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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
TRENTON VICINAGE

STATE OF NEW JERSEY,	:	HON. JOEL A. PISANO, U.S.D.J.
Plaintiff,	:	Civ. Action No. 07-04698 (JAP)(JJH)
v.	:	**AFFIDAVIT OF ANN CLEMENCY KOHLER IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT**
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,	:	
Defendant,	:	

I, ANN CLEMENCY KOHLER, of full age, being duly sworn according to law, hereby depose and state:

1. I am the Deputy Commissioner of the Department of Human Services and have oversight for the Division of Medical Assistance and Health Services ("DMAHS"), the Division of Disability Services, the Office of Budget Planning and the Office of Finance. I have held this position since March 2007. As such, I am fully familiar with New Jersey's State Children Health Insurance Program ("SCHIP"), FamilyCare, formerly known as NJKidCare.

2. Prior to this, I was the Director of DMAHS in the Department of Human Services, appointed in 2002.

3. I am a member of the Executive Committee of the National Association of Medicaid Directors ("NASMD"), as well as a member of the Medicare Modernization Act State Workgroup. I am the NASMD Chair of the Medicaid and Mental Health Technical Advisory Group.

4. I have worked in healthcare administration since 1979 when I began my employment with DMAHS and I became the Deputy Director of DMAHS in 1993. I left state government for a short time to develop and coordinate health insurance products for a health maintenance organization.

5. From 1996 to 2000, I was the Medicaid Director for the State of New York, the largest Medicaid agency in the country. I returned to New Jersey in 2000 and was appointed to a management position in the Office of Management and Budget (OMB). While at OMB, I was responsible for the oversight of the budget and fiscal operations for both the Departments of Human Services and Health and Senior Services. I served as the contract manager for the Federal maximization and program efficiency contracts that generated millions in federal revenue.

New Jersey's SCHIP Program

6. New Jersey's original state child health plan ("state plan") under SCHIP was approved by the Centers for Medicare &

Medicaid Services ("CMS") on April 27, 1998. New Jersey's original state plan provided for a twelve-month period of uninsurance for the purpose of preventing crowd-out.

7. New Jersey's experience with its child health plan demonstrated that while the twelve-month waiting period served as a barrier to people applying to New Jersey's FamilyCare program, it did not have an effect upon crowd-out.

8. On February 9, 1999, New Jersey submitted its first plan amendment to CMS. That amendment shortened the waiting period from twelve months to six months.

9. On May 7, 1999, CMS approved New Jersey's first plan amendment, allowing New Jersey to shorten the time that children must be uninsured before applying for FamilyCare from twelve months to six months.

10. When CMS reviews a state plan amendment, it reviews not only the amendment, but also the full state plan, as amended. CMS has the ability to comment or request additional information regarding portions of the state plan not affected by the particular plan amendment. In fact, CMS can reject a plan amendment with a finding that an unrelated portion of the state plan is not in conformance with the law. 42 C.F.R. § 457.150.

11. New Jersey submitted its second plan amendment on May 6, 1999. This amendment established NJKidCare Plan D. Through the use of disregards, New Jersey expanded its NJKidCare Plan to

children in families with incomes up to three hundred and fifty percent of the Federal Poverty Level ("FPL").

12. CMS approved New Jersey's second plan amendment on August 3, 1999. That amendment provided health insurance to an additional 9,000 children in New Jersey by September 1999.

13. New Jersey submitted a third plan amendment to CMS on September 21, 1999. This amendment added exceptions to the six-month waiting period.

14. CMS approved New Jersey's third plan amendment on July 7, 2000. The six-month waiting period was included in the amended plan approved by CMS.

15. New Jersey submitted a fourth plan amendment to CMS on December 18, 1999. CMS approved New Jersey's fourth plan amendment on January 1, 2000.

16. New Jersey submitted a fifth plan amendment to CMS on February 4, 2002. CMS approved New Jersey's fifth plan amendment on April 23, 2002.

17. New Jersey submitted a sixth plan amendment to CMS on May 7, 2002. CMS approved New Jersey's sixth plan amendment on July 22, 2002.

