AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

H.R. 5998, THE PROTECTING CHILDREN'S HEALTH COVERAGE ACT OF 2008

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MAY 15, 2008

Serial No. 110–118

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

54–777 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, JR., New Jersey
BART GORDON, Tennessee
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
Vice Chairman
LOIS CAPPS, California
MIKE DOYLE, Pennsylvania
JANE HARMAN, California
TOM ALLEN, Maine
JAN SCHAKOWSKY, Illinois
HILDA L. SOLIS, California
CHARLES A. GONZALEZ, Texas
JAY INSLEE, Washington
TAMMY BALDWIN, Wisconsin
MIKE ROSS, Arkansas
DARLENE HOOLEY, Oregon
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
CHARLIE MELANCON, Louisiana
JOHN BARROW, Georgia
BARON P. HILL, Indiana

JOE BARTON, Texas
Ranking Member
RALPH M. HALL, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
NATHAN DEAL, Georgia
ED WHITFIELD, Kentucky
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES W. "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
ROY BLUNT, Missouri
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
JOSEPH R. PITTS, Pennsylvania
MARY BONO MACK, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee

PROFESSIONAL STAFF

DENNIS B. FITZGIBBONS, *Chief of Staff*
GREGG A. ROTHSCHILD, *Chief Counsel*
SHARON E. DAVIS, *Chief Clerk*
DAVID CAVICKE, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

FRANK PALLONE, JR., New Jersey, *Chairman*

HENRY A. WAXMAN, California
EDOLPHUS TOWNS, New York
BART GORDON, Tennessee
ANNA G. ESHOO, California
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
Vice Chair
TOM ALLEN, Maine
TAMMY BALDWIN, Wisconsin
ELIOT L. ENGEL, New York
JAN SCHAKOWSKY, Illinois
HILDA L. SOLIS, California
MIKE ROSS, Arkansas
DARLENE HOOLEY, Oregon
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
JOHN D. DINGELL, Michigan *(ex officio)*

NATHAN DEAL, Georgia,
Ranking Member
RALPH M. HALL, Texas
BARBARA CUBIN, Wyoming
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
JOE BARTON, Texas *(ex officio)*

CONTENTS

	Page
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	1
Hon. Nathan Deal, a Representative in Congress from the State of Georgia, opening statement	9
Hon. Tammy Baldwin, a Representative in Congress from the State of Wisconsin, opening statement	10
Hon. Heather Wilson, a Representative in Congress from the State of New Mexico, opening statement	11
Hon. Gene Green, a Representative in Congress from the State of Texas, prepared statement	122
Hon. Anna G. Eshoo, a Representative in Congress from the State of California, prepared statement	128

WITNESSES

Peter Orszag, Director, Congressional Budget Office	12
Prepared statement	14
Dayna Shah, Managing Associate General Counsel, U.S. Government Accountability Office	32
Prepared statement	34
Morton Rosenberg, Specialist in American Public Law, American Law Division, Congressional Research Service	49
Prepared statement	52
Gary Alexander, director, Rhode Island Department of Human Services	75
Prepared statement	78
Lesley Cummings, executive director, The California Managed Risk Medical Insurance Board	83
Prepared statement	85

SUBMITTED MATERIAL

H.R. 5998	4

H.R. 5998, THE PROTECTING CHILDREN'S HEALTH COVERAGE ACT OF 2008

THURSDAY, MAY 15, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:10 a.m., in room 2322 of the Rayburn House Office Building, Hon. Frank Pallone Jr. (chairman) presiding.

Members present: Representatives Pallone, Green, Baldwin, Engel, Dingell (ex officio), Deal, Wilson, Burgess, and Barton (ex officio).

Staff present: Bridgett Taylor, Amy Hall, Brin Frazier, Lauren Bloomberg, Hasan Sarsour, Jason Powell, Ryan Long, Brandon Clark, and Chad Grant.

Mr. PALLONE. The meeting of the subcommittee is called to order, and today we are having a hearing on "H.R. 5998, the Protecting Children's Health Coverage Act of 2008." And I will now recognize myself for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The legislation before us is a bill that I introduced recently with my friend and colleague from New Hampshire, Representative Carol Shea-Porter. And our legislation would invalidate the so-called CMS August 17 Directive preventing CMS from applying any of the provisions included in the directive when it reviews state plans. It also requires CMS to review within 30 days the original proposals from States whose plans were either rejected or amended based on that directive.

As you know, for over 10 years, the State Children Health Insurance Program, or SCHIP, has had remarkable success in covering millions of low-income children, who would otherwise have nowhere else to turn, to obtain health coverage. And thanks to SCHIP, more than seven million children annually are able to obtain health coverage and receive the medical care that they need to live happy and healthy lives.

Last year we tried to build on the success of SCHIP by passing the Children's Health Insurance Program Reauthorization Act, or CHIPRA, of 2007, a bill that was negotiated on a bipartisan, bicameral basis. This bill would have provided states with the financial resources and tools they need to maintain their current pro-

grams as well as help them reach millions of low-income children who are presently eligible but not enrolled.

CHIPRA passed the House two times with significant support from both parties, but sadly, even though a majority of Americans and their representatives in Congress agreed that it was the right thing to do to cover more kids, the President disagreed. And the President actually vetoed the CHIP Reauthorization twice, and the majority of the House Republicans refused to join us in overriding the veto.

But blocking the will of Congress and the American public was not enough. The President also decided that he would try to single-handedly undermine the CHIP program to administrative PHEAA. In the earning evening of Friday, August 17, last year during the midst of a congressional recess, after many people had gone home for the weekend, the Bush Administration issued a letter to state health officials that has come to be known as the August 17 Directive, and I have taken issue with this directive on two grounds.

First, the substance contained within it, as well as the process in which it came to be. The policies put forward by the Administration and its directive fly in the face of SCHIP's intended purpose as well as what we were trying to accomplish with last year's reauthorization. The August 17 Directive would impose strict new requirements on states and beneficiaries that are not only impossible to achieve but make little, if any, sense.

For example, under the new directive, states would be prohibited from covering children in families with incomes above 250 percent of the federal poverty level or $44,000 for a family of three, unless 95 percent of all children eligible for Medicaid and CHIP with incomes below 200 percent are already enrolled. After talking with numerous state health officials, it is unclear how many states would be able to meet this requirement, if any.

Even more mind-boggling, the directive prevents states from enrolling for 1 year eligible children who lose their private health insurance. The Administration has yet to provide an answer on what these children should do during this year, other than the President's suggestion that the uninsured can simply go to the emergency room when they need care.

If implemented, the August 17 Directive will severely limit state flexibility, which has been the hallmark of SCHIP since its inception, and also the directive will greatly restrict enrollment. We have already seen its effects. The directive has already been used to either reject or scale back plans in states like Indiana, Louisiana, Ohio, Oklahoma, and New York that had planned to expand their programs in order to provide health care coverage to tens of thousands of presently uninsured children.

I am also alarmed about what will happen in places like my home state of New Jersey, which already covers children in this income range. If this directive were to go into effect, it would severely limit my State's ability to develop solutions that meet the unique needs of our State's uninsured population. According to our state officials, this directive could reduce enrollment of children in this income range by 84 percent, and I think that is appalling.

Aside from the substance of this directive, I am dismayed by the process in which it was developed and issued. The Bush Adminis-

tration broke the law when it issued this directive because it bypassed Congress and blocked any opportunity for public comment. As we will hear today, this is not just my opinion. Both GAO and CRS have concluded that the directive and the way it was issued violates the Congressional Review Act. And I am looking forward to hearing their testimony in that regard.

In sum, I am clearly opposed, as you can tell, to the Administration's August 17 Directive. It does nothing to move the ball forward in terms of covering more uninsured kids and, in fact, turns the clock back on our efforts over the past 10 years.

For those reasons, I think that we must block the directive from taking effect, which my legislation would do, and refocus our efforts on strengthening SCHIP.

And I now recognize Mr. Deal, our ranking member, for an opening.

[H.R. 5998 follows:]

I

110TH CONGRESS
2D SESSION

H. R. 5998

To nullify any effectiveness of the August 17, 2007, State health official letter issued by the Centers for Medicare & Medicaid Services.

IN THE HOUSE OF REPRESENTATIVES

MAY 8, 2008

Mr. PALLONE (for himself, Ms. SHEA-PORTER, Mr. ALTMIRE, Ms. BALDWIN, Mr. BRALEY of Iowa, Mrs. CAPPS, Mr. COURTNEY, Ms. DEGETTE, Ms. DELAURO, Mr. DINGELL, Mr. DOYLE, Mr. ELLISON, Mr. ENGEL, Ms. ESHOO, Mr. GENE GREEN of Texas, Ms. HARMAN, Mr. HODES, Ms. HOOLEY, Mr. INSLEE, Mr. LARSON of Connecticut, Mr. MARKEY, Mr. MURPHY of Connecticut, Mr. PATRICK J. MURPHY of Pennsylvania, Mr. RANGEL, Mr. RUSH, Ms. SCHAKOWSKY, Ms. SOLIS, Mr. STARK, Mr. STUPAK, Mr. TOWNS, Mr. WALZ of Minnesota, Mr. WAXMAN, and Mr. WELCH of Vermont) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To nullify any effectiveness of the August 17, 2007, State health official letter issued by the Centers for Medicare & Medicaid Services.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Protecting Children's
5 Health Coverage Act of 2008".

1 **SEC. 2. NULLIFYING ANY EFFECTIVENESS OF AUGUST 17,**
2 **2007, LETTER.**

3 (a) IN GENERAL.—With respect to the August 17th
4 Letter (as defined in subsection (c)(1)), the following shall
5 apply:

6 (1) Such Letter shall have no force or effect.

7 (2) The Secretary of Health and Human Serv-
8 ices is prohibited from applying or enforcing any pol-
9 icy, directive, or requirement contained in such Let-
10 ter, or any other policy, directive, or requirement
11 issued on or after August 17, 2007, substantially
12 similar to those contained in such Letter, unless
13 such policy, directive, or requirement is explicitly
14 contained in a regulation in effect before such date.

15 (3) In order to restore States, to the maximum
16 extent practicable, to the position they would have
17 been in if the August 17 Letter had not been issued
18 or applied, to the extent that a State's request
19 (through CHIP or Medicaid plan amendment, dem-
20 onstration project, or otherwise) made before the
21 date of the enactment of this Act to extend health
22 insurance through CHIP or Medicaid to uninsured
23 children, or to maintain previously existing CHIP or
24 Medicaid eligibility for children—

25 (A) was denied, in whole or in part, by
26 CMS on or after August 17, 2007, and before

1 the date of the enactment of this Act based, in
2 whole or in part, on the application of any pol-
3 icy, directive, or requirement contained in the
4 August 17th Letter, CMS shall, upon the writ-
5 ten request of a State made within 30 days
6 after such date of enactment, reconsider and
7 issue a new decision on the State's request
8 within 30 days of the date of such written re-
9 quest and without reliance on any such policy,
10 directive, or requirement;
11 (B) was approved before such date of en-
12 actment but had been modified, in whole or in
13 part, by a State before such approval specifi-
14 cally in response to the application of any such
15 policy, directive, or requirement, CMS shall,
16 upon the written request of the State made
17 within 30 days after such date of enactment,
18 issue a decision to approve or disapprove re-
19 moval of the modification (and restoration of
20 the original request) within 30 days of the date
21 of such written request and without reliance on
22 any such policy, directive, or requirement; or
23 (C) has been modified by a State, but not
24 acted upon by CMS, before such date of enact-
25 ment specifically in response to the application

of any such policy, directive, or requirement, upon the written request of the State made within 30 days after such date of enactment, the modification shall be deemed withdrawn and the request, with such modification withdrawn, shall be treated, effective as of the date of such written request, as if the modification had never been included with respect to such request and the CMS deadline otherwise applicable to acting on such request shall continue to apply without regard to the withdrawal of such modification.

(b) CONSTRUCTION.—Nothing in this section, or the enactment of this section, may be construed to suggest that the August 17th Letter ever had any force or effect.

(c) DEFINITIONS.—In this section:

(1) The term "August 17th Letter" means the State Health Official Letter #07–001 from the Director of the Center for Medicaid and State Operations of CMS dated August 17, 2007, to State Health Officials, and includes the State Health Office Letter #08–003 from such Director dated May 7, 2008, to such Officials regarding application of such August 17, 2007, letter.

1 (2) The term "CHIP" means the State Chil-
2 dren's Health Insurance Program under title XXI of
3 the Social Security Act.
4 (3) The term "CMS" means the Centers for
5 Medicare & Medicaid Services.
6 (4) The term "Medicaid" means the program
7 under title XIX of the Social Security Act.
8 (5) The term "State" has the meaning given
9 such term for purposes of CHIP.

○

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. Thank you for calling this hearing today, which will give us an opportunity to review your legislation, which addresses the August 17 letter from CMS. The letter outlines some guidelines that CMS planned to use when considering whether or not a state SCHIP plan adequately discouraged individuals from leaving private coverage in order to enroll in a government-financed health care plan.

This concern about government coverage crowding out private health insurance is a legitimate one. When the nonpartisan Congressional Budget Office reviewed past iterations of legislation to reauthorize the SCHIP Program, they concluded that for every 100 children who gain public coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

More specifically in the case of the reauthorization, CBO concluded that about one-third of the children who would be newly covered under SCHIP and Medicaid programs in the bill would otherwise have had private coverage.

In last year's reauthorization efforts, I fully supported reforms to SCHIP which would prevent crowd out of private insurance. I also supported creating a meaningful test to ensure that states covered the poorest children before moving up the income scale. As my chairman has indicated, his State of New Jersey, which has dramatically increased the income eligibility under SCHIP, they have not only left their poorest citizens behind, but they have also increased the likelihood of crowd out because wealthier populations are more likely to have access to private insurance.

If the chairman is dissatisfied with the method used by CMS to implement policies to discourage crowd out, I believe that members on our side of the aisle would be willing to work with him to achieve these goals through legislative means. However, as I read this legislation that we are considering, it appears to be an attempt to prohibit CMS from taking reasonable steps to ensure that states like New Jersey, which have left nearly a quarter of their poorest citizens behind, would actually do the hard work to cover the neediest children.

In fact, New York submitted a state plan amendment to receive federal SCHIP matching payments for covering children with family incomes up to 400 percent of the federal poverty level, or $84,800 for a family of four. So far, this is the only state plan amendment to be denied based upon the policies described in the August 17 guidance letter.

H.R. 5998 would force the secretary to promptly reconsider New York's state plan amendments to go to 400 percent of the federal poverty level without using the policies in the August 17 guidance letter. It seems all too likely that this legislation is an attempt to allow New York to receive federal taxpayer dollars to subsidize the health expenditures of New Yorkers making nearly $85,000 a year. Coming from a state where the median income is just above $45,000, it is difficult for me to contemplate sending the federal taxpayers' dollars from my state to families making nearly twice the median household income of my state of Georgia.

I look forward to the testimony of our witnesses today and in particular the insights of the officials from Rhode Island, whose State was able to comply with the requirements of the August 17 letter. And I think our witnesses should be able to provide us an important perspective on these issues, and I thank all of you for your attendance here today.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal. The gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman. I appreciate the fact that you are holding this important hearing, and I am proud to also be an original cosponsor of your bill, "The Protecting Children's Health Coverage Act of 2008."

Mr. Chairman, I know that you and other members of this committee were very disappointed last year when the Administration failed to work with us in ensuring health care access to the 10 million kids who would have been covered under the House-passed SCHIP bill. And these administrative actions, like the August 17 Directive and the Medicaid regulations that the House recently voted to temporarily halt, are really like pouring salt into the wounds left by that disappointment last year with SCHIP being vetoed.

Mr. Chairman, I believe that every American has a right to comprehensive, affordable health care, and I believe that 8.7 million uninsured kids is 8.7 million too many. I believe that the SCHIP Program has proven to be an effective partnership between the Federal Government and the states in covering uninsured children. And I believe that states who want to expand their SCHIP Programs to cover more uninsured children should not be prevented from doing so.

The August 17 Directive is harmful. It is overreaching, and it is an attack on SCHIP. Both the Government Accountability Office and the Congressional Research Service have issued legal opinions that the August 17 Directive violates the Congressional Review Act. This directive will result in more uninsured children, and that is simply unacceptable.

So, Mr. Chairman, I am proud to be an original cosponsor of H.R. 5998. This bill would nullify the August 17 Directive and will ensure that states can continue to cover uninsured children to the extent that they can.

Mr. Chairman, thank you for holding this hearing. Thank you to our witnesses who will testify today. I am disappointed that the Administration did not accept our invitation to defend their actions, but I look forward to today's discussion. And I yield back the balance of my time.

Mr. PALLONE. Thank you. The gentlewoman from New Mexico, Ms. Wilson.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. WILSON. Thank you, Mr. Chairman. I am actually a supporter of the Children's Health Insurance Program. I think it has been an important program to reduce the number of uninsured children in America. In New Mexico, 25,000 low-income children get access to health care through the Children's Insurance Program. In New Mexico, we call it New MexiKids.

I also agree with those who say that SCHIP should be targeted to the lowest income kids. I actually was a cabinet secretary for child welfare in New Mexico when we implemented the program initially, and it is a very good and effective program. But it needs some things to be fixed.

In particular, the legislation as it was initially passed 10 years ago did not have the same requirements that exist in other federal programs to make sure that those who sign up are American citizens. It also does not have any cap, an upper-income cap, and a lot of states have involved adults in the program. This is a program that is intended to provide health insurance to low-income children who are American.

The August 17 letter attempts to offer states guidance on how to comply with some principles which were embodied in the original SCHIP legislation and strengthen bipartisan SCHIP reauthorization legislation considered by Congress last year and vetoed by the President. But I think there are some important questions to be asked about the August 17 Directive.

First, does the policy outlined in the letter clarify existing requirements and law, or does it go beyond to limit the ability of states to design their own SCHIP Programs as they see fit? Second, if it does amend existing regulations, should these policy changes go through the rule-making process to give states and interested parties the ability to provide public comment? And third, if it does amend existing law or congressional intent, should Congress consider these policy changes and give them statutory authority?

I look forward to hearing the answer to some of these questions here today, and I hope that in this next Congress we can stop some of the demagoguery from the far left and the far right and reauthorize a program that has been effective at helping low-income children get access to health care and it also fixes some problems with SCHIP by getting adults out of the program, limiting it to low-income American children.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Ms. Wilson. I believe that concludes our opening statements by members of the subcommittee, so we will now turn to our panel. And we do have but one panel today, a very good one. And I want to welcome everybody, welcome all of you for being here today.

Let me introduce you from left to right, starting with Dr. Peter Orszag, who is Director of the Congressional Budget Office. Welcome. And then next to him is Ms. Dayna Shah, who is Managing Associate General Counsel for the GAO. And next to her is Mr. Morton Rosenberg, who is a specialist in American Public Law from the American Law Division of the Congressional Research

Service, or CRS. And next to him is Mr. Gary Alexander, who is Director of the Rhode Island Department of Human Services. And then we have Ms. Lesley Cummings, who is Executive Director of the Managed Risk Medical Insurance Board in Sacramento, California. Welcome.

We have 5-minute opening statements. They become part of the hearing record. The committee may also ask you, as you will notice from some of our questions as we proceed, to provide us some statements in writing as follow up. And we will get back to you with those questions so you can respond in writing. And those would also be included in the record once you get back to us.

But we will start with Peter Orszag. Thank you for being here, and thank you for all you do over the years.

STATEMENT OF PETER ORSZAG, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. ORSZAG. Thank you very much, Mr. Pallone, Mr. Deal, members of the Committee. I will be brief, and let me make four points. First, SCHIP has significantly reduced the number of low-income children who lack health insurance in the United States. You can see in Figure 1 of my testimony on page 8 that there was a dramatic reduction, about 25 percent, in the share of children between 100 and 200 percent of the poverty level who are uninsured in any given year at around the time that SCHIP was enacted. Those are the children who represent the bulk of beneficiaries under the SCHIP Program.

At higher income levels, there was no reduction in uninsurance rates and it is therefore reasonable to conclude that the program had a lot to do with the reduction in uninsurance between 100 and 200 percent of poverty. There was also a reduction below the poverty level, and that is likely a reflection of the outreach efforts that were involved in SCHIP increasing enrollment in Medicaid where children below 100 percent of poverty are disproportionately concentrated.

The enrollment of children in public coverage in both SCHIP and Medicaid, however, as a result of SCHIP, has not led to a one-for-one reduction in the number of low-income children who are uninsured. In the specific case of SCHIP, the program provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than alternative coverage, making it attractive to families.

On the basis of our review of the research literature, CBO has concluded that for every 100 children covered under SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

Third, CBO's analysis of CHIPRA, as passed by the House of Representatives, suggests that the legislation would increase coverage under Medicaid and SCHIP in 2012 by 5.8 million children, of whom 3.9 million would otherwise be uninsured and roughly two million would have otherwise had insurance. In other words, about a third of the children who would be newly covered under the legislation who would otherwise have had private coverage.

Given the scale of the increase in coverage that was entailed in that program, it is extraordinarily unlikely that you would be able

to get crowd-out rates significantly below a third through any feasible policy intervention.

Finally, on August 17, 2007, as has already been mentioned, the Administration issued a directive to state health officials under CBO's baseline in which funding in future years is constrained to be $5 billion a year. That directive has only very minimal effects on enrollment of children in SCHIP primarily because States are so constrained under that baseline funding that whether children above 250 percent are newly covered or not doesn't matter that much because there is so much downward pressure on enrollment in general under that baseline concept.

If you provided additional funding to the program, the effect of the directive could be somewhat larger, and we could have a discussion of that during the question-and-answer period.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Orszag follows:]

Congressional Budget Office

Testimony

Statement of
Peter R. Orszag
Director

Covering Uninsured Children in the State Children's Health Insurance Program

before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

May 15, 2008

This document is embargoed until it is delivered at 10:00 a.m. (EDT) on Thursday, May 15, 2008. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Pallone, Congressman Deal, and Members of the Subcommittee, it is my pleasure to appear before you today to discuss the State Children's Health Insurance Program (SCHIP). My testimony makes the following main points:

- SCHIP has significantly reduced the number of low-income children who lack health insurance. According to the Congressional Budget Office's (CBO's) estimates, the portion of children in families with income between 100 percent and 200 percent of the poverty level who were uninsured fell by about 25 percent between 1996 (the year before SCHIP was enacted) and 2006. In contrast, the rate of uninsurance among higher-income children remained relatively stable during that period. The difference probably reflects the impact of the SCHIP program.

- The states' outreach efforts and simplified enrollment processes for SCHIP appear to have also increased the share of eligible children who participate in Medicaid—and contributed to a decline in the percentage of children living below the poverty level who are uninsured.

- The enrollment of children in public coverage as a result of SCHIP has not led to a one-for-one reduction in the number of low-income children who are uninsured, however. Almost any increase in government spending or tax expenditures intended to expand health insurance coverage will displace private coverage to some degree. In the specific case of SCHIP, the program provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than alternative coverage. As a result, the program displaces—or "crowds out"—private coverage to some extent. On the basis of a review of available research, CBO has concluded that for every 100 children who gain public coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

- CBO's analysis of the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House of Representatives, suggested that the legislation would result in 5.8 million children gaining coverage under Medicaid or SCHIP in 2012. Of that increase, CBO estimated, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage. In other words, about one-third of the children who would be newly covered under SCHIP and Medicaid would otherwise have had private coverage. That crowd-out rate is probably about as low as feasible for a voluntary program to increase coverage among children, given the size of the proposed expansion. (Policies to reduce the rate below that level would most likely also reduce the number of children enrolled in the program who would otherwise be uninsured.)

- On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a directive to state health officials that imposes certain minimum requirements on states seeking to enroll children in SCHIP whose families have income above 250 percent of the poverty level. CBO's analysis suggests that the directive's impact on enrollment is likely to be modest under current law, given the way CMS appears to be implementing it and, more important, given the funding levels assumed in CBO's baseline. The directive could have a substantially larger impact on enrollment in SCHIP if the Congress expanded the program significantly.

- On May 7, 2008, CMS released a follow-up letter clarifying certain aspects of the August 17 directive. The clarifications issued by CMS are generally consistent with how CBO originally interpreted the August 17 letter; therefore, CBO has not altered its estimates of the policy's impact on the cost and coverage of SCHIP.

Overview of the State Children's Health Insurance Program

The State Children's Health Insurance Program was established by the Balanced Budget Act of 1997 to expand health insurance coverage to uninsured children in families with income that is modest but too high to qualify for Medicaid. SCHIP is financed jointly by the federal government and the states, and it is administered by the states within broad federal guidelines. The Congress provided approximately $40 billion in funding for SCHIP for fiscal years 1998 through 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) extended funding for the program through March 2009.

Eligibility and Enrollment

States have considerable flexibility in designing their eligibility requirements for SCHIP. According to the SCHIP statute, states may cover children living in families with income up to 200 percent of the federal poverty level or 50 percentage points above their Medicaid threshold.[1] States are allowed to disregard certain types of income and expenses in determining eligibility for the program. In 2008, 23 states allow a maximum income equal to 200 percent of the poverty level, 20 states set the limit above 200 percent of the poverty level, and 7 states set it below 200 percent of the poverty level.[2] North Dakota has the lowest threshold, at 140 percent of the poverty level, while New Jersey has the highest, at 350 percent of the poverty level.[3]

1. States are required to maintain the Medicaid threshold (or level of income determining eligibility) that was in place just before SCHIP was enacted. That requirement, for what is termed "maintenance of effort," prevents states from lowering their Medicaid threshold in order to receive a higher matching rate under SCHIP for children who otherwise would have been covered by Medicaid.

2. See Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, CRS Report for Congress RL30473 (Congressional Research Service, March 12, 2008).

3. New Jersey has effectively expanded its threshold to 350 percent of the poverty level by disregarding all income between 200 percent and 350 percent of the poverty level.

Table 1.

Enrollment in the State Children's Health Insurance Program, 1998 to 2006

Fiscal Year	Number of Children (Thousands)	Percentage Change from Previous Year	Number of Adults (Thousands)	Percentage Change from Previous Year
1998	660	n.a.	0	n.a.
1999	2,014	205	0	n.a.
2000	3,358	67	0	n.a.
2001	4,603	37	234	n.a.
2002	5,354	16	374	60
2003	5,985	12	484	29
2004	6,103	2	646	33
2005	6,114	0	639	-1
2006	6,745	9	671	5
2007[a]	7,145	6	587	-13

Source: Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Notes: n.a. = not applicable.

