

February 2009

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

CMS Should Improve Efforts to Assess whether SCHIP Is Substituting for Private Insurance



GAO

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Highlights of [GAO-09-252](#), a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

Congress created the State Children's Health Insurance Program (SCHIP) to reduce the number of uninsured children in low-income families that do not qualify for Medicaid. States have flexibility in structuring their SCHIP programs, and their income eligibility limits vary. Concerns have been raised that individuals might substitute SCHIP for private health insurance—known as crowd-out. GAO was asked to examine the Centers for Medicare & Medicaid Services' (CMS) and states' efforts to minimize crowd-out and determine whether it should be a concern. GAO examined (1) CMS's guidance to states for minimizing crowd-out and assessment of whether it should be a concern and (2) states' policies to minimize crowd-out and how they assess whether it should be a concern. To do the work, GAO reviewed federal laws and guidance, examined state annual reports, and interviewed CMS officials. GAO also interviewed SCHIP officials from nine states.

What GAO Recommends

To improve information on whether crowd-out should be a concern in SCHIP, GAO recommends that the Acting Administrator of CMS ensure that states (1) collect and report consistent information on the extent to which SCHIP applicants have private insurance available to them and (2) take appropriate steps to determine whether available private health insurance is affordable for SCHIP applicants.

To view the full product, including the scope and methodology, click on [GAO-09-252](#). For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

CMS Should Improve Efforts to Assess whether SCHIP Is Substituting for Private Insurance

What GAO Found

CMS provided guidance to states about activities to minimize crowd-out in SCHIP, and the information it collected was of limited use in assessing the extent to which crowd-out should be a concern. Along with this guidance, CMS instituted specific requirements for certain program designs it identified as being at greater risk of crowd-out, including programs with higher income eligibility thresholds. CMS said that among other sources, it used states' SCHIP annual reports to assess the occurrence of crowd-out, and on this basis it believed that crowd-out was occurring. Yet each of the approaches CMS used was limited in providing information about the occurrence of crowd-out and thus the extent to which it should be a concern. CMS did not collect certain indicators of the potential for crowd-out in SCHIP annual reports, such as the extent to which private health insurance was available and affordable to families. States' responses to CMS were inconsistent: GAO's review of annual reports for 2007 found that less than half of the 50 states and the District of Columbia provided a percentage in response to CMS's question on the percentage of applicants who dropped private health insurance to enroll in SCHIP.

In general, states implemented similar types of policies in their activities to minimize crowd-out, but not all states collected information adequate to assess whether crowd-out should be a concern. The majority of states used policies such as waiting periods—a required period of uninsurance before an applicant can enroll in SCHIP—to try to reduce incentives for dropping private health insurance. All 39 states with waiting periods offered exemptions for involuntary loss of private health insurance. These exemptions were mostly related to whether insurance was available rather than affordable. Not all states collected information that was adequate to assess whether crowd-out should be a concern. For example, while all 50 states and the District of Columbia asked SCHIP applicants if they were currently insured, 24 states asked applicants if they had access to private health insurance, which is important to understanding the potential for crowd-out. Of the 9 states we interviewed, 5 states measured the occurrence of crowd-out, but they all used different methodologies to develop their estimates; the remaining 4 states did not measure crowd-out. None of the officials in the 9 states viewed crowd-out as a concern, with most basing this assessment on a variety of factors, including the lack of available and affordable private health insurance for the SCHIP population in their state.

Overall, CMS concurred with the report's findings and recommendation, but raised concerns regarding the difficulty of measuring crowd-out, particularly assessing the affordability of private coverage. While GAO agrees that measuring crowd-out is complicated, the actions GAO recommends are an essential first step to better assessing whether concerns about crowd-out are warranted.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
FPL	federal poverty level
MEPS	Medical Expenditure Panel Survey
SCHIP	State Children's Health Insurance Program

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United States Government Accountability Office
Washington, DC 20548

