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

STATE OF NEW JERSEY, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant.	HON. JOEL A. PISANO, U.S.D.J. Civ. Action No. 07-04698 (JAP) (JJH)

BRIEF OF AMICI CURIAE IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

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PRELIMINARY STATEMENT

The undersigned professors, academics and clinicians of health policy, law, and medicine (collectively, the "Health Policy Scholars"), respectfully submit this brief in support of Plaintiff's Motion for Partial Summary Judgment.[1]

INTEREST OF AMICI

Amici are scholars and experts in health policy, health law, pediatrics, health economics, and health management. Among them are distinguished professors, a former U.S. Assistant Secretary of Health, chief administrators of prominent medical institutions and universities, and practicing clinicians.[2] Amici have testified before Congress, advised federal policymakers, drafted legislation and published innumerable articles, reports, studies and books related to the design, operation and effects of public health insurance in the United States. Together they have contributed an extensive body of written work and research that informs the development of federal and state health laws and policies, particularly in the area of child health policy.

SUMMARY OF ARGUMENT

In this case, Plaintiff, the State of New Jersey, challenges a Directive issued on August 17, 2007 (the "Directive") by the Centers for Medicare and Medicaid Services ("CMS"), regarding the State Children's Health Insurance Program ("SCHIP"), a federal-state public health insurance program for low-income children.

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[1] Plaintiff and Defendant have both consented to the Health Policy Scholars filing an amici curiae brief.

[2] See List of Health Policy Scholars attached hereto as Exhibit 1.

See Directive, Letter from Centers for Medicare & Medicaid Servs. ("CMS"), U.S. Dep't of Health & Human Servs., at 1 (Aug. 17, 2007), attached hereto as Exhibit 2. The Directive orders states to implement certain policies and procedures to prevent the "substitution of public SCHIP coverage for private [health] coverage," a phenomenon commonly called "crowd-out,"[3] and to promote the "effective and efficient provision" of child health coverage. Id. at 1. These prescribed policies reflect a fundamental shift in federal SCHIP policy and would have the effect of elevating the prevention of health insurance crowd-out over the provision of health coverage to uninsured low-income children.

More important, and of particular concern to expert amici, is 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 actually to reduce crowd-out – would 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.

[3] "Crowd-out" refers to a variety of phenomena, including when employers discontinue (or do not offer) employer-sponsored insurance to employees or their child dependents, or when families do not enroll in or discontinue private health insurance (whether offered by an employer or purchased in the private insurance market) otherwise available to them.

CMS issued these significant and unprecedented requirements by means of a two-and-a-half page Directive without an opportunity for comment from experts, affected stakeholders, or the public. There was no opportunity to highlight in the public record the fundamental disconnect between the Directive's requirements and the substantial body of research regarding public health insurance programs and crowd-out. The research and data that amici present here, improperly excluded from the administrative process by CMS reveal the fundamental failure of the Directive's requirements to achieve legitimate purposes under the SCHIP statute, and demonstrate how they are at odds with the Directive's self-proclaimed goals.

Specifically, amici believe that it will assist the court to know that:

(1) The Directive prohibits a state from extending (or continuing) coverage to children with household incomes over 250 percent federal poverty level ("FPL") unless the state enrolls 95 percent of eligible children with household incomes under 200 percent of the FPL into Medicaid or SCHIP. This condition serves as a de facto bar to coverage of children with household incomes over 250 percent FPL - and would do nothing to ensure any greater coverage of the lowest-income children. As shown below, a review of the substantial body of research on enrollment into means-tested public health insurance programs and other voluntary enrollment arrangements reveals that the 95 percent standard has never been met and is virtually unachievable in the absence of an automatic enrollment process (i.e., a process that would enroll

all apparently eligible children without requiring an application), which Medicaid and SCHIP are prohibited, by federal law, from employing.

(2) The Directive also requires that for children with family incomes above 250 percent FPL, a state must impose a minimum 12-month waiting period (a period of "uninsurance") prior to allowing SCHIP enrollment for children who previously had private health coverage. This requirement has no basis in the extensive literature analyzing the impact of waiting periods on crowd-out, nor in the real-life experience of states that have been moving in recent years to reduce their waiting periods, with CMS approval. Furthermore, an extensive body of literature shows the threat to children's health posed by this requirement.

(3) The Directive prohibits a state from extending (or continuing) coverage to children with household incomes over 250 percent FPL unless the state can demonstrate that the number of children insured through private employers has not decreased by more than two percent over the prior five-year period. This precondition fails to take into account extensive research on the principal causes and extent of the nationwide decline in employer-sponsored insurance ("ESI") and fails to recognize that state programs have negligible effects on this decline - thereby linking SCHIP coverage to unrelated events.[4]

[4] The Directive contains other requirements that raise concerns about program administration and consistency with the SCHIP statute. Because our brief is focused on policy research, we do not address these other issues here.

Each of these Directive requirements, therefore, establishes highly specific standards that, had a proper record been made, would have been shown to have no connection to the evidence or to the statute itself. To be clear, it is not the position of the amici that, through its Directive, CMS has made unwise policy decisions; rather, it is their collective view that the agency's decisions have *no* basis in evidence or the law.

BACKGROUND

A. State Children's Health Insurance Program

Congress enacted SCHIP as part of the Balanced Budget Act of 1997 after a period of steady decline in the number of children covered by private health insurance. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 552 (1997). The primary goal of the legislation was "to provide States with the tools they need to effectively . . . expand . . . coverage to low-income uninsured children in a manner that will increase their access to and use of quality primary and preventive care." H.R. Rep. No. 105-149, at 603 (1997). Thus, SCHIP establishes a state entitlement to federal funds for the provision of health insurance to children who are ineligible for Medicaid but are unable to afford private health insurance.

All fifty states and the District of Columbia currently participate in SCHIP, and over 6.6 million children are covered by the program during the course of the year.[5] Approximately sixteen states, including New Jersey and the District of

[5] The State Children's Health Ins. Program, Cong. Budget Office (2007), http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf.

Columbia, currently provide coverage for children in families with incomes over the 250 percent FPL. All states have developed and implemented measures to monitor or prevent crowd-out as required by the statute.

B. CMS Directive

On August 17, 2007, while Congress was debating legislation to reauthorize SCHIP, CMS issued the Directive at issue in this action. At the time, the Administration had proposed that the reauthorization bill limit SCHIP eligibility to 200 percent FPL.[6] Just before CMS released its Directive, however, the House and the Senate had rejected the Administration's approach with each chamber passing SCHIP reauthorization bills that did not cap income eligibility at 200 percent FPL.

The stated purpose of the Directive is to address how CMS reviews state requests and existing state plans that extend eligibility under SCHIP to children with effective household income levels above 250 percent FPL. Directive, at 1. Under the Directive, states will not be permitted to use SCHIP funds to cover children with household income levels above 250 percent FPL unless they adopt certain "general crowd-out strategies with certain important components." Id. States must (1) meet an enrollment target rate of 95 percent of all eligible children at 200 percent FPL or lower enrolled in the state's Medicaid or

[6] SCHIP Reauthorization: Can the Nation Move Forward Without Going Backward?, Ctr. for Children & Families, Georgetown Univ. Health Policy Inst. (2007), http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/schip%20reauthorization%20exec%20sum.pdf.

SCHIP program; (2) demonstrate that employer-based coverage of children among the target population has not declined in the state by more than two percent over the past five years; and (3) impose 12-month waiting periods for children who try to enroll in SCHIP following private coverage. Id. at 2. States with existing coverage of children with household incomes above 250 percent FPL were informed that they had 12 months to comply with the Directive before CMS would take corrective action. Id. at 2. Prior to the issuance of the two-and-a-half page Directive, states were required only to describe the strategies that they intended to use to prevent crowd-out, and were not required to adopt any particular measures. The Directive therefore imposes new burdens on states and conflicts with state child health plans previously approved by CMS.

Despite the clear impact the Directive's strategies would have on states and the children to whom they provide coverage, CMS did not provide an opportunity for interested parties to comment on the Directive. Nor did the agency provide any indication of what data it considered in developing these strategies. (The Directive refers vaguely to "information and experience" CMS has gained from the operation of SCHIP. Id. at 1.)

STANDARD OF REVIEW

The Administrative Procedure Act ("APA") requires agencies to give interested parties an opportunity to participate in administrative rulemaking. See 5 U.S.C. § 553(c) (2007). This requirement "is designed to ensure that affected parties have an

opportunity to participate in and influence agency decision making at an early stage . . .” New Jersey Dep’t of Envtl. Prot. v. United States Envtl. Prot. Agency, 626 F.2d 1038, 1049 (D.C. Cir. 1980). Accepting comments from the public “enables the agency promulgating the rule to educate itself before establishing rules and procedures which have a substantial impact on those regulated.” Texaco v. Fed. Power Comm’n, 412 F.2d 740, 744 (3d Cir. 1969) (citation omitted).

Once it has gathered information from and noted the concerns of interested parties, an agency is obligated to “examine the relevant data and articulate a satisfactory explanation for its action . . . including a rational connection between the facts found and the choices made.” Motor Vehicle Mfr. Ass’n v. State Farm Auto. Fund Ins. Co., 463 U.S. 29, 31, 43 (1983) (citation omitted). In instances where an agency excludes the public from the rulemaking process and “entirely fail[s] to consider an important aspect of the problem [at issue], offer[s] an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise,” the resulting rule is arbitrary and capricious and therefore invalid. Id. at 43.

Here, in promulgating the Directive’s requirements, CMS has clearly violated the APA. Plaintiff’s brief in support of its motion for partial summary judgment provides a comprehensive explanation of the Directive’s procedural defects and its invalidity. Amici will not restate Plaintiff’s argument here.

Rather, in the following sections, amici will present evidence that would have been submitted in a public comment period, but that was neither heard nor considered by CMS in connection with the Directive. This evidence demonstrates, on substantive grounds, that the Directive is arbitrary and capricious.

ARGUMENT

A. The Directive's 95 Percent Enrollment Rate Is Unattainable Under Current Federal Rules, Making CMS' Requirement Arbitrary And Capricious For Its Stated Purpose.

Under the Directive, a state's coverage of children with household incomes above 250 percent FPL is contingent on the "[a]ssurance 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." Directive, at 2. CMS' stated objective in mandating attainment of a target enrollment rate is to ensure that states have implemented "'reasonable procedures' to prevent substitution of public SCHIP coverage for private coverage," and that "extension of eligibility to children at these higher effective income levels do[es] not interfere with the effective and efficient provision of child health assistance . . . to the core SCHIP population of uninsured targeted low income children." Directive, at 1.

Despite CMS' stated objective, research establishes that the Directive's requirement imposes an onerous, and virtually unachievable, prerequisite on states seeking to expand (or maintain) SCHIP coverage for more uninsured children. As described further below, the national participation rate of eligible children in Medicaid and SCHIP falls well below the 95

percent threshold, and a review of the research regarding enrollment in voluntary insurance arrangements reveals no evidence that any state, including states that have undertaken extensive outreach efforts to increase enrollment of eligible lower-income children,[7] has ever approached a 95 percent enrollment rate.

Furthermore, the research reveals that the obstacles to achieving a 95 percent enrollment rate are hardly limited to SCHIP and Medicaid. No public program has reached an enrollment rate of this magnitude without implementing automatic enrollment, a strategy that cannot, under federal law, be used in Medicaid or SCHIP. Without significant changes in federal rules, states simply will not be able to meet the Directive's mandated target enrollment rate. This makes the requirement a de facto bar, rather than a targeted incentive, for states to obtain or maintain SCHIP eligibility levels over 250 percent FPL.

Analyses of child participation rates in SCHIP and Medicaid using generally accepted methodologies show average national participation rates far below 95 percent,[8] and no individual

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[7] Susan R. Williams & Margo L. Rosenbach, Evolution of State Outreach Efforts Under SCHIP, 28 Health Care Financing Review 95, 98-103 (2007), http://www.mathematica-mpr.com/publications/PDFs/evolutionstate.pdf.

[8] Lisa Dubay, Jocelyn Guyer, Cindy Mann, & Michael Odeh, Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward, 26 Health Affairs 370, 374 (2007), attached hereto as Exhibit 3; Julie L. Hudson & Thomas M. Selden, Children's Eligibility and Coverage: Recent Trends and a Look Ahead, 26 Health Affairs, web exclusive (2007), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.5.w618; Making Real Gains for Children: Strategies for Reaching the More Than Six Million Uninsured Children Eligible for Medicaid and SCHIP, Ctr. for Children & Families, Georgetown

state rate reaching the 95 percent level.[9] Recent estimates of the national participation rate in SCHIP and Medicaid range from approximately 63-68% to 79-82%, respectively.[10]

Despite this body of academic research, a CMS official suggested in Congressional testimony that some states could, or had, met the 95 percent threshold.[11] This perspective may be based on CMS' own state-level Medicaid and SCHIP participation rate estimates that it unofficially released shortly after issuing the Directive,[12] in which CMS actually estimated that more than 40 states had participation rates of more than 100 percent of children below 200 percent FPL.[13] Researchers have overwhelmingly criticized CMS' calculations,[14] and CMS itself

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Univ. Health Policy Inst., at 2, Figure 2 (2007), http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf publications/federal schip policy/making real gains for children.pdf; Stan Dorn, Eligible but Not Enrolled: How SCHIP Reauthorization Can Help, The Urban Inst., Health Policy Online: Timely Analysis of Health Policy Issues, at 1 (2007), http://covertheuninsured.org/pdf/stateflex0907.pdf; Genevieve M. Kenney, Medicaid and SCHIP Participation Rates: Implications for New CMS Directive, The Urban Inst., Health Policy Online: Timely Analysis of Health Policy Issues, at 1 (2007), http://www.urban.org/UploadedPDF/411543_medicaid_schip.pdf.

[9] Due to methodological issues, particularly sample size, undercount, and variation in eligibility requirements, attempts at estimating state-specific participation rates are infrequently undertaken. However, estimates generated using the most sound methodologies available found that no state came close to reaching the CMS-mandated target enrollment rate. See Medicaid /SCHIP Participation Rate Among Low-Income Children Under 19, 2004-2005, Ctr. for Children & Families, Georgetown Univ. Health Policy Inst. (2007), attached hereto as Exhibit 4.

[10] See supra, note 8.

[11] Kohler Aff. Ex. C. at 5.

[12] Kenney, supra, note 8, at 2-3.

[13] See Medicaid/SCHIP Enrollment of Children Population Compared to Children <200 Percent FPL, Ctr. for Medicare and Medicaid Servs. (2007), attached hereto as Exhibit 6.

[14] Kenney, supra, note 8, at 2-3.

appears uncommitted to the estimates, rejecting New York's recent application to expand SCHIP eligibility on the grounds that the state had not satisfied the 95 percent enrollment rate[15] despite CMS' own estimate that New York's rate was 144 percent.[16]

CMS' anomalous estimates notwithstanding, Medicaid and SCHIP participation rates for low-income children are significantly higher than participation rates in other means-tested public programs.[17] Further, research on program enrollment shows that only automatic enrollment strategies – strategies that are impermissible under Medicaid and SCHIP's federal rules – could possibly improve enrollment rates to approach the Directive's 95 percent target.[18] Medicare Part B, a program whose eligible

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[15] Letter from Kerry Weems, acting Dir., U.S. Dep't Health & Human Servs. to Judith Arnold, Dir., Div. of Coverage & Enrollment, State of N.Y. Dep't of Health (Sept. 7, 2007), attached hereto as Exhibit 7.

[16] In addition, the CMS official suggested that a recent Urban Institute analysis might also provide support for the proposition that states were meeting the 95% target enrollment rate requirement. That study, which did not calculate state-by-state participation rates, was rejected by the nonpartisan Congressional Budget Office (CBO) as an inappropriate basis for developing policies aimed at enrolling more eligible children in public health insurance programs. See Letter from Peter Orszag, Dir., CBO to the Hon. Max Baucus, Chairman, Comm. on Fin. (July 24, 2007), attached hereto as Exhibit 8.

[17] Dorn, supra, note 8, at 2, Figure 1. According to the U.S. Government Accountability Office, none of the many means-tested public programs it studied had succeeded in enrolling more than 75 percent of eligible individuals, and Medicaid and SCHIP had relatively high participation rates compared to other programs studied. Rep. to the Ranking Minority Member, Comm. on the Budget, H.R., No. GAO-05-221, Means-Tested Programs: Info on Program Access Can Be an Important Mgmt. Tool, at 3-5, as reprinted by the Gov't Accountability Office (2005), http://www.gao.gov/highlights/d05221high.pdf.

[18] Dahlia K. Remler & Sherry A. Glied, What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs, 93 Am. Journal of Pub. Health 67, 72-73 (2003); Stan Dorn and

enrollees are automatically enrolled in the program unless they affirmatively "opt out" of coverage, has an unrivaled enrollment rate of 95.5 percent.[19] Research has documented other examples of enrollment in both health and non-health programs – including prescription drug discount programs and retirement savings accounts – that reflect the inherent challenge of obtaining high participation rates in the absence of automatic enrollment.[20] To be sure, these studies also reveal that attainment of 95 percent participation rates in voluntary programs is uncommon even when enrollment procedures are streamlined to the point of being automatic, which is not possible with SCHIP's means-tested eligibility criteria.

Notwithstanding findings about the effectiveness of automatic enrollment in increasing participation rates, states are not able to adopt auto-enrollment in Medicaid and SCHIP

Genevieve Kenney, Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Fed. Policy Makers, The Commonwealth Fund (2006), http://www.commonwealthfund.org/usr_doc/Dorn_auto-enrollingchildren_931.pdf?section=4039.

[19] Remler and Glied, supra, note 18, at 68, Table 1.

[20] Dorn and Kenney, supra, note 18. Prior to the commencement of a full outpatient prescription drug benefit under Medicare, the federal government offered a drug discount card and a $600 stipend to cover drug purchases for low-income seniors. Some seniors were automatically enrolled in the drug card program based on their prior participation in particular means-tested public programs. In states where auto-enrollment was implemented, rates of enrollment by eligible participants ranged from 80 to 90 percent, levels which were dramatically higher than states requiring voluntary enrollment, where participation ranged from 2 to 40 percent. There were similar findings in the realm of private retirement accounts. When employees have to establish their own accounts, only 9 percent of eligible individuals enroll; even when employees are *automatically enrolled unless they "opt-out"* of coverage, 90 percent of eligible individuals participate. Dorn, supra, note 8.

because current federal law requires individuals affirmatively to apply. Moreover, citizenship and identity documentation requirements under the Deficit Reduction Act (DRA) of 2005 make it virtually impossible to automate a process that would provide sufficient proof of an individual's program eligibility to meet federal requirements.[21] In fact, several studies show that the new federal documentation requirements are already inhibiting state enrollment of eligible citizens in Medicaid,[22] and children's enrollment specifically.[23]

Review of the relevant policy literature on enrollment rates shines a revealing light on the Directive's 95 percent enrollment requirement. Not only is there no evidence that a 95 percent enrollment rate for low-income children in a program with complex eligibility and documentation requirements is achievable, but

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[21] Patricia Boozang, Melinda Dutton, & Julie Hudman, Citizenship Documentation Requirements in the Deficit Reduction Act of 2005: Lessons From New York, Kaiser Comm'n on Medicaid and The Uninsured (2006), http://www.kff.org/medicaid/upload/7534.pdf.

[22] Rep. to Cong. Requesters, No. GAO-07-889, States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens, as reprinted by the Gov't Accountability Office (2007), http://oversight.house.gov/documents/20070724110408.pdf; Vernon Smith, et al., As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget for State Fiscal Years 2007 and 2008, The Kaiser Comm'n on Medicaid and the Uninsured, at 7 (2007), http://www.kff.org/medicaid/upload/7534.pdf; Donna Cohen Ross, New Medicaid Citizenship Documentation Requirement Is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up, Ctr. on Budget and Policy Priorities, at 3-7 (2007), http://www.cbpp.org/2-2-07health.pdf; See also Unintended Consequences: The Impact of New Medicaid Citizenship Documentation on Virginia's Children, VA Health Care Found. (2007), http://www.vhcf.org/uploads/resource/DRAStudyUnintendedConsequencesFINAL52407.pdf.

[23] Gov't Accountability Office, supra, note 22, at 6.

there is overwhelming evidence that it is not. With no public comment process, CMS has not been required to defend the 95 percent standard, nor has it been compelled to explain how it could possibly be achieved. Seen this way, the Directive's requirement is much more a de facto bar to covering children with household incomes over 250 percent FPL than an incentive for states to target the enrollment of lower-income children. Accordingly, the 95 percent enrollment rate is an arbitrary and capricious standard when measured against the agency's own stated goals.

B. States' Experience, CMS' Prior Decisions And Policy Research Provide No Support For The Effectiveness Of 12-Month Waiting Periods But Demonstrate Their Potential Harm, Rendering The Requirement Arbitrary And Capricious.

The Directive requires states that provide SCHIP coverage to children with household incomes of more than 250 percent FPL to "establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage." Directive, at 2. As with the other "strategies" set forth in the Directive, CMS' stated objective is to ensure that states have "'reasonable procedures' to prevent substitution of public SCHIP coverage for private coverage." Directive, at 1.

Despite CMS' mandate of a minimum 12-month waiting period as a necessary anti-crowd-out strategy, the requirement runs counter to an extensive body of research on waiting periods, as well as to states' actual reported experience, and to a long history of CMS decisions to approve shortened waiting periods. Furthermore, the literature is replete with evidence that longer waiting

periods increase the number of uninsured children and thus pose a serious and unjustified threat to their health.

1. Research Findings Do Not Suggest That A 12-Month Waiting Period Is A Reasonable Anti-Crowd-Out Strategy.

Despite a vigorous debate among experts about the effectiveness of waiting periods in general at reducing crowd-out, there is no such dispute about periods of 12-month duration. A detailed review of the policy literature does not reveal a single published study that substantiates CMS' conclusion that a 12-month waiting period is a more – or even equally – effective anti-crowd-out strategy than shorter waiting periods currently used by the overwhelming majority of states.[24]

Using a variety of methodologies, several teams of researchers have determined that waiting periods have little or no effect in limiting the degree of crowd-out associated with SCHIP.[25] Inasmuch as these studies contradict the proposition

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[24] Of the 37 states that have implemented waiting periods, Alaska is the only state to implement a 12-month waiting period with respect to children covered under a SCHIP-Medicaid expansion. See Donna Cohen Ross & Aleya Horn, Health Coverage for Children and Families in Medicaid & SCHIP: State Efforts Face New Hurdles, Kaiser Comm'n on Medicaid and the Uninsured, at 32, Table 2 (2008), http://www.kff.org/medicaid/upload/7740.pdf. Illinois requires 12-month waiting periods for children covered by its state-funded expansion of children's health insurance. Id. The remaining states have implemented waiting periods of between one and six months. Id.

[25] See Cynthia Bansak & Steven Raphael, The Effects of State Policy Design Features on Take-Up and Crowd-Out Rates for the State Children's Health Ins. Program, 26 J. Policy Analysis & Mgmt. 149, 159-60, 167 (2006); Barbara Wolfe and Scott Scrivner, The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up, 24 J. Policy Analysis & Mgmt. 499 (2005). Jonathan Gruber and Kosali Simon, Crowd-Out Ten Years Later: Have Recent Public Ins. Expansions Crowded Out Private Health Ins.?, 14-16 (Nat'l Bureau of Econ. Research, Working

that waiting periods help reduce crowd-out at all, they certainly do not provide evidence to suggest that a 12-month waiting period is a reasonable anti-crowd-out strategy.[26] While some other studies suggest that waiting periods may reduce crowd-out, none actually evaluates the impact of a 12-month waiting period or even asserts that such a lengthy waiting period would have positive anti-crowd-out effects. In fact, at least one of the studies that supports the use of waiting periods to counter crowd-out suggests that a 12-month waiting period is unnecessarily long.[27] Other studies only examined waiting periods of six months or less.[28] In short, the extensive body of research on waiting periods provides no basis for CMS' insistence on keeping children uninsured for such a lengthy period of time.

2. The Experience Of States With Waiting Periods And CMS' Prior Decisions Contradict The Directive's 12-Month Requirement.

The 12-month requirement also lacks any basis in states' experience with waiting periods in the SCHIP program. Currently, 37 states, including almost all of those that cover children with household income exceeding 250 percent FPL, require some period, ranging from 1 to 12 months, of uninsurance prior to SCHIP

Paper No. 12858, 2007), attached hereto as Exhibit 9.

[26] See Gruber & Simon, supra, note 25, at 24, 28.

[27] Anthony T. LoSasso & Thomas C. Buchmueller, The Effect of the State Children's Health Ins. Program on Health Ins. Coverage, 23 J. Health Econ. 1059, 1078 (2004), http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf (finding that a 5-month waiting period for all states would effectively eliminate crowd-out).

[28] See Karl Kronebusch and Brian Elbel, Enrolling Children in Pub. Ins.: SCHIP, Medicaid, and State Implementation, 29 J. Health Politics, Policy & Law 451, 477 (2004).

enrollment.[29] A review of state SCHIP policies reveals that a majority of states that once required a 12-month period of uninsurance prior to enrollment have subsequently reduced the length of their waiting periods substantially. At the time SCHIP was implemented, Alaska, Arkansas, New Jersey, New Mexico, and Virginia all required 12-month waiting periods.[30] After some years of experience with the program, all of these states, with the exception of Alaska, have now reduced their waiting periods to three to six months.[31] Furthermore, several states that initially required waiting periods of up to six months have now dispensed with the waiting period requirement altogether.[32] Notably, every state decision to reduce the length of its SCHIP waiting period or to discontinue using waiting periods had to be approved by CMS. See 42 C.F.R. § 457.60 (requiring submission of state plan amendment to CMS to change anti-crowd-out procedures).