18. New Jersey submitted a seventh plan amendment to CMS on July 22, 2003. CMS approved New Jersey's seventh plan amendment on October 16, 2003.

19. New Jersey submitted an eighth plan amendment to CMS

on June 29, 2004. CMS approved New Jersey's eighth plan amendment on September 13, 2004.

20. New Jersey submitted a ninth plan amendment to CMS on December 23, 2004. CMS approved New Jersey's ninth plan amendment on March 14, 2005.

21. CMS approved all of New Jersey's plan amendments from 1999 to 2005, each of which included a six-month waiting period.

22. On April 4, 2005, New Jersey submitted a tenth plan amendment to CMS. New Jersey withdrew that plan amendment on May 30, 2005.

23. On May 30, 2005, New Jersey submitted an eleventh plan amendment. This amendment reduced the six-month waiting period to three months, and increased the threshold of presumptive eligibility from two hundred percent of the FPL to three hundred and fifty percent of the FPL.

24. New Jersey provided CMS with additional information concerning the eleventh plan amendment on June 24, 2005 and October 14, 2005. The information addressed CMS's concern about the mechanisms utilized in New Jersey for monitoring potential crowd-out problems.

25. CMS approved New Jersey's eleventh plan amendment on November 22, 2005. CMS did not require New Jersey to implement any additional crowd-out procedure.

26. The three-month waiting period has been codified by

the New Jersey Department of Human Services at N.J.A.C. 10:78-3.6(c)2.

27. There are approximately 124,000 children currently enrolled in New Jersey FamilyCare.

28. In 2006, 388 applicants (slightly more than 0.5 percent of total applicants) were found to have insurance in the three months prior to applying for New Jersey FamilyCare.

29. In 2006, 1,820 applicants (3.2 percent of total applicants) were found to have health insurance at the time of their application to New Jersey FamilyCare.

August 17, 2007 CMS Letter

30. On August 17, 2007, CMS issued a letter ("August 17, 2007 Letter") that requires New Jersey to implement significant changes to its previously approved state plan. Attached hereto as Exhibit A is a true copy of the August 17, 2007 Letter.

31. The August 17, 2007 Letter requires that New Jersey expand its waiting period from three months to twelve months. New Jersey's experience has been that a three-month waiting period is sufficient to prevent crowd-out.

32. The August 17, 2007 Letter requires that New Jersey assure that New Jersey has enrolled at least 95 percent of the children in New Jersey below 200 percent of the FPL who are eligible for SCHIP or Medicaid. New Jersey has never done this before, and has never been required to do so as part of any of

its prior plan amendments. Doing so could impose a significant burden on New Jersey and result in a reduction in the number of children covered under New Jersey's FamilyCare program.

33. The August 17, 2007 Letter requires that New Jersey assure 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. New Jersey has never done this before, and has never been required to do so as part of any of its prior plan amendments. Doing so could impose a significant burden on New Jersey and result in a reduction in the number of children covered under New Jersey's FamilyCare program.

34. The August 17, 2007 Letter requires that New Jersey assure that New Jersey's state plan is not more favorable than any competing private 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. New Jersey has never done this before, and has never been required to do so as part of any of its prior plan amendments. Doing so would impose a significant burden on New Jersey and result in a reduction in the number of children covered under New Jersey's FamilyCare program.

35. Implementing the changes required by the August 17, 2007 Letter would be costly and time consuming. New Jersey would need to amend one regulation (N.J.A.C. 10:78-3.6(c)) and

likely promulgate others. This would require compliance with the New Jersey Administrative Procedure Act, a lengthy and involved process. N.J.S.A. 52:14B-3.1;-4;-4.1;-4.1a. Moreover, DMAHS may need to implement new procedures, potentially hire and train new individuals, and possibly procure supplies and technical support to assure compliance with the August 17, 2007 Letter. Further, DMAHS might need to begin auditing private employer plans, something it does not currently do, in order to make the assurances demanded in the August 17, 2007 Letter.

