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SCHIP at the Crossroads: California's Options in Responding to New Federal Funding Conditions

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Prepared by
Peter Harbage and Hilary Haycock
Harbage Consulting, LLC

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About the Authors

Peter Harbage is president of Harbage Consulting, LLC, an independent firm specializing in national and California health policy. Hilary Haycock is as an independent consultant to the firm who drafted a significant portion of the text.

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Executive Summary

For more than ten years, the State Children’s Health Insurance Program (SCHIP) has played an integral role in providing health coverage for millions of children. California has the nation’s largest SCHIP program, known as Healthy Families. The state receives roughly 16 percent of all annual federal SCHIP funds¹ and covers approximately 1 million children and mothers through Healthy Families and other SCHIP-funded programs.²

The past 18 months have seen significant developments in SCHIP policy. Following extended debate and an ultimate presidential veto of a long-term national SCHIP reauthorization plan, Congress extended federal funding for SCHIP until March 2009.

However, the top issue confronting the future program design of SCHIP is a set of conditions for states wishing to use federal funds to cover children with family incomes above 250 percent of federal poverty level (FPL). The conditions were issued in an August 17, 2007 letter from the Centers for Medicare and Medicaid Services (CMS), commonly known as the CMS “directive.”

Key Conditions for Federal SCHIP Funding as Conveyed in the CMS Directive

To use federal funds to cover children with family incomes above 250 percent of the FPL, states must:

- Monitor “health insurance status at the time of application.”
- Verify “family insurance status through insurance databases...which must include information regarding coverage provided by a non-custodial parent.”
- Prevent “employers from changing dependent coverage policies that would favor a shift to public coverage.”
- Ensure that, “the cost-sharing requirement under the State plan compared to...competing private plans [is] 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 5 percent family cap.
- “Establish a minimum of a one year waiting period of uninsurance for individuals prior to receiving coverage.”
- Assure “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.”
- Assure “that the number of children in the target population insured thorough private employers has not decreased by more than two percentage points over the prior five year period.”
- Assure, “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: August 17, 2007 from CMS Letter to State SCHIP program directors.

These policy changes have come under fire from state and federal policymakers. States have faced challenges both in interpreting the ambiguous language of the directive and determining if and how these conditions might be implemented. A number of states have taken the directive to federal court, creating the possibility of a judicial order blocking its implementation. Several congressional agencies have issued opinions questioning CMS' legal authority to issue or enforce the new requirements. While these agencies do not have the power to rescind the directive, their findings have been the subject of congressional hearings and legislation that would nullify its proposed changes.

Compliance would require significant changes to California's SCHIP programs. Given the possibility that the new conditions will be rescinded by Congress, the federal courts, or even a new president in 2009, California policymakers have three broad options to consider:

- **Option 1: Attempt to Comply by Meeting All Directive-Specified Conditions.** California is already in compliance with several of the directive's conditions. The state could attempt to meet the others, but will likely have difficulty doing so.
- **Option 2: Comply by Changing Healthy Families' Eligibility Level or Foregoing Federal Funding.** In order to avoid having to comply with the directive's problematic conditions, California can use state money to replace the federal funds that now cover children with family incomes above 250 percent of the FPL. Alternatively, the state could stop enrolling children who would trigger the directive's conditions.
- **Option 3: Continue to Claim Federal Funds While Considering Program Changes.** California could continue to claim federal funds while working with the federal government towards compliance, or in the hope that the federal government will not enforce compliance.

At the time of the publication of this report, it was the expressed opinion of Governor Arnold Schwarzenegger and other California officials that the directive is misguided.³ It seems unlikely that the state will be in compliance with the directive by the CMS deadline of August 18, 2008, for at least two primary reasons:

- *Lack of Federal Guidance.* One of the directive's central challenges is interpreting the language of its conditions and how they should be implemented. Even a subsequent letter to the states in May 2008 failed to provide the necessary clarification. Significant additional information regarding implementation of the directive is needed from the federal government. As this analysis shows, it will be difficult for California to determine how to comply or confirm compliance without this information.
- *More Work in California Needs to be Completed.* California has significant work ahead if the state is to make the changes required to comply with the directive, including passing legislation and (depending on the state's policy decisions) possibly identifying new sources of SCHIP funds. California's ability to move quickly is hampered by the state's budget deadlock.

In part, California's response will depend on federal action. The two most likely scenarios are:

- *CMS as Partner*. Historically, CMS has pursued the implementation of a new policy such as the SCHIP directive as a partner, working with states to find mutually agreeable forms of compliance. This is consistent with a May 7th letter from CMS addressing implementation of the directive, which says that, "we will continue to work with affected States and review requests for alternative approaches on a case-by-case basis to ensure compliance."⁴
- *CMS as Regulator*. As the culmination of a contentious year for SCHIP policymaking, the directive has been highly controversial; however CMS has continued to stand by the directive's conditions. It is possible that the federal government would pursue the matter as a regulator, with several courses of action for enforcing compliance.

If CMS responds as a partner, California policymakers can try to develop a way to compromise with CMS on the policy. Given statements by Governor Schwarzenegger, it seems that any compromise would need to be in the state's favor—meaning that California would be able to keep the current eligibility rules and federal funding for its SCHIP program.

However, if CMS attempts to force compliance, California will face a different set of policy and financing options. Compliance with the directive would seem to require California to stop using federal funds to cover newly enrolled SCHIP children whose families earn more than 250 percent of the FPL immediately. The state's failure to comply could lead the federal government to actively enforce the directive. For example, CMS could seek to penalize California by withholding the estimated \$1.2 million in federal funds that the state uses every month to cover such children.

Should the directive take effect, California faces challenges in attempting to claim federal dollars and will need to resolve important legal questions. Even so, adopting a wait-and-see approach as Congress and the courts proceed through their processes is a viable option for the state. Deciding not to comply could arguably be seen as rational as it reduces the administrative labor needed to change state laws and program rules in response to what could be a short-lived federal policy.

Background

In the past decade, states have used their authority under SCHIP to significantly expand health coverage for children. In federal fiscal year (FFY) 2005, 6.1 million children were enrolled in SCHIP, contributing to a drop in the percentage of low-income, uninsured children from 22.3 percent in 1997 to 14.9 percent.⁵ A string of federal developments in the second half of 2007, including the CMS directive,⁶ appear designed to curtail program growth. Despite SCHIP's bipartisan popularity, long-term reauthorization with funding to ensure continued program growth failed to secure enough votes to override a presidential veto. A timeline of federal events related to SCHIP is summarized in Appendix A.

Reauthorization Efforts

In February 2007, President Bush proposed reauthorizing SCHIP with a \$5 billion increase above the annual baseline funding of \$25 billion over five years (resulting in an estimated \$6 billion per year for the states).⁷ State officials and children's care advocates viewed this as inadequate and urged Congress to consider a stronger reauthorization package with an increase large enough to meet the growth that had already occurred in state programs, as well as provide room for further expansions.

