



Children's Health Insurance and the House-passed 2007 SCHIP Reauthorization Legislation

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Summary of CRS Testimony

In 2006, the percentage of children in the United States without health insurance increased significantly for the first time in several years. In December 2007, the unemployment rate jumped to 5.0%, its highest level in two years. The January 2008 unemployment numbers are scheduled for release on Friday and may give insight to future health insurance trends, since research has shown that health insurance coverage closely follows employment.

The changing picture of children's health insurance coverage and the evolving nature of last year's SCHIP legislation has provoked some fundamental questions about health insurance proposals generally and SCHIP in particular, which I pose as follows:

1. If you build it, will they come?
2. If you build it, how many non-targeted individuals will come — and how many is acceptable?
3. If you build it, who should design the structure — and with how much flexibility?
4. If you build it, what should that structure be?

This testimony responds to each of these questions using the provisions in the three House-passed SCHIP reauthorization bills in 2007. The role of CRS is *not* to assess whether any particular approach or answer is the “right” one. Rather, it is to distill the complex issues that are inevitable with any health insurance proposal into a framework that may be helpful, and to use that framework to analyze the House-passed SCHIP reauthorization bills. Doing so thus provides a case study on how the questions above can be answered while describing how some specific, controversial aspects of SCHIP coverage were addressed in the legislation.

Chairman Pallone, Mr. Deal, and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Health Care Financing with the Congressional Research Service (CRS). Thank you for the opportunity to testify about the characteristics of uninsured children and of SCHIP reauthorization legislation passed in the House over the past year.

The three SCHIP reauthorization bills passed by the House in 2007 were:

- H.R. 3162 (Children’s Health and Medicare Protection Act of 2007, or CHAMP);
- H.R. 976 (Children’s Health Insurance Program Reauthorization Act of 2007, or CHIPRA); and
- H.R. 3963 (also known as CHIPRA).

Although CHAMP passed only the House, both CHIPRA bills (H.R. 976 and H.R. 3963) passed both chambers of Congress and were vetoed by the President in 2007.

Getting health insurance to children (or any population) is not rocket science — it’s harder. In rocket science, you have constants. You know what speed is necessary to escape the Earth’s atmosphere. You can calculate precisely how much fuel is needed. How often do you hear debates about the measure of gravity’s pull, whether a certain orbit is too high or too low, or what the best path is to get there? But when it comes to health insurance, there are important, fundamental debates about what the goal is, what the best path is to that goal, who should pay for it, and how to reconcile the tensions between laudable but often contradictory aims.

In the movie “Field of Dreams,” the main character cuts a baseball field out of his Iowa cornfield in response to a voice that whispered, “If you build it, he will come.” To

help frame the complex issues regarding SCHIP reauthorization and uninsured children, both for looking back and moving forward, I'll ask four questions that are variants of that movie quote that I hope will be illuminating. The first is:

If you build it, will they come?

The question holds for virtually all efforts to expand health insurance through federal legislation, whether through public programs, tax initiatives, etc. With respect to children, on any given day in 2006, approximately nine million were without health insurance. Most of these children came from two-parent families (53%). Most had a parent who worked full time all year (63%).¹ And most were *eligible* for Medicaid or SCHIP (62%).² In other words, the Federal government and states built it, but 6 million eligible uninsured kids did not come. Among these eligible uninsured children, it is still the case that most were in two-parent families and in a family where a parent worked full time.³

So how to get them to come? All of the House-passed SCHIP reauthorization bills would have provided bonus payments to states that (1) increased child enrollment in Medicaid or SCHIP by certain amounts, and (2) performed a certain number of specified outreach or enrollment activities. This latter requirement ensured that enrollment growth alone — from a recession, for example — was not enough to prompt bonus payments to

¹CRS Report 97-975, *Health Insurance Coverage of Children, 2006*, by Chris L. Peterson and April Grady, September 12, 2007.

²Julie L. Hudson and Thomas M. Selden, "Children's Eligibility And Coverage: Recent Trends And A Look Ahead," *Health Affairs* Web exclusive, August 16, 2007, pp. w618-629.