36. In order to meet the deadline set forth in the August 17, 2007 Letter (assuming that meeting that deadline is in fact possible), New Jersey would need to begin making these changes immediately. Implementing these changes could consume valuable resources

37. HHS has the authority to cut all or part of New Jersey's SCHIP funding if it deems New Jersey to not be in conformance with federal requirements, and specifically with the requirements of the August 17, 2007 Letter. 42 C.F.R. § 457.203(d). While New Jersey may be able to obtain a refund of such funding at a later date, after it appealed to the court of appeals 42 U.S.C. § 1316(d), the need for funding health care is immediate and ongoing. A significant cut in New Jersey's funding could result in eligible children losing health insurance benefits for a considerable period of time. Repaying

money at a later date will not provide these children the health insurance benefits they needed at the time the funds were improperly withheld. Such repayment would not occur until after a determination by a federal circuit court ruling overturning the Secretary's determination. Thus, New Jersey could be without appropriate funding for a significant period of time.

38. There is no doubt that the requirements of the August 17, 2007 Letter are mandatory. This is especially so in light of the threat of corrective action in the August 17, 2007 Letter.

39. On January 25, 2008, CMS sent a second letter to the state SCHIP directors (the "January 25, 2008 Letter"). Attached hereto as Exhibit B is a true copy of the January 25, 2008 Letter. The January 25, 2007 Letter was intended to clarify how CMS "applies existing statutory and regulatory requirements" for states that expand eligibility to their programs to beyond two hundred and fifty percent of the FPL.

40. Specifically, the January 25, 2008 letter provides, "States, such as yours, that currently provide coverage to children with effective family incomes over 250 percent of the FPL have 12 months or until August 16, 2008, to come into compliance with the required crowd-out strategies and assurances laid out in the August 17th SHO for new enrollees."

41. The January 25, 2008 letter further provides that CMS

will work with the states to allow them to enroll additional children at higher family income levels "if the reasonable standards of the August 17th guidance are met."

42. The January 25, 2008 letter concludes, "we look forward to upcoming discussions on your State's crowd-out strategy implementation plan and 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."

43. The Director of CMS, Dennis G. Smith stated in testimony to Congress that "the 95 percent goal is not only achievable, but should be expected and demanded." He stated that CMS is working with the state to implement the requirements of the August 17, 2007 Letter. The August 17, 2007 Letter "sets out procedures and assurances that should be in place when states enroll new applicants with family incomes in excess of 250 of the [FPL]." Attached hereto as Exhibit C is a true copy of Director Smith's January 29, 2008 testimony before Congress.

44. On February 20, 2008 Kathleen M. Farrell of CMS contacted me to discuss compliance with the August 17, 2007 Letter.

45. Ms. Farrell sent an e-mail on February 22, 2008, following up on the February 20, 2008 conversation, "about establishing compliance with the August 17th SHO Letter."

Attached hereto as Exhibit D is a true copy of the February 22, 2008 e-mail from Kathleen M. Farrell.

46. The February 20, 2008 e-mail confirms that she "also discussed the requirement that cost sharing under the SCHIP 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 percentage point." Ms. Farrell reiterated that the one year period of uninsurance was "required only for new enrollees after August 16th.".

47. Ms. Farrell concluded her February 20, 2008 e-mail by stating that CMS looks "forward to working with you on achieving compliance."

Other Jurisdictions

48. New Jersey is not the only state to have expanded SCHIP coverage to families with income at or above two hundred and fifty percent of the FPL.

49. For example, California, Rhode Island and Washington State have eligibility levels of up to 250 percent of the FPL; Minnesota has an eligibility level of up to 275 percent; and Connecticut, the District of Columbia, Hawaii, Maryland, Massachusetts, Missouri, New Hampshire, Pennsylvania and Vermont have an eligibility level of up to 300 percent.

50. None of these states have a waiting period of uninsurance of more than six months. In fact, Minnesota and

Washington State have a four-month waiting period; California has a three-month waiting period; Connecticut has a two-month waiting period; Vermont has a thirty-day waiting period and the District of Columbia, Hawaii and Rhode Island have no waiting period whatsoever.