The figures for the number of people enrolled reflect enrollment at any time during the year. The number of people enrolled in an average month would be about 60 percent of the above totals. There was a change in reporting between 2004 and 2005. Prior to 2005, in states with a combination program, children enrolled in both the Medicaid expansion and the separate program during a given year were counted twice. Starting in 2005, however, those children were counted only in the program where they were last enrolled.

a. Preliminary.

A number of states have used waivers of statutory provisions to expand coverage under SCHIP to adults. About 80 percent of the adults who were enrolled in SCHIP in 2007 were parents, 19 percent were childless adults, and 1 percent were pregnant women. Covering parents may help increase participation among children because parents who are eligible may be more likely to enroll their children also.

The number of children enrolled in SCHIP at any time during the year increased from 660,000 in 1998 to 7.1 million in 2007 (see Table 1). As states first implemented their programs, enrollment grew very rapidly, reaching almost 6 million children by 2003. Since then, enrollment has grown more slowly as states' programs have matured and some states have enacted policies to restrict enrollment in response to budgetary pressures. About 587,000 adults were enrolled at some point during 2007.

Benefits

States can provide SCHIP coverage by expanding Medicaid to include children not eligible for that program, creating a separate program under SCHIP, or using a combination of the two approaches. In 2008, 8 states are using an expansion under Medicaid, 18 states operate a separate program, and 24 states are using a combination

approach.[4] States that provide SCHIP coverage by expanding Medicaid must provide the same benefits that are available under their Medicaid program and follow all other requirements of that program. States that create a separate program under SCHIP are subject to certain minimum standards, including providing a benefit package that is based on one of several specified "benchmark" insurance plans or an alternative that is actuarially equivalent or otherwise approved by the federal government.

The Financing of SCHIP

The statute that established SCHIP set national funding levels for each year from 1998 to 2007. In addition, it specified a formula for determining each state's share of the federal funding, a matching rate for federal reimbursement of SCHIP spending, and a mechanism for redistributing states' unused SCHIP funds.

The annual funding levels specified in the original SCHIP legislation were as follows: for 1998 through 2001, roughly $4.2 billion annually; for 2002 through 2004, about $3.2 billion per year; for 2005 and 2006, $4 billion per year; and for 2007, $5 billion. MMSEA provided $5 billion for 2008 and that same amount for 2009 (which is available to the states through March 2009) and up to $1.6 billion in additional funds for 2008 and $275 million in additional funds in 2009 to be used for states that exhaust their federal funds.

Each year, federal funding for SCHIP is allocated among states on the basis of a formula that takes into account the number of children in low-income families in each state, the number of such children who are uninsured, and wages in the health services sector in the state relative to the national average. States must provide matching funds for expenditures from their federal allotments and have up to three years to spend those allotments. Funds that are not spent within three years are redistributed to states that have exhausted their allotments and are made available to those states for an additional year.

To encourage states to participate in SCHIP, the federal government pays a higher share of their spending on SCHIP than it pays for Medicaid. The federal government's matching rate for SCHIP varies among states from 65 percent to 83 percent; the federal matching rate for Medicaid varies from 50 percent to 76 percent.[5] The national average matching rate for SCHIP is 70 percent and for Medicaid, 57 percent. Although federal funding is made available on a matching basis for both programs, the nature of the programs differs significantly because SCHIP is a grant program in which federal spending is capped in advance whereas Medicaid is an entitlement program with no predetermined limit on spending.

---

4. See Herz, Peterson, and Baumrucker, *State Children's Health Insurance Program: A Brief Overview.*

5. SCHIP's formula for determining the matching rate is based on the state's federal medical assistance percentage (FMAP), as used in the Medicaid program, and equals FMAP + 0.3 * (100 - FMAP), with an upper limit of 85 percent.

Rules for the redistribution of unused funds have been amended a number of times, both by extending and shortening the periods during which unspent funds are available. Because states were initially slow in spending their allotments, the Congress allowed the states to retain some of their allotments longer than three years. In contrast, because recent spending has outpaced federal funding, the National Institutes of Health Reform Act of 2006 (Public Law 109-482) required that a portion of unspent 2005 allotments be redistributed in 2007 instead of 2008.

The type of program that a state operates under SCHIP has distinct implications for funding levels. States choosing to implement SCHIP by expanding Medicaid may continue receiving federal matching funds at that program's lower federal matching rate once their SCHIP spending exceeds their available funds. In contrast, states operating a separate program receive federal matching funds (at the enhanced rate) only up to the amount determined by the allocation formula (unless they convert their program to a Medicaid expansion).

Expenditures for SCHIP

Initially, federal spending on SCHIP was well below the annual funding levels, as states implemented their programs (see Table 2). However, since 2002, federal spending has exceeded the annual allotments every year. Because unspent funds from previous years and the redistribution of other states' unspent funds provide additional SCHIP financing for some states, those states have forestalled exhausting their federal funds. Recently, however, some states have had insufficient federal funds available to fully match their SCHIP spending. As a result, the Congress has acted several times to provide additional funding. The Deficit Reduction Act of 2005 (P.L. 109-171) appropriated an extra $283 million in federal funding to support states' SCHIP spending in 2006. The National Institutes of Health Reform Act of 2006 included provisions modifying the redistribution of unspent funds from previous years to provide additional funds in 2007.[6] The U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28) appropriated up to $650 million in additional federal funding. Most recently, MMSEA provided up to $1.6 billion in additional funds for 2008 and $275 million in additional funds for 2009 to cover states' spending through March 2009.

6. The National Institutes of Health Reform Act of 2006 reduced the availability of 2005 allotments in some states from three years to two and a half. Specifically, states forfeited half of their unspent 2005 funds (not exceeding $20 million) if their total available funds as of March 31, 2007, were at least twice their projected spending in 2007. The law also specified that spending in 2007 from redistributed funds on adults who were not pregnant would be reimbursed at Medicaid's lower matching rate.

Table 2.

Allotments and Spending Under the State Children's Health Insurance Program, 1998 to 2007

(Millions of dollars)

Fiscal Year	SCHIP Allotments[a]	Allotments Unspent After 3 Years[b]	Federal Spending	Funds Expiring
1998	4,235	n.a.	122	0
1999	4,247	n.a.	922	0
2000	4,249	n.a.	1,929	0
2001	4,249	2,034	2,672	0
2002	3,115	2,819	3,776	0
2003	3,175	2,206	4,276	0
2004	3,175	1,749	4,645	1,281
2005	4,082	643	5,089	128
2006	4,365 [c]	173	5,452	0
2007	5,040	62	6,000	0
2008[d]	6,000	58	7,094	0

Sources: Congressional Budget Office, Congressional Research Service, the Balanced Budget Act of 1997, the Deficit Reduction Act of 2005, and the Centers for Medicare and Medicaid Services.

a. For both states and territories.

b. In general, states' annual allotments are available for three fiscal years. Any funds unspent after three years become available to other states with projected spending in excess of their allocation plus any available funds from previous years.

c. Includes additional funding from the Deficit Reduction Act of 2005.

d. Projection by the Congressional Budget Office.

The Effect of SCHIP on Children's Health Insurance Coverage

SCHIP has significantly increased the number of children from low-income families who have health insurance, but enrollment in the SCHIP program is greater than the corresponding decrease in the number of uninsured low-income children. SCHIP provides a source of coverage that is less expensive to enrollees and often provides a broader range of benefits than private coverage; as a result, some people who otherwise would have obtained private health insurance coverage have instead enrolled in SCHIP. Estimates of the extent to which private coverage has declined in response to the program vary, but the available evidence strongly suggests the net effect of the program has been to reduce the number of uninsured children.

Changes in the Number of Uninsured Children

Information on changes in the number of children who are uninsured comes from self-reported data collected in household surveys. The estimates presented here are based on data from the Annual Social and Economic Supplements to the Current Population Survey, conducted by the Census Bureau, which is the most widely cited source of information on insurance coverage. Although the survey is intended to measure the number of people who were uninsured throughout the calendar year, it yields estimates that are similar to other surveys' estimates of the number of people who were uninsured at a particular point in time.[7]

SCHIP should be expected to have had the greatest effect on the extent of insurance coverage among children in families with income between 100 percent and 200 percent of the poverty level because that was the group that had the greatest increase in eligibility for public coverage.[8] According to CBO's analysis, the percentage of children in that income range who were uninsured fell from 23 percent in 1996 (the year before SCHIP was created) to 17 percent in 2006, a reduction of about 25 percent (see Figure 1). The rate of uninsurance was relatively stable among children in families with income over 200 percent of the poverty level. For example, among children whose families had income between 200 percent and 300 percent of the poverty level, the rate of uninsurance remained at about 10 percent from 1996 to 2006.[9]

Among children in families below the poverty level, the rate of uninsurance rose from 24 percent in 1996 to 27 percent in 1998 and then fell to 22 percent in 2006. The increase from 1996 to 1998 in the percentage of such children who were uninsured

---

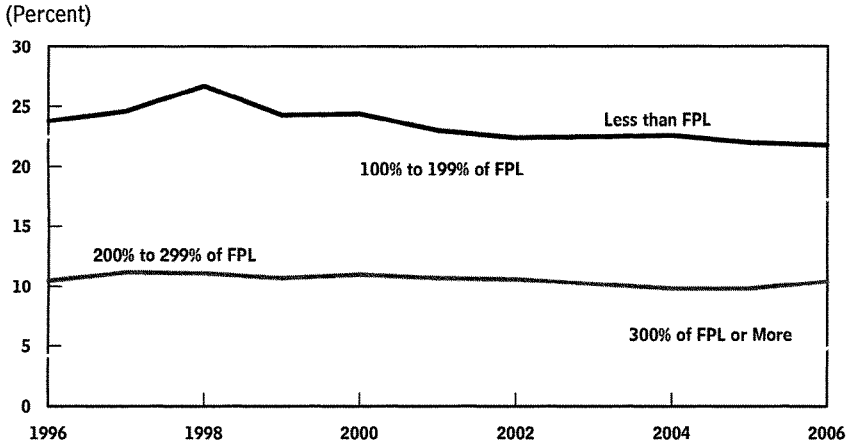
7. For a discussion of the strengths and limitations of the Current Population Survey and other household surveys for measuring insurance coverage, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003).

8. One recent study found that the rate of eligibility of children in families with income between 100 percent and 200 percent of the poverty level increased 70 percentage points from 1996 to 2002—compared with an increase of about 30 percentage points among children in families with income between 200 percent and 300 percent of the poverty level, an increase of 10 percentage points among those below the poverty level, and an increase of 8 percentage points among those between 300 percent and 400 percent of the poverty level. See Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* Working Paper No. W12858 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

9. In its analysis, CBO accounted for the fact that a "confirmation" question was added to the Current Population Survey beginning with the interviews that collected data for 1999. The new question asked people who did not report having any of several types of insurance coverage whether, in fact, they were uninsured. CBO compared estimates of uninsurance rates with and without the data from the confirmation question and used those two sets of estimates to create an adjustment factor (separately for each income group) that it applied to the estimates for years prior to 1999 to make them comparable with estimates for later years.

Figure 1.

Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level, 1996 to 2006



Source: Congressional Budget Office based on data from the Current Population Survey for 1996 to 2006.

Note: FPL = federal poverty level.

was accompanied by a drop in Medicaid coverage, which some analysts have cited as an unintended consequence of the welfare reform law that was enacted in 1996.[10]

The decline in the percentage of such children who were uninsured after 1998 was accompanied by an increase in Medicaid coverage. In general, SCHIP did not make more children in families below the poverty level eligible for public coverage because most were already eligible for Medicaid. However, the percentage of children eligible for Medicaid who participated in that program increased, which some analysts have attributed partly to states' outreach efforts for SCHIP (because applicants for SCHIP were enrolled in Medicaid if they were found to be eligible for that program) and the simplified application procedures that states adopted for both SCHIP and Medicaid.[11]

10. See, for example, Karl Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs*, vol. 20, no. 1 (January/February 2001), pp. 97–111.

11. See Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002," *Health Affairs*, vol. 23, no. 5 (September/October 2004), pp. 39–50.

Those changes in the percentage of children who were uninsured do not yield an estimate of the impact of SCHIP because there are many other factors—such as changes in employment levels, family income, and health insurance premiums—that affect children's health insurance coverage. Nevertheless, the fact that the greatest reduction in the percentage of children who were uninsured occurred among those who had the greatest increase in eligibility for public coverage after SCHIP was established strongly suggests that the program has reduced the number of children in low-income families who are uninsured. As discussed below, however, estimating the effect of SCHIP on children's health insurance coverage requires a more sophisticated analysis that controls for other factors that influence coverage and accounts for the program's effects on the number of people with private insurance.

Children's Participation in SCHIP

The number of children who participate in SCHIP depends in part on low-income parents' awareness and understanding of the program, their attitudes toward public insurance programs and health insurance in general, and the ease of the application process. Nearly all states have promoted SCHIP through mass media campaigns, and most have used community-based efforts such as educational sessions and home visits.[12] States have also implemented simpler enrollment procedures for SCHIP than those used for Medicaid (although some have also adopted simpler enrollment procedures for Medicaid). For example, most states do not require a face-to-face interview for a parent to apply for SCHIP or to renew coverage but instead use simple mail-in application forms, and most do not impose an asset test (that is, basing eligibility on the amount of assets a family owns). Most states have a 12-month renewal period, which enables children to remain enrolled in SCHIP for a year unless their family reports a change in income or other circumstances.[13] Since 2001, though, some states have reduced their outreach efforts and retracted certain simplified enrollment procedures in response to fiscal pressures.[14]

According to one study, 29 percent of the children who were eligible for SCHIP in 2005 on the basis of their family's income participated in the program.[15] Half of the eligible children were covered by employment-based health insurance, 6 percent had other coverage, and 15 percent were uninsured. According to that study's estimates, the uninsured children who were eligible for SCHIP accounted for over a fifth of all

12. Margo Rosenbach and others, *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* (report submitted by Mathematica Policy Research, Inc., to the Centers for Medicare and Medicaid Services, March 2003).

13. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006* (January 9, 2007), available at www.kff.org/medicaid/7608a.cfm.

14. Ibid.

15. Genevieve Kenney and Allison Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents, Health Policy Online, no. 15* (Washington, D.C.: Urban Institute, February 2007).

uninsured children in 2005. Other studies have estimated that between 60 percent and 75 percent of all uninsured children are eligible for either Medicaid or SCHIP.[16]

Although all of those studies were based on rigorous statistical methods, they have important limitations because they relied on data collected in household surveys to determine children's health insurance coverage and to identify children who were eligible for SCHIP or Medicaid. Coverage in public programs such as Medicaid is underreported in such surveys, but the implications of that underreporting for the estimated number of people who are uninsured is unclear. There is some evidence that many people who are enrolled in Medicaid but who do not report having coverage under the program may report having private coverage instead.[17] There is also evidence that some SCHIP enrollees report having private nongroup insurance, which is not surprising in that many states design their programs to resemble private insurance.[18] Additional research is needed to fully understand the implications of the underreporting.

Another potential problem is that survey data on such things as types of income and expenses that may be disregarded for determining eligibility are also subject to misreporting. In addition, some major surveys (such as the Current Population Survey) collect data on annual income but no information on fluctuations during the year, which would be relevant for determining eligibility for SCHIP.

The Effect of SCHIP on Private Coverage

Determining the extent to which enrollment in SCHIP is offset by reductions in private coverage is important for evaluating the overall effects of the program and for assessing the extent to which government spending on the program has reduced the number of children who are uninsured. The crowding out of private coverage can occur through various mechanisms. For example, some parents who would have otherwise had family coverage through their employer might decline it for their children—or might decline coverage altogether—if their children are eligible for SCHIP. In addition, previously unemployed parents might be more likely to decline coverage at a new job if their children are enrolled in SCHIP. To the extent that SCHIP makes private coverage less important for some families, the program might also increase the likelihood that low-income parents take jobs that offer higher cash wages rather than

16. See Selden, Hudson, and Banthin, "Tracking Changes in Eligibility and Coverage Among Children"; and Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs,* Web Exclusive, November 30, 2006.

17. See Kathleen Thiede Call and others, "Uncovering the Missing Medicaid Cases and Assessing Their Bias for Estimates of the Uninsured," *Inquiry,* vol. 38, no. 4 (Winter 2001/2002), pp. 396–408.

18. See Joel C. Cantor and others, "The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market," *Health Services Research,* vol. 42, no. 4 (August 2007), pp. 1739–1757; and Anthony T. Lo Sasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics,* vol. 23, no. 5 (2004), pp. 1059–1082.

health insurance. Thus, even in the majority of states where SCHIP covers only children, the program could reduce private coverage among adults as well as children.

SCHIP can also reduce private coverage by influencing the actions of employers. If employers of low-wage workers believe that SCHIP makes health insurance less important in attracting high-quality employees, some might reduce their contribution to the premiums for family coverage, reduce the level of benefits offered, stop offering family coverage, or stop offering insurance altogether. Such actions could lead to less private coverage among families that are eligible for SCHIP as well as for those that are not.

Families that substitute SCHIP for private coverage are generally better off because the cost (to the enrollees) is lower and the package of benefits may be more extensive. However, to the extent that employers respond to SCHIP by increasing premiums, reducing benefits, or declining to offer coverage, other families could be worse off.

Little is known about how employers have responded to SCHIP. As discussed below, the limited evidence that is available suggests that SCHIP has not affected employers' decisions on whether to offer coverage but may have caused them to modestly raise employees' premiums for family coverage relative to the premiums for individual coverage. The implication is that most of the reduction in private coverage associated with the existence of SCHIP appears to result from parents choosing to forgo private insurance for their children and instead enroll them in SCHIP, presumably because the parents believe the program offers better benefits or lower costs than private insurance.

The existence of SCHIP may also affect private coverage by increasing enrollment in the Medicaid program—a consequence of the outreach that states have conducted for SCHIP and the simplified application procedures that many have adopted (in some cases, for Medicaid as well as for SCHIP). That increased enrollment in Medicaid has probably been offset to some extent by a reduction in private coverage, for the same reasons that enrollment in SCHIP has probably been partly offset by a reduction in private coverage. The reduction in private coverage associated with the increase in Medicaid coverage is probably smaller than that associated with enrollment in SCHIP, however, because people eligible for Medicaid have lower income and less access to private insurance than people eligible for SCHIP do.

Efforts to Limit the Substitution of SCHIP for Employment-Based Health Insurance. Federal law requires that the states have procedures in place to prevent people from substituting SCHIP for employment-based insurance. The Congress included that provision in the authorizing legislation because of concern about substitution, in part resulting from a study that estimated that an expansion of Medicaid in the late 1980s

and early 1990s caused a decline in private coverage that was about half the size of the increase in Medicaid coverage.[19] Subsequent studies obtained much lower estimates for the effects of Medicaid on private coverage.[20]

The potential for SCHIP to displace employment-based insurance is greater than it was for the expansion of Medicaid because the children eligible for SCHIP are from families with higher income and greater access to private coverage. According to one study, 60 percent of the children who became eligible for SCHIP had private coverage in the year before the program was established.[21]

States have included a variety of features in their programs to try to prevent SCHIP from displacing employment-based insurance. A widely used approach is to impose a waiting period—that is, a specified length of time that children must be uninsured before becoming eligible for SCHIP. In 2006, 35 states had a waiting period, the two most common being six months (imposed by 16 states) and three months (imposed by 11).[22] Only one state had a waiting period that was longer than six months. Many states allow exceptions to the waiting period—when a parent loses private coverage for reasons considered involuntary (by losing his or her job, switching to a job that does not offer family coverage, or becoming disabled, for instance) or when the available insurance is considered too expensive (if the employee's premiums exceed a specified percentage of income, for example, or if the employer contributes less than 50 percent to the cost of coverage).[23] Most states collect insurance information on the application for SCHIP, and some verify that information with employers. Some states try to limit the displacement of employment-based insurance by requiring premiums and copayments within SCHIP.

Estimates of the Effects of SCHIP on Private Coverage. Estimates vary about the extent to which SCHIP has resulted in less private coverage. The available studies, which have focused on the effects of SCHIP on children, use various data sources and methods. On the basis of a review of the available studies, CBO concludes that the reduction in private coverage among children is most probably between a quarter and

19. That estimate included changes in coverage among children, women of childbearing age, and other adults (who were not eligible for Medicaid). Among children, the study found, the reduction in private coverage was equal to 40 percent of the increase in public coverage. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *The Quarterly Journal of Economics,* vol. 111, no. 2 (May 1996), pp. 391–430.

20. See, for example, Linda J. Blumberg, Lisa Dubay, and Stephen A. Norton, "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics,* vol. 19, no. 1 (2000), pp. 33–60.

21. See Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry,* vol. 42, no. 3 (Fall 2005), pp. 232–254.

22. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents.*

23. Rosenbach and others, *Implementation of the State Children's Health Insurance Program.*

a half of the increase in public coverage resulting from SCHIP.[24] That is, 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.[25]

Measuring the extent to which SCHIP is associated with a decline in private coverage is difficult because it requires comparing the insurance coverage of people under current law with an estimate of the coverage they would have had if the program did not exist. Analysts have estimated the reduction in private coverage attributable to SCHIP by using various statistical models to try to remove the effects of other factors that affect private coverage. All studies that have been conducted to date have estimated the reduction in private coverage among children only; they do not capture any possible reduction in private coverage among parents or other adults. Consequently, the available estimates probably understate the total extent to which SCHIP has reduced private coverage.

Some studies have estimated crowd-out by examining the insurance coverage of participants in SCHIP before they enrolled in the program. Such studies classify enrollees who had private insurance prior to being in SCHIP as having potentially substituted SCHIP for private coverage, and they classify those who were uninsured or covered by Medicaid as not having substituted SCHIP for private coverage. One such study found that 28 percent of children enrolled in SCHIP in 10 states had private coverage at some time during the six months before they enrolled in the program.[26] Such studies probably understate the full extent to which SCHIP reduces private coverage because they do not account for the fact that some of the children who were uninsured or enrolled in Medicaid prior to enrolling in SCHIP may have obtained private

24. That range includes estimates obtained under various approaches. Estimates differ under alternative specifications of the statistical models that analysts have used; some specifications yield estimates that are below or above the range cited. That range encompasses the estimates from specifications in the studies that CBO reviewed and considered most reliable.

25. Nearly all studies have estimated the effect of SCHIP on private coverage generally (including both employment-based insurance and private nongroup coverage). Some observers might argue that studies should focus on the effects of the program on employment-based insurance, because federal law requires states to have procedures in place to prevent the substitution of SCHIP for such coverage. However, estimates of the effects of SCHIP are not likely to be affected measurably by whether or not private nongroup insurance is included. According to CBO's analysis of data from the Current Population Survey, only about 6 percent of children in families with income between 100 percent and 200 percent of the poverty level had private nongroup insurance in the year before SCHIP was enacted, while about half had employment-based insurance. Moreover, a recent study found that, although SCHIP reduced coverage of children by employment-based insurance, it had no effect on private nongroup coverage of them. See Lisa Dubay and Genevieve Kenney, *The Impact of SCHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families* (working paper, Washington, D.C.: Urban Institute, May 2007).

26. See Anna Sommers and others, "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs,* vol. 26, no. 2 (March/April 2007), pp. 529–537.

coverage if SCHIP had not been established.[27] Moreover, such studies do not account for the possibility that some of the children who were uninsured prior to enrolling in SCHIP may have lost coverage as a result of parents' or employers' response to the program (such as a decision by employers to drop family coverage or raise the premiums). In addition, in the surveys that are conducted for such studies, some parents might not have reported their children's private coverage before they enrolled in SCHIP out of fear that their children could be dropped from the program if the state authorities learned about that coverage.

There is limited evidence on whether SCHIP has affected employers' decisions about offering health insurance. Only one study has examined that issue, and it analyzed employers' responses to SCHIP only through 2001.[28] It found no evidence that employers stopped offering single or family coverage in response to SCHIP but did find evidence suggesting that employers of low-wage workers reacted to the program by increasing the marginal cost of family coverage (which was defined as the difference between employees' premiums for family coverage and single coverage). For example, the study estimated, a hypothetical employer with 20 percent of its workforce with children eligible for public coverage would increase employees' marginal cost of family coverage by about $120 per year (in 2001 dollars). The estimated increase was larger in states that experienced a higher-than-average increase in eligibility for public coverage following the establishment of SCHIP and larger for employers with a higher percentage of the workforce with children eligible for public coverage.

The study also examined the extent to which employees accepted private insurance that was offered. It found evidence suggesting that SCHIP reduced the percentage of employees who accepted any private coverage, generally, and family coverage, specifically. For example, at a hypothetical employer at which 20 percent of the workforce had children eligible for public coverage, the estimated percentage of employees who accepted any offer of insurance fell by an average of 1 percentage point. Among employees who accepted any coverage, a similar decline occurred in the percentage of workers who accepted family coverage. The estimated declines were greater for employers that had a higher percentage of workers with children eligible for public coverage. Such findings suggest that SCHIP can reduce private coverage of adults as well as children—in other words, that some workers may respond to SCHIP by declining coverage altogether, not merely declining coverage for their children.

---

27. The uninsured population is not a static group but is constantly changing. Some people are uninsured for long periods, while others are uninsured for shorter periods, such as between jobs. See Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?*

28. Thomas Buchmueller and others, "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, vol. 42, no. 3 (Fall 2005), pp. 218–231.

Crowd-Out Effects from Expansions of SCHIP. Estimates reported in recent research measure average changes in private coverage since SCHIP has been implemented, which may differ from what would occur if policies were adopted to increase enrollment. For example, policies designed to increase enrollment among children who are currently eligible would involve less reduction in private coverage than would expanding the program to cover children in families with higher income. Such an expansion to those with higher income would probably involve greater crowd-out of private coverage than has occurred to date because such children have greater access to private insurance.[29]

CBO has previously analyzed the effects of H.R. 976, the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House of Representatives. That analysis indicated that the legislation would result in 5.8 million children gaining coverage under Medicaid or SCHIP in 2012. Of that total, CBO estimated, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage. Under H.R. 3963, the Children's Health Insurance Program Reauthorization Act of 2007, as passed by the House, the outcome would be the same. Compared with the outcome under current law, the act would result in 5.8 million children gaining coverage under Medicaid or SCHIP, according to CBO's estimates. Again, of that total, 3.8 million children would otherwise have been uninsured, and 2.0 million children would otherwise have had private coverage.

