



## Out of Touch: A Status Report on CMS's August 17<sup>th</sup> Directive

### Introduction

On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) sent a letter to state health officials sharply restricting the ability of states to cover uninsured children through the State Children's Health Insurance Program (SCHIP). The policy, known as the "August 17<sup>th</sup> directive," affects states' ability to cover children with family income above 250 percent of the federal poverty level (FPL), the equivalent of \$44,000 annually for a family of three. In short order, the policy was criticized by 30 Governors and numerous members of Congress and was the subject of lawsuits brought by affected states and families. It was issued just as a number of states had enacted expansions in SCHIP coverage over 250 percent of the FPL, using the flexibility that states always have had to decide the income level of children who need help securing affordable coverage through SCHIP.

The directive already has forced several states to delay, scale back, or state fund their efforts to cover uninsured children, even as the weakening economy has created more strain and hardship for moderate-income families seeking affordable coverage for their children. In the months ahead, children in even more states will be affected by the policy at a time when there is a growing recognition that the economic downturn will be adding to the numbers of children who lack private employer-based coverage and whose families will need affordable coverage alternatives through SCHIP and Medicaid.

In earlier issue briefs on the August 17<sup>th</sup> directive, the Center for Children and Families (CCF) provided an in-depth analysis of the requirements of the directive and a status report on its impact as of December 2007.<sup>1</sup> More recently, new data and analyses regarding the directive (see below) have been released by state officials, research

### New Resources on the August 17<sup>th</sup> Directive

- April 9, 2008, hearing before the U.S. Senate Finance Committee, Subcommittee on Health Care: <http://finance.senate.gov/sitepages/hearing040908.htm>
- January 29, 2008 and February 26, 2008 hearings before the U.S. House of Representatives, Energy and Commerce Committee, Subcommittee on Health: [http://energycommerce.house.gov/cmte\\_mtgs/110-he-hrg.012908.CoveringUninsured.shtml](http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.012908.CoveringUninsured.shtml) and [http://energycommerce.house.gov/cmte\\_mtgs/110-he-hrg.022608.SCHIP.Progress.shtml](http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.022608.SCHIP.Progress.shtml)
- Legal opinions by the Government Accountability Office and the Congressional Research Service: <http://www.gao.gov/decisions/other/316048.pdf> and <http://ccf.georgetown.edu/index/cms-august-17-directive-impact>
- New report by the National Academy for State Health Policy: [http://www.nashp.org/Files/shpbriefing\\_cmsdirective.pdf](http://www.nashp.org/Files/shpbriefing_cmsdirective.pdf)
- State data gathered by the Center for Children and Families and summarized in Appendix 1.

organizations, and policy experts. These new data, reports, affidavits, and analyses raise significant questions about the policy basis for and the potential adverse effects of the August 17<sup>th</sup> directive, as well as the process by which CMS issued the policy. This issue brief provides an update on the impact of the directive as of April 2008 drawing on these new resources.

### Key Elements of the August 17<sup>th</sup> Directive

Under the directive issued by CMS on August 17, 2007, states cannot receive federal SCHIP funds to enroll children with gross family income above 250 percent of the FPL unless:

- 95 percent of all children eligible for Medicaid and SCHIP with income below 200 percent of the of the FPL are already enrolled; 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 can meet these new requirements, the directive would further require the state to:

- Impose a 12-month waiting period (children who had ESI in the past but now qualify for SCHIP would have to remain uninsured for 12 months from the time their coverage ended); and
- Charge families the maximum cost sharing permitted by federal law (five percent of family income) unless the state can show that the premiums it would charge are not more favorable than those charged by comparable private plans by more than one percent of family income.

The former Director of CMS has stated that the directive applies to Medicaid as well as to SCHIP.<sup>2</sup>

### Impact on Children

In the face of the growing need for coverage prompted by the rising cost of health insurance, over the past two years states have been pursuing plans to cover more uninsured children. The August 17<sup>th</sup> directive has forestalled much of this momentum by moving federal policy in the opposite direction. Instead of providing tools and support for states to remove barriers to coverage, the directive puts new, potentially insurmountable federal hurdles in the path of states trying to cover more moderate-income children whose families lack access to affordable insurance. To a degree often not recognized, the directive already has taken a substantial toll on state coverage initiatives with the result that tens of thousands of children have lost out on coverage. In the months ahead as more states are required to come into compliance, many more children will be affected.

