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ON

COVERING UNINSURED CHILDREN: THE IMPACT OF THE AUGUST 17 SCHIP DIRECTIVE

BEFORE THE

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CMS
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Testimony of
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Before the Senate Committee on Finance, Health Care Subcommittee

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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-

[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:

[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.

[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.

[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.