February 20, 2009

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

Congress created the State Children's Health Insurance Program (SCHIP) in August 1997 with the goal of significantly reducing the number of low-income uninsured children. SCHIP offers health insurance for children in low-income families that do not qualify for Medicaid and are not enrolled under a group health plan or under other health insurance.¹ The program enrolled over 7 million children at some point during fiscal year 2007. States that participate in SCHIP receive a larger share of federal funds—an enhanced federal matching rate—than what is offered under Medicaid.² States have considerable flexibility in structuring their SCHIP programs and may use one of three basic options: (1) expanding Medicaid, (2) establishing a separate child health program, or (3) combining these two approaches. States also vary in the income eligibility limits that they have established for SCHIP. States' inclusion of higher income eligibility levels—some at or exceeding three times the federal poverty level (FPL)³—has increased concerns about the possible substitution of public health insurance under SCHIP for private insurance—a phenomenon

¹SCHIP defines low-income in terms of the federal poverty level (FPL), which is a measure used to establish eligibility for certain federal assistance programs, including SCHIP. SCHIP defines low-income children as those in families earning up to 200 percent of FPL, or 50 percentage points above a state's existing Medicaid eligibility standard as of March 31, 1997. Therefore, states vary in their definition of low-income families. For example, Delaware's SCHIP program covers children up to 200 percent of FPL, while Washington's covers children up to 250 percent of FPL.

²Medicaid program expenditures are shared between states and the federal government with each state's share determined by a formula that compares a state's per capita income to the national average. Federal matching rates for SCHIP are "enhanced"—they are established under a formula that takes 70 percent of a state's Medicaid matching rate and adds 30 percentage points, with an overall federal share that may not exceed 85 percent. Thus, a state with a 50 percent Medicaid match receives a 65 percent match under SCHIP.

³The FPL is updated annually to reflect changes in the cost of living and varies according to family size. For example, 200 percent of FPL for a family of four was \$42,400 in 2008.

known as crowd-out.⁴ Under the SCHIP program, states must monitor crowd-out. In certain circumstances, states must also describe their policies to minimize crowd-out in their state plan for SCHIP, which must then be reviewed and approved by the Centers for Medicare & Medicaid Services (CMS), the agency responsible for administering SCHIP.

Efforts to assess the potential for crowd-out vary in their methodological approaches, definitions of crowd-out, and estimates of the extent to which it occurs.⁵ For example, some studies measured crowd-out by including any decline in private health insurance within the population, while other studies did not count certain instances where insurance was not available to applicants—such as individuals who lost private health insurance because of job loss and took up SCHIP—in their measurement. Additionally, researchers varied in how they separated changes in private health insurance because of SCHIP from other confounding factors, such as changes in the economy. As a result, crowd-out estimates—the percentage of SCHIP enrollees who left private health insurance to enroll in SCHIP—have been as low as 0 percent and as high as 60 percent nationally.⁶

Uncertainty surrounding the extent to which crowd-out occurs has led to debates about how to ensure that children have access to health insurance while making certain that SCHIP does not crowd-out private health

⁴In general, the issue of substitution of SCHIP for private health insurance arises primarily with regard to group health plans, which are employer-sponsored plans that provide health care benefits to employees. See 42 C.F.R. § 457.10. We use the term private health insurance to denote health care benefits provided by group health plans.

⁵See, for example, J. Gruber and K. Simon, “Crowd Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” National Bureau of Economic Research Working Paper 12858, January 2007; and T. T. Alteras, *Understanding the Dynamics of “Crowd-out”*: Defining Public/Private Coverage Substitution for Policy and Research Working Paper 12858, (Washington, D.C.: Academy for Health Services Research and Health Policy, June 2001).

⁶Precise crowd-out estimates vary according to their definition and chosen parameters. For example, some studies estimate crowd-out as the change in the number of individuals with private health insurance relative to the change in those publicly insured. A crowd-out estimate of 30 percent, for instance, would mean that 30 out of 100 children enrolling in SCHIP dropped private health insurance to enroll in the program. For a summary of studies on SCHIP crowd-out, see S.S. Limpa-Amara, A. Merrill, and M. Rosenbach, *SCHIP at 10: A Synthesis of the Evidence on Substitution of SCHIP for Other Coverage*, Final Report (Cambridge, Mass.: Mathematica Policy Research, Inc., September 2007).

insurance. SCHIP was reauthorized on February 4, 2009, and concerns about crowd-out remain.⁷

To help Congress understand crowd-out, you asked us to examine CMS's and states' efforts to minimize crowd-out and how they assess whether crowd-out should be a concern.