These roadblocks to coverage come just as there is growing recognition that the downturn in the economy will push the number of uninsured children upward *unless* SCHIP and Medicaid are available to families. A recent report prepared by researchers at the Urban Institute finds that a one percentage point increase in the unemployment rate results in 700,000 children and 1.7 million adults losing their employer-based coverage.<sup>3</sup> If SCHIP and Medicaid continue to be available to them, the vast majority of these children can avoid joining the ranks of the uninsured. (In contrast, many adults who lose employer-based coverage when unemployment rises are not eligible for public coverage and, as a result, are much more likely to become uninsured.) The directive, however, threatens to weaken the capacity of SCHIP to serve as a backup source of affordable coverage for moderate-income families affected by rising unemployment and under-employment as well as by higher gas and food prices.

### What the Directive Has Meant for Emily Demko in Ohio

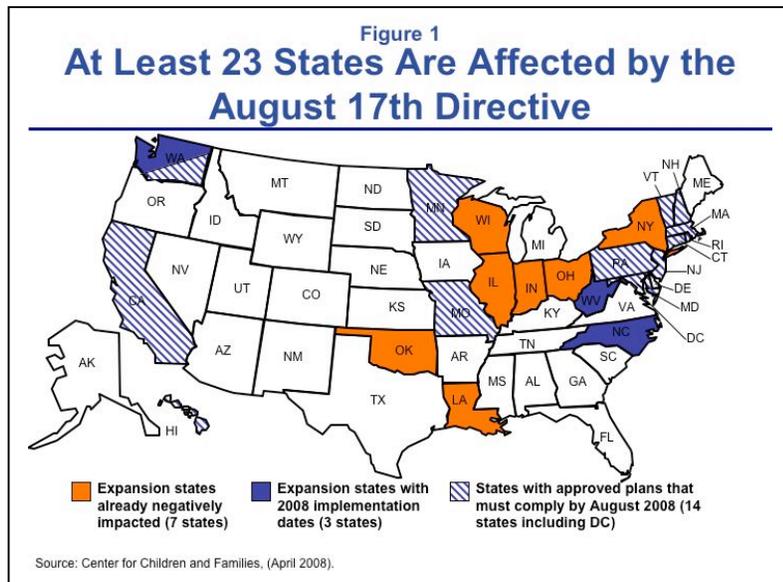
Three year-old Emily Demko was born with Down Syndrome. Emily's family has explored numerous insurance options, but due to Emily's pre-existing condition, the Demkos were denied private coverage. For a while, Emily qualified for Medicaid. However, her father's income rose (he is a self-employed building contractor), and Emily lost her coverage and became uninsured. At the time, Ohio's income eligibility level for Medicaid/SCHIP (Ohio's SCHIP program is a Medicaid expansion) was set at 200 percent of the FPL. As her mother explains, "That very same month (that Emily lost Medicaid coverage), we had bills for her in excess of \$3,500. These bills were devastating. We had to make decisions about her therapies, and ultimately, she has been reduced to 20 minutes of speech therapy a week. This isn't nearly enough to help her skills grow."

Last year, however, Ohio policymakers acted to expand the state's Medicaid and SCHIP program to cover children like Emily, with incomes up to 300 percent of the FPL. Families would pay premiums for the coverage. The expansion was scheduled to go into effect this year, but it was blocked by the August 17<sup>th</sup> directive.<sup>4</sup> Emily and thousands of other Ohio children who would have qualified for coverage remain uninsured.

**Tens of thousands of children already have lost out on coverage as a direct result of the directive.** In the eight 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 family income 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. For example, Louisiana, Ohio, and Oklahoma each adopted legislation in 2007 to expand coverage for uninsured children up to 300 percent of the FPL. As a result of the directive, all three states had to delay or roll back their coverage plans with the consequences that some 26,000 to 44,000 children missed out on the chance to gain insurance through SCHIP.<sup>5</sup> Other states, such as North Carolina and West Virginia, have put their expansions on hold until the future of SCHIP is more settled. New York is planning to use state funds for its expansion, which has already been delayed significantly due to the directive. Wisconsin moved forward despite the directive, but has been forced to rely entirely on state funds to cover

children above 250 percent of the FPL. With the economic downturn creating a greater need for coverage *and* pressure on state budgets,<sup>6</sup> many states cannot rely on this strategy and those that have may find it difficult to sustain state financing in the long-term.

