



Georgetown University Health Policy Institute
Center for Children and Families



“Covering Uninsured Children: The Impact of the August 17 CHIP Directive”

**Testimony Submitted to the
Subcommittee on Health Care
Committee on Finance**

By

Cindy Mann, JD

**Research Professor and Executive Director
Center for Children and Families
Georgetown University Health Policy Institute**

April 9, 2008

Good afternoon Chairman Baucus, Senator Grassley, Subcommittee Chairman Rockefeller, Senator Hatch and distinguished members of the Subcommittee. Thank you for the invitation to participate in this hearing on the impact of the August 17th directive issued by the Centers for Medicare and Medicaid Services (CMS). I am Cindy Mann, a Research Professor at Georgetown University and the Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute. Soon after enactment of the State Children's Health Insurance Program (SCHIP), I served as the director of the group within the Health Care Financing Administration (now CMS) that oversees the implementation of SCHIP and Medicaid for children and families at the federal level. Since leaving the department in early 2001, I have worked with federal and state policymakers on SCHIP, Medicaid, and private coverage options and have analyzed how federal and state policies and procedures have affected children's coverage.

In my testimony, I will focus on the August 17th directive's impact on children's coverage and describe the extent to which the new policies depart from longstanding federal SCHIP and Medicaid rules and practices. The directive, which was issued as a letter to state SCHIP directors, imposes new and likely insurmountable hurdles for states covering or planning to cover children with family incomes above 250 percent of the federal poverty level (FPL), the equivalent of \$44,000 in annual income for a family of three. By August 2008, at least 23 states will be affected by this new policy.

The directive already has taken a significant toll on state efforts to cover children at a time when the number of uninsured children is rising and more families are experiencing hardship due to the downturn in the economy. SCHIP was specifically designed to bridge the gap for families with incomes above Medicaid levels but still too low to afford private health insurance. Many children in families with incomes above 250 percent of the FPL have access to affordable employer-based insurance, but in light of rising health care costs and the evolving job market increasingly some do not. SCHIP has been a remarkably successful program in part because it has always provided states the discretion to decide which families need help purchasing affordable coverage in their

state, within the limits of available funding. SCHIP coverage is not free for families with more moderate incomes, but it is affordable.

The directive abruptly and unilaterally changes SCHIP and Medicaid rules and disrupts longstanding SCHIP programs without any evidence that the policies it mandates will further what we can all agree is the top priority of SCHIP and Medicaid – covering the lowest income children. The members of this Subcommittee and Committee, most notably Senators Baucus, Grassley, Rockefeller and Hatch, crafted a bipartisan SCHIP reauthorization bill last year that addressed these important and complex issues in thoughtful, constructive ways. Later in the year, the Congress enacted a SCHIP extension bill to keep SCHIP coverage and state coverage plans intact until SCHIP could be reauthorized. That goal, however, is being undermined through the backdoor by a set of policy prescriptions that lack support in the research literature or in state experiences and that did not even go through normal rulemaking procedures. A moratorium on the August 17th directive would keep longstanding federal rules and state flexibility in place and avert the loss of coverage until Congress can more thoroughly address these issues in the context of SCHIP reauthorization.

More children need coverage, particularly during this economic downturn.

Over the last decade, the country achieved significant gains covering children even as the uninsured rate for adults rose sharply. Between 1996 and 2006, the percent of low-income children without health insurance dropped by more than one-third, largely as the result of enrollment in Medicaid and SCHIP. The most recent Census Bureau data, however, show that the number of children without health insurance has begun to climb. If children continue to lose coverage at the same rate they lost coverage in 2006, almost 2,000 children a day will join the ranks of the uninsured. Sadly, it is likely that the number of children losing coverage this year will be even higher because of the economic downturn. In light of growing need, this is a time for states and the federal government to deepen, not restrict, their support for children's health coverage programs.

States have responded to this growing need in a variety of ways, including conducting outreach and improving enrollment and renewal procedures. Over the past two years,

many states have also increased their income eligibility levels to reach more uninsured children. The August 17th directive is specifically aimed at stopping or restricting states' ability to cover children with gross family incomes above 250 percent of the FPL. Some 14 states had covered children in this income range before the directive was issued, some since the very beginning of the program. Currently, at least 23 states cover children, or have enacted legislation to cover children, in this income range (Figure 1). Some states have adopted these income eligibility levels because of the higher cost of living in their state, but the growing interest in expanding children's coverage programs in states as diverse as Ohio, Oklahoma, Washington, and West Virginia is probably best explained by the fact that the cost of health insurance has been rising far more rapidly than earnings and fewer families have access to affordable coverage through their jobs. As a result, more moderate-income families may need access to affordable coverage through SCHIP.