³Op. cit., Exhibit 3, online data supplement.

states. According to the Congressional Budget Office (CBO), the first House-passed SCHIP reauthorization bill, CHAMP, would have increased Medicaid and SCHIP enrollment by 7.5 million in FY2012, for a total of 35.8 million enrollees. The two vetoed CHIPRA bills both would have increased FY2012 enrollment by 5.8 million, for a total of 34.1 million enrollees. In all three bills, the increased enrollment would have occurred largely among current eligibility groups, rather than new ones.⁴

This leads to the second question regarding health insurance proposals:

If you build it, how many *non-targeted* individuals will come — and how many is acceptable?

Crowd-out. The question is not *whether* non-targeted individuals will come, but how many. In terms of who is *not* targeted for SCHIP, the original SCHIP statute is clear that (1) children must be uninsured in order to be eligible for SCHIP,⁵ and (2) states must have strategies to prevent the substitution of SCHIP coverage for private coverage,⁶ commonly referred to as crowd-out.⁷

⁴CBO cost estimates for H.R. 3162 (8/1/07), H.R. 976 (9/25/07), and H.R. 3963 (10/24/07), available at [www.cbo.gov]. In FY2012 specifically, Titles I and VIII of H.R. 3162 would have increased federal spending by \$16.5 billion; H.R. 976 and H.R. 3963 would have increased federal spending by \$10.6 billion and \$10.8 billion, respectively. Cumulatively over FY2008 to FY2012, increased federal spending for Medicaid and SCHIP would have been \$51.8 billion, \$34.9 billion, and \$35.4 billion, respectively.

⁵For example, see §2110(b)(1)(C) of the Social Security Act.

⁶For example, see §2102(b)(3)(C) of the Social Security Act.

⁷It is helpful to think about crowd-out not only in terms of individuals but also dollars. For example, if a proposal would provide additional funds for the purchase of health insurance to those who already have coverage, then public dollars are crowding out private dollars.

Crowd-out is problematic for those whose sole objective is to lower the number of uninsured children with a particular amount of funding.⁸ If funds set aside for reducing the number of uninsured go entirely to those who are already insured, then the funds would be exhausted without affecting the number of uninsured. Thus, for those wishing to maximize the reduction in uninsured with a particular amount of funding, crowd-out should be minimized. In other words, if you build it, then build it so the fewest non-targeted individuals come.

According to CBO, all three House-passed SCHIP reauthorization bills had similar crowd-out rates, of about one-third. This means that for every three individuals enrolled in Medicaid or SCHIP in FY2012 because of the legislation, two would have been uninsured and one would have had other coverage in the absence of the legislation. While CHAMP and the first CHIPRA bill were being debated, the Director of CBO said the bills “are tilting the incentives towards lower income populations which are associated with lower crowd-out rates. ... (I)n our analysis, we don’t see very many other policy options that would reduce the number of uninsured children by the same amount without creating more crowd-out than under the House and Senate proposals [H.R. 3162 and H.R. 976, respectively]. The policy question at hand is whether those types of reductions are worth the cost that is involved.”⁹ As health economist Jon Gruber (who

⁸There may be other health policy goals, such as ensuring an adequate benefit package or obtaining increased enrollment in certain types of coverage, for which crowd-out might not be counterproductive.

⁹Peter Orszag, presentation at Alliance for Health Reform briefing “Who’s Counting? What is Crowd-Out, How Big Is It and Does It Matter for SCHIP?” August 29, 2007, transcript pp. 17, 19, available at [<http://www.allhealth.org/briefingmaterials/CrowdOutandSCHIP-879.pdf>].

has corresponded with this Committee on crowd-out issues¹⁰) put it, “It’s like fishing for tuna. When you let down the tuna nets, you catch some dolphin too.”¹¹ For any number of tuna caught, how many dolphins are acceptable — if any? In other words, whether the crowd-out is “too much” compared to the reduction in uninsured is a more subjective question than a technical one.