51. CMS has approved the state plans for each of these states.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Ann Clemency Kohler

Dated: 3/27/08

KOHLER AFFIDAVIT
EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

AUG 17 2007

SHO #07-001

Dear State Health Official:

This letter clarifies how the Centers for Medicare & Medicaid Services (CMS) applies existing statutory and regulatory requirements in reviewing State requests to extend eligibility under the State Children's Health Insurance Program (SCHIP) to children in families with effective family income levels above 250 percent of the Federal poverty level (FPL). These requirements ensure that extension of eligibility to children at these higher effective income levels do not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage to the core SCHIP population of uninsured targeted low income children.

Section 2101(a) of the Social Security Act describes the purpose of the SCHIP statute "to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage." Section 2102(b)(3)(C) of the Act, and implementing regulations at 42 CFR Part 457, Subpart H, require that State child health plans include procedures to ensure that SCHIP coverage does not substitute for coverage under group health plans (known as "crowd-out" procedures). In addition, section 2102(c) of the Act requires that State child health plans include procedures for outreach and coordination with other public and private health insurance programs.

Existing regulations at 42 C.F.R. 457.805 provide that States must have "reasonable procedures" to prevent substitution of public SCHIP coverage for private coverage. In issuing these regulations, CMS indicated that, for States that expand eligibility above an effective level of 250 percent of the FPL, these reasonable crowd-out procedures would include identifying specific strategies to prevent substitution. Over time, States have adopted one or more of the following five crowd-out strategies:

- Imposing waiting periods between dropping private coverage and enrollment; - up to 12 mos in 1997
- Imposing cost sharing in approximation to the cost of private coverage; - we do
- Monitoring health insurance status at time of application;
- Verifying family insurance status through insurance databases; and/or
- Preventing employers from changing dependent coverage policies that would favor a shift to public coverage.

As CMS has developed more experience and information from the operation of SCHIP programs, it has become clear that the potential for crowd-out is greater for higher income beneficiaries. Therefore, we are clarifying that the reasonable procedures adopted by States to prevent crowd-out pursuant to 42 C.F.R. 457.805 should include the above five general crowd-out strategies with certain important components. As a result, we will expect that, for States that expand eligibility above an effective level of 250 percent of the FPL, the specific crowd-out

strategies identified in the State child health plan to include all five of the above crowd-out strategies, which incorporate the following components as part of those strategies:

- 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. private co. does check

In addition, to ensure that expansion to higher income populations does not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage, and to prevent substitution of SCHIP coverage for coverage under group health plans, we will ask for such a State to make the following assurances:

- 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); CMS says NH @ 104%; we thought 69%-8
- 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 - Not sure how to monitor, esp w/ downward trend in private sector
- 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. - currently quarterly reports

We will continue to review all State monitoring plans, including those States whose upper eligibility levels are below an effective level of 250 percent of the FPL, to determine whether the monitoring plans are being followed and whether the crowd-out procedures specified in the SCHIP state plans are reasonable and effective in preventing crowd-out.

CMS will apply this review strategy to SCHIP state plans and section 1115 demonstration waivers that include SCHIP populations, and will work with States that currently provide services to children with effective family incomes over 250 percent of the FPL. 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. We would not expect any effect on current enrollees from this review strategy, and anticipate that the entire program will be strengthened by the focus on effective and efficient operation of the program for the core uninsured targeted low-income population. We appreciate your efforts and share your goal of providing health care to low-income, uninsured children through title XXI.

If you have questions regarding this guidance, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs, who may be reached at (410) 786-5647.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

KOHLER AFFIDAVIT
EXHIBIT B

Dear SCHIP Director:

This letter is a follow-up to the State Health Official Letter (SHO) of August 17, 2007, that clarifies how the Centers for Medicare & Medicaid Services (CMS) applies existing statutory and regulatory requirements in reviewing eligibility expansions under the State Children's Health Insurance Program (SCHIP) to families with effective family income levels above 250 percent of the Federal poverty level (FPL).