SCHIP was specifically designed to reach families whose incomes are too high to qualify for Medicaid and too low to afford private insurance, and in recent years that affordability gap has been widening. Over the past decade, the cost to families of buying into employer-sponsored coverage rose by 103 percent while their earnings grew by only 33 percent (Figure 2). The average total cost of family coverage through a private group health insurance plan is now more than \$12,000 a year. A family with moderate income whose employer contributes a substantial portion of that premium cost might be able to afford to purchase that coverage, but if the employer does not make a significant contribution to the cost of the insurance the coverage may be well beyond the family's reach. A \$12,000 premium would consume more than one fourth (27 percent) of the total annual income for a family of three at 250 percent of the FPL. Additionally, parents working for firms that do not offer family coverage or who are not eligible for employer-based coverage or who are self-employed face particular challenges affording private insurance for their children. Given rising costs and job market trends, it is not surprising that nearly half of the additional 710,000 children who became uninsured between 2005 and 2006 were in families with more moderate incomes.

States have turned to SCHIP and Medicaid to help address this affordability gap because the programs have a proven track record of providing families with a cost-effective

coverage option for their children. SCHIP does not provide free coverage. Families pay premiums and copayments, but the coverage financed with SCHIP is affordable, and the research has shown that it offers children access to care in an efficient and effective manner.

The directive is unraveling state coverage efforts.

In the face of the growing need for coverage, the August 17th directive moves federal policy in exactly the wrong direction. Instead of providing tools and support for states to remove barriers to coverage, the directive puts new, potentially insurmountable hurdles in the path of states trying to cover uninsured children. In the few months since the directive has been in effect, not one state seeking to expand coverage has had a plan approved by CMS to cover children with gross incomes above 250 percent of the FPL. Instead, tens of thousands of uninsured children have lost out on coverage that their state had determined they needed and had planned to offer. About 26,000 children lost out on coverage in just three of the states that already have been affected by the directive – Louisiana, Ohio, and Oklahoma. Each of these states had enacted state legislation to expand coverage for children with family incomes up to 300 percent of the FPL, and all three states have had to roll back their coverage plans as a result of the directive.

Many more children will lose coverage or the opportunity of coverage as more states become subject to the directive. The 14 states that already have approved plans to cover children in this income range are required by the directive to comply with its terms by August 2008. CMS has said that it will not require these states to disenroll currently enrolled children with incomes above 250 percent of the FPL. This policy, however, will do little to avert the shutdown of coverage among children in this income range in states that have long covered these children. Program turnover is considerable, particularly among children in this income range. Some leave the program because overtime pay or a wage increase permanently or temporarily puts them over the state's income eligibility level; some leave because affordable employer-based coverage becomes available to the family; and some leave because of burdensome or confusing renewal procedures. The rules announced by CMS would not permit states to enroll new applicants or to re-enroll eligible children who once were covered by the program. As a result, Hawaii, New

Jersey, and New Hampshire expect that within two years of when the directive is applied, enrollment of children with incomes above 250 percent of the FPL will fall by 76 percent, 84 percent, and 97 percent, respectively.

The directive unilaterally alters longstanding federal policy.

The August 17, 2007 CMS directive was issued just as Congress was debating SCHIP reauthorization. It was released as a letter to state health officials, not as a proposed regulation. States and other stakeholders had no prior notice of the rule and no opportunity to comment, and the kind of important details about new rules that are normally explained in the context of the regulatory process have yet to be explained in writing.

To appreciate just how much of a change in policy the directive represents, it is useful to compare the directive requirements with longstanding SCHIP rules and practice. The directive imposes two new conditions that have never been applied before as a condition of providing coverage to children with family incomes above 250 percent of the FPL. States must show that they are covering 95 percent of eligible low-income children and that employer-sponsored coverage for low-income children has not declined by more than two percentage points over the prior five years. If a state can meet both of these potentially impossible standards (to date, no state seeking to expand coverage has), the state must charge a certain level of premium (in most cases, equal to the maximum allowed by law) and impose a 12-month waiting period.