While these recent CMS approvals of *reduced* waiting periods are contrary to the anti-crowd-out requirement set forth in the Directive, the agency's prior decisions to approve reduced waiting periods were prudent given the actual amount of crowd-out

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[29] Ross & Horn, supra, note 29 (discussing states with waiting periods between July 2005 and July 2006); See also Shanna Shulman & Margo Rosenbach, SCHIP at 10: A Synthesis of the Evid. on Substitution of SCHIP for Other Coverage – Final Rep., Mathematica Polciy Research, Inc., at 4 (2007), http://www.mathematica-mpr.com/publications/pdfs/SCHIPaccess.pdf (discussing states with waiting periods in fiscal year 2004).

[30] Ross & Horn, supra, note 29.

[31] Id.

[32] Iowa, Kansas, Mississippi, and North Carolina each had 6-month waiting periods when SCHIP was first implemented and now have no waiting period requirement. Rhode Island and Louisiana had waiting periods of four and three months, respectively, but discontinued their waiting period requirements. Id.

reported by states. A majority of states with waiting periods of six months or less that cover children with household incomes above 250 percent FPL and that reported their annual incidence of crowd-out indicated that they experienced a low or insignificant level of crowd-out.[33] State crowd-out data simply does not reveal a correlation between shorter waiting periods and higher levels of crowd-out. This disconnect between CMS' apparent change in policy with respect to the use of waiting periods and the agency's prior administration of SCHIP further evinces that the Directive is without basis in policy and is arbitrary and capricious given the stated objectives of the new policy.

3. There Is No Dispute That Waiting Periods Have A Material And Negative Impact On Children's Health.

While academic research may diverge as to the efficacy of waiting periods as an anti-crowd-out strategy, there is no dispute that waiting periods dramatically decrease the rate at which otherwise eligible children take-up SCHIP benefits,[34] and

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[33] In annual state SCHIP reports for fiscal year 2005, states with eligibility levels above 250 percent FPL estimated the following "incidence of substitution": Connecticut - .15 percent of applicants had ESI within two months prior to application; Georgia - .2 percent of applicants had ESI within the two months prior to enrollment; Massachusetts - 0 percent because applicants must obtain ESI if they can afford it; Minnesota - "estimated to be very low"; New Mexico - Less than 1 percent; New York - Less than 3 percent; Pennsylvania - "insignificant" substitution; Rhode Island - "minimal" substitution; Washington - .5 percent of enrollees had ESI within four months prior to application. California reported the highest incidence of crowd-out with 8 percent of SCHIP enrollees that had ESI within the three months prior to enrollment. See SCHIP Annual Reports, http://www.cms.hhs.gov/NationalSCHIPPolicy/06_SCHIPAnnualReports.asp.

[34] Bansak and Raphael, supra, note 25, at 164-67; Wolfe & Scrivner, supra, note 25, at 512; LoSasso & Buchmueller, supra, note 27, at 1078.

increase the number of uninsured children.[35] And it is well-established that a lack of health insurance has a negative effect on children's health status, since it limits access to essential primary care, reduces the care children receive overall and increases the risk of inadequate care.[36] For children, in particular, studies have shown that "health insurance is a powerful predictor of children's degree of access to and use of primary care."[37] SCHIP bridges the gap between low-income children and regular medical care. Research indicates that in comparison to children with health coverage, uninsured children have fewer well-child visits, worse access to specialists, fewer immunizations and have more visits to the emergency room.[38]

Furthermore, research shows that waiting periods have particularly harsh consequences for chronically ill children. Uninsured chronically ill children are "significantly more likely to report unmet need for routine care, and specialty care, as

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[35] Wolfe, supra, note 25, at 510.

[36] See, e.g., Barbara Starfield, et al., Contribution of Primary Care to Health Sys. & Health, 83 Millback Q. 457, 474 (2005), http://www.fammed.tulane.edu/news/Contrib%20of%20PC%20to%20health%20systems%20starfield%20milbk%20qurt%202005.pdf; Lynn M. Olson, Suk-fong S. Tang, & Paul W. Newacheck, Children in the United States with Discontinuous Health Ins. Coverage, 353 New Eng. J. Med. 382, 382-91 (2005).

[37] Newacheck, et al., Health Ins. and Access to Primary Care for Children, 338 New Eng. J. Med. 513, 517 (1998).

[38] Michael Kogan, et al. The Effect of Gaps in Health Ins. on Continuity of a Regular Source of Care Among Preschool-Aged Children in the United States, 274 JAMA 1429, 1433 (1995); See also Shulman & Rosenbach, supra, note 29, at 9 ("SCHIP enrollment was associated with an increased likelihood of having a usual source of care and widespread reductions in unmet need and delayed care.").

well as delayed or foregone care."[39] At least one study shows that chronically ill children are also disproportionately represented among children moving to SCHIP from private coverage, possibly as a result of inadequate private sector coverage for chronic conditions.[40]

The principal "concern about waiting periods is that they can harm children by enforcing or prolonging gaps in insurance coverage."[41] Establishing 12-month waiting periods will undoubtedly increase the number of uninsured children, and delay children's access to care, without any demonstrable impact on crowd-out. The periods without insurance coverage are likely to have serious consequences for children since they will lose access to preventive care, hearing, vision, developmental screening, immunizations, and early intervention.[42]

CMS has provided no empirical basis for its 12-month waiting period requirement. Given the dramatic turnaround from waiting period durations previously approved by CMS and currently in place, it is difficult to conceive of a rational basis for such a

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[39] Aimee Jeffrey and Paul Newacheck, Role of Ins. for Children with Special Health Care Needs: A Synthesis of the Evidence, 118 Pediatrics 1030 (2006), http://pediatrics.aappublications.org/cgi/reprint/118/4/e1027; see also Amy Davidoff, Genevieve Kenney and Lisa Dubay, Effects of the State Children's Health Ins. Program Expansions on Children with Chronic Health Conditions, 116 Pediatrics 37 (2004), http://pediatrics.aappublications.org/cgi/reprint/116/1/e34.

[40] Laura P. Shone, et al., Crowd-Out in the State Children's Health Ins. Program: Incidence, Enrollee Characteristics and Experiences and Potential Impact on New York's SCHIP, 43 Health Servs. Research, *11 (2008), attached hereto as Exhibit 10.

[41] Id.

[42] Kogan, supra, note 38, at 1433.

change that is unsubstantiated by research or state experience and is inconsistent with the primary statutory goal of reducing the number of uninsured children. For all of these reasons, the 12-month waiting period requirement articulated in the Directive is arbitrary and capricious.

C. It Is Irrational, Arbitrary And Capricious To Condition Approval Of SCHIP Income Eligibility Levels On Employer-Sponsored Insurance Enrollment That Cannot Be Controlled By States.

Under the Directive, states may not provide SCHIP coverage to children with family incomes above 250 percent FPL unless they can demonstrate that there has not been a decline of more than 2 percent over a five-year period in the number of children covered by ESI in their jurisdiction. Directive, at 2. Because neither empirical evidence nor research studies suggest that there is a direct link between SCHIP eligibility levels and ESI enrollment, this new standard lacks any basis in fact or policy and imposes an impediment to coverage that is inconsistent with the SCHIP statute.

Conditioning SCHIP coverage on rates of ESI enrollment involves two assumptions: first, that SCHIP crowd-out is a principal cause of declining rates of ESI among children, and second, that states can control rates of ESI enrollment among children. Both of these assumptions are inconsistent with what is known about the factors that influence employers' decisions to offer ESI and employees' decisions to take it up.

There is no evident relationship between SCHIP eligibility levels and current rates of ESI enrollment. See Exhibit 11a attached hereto. For example, during the period from 2004 to

2006, states that experienced the greatest decline in ESI enrollment of children had widely varying SCHIP income eligibility levels. As illustrated in Exhibit 11b, Kansas, a state with relatively low income-eligibility limits experienced more than an 8 percent decline in ESI enrollment. See Exhibit 11b attached hereto. Meanwhile Maine, a state with a higher eligibility limit, experienced a 4.6 percent increase in ESI enrollment during the same period. See Exhibit 11c attached hereto. A review of the actual experiences of states demonstrates that the decrease in ESI rates has no relationship with SCHIP eligibility levels, and CMS has not to date cited any evidence to the contrary.

It is also well-known that national rates of enrollment in ESI have been in a relatively steady decline since the late 1980s,[43] almost a decade before SCHIP's enactment. The exact cause of this decline has been subject to much study and research.[44] It is abundantly clear that employers' decisions whether to offer health insurance benefits in the face of substantial increases in benefit costs have a significant impact on ESI enrollment, and have resulted in a material decrease in

[43] A U.S. Department of Health & Human Services analysis estimated that national ESI enrollment rates dropped from 69.6 percent in 1996 to 62.4 percent in 2002 - a 7.2 percent drop in just six years. M.W. Stanton & M.K. Rutherford, Employer-Sponsored Health Ins.: Trends in Cost and Access: Agency for Healthcare Research and Quality, 17 Agency for Healthcare Research & Quality, at 3 (2004), http://www.ahrq.gov/research/empspria/empspria.pdf. See e.g. Health Ins. for Children, GAO/HEHS 96-129 (1996).

[44] James D. Reschovsky, et al., Why Employer-Sponsored Ins. Coverage Changed, 1997-2003, 25 Health Affairs 774, 780 (2006), attached hereto as Exhibit 12.

the percentage of employers that offer ESI to their employees irrespective of SCHIP eligibility levels in the applicable jurisdiction. The average employer premium contribution per enrolled employee for family coverage increased from $5,256 in 2001 to $8,824 in 2007.[45] Correspondingly, the percentage of firms offering health insurance declined from 69 percent in 2000 to 60 percent in 2007.[46] In addition, it is estimated that during a recessionary period in 2001, the reduction in employers' offers to low-income people accounted for approximately 24 percent of the overall decline in the rate of ESI enrollment among low-wage earners.[47]

The decision of employers to offer ESI and the primary factors in that decision, the cost of coverage and the condition of the economy, are essentially beyond states' regulatory authority. Business cycles have been identified as significant "drivers of short-term trends in employer coverage."[48] Since ESI is "a voluntary, market institution," it is not surprising that employers generally offer health insurance only when it is

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[45] Jennifer Jensen, CRS Report for Cong.: Spending by Employers on Health Insurance, Cong. Research Serv. RS22735, at 3 (2007), http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1328&context=key_workplace.

[46] Kaiser Family Found. & Health Research and Educ. Trust, Employer Health Benefits 2007 Annual Survey, at 34 (2007), http://www.kff.org/insurance/7672/upload/76723.pdf.

[47] Linda J. Blumburg and John Holahan, Work Offers and Take-Up: Decomposing the Source of Recent Declines in Employer-Sponsored Ins., 9 The Urban Inst., at 2 (2004), http://www.urban.org/UploadedPDF/1000645_healthpolicyonline_no9.pdf.

[48] Reschovsky, supra, note 44.

economically feasible.[49] While government does have a role in the ESI marketplace, the dominant role has been assumed by federal, not state, authorities, through the Employee Retirement and Income Security Act ("ERISA"), a federal statute that preempts most state laws. 29 U.S.C. § 1144(a) (2007). Consequently, state reform efforts have had little impact on rates of ESI enrollment.[50] By requiring states to provide CMS with assurances of a particular rate of ESI enrollment, the agency conditions SCHIP coverage on a measure that states have little, if any, ability to control.

Once again, a review of the research and data reveals that CMS' standards oversimplify and misconstrue the causes of crowd-out and utterly miss the mark in trying to reduce it. Falling ESI coverage is a national problem subject to macroeconomic factors separate and apart from SCHIP. The ESI standard set out in the Directive bears little, if any, relationship to SCHIP crowd-out, and is an ill-suited tool to monitor or actively prevent crowd-out. Accordingly, it is irrational, arbitrary and capricious and should be deemed invalid as a matter of law.

CONCLUSION

For all of the reasons stated above, the Court should grant Plaintiff's Motion for Partial Summary Judgment.

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[49] Sherry A. Glied, The Employer-Based Health Ins. Sys.: Mistake or Cornerstone, in Policy Challenges in Modern Health Care 42, 44 (David Mechanic, et al. Eds.) (2005), http://www.rwjf.org/files/research/037-Part%201-Chapter%203.pdf.

[50] Stanton & Rutherford, supra, note 43, at 6.

Respectfully submitted,

Dated: April 4, 2008

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EXHIBIT 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
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7500 Security Boulevard, Mail Stop S2-26-12
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

August 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;
- Imposing cost sharing in approximation to the cost of private coverage;
- 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.

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);
- Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period; and
- Assurance that the State is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements.

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,

/s/
Dennis G. Smith
Director

cc:

CMS Regional Administrators

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

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EXHIBIT 3

Medicaid At The Ten-Year Anniversary Of SCHIP: Looking Back And Moving Forward

Medicaid and SCHIP have reduced the number of uninsured low-income children by a third, but much more needs to be done.

by Lisa Dubay, Jocelyn Guyer, Cindy Mann, and Michael Odeh

ABSTRACT: The adoption of the State Children's Health Insurance Program (SCHIP) in 1997 spurred widespread efforts to simplify and revitalize Medicaid coverage for children. To an extent often not recognized, these Medicaid improvements were a key factor behind much of the progress that has been made in covering low-income children: These children's uninsurance rate dropped from 22.3 percent in 1997 to 14.9 percent in 2005, and more than 70 percent of those gains can be attributed to Medicaid. The program, however, faces a number of issues that will need to be addressed if the country is to continue to make progress. [*Health Affairs* 26, no. 2 (2007): 370–381; 10.1377/hlthaff.26.2.370]

As the ten-year anniversary of the enactment of the State Children's Health Insurance Program (SCHIP) approaches, it is important to assess the role that its larger companion program, Medicaid, plays in the coverage system for children and the relationship between the two programs. Designed to sit on the shoulders of Medicaid, SCHIP was focused on covering children whose family incomes are above Medicaid levels but too low to afford private insurance. At the same time, the law that established SCHIP was mindful of Medicaid's role as a key component of the public insurance system for children and included several provisions specifically addressing Medicaid.

Most fundamental is that the law allows states to use their SCHIP funds to expand coverage for children either through Medicaid or through a separate program, and it requires states with separate programs to coordinate enrollment with Medicaid.[1] Coordination was seen as vital to preventing children from falling through the cracks of a two-program system and to assure that Medicaid-eligible children were enrolled in Medicaid.[2] Other provisions of the law—in particular, the "continuous eligibility" and "presumptive eligibility" options—were specifi-

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DOI 10.1377/hlthaff.26.2.370

cally aimed at boosting participation rates for Medicaid-eligible children.[3] In other words, SCHIP's drafters anticipated and intended that the program would have important "spillover" effects for Medicaid.

The reality probably exceeded even these considerable expectations. SCHIP's enactment was followed by unprecedented levels of activity aimed at reducing the uninsurance rate for children, through both Medicaid and SCHIP.[4] Every state took steps to streamline and improve the enrollment process. In addition, education and outreach campaigns were conducted by schools, community organizations, foundations, and states.[5] These efforts represented a fundamental shift with major implications for Medicaid and for children's coverage.[6] Most of these initiatives remain in place today, although some were abandoned or curtailed amid state fiscal pressures in the early 2000s.[7]

Just as SCHIP's implementation offered new opportunities to strengthen Medicaid's role in covering children, SCHIP reauthorization is an occasion to examine Medicaid's coverage role for children over the past ten years and to consider what further improvements might be needed. In this paper we examine the relative roles of Medicaid and SCHIP in providing coverage to children and in reducing the uninsurance rate of low-income children since 1997, as well as Medicaid's role in serving the most vulnerable U.S. children. We provide evidence for the need for additional Medicaid reforms to ensure that Medicaid will continue to meet the needs of low-income children and families, and to do so better.

Study Data And Methods

■ **Data.** Data for this paper were drawn from four nationally representative household surveys in various years: the National Survey of America's Families (NSAF), the Current Population Survey (CPS), the National Health Interview Survey (NHIS), and the National Survey of Children's Health (NSCH), as well as the Medicaid Management Information System (MMIS) and published data.

■ **Eligibility simulations.** In analyses using CPS and NSAF data, we separately identified Medicaid- and SCHIP-eligible children using a detailed eligibility simulation.[8] In analyses using NHIS data, we used a simpler proxy for Medicaid and SCHIP eligibility. Specifically, we considered children in families with incomes below 125 percent of the federal poverty level to be eligible for Medicaid and those with family incomes of 125–200 percent of poverty to be eligible for SCHIP.[9] In both the detailed simulation models and the simpler eligibility measure, we considered children who are served by Medicaid through a SCHIP-financed Medicaid expansion to be SCHIP-eligible.

■ **Insurance coverage trends.** We used NHIS data rather than CPS data for insurance coverage trends because the insurance questions in the former have remained consistent over time and represent a clear point-in-time estimate.

■ **Family characteristics and health status.** We derived data on family characteristics of children covered by Medicaid and SCHIP from the CPS and included the

income of the child's health insurance unit and the composition of adults and children in the child's family. We drew data on health status from the NSCH and included whether the parent reports that the child is in fair or poor health; whether the child is determined to have special health care needs using the Children with Special Health Care Needs (CSHCN) screener; and whether the child is limited or prevented in any way from doing what most children of the same age can do.

Roles Of Medicaid And SCHIP In Insuring Children

Although SCHIP often receives more public recognition, Medicaid is the more important source of public insurance coverage for children: It covers the majority of publicly insured children, including those most vulnerable economically.[10] Based on March 2005 CPS data, 64.5 percent of children eligible for public health insurance coverage are eligible under Medicaid, while 35.4 percent are eligible under SCHIP (Exhibit 1). The distribution of actual coverage in the two programs is even more heavily weighted toward Medicaid. Almost 80 percent of children actually enrolled in public coverage are enrolled in Medicaid. This same pattern is true when administrative data from the MMIS are considered.

■ **Overall trends in coverage.** Medicaid has also played a key role in coverage trends. Much has been written about the increases in public insurance coverage and reductions in uninsurance since SCHIP was implemented. It is difficult, if not impossible, to disentangle the individual effects of SCHIP's financial incentives to expand coverage, the outreach efforts and steps taken to simplify eligibility and renewal procedures after the enactment of SCHIP, concurrent changes in the economy, rising health care costs, and declining rates of employer-based coverage. Nonetheless, examining trends in children's coverage since the implementation of SCHIP provides much insight into the programmatic sources of coverage improvements.

The share of all children with public insurance coverage increased from 18.7 percent in 1997 to 27.0 percent in 2005 (Exhibit 2). This steady increase over time, with the exception of a small dip between 1997 and 1998, is consistent with both

EXHIBIT 1
Distribution Of Eligible And Covered Children, By Program, 2004

	Eligible for public health insurance coverage (CPS) (%)	Covered by public health insurance coverage (CPS) (%)	Covered by public health insurance coverage (MMIS) (%)
Medicaid	65	78	82
SCHIP	35	22	18

SOURCES: Urban Institute analysis of data from the March 2005 Current Population Survey (CPS); and Center for Children and Families analysis of data from the fiscal year 2004 Medicaid Management Information System (MMIS).
NOTE: For the share of children covered by public insurance, children enrolled in State Children's Health Insurance Program (SCHIP)–financed Medicaid expansions are identified as being enrolled in SCHIP.

EXHIBIT 2
Insurance Status For Children Under Age Nineteen, 1997-2005

Poverty level/ coverage source	1997	1998	1999	2000	2001	2002	2003	2004	2005
All children (millions)	74.3	75.1	75.8	76.0	76.2	76.6	76.4	76.8	77.1
Public	18.7%	17.6%	18.2%	19.4%	21.1%	24.3%	25.8%	26.3%	27.0%
Employer	64.0	65.4	66.1	64.9	64.4	62.3	59.7	60.0	59.4
Other	3.8	4.8	4.4	4.0	4.2	3.5	4.7	4.0	3.9
Uninsured	13.5	12.2	11.2	11.7	10.3	9.9	9.8	9.6	9.7
Children <200% FPL (millions)	34.6	33.9	33.9	34.1	33.6	34.4	35.4	35.5	35.2
Public	36.6%	34.7%	36.2%	37.7%	41.3%	46.8%	48.2%	49.3%	50.6%
Employer	38.3	39.8	40.1	38.9	37.5	34.7	32.7	32.5	31.5
Other	2.9	4.0	3.6	3.4	3.3	2.7	3.2	3.0	3.0
Uninsured	22.3	21.5	20.1	20.0	18.0	15.8	15.9	15.2	14.9
Children <125% FPL (millions)	21.2	20.8	19.9	20.1	20.5	21.0	21.6	21.3	21.5
Public	50.5%	47.7%	49.1%	49.5%	52.0%	58.0%	58.8%	61.4%	61.5%
Employer	23.0	25.4	25.8	25.6	25.1	22.9	21.8	20.4	20.4
Other	2.2	3.1	2.9	2.7	2.5	1.8	2.6	2.2	2.4
Uninsured	24.3	23.8	22.2	22.1	20.4	17.3	16.9	16.0	15.7
Children 125–200% FPL (millions)	13.4	13.1	14.0	14.0	13.2	13.4	13.7	14.2	13.7
Public	14.6%	13.9%	17.8%	20.8%	24.7%	29.2%	31.6%	31.3%	33.4%
Employer	62.6	62.7	60.4	58.0	56.7	53.3	50.0	50.7	48.8
Other	3.9	5.5	4.6	4.3	4.4	4.0	4.0	4.1	4.0
Uninsured	19.0	17.9	17.2	16.9	14.2	13.5	14.3	13.9	13.7

SOURCE: Center for Children and Families analysis of data from the National Health Interview Survey, various years.
NOTES: "Public" includes Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), other government, and other public insurance; "employer" includes private coverage obtained through work or a union and military coverage; "other" includes all other types of private coverage; "uninsured" includes those without any insurance, only single service coverage, and Indian Health Service coverage. FPL is federal poverty level.

the implementation of SCHIP and the economic downturn during 2001–2003.[11] The dip was likely due at least in part to program transition issues following enactment of the 1996 welfare law.[12]

Trends in the share of all children with employer-sponsored coverage followed a different pattern. Nearly two-thirds of children had employer-sponsored coverage in 1997, and the share of children with such coverage grew in the early years following SCHIP implementation (Exhibit 2). It began to fall steadily beginning in 2000, dropping to 59.4 percent by 2005. Although some of this decline can be attributed to public coverage expansions that "crowded out" private insurance, much of it likely is due to other factors such as rapid increases in health insurance premiums and the broader economic decline.[13] Evidence of this is found in the comparable decline in employer coverage that was observed for adults during this period, even though public coverage for adults did not change greatly.[14] Notwithstanding the private coverage losses, the rate of unin-surance among all children declined steadily from 1997 to 2005 because of public coverage gains (Exhibit 2).

■ **Changes for low-income children.** Much larger changes occurred for low-income children (those with incomes below 200 percent of poverty) than for high-income children. Between 1997 and 2005, the share of low-income children covered by public programs rose 14.0 percentage points, the share with employer coverage

declined 6.9 percentage points, and the share that were uninsured fell 7.3 percentage points (Exhibit 2). However, different patterns of change applied to Medicaid-eligible than to SCHIP-eligible low-income children. Among Medicaid-eligible children, most of whom were eligible before SCHIP implementation, there was an 11.2-percentage-point increase in public coverage, a 3.3-percentage-point decline in employer coverage, and an 8.0-percentage-point decline in uninsurance. In contrast, SCHIP-eligible low-income children experienced an 18.0-percentage-point increase in public coverage, an 11.6-percentage-point decline in employer coverage, and a 6.6-percentage-point decline in uninsurance (Exhibit 2).

As mentioned earlier, an array of trends, including broad economic forces and rising health insurance premiums, affected the coverage of low-income children. What is clear from the NHIS data, however, is that following implementation of SCHIP, approximately 50 percent of the increase in public coverage among low-income children was due to increases in Medicaid coverage.[15] These data are similar to evidence from administrative data, which suggests that approximately half of the increase in enrollment in Medicaid and SCHIP between 1997 and 2004 was due to increases in Medicaid coverage.[16] Perhaps most striking is the fact that declines in uninsurance among low-income children were driven in large part by declines in uninsurance among Medicaid-eligible children. The gains in Medicaid enrollment between 1997 and 2005 accounted for 73.8 percent of the decrease in uninsurance among low-income children during this period.[17]

■ **Public program participation trends.** Other evidence of the role of Medicaid in coverage trends and the "spillover" effect of SCHIP on Medicaid can be found by examining trends in participation among children eligible for Medicaid since SCHIP was adopted. The three rounds of the NSAF used a detailed eligibility simulation to identify children eligible for Medicaid and SCHIP. Estimates of participation reflect the share of those children who are income-eligible for Medicaid and not covered by private insurance who participate in Medicaid or SCHIP. These patterns varied by eligibility for Medicaid and SCHIP. Participation in Medicaid went from 71.4 percent in 1997 to 78.8 percent in 2002, with a dip to 69 percent in 1999, likely as the result of states' implementation of federal welfare changes.[18] Participation rates also increased for SCHIP-eligible children from 44 percent in 1999 to 63 percent in 2002, but the participation rates lagged behind those of Medicaid in 2002.

Role Of Public Coverage In Serving Vulnerable Children

■ **Economic status.** Along with driving much of the coverage improvement among low-income children over the past decade, Medicaid plays a particularly important role for some of the most vulnerable U.S. children. Because Medicaid and SCHIP are means-tested programs, children with public coverage are more economically disadvantaged than the population as a whole. Moreover, Medicaid serves an even more economically vulnerable population than SCHIP does. Some 76.2 percent of Medicaid-covered children are in families with incomes below poverty, while a

comparable percentage of SCHIP-covered children (77.9 percent) live in families with incomes of 100–199 percent of poverty (Exhibit 3).