I want to reaffirm that this guidance was specifically designed to apply to new applicants, rather than to individuals currently served by the program. States, such as yours, that currently provide coverage to children with effective family incomes over 250 percent of the FPL have 12 months or until August 16, 2008, to come into compliance with the required crowd-out strategies and assurances laid out in the August 17th SHO for new enrollees.

It is our intention to work cooperatively with you so that your state will be able to permit the enrollment of additional children in higher income families if the reasonable standards of the August 17th guidance are met. And as such, we would like to begin discussions on how your State will implement appropriate procedures, if they are not already in place. Specifically, we look forward to upcoming discussions on your State's crowd-out strategy implementation plan and 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. I would ask that you work with Ms. Kathleen Farrell, Director of the Division of State Children's Health Insurance, and her staff, to set up a conference call in the next few weeks. Ms. Farrell may be reached at 410-786-1236.

Sincerely,

Susan Cuerdon

KOHLER AFFIDAVIT
EXHIBIT C

Testimony of
Dennis G. Smith
Director
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
Before the House Energy & Commerce Subcommittee on Health
"Covering Uninsured Kids: Missed Opportunities for Moving Forward"
January 29, 2008

Chairman Pallone, Congressman Deal, thank you for inviting me to testify on today's topic as you renew the important work of reauthorizing the State Children's Health Insurance Program (SCHIP). The Administration strongly supports this important program and its full reauthorization. Last year, additional funding for the program was provided to ensure stability in the program through March 2009. We look forward to working with all members during this time to achieve the goal of reauthorization through 2013.

The full picture of our commitment to insuring low-income children includes Medicaid as well as SCHIP. Medicaid is approximately four times larger than SCHIP in terms of enrollment of children and just over six times larger in terms of expenditures for children. Total Federal and State Medicaid spending on children will exceed $400 billion over the next five years and $1 trillion over the next ten years. There are important budgetary and programmatic interactions between SCHIP and Medicaid that are appropriate to consider in the context of reauthorization.

Background

When Congress was considering the legislation that became Title XXI more than ten years ago, there was a widely held view that 10 million children in the United States lacked health insurance. It was recognized that many of these children were already

eligible for Medicaid but were not enrolled, and that many of these children were uninsured but lived in families with sufficient income to be able to afford coverage. Congress ultimately adopted an approach that was targeted to children with family incomes above existing Medicaid levels who lived in families for which the cost of insurance was beyond their reach. It set a general upper limit of income eligibility at the higher of 200 percent of the federal poverty level (FPL) or 50 percentage points above a state's Medicaid level. Under the FPL guidelines released last week for 2008, 200 percent of FPL is $42,400 for a family of four and 250 percent of FPL is $53,000 for a family of four. Just by way of comparison: the median income in the United States for a family of four is approximately $59,000.

SCHIP is a unique compound of incentives and checks and balances. Congress rejected the idea of simply re-creating Medicaid and its complexities. States with an approved SCHIP plan are eligible for Federal matching payments drawn from a state-specific capped allotment. While the program provides states with a great deal of program flexibility, including using Medicaid as their vehicle for administering Title XXI, it also creates the expectation that states will adopt policies to stay within their capped allotments. Capped appropriations and capped allotments were critical features of that bipartisan compromise. The legislation appropriated $40 billion over ten years, an amount that would support the number of children thought to be in the target population group. That level of funding clearly was not designed or intended to serve children at all income levels, nor was it intended to create a new entitlement for coverage.

Congress also realized that millions of children were eligible for Medicaid but were not enrolled. To ensure the success of SCHIP and avoid the possibility of creating a

new program that would not be taken up by the states, the idea of an enhanced match rate was ultimately adopted as the means of providing states with sufficient incentive to aggressively find and enroll uninsured low-income children. Thus, SCHIP provides a 70 percent federal match rate on an average national basis compared to the 57 percent average match rate for Medicaid. But central to the bipartisan discussion at that time was the question, "for whom is the enhanced match intended?" That question remains central to reauthorization today.