In this report, we examine (1) CMS's guidance to states aimed at minimizing crowd-out and the agency's efforts to assess whether crowd-out should be a concern and (2) states' policies to minimize crowd-out in their SCHIP programs, including how states assess whether crowd-out should be a concern.

To determine CMS's guidance to states and the agency's efforts to assess whether crowd-out should be a concern, we reviewed relevant SCHIP legislation and CMS guidance, interviewed CMS officials, and reviewed 2007 SCHIP annual reports from all 51 states.⁸ To determine states' policies to minimize crowd-out and their efforts to assess whether crowd-out should be a concern, we reviewed state documents from all 51 states, including SCHIP annual reports, state SCHIP plans, and SCHIP applications from 2007. We sent the information from our review to SCHIP officials from all 51 states for verification.⁹ We also conducted a literature review to determine the effect of activities to minimize crowd-out. To further understand CMS's guidance, states' activities to minimize crowd-out, and assessments of whether crowd-out should be a concern, we selected a sample of 9 states (California, Georgia, Missouri, New Jersey, New Mexico, New York, North Dakota, Oklahoma, and Oregon) and interviewed SCHIP officials from those states. To select the 9 states, we considered SCHIP program structure, SCHIP eligibility level, total SCHIP program enrollment, and geographic variation. Together, the states in our sample represented approximately 40 percent of all SCHIP enrollees in 2007.

⁷See Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, Stat. . . In general, the amendments made by this Act are effective April 2009.

⁸In this report, we use the term state to refer to the 50 states and the District of Columbia.

⁹We received complete verification from 46 of 51 states; 3 states did not respond and 2 states provided incomplete responses. We contacted states by phone and sent information by e-mail about GAO's review and how to verify information. We used information identified through our review of state documents if a state did not respond or provided an incomplete response.

For our analysis, we considered an individual's access to private health insurance to consist of two main factors—availability and affordability. In this report, private insurance is said to be available to individuals if their employers offered health insurance and if these individuals and their families were eligible for this benefit.¹⁰ Affordability refers to the capacity of low-income families to purchase available private health insurance.¹¹ For purposes of this report, we did not further define levels of availability or affordability.¹²

We defined crowd-out as the substitution of SCHIP for private health insurance. Crowd-out can occur when employers drop, decrease, or decide not to offer private health insurance to employees because SCHIP is available. Crowd-out can also occur when individuals either drop private health insurance or do not enroll in private health insurance because SCHIP is available. We did not include in our definition of crowd-out the substitution of SCHIP for Medicaid. We included information as reported by states but did not conduct interviews with employers or insurers to corroborate it. We conducted this performance audit from July 2008 through February 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

CMS provided guidance to states regarding activities to minimize crowd-out in SCHIP, and the information it collected was of limited use in assessing whether crowd-out should be a concern. In issuing guidance to states, CMS instituted specific requirements for program designs that the agency identified as being at greater risk of crowd-out, including programs with higher income eligibility thresholds. For example, the agency required separate child health programs at all eligibility thresholds to monitor crowd-out, and it required states with SCHIP income eligibility

¹⁰See Social Security Act § 2102(b)(3); 42 C.F.R. §§ 457.800-.810(2008).

¹¹If available insurance is not affordable, families may decline such insurance regardless of SCHIP, and by definition, crowd-out would not occur.

¹²For example, other considerations that could apply to assessments of crowd-out include analyzing the value or type of insurance offered, for example, whether available insurance is creditable.

levels from 201 to 250 percent of the FPL to monitor crowd-out and take action if levels of crowd-out reached an agreed-upon threshold. CMS reported reviewing states' SCHIP annual reports, analyzing national trends in public and private health insurance, and commissioning studies on SCHIP, and on this basis believed crowd-out was occurring. However, each of the approaches CMS used provided limited information on the occurrence of crowd-out and thus on the extent to which it should be a concern. CMS did not collect certain indicators that could improve assessments of the potential for crowd-out in the SCHIP annual report, such as the extent to which private health insurance was available and affordable to SCHIP-eligible children. Moreover, states did not provide CMS with consistent responses in their annual reports. For example, our review of SCHIP annual reports for 2007 found that less than half of the 51 states provided a percentage in response to CMS's question on the percentage of applicants who dropped private health insurance to enroll in SCHIP.