Certain immigrants’ ineligibility. Another group that SCHIP does not target for enrollment is legal immigrants who have been in the country for less than five years and unauthorized aliens (the latter group often referred to as “illegal immigrants”).¹² If these individuals meet all eligibility criteria except immigration status, then health care providers who give emergency medical care to them may receive reimbursement from Medicaid. However, these noncitizens are not eligible to be “insured” with full coverage by Medicaid or SCHIP under current law. CHAMP would have given states the option to extend eligibility to legal immigrants who have not been in the U.S. for five years.¹³ The CHIPRA legislation vetoed by the President did not include this provision. None of the three House-passed bills would have changed current law regarding illegal aliens’

¹⁰Letter from Jonathan Gruber, professor of economics, Massachusetts Institute of Technology, to Representative John Dingell, Chairman, House Energy and Commerce Committee, February 28, 2007, available at [http://energycommerce.house.gov/Press_110/110-ltr.022807.Gruber_ltr_to_Dingell.pdf].

¹¹Jane Bryant Quinn, “The Kids Aren’t All Right,” *Newsweek*, October 20, 2007, available at [www.newsweek.com/id/57366/output/print].

¹²The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193).

¹³Sec. 132 of CHAMP.

eligibility for Medicaid or SCHIP; individuals who are not legal residents would still be ineligible for non-emergency coverage.¹⁴

Citizenship documentation. The Deficit Reduction Act of 2005 (DRA) requires citizens and nationals applying for Medicaid who claim to be citizens to provide both proof of citizenship and identity. Before DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence.¹⁵

CHAMP would have made the DRA Medicaid citizenship documentation requirements for children optional to states, among other changes.¹⁶ Rather than make the documentation requirements entirely optional, the first CHIPRA bill provided a specific alternative, which would allow state to use the Social Security Number (SSN) provided by individuals and verified by the Social Security Administration (SSA). The bill also would have added a requirement for citizenship documentation in SCHIP.¹⁷ The second CHIPRA bill had these provisions, but also would have provided \$5 million for SSA and required SSA to determine whether an individual's name and SSN were consistent with its records.¹⁸

¹⁴Sec. 135 of CHAMP and Sec. 605 of CHIPRA.

¹⁵For additional information, see CRS Report RS22629, *Medicaid Citizenship Documentation*, by April Grady.

¹⁶Sec. 143 of CHAMP.

¹⁷Sec. 211 of H.R. 976.

¹⁸Sec. 211 of H.R. 3963.

According to CBO, CHAMP's altering of citizenship documentation would increase federal spending in FY2008-2012 by approximately \$800 million. Over that same period, federal spending under both CHIPRA bills would have increased because of the changes in citizenship documentation by \$1.4 billion.¹⁹ CBO suggests that this cost would result from increased enrollment among citizens, rather than unauthorized aliens or other ineligible noncitizens, since "(a)available evidence, based on state reports and other information provided by state officials, suggests that virtually all of those who have been unable to provide the required documentation are U.S. citizens."²⁰

The third question is:

If you build it, who should design the structure — and with how much flexibility?

Children in higher-income families. For example, the statute clearly states that SCHIP eligibility is for "targeted low-income children" whose family income is below 200% of poverty²¹ or, if higher, up to 50 percentage points above the state's pre-SCHIP Medicaid levels.²² On the other hand, states have the flexibility to define how income is counted so that states could effectively expand eligibility of all children to

¹⁹CBO cost estimates for H.R. 3162 (8/1/07), H.R. 976 (9/25/07), and H.R. 3963 (10/24/07), available at [www.cbo.gov].

²⁰Letter from CBO Director Peter R. Orszag to Speaker Nancy Pelosi, October 25, 2007, available at [<http://www.cbo.gov/ftpdoc.cfm?index=8742&type=1>].

²¹For 2008, 200% of poverty for a family of three is approximately \$35,000 a year in countable income.

²²§2110(b) of the Social Security Act. Children are defined in SCHIP statute as under age 19. CHAMP would have given states the option to expand eligibility to those under age 21 (Sec. 131). This provision was not in the CHIPRA bills vetoed by the President.

whatever income level they choose.²³ This flexibility may now be limited somewhat, based on the criteria set forth in the August 17, 2007, letter from Dennis Smith to state health officials for states seeking to expand SCHIP eligibility to children with “effective” family income above 250% of poverty.²⁴ The letter illustrates the ongoing tension between state flexibility versus federal control and between the legislative branch and the executive branch: If you build it, who designs it — and with how much flexibility?