■ **Health status.** Children with public coverage also are more vulnerable in terms of their health compared with children who have private coverage and, based on some indicators, with uninsured children. Children with public coverage, the vast majority of whom are covered by Medicaid, are significantly more likely than other groups to be in fair or poor health, to have limits on activities, and to have special health care needs (Exhibit 4). Because of the higher prevalence of poor health status, health conditions, and limitations among children who are publicly insured, Medicaid and SCHIP serve a disproportionate share of these children relative to private insurers. Although about 27 percent of all children are covered by Medicaid or SCHIP, 57 percent of all children in poor health and 47 percent of all children with an activity limitation are covered by Medicaid or SCHIP (Exhibit 5).

Issues Affecting Medicaid's Ability To Serve Children Over The Next Decade

As policymakers consider ways to further narrow the uninsurance gap for children over the next decade, in the context of SCHIP reauthorization, it will be important to examine three key issues facing Medicaid and options for addressing them: enrolling eligible but uninsured children; addressing gaps in coverage; and ensuring children's access to needed, high-quality care.

■ **Enrolling and retaining eligible children.** As detailed above, Medicaid, even more than SCHIP, has had notable success in achieving a relatively high participation rate among eligible children over the past decade. Nevertheless, some 4.4 million uninsured children are eligible for Medicaid (and an additional 1.7 million are eligible for SCHIP).[19] These Medicaid-eligible children account for more than half of all uninsured U.S. children.

Strategies are available to increase Medicaid participation rates: Simplifying application forms, lengthening the time between renewals, adopting continuous eligibility, and eliminating requirements for families to document matters that the

EXHIBIT 3
Children In Medicaid And The State Children's Health Insurance Program (SCHIP), By Family Income, 2005

Family income	All children (%)	Medicaid-covered children (%)	SCHIP-covered children (%)
Less than 100% FPL	23.2	76.2	1.2
100–199% FPL	19.7	21.8	77.9
200–299% FPL	16.4	1.5	19.6
300+% FPL	40.7	0.5	1.3

SOURCE: Urban Institute analysis of data from the March 2005 Current Population Survey.
NOTE: FPL is federal poverty level.

EXHIBIT 4
Rate Of Health Status Indicators Among Children, By Insurance Coverage Status, 2003–2004

	Coverage source (%)		
	Public	**Private**	**Uninsured**
Child is in fair or poor health	6.73	1.37[a]	5.60
Child has activity limitations	9.59	4.04[a]	4.76[a]
Child has special health care needs	21.82	16.81[a]	10.44[a]

SOURCE: National Survey of Children's Health, 2003–2004.
[a]Statistically significant difference from rate for publicly insured ($p \leq 0.05$).

Medicaid agency can verify in other ways have been shown to greatly affect enrollment.[20] However, states do not always pursue these strategies, or they might abandon or curtail them when state budgets are under pressure, because effective strategies will result in additional coverage costs.[21] This is a particular problem for Medicaid, given that the federal government pays a lower share of coverage costs compared with its payments to SCHIP. To address this, federal Medicaid matching rates could be enhanced, as they are in SCHIP. A more modest and targeted approach (that could apply to SCHIP as well) would be to provide performance-based fiscal support to states that succeed in their enrollment efforts. For example, the federal government could provide an enhanced matching rate to states that greatly increase participation rates (in Medicaid and SCHIP) or that consistently maintain high participation rates. Such a strategy would allow states to decide for themselves the best way to enroll eligible children while easing the fiscal concerns that might deter some states from pursuing effective strategies.

States also are coping with a new barrier to simplifying their Medicaid application process for children. Because of a provision included in the Deficit Reduction Act (DRA) of 2005, states now are mandated to require proof of citizenship from U.S. citizens who apply for Medicaid or seek to renew their Medicaid coverage.[22]

EXHIBIT 5
Distribution Of Children, By Health Status Indicators And Insurance Coverage, 2003–2004

	Coverage source (%)			
Health status	**Public**	**Private**	**Uninsured**	**Total**
Population distribution	27.44	63.88	8.74	100.0
Child is in fair or poor health	57.48	27.27	15.25	100.0
Child has activity limitations	46.71	45.90	7.39	100.0
Child has special health care needs	33.95	60.87	5.18	100.0

SOURCE: National Survey of Children's Health, 2003–2004.
NOTE: Distribution of health status indicator is statistically different ($p \leq 0.05$) from distribution of population for all indicators.

Only a limited range of documents are acceptable.[23] State officials have indicated that the requirement, which applies primarily to children and their parents, is creating new barriers to coverage for eligible children whose families might not have the required documents on hand.[24] Of particular concern is that the new requirement makes it difficult for states to continue to allow families to apply for coverage through the mail, a basic step that all but a handful of states have taken to simplify their application processes.[25] One option for easing these stresses is to give states flexibility in determining how best to verify citizenship.

The data also suggest that more needs to be done to increase families' awareness of public coverage programs. Such awareness is up, but, in 2002, more than four in ten parents of low-income uninsured children did not know that their children could participate in Medicaid or SCHIP without receiving welfare. At the same time, among low-income children whose parents had heard of either Medicaid or SCHIP, 81.7 percent of parents said that they would enroll their children if told they were eligible.[26] Experience to date suggests that ongoing education and strategically targeted outreach campaigns, including community-based application assistors, can be effective in increasing awareness, prompting applications, and educating families about the need to renew coverage regularly.[27]

■ **Addressing gaps in coverage.** Between Medicaid and SCHIP, states have broad flexibility to determine the extent to which they will provide publicly subsidized coverage to children. But some notable gaps remain. States are barred from using federal Medicaid (or SCHIP) funds to cover many immigrant children, including many legal immigrants who have lived in the country for less than five years.[28] About one-quarter of all children who are uninsured and otherwise eligible for Medicaid or SCHIP are excluded because of immigration restrictions.[29]Also, research has shown that when all family members are eligible for coverage, children are more likely to enroll and be able to obtain needed care.[30] Most states, however, have much more restrictive coverage policies for parents than they do for children. In all but fourteen states, parents earning wages that are well below poverty have incomes too high to qualify for Medicaid. Some states cover parents at income levels no higher than 10–20 percent of poverty.[31] States have the option to provide family-based coverage, with its attendant benefits for children, but experience with both children's and parents' coverage suggests that in the absence of a federal coverage mandate, additional federal support (such as an enhanced matching rate) will likely be needed to encourage more states to take up this option.[32]

■ **Ensuring children's access to high-quality care.** Over the next ten years, Medicaid also will need to preserve and in some ways strengthen its role in providing comprehensive coverage for children. The program has a history of providing access to care, particularly preventive care, for poor and near-poor children at a rate comparable to that of private coverage and offering even greater protection for families against excessive out-of-pocket costs.[33] The findings of a limited number of studies on Medicaid's role in promoting access among children with special health

care needs are not uniform, but the majority of studies indicate that Medicaid is as good as or often better than private coverage.[34] Increasingly, however, it is clear that it is not appropriate to use privately financed coverage as the benchmark against which Medicaid is judged because of the quality shortcomings of private coverage. A recent Commonwealth Fund study, for example, found that fewer than half of all U.S. children are receiving adequate developmental and psychological surveillance, screening for health risks such as lead exposure, or anticipatory guidance.[35]

Continuity of benefits specific to children. A threshold issue is whether Medicaid will continue to provide its benefit package. Unlike the SCHIP benefit package, which is based in large part on private-sector benefit models designed to cover working adults, Medicaid's benefit package for children is specifically designed for children. It requires children to be provided with regular health, dental, hearing, and vision screening, as well as any care that is medically necessary.[36] Although some SCHIP programs offer a comprehensive benefit package, others are more limited. For example, under federal SCHIP standards, some SCHIP plans limit mental health services, speech and physical therapy, or dental care; they do not cover certain types of services (such as family therapy); or they operate under medical-necessity standards that do not reflect the fact that children have different needs than adults do.[37] In the recent debate over the DRA, policymakers discussed whether to weaken the federal standards governing the Medicaid benefit package for children by bringing them in line with SCHIP. It is possible that during the SCHIP reauthorization debate, this set of questions will arise again.

Provider reimbursement. Also relevant to this debate are concerns about the adequacy of provider reimbursement rates in Medicaid. Rates are set by states, with no federal oversight and few federal standards. In some cases, rates are comparable to commercial rates, and in others, they fall below costs, impeding access and quality initiatives.[38] If they believe that they are underpaid when they treat Medicaid patients, providers might be reluctant to undertake new initiatives on behalf of Medicaid patients or, in some cases, even to take them on as patients.

Accomplishments And Challenges

As intended by the drafters of the original SCHIP statute, Medicaid and SCHIP have generally worked well together over the past decade. Medicaid serves as the backbone of the public coverage system for U.S. children, covering more than eight in ten publicly insured children. It plays a particularly vital role for children with special health care needs and those whose family incomes leave little room for paying for uncovered medical care. SCHIP has touched off widespread and largely successful efforts to revitalize and modernize Medicaid coverage for children. Together the two programs have reduced the uninsurance rate of low-income children by a third, with Medicaid accounting for the majority of the gains.

Medicaid, however, faces important challenges. Over the next ten years, to build on the successes to date, policymakers will need to find ways to enroll unin-

sured children who are eligible for Medicaid; to sustain and strengthen coverage during economic downturns; to fill remaining gaps in state coverage and financing options for discrete groups of children and parents; and to ensure that Medicaid leads the nation in improving the quality of care that children receive.

The authors are grateful for the helpful comments of Genevieve Kenney and Barbara Lyons, who reviewed an earlier version of this paper.

NOTES

1. 42 U.S. Code, sec. 2101.
2. 42 U.S. Code, sec. 2102(b)(3)(B).
3. *Balanced Budget Act of 1997* (P.L. 105-33). The continuous-eligibility option allows states to assure that children can stay enrolled in Medicaid, without interruption, for up to twelve months. Presumptive eligibility permits health care providers and other designated people to enroll children who appear to be eligible for coverage while their applications are formally reviewed.
4. P. Cunningham, J. Reschovsky, and J. Hadley, "SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage," Issue Brief no. 59 (Washington: Center for Studying Health System Change, December 2002); and D.C. Ross and I. Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13, no. 1 (2003): 81–97.
5. J. Moore, "CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applications," Issue Brief no. 748 (Washington: National Health Policy Forum, 19 October 1999); and J. Ryan, "SCHIP Turns Five: Taking Stock, Moving Ahead," Issue Brief no. 781 (Washington: NHPF, 15 August 2002).
6. J. Wooldrige et al., "Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress" (Washington: Mathematica Policy Research and Urban Institute, 26 October 2005).
7. In 2003, on the heels of the economic downturn of the early 2000s, nearly half of all states made it more difficult for eligible children to acquire or retain public coverage. D.C. Ross and L. Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, October 2004, http://www.kff.org/medicaid/7191.cfm (accessed 22 January 2007). As chronicled in a series of annual reports by Ross and Cox, available online at http://www.kff.org, many of these retrenchments were later reversed.
8. Eligibility was based on the following models with adjustment for immigrant status but not Medicaid undercount: L. Dubay and G. Kenney, "Assessing SCHIP Effects using Household Survey Data: Promises and Pitfalls," *Health Services Research* 35, no. 5, Part 3 (2000): 112–127; and L. Dubay, J. Holahan, and A. Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* 26, no. 1 (2007): w22–w30 (published online 30 November 2006; 10.1377/hlthaff.26.1.w22).
9. Analyses of the NHIS rely on imputed income data to identify children in different income groups. The NHIS uses a multiple-imputation methodology to impute data. In the absence of a detailed eligibility model, the threshold of 125 percent of the federal poverty level is used to distinguish between Medicaid- and SCHIP-eligible children. This may in fact understate Medicaid's importance, given that 12 percent of Medicaid-eligible children live in families with incomes above 125 percent of poverty (authors' tabulation of detailed eligibility simulation using data from the CPS).
10. For example, see J. Broder, "Health Coverage of Young Widens with States' Aid," *New York Times*, 4 December 2005.
11. The second half of the 1990s continued one of the longest economic expansions in U.S. history; see J. Jermann and V. Quadrini, "Stock Market Boom and the Productivity Gains of the 1990's," NBER Working Paper no. 9034 (Cambridge, Mass.: National Bureau of Economic Research, 2002). This period of profound economic growth ended with the start of a recession in March 2001. NBER, "Business Cycle Expansions and Contractions," 2005, http://www.nber.org/cycles.html (accessed 28 December 2006).
12. B. Garrett, J. Holahan, and A. Yemane, "Unemployment, Welfare Reform, and Medicaid Enrollment" (Abstract, AcademyHealth Services Research and Health Policy Annual Meeting, Washington, D.C., June 2002); C. Burke and C. Abbey, "Managing Medicaid Take-Up, Medicaid Enrollment Trends: 1995–2000" (Albany: Rockefeller Institute of Government, August 2002); and L. Dubay, L. Blumberg, and A. Luque,

"Participation in Public Health Insurance Programs in the Wake of Welfare Reform and SCHIP Implementation" (Washington: Urban Institute, 2006).

13. J.L. Hudson, T.M. Selden, and J.S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry* 42, no. 3 (2005): 232–254; and L. Dubay and G. Kenney, "Estimating the Impact of SCHIP on Insurance Coverage and Access to Care" (Paper presented at the American Public Health Association annual meeting, Washington, D.C., November 2004). Although each of these studies found some evidence of crowding out among the SCHIP population, they found very little among the Medicaid population. Consequently, crowding out is unlikely to be driving the overall declines in employer-sponsored coverage for all children, given the small share of children made eligible under SCHIP. On increases in premiums and broader economic trends, see Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2006 Annual Survey,* September 2006, http://www.kff.org/insurance/7527/index.cfm (accessed 2 January 2007); NBER, "Business Cycle Expansions and Contractions"; and J. Jermann and V. Quadrini, "Stock Market Boom and the Productivity Gains of the 1990's," NBER Working Paper no. 9034 (Cambridge, Mass.: NBER, 2002).
14. Authors' tabulations of data from the NHIS; and J. Holahan and A. Cook, "Changes in Economic Conditions and Health Insurance Coverage, 2000–2004," *Health Affairs* 24 (2005): w498–w508 (published online 1 November 2005; 101377/hlthaff.w5.498).
15. Of the increase in public coverage of 5.2 million low-income children identified in the NHIS, 2.5 million were children in families with incomes below 125 percent of poverty. Some of the change in public coverage was due to shifts in the share of children in each of the two low-income groups. When this is accounted for, the share of the increase attributable to Medicaid rises to 47 percent.
16. The number of people enrolled in SCHIP over the course of a year increased from 0 in 1997 to 6.2 million in 2004, while the number of children enrolled in Medicaid over this same period increased 6.8 million, from 21 million to 27.8 million. SCHIP data are from the Centers for Medicare and Medicaid Services (CMS), and Medicaid data are from the CMS in 1997 and the Congressional Budget Office in 2004. The NHIS and administrative data differ for a number of reasons, including underreporting of coverage on household surveys; the fact that the NHIS represents a point-in-time estimate while the administrative data represent ever covered over the course of the year; and other sources of measurement error in both data sources.
17. Of the 2.4 million decline in the number of uninsured low-income children, 1.8 million was attributable to children with family incomes below 125 percent of poverty. When changes in the distribution of children between the two low-income groups are accounted for, the share attributable to Medicaid declines to 72 percent. Although Medicaid had a larger role than SCHIP did in lowering the uninsurance rate among low-income children, SCHIP also contributed to strengthening coverage rates among children with family incomes above 200 percent of poverty.
18. K. Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs* 20, no. 1 (2001): 97–111.
19. Urban Institute analysis of data from the March 2005 Current Population Survey.
20. L. Summer and C. Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies,* June 2006, http://www.cmwf.org/usr_doc/Summer_instabilitypubhltinschildren_935.pdf (accessed 29 January 2007); D. Horner and B. Morrow, *Opening Doorways to Health Care for Children: Ten Steps to Ensure Eligible but Uninsured Children Get Health Insurance,* April 2006, http://www.kff.org/medicaid/7506.cfm (accessed 29 January 2007); and J. Ferber, "Measuring the Decline in Children's Participation in the Missouri Medicaid Program," March 2006, http://www.masw.org/policy/2006/reports/Childrens_participation.pdf (accessed 18 January 2007).
21. For a state-specific case study of the impact of budget considerations on eligibility simplification efforts, see A. Dunkelberg and M. O'Malley, "Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts," July 2004, http://www.kff.org/medicaid/7132.cfm (accessed 22 January 2007).
22. *Deficit Reduction Act of 2005,* P.L. 109-171, 120 Stat. 80, Sec. 6036 (8 February 2006).
23. Interim final regulations on the new directive were issued by the CMS on 12 July 2006. "Medicaid Program; Citizenship Documentation Requirements," *Federal Register* 71, no. 133 (2006): 39214–39229.
24. Medicaid recipients enrolled in the federal Supplemental Security Income (SSI) program or in Medicare are exempt from the new requirement, effectively making it a non-issue for most seniors and people with disabilities.
25. Seminar titled "Strategies to Reduce Insurance Instability in Public Programs: Coping with New Medicaid Rules regarding Citizenship Verification and Program Premiums," convened by the Commonwealth Fund, 29 September 2006. Also see N. Kay, C. Pernice, and A. Cullen, "Charting SCHIP III: An Analysis of

the Third Comprehensive Survey of State Children's Health Insurance Programs" (Portland, Maine: National Academy for State Health Policy, September 2006). States with the capacity to conduct data matches with their office of vital statistics and other state agencies may have more success retaining mail-in application and renewal procedures. See L. Ku, D.C. Ross, and M. Broaddus, "Documenting Citizenship and Identity using Data Matches: A Promising Strategy for State Medicaid Programs" (Washington: Center on Budget and Policy Priorities, 1 September 2006).

26. G. Kenney, J. Haley, and A. Tebay, "Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children Is High," Snapshots of America's Families III, no. 2 (Washington: Urban Institute, July 2003).
27. L. Felland and A. Staiti, "Communities Play Key Role in Extending Public Health Insurance to Children," Issue Brief no. 44 (Washington: HSC, October 2001); and Children's Defense Fund, "Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities," April 2006, http://www.kff.org/medicaid/7495.cfm (accessed 29 January 2007).
28. S. Rosenbaum, "Medicaid Eligibility and Citizenship Status: Policy Implications for Immigrant Populations," Policy Brief, August 2000, http://www.kff.org/medicaid/2201-index.cfm (accessed 22 January 2007).
29. Authors' tabulation of data from the 2005 CPS.
30. L. Dubay and G. Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research* 38, no. 5 (2003): 1283–1301.
31. See D.C. Ross and L. Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington: Kaiser Commission, October 2005), Table 3.
32. For proposed legislation, see S. 1843, A bill to amend titles XIX and XXI of the Social Security Act to provide for FamilyCare coverage for parents of enrolled children, and for other purposes (introduced in the U.S. Senate 10 November 2003).
33. See G. Kenney, J. Haley, and A. Tebay, "Children's Insurance Coverage and Service Use Improve," Snapshots of America's Families III, no. 1 (Washington: Urban Institute, 2003); and Y. Shen and J. McFeeters, "Out-of-Pocket Health Spending between Low- and Higher-Income Populations: Who Is at Risk of Having High Expenses and High Burdens?" *Medical Care* 44, no. 3 (2006): 200–209.
34. A.E. Jeffrey and P.W. Newacheck, "Role of Insurance for Children with Special Health Care Needs: A Synthesis of the Evidence," *Pediatrics* 118, no. 4 (2006): e1027–e1038.
35. P. Chung et al., "Preventive Care for Children in the United States: Quality and Barriers," *Annual Review of Public Health* 27 (2006): 491–515.
36. Under the SCHIP statute, states have much flexibility to design their benefit packages for separate programs based on a number of benchmarks, including the Blue Cross/Blue Shield preferred provider option provided to federal employees; the health maintenance organization in a state with the largest commercial, non-Medicaid enrollment; any plan offered to a state employee; or coverage approved by the secretary of health and human services. See S. Rosenbaum, A. Markus, and C. Sonosky, "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP," *Journal of Health and Biomedical Law* 1, no. 1 (2004): 1–47; and A.H. Fox and P. McManus, "A Fifty-State Analysis of Medicaid Benefit Coverage for Children without EPSDT" (Memorandum to the March of Dimes and National Association of Children's Hospitals), September 2005, http://www.mchpolicy.org/publications/medicaid.html (accessed 29 January 2007).
37. C. Mann and E. Kenney, "Differences That Make a Difference: Comparing Medicaid and the State Children's Health Insurance Program Federal Benefit Standards," Family Coverage Matters, Issue Brief (Washington: Center for Children and Families, Georgetown University Health Policy Institute, 2005).
38. The American Academy of Pediatrics (AAP) has estimated that Medicaid (and SCHIP) payment rates are 65 percent of private-pay and 70 percent of Medicare rates. See AAP, "2006 Pediatric Medical Cost Model," http://www.aap.org/research/pedmedcostmodel.cfm (accessed 28 December 2006). Many states rely on managed care organizations to deliver care to children in Medicaid, but here, as well, rates can vary widely across states, and some managed care companies report less satisfaction with Medicaid than with SCHIP. J. Holahan and S. Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001," *Health Affairs* 22, no. 1 (2003): 204–218; and M. Gold et al., "Participation of Plans and Providers in Medicaid and SCHIP Managed Care," *Health Affairs* 22, no. 1 (2003): 230–240.

EXHIBIT 4

Georgetown University Health Policy Institute
Center for Children and Families

Medicaid/SCHIP Participation Rate Among Low-Income Children Under 19, 2004-2005

State	Medicaid/SCHIP Participation Rate*
Nation	74%
Alabama	89%
Alaska	80%
Arizona	67%
Arkansas	85%
California	73%
Colorado	55%
Connecticut	78%
Delaware	67%
District of Columbia	88%
Florida	62%
Georgia	76%
Hawaii	90%
Idaho	78%
Illinois	72%
Indiana	80%
Iowa	83%
Kansas	79%
Kentucky	81%
Louisiana	83%
Maine	86%
Maryland	74%
Massachusetts	89%
Michigan	85%
Minnesota	76%
Mississippi	79%
Missouri	81%
Montana	68%
Nebraska	83%
Nevada	55%
New Hampshire	79%
New Jersey	69%
New Mexico	71%
New York	83%
North Carolina	72%
North Dakota	67%
Ohio	79%
Oklahoma	75%
Oregon	74%
Pennsylvania	75%
Rhode Island	85%
South Carolina	81%
South Dakota	82%
Tennessee	78%
Texas	62%
Utah	68%
Vermont	92%
Virginia	74%
Washington	83%
West Virginia	83%
Wisconsin	81%
Wyoming	78%

Note: Data are averaged over two years to achieve adequate sample size and in so doing make the estimates more reliable.

* The Medicaid/ SCHIP participation is calculated as the number of children enrolled in Medicaid or SCHIP as a percentage of the sum of these enrollees and the number of uninsured children.

Source: Center on Budget and Policy Priorities analysis of the Annual Social and Economic Characteristics supplements to the Census Bureau's 2005 and 2006 Current Population Surveys.

Updated: 7/31/2007

EXHIBIT 5

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.

[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.