In general, states implemented similar types of policies in their activities to minimize crowd-out, but not all states collected information adequate to assess whether crowd-out should be a concern. The majority of states implemented policies, such as waiting periods—a required period of uninsurance before an applicant can enroll in SCHIP—and premiums, with the aim of reducing incentives for individuals to drop private health insurance. All 39 states with waiting periods offered exemptions designed to account for instances where a child involuntarily lost private health insurance. These exemptions were mostly related to the availability of insurance rather than the affordability of it. Officials from our sample of 9 states generally believed that the policies they implemented were effective in minimizing crowd-out, but they provided little support for this assessment. Not all states collected information that was adequate to assess whether crowd-out should be a concern. For example, while all 51 states asked SCHIP applicants if they were currently insured, 24 states asked applicants if they had access to private health insurance through their employers, which is important to understanding the potential for crowd-out. Within our sample of 9 states, 5 states measured the occurrence of crowd-out, but they developed their estimates differently; the remaining 4 states did not measure crowd-out. None of the officials from the sample states viewed crowd-out as a concern, with most basing this assessment on a variety of indicators, including the lack of available and affordable private health insurance for the SCHIP population in their state.

To improve information on whether crowd-out should be a concern in SCHIP, we recommend that the Acting Administrator of CMS ensure that states (1) collect and report consistent information on the extent to which SCHIP applicants have private insurance available to them and (2) take appropriate steps to determine whether available private health insurance is affordable for SCHIP applicants.

Overall, CMS concurred with the report's findings, conclusions, and recommendation; however, it identified several items of concern that it addressed in written comments. CMS stated that the issue of crowd-out is complicated and that trying to measure it is difficult because of variations in definition and methodological approaches. In particular, CMS raised concerns about collecting and assessing information to determine whether health insurance was affordable for those who had access to private coverage. We agree that measuring crowd-out—particularly in terms of assessing affordability of coverage—is complicated. However, as noted in our report, some states already make such designations in their assessments of an individual's access to private health insurance.

Background

SCHIP is a federal-state program that, in general, allows states to provide health insurance to children in families with incomes of up to 200 percent of FPL, or 50 percentage points above states' Medicaid eligibility limits that were in place as of March 31, 1997.¹³ States submit plans for their use of SCHIP funds to CMS. The agency reviews and approves these plans and monitors their implementation. Within broad federal guidelines, states have considerable flexibility in designing their SCHIP programs in terms of establishing eligibility guidelines, the scope of benefits, and administrative procedures. A number of states have made use of this flexibility by expanding SCHIP eligibility to children in families with income levels as high as 350 percent of FPL.¹⁴

¹³See Pub. L. No. 105-33, §§ 4901, et. seq., 111 Stat. 251, 552, codified at 42 U.S.C. § 1397aa(a), 1397jj.

¹⁴As of July 31, 2008, 21 states reported providing SCHIP for children in families with incomes above 200 percent of FPL. The state with the highest FPL is New Jersey, which provides SCHIP for children in families earning up to 350 percent of FPL, or \$74,200 annually for a family of four.

States' choices in structuring their SCHIP programs have important programmatic and financial implications. States have three basic options for structuring their SCHIP programs: (1) a Medicaid expansion program, (2) a separate child health program, or (3) a combination program that includes both a Medicaid expansion and a separate child health program. A Medicaid expansion program allows a state to expand eligibility levels within the state's existing Medicaid program and requires the state to follow Medicaid rules, including those on eligibility determination, benefits, and cost sharing.¹⁵ States that operate Medicaid expansions continue to receive federal funds at the regular Medicaid matching rate after they have exhausted their SCHIP funds.¹⁶ In contrast, a separate child health program may depart from Medicaid rules, including introducing limited cost sharing and creating waiting lists for enrollment. A separate child health program only receives a defined SCHIP allotment from the federal government, and the state can limit its own annual contribution and or enrollment once funds for SCHIP are exhausted. Even programs with the same structure do not always operate in the same way. For example, Medicaid expansion programs can operate under a section 1115 demonstration waiver, which allows states to implement policies that do not follow traditional Medicaid rules.¹⁷ Similarly, separate child health programs can operate as "Medicaid look-alike" programs, generally following Medicaid rules but maintaining limited funding.