CHAMP, which was passed by the House prior to the issuance of the August 17 CMS letter, had no provisions altering states’ flexibility in defining income or the federal matching rate for various SCHIP-enrolled individuals. (The federal government reimburses approximately 57% of states’ Medicaid costs, based on a state-specific percentage called the Federal Medical Assistance Percentage, or FMAP. For SCHIP, there is an enhanced FMAP, or E-FMAP, which averages about 70% of states’ costs.) The two CHIPRA bills that ultimately passed both chambers of Congress would have effectively nullified the August 17 letter.²⁵

Unlike CHAMP, the CHIPRA bills would have reduced or eliminated federal SCHIP payments for certain higher-income SCHIP children. The first House-passed CHIPRA bill specified that the regular FMAP would be used for SCHIP enrollees whose effective family income would exceed 300% of poverty using the state’s policy of

²³See 66 *Federal Register* 2320, January 11, 2001, and 42 CFR 457.10. For additional discussion, see April Grady, “Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income,” CRS Congressional Distribution memorandum, November 29, 2007, available upon request.

²⁴Letter from Dennis G. Smith, Director of the Center for Medicaid and State Operations of the Centers for Medicare and Medicaid Services (CMS), SHO #07-001, August 17, 2007, available at [<http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>].

²⁵Sec. 116(g) of CHIPRA.

excluding “a block of income that is not determined by type of expense or type of income,” with an exception for states that already had a federally approved plan or that had enacted such state legislation.²⁶ The second version of CHIPRA would have prohibited *any* federal SCHIP payments for SCHIP enrollees whose effective family income would exceed 300% of poverty using the state’s policy of excluding “a block of income that is not determined by type of expense or type of income,” with an exception for states that already had a federally approved plan but *not* for states that had merely enacted such state legislation.²⁷ Those who want to eliminate any possibility of federal payments for children above 300% of poverty have correctly stated that the legislation could still permit payment for some children with gross income above that level. For example, SCHIP financing would be permitted and could occur if states disregarded income above 300% of poverty that is a particular type of income, such as wages, or by using Medicaid funding, for which states’ flexibility to count income would not have been altered by the CHIPRA bills.²⁸

SCHIP coverage of adults. Another issue that highlights the trade-offs with providing flexibility to states and the executive branch is the use of Section 1115 waivers, by which the Administration can waive certain strictures of statute. Certain states that have covered adults with SCHIP funds were permitted to do so almost entirely through the use of these waivers. These waivers, which initially are effective for five

²⁶Sec. 114 of H.R. 976.

²⁷Sec. 114 of H.R. 3963.

²⁸Sec. 115(a) of both CHIPRA bills, H.R. 976 and H.R. 3963.

years, must be approved by the Administration and then are subject to re-approval every three years.

Waivers permitting the coverage of parents with SCHIP funds were first approved under the Clinton Administration. However, Clinton Administration officials said that waivers to cover nonpregnant childless adults in SCHIP would not be approved.²⁹ SCHIP waivers covering nonpregnant childless adults were granted under the Administration of George W. Bush. These approvals occurred in response to a Bush initiative (Health Insurance Flexibility and Accountability (HIFA) demonstration initiative) to expand health insurance coverage to low-income individuals, and at a time when \$2 billion to \$3 billion in unspent SCHIP funds was available for redistribution among certain states.³⁰

By FY2006, however, several states faced the prospect of being “shortfall states” — that is, states that exhausted all their available federal SCHIP funding. Although none of the potential shortfall states covered childless adults under SCHIP as an eligibility category, several covered parents. In addition to appropriating \$283 million to eliminate projected FY2006 shortfalls, DRA also prohibited the Administration from approving any new waivers that permitted SCHIP funds to be used for nonpregnant childless

²⁹Health Care Financing Administration (HCFA), Letter to State Health Officials, July 31, 2000, available at [<http://www.cms.hhs.gov/smdl/downloads/sho073100.pdf>], p. 6: “We also will consider SCHIP demonstration requests to cover pregnant women with incomes above 185 percent of the Federal poverty level (for States that have already covered pregnant women up to 185 percent of the FPL through Medicaid at the regular matching rate), but we will not consider demonstration proposals to use SCHIP funds to cover other adults without children.”