EXHIBIT 6

Medicaid/SCHIP Enrollment Children Population Compared to Children <200 Percent FPL

Age: 00 to 18 years	Income-to-Poverty Ratio in 2006
	Total Age 00-18 Below 200%
Totals	30,185,781
State	
AL	445,664
AK	59,597
AZ	824,894
AR	400,372
CA	4,163,544
CO	427,078
CT	215,912
DE	70,735
DC	61,158
FL	1,687,665
GA	1,030,128
HI	92,001
ID	181,963
IL	1,134,517
IN	553,348
IA	273,605
KS	282,150
KY	480,517
LA	503,116
ME	101,647
MD	358,531
MA	448,460
MI	944,704

	SEDS - Number of Children Ever Enrolled During the Year FY2006			Medicaid/SCHIP enrollment as % of <200% FPL	SCHIP Upper Income Limit (%FPL)
	Medicaid	SCHIP	TOTAL		
	29,548,838	6,624,152	36,172,990	119.83%	
AL	487,567	84,257	571,824	128.31%	200
AK	88,340	22,227	110,567	185.52%	200
AZ	669,963	96,669	766,632	92.94%	200
AR	471,091	3,440	474,531	118.52%	100
CA	4,230,871	1,391,405	5,622,276	135.04%	250
CO	358,890	69,997	428,887	100.42%	185
CT	271,464	23,110	294,574	136.43%	300
DE	85,369	10,751	96,120	135.89%	200
DC	85,031	6,332	91,363	149.39%	200
FL	1,667,892	303,595	1,971,487	116.82%	200
GA	1,144,432	343,690	1,488,122	144.46%	235
HI	95,105	22,031	117,136	127.32%	200
ID	135,619	24,727	160,346	88.12%	150
IL	1,366,531	316,781	1,683,312	148.37%	185
IN	575,121	133,696	708,817	128.10%	200
IA	219,687	49,575	269,262	98.41%	200
KS	196,581	48,934	245,515	87.02%	200
KY	401,422	64,861	466,283	97.04%	200
LA	650,171	142,389	792,560	157.53%	150
ME	137,481	31,114	168,595	165.86%	200
MD	355,247	136,034	491,281	137.03%	300
MA	520,014	190,640	710,654	158.47%	200
MI	951,184	118,501	1,069,685	113.23%	200

Medicaid/SCHIP Enrollment Children Population Compared to Children <200 Percent FPL Cont'd

Age: 00 to 18 years	Income-to-Poverty Ratio in 2006		SEDS - Number of Children Ever Enrolled During the Year FY2006			Medicaid/SCHIP enrollment as % of <200% FPL	SCHIP Upper Income Limit (%FPL)
	Total Age 00-18 Below 200%		Medicaid	SCHIP	TOTAL		
State							
MN	373,004	MN	376,437	5,343	381,780	102.35%	280
MS	438,161	MS	426,223	83,359	509,582	116.30%	200
MO	591,541	MO	550,418	106,577	656,995	111.06%	300
MT	87,547	MT	53,092	17,304	70,396	80.41%	150
NE	158,792	NE	155,264	44,981	200,245	126.11%	185
NV	266,847	NV	147,256	39,317	186,573	69.92%	200
NH	66,409	NH	80,129	12,393	92,522	139.32%	300
NJ	594,066	NJ	501,843	120,884	622,727	104.82%	350
NM	231,362	NM	319,979	25,155	345,134	149.17%	235
NY	1,879,897	NY	2,026,972	688,362	2,715,334	144.44%	250
NC	1,034,654	NC	898,023	247,991	1,146,014	110.76%	200
ND	54,796	ND	35,720	6,318	42,038	76.72%	140
OH	1,108,697	OH	1,014,992	218,529	1,233,521	111.26%	200
OK	468,980	OK	369,040	116,012	485,052	103.43%	185
OR	347,223	OR	278,283	59,039	337,322	97.15%	170
PA	1,059,362	PA	10,140,40	188,765	1,202,805	113.54%	200
RI	82,572	RI	91,465	25,492	116,957	141.64%	250
SC	474,812	SC	499,685	68,870	568,555	119.74%	150
SD	77,098	SD	39,615	14,584	54,199	70.30%	200
TN	662,323	TN	691,539	0	691,539	104.41%	100
TX	3,246,912	TX	2,753,852	585,461	3,339,313	102.85%	200
UT	325,285	UT	175,705	51,967	227,672	69.99%	200
VT	35,940	VT	67,704	6,314	74,018	205.95%	300
VA	610,839	VA	416,328	137,182	553,510	90.61%	200
WA	484,049	WA	658,620	15,000	673,620	139.16%	250
WV	192,057	WV	235,666	39,855	275,521	143.46%	200
WI	449,106	WI	453,474	56,627	510,101	113.58%	185
WY	42,145	WY	52,401	7,715	60,116	142.64%	133

Source: U.S. Census Bureau: Current Population Survey, Annual Social and Economic Supplement, 2007 & CMS SEDS

EXHIBIT 7

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP - 7 2007

Ms. Judith Arnold, Director
Division of Coverage and Enrollment
Office of Health Insurance Programs
State of New York Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237-0004

Dear Ms. Arnold:

I am responding to your request for approval of a title XXI State plan amendment (SPA) dated April 12, 2007, with additional information submitted on May 9, 2007, and August 27, 2007. This SPA seeks to increase the financial eligibility standard for its separate State Children's Health Insurance Program (SCHIP) from the current effective family income eligibility level at or below 250 percent of the Federal poverty level (FPL) to an effective family income eligibility level at or below 400 percent of the FPL. The SPA also proposes to implement a 6-month waiting period of prior uninsurance for children with family incomes above 250 percent of the FPL, with certain listed exceptions. After extensive review of this SPA by the Department of Health and Human Services, I regret to inform you that we are not approving this SPA.

Section 2101(a) of the Social Security Act (the Act) specifies that the purpose of title XXI is to "expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children." New York has not demonstrated that its program operates in an effective and efficient manner with respect to the core population of targeted low-income children. Specifically, it has failed to provide assurances that the State has enrolled at least 95 percent of the children in the core targeted low-income child population, those with family incomes below 200 percent of the FPL. As outlined in an August 17, 2007, letter to State Health Officials, such assurances are necessary to ensure that expansion to higher income populations does not interfere with the effective and efficient provision of child health assistance. In the absence of such an assurance, I cannot conclude that New York is effectively and efficiently using available resources to serve that core population, such that expansion to higher income levels would not divert resources from serving the core population.

Section 2102(b)(3)(C) of the Act requires that State plans include procedures to ensure that SCHIP insurance does not substitute for coverage under group health plans. Applicable regulations at 42 CFR section 457.805 implement this requirement by mandating that the State plan include a description of "reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health

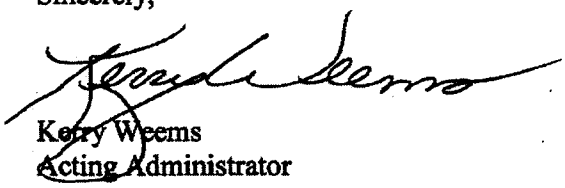
plans." In issuing this regulation, the Centers for Medicare & Medicaid Services (CMS) acknowledged that, at higher family income eligibility levels, there is a greater likelihood of substitution of coverage. At the high proposed family income eligibility levels, reasonable procedures should include a full range of procedures to discourage substitution. New York's proposal does not include procedures to prevent such substitution that include a 1-year period of uninsurance for populations over 250 percent of the FPL. Additionally, New York's proposed cost sharing has not met the requirement that cost sharing under the State plan compared to cost sharing required by competing private plans not be more favorable to the public plan by more than 1 percent of the family income, nor has the State proposed to set its cost sharing at the 5 percent family cap. Absent such procedures, I cannot find that New York meets the requirement for reasonable procedures to prevent substitution of coverage.

For these reasons, and after consulting with the Secretary as required under 42 CFR section 457.150(c), I am unable to approve this SPA for expanding coverage. This disapproval is consistent with the August 17, 2007, letter to State Health Officials discussing how these existing statutory and regulatory requirements should be applied to all States expanding SCHIP effective eligibility levels above 250 percent of the FPL.

If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth at Federal regulations at 42 CFR section 457.203. Your request for reconsideration may be sent to Ms. Cynthia Potter, CMS, Center for Medicaid and State Operations, 7500 Security Boulevard, Mail Stop S2-25-22, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Sue Kelly, Associate Regional Administrator, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health, 26 Federal Plaza, Room 3811, New York, NY 10278-0063.

Sincerely,



Kerry Weems
Acting Administrator

cc: CMS Region II, New York

EXHIBIT 8

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Peter R. Orszag, Director

July 24, 2007

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In response to your letter of July 10, the Congressional Budget Office (CBO) has examined available estimates of the number of children who lack health insurance but are eligible for Medicaid or the State Children's Health Insurance program (SCHIP). Some empirical studies have found that there are between 5 million and 6 million such children. In contrast to those studies, the Administration recently estimated that a much smaller number, 1.1 million children, lack health insurance but are eligible for Medicaid or SCHIP.

A major reason that the Administration's figure is much lower than other estimates is that they address different questions. In particular, the Administration's estimate addresses how many children are uninsured for an entire year and are eligible for Medicaid or SCHIP. That estimate does not include all uninsured children who are eligible for the programs, however, because substantial numbers of children are uninsured for part of the year and are eligible for public coverage during that period. Consequently, the Administration's estimate understates the number of uninsured children who might participate in Medicaid or SCHIP under policies aimed at expanding enrollment.

The other estimates from the research literature are instead based on the number of children who are uninsured and eligible for Medicaid or SCHIP at a particular point in time. That concept provides a more appropriate measure of the number of children who are uninsured and eligible for public coverage on average over the course of the year, which is the more relevant concept for both policy judgments and budget scoring. (For example, consider two children, one of whom is uninsured for the first six months of the year and the second of whom is uninsured for the second six months of the year. The Administration's estimates would not count either child as uninsured, because neither was uninsured for the entire year. In any month, however, one of them would be uninsured and potentially eligible for coverage under a public program.)

Two recent studies that use data from different household surveys conclude that about 5.4 million children are uninsured and eligible for Medicaid or SCHIP at any given point in time. One study used data from the Current Population Survey (CPS) by the Bureau of the Census.[1] The authors of that study, like CBO, interpret CPS estimates as approximating the number of people who are uninsured, on average, at any point in time. The second study used data from the Medical Expenditure Panel Survey (MEPS).[2]

The researchers who developed the Administration's recent estimates used the CPS but, unlike the authors of the first study cited, they interpreted the estimates as measuring the number of people uninsured all year.[3] Although the CPS is theoretically intended to measure that concept, evidence indicates that the survey's estimates more closely approximate the number of people who are uninsured at a particular point in time—a fact that the Census Bureau acknowledges.[4]

The study using the MEPS, cited above, examined the same concept as the one addressed by the Administration's estimates—the number of children uninsured all year rather than at a point in time—but obtained different estimates. Using data from the MEPS, researchers from the Agency for Healthcare Research and Quality have estimated that 2.7 million children are uninsured all year and eligible

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1. John Holahan, Allison Cook, and Lisa Dubay, *Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?* (Washington, D.C.: The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, February 2007), available at www.kff.org.

2. Congressional Research Service, "Description of the Varying Estimates of Uninsured Children Who Were Eligible for Public Coverage" (based on estimates prepared by the Agency for Healthcare Research and Quality, June 21, 2007).

3. The Administration's new estimates are presented in Kenneth Finegold and Lisa Giannarelli, "TRIM3 Simulations of Full-Year Uninsured Children and their Eligibilty for Medicaid and SCHIP"(Washington, D.C., The Urban Institute, June 14, 2007).

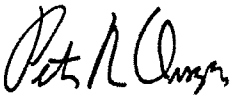
4. The assumption of whether or not the CPS measures the number of people who are uninsured at a point in time or all year influences how researchers make certain adjustments to the data that determine the final estimates. The assessment that estimates in the CPS more closely approximate the number of people who are uninsured at a point in time is based on comparisons with estimates from other surveys that are thought to measure insurance coverage more accurately than the CPS. See Congressional Budget Office, *How Many People Lack Health Insurance and for How Long?* (May 2003), and U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (August 2006), p. 20.

for either Medicaid or SCHIP.[5] Why those estimates from the MEPS are over twice as high as the Administration's recent estimates using the CPS is not known. But the MEPS is widely regarded as yielding better estimates of the number of people who are uninsured all year than the CPS: For the MEPS, people are interviewed multiple times during the year, whereas for the CPS, people are interviewed in March about their insurance coverage over the previous calendar year, so their responses may be less accurate (to the extent that respondents do not remember or accurately report coverage during earlier months of that year).

In summary, CBO regards the estimates of between 5 million and 6 million children who are uninsured and eligible for Medicaid or SCHIP as more appropriate for considering policies aimed at enrolling more eligible children in those programs.

I hope that this information is useful to you. If you or your staff have any questions, please feel free to contact me at (202) 226-2700 or Lyle Nelson at (202) 226-2666.

Sincerely,



Peter R. Orszag
Director

cc: Honorable Charles E. Grassley
Ranking Member

5. Congressional Research Service, "Description of the Varying Estimates of Uninsured Children Who Were Eligible for Public Coverage."

EXHIBIT 9

NBER WORKING PAPER SERIES

CROWD-OUT TEN YEARS LATER: HAVE RECENT PUBLIC INSURANCE EXPANSIONS CROWDED OUT PRIVATE HEALTH INSURANCE?

Jonathan Gruber
Kosali Simon

Working Paper 12858
http://www.nber.org/papers/w12858

NATIONAL BUREAU OF ECONOMIC RESEARCH
1050 Massachusetts Avenue
Cambridge, MA 02138
January 2007

Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?

Jonathan Gruber and Kosali Simon

NBER Working Paper No. 12858
January 2007
JEL No. H3,I1

ABSTRACT

The continued interest in public insurance expansions as a means of covering the uninsured highlights the importance of estimates of "crowd-out", or the extent to which such expansions reduce private insurance coverage. Ten years ago, Cutler and Gruber (1996) suggested that such crowd-out might be quite large, but much subsequent research has questioned this conclusion. We revisit this issue by using improved data and incorporating the research approaches that have led to varying estimates. We focus in particular on the public insurance expansions of the 1996-2002 period. Our results clearly show that crowd-out is significant; the central tendency in our results is a crowd-out rate of about 60%. This finding emerges most strongly when we consider family-level measures of public insurance eligibility. We also find that recent anti-crowd-out provisions in public expansions may have had the opposite effect, lowering take-up by the uninsured faster than they lower crowd-out of private insurance.

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The past two decades in the U.S. have seen two striking parallel trends: a rise in the number of uninsured individuals, and a rise in the number of publicly insured individuals. From 1984 through 2004, the share of the non-elderly U.S. population that is uninsured rose from 13.7% to 17.8%. At the same time, the share of non-elderly U.S. population that is publicly insured rose from 13.3% to 17.5%. In other words, despite an enormous expansion in the public health insurance safety net in the U.S., the number of uninsured continues to grow.

There are two possible explanations for this phenomenon. The first is that other factors were occurring over time that put upward pressure on the number of uninsured, so that public insurance increases simply "stemmed the tide" of rising uninsurance (Shore-Sheppard, 2005). The second is that public insurance expansions did not do much towards stemming the tide because most of the rise in public insurance simply came from a fall in private insurance. As is clear from the numbers above, over this same twenty year period the share of the U.S. non-elderly population with private health insurance fell from 70.1% to 62.4%[1].

The notion that public insurance expansions simply erode private insurance coverage, rather than providing coverage to those otherwise uninsured, is known as "crowd-out". This term was first used by Cutler and Gruber (1996) ten years ago, and they proceeded to suggest that crowd-out was sizeable for public insurance expansions over the late 1980s and early 1990s. Their central estimates suggest that the number of uninsured only fell by one-half as much as the number of publicly insured rose, due to offsetting reductions in private insurance.

There has been a large subsequent literature on the crowd-out question, and it has produced results that are mixed, but are generally below those of Cutler and Gruber (1996). At

the same time, there has been a large evolution in the policy environment with the introduction of the CHIP program in 1998. This program provided federal financing for new state public insurance expansions to higher income families than were covered by previous expansions. Since crowd-out is more likely in higher income populations (where a higher percentage of eligibles already have private insurance), it is possible that crowd-out could be even larger in recent years. On the other hand, concerned about this issue, a number of states have put in place tools to combat crowd-out that may have reduced this as a policy issue.

In this article, we revisit the important question of effective public insurance expansions are in reducing the number of uninsured. In doing so, we make three innovations relative to past literature. First, we address the criticisms that have been levied against the Cutler and Gruber (1996) method, providing a comprehensive analysis of alternative approaches to the question. Second, we focus on the period from 1996 to 2002, allowing us to model the extent of crowd-out for the more recent public insurance expansions. Finally, we consider in detail the role of anti-crowdout mechanisms such as waiting periods and enrollee costs.

We have three primary findings. First, crowd-out remains a pervasive phenomenon for recent public insurance expansions. Our central estimates suggest crowd-out of about 60%: that is, the number of privately insured falls by about 60% as much as the number of publicly insured rises. These magnitude of crowd-out is, however, fairly sensitive to the various empirical approaches presented below.

Second, it appears quite important to model crowd-out as a *family* phenomenon, not an individual phenomenon. Crowd-out estimates are much larger when family-wide effects of

[1] Data from Fronstin (1986, 2005). The definition of insurance coverage changed over this period, so we have

eligibility are accounted for, incorporating the spillover onto other family members of eligibility expansions.

Finally, we find suggestive evidence that anti-crowd-out provisions are working to reduce *both* the enrollment of the otherwise uninsured and the otherwise privately insured. On net, we find that if anything these provisions cause crowd-out to rise, not fall, as the number of uninsured joining the program falls faster than the number of privately insured joining the program. This finding, although not statistically precise, is most noticeable for the imposition of enrollee costs under SCHIP.

Our paper proceeds as follows. Part I provides background on both the expansions of the Medicaid program and on previous literature on the crowd-out question. Part II discusses our data and empirical strategy. Part III presents our basic results, while Part IV considers in particular the estimated role of anti-crowdout provisions of recent SCHIP laws. Part V concludes.

Part I: Background

Public Insurance for the Non-Elderly

The Medicaid program was introduced in the late 1960s as a health insurance component for state cash welfare programs which targeted low-income single-parent families. Beginning in the mid-1980s, the Medicaid program was slowly separated from cash welfare programs, first by extending benefits to low-income children in two-parent families, and then by raising the income eligibility thresholds for two groups: children and pregnant women (who were covered only for

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chain-linked the series using 1994 as the reference point.

the costs associated with pregnancy, not other health costs). As a result, by the mid-1990s, most children in America below the poverty line, and all young children below 133% of the poverty line ($24,427 for a family of four), were eligible for Medicaid.[2]

In 1997, the Medicaid program for children was augmented by the Children's Health Insurance Program (CHIP). The goal of CHIP was to expand the eligibility of children for public health insurance beyond the existing limits of the Medicaid program. This program provides $4 billion per year (on average) through 2007 for states to expand their health insurance coverage beyond Medicaid levels, either using expansions of the Medicaid program, or a new program that more closely mimics private health insurance. To provide incentives for states to expand their low-income health care coverage using CHIP funds, the federal government pays a higher share of the state's CHIP costs than it pays of the state's Medicaid costs.

Currently, all children (through age 19) are eligible for Medicaid up to 100% of the poverty line, and children under age 6 and pregnant women are covered to 133% of the poverty line. Many states extended Medicaid eligibility farther for both children and pregnant women. In addition, 38 states and D.C. cover children who are not eligible for Medicaid under SCHIP (which could take the form of a Medicaid expansion or the creation of a new program) up to 200% of the poverty line ($36,800) or higher; children in New Jersey, for example are eligible up to 350% of the poverty line ($64,400).

While federal Medicaid rules require states to cover major services such as physician and hospital coverage, they do not require states to pay for optional services such as prescription

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[2]See Gruber (2003) for a review of the institutional features of Medicaid; for more precise details, see Green Book (2004).

drugs or dental care. Despite this, all states have chosen to cover most optional benefits; all states cover prescription drugs and optometrist services, for example, and almost all cover dental services. For the traditional Medicaid population, these services are provided with little or no copayment required (in states that have CHIP, the copayments are allowed to be somewhat higher for those above 150% of the poverty line). This package of services is much more generous than virtually any private insurance plan. Thus, Medicaid is really "the best insurance money can't buy"!

Just as states can tailor their eligibility requirements to best suit their tastes, they can also regulate the rate at which health service providers are reimbursed. Unlike the case for services covered (in which all states cover basically the same health care services), there is more variability across the states in provider reimbursements. In most states, Medicaid reimburses physicians at a much lower level than the private sector, which often leads physicians to be unwilling to serve Medicaid patients. For childbirth, for example, the reimbursement rate to physicians under Medicaid averages about half of the private sector reimbursement rate. In one survey, one-third of all physicians reported that they serve no Medicaid patients, and another third reported that they limit access of Medicaid patients to their practice. Thus, while the coverage provided by Medicaid is very generous in all states, in a number of states individuals may have trouble availing themselves of that coverage because physicians do not want to accept them as patients.

Theory

The theoretical case for and against crowd-out is developed graphically in Cutler and

Gruber (1996), and we review those arguments here. Since Medicaid is both less expensive and more comprehensive than most private insurance, many individuals will find it attractive to switch to Medicaid when made eligible. At the same time, the fact that providers are less willing to see Medicaid patients may make Medicaid less attractive and mitigate this switching. Medicaid entitlements are also variable, due both to policy changes and the fact that income growth can end eligibility, making this a less attractive alternative to private insurance.

Crowd-out of private insurance should be much more likely for those holding non-group insurance than for those holding insurance through an employer. Non-group insurance is much less comprehensive than employer-provided insurance, and its prices are typically higher and more variable. Moreover, when an individual switches from non-group insurance to public insurance, they see the entire savings of the switch. On the other hand, workers who leave employer-based insurance systems to move to public insurance may not see any of the savings from doing so. While empirical evidence suggests that health insurance costs are passed back to workers (Gruber, 1994; Sheiner, 1994), this research has not established whether this pass back occurs in response to individual or group choices of insurance. If individual workers do not receive the savings from choosing not to purchase insurance, they will perceive moving to Medicaid as a reduction in health insurance but not as an increase in other consumption. Fewer people will drop private insurance coverage in this case.

In the absence of complete wage shifting, employers may encourage workers to drop coverage in other ways. One way to do this is to reduce the generosity of the benefits offered, or in the limit, to simply stop offering insurance to the workers; in either case, these limitations on the private option will make the public option relatively more attractive. Alternatively,

employers can reduce the share of the premium that they pay. When employees pay more of the premium, the link between Medicaid receipt and additional income may be more direct (since it does not operate through the veil of shifting to wages). In addition, because there is a tax subsidy for employer spending on insurance but not for individual spending, increasing the share of the premium that employees pay directly effectively raises the price of private insurance relative to Medicaid.

Because of IRS non discrimination rules, however, neither of these actions can be used selectively for those workers eligible for public insurance. If insurance is offered, it must be offered to all full time workers. As a result, all of these actions increase the total cost of insurance for employees that do not qualify for public coverage, since they lose the tax subsidy for some insurance purchases, or (if employers drop coverage) they must purchase insurance in the more expensive individual market.

On net, therefore, the link between health insurance and employment may increase or decrease the amount of crowd-out. If worker specific shifting is not possible, then crowd-out may be reduced, as employees do not realize the savings from moving to the public sector. If employers increase cost sharing or reduce coverage for all workers, however, more workers may decide to drop coverage than are immediately eligible for Medicaid.

Past Research

The initial work on this question was carried out by Cutler and Gruber (1996), who examined crowd-out during the initial Medicaid expansions of the 1987-1992 period. They did so using the Current Population Survey (CPS), the most common source of information on

insurance coverage. Their approach was to use state rules to assign each individual eligibility for public insurance based on family income and demographics (marital status, number of children, ages of children). They initially model coverage of any individual as a function of their eligibility, but they recognize that this approach misses spillovers from other family members; for example, when children are made eligible for public insurance, their parents may drop the entire family from coverage. They therefore move to a family-based measure of coverage.

Cutler and Gruber also recognized that eligibility was determined by many of the same factors that drive health insurance coverage; e.g. low income families are both eligible and more likely to be uninsured. They therefore used the "simulated instrument" of Currie and Gruber (1996a,b), whereby each state's eligibility rules is applied to a fixed national population, and the average eligibility by state, year, and age is used as an instrument. This essentially acts as a parameterization of the variation in complicated eligibility rules across states and over time.

As noted, Cutler and Gruber found very high rates of crowd-out. They defined crowd-out in two ways. The first is the reduction in private insurance relative to the growth in public insurance; the second is one minus (the change in uninsurance / the growth of public insurance). If insurance categories were mutually exclusive, these definitions would yield identical results. In fact, however, there is in the CPS a very significant overlap between the private insurance and public insurance categories, and the share of individuals in this overlap group (reporting both private and public coverage) tends to rise as Medicaid expands. The most likely causal interpretation is that these individuals are moving at some point during the measurement period from private to public insurance. In that case, the first definition understates crowd-out, and the second is appropriate.

Looking first directly at children, Cutler and Gruber found that for every 100 children joining Medicaid due to the expansions of the 1987-1992 period, 31 children were losing private health insurance, but the number of uninsured was only going down by 60, so that crowd out was between 31 and 40%. Expanding the analysis to account for family spillovers, their crowd-out estimate overall rises to 50% (using the second definition). This still does not account for any crowd-out due to firm decisions to drop insurance or reduce employer contributions; an earlier version of their paper, work by Shore-Sheppard, Buchmueller, and Jensen (2000) and by Buchmueller, Cooper, Simon and Vistnes (2005), finds a response along the second dimension but not the first.

This article started a sizeable literature devoted to estimating crowd-out effects, as reviewed in Table 1. This literature has produced very mixed results which are sensitive to the methodology, the data set, and the definition of crowd-out (how the overlap population is handled). The first alternative approach was to examine the trends in insurance coverage of children made eligible by expansions. In two articles written shortly after the Cutler-Gruber analysis, Dubay and Kenney (1996, 1997) compared the insurance coverage change for populations eligible for Medicaid expansions to that for populations ineligible for expansions. They used the first definition, the change in private insurance relative to public insurance, and found much smaller crowd-out for those below poverty, but moderate crowd-out above poverty, with comparable estimates to Cutler and Gruber for pregnant women 133-185% of poverty. The problem with this approach, however, is that it assumes that there are no other factors changing over time differentially for children and adult men, which seems unlikely. Thorpe and Florence (1998) took a different approach, assessing the share of children with privately insured parents

who move to Medicaid as it expands. They find that only 16% of such children made this move. But this approach does not control for other factors determining such moves, or allow for the fact that Medicaid expansions may also have caused parents to lose private insurance.

A second approach was to more directly compare children made eligible by expansions to those of different ages and incomes who were not made eligible, using longitudinal data to follow individuals over time. The first paper to do so was Yazici and Kaestner (2000), who used the National Longitudinal Survey of Youth (NLSY) to compare the change in insurance coverage of children becoming eligible to those not becoming eligible over the 1988 - 1992 period. Their results are very sensitive to the treatment of the "overlap" population, however: depending on the definition of crowd-out used, crowd-out is either much smaller or larger than the Cutler and Gruber estimates.