These policies dramatically alter longstanding rules. Federal law has always provided states the flexibility to set income eligibility levels, subject to available funding. Even in the first years of SCHIP, states covered children with incomes above 200 percent of the FPL through the discretion granted to states in the 1997 statute to adopt income deductions and disregards. The law neither requires nor authorizes any one-size-fits-all federal preconditions before a state can cover children with more moderate incomes. It also affords states flexibility to set their cost sharing rules, subject to an overall maximum (five percent of income) and to devise state-specific strategies to limit the substitution of public for private coverage.

Consistent with the flexibility accorded states, SCHIP eligibility levels have always varied widely across the states. Most states began their programs with income eligibility levels at or below 200 percent of the FPL, but some states, like New Hampshire, started out covering a broader group of children. (Prior to SCHIP, New Hampshire was already covering children up to 185 percent of the FPL in its Medicaid program.) Its plan to cover children through SCHIP up to 300 percent of the FPL was approved by CMS in September 1998.

Similarly, there is considerable variation across states with respect to the premiums they charge families that enroll their children in SCHIP. Most states charge premiums or other cost sharing, but the amount varies widely across the nation. No state currently sets its premium as high as the five percent maximum level permitted by law.

States also have adopted different policies with respect to crowd out. Most have waiting periods but the waiting periods vary in length and in the exemptions allowed. In general, states have been shortening or dropping their waiting periods – with CMS approval – largely because of the negative impact on coverage and the lack of evidence that these periods of uninsurance are effective in limiting substitution. Before August 17, 2007, only two states imposed a 12-month waiting period in their SCHIP program.

The extent to which the directive represents a sharp departure from longstanding rules is illustrated by considering Pennsylvania's experience. Pennsylvania was the last state (not including the District of Columbia) to expand coverage for children up to 300 percent of the FPL with CMS approval before the directive was issued. It was not required to meet a participation rate requirement or show that its employer-sponsored insurance coverage rates for low-income children had not declined by more than two percentage points over the past five years before gaining approval. The approved plan includes a waiting period for children who previously had employer-based coverage, but the waiting period is for six months, not 12 months, and it exempts children under age two. The approved plan includes premiums for families in the expansion group, but not as high as five percent of family income. It appears, therefore, that the Pennsylvania plan approved just a few months before the directive was issued is no longer approvable under the terms of the directive (Pennsylvania has until August 2008 to comply), and yet neither federal law nor

regulations have been changed since CMS approved this plan. The state reports that over the first year of implementation, 17,000 children gained coverage, including 10,000 low-income children (59 percent of the total) who were previously eligible but unenrolled.

Not only does this new policy differ sharply from longstanding federal rules, it also is markedly different than the provisions adopted in last year's SCHIP reauthorization bills. Both versions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) constrained state flexibility to expand coverage but in ways that are significantly different than the August 17th directive. The first CHIPRA bill lowered the matching rate for coverage above 300 percent of the FPL while the second bill capped eligibility at 300 percent of the FPL, allowing for certain deductions such as for work-related child care expenses. Most significantly, in terms of improving participation rates among low-income children, both bills provided states with new financing, incentives, and policy options to boost enrollment among already eligible but uninsured children, including children eligible for Medicaid – the lowest income uninsured children. According to Congressional Budget Office estimates, 87 percent of the nearly four million children who would have gained coverage under the bill were uninsured children who were already eligible for SCHIP or Medicaid.

The matters addressed by the directive are best addressed in the context of SCHIP reauthorization, and, in the meantime, children's coverage should be protected.

As you know, neither CHIPRA bill became law. The legislation adopted by Congress and signed by the President in December 2007 extends SCHIP funding through March 2009. Congress' intent in enacting this stopgap measure was to maintain current coverage and coverage plans until SCHIP could be reauthorized. The law provides funding sufficient to allow states to keep children's coverage intact and to proceed with their coverage plans until March 2009. The August 17th directive, however, is undermining this goal. In states such as Louisiana, Indiana, Ohio, and Oklahoma, the directive has already taken a considerable toll on state efforts to cover children.

SCHIP has been a remarkably successful program. The strong bipartisan support for CHIPRA demonstrated that most members of the Congress want to strengthen not

weaken SCHIP and Medicaid's ability to cover uninsured children. The sweeping new policies imposed by the CMS directive take the nation down a different road. These far-reaching policies relating to eligibility levels, the interaction between public and private insurance, and the strategies that are effective in improving participation rates among eligible but unenrolled children are important but complicated policy issues that are best addressed within the context of SCHIP reauthorization.

