application to state programs of a number of bad policies and provide clarity for the immediate future, something of enormous value to the states and uninsured children. States could cease spending considerable staff time and resources trying to negotiate with CMS or making the significant system changes that would be required to comply with the requirements and concentrate on providing coverage to the nation's uninsured low-income children.

I would again like to thank you for the invitation to participate in this hearing and the opportunity to represent California's SCHIP program. SCHIP has been a shinning example of how government can truly serve its neediest constituents. The wise investment in the health of the children of the United States will pay long-term dividends

in healthier children, children who are better prepared to learn in school, students who achieve greater educational success, and individuals who grow into productive members of our society in the future.

Federal Poverty Level Chart

What does it mean to be at 200% FPL in California?

(200% FPL for a Family of Four in 2008 = $42,400/year)

Large/Urban Cities:

If you made $42,400/year in:	Then you need the following salary to maintain the same standard of living in *San Francisco, CA*	Percent Difference
Atlanta, GA	$74,327	75%
Washington DC	$51,345	21%

Mid-Size Cities:

If you made $42,400/year in:	Then you need the following salary to maintain the same standard of living in *Sacramento, CA*	Percent Difference
Des Moines, IA	$56,629	34%
Austin, TX	$54,082	28%

Small Cities:

If you made $42,400/year in:	Then you need the following salary to maintain the same standard of living in *Bakersfield, CA*	Percent Difference
Tuscaloosa, AL	$48,774	15%
Asheville, NC	$46,268	9%

Source: CNN.com, downloaded April 2008. Prepared by: Peter Harbage and Lisa Chan-Sawin, Updated April 2008.

Attachment 1-“Assessing California’s Ability to Comply with New Federal SCHIP Rules” California HealthCare Foundation, Harbage Consulting, October 5, 2007

Attachment 2-“Crowd-Out in the Healthy Families Program, Does it Exist?” Institute for Health Policy Studies, UCSF, August 2002