In September 2007, Congress passed the first bipartisan compromise bill on SCHIP reauthorization, the Children's Health Insurance Program Reauthorization Act (CHIPRA, H.R. 976). The legislation would have more than doubled SCHIP spending by adding \$35 billion in new funding over a five-year period, and expanded coverage to more than four million children. A primary reason given by the legislators who supported the president's veto was the increase in government health spending required under the bill.⁸

Congress passed a second, similar SCHIP compromise bill, CHIPRA 2 (H.R. 3963), in November 2007. This bill attempted to address the opposition's concerns by creating a firm income eligibility cap at 300 percent of the FPL. Despite continued bipartisan support and growing public pressure, the compromise bill failed to win a veto-proof majority in the House of Representatives. In vetoing the measure, the president stated his opposition to a new tobacco tax funding mechanism, as well as any increase in new funding for SCHIP above \$20 billion over five years.

The SCHIP Extension Bill

Following the second presidential veto, Congress began work on a short-term solution to continuing program funding for SCHIP. Most of the leadership on this issue came from Democratic legislators, but there was also support among the Republican caucus, as demonstrated by an extension proposal from Representative Joe Barton (R-TX). Eventually, a bill to extend SCHIP, as well as address several Medicare and Medicaid issues, passed during the final week of the 2007 legislative session and was signed into law by President Bush on December 29th.

The extension bill, the Medicare, Medicaid and SCHIP Extension Act of 2007 (S. 2499), is designed to maintain state SCHIP programs as they are rather than fund expansions. The bill continues the baseline allotment of \$5 billion per year. Additional funds are available as

incentives for programs to increase enrollment within existing eligibility levels, or to make up for budget shortfalls due to growth in health care costs and inflation. Those additional funds total just \$1.6 billion in 2008 and \$275 million for the first two quarters of the 2009 federal fiscal year.

The extension expires March 2009, offering a relatively small amount of time for the new Congress and president taking office in January 2009 to agree upon a longer-term reauthorization plan. Congressional attention will likely not return to this issue until after the presidential election in November 2008.

Issues Raised During the SCHIP Debate

The debate around the reauthorization of SCHIP centered around three issues: eligibility rules, the potential effect on the private insurance market, and financing. These are likely to be the same issues debated as part of the March 2009 reauthorization deadline.

Eligibility Levels. The original SCHIP statute targets children in families with incomes below 200 percent of the FPL, but allows states the flexibility to expand coverage to higher income levels.⁹ Several reauthorization proposals that passed with bipartisan support would have expanded income eligibility levels up to 300 percent or 400 percent of the FPL. However, a minority of congressional Republicans favored both a lower income cap and the elimination of income exemptions (known as “disregards”) and deductions. These Republican legislators were able to prevent Congress from passing income expansions with a veto-proof supermajority.

Income exemptions and deductions effectively broaden access to public programs by overlooking certain types of income or offering credit for certain expenses, such as child care, when determining eligibility. Eliminating income exemptions could make thousands of California children ineligible for continued SCHIP coverage. While the SCHIP program was designed for children in families earning up to 200 percent of FPL, California has expanded eligibility to 250 percent of the FPL by disregarding family incomes between 200 and 250 percent of the FPL and using income deductions to allow children in families with even higher gross income to enroll.¹⁰

Crowd-out. One of the most contentious issues in the reauthorization debate involved the extent to which a significant expansion of SCHIP would induce people to substitute public coverage for private insurance, a phenomenon known as “crowd-out.”¹¹ The Republican Caucus and the Bush administration argued that the SCHIP benefit package was too generous and might entice employers to drop health insurance for their workers or dependents. The administration argued that further expanding coverage to such high income levels would cause unacceptable rates of substitution of private coverage. To address this, the Bush administration and other Republicans sought to increase cost-sharing and reduce benefits with the goal of ensuring that premiums for public health coverage reflect the private market, thus making the shift from private to public insurance less attractive for individuals and families.

In fact, the SCHIP program already includes protections against crowd-out at the state level. For example, California's Healthy Families program requires children with employer-sponsored insurance to be uninsured for three months before they become eligible for the public program. Although the evidence is mixed, some studies have shown that this and other protections instituted by states are working to minimize crowd-out, and that California employers are not dropping coverage for workers in favor of the public program.¹²

Financing. When SCHIP was first authorized in 1997, there was significant debate over the program's financing structure. Although many wanted SCHIP to be an entitlement program where all eligible individuals would be guaranteed coverage, the compromise was to provide funding for SCHIP through block grants.

The basic financing structure of SCHIP has been challenging for states.¹³ The SCHIP block grant formula has been criticized for being unresponsive to economic cycles, inconsistently funded over the past decade, and inadequately targeted.¹⁴

Although much of the 2007 debate focused on the overall level of funding needed for the program to be successful, other financing issues discussed during the reauthorization debate included:

- Whether the program should remain a block grant or become an entitlement program;
- Adjusting funding levels for medical inflation;
- Possibly changing the formula for distributing funds to the states; and,
- Whether an increase in the federal tobacco tax was a sufficient and appropriate source of funding for the program.¹⁵

The President's Budget

Despite the objections of Congress and the states, the Bush administration included several controversial provisions for SCHIP in FFY 2009 budget proposed in January 2008.

In his budget, the president proposes reauthorizing SCHIP until 2013 with additional funding, as well as additional eligibility restrictions. The president's budget includes an additional \$19.7 billion in funding above baseline, which is higher than his original \$5 billion proposal but still short of what states say they need to sustain existing programs.¹⁶ In addition, the budget extends the restrictions in the CMS directive (discussed in greater detail below) to children in families earning between 200 percent and 250 percent of the FPL, and establishes an eligibility cap at family incomes of 250 percent of the FPL.

The U.S. House and Senate passed concurrent budget resolutions setting aside \$50 billion over five years for the program if it is reauthorized. The next step in the federal budget process will be to formalize that funding stream through an appropriations bill, subject to the House PAYGO rule requiring the identification of revenue sources—one of the key unresolved issues from the reauthorization debate. Thus far, the congressional budget proposals do not include the president's eligibility restrictions.

The CMS Directive and California's Response

As Congress debated changes to program funding levels and sought compromises on eligibility rules and benefit packages, the Bush administration made a number of administrative changes that increased the pressure on states to limit SCHIP programs.

The CMS Directive

In a letter to state health officials, dated August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) established eight new conditions that states must meet to use federal funds to provide SCHIP coverage to children in families with a gross income above 250 percent of the FPL.¹⁷ As conveyed in the directive, the conditions require states to:

- Monitor “health insurance status at the time of application.”
- Verify “family insurance status through insurance databases... which must include information regarding coverage provided by a non-custodial parent.”
- Prevent “employers from changing dependent coverage policies that would favor a shift to public coverage.”
- Ensure that, “the cost sharing requirement under the State plan compared to... competing private plans [is] 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 5 percent family cap.
- “Establish a minimum of a one year waiting period of uninsurance for individuals prior to receiving coverage.”
- Assure “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.”
- Assure “that the number of children in the target population insured thorough private employers has not decreased by more than two percentage points over the prior five year period.”
- Assure, “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.”

The Bush administration has asserted that the conditions are designed to ensure the SCHIP program would maintain its focus on the lowest-income children, as well as limit the potential crowd-out of private coverage. State officials, the advocacy and policy communities, and many lawmakers have expressed concern that the new requirements effectively limit program growth and could significantly change state operations. Concerns have also been raised that the Bush administration has not followed appropriate regulatory procedures in calling for the conditions to be implemented.