³⁰Evelyn P. Baumrucker, “Chronological Analysis of Populations Added to the State Children's Health Insurance Program (SCHIP) through March 2007,” draft Congressional Distribution memo.

adults.³¹ States that already had approved waivers for coverage of nonpregnant childless adults could continue them.

Prior to 2007, waiver renewals for states covering parents were approved, even for those projected to face shortfalls for the foreseeable future (e.g., New Jersey, Rhode Island). Beginning in 2007, however, waiver renewals for states covering parents have *not* been approved (e.g., Illinois, Oregon) or have begun to transition parents out of SCHIP coverage (e.g., Wisconsin). Oregon also covered childless adults under its SCHIP waiver but has never been projected to be in shortfall; its SCHIP waiver expired October 31, 2007. Some of these adult groups are now eligible for Medicaid-financed coverage in the state.³² The only SCHIP adult coverage waiver up for renewal in FY2008 is Rhode Island's, which is set to expire on July 31, 2008.

While these waiver negotiations were ongoing between certain states and the Administration in 2007, the SCHIP legislation also addressed the issue of adult SCHIP coverage. Under CHAMP, the Secretary of Health and Human Services (HHS) would be prohibited from paying SCHIP funds to a state for adult coverage — childless adults or parents — “unless the Secretary determines that no eligible targeted low-income child in the State would be denied coverage because of such eligibility. In making such determination, the Secretary must receive assurances that (1) there is no waiting list ... for targeted low-income children ... ; and (2) the State has in place an outreach program to reach all targeted low-income children in families with incomes less than 200 percent of

³¹P.L. 109-171, Sec. 6102.

³², p. 12.

the poverty line.”³³ In a letter to state health officials on July 31, 2000, the Clinton Administration effectively established these criteria as a precondition for approving expansions to groups that are not “the core population of low-income children intended to be served by SCHIP.”³⁴

The first House-passed version of CHIPRA would have phased out SCHIP coverage of nonpregnant childless adults after two years. In FY2009, federal reimbursement for such coverage would be reduced to the Medicaid FMAP, and only for individuals who were actually enrolled in FY2008; new nonpregnant childless adults would not be eligible for federal SCHIP payments in FY2009. Under the second CHIPRA bill, SCHIP coverage of nonpregnant childless adults would have terminated on December 31, 2008. Under both bills, such states would be permitted to apply for Medicaid waivers to continue coverage for these populations, but subject to a specified budget-neutrality standard (tied to the state’s 2008 spending on this population).³⁵

The two versions of CHIPRA were identical with respect to the treatment of parents. Coverage of parents would still be allowed, but beginning in FY2010, allowable spending under the waivers would be subject to a set-aside amount from a separate allotment and would be matched at the state’s regular Medicaid FMAP unless the state was able to prove it met certain coverage benchmarks (related to performance in providing coverage to children). In FY2011 and FY2012, even states meeting the

³³Sec. 134 of CHAMP.

³⁴Health Care Financing Administration (HCFA), Letter to State Health Officials, July 31, 2000, available at [<http://www.cms.hhs.gov/smdl/downloads/sho073100.pdf>], p. 4.

³⁵Sec. 112 of CHIPRA.

coverage benchmarks would not get the enhanced FMAP for parents but an amount between the regular and enhanced FMAPs.³⁶

The fourth and final, and perhaps most fundamental, question posed here regarding health insurance proposals:

If you build it, what should that structure be?

Public vs. private. Nearly 100 years ago, Americans debated whether health insurance proposals leaned too heavily toward government regulation and mandates versus the free market and individual choice.³⁷ Similar concerns were raised regarding the SCHIP reauthorization legislation last year.³⁸ But discussions about what structure of health insurance the nation *should* have are impeded by the challenges to defining what structure the nation *currently* has. The current U.S. health insurance system is a hodgepodge of public and private influences. For example, “private insurance,” including employer-sponsored coverage, is projected to generate tax expenditures of at least \$130 billion this year.³⁹ In addition, public policy often requires private insurance to meet certain criteria, in terms of the benefits offered, the requirements necessary for

³⁶Ibid.