Subsequent papers using this approach have turned from the CPS to the Survey of Income and Program Participation (SIPP). The SIPP has a smaller sample and does not uniquely identify all states. At the same time, it is a longitudinal survey which allows researchers to follow insurance status changes over time, and the timing of the insurance question is much clearer than in the CPS.[3] Blumberg, Dubay and Norton (2000) used the 1990 SIPP to show that, of those children made eligible by expansions, only 4% as many lost private coverage as gained public coverage. Their calculation assumes that all those with dual coverage are on Medicaid, providing a lower bound on crowd-out. Card and Shore-Sheppard (2004) pursue a similar analysis in the 1990-1993 SIPP, although they did not follow the same children over time but

[3] The CPS asks respondents in March about their insurance coverage during the previous year, and it is unclear if respondents are actually reporting on current or last year's insurance coverage. The SIPP, in contrast, asks about current insurance coverage.

rather used these surveys as repeated cross-sections. They found no crowd-out for those below poverty, or between 100-133% of poverty, in response to expansions to those populations, but they did find large crowd-out for those below poverty when eligibility was expanded to 133% (perhaps through informational spillovers). An issue with all of these studies, however, is that income is treated as exogenous in assigning children to treatment and control groups, ignoring any possible effects of the expansions on income which may shift children across groups.

The third approach pursued by this literature has been to consider alternative specifications of the Cutler-Gruber (1996) simulated instruments approach. Shore-Sheppard (2005) replicates the Cutler-Gruber findings, but she finds that they are very sensitive to the set of controls in the model. In particular, when she controls for differential time trends by age of child (a full set of age*year interactions), her crowd-out estimate falls to zero. But, as with other CPS analyses, this result is very sensitive to the treatment of the overlap population; using the second definition of crowd-out, her estimates are quite similar to those of Cutler-Gruber even when the extra controls are included. Ham and Shore-Sheppard use the SIPP to replicate the Cutler-Gruber approach, however, and they find no crowd-out. They are able to replicate Cutler-Gruber in the CPS, and they highlight the sensitivity of the findings to the data set used.

Several papers have also considered the effects of the most recent expansions in public insurance. Hudson, Selden and Banthin (2005) use both the Cutler-Gruber approach and the approach of comparing eligible to ineligible children over time with data from the Medical Expenditure Panel Survey (MEPS). They find variable but generally large crowd-out estimates from these approaches. LoSasso and Buchmueller (2004) use a Cutler-Gruber approach with CPS data and estimate a 50% crowd-out of private insurance and also find that the anti-crowdout

provisions in the form of a waiting period have been effective in reducing crowd-out. In a paper that focuses on parental expansions under Medicaid, Aizer and Grogger (2003) use CPS data and find that parental expansions increased the coverage of parents as well as their children through a possible spillover effect. Their method is a within-state differences in differences approach using target and control groups within expansion states, before and after expansions. They find that expansions increased public coverage for mothers by 2.7 percent and reduced private coverage by a statistically insignificant 1.3%. For children, it increased public coverage by 5.3% and decreased private coverage by a statistically insignificant 1.2%.

The literature on crowd-out is therefore marked by three eras. The first is the initial Cutler and Gruber study, which finds large crowd-out. The second is further work on the crowd-out effects of expansions in the 1980s and early 1990s, which generally have not corroborated the large crowd-out findings of Cutler and Gruber. These results also suggest that the earlier findings may be driven by data set choice (the CPS) and specification (the omission of age*year interactions). Finally, a recent literature on the late 1990s and early 2000s expansion of public insurance once again finds large crowd-out effects.

This newer literature, however, has not grappled with the criticisms levied against the older literature. None of the new studies have used the SIPP, the data set which is likely most appropriate for this study and in which the earlier crowd-out results were not replicated. None of the studies have addressed differences in results from the group over time comparisons (as in Card and Shore-Sheppard) and the instrumental variables regression method (as in Cutler and Gruber). And none of the studies has explored the robustness to the inclusion of additional controls for changes over time as in the Shore-Sheppard study of the earlier period.

Moreover, there has been relatively little exploration of the unique feature of public insurance expansions in recent years: the increased use of anti-crowdout provisions. The one exception is the LoSasso and Buchmueller paper, which looks at waiting periods. Perhaps more important in the era of the SCHIP program is the imposition of non-trivial costs on enrollees, either in the form of premiums or copayments. These costs can lead both to less take-up by needy uninsured, as well as less crowd-out from those who are insured. Which effect is stronger is an empirical question.

Part II: Data and Empirical Strategy

Data

Given the advantages of the SIPP noted above, and the fact that SIPP-based analyses have been less likely to find sizeable crowd-out, our analysis will focus on this data set. We use the 1996 and 2001 panels of the SIPP: The 1996 panel covers the 1996 to 2000 period, while we use the 2001 panel for 2001 and 2002.

Given the importance of the "overlap" issue raised earlier, we pursue an approach in the SIPP which provides a range of results depending on the interpretation of this overlap. Our key dependent variables measure (a) coverage by Medicaid *only* (no overlap with other insurance), (b) coverage by private insurance *only*, and (c) the extent of overlap between public and private. We can therefore produce two estimates: (i) assuming changes in overlap represents only individuals moving from private insurance to Medicaid (the most likely explanation) and (ii) remaining agnostic about the overlap and simply comparing the groups only on Medicaid and private insurance.

Our sample uses children aged 0-18 years as well as parents aged 19-64 years of age. We use only the 4th reference month observations from each SIPP wave (thus we have upto one observation every 4 months on an individual, picked in a manner that minimizes recall bias). In the 2001 panel of the SIPP, we keep data only through the end of 2002 as this is the end period of our study. We delete observations from states that cannot be uniquely identified in the SIPP (Maine, Vermont, North Dakota, South Dakota, Wyoming). These states together account for 1.3% of the US non-elderly population in 2000 (author calculations using U.S. Census Bureau population data).

Table 2 shows sample means for our data set. There are 405,389 observations on children (where an observation is a person-month). This shows, for example, that 18% of children are on Medicaid alone.

Empirical Methodology

In order to address the various approaches considered in previous studies, we use two empirical methodologies. We begin with descriptive cross-tabulations that follow the approach of Card and Shore-Sheppard (2004), showing the change in insurance coverage in populations made eligible and not made eligible by expansions. Unlike Card and Shore-Sheppard, however, we consider the possibility that income may be endogenous to the expansions, and also show results using a fixed base period income that is not subject to this potential contamination.

Our second empirical methodology follows the original approach of Cutler and Gruber (1996), assigning eligibility to individuals, and then instrumenting with "simulated eligibility". Thus, our basic approach is to run regressions of the form

1) $Ins_{ijt} = \alpha + \beta ELIG_{ijt} + \phi X_{ijt} + \upsilon_j + \rho_t + \varepsilon_{ijt}$

where the subscript i denotes individuals, j denotes states, and t denotes time (year by month); INS is a measure of insurance coverage; ELIG is individual i's eligibility for insurance; X is a set of individual and state level characteristics; and ρ_t and υ_j are a set of year by month (t) and state (j) dummies, respectively. We include controls for the following characteristics: number of families on cash assistance by month by state, state unemployment rate by month, family monthly income as a percent of the FPL and its square, an indicator for being female, a set of indicators for the number of children in the family (one, two, three, fours, five or more),the number of adults in the family who work for a firm with over 100 workers, the number in the family who work full time, the number in the family who have only high school completion, the number in the family who have some college completion, who have college completion or more, whether family is headed by a single female, single male, whether male head is unemployed in a two parent household, indicators for race and ethnicity (White, Black, Hispanic vs others) and fixed effects for each age 0-18 for kids. In specifications that consider the impact of family level eligibility, we also include a set of additional controls for family composition by age categories: dummy variables for having one, or more than two, family members of a given age in the interval 0-18 (36 dummy variables) and dummy variables for total family size (up to 14). Standard errors are clustered by state.

There are two major threats to the validity of this estimate of the effect of eligibility on insurance coverage. The first is the fact that eligibility is determined by many of the same factors that determine insurance coverage. In principle, we can control for these factors in the X vector, but in practice eligibility is a complicated non-linear combination of these factors that is

difficult to capture in the control set. Currie and Gruber (1996a,b) introduced an instrumental variables approach to solving this problem, by taking a fixed national population in each year and applying each state's rules to that population. In this way, the only feature that differs across states is the rules and not other factors in the X vector.

A second threat is omitted variables that affect both eligibility rules and insurance coverage. As discussed above in the context of Shore-Sheppard (2005), there may be omitted trends in insurance coverage by child age or state that are correlated with expansions in eligibility. Following Shore-Sheppard, we consider the robustness of our results to controls for such omitted factors.

Part III: Results

Cross-Tabulations

We begin our analysis with cross-tabulations that clearly show the patterns of insurance coverage over time. To do so, we take just the starting and ending years of our data (1996 and 2002, respectively) and tabulate public only, private only, and overlap between private and public insurance by age group and income group. We begin with simple tabulations by income group, considering children in families with incomes below the poverty line, between 100 and 200% of the poverty line, between 200 and 300% of the poverty line, and between 300 and 400% of the poverty line. As Table 3 shows, for those broad income groups, the change in eligibility from 1996 to 2002 was 10.3%, 72.2%, and 29.1%, and 7.6%, respectively. There is clearly important variation along the income distribution in changes in eligibility, particularly for the group of children between 100 and 200% of the poverty line.

The next three columns of Table 3 show the associated change in Medicaid coverage, private insurance coverage, and the overlap (both public and private). As would be expected, the rise in Medicaid coverage is largest for the group between 100 and 200% of poverty. And, consistent with crowd-out, this is also the group that sees the largest decline in private coverage.

To evaluate these changes, Table 4 takes the data from Table 3 and computes some difference-in-difference tabulations of private and public coverage. There are two columns of results, corresponding to (a) assuming that the individuals who report both private and public coverage are moving from private to public insurance coverage, (b) excluding from the calculation the set of individuals who report both private and public coverage. As discussed earlier, we find approach (a) to be the most plausible given the expansion of public insurance over this period, but it is important to assess the sensitivity to this assumption.

Each row in the top panel computes the three difference in difference comparisons available from the income group data, comparing the treatment group of 100-200% of poverty to three different control groups. The estimates in the table show the ratio of the change in private insurance to the change in public insurance for each case. As is clear, these estimates imply very large crowd-out, and are not particularly sensitive to the use of the overlap group. The lowest crowd-out estimate here is 58%, and the largest is over 100%.

The second panel of Table 3, and the corresponding second panel of Table 4, perform this same exercise but with one important change: we use the base income (as of the start of the SIPP panel) of respondents to categorize them, rather than using current income. This approach controls for any potential income endogeneity to public insurance eligibility, which is not accounted for by using current income. Base period income is inflated to actual year and month

using the national monthly Consumer Price Index.

As Table 3 shows, using this approach yields much less sharp distinctions in eligibility change over time across income groups, as is to be expected from the fact that the treatment is noisier since incomes change over time. Nevertheless, Table 4 shows that the crowd-out estimates implied by these changes are fairly similar, albeit somewhat lower, than those using current income. The range of crowd-out estimates here is from 47% to 92%. Thus, in contrast to the earlier findings from Card and Shore-Sheppard (2004), the evidence of crowd-out from this approach is quite strong.

Instrumental Variables Regressions

We next move from these cross-tabulations to instrumental variables regressions of the type described in the previous section. The instrument is created by first taking a random sample of 300 children of each age (and their families) from each year of the SIPP. This national sample is used for each of the 12 months in each of the years, with the eligibility rules in each state (in each year and month) to calculate the fraction of the national sample of a given age who are eligible for public insurance (and also for Medicaid and SCHIP forms separately). Table 5 shows estimates from (1) above estimated using different dependent variables for insurance status, and different measures of eligibility (based on own eligibility or the eligibility of the family). We also distinguish between models that include two-way interactions between age, year and state ("All interactions") and ones without these interactions ("Baseline"). We show only the coefficient (and standard error) of interest in a regression that includes all of the controls described above. Each row represents a different specification; each column represents a

different dependent variable. The two columns labeled "Crowd" are the exceptions, where we calculate the implied crowd-out magnitude in the two ways discussed earlier.

The first row shows the estimates on the eligibility variable from our base IV specification. For example, the coefficient of 0.072 in the first row, first column, implies that, for every 100 children made eligible for insurance through the expansions of the 1996-2002 period, 7.2 children gain Medicaid coverage (and no other type of coverage). This is a very low marginal take-up rate, but it is consistent with the fact that most children in the income ranges made eligible for insurance already had insurance coverage. Indeed, among children made newly eligible over this period, 80% had other insurance coverage before they became eligible. Thus, if take-up were restricted to the previously uninsured, then over one-third of the newly eligible uninsured would be taking up.

The second column of the first row shows the effect of eligibility on private insurance coverage (with no overlap with other coverage). The estimate here suggests a small and insignificant effect: for each 100 children being made eligible, only 1.7 children lose private insurance. The third column shows the impact of eligibility on being recorded as having both public and private coverage; this is marginally significant and suggests that for each 100 children made eligible, 1.5 are coded as having both types of coverage.

The implications for crowd-out estimates are shown in the next two columns. As before, we consider two measures of crowd-out, depending on how the overlap population is treated. Crowd1 refers to the first method, assuming that the overlap group move from private to public, while Crowd2 ignores the overlap group. The estimates here suggest modest crowd-out of 24-37%.

The next two columns of the table divide the sample of privately insured into those with employer insurance and non-group insurance exclusively. The effects on both types of insurance are insignificant, although there are significant overlap effects in each case (see last two columns).

As emphasized by Cutler and Gruber (1996), it seems likely that the entire family's eligibility for Medicaid is relevant to both take-up and crowd-out. On the take-up side, parents may be more likely to enroll their children if other children, or the parents themselves, are eligible for coverage as well. Indeed, Sommers (forthcoming) finds that Medicaid enrollment among eligible children is higher if siblings are also eligible. On the crowd-outside, insurance is often purchased for the entire family, so it would not be surprising that as more family members are eligible for public insurance it increases the pressure to drop private insurance.

To investigate this issue, we replace our measure of individual eligibility with a measure of family eligibility: the % of the family (including the focal member) that is eligible for public insurance, which varies from zero for no eligibility to 100% for family eligibility. The family includes children aged 0-18 and their parents aged 19-64.[4] We create an instrument in the same way, using the family mean of simulated eligibility rather than the simulated eligibility for that child. Since the regression includes the detailed demographic controls discussed earlier, we are not identifying the model from demographic differences across families but rather solely from variation in simulated eligibility.

The results of this exercise are shown in the second set of rows of Table 5 (family eligibility). As expected, we find somewhat higher take-up; making the entire family eligible

raises the odds that a child takes up Medicaid by 10.9% (although this is not significantly different from the 7.2% take-up rate for own eligibility). The larger difference is for private insurance, where there is now a sizeable and statistically significant negative coefficient of -0.066; there is also an increase in the overlap coefficient to 0.027. As a result, the estimated crowd-out is sizeable for this specification, ranging from 61% to 68%. This is comparable to the difference-in-difference tabulations from the previous table, which is sensible since those were comparing broad income groups which would incorporate family eligibility rather than own eligibility.

This significant reduction in private insurance reflects a reduction in employer-provided insurance, with no effect on non-group insurance (although some effect on the group that overlaps between non-group insurance and public insurance). For each 10 percentage point increase in the share of the family made eligible for Medicaid, there is a 0.66 to 0.9% reduction in employer-provided coverage, depending on the treatment of the overlap group. This amounts to a 1 to 1.36 percent reduction in the level of employer-provided health insurance for each 10 percentage point increase in the share of the family made eligible for Medicaid.

Controlling for Other Omitted Factors

As emphasized by Shore-Sheppard (2005), a key assumption of models such as these is that there are no omitted factors correlated with legislative patterns of eligibility. For example, there could be differential trends in insurance coverage by age that are correlated with, but not caused by, the Medicaid expansion. Shore-Sheppard found that Cutler-Gruber type models were

[4] There are some children in the children's regression who were not matched to parents in the data set-these children

very sensitive to the inclusion of controls for these factors.

To address this point, we have re-estimated our models controlling for the full set of second-order interactions: state*age; age*year; and state*year. The first controls for the fact that state fixed factors may operate differently at different ages; while children may be the same on average in state A and state B, there could be large differences by age that just average out. The second and third terms address Shore-Sheppard's concern that other factors are changing over time differentially by age groups of children or by state. These results are shown in rows 2 and 4 of the table.

In the case of own eligibility, in rows 1 and 2, columns 1 and 2, there is a weakening of the effects on both take-up and crowd-out. In the case of family eligibility (rows 3 and 4), however, both get stronger – in particular the reduction in private insurance. In this case, there is a fairly tightly estimated crowd-out of 78% to 81%. Once again, however, this comes primarily from those with employer-based insurance, suggesting little crowd-out of non-group insurance.

Summary

To summarize, our results suggest that crowd-out is not sizeable if the individual's own eligibility alone is considered, but that once family eligibility is considered crowd-out grows in importance. This conclusion is robust to all of the methods employed in the previous literature, such as examining group trends over time, using instrumental variables regression, and controlling for possible omitted time trends.

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are included in the family regressions with the same information as in the individual regressions.

Part IV: The Role of Anti-Crowd-Out Provisions

A major difference between recent expansions of insurance for children and previous rounds of expansion is the attention that has been paid to crowd-out and the use by states of anti-crowd-out provisions in their SCHIP programs. The most prominent of these is waiting periods, whereby individuals have to show their lack of health insurance coverage for some period before enrolling in SCHIP. 34 states have waiting periods in their SCHIP programs as of 2000: the most common waiting period is 6 months (15 states), and the longest is 12 months (in the states of Alaska, New Mexico and Virginia). The results of LoSasso and Buchmueller (2004) suggest that such waiting periods might be important, as they show significant crowd-out without waiting periods that disappears when waiting periods increase up to 5 months.

We revisit that analysis here using our SIPP data and specifications. We first divide our variable for eligibility into eligibility for traditional Medicaid, which has no waiting period, and eligibility for SCHIP, which can have a waiting period in some states. We then add an interaction of the SCHIP eligibility term with the state's waiting period. Our instruments are adjusted accordingly: we use a simulated eligibility measure for SCHIP and Medicaid separately, and interact the former with months of waiting period in the state/year cell. This specification parallels that of LoSasso and Buchmueller (2004), except that we allow for separate direct effects of Medicaid and SCHIP, while they impose the same direct effect.

The results of this analysis are shown in Table 6, both for own eligibility (the first half of the Table) and family eligibility (the second half of the table). There are three sets of rows under each part. The first set shows the impact of eligibility for Medicaid; the second set shows the impact of eligibility for SCHIP and the third shows the interaction between eligibility for SCHIP

and the waiting period in the state. The crowd-out calculations are presented for Medicaid coverage, SCHIP coverage (assuming no waiting period), and for SCHIP with the standard deviation of waiting periods among states that have a waiting period (2 months). For example, the value of 0.36 for "Crowd1" (which assumes that the overlap between private and public coverage represents a movement from private to public coverage) in the baseline specification row corresponding to "Medicaid" in the first panel indicates 36% crowd-out, The value of 0.54 for "Crowd1" corresponding to the "SCHIP" line indicates 54% crowdout for SCHIP eligibility, assuming a 0 month waiting period. The value of 0.59 in the row below that indicates 59% crowd-out for SCHIP eligibility using a 2 month waiting period.

Unfortunately, many of our estimates here are imprecise. But the results suggest that crowd-out is at least as great for the SCHIP program, with no waiting period, as it is for the Medicaid program. Most strikingly, we find little evidence that waiting periods reduce crowdout. This is contrary to findings published in LoSasso and Buchmueller (2004).[5] Crowd-out is almost as large for states with waiting period as for those without in the specification using the child's own eligibility; and crowd-out is much *larger* when family eligibility is used. For example, using the Crowd1 definition and including all interactions, crowd-out is 60% for SCHIP if no waiting period, and 110% when using a two month waiting period. This reflects the fact that take-up of Medicaid coverage is declining faster than is crowd-out of private coverage as waiting periods are introduced. The imprecision of these results makes strong conclusions inappropriate, but there is certainly no reason to conclude that waiting periods are lowering the crowd-out rate.

SCHIP Costs

Another important new feature of SCHIP programs was the increase in costs that enrollees could bear. Medicaid is free and imposes only nominal copayments on enrollees. SCHIP enrollment, however, can be subject to premiums, and copayments for services can be nontrivial for those above 150% of poverty (but premiums and copayments can not add up to more than 5% of income). In principle, these charges can also serve as anti-crowd-out provisions, deterring those with private insurance from dropping that coverage. But they may also deter individuals who are eligible for signing up for the program as well.

To investigate this issue, we have created a variable for each child which is the expected cost sharing faced during the year in dollars. To construct this, we assign each SCHIP-eligible child in the SIPP their expected usage of health care (dollars by category, number of visits by category, as well as total cost in dollars) during the year from the MEPS by age categories and gender. The health care services we consider are doctor visits, hospital stays, and prescription drugs. We use the cost sharing rules that apply to children by the type of insurance for which they are eligible (Medicaid or SCHIP), their age, family structure and income which are often used to determine whether cost sharing will apply to a certain child. By dividing the estimated out of pocket costs by the estimated total costs for health care, we calculate the expected cost sharing fraction. The instrument is created in a similar way as for eligibility (at the state/age/year level) except here we limit the sample to just the children who are estimated to be eligible for SCHIP. We then use the same regression framework just described, breaking out

[5] LoSasso and Buchmueller have kindly replicated our specification in their data and continue to find evidence that

separately Medicaid and SCHIP eligibility, and interacting this cost-sharing variable with the latter.

The results of this exercise are shown in Table 7 (which is arranged in a manner similar to Table 6) and are quite striking. There is a negative and significant interaction of the cost-sharing variable with SCHIP eligibility in the Medicaid take-up equation, indicating that although making someone eligible for SCHIP has a positive but statistically significant effect on take-up, the incremental impact on take-up of requiring cost sharing decreases take-up in a statistically significant manner. The 0.105 (standard error 0.03) coefficient on the Medicaid variable in the first column indicates a statistically significant increase in public coverage of 10.5 percentage points as a result of Medicaid expansions. The 0.052 coefficient on the SCHIP eligibility variable (standard error 0.04) in the first column indicates a statistically insignificant increase of public coverage by 5.2 percentage points from an SCHIP expansion with no cost sharing. In contrast, the statistically significant coefficient of -0.383 indicates that as cost sharing increases, the effect of SCHIP expansion on increases in public coverage decreases. As the total expected amount a child pays out of pocket under SCHIP as fraction of their expected total costs rises from zero to one, the take-up of SCHIP reduces by 38.8 percentage points. On the other hand, there are positive interactions in both the private insurance and overlap equations, although neither is statistically significant.

We interpret these results by showing coverage effects implied by a 0.08 (one standard deviation) cost-sharing percentage, relative to a state with an SCHIP program with no cost-sharing. The results imply that crowd-out is higher for Medicaid than for SCHIP with no cost-

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waiting periods reduce crowd-out. Thus, the main difference between our results appears to be the data set used.

sharing– but it is highest (depending on the inclusion of interactions) for SCHIP with cost-sharing at the median of states that have cost-sharing. For example, for family eligibility and the Crowd1 definition, crowd-out is 64% for Medicaid, 30% for SCHIP with no costs, and 80% for SCHIP with one standard deviation higher costs. Once interactions are included, however, the crowd-out effects are comparable on all three coefficients.

Once again, our findings in Table 7 suggest that state efforts to increase financial barriers to public programs may deter the use of those programs by those who need them at a faster rate than it is deterring the use of those programs by those who are crowded out. While the conclusion imprecise, there is certainly no evidence that imposing costs on beneficiaries is reducing crowd-out of private insurance.

Part V: Conclusions

Despite large increases in eligibility of children for public insurance over the past two decades, continued increases in eligibility remain a popular option for expansions of insurance coverage in the U.S. Central to evaluating such policy initiatives is understanding the degree to which expanded public insurance entitlements will reduce private insurance coverage. This "crowd-out" problem has become the subject of a large literature over the past decade. The purpose of this paper was to bring to bear the improved methods and data from this literature to draw conclusions about the ultimate magnitude of crowd-out.

We have three primary conclusions. First, crowd-out is significant. Our central estimates suggest that crowd-out is on the order of 60%: private insurance coverage is reduced by 60% as much as public insurance coverage rises when there are public eligibility expansions. This result

is not statistically precise, but emerges from several different approaches, in particular both changes in cohorts over time and instrumental variables regression models.

Central to this finding is our second conclusion: family eligibility matters. Crowd-out is only about half as large when we consider individuals only, but this higher magnitude emerges when we consider the entire family's eligibility for Medicaid. Making more of the family eligible for public insurance lowers private insurance coverage at a much more rapid rate than it raises public insurance take-up.

Finally, and perhaps most interestingly, our findings suggest that the anti-crowdout efforts that have accompanied the SCHIP program have probably raised crowd-out more than lowering it. The imprecision of our results in Section IV limit the power of these conclusions, but they certainly suggest that features such as waiting periods and especially cost-sharing lower take-up by the uninsured faster than they deter crowd-out from private insurance.

Despite our ability to synthesize many of the issues raised in previous research, there is more work to be done on this important topic. The highest priority should clearly be to explore further the issues raised in Section IV about how the design of public insurance expansions affects take-up and crowd-out. More generally, as states experiment more broadly with alternatives such as private purchasing pools, understanding the degree of substitutability between private and publicly subsidized insurance, and how that features with the nature of the publicly-subsidized insurance, becomes a critical area for future research.

