

# The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs

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The Centers for Medicare and Medicaid Services (CMS) released on August 17, 2007 a letter to state health officials (SHO #07-001) which has major implications for the State Children's Health Insurance Program (SCHIP) and children's health coverage. According to CMS, its directive addresses the potential for crowd-out when SCHIP programs cover children with "effective" family incomes exceeding 250 percent of the federal poverty level, or approximately \$52,000 for a family of four. Crowd-out refers to the substitution of publicly funded coverage for private health insurance.

Long-standing federal SCHIP regulations require that states have "reasonable procedures" to deter crowd-out. CMS has indicated in the past that

states with eligibility levels of more than 250 percent of the federal poverty level should have strategies in place to deter crowd-out. In the August 17 directive, CMS indicated that states now must implement what it identifies as the five most common strategies to deter crowd-out, and must incorporate three specific components into these strategies. States also must provide assurances that three other conditions are met when expanding coverage to families with gross family incomes above 250 percent of the federal poverty level. (See Table 1 for the specific provisions within CMS's August 17, 2007 directive.)

The requirements in the August 17 directive have raised questions and concerns among states, especially among the 24 states that appear to be affected due to current or recently approved eligibility levels (see Table 2 for a list of states). To date, CMS 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 the National Academy for State Health Policy (NASHP) and submitted at the suggestion of CMS. In February 2008, CMS initiated phone calls in order to discuss compliance with the directive with many of the states previously approved to cover children in families with incomes above 250 percent of the federal poverty level. States and other parties have filed three lawsuits that maintain, among other things, that CMS issued the directive without following the Administrative Procedures Act, which regulates the rulemaking process.

Many advocates for children's coverage are urging Congressional action to prevent the implementation of the directive. Among states and advocates alike, there is concern that aspects of the directive work against achieving the goals of SCHIP and the broader purpose of assuring that children have health coverage and access to quality care.

NASHP has assisted and worked with state SCHIP directors since the program's inception in 1997. At the

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## Table 1. Provisions within the August 17 letter from CMS

### *Common strategies to deter crowd-out*

- Impose a waiting period between dropping private coverage and allowing enrollment;
- Impose cost sharing in approximation to the cost of private coverage;
- Monitor health insurance status at time of application;
- Verify family insurance status through insurance databases; and
- Prevent employers from changing dependent coverage policies that would favor a shift to public coverage.

### *Components to be incorporated as part of identified crowd-out strategies (noted above)*

- The cost sharing requirement under the state plan compared to the cost sharing required by competing private plans must not be more favorable to the public plan by more than one percent of the family income, unless the public plan's cost sharing is set at the five percent family cap;
- The state must establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage; and
- Monitoring and verification must include information regarding coverage provided by a noncustodial parent.

### *Assurances required*

- Assurance that the state has enrolled at least 95 percent of the children in the state in families with income below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps taken to enroll these eligible children);
- Assurance 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; and
- Assurance that the state is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements.

Source: Centers for Medicaid and Medicare State Operations, Health Official Letter (Baltimore, MD: U.S. Department of Health and Human Services, August 2007), SHO #07-001.

request of SCHIP directors in states that may be affected by the directive, NASHP convened a workgroup to discuss the provisions contained in the August 17 letter. A number of 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. As a result of these workgroup calls, NASHP has identified four of the requirements in the directive as causing the greatest concern among states. Most of the affected states believe the directive includes a number of requirements that will be very challenging, and in some cases impossible, to meet.

This *State Health Policy Briefing* examines the four requirements within the directive that are of greatest concern to states. It also provides details and context on CMS's directive requirements, background on current state policy

and practice related to each requirement, and a discussion of the issues and implications for states in assessing the feasibility and implications of responding to the new requirements. While this *Briefing* expresses many of the concerns and questions raised by the states in the workgroup, it does not represent all state viewpoints or opinions.

### **About the National Academy for State Health Policy**

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.

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**Table 2. States affected by the August 17 letter from CMS**

State	Program Type	Current Eligibility (Percent FPL)	State Enacted Eligibility - Not Yet Implemented
<i>Federally approved and implemented prior to August 17, 2007</i>			
California	Combination	250	
Connecticut	S-SCHIP	300	
District of Columbia	M-SCHIP	300	
Georgia	S-SCHIP	235	
Hawaii	M-SCHIP	300	
Maryland	Combination	300	
Massachusetts	M-SCHIP	300	
Minnesota	Combination	275	
Missouri	M-SCHIP	300	
New Hampshire	Combination	300	
New Jersey	Combination	350	
New Mexico	M-SCHIP	235	
Pennsylvania	S-SCHIP	300	
Rhode Island	Combination	250	
Vermont	S-SCHIP	300	
<i>State enacted eligibility increases - not yet implemented</i>			
Indiana	Combination	200	300
Louisiana*	M-SCHIP	200	300
New York	S-SCHIP	250	400
North Carolina	S-SCHIP	200	300
Ohio	M-SCHIP	200	300
Oklahoma	M-SCHIP	185	300
Washington	S-SCHIP	250	300
West Virginia	S-SCHIP	220	300
Wisconsin*	M-SCHIP	185	300

**Notes:** States marked with \* have received approval from CMS to increase their SCHIP program's income eligibility to 250 percent of the federal poverty level. As a result of the August 17 letter, these states did not pursue approval for the entire increase approved by their state legislatures.