³⁷Theodore Roosevelt, address before the convention of the National Progressive Party, Chicago, August 1912, available at [<http://www.ssa.gov/history/trplatform.html>]. “Health Insurance for New York’s Workers,” *New York Times*, January 30, 1916, p. SM8. “McSweeney Opposes Sickness Insurance,” *Boston Daily Globe*, December 8, 1916, p. 12.

³⁸See, for example, Michael F. Cannon, “Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs,” *Cato Institute Briefing Papers*, No. 99, September 13, 2007, available at [<http://www.cato.org/pubs/bp/bp99.pdf>].

³⁹U.S. Joint Committee on Taxation, “Estimates of Federal Tax Expenditures for Fiscal Years 2007-2011,” September 24, 2007, p. 33, available at [<http://www.house.gov/jct/s-3-07.pdf>].

certain regulatory or tax advantages, etc. On the flip side, “public” insurance, like Medicaid and SCHIP, provides much of its coverage through private insurers.⁴⁰ Thus, health policy options are rarely binary choices between something wholly “private” or “public,” but tend to be gradations of one over the other, in the hopes that the trade-offs are beneficial on net.

Premium assistance. One way in which SCHIP can lean more toward private coverage is to “encourage more states to adopt premium assistance,”⁴¹ which is where SCHIP funds are used to pay a portion of the premium for employer-sponsored health insurance. When considering any variation in health insurance structure, such as premium assistance, the first three questions can be considered again: If you build it, will they come? How many non-targeted individuals will come — and how many is acceptable? Who will design the structure — and with how much flexibility?

In March 2007, CMS noted that a dozen states had implemented premium assistance programs with SCHIP funds.⁴² One of the largest obstacles to states creating SCHIP premium assistance programs has been the strictures in the statute, hearkening back to the question of who should do the designing. Under current law, states may implement premium assistance programs in SCHIP if the employer plan (1) covers

⁴⁰“We find that, in 2005, approximately 70 percent of all children enrolled in SCHIP were in managed care plans and almost 90 percent of SCHIP programs using managed care contracted with one or more plans that primarily serve the commercial market” (John McInerney, “SCHIP Delivery Systems,” National Academy for State Health Policy’s *State Health Policy Monitor*, October 2007, p. 1, available at [www.nashp.org/files/shpmonitor_SCHIPdelivery.pdf]).

⁴¹Nina Owcharenko, “Reforming SCHIP: Using Premium Assistance to Expand Coverage,” The Heritage Foundation’s *WebMemo*, No. 1466, May 22, 2007, p. 1, available at [www.heritage.org/research/healthcare/wm1466.cfm].

⁴²“The State Children’s Health Insurance Program (SCHIP),” CMS PowerPoint presentation, March 22, 2007, p. 14.

SCHIP minimum benefits, (2) meets SCHIP cost-sharing ceilings (5% of family income), and (3) ensured enrollees have not had group coverage for a specified period of time (typically four to six months). However, it has proved prohibitive for many employer plans and states to meet all of these requirements. In addition, in the event the plan's benefit package or cost-sharing burdens do not abide by the SCHIP statute, federal law prohibits SCHIP from providing wrap-around coverage.⁴³ "Covering only children (as opposed to whole families) within a narrow band of eligibility appears to be a contributing factor to low enrollment."⁴⁴ To circumvent these restrictions, most states operating SCHIP premium assistance programs do so under waivers.⁴⁵

One of the reasons the waiver authority for SCHIP premium assistance seemed advantageous was because states could provide coverage to members of the entire family under the group plan who might not otherwise be eligible for Medicaid or SCHIP (e.g., parents). Thus, policies seeking to limit the enrollment of certain non-targeted individuals might work against efforts to increase enrollment in a structure like premium assistance. Comparisons across states also found that enrollment in premium assistance programs was greatest when the state *required* SCHIP-eligible individuals to enroll in the

⁴³The Medicaid premium assistance program permits a wrap-around to ensure adequate coverage and appears to have substantially more enrollment.

⁴⁴Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum's *Issue Brief*, No. 812, July 17, 2006, p. 8, available at [http://nhpf.ags.com/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf].