On May 7, 2008, CMS released a second letter to state health officials offering clarification of several of the new policies outlined in the August 17th directive. The letter asserted that the conditions only apply to new enrollees, not current beneficiaries. In addition, states do not have to apply several of the conditions concerning cost-sharing and waiting periods to applicants with family incomes below 250 percent of the FPL. In essence, the directive creates a two-tier SCHIP program, presenting a barrier for states seeking to expand or streamline their programs.

CMS has yet to suggest what action the agency or Bush administration may take to enforce the directive or address non-compliance.

California Children Covered by the Directive

While the May 7th letter clarifies that children currently enrolled in SCHIP programs are not affected immediately, the directive would affect the following populations of children when they try to enroll in SCHIP programs:

- **Children in Healthy Families with Household Incomes above 250 Percent of the FPL.** California has used the flexibility provided by the existing law to cover children in families with incomes above 250 percent of the FPL based on income exemptions and deductions. Healthy Families now covers 34,000 such children, with a total of 14,000 new enrollments every year.¹⁸ In the enrollment process, certain exemptions and deductions are applied to a family's gross income to yield a "net income," which is then used to determine program eligibility.¹⁹
- **Newborns in the Access for Infants and Mothers (AIM) Program with Household Incomes above 250 Percent of the FPL.** Today, AIM uses SCHIP dollars to cover children and pregnant woman with family incomes up to 300 percent of the FPL. While CMS has indicated that pregnant women and unborn children can still be covered under the directive, this exemption is not specifically extended to newborn infants. The number of infants with a family income above 250 percent of the FPL who are newly enrolled in AIM each year is estimated to be 1,500.²⁰
- **Some Children Enrolled in the Children's Health Initiative.** California has permission from the federal government to use SCHIP dollars to cover children with household incomes of up to 300 percent of the FPL in San Mateo, Santa Clara, and San Francisco counties, a population that now totals 1,100 kids. An application to expand coverage to Santa Cruz County is pending.

Finally, in 2007, the Assembly passed ABX1 1, which would have expanded coverage in Healthy Families to children with household incomes up to 300 percent of the FPL, affecting up to 100,000 previously uninsured children.²¹ The directive would have a direct impact on any such proposed expansion.

Current Status of the Directive

It may be that no further policy response will be needed because Congress or the courts will halt implementation. State and federal policymakers have begun exploring options to challenge the directive. New York, New Jersey, Illinois, Maryland, and Washington have challenged the directive in federal court, with the support of a number of other states, child health advocates and policy experts. Several Congressional agencies have issued opinions questioning CMS' legal authority in issuing or enforcing the new requirements. While these agencies do not have the power to rescind the directive, their findings have been the subject of Congressional hearings and legislation that would nullify its proposed changes. An outline of actions related to the directive at the federal and state level is available in Appendix A.

California’s Response

Thus far, California’s response to the CMS directive has been to highlight how it would disrupt the Healthy Families program. It has underlined this message through a variety of channels, including filing an amicus brief in support of a multi-state lawsuit challenging the directive. While nuances exist, California generally has three options for responding to the directive’s requirements:

Option 1:

Attempt to Comply by Meeting All Directive-Specified Conditions

Of the eight conditions set forth by the CMS directive, the state already complies with two and could easily meet a third. However, although California could attempt to comply with the remaining five conditions, the state is unlikely to be successful given the lack of clear federal guidance. Table 1 briefly outlines each of the directive’s eight conditions and specifies whether California is already in compliance, where program changes would bring California’s program into compliance, or if the state is unlikely to achieve compliance.

Table 1: Key Elements of the CMS Directive, and California’s Compliance

Key Elements of the CMS Directive	California Compliance	Sections of California Law Affected*	More Federal Guidance Needed to Implement
“Monitoring and verifying health insurance status at the time of application,” which must “include information regarding coverage provided by a non-custodial parent.”	Appears to comply	None	Yes
“Preventing employers from changing dependent coverage policies that would favor a shift to public coverage.”	Already complies	None	Yes
Implement “a minimum one year period of uninsurance for individuals prior to receiving coverage.”	Must extend current 3-month waiting period by 9 months to comply	Insurance Code 12693.71	Yes
“Verifying family insurance status through insurance databases.”	Must establish database and require insurers to report insurance status	New Legislation Needed	Yes

“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 5 percent family cap.” Also, states must impose “cost sharing in approximation to the cost of private coverage.”	Must increase cost-sharing to comply	Insurance Code 12693.43 and 12693.615	Yes
“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.”	Must increase reporting frequency, and possibly update crowd-out data collection and reporting	None	Yes
Assuring “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.”	It is not clear that the state can affect the employer market to achieve this requirement.	New Legislation Needed	Yes
Assuring “that at least 95 percent of children in the State with family incomes below 200 percent of the FPL have coverage can be supported by data demonstrating Medicaid, SCHIP or private coverage.” ²²	It is not clear how the state could achieve this requirement.	New Legislation Needed	Yes

Source: Authors’ analysis

* For those sections where it is indicated that no affect on current California law, this is based on the best available understanding of federal guidance. In the event the federal government revises the guidance, state law change may be needed.

Requirements California Could Meet. California could alter its SCHIP programs to address four conditions from the CMS Directive:

1. *Establishing a minimum one year waiting period.* California now requires a three-month waiting period between the loss of employer-sponsored insurance and the start of Healthy Families coverage, while also allowing for certain exceptions, such as the death of a parent. Implementing the one-year waiting period would require a change to California Insurance Code Section 12693.71. The state would also need to seek clarification from CMS on what if any exceptions can be allowed.

The May 7th letter clarified that this requirement does not have to be applied to new enrollees with family incomes below 250 percent of the FPL. However this would effectively leave California with a two-tier benefit program. While the letter also reaffirmed a commitment to a 12-month waiting period, it also opened the door for states to negotiate an exemption if they can provide data showing that shorter waiting periods do not encourage crowd-out.

Lengthening the waiting period could have a negative impact on the health of children on the waiting list.²³ Research has shown that gaps in coverage result in individuals delaying care, or receiving care in inappropriate and costlier settings, such as the local emergency rooms rather than with a primary care doctor.²⁴

2. *Requiring states to impose cost sharing in proportion to the cost of private coverage.* This would require “cost sharing under the state plan, when compared to cost sharing by competing private plans, to be no more favorable to the state plan by more than one percent of family income, unless the public plan’s cost sharing is set at the five percent family cap.”²⁵ The May 7th letter clarified that this condition does not need to be applied to children with family incomes below 250 percent of the FPL.

There are several issues with the implementation of this requirement. First, it is unclear how a “competing private plan” would be defined, given that child-only coverage is not widely sold across the state. If these types of plans are not available for comparison in some counties, the state may be forced to use family coverage, which tends to have higher cost-sharing requirements. CMS has suggested that an equation could be used to determine the cost-sharing amount for children under a family plan, but has yet to make that equation public.²⁶ To implement this requirement, the state needs more specificity from the federal government on the nature of the calculation. Complying would also likely require changing the law controlling Healthy Families premium payments (California Insurance Code Section 12693.43) and co-pays (California Insurance Code Section 12693.615).