**More children are at risk of losing coverage in the months ahead.** By August 2008, at least 23 states will be affected by the directive (Figure 1).<sup>7</sup> These include states whose plans to cover more uninsured children have been thwarted (described above), as well as states that have long covered children above 250 percent of the FPL. The 14 states that already have approval to cover such children are required by the directive to comply with its terms by August 2008 or to stop enrolling newly-eligible children. California, for example, offers coverage to some 32,000 children with family income modestly above 250 percent of the FPL.<sup>8</sup> In August 2008, it will lose the chance to enroll newly-eligible children in this income range unless it can comply with the directive, which currently appears unlikely.<sup>9</sup>



### Children will lose out on coverage even if a state is able to meet the August 17<sup>th</sup> directive requirements.

While no state has yet been approved to cover children with incomes above 250 percent of the FPL under the terms of the directive, if a state were to be granted approval, the directive requires states to implement a 12-month waiting period for children who had employer-sponsored coverage in the past *and* requires states to charge the maximum level of cost sharing allowed. It is unclear whether states will be permitted to allow any exceptions to the waiting period to account for situations such

as when a parent dies or the parent's employer goes out of business or substantially increases the cost of participating in the employer-based plan. These new rules will force significant policy changes to state programs. California, for example, would be required to quadruple the length of its current waiting period (which is three months), drop some or all of its exceptions to the waiting period, and increase premiums by up to 600 percent for families in the affected income range.<sup>11</sup>

Many states and researchers believe that these requirements will cause considerable harm to children. Virtually all states that cover children in moderate-income families charge premiums, but states have always been given the flexibility to set the levels of those premiums, subject to federal maximums. Premiums that are too high can keep families from enrolling their children or cause families to drop out of coverage over time.<sup>12</sup> Lengthy waiting periods, by definition, cause uninsured children to go without coverage, substantially diminishing their access to care. In addition, as discussed below, they may not be effective in combating crowd out.<sup>13</sup>

### Implications of CMS's "Grandfathering" Policy

CMS has advised states that they will not be required to terminate coverage for children with family income above 250 percent of the FPL who already are enrolled in SCHIP. This "grandfathering" policy, however, will do little to avert the shutdown of coverage among moderate-income children over time. The reason is that program turnover in SCHIP is considerable. Some children leave the program when their family income rises due to overtime pay or a wage increase; some leave because affordable employer-based coverage becomes available to the family; and some leave because of burdensome or confusing renewal procedures. Since the directive prohibits states from enrolling newly eligible children or even re-enrolling those who drop out for a short period, the grandfathering rule only temporarily forestalls the shutdown of coverage for moderate-income children. For example, Hawaii, New Jersey, and New Hampshire expect that within two years of when the directive is applied, 76 percent, 84 percent, and 88 percent, respectively, of the moderate-income children in their SCHIP programs will have disenrolled.<sup>10</sup> This will leave these states with only a small shadow of their original programs for such children.

### **SCHIP Keeps Connecticut Children Covered Despite Growing Family Budget Pressures**

Cynthia Williams lives in Bridgeport, Connecticut with her husband, two teenage children, and her two nephews. She is the sole support for her immediate family, working for the past 11 years for a cell phone company in New York City.

Cynthia has health insurance for herself through her employer, but the cost of covering the family through her employer plan was prohibitive. Fortunately, she has been able to cover her two children, Cassie and Corell, through Connecticut's SCHIP program, HUSKY B, paying \$50 a month plus \$5 copayments. She values the coverage even though her children are healthy—they get regular medical and dental check-ups, although there also have been times when the value of having insurance in an emergency hit home. When Cassie got hurt and needed to be rushed to the emergency room to treat a nearly severed finger, HUSKY covered the treatment she needed.

With rising prices, the struggles of keeping current with bills are topmost on Cynthia's mind. "I make \$60,000 a year and that may sound like a lot, but everything's going up—food prices, utility bills, gas for the car so I can get to work," she explained. "It all adds up and sometimes I have to make choices between buying food and paying the premiums for health insurance." So far she has been able to keep up her HUSKY payments, but she does not know how she or other families in her situation could pay for health insurance if an affordable choice like HUSKY was no longer available.

### **Goals of the Directive**

The stated goals of the directive, which include promoting enrollment of more low-income children and reducing crowd out, are widely shared by state and federal policymakers on both sides of the aisle. Increasingly, however, questions are being raised about whether the directive furthers either of these goals.

