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Moving Backward:

Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children

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Key Findings

Recently, state activity focused on reducing the number of children without health coverage has moved forward at a record pace. Building on the State Children's Health Insurance Program (SCHIP) and Medicaid, over the past 18 months more than half of all states have taken significant action to cover more uninsured children.[1] Progress in closing the uninsured gap among children, however, has been thwarted by a new federal directive, which, in effect, imposes a gross income cap in SCHIP equal to 250 percent of the federal poverty level (FPL). A review of state activity since the directive was issued on August 17, 2007 by the Centers for Medicare and Medicaid Services (CMS) shows that the new policy has already had a substantial negative impact on children's coverage and on states' ability to design and finance their programs.

- **Uninsured children have already lost out on coverage**. In just the short period since the CMS directive has been in effect, thousands of uninsured children have lost out on coverage that their state had determined they needed. Tens of thousands more are at risk of losing their coverage, as more states are required to comply with the new rules.
- **By August 2008 nearly half of all states will be affected by the directive.** Different states are affected at different times depending on their programs and their coverage plans. As a result of the directive:
  - Four states that had enacted legislation to expand their SCHIP programs to cover more uninsured children have already been forced to halt or cut back their coverage plans.
  - Two other states have chosen to finance a portion of their expansion with state funds rather than not cover children in the expansion group. It is unclear how long these states will be able to sustain coverage without federal financial support.
  - Eighteen states will be affected over the next eight months, including 14 states that covered children above the new federal income cap with federal approval before the directive was issued, in most cases for many years. These states will likely be forced to roll back their eligibility levels at some point before August 2008, or assume new coverage costs with state funds.
- **Basic questions about what the rules require and how CMS will implement the rules remain unanswered.** State administrators still do not have answers from CMS to key questions about how the new directive will be implemented, making it difficult for states to plan, creating uncertainty for families, and potentially leading to an inconsistent application of the new rules.

At the same time that the CMS directive is stopping coverage gains and causing eligibility rollbacks, the affordability gap faced by families trying to insure their children continues to widen. Nationwide, the number of children without coverage is growing at a rate of about 2,000 per day.[2]

The August 17 Directive

On August 17, 2007, CMS issued a new directive in the form of a letter to SCHIP directors.[3] The directive, issued as Congress was finalizing legislation to reauthorize SCHIP, dramatically alters the rules that have governed SCHIP for the past ten years. In effect, the new rules impose a uniform, federal gross income cap in SCHIP equal to 250 percent of the federal poverty level (FPL), the equivalent of $42,925 a year for a family of three in 2007. The cap applies to states that have long covered children in this income range, as well as to states that plan to cover these children in the future.

Because the Secretary of Health and Human Services does not have the direct legal authority to impose an income cap in SCHIP,[4] the guidance attempts to accomplish this result by requiring states to meet certain conditions if they want to cover children with incomes above 250 percent of the FPL.[5] Few, if any, states will be able to meet these requirements.

- **Participation Rate Requirements.** Under the directive, states must show that they have enrolled at least 95 percent of all children eligible for SCHIP or Medicaid who have incomes below 200 percent of the FPL. No means-tested program where people have to apply and be reviewed for eligibility has reached this high standard of participation. In fact, Medicare, which is not means-tested and where people are enrolled automatically, has a participation rate of about 95 percent. By comparison, the low-income subsidy for the Medicare part D prescription drug benefit, which is means tested, has a participation rate of only 43 percent.[6] SCHIP and Medicaid participation rates are considerably higher—about 63 percent and 79 percent, respectively—but state-level participation rates vary widely and are difficult to measure accurately due to data limitations.[7]
- **Employer Coverage Requirements.** Even if a state can show it meets these participation rates, it will not be permitted to cover children with incomes above 250 percent of the FPL unless it can also show that private employer-based coverage for lower income children has not declined by more than two percentages points over the past five years. Employer coverage has been declining sharply for all groups of Americans, including children.[8] States have little control over these trends.