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Table 1
Literature on Crowd-Out

Article	Data Source	Methodology	Crowd-Out Definition	Results
Cutler and Gruber (1996)	1987-1992 CPS	Instrument eligibility with simulated eligibility based on entire nation; control for state, year, age; consider family-level spillovers	γPrivate Insurance / Public Insurance) or (1 – {Uninsured / Public Insurance})	Children 31% or Children: 40% Family Level: 50%
Dubay and Kenney (1996)	1988 & 1993 CPS	Change in insurance coverage of children relative to change for adult men	γPrivate Insurance / Public Insurance)	Below poverty: 15% 100-133%: 22%
Dubay and Kenney (1997)	1988 & 1992 CPS	Change in insurance coverage of pregnant women relative to change for men	γPrivate Insurance / Public Insurance)	Below poverty: 0% 100-133%: 27% 133-185%: 59%
Thorpe and Florence (1998)	1989-1994 NLSY	Measure movement from private insurance onto Medicaid among children with privately insured parents	% of those entering Medicaid with privately insured parents	16%
Blumberg, Dubay and Norton (2000)	1990 SIPP Panel	Compare change in insurance coverage of children made eligible by expansions to those not made eligible	% of children made eligible losing private relative to gaining public	4%
Yazici and Kaestner (2000)	1988 & 1992 NLSY	Compare change in insurance coverage of children becoming eligible to those not becoming eligible	(1 – {Uninsured / Public Insurance}) or γPrivate Insurance / Public Insurance)	55-59% 5-24%
Aizer and Grogger (2003)	1995-2002 CPS	Compare change in insurance, for those above AFDC eligibility vs below, in states with adult expansion, before vs after expansion	Coefficient on private coverage equation (no crowd-out calculations)	Statistically insignificant effect on private coverage for mothers and for children
Card and Shore-Sheppard (2004)	1990-1993 SIPP Panels	Compare changes in insurance coverage of children around income and age limits for eligibility	γPrivate Insurance / Public Insurance)	Below poverty, eligible for <100: 0 Below poverty, eligible for 100-133: 50% 100-133: 0

LoSasso and Buchmueller (2004)	1996-2000 CPS	Instrument eligibility with simulated eligibility based on entire nation; control for state, year, age, state*year; interact with state waiting periods	γPrivate Insurance / Public Insurance)	Average: 50% Varies with state waiting periods
Shore-Sheppard (2005)	1987-1995 CPS	Same as Cutler-Gruber, but add additional controls - children only	(1 – {Uninsured / Public Insurance}) or γPrivate Insurance / Public Insurance)	33% (age/year controls) - 59% (all controls) 0
Ham and Shore-Sheppard (2005)	1985-1995 SIPP	Instrument eligibility with simulated eligibility based on all other states; control for state, year, age	γPrivate Insurance / Public Insurance)	No Crowdout
Hudson, Selden and Banthin (2005)	1996-2002 MEPS	Compare changes in children made eligible and remaining ineligible; instrument with simulated eligibility	γPrivate Insurance / Public Insurance)	Comparison: 25-55% IV: 39-70%

Table 2
Descriptive Statistics of Selected Variables

Variable	*Mean*	*St. Dev*
Medicaid only	0.18	0.39
Private insurance only	0.63	0.48
Both Medicaid and private insurance	0.02	0.14
Employer insurance only	0.59	0.49
Non-group insurance only	0.03	0.18
Uninsured	0.15	0.36
Both non-group insurance and Medicaid	0.00	0.04
Both employer insurance and Medicaid	0.02	0.14
Eligible for public insurance (any)	0.43	0.50
Instrument for above	0.43	0.16
Eligible for SCHIP	0.08	0.26
Instrument for above	0.08	0.11
Eligible for Medicaid (as opposed to SCHIP)	0.36	0.48
Instrument for above	0.36	0.15
Family level eligibility (any)	0.34	0.41
Instrument for above	0.32	0.14
Family level eligibility for Medicaid	0.30	0.41
instrument for above	0.27	0.13
Family level eligibility for SCHIP	0.04	0.16
Instrument for above	0.04	0.06
Waiting period in months	1.53	2.48
Waiting period, conditional on not being zero	4.48	2.19
Cost sharing (fraction of expected costs paid out of pocket through premiums and other means)	0.04	0.08
The above, conditional on not being zero	0.12	0.08
Age in years	9.08	5.33
Female (1=yes, 0=no)	0.49	0.50
White	0.64	0.48
Black	0.16	0.37
Hispanic	0.15	0.36
Family income as % FPL	275.20	314.00
Single female headed family	0.26	0.44
Single male headed family	0.04	0.20
Unemployed married male headed family	0.06	0.23
Welfare caseload (families by month/state)	163566	211445
Unemployment rate (month/state)	4.93	1.08
Observations	405,389	

Notes: Unweighted data from the SIPP 1996 and 2001 panels. From the 2001 panel, we exclude data after December 2002. Children are aged 0-18 years. Only 4th reference month observations are kept (one response per wave). States that are unidentified in the SIPP include North Dakota, South Dakota, Maine, Wyoming, and Vermont.

Table 3
Tabulations

Tabulations Using Actual Income				
Income Group	Change in Eligibility	Change in Medicaid	Change in Private	Overlap
<100% FPL	0.103	0.023	-0.007	0.002
100-200% FPL	0.722	0.126	-0.123	0.021
200-300% FPL	0.291	0.052	-0.08	0.014
300-400% FPL	0.076	0.019	-0.047	-0.001

Tabulations Using Base Period Income				
Income Group	Change in Eligibility	Change in Medicaid	Change in Private	Overlap
<100% FPL	0.101	0.007	0	0.012
100-200% FPL	0.478	0.14	-0.122	0.016
200-300% FPL	0.38	0.057	-0.083	0.008
300-400% FPL	0.21	0.024	-0.06	0.001

Note: Calculations are based on authors' tabulations of 1996 and 2002 SIPP data.

Table 4
Crowd-out Calculations from Tabulations in Table 3

Tabulations Using Actual Income Income Group	Crowd1	Crowd2
DD1: 100-200% relative to <100%	1.11	1.13
DD2: 100-200% relative to 200-300%	0.62	0.58
DD3: 100-200% relative to 300-400%	0.76	0.71
Tabulations Using Base Period Income **Income Group**	**Crowd1**	**Crowd2**
DD1: 100-200% relative to <100%	0.92	0.92
DD2: 100-200% relative to 200-300%	0.52	0.47
DD3: 100-200% relative to 300-400%	0.59	0.53

Notes: Crowd1 assumes that the overlap is a move from private to public coverage; Crowd2 ignores the overlap.

Table 5
Effect of Eligibility for Any Public Insurance on Insurance Status

		Public only	Private only	Both Public and private	Crowd 1	Crowd 2	Employer coverage only	Non group coverage only	Both Public and non group	Both Public and employer coverage
Own eligibility	Baseline	0.072*** (0.02)	-0.017 (0.02)	0.015** (0.01)	0.37	0.24	-0.011 (0.02)	-0.006 (0.01)	0.003*** (0.001)	0.013** (0.01)
	All interactions	0.055*** (0.02)	-0.011 (0.02)	0.008 (0.01)	0.30	0.20	0.004 (0.03)	-0.012 (0.02)	0.003 (0.004)	0.005 (0.01)
Family eligibility	Baseline	0.109*** (0.03)	-0.066** (0.03)	0.027** (0.01)	0.68	0.61	-0.066** (0.03)	0.0004 (0.01)	0.004* (0.002)	0.024** (0.01)
	All interactions	0.156*** (0.05)	-0.122*** (0.04)	0.027* (0.01)	0.81	0.78	-0.121** (0.05)	-0.001 (0.02)	0.004 (0.003)	0.025* (0.02)

Notes: Standard errors are in parentheses. Each estimate is from a separate regression. * indicates statistical significance at the 10% level; ** indicates significance at the 5% level; and *** indicates significance at the 1% level. Number of observations is 405,389. All interactions refer to state*age, state*year and age*year.

Table 6
Effect of Eligibility for Medicaid and SCHIP on Insurance Status (Months interaction)

		Public only	Private only	Both public and private	Crowd 1	Crowd 2	Employer coverage only	Non group coverage only	Both public and non group	Both public and employer coverage
Own eligibility										
Baseline	Medicaid	0.101***	-0.026	0.016**	0.36	0.26	-0.025	-0.002	0.002*	0.014*
		(0.03)	(0.02)	(0.01)			(0.02)	(0.01)	(0.001)	(0.01)
	SCHIP	0.054*	-0.023	0.013	0.54	0.43	-0.009	-0.014	0.006***	0.006
		(0.03)	(0.03)	(0.01)			(0.03)	(0.01)	(0.001)	(0.01)
	SCHIP*months	-0.011**	0.006	0.003	0.59	0.34	0.006	0.001	0.0001	0.004
		(0.01)	(0.01)	(0.003)			(0.01)	(0.003)	0.0002	(0.002)
All interactions	Medicaid	0.078	-0.025	-0.021	0.36	0.26	-0.024	-0.001	0.005	-0.024
		(0.11)	(0.03)	(0.28)			(0.03)	(0.02)	(0.01)	(0.28)
	SCHIP	0.011	0.02	-0.002	0.54	0.43	0.052	-0.032*	0.007**	-0.01
		(0.06)	(0.05)	(0.14)			(0.04)	(0.02)	(0.003)	(0.14)
	SCHIP*months	-0.004	-0.007	0.001	0.59	0.34	-0.01	0.003	-0.001***	0.003
		(0.01)	(0.01)	(0.02)			(0.01)	(0.004)	(0.001)	(0.02)
Family eligibility										
Baseline	Medicaid	0.145***	-0.086***	0.029**	0.7	0.59	-0.086***	0.0002	0.003	0.027**
		(0.04)	(0.03)	(0.01)			(0.03)	(0.02)	(0.002)	(0.01)
	SCHIP	0.051	-0.027	0.01	0.6	0.53	-0.028	0.001	0.008**	0.002
		(0.05)	(0.05)	(0.01)			(0.06)	(0.02)	(0.003)	(0.01)
	SCHIP*months	-0.017	0.003	0.008**	1.1	1.24	0.002	0.001	0.0003	0.009**
		(0.01)	(0.01)	(0.004)			(0.01)	(0.004)	(0.001)	(0.004)
All interactions	Medicaid	0.217***	-0.163***	0.028	0.7	0.59	-0.156**	-0.008	0.004	0.026
		(0.06)	(0.05)	(0.02)			(0.06)	(0.02)	(0.004)	(0.02)
	SCHIP	0.009	0.049	-0.009	0.6	0.53	0.024	0.025	0.006	-0.015
		(0.04)	(0.06)	(0.02)			(0.07)	(0.03)	(0.01)	(0.02)
	SCHIP*months	-0.009	-0.018	0.012***	1.1	1.24	-0.019	0.0004	-0.001	0.014***
		(0.01)	(0.02)	(0.004)			(0.02)	(0.01)	(0.001)	(0.004)

Notes: Standard errors are in parentheses. Each set of estimates (Medicaid, SCHIP and SCHIP*months) is from a separate regression. * indicates statistical significance at the 10% level; ** indicates significance at the 5% level; and *** indicates significance at the 1% level. Number of observations is 405,389. All interactions refer to state*age, state*year and age*year.

Table 7
Effect of Eligibility for Medicaid and SCHIP on Insurance Status (Cost Sharing Interactions)

		Public only	Private only	Both Public and private	Crowd 1	Crowd 2	Employer coverage only	Non group coverage only	Both Public and non group	Both Public and employer coverage
Own eligibility										
Baseline	Medicaid	0.105***	-0.03	0.015*	0.39	0.30	-0.028	-0.001	0.002	0.014*
		(0.03)	(0.02)	(0.01)			(0.02)	(0.01)	(0.001)	(0.01)
	SCHIP	0.052	-0.005	0.008	0.22	0.10	0.015	-0.021	0.004**	0.003
		(0.04)	(0.03)	(0.01)			(0.03)	(0.01)	(0.002)	(0.01)
	SCHIP*%costs	-0.383**	0.148	0.054	0.87	0.79	0.091	0.058	0.011	0.055
		(0.19)	(0.15)	(0.03)			(0.15)	(0.08)	(0.01)	(0.04)
All interactions	Medicaid	0.094***	-0.023	0.004	0.36	0.26	-0.02	-0.002	0.004	0.001
		(0.03)	(0.03)	(0.01)			(0.03)	(0.02)	(0.002)	(0.01)
	SCHIP	0.015	-0.01	0.018	0.54	0.43	0.02	-0.03	0.003	0.016
		(0.03)	(0.04)	(0.01)			(0.03)	(0.02)	(0.003)	(0.01)
	SCHIP*%costs	-0.233	0.285	-0.005	0.54	0.42	0.179	0.106	0.01	-0.019
		(0.18)	(0.28)	(0.06)			(0.25)	(0.12)	(0.01)	(0.06)
Family eligibility										
Baseline	Medicaid	0.154***	-0.088***	0.027**	0.64	0.57	-0.085***	-0.003	0.003	0.026*
		(0.04)	(0.03)	(0.01)			(0.03)	(0.02)	(0.002)	(0.01)
	SCHIP	0.072	-0.015	0.01	0.30	0.21	0.006	-0.021	0.005	0.005
		(0.06)	(0.05)	(0.01)			(0.05)	(0.02)	(0.003)	(0.01)
	SCHIP*%costs	-0.838**	0.182	0.102	0.80	0.09	-0.073	0.256*	0.02	0.104
		(0.33)	(0.22)	(0.08)			(0.22)	(0.14)	(0.02)	(0.08)
All interactions	Medicaid	0.222***	-0.168***	0.027	0.66	0.59	-0.156***	-0.012	0.004	0.025
		(0.06)	(0.05)	(0.02)			(0.06)	(0.02)	(0.004)	(0.02)
	SCHIP	0.034	0.011	0.013	0.61	0.53	0.023	-0.012	0.0004	0.012
		(0.06)	(0.05)	(0.02)			(0.06)	(0.02)	(0.01)	(0.02)
	SCHIP*%costs	-0.635	-0.122	0.132	0.62	0.54	-0.572**	0.449***	0.02	0.123
		(0.50)	(0.27)	(0.15)			(0.27)	(0.16)	(0.03)	(0.15)

Notes: Standard errors are in parentheses. Each set of estimates (Medicaid, SCHIP and SCHIP*%costs) is from a separate regression. * indicates statistical significance at the 10% level; ** indicates significance at the 5% level; and *** indicates significance at the 1% level. Number of observations is 405,389. All interactions refer to state*age, state*year and age*year.

EXHIBIT 10

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State Level Special Issue–Part 2

Crowd-Out in the State Children's Health Insurance Program (SCHIP): Incidence, Enrollee Characteristics and Experiences, and Potential Impact on New York's SCHIP

Laura P. Shone, Paula M. Lantz, Andrew W. Dick, Michael E. Chernew, and Peter G. Szilagyi

Background. The extent to which the State Children's Health Insurance Program (SCHIP) crowds our private insurance is poorly understood.
Objective. To assess the incidence of crowd-out and enrollee characteristics associated with crowd-out.
Data. Parent telephone survey for 2,644 children after enrollment in NY SCHIP.
Measures and Analyses. Crowd-out is measured based on enrollee reports of coverage (and loss of coverage) before SCHIP. Multivariate logistic regression is used to relate crowd-out to enrollee characteristics.
Principal Findings. Only 7.1 percent of SCHIP enrollees dropped private coverage $\leq$ 6 months before SCHIP, suggesting relatively modest crowd-out. Crowd-out was associated with some enrollee traits including income, but not with health status.
Implications. Most movement from private to public insurance in NY was not crowd-out. Under current program structure in NY, crowd-out concerns should not dampen enthusiasm for SCHIP.

Key Words. waiting periods, crowd-out, substitution, uninsured children, children's health insurance, state children's health insurance program, SCHIP

The State Children's Health Insurance Program (SCHIP) offers public coverage to eligible children who would otherwise remain uninsured, (Blumberg 2003). Public coverage expansions can displace or "crowd-out" private health insurance if some individuals drop private coverage to enroll in public programs (Davidson, Blewett, and Call 2004).

The incidence of crowd-out is important if public funds support coverage for children who could obtain (private) insurance elsewhere (Alteras

2001). Strategies to deter crowd-out were required in SCHIP. Many states chose waiting periods, which specify a mandatory uninsured gap to qualify for SCHIP (Agency for Healthcare Research and Quality 1998a, b). The regulations for use of waiting periods depend on states' SCHIP models: separate SCHIP, Medicaid expansion, or combination (Rosenbach et al. 2003). At the time of this study in 2000, 37 states had waiting periods averaging 3–6 months and nine were using existing Medicaid provisions, which do not allow waiting periods without approved federal waiver (Centers for Medicare and Medicaid Services 2003). New York was one of only four separate SCHIP or combination program states without waiting periods (National Conference of State Legislatures 2003). In 2006, 35 states had waiting periods, commonly between 3–6 months (Congressional Budget Office 2007).

New York measured and had evidence of minimal crowd-out during the mid-1990s in their SCHIP-precursor program, Child Health Plus. Therefore, it was approved in 1997 as the state's SCHIP plan with continued monitoring, but without a waiting period (Rosenbach et al. 2003). New York's definition of crowd-out as approved in the state plan stipulates that: (1) the last insurance before SCHIP was private; (2) it covered the child within $\leq$ 6 months before SCHIP; and (3) was lost because "cost of [prior insurance] went up or SCHIP is [cheaper] or [better] than [prior insurance]" (Centers for Medicare and Medicaid Services 2003; Rosenbach et al. 2003). Other reasons for coverage change including changes in employment, family (marital) structure, relocation, loss/death of a spouse or parent, or other loss of access to employer benefits, are among the allowable exemptions to waiting periods in other states (Rosenbach et al. 2003), and therefore are not considered crowd-out in New York.

Two terms—"substitution" and "crowd-out"—have been used interchangeably despite important distinctions that have policy implications. "Substitution" describes shifts in aggregate toward public and away from

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private coverage after a public health insurance expansion (Dubay 1999). Some substitution can be explained by life changes such as parent employment or marital status that sever links to private insurance; in contrast, "crowd-out" is one type of substitution that occurs *only* when children who could have private insurance enroll in public coverage instead (Davidson, Blewett, and Call 2004). Crowd-out typically refers to a percentage of total enrollees (Sommers et al. 2006), however, data sources that are commonly used to examine substitution lack the detail needed to make the important distinction between substitution and crowd-out (Dubay 1999; Davidson, Blewett, and Call 2004).

Most substitution estimates use large datasets and rely on complex statistical methods to identify income-eligible children, compare coverage trends, and attempt to determine what share of children might have had private coverage if public options had not expanded (Sommers et al. 2006). These studies have used various data sources, definitions, and methods and have produced various estimates (Dubay 1999; Shone and Szilagyi 2005). Cross-sectional estimates range from <20 to ≥ 50 percent compared with <10 percent from analyses of longitudinal or survey data (Feinberg et al. 2001). These studies provide few explanations for insurance transitions; although limited more by data than method, explanations are essential to understanding the extent and implications of crowd-out in SCHIP (Davidson, Blewett, and Call 2004).

Before the passage of SCHIP in 1997, several states had existing SCHIP-like health insurance programs to provide free or low-cost public coverage to low-income uninsured children whose parents earned too much to qualify for Medicaid. Participant surveys have measured enrollees' health insurance access and coverage before joining some of these programs. These studies reported that: 5 percent of Florida enrollees had private coverage within ≤ 12 months (Shenkman et al. 1999); 7 percent of enrollees in Minnesota dropped private coverage to enroll in a state program (Call et al. 1997); and 4 percent of enrollees in Massachusetts held private coverage before joining a state plan (Feinberg et al. 2001). Following the passage of SCHIP, results from studies of SCHIP programs themselves found that 22 percent of Kansas enrollees had private coverage within ≤ 12 months (Allison et al. 2003), and 8 percent of California enrollees dropped employer-based coverage within 3 months before SCHIP (Hughes, Angeles, and Stilling 2002). In Florida, an estimated 18 percent of enrollees were eligible for an employer-based plan when surveyed after enrollment (Nogle and Shenkman 2004). One multistate study found that 72 percent of enrollees lacked access to private coverage for ≥ 6

months before SCHIP. Of 28 percent who had private coverage during that time, only half lost it for reasons that the authors classified as crowd-out (Sommers et al. 2006). These studies help explain insurance transitions, yet lack detail about enrollee characteristics or experiences.

This study is possible in NY because crowd-out monitoring has occurred since the inception of SCHIP, yet no waiting period deterrent has ever been in place in NY. New York SCHIP policy states that a 6-month waiting period will be considered if the statewide crowd-out incidence averages 8 percent or greater in any consecutive 9-month period (Rosenbach et al. 2003). We report findings from a statewide study of NY's SCHIP that was part of the Children's Health Insurance Research Initiative (CHIRI™). As part of the statewide enrollee interview, we included the crowd-out questions used on NY's application forms for ongoing crowd-out monitoring. Assuming that children who meet criteria for crowd-out could have been subject to a waiting period if one had been in place, our goals were to analyze the incidence of crowd-out using the state's methods in a context that was removed from the application process, and to identify possible disparities in the characteristics of children who could potentially be affected by waiting periods.

OBJECTIVES

With a unique dataset, our objectives were: (1) to assess prior insurance coverage and reasons for loss among enrollees in NY SCHIP; and (2) to estimate the incidence of crowd-out; and (3) to identify associations between crowd-out and enrollee characteristics to identify potential disparities.

METHODS

Sample, Subjects, and Data Collection

Our sampling and data collection methods are described in detail elsewhere (Dick et al. 2002). Using state administrative files to identify new enrollees in SCHIP between November 1, 2000 and March 31, 2001, we generated a random sample of 9,101 unique children (one index child per household), stratified by age group (0–5, 6–11, and 12–18 years) and region of NY (New York City [NYC], NYC Environs, Upstate Urban, and Upstate Rural) based on U.S. Bureau of the Census standard metropolitan statistical areas. The

National Opinion Research Center conducted telephone interviews in English and Spanish between March 15, 2001 and September 15, 2001.

Measures to Assess Crowd-Out used NY State's policy criteria for coverage history before SCHIP (Medicaid, private, none), time since coverage loss, and reasons for loss of prior insurance including: employment or marital status change, employer change in benefit offerings, or parent report that SCHIP was cheaper or offered better benefits than the child's last insurance We used the state's definition that crowd-out occurred when private coverage held within 6 months or less before SCHIP was lost because "the cost of [other] insurance went up and I could not afford it any more," or "SCHIP is cheaper," or "SCHIP has better benefits [than last insurance]" (Rosenbach et al. 2003; Centers for Medicare and Medicaid Services 2003).

Measures of Enrollee Characteristics included child age and race/ethnicity; household income, highest education and employment status of either parent, and other household factors. Child health status measures included diagnosis of asthma (National Heart, Lung, Blood Institute 1997) or chronic health conditions (Child and Adolescent Health Measurement Initiative 2003), overall health status rating, and measures of parental worry about the child's health.

Analyses

We calculated proportions and standard errors to describe health insurance experiences before SCHIP and incidence of crowd-out. We compared proportions and standard errors using χ^2 statistics to examine variation in incidence by key demographic characteristics including child age, race/ethnicity, and health status. We performed multivariate logistic regression to identify significant independent associations between enrollee characteristics and crowd-out status (yes/no). All analyses were performed using the SVY commands in *Stata 10.0* to account for the complex sampling design and generate appropriately weighted statewide estimates (StataCorp 2007).

RESULTS

Of 9,101 index children in the sample frame, we successfully contacted 7,293 (80 percent), and 3,658 (50 percent) of those were eligible for the study. Disposition of 3,658 eligible participants included 957 refusals (26 percent) and 487 other nonresponses due to language barrier or

unavailability (e.g., travel, incarceration) for interview (13 percent). Of 3,658 eligibles, 2,701 gave consent (74 percent), with 2,644 full interviews completed (72 percent).

Time Uninsured, Prior Health Insurance, and Coverage Loss

As shown in Table 1, 62 percent of enrollees were uninsured for a year or more, and a third had never been covered by health insurance before SCHIP. Approximately 48 percent reported private and approximately 44 percent reported Medicaid as the last insurance held before SCHIP.

Table 2 shows reasons for coverage loss among new SCHIP enrollees. The first results column shows the frequency for each reason among those ($n = 738$) who had private insurance within 6 months before SCHIP. Among this group, 25 percent lost coverage for reasons that met the definition of crowd-out (i.e., the cost of insurance went up, SCHIP costs less, or SCHIP has better benefits). However, estimates of crowd-out in SCHIP programs and comparisons of crowd-out across states are typically calculated using all enrollees (as opposed to only those who had private insurance before SCHIP) as the denominator (Allison et al. 2003; Call et al. 1997; Feinberg et al. 2001; Hughes, Angeles, and Stilling 2002; Shenkman et al. 1999). Using this method, the estimate of crowd-out in NY is 7.1 percent (column 2, Table 2). Estimating crowd-out as a percent of total enrollees is consistent with New York's threshold policy indicating that "the State will impose a waiting period of

Table 1: Time Uninsured and Source of Prior Health Coverage among New SCHIP Enrollees

	Proportion (SE) ($n = 2,644$)
Uninsured > 12 months before SCHIP*	61.7 (2.4)
Uninsured 6–12 months	4.9 (1.1)
Uninsured < 6 months	33.3 (3.8)
Last insurance held before SCHIP	
Private	47.5 (3.1)
Medicaid†	43.9 (3.2)
Other (e.g., Military; CHAMPUS; TRICARE, etc.)	9.3 (2.6)

*Includes 33.5% that were never insured in child's lifetime, plus 28.2% who had prior coverage with an uninsured gap of ≥ 12 months.

†Families could move from prior Medicaid to SCHIP if they experience an increase in income (due to employment or marital change and others).

SCHIP, State Children's Health Insurance Program.