**Sources:**

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.

Cindy Mann and 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, Dec. 2007) 3.

## Assuring a Participation Rate of 95 percent in SCHIP and Medicaid

### DIRECTIVE REQUIREMENT

CMS's directive requires states covering children with gross 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.<sup>1</sup> While states share the goal of maximizing enrollment of eligible uninsured children, there are both measurement and feasibility issues that are raised by this assurance requirement.

### CURRENT STATE POLICY AND PRACTICE

Since SCHIP was created in 1997, states have endeavored to increase coverage for low-income children in families with income below 200 percent of the federal poverty level. More

than 90 percent of SCHIP enrollees are from families with incomes in this range.<sup>2</sup> States expend significant resources on outreach to find and enroll these eligible children, and have instituted a variety of measures to improve enrollment and retention practices. The vast majority of children with family income below 200 percent of the federal poverty level who are eligible for either Medicaid or SCHIP are covered.<sup>3</sup>

Additionally, a number of states have found that increasing eligibility to higher income levels has been instrumental in reaching more eligible children in families with income below 200 percent of the federal poverty level. Using existing federal statutory options or through federally approved waivers, many states have established eligibility levels above 200 percent of the federal poverty level for SCHIP. Establishing higher eligibility levels can reinforce the message that children can qualify even if their parents are working and earning low to moderate incomes. Many parents report lack of awareness of Medicaid and SCHIP, as low-income, uninsured children typically live in working households which have little contact with government assistance programs.<sup>4</sup> States have found increasing eligibility levels brings in lower-income children whose families might have been unaware that they were eligible at the lower income limits. As examples:

- Illinois' universal children's coverage program, AllKids, initially enrolled 166,000 children. Approximately 70 percent (114,000) had been eligible previously but uninsured.<sup>5</sup>
- In New York's proposed SCHIP expansion to children in families with income up to 400 percent of the federal poverty level, 93 percent of the additional estimated spending would have been allocated toward covering eligible but unenrolled children in families with income below 250 percent of the federal poverty level (the state's current eligibility limit). New York anticipated a similar experience to Illinois' in getting out the message that it's not just the very poor who qualify for SCHIP.<sup>6</sup>

## ISSUES AND IMPLICATIONS

Participation rates are difficult for states to measure. 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 and the inclusion of undocumented immigrants in the survey. The agency has informed some states that a variety of other data sources, including state surveys, could also be used. However, a number of researchers and other experts believe that most states will have difficulty demonstrating 95 percent participation using available sources and methodology.

CMS has not provided a rationale for the 95 percent rate. Since no state, to date, has successfully convinced CMS that it has reached the standard, many believe it is an unrealistic requirement. Even with the most aggressive outreach and enrollment strategies, it is likely to remain a difficult requirement for most states to reach. The participation rates for Medicaid and SCHIP are higher than most other programs targeting low-income Americans. Participation in the federal Food Stamp Program is approximately 50 percent of those eligible, roughly 30 percent below the participation rate for SCHIP.<sup>7</sup> Even in Medicare Part B, in which seniors are enrolled automatically unless they specifically opt-out, the participation rate just exceeds 95 percent (95.5 percent enrolled).<sup>8</sup>

If some states can develop methods to document 95 percent participation rates in their states, many directors would still have 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).

## Establishing a Minimum 12-month Waiting Period

### DIRECTIVE REQUIREMENT

CMS's directive requires states to establish – for children with family income 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. At this time, CMS has not indicated whether or not exceptions to the rigid standard, for example, due to death of a parent or involuntary job loss, will be considered.