If a state is able to meet these conditions it would be permitted to cover children with incomes above 250 percent of the FPL, but then two new restrictions would apply:

- **Mandatory 12-month waiting period.** If an eligible, uninsured child had employer-based coverage in the past, the directive requires that the child remain uninsured for 12 months following the loss of private coverage.
- **Mandatory level of cost sharing.** States must charge families costs that are no less than one percentage point of family income below those charged by employer plans, or (if such information were not available to a state) the costs charged must be at the maximum level permitted by law (five percent of family income). All states that cover families at these income levels in SCHIP charge cost sharing (premiums, copayments or coinsurance), but virtually no state imposes cost sharing at levels this high. Costs that are too high can discourage families with eligible children from enrolling or prevent them from using needed care.

States Affected

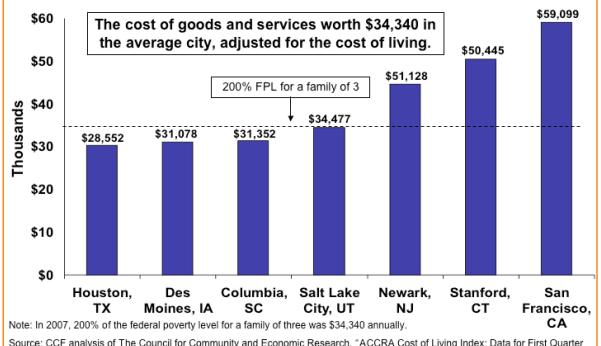
Currently, nearly half of all states—23 states—either cover children with gross family incomes above 250 percent of the FPL or have enacted state legislation to do so (Table 1). These include states as diverse as New Hampshire, Oklahoma, and Pennsylvania.

- **Fourteen states are already covering children in this income range.** Fourteen states had approved plans to cover children in this income range before the directive was issued; some have had their coverage in place for nearly ten years. According to the directive, these states have until August 2008 to come into compliance.[9]
- **Ten states have enacted expansions that need federal approval.** Ten states enacted legislation to cover children in this income range but had not implemented the expansion before the directive was issued. (Washington is among the group of 14 and the group of ten.[10]) These states have to

One-Size-Fits-All Federal Cap Ignores Large Variations in State Costs of Living

SCHIP rules have always permitted states the flexibility to determine the income eligibility levels for their programs, in part to allow them to take into account differences in the cost of living. As illustrated below, the cost of the same goods and services can be significantly higher for families living in different regions of the country.

The Cost of Living Differs Across the Country



Note: In 2007, 200% of the federal poverty level for a family of three was $34,340 annually.

Source: CCF analysis of The Council for Community and Economic Research, "ACCRA Cost of Living Index: Data for First Quarter 2007," (May 2007).

submit their plans to CMS for approval before they can receive SCHIP funding for their new coverage. As of this date:

- **Indiana**, planned to implement its expansion from 200 to 300 percent of the FPL in 2007, but has not moved forward as a result of the directive.
- **Louisiana** and **Oklahoma** enacted legislation to expand coverage for children with family incomes between 200 and 300 percent of the FPL, but as result of the directive both states have rolled back their plans and will cover children only up to 250 percent of the FPL.
- **New York** planned to expand coverage from 250 to 400 percent of the FPL but it's plan was denied by CMS on September 7, 2007.
- **Ohio**'s request to expand coverage from 200 to 300 percent of the FPL is pending with CMS. The state has been advised by CMS that its plan likely will be turned down.[11]
- **Wisconsin** expanded coverage for children from 200 to 300 percent of the FPL, but as a result of the directive it is financing coverage for children with family incomes above 250 percent of the FPL with state funds.
- **Illinois** implemented its expansion from 200 to 300 percent of the FPL with state funds, but prior to the directive had planned to seek federal SCHIP funding.
- Three other states (**North Carolina, Washington,** and **West Virginia**) enacted coverage expansions for children with incomes up to 300 percent of the FPL, which have implementation dates in 2008; they will have to submit their plans to CMS over the next few months.

Table 1: States Currently Affected By The August 17th CMS Directive

States with enacted effective coverage levels above 250% FPL	States that covered children above 250% FPL before the directive and will need to comply by August 2008	States that have curtailed children's coverage expansions due to the directive	States that have implemented children's coverage expansions using state funds due to the directive	States with coverage expansions scheduled to be implemented in 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		
North Carolina				X
Ohio				X
Oklahoma		X		
Pennsylvania	X			
Rhode Island	X[2]			
Vermont	X			
Washington	X[2]			X
West Virginia				X
Wisconsin			X	
Total[1] = 23	**14**	**4**	**2**	**4**

Notes:

[1] Column totals do not add up to 23 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).

[3] Illinois state-funded its expansion prior to the directive, but planned to apply for SCHIP funds for the expansion.

In addition to these 23 states, the directive affects other states because CMS has announced a new effort to monitor all states' crowd out prevention policies and the directive will deter states from covering more children. In light of the growing cost of health insurance and a recent spike in the number of uninsured children, this will hamper growing state interest in making program changes to reach more uninsured children.

The Impact on Children

It is not possible to state with precision exactly how many children are, or will be, affected by the directive, but it is clear that thousands of uninsured children have already lost the opportunity to gain coverage and tens of thousands more will be affected over time. For example:

- Louisiana's cutback in its planned expansion will prevent half of the children it intended to cover from qualifying, affecting about 4,000 uninsured children.[12]
- According to estimates from Oklahoma, 7,500 uninsured children will lose out on coverage as a result of the directive.[13]
- About 20,000 children in Ohio are in the income range covered by Ohio's planned expansion, which CMS has indicated that it will not approve.[14]
- New York had expected to enroll 46,600 uninsured children through its denied expansion, which had been scheduled to go into effect in September 2007.[15]
- Washington estimates that 4,600 children with incomes between 250 and 300 percent of the FPL are uninsured, but as a result of the directive none of these children are likely to gain SCHIP-funded coverage.[16]

The 14 states that may be forced to roll back their already-approved eligibility levels do not report data on the numbers of children with incomes above the CMS income cap, but thousands of children could be affected in these states starting in August 2008. CMS has indicated that the individual children enrolled at the time the state is forced to roll back eligibility can remain in the program if they remain continuously enrolled, but if eligibility rollbacks occur, other uninsured children will be prevented from gaining coverage.

In addition, children with incomes *below* the CMS cap might also be affected. Every state that has undertaken an expansion has noted that the program changes have had a positive impact on boosting participation rates among previously eligible, lower income children. The three states with the most recent experience expanding coverage to children—Illinois, Massachusetts, and Pennsylvania—have found that one-half to two-thirds of the children who have gained coverage since their expansion were lower income children who had previously been eligible.[17]

It is important to note that the SCHIP program can only cover uninsured children. Thus, the loss of coverage or the missed opportunity for gaining SCHIP coverage is, by definition, only experienced by children who have no other coverage. Currently, 9.4 million children under 19 are uninsured nationwide; most have incomes below 200 percent of the FPL, but a growing number are in families with more moderate incomes.[18] Nearly half (48 percent) of children who joined the ranks of the uninsured last year had incomes between 200 and 400 percent of the FPL.[19] The growing number of uninsured children in this income range is not surprising given rising health care costs. For example, family premiums for employer-based coverage have grown by over 100 percent since 1996.[20]

Cost Shifts to States

As noted above, two states that had planned to expand coverage with federal SCHIP funds to children up to 300 percent of the FPL and that have been stopped by the directive have decided to cover the children with state dollars. Under SCHIP rules, the federal government pays from 65 percent to 85 percent of the share

A Lost Opportunity

Two girls, ages 3 and 1, live with their parents in a small town in New York. Their mother works full-time as a manager at a fast food restaurant and their father works full-time as a stone fabricator. No one in the family has health insurance. After the local clinic told them about New York's SCHIP program expansion, the parents applied for coverage for the youngsters and paid the first monthly premium. When the expansion did not go through due to CMS's denial of New York's plan, the family lost the opportunity to cover the girls. The family's income, which fluctuates due to overtime, is currently just over the state's pre-expansion SCHIP eligibility guidelines. Both children need coverage for regular check ups, and the younger girl has a hernia and may need surgery. The family is already struggling, working overtime to pay rent, heat and electricity, car payments and insurance, and groceries. They do not know how they will pay for their baby's surgery.

of coverage costs up to the state's capped allotment, but under the CMS directive the federal government will no longer pay its share of costs for children with family incomes above 250 percent of the FPL in most or all states with such coverage.

The advances for children's coverage that have been achieved over the past ten years through SCHIP and Medicaid have depended on the federal-state financial partnership; it is not clear how many states will be willing and able to pick up the federal share of the cost or how long the states that have done so will be able to sustain that commitment, particularly in a economic downturn.

Unanswered Questions

The August 17 directive raises many questions about how CMS intends to implement the new rules. For example, it is not clear what data CMS will accept to show participation rates among eligible low-income children, employer-based coverage trends, and cost sharing levels among employer-based insurance. In addition, questions have been raised about whether states can allow any exceptions to the required 12-month waiting period (such as when the insured parent dies or leaves a job involuntarily) and whether a state can take account of any expenses a family may have (such as child care costs for work or child support paid pursuant to a court order) in applying the 250 percent of the FPL income cap.

Since the directive has been in place, CMS has not provided any additional written guidance nor responded to written questions submitted on behalf of state SCHIP directors.[21] The answers could not only provide important information as to the allowable scope of SCHIP-funded coverage, but could have significant implications for existing programs and states' ability to coordinate the new expansions with pre-expansion coverage. For example, if states are not permitted to apply the deductions in their SCHIP expansions that they have long had in place in their SCHIP programs, eligibility systems will need to be revised. New measures may need to be adopted to coordinate SCHIP eligibility determinations with Medicaid. In Medicaid, states are required by federal law to use net income when determining a child's eligibility.[22]

Conclusion

In just a few short months, the August 17 CMS letter issued to state SCHIP directors has resulted in the loss of coverage for thousands of children and caused significant disruption and uncertainty for states. The impact will grow over the next few months, as the remaining states that have enacted expansions move closer to their planned date of implementation and as the 14 states that already cover children above 250 percent of the FPL are required to come into compliance with the directive.

This analysis was written by Cindy Mann and Michael Odeh. It was produced by the Center for Children and Families (CCF). CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families.

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Endnotes

[1] Center for Children and Families, "Children's Health Coverage: States Moving Forward," (May 2007).

[2] Center for Children and Families, "American Families Face Harsh Reality: 2,000 Children Join the Ranks of Uninsured Each Day," (October 2007).

[3] Letter from Dennis Smith, Director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials (SHO #07-001), (August 17, 2007), available at http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf (accessed December 10, 2007).

[4] Letter from Secretary Leavitt to Senator Grassley (July 31, 2007), available at http://finance.senate.gov/press/Gpress/2007/prg081607a.pdf (accessed on December 10, 2007); and A. Grady, "Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income," Congressional Research Service (November 29, 2007).

[5] The 250% cap imposed by the directive appears to refer to gross income, meaning that children could not qualify for SCHIP-funded coverage if their family's gross incomes are above 250% of FPL. Many states calculate eligibility for SCHIP based on net income, applying deductions for expenses such as childcare or other work-related expenses.

[6] Kaiser Commission on Medicaid and the Uninsured, "SCHIP Reauthorization: Key Questions in the Debate; A Description of the New Administrative Guidance and the House and Senate Proposal," (August 2007). This calculation excludes dual eligible who are automatically enrolled in the low-income subsidy, as well as a small number of beneficiaries with employer coverage.

[7] Based on estimates by the Urban Institute of the Census Bureau's Current Population Survey (using data aggregated for the two most recent years); state Medicaid/SCHIP participation rates among low-income children range from a low of 51 percent in Nevada to a high of 89 percent in Vermont. These data, however, do not account for children who may be income-eligible for Medicaid and SCHIP but who do not meet other eligibility requirements, such as immigration status. In addition, for some states the state-level data is based on small sample sizes. See also, G. Kenney, "Medicaid and SCHIP Participation Rates: Implications for New CMS Directive," Urban Institute (September 2007).

[8] Between 2000 and 2006, rates of employer-sponsored coverage fell four percentage points for nonelderly adults workers and almost nine percentage points for children under 18; P. Frontsin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," Employee Benefit Research Institute (October 2007).

[9] CMS has indicated that if a state is not compliant with the new conditions the state will be able to continue to cover the individual children already enrolled; it will not be able to enroll newly eligible children. Because of frequent changes in family incomes and coverage losses at the point of renewal, often due to procedural barriers, the "grandfathered" children may also lose coverage over time and not be able to regain it even if they remain eligible.

[10] Washington's income eligibility level is currently set at 250% of the FPL, but it calculates eligibility based on *net* income. The state has enacted legislation to expand coverage up to 300% of the FPL.

[11] J. Riskind, "Squabble Delays Coverage," *Columbus Dispatch* (December 3, 2007).

[12] Communication with Kyle Viator, Director of Operations Louisiana Children's Health Insurance Program, Department of Health & Hospitals (December 10, 2007).

[13] Oklahoma Office of the Governor (June 4, 2007), *Gov. Henry Signs Health Insurance Measures,* Press release, available at http://www.governor.state.ok.us/display_article.php?article_id=949&article_type=1 (accessed December 10, 2007); and Oklahoma Health Care Authority. "Sooner Care Section 1115(a) Demonstration Waiver, Revised Amendment Request," (October 2007).

[14] *Op. cit.* (10). According to estimates by the Ohio Department of Job and Family Services, Office of Ohio Health Plans based on the 2004 Ohio Health Survey, there were 18,300 uninsured children in families with income between 200% and 250% of the FPL and 12,000 uninsured children in families with income between 250% and 300% of the FPL. Note that these are the total number of uninsured children in this income range as of 2004; not all of these children would be expected to actually enroll, but the state has not projected participation rates.

[15] Communication with Judith Arnold, Director, Division of Coverage & Enrollment, Office of Health Insurance Programs, New York State Department of Health (December 10, 2007).

[16] Washington State House of Representatives, Office of Program Research, "Bill Analysis; SB 5093," (2007), available at http://www.leg.wa.gov/pub/billinfo/2007-08/Pdf/Bill%20Reports/House/5093.HBA%2007.pdf (accessed December 11, 2007). Note that these are the total number of uninsured children in this income range; not all of these children would be expected to actually enroll, but the state has not projected participation rates.

[17] Based on data collected for a forthcoming report from the Center for Children and Families on state coverage expansions enacted in the past two years.

[18] *Op. cit.* (2).

[19] J. Holahan & A. Cook, "What Happened to the Insurance Coverage of Children and Adults in 2006?," Kaiser Commission on Medicaid and the Uninsured (September 2007).

[20] C. Mann & M. Odeh, "The Growing Health Insurance Affordability Gap for Children and Families," Center for Children and Families (October 2007); and Kaiser Family Foundation, "Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level," (February 2007).

[21] On September 20, 2007, Catherine Hess and John McInerney with the National Academy for State Health Policy sent a letter on behalf of SCHIP directors to Katherine Farrell, Director of the SCHIP Division at CMS with a list of questions about the directive. According to NASHP, as of December 11, 2007, no response has been provided.

[22] A. Grady, "Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income," Congressional Research Service (November 29, 2007).