CMS August 17th Directive Fact Sheet

Overview

Issued by the Centers for Medicare and Medicaid Service (CMS) on August 17, 2007 (with a May 7, 2008 clarifying letter), the directive imposes new conditions that states must meet in order to cover children with gross family income above 250 percent of the federal poverty level (FPL), the equivalent of $44,000 a year for a family of three. By imposing these conditions, the directive in effect imposes a one-size-fits-all income cap on children's coverage, limiting state flexibility and reversing longstanding federal policy.

- With the worsening economy, and rising gas, food and health care prices, more families are struggling to afford health care coverage for their children. Rather than supporting state efforts to help these families, the directive is forcing states to roll back and restrict children's coverage.
- Almost half of the states could by affected by the directive, including states that have covered children in this income range for many years under federally-approved plans.
- On a bipartisan basis, Congress extended SCHIP to keep coverage intact until the program could be reauthorized. The directive is undermining this objective by unraveling coverage for tens of thousands of children.

What are the major requirements of the directive?

- States cannot receive federal funds (CMS has said that the directive applies to Medicaid as well as SCHIP) to enroll children with gross family income above 250 percent of the FPL unless:
  - 95 percent of children with family income below 200 percent of the FPL have coverage (Medicaid, SCHIP, or private); and
  - Employer-sponsored insurance (ESI) for children below 200 percent of the FPL has not dropped by more than two percentage points over the prior five years.
- If a state meets these requirements, it must establish two program rules for children in the expansion group:
  - Impose a 12-month waiting period (CMS states it will consider alternative proposals, with justification, to this rule); and
  - Charge families the maximum cost sharing permitted by federal law.

What are some of the issues with the policy?

- State officials generally believe that these standards are difficult to meet. Already states have had their coverage expansion plans turned down and several states have had to halt or limit their plans because of the directive. Even for those states deemed in compliance with the standards, the policy creates largely insurmountable hurdles and new hoops for states and families.

  - According to the published U.S. Census, no state has achieved a 95 percent coverage rate for low-income children. CMS states that it will consider other data and adjustments, but it remains unclear what will meet CMS standards and whether there will be any objective basis for acceptance or rejection.

  - ESI rates have been dropping for children as well as for adults. States have little control over businesses' coverage decisions and rising health care costs, and yet can be precluded from covering moderate-income children if ESI coverage drops by more than two percent.

- The mandated waiting periods and high cost sharing strip away state flexibility and undermine efforts to cover uninsured children. The director of the Congressional Budget Office and others have raised questions about the effectiveness of the directive's waiting period and cost sharing requirements as tools to curb crowd out (a stated goal of CMS). In fact, some research suggests that the measures may have as much of a negative effect on the enrollment of uninsured children as they do on children who otherwise might have had private coverage.
  - Most states charge premiums in SCHIP, but not as high as the levels required by the directive.
  - Waiting periods are common in SCHIP, but few states impose them for as long as 12 months.

Which states are affected? (See table for the list of states.)

- States that already cover children above 250 percent of the FPL under CMS-approved plans must comply by August 2008.
  - States that cannot comply will no longer receive federal funds to enroll children at this level.
  - Children already covered could remain on the program but if they drop off for any reason (e.g., overtime pay that temporarily puts them over eligibility levels) they could not re-enroll.
- Ten states that enacted state laws to expand coverage before the directive was issued are also affected. Half of these states have already had to halt, delay, limit, or fund with state dollars, their planned coverage expansions for children. As a result, tens of thousands of uninsured children have already lost the opportunity for coverage.

What has Congress done?

- When enacting SCHIP, Congress gave states the flexibility to set income eligibility levels for children, subject to available federal funds. States must pay their share of all coverage expansions.
- The SCHIP reauthorization bills adopted by Congress (H.R. 976 & H.R. 3963) would have nullified the directive and replaced it with an alternative set of policies to increase coverage of the lowest income children without eliminating SCHIP for their more moderate-income counterparts.
- When President Bush's vetoes prevented reauthorization of SCHIP, Congress enacted the SCHIP Extension Act (S. 2499) in December 2007 to keep the program intact until SCHIP could be reauthorized, with funding provided through March 2009. The directive serves as a back door way of unraveling the existing SCHIP program.

Will the directive help enroll more children?

- One of the most important steps that states can take to make further coverage gains for children is to enroll uninsured children who are already eligible for Medicaid and SCHIP. Seven out of ten uninsured children are in this group. The directive does not provide states with tools, financing, or effective incentives to enroll these children. The focus of the directive is on imposing an income limit on publicly funded coverage, rather than encouraging enrollment of eligible children. The director of the CBO has said the directive will result in zero new enrollments of already eligible children.
- Constructive steps can be taken to assure that children eligible for Medicaid or SCHIP are enrolled. For example, the SCHIP reauthorization bills that were vetoed by the President would have given states new enrollment options and additional federal support to help pay for the cost of coverage *if* they had success enrolling the lowest income children—those eligible for Medicaid.
- With the cost of health insurance rising far more rapidly than wages and the average cost of employer-based insurance for family coverage topping $12,000 a year, more and more families are struggling to find affordable coverage for their children. The impact on families will only worsen in the economic downturn. Many states are responding to this widening health insurance affordability gap, but the directive is moving the country in the opposite direction.

State Impact of the August 17th CMS Directive

States with enacted effective coverage levels above 250% FPL	Must meet directive requirements by August 2008	Deemed by CMS to meet directive requirements	Curtailed children's coverage due to the directive	Uses only state funds for coverage expansion due to the directive	Does not plan to implement coverage expansion before August 2008
California	X[2]				
Connecticut	X				
District of Columbia	X				
Hawaii	X				
Illinois				X[3]	
Indiana			X		
Louisiana			X		
Maryland	X				
Massachusetts	X				
Minnesota	X				
Missouri	X				
New Hampshire	X				
New Jersey	X				
New York				X[4]	
North Carolina					X
Ohio			X[5]		
Oklahoma			X		
Pennsylvania	X				
Rhode Island		X[2]			
Tennessee			X[2]		
Vermont	X				
Washington	X[2]				X
West Virginia					X
Wisconsin				X	
Total[1] = 24	**13**	**1**	**5**	**3**	**3**

Notes:
[1] Column totals do not add up to 24 because Washington state appears in two columns.
[2] These states have eligibility standards set at 250% FPL but cover some children with higher incomes because they apply income deductions (for example, for child care expenses). Due to the directive, Tennessee no longer applies disregards in determining income eligibility.
[3] Illinois state-funded its expansion prior to the directive, but planned to apply for SCHIP funds for the expansion.
[4] New York has appropriated funds to cover the full cost of expanding coverage up to 400% FPL as they pursue legal recourse against CMS for denying their State Plan Amendment.
[5] Ohio is exploring a number of options to expand coverage above 250% FPL.

Source: Center for Children and Families.
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