Those estimates suggest that about one-third of the children who would be newly covered under SCHIP and Medicaid would otherwise have had private coverage. For expansions of public coverage of the scale that would occur under those bills, it is unlikely that crowd-out rates could be substantially reduced below one-third.[30] Although it is possible to establish policies that would reduce the extent to which SCHIP displaces private coverage, such policies would probably also reduce the enrollment of people who were not substituting public coverage for private coverage.

---

29. According to CBO's analysis of data from the Current Population Survey, 50 percent of children in families with income between 100 percent and 200 percent of the poverty level had private coverage in 2005. The rate of private coverage was 77 percent among children in families with income between 200 percent and 300 percent of the poverty level, 89 percent among those between 300 percent and 400 percent of the poverty level, and 95 percent among those over 400 percent of the poverty level.

30. Another point of comparison is CBO's estimate for the original SCHIP authorizing statute, the Balanced Budget Act of 1997. At that time, the agency estimated that 40 percent of children covered under SCHIP would otherwise have had private insurance coverage.

Effects of a Recent Directive on Enrollment in SCHIP

According to a letter that the Centers for Medicare and Medicaid Services issued to state health officials on August 17, 2007, a state covering children in families with income above 250 percent of the poverty level or proposing to expand coverage to such children is required to have already enrolled at least 95 percent of eligible children in families with income below 200 percent of the poverty level. In addition, private employment-based insurance coverage for children in low-income families in the state may not have decreased by more than 2 percentage points over the prior five-year period. Further, the directive requires such a state to adopt five strategies for minimizing the substitution of coverage under SCHIP for private coverage. The states must:

- Impose a waiting period of at least one year between the dropping of private coverage and enrollment in SCHIP for children in families with income above 250 percent of the poverty level;
- Impose cost sharing in SCHIP that approximates the cost of private coverage;
- Monitor health insurance status at the time parents apply for coverage for their children under SCHIP;
- Verify families' insurance status through insurance databases; and
- Prevent employers from changing dependent coverage polices to favor a shift to public coverage.

On May 7, 2008, in response to inquiries from the states, CMS released a follow-up letter explaining certain aspects of the August 17 directive. The May 7 letter provides the following clarifications:

- Policies intended to prevent substitution apply only to children entering the program for the first time, not to those already enrolled (unless they leave the program and reapply later);
- States may submit alternatives to the 95 percent coverage test, which CMS will consider and approve if those states present supporting data showing their effectiveness in reducing crowd-out;
- CMS believes most states already meet the 95 percent test and will work with states regarding data sources CMS considers acceptable; and
- The policies stipulated in the August 17 directive do not apply to unborn children.

The clarifications that CMS issued in its letter of May 7 are generally consistent with how CBO originally interpreted the directive of August 17; therefore, CBO has not altered its estimates of the policy's impact on cost and coverage.

CBO's analysis suggests that the impact of the directive on enrollment is likely to be modest under funding levels assumed in CBO's baseline projections. According to program and survey data, about 80 percent of enrollment in SCHIP in all states is by families with income below 200 percent of the poverty level; about 15 percent of enrollment, between 200 percent and 250 percent of the poverty level; and less than 5 percent, over 250 percent of the poverty level. CBO assumes that families in the last category—constituting less than 5 percent—are potentially affected by the August 17 directive.

Consistent with those overall findings, administrative data suggest that fewer than 20 states provide SCHIP coverage for children in families with income above 250 percent of the poverty level. Even in those states, the great majority of those covered children are from families with income below 200 percent of the poverty level. (Some states, however, had planned to expand their coverage to families with income above 250 percent of the poverty level but dropped such plans after the directive was issued.)

Given the way that CMS appears to be implementing the directive, the provision most likely to affect enrollment is the requirement that states impose at least a one-year waiting period between private coverage and enrollment in SCHIP for children in families with income above 250 percent of the poverty level. Only two states currently have a waiting period as long as one year; many require no waiting period; and the majority of states with waiting periods set them at only three or six months. The requirement for a one-year waiting period would therefore mean that a number of children who currently could obtain coverage either immediately or three to six months after leaving private coverage would have their enrollment delayed or might never enroll in SCHIP, if they obtained private coverage during the waiting period. On the basis of an analysis of current waiting periods, CBO estimates that, under current law, enrollment in SCHIP would be reduced by 0.1 percent as a result of CMS's action.

The directive could have much greater impact on enrollment in SCHIP if the Congress expanded the program significantly. Under its baseline projections for SCHIP, which assume continued allotments of about $5 billion per year, CBO estimates that enrollment of children in SCHIP will fall from 6.8 million in 2009 to 3.3 million in 2018, as the growth in health care costs per person diminishes the number of children that states can cover with a fixed sum of money. However, if the Congress substantially increased SCHIP funding, additional states would probably wish to expand their programs to children in families with income above 250 percent of the poverty level. In that case, the directive of August 17 would be a more significant constraint on enrollment.

Mr. PALLONE. Thank you, Doctor. Ms. Shah.

STATEMENT OF DAYNA SHAH, MANAGING ASSOCIATE GENERAL COUNSEL, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. SHAH. Mr. Chairman and members of the subcommittee, I am pleased to be here this morning to discuss GAO's recent opinion about the August 17 letter issued by CMS concerning crowd-out or the substitution of SCHIP for other insurance coverage.

In GAO's opinion, the August 17 letter is a rule. Under the Congressional Review Act and as required by that Act, the letter must be submitted to Congress and to the GAO before it can take effect.

Before I get to the heart of GAO's opinion, I would like to note that the definition of rule in the Review Act adopts the definition in the Administrative Procedure Act, or APA, with some exceptions, none of which are applicable here.

While the focus of inquiry under the APA is often whether a statement is binding and whether it must follow notice and comment requirements, there are many types of agency statements that are not binding, do require notice and comment, but nevertheless are rules under the APA's broad definition.

As a result, the answer to the question of whether a particular agency statement is a rule under the APA and under the Congressional Review Act does not turn on whether the rule is binding or subject to notice and comment requirements.

Three particular elements of the APA definition were relevant to our review of the August 17 letter. Specifically, the letter was applicable generally. It extended to all States seeking to cover children with effective family incomes above 250 percent of the federal poverty level, as well as those States already covering such children.

Second, the letter had future effect. It was not concerned with present or past conduct. Finally, the letter was designed to implement, interpret, or prescribe law or policy, in that it purported to clarify and explain the manner in which CMS supplied statutory and regulatory requirements to these states and sought to promote the implementation of SCHIP statutory requirements. The letter therefore met the general definition of rule.

Three additional features of the August 17 letter supported our view that it is a rule that should have been submitted for review by Congress. First, the letter represented a marked departure from CMS's settled interpretation of the regulatory provision governing crowd-out. Case law indicates that a change in settled interpretation may only be made by a rule.

Second, the letter gave a deadline for states to come into compliance by telling states currently covering children with effective family incomes over 250 percent of the federal poverty level that CMS expected those states to implement the letter's provisions within 12 months or face possible corrective action.

Third, we found it striking that CMS expressly relied on the August 17 letter last September when it disapproved New York's request to amend its SCHIP plan. CMS's application of the letter in this way confirmed that it viewed the letter as having a binding effect.

Finally, a note about general statements of policy. CMS told us that the August 17 letter was a statement of policy announcing the course that the agency intended to follow in adjudications concerning compliance with regulatory requirements. In addition, the Justice Department characterized the letter as being either a statement of policy or an interpretive rule.

Courts have generally held that a statement of policy is a type of rule, although not the type of rule requiring notice and comment. That said, the August 17 letter does not have the characteristics of statements of policy identified in case law. Its language has little of the tentativeness that courts had associated with policy statements.

In addition, as I mentioned earlier, CMS itself treated the letter as a binding rule rather than a policy statement when it expressly relied on it to disapprove a State's plan amendment.

Mr. Chairman, that concludes my statement. I would be pleased to address any questions that you or other members of the subcommittee may have.

[The prepared statement of Ms. Shah follows:]

United States Government Accountability Office

GAO

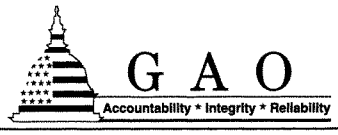
Testimony
Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Thursday, May 15, 2008

CONGRESSIONAL REVIEW ACT

Applicability to CMS Letter on State Children's Health Insurance Program

Statement of Dayna K. Shah
Managing Associate General Counsel
Office of General Counsel



GAO-08-785T

May 15, 2008

GAO
Accountability · Integrity · Reliability

Highlights

Highlights of GAO-08-785T, a testimony before Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

CONGRESSIONAL REVIEW ACT

Applicability to CMS Letter on State Children's Health Insurance Program

Why GAO Did This Study

The State Children's Health Insurance Program (SCHIP) finances health care to low-income, uninsured children whose family incomes exceed the eligibility limits under their state's Medicaid program, but who cannot afford other health insurance coverage. To participate in SCHIP, a state must submit a plan that describes how its program meets applicable requirements and must receive approval of the plan from the Centers for Medicare & Medicaid Services (CMS).

On August 17, 2007, CMS issued a letter purporting to clarify statutory and regulatory requirements related to preventing SCHIP substitution for other insurance coverage in states wishing to cover children with effective family incomes in excess of 250 percent of the federal poverty level (FPL). The letter indicates that CMS will apply measures identified in the letter to state proposals to cover these children, as well as to states that already cover them, and may take corrective action against states that fail to adopt the measures within 12 months.

In response to a request from the Chairman of the Subcommittee on Health Care, Senate Committee on Finance, and a member of that Subcommittee, GAO considered whether the letter is a rule under the Congressional Review Act (the Review Act). This testimony is based on the resulting opinion, *Applicability of the Congressional Review Act to Letter on State Children's Health Insurance Program*, B-316048, April 17, 2008.

To view the full product,click on GAO-08-785T.
For more information, contact Dayna K. Shah at (202) 512-8208 or shahd@gao.gov.

What GAO Found

The definition of "rule" in the Congressional Review Act incorporates by reference the definition of "rule" in the Administrative Procedure Act (APA), with some exceptions. The APA definition of rule includes three elements relevant to GAO's consideration of the SCHIP letter: an agency statement is a rule if it is of general applicability; of future effect; and designed to implement, interpret, or prescribe law or policy. GAO concluded that the letter meets these criteria and that none of the exceptions in the Review Act apply. GAO found the letter to be of general applicability since it extends to all states that seek to enroll children with effective family incomes exceeding 250 percent of the FPL in their SCHIP programs, as well as to states that have already enrolled such children. In addition, GAO found it to be of future effect, that is, concerned with policy considerations for the future rather than the evaluation of past or present conduct. Finally, GAO found that the letter is designed to implement, interpret, or prescribe law or policy since it purports to clarify and explain the manner in which CMS applies statutory and regulatory requirements to states that want to extend coverage under their SCHIP programs to children with effective family incomes above 250 percent of the FPL and seeks to promote the implementation of statutory requirements applicable to state plans.

The history of the regulatory provision regarding substitution of coverage supported the view that the August 17 letter is a rule. In issuing the proposed and final rules to implement SCHIP, CMS indicated that it could not require states to adopt any particular measures to prevent substitution of coverage, stating that it did not have a statutory or empirical basis for doing so. In its August 17 letter, however, CMS states that its experience and information derived from the operation of SCHIP programs have made it clear that the potential for substitution is greater at higher income levels, and states seeking to expand their SCHIP populations should implement specific strategies to prevent substitution of coverage. Thus, the letter amounts to a marked departure from the agency's settled interpretation of the regulation regarding substitution of coverage, and case law indicates that such a change may be made only by rule. Moreover, the agency expressly relied on the letter to disapprove a state request to amend its SCHIP plan to cover children with family incomes in excess of 250 percent of the FPL, confirming that the letter has binding effect and is, therefore, a rule.

In response to GAO's inquiries, CMS stated that the letter is a general statement of policy announcing the course that the agency intends to follow in adjudications concerning compliance with requirements already set forth in regulations. The GAO opinion explained that statements of policy would appear to fit within the definition of rule in the APA and that courts have referred to them as rules. However, GAO also concluded that the August 17 letter does not have the characteristics of a statement of policy identified in case law. It evidences little, if any, of the tentativeness that is the hallmark of a policy statement, and the agency has relied on the letter to disapprove a state plan amendment, treating the letter as if it were a binding rule.

Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to participate in today's hearing on the August 17, 2007, letter issued by the Centers for Medicare & Medicaid Services (CMS) on the State Children's Health Insurance Program (SCHIP). My testimony focuses on GAO's April 17, 2008, opinion, which addressed whether the CMS letter is a rule for purposes of section 251 of the Contract with America Advancement Act of 1996,[1] commonly referred to as the Congressional Review Act (the Review Act).[2] In that opinion, we concluded that the letter is a rule under the Review Act, which, consistent with the Act's requirements, must be submitted to Congress and the Comptroller General before it can take effect.

Background

SCHIP finances health care to low-income, uninsured children whose family incomes exceed the eligibility limits under their state's Medicaid program, but who cannot afford other health insurance coverage.[3] To participate in SCHIP, a state must submit a plan that describes how its program meets applicable requirements and must receive approval of the plan from CMS.[4] States are required to amend their plans to reflect changes in federal law, regulation, or policy, and changes in the operation of their programs, including, for example, changes in eligibility criteria or benefits.[5]

[1] Pub. L. No. 104-121, § 251, 110 Stat. 847, 868-74, *codified at* 5 U.S.C. §§ 801-808.

[2] *Applicability of the Congressional Review Act to Letter on State Children's Health Insurance Program*, B-316048, April 17, 2008. The opinion is available at http://gao.gov/decisions/other/other.htm.

[3] *See* 42 U.S.C. § 1397aa.

[4] 42 U.S.C. § 1397aa(b). The authority vested in the Secretary of Health and Human Services to approve and disapprove SCHIP state plans and plan amendments has been delegated to the Administrator of CMS. *State Child Health; Implementing Regulations for the State Children's Health Insurance Program*, 64 Fed. Reg. 60882, 60895 (Nov. 8, 1999) (proposed rule).

[5] 42 C.F.R. § 457.60.

State SCHIP programs are subject to a number of statutory provisions that are designed to ensure that SCHIP coverage does not become a substitute for other public or private coverage. For example, a state plan must describe the procedures used to ensure that coverage under the plan does not substitute for coverage under group health plans, generally referred to as "crowd out."[6] Regulations promulgated by CMS require states to adopt "reasonable procedures" to prevent crowd out.[7] Since CMS promulgated the regulations in 2001, states have adopted a number of different measures to prevent crowd out, which CMS has approved.

In its August 17 letter, CMS purports to clarify the statutory and regulatory requirements concerning prevention of crowd out for states wishing to provide SCHIP coverage to children with effective family incomes in excess of 250 percent of the federal poverty level (FPL) and identifies a number of particular measures that these states should adopt. For example, according to the letter, states should impose cost sharing in approximation to the cost of private coverage and establish a minimum of a 1-year period of uninsurance for individuals prior to receiving coverage. In addition, the letter states that CMS will seek a number of assurances from states, including an assurance that the state has enrolled at least 95 percent of the children in the state with family incomes below 200 percent of the FPL who are eligible for SCHIP or Medicaid. The letter indicates that CMS will apply the measures to states' proposals to cover children with effective family incomes in excess of 250 percent of the FPL, as well as to states that already cover such children. According to the letter, CMS may take corrective action against states that fail to adopt the identified measures within 12 months.

Discussion

The definition of "rule" in the Review Act incorporates by reference the definition of "rule" in the Administrative Procedure Act (APA), with some exceptions. To determine whether the August 17 letter is a rule under the Review Act, we thus considered whether the letter is a rule under the APA

[6] 42 U.S.C. § 1397bb(b)(3)(C).

[7] 42 C.F.R. § 457.805.

and whether it falls within any of the exceptions contained in the Review Act.[8] Section 551(4) of the APA defines the term rule in pertinent part as "[t]he whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency . . . ."[9] This definition of rule has been said to include "nearly every statement an agency may make."[10]

Agency statements that create binding legal norms—those that, for example, grant rights, impose obligations, or affect private interests—are rules under the APA.[11] These rules—usually called legislative rules—generally must be promulgated through notice and comment rulemaking procedures under 5 U.S.C. § 553. Courts have found that other agency pronouncements also are rules as defined in 5 U.S.C. § 551, even if they do not create binding legal norms and are not subject to notice and comment rulemaking requirements under section 553. For example, agency

[8] The Review Act excepts the following from its definition of rule: (1) rules of particular applicability, including a rule that approves or prescribes for future application rates, wages, prices, services, or allowances therefor, corporate or financial structures, reorganizations, mergers, or acquisitions thereof, or accounting practices or disclosures bearing on any of the foregoing; (2) rules relating to agency management or personnel; and (3) rules of agency organization, procedure, or practice that do not substantially affect the rights or obligations of non-agency parties. 5 U.S.C. § 804(3). As discussed below, the letter is not a statement of particular applicability; rather, it substantially affects all states that seek to cover children with effective family incomes in excess of 250 percent of the FPL, as well as those states that already cover these children. The letter does not relate to agency management or personnel, and it does not relate to "agency organization, procedure, or practice" with no substantial effect on non-agency parties. Accordingly, we concluded that none of these three exceptions apply to the August 17 letter.

[9] 5 U.S.C. § 551(4).

[10] *Batterton v. Marshall*, 648 F.2d 694, 700 (D.C. Cir. 1980) (*citing* 5 U.S.C. § 551(4)).

[11] *Id.* at 700-02.

guidance documents and manuals have been held to be rules.[12] Agency documents that clarify or explain existing legal requirements also have been held to be rules.[13] Whether a particular agency pronouncement is a rule under section 551, therefore, does not turn on whether the rule is subject to notice and comment rulemaking requirements under section 553. Legislative history of the Review Act confirms that it is intended to include almost all rules that an agency issues and reaches far more than those that must be promulgated according to the notice and comment requirements of section 553.[14]

The APA definition of rule includes three elements relevant to our consideration of the SCHIP letter: an agency statement is a rule if it is of general applicability; of future effect; and designed to implement, interpret, or prescribe law or policy. We concluded that the August 17 letter meets these criteria. We found the letter to be of general, rather than particular, applicability since it extends to all states that seek to enroll children with effective family incomes exceeding 250 percent of the FPL in their SCHIP programs, as well as to all states that have already enrolled

[12] *See Reno v. Koray*, 515 U.S. 50, 60–61 (1995) (internal agency guideline was a rule under the APA); *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 99–100 (1995) (provision of the Medicare Provider Reimbursement Manual was a rule under the APA); *Appalachian Power Co. v. Environmental Protection Agency*, 208 F.3d 1015, 1021–22 (D.C. Cir. 2000) (agency guidance document can be rule under the APA); *Professionals and Patients for Customized Care v. Shalala*, 56 F.3d 592, 601–02 (5th Cir. 1995) (FDA Compliance Policy Guide was a rule, but was exempt from notice and comment procedures as a statement of policy or interpretative rule).

[13] *See, e.g., A.D. Transport Express, Inc. v. United States*, 290 F.3d 761, 768 (6th Cir. 2002) (order explaining agency regulation is an interpretative rule under the APA); *Guardian Federal Savings and Loan Ass'n v. Federal Savings and Loan Insurance Corp.*, 589 F.2d 658, 664 (D.C. Cir. 1978) (agency statements that clarify laws or regulations are rules under the APA).

[14] 142 Cong. Rec. H3005 (daily ed. Mar. 28, 1996) (statement of Rep. McIntosh) (noting that although agency interpretive rules, general statements of policy, guideline documents, and agency policy and procedure manuals may not be subject to notice and comment requirements, they are covered under the congressional review provisions of the new chapter 8 of title 5).

such children.[15] In addition, we found it to be of future effect, that is, concerned with policy considerations for the future rather than the evaluation of past or present conduct.[16] Finally, the letter purports to clarify and explain the manner in which CMS applies statutory and regulatory requirements to states that want to extend coverage under their SCHIP programs to children with effective family incomes above 250 percent of the FPL and seeks to promote the implementation of statutory requirements applicable to state plans. Accordingly, we found that the letter is designed to implement, interpret, or prescribe law or policy.[17]

The history of the regulatory provision regarding substitution of coverage supported our view that the August 17 letter is a rule. In the preamble to the proposed rule to implement SCHIP, CMS indicated that it could not require states to adopt any particular measures to prevent substitution of coverage, stating that it did not have a statutory or empirical basis for doing so.[18] CMS confirmed this interpretation in a final rule.[19] In its August 17 letter, however, CMS states that its experience and information derived from the operation of SCHIP programs have made it clear that the potential for substitution is greater at higher income levels, and states seeking to expand their SCHIP populations should implement specific

[15] *Cf. U.S. Dep't of Justice, Attorney General's Manual on the Administrative Procedure Act* 13 (1947) (the term rule includes statements of particular applicability applying either to a class or to a single person).

[16] *See Bowen v. Georgetown University Hospital*, 488 U.S. 204, 216 (1988) (Scalia, J., concurring) ("future effect" means that agency statement will have legal consequences for the future); *see also U.S. Dep't of Justice, Attorney General's Manual on the Administrative Procedure Act* at 14 (rulemaking regulates the future conduct of either groups of persons or a single person and is essentially legislative in nature because it operates in the future and is primarily concerned with policy considerations, while adjudication is concerned with the determination of past and present rights and liabilities).

[17] *See A.D. Transport Express, Inc.*, 290 F.3d at 768 (order explaining agency regulation is an interpretative rule under the APA); *Guardian Federal Savings and Loan Ass'n*, 589 F.2d at 664 (agency statements that clarify laws or regulations are rules under the APA).

[18] 64 Fed. Reg. at 60921-22.

[19] *See State Child Health; Implementing Regulations for the State Children's Health Insurance Program*, 66 Fed. Reg. 2490, 2601-05 (Jan. 11, 2001) (final rule).

strategies as "reasonable procedures" to prevent substitution of coverage (for example, a minimum 1-year period of uninsurance before receiving SCHIP coverage). Thus, the letter amounts to a marked departure from the agency's settled interpretation of the regulation regarding substitution of coverage, and case law indicates that such a change may be made only by rule.[20]

We also found it significant that CMS had expressly relied on the letter to disapprove a state's request to amend its SCHIP plan to cover children with family incomes above 250 percent of the FPL. Specifically, in April 2007, the state of New York requested permission from CMS to amend its SCHIP plan to provide coverage to children with family incomes up to 400 percent of the FPL. CMS denied New York's request with specific reliance on the terms of the August 17 letter. For example, CMS indicated that the state failed to provide assurances that it had enrolled at least 95 percent of the children with family incomes below 200 percent of the FPL and that "as outlined in an August 17, 2007, letter, . . . such assurances are necessary to ensure that expansion to higher income populations does not interfere with the effective and efficient provision of child health assistance." CMS also cited the fact that the state's proposal did not include a 1-year period of uninsurance for populations over 250 percent of the FPL. CMS concluded stating that its disapproval was "consistent with the August 17, 2007, letter to State Health Officials discussing how . . . existing statutory and regulatory requirements should be applied to all States expanding SCHIP effective eligibility levels above 250 percent of the FPL." This application of the letter to deny New York's proposed plan

[20] *See SBC Inc. v. Federal Communications Commission*, 414 F.3d 486, 498 (3d Cir. 2005) (if agency's present interpretation of regulation is a fundamental modification of previous interpretation, the modification can only be accomplished through notice and comment rulemaking); *Shell Offshore Inc. v. Babbitt*, 238 F.3d 622, 629 (5th Cir. 2001) (settled policy of an agency is binding on the agency and may be changed only through a rule); *Alaska Professional Hunters Ass'n v. Federal Aviation Administration*, 177 F.3d 1030, 1033-34 (D.C. Cir. 1999) (an agency is bound by settled interpretation given to its own regulation that agency can change only by rulemaking).

amendment served to confirm that the letter has binding effect and is, therefore, a rule.[21]

During the course of our work, we requested the views of the General Counsel of the Department of Health and Human Services on whether the August 17 letter is a rule for purposes of the Review Act.[22] The response from the Director of the Center for Medicaid and State Operations within CMS did not directly address that issue. CMS indicated, however, that the letter is a "general statement of policy that announces the course which the agency intends to follow in adjudications concerning compliance with requirements already set forth in regulations." The agency also referred us to a document prepared by the Department of Justice, which asserted that the August 17 letter was a general statement of policy.

As discussed in our opinion, general statements of policy would appear to fit squarely within the definition of rule in the APA since they advise the public prospectively of the manner in which an agency proposes to exercise a discretionary power or what the agency will propose as policy.[23] Further, courts have referred to them as rules.[24] While some cases seem to

[21] *See Appalachian Power Co.*, 208 F.3d at 1020-21 (if an agency treats a pronouncement as if it were controlling, if it bases enforcement actions on the policies in the document, and if it leads private parties or states to believe they must comply with the pronouncement's terms, it is a rule); *McLouth Steel Products Corp. v. Thomas*, 838 F.2d 1317, 1321 (D.C. Cir. 1988) (because agency used policy statement to determine regulated entities' obligations, policy statement is, therefore, a rule).

[22] In documents filed in related litigation, the Department of Justice has characterized the August 17 letter as a rule. *See New York v. United States Dep't of Health and Human Services*, No. 07 Civ. 08621 (S.D.N.Y. filed Oct. 4, 2007) (Def's Mem. Supp. Mot. Dismiss, p. 33).

[23] *See U.S. Dep't of Justice, Attorney General's Manual on the Administrative Procedure Act* at 30, n. 3.