### CURRENT STATE POLICY AND PRACTICE

In accordance with federal policy dating back to 2001,<sup>9</sup> 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.<sup>10</sup> In addition, as mentioned earlier, 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 a recent NASHP state survey, the most frequently reported means used to deter crowd-out is a waiting period for children covered previously by a private insurance policy.<sup>11</sup> Although it is unclear at this time how many states will be affected by the August 17 directive, 19 of the 24 states<sup>12</sup> 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. These range from one to six months. However, most states report requiring a six-month waiting period between leaving private coverage and joining SCHIP.<sup>13</sup> All of the states that require 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. The most common exceptions used by states are:

- Loss of insurance due to parent's death, divorce, or an absentee parent dropping coverage;
- Involuntary loss of employment;

- Involuntary loss of employer-sponsored coverage;
- Parent starts a new job;
- When cost-sharing requirements for private insurance are determined to be too expensive, most often defined as ten percent or more of income.<sup>14</sup>

### ISSUES AND IMPLICATIONS

As noted, states that utilize waiting periods generally institute the requirement for children who were covered previously by private plans. In general, states have not required children to be uninsured for a set length of time prior to applying for SCHIP, as the CMS directive will require. States are concerned that CMS may be suggesting that regardless of prior coverage status or changed circumstances, children will have to remain uninsured for a year before they are eligible for SCHIP coverage. Many states consider a 12-month waiting period to be an overly broad policy that can have a negative impact on SCHIP's goals to increase coverage and access to care for children.

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. Gaps in coverage may deny children the preventative and diagnostic care that could have lasting implications for their healthy development. Research indicates the following impacts of uninsurance on children:

- Gaps in insurance coverage result in delayed care, inappropriate care, and costlier care.<sup>15</sup>
- Children with gaps in health care coverage greater than six months have been shown to have the highest rates of unmet needs.<sup>16</sup>
- Compared with those insured for a full year, children with gaps in coverage are less likely to report that they have a usual source of care other than an emergency room.<sup>17</sup>
- Research done in Washington State indicates that uninsured children visited an emergency room more than twice as often during a six-month period as children with no gap in coverage.<sup>18</sup>
- A recent study of New York's SCHIP program indicates that children insured by SCHIP are more likely than uninsured children to have a usual source of care.<sup>19</sup> The study further demonstrates that children without a usual source of care are more likely to have unmet care needs and/or inappropriate visits to the emergency room.

Considering the current and projected state of the economy, states are aware that employers may begin to look for ways to cut their costs, which may result in families los-

ing employer-sponsored coverage or their jobs. Even in good economic times, privately insured children, just like children insured in Medicaid and SCHIP, are prone to coverage interruptions.<sup>20</sup> Public insurance programs can often fill in the gaps in coverage during these durations. If it does not allow exceptions to this one-year waiting period, CMS could be creating a punitive barrier that keeps children uninsured as a result of an economic downturn rather than through their family's willful substitution of public coverage for private coverage.

In addition, a 12-month waiting period may have minimal impact on crowd-out. Research in 2007 by MIT economist Jonathan Gruber and Cornell economist Kosali Simon on crowd-out suggests that waiting periods in states will not lower significantly the crowd-out rate when compared against states with no waiting periods. While there is substitution in SCHIP (and any other coverage option), according to Gruber and Simon, they do not believe that requiring children to wait for coverage will impact crowd-out.<sup>21</sup>

Another concern of states is the significant administrative challenges this provision poses for their programs. For instance, states 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 can appear complicated already to the families it serves. Costly technical systems changes may be needed to process applications and determine eligibility (this applies to other directive requirements as well).

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, states that could be affected largely view this waiting period provision as poor public policy. Requiring a standard one-year waiting period will reduce the flexibility of states' SCHIP programs, impose unfunded administrative burdens, and will have potential negative consequences for children's health. Also, while states operating separate-SCHIP programs could comply, it is unclear how states operating Medicaid-expansion SCHIP programs could comply, given that federal Medicaid rules govern these programs – and these rules prohibit states from adopting waiting periods. Unless directed otherwise by CMS, states operating Medicaid-expansion SCHIP programs would have to pursue section 1115 waivers to implement a waiting period in order to comply with this provision.

## Assuring that Employer-Sponsored Insurance has not Declined by more than Two Percentage Points in the Past Five Years

### **DIRECTIVE REQUIREMENT**

The CMS directive requires that if a state wishes to cover children with gross family incomes above 250 percent of the federal poverty level, it must show that the employer-sponsored insurance (ESI) rate for low-income children has not declined in the state by more than 2 percentage points over the past five years.

### **CURRENT STATE POLICY AND PRACTICE**

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 2005.<sup>22</sup> SCHIP reauthorization legislation attempted to amend the rules to make it easier for states to begin to offer premium assistance for SCHIP enrollees.

Despite their interest in promoting ESI, states have no control over private employers' decisions to offer insurance coverage, as employers are regulated under federal ERISA. 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.<sup>23</sup> And, although they 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.

As mentioned earlier, federal law already requires all states to monitor crowd-out in SCHIP, and also requires states with higher income eligibility limits to have strategies to deter crowd-out (such as waiting periods or cost sharing) in place. Most states have not seen a great deal of substitution at any income level.

### **ISSUES AND IMPLICATIONS**

With few exceptions, most states will be unable to meet