Table 2: Reasons for Coverage Loss among New SCHIP Enrollees*

	Private Insurance < 6 Months before SCHIP (n = 738) 27.9 (2.0)	*All Enrollees (n = 2,644) 100 (0.0)*
Reasons for Coverage Loss		
1. Parent lost or changed jobs	55.2 (4.1)	27.8 (2.6)
2. Changed or lost spouse (marital status change or death)	8.9 (1.2)	7.4 (1.3)
3. Employer stopped offering or terminated all health coverage	16.7 (4.5)	7.4 (2.1)
4. Employer stopped offering or terminated child health coverage	6.1 (1.2)	3.1 (1.0)
5. Hassle/too much paperwork	5.1 (1.3)	14.4 (2.1)
6. Other (e.g., relocation, parent disability, dropped by other plan)	11.6 (2.0)	20.4 (2.2)
Crowd-Out† (>1 of 7–9, below, without any other reasons 1–6)		
7. Cost of other insurance went up 8. SCHIP costs less 9. SCHIP has better benefits	25.3 (3.6)	7.1 (1.1)

*Crowd-out in NY includes the "[percent] of total enrollment [that has] dropped employer based health insurance to enroll in [SCHIP]" (Centers for Medicare and Medicaid Services, New York Title XXI Program Fact Sheet, 2007).

†Percentages do not sum to 100 because respondents could give more than one reason.

SCHIP, State Children's Health Insurance Program.

uninsurance if the State finds that greater than 8 percent of total enrollment has dropped employer based health insurance to enroll in [SCHIP]" (Centers for Medicare and Medicaid Services, New York Title XXI Program Fact Sheet 2007).

Parental job change or loss was the dominant reason for coverage loss, affecting nearly a third of all enrollees (Table 2). In addition, 10 percent of all enrollees lost prior coverage because an employer terminated health coverage options—either altogether (7 percent) or just for children (3 percent) (Table 2). Such reasons have been classified as involuntary coverage loss (Sommers et al. 2006). In contrast, parents of 7.1 percent of enrollees reported one or more reasons that meet the definition of crowd-out as the reason for loss of private coverage within the 6 months before SCHIP enrollment. These reasons include: (1) "the cost of [other] insurance went up and I could not afford it any more," (2) "SCHIP is cheaper," or (3) "SCHIP has better benefits [than last insurance]." Any report of one or more of these reasons without report of any other reason was classified as crowd-out.

Crowd-Out and Enrollee Characteristics (Table 3)

Crowd-out was greatest among children who were white or above the lowest income tier; whose parents went beyond high school or graduated from college; whose parents were working full-time; and whose mothers were born in the United States (Table 3). Crowd-out was lower among parents who worried more about their child's health or felt that their child was less healthy than other children. Crowd-out did not vary significantly by child age group, residence with a single parent, parent perception of overall health status, or presence of a chronic health problem or asthma.

We performed multivariate analyses to identify potential disparities in the characteristics of children who have increased odds of crowd-out and thus might be subject to waiting periods (Table 3). Our multivariate results confirm our bivariate results for all except parental worry about the child. Adjusting for covariates, children had significantly greater odds of crowd-out if they were: age 3–5 years; perceived by parents as not being any "less healthy than other children"; living with parents who had education beyond high school or were working full-time, or children of US-born mothers. Hispanic children had significantly lower odds of crowd-out. Importantly, even after adjusting for covariates, there were no significant differences in crowd-out by overall health status, report of prior serious illness, or presence of special health needs (CSHCN) or asthma.

DISCUSSION

This study examined crowd-out in SCHIP in ways that have not been possible historically. Our results provide new insights regarding how crowd-out might affect SCHIP programs, the potential effects of waiting periods on children who could be subject to them, and how to measure crowd-out.

Twenty-eight percent of enrollees lost private insurance in the 6 months before entering SCHIP. After accounting for coverage change that is not crowd-out (job change, family/marital status change, relocation, etc), only 7.1 percent of enrollees had reasons for enrolling in SCHIP that were classified by NY as crowd-out. This classification scheme and both resulting percentages are nearly identical to that reported in a 10-state study (Sommers et al. 2006). This level of individual detail about reasons for coverage change is unusual, yet is essential to distinguish children that could have private insurance elsewhere from children who lack options and could otherwise be uninsured—the target population of SCHIP (Balanced Budget Act 1997).

Table 3: Incidence of Crowd-Out and Odds of Crowd-Out (Risk for Waiting Period) by Enrollee Characteristics

Measure	*Values*	*Bivariate Crowd-Out % (SE) p-value*	*Multivariate* Odds of Crowd-Out OR (95% CI), p-value*
Overall crowd-out incidence		7.1 (1.1)	
Child age at SCHIP enrollment	1 year	5.9 (1.5)	1.3 (0.6–2.6), $p = .46$
	2 years	3.8 (1.3)	0.9 (0.4–2.1), $p = .80$
	3–5 years	9.2 (1.4)	1.8 (1.1–3.0), $p = .03$
	6–11 years	9.2 (3.1)	2.1 (1.0–4.4), $p = .06$
	12–18 years	4.0 (0.7), $p = .10$	1.0
Child race/ethnicity[†]	Black, non-Hispanic	8.6 (2.9)	1.1 (0.6–1.9), $p = .72$
	Hispanic	1.8 (0.5)	0.9 (0.8–0.96), $p < .001$
	White, non-Hispanic	14.4 (2.3), $p < .001$	1.0
Income as percent of federal poverty level	≥ 223%	12.6 (3.1)	0.9 (0.4–1.9), $p = .80$
	160–222%	13.3 (4.1)	1.6 (0.9–2.8), $p = .10$
	<160%	5.6 (1.2), $p = .012$	1.0
Single parent	Yes	(2.0)	1.7 (0.9–3.2), $p = .14$
Household	No	6.3 (0.8), $p = .49$	1.0
Highest education level of any parent in household	≥ College graduation	(3.3)	4.1 (1.4–12.0), $p = .01$
	> High school	(3.7)	3.2 (1.0–9.9), $p = .05$
	= High school	(0.8)	1.4 (0.5–3.6), $p = .54$
	< High school	1.3 (0.5), $p < .001$	1.0
Maximum level of employment of any parent in household	Working full-time	10.4 (1.7)	4.9 (1.3–18.5), $p = .02$
	Working part-time	1.2 (0.5)	0.4 (0.1–2.3), $p = .31$
	Not working	1.6 (0.5), $p < .001$	1.0
Child's mother[‡] born in United States	Yes	(2.1)	2.3 (1.0–5.4), $p = .05$
	No	3.1 (1.1), $p < .001$	1.0
Worry more about child's health [§]	No	(1.9)	0.8 (0.4–2.0), $p = .68$
	Yes	4.2 (1.2), $P = .005$	1.0

Table 3. *Continued*

Measure	*Values*	*Bivariate Crowd-Out % (SE) p-value*	*Multivariate* Odds of Crowd-Out OR (95% CI), p-value*
Child is less healthy than other children[§]	No	(1.2)	3.6 (1.3–9.8), $p = .01$
	Yes	1.4 (0.6), $p < .001$	1.0
Child has never been seriously ill[§]	Yes	7.5 (1.4)	0.7 (0.4–1.2), $p = .15$
	No	6.1 (1.7), $p = .550$	1.0
Child overall health status	Excellent/good	7.6 (1.2)	1.4 (0.5–4.0), $p = .57$
	Fair/poor	3.1 (1.3), $p = .042$	1.0
Child has special health need (CSHCN)	Yes	6.6 (2.4)	1.0 (0.5–2.0), $p = .95$
	No	7.2 (1.2), $p = .843$	1.0
Child has asthma	Yes	10.2 (3.1)	1.6 (0.8–3.2), $p = .22$
	No	6.5 (1.2), $p = .205$	1.0

*Model adjusted for all characteristics shown in the table.

[†]Results weighted to be representative statewide for the population of white, black, and Hispanic children newly enrolled in SCHIP between November 1, 2000 and March 31, 2001. Three-quarters of new enrollees were members of racial/ethnic minority groups (21% non-Hispanic white, 24% non-Hispanic black, 36% Hispanic, and 19% other).

[‡]>95% of respondents were the child's biological mother.

[§]Variable and response terms are worded as asked using nationally validated General Health Subscale of the Child Health Questionnaire (CHQ) (Landgraf, Abaetz, and Ware, 1996).

[¶]>95% of respondents were the child's biological mother.

SCHIP, State Children's Health Insurance Program.

It would be concerning if the group that could be affected by waiting periods disproportionately comprised children with poorer health status or those from racial/ethnic minority groups. Instead, we found that the mix of children who could be affected by waiting periods if they were to be implemented resembles the overall mix of SCHIP enrollees (Brach et al. 2003). More crowd-out occurred among white children at higher levels of income, parent education, or employment. Though not statistically significant, this population of children included clinically significant prevalence of chronic health care needs (7 percent) and asthma (10 percent). From a policy perspective, both require access to regular medical care (Rosenbaum and Budetti 2003). The primary concern about waiting periods is that they can harm children by enforcing or prolonging gaps in insurance coverage (Glied 2002; Ku and Ross 2002; Olson, Tang, and Newacheck 2005). Uninsured children have experienced health complications while waiting for SCHIP coverage (Silberman et al. 2003). Thus, an increased prevalence of waiting periods among those with chronic health care needs could have clinical ramifications for children who have ambulatory-sensitive conditions such as asthma (Satchell and Pati 2005).

The potential value of a waiting period to deter crowd-out depends on the methods used for defining and monitoring crowd-out. New York does not have a waiting period, but they do have detailed monitoring information that distinguishes between coverage loss that may be preventable and coverage loss that probably is not. This difference is visible in New York. Although nearly 30 percent of new enrollees moved from private to public coverage within the 6-month period before enrolling in SCHIP, most lost private coverage for reasons other than crowd-out, whereas only 7 percent chose SCHIP because it was "cheaper or better" than the child's prior private coverage. Some portion of the latter may have been preventable; however, it is unlikely that all reasons for the loss of private coverage before enrolling in SCHIP could have been prevented or deterred with a waiting period in place. The value of waiting periods may be that they provide incentives to parents to keep rather than drop private coverage. Nonetheless, waiting periods will not deter families who lose coverage for reasons beyond their control from enrolling in SCHIP. Policies for measuring and monitoring crowd-out must include detail similar to the New York study to ensure that children who have lost coverage for reasons other than true crowd-out are not subject to potentially harmful gaps in insurance coverage.

LIMITATIONS

This study examines a sample of children who were: successfully enrolled in NY's SCHIP; new enrollees versus longer-term enrollees; white, black, or Hispanic; whose parents spoke either English or Spanish; and whom we were able to locate and interview, and cannot be generalized more broadly. Our study involved a longitudinal pre–post study of new enrollees during the year before and year during SCHIP. We did not sample longer-term enrollees, and results over longer periods may vary.

We used instruments and measures that were nationally validated for self-report of health care and insurance information, however, limitations of self-report apply.

Our study cannot determine the counterfactual. There is no way to know what parents would have done if waiting periods had been in place or if SCHIP did not exist. This is a challenge in measuring crowd-out and waiting periods alike, because most studies rely on sources that lack individual-level data (Davidson, Blewett, and Call 2004), or because it is not possible to identify and sample families who have already done something else. We cannot distinguish those who, under different circumstances, may have kept existing coverage, obtained other coverage, or remained uninsured.

Although our results provide new information about prior health insurance, enrollee characteristics and health experiences in conjunction with crowd-out, these results may differ under different SCHIP eligibility criteria. Further studies to address these questions are needed.

CONCLUSIONS AND POLICY IMPLICATIONS

After accounting for private coverage loss that is not crowd-out, only 7 percent of enrollees had reasons for enrolling in SCHIP that were classified by NY as crowd-out. Some persons who lose private insurance have private coverage alternatives, whereas others lack those options. The SCHIP target population includes the latter. This group is dynamic, and the profile of characteristics and experiences of uninsured children will evolve as unraveling of private coverage progresses up the income scale (Strom 2003).

Our analyses of enrollee characteristics may offer insight to states in considering waiting period policies in terms of better understanding the different reasons for coverage change. The variety of policy options available to balance increasing public coverage need with limited fiscal resources

suggests that variation in states' waiting period policies may continue. It is therefore essential to monitor individual characteristics and experiences to understand specific reasons for movement from private to public coverage and to distinguish preventable movement from other market forces. New research should examine the effects of state policy decisions about SCHIP eligibility, crowd-out, exclusions, and waiting periods as policies evolve.

Although measurement of crowd-out is confounded in states where deterrents already exist, results in other states could be similar to our results in NY. A study in 10 states including NY found the same degree of overall movement from private to public coverage within the 6 months before SCHIP (just under 30 percent). After classifying reasons for coverage change, they found the same smaller proportion of 7 percent crowd-out. Results could also vary across states and over time with market changes and secular trend. Our results demonstrate that ongoing detailed monitoring is important in distinguishing crowd-out from these other factors in movement from private to public coverage.

Crowd-out in NY could represent an upper bound relative to other states, because NY has one of the higher income-eligibility thresholds and does not have a waiting period deterrent in place. Then again, because income thresholds in NY reflect, in part, the higher cost of living in NY, our results could be on par with other states after accounting for other market differences in access to and costs of creditable private coverage. Ongoing detailed measurement of individual reasons for coverage change are essential to answer this question.

Monitoring is essential for implementation of waiting periods, and detailed monitoring may improve the precision of how waiting period policies are applied. Monitoring in NY, via the application form, is institutionalized part of the application process at little to no added cost. States with waiting periods use various procedures to verify other coverage, ranging from individual contact to cross-linkage of administrative data (Rosenbach et al. 2003). These procedures would add to the costs and time needed to process applications if implemented in NY.

Our results have implications for both state and federal policy makers. Several states have proposed increases in income eligibility levels, raising questions about possible crowd-out, and crowd-out emerged as the major point of contention in federal SCHIP reauthorization. Our results add to understanding of the range of estimates, emphasize the role of monitoring and importance of measurement methods, and illustrate some distinctions that

are possible and necessary to understand the incidence of crowd-out and the potential role and impact of waiting periods in SCHIP policy.

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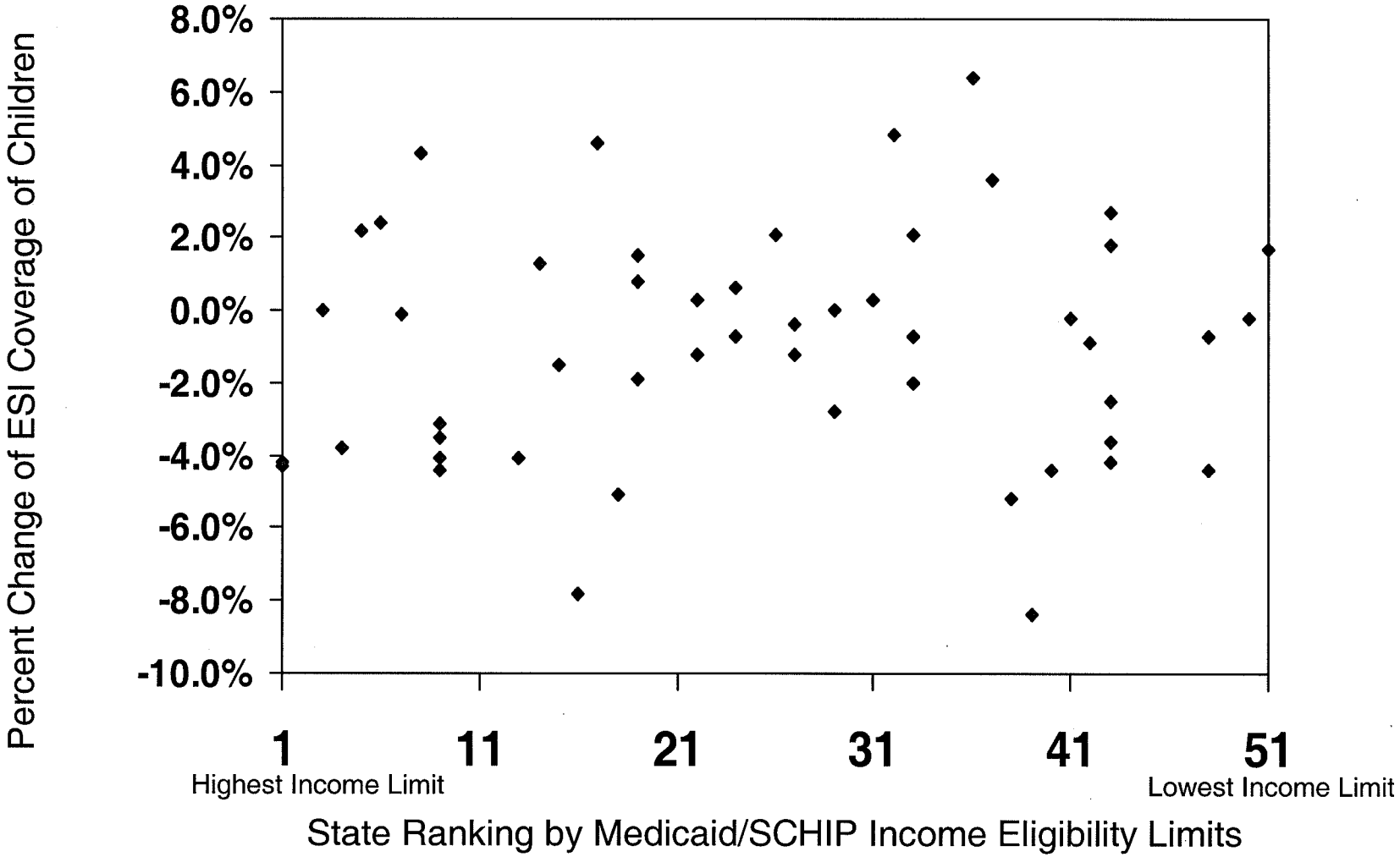
EXHIBIT 11

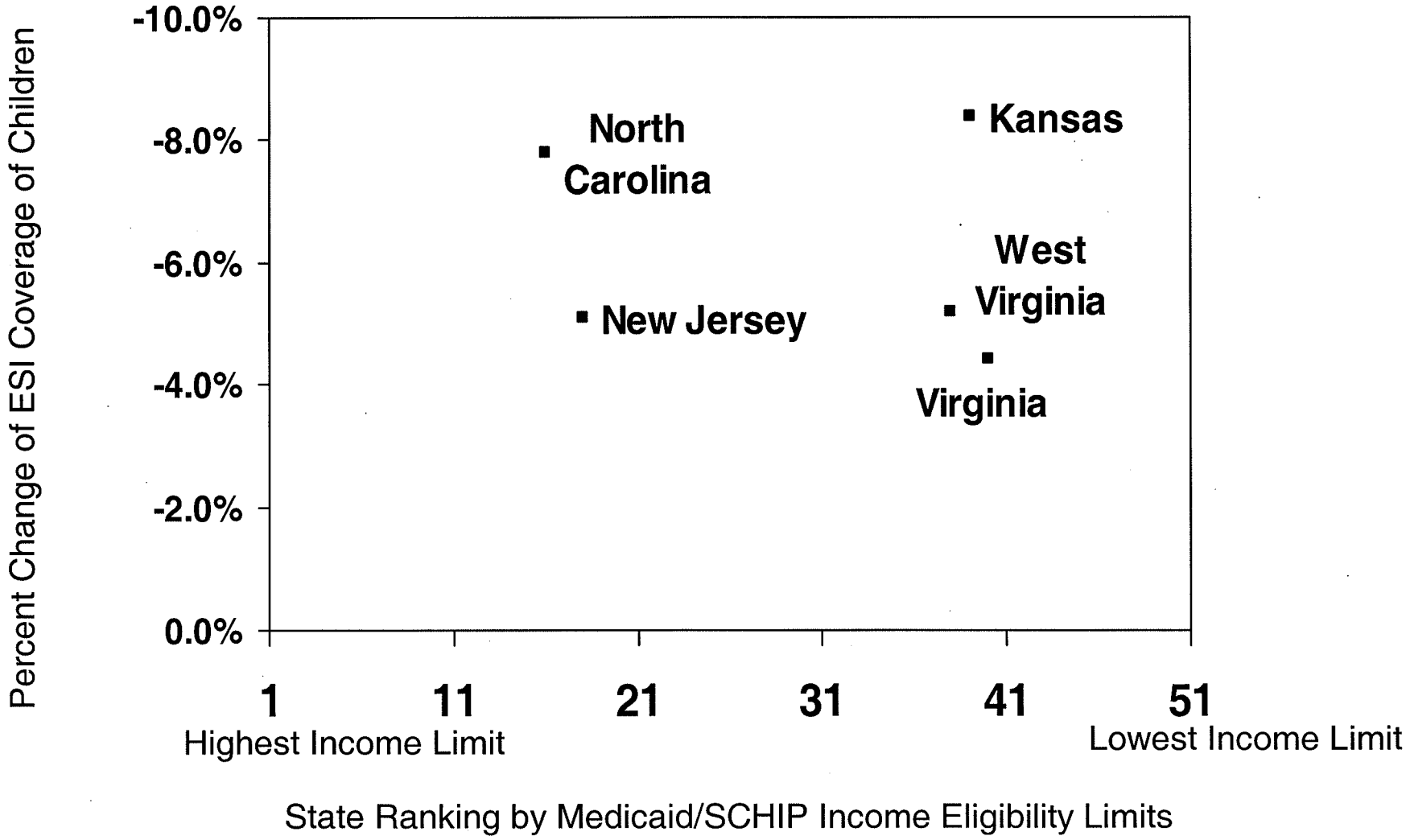
Relationship Between Percent Change of Children Covered by Employer Sponsored Insurance by State and State Medicaid/SCHIP Income Eligibility Limits 2004-2006



Each slide in Exhibit __ illustrates the change in the number of children covered by employer sponsored insurance in each State, including the District of Columbia, and the income eligibility limit for each State's SCHIP/Medicaid programs. On the x-axis States are ranked by their SCHIP/Medicaid income eligibility limits from the State that caps eligibility at highest income level to the State that caps eligibility at the lowest income level. The y-axis lists the corresponding percentage change in the number of children covered by ESI in each State. This scatterplot diagram shows that there is clear no relationship between income eligibility limits and changes in the level of ESI coverage among children. No statistically significant relationship between change in ESI coverage and state eligibility levels was found.

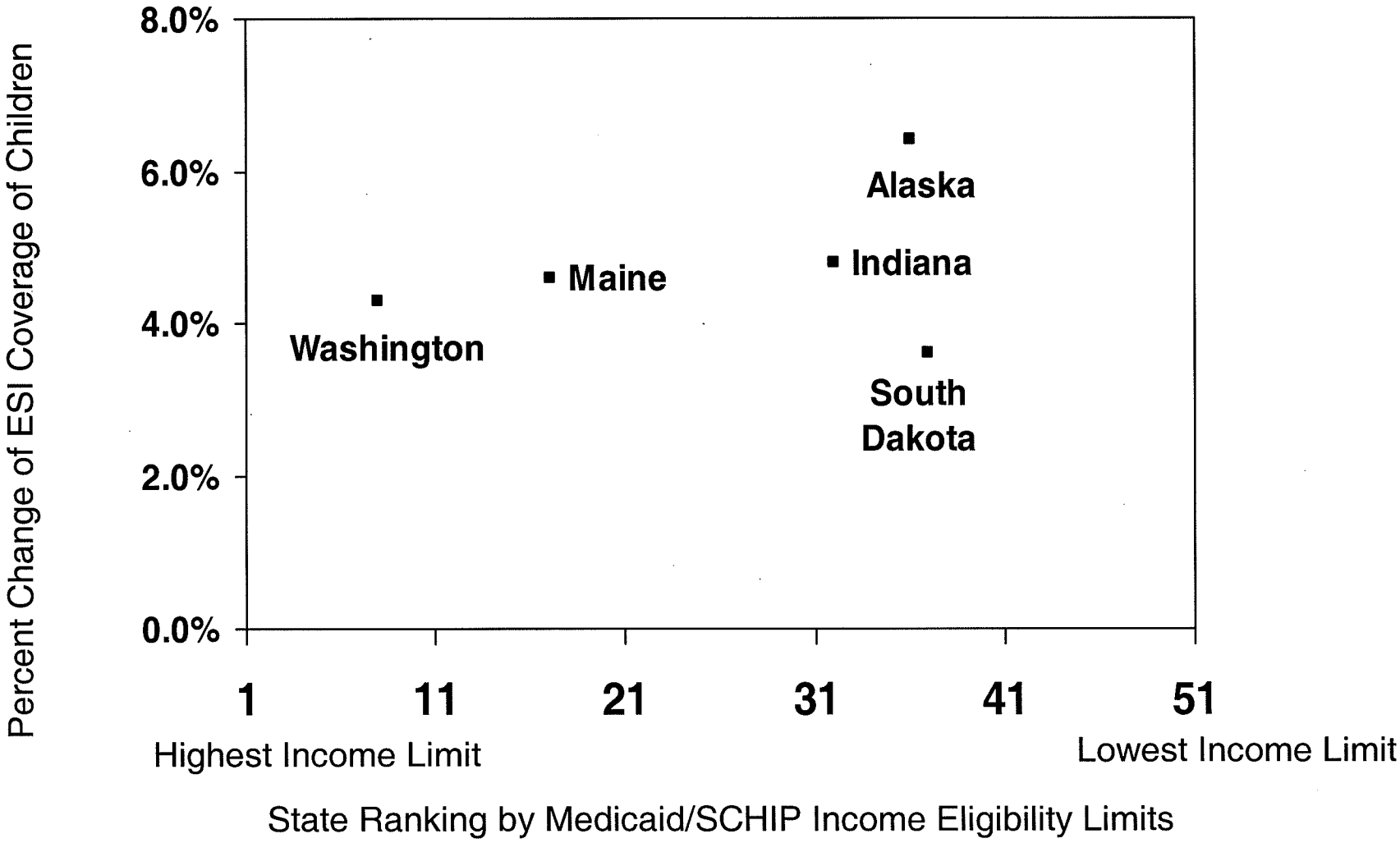
Source: Data and rankings obtained from statehealthfacts.org. Analysis conducted by GWU Department of Health Policy

Three of Five States with the Greatest Declines in Percent of Children Covered by Employer Sponsored Insurance Also Capped Medicaid/SCHIP Eligibility at the Lowest Income Levels 2004-2006



Source: Data and rankings obtained from statehealthfacts.org. Analysis conducted by GWU Department of Health Policy.