[24] *See, e.g., Chrysler v. Brown*, 441 U.S. 281, 301 (1979) ("the central distinction among agency regulations found in the APA is that between 'substantive rules' on the one hand and 'interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice' on the other"); *Noel v. Chapman*, 508 F.2d 1023, 1030 (2d Cir. 1975) (general statement of policy is a rule directed at agency staff on how it will perform discretionary function); *Guardian Federal Savings and Loan Ass'n*, 589 F.2d at 666 (describing test for determining whether "a rule is a general statement of policy").

suggest that general statements of policy are not rules under the APA,[25] the better reading of these cases, in our view, is that statements of policy are rules under section 551 of the APA but not the type of rules for which the APA requires notice and comment procedures because they are tentative statements of future intent and by their nature do not have the force of law.

Further, even if these cases are read to mean that general statements of policy are not rules under the APA, we found that the August 17 letter does not have the characteristics of a general statement of policy identified in case law. One case provided a particularly useful explanation of the type of language typically found in an agency general statement of policy. In *Pacific Gas and Electric Co. v. Federal Power Commission*,[26] the United States Court of Appeals for the District of Columbia Circuit considered a pronouncement, styled a "statement of policy," that expressed the Federal Power Commission's (Commission) view of how deliveries of natural gas should be prioritized during periods of shortage. The court held that the pronouncement was a general statement of policy, noting the tentative nature of the statement and the Commission's acknowledgment that any particular decisions on curtailment could only be made in further proceedings. Among other things, the court found it significant that the statement indicated it was the curtailment policy that the Commission "proposes to implement" and the "plan preferred by the Commission," which "will serve as a guide in other proceedings." In addition, the Commission itself intended the statement only "to state initial guidelines as a means of facilitating curtailment planning and the adjudication of curtailment cases." In effect, the Commission statement was a starting point to frame consideration of future proposals.

[25] *See, e.g.*, *Sugar Cane Growers Cooperative of Florida v. Veneman*, 289 F.3d 89, 95 (D.C. Cir. 2002) (some agency pronouncements lack the firmness of a prescribed standard to be considered rules); *Syncor International Corp. v. Shalala*, 127 F.3d 90, 94 (D.C. Cir. 1997) (the primary distinction between a rule and a general statement of policy is whether the agency intends to bind itself to a legal position); *Pacific Gas and Electric Co. v. Federal Power Commission*, 506 F.2d 33, 37 (D.C. Cir. 1974) (suggesting that policy statements are not rules under the APA).

[26] 506 F.2d 33 (D.C. Cir. 1974).

We analyzed CMS's August 17 letter under the criteria used by the court to determine that the Commission's pronouncement was simply a statement of policy and concluded that the letter does not meet the criteria. The specific measures identified in the letter are not characterized as "proposals" or measures that are under development or to be implemented or adopted by later action; on the contrary, the letter sets forth specific strategies that states seeking to expand their SCHIP populations should implement as "reasonable procedures" to prevent substitution of coverage. In addition, the letter contains no indication that the strategies are only guidelines that may or may not be applied in subsequent proceedings or express reference to exceptions in particular instances. Finally, the time frame specified in the letter for states to conform to the CMS "review strategy" evidences the agency's intention to give the letter present and binding effect; if the letter were simply precatory or tentative in nature, then there would be no need to establish a deadline by which states would need to implement the measures in the letter or face the possibility of a corrective action by the agency.[27] Because the letter establishes a deadline by which "affected States" need to implement its measures or face the possibility of corrective action, we found that it evidences little, if any, of the tentativeness that is the hallmark of a policy statement.

In addition to the particular language of a statement, courts look to an agency's actions in relation to the statement to determine whether it is a general statement of policy. As a number of courts have noted, a critical test of whether a rule is a general statement of policy is its practical effect in subsequent administrative proceedings. If the agency relies solely on the pronouncement itself to determine rights and obligations of others, the agency has treated the policy statement as if it were a binding rule, not a

[27] *Cf. Community Nutrition Institute v. Young*, 818 F.2d 943, 947 (D.C. Cir. 1987) (agency pronouncement instructing regulated entities to obtain "exception" from standard in announcement indicated pronouncement was intended to be binding).

general statement of policy.[28] CMS's express reliance on the August 17 letter to deny the state of New York's request to amend its SCHIP plan led us to conclude that the letter is not a policy statement. This conclusion was reinforced by our observation that the August 17 letter reflects a significant change in the agency's settled interpretation of 42 C.F.R. § 457.805, which policy statements by their nature do not do.[29]

Conclusion

We concluded that the August 17, 2007, letter to state health officials is a rule for the purpose of the Review Act on the grounds that it is a statement of general applicability and future effect designed to implement, interpret, or prescribe law or policy with regard to SCHIP. Furthermore, we found that the letter does not come within any of the exceptions to the definition of rule contained in the Review Act. We expressed no opinion on the applicability of any other legal requirements, including, but not limited to, notice and comment rulemaking requirements under the APA, or whether the August 17 letter would be a valid interpretation of statutes or regulations.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions that you or other Members of the Subcommittee may have.

Contacts and Acknowledgments

For further information regarding this testimony, please contact Dayna Shah at (202) 512-8208 or shahd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page

[28] *See Public Citizen, Inc. v. United States Nuclear Regulatory Commission*, 940 F.2d 679, 682-83 (D.C. Cir. 1991) (courts look to agency's actual application of statement to determine its nature if language and context of agency statement are not conclusive); *Guardian Federal Savings and Loan Ass'n*, 589 F.2d at 666 (in subsequent administrative proceeding, agency cannot claim that prior statement of policy itself resolves contested issues).

[29] *See Syncor International Corp.*, 127 F.3d at 94 (a general statement of policy does not impose, elaborate, or interpret a legal norm, but explains the agency's manner of enforcing the existing legal norm).

of this statement. Major contributors to this testimony were Helen Desaulniers and Kevin Milne.

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "E-mail Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, DC 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

PRINTED ON RECYCLED PAPER

Mr. PALLONE. Thank you, Ms. Shah. Mr. Rosenberg.

STATEMENT OF MORTON ROSENBERG, SPECIALIST IN AMERICAN PUBLIC LAW, AMERICAN LAW DIVISION, CONGRESSIONAL RESEARCH SERVICE

Mr. ROSENBERG. I am Morton Rosenberg, a Specialist in American Public Law in the American Law Division of the Congressional Research Service. I thank you for inviting me here today to comment on the legal and practical issues associated with the August 17, 2007 letter issued by the Director of the Center of Medicaid and State Operations of the Centers for Medicare and Medicaid Services to all State health officials.

That letter, as you are aware, ostensibly clarified how CMS would apply existing statutory and regulatory requirements in its review of state request to extend eligibility of the SCHIP Program to children and families with effective income levels above 250 percent of the federal poverty level.

Our analysis of the statutory scheme of the CRA, its legislative history, opinions of the general counsel of GAO, indicates that the drafters of the congressional review provision were concerned with the then-prevalent actions that had the practical effect of imposing binding norms on non-agency parties without being promulgated in conformance with requirements of notice and comment rulemaking. And in response, Congress adopted a very broad definition of the term rule that would capture such actions for congressional review. The rulings of several appellate courts recognizing the invalidity of such actions support the CRA's history and the GAO interpretations.

The courts have also indicated that past practices of an agency in implementing a rulemaking may be looked at for insight as to the understanding the reliance that regulated parties and beneficiaries have placed on such past agency practices. In such instances, the courts have held that an abrupt change of course requires a new rulemaking proceeding to substantively alter those practices and relied-on interpretations.

In this instance, the CMS practice under the 2001 crowd-out rules arguably have created a binding norm, and therefore changing such practices would be an action that is covered by the CRA and that such changes may not be implemented until they are reported to Congress and the Controller General.

And so concluding, I have taken into account CMS's May 7 clarification of its August 17, 2007 clarification, which does not alter the nature, I believe, of the 2007 letter.

I thought it would be useful to you if I focused to provide you with my understanding of the nature, purpose and intent of the review scheme established by the CRA and how and why it differs from the scheme of judicial review with final agencies rules under the Administrative Procedure Act.

In particular, I want to focus on Congress's adoption of a broader definition of the rule under the CRA that is applicable to judicially reviewable rules under the APA and why that may make a difference in how Congress might address the current controversy.

The congressional review mechanism, properly known as the Congressional Review Act, requires that all agencies promulgating

a covered rule must submit that report to each house of Congress and to the controller general. And it must accompany it with a copy of the rule, a concise general statement describing the rule, and a proposed effective date. A covered rule under the statute cannot take effect if the report is not submitted.

The broad definition of a rule found in the CRA is adopted from 5514 of the Administrative Procedure Act, which provides that the term rule means the whole or part of agency statement of general applicability and future effect desired to implement, interpret, or prescribe law policy. The legislative history of that 5514 indicates that term is to be very broadly construed and that is covers all kinds of documents and is not limited to substantive rules but embraces interpretative, organizational, and procedural rules as well. And the courts have recognized that it covers virtually every statement an agency can make.

The drafters of the Congressional Review Act arguably purposely adopted the broadest possible definition of the term rule when they incorporated that provision from the APA. The history of the CRA makes it clear that adoption of the broad definition of rule, the review process would not be limited to coverage of only rules that were required to comply with the notice and comment provisions of the APA or any other statutorily required variations of the notice and comment procedures but would rather encompass a wide spectrum of agency activities characterized by their effect on the regulated public.

The committee stated the committee's intent in these subsections is to include matters that substantially affect the rights and obligations of outside parties. The essential focus of this inquiry is not on the type of rule but on its effect on the rights and obligations of the parties.

The drafters of the CRA indicated their awareness of the practice of agencies at that time of avoiding the notification and public participation requirements of the APA by utilizing the issuance of other documents as a means of binding the public either legally or practically. And know that it was the intent of the legislation to subject just such documents to cvongressional scrutiny.

Again the framers emphasize the adoption of the broad definition of a covered rule was to focus Congress not on the type of rule but on the rule's effect on the rights or obligations of non-agency parties.

In sum, it is arguable that the heart of the drafters' design of the CRA was the creation of a review mechanism that would uncover and remedy in a timely manner what were viewed as agency attempts to evade congressional oversight, presidential executive order review, and the requirements of public comment and judicial review under the APA.

Time-consuming legislation was seen as an anathema to achieving accountable agency public policy results. The critical point here then is that Congress does not have to rely on the uncertainty of lengthy civil litigation. It can call up for review any covered rule it wishes. It is not required to demonstrate standing, rightness, finality, jurisdiction, or any showing of arbitrariness or unreasonable decision making. You simply have to determine that it is contrary to the way that you expect the program to be administered. And

if you use the CRA properly, you have the benefit of expedited consideration of a disapproval measure, which, if not vetoed, accomplishes a retroactive nullification that is not subject to judicial review.

Finally, this process can be initiated even though the document has not been reported. Thank you.

[The prepared statement of Mr. Rosenberg follows:]

STATEMENT

OF

MORTON ROSENBERG
SPECIALIST IN AMERICAN PUBLIC LAW
CONGRESSIONAL RESEARCH SERVICE

BEFORE THE

HOUSE SUBCOMMITTEE ON HEALTH OF THE ENERGY AND COMMERCE COMMITTEE

CONCERNING

"H.R. 5998, PROTECTING CHILDREN'S HEALTH COVERAGE ACT OF 2008"

PRESENTED ON

MAY 15, 2008

Mr. Chairman and Members of the Subcommittee

I am Morton Rosenberg, a Specialist in American Public Law in the American Law Division of the Congressional Research Service (CRS). I thank you for inviting me here today to comment on the legal and practical issues associated with an August 17, 2007 letter issued by the Director of the Center for Medicaid and State Operations of the Centers for Medicare and Medicaid Services (CMS) to all state health officials. That letter ostensibly "clarified" how CMS would apply existing statutory and regulatory requirements in its review of state requests to extend eligibility under the State Children's Health Insurance Program (SCHIP) to children in families with effective family income levels above 250 percent of the Federal poverty level (FPL).

In particular, you inquire whether the CMS "clarification" letter is a rule under the Congressional Review Act (CRA) which should have been reported to the Congress and subjected to review and possible nullification by passage of a joint resolution of disapproval. As you are aware, the Chairman of the Senate Finance Committee asked CRS to address this question, and on January 10, 2008, we responded that our examination of the statutory scheme of the CRA, its legislative history, Government Accountability Office (GAO) opinions interpreting the scope of the coverage of the term "rule" under the Act, and analogous judicial precedents, suggested that a reviewing court is likely to hold that the legal or practical effect of the CMS document is to alter the rights, duties and obligations of non-agency parties subject to the document. As a consequence, the agency's action arguably should have been submitted for congressional review under the CRA before it could become effective.[1] Subsequently, the Chairman and Ranking Minority Member of the Senate Finance

---

[1] For a broad overview and assessment of the CRA since its passage in 1996, see Morton Rosenberg, CRS Report RL30116, *Congressional Review of Agency Rulemaking: An Update and Assessment of the Congressional Review Act After a Decade*, May 8, 2007 (CRA Report). For an in-depth discussion of procedural issues that may arise during House and Senate consideration of disapproval resolutions, see (continued...)

Committee also asked GAO to assess the CMS action. GAO concluded that the letter was "a rule that must be submitted for review under the CRA before it can take effect because it is a statement of general applicability and future effect designed to implement, interpret or prescribe law or policy with regard to the SCHIP program."[2] Both analyses were publicly released by the Chairman on April 18, 2008.[3]

This testimony will proceed as follows. First, we will describe the content and scope of the CMS letter and the agency's subsequent actions enforcing its prescriptions. Next, congressional, state, and public reactions to the letter and subsequent CMS action are described, followed by a review of the legislative history of the 2001 rule that established the regulatory scheme that was clarified by the CMS letter. We will then explain the nature, purpose, and intent of the review scheme established by the CRA and how and why it differs from the scheme of judicial review of final agency rules under the Administration Procedure Act (APA). In particular, we will focus on Congress' adoption of a broader definition of a rule under the CRA than is applicable to judicially reviewable rules under the APA, and address the question whether the CRA review process may be initiated even if an agency has not reported a covered rule. The testimony concludes with an assessment of legislative options available to it under the CRA and otherwise.

---

[1] (...continued)
Richard S. Beth, CRS Report RL31160 *Disapproval of Regulations by Congress: Procedure Under the Congressional Review Act*, October 10, 2001 (Archived).

[2] Letter to the Honorable John D. Rockefeller, IV, Chairman, Senate Subcommittee on Health Care, Committee on Finance, and the Honorable Olympia Snowe, Ranking Minority Member, Senate Subcommittee on Health Care, Committee on Finance, B-316048, April 17, 2008.

[3] BNA Daily Report for Executives, "Lawmakers Cite GAO, CRS Findings In Faulting CMS's 2007 Enrollment Directive," No. 76, April 21, 2008 at A17.

The CMS Letter

The CMS letter explained that its experience and the information gathered in the operation of SCHIP programs indicated that procedures that had been utilized by the states to ensure SCHIP coverage under private group health plans (so called "crowd-out" procedures) were not working effectively and that it had "become clear that the potential for crowd-out is greater for higher income beneficiaries." As a consequence of this determination, the CMS letter announced that henceforth the five crowd-out "strategies" that over the years had been identified as reasonable crowd-out prevention procedures, any one or more of which could be adopted by a state, if they were considered necessary, were now mandatory in their entirety on states that expanded eligibility above the effective level of 250% of the FPL. States would now also have to incorporate three new components as part of these strategies, including requiring state establishment of a one-year period of uninsurance for individuals prior to receiving aid. In addition, a state must now make "assurances" that it has enrolled at least 95% of the children in the state below 200 percent of the FPL who are eligible for SCHIP or Medicaid; that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period; and that the state is current with all reporting requirements in SCHIP and Medicaid reports relating to crowd-out requirements. The new review requirements apply to SCHIP state plans and section 1115 demonstration waivers that include SCHIP populations. CMS stated it "expected affected States to amend their SCHIP state plan (or 1115 demonstrations) in accordance with this review strategy within 12 months, or CMS will pursue corrective action" to effect compliance with the CMS guidance.

Reaction to the CMS Letter

The CMS letter raised immediate concerns among some Members of Congress, certain states and with child health interest groups that the new conditions imposed would effectively make it difficult if not impossible, for states to cover uninsured children.[4] Proponents of the CMS action countered that it clarifies existing law, preserves SCHIP for the core population it was intended to serve, deters further erosion of private coverage, and ensures that states are moving forward on meeting the basic goals of the program.[5]

A SCHIP reauthorization bill, H.R. 976, addressing the source of the concerns raised by the CMS letter, was sent to the President and was vetoed on October 18, 2007. A modified version of H.R. 976, H.R. 3963, was sent to the President who again vetoed it on November 12. Congressional overrides of both vetoes failed.[6] On September 7, 2007, the Acting Administrator of CMS denied New York State's state plan amendment (SPA) which would increase the financial eligibility standard for its separate SCHIP program from its current effective family income eligibility level to or below 400 percent of the FPL. The SPA also proposed to implement a six month waiting period of prior uninsurance for children with family incomes above 250 percent of the FPL with certain limited exceptions. The denial was the first to rely on the CMS letter. CMS held that New York had "failed to provide assurances that the state had enrolled at least 95 percent of the children in the core targeted low-income child population, those with family incomes below 200 percent of the FPL. In the absence

---

[4] See, *e.g.* Cindy Mann and Michael Odeh, "Moving Backward: Newly Imposted Limits on States' Ability to Cover Children, " Center for Children and Families, Georgetown University Health Policy Institute (August 30, 2007) accessible at http://ccf.georgetown.edu/pdfs/cmsdirective.pdf (Moving Backward).

[5] See, *e.g.* Nina Owcharenko, "The Administration's SCHIP Regulations: A Sound Prescription," Web Memo No. 1591, August 27, 2007, accessible at www.heritage.org/ research/ healthcare/ wm15911cfm.

[6] See CRS Report RS22746, "SCHIP: Differences between H.R. 3963 and H.R. 976," by Evelyne P. Baumrucker, et al.

of such assurances, I cannot conclude that New York is effectively and efficiently using available resources to serve that core population, such that expansion to higher income levels would not divert resources from serving the core population." The CMS Director also found unreasonable New York's procedures for deterring crowd-out by having a six month rather than a one-year uninsurance period for populations over 250 percent of the FPL as required by the August 2007 CMS letter.

On October 4, 2007, New York, joined by Illinois, Maryland, and Washington, filed suit in federal district court in the Southern District of New York challenging the validity of the CMS letter on the grounds that it "constituted illegal rulemaking not in conformance with applicable requirements of the Administrative Procedure Act" and HHS's published rulemaking policy; that "the requirements it imposed are in excess of the authority vested in the Secretary of HHS under applicable law;" and that "it imposes requirements that are not set forth in statute or codified regulations... ."[7]

The New York rejection and its lawsuit, underlines the potentially large direct impact the CMS letter may have.CMS has determined that "states with eligibility above 250 percent FPL when income disregards are included are California, Connecticut, the District of Columbia, Georgia, Hawaii, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, Pennsylvania, Rhode Island, Tennessee, Vermont, and Washington."[8] Four other states have income eligibility thresholds at or slightly below 250 percent of the FPL but apply deductions when computing eligibility.[9]

---

[7] Complaint, *State of New York et al. v. U.S. Department of Health and Human Services*, Case no. 07-CIV-8621, filed October 4, 2007.

[8] See, letter to The Honorable Joe Barton, from Dennis G. Smith, Director, Center for Medicaid and State Operations, dated January 22, 2008.

[9] For instance, by deducting income used to pay for child care expenses.

The Legislative History of the Crowd-Out Rule

The number of states that currently exceeds the new 250 percent of FPL eligibility threshold is arguably reflective of the policy of flexibility that prevailed since the adoption of the current rulemaking scheme in 2001.[10] The Statement of Basis and Purpose accompanying and explaining the 2001 final rule makes it clear that many rigid standards in the original Notice of Proposed Rulemaking were abandoned after consideration of public comments. The crowd-out procedure language at 42 C.F.R. § 457.805, relied upon by CMS as authority for the more stringent guidance restrictions here in question, simply requires that "[t]he state plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the state plan does not substitute for coverage provided under group health plans as defined at section 457-10." The introduction to the 2001 rules' preamble explains:

> Due to a general lack of evidence of the existence of substitution below 200 percent of the FPL and the significant number of comments received on this subject, we have revised the final rule to clarify our policy related to substitution. The preamble to the final rule clarifies that for coverage provided other than through premium assistance programs, we will no longer require a substitution prevention strategy for families with incomes below 250 percent of the FPL. Instead, States will be required to monitor the occurrence of substitution below 200 percent of the FPL. Between 200 and 250 percent of the FPL, we will work with States to develop procedures, in addition to monitoring, to prevent substitution that would be implemented in the event that an unacceptable level of substitution is identified. Above 250

[10] See 66 Fed. Reg. 2490, 2493, 2602-2610 (January 11, 2001).

percent of the FPL, States must have a substitution prevention mechanism in place, however we encourage States to use other strategies than waiting periods.

For States wishing to utilize premium assistance programs, we have revised the final rule to provide additional flexibility. While we have retained the 6-month waiting period without group health plan coverage, States have flexibility to include a number of exceptions for circumstances such as involuntary loss of coverage, economic hardship, and change to employment that does not offer dependent coverage. We have also removed the requirement for States to demonstrate an employer contribution of at least 60 percent when providing coverage through premium assistance programs. Rather, we have clarified that States must demonstrate cost-effectiveness of their proposals by identifying a minimum contribution level and providing supporting data to show that the level is representative of the employer-sponsored insurance market in their State.

Finally, the final rule provides that the Secretary has discretion to reduce or waive the minimum period without private group health plan coverage. [11]

The subsequent discussions in the preamble of the rule with respect to the need for flexibility and working with the states with respect to individualizing crowd-out procedures flesh out the introductory remarks:

---

[11] 66 Fed. Reg. at 2493.

Our review of States' March 31, 2000 evaluations indicated that in those States with data on substitution of private coverage with SCHIP coverage, there was little evidence that substitution was as great an issue as initially anticipated. However, because of the current lack of conclusive data around the level of substitution which may be occurring below 200 percent of FPL, we maintain that monitoring of substitution of coverage in SCHIP is critical.

As noted above, we have revised the policy stated in the preamble to the NPRM regarding substitution procedures relating to SCHIP coverage provided outside of programs that offer premium assistance for coverage under group health plans as follows:

- States that provide coverage to children in families at or below 200 percent of FPL must have procedures to monitor the extent of substitution of SCHIP coverage for existing private group health coverage, as was the policy for such coverage provided to families under 150 percent of FPL proposed in the preamble to the NPRM.

- At a minimum, States that provide coverage to children in families with incomes over 200 percent of FPL should have procedures to evaluate the incidence of substitution of SCHIP coverage for existing private group health coverage. In addition, States offering coverage to children in families over 200 percent of FPL must identify in their State plans specific strategies to limit substitution if monitoring efforts show unacceptable levels of

substitution. States must monitor the occurrence of substitution and determine a specific trigger point at which a substitution prevention mechanism would be instituted, as described in the State plan.

- For coverage above 250 percent of the FPL, because evidence shows that there is a greater likelihood of substitution at higher income levels, States must have substitution prevention strategies in place, in addition to monitoring.

Although a period of uninsurance is one possible substitution prevention procedure, we invite States to propose other effective strategies to limit substitution. States may submit amendments to their State plans if they would like to modify their current policies in light of the policies discussed here. We plan to work closely with States to develop appropriate substitution strategies, monitoring tools, and trigger mechanisms. As part of monitoring for substitution of coverage, States should also study the extent to which anti-substitution policies require children who have lost group health coverage through no fault of their own or their employer to wait to be enrolled in SCHIP. To the extent that monitoring finds that such children are forced to go without coverage, States should consider adjustments to their substitution prevention policies that permit exceptions for children who should not be the target of such policies. We will continue to ask States to assess their substitution prevention procedures in their annual reports.

Finally, we note that because the regulatory text at §457.805 required that the State plan include reasonable procedures to prevent substitution and made no distinction for eligibility levels for coverage under State plans, we have not revised the regulation text. It is consistent with our revised policy.[12]

* * *

We agree that State's substitution prevention efforts should be considered in the context of the entire State plan with consideration given to a State's particular needs and goals. To this end, we have retained a flexible regulatory requirement regarding substitution and indicated that HCFA will incorporate additional flexibility in its plan review process.[13]

* * *

As stated above, periods of uninsurance will not be required unless coverage is provided via premium assistance through group health plans, coverage is provided to children with significantly higher income levels, or substitution has been identified as a problem in the State. [14]

* * *

As indicated above, outside of premium assistance programs, States have broad discretion to develop substitution prevention policies that best serve their particular populations. States that choose to retain or impose periods of uninsurance are encouraged to include exceptions that help prevent the imposition of undue hardship under a range of circumstances, including loss

---

[12] *Id.* at 2603.

[13] *Id.* at 2604.

[14] *Id.*

of insurance through no fault of the family, extreme economic hardship, death of a parent, etc.[15]

It is possible that substantial departures from these apparent understandings may be seen by a reviewing court as requiring adherence to the notice and comment process required by Section 553 of the Administrative Procedure Act.

Congressional Review of Agency Rules

The congressional review mechanism, codified at 5 U.S.C. §§ 801-808, and popularly known as the Congressional Review Act (CRA), requires that all agencies promulgating a covered rule must submit a report to each House of Congress and to the Comptroller General (CG) that contains a copy of the rule, a concise general statement describing the rule (including whether it is deemed to be a major rule), and the proposed effective date of the rule. A covered rule cannot take effect if the report is not submitted.[16] Each House must send a copy of the report to the chairman and ranking minority member of each jurisdictional committee.[17] In addition, the promulgating agency must submit to the CG (1) a complete copy of any cost-benefit analysis; (2) a description of the agency's actions pursuant to the requirements of the Regulatory Flexibility Act and the Unfunded Mandates Reform Act of 1995; and (3) any other relevant information required under any other act or executive order. Such information must also be made "available" to each House.[18]

---

[15] *Id.*

[16] 5 U.S.C. § 801(a)(1)(A).

[17] 5 U.S.C. § 801(a)(1)(C).

[18] 5 U.S.C. § 801(a)(1)(B).