Federal law requires states to implement policies to minimize the potential for crowd-out. The SCHIP statute defines a "targeted low-income child" as one from a family that does not qualify for Medicaid and is not covered under a group health plan or under other health insurance.¹⁸ To help

¹⁵Federal regulations do not allow SCHIP programs operating as Medicaid expansion programs to apply eligibility-related substitution prevention provisions, because such eligibility conditions are inconsistent with the Medicaid statute. Examples include provisions related to establishing waiting periods of uninsurance for individuals who are enrolled in private health insurance.

¹⁶A Medicaid expansion creates an entitlement by requiring the states to continue providing services to eligible children even when states exceed their SCHIP allotments. At that point, states with Medicaid expansion programs continue to receive federal matching funds—but at the Medicaid matching rate rather than the enhanced match that SCHIP provides.

¹⁷Section 1115 of the Social Security Act allows waivers to many of the statutory requirements of Medicaid or SCHIP in the case of experimental, pilot, or demonstration projects that promote program objectives. For example, SCHIP programs operating under a section 1115 waiver may have eligibility-related substitution prevention provisions.

¹⁸Pub. L. No. 105-33, § 4901, 111 Stat. at 569.

minimize crowd-out, states are required to implement policies that would discourage a family from dropping other private health insurance, and states must coordinate eligibility screening with other health insurance programs, such as Medicaid.¹⁹

CMS has provided general guidance to the states regarding activities to minimize and monitor crowd-out. In 1998 and 2001, CMS outlined the types of activities states would need to implement to minimize and monitor crowd-out, and gave states flexibility in choosing specific activities. In August 2007, CMS issued additional guidance for states that wished to expand eligibility to children in families with effective income levels at or above 250 percent of FPL.

Most research efforts describe crowd-out as the movement of individuals from private to public health insurance.²⁰ However, among these research efforts there is no universally accepted method to measure the extent of crowd-out, and as a result, estimates vary widely. One reason for this variation is differences in study type. Broadly, researchers have used population-based, enrollee-based, and applicant-based studies to measure crowd-out. Population-based studies measure crowd-out by estimating any decline in private health insurance within a population. Enrollee-based studies estimate the number of SCHIP enrollees who had insurance within a specified time frame, accounting for specific losses of private health insurance because of job loss or other circumstances. Applicant-based studies use state application data to identify the number of applicants declined for having current or prior health insurance. (See table 1.) Instead of providing a measure of crowd-out, applicant-based studies estimate the amount of crowd-out averted because of a state's eligibility determination process.

¹⁹See 42 U.S.C. §§ 2105(c)(3), 2102(b)(3).

²⁰L.A. Blewett and K.T. Call, "Revisiting Crowd-Out," Robert Wood Johnson Foundation Synthesis Project, September 2007, 1; A. Sommers, et al., "Substitution of SCHIP For Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs*, vol. 26, no. 2 (2007), 529; S.S. Limpa-Amara, A. Merrill, and M. Rosenbach, *SCHIP at 10: A Synthesis of the Evidence on Substitution of SCHIP for Other Coverage*, Final Report, and M. Rosenbach, et al., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access*, Final Report (Washington, D.C.: Mathematica Policy Research, Inc., September 2007), 34.