**The directive may actually deter enrollment of low-income children.** In providing its rationale for the directive, CMS has said that it is seeking to promote coverage of more low-income children. The directive may actually have the opposite effect by deterring new enrollment among already-eligible, low-income children. Experience shows that expanding coverage to more moderate-income children promotes enrollment among already-eligible children.<sup>14</sup> As Alan Weil, the Director of National Academy for State Health Policy (NASHP), explained when testifying before Congress, "Establishing higher eligibility levels can reinforce the message that children can qualify even if their parents are working and earning low to moderate incomes."<sup>15</sup> This is borne out by data from states that expanded coverage to moderate-income children before the directive was issued (Table 1). As the NASHP report notes, "a number of states have found that increasing eligibility to higher income levels has been instrumental in reaching more eligible children in families with income below 200 percent of the federal poverty level."<sup>16</sup>

In many instances, states required by the directive to roll back their expansion plans anticipated they would reach more low-income children by expanding coverage to moderate-income children. For example, Louisiana estimated that if it expanded coverage to 300 percent of the FPL, about three times as many already-eligible children

(24,000) would enroll as newly-eligible children (about 8,000).<sup>17</sup> Under a similar expansion proposal, Oklahoma estimated that the state would enroll 45,000 newly-eligible children and almost the same number (42,000) of already-eligible children.<sup>18</sup> Both of these states were forced by the directive to scale back their expansions and, in the process, may have lost the opportunity to cover some of these already-eligible children.

**The directive may be ineffective in preventing crowd out.** In explaining the directive, CMS also cited concerns about crowd out at higher income levels as part of its rationale for the directive. There is little dispute that crowd out occurs and that it increases as states expand coverage further up the income scale.<sup>19</sup> However, there is considerable uncertainty about the causes or the magnitude of the problem and little evidence about the effectiveness of the directive's specified anti-crowd out measures.<sup>20</sup> Of particular concern are the requirements that states impose a 12-month period of uninsurance on moderate-income children before they can enroll in SCHIP and that they impose maximum cost sharing on moderate-income families. The NASHP report highlights that many state officials believe both measures may not reduce crowd out, but will reduce children's access to care.<sup>21</sup>

In an amicus brief filed on behalf of states by various experts, it is noted that only a handful of states ever have used a 12-month waiting period.<sup>22</sup> Among those that have, nearly all have replaced them with shorter waiting periods after finding that they keep children from securing needed care and do not appear to be particularly effective in minimizing crowd out. For example, New Jersey had a 12-month waiting period for many years, but it found that while the waiting period did serve as a barrier to children enrolling in New Jersey's FamilyCare program, it did little to prevent crowd out. As a result, several years ago—with CMS approval—New Jersey reduced its crowd out period to three months.<sup>23</sup>

CBO also has raised some questions about the effectiveness of the directive's prescribed 12-month waiting period and cost sharing requirements as tools to curb crowd out. CBO Director Peter Orszag recently testified that based on existing evidence, it is not clear that the 12-month waiting period and the higher cost sharing mandated by the August 17<sup>th</sup> directive will help to reduce crowd out. Dr. Orszag said he “would just urge a little bit of caution in jumping to the conclusion that some of the provisions that are proposed to reduce crowd-out rates will actually succeed in doing so, given that the existing research is raising questions about whether they are

**Table 1: Expansions Result in Enrollment of Previously-Eligible Low-Income Children**

State (Time period of data since expansion)	Total New Enrollment Since Expansion	Enrollment of Previously-eligible Children Since Expansion	Previously-eligible Children as a Percent of All New Enrollees Since Expansion
<b>Illinois</b> (November 2005-November 2007)	200,000	140,000	<b>70%</b>
<b>Massachusetts</b> (July 2006-February 2008)	45,000	26,000	<b>58%</b>
<b>Pennsylvania</b> (March 2007-April 2008)	17,000	10,000	<b>59%</b>

Source: Data provided by the Illinois Department of Healthcare and Family Services (December 8, 2007), Pennsylvania Department of Insurance (April 7, 2008), and Massachusetts Office of Health and Human Services (April 28, 2008).

effective.”<sup>24</sup> To the contrary, these two 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.

### Research and Policy Basis for the Directive

Many of the new analyses of the directive have raised questions about the research and policy basis for the directive. They suggest that CMS is relying on questionable data to make high-stakes decisions about which states can cover more children, as well as that states are being expected to comply with requirements over which they have little or no control.