Section 804(3) adopts the definition of "rule" found at 5 U.S.C. § 551(4) which provides that the term rule "means the whole or part of an agency statement of general . . . applicability and future effect designed to implement, interpret, or prescribe law or policy."[19] The legislative history of Section 551(4) indicates that the term is to be broadly construed: "The definition of rule is not limited to substantive rules, but embraces interpretive, organizational and procedural rules as well."[20] The courts have recognized the breadth of the term, indicating that it may encompass "virtually every statement an agency may make,"[21] including interpretive and substantive rules, guidelines, formal and informal statements, policy proclamations, employee manuals and memoranda of understanding, among other types of actions.[22] Thus a broad range of agency action is potentially subject to congressional review.

The drafters of the congressional review provision arguably adopted the broadest possible definition of the term "rule" when they incorporated § 551(4) of the APA. As just indicated, the legislative history of § 551(4) and the case law interpreting it make clear that it was meant to encompass all substantive rulemaking documents — which may include policy statements, guidances, manuals, circulars, memoranda, bulletins and the like — which as a legal or practical matter an agency wishes to make binding on the affected public.

---

[19] 5 U.S.C. § 804(3) excludes from the definition "(A) any rule of particular applicability, including a rule that approves or prescribes for the future rates, wages, prices, services, or allowance therefore, corporate or financial structures, reorganizations, mergers, or acquisitions thereof, or accounting practices or disclosures bearing on any of the foregoing; (B) any rule relating to agency management or personnel; or (C) any rule of agency organization, or practice that does not substantially affect the rights or obligations on non-agency parties."

[20] Attorney General's Manual on the Administrative Procedure Act 13 (1948).

[21] *Avoyelles Sportsmen's League, Inc. v. Marsh,* 715 F.2d 897 (5th Cir. 1983).

[22] See, e.g., *Chem Service, Inc. v. EPA,* 12 F.3d 1256 (3d Cir. 1993)(memorandum of understanding); *Caudill v. Blue Cross and Blue Shield of North Carolina,* 999 F.2d 74 (4th Cir. 1993)(interpretative rules); *National Treasury Employees Union v. Reagan,* 685 F.Supp 1346 (E.D. La 1988)(federal personnel manual letter issued by OPM); *New York City Employment Retirement Board v. SEC,* 45 F.3d 7 (2d Cir. 1995)(affirming lower court's ruling that SEC "no action" letter was a rule within § 551(4)).

The legislative history of the CRA[23] emphasizes that by adoption of the § 551 (4) definition of the term "rule", the review process would not be limited only to coverage of rules required to comply with the notice and comment provisions of the APA or any other statutorily required variations of notice and comment procedures, but would rather encompass a wider spectrum of agency activities characterized by their effect on the regulated public: "The committee's intent in these subsections is . . . to include matters that substantially affect the rights or obligations of outside parties. The essential focus of this inquiry is not on the type of rule but on its effect on the rights and obligations of non-agency parties."[24] The drafters of the legislation indicated their awareness of the practice of agencies avoiding the notification and public participation requirements of APA notice-and-comment rulemaking by utilizing the issuance of other documents as a means of binding the public, either legally or practically,[25] and noted that it was the intent of the legislation to subject just such documents to congressional scrutiny:

> The committees are concerned that some agencies have attempted to circumvent notice-and-comment requirements by trying to give legal effect to general statements of policy, "guidelines," and agency policy and procedure manuals. The committees admonish the agencies that the APA's

---

[23] Joint Explanatory Statement of House and Senate Sponsors, 142 Cong. Rec. E 571 (daily ed. April 19, 1996); 142 Cong. Rec. S 3681 (daily ed. April 18, 1996).

[24] Join Explanatory Statement of House and Senate sponsors, *supra* n.22, at E 579, S 3687.

[25] This practice has been long recognized and criticized in administrative law commentaries. See, e.g., Robert A. Anthony, Interpretive Rules, Policy Statements, Guidances, Manuals, and the Like — Should Federal Agencies Use Them To Bind The Public? 41 Duke L.J. 1311 (1992). See also, General Accounting Office, Federal Rulemaking: Agencies Often Published Final Actions Without Proposed Rules, GAO/GGD-98-126 (August 1998).

> broad definition of "rule" was adopted by the authors of this legislation to discourage circumvention of the requirements of chapter 8.[26]

During floor consideration of the CRA, Representative McIntosh, a principal sponsor of the legislation, emphasized the importance that the effect on private parties was to have in determining what is a covered rule:

> Pursuant to section [804(3)(C)], a rule of agency organization, procedure, or practice, is only excluded if it "does not substantially affect the rights or obligations of nonagency parties." The focus of the test is not on the type of rule but on its effect on the rights or obligations of nonagency parties. A statement of agency procedures or practice with a truly minor, incidental effect on nonagency parties is excluded from the definition of the rule. Any other effect, whether direct or indirect, on the rights and obligations of nonagency parties is a substantial effect within the meaning of the exception. Thus, the exception should be read narrowly and resolved in favor of nonagency parties who can demonstrate that the rule will have a non-trivial effect on their rights and obligations.[27]

Representative McIntosh also asserted that rules subject to congressional review are not the same as those subject to APA notice and comment requirements:

---

[26] Join Explanatory Statement of House and Senate sponsors, *supra* n.21, at E 578, S 3687.

[27] 142 Cong. Rec. H3005 (daily ed. March 28, 1996).

> All too often, agencies have attempted to circumvent the notice and comment requirements of the Administrative Procedure Act by trying to give legal effect to general policy statements, guidelines, and agency policy and procedure manual. Although agency interpretative rules, general statements of policy, guideline documents, and agency and procedure manual may not be subject to the notice and comment provisions of section 553(c) of title 5, United States Code, these types of documents are covered under the congressional review provisions of the new chapter 8 of title 5.
>
> Under section 801(a), covered rules, with very few exceptions, may not go into effect until the relevant agency submits a copy of the rule and an accompanying report to both Houses of Congress. Interpretive rules, general statements of policy, and analogous agency policy guidelines are covered without qualification because they meet the definition of a "rule" borrowed from section 551 of Title 5, and are not excluded from the definition of rule.[28]

To date, at least nine agency failures to report agency actions have come to the attention of committee chairmen and Members and were referred to the Comptroller General for determinations whether they were covered rules. In six of the nine cases the Comptroller General determined the action documents to be reportable rules.[29] Two are pertinent to the instant matter.

---

[28] *Id.*

[29] See CRA Report, *supra* n. 1, at 26-27. The nine GAO determinations include its April 17, 2008 opinion on the August 17, 2007 SCHIP letter.

In Opinion Number B-281575 (January 20, 1999), GAO advised that an "Interim Guidance for Investigating Title VI Administrative Complaints Challenging Permits" issued by the Environmental Protection Agency (EPA) was a reportable rule. EPA had argued that the rule fell within the exception of 5 U.S.C. § 804 (3)(C) as a "rule of agency organization, procedure or practice that does not substantially affect the rights or obligations of non-agency parties." The GAO General Counsel noted that "it is the substance of what EPA has purported to do and has done which is decisive." Here, the General Counsel found that the Interim Guidance established procedures that departed from existing rules, giving the recipients of a complaint rights they did not have under those rules, and held "they clearly alter the existing regulation and give significant rights they did not previously possess for obtaining dismissal of a complaint. In this respect these new steps meet the elements of a substantive rule: they affect the rights and duties of the recipient, the complainant, and the affected populations; they will have future effect and they change the existing regulation."

In Opinion Number B-286338 (October 17, 2000) the issue involved the Farm Credit Administration's (FCA) establishment of a National Charter Initiative which would accept applications for national charters that would remove regulatory geographic barriers imposed on Farm Credit System banks. Geographic jurisdiction limitations had been a historic policy of the FCA which it attempted to alter in a 1998 notice-and-comment rulemaking. The proposal was dropped from the final rule, but FCA attempted to accomplish this purpose through its so-called National Charter Initiative. The GAO General Counsel rejected the claim that the application process set up by the Initiative was adjudicatory in nature, finding that since the express purpose of the Initiative was to change the geographic limitation policy, it was unrelated to any particular institution's application. Rather, the General Counsel found, it was of general applicability, future effect, and prescribed a change in

policy that would have a substantial effect on non-agency parties and thus was a reportable rule.

In an analogous manner, the courts have looked behind the label an agency has given a particular action document to ascertain the practical effect it has had on non-agency parties. Where the courts have discerned that the agency document has substantively changed the rights, duties and obligations of regulated persons, they have held the agency action invalid for failure to comply with the APA's notice and comment requirements. For example, in *Appalachian Power Co.* v. *EPA*,[30] the appeals court dealt with a claim by electrical power companies and trade associations that a "guidance" document allegedly imposed unauthorized requirements on states in connection with their operating permit purposes. The court found that the document was a final binding decision of the agency subject to judicial review, the guidance broadened the underlying agency rule and that its promulgation was impermissible absent notice and comment rulemaking procedures. The court held that: "If an agency acts as if a document issued at headquarters is controlling in the field, if it treats the document in the same manner as it treats a legislative rule, if it bases enforcement actions on the policies or interpretations formulated in the document, if it leads private parties or State permitting authorities to believe it will declare permits invalid unless they comply with the terms of the document, then the agency's document is for all practical purposes 'binding.'"

Similarly, in *Chamber of Commerce of the U.S.* v. *Department of Labor*,[31] OSHA had issued a directive stating that employers in certain industries that participated in a

---

[30] 208 F.3d 1015, 1020-23 (D.C. Cir. 2000).

[31] 174 F.3d 206, 211-13 (D.C. Cir. 1999).

"cooperative compliance program" would have significantly reduced risk of being subject to an inspection. The cooperative program included some requirements that "exceed[ed] those required by law." The appeals court concluded that:"In practical terms, the [DOL] Directive places the burden upon those employers that fail to join [the program], and will have a substantial impact upon all employers within its purview — including those that acquiesce in the agency's use of 'leverage' against them."[32]

In sum, it is arguable that at the heart of the drafters' design of the CRA was the creation of a review mechanism that would uncover and remedy in a timely manner what were viewed as agency attempts to evade congressional oversight, presidential executive order review, and the requirements of public comment and judicial review under the APA. Time consuming litigation was seen as an anathema to achieving accountable agency policymaking actions.[33]

---

[32] See also, *National Family Planning and Reproductive Health Assoc.* v. *Sullivan*, 979 F. 2d 227, 229 ("The new 'Directives' neither clarify nor explain the previous regulation, which was adopted by notice and comment rulemaking, but instead effectively amend the 1988 regulations to significantly alter its meaning, as previously interpreted and enforced by HHS and upheld by the Supreme Court in *Rust v. Sullivan* [500 U.S. 173(1991)]."). See also, *Davidson v. Glickman*, 169 F.3d 996 (5th Cir. 1999); *Snyder Intl.* v. *Shalala*, 127 F.,3d. 90 (D.C. Cir. 1997); *Paralyzed Veterans of America v. D.C. Area L.P.*, 117 F. 3d 579, 587 (D.C. Cir. 1997); *Hoctor* v. *U.S. Department of Agriculture*, 82 F.3d. 165 (7th Cir. 1996). See generally, Jefferey S. Lubbers, "A Guide to Federal Agency Rulemaking," pp.73-104 (4th ed. 2006).

[33] On May 7, 2008, CMS issued a letter to all state health officials further clarifying its communication of August 17, 2007. The 2007 letter stated that CMS did "not expect any effect on current enrollees." The May 7 letter states that "any changes made to a State's crowd-out procedures in response to the August 17 letter need not be applied to prior enrollees . .. as long as they remain continually enrolled in the program." With respect to whether the 12-month uninsurance period applied to all enrollees or only those enrollees with effective family incomes above 250 percent of the FPL, CMS responded that it "need not" apply to enrollees at or below the 250 percent FPL level, but that "States do have the option to apply these crowd-out procedures to enrollees [with such incomes] as part of efforts to ensure that SCHIP coverage does not substitute for private coverage." CMS reiterated that the 12-month period of uninsurance "is the standard by which States will be evaluated" but will review "alternatives" and the "justification" for these, and "consider exceptions" if the State provides "justifications and data demonstrating low substitution risk." The nature of such data is not detailed. Finally, CMS states that it is "convinced" that States can provide assurance that at least 95 percent of the children in the State with family incomes below 200 percent of the FPL have coverage by using available data. It would not appear that new clarification alters our conclusion that the overall effect of the August 17 letter effects a substantive alteration of the 2001 crowd-out rule.

Does An Agency's Failure to Report a Covered Rule Preclude Initiation Of the CRA Review Process?

Under Section 802(a) of the CRA[34] a joint resolution of disapproval must be introduced within 60 calendar days (excluding days either House of Congress is adjourned for more than three days during a session of Congress) after the agency reports the rule to the Congress in compliance with Section 801(a)(1). Timely introduction of a disapproval resolution allows each House 60 session or legislative days to consider it through the use of expedited consideration procedures, and if passed, allows retroactive nullification of an effective rule and the limitation on an agency from promulgating a "substantively similar" rule without subsequent congressional authorization to do so by law.[35]

The question arises in the instant situation as to when the 60 calendar period for introducing a disapproval resolution starts. Arguably, in the case of a failure of an agency to report a covered rule, the 60-day clock should not begin running until the required report is submitted. Otherwise, an agency could evade congressional scrutiny (and the Act's expedited consideration procedures) by simply not reporting. Support for such a reading is presented by the first sentence of the Act which makes it clear that a failure to report a covered rule means that the "rule" cannot be enforced. [36] That requirement triggers at least two possible actions: a lawsuit by an injured private party to enjoin enforcement by the non-reporting agency; and/or the filing of a disapproval resolution by a Member of Congress. Effectively, the first option has been exercised by New York and other states by filing their lawsuit

---

[34] 5 U.S.C. 802(a).

[35] See CRS Report at 35-40.

[36] 5 U.S.C. 801(a).

against CMS. But, that does not preclude the use of the CRA mechanism at the same time, since the purposes of CRA review and APA judicial review are distinguishable and reflect the CRA drafters' recognition that APA lawsuits take a long time to resolve. One federal district court has recognized in a related context[37] that to allow "agencies to evade the strictures of the CRA by simply not reporting new rules [and thereby bar courts] from reviewing their lack of compliance. . .would be at odds with the purpose of the CRA, which is to provide a check on administrative agencies' power to set policies and essentially legislate without congressional oversight."[38] Moreover, there is a Senate precedent for such action. In 2001 Senator Barbara Boxer filed S.J. Res. 9 to disapprove the State Department's Administrator of International Development's (AID) restoration of the so-called Mexico City Policy, which limited the use of federal and non-federal monies by non-governmental organizations to directly fund foreign population planning programs which support abortion or abortion-related activities. The AID Director did not report his action, directed by President Bush, to Congress. Before Congress could act, President Bush rescinded the presidential delegation of authority to the AID Director and issued the implementing directive himself. The CRA is not applicable to such presidential directives. The filing of the disapproval resolution before the presidential action had the apparent approval of the Senate Parliamentarian.[39]

Conclusion

---

[37] CRA Report at 30-31.

[38] *United States* v. *Southern Indiana Gas and Electric Co.*, 2002 U.S. Dist. LEXIS 20936.

[39] See CRA Report at 15-16.

Our analysis of the statutory scheme of the CRA, its legislative history, and opinions of the General Counsel of GAO, indicates that the drafters of the congressional review provision were concerned with then-prevalent agency actions that had the practical effect of imposing binding norms on non-agency parties without being promulgated in conformance with requirements of notice-and-comment rulemaking. In response, Congress adopted a broad definition of the term "rule" that would capture such actions for congressional review. The rulings of several appellate courts recognizing the invalidity of such actions support the CRA's history and the GAO interpretations. The courts have also indicated that the past practice of an agency in implementing a rulemaking may be looked at for insight as to the understanding and reliance regulated parties and beneficiaries have placed on such past agency practices. In such instances, the courts have held that an abrupt change of course requires a new rulemaking proceeding to substantively alter those practices and relied upon interpretations.[40] In this instance, CMS practice under the 2001 crowd-out rules arguably has become a "binding norm," and therefore changing such past practices would be an action that is covered by the CRA that may not be implemented until it is reported to Congress and the Comptroller General.

There are observers who argue that the current HHS practice is the appropriate one. Congress has a number of options should it choose to act. We believe the introduction of a disapproval resolution would be supportable even though the CMS letter has not been reported by the agency. Such a filing would proceed under the expedited consideration procedures of the CRA. Although passage of a disapproval resolution might be swift, it may, however, be subject to another presidential veto. Passage by the House of H.R. 5998, even

---

[40] See, *e.g.*, *Motor Vehicle Manufacturing Assoc.* v. *State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29 (1983).

if quickly achieved, would not receive the non-amendable, filibuster-proof procedures of the Senate afforded by the CRA. Another possibility would be the use of an appropriations limitation to delay implementation of the CMS letter. There is evidence of increased usage of such limitations to stall proposed and final rulemakings in recent years.[41]

[41] See Curtis W. Copeland, "Congressional Influences on Rulemaking Through Appropriations Provisions," CRS Report No. RL34354.

Mr. PALLONE. Thank you, Mr. Rosenberg. Thank you.
Mr. Alexander.

STATEMENT OF GARY ALEXANDER, DIRECTOR, RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Mr. ALEXANDER. Thank you very much, Mr. Chairman, Ranking Member Deal, and other members of the Committee. My name is Gary Alexander. I am the director of the Rhode Island Department of Human Services. The Rhode Island Department of Human Services is entrusted with, among other programs, the Medicaid program, the TANF Program, food stamps, and the State's department of Veterans' Affairs.

I would like to talk to you today about Rhode Island's experience with Medicaid and SCHIP crowd-out and our ability to comply with the provisions outlined in the CMS State health official letter from August 17, 2007.

Rhode Island's Medicaid program recognized the potential for crowd-out of private health insurance and its managed care program known as Right Care almost a decade ago. As we experienced an increase in enrollment in the late 1990s, policymakers quickly identified the risks to Right Care's fiscal sustainability and viability and in response, adopted a series of health reforms aimed at stabilizing the program.

Those reforms were guided by the following principles. The preservation of employer-sponsored insurance, ensuring that there are no incentives for employers to shift or dump their employees from private to public coverage, the wise and responsible use of public dollars, ensuring continued health coverage for long-income beneficiaries, and to promote personal responsibility through beneficiary cost sharing.

As a result, Rhode Island created the Right Share Premium Assistance Program and established cost-sharing requirements for Right Care and Right Share beneficiaries above 150 percent of the federal poverty level. Rhode Island sought and received approval from CMS through a state plan amendment to create the Right Share Public/Private Partnership. This program is aimed at helping eligible beneficiaries maintain employer-sponsored insurance.

In the Right Share program, the State pays the beneficiary's portion of the employer-sponsored insurance and provides wraparound services through the State Medicaid program. A portion of that state share may be paid by the beneficiary as a monthly premium. This arrangement has been extremely successful at maintaining the employee/employer link.

CMS has agreed that this is an acceptable alternative to a 1-year waiting period because we are able to effectively capture the employer coverage and avoid any crowd-out issues.

Right Share has been very successful helping lower-income families maintain employer-sponsored insurance and avoid moving to a completely government-funded health program. Currently 90 percent of Right Share families have an income below 185 percent of the federal poverty level. Those families are at greatest risk for dropping their employer-sponsored insurance and becoming crowd-out statistics.

The Right Share approach has maintained the employer share at a savings of $1 million for every 1,000 enrollees every single year. Those are costs that would have likely come to the state as employers have passed higher commercial premiums onto their employees, creating an affordability problem for lower income families.

Rhode Island also received approval to require monthly premiums for families with incomes over 150 percent of the federal poverty level. For higher income enrollees, monthly premiums have lessened the gap between the cost of maintaining employer-sponsored insurance and enrolling in a government program. This is intended to dissuade employees from dropping commercial health plans for less expensive, government-funded coverage.

To avoid losing the lower-income enrollees to relatively high cost sharing efforts, Rhode Island has opted for a sliding scale monthly premium based on income. Our ability to maintain a high percentage of eligible persons enrolled is evidence that we have been successful at balancing these competing interests.

Additional measures contained in the CMS letter include the monitoring of possible health coverage through non-custodial parents, a requirement that 95 percent of eligible children under 200 percent of the poverty level are ensured, and an assurance that the number of children under 200 percent of the federal poverty level covered by private insurance has not decreased by more than 2 percent over the past 5 years.

As part of Rhode Island's Medicaid program, Integrity Procedures, the state routinely conducts third-party liability checks in an effort to determine any other source of insurance coverage, which would include coverage associated with non-custodial parents. These checks are conducted routinely and in conjunction with commercial insurers.

Rhode Island has complied with the assurance that 95 percent of eligible children under 200 percent of the federal poverty level are insured. Compliance was achieved through long-term outreach and a commitment to sustaining commercial insurance through the Right Share premium assistance program.

Rhode Island has a history of strong community advocacy. With these community partners, the state has been able to enroll tens of thousands of children in this program. Efforts to educate the public about this program continue on a daily basis. The assurance that limits the potential decrease in commercial insurance coverage for this population to 2 percent over 5 years is the most difficult provision to meet.

Statewide insurance initiatives to expand access and affordability are not under the purview of the state Medicaid program. But in Rhode Island, they have played an active role in those strategic discussions. The ability for long-income Rhode Islanders to afford commercial health insurance is important to the governor and to the fiscal integrity of the State's Medicaid program.

In conclusion, compliance with the CMS letter dated August 17, 2007 was not the result of last minute program changes or quick fixes by the Medicaid department. Rhode Island has been able to avoid crowd-out issues because of a long-term reasoned approach that seeks to maintain an enrollee's existing coverage, which will

not create disincentives so that beneficiaries will migrate to big government programs.

I thank you very much for the chance to speak.

[The prepared statement of Mr. Alexander follows:]

Testimony
House Committee on Energy and Commerce, Subcommittee on Health

SCHIP Crowd-Out Rule Changes (August, 2007)

Good afternoon Chairman Pallone, Ranking Member Deal, and members of the Committee, my name is Gary Alexander I am the Director of the Department of Human Services in Rhode Island. I would like to thank you for the opportunity to offer testimony on Rhode Island's experience with Medicaid and SCHIP crowd-out and our ability to comply with provisions outlined in the CMS State Health Official letter dated August 17, 2007.

Rhode Island's Medicaid Program recognized the potential for crowd-out of private health insurance in its managed care program, known as RIte Care, almost a decade ago. As we experienced an increase in enrollment in the late 1990's policymakers quickly identified the risks to RIte Care's fiscal viability, and in response, adopted a series of health reforms aimed at stabilizing the program. Those reforms were guided by the following principles: the preservation of employer sponsored insurance, ensuring that there are no incentives for employers to shift their employees from private to public coverage, the wise and responsible use of public dollars, ensuring

continued health coverage for low-income beneficiaries, and to promote personal responsibility thought beneficiary cost sharing. As a result, Rhode Island created the RIte Share premium assistance program and established cost sharing requirements for RIte Care and RIte Share beneficiaries above 150% of the Federal Poverty Level.

Rhode Island sought and received approval from CMS, through a State Plan Amendment, to create the RIte Share public-private partnership. This program is aimed at helping eligible beneficiaries maintain employer sponsored insurance. In the RIte Share program, the State pays the beneficiary's portion of the employer sponsored insurance and provides wrap-around services through the state Medicaid program. A portion of that State "share" may be paid by the beneficiary as a monthly premium. This arrangement has been extremely successful a maintaining the employee/employer link. CMS has agreed that this is an acceptable alternative to a one year waiting period, because we are able to effectively capture the employer coverage and avoid any crowd-out issues.

The RIte Share has been very successful helping lower income families maintain employer sponsored insurance and avoid moving to a

completely government funded health plan. Currently, 90% of RIte Share families have an income below 185% of the Federal Poverty Level. Those families are at greatest risk for dropping their employer sponsored insurance and becoming crowd-out statistics. The RIte Share approach has maintained the employer share at a savings of $1 million for every 1000 enrollees every year. Those are costs that would have likely come to the state as employers have passed higher commercial premiums on to their employees, creating an affordability problem for lower-income families.

Rhode Island also received approval to require monthly premiums for families with incomes over 150% of the Federal Poverty Level. For higher income enrollees, monthly premiums have lessened the gap between the cost of maintaining employer sponsored insurance and enrolling in a government alternative. This is intended to dissuade employees from dropping commercial health plans for less expensive government funded coverage. To avoid losing the lower-income enrollees to relatively high cost sharing efforts, Rhode Island has opted for a sliding scale monthly premium based on income. Our ability to maintain a high percentage of eligible persons enrolled is evidence that we have been successful at balancing these competing interests.

Additional measures contained in the CMS SHO letter include the monitoring of possible health coverage through non-custodial parents, a requirement that 95% of eligible children under 200% of the Federal Poverty Level are insured, and an assurance that the number of children under 200% of the Federal Poverty Level covered by private insurance has not decreased by more than 2% over the past five year.

As part of RI Medicaid's program integrity procedures, the State routinely conducts third-party liability checks in an effort to determine any other source of insurance coverage, which would include coverage associated with non-custodial parents. These checks are conducted routinely and in conjunction with commercial insurers.

Rhode Island has complied with the assurance that 95% of eligible children under 200% of the Federal Poverty Level are insured. Compliance was achieved through long-term outreach and a commitment to sustaining commercial insurance through the RIte Share program. Rhode Island has a history of strong community advocacy; with these community partners, the

State has been able to enroll tens of thousands of children in this program. Efforts educate the public about this program continue on a daily basis.

The assurance that limits the potential decrease in commercial insurance coverage for this population to 2% over 5 years is the most difficult provision to meet. Statewide insurance initiatives to expand access and affordability are not under the purview of the State Medicaid Program, but in Rhode Island they have played an active role in those strategic discussions. The ability for low income Rhode Islanders to afford commercial health insurance is important to Governor and to the fiscal integrity of the State's Medicaid Program.

In conclusion, compliance with the CMS SHO letter, date August 17, 2007, was not the result of last minute program changes or quick fixes. Rhode Island has been able to avoid crowd-out issues because of a long-term reasoned approach that seeks to maintain an enrollee's existing coverage, creates disincentives for migrating from commercial to government funded health coverage, and maximizes the use of public dollars.

Mr. PALLONE. Thank you, Mr. Alexander. Ms. Cummings.

STATEMENT OF LESLEY CUMMINGS, EXECUTIVE DIRECTOR, THE CALIFORNIA MANAGED RISK MEDICAL INSURANCE BOARD

Ms. CUMMINGS. Thank you, Mr. Chairman and Mr. Deal and other members of the Committee. We really appreciate the opportunity that you invited us here to talk to you about how we would see the effect of the August 17 directive applying to California.