Table 1: SCHIP Crowd-Out Estimates, by Study Type

Characteristic	Population-based studies ^a	Enrollee-based studies ^b	Applicant-based studies ^c
Area of focus	National examination of trends in public and private health insurance	Multistate or state-specific examination of SCHIP recipients	State-specific review of applicant data
Crowd-out estimate	0 to 60 percent	0.7 to 15 percent	0 to 17 percent
Description of crowd-out estimate	Compares change in private health insurance relative to change in public insurance	Estimates the percentage of children enrolled in SCHIP who had private health insurance within a specified time frame.	Estimates the percentage of families that applied for SCHIP but were declined because of existing or prior private health insurance
Sources of data	Current Population Survey, Medical Expenditure Panel Survey, and Survey of Income and Program Participation ^d	Telephone and mail surveys	State administrative data from applications

Source: GAO analysis of research, as of November 2008.

Note: GAO's analysis is similar to that conducted by Mathematica Policy Research, Inc. See S.S. Limpa-Amara, A. Merrill, and M. Rosenbach. Last accessed on December 4, 2008, at http://www.mathematica-mpr.com/publications/redirect_pubsdb.asp?strSite=pdfs/SCHIPsubstitution.pdf.

^aFor an example of this type of study, see J. Gruber and K. Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?"

^bFor an example of this type of study, see L.P. Shone, et al., "Crowd-Out in the State Children's Health Insurance Program (SCHIP): Incidence, Enrollee Characteristics and Experiences, and Potential Impact on New York's SCHIP," *Health Services Research*, vol. 43, no. 1, Part II (February 2008).

^cFor an example of this type of study, see S.S. Limpa-Amara, A. Merrill, and M. Rosenbach.

^dThe population-based studies reviewed used data from a variety of surveys that differed according to sample size, study type (for example, longitudinal versus cross-sectional), population characteristics (for example, applying different income levels), and insurance information collected.

Assessments of the potential for crowd-out must take into account an understanding of the extent to which private health insurance is available and affordable to low-income families that qualify for SCHIP. With regard to the availability of private health insurance, the extent to which private firms offer health insurance to their employees varies by state. According to the 2006 Medical Expenditure Panel Survey (MEPS), 55.8 percent of private sector firms offered insurance—either individual or family health insurance—to their employees. Across the states, the percentage of private sector firms offering individual or family health insurance to their

employees ranged from 89.6 percent of firms in Hawaii to 40.1 percent of firms in Montana.²¹ Smaller firms were less likely to offer individual or family health insurance to their employees than larger firms. For example, 35.1 percent of firms with fewer than 10 employees offered individual or family health insurance, while 98.4 percent of firms with 1,000 or more employees offered individual or family health insurance to their employees. There is some evidence suggesting that the availability of private health insurance for families is declining. For example, a recent study found that from 2003 through 2007, the percentage of low-income employees offered individual insurance through their employers did not change, but the percentage of low-income employees offered family health insurance decreased from 71.1 percent to 63.6 percent.²²

With regard to affordability, MEPS looks at the amount that individuals paid annually in order to obtain private health insurance.²³ The national average annual premium—which includes both employee and employer contributions—for a single employee was \$4,118 and for a family was \$11,381. Premiums also showed some variation by state, ranging from \$3,549 in Hawaii to \$4,663 in Maine for an individual, while premiums for family health insurance ranged from \$9,426 in Hawaii to \$12,686 in New Hampshire.

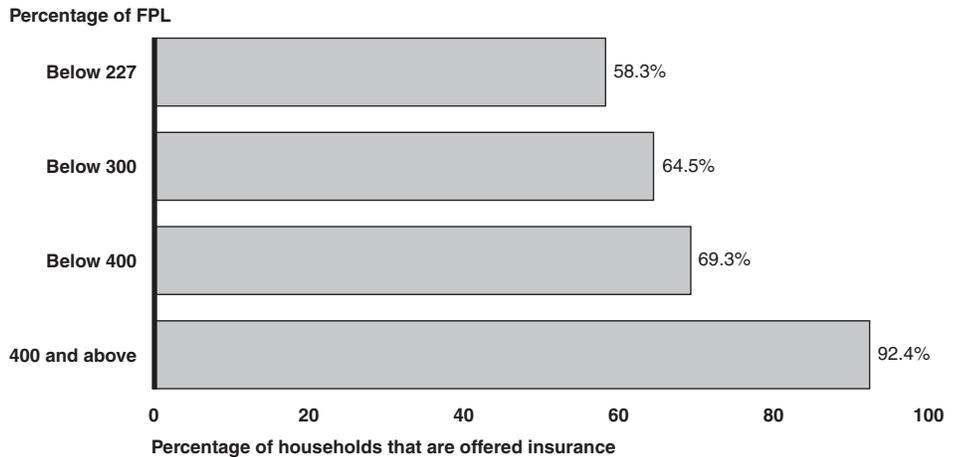
When viewed by household income level, households at higher income levels were more likely to be offered health insurance—either individual or family health insurance—through their employers. For example, employed households with incomes less than 300 percent of FPL were less likely to be offered health insurance than households earning more than 300 percent of FPL. (See fig. 1.)