**The 95 percent standard is considered unattainable unless CMS relies on questionable data or methodologies.** Since the directive was issued on August 17, 2007, the requirement that states enroll 95 percent of low-income children has been particularly controversial. In evaluating the requirement, an Urban Institute analysis found that

“without adequate federal financing and a number of related federal policy changes, very few states are likely to reach 95 percent participation among low-income children. In addition, there are serious methodological challenges and data limitations that will need to be resolved before CMS can develop reliable state-level estimates as the basis for approving or denying state SCHIP plans.”<sup>26</sup> No state, to date, has successfully convinced CMS that it has reached the standard, which, according to the NASHP report, many states believe is “an unrealistic requirement.”<sup>27</sup>

Despite the widespread doubts about whether states realistically can meet the 95 percent requirement, CMS has testified that most states meet the standard.<sup>28</sup> This contradiction is explained by the apparent willingness of CMS to rely on data methodologies that are considered highly questionable when calculating participation rates. For example, CMS has produced a chart showing that most states already have enrolled more than 100 percent of the low-income children who are eligible for coverage, a finding that the CRS has described as lacking “face validity.”<sup>29</sup>

### CBO, CMS, and the 95 Percent Participation Rate Requirement

In evaluating the fiscal impact of the directive, the Congressional Budget Office (CBO) has said that the directive is unlikely to have a significant fiscal impact. This is largely because CBO is assuming that SCHIP funding will drop precipitously after March of 2009, which is when the program is slated to expire. As a result, CBO assumes that states will not have enough resources to sustain their existing SCHIP programs, much less to pursue newly-adopted expansions. CBO cannot assume that Congress will act in the future to reauthorize the program at more adequate funding levels, even though it is widely expected to do so.

Moreover, CBO has decided to accept the assurances of CMS that states in the future will not have trouble meeting the directive requirements, which also led to CBO estimating a relatively small impact from the directive. This decision, however, should not be viewed as CBO endorsing the way that CMS has used the data when justifying the directive. To the contrary, in commenting on its decision to accept CMS’s assertion that most states readily can meet the participation rate requirement, Peter Orszag, the Director of CBO, testified that “it reminds me of the joke about the guy who won the lottery by picking the number 36. And someone said, ‘why did you pick 36?’ He said, ‘well I’ve got six grandkids and their average age is seven, and six times seven is 36.’”<sup>25</sup>

According to CMS's analysis, Texas has a participation rate of 103 percent while Vermont has a participation rate of 206 percent.<sup>30</sup>

Even many state officials, who could benefit from CMS's willingness to rely on questionable data, are concerned about CMS's approach to the 95 percent requirement. Of particular concern is that the lack of clear and valid data could lead to arbitrary decision-making. As the director of NASHP noted in his testimony before Congress, "CMS sits down with them [states] one-on-one and says, well, you show us what data you think would make it clear that you have met the 95 percent standard, and that is not a good basis on which to determine whether or not States can expand coverage."<sup>31</sup> In fact, CMS already has rejected the expansion of one state, New York, in part on the grounds that it did not meet the participation rate requirement<sup>32</sup> even though it has a participation rate in excess of 144 percent under CMS's analysis.

**The directive withholds federal SCHIP funds based on trends in employer-based coverage over which states have little or no control.** State officials have noted that they share the federal government's interest in protecting and strengthening employer-sponsored insurance (ESI) coverage. However, many differ with the directive's assessment that states should be precluded from covering more uninsured children if employer-based coverage has declined by more than a minimal amount in recent years. Firms decide to offer insurance for many reasons, and states have very little ability to affect those decisions. As reported by NASHP, "Despite their interest in promoting ESI, states have no control over private employers' decisions to offer insurance coverage, as employers are regulated under federal ERISA.... And, although they can

regulate private insurance companies within their jurisdictions, states cannot change the decisions of individual employers regarding premiums or cost sharing imposed on employees."<sup>33</sup> This perspective is borne out by academic research, which indicates that health care costs, labor market trends, demographic trends, and other factors over which states have minimal, if any, control largely determine trends in employer-based coverage.<sup>34</sup>

### Overstepping of CMS Authority

In the weeks after the directive was issued, a number of states brought lawsuits against CMS (see box, next page), charging that the agency did not have the authority to abruptly and unilaterally change the SCHIP rules that since the inception of the program have allowed states to decide which uninsured children should be covered through SCHIP. Adding to the sense the CMS overstepped its authority and may have acted illegally are recent legal memos from the GAO and the American Law Division of the CRS.<sup>35</sup> The opinions independently conclude that the directive represents a marked departure from longstanding SCHIP rules and is not, as CMS has maintained, a simple clarification of the agency's existing rules. Under the Congressional Review Act, a new rule (versus the clarification of an existing rule), should be sent to Congress for review, which was not done with respect to the directive.

The new legal opinions help to validate the perspective that the directive has illegally, altered established SCHIP rules through a "backdoor" mechanism. By making these far-reaching and harmful changes through a mere letter to state officials, without any notice to stakeholders, Governors, families, and others were left with no opportunity to comment on how they might affect children's coverage. Not only does this raise the issue of whether CMS overstepped its legal bounds but it may have led to the poor research and data basis

for the policy. As Alan Weil, Director of NASHP, noted in testimony before Congress, “Because the directive was written and issued without any input from states, it includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd-out.”<sup>36</sup>

### Conclusion

A growing body of new resources indicates that CMS overstepped its bounds in issuing the directive and has put forth a policy with little or no basis in the research literature and state experiences. The directive abruptly and

unilaterally changes SCHIP and Medicaid rules and disrupts longstanding SCHIP programs without any solid evidence that the policies it mandates will further what all agree is the top priority of SCHIP and Medicaid – covering the lowest-income children. To the contrary, it already has taken a significant toll on state efforts to cover children. In the months ahead, even as the number of uninsured children is rising and more families are experiencing hardship due to the downturn in the economy, it will do even greater harm unless action is taken.

### States and Families Sue CMS On the Directive

**New Jersey** sued CMS over the directive, on October 1, 2007 claiming that (1) it was issued illegally without notice and comment as required by federal law; and (2) the Secretary of HHS does not have the legal authority to impose the requirements and policies in the directive.<sup>37</sup>

**New York, Illinois, Maryland, and Washington** filed suit on October 4, 2007 in federal court on similar grounds. To date, five other states, **California, Connecticut, Massachusetts, New Hampshire, and New Mexico** have filed “friend of the court” briefs in support of the four states that have sued. Others, including **New York City**, also filed supporting briefs.<sup>38</sup>

**Families of children** who were eligible for the New York expansion and who applied for coverage under the program before CMS denied the plan also filed suit on January 17, 2008.<sup>39</sup>

**Ohio and New York** both have administrative appeals pending before HHS relating to the denials of their state plan proposals.

## Appendix 1: Data on the Number of Children Affected by the August 17<sup>th</sup> Directive

In February 2008, CCF surveyed SCHIP directors in the 23 states affected by the directive in order to obtain data on the number of children potentially at risk as a result of the directive. This appendix reports the number of children potentially affected based on survey responses provided by states in combination with other sources of data, such as affidavits filed in the court cases.

Prior to August 17, 2007, 14 states had already received federal approval to expand coverage for children above 250 percent of the FPL. These states currently enroll children with gross incomes above 250 percent of the FPL, however the August 17<sup>th</sup> directive jeopardizes the capacity of these states to continue to offer coverage in this income range. Current enrollment data is reported below, however these children are not at immediate risk of losing coverage (see “Grandfathering” policy box on page 4).

- As of December 31, 2007, **California** covered some 31,607 children with income modestly above 250 percent of the FPL through their primary SCHIP program, plus an additional 3,809 infants through the SCHIP-funded Access for Infants and Mothers (AIM) program.
- As of April 1, 2008, **Connecticut** covered about 5,000 children with income above 250 percent of the FPL.
- As of December 2007, **Hawaii** covered 275 children with income above 250 percent of the FPL.
- In January 2008, **Maryland** covered 3,266 children with income above 250 percent of the FPL.
- As of December 31, 2007, **Massachusetts** covered about 5,600 children with income above 250 percent of the FPL.
- In early 2008, **New Hampshire** covered 2,140 children with income above 250 percent of the FPL.
- In February 2008, **New Jersey** covered 10,409 children with income above 250 percent of the FPL.
- In February 2008, **Pennsylvania** covered about 4,000 children with income above 250 percent of the FPL.
- **Washington** covers approximately 1,800 children with income modestly above 250 percent of the FPL.
- States for which responses or other data were not provided are: **District of Columbia, Minnesota, Missouri, Rhode Island, and Vermont.**

Ten states had enacted legislation to expand coverage above 250 percent of the of the FPL prior to August 17, 2007. As a result of the August 17<sup>th</sup> directive, the coverage plans in these states have been delayed, scaled back, and/or funded with state dollars.

- **Louisiana** initially estimated that an expansion to 300 percent of the of the FPL would cover 7,774 new children in the first year and 24,000 previously eligible, lower-income children; by scaling back the expansion to 250 percent of the of the FPL, the state estimates it can extend coverage to 4,000 fewer children than originally expected.
- **New York** expected to enroll 50,000 children with incomes of 251-400 percent of the FPL. The state recently decided to state fund its expansion, but the directive has created a significant delay.

- **North Carolina** estimates that there are about 38,000 uninsured children with incomes from 200-300 percent of the FPL.
- **Ohio** estimates that there are over 30,000 uninsured children with incomes from 200-300% FPL, of which about 12,000 have incomes from 250-300 percent of the FPL.
- **Oklahoma** initially estimated that an expansion to 300 percent of the of the FPL would cover 45,000 new children and 42,000 previously eligible, lower-income children; by scaling back the expansion to 250 percent of the of the FPL, the state estimates it will have to extend coverage to 10,000 fewer children than originally expected.
- **Washington** state estimates that in the first six months of an expansion to 300 percent of the FPL, about 3,000 newly-eligible children and about 2,700 previously-eligible children would be covered.
- States for which responses or other data were not provided are: **Illinois, Indiana, West Virginia, and Wisconsin.**

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## Endnotes

<sup>1</sup> C. Mann & M. Odeh, "Moving Backward: New Federally Imposed Limits on States' Ability to Cover Children," Center for Children and Families (August 2007); and C. Mann & M. Odeh, "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive to Impose New Limits on States' Ability to Cover Uninsured Children," Center for Children and Families (December 2007).

<sup>2</sup> The legal basis for extending the directive to Medicaid is not clear, but Dennis Smith, the former Medicaid director at CMS, has stated on a number of occasions that the policy does apply to Medicaid; for example, see R. Pear, "U.S. Curtailing Bids to Expand Medicaid Rolls," *New York Times* (January 4, 2008).

<sup>3</sup> S. Dorn, B. Garrett, J. Holahan, & A. Williams, "Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses," Kaiser Commission on Medicaid and the Uninsured (April 2008).

<sup>4</sup> Letter from Kerry Weems, Acting Director, Centers for Medicare and Medicaid Services to Cristal Thomas, Ohio Department of Job and Family Services (December 20, 2007); CMS determined that Ohio could not use Medicaid funds to cover children up to 300 percent of the FPL because Ohio had SCHIP funds available and must use those SCHIP funds first. Had Ohio attempted to expand through SCHIP, however, the August 17<sup>th</sup> directive presumably would have been applied by CMS. Ohio is challenging the denial of its Medicaid state plan expansion, and it has filed a plan to expand coverage through SCHIP but only up to 250 percent of the FPL. The SCHIP plan amendment is pending with CMS.

<sup>5</sup> Data provided by Oklahoma Health Care Authority (March 14, 2008), Louisiana Department of Health and Hospitals (December 10, 2007), and Ohio Department of Job and Family Services (2008). By rolling back their expansions to 250 percent of the FPL, 10,000 and 4,000 children in Oklahoma and Louisiana, respectively, have missed out on coverage; Ohio's delayed expansion could mean that about 12,000 children with income from 250-300 percent of the FPL and over 18,000 children with income from 200-250 percent of the FPL may miss out on coverage.

<sup>6</sup> *Op. cit.* (3).

<sup>7</sup> The District of Columbia is treated as a state for purposes of this analysis.

<sup>8</sup> Data provided by California Managed Risk Medical Insurance Board (April 25, 2008). California's primary SCHIP program, known as Healthy Families, covers uninsured children with family income up to 250 percent of the FPL. In evaluating a family's income, the program allows families to disregard up to \$90 in earnings, child care expenses (up to \$175 or \$200, depending on the age of the child), and up to \$175 per month in alimony, child support, and disabled dependent care.

<sup>9</sup> Harbage Consulting, "Assessing California's Ability to Comply with New Federal SCHIP Rules," California Health Care Foundation (October 5, 2007).

<sup>10</sup> Data provided by Hawaii Department of Human Services (February 22, 2008), New Jersey Department of Human Services (March 19, 2008); and New Hampshire Healthy Kids Corp. (May 2, 2008).

<sup>11</sup> Center for Children and Families analysis of California's *Healthy Families* program.

<sup>12</sup> For example, see G. Kenney, *et al.*, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry*, 43: 345-361 (2006); G. Kenney, *et al.*, "Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States," *Inquiry*, 43: 378-392 (Winter 2006/2007); and G. Kenney, *et al.*, "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research*, 42: 2354-2372 (December 2007).

<sup>13</sup> For example, see Health Policy Academics Amicus Brief in *State of New Jersey v. United States Department of Health and Human Services*, 3:07-cv-04698-JAP-JJH (2008).

<sup>14</sup> J. Hudson, T. Selden, & J. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry*, 42: 232-254 (Fall 2005); and A. Davidoff, G. Kenney, & L. Dubay, "Effects of the State Children's Health Insurance Program Expansions on Children With Chronic Health Conditions," *Pediatrics*, 116: e34-e42 (July 2005).

<sup>15</sup> A. Weil, *Covering Uninsured Children: The Impact of the August 17<sup>th</sup> CHIP Directive*, Testimony before the U.S. Senate Finance Committee, Subcommittee on Health Care (April 9, 2008).

<sup>16</sup> See pg. 4 of J. McInerney, M. Hensley-Quinn, & C. Hess, "The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs," National Academy for State Health Policy (April 2008); NASHP has assisted and worked with state SCHIP directors since the program's inception in 1997. The report is based on a series of structured discussions with SCHIP officials in states affected by the directive conducted in early 2008.

- <sup>17</sup> Data provided by Louisiana Department of Health and Hospitals (March 3, 2008).
- <sup>18</sup> Data provided by Oklahoma Health Care Authority (March 14, 2008).
- <sup>19</sup> In an extensive review of the literature, the Congressional Budget Office, has concluded that probably for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children, but assumes that initiatives to reach more uninsured children already eligible for Medicaid results in a reduction in private coverage of 20 children; see Congressional Budget Office, “The State Children’s Health Insurance Program,” (May 2007).
- <sup>20</sup> For a broader discussion on crowd out, see Center for Children and Families, “Addressing Crowd Out,” (March 2008).
- <sup>21</sup> *Op. cit.* (16).
- <sup>22</sup> *Op. cit.* (13).
- <sup>23</sup> As described in C. Mann, Declaration in *State of New York, State of Illinois, State of Maryland, State of Washington v. United States Department of Health and Human Services*, 07-CIV-8621 (2007).
- <sup>24</sup> P. Orszag, *Covering Uninsured Children: The Impact of the August 17 CHIP Directive*, Transcript of oral testimony before the U.S. Senate Finance Committee, Subcommittee on Health Care (April 9, 2008).
- <sup>25</sup> *Ibid.*
- <sup>26</sup> G. Kenney, “Medicaid and SCHIP Participation Rates: Implications for New CMS Directive,” Urban Institute (September 2007).
- <sup>27</sup> *Op. cit.* (16), pg. 4.
- <sup>28</sup> D. Smith, *Covering Uninsured Children: The Impact of the August 17 CHIP Directive*, Transcript of oral testimony before the U.S. Senate Finance Committee, Subcommittee on Health Care (April 9, 2008).
- <sup>29</sup> C. Peterson, *August 17 SCHIP Letter: 95% Enrollment Target for Eligible Low-Income Children*, Testimony before the U.S. Senate Finance Committee, Subcommittee on Health Care (April 9, 2008).
- <sup>30</sup> Powerpoint presentation from the Centers for Medicare and Medicaid Services to the National Association of State Medicaid Directors (Undated); these data have been made available at <http://ccf.georgetown.edu> .
- <sup>31</sup> A. Weil, *Covering Uninsured Children: The Impact of the August 17 CHIP Directive*, Transcript of oral testimony before the U.S. Senate Finance Committee, Subcommittee on Health Care (April 9, 2008).
- <sup>32</sup> Letter from Kerry Weems, Acting Director, Centers for Medicare and Medicaid Services to Judith Arnold, Office of Health Insurance Programs, New York Department of Health (September 7, 2007).
- <sup>33</sup> *Op. cit.* (16), pg. 6.
- <sup>34</sup> Y. Shen & S. Zuckerman, “Why Is There State Variation in Employer-Sponsored Insurance?,” *Health Affairs*, 22: 241-251 (January/February 2003); see also *op. cit.* (3).
- <sup>35</sup> Letter from the U.S. Government Accountability Office to Senators Rockefeller and Snowe, (April 17, 2008); and Letter from Morton Rosenberg, Specialist in American Public Law, Congressional Research Service, to Senator Rockefeller, (January 10, 2008).
- <sup>36</sup> *Op. cit.* (16).
- <sup>37</sup> *State of New Jersey v. United States Department of Health and Human Services*, 3:07-cv-04698-JAP-JJH (2007).
- <sup>38</sup> *State of New York, State of Illinois, State of Maryland, State of Washington v. United States Department of Health and Human Services*, 07-CIV-8621 (2007).
- <sup>39</sup> *Morganne and Olivia Miles, by their mother Krystal Titus, et al. v. Michael O. Leavitt, Secretary, United States Department of Health and Human Services*, 08-CV-0432 (2008).