Enrollment Exceeds Expectations

If the goal ten years ago was to enroll 10 million children, then expectations have been exceeded. In 1998, the number of children "ever-enrolled" in Medicaid (enrolled at least for some period of time) was 19.6 million. States enrolled approximately 670,000 children in SCHIP in that first year for a combined total of more than 20 million children. Since then, combined Medicaid and SCHIP enrollment has increased every year. In FY 2006, more than 36 million children were enrolled (at least for some period of time) in Medicaid and SCHIP combined, an increase of 16 million children above the 1998 Medicaid level.

Since 1998, enrollment of children in SCHIP and Medicaid has increased nearly 80 percent, while growth in the total number of children in the U.S. population as well as the number of children in families below 200 percent FPL over the same period has been nominal. Enrollment in Medicaid and SCHIP now exceeds the number of children below 200 percent FPL. Therefore, it is clear that Medicaid and SCHIP are covering children in higher-income families.

"95 Percent Enrollment Goal"

It is because of this tremendous growth in Medicaid and SCHIP enrollment relative to the overall population and to the low-income population specifically that we believe our adopted goal of 95 percent enrollment of low-income children before expanding eligibility to higher income populations is both reasonable, in light of the statutory purpose of SCHIP to serve low-income children, and is achievable.

We anticipate working with states to determine their specific rates of coverage. It is unfortunate that some groups have prejudged compliance as they have relied on flawed national data to make comparisons regarding state performance. For example, it is widely recognized that the Current Population Survey (CPS) undercounts Medicaid participation. In the most recent CPS data released last year, the Census Bureau reported 20.7 million children ever enrolled in FY 2006, when enrollment reported by states for Medicaid and SCHIP combined in that same period was over 36 million.

We believe the 95 percent goal is further supported by last year's work conducted by the Urban Institute which shows much lower uninsurance rates among Medicaid and SCHIP eligible children than expected.[1] This study was not unanimously received as good news at the time, but we believe it demonstrates that states are far more successful than given credit. Therefore the 95 percent goal is not only achievable, but should be expected and demanded. Indeed, our view is that a number of states are already meeting the 95 percent goal.

We strongly believe, as the future of SCHIP as a program is considered, that states be required to put poor children first before they expand to higher income levels.

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[1] "Eligible But Not Enrolled: How SCHIP Reauthorization Can Help," September 24, 2007 [available at http://www.urban.org/publications/411549.html].

The federal government has tied financial incentives to performance standards in other public benefits programs with good results.

I want to reaffirm our previously stated position that children currently enrolled in SCHIP should not be affected as we work with states to implement the August 17, 2007 State Health Official (SHO) letter. The guidance sets out procedures and assurances that should be in place when states enroll new applicants with family incomes in excess of 250 percent of the federal poverty level (FPL) – that is, in excess of the median family income in the United States. But the guidance is not intended to affect enrollment, procedures, or other terms for such individuals currently enrolled in State programs.

"Crowd-Out"

The goal of SCHIP is to increase the rate of insurance among our nation's children in low-income families. "Crowd-out" or the substitution of existing coverage does not increase insurance rates, it merely shifts the source of funding. It is a public policy concern because it increases public expenditures without necessarily improving access to care or health status. It is also a concern because, as healthy lives are shifted out of the private sector insurance pools, there is a detrimental impact on those who remain. Insurance fundamentally means the sharing of risk. When the private pool of healthy insured lives shrinks and the risk cannot be spread as widely as before, the cost will rise for those who remain, triggering another cost increase which is likely to displace yet another group of people, whether employers or employees or both.

Crowd-out is not a new topic. There were numerous papers written on Medicaid and crowd-out prior to the enactment of SCHIP and it remains a popular subject today. The pre-SCHIP papers on crowd-out dealt primarily with populations below 200 percent

of FPL, many of whom were assumed to not have access to employer-sponsored health insurance or the means to contribute the employee share of costs. There are a variety of opinions on how to define crowd-out, how to measure it, and how to prevent it. In its paper on SCHIP last May, the Congressional Budget Office (CBO) neatly summarized the research on this topic and concluded that, "... in general, expanding the program to children in higher-income families is likely to generate more of an offsetting reduction in private coverage (and therefore less of a net reduction in uninsurance) than expanding the program to more children in low-income families." The CBO estimates on the SCHIP legislation that the President vetoed reinforce the findings of its May study.