Potential New Cost-Sharing Level

California may opt to set cost-sharing at the five percent of family income cap, although there are drawbacks to this approach both for the state and for families:

- *Increased administrative burden.* The cost-sharing process would be different for families below 250 percent of the FPL and those above, thereby imposing an administrative burden on the state as it creates a system for tracking cost-sharing among different populations.
- *Perverse economic incentives.* There would also be a significant disparity in cost burdens for families. Families whose income increased from 249 to 251 percent of the FPL would face higher health care costs under the directive. This would create a perverse economic incentive for families to keep their income low enough to avoid the significant increase in cost-sharing.

- *Elimination of current cost-sharing protections.* Changes to California law would be required for MRMIB to eliminate existing cost-sharing protections. Premiums are now set at a maximum of \$15 per child per month. Co-payments are capped at \$250 per family per year, though dental and vision co-pays are outside this cap. Today, the average Healthy Families enrollee (who is at 164 percent of the FPL) pays 1.6 percent of family income in cost sharing and premiums.

To pursue the 5 percent cap approach, California could choose among a range of options:

- Eliminate existing co-pays and set a monthly premium level that would achieve the 5 percent level; or
- Maintain existing co-pays and premiums and then reconcile charges at the end of the year so that the state receives a full payment.

Table 2 illustrates what these choices could mean for California families. Regardless of the method used to raise premiums, the burden on the family with a household income at 251 percent of the FPL would be substantial, with cost-sharing for a family of four set at a minimum of \$2,592 annually—a four-fold increase over today’s maximum of \$610.

Table 2. Annual Cost-Sharing Under Healthy Families Rules vs. CMS Directive
Average Family of Four Earning 251 Percent of the FPL (\$51,832)

	Healthy Families Rules	CMS Directive Conditions	
		Option One: Premium Only	Option Two: End-of-Year Reconciliation
Premium	\$360	\$2,592	\$360
Maximum Health Care Cost-Sharing	\$250	\$0	\$250
End-of Year Payment by Family	\$0	\$0	\$1,982
Total Paid by Family	\$610	\$2,592	\$2,592

3. *Verifying family insurance status through insurance databases.* Currently, Healthy Families health plans voluntarily report to MRMIB if a child previously was previously covered by employer-sponsored insurance, and when that coverage ended. To comply with the CMS directive, California would need to require reporting from *all* health insurance plans. This would increase administrative costs to the state as well as to insurers, possibly increasing the cost of private coverage. A 2006 analysis by the Legislative Analyst’s Office (LAO) estimated that establishing

a similar insurance database at the California Department of Motor Vehicles to track car insurance would cost more than \$42 million.²⁷ To implement this requirement, the state needs more specificity from CMS on the exact reporting requirements and their frequency. To make this change, more budget authority would be needed for the administrative burden, as well as new legislation requiring health plan reporting. The resulting cost to the state and to the health plans has not been estimated.

4. *Assuring that the state is current with all reporting requirements in SCHIP and Medicaid, and reports on a monthly basis on data relating to the crowd-out requirements.* California is already current on existing federal reporting requirements every quarter. It should be possible to achieve monthly reporting. However, this would require additional administrative costs to the state during a time when the state faces a significant budget deficit in a tight economy.²⁸ Moreover, it is unclear how the state would be able to measure “crowd-out.” To meet this requirement, the federal government would need to issue more detailed guidance. MRMIB may need greater budget authority to cover the additional administrative burden.

Two Requirements California Will Have Difficulty Meeting. There are two conditions that California does not expect to be able to meet, although additional information is needed from CMS before the state could be certain of compliance in either case. Also, in both cases, new legislation for the Insurance Code would most likely be needed to bar eligibility of children with family incomes above 250 percent of the FPL in the event that the state reached a point where compliance could not be assured.

1. *Ninety-Five Percent Coverage.* The CMS Directive originally asked states to meet a high standard of enrolling 95 percent of eligible children with household incomes under 200 percent of the FPL in Medicaid or SCHIP before using federal funds to cover higher-income children. The May 7th letter lowered that standard to the slightly less difficult goal of assuring that 95 percent of children in the lower-income group had coverage of any kind—Medicaid, SCHIP, or private. The percentage of children in California who are uninsured is lower today than it was ten years ago. However, it is still not clear if any state can reliably reach the 95-percent coverage level for children in families earning less than 200 percent of the FPL.

An analysis of 2005 data from the California Health Interview Survey (CHIS) shows that 86.6 percent of children in this group have some type of health coverage, not the 95 percent required by the directive.²⁹ The distribution of type of coverage for these children is as follows:

- Medi-Cal: 54.8 percent;
- Healthy Families: 9.2 percent;
- Other public program: 1.7 percent;
- Employer-based: 18.3 percent; and
- Privately purchased coverage: 2.5 percent.

A recent analysis of the Current Population Survey completed by the Center for Children and Families at Georgetown University found that California’s coverage rate for these children is 80 percent.³⁰

California will need to raise enrollment rates of children eligible for SCHIP and Medicaid in order to try to reach the 95-percent coverage threshold. The 2005 CHIS survey data suggests that 88 percent of California children eligible for SCHIP and Medi-Cal are already enrolled. This is a relatively high participation rate for any voluntary federal or state means-tested benefit program—the average SCHIP participation rate is between 72 and 79 percent.³¹ Food stamp participation in 2005 was estimated to be 65 percent.³² No state has ever achieved 95 percent program participation.³³

Compounding the challenge of meeting this threshold is ambiguity regarding CMS' choice of data to assess compliance. In the May 2008 letter, CMS states that they will work with states individually to identify the appropriate state-level survey or other data to “refine” the Census Bureau’s Current Population Survey (CPS), the only national source of state-level estimates on children’s health insurance status and family income for all 50 states.³⁴

2. *Ensuring That Employer-Sponsored Coverage Drops by No More Than 2 Percent over Five Years.* To meet this requirement, California must assure that the level of children with family incomes below 200 percent of the FPL who have employer-sponsored insurance has not fallen by more than 2 percentage points over the previous five years.

The analysis conducted for this paper was not able to identify any data able to show that California can fulfill this condition. According to one data set, the rate of ESI for California children below 200 percent of the FPL fell from 28.5 percent in 2001 to 18.3 percent in 2005.³⁵ Most states have seen reductions in employer-sponsored insurance for all populations and at all income levels.³⁶ This erosion has occurred for both children and adults, and is believed to be driven by factors other than expansions of public coverage. Rising health care costs and premiums have caused employers to offer fewer benefits, require higher cost sharing, or stop providing coverage altogether. Overall economic changes are also playing a role in declining employer-sponsored insurance rates. For example, more Americans are working in service and construction jobs, which are less likely to come with health coverage.³⁷ States have little policy and no regulatory control over whether employers provide health insurance or not.

Option 2:

Comply by Changing Eligibility for Healthy Families or Foregoing Federal Funds

If all of the Directive’s requirements cannot be met, then federal funds would not be available for any newly enrolled children with family incomes over 250 percent of the FPL. To be in compliance, the state could respond by: (1) using state funds compensate for lost federal funds; or (2) stopping enrollment of children who would trigger the directive’s conditions.