First, I wanted to note that SCHIP, one of the things that we have all loved about it and continue to love about it, is that it has provided States with a lot of flexibility to look at the circumstances in its State and decide what it needs in terms of coverage of children. This is really important because every State has a difference in its rates of uninsurance, in the income of people in the State, of the incidents of employer-sponsored coverage. So it is really important to take those things into consideration when designing a program.

In California, we designed a program that began in July 1998 with coverage of children to 200 percent of the federal poverty level with the application of income disregards used by Medicaid. Why did we do that? Because we wanted somebody to go into Medicaid if they should, and if you use a different standard, you wouldn't be able to do that. This was approved by the Federal Government.

In 1999, we expanded coverage to children up to 250 percent of poverty again using this net income standard. Another thing that was a future of our program then and was approved by CMS at that time was a 3-month waiting period for our entire program.

Next in 2006, at the urging of the administration, California elected to cover pregnant women with SCHIP dollars, and that is to an income of 300 percent of federal poverty level and coverage for the woman's children for 2 years at 300 percent poverty level. We have built a fabulous program in California. We cover a million people. That is through Medicaid, through our pregnancy program, through our program for children. So we have really taken the opportunity and worked with it to create what I think anybody in our state said would be a fabulous program.

Nevertheless, despite the fact that we cover up to 250 percent in our SCHIP program, up to 300 percent for pregnant women, the average family income for a child in our program is 165 percent. Now, why? Because the incidents of employer-sponsored coverage increases as you get higher up in the income so fewer people need it. But that doesn't mean there aren't uninsured people there. They are there, and they don't have access to employer-sponsored coverage. It is just that it is to a fewer of them. So our state would like to go to 300 percent of coverage would be not allowed to under the terms of the August 17 letter, but we see the need in that population.

What has happened as a result of the letter? Coverage has been affected now in a number of other states that wanted to expand their coverage, and they have been denied, coverage like Louisiana, Oklahoma, Ohio. We ourselves in California are one of the 14 states that CMS has said you have a year to come into compliance. So we are in that category where we haven't asked for an expan-

sion, but we are expected to make changes to our program if we are going to continue to serve children or pregnant women with incomes above 250 percent of the poverty level.

Well, so how able are we to make these changes? People have talked to you about a number of these. I am not going to mention all of them again, but I would like to just go through a couple of them that seem particularly challenging to us.

One, the provision that there have not been a decline in employer-sponsored coverage for children over a five-year period. We have had a decline higher than that for adults where there is no public program waiting to take somebody out. So that is not a feature of crowd-out. That is a feature of the fact that employer-sponsored coverage is declining. And that is true not just in California but in other states.

Cost sharing. The letter would require you to increase your cost sharing up to 5 percent of family income, unless you can demonstrate in some way that is totally unclear that the relationship between private coverage and your program coverage is less than 1 or 2 percent. Well, I don't see how anybody would ever do that, and if you have to increase to 5 percent, in our State, you would be increasing families' premiums by thousands and thousands of dollars.

We are aware of the issue of cost sharing. We also pay a third of the cost of this program. Our governor has proposed increasing premiums in the budget year but not up to 5 percent of family income. He has proposed it to 2.7 percent.

So that is just a couple of the things I would bring to your attention, a number of them are laid out in my testimony. What will it mean to us in California if 817 is implemented? We won't be able to expand to 300. We will have to reduce services to children who have net incomes at 250 percent rather than gross. That is about 14,000 children per year. And we don't know what it means about our pregnant women because the application of these rules to pregnant women is unclear.

And on that point of things being unclear, we think that one of the really challenging things about the August 17 letter is that it is not transparent. There are not uniform standards. There are negotiations going on with States on a one-on-one basis where you can come forward and see if this particular database or that particular database would satisfy.

One of the really challenging things about doing that particularly to meet the 250 percent standard—I am sorry, 90 percent of children at 200 percent, is that that is a way that you could then be falsely indicating that you don't have as many uninsured children as you really do. And it will affect your formula when it comes down to passing out state SCHIP dollars. Because if you jerry-rig databases and come in and go good news, according to this database, we are at 92 percent. But if in fact you are—and nobody will ever really know this number, but at 80 percent and your economy is going down and more people are qualifying, you will just deny your state the money that you need to serve those children.

So that is my comments. Thank you.

[The prepared statement of Ms. Cummings follows:]

Arnold Schwarzenegger, Governor

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

Board Members
Clifford Allenby, Chair
Areta Crowell, Ph.D.
Richard Figueroa
Sophia Chang, M.D., M.P.H

Ex Officio Members
Jack Campana
Kimberly Belshé
Dale E. Bonner

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

H.R. 5998
Protecting Children's Health Coverage Act of 2008
May 15, 2008 Hearing

Testimony submitted by
Lesley Cummings
Executive Director
California Managed Risk Medical Insurance Board

Chairman Dingell; Subcommittee Chairman Pallone; Ranking Member Barton; Ranking Member Deal; Representatives Waxman, Eshoo, Capps, Solis; and distinguished members of the subcommittee thank you for the invitation to participate in this hearing on H.R. 5998-the Protecting Children's Health Coverage Act of 2008. I am Lesley Cummings, Executive Director of the California Managed Risk Medical Insurance Board (MRMIB), the state agency that administers California's State Children's Health Insurance Program (SCHIP) also known at the Healthy Families Program (HFP), as well as several other health programs.

California's SCHIP

In California, SCHIP funding provides coverage to over one million uninsured children and pregnant women through Healthy Families, the state Medicaid program (known as Medi-Cal) and Access for Infants and Mothers Program. California's SCHIP is the largest in the United States and is larger than the combined total of the second and third largest states' SCHIP programs.

The program opened in July 1998 under a state plan approved by CMS. Initially, the program served children with family incomes up to 200% of the federal poverty level (FPL) after application of Medicaid income deductions. In 1999, California expanded coverage to include children with family incomes up to 250% of the FPL (net of income deductions). CMS approved California's state plan amendment for the expansion on November 23, 1999. California's 3 month waiting period for coverage applied to the expansion population as well as the original population and was approved by CMS. In 2006, California chose to implement the option to cover pregnant women using SCHIP funding; this expansion to cover pregnant women was strongly encouraged by the Bush

Administration. As part of that state plan amendment (SPA) approved by CMS on March 28, 2006, pregnant women are covered up to 300% of poverty as are their infants through the second birthday. Governor Schwarzenegger and the legislative leadership are interested in expanding coverage of children to 300% of poverty and have included the expansion as one element of the health care reform proposals that have been under active discussion. In the meantime, California, under a state plan amendment approved by CMS July 10, 2004, already allows 3 counties with local programs serving children up to 300% of poverty to draw down SCHIP funding to match their county funding. Thus, CMS was a partner with California in the design of our SCHIP program, its eligibility levels and crowd out policies. The program, as approved by CMS in the original state plan and in 12 state plan amendments CMS also approved, is in compliance with existing SCHIP law and regulations.

We believe Congress was absolutely correct in designing broad state flexibility into the SCHIP law, recognizing that a "one-size-fits-all" administration structure would not be the best model. This state flexibility has been of enormous value to California in designing and implementing the Healthy Families Program. As a state, California has a higher cost of living than most other states (see chart on page 11 of this document), a lower rate of employer sponsored coverage, and a higher rate of uninsurance. Having the ability to take these issues into consideration has been essential as the state has assessed its approach to children's coverage and universal coverage. And while Governor Schwarzenegger and other California policy makers believe California children should be eligible up to 300% of poverty (net of income deductions), the Healthy Families Program's average child has a family income of 165% of poverty. This

only makes sense given that the lower a family's income, the greater the likelihood that the family will be uninsured.

California is concerned that CMS attempted to make significant changes in SCHIP rules, without sharing the "guidance" with states in advance or providing for a period of public comment prior to issuance. Governor Schwarzenegger wrote to President Bush on August 29, 2007 and Secretary Leavitt on September 17, 2007 asking that they withdraw the CMS directive. The states of New York (joined by Illinois, Maryland and Washington) and New Jersey have filed lawsuits against the federal Department of Health and Human Services (HHS) seeking to prevent HHS from disapproving any state plan amendment using the criteria based on the August 17, 2007 directive. Governor Schwarzenegger also directed the California Attorney General to file an amicus brief in support of New York's lawsuit. The brief was filed on April 18, 2008 jointly with the states of Connecticut, Massachusetts and New Mexico. In addition, a New York advocacy organization has filed a lawsuit against the Secretary of HHS asking for similar relief.

Impact of the Directive on California and Other States

Children in a number of states already have been adversely affected by the application of the August 17 directive's requirements. A Families USA's February 2008 report estimates that the directive has already prevented more than 150,000 children nationally from getting health care in states that have tried to expand SCHIP coverage. According to Georgetown University's Center for Children and Families, four states that enacted legislation expanding their SCHIP programs have been forced to halt or cut

back their coverage expansion plans. Two other states have chosen to finance their expansion with state-only funds and an additional eighteen states are expected to be affected over the next five months, including fourteen that cover children above an "effective" (i.e. gross) income level of 250% of poverty. Tennessee, which like California has traditionally applied Medicaid income disregards when determining income eligibility, has had to change over to a gross income standard in order to receive CMS approval. States must apply income deductions to family income consistent with their Medicaid programs if they want to assure that children will be appropriately enrolled in Medicaid. The requirement to calculate gross income at higher income levels means that states must maintain 2 separate eligibility systems, a costly and confusing situation for states and families.

California is one of the 14 states that CMS has identified as having eligibility at a level that requires program changes consistent with the requirements and assurances of the August 17 letter. CMS has told these 14 states that they must be in compliance within one year or cease covering new children with gross family incomes above 250%. A report commissioned by the California HealthCare Foundation "Assessing California's Ability to Comply with New Federal SCHIP Rules", Harbage Consulting, October 5, 2007, (included as Attachment 1) made a preliminary analysis of California's ability to comply with each of the directive's requirements. According to the August 17 letter a state must comply with **ALL** requirements and assurances to serve children with gross incomes above 250% of poverty.

According to the report, California would have difficulty with the following requirements from the directive:

- Assuring that the state has enrolled in Medicaid or SCHIP at least 95% of children with incomes below 200% FPL. CMS invites states to offer data from a variety of sources to make this determination, including the Urban Institute's TRIM model. There is something critical at stake here. Even presuming that states could find data sources that work, by agreeing to the CMS refinement process states would be undercounting the number of uninsured children in the state. The SCHIP funding formula takes the number of uninsured children into consideration. As a result, states would risk a reduction in funding because the count would show fewer uninsured children. And this would be occurring at a time when the national economy is slowing and the number of uninsured in growing.

  The report notes that the Urban Institute's TRIM model suggests California has met the standard and enrolled 135 percent of the children eligible for Medi-Cal and Healthy Families. On its face, this is not credible. It is clear that California has yet to enroll all of its eligible uninsured SCHIP children. A 2005 state survey indicates that California has reached approximately 88 percent of the children at or below 200 percent of poverty but it does not account for the recent economic slowdown which is increasing the number of uninsured in California and nationally.
- Redefining "uninsured children" as those without coverage for a period of one year, would require a fourfold increase in California's waiting period before a child is eligible for SCHIP coverage. California has seen no reason to believe that such a long period of uninsurance is necessary to prevent crowd out. (See Attachment 2). The redefinition of an uninsured child by CMS does not change

the fact that the child is uninsured and will lack access to preventive cost-efficient health care. The impact to families is that they will wait until their child is sicker to seek health care through the emergency room, -- the least cost efficient vehicle for delivering care. Not only will this redefinition of being uninsured have adverse consequences on the health of children nationwide, it will have adverse impacts on the financial health of struggling low-income working families who will potentially be liable for the full costs of the emergency room visits. Also, the one year waiting period will potentially direct hundreds of thousands of children nationwide to seek basic preventive health care in emergency rooms, further stressing these already overtaxed facilities. This not only impacts the children diverted to the hospital settings but reduces access for anybody needing emergency services because of the unnecessary redirection of children's basic health care delivery to hospital emergency departments. CMS originally told states there would be no exceptions to this requirement. On May 7, 2008 CMS released a letter to "clarify" aspects of the August directive. On this issue, the letter indicated that CMS is willing to discuss exceptions with states, although the letter reiterates that one year is still considered the standard. CMS has provided no guidance as to what exceptions would be acceptable.

- Increasing cost-sharing to five percent of family income (the maximum allowed under federal law) unless the state can demonstrate that there is less than a one percent difference between public and private coverage. Requiring a family contribution at five percent of income would increase family premiums by a factor of 14 times in California – thousands of dollars in new family costs. Private insurance cost-sharing has not been developed with the need to be compatible with the needs of low-income families, so it is not clear why a comparison to

private insurance is the appropriate standard. Further, it is unclear how states, in general, or California, in particular, could make this demonstration given the wide range of health insurance products. And implementing it would require that California make significant and costly system changes to track familial premiums and co-payments to ensure that they do not exceed the federal maximum. [Note: In his budget for 2008/9, the Governor has proposed premium and co-payment increases for families with incomes above 150 percent of FPL. These would increase family cost sharing from the present level of around 1.8 percent of family income to between 2.3 to 2.7 percent of family income.]

- Assuring that the number of children in the target population insured through private employers has not decreased by more than two percentage points over a five year period. California, like many states, is experiencing an erosion in employer sponsored coverage and could not even provide this assurance for adults. As health care costs rise, employers are reducing their health benefits nationally and without regard to the existence of public programs. From 2002-2005, California experience a three percent drop in employer sponsored coverage for adults according to the California Employer Health Benefits Survey, 2007.
- Verifying family insurance status through insurance databases. HFP relies on its participating plans to report whether an enrolled child previously had employer sponsored coverage. HFP could implement this requirement, but it would significantly increase administrative costs. According to California's Legislative Analyst, a proposed new system to verify auto insurance in California will cost over $40 million.

Another troubling aspect to CMS's approach with the August 17 letter is that CMS has failed to provide a transparent and consistent standard that will be applied to all states. Instead, CMS apparently plans to negotiate with states on a state-by-state basis concerning each requirement and assurance. The CMS' August 17 letter and its May 7, 2008 follow-up letter invites the SCHIP states to engage in discussions with the agency to better understand the requirements and how they will be put into operation. On February 29, 2008 California had such a discussion with CMS and will be scheduling additional calls in the future. However, states have not received written guidance or direction from CMS on what data sources will be used to measure compliance and what processes will be used for SCHIP states that are not able to meet all of the directive requirements, or on what timeline CMS will proceed.

It is similarly unclear which SCHIP populations would be subject to the requirements. When CMS issued the original August 17 letter, California estimated that it would affect 35,000 enrolled children with gross family incomes above 250% FPL (because of the application of income deductions). In the May 7 letter, CMS specifies that the provisions would not apply to existing enrollees. Nevertheless, they would apply to children who are newly applying at this income level, some 14,000 children per year. We are unclear whether or not CMS would be applying the rules to pregnant women. In our phone conversation, we were told that the August 17 provisions did not apply to them. However, the May 7 letter merely exempts them from the one year of uninsurance requirement.

H.R. 5998

In a letter to Senators John Rockefeller and Olympia Snowe dated April 17, 2008, the Governmental Accountability Office (GAO) concluded that the August 17th letter is a rule under the Congressional Review Act and "[t]herefore, before it can take effect, it must be submitted to Congress and the Comptroller General." Similarly, in an earlier memorandum to Senator Rockefeller (January 10, 2008), the Congressional Research Service suggested that a reviewing court would likely reach the same conclusion. The American Public Health Services Association and the National Association of State Medicaid Directors wrote to the HHS secretary on April 23, 2008 urging withdrawal of the August 17 directive on that basis and on the basis of deep concerns about the content of the directive.

The enactment of H.R. 5998 would specifically nullify the policies established in the August 17 letter, and subsequent guidance letters. This would stop the application to state programs of a number of bad policies and provide clarity for the immediate future, something of enormous value to the states and uninsured children. States could cease spending considerable staff time and resources trying to negotiate with CMS or making the significant system changes that would be required to comply with the requirements and concentrate on providing coverage to the nation's uninsured low-income children.

I would again like to thank you for the invitation to participate in this hearing and the opportunity to represent California's SCHIP program. SCHIP has been a shinning example of how government can truly serve its neediest constituents. The wise investment in the health of the children of the United States will pay long-term dividends

in healthier children, children who are better prepared to learn in school, students who achieve greater educational success, and individuals who grow into productive members of our society in the future.

Federal Poverty Level Chart

What does it mean to be at 200% FPL in California?

(200% FPL for a Family of Four in 2008 = $42,400/year)

Large/Urban Cities:

If you made $42,400/year in:	Then you need the following salary to maintain the same standard of living in *San Francisco, CA*	Percent Difference
Atlanta, GA	$74,327	75%
Washington DC	$51,345	21%

Mid-Size Cities:

If you made $42,400/year in:	Then you need the following salary to maintain the same standard of living in *Sacramento, CA*	Percent Difference
Des Moines, IA	$56,629	34%
Austin, TX	$54,082	28%

Small Cities:

If you made $42,400/year in:	Then you need the following salary to maintain the same standard of living in *Bakersfield, CA*	Percent Difference
Tuscaloosa, AL	$48,774	15%
Asheville, NC	$46,268	9%

Source: CNN.com, downloaded April 2008. Prepared by: Peter Harbage and Lisa Chan-Sawin, Updated April 2008.

Attachment 1-"Assessing California's Ability to Comply with New Federal SCHIP Rules" California HealthCare Foundation, Harbage Consulting, October 5, 2007

Attachment 2-"Crowd-Out in the Healthy Families Program, Does it Exist?" Institute for Health Policy Studies, UCSF, August 2002

Arnold Schwarzenegger, Governor

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

Board Members
Clifford Allenby, Chair
Areta Crowell, Ph.D.
Richard Figueroa
Sophia Chang, M.D., M.P.H

Ex Officio Members
Jack Campana
Kimberly Belshé
Dale E. Bonner

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

H.R. 5998
Protecting Children's Health Coverage Act of 2008
May 15, 2008 Hearing

Summary of Testimony submitted by
Lesley Cummings, Executive Director
California Managed Risk Medical Insurance Board

I. California (CA) State Children's Health Insurance Program (SCHIP)

   a. CA SCHIP state plan approved by Centers for Medicare and Medicaid Services (CMS) as well as 12 other state plan amendments
   b. Importance of Congressional design of broad state flexibility in SCHIP statute
   c. State concerns about CMS attempts to make major changes to SCHIP eligibility via a letter, without sharing guidance in advance with state or allowing public comment period

II. Impact of Directives on California and Other States

   a. Summary of directive impacts on children to date
   b. Assessing CA ability to comply with the directive and impacts of specific directive requirements

III. H.R. 5998

   a. Governmental Accountability Office and Congressional Research Service opinions on the directive
   b. H.R. 5998 would restore clarity to states and families on SCHIP program eligibility rules.

Assessing California's Ability to Comply with New Federal SCHIP Rules

Prepared for
California HealthCare Foundation

Prepared by
Harbage Consulting

October 5, 2007

Acknowledgments
The authors would like to thank Lesley Cummings at the Managed Risk Medical Insurance Board for her assistance. All conclusions are those of the authors.

About the Authors
Harbage Consulting is a public-policy consulting firm based in Sacramento. The principal authors for this paper were Peter Harbage and Hilary Haycock.

About the Foundation
The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

Introduction

On August 17, 2007, the U.S. Centers for Medicare and Medicaid Services (CMS) issued a letter to state health officials establishing new requirements to cover higher-income children in the State Children's Health Insurance Program (SCHIP) that would prevent the displacement of private coverage — a phenomenon known as "crowd-out." Under the directive, the new requirements must be fulfilled by states that offer SCHIP coverage to children in families earning above 250 percent of the Federal Poverty Level (FPL), now set at $42,925 for a family of three. States seeking to expand coverage to children through SCHIP must demonstrate compliance with the requirements for the expansion to be approved, while those already covering such children must comply within 12 months or face unspecified "corrective action."

This new directive could have a significant impact on California. The state is required to meet the new requirements as the state enrolls some individuals into SCHIP-funded programs with family income above 250 percent of the FPL. In addition, the requirements could pose a significant barrier to the plans of Governor Schwarzenegger and legislative leaders to further expand eligibility for public health insurance to children in families earning up to 300 percent of the FPL.

This paper outlines the new federal requirements and examines California's ability to comply. It does not address the complex legal questions regarding the federal government's discretion to require changes to California's program or to institute corrective action. The State of New York and four other states will pursue questions of federal authority in court,[1] especially in the absence of federal rule-making.[2] For purposes of this paper, it is assumed that the requirements will be implemented.

While the federal government has said that full compliance with each requirement is needed, it is unlikely that California will be able to meet that standard. If California cannot fully comply, the state will be have to consider whether to challenge the federal requirements, face the promised corrective action, or stop using SCHIP funds to cover Californians who are in families with incomes above 250 percent of the FPL.

California's SCHIP Spending and Application of the Directive

California has the largest SCHIP program in the nation, covering more than 1 million low-income, uninsured children and women and spending about 16 percent of all federal SCHIP funds. California uses its SCHIP funds to support other public insurance programs, including Medi-Cal and Access for Infants and Mothers (AIM). The directive applies to California because several SCHIP-funded programs offer coverage to several different populations with incomes above an effective income level of 250 percent of the FPL.

Healthy Families Program

Healthy Families is only open to children in families with incomes up to 250 percent of FPL, as defined by California on a "net income" basis. The CMS directive only considers gross income. The distinction is technical, but important. Gross income refers to the total family income, while net income in the context of a Healthy Families application refers to how much a family is considered to have made after specific deductions are applied. California's state plan allows a number of deductions to monthly income consistent with the rules governing Medi-Cal, including: earned income ($90 per working adult); child care (between $200 and $175 depending on age); and alimony, child support, and disabled dependent care ($175). MRMIB estimates that there are about 34,000 children enrolled in Healthy Families with incomes above 250 percent of the FPL.[3]

Access for Infants and Mothers
AIM covers pregnant women with incomes between 200 percent and 300 percent of the FPL. Babies born to AIM women, referred to as "AIM-linked babies," also have SCHIP-funded coverage until age 2. AIM covers about 8,400 women and approximately 15,000 infants. While the directive never specifically discusses adults, it could be interpreted to include pregnant women.

Healthy Kids Programs
California has an approved state plan amendment (SPA) that allows San Mateo, Santa Clara, and San Francisco to use federal SCHIP funds to pay for coverage provided to children in families with incomes between 250 percent and 300 percent of the FPL. There are now about 1,100 children enrolled in these programs. California also submitted an application to expand the SPA to Santa Cruz, but that application is on hold pending a request for information from CMS related to the August 17 directive.

Potential Healthy Families Program Expansions
California's broader health reform efforts rely heavily on SCHIP funding and the state's ability to make use of additional federal funding. Governor Schwarzenegger and the Democratic leaders in the state legislature put forth proposals calling for an expansion of the program to cover uninsured children in households with incomes up to 300 percent of the FPL, a population estimated to be as large as 100,000.[4]

Can California Comply?

The August 17 directive represents a major shift in CMS policy. The CMS letter does not go into sufficient detail for the ramifications of the directive to be fully understood, but it is possible to offer an initial analysis of California's ability to comply. This paper focuses on the eight new requirements specified in the letter, which are divided into three categories, namely, those where California is likely:

- In compliance already;
- Able to comply if the state wishes; and,
- Unable to comply in the near term.

California's program may already comply with the following requirements:

✓ *Requirement: "Monitoring and verifying health insurance status at the time of application," which must "include information regarding coverage provided by a non-custodial parent."*

Status: The Healthy Families application requires applicants to attest that the child has not had employer-based coverage for the last three months. It does not specifically ask about coverage that may have been provided by non-custodial parents.

Implementation: California would appear to be in compliance. The question about health insurance on the Healthy Families application is broad, and it is likely that coverage offered by a non-custodial parent is already being reported.

✓ *Requirement: "Preventing employers from changing dependent coverage policies that would favor a shift to public coverage."*

Status: Section 12693.82 of the California Insurance Code makes it an unfair labor practice for employers to refer the children of employees to the Healthy Families program "for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment." In addition, Section 12693.83 makes it an unfair labor practice "to change the employee-employer share-of-cost ratio based upon the employee's wage base or job classification or to make any modification of coverage for employees and employee's dependents," in order to drive dependent children to enroll in Healthy Families.

Implementation: California would appear to be in compliance. Without additional federal guidance, it is unclear what more California could do on this point.

California could alter its programs to comply with the following requirements:

✓ *Requirement: Implement "a minimum one year period of uninsurance for individuals prior to receiving coverage."*

Status: California now requires a waiting period of three months between employer-based coverage and enrollment in Healthy Families. The state's rules do not apply to children with prior individual coverage and allow some exceptions, such as death of a parent. The majority of states have waiting periods of fewer than six months, and the trend has been to shorten the wait between employer-based coverage and SCHIP eligibility.[5]

Implementation: The waiting period would need to be increased fourfold, and would by definition require children to go without insurance for much longer intervals to remain eligible.

✓ *Requirement: "Verifying family insurance status through insurance databases."*

Status: The Healthy Families program relies on private health plans to report if the child previously had employer-based coverage. For example, if private insurance companies inform the state a child was previously enrolled in group insurance within the three-month window or is dually enrolled under custodial and non-custodial parents, the state disenrolls that child from Healthy Families.

Implementation: Increasing the use of private insurance databases to verify the insurance status of every Healthy Families applicant is possible, but would impose additional administrative costs on the state.

✓ *Requirement: "The cost sharing requirement under the state plan compared to the cost sharing required by competing private plans must not be more favorable to the public plan by more than 1 percent of the family income, unless the public plan's cost sharing is set at the 5 percent family cap." Also, states must impose "cost sharing in approximation to the cost of private coverage."*

Status: Cost sharing in Healthy Families is on average 1.8 percent of family income (for a family of three).[6] Monthly premiums range between $4 and $15 per child, depending on family income, with a monthly per-family cap of $45. Co-pays also apply. Costs are based on a family's ability to pay, not on cost sharing in the private market.