As early as February 1998, the federal government released instructions to the states on how it would review strategies to protect against substitution of private coverage. In a February 13, 1998 State Health Official letter, co-signed by the Director of the Center for Medicaid and State Operations at the Health Care Financing Administration and the Acting Administrator of the Health Resources and Services Administration, the federal government provided that, "States that provide insurance coverage through a children's only and/or a State plan (as opposed to subsidizing employer-sponsored coverage) or expand through Medicaid will be required to describe procedures in their State CHIP plans that reduce the potential for substitution. ... After a reasonable period of time, the Department will review States' procedures to limit substitution. If this review shows they have not adequately addressed substitution, the Department may require States to alter their plans."

Another federal agency within the Department of Health and Human Services, the Agency for Healthcare Research and Quality, listed several strategies to prevent crowd-out at that time which included:[2]

- Institute waiting periods (3, 6, or 12 months)
- Limit eligibility to uninsured or under-insured
- Subsidize employer-based coverage
- Impose premium contributions for families above 150 percent of the Federal poverty level
- Set premiums and coverage and levels comparable to employer-sponsored coverage
- Monitor crowd-out and implement prevention strategies if crowd-out becomes a problem

States faced competing pressures as they designed their SCHIP programs. Effective crowd-out strategies were measured against pressures to quickly build enrollment. Decision makers at the state level faced strong public criticism for "turning back" federal funds that would go to other states or be returned to the Federal Treasury.

As the 16 million children were being added to Medicaid and SCHIP, the percent of children between 100 and 200 percent of poverty with private insurance declined. In 1997 according to data from the 2006 National Health Interview Survey, 55 percent of children in families with income at this level had private insurance. But by 2006, the percentage had declined to 36 percent. [3]

Eligibility Expansions

Currently there are 20 jurisdictions (19 states and the District of Columbia) that cover children in families with income greater than 200 percent of FPL, of which 17 jurisdictions cover children in families with income equal to or greater than 250 percent

[2]See http://www.ahrq.gov/chip/Content/crowd_out/crowd_out_topics.htm.
[3]See http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200712.pdf. The data are derived from the Family Core component of the 1997–2007 NHIS, which collects information on all family members in each household. Data analyses for the January – June 2007 NHIS were based on 41,823 persons in the Family Core.

FPL. In addition, there are three states that cover children in families with income thresholds above 200 percent of FPL that apply income disregards in an amount we believe is likely to exceed the 250 percent FPL threshold. Expansions of SCHIP to higher income levels occurred early in the program or just in the past two years. Of the 19 states and the District of Columbia that provide coverage above 200 percent of the poverty level, 13 of them received approval to cover those higher incomes by July 2001 or earlier. Of those 13 states, eight were "qualifying states," that had increased Medicaid eligibility prior to the creation of SCHIP.

The other seven states that have expanded eligibility above 200 percent FPL occurred in January 2006 or later. With the exception of Hawaii, the eligibility limits were approved as state plan amendments, not as waivers as has been widely reported. After a five-year period in which no state raised their eligibility level, there clearly are growing interests or pressures among additional states to expand eligibility beyond the statutory definition. It is important to understand those interests or pressures in order to design an appropriate response.

Federal responses may be different than the choices made ten years ago and should include approaches outside of SCHIP as well as within the program. One area that seems particularly ripe for a new approach within SCHIP is premium assistance. Perhaps some of the crowd-out effect could have been prevented if SCHIP were used to a greater extent to support private coverage rather than replace it.

Conclusion

SCHIP has been highly successful in the mission it was given to increase coverage among uninsured low-income children. But that success does not mean SCHIP can or will be as successful when populations at higher incomes are involved.