State Funds. MRMIB estimates that 14,000 children in households earning more than 250 percent of the FPL enroll in Healthy Families every year, and it is likely that another 1,500 enroll in the AIM program.³⁸ For these children to be covered solely with state funds would cost approximately \$13 to 15 million for one year, or roughly \$1.2 million a month.³⁹

California is facing a significant budget deficit. In May, the governor released a revised budget calling for a total of \$3.4 billion in cuts to health and human service programs. This comes on top of a 10 percent reduction in Medi-Cal reimbursement rates that took effect on July 1st. While the Democratic budget proposal would restore a number of those cuts, some reductions would stay in place.⁴⁰ This environment means there would be a struggle to find additional state dollars for the SCHIP program. To make this program change, new budget authority would be needed. It is also possible new legislation will be necessary to make this change in the insurance code.

Stop Enrolling Higher-Income Children. The May 7th letter explains that the conditions of the CMS directive would not apply to children already enrolled in SCHIP programs who remain in the program continuously, and that certain conditions would not apply to children with family incomes below 250 percent of the FPL. Thus, all of the directive's conditions may only apply to newly enrolled children above that income threshold. Therefore, a second alternative would be for California to stop enrolling higher-income children who would trigger the Directive's conditions. To take this step, the state would be required to make changes in existing Healthy Families eligibility law.⁴¹

However, while higher-income children who are already enrolled would be grandfathered in to the program, it is likely that some will eventually drop out for various reasons. At that point, those children will be barred from the program.

Option 3:

Continue to Claim Federal Funds While Considering Program Changes

Within Medicaid and SCHIP, the federal and state governments have a long history of working together to implement complex policy decisions. If other complex program changes are any indication, such as the delinking of AFDC from Medicaid or the issues around *ex parte* redetermination of Medicaid eligibility, there is every reason to suspect that the states will be able to continue to claim federal dollars for covered children while efforts to achieve compliance are negotiated.

As discussed below, there are pros and cons to continuing to claim SCHIP dollars for higher-income children after the directive takes effect. By submitting a claim, California retains at least the possibility of obtaining funding, with the burden of the decision being placed on the federal government to either act as a partner in reimbursing the state's claim as the directive is negotiated or to act as regulator and attempt to punish the state for non-compliance. Further, any denied claims are subject to appeal.

In the event that the federal government attempts to block state funding, there are several accounting and financial procedures that the federal government could employ. It is also possible that the state might reject the concept of working with the federal government and

refuse to implement the directive, which could also trigger a compliance action by the federal government.

Compliance with Federal Rules in SCHIP and Medicaid

SCHIP and Medicaid follow related and well-established procedures for payment, with the accounting rules for the newer SCHIP program having been built on existing Medicaid financial processes.

For both programs, the fundamental building block is the state plan, a set of documents akin to a contract between the state and federal government detailing the rules used to operate the program and the methodology used to reimburse state costs. A state plan amendment (SPA) is used to alter the state plan, and all SPAs must be approved or disapproved by the federal government. Once approved, there are limited circumstances under which the federal government can change the state plan. For SCHIP, federal regulations state:⁴²

- (f) Continued approval. An approved state plan continues in effect unless—*
- (1) The State adopts a new plan by obtaining approval under §457.60 of an amendment to the state plan;*
 - (2) Withdraws its plan in accordance with §457.170(b); or*
 - (3) The Secretary finds substantial noncompliance of the plan with the requirements of the statute or regulations.*

In essence, the conditions outlined in the CMS letter are not so much a “directive” as a request to states to alter their state plan to come into compliance with a change in policy, and for which CMS has limited ability to require compliance. As reflected in the regulation, the state plan system is designed to promote stability for states that have entered into partnership with the federal government. This point is subtly but clearly made in the directive itself, “We expect affected States to amend their SCHIP state plan (or 1115 demonstration) in accordance with this review strategy within 12 months, or CMS may pursue corrective action.”⁴³

Therefore, if California does not come into compliance, it will be up to CMS to take the corrective action it deems necessary and that is permissible under federal law. It is difficult to predict what CMS may do as the agency has not offered any guidance to date on compliance. Payment disputes among states and the federal government are not uncommon. If CMS wanted to take a regulatory role, the agency could exercise one or more of the following standard options for this type of situation:

- 1) *Delay or Refuse Approval of Pending State Plan Amendments and Waiver Requests.* CMS has significant discretion in the approval of SPAs and waiver requests, though discretion around SPAs has declined over the last several years. In disputes between the federal government and states, it is not uncommon for the federal government, where it has discretion, to try to hold state requests in abeyance while the dispute is resolved. This approach would likely extend beyond SCHIP to Medicaid requests pending before CMS.

- 2) *Initiate a Deferral.* If a state claims federal matching funds for an activity deemed inappropriate by CMS, then a “deferral” can be made, which is basically a stop payment order on the activity in question. Under this scenario, the state would indicate intent to use federal dollars to cover the children in question and the federal government could refuse to make payment. Once this happens, California is eligible to appeal the decision to the U.S. Health and Human Services Departmental Appeals Board (DAB) for a hearing.
- 3) *Initiate a Disallowance.* In Medicaid and SCHIP accounting, it is more common for an overpayment to be discovered after the state has received the federal dollars in question. In these cases, the federal government can seek a disallowance, which is basically the withholding of a future payment in the amount that was believed previously paid in error. Any disallowance can be appealed to the DAB for a hearing.
- 4) *Rescinding the State Plan for Non-Compliance:* From a programmatic point of view, CMS could essentially attempt to “cancel” Healthy Families. This step has never been taken by the federal government, though the regulations do allow for it, as explained above. CMS has no procedures or rules specified for rescinding a state plan, in whole or part, which would seem a necessary precursor to taking such a drastic step. If CMS proceeded under the regulations, there are two key questions would determine the state’s vulnerability:
 - Does non-compliance with the directive rise to the level of “substantial non-compliance” when the federal funds at stake are about 1 percent of monthly federal spending?
 - Does the directive have the legal standing of either a “statute” or “regulation,” as called for in the regulation? If not, the regulations allowing for program rescission may not apply at all. On its face, the directive is neither a formally promulgated regulation nor a statute, though CMS could try to move through the time-consuming process to issue formal regulations.

There is no precedent for pursuing a false claim against a state official who has filed a claim for federal funds and affirmatively stated their rationale for doing so in good faith. However, it is important to be aware that civil penalties for non-compliance with the CMS directive are at least theoretically available to the Department of Justice under the Federal False Claims Act. A person can be held liable if he or she “knowingly presents, or causes to present, to an officer or employee of the United State Government or member of the Armed Forces of the United States a false or fraudulent claim for payment or approval.”⁴⁴

Possible Outcomes for Non-Compliance in 2008

Any state pursuing a non-compliance strategy puts their spending at risk for not receiving the federal matching funds otherwise owed. If California continued to operate its existing SCHIP programs and federal dollars were denied under the Directive, the state could lose an estimated \$1.2 million per month, or \$5.4 million for the 2008 calendar year.

In the short-run (through 2008), there may be little practical affect from non-compliance. At the end of each quarter of the FFY,⁴⁵ states file a claim with the federal government. With the Directive taking effect in mid-August, the first opportunity for California to lose any federal funds will be mid-September when \$2.1 million in Q4 FFY 2008 in payments for the newly enrolled children over 250 percent of the FPL are due. The second opportunity will be a loss of \$3.3 million in mid-January when the payments for Q1 FFY 2009 are to be made.