Two of Five States with the Greatest Increase in Percent of Children Covered by Employer Sponsored Insurance Also Had Generous Medicaid/SCHIP Income Eligibility Criteria 2004-2006



Source: Data and rankings obtained from statehealthfacts.org. Analysis conducted by GWU Department of Health Policy

Methodology: The state rankings by Medicaid/SCHIP income eligibility limits and percent changes in ESI coverage of children for Exhibits __ to __ were created using income eligibility and ESI data from the period 2004 – 2006 complied by Statehealthfact.org data. The data divides the population of children covered by public health insurance into 4 subsets: (i) Medicaid for Infants; (ii) Medicaid for Age 1-5; (iii) Medicaid for Age 6-18; and (iv) Separate SCHIP Eligibility. Income eligibility levels for each population subset vary among states. States were ranked for each population subset. These rankings were then averaged to create a composite ranking. States which incorporate their SCHIP program into Medicaid had their SCHIP Eligibility ranking omitted, and their composite ranking was composed of only the Medicaid income eligibility rankings.

EXHIBIT 12

TRENDS

Why Employer-Sponsored Insurance Coverage Changed, 1997–2003

Job quality plays a major role in workers' access to employer coverage and the conditions that encourage take-up.

by James D. Reschovsky, Bradley C. Strunk, and Paul Ginsburg

ABSTRACT: Four and a half million Americans gained employer-sponsored health insurance coverage during 1997–2001, while nearly nine million lost coverage in the ensuing economic downturn (2001–2003), after population growth was accounted for. Macroeconomic trends affecting employment, job quality, and incomes drove most of the coverage changes, although key factors varied during the two periods. Take-up rates affected coverage, mostly reflecting the interaction of premium cost trends and labor-market tightness, but take-up also was influenced by the implementation of the State Children's Health Insurance Program (SCHIP) during 1997–2001. Coverage among low-income people was most affected by economic conditions and premium costs. [*Health Affairs* 25, no. 3 (2006): 774-782; 10.1377/hlthaff.25.3.774]

THE CENSUS BUREAU reported in August 2005 that the share of the nonelderly U.S. population covered by employer-sponsored health insurance fell 0.6 percentage points between 2003 and 2004.[1] This decline occurred while the economy was growing, which suggests that the long-noted decline in employer coverage continues, contributing to greater uninsurance and growing burdens on public programs.

Researchers have long identified the state of the economy and the cost of health insurance as major drivers of changes in employer coverage rates.[2] Employment levels fluctuate during business cycles, consequently affecting people's access to coverage. The economy also affects the incomes of working families, which influences take-up rates. Health insurance costs primarily affect take-up rates, although costs can also influence employers' offer and eligibility decisions.

Two other factors have recently received considerable attention. First is the crowding out of private insurance by public insurance, which is accentuated when public insurance eligibility expands or private insurance costs increase.[3] Second are hypothesized structural economic changes that are reducing the average "quality of jobs" by shifting employment from larger to smaller establishments, from industries with traditionally high insurance offer rates to ones with low rates, and in general toward lower-wage jobs.[4]

This paper examines factors driving the job-based insurance rate over two contiguous, but very different, time periods: 1997–2001 and 2001–2003. We estimate that 4.5 million people gained employer coverage during 1997–

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2001, while nearly nine million lost it in the shorter 2001–2003 period, after population gains were accounted for. The first period was characterized by robust economic growth and modest growth in health care premiums; the second period, by a short but sharp recession in 2001 and a slow recovery along with double-digit annual premium increases. Comparing the factors driving changes in employer coverage during these two periods provides insights into the underlying dynamics of employer coverage.

Study Data And Methods

■ **Data source.** Our analysis used the Community Tracking Study (CTS) Household Survey, a large, representative telephone survey of the civilian population in the contiguous forty-eight states that covers a broad array of health-related topics. We used Rounds One, Three, and Four of the survey, conducted in 1996–97, 2000–01, and 2003, respectively. Response rates ranged from 59 percent to 65 percent. For simplicity, we refer to the periods defined by the three surveys as covering 1997–2001 and 2001–2003. All analyses used survey weights, and standard errors account for complex survey design. Our unit of analysis was nonelderly people, providing sample sizes for the three CTS rounds of 53,268, 51,676, and 39,262, respectively.

■ **Analysis.** We used a shift-share analysis to decompose changes in the coverage rate over time into structural components. We specified an equation explaining the coverage rate as a function of nine factors and then assessed the contribution of each factor to rate changes by, in essence, comparing actual coverage rates with those calculated to have occurred had each factor been individually held constant at its prior time-period value.[5]

■ **Components of coverage.** *Employment, offer, eligibility, and take-up.* As in most previous shift-share analyses of employer coverage rates, we investigated the role of employment rates and conditional offer, employer coverage eligibility, and take-up rates (the product of which equals the job-based coverage rate).[6] Because the option of family coverage is virtually ubiquitous, provided to 99 percent of all workers offered coverage in 2005, employment, offers, and eligibility are all defined in a family context.[7] For instance, if one family adult has an employer coverage offer, all family members are assumed to have access to the offer.

To better characterize how employment affects access to employer coverage, we characterized family employment not as simple rate, but in terms of the percentage of the population in families with two full-time workers, one full-time worker, or part-time workers only.

Job quality. We extended the previous shift-share analyses of employer coverage by adding several additional components. We investigated the hypothesized structural employment changes toward jobs that are less likely to provide health benefits: those in smaller firms, in certain industries, and with lower wages. We combined these various dimensions into a "job-quality" scale. Adding job quality (conditioned on family employment) allowed us to assess whether any changes in offer, eligibility, or take-up rates are attributable to firms' altering their benefit policies as opposed to changes in the mix of jobs in the U.S. economy toward or away from those historically likely to provide any health benefits or health benefits of greater or lesser generosity. To create the job-quality scale, we used a sample of full-time workers from all four rounds of the CTS survey (N = 82,090) and regressed the likelihood that their job carried health benefits on interactions between six employer-size variables, fourteen industry and government categories, and four wage categories. Predicted values were then divided into eight equal-size groups and assigned to working families. In families with multiple workers, the best-quality job is assigned.[8]

Family income and SCHIP eligibility. We also included two components that are related to the likelihood of taking up employer coverage; this allowed us to better isolate the role of insurance costs on take-up. We accounted for changes over time in the distribution of family incomes among those with access to job-based coverage. Because we already controlled for family employment and job quality, changes in the distribution of family incomes (expressed

as a percentage of the federal poverty level, in five categories) are the result of changes in real wages, hours worked, and the quality of secondary jobs. We further accounted for the major expansion in eligibility for public insurance among low-income children resulting from the State Children's Health Insurance Program (SCHIP) of 1997, which might have motivated some to substitute public for private coverage ("crowding out").[9]

Nonworking and self-employed families. Finally, some nonworking and self-employed families retain coverage from former employers through the Consolidated Omnibus Budget Reconciliation Act (COBRA) or as a retiree benefit. Consequently, the final two components represent shifts in the coverage rates of these two groups.

Altogether, we examined nine components: family employment; quality of best job in the family; insurance offer rate; insurance eligibility rate; family income; SCHIP eligibility rate; take-up rate; coverage rate among people in nonworking families; and coverage rate among people in self-employed families. With the exception of the last two components, each is conditioned on those preceding it.[10]

Study Results

■ **Employer-sponsored coverage rates.** The percentage of the nonelderly population covered by job-based health insurance rose 1.9 percentage points during 1997–2001, while it fell 3.6 percentage points in the second and shorter period, 2001–2003 (Exhibit 1). Family

EXHIBIT 1
Trends In The Rate Of Employer-Sponsored Insurance (ESI) And Factors Contributing To It, Selected Years 1997–2003

				Change over time[a]	
Decomposition component	**1997**	**2001**	**2003**	**1997–2001**	**2001–2003**
ESI rate	65.1%	67.0%	63.4%	1.9**	-3.6**
Family workforce participation					
2 full-time workers	22.4	21.8	18.7	-0.6	-3.1**
1 full-time worker	52.7	53.2	52.7	0.6	-0.5
Part-time workers only	6.1	6.1	7.1	0.0	1.0**
Self-employed	2.8	2.8	2.6	0.0	-0.3
No workers	16.0	16.1	19.0	0.1	2.9**
Job quality (people in working families)					
Best (categories 1 & 2)	32.6	32.9	30.5	0.3	-2.4**
Good (categories 3 & 4)	27.8	28.7	27.7	0.9	-1.0
Fair (categories 5 & 6)	21.9	21.1	21.9	-0.8	0.8
Poor (categories 7 & 8)	17.7	17.3	19.9	-0.4	2.6**
Offer rate	88.0	88.9	86.7	1.0**	-2.2**
Eligibility rate	95.1	95.4	95.7	0.3	0.3
Income as percent of poverty (people in families with ESI access)					
<100 percent	7.4	5.8	5.7	-1.6**	-0.1
100–149 percent	8.7	7.1	6.9	-1.6**	-0.2
150–199 percent	10.2	8.0	8.8	-2.2**	0.8
200–299 percent	19.3	19.8	19.2	0.4	-0.6
300+ percent	54.3	59.3	59.5	5.0**	0.2
Have children, eligible for public insurance	4.0	9.9	9.8	5.8**	-0.0
Take-up rate	88.8	89.3	87.9	0.5	-1.5**
ESI rate in self-employed families	21.6	23.8	20.4	2.2	-3.4
ESI rate in nonworking families	26.1	30.5	30.0	4.4**	-0.4

SOURCE: Community Tracking Survey, 1996–1997, 2000–2001, and 2003.
[a] Percentage points.
**$p \leq .05$

employment changed little in the earlier period. Between 2001 and 2003, however, there was a sizable reduction in employment, most notably indicated by a 3.1-percentage-point decline in the proportion of people in families with two full-time workers and a 2.9-percentage-point gain in the proportion in families with no workers.

Job quality changed little in the late 1990s but declined in the later period. For instance, during 2001–2003 the number of people in regular working families with jobs in the two highest job-quality categories declined about 2.5 percentage points, while the number with jobs no better than the two lowest job-quality categories rose an equivalent amount. Offer rates grew a modest one percentage point during the earlier period but fell 2.2 percentage points over the later period. Incomes among those in families with access to employer coverage grew during 1997–2001 and changed relatively little during 2001–2003. Among those with access to employer coverage, the percentage eligible for children's public insurance coverage through Medicaid or SCHIP more than doubled during 1997–2001 but was unchanged in the later period. Take-up rates grew slightly during the earlier period but fell 1.5 percentage points in the later period. Finally, there was a rapid increase in the percentage of people in nonworking families covered by employer-sponsored insurance over the 1997–2001 period, a trend also found in data from the Current Population Survey (CPS).[11]

■ **Decomposition of coverage changes.** The relative importance of the various factors differed considerably over the two periods, largely reflecting the different economic climates (Exhibit 2).

There was a small decline in coverage during 1997–2001 attributable to employment changes. This masks an increase in coverage attributable to increased employment during 1997–1999 and likely reflects a sharp increase in the unemployment rate during the latter part of the survey's 2000–2001 field period. In contrast, lower family employment accounted for more than half of the decline in employer coverage during 2001–2003, resulting in more than five million people losing coverage, a figure roughly corresponding to the number of people who lost employment during this period, after population growth is accounted for. The number of family workers and their full- or part-time status, rather than whether the family had a worker or not, are key to the likelihood of having job-based coverage. Had we only characterized people as being in working

EXHIBIT 2
Decomposition Of Changes In Employer-Sponsored Insurance (ESI) Coverage, 1997–2001 And 2001–2003

	1997–2001		2001–2003	
Component	Change in ESI rate[a]	Change in population	Change in ESI rate[a]	Change in population
Family workforce participation	−0.1	−261,000	−2.1	−5,122,000
Job quality	0.3	816,000	−1.1	−2,776,000
Offer rate	0.3	805,000	−0.2	−490,000
ESI eligibility	0.1	278,000	0.5	1,143,000
Income (among those with ESI access)	0.5	1,070,000	0.1	219,000
Child with public coverage eligibility	−0.3	−647,000	−0.01	−20,000
Take-up	0.4	829,000	−0.6	−1,459,000
ESI in self-employed families	0.1	128,000	−0.1	−223,000
ESI in nonworking families	0.6	1,474,000	−0.1	−205,000
Total	1.9	4,492,000	−3.6	−8,935,000

SOURCE: Community Tracking Survey, 1996–1997, 2000–2001, and 2003.
[a] Percentage points.

families versus nonworking or self-employed families, employment effects in the earlier period would have nearly disappeared, and they would have been cut in half during the later period.

■ **Job quality.** Shifts in job quality had sizable effects on coverage rates. However, rather than the secular decline in job quality that some have posited, job quality appears to reflect business cycles.[12] During the period of economic growth in the late 1990s, job quality improved (Exhibit 1), translating into a gain of more than 800,000 people with employer coverage. However, average job quality fell dramatically during 2001–2003 and is associated with a decline of 2.8 million people with job-based coverage. The effect of declining job quality during 2001–2003 would have been even greater had we used the simplified employment variable, which suggests that it was often the best-quality job in families that was lost.

■ **Offer and eligibility rates.** After job quality is controlled for, rising offer rates during 1997–2001 increased the number of workers with employment-based coverage by about 800,000, while about a half-million lost coverage during 2001–2003 because of fewer offers. Somewhat surprisingly, eligibility rates increased during both periods, resulting in increases of roughly 300,000 people in 1997–2001 and 1.1 million in 2001–2003 with job-based coverage. Had we not controlled for shifts in job quality, a greater portion of the change in coverage would have been attributed to offer and eligibility rates.

■ **Income, crowd-out, and take-up.** Not only did the number of people with access to employer coverage increase during the period of economic growth in the late 1990s, but among those with access to employer insurance, incomes rose. Even after family workforce participation and job quality are controlled for, higher real incomes resulted in 1.1 million people taking up employer coverage during 1997–2001, followed by a small increase in 2001–2003.

Growth in public insurance eligibility for children resulted in about 650,000 fewer people taking up coverage between 1997 and 2001. During 2001–2003, however, eligibility rules changed little, and their effect on coverage rates was negligible. After allowing for family incomes and the effect of the SCHIP implementation, we saw take-up rates as increasing employer coverage over the earlier period by more than 800,000 individuals but decreasing coverage over the later period by about 1.5 million. The sizable drop in take-up during the later period is consistent with sharp increases in employee premium cost sharing (particularly for family coverage) and in consumer cost sharing for health care services.[13]

The contribution of higher take-up rates on coverage during 1997–2001 would have been larger had we not accounted for gains in job quality, which indicates that higher-quality jobs provide more-attractive insurance benefits. Similarly, higher family incomes during this period promoted take-up of insurance offers, both directly and by making fewer children eligible for public coverage. Had we accounted for neither family income nor SCHIP eligibility, take-up in the earlier period would have been shown as modestly suppressing employer coverage, consistent with the modest increases in insurance costs. In contrast, controlling for income levels or public insurance eligibility had negligible impacts on the take-up effects in the later period.

■ **Employer coverage among nonworking families.** Consistent with the patterns evident in Exhibit 1, more than a third of the increase in employer coverage during 1997–2001 is attributable to an increase in the percentage of people in nonworking families with job-based coverage. The most likely explanation for this phenomenon is an increase in COBRA coverage. Between 1997 and 2000, COBRA enrollment grew 1.4 million, closely corresponding with our results.[14]

■ **Effects on various socioeconomic groups.** Business cycles and rising health care costs are likely to have their greatest effect on the employer coverage of lower-income workers. Consequently, we replicated our analysis on three predicted income groups. The size and composition of income groups change

during a business cycle. As a result, had we defined the groups based on current income, we could not have distinguished the underlying reasons for changes in coverage from changes in the composition of the subpopulations we were investigating. Therefore, we defined our groups based on predicted (or "permanent") family incomes, based on a model in which family income was regressed on "human capital" variables: age, race, sex, family composition, education, and health status. Income was defined as a percentage of the federal poverty level (less than 200 percent, 200–399 percent, and 400 percent or more), which adjusts for inflation and family composition. The regression used pooled data from all four CTS rounds. Because of smaller sample sizes, public insurance eligibility could not be included as a component of these decompositions.

We classified 19 percent, 39 percent, and 42 percent of the population into categories of predicted low, middle, or high socioeconomic status (SES), representing populations equaling fourty-four, eighty-nine, and ninety-six million people, respectively. Not surprisingly, changes in job-based coverage were felt the most among low- and middle-income groups (Exhibit 3). Gains in job-based coverage during 1997–2001 were 2.3, 2.4, and 1.0 percentage points for the predicted low-, middle-, and high-income groups, respectively. During 2001–2003, the three groups experienced de-

EXHIBIT 3
Decomposition Of Changes In Employer-Sponsored Insurance (ESI) Coverage, By Time Period And Predicted Income, 1997–2001 And 2001–2003

	Predicted low income[a]		Predicted middle income[a]		Predicted high income[a]	
1997–2001	**Change in ESI rate[b]**	**Change in population**	**Change in ESI rate[b]**	**Change in population**	**Change in ESI rate[b]**	**Change in population**
Family workforce participation	0.6	289,000	0.2	182,000	−0.5	−535,000
Job quality	−0.2	−94,000	0.3	310,000	0.4	466,000
Offer rate	0.5	237,000	0.4	410,000	0.0	40,000
ESI eligibility	0.5	260,000	0.2	150,000	−0.2	−179,000
Income (among those with ESI access)	1.0	478,000	0.6	608,000	0.2	246,000
Take-up	−0.7	−346,000	0.2	187,000	0.5	539,000
ESI in self-employed families	0.1	37,000	0.2	168,000	−0.1	−137,000
ESI in nonworking families	0.5	248,000	0.3	269,000	0.6	659,000
Total	2.3	1,110,000	2.4	2,283,000	1.0	1,099,000
2001–2003						
Family workforce participation	−2.9	−1,438,000	−2.1	−1,992,000	−0.5	−491,000
Job quality	−1.7	−817,000	−1.7	−1,649,000	−0.8	−873,000
Offer rate	−1.2	−606,000	−0.2	−224,000	0.3	353,000
ESI eligibility	0.4	203,000	0.5	478,000	0.2	188,000
Income (among those with ESI access)	1.0	473,000	−0.4	−409,000	0.1	142,000
Take-up	−0.7	−327,000	−1.1	−1,034,000	−0.4	−401,000
ESI in self-employed families	−0.2	−121,000	−0.1	−78,000	0.0	−23,000
ESI in nonworking families	0.5	237,000	−0.1	−142,000	−0.4	−381,000
Total	−4.9	−2,397,000	−5.8	−5,050,000	−1.3	−1,487,000

SOURCE: Community Tracking Survey, 1996–1997, 2000–2001, and 2003.

[a] Predicted income was based on a regression in which the log of family income as a percentage of the federal poverty level was regressed on family composition, education of family head and spouse (if any), age and sex of family head, health of family head and spouse, race/ethnicity of family head, and number of children. "Low income" includes those whose predicted incomes fall below 200 percent of poverty; "middle income" includes those at 200–399 percent; and "high income" includes those with incomes of 400 percent or higher.

[b] Percentage points.

clines of 4.9, 5.8, and 1.3 percentage points, respectively, in their coverage rates.

Impact of economic changes. Macroeconomic changes affected the workforce participation of lower-income groups the most, in terms of both increasing their employer coverage during 1997–2001 and decreasing it during the economic downturn of 2001–2003. For instance, 2.9 percent of the predicted low-income group lost coverage because of lower workforce participation in the later period. Surprisingly, the highest-income group had declines in coverage associated with family employment of about 0.5 percent during both periods.

Impact of job quality. During the earlier period, both middle- and higher-income groups gained coverage because of improved job quality, while the low-income group experienced a small decline. The economic downturn during 2001–2003 likely contributed to reductions in job quality for all income groups, accounting for a 1.7-percentage-point reduction in the coverage rate for those in the low- and middle-income groups and a 0.8-percentage-point loss among those in the highest-income group. Although the percentage-point decline in the highest-income group was the smallest, job quality figured as the most important factor for this group, contributing to nearly 900,000 high-income people losing employer-sponsored coverage.

During the earlier period, income growth among those with access to employer coverage had its greatest effect in rising coverage among lower-income people. This is not surprising, since the take-up rate among higher-income people was already well above 90 percent. Yet coverage rates among low-income people fell because of lower take-up, after income is controlled for.

Effects of cost sharing and take-up. Although increases in average worker contributions to premiums and cost sharing for health care services were modest during 1997–2001, low-wage workers were most affected.[15] During the later period, all income groups lost coverage because of lower take-up, with the greatest effect among middle-income people, accounting for more than one percentage point of their 5.8-percentage-point decline in coverage. Even among high-income people, lower take-up accounted for 0.4 points of their 1.3-percentage-point decline in coverage.

Summary And Discussion

■ **Business cycles and other drivers of change.** Many interrelated factors influence employer-sponsored health insurance rates. Foremost, business cycles are important drivers of short-term trends in employer coverage. These operate primarily through workforce participation but secondarily through the average quality of jobs and family incomes. Higher-quality jobs are more likely to provide both access to employer-sponsored coverage and conditions that encourage insurance take-up: higher wages, lower employee cost sharing, and more generous plan benefits.

During the economic boom years of 1997–2001, the gain in employer coverage was moderated by dramatic expansions in public insurance eligibility for children as a result of SCHIP. Although crowding out can occur through other, less direct mechanisms, the effect on take-up is likely to be the most important component. Yet the estimated loss of coverage (–667,000 workers) over the two periods is quite modest compared with the 3.7 million children enrolled in SCHIP and Medicaid expansion programs by 2003.[16]

After workforce participation, job quality, family incomes, and SCHIP eligibility are controlled for, we would expect take-up rates to follow trends in health insurance premiums and benefit packages. Indeed, we found a sharp drop-off during 2001–2003, when a portion of double-digit premium increases were shifted to workers in the form of greater premium cost sharing and benefit buy-downs. Although premiums grew at a modest rate during the late 1990s, we found that take-up increased. This suggests that benefit packages and hence take-up are influenced by the interaction of both underlying costs and the tightness of the labor market.

Lower- and middle-income workers are most susceptible to business cycles. They en-

joyed the greatest gain in coverage rates in the late 1990s but also suffered the greatest decline in coverage in 2001–2003. Lower-income workers are also the most susceptible to cost pressures on the system. They alone lost coverage because of lower take-up during the late 1990s when cost pressures were modest.

■ **Future trends.** What do the results portend for the future? Although the improving economy foreshadows gains in the number of people with employer-sponsored insurance, the recent Census Bureau numbers suggest that other forces could continue to weaken the employer coverage system over the long term. Most important and well established is that health care costs grow faster than wages, a trend largely driven by improvements in health care technology.[17] Although this trend briefly reversed itself in the mid-1990s at the height of managed care's influence, there are few technical, market, or policy tools on the horizon likely to reverse it anytime soon.[18] Increasing health care costs will likely continue to depress take-up rates and, for firms that employ mostly low-wage workers, perhaps offer and eligibility rates as well. Although higher-wage workers are likely to see the effect in the form of lower wages and less generous health benefits, low-income workers are the most likely to lose employer-sponsored coverage altogether.

The second long-term trend concerns the decline in job quality. Whether or not such a decline actually exists is in dispute.[19] Although our research suggests that job quality is an important driver of employer coverage, we also found that coverage is responsive to business cycles. Our data series, which covers a single business cycle, is too short to establish whether a long-term trend exists.

Finally, the strong association between macroeconomic trends and employer coverage suggests that publicly sponsored health insurance programs have an important countercyclical role. Most of the decline in employer coverage between 2001 and 2003 was offset by increases in public coverage through a combination of automatic stabilizers (job loss makes some eligible) and policy changes.[20] Policymakers should keep this in mind as they grapple with Medicaid and SCHIP's severe budgetary strains.

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5. The equation consisted of three additive components, comprising the coverage rate for people in regular working families, nonworking families, and families with only self-employed workers, weighted by population shares. The first component, accounting for roughly 80 percent of the nonelderly population, is further specified as the product of conditional offer, eligibility, and take-up rates in 240 subgroups defined by three family employment, eight job quality, five family income, and two child public insurance eligibility categories, which is aggregated by weighting

each subgroup by its share of the population. The contribution of these last four factors to coverage rate changes was assessed by manipulating their population shares. A covariance term is also part of the equation. We suppressed it by ratio adjusting other results because it is always small and not interpretable.

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8. Although families with better-quality jobs will tend to have higher incomes, the measure is independent of secular income trends or changes in the tendency of specific types of jobs to carry health benefits. This is because the regression uses pooled data, and wages are normalized by the Bureau of Labor Statistics (BLS) employer wage index.
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
TRENTON VICINAGE

STATE OF NEW JERSEY, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant.	HON. JOEL A. PISANO, U.S.D.J. Civ. Action No. 07-04698 (JAP)(JJH) **CERTIFICATE OF SERVICE**

I, KENNETH D. FRIEDMAN, hereby certify that, on April 4, 2008, I caused a true and correct copy of the Brief of Amici Curiae in Support of Plaintiff's Motion for Partial Summary Judgment with accompanying exhibits to be served via the CM/ECF System for the United States District Court, District of New Jersey upon the following persons at the last known addresses:

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