⁴⁵The Bush Administration's HIFA initiative required states' waiver proposals to emphasize private health insurance coverage, with premium assistance noted for particular flexibility that would be granted to states in terms of benefits, cost-sharing and cost-effectiveness requirements. Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," July 25, 2001, available at [http://www.nahu.org/legislative/uninsured/CMS_HIFAGuide.doc].

job-based coverage they were offered as a precondition of SCHIP enrollment, which harkens back to the trade-off between government mandates and individual choice.⁴⁶

In the absence of a workable premium assistance program, if a child's coverage through SCHIP is much less expensive to the family relative to out-of-pocket premiums for job-based coverage, a parent might opt to have the child in SCHIP. Recent research from the Agency for Healthcare Research and Quality shows this might be the case. For example, in 1997, prior to the implementation of SCHIP, 5.1% of single parents had private coverage for themselves but public coverage for the kids; by 2005, that percentage rose significantly, to 15.5%.⁴⁷ One might argue that premium support should be crafted to prevent the further growth in this percentage, particularly if the increase observed among children between 1997 and 2005 was among those who would have had private coverage in the absence of public coverage. However, the research did not attempt to determine this (and such estimates are difficult and extremely sensitive to the technical assumptions made in the analysis). Considering that one out of six families in job-based coverage pay more than 10% of their take-home income in health insurance and health care, it is possible that enrolling the children in public coverage like SCHIP

⁴⁶Shirk and Ryan, p. 12.

⁴⁷Among single parents who were *not* offered job-based coverage, the percentage with the entire family uninsured dropped, primarily because of a significant increase in the percentage of families where the adults were uninsured but the children had public coverage (20% in 1997 and 30% in 2005). Jessica P. Vistnes and Barbara S. Schone, "Pathways To Coverage: The Changing Roles Of Public And Private Sources," *Health Affairs*, January/February 2008, Exhibits 2 and 3.

may have prevented the entire family from becoming uninsured because of the cost of family coverage.⁴⁸

The House-passed CHAMP bill had no premium assistance provisions. Title III of both House-passed CHIPRA bills was devoted to premium assistance. Under CHIPRA, states would have the option to offer premium assistance for children eligible for employer-based coverage, if the employer pays at least 40% of the total premium (and meets certain other requirements). Under CHIPRA, a state offering premium assistance could not require SCHIP-eligible individuals to enroll in an employer's plan; individuals eligible for SCHIP and for employment-based coverage could choose to enroll in regular SCHIP rather than the premium assistance program. The premium assistance subsidy would generally be the difference between the worker's out-of-pocket premium that included the child(ren) versus only covering the employee.⁴⁹

Under CHIPRA, for employer plans that do not meet SCHIP benefit requirements, not only is a wrap-around permitted but would be required. For the child's coverage using premium assistance, no cost-effectiveness test would be required regarding the cost of the private coverage (plus any necessary wrap-around) relative to

⁴⁸Jessica S. Banthin et al., "Financial Burden of Health Care, 2001-2004," *Health Affairs*, January/February 2008, Exhibit 1. See also "Shared Testimony of Craig and Kim Lee Bedford," testimony before the Senate Finance Committee, February 1, 2007, available at [<http://finance.senate.gov/hearings/testimony/2007test/020107kbttest.pdf>]. Mr. Bedford said he was self-employed and purchased private coverage for himself and his wife, but the children were enrolled in SCHIP. Prior to enrolling the Bedford children in SCHIP, "(e)ven though the business was growing, our health insurance costs were still close to 25% of our gross income." After enrolling the children in SCHIP, the family was "able to cut our health spending by 60%. ... Unfortunately, the cost of our coverage has grown also. In 2006, health insurance premiums for my wife and me cost the same as the family plan we had in 2002, and still account for 13% of our gross income" (p. 5).

⁴⁹Generally, the premium costs of parents would not have been covered. The exception would be where the parent is already eligible for SCHIP in the state using waiver authority, as previously discussed.

regular SCHIP coverage. However, if the SCHIP cost of covering the entire family in the employer-sponsored plan is less than regular SCHIP coverage for the eligible individual(s) alone, then the premium assistance subsidy could be used to pay the entire family's share of the premium. In states that offered premium assistance, CHIPRA would have required states and participating employers to do outreach.

I hope my comments have been helpful. Thank you.