Possible Outcomes for Non-Compliance in 2009

The outcomes of the multi-state lawsuit against the directive and the November election are the most important factors determining any consequences for California's continued noncompliance with the Directive in 2009. As a factual matter, the directive has been issued at the discretion of the Bush administration. The continued enforcement of the directive will be the purview of a new administration as of January 21, 2009. While Senator McCain has expressed support for the Bush administration policy, the Democratic nominee, Senator Obama, has taken the opposite point of view. The next president will have the controlling word over this program, including the ability to terminate the directive. And given the questions regarding the directive's legality, the next administration may have avenues available to deem that it was never put into effect.

While the federal government could refuse to pay California the estimated \$1.2 million per month for covering children in SCHIP otherwise blocked by the directive in 2008, the state is under no obligation to comply. It is a viable choice for the state to wait and assess the legal issues as Congress and the Courts proceed through their processes. A non-compliance approach could also be seen as more administratively rational as it reduces the need to work to pass and change laws and program rules in response to what could be a short-lived policy. Within the California Legislature, there has been no debate regarding providing additional legislative or budget authority to MRMIB regarding the directive.

Conclusion

Over the past ten years, SCHIP has been a useful tool for states to use in their efforts to expand health coverage. Many program supporters, both in California and at the national level, believe SCHIP could also play an important role as policymakers grapple with comprehensive health reform designed to reach universal coverage. Although it is unlikely the federal government would end the SCHIP program entirely, major elements of the program's design and policy have come under significant debate. The character of that debate will depend greatly on the next administration.

Until that administration takes office in January 2009, just months before SCHIP extension funds run out, the debate around the program is likely to remain focused on the policy changes outlined in the CMS directive, scheduled to take effect on August 18, 2008. It is unlikely that California's will be able to comply, given the complexity of the changes required, the economic and budget conditions, and the lack of information from CMS needed for implementation.

In addition, those policy changes are facing legal challenges both through congressional action and a lawsuit brought by a number of states. California policymakers also have been clear in expressing the belief that the directive is misguided, filing an amicus brief in the lawsuit and bringing their concerns before Congress.

There are risks and benefits to California in seeking to either comply with difficult new regulations that may soon be overturned or to maintain the current program and facing regulatory action from CMS. Ultimately, policymakers must consider their hopes and plans for the future of the SCHIP program.

APPENDIX A: SCHIP Timeline (California Events in Bold Italics)

- July 1998*** ***California opens enrollment for Healthy Families under a state plan approved by the Centers for Medicare and Medicaid Services (CMS). Initially, the program served children with family incomes up to 200 percent of the Federal Poverty Level (FPL) after applying Medicaid income deductions.***
- November 23, 1999*** ***CMS approves California’s state plan amendment (SPA) for expansion to include children with family incomes up to 250 percent of the FPL after applying Medicaid income deductions. This SPA included CMS approval for a 3-month waiting period between losing coverage and HFP eligibility.***
- July 10, 2004*** ***CMS approves a SPA allowing counties with local programs serving children up to 300 percent of the FPL to draw down SCHIP funding to match county funding.***
- March 28, 2006*** ***CMS approves another SPA covering pregnant women up to 300 percent of the FPL using SCHIP funding, under the encouragement of the Bush Administration.***
- February 5, 2007 President Bush releases his FFY 2008 budget, which proposes increasing SCHIP funding by \$4.8 billion above baseline.
- March 13, 2007 House Energy and Commerce Committee Chair John Dingell (D-Mich.) and Sen. Hillary Rodham Clinton (D-N.Y.) introduces a proposal that would increase federal funds for SCHIP by at least \$50 billion over five years.
- April 26, 2007 Senators John Rockefeller (D-W.Va.) and Olympia Snowe (R-Maine) introduces S. 1224 to reauthorize and expand SCHIP to cover six million additional children over the next 10 years.
- June 5, 2007*** ***Governor Schwarzenegger writes to Congress urging their support for SCHIP reauthorization.***
- July 24, 2007 Chairman Dingell introduces H.R. 3162, the Children’s Health and Medicare Protection Act (“CHAMP Act”), a package that includes major changes to Medicare, as well as \$50 billion for children’s health coverage under Medicaid and SCHIP. It is financed through a tobacco tax increase and reductions in payments to Medicare Advantage plans.
- July 26, 2007 Finance Committee Chairman, Max Baucus, introduces S. 1893, the Children’s Health Insurance Program Reauthorization Act

- (“CHIPRA”). Developed on a bipartisan basis with Senators Rockefeller, Grassley, and Hatch, the bill provides \$35 billion in new funding for children’s coverage financed by a tobacco tax increase.
- August 1, 2007 House passes CHAMP Act.
- August 2, 2007 Senate passes CHIPRA. For technical reasons, the bill is relabeled as H.R. 976.
- August 17, 2007 CMS releases a new directive to states regarding SCHIP expansions above 250 percent of the FPL.
- August 29, 2007 *Governor Schwarzenegger and Governor Eliot Spitzer write to President Bush requesting the withdrawal of the CMS directive.***
- August 29, 2007 *Governor Schwarzenegger, in a letter signed by 30 governors, writes to Secretary Leavitt requesting the withdrawal of the CMS directive.***
- September 12, 2007 Senator Edward Kennedy (D-MA) introduces a bill (S. 2049) to effectively render the CMS directive null and void.⁴⁶
- September 17, 2007 Congressman Frank Pallone, Jr. introduced a companion bill (H.R. 3555) to Senator Kennedy’s S. 2049. The legislation would prohibit the Secretary of Health and Human Services from implementing any requirements similar to those in the CMS directive.⁴⁷
- September 25, 2007 House passes CHIPRA, with amendments.
- September 27, 2007 Senate passes Houses version of CHIPRA, and sends to the President for signature.
- September 30, 2007 Existing SCHIP Program Expires.
- October 3, 2007 President Bush vetoes CHIPRA.
- October 4, 2007 Multi-state lawsuit filed against the Bush administration at the U.S. District Court, Southern District of New York. The goal of the suit is to stop the federal government from requiring that individual state SCHIP plans meet the directive’s conditions for covering children above 250 percent of the FPL. The suit alleges that (1) the directive is illegal because it violates provisions of the SCHIP statute; (2) the requirements are in excess of the authority vested in the Secretary of Health and Human Services; (3) the requirements are not set forth in statute or codified regulations, rendering them invalid;⁴⁸ and (4) the directive violates the federal Administrative Procedures Act because

it was issued without an opportunity for public comment. A hearing date for the case has not been set.