Implementation: Given the wide range of health insurance products available in California, it would be very difficult to calculate a 1 percent difference as called for in the new requirement. The definition of a "competing private plan" is not offered by CMS, raising questions about how to implement the requirement.

If California is required to maximize a family's contribution to meet the federal 5 percent of income cap, the state would charge far higher premiums and copayments. A family earning $50,000 a year would be charged $208 a month, regardless of the number of children — an amount almost 14 times greater than the highest per-child premium rate charged by Healthy Families today.

✓ *Requirement: "Assurance that the state is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements."*

Status: California is up-to-date on all existing reporting requirements.

Implementation: California likely could generate monthly updates on how the state is complying with the new CMS requirements. However, this would increase administrative cost and complexity. Moreover, the difficult challenge of measuring "crowd out" will add to this complexity.

California would have difficulty complying with the following requirements:

✓ *Requirement: Assuring "that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period."*

Status: California, like the United States overall, is experiencing an erosion in employer-based coverage. While "target population" is not defined in the CMS letter, the rate of employment-based insurance for California children in families with incomes below 200 percent of the FPL fell from 28.5 percent in 2001 to 18.3 percent in 2005.[8] For all California children over the same period, the rate of employment-based insurance for those in families earning more than 300 percent of the FPL fell 3.8 percent.

Implementation: Given the lack of an accepted data standard, it is unclear on what basis California might offer the required assurance beyond simply asserting its compliance. The prospect for state health reform also clouds the picture. While the legislative debate in Sacramento includes a possible requirement that employers offer insurance, some may choose to pay a penalty instead, leaving the overall rate of employer-based coverage unchanged.

✓ *Requirement: Assuring "that the state has enrolled at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps the state takes to enroll these eligible children)."*

Status: It is difficult to assess California's current status because different data sources can yield different results. Data from the Urban Institute's TRIM model suggests that California, like many states, can reach the CMS benchmark. But this data also shows that California has 135 percent of the children eligible for Medi-Cal and Healthy Families enrolled. CHIS data indicates that California does not meet the CMS threshold, with about 88 percent of all Medi-Cal- and Healthy Families-eligible children enrolled in the program.[9]

Implementation: The key question for California turns on what data the federal government will use to make this calculation. While expanding efforts to identify and encourage enrollment may help reduce the number of eligible and uninsured children, it is not clear that the 95 percent level is feasible.

Conclusion

The new CMS requirements as outlined in their August 17 letter represent a major shift in CMS policy. While California can meet some of the requirements, full compliance does not appear likely or possible. Since the federal government is seeking full compliance, the state could face federal penalties for covering some children in families earning incomes above 250 percent of the FPL and may be prevented from expanding eligibility for Healthy Families. The changes would result in higher administrative costs and children going without insurance for longer periods before becoming eligible for Healthy Families coverage.

Endnotes

[1] Joan Gralla, "Five states to sue over child health plan," Reuters, September 30, 2007. California will file an amicus brief in the case on behalf of those suing the federal government.
[2] The items in the CMS letter are requirements for which CMS states it has statutory authority. CMS has not begun a rule-making process that would result in formal rules that would carry more legal weight.
[3] Author conversation with Managed Risk Medical Insurance Board staff.
[4] Peter Harbage et al, *Funding California's SCHIP Coverage: What will it Cost?* California HealthCare Foundation, May 2007.
[5] Lutzky Westpfahl, Amy, and Ian Hill, *Has the Jury Reached a Verdict? States Early Experiences with Crowd Out Under SCHIP*, Urban Institute, June 2001.
[6] Author conversation with Managed Risk Medical Insurance Board staff.

Crowd-Out in the Healthy Families Program: Does it Exist?

Dana Hughes, DrPH
January Angeles, MPP
Erik Stilling, PhD

Institute for Health Policy Studies
University of California, San Francisco

August 2002

This research was supported by funds from the California Program on Access to Care (CPAC), California Policy Research Center, University of California. The views and opinions expressed do not necessarily represent those of The Regents of the University of California, CPAC, its advisory board, or any State or County executive agency represented thereon.

Executive Summary

Researchers from the University of California, San Francisco undertook a study of children's coverage prior to enrollment in Healthy Families. Children with employer-related insurance within 3 months prior to enrolling in the program are ineligible, as a means to discourage employers and families from supplanting private insurance with public insurance. This research was designed to determine the extent to which this phenomenon, called "crowd-out," exists within the Healthy Families program.

Telephone interviews were conducted between April 10 - April 24, 2002 of 57 Spanish-speaking and 468 English-speaking parents and guardians of children newly enrolled in the Healthy Families program. The major findings of this study are:

- Some crowd-out is occurring, but at very low levels (8%);
- When crowd-out does occur, it tends to happen among lower income families and is largely because parents can no longer afford the employment-related coverage for their children. In fact, nearly half (45%) of the families reported that they had been paying more than $50 per month for their child's employment-related coverage;
- Based on this survey, it does not appear that employers are encouraging children to drop coverage and enroll in the Healthy Families Program. None of the respondents indicated that this occurred; and
- The coverage status of parents indicates that children were dropped from employment-related coverage, but parents tend to retain their own employment-related coverage.

RECOMMENDATIONS

These findings suggest that public policy in California should not focus on crowd-out as a phenomenon that affects eligibility for public programs, but rather should identify ways to ensure that children have coverage, whether through employment-related approaches or public programs. Among the policy options is providing assistance to low-income families in their ability to purchase and maintain employment-related insurance. The state could also explore once more the feasibility of implementing the provision in the law establishing the Healthy Families Program, which permits employers to provide premium support for their employees' dependents. Another (though not mutually exclusive) option is the imposition of a financial test with respect to determining if crowd-out occurs. That is, eligibility for publicly subsidized programs should take into account not only whether or not a child recently had previous coverage, but also if that coverage was affordable to the family. Some states have already instituted such policies. For example, Georgia allows "substitution" (or, in other words, does not consider it crowd-out) if previous insurance coverage cost the family more than 5% of the family income.

INTRODUCTION

In response to the lack of health coverage in the United States, Congress enacted the Balanced Budget Act of 1997, which amended the Social Security Act to include Title XXI, the State Children's Health Insurance Program (SCHIP). The goal of SCHIP is to increase access to health care for children whose family incomes are too high to qualify for Medicaid and too low to afford private coverage. The program provides approximately $40 billion in matching funds to states over ten years; California's total SCHIP allotment for the Healthy Families Program amounts to $4.5 billion.

There is concern among some policymakers and program planners that the creation and expansion of publicly subsidized programs may supplant and "crowd-out" private, employment-related insurance, rather than cover uninsured individuals. Concern about crowd-out originally emerged in the early and mid-1990s when policymakers and researchers examining trends in health insurance coverage noted that as Medicaid enrollment rose during the 1980's and 1990's the number and percentage of children covered under private insurance plans declined. This led to speculation that the Medicaid expansions for children may not have extended coverage to previously uninsured children, but rather covered children who already had private insurance.

To date, some research has been conducted on the presence of crowd-out, but the results have been mixed. In a study using data from the Current Population Survey (CPS), Cutler and Gruber found that nearly half of the increase in Medicaid enrollment was offset by a decrease in private insurance coverage.[i] On the other hand, other studies using the same data report significantly less crowd-out. Dubay and Kenney found a crowd-out effect of 12% for children under 11 years of age, and 14% for pregnant women.[ii] Determining the presence and extent of crowd-out is an important policy matter because it has been used extensively in arguments against the expansion of publicly funded health insurance programs. For example, at the national level, crowd-out was a major argument against the establishment of SCHIP, which led to the creation of Healthy Families in California.[iii]

Researchers from the University of California, San Francisco undertook a study of families' coverage prior to their child's enrollment in Healthy Families. In California, children with employment-related insurance within 3 months of applying for Healthy Families coverage are not eligible. This study was conducted to determine the extent to which crowd-out exists within Healthy Families as well as help to demonstrate California's commitment to rigorous monitoring of the issue.

METHODOLOGY

Sample Selection

The Managed Risk Medical Insurance Board (MRMIB), the agency that administers Healthy Families, provided the contact data based on a random sample of 3,000 recent enrollees (i.e., children who enrolled within 60 days of the date the sample was drawn). MRMIB provided names and contact information for 1,500 enrollees above 200 percent of the poverty level, and 1,500 enrollees below the

poverty level. (This reflects an over-sampling of the higher income group to ensure that they were adequately represented in the final sample.) Only English and Spanish speakers were interviewed. The sample was reduced by excluding those whose Healthy Families coverage began more than two months before the data pull, enrollees who did not have phone numbers, duplicates from households (based on a sort of parents' names and addresses) and individuals who indicated that they did not want to be called (by returning a self-addressed, stamped post card sent to each potential subject for this purpose). The final sample-frame included 1,958 enrollees at or above 200 percent of poverty and 1,042 enrollees below 200 percent of poverty.

Data Collection

Parents and guardians of enrolled children were contacted initially by mail to inform them about the study and to request their participation. The mailing, written in both English and Spanish, included a letter of introduction, a study information sheet, and a self-addressed, stamped postcard that individuals could return if they did not want to participate in the study. In addition, a $10 incentive was promised to those respondents who completed the telephone interview and was subsequently mailed to the respondents).

The researchers developed a telephone survey instrument to assess the extent and nature of crowd-out among newly enrolled participants in California's Healthy Families Program. The instrument was based on validated surveys designed to elicit similar information, and on the feedback from program administrators to ensure inclusion of pertinent policy and program questions. Corey, Canapary, and Galanis Research (CC&G), a San Francisco survey research firm, phoned parents and guardians to request their consent to participate in the study and conduct the interview. English-speaking interviewers made all initial calls on the randomly drawn sample. Interviews were conducted with qualified respondents if possible. This includes respondents who spoke English well enough to do the interview. If a Spanish-speaking respondent was unable to do the interview in English, he/she was called back by a bilingual (Spanish/English) interviewer. CC&G conducted the telephone survey using a computer assisted telephone interview (CATI) format. Telephone calls were made 3 weeks after the letters were mailed to potential participants. The sample of individuals randomly selected to be called was 783. In total, 525 interviews were completed. This represents an overall completion rate of 67% (525 divided by 783). The (See Tables 5 and 6 in the appendix.)

RESULTS

Characteristics of Enrollees

Of the total 525 interviews with families who participated in the survey, 468 were in English and 57 interviews were conducted in Spanish. As Table 1 illustrates, the majority of the children in the sample are Hispanic (63 percent), while whites comprise the next largest group at 25 percent. Asians

and African Americans each make up four percent of the total sample, and the remaining three percent belong to other ethnic groups. This distribution is somewhat different than that of current Healthy Families enrollees. (Sixty-seven percent of current enrollees are Latino, 16% are White, 13% are Asian, 3% are African American and less than 1% are of other ethnicities.) Sixty-four percent of interviewed families have one working adult in the household and a mean household income of $32,100. The average family size is four.

Table 1: Profile of Survey Participants

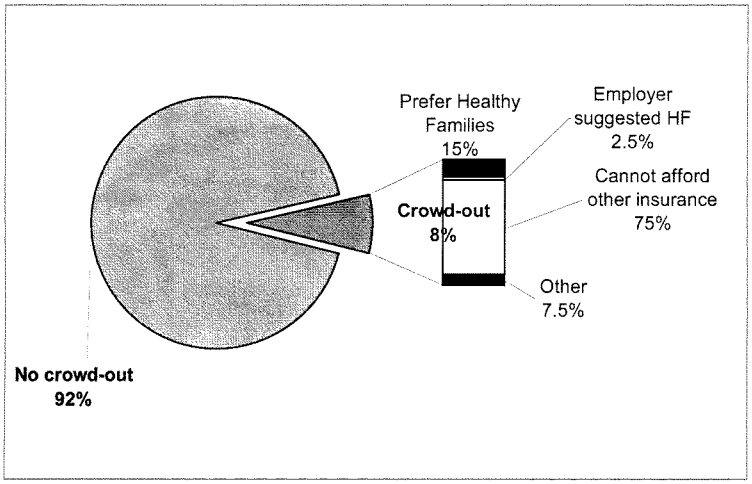
Demographic Characteristics	All Respondents		English-Speaking Respondents		Spanish-Speaking Respondents	
	Number	Percent (n=525)	Number	Percent (n=525)	Number	Percent (n=525)
Total	525	100%	468	89%	57	11%
Race/Ethnicity						
Hispanic/Latino	332	63.2%	275	52%	57	11%
White	132	25.1%	132	25%	0	0%
Asian	22	4.2%	22	5%	0	0%
African American	22	4.2%	22	5%	0	0%
Other	17	3.2%	17	4%	0	0%
Family Income						
100-199% FPL	363	69%	320	61%	43	8%
200-250% FPL	162	31%	148	28%	14	3%
Household Type						
Single parent	125	24%	121	23%	4	1%
Dual parent	400	76%	347	66%	53	10%
Full- or Part-Time Employed Adults in Household						
None	29	6%	27	5%	2	0.4%
1	334	64%	301	57%	33	6%
2	162	30%	140	27%	22	4%
Family Size						
2	47	9%	45	9%	2	0.4%
3	138	26%	126	24%	12	2%
4	174	33%	157	30%	17	3%
5	108	21%	90	17%	18	3%
6 or more	58	11%	50	10%	8	2%

The Presence of Crowd-Out in Healthy Families

We estimate crowd-out in the Healthy Families Program to be 8%. (Figure 1) That is, only 8% of the sample had previous insurance within the three months prior to enrolling in Healthy Families and dropped that insurance for reasons that constitute crowd-out. These reasons include families who had access to employment-related coverage but dropped it because the employment coverage was unaffordable (n=30), who preferred Healthy Families (n=6), whose employer suggested enrollment in Healthy Families (n=1), and who dropped it for other reasons (n=3). (The percentage of children

exhibiting crowd-out may actually be might be lower if the "other" category of reasons for dropping previous health insurance is excluded from the numerator. However, because we cannot know with certainty whether or not these reasons fall within the definition of crowd-out, we included them.) (See the appendix for demographic characteristics of the crowd-out group compared to the non-crowd-out group.)

Figure 1: Estimate of Crowd-Out in California's Healthy Families Program



Crowd-out represents a small portion of enrollment. When crowd-out occurs, it is because the family can no longer afford employer coverage.

Crowd-Out by Family Income

When considering family income, lower income children were more likely than higher income children to have had prior insurance that constitutes crowd-out. Specifically, 68% of all children exhibiting crowd-out had incomes between 100% and 199% of the federal poverty level. (Table 2) At first blush, this finding appears counterintuitive since children in higher incomes are more likely to have employment-related insurance. However, the most frequently cited reason for ending their employment-related insurance was that the family could not afford it (75%). Moreover, lower income parents were most likely to report not being able to afford the insurance (45% for lower income families versus 30% of higher income families.) This is corroborated by responses to a follow-up question of families who indicated they preferred Healthy Families. When asked why they preferred Healthy

Families, five of the six crowd-out families said they preferred it because the program is "less expensive." (Not shown.)

Table 2: Crowd-Out Related Reasons for Ending Employment-Related Insurance Coverage, 0-3 Months Prior to Enrollment in Healthy Families

Reasons for ending employment-related insurance coverage	Total		100% to 199% of FPL		200% to 250% of FPL	
	Number	Percent (n=40)	Number	Percent (n=40)	Number	Percent (n=40)
Prefer Healthy Families	6	15%	5	13%	1	2%
Employer suggested enrollment of child in Healthy Families	1	2%	1	2%	0	0%
Cannot afford other insurance	30	75%	18	45%	12	30%
Other	3	8%	3	8%	0	0%
Total	40	100%	27	68%	13	32%

Cost of Employment-related Coverage: Crowd-Out versus Non-Crowd-Out Groups

The cost of previous coverage among children exhibiting crowd-out varied greatly and ranged from less than $10 per month to more than $75. (Table 3) More than a quarter (27%) of the crowd-out group reported that they paid more than $75 per month for their child's coverage. Only 13% of the crowd-out group indicated that they paid $10 or less per month for previous coverage. These high costs among the crowd-out group likely explain that they dropped previous coverage because they couldn't afford it.

Table 3: Cost of Previous Coverage

Cost of Previous Coverage	Crowd-Out Group	
	Number	Percent (n=40)
$10 or less per month	5	13%
$11-$25 per month	1	3%
$26-$50 per month	7	17%
$51-$75 per month	7	18%
More than $75 per month	11	27%
Other	8	18%
Don't Know	1	3%
Total	40	100%

Parent's Insurance Status: Respondents (typically parents or guardians of enrolled children) were asked about their own insurance status. (Table 4) Of the 27 crowd-out parents with current insurance, 25 had private insurance through an employer or union. This suggests that parents of the crowd-out group of children may have dropped only dependent coverage and retained their own coverage.

Table 4: Respondent/Parents' Insurance Status

Respondent/Parents' Insurance Status	Crowd-Out	
	Number	Percent (N=40)
Currently insured	27	68%
Currently uninsured	12	30%
Don't know	1	2%
Total	40	100%

DISCUSSION AND RECOMMENDATIONS

This study was undertaken to determine the extent to which crowd-out, the substituting of employment-based health insurance with public health insurance – exists within the Healthy Families program. Based on survey responses of parents of newly enrolled children, we learned that there is some extent of crowd-out in the program: 8% of newly enrolled children had employment-related insurance within the previous three months that is not considered legitimate. (This figure might be actually lower if the "other" category of reasons for dropping previous health insurance is excluded from the numerator. However, because we cannot know with certainty whether or not these reasons fall within the definition of crowd-out, we included them to ensure the most conservative interpretation.) Other states have found varying degrees of employment-related insurance prior to enrollment in public programs. Eleven percent of children in Florida's Healthy Kids program[iv] and 3.5% of respondents to a 1995 survey of the MinnesotaCare program indicated that they gave up employment-related insurance to enroll in the state program.[v] (Note that these analyses of the experiences in other states are not directly analogous to this analysis due to different definitions and different timeframes under study. In addition, the Minnesota program measured previous coverage among both adults and children.)

Although the findings from this study are within the range of Florida's experiences (and higher than that of Minnesota), several distinctions between the periods when the studies were conducted and the circumstances of the states are important to note. First, this study was conducted at a time when the California economy was on a steep decline with no concomitant reduction either in the high cost of living in the state for families or tough financial conditions for businesses. At the same time, the cost of

health care has increased, leading to higher premiums for families as well as reductions in dependent coverage provided by employers. In addition, this study's time frame covered the period in which most employees were given the opportunity to change their employment-related insurance plans through the end-of-year open enrollment period (a period when increases in employee contributions are introduced). Together, these factors may have contributed to employers dropping health insurance coverage and/or families electing to drop coverage, circumstances that were not present during the periods when the other studies were conducted.

More important, this study demonstrates that the unaffordability of previous health insurance was the single most important reason for crowd-out in the Healthy Families Program. Seventy five percent of the parents whose children had health insurance in the three months prior to enrollment in Healthy Families for reasons that constitute crowd-out reported that they dropped that prior coverage because it was unaffordable. This finding is further supported by the predominance of crowd-out among lower income families and the far higher costs of previous coverage among the crowd-out group. Of all parents whose children exhibited crowd-out, 68% were in this lower income group and 45% of these reported that they dropped previous coverage because they could not afford it. Further, nearly half (45%) of the crowd-out group paid more than $50 per month for their children's coverage under the previous coverage.

These findings throw into question whether crowd-out really exists in California, even at low levels such as 8%. To the extent that the vast majority of these low income families dropped relatively expensive employment-related insurance and enrolled their children in Healthy Families for financial reasons, it is arguable that this is not crowd-out but a sound financial decision, affording families a degree of discretionary income to address other family needs. This suggests that public policy in California should not focus on crowd-out as a phenomenon that influences eligibility rules for public programs, but rather should identify ways to ensure that children have coverage, whether through employment-related approaches or public programs.

We recommend three policy options for the State of California (which are not mutually exclusive):

- Assist low-income families financially in purchasing and maintaining employment-related insurance;
- Explore the feasibility of implementing the voucher provision in the law establishing the Healthy Families Program that permits employers to obtain subsidized premium support for their employees' dependents; and
- Impose a financial test when determining if crowd-out occurs.

With this third option, eligibility for publicly subsidized programs would take into account not only whether or not a child recently had previous coverage, but also if that coverage was affordable to the family. Some states have already instituted such policies. For example, Georgia allows "substitution" (in other words, does not consider it crowd-out) if previous insurance coverage cost the family more than 5% of the family income. In this study, the proportion of annual premiums of prior employment-related insurance to annual incomes of parents suggests that no fewer than (and likely more than) 10 percent of the children in the crowd-out group would be permitted to substitute coverage if Georgia's criterion were applied to California. (Note that in this calculation, respondents' premium costs were calculated at the *lowest* amount in a range when respondents were unable to offer a specific cost per month. California would also need to take into account such factors as family size, number of children, and allowable deductions in this calculation, which would presumably decrease the number of children in the crowd-out group.)

California should consider these policy options given the apparent burden of high health care costs on low-income families – to the extent that it exists at all. Parents need options for health insurance coverage for their children and Healthy Families appears to be a reasonable option for low-income families. This is true even for the few families that previously had employment-related but expensive coverage and other financial demands on their relatively low income.

Appendix

Table 5: Crowd-Out Survey Fieldwork Information and Sample Disposition

Field interviewing for the 2002 Crowd-Out Survey was conducted by telephone from April 10 - April 24, 2002. All fieldwork was done at the offices of Corey, Canapary & Galanis Research (CC&G) in San Francisco. Interviewing was conducted in English and Spanish. In total, 525 interviews were completed with Healthy Family program enrollees. The sample of individuals randomly selected to be called was 783. This represents an overall completion rate of 67% (525 divided by 783). The table, which follows, details the disposition of the sample.

Sample Available

	Number
Total sample (names/numbers) provided by UCSF	3,000
Respondents who sent back postcards indicating they not be called for the project	-115
Total sample (names/numbers) available	2,885
Sample (names/numbers) attempted by CC&G	783

Table 6: Disposition of Sample by Language

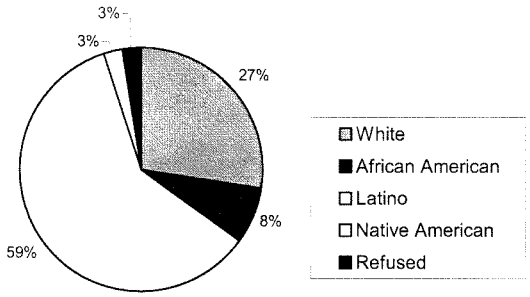
	English	Spanish	Total
Completes	*468*	*57*	*525*
DISQUALIFIED			
Child not enrolled in Health Families	5	1	6
Child not enrolled in Healthy Families during study timeframe	2	1	3
No Eligible Respondent	21	5	26
Language Barrier	7	-	7
Fax Number	2	-	2
Answering Machine/No Answer/Busy	69	22	91
Not At Home/Call Back	15	11	26
Disconnected/Wrong Number	63	-	63
QUALIFIED			
Respondent terminated call	1	0	1
Respondent refused to participate	29	4	33
	682	101	783

**In most cases, these respondents were called at least 4 times.*

Characteristics of Families: Crowd-Out versus Non-Crowd-Out Groups

Race and Ethnicity: The vast majority of children in the crowd-out group identified as Latino (59%). (Figure 2) Another 27% were White, 8% African American and 3% Native American. This distribution is essentially equivalent to that of the group for which there was no evidence of crowd-out. (Not shown.)

Figure 2: Race and Ethnicity of Children in the Crowd-Out Group (n = 40)



Family Income: The distribution of income as a percentage of the Federal Poverty Level was largely equivalent between the two groups. (Table 7) Approximately two-thirds of each group had incomes between 100% and 199% of the poverty level and one-third had incomes between 200% and 250% of the poverty level.

Table 7: Income as a Percentage of the Federal Poverty Level

Income Level	Crowd-Out		Non-Crowd-Out	
	Number	Percent (n=40)	Number	Percent (n=485)
100% to 199% of FPL	26	65%	335	69%
200% to 250% of FPL	14	35%	148	31%
Missing data	-	-	2	0%
Total	40	100%	485	100%

Parents' Employment Status: Generally equivalent proportions of parents had at least one parent who worked full time, though the crowd-out group was slightly more likely to have at least one parent employed full time. (Table 9)

Table 8: Parents' Employment Status

Employment Status	Crowd-Out		Non-Crowd-Out	
	Number	Percent (n=40)	Number	Percent (n=485)
At least one parent employed full time	34	85%	398	82%
1 parent employed part time	1	2%	35	7%
2 parents employed part time	0	0%	30	7%
No parent employed	5	13%	22	4%
Total	40	100%	485	100%

[i] Cutler D, and Gruber J. The Effect of Medicaid Expansions on Public Insurance, Private Insurance, and Redistribution. *American Economic Review.* Volume 86, No. 2. 1996.
[ii] Dubay L, and Kenney G. Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children. *The Future of Children.* Volume 6, No. 1. 1996.
[iii] Hearne. Coordinating Children's Coverage Expansions with Employer-Sponsored Coverage. Washington, DC: Institute for Health Policy Solutions.
[iv] Institute for Child Health Policy. Florida KidCare Program Evaluation Report. University of Florida. January 2000.
[v] Call KT, Lurie N, Jonk Y, Feldman R, Finch MD. Who is still uninsured in Minnesota? *JAMA.* 1997;278:1191-1195.

Mr. PALLONE. Thank you very much, Ms. Cummings. And thank you to all the panel. I think you have been very succinct in explaining to us the impact of the August 17 memo.

We will now turn to questions. I will recognize myself for 5 minutes, and I will start with Dr. Orszag. One of the Administration's stated goals in issuing the August 17 directive is to improve enrollment of low-income children in families with incomes below $35,200, which is the 200 percent of the federal poverty level. But many of us have questioned whether this directive will actually achieve this goal. Can you tell me how many currently eligible but unenrolled children in families with incomes below $35,200 a year does CBO assume gain new coverage as a result of the directive?

Mr. ORSZAG. Under our baseline?

Mr. PALLONE. Yes.

Mr. ORSZAG. Effectively zero.

Mr. PALLONE. OK, does the CBO assume that the net effect of the directive is to help improve enrollment of eligible but uninsured children in families with incomes below that $35,200 a year? Or does CBO assume the net effect of the directive is to prevent states that cover children in families with incomes above the $44,000 a year from continuing to cover those children?