²¹MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers.

²²P. Cunningham, S. Artiga, and K. Schwartz, *The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007*, (Washington, D.C.: Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, November 2008).

²³Considerations of the affordability of private insurance could also be based on the share of income one spends on health insurance, as well as on such factors as income level and cost of living.

Figure 1: Estimates of the Percentage of Employed Households That Are Offered Individual or Family Health Insurance through Their Employers, by Percentage of FPL



Source: GAO analysis of the 2006 Medical Expenditure Panel Survey.

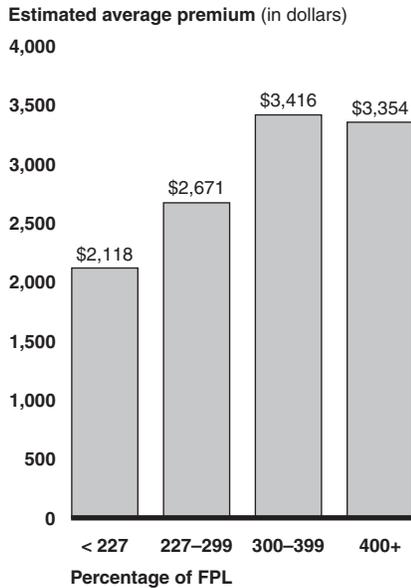
Notes: Offers of health insurance include offers of both individual and family health insurance. The standard error rate for the estimates in this figure is within +/- 3 percentage points.

The 227 percent of FPL represents the national average income level for the SCHIP population in 2006, or about \$45,400 for a household or family of four. This average was weighted by the FPL and enrollment levels of each state.

In addition to employers offering health insurance, the costs of such insurance play an important role in the extent to which individuals accept such insurance. Based on an analysis of MEPS, lower-income households paid less for insurance premiums—either individual or family health insurance—than did households with higher incomes (see fig. 2). However, the estimated premiums paid by lower-income households constituted a larger percentage of the total income for these households (see fig. 3).²⁴

²⁴The estimated premiums paid do not include other out-of-pocket costs that insured individuals could face, such as co-payments and deductibles. Additionally, the extent to which private health insurance policies were equivalent in terms of benefits, out-of-pocket costs, or other features is not known.

Figure 2: Estimated Average Annual Premiums Households Paid for Individual or Family Health Insurance, by FPL

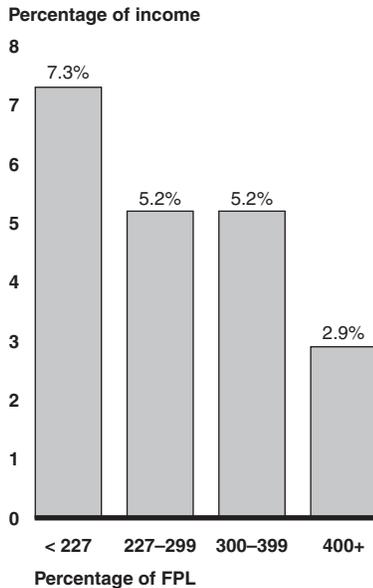


Source: GAO analysis of the 2006 Medical Expenditure Panel Survey.

Notes: The estimated average annual premiums paid do not include other out-of-pocket costs that insured individuals could face, such as co-payments and deductibles. These percentage of income estimates include spending for both individual and family health insurance premiums. The standard error rate for the estimates in this figure is within +/- \$608.

The 227 percent of FPL represents the national average income level for the SCHIP population in 2006, or