- October 4, 2007 California, along with three other states, has also filed an amicus brief in support of the plaintiffs.⁴⁹ In the brief, these states allege that not only does the CMS directive violate federal rulemaking laws, but several of its provisions are impossible to meet.⁵⁰
- October 18, 2007 Vote to override the President's veto of CHIPRA (H.R. 976) fails.
- October 25, 2007 House passes CHIPRA 2 (H.R. 3963), a revised version of the \$35 billion SCHIP reauthorization package. While similar to the original CHIPRA legislation in most respects, CHIPRA 2 goes even further in shutting down state flexibility to cover children above 300 percent of the FPL; speeding up the elimination of coverage for adults; and modifying the citizenship documentation requirements in Medicaid and SCHIP.
- October 24, 2007** ***Emergency regulations establishing an enrollment cap and process for disenrollment in the case of inadequate program funding is proposed to California's Managed Risk Medical Insurance Board (MRMIB).***
- November 1, 2007 Senate passes CHIPRA 2, and sends to the President for signature.
- November 5, 2007** ***MRMIB adopts regulations that authorized establishing an enrollment cap and disenrolling children at annual eligibility review in the event of inadequate program funding.***
- December 12, 2007 President Bush vetoes CHIPRA 2 (H.R. 3963).
- December 18, 2007 Senators Max Baucus (D-MT) and Charles Grassley (R-IA) introduce the SCHIP Extension bill, the Medicare, Medicaid and SCHIP Extension Act of 2007 (S. 2499). It includes funding for SCHIP until March 2009.
- December 19, 2007 Congress passes the SCHIP Extension bill (S. 2499).
- December 29, 2007 President signs SCHIP Extension bill, the Medicare, Medicaid and SCHIP Extension Act of 2007 (S. 2499).
- January 10, 2008 Congressional Research Service (CRS) reviewed the legality of the CMS directive, specifically addressing the question of whether it violates the Congressional Review Act (CRA) at the request of Senator Rockefeller. The CRA requires that all agencies promulgating a rule which alters the rights, duties, and obligations of

states must submit a report to each chamber of Congress as well as the Comptroller General.⁵¹ The CRS concludes in a letter to Senator John Rockefeller that the directive is a rule under the Congressional Review Act, requiring Congressional approval. As a covered rule, “the agency’s action should have been submitted for review,”⁵² and cannot take effect if the report is not submitted.⁵³

- January 23, 2008 Vote to override the President’s veto of CHIPRA 2 (H.R. 3963) fails.
- February 4, 2008 President Bush releases his FFY 2009 budget, which proposes increasing SCHIP funding by \$19.7 billion above baseline.
- April 3, 2008 California Assemblyman John Laird (D) introduces AJR 54, a joint resolution urging the President and Congress to rescind the requirements of the CMS directive.***
- April 3, 2008 The Chair of the Senate Finance Subcommittee on Health Care, John Rockefeller (D-WV), introduced legislation to suspend the directive.⁵⁴ In an April 10, 2008 hearing, Rockefeller called the 95 percent requirement an impossibly high benchmark that no outreach program has yet to attain.⁵⁵ Rockefeller also questioned CMS’ legal authority to limit SCHIP enrollment, or federal funding for SCHIP enrollment, to children with household incomes below 250 percent of the FPL.⁵⁶
- April 7, 2008 More than 25 prominent experts in health policy and child health filed an amicus brief in support of the plaintiff states. In the brief, these experts allege that:
 “...the harsh strategies mandated in the Directive – which are utterly disconnected from research and experience relating to crowd-out and which are poorly designed to actually reduce crowd-out – would at the same time significantly increase the number of children who lack health coverage. In short, the specific strategies imposed by the Directive threaten the primary statutory objective of SCHIP – to provide coverage to low income uninsured children and thereby increase children’s access to health care – without any evidence that they would effectively advance the policy goals stated in the Directive.”⁵⁷
- April 17, 2008 In February 2008, Senator Rockefeller and Senator Olympia Snowe (R-Maine) also asked the Government Accountability Office (GAO) to review the legality of the directive. In a letter to Senators John Rockefeller and Olympia Snowe on this date, the GAO concurs with the January 10th CRS conclusion that the directive “makes significant changes to present and future policies without being subject to public comment or Congress.”⁵⁸ Thus, consistent with CRS, the GAO

concluded the Administration overstepped its authority by issuing the rule changes without congressional review.

- April 18, 2008*** ***California, along with Connecticut, Massachusetts and New Mexico, files an Amicus Brief in support of a multi-state lawsuit challenging the Directive.***
- April 23, 2008 American Public Health Services Association and the National Association of State Medicaid Directors submit a letter to Secretary Leavitt urging the withdrawal of the directive.
- May 7, 2008 CMS releases a follow-up letter to the original directive.
- May 8, 2008 Congressman Pallone introduces a new bill, the Protecting Children's Health Coverage Act of 2008, which also would nullify the directive. This bill includes 33 cosponsors and has been referred to the House Energy and Commerce Committee.⁵⁹ However, according to *Congressional Quarterly Today*, “Many Republicans support the principle behind the [Directive], meaning that Pallone’s bill stands little chance of passing the Senate, where it could be filibustered.”⁶⁰ A disapproval resolution could still be passed by Congress to nullify the directive. Unlike stand-alone bills, disapproval resolutions cannot be filibustered in the Senate. However, Representative Pallone has said he would prefer to pass his bill, instead of a disapproval resolution, because it also would require CMS to reconsider a request from New York to expand its SCHIP program, which the agency previously disapproved.⁶¹
- May 15, 2008 At a House Energy and Commerce Health Subcommittee hearing, legal representatives from the GAO and the CRS confirmed their findings that the Bush administration had improperly issued the CMS directive. During the hearing, Morton Rosenberg, a legal specialist for CRS, and Dayna Shah, managing associate general counsel for GAO, said the directive amounted to a regulation and should have been vetted in Congress using the same process as other administrative rules. ***Leslie Cummings, Executive Director of the Managed Risk Medical Insurance Board (MRMIB) that administers the Healthy Families Program also testified. She indicated that California’s program could be substantially affected by the CMS Directive, and supported nullifying the Directive’s conditions to allow the states and federal government to resume focus on ensuring the future of the program.***⁶²
- June 26, 2008 The Senate Appropriations committee approves the FY 2009 Labor-Health and Human Services-Education Appropriations bill, which includes an amendment calling for a moratorium on the new SCHIP

requirements. The measure is sponsored by New Jersey Senator Frank Lautenberg. A previous version of the Lautenberg moratorium was included in the domestic spending portion of the Emergency Supplemental funding bill for Iraq. While the House removed the language from the Emergency Supplemental, the bill did receive approval from both Democrats and Republicans, showing the measure could gain bipartisan support with the correct packaging.⁶³

July 8, 2008

AJR 54, a joint resolution urging the President and Congress to rescind the requirements of the CMS directive, is chaptered by the California Secretary of State having passed both houses of the California Legislature.

Endnotes

¹ California HealthCare Foundation. *The Future of California's SCHIP Program: Analyzing the Proposed Federal Legislation*. Oakland, CA: July 2007.

(<http://www.chcf.org/documents/policy/TheFutureOfCAsSCHIPProgram.pdf>)

² California HealthCare Foundation. *The Possible Impact upon California of Reduced SCHIP Funding*. Oakland, CA: September 2007.

(<http://www.chcf.org/documents/policy/PossibleImpactUponCAOfReducedSCHIPFunding.pdf>)

³ Amicus Brief filed by State of California, et al. regarding *State of New York et al. v. U.S. Department of Health and Human Services*, Case no. 07-CIV-8621, filed October 4, 2007. Available online at:

(http://www.mrmib.ca.gov/MRMIB/HFP/NY_SCHIP_AMICUS_BRIEF_FINAL.pdf) And: Testimony submitted to the United States House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, by Lesley Cummings, as part of the May 15, 2008 Hearing on H.R. 5998, Protecting Children's Health Coverage Act of 2008.

