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

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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 A	Total (denominator) B	Total insured (numerator) C	Insured percentage D = C / B	Margin of error E	Lower bound F = D - E	Upper bound G = D + E	Sample size 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 A	Total (denominator) B	Total insured (numerator) C	Insured percentage D = C / B	Margin of error E	Lower bound F = D - E	Upper bound G = D + E	Sample size 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

[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

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[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).