We hope that the lessons of the past will guide how we use the fresh opportunity before us and the Administration looks forward to working with all members to forge reauthorization in the same bipartisan spirit in which SCHIP was created.

KOHLER AFFIDAVIT
EXHIBIT D

From: Farrell, Kathleen M. (CMS/CMSO) [mailto:Kathleen.Farrell@cms.hhs.gov]
Sent: Friday, February 22, 2008 12:27 PM
To: Ann C. Kohler
Cc: Cuerdon, Susan J. (CMS/CMSO); Peltz, Linda L. (CMS/CMSO); Strauss, Richard (CMS/CMSO); Cuneo, Kathleen V. (CMS/CMSO); Green, Stacey D. (CMS/CMSO); Harris, Monica F. (CMS/CMSO); Garner, Angela D. (CMS/CMSO)
Subject:

Ann,

I want to thank you for taking time to talk with us on Wednesday about establishing compliance with the August 17th SHO letter. As I mentioned, this is a follow up to that conversation to recap.

95% Assurance- We discussed the shortcomings of the CPS data, particularly in regards to the Medicaid undercount and since it also includes children that would not be programmatically eligible. Without any adjustments, in looking at the number of children under 200% of the FPL in the State who were uninsured in that income level, calculating from the CPS data, we get 22 percent uninsured. We also discussed the possibility of looking at state specific survey information that would be helpful in refining the CPS data. We also mentioned using the ever enrolled numbers for the SCHIP and Medicaid programs in the numerator.

Decrease in private insurance coverage- When we looked at CPS data for children under age 19, under 200 percent FPL, covered under private insurance by state 2002-2006, New Jersey had 38.90% in 2002 and 34.20% in 2006. The State may also want to talk with the Insurance Commission or other data sources to refine this percentage.

Reporting requirements- New Jersey is not current with all reporting requirements, specifically SARTs and the first quarter reporting for this year in SEDs. As I mentioned, we have not developed the reports related to crowd-out requirements.

Cost sharing strategy- We also discussed the requirement that cost sharing under the SCHIP 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 percentage point. As I mentioned, we are not prescribing what data source you use to show that NJ meets this requirement, but we did share with you some resources we have found. The Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPs) has several tables with State specific data that contain information on private sector health insurance costs. You may access these tables through www.meps.ahrq.gov. Our approach in determining the private sector cost sharing for purposes of comparison was to take the **Average annual Employee contribution- family coverage** and subtract the **Average annual Employee contribution- single coverage.** The difference between these numbers is effectively the family's cost

for additional person coverage. This amount plus the **Average out of pocket (OOP) costs for children- private** could be used in calculating the **Avg. total cost sharing/Avg median income** to determine the percentage of family income under private plans. As I mentioned, we had taken a preliminary review of the MEPs data and are providing the information that we pulled off for CT-the specific charts used are noted at the bottom. We anticipate that you will work with your Insurance Commission or other data sources and only provide this as a sample of the available data.

State	Avg annual total premium- family coverge[1]	Avg annual Employee contribution- family coverage[2]	Avg annual Employee contribution- single coverage[3]	Difference (effective cost for additional person coverage)	Avg OOP costs for children- private	SCHIP Premium	SCHIP OOP costs
New Jersey	$11,403	$2,742	$847	$1,895	$790	$1,446	

1- Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPs)- table II.D.1(2005) www.meps.ahrq.gov

2- ibid. - table II.D.2(2005)

3- ibid. - table II.C.2(2005)

One year period of uninsurance- I want to reiterate that this is required only for new enrollees after August 16th, with incomes in excess of 250% of the FPL. In terms of exceptions to the period of uninsurance, we will review any proposed exceptions and justifications in making a determination.

We look forward to working with you on achieving compliance. You can let us know what approach you want to take, but it may work best if we set up a schedule to tackle each item one at a time. I think now is an appropriate time to begin gathering data sources and determining if you do indeed need to make legislative changes. Please contact me directly if you have additional questions.

Kathleen Farrell

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