⁴ Letter from Dennis Smith, Director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials (SHO #08-003): May 8, 2008.

(<http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/cms%20directive/cmsmay7ltr.pdf>)

⁵ Jeanne Lambrew, "The State Children's Health Insurance Program: Past, Present, and Future," The Commonwealth Fund, January 2007. Available online at:

http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf?section=4039.

⁶ This "directive" is a letter to state health officials from CMS, through which the agency often provides policy guidance in advance of promulgating federal regulations.

⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "2008 Budget in Brief," February 5, 2008, p. 65. Available online at: www.hhs.gov/budget/08budget/2008BudgetInBrief.pdf

. "Baseline funding" is a technical term for the amount of money that is assumed will be allocated to SCHIP over the next five years. Currently, the Congressional Budget Office assumes SCHIP will be reauthorized at baseline funding levels — \$25 billion over the next five years. Any funding above \$25 billion would count against federal pay-as-you-go budget requirements.

⁸ Congressman Robert B. Aderholt Press Release. *Aderholt Opposes \$35 Billion Expansion of Government Health Insurance: SCHIP Bill Includes \$6.5 Billion Giveaway For Illegal Immigrants*. September 26, 2007.

Available online at: <http://aderholt.house.gov/?sectionid=20§iontree=6.20&itemid=649>.

⁹ States are specifically able to set eligibility levels at 50 percentage points higher than the Medicaid eligibility level the state had in place in 1997 when SCHIP was enacted. And further exceptions permit states to expand eligibility even further. See Elicia Herz, Chris Peterson, and Evelyne Baumrucker, "State Children's Health Insurance Program (SCHIP): A Brief Overview," Congressional Research Service for Congress, March 12, 2008. <http://ccf.georgetown.edu/index/cms-filesystem-action?file=research%2Fabout+medicaid%2Fschip+overview+3-12-08.pdf>

¹⁰ California completely disregards family income between 200 and 250 percent of the FPL in order to allow all children in families with gross income below 250 percent of FPL to enroll. Thus, a family earning 240 percent of FPL is considered to have an income of just 200 percent of FPL. Families earning gross incomes that are above 250 percent of the FPL may also be eligible for the program if their net income is below 250 percent of FPL after deducting certain types of income, such as alimony, or expenses, such as childcare. This is how California and many other states expanded eligibility for children in families earning 200 percent to 250 percent of FPL. Current rules regarding income disregards in SCHIP are in sync with Medi-Cal. Changes to the policy as required by the federal government would increase administrative costs and complexity as there would now be two separate sets of disregard rules.

¹¹ Crowd-out occurs when privately insured individuals drop their coverage in order to take advantage of a public insurance program. Crowd-out can be both the result of an individual's decision to drop coverage, or an employer's decision to stop offering coverage for employees who are otherwise eligible for a public program. This impedes the ability of public health insurance programs to reduce the number of uninsured individuals.

¹² D Hughes, J. Angeles, "Crowd-Out in the Healthy Families Program: Does it Exist?" Insitute for Health Policy Studies, UCSF, August 2002. Available at: http://www.mrmib.ca.gov/MRMIB/HFP/HFP_Crowd-Out_Study_Dana_Huges_2002.pdf.

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- ¹³ The Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured. *SCHIP: Let the Discussions Begin*. Webcast of Capitol Hill Briefing. February 9, 2007. Available at: www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2045
- ¹⁴ California HealthCare Foundation, *The Future of California's SCHIP Programs: Analyzing the Proposed Federal Legislation*, July 2007. Available online at: <http://www.chcf.org/documents/policy/TheFutureOfCAsSCHIPProgram.pdf>.
- ¹⁵ Ibid.
- ¹⁶ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "2008 Budget in Brief," February 5, 2008, p. 65, at www.hhs.gov/budget/08budget/2008BudgetInBrief.pdf and "2009 Budget in Brief," p. 64, at www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf.
- ¹⁷ The President's Budget proposals would extend these conditions to states providing coverage to children with family incomes above just 200 percent of the FPL.
- ¹⁸ California HealthCare Foundation. *Assessing California's Ability to Comply with New Federal SCHIP Rules*. Oakland, CA: October 2007. (<http://www.chcf.org/documents/policy/AssessingCompliancewithSCHIP.pdf>)
- ¹⁹ Income from one of the following sources: Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Court-Ordered Child and Spousal Support, Workers' Compensation, or Unemployment. Spending on the following activities: Court-Ordered Child and Spousal Support, Child day care (up to \$200 a month); and, Disabled dependent care (up to \$175 a month).
- ²⁰ HFP Children: Testimony submitted to the United States House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, by Lesley Cummings, as part of the May 15, 2008 Hearing on H.R. 5998, Protecting Children's Health Coverage Act of 2008. AIM Children: Author's estimate.
- ²¹ ABx1 1 (Núñez/Perata). Available online at: http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0001-0050/abx1_1_bill_20080116_amended_sen_v95.html.
- ²² The original CMS directive required a higher standard: the "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 (including a description of the steps the state takes to enroll these eligible children)."
- ²³ Ibid.
- ²⁴ Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies*, Georgetown University Health Policy Institute and The Commonwealth Fund). Available online at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=376823.
- ²⁵ Letter from Dennis Smith, Director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials (SHO #07-001), (August 17, 2007), available at <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>.
- ²⁶ John McInerney et al. *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs*. National Academy for State Health Policy. April 2008.
- ²⁷ Legislative Analyst's Office. Analysis of the 2006-07 Budget Bill, Dept. of Motor Vehicles (2740). Available online at: http://www.lao.ca.gov/analysis_2006/transportation/tran_06_2740_an106.html.
- ²⁸ Jenny O'Mara et al. *California Governor Sees Wider Deficit Amid "Tough Year"*. Reuters. April 24, 2008. Available online at: <http://www.reuters.com/article/domesticNews/idUSN2460889720080424?sp=true>.
- ²⁹ Based on the author's analysis of CHIS data, showing that in 2005, for 0 to 18, from 0 to 199 percent of the FPL, the Medicaid enrollment was 2.5 million and the eligible not enrolled number is 241,000 and the SCHIP enrollment was 433,000 and 163,000 eligible and not enrolled.
- ³⁰ Center for Children and Families, "New CMS Letter on the August 17th Directive Does Not Materially Change the Policy But Does Raise New Questions," Georgetown University Health Policy Institute, May 19, 2008. Available at: <http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/cms%20directive/may%2019%202008%20clarification.pdf>.
- ³¹ Lisa Dubay et al. *Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era*. The Urban Institute. March 2002. Available online at: <http://www.urban.org/publications/310430.html>.
- ³² Karen Cunyngnam et al. *Reaching Those In Need: State Food Stamp Participation Rates in 2005*. Mathematica Policy Research Inc. for the U.S Dept. of Agriculture, Food and Nutrition Service. October 2007. Available online at: <http://www.fns.usda.gov/oane/menu/published/FSP/FILES/Participation/Reaching2005.pdf>.

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