Mr. ORSZAG. Again, under our baseline the effect is very modest, but the fact that it is there is mostly because of the waiting period that is imposed on children above 250 percent.

Mr. PALLONE. Which is the $44,000?

Mr. ORSZAG. Right.

Mr. PALLONE. OK, I personally believe, Dr. Orszag, that the August 17 directive is punitive to both states and children, and I also believe that we can increase enrollment of the poorest children without harming moderate-income children.

The CHIPRA bill, the bill that we passed last year that the President vetoed, the expansion, that actually helps states enroll more of the lowest income children without penalizing States looking to cover children at moderate income levels. And I just wanted to ask you from CBO's standpoint, do you believe that the CHIPRA bill would have been more effective at reaching the lowest-income eligible but not insured children than this August 17 directive?

Mr. ORSZAG. It is quite difficult to compare something that significantly expands the program to the effect of a directive. Again, as I said earlier, the effect of the directive relative to our baselines is effectively zero on take-up among low- or moderate-income children. Whereas the legislation that was proposed did have a significant increase in enrollment including among those who are currently eligible but unenrolled.

Mr. PALLONE. You may have heard Mr. Alexander's comments that having a beneficiary pay a portion of the state's share would reduce crowd-out. Would you agree with that?

Mr. ORSZAG. I think the evidence on that is quite inconclusive. In fact, the leading researcher in this area is Professor John Gruber of MIT, and with regard to both waiting periods, but especially with regard to cost sharing, his results suggest that it is not clear. I actually have the study with me, and I will just quickly read: "Findings suggest that state efforts to increase financial barriers to public barriers"—that would be cost sharing—"may deter

the use of those programs by those who need them"—he means uninsured people—"at a faster rate than it is deterring the use of those programs by those who are crowded out. While the results are imprecise, there is certainly no evidence that imposing costs on beneficiaries is reducing crowd-out of private insurance."

Mr. PALLONE. OK, thank you. Now, let me ask Mr. Rosenberg. CMS has said repeatedly that they will work with states to help them meet some of these tests in the August 17 directive. For example, CMS has initially indicated informally that there would be no exceptions to the 1-year waiting period or requirement that children must be uninsured for a full year before qualifying for CHIP. But in the May letter, you know, that they recently did, CMS now says it will consider exceptions.

My fear is that working with states and these exceptions could be applied arbitrarily in the absence of any regulations and any specificity. Doesn't this give CMS the power to approve one state and disapprove another even if they are in the exact same circumstances? And for example, while Rhode Island did not have to change the way it calculates eligibility levels for CHIP, other states like Indiana and Tennessee have already been told by CMS that they must change that part of their program.

I will ask either Ms. Shah or Mr. Rosenberg actually. Doesn't this approach have the potential to undermine requirements for a fair, transparent, and equitable review process? Mr. Rosenberg or Ms. Shah or both of you?

Ms. SHAH. I agree with you that I think it does introduce a great deal of uncertainty as to what states are expected to do, and there is a potential for inconsistency. It is especially unclear since the issuance of the May 7 letter what exactly is the position of all of the strategies and assurances that are set out in the August 17 letter. And I think probably further clarification would be needed.

If CMS's intent was to require uniformity among states by issuing the August 17 letter, I don't think this strategy is going to work.

Mr. PALLONE. Mr. Rosenberg?

Mr. ROSENBERG. I would agree with Ms. Shah and just add that it provides a certain amount of leverage for CMS to the States to engage in perhaps disparate action. Once again, it appears to be an attempt to move toward and to satisfy potential court scrutiny that will say that we are still being flexible. In fact, the evidence of past practice in the departure and the leverage that might be affected by this, I agree with Ms. Shah that this doesn't change the difficulties in their potential legal problems that are raised by both the August 17 letter and the clarification, so to speak, of the May 7 letter.

Mr. PALLONE. Thank you. I just wanted to ask unanimous consent to enter into the record a letter from, I guess, over 100 different organizations that have opposed the August 17 Directive. Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman. I am going to ask you all to be brief in the responses because I am going to try to cover a lot. Ms. Shah and Mr. Rosenberg, you have given this committee something that probably only a third-year law student who is

bogged down in an administrative law class could ever appreciate, and that is the bureaucracy's minutiae mindset.

Now, the thrust of this whole thing is Congress passed a statute called the SCHIP Program. Regulations were adopted by CMS, the administrative executive branch agency designed to implement that statutory program. And now we are arguing about whether a letter is a rule that must go through some bureaucratic process in order to have force and effect. I want to go back to a more simplistic approach.

I would like to ask the two of you, the experts, and please be brief, can an executive branch agency such as CMS enforce a statute passed by Congress that delegates them the authority to enforce the statute without this minutiae? Does it depend on how specific the statute is?

Mr. ROSENBERG. Supreme Court case law and court of appeals case law make it clear that in delegating authority to an agency to promulgate rules and when that agency promulgates such rules, if it then——

Mr. DEAL. I am not talking about rules. I am talking about statute. Let me read you the statutory language. Statutory language says that through intake and follow-up screening, that only targeted low-income children are furnished child health assistance under state child health plan. And it also goes on to say that the state child health plan does not substitute for coverage under group health plans. That is the statutory language. The regulatory language as to part of it says the state plan must include a description of reasonable procedures to ensure that health benefits coverage provided under state plan does not substitute for coverage provided under group health plans as defined in the code section that it is designed to enforce.

Now what I hear you saying is that—and you quoted it—said that a rule covers every statement that an agency can make. It becomes a rule and must follow the procedures of adoption of a rule. I would like to ask you this question, Ms. Shah, since you used the illustration of the New York plan being denied. Could CMS have denied the New York state plan amendment if they just never issued the August 17 letter based on the authority given them under the statute and under the regulation?

Ms. SHAH. Well, CMS would have to follow whatever the regulation and the established interpretation of that regulation was over the years.

Mr. DEAL. I take that to be a yes.

Ms. SHAH. But you see in the case of New York, they applied that letter requiring a whole host——

Mr. DEAL. I am saying if they had never written the letter——

Ms. SHAH. Yes.

Mr. DEAL [continuing]. Could they have denied the plan if they had just never written the letter?

Ms. SHAH. They may not have. It might have been viewed as——

Mr. DEAL. Well, then how did they approve Mr. Alexander's Rhode Island plan?

Ms. SHAH. But to require a whole host of strategies, which they required New York to comply with here, without having required

that of any other State previously, might have been viewed as arbitrary and capricious and again have resulted in a lawsuit.

Mr. DEAL. In other words, you are really making the argument that some of us have made before when our colleagues on the other side have said and criticized the Administration for approving state plans that have allowed them to go above 200 percent of poverty for their SCHIP program. You are basically saying that the Administration had no discretion to deny those plans. Is that right?

Ms. SHAH. The Administration has a great deal of discretion in the way it implements programs, but where there has been a settled interpretation of how a statute or regulation is to be implemented, case law is very clear that there has to be a—it is considered a rule and——

Mr. DEAL. OK. So in other words, we can't pass a statute that is specific enough that says that you don't have crowd-out and that you ensure poor children first. The statute is not specific enough. The regulation that goes further detail to saying how to implement that statute is not detailed enough, that we then have to go to implementing rules that deal with this minutiae before CMS can do anything to enforce this SCHIP Program?

Ms. SHAH. Well, very interestingly, when this rule was promulgated——

Mr. DEAL. Well, you said it was a letter, and the letter is the equivalent of a rule.

Ms. SHAH. No, I am talking about the regulation.

Mr. DEAL. OK.

Ms. SHAH. When the regulation was promulgated, there was a debate at that time as far as what the crowd-out strategies should be. And CMS at that time said that they considered requiring a set of specific procedures that each state would have to use. They rejected that option because the statute authorizes states to design approaches to prevent substitution, not the Federal Government. In other words, they questioned whether they had the authority to impose a certain set of procedures.

Mr. DEAL. Are you saying CMS has no discretion then in the administration of this program?

Mr. ROSENBERG. CMS, when it promulgated the 2001 rule, provided guidelines, provided the rules by which they would grant or deny. They gave great flexibility. If they want to change that flexibility and put in more rigid rules, they have to, according to the Supreme Court, go back and change the rule the same way they promulgated it, which is by notice and comment rulemaking. But remember what Ms. Shah and I are dealing with is not the APA. We are dealing with the Congressional Review Act, which has much broader standards for review by Congress. And if Congress wants to look at the amendment that has been made, or the document of August 17, they can do that, and they can use different kinds of analysis and reasons for overturning it if they can get majorities to affect a disapproval resolution.

Mr. DEAL. I think you both illustrated the point I was making in my first statement. Thank you.

Mr. PALLONE. Thank you, Mr. Deal. Next is our vice chair, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, for, one, holding the hearing, and I apologize for jumping back and forth because we have a nursing home hearing downstairs in O&I, those of us who are on that committee. But I would like to ask unanimous consent to have my full statement placed into the record.

[The prepared statement of Mr. Green follows:]

STATEMENT OF HON. GENE GREEN

Thank you Mr. Chairman for holding this hearing today on H.R. 5998, the Protecting Children's Health Coverage Act of 2008. As an original cosponsor of this bill, I am pleased we are moving this quickly through the legislative process.

The SCHIP program has been a priority for me because my home state of Texas has one of the highest uninsured rates of children in the US with nearly 20 percent uninsured compared to 11 percent nationwide.

Today, we will discuss H.R. 5998, which will nullify the August 17th directive. The August 17th directive is a letter the Administration sent to State Medicaid and SCHIP directors outlining certain conditions states must meet if they want to cover children in families with incomes above 250% of the federal poverty level.

One other provision outlined in the directive bars children who have been dropped from employer based insurance from participating in CHIP for a full 12 months. These types of hurdles do not help get those uninsured children who are eligible for CHIP in the program.

In Texas, SCHIP only covers children at 200% and below the federal poverty level, but we have still experienced some significant problems enrolling children in the CHIP program. In fact, Texas CHIP participation has never been above 85%.

The State of Texas has not been wise with the SCHIP program and has lost over $850 million in matching funds due to many missteps including kicking children off of the SCHIP roles and forcing them to reregister every 6 months.

According to the US Census Bureau, 1.5 million Texas children are uninsured. Many of those children are actually eligible for Medicaid or CHIP, but are not enrolled in either program. The fact of the matter is,the number of insured children is growing, not only in Texas, but throughout the US and the August 17 directive does not help reduce the number of uninsured children.

The two SCHIP reauthorization bills that we passed and that the President vetoed actually allowed states to sustain current programs and cover an additional 4 million uninsured children by 2012.

Adding new challenges and hurdles for states to meet before they can enroll additional children does nothing to solve the problems we have insuring children in this country.

The last thing we need to do is make it harder to enroll children in the CHIP program when states like Texas are experiencing problems enrolling children in the first place.

The August 17th directive represents a fundamental policy change in the SCHIP program and was published in the form of a letter from CMS to state health officials and not moved through the promulgated rule process, which would have required a comment period for stakeholders before the rule went into effect.

Both the GAO and CRS have stated this letter violated the Congressional Review Act and while the Administration has attempted to clarify the underlying policy in the August 17th directive, the fact is it made significant changes to the SHIP program which made it more difficult for states to expand their SCHIP programs and violated congressional review processes.

That's why I strongly support H.R. 5998 and I hope we will move this bill swiftly through the Committee.

Thank you Mr. Chairman, I yield back my time.

Mr. GREEN. I guess my concern in the hearing is the August 17 Directive. In coming from Texas, I have been so frustrated, and the members of this committee know that, that using the 1-year waiting period or even the not having insurance for 1 year is a way you reduce your enrollment. And I know that happened in Texas in 2003. 2005 it wasn't corrected, and in 2007, they did add some children back. And the formula now, I think it is just below 200 per-

cent of poverty they have the year that you can have insurance for the full year.

I know we are talking about two different things, but I think they are interrelated because if you make a child wait a year from losing their private sector employment—although it is interesting—and I will ask this question. It is interesting that CMS said that it didn't include unborn children. So they are giving health insurance to the same family for a child that is born within that year period, but if you are a child that is 2 years old, you have to wait that year. I would have to understand the convoluted reasoning for that. You know I don't know why we would have an arbitrary year waiting period because you are the children without health care. And that was the original intent in '97. A number of us were here when we voted for that balanced budget act. I didn't vote for the balanced budget act, but I voted for the CHIP side because I knew that was needed.

Let me ask—CMS said they will work with the states to help meet some of these tests to the August 17 Directive. For example, CMS has initially indicated informally that there will be no exceptions to the 1-year waiting period, a requirement that children must be uninsured for a full year before qualifying for CHIP coverage. In the May letter, CMS now says it will consider exceptions. My fear is that this working with the States, these exceptions could be applied arbitrarily and in the absence of regulations in any specificity. Doesn't this give the CMS power to approve one state and disapprove another even if they have the exact same circumstances? Ms. Cummings or anyone on the panel?

Ms. CUMMINGS. Mr. Green, that is exactly one of the concerns that we raised in our testimony is this approach of negotiation and different states being able to use different databases to make cases is one that does seem to us to lead to a non-uniform approach, which arouses concern.

The other thing is that we haven't today yet mentioned that the August 17 letter said you must satisfy all of the conditions so that we in California, for example, are in a situation where we could satisfy a couple of them. But, for instance, this issue about replacement of employer-sponsored coverage. Given that the adults in our state have an erosion of employer-sponsored coverage of over that amount, there is no way we are going to satisfy it with children. And so you just end up being out of luck.

Mr. GREEN. Ms. Shah and Mr. Rosenberg, I know from the GAO and CRS. Do you have anything from your reports on that issue, the arbitrariness it could have unless we actually have some regulations that—I like the Federal Government to work with the States. But I also like it to be on the same playing field, I guess. That is what my concern is.

Ms. SHAH. Well, I know GAO often looks at federal programs to see how states are implementing them and whether they have been consistent across states. I don't know about this particular concern, but I think it is something that, from a problematic side, they might look into some time in the future.

Mr. GREEN. Mr. Rosenberg?

Mr. ROSENBERG. I did not address that and wasn't asked to address that in my statements.

Mr. GREEN. OK. To point out, with regard to CHIP, it seems that the administration has used a lot of fuzzy math on it. Do you agree with that?

Mr. ORSZAG. You are probably referring to the 95 percent participation rate test——

Mr. GREEN. Yes.

Mr. ORSZAG [continuing]. Which has been interpreted—my job is to evaluate the effects of how they are interpreting a certain test. They appear to be interpreting the test in a particular way whereby the vast majority of states would pass the test, and a substantial number of states would have participation rates significantly above 100 percent.

Mr. GREEN. How do you get above 100 percent? Frankly, I would love to get there in Texas.

Ms. CUMMINGS. Mr. Green.

Mr. GREEN. Yes?

Ms. CUMMINGS. There are a number of ways you can get 100 percent. According to one set of data, we are at 130 percent. What does that mean? Does that mean we have served all the uninsured children? No. If we go to look at the CPS's, is that 130 figure confirmed? No. If we go to our own state survey data, is that number confirmed? No.

Mr. GREEN. OK, I know I am out of time, Mr. Chairman. Thank you for your patience.

Mr. PALLONE. Thank you, Mr. Green. Ranking member of the full committee, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman, and thank you for having a hearing on this. It is good. We have been discussing SCHIP for over a year and a half. For the first year, all we did was discuss it on the floor. It is good to actually have real people testifying on real bills. I am not a supporter of your bill, but I think it is an honest bill and I think it is worthy of being debated.

My first question is to Dr. Orszag. CMS has stated that of the 15 states that have submitted data to comply with this August 17 letter, they have looked at 11 of those data sets. Nine of those states comply with the 95 percent test, and they say that they think every state will be able to. I believe CBO has looked at that same data set and concurs with that assessment. Is that correct?

Mr. ORSZAG. I would concur that it appears that given the way that CMS is interpreting or applying the 95 percent test, the vast majority of states will either automatically pass it even with no effort or very close.

Mr. BARTON. OK, and you seem to imply in your answer that CMS isn't looking at the data correctly? The way they look at it, are they using some unusual, exotic methodology?

Mr. ORSZAG. I think it would be fair to say that the way they are applying that test is not the way that most analysts would do so, yes.

Mr. BARTON. Would you say that they are applying the test more stringently or more loosely?

Mr. ORSZAG. More creatively.

Mr. BARTON. I don't understand creative.

Mr. ORSZAG. Well, conceptually it is hard to get participation rates—or not conceptually, just simple mathematics that are above

100 percent. And the way that they appear to be applying this test, you can easily get participation rates above 100 percent. The reason is that they are looking——

Mr. BARTON. Now, what I mean——

Mr. ORSZAG. What is the underlying reason? The underlying reason is they are saying you are insured if you have insurance at any point during the year. So if you have insurance just for half of January, you are good to go. And obviously that means that there are a lot of people who are uninsured for the vast majority or in any given month who would be counted as insured under their methodology. Or I should say their apparent methodology.

Mr. BARTON. What would a normal analyst use as a length of insurance? The entire year, half the year?

Mr. ORSZAG. Or a point in time. You look at the population at a point in time or over a month or something, average monthly insurance and average monthly enrollment and what share of the population would be uninsured over a month. Or you could do it over different periods of time, but the way that they are doing both the nominator and denominator in this——

Mr. BARTON. Numerator and denominator.

Mr. ORSZAG. The numerator and the denominator gives you answers that don't make a lot of sense.

Mr. BARTON. OK. Now, Mr. Alexander, your state has received a compliance letter, I believe, from CMS. Is that correct?

Mr. ALEXANDER. Correct, yes.

Mr. BARTON. And what did you do that you weren't doing before to show the CMS that you could comply with this directive?

Mr. ALEXANDER. Well, as I had stated in my testimony, Rhode Island has had a premium assistance program for some time, and this is not something new that Rhode Island had to do post-August 17. So not only has Rhode Island had a commitment to insuring our poorest children, but in regards to the 95 percent, we closely monitor those people that are coming in and on and off the program. So if somebody had health insurance for just a month or if somebody has health insurance for 6 months, we are watching that very closely.

Mr. BARTON. So and CMS worked with your state and you to do this?

Mr. ALEXANDER. CMS has been nothing but a big help to us in terms of either complying with the provisions in the letter or on a day-to-day basis with our program. Of course, all states have challenges. Rhode Island is—I am just a small boy from a small state. So, as I am sitting up here looking at all the big states in front of me——

Mr. BARTON. A state is a state.

Mr. ALEXANDER. Yes, well you are correct, but Rhode Island is more like a county. So although——

Mr. BARTON. Tell that to the Congressman from Rhode Island.

Mr. ALEXANDER. Well, we will, but although as you know——

Mr. BARTON. His vote counts just as much as mine.

Mr. ALEXANDER. As you know, we can bang with the best of them when it comes to the political arena.

Mr. BARTON. Yes.

Mr. ALEXANDER. But in regards to your question of course, we did not have any major problem complying with the August 17 letter. I can only speak as to——

Mr. BARTON. Well, based on your efforts—because my time is about to expire—do you think that the other states that wish to comply will be able to work with the CMS and get compliance at the 95 percent rate?

Mr. ALEXANDER. Based on my experience, I would say yes.

Mr. BARTON. OK.

Mr. ALEXANDER. But I am not working the other states.

Mr. BARTON. I understand that.

Mr. ALEXANDER. But based on my experience, I would say yes. I think we have an excellent model in Rhode Island.

Mr. BARTON. Mr. Chairman, my time has expired. Let me simply say this before I yield back. Any states can cover any child in their state at any level of income with state-only dollars. All the CMS is trying to do is the law that we passed 10 years ago is that if you want federal matching funds, you should try to cover your low-income children first at the 95 percent level. And as we have pointed out, the states that are actually working in a good faith effort to do that seem to be able to comply with that directive. So I hope that we will take that into consideration before you attempt to move this piece of legislation. But I sincerely appreciate you holding this legislative hearing. I think that is the way to do it. And with that, I yield back.

Mr. PALLONE. Thank you, Mr. Barton. Mr. Engel for questions.

Mr. ENGEL. Thank you, Mr. Chairman. As I was saying, right in the nick of time. Let me follow up on early questions related to New York's state plan amendment.

New York first submitted a state plan amendment to CMS last April to expand on the number of individuals covered. Five times, and let me say that again, five times CMS stopped the clock on considering the proposal by asking the state of New York questions about the proposal. New York repeatedly engaged with CMS and provided answers in a timely fashion.

Only after the draconian August 17 letter was sent out, which both GAO and CRS says violates the Congressional Review Act, did CMS deny New York's application. They used the August 17 CMS Directive as the basis for doing so. There is no doubt about this. They said it time and time and time again.

So the administration's argument that the August 17 Directive is not binding is obviously contrary to actions they have already taken, as I just explained.

So let me start with Ms. Shah. In the brief file by the Department of Justice in the case of New Jersey versus the U.S. Department of Health and Human Services, the DOJ argues that the directive is non-binding. Isn't it true, however, that the Department of Health and Human Services has already denied a number of states' efforts to expand coverage to uninsured children based on this directive?

Ms. SHAH. In the course of our legal opinion, we were concerned with whether it was a violation of the Congressional Review Act, so we didn't look at particular states except for New York because the denial of the New York state plan amendment, the August 17

letter was specifically cited in that denial. But I understand that some states, other states have been affected by the letter.

Mr. ENGEL. Well, let me ask you this and perhaps Mr. Rosenberg as well. In addition, hasn't the Department of Health and Human Services forced the number of States to scale back or modify proposals to cover uninsured children based on the requirements in the directive?

Mr. ROSENBERG. I have seen reference to those kinds of allegations. I am not aware of actually factual—that leverage or whatever was used, on the basis of that, to have the state scale back. If that can be demonstrated in an APA case, that could be persuasive to the courts in addition to the New York state actual rejection.

Mr. ENGEL. OK, isn't it true though that the Department of—the argument that the August 17 Directive is not binding is contrary to actions they have already taken? Perhaps Ms. Cummings could answer that.

Ms. CUMMINGS. Well, one thing that was in testimony previously submitted in a congressional hearing by Georgetown, by the Center for Children and Families, was that Louisiana, Oklahoma, and Ohio had had to—failed to pursue getting 300 percent of federal poverty level coverage in their state because of the 8/17 directive.

In our state, for example, the hammer doesn't hit until at some point in the future because we are one of 14 states that have been told that we must come into compliance. Our state would like to go to 300 percent of federal poverty level. If we tried that right now, we are sure that we would be stopped. But we don't actually have anything on the table to do that.

What we do have is what happens to children who have incomes of 250 percent with the application of income deductions because that is something that CMS has indicated, although not said in writing, but will no longer be possible. That affects 14,000 children a year in our state.

Mr. ENGEL. Thank you. Ms. Shah, let me go back to you. In spite of DOJ's argument for the district court that the directive is nonbinding, didn't GAO determine that the August 17 letter is, in fact, binding?

Ms. SHAH. What we did determine was that it meant the three-part test that needed to be of an APA rule and had to be submitted to GAO. But in reinforcing our determination that this was a rule that had to be submitted to Congress and to GAO, we noted that there were certain elements of the August 17 letter that did indeed appear to have a binding effect. And one of those was that it was applied in the case of New York and also the language of the letter itself imposing a 1-year deadline for states to come into compliance with what was set forth in that letter.

Mr. ENGEL. Let me ask you this, Ms. Shah. If CMS were to clarify if the August 17 Directive was not intended to be binding, would the agency still have a problem for failing to comply with the requirements of a Congressional Review Act?

Ms. SHAH. Yes they would because that's not one of the criteria that is needed to be a rule for the purposes of the Congressional Review Act. Basically for a rule, it just has to be a rule that is of general applicability, having future effect, and designed to imple-

ment, interpret or prescribe law or policy. That reaches a range of statements that are well beyond those that are binding.

Mr. ENGEL. Mr. Rosenberg——

Mr. PALLONE. We are up to——

Mr. ENGEL. Am I done?

Mr. PALLONE. You are, yes.

Mr. ENGEL. OK.

Mr. PALLONE. Sorry.

Mr. ENGEL. Thank you.

Mr. PALLONE. All right, thank you very much. Thanks. That concludes our questions. This actually went very quickly, but it doesn't mean that we didn't learn a lot. I thought it was very worthwhile and I——

Mr. DEAL. Mr. Chairman.

Mr. PALLONE. Yes?

Mr. DEAL. Since I was very hurried in my questions, I just want to express to all of you, and I didn't get a chance to ask all of you questions, I want to thank all of you for being here. I think this mental exercise, if it is that, and the substantive issues that lie behind it are much more important, I think, technically than the issue of the August 17 letter. That is the underlying purpose of the legislation, and I think all of us want to work cooperatively with the states in trying to work out the problems that they face in keeping with what the purpose of the SCHIP program is. Thank you very much.

Mr. PALLONE. Thank you, Mr. Deal. Let me just remind you that members may submit additional written questions, and we should have those to the clerk within the next 10 days. So in another 10 days or so, you may get additional written questions which obviously we would like you to respond to. But again, thank you again. And without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF HON. ANNA G. ESHOO

Thank you Mr. Chairman for holding this important hearing on the future of SCHIP.

In the 10 years since its inception, SCHIP has been successful in reducing the number of uninsured low-income children in the United States by one-third. In California, we cover over 1 million children who otherwise would not have any coverage and care. I ever American should have healthcare and above all, every child should be covered, regardless of their parent's employment situation or wealth.

On August 17th, 2007, CMS adopted a draconian directive that effectively prevents any state from covering children in families earning 250% above the federal poverty level ($43,000 for a family of three) unless they can achieve impossible-to-attain standards. For example, states must enroll 95% of all eligible children under 200% of poverty before they can expand their SCHIP program. No federal means-tested program of any kind comes close to 95% enrollment. The result is that states are forced to scale back plans to cover thousands of children.

The bill before us today will nullify the harmful, and likely illegal, directive that the Administration put out last August. The GAO and CRS have each issued legal opinions that the directive violates the Congressional Review Act (CRA), a law intended to keep Congress and the public informed about the rulemaking activities of federal agencies and to allow congressional review of such rules.

I look forward to hearing from our witnesses who have had direct experience with these cuts to SCHIP, as well as from the GAO and CRS about the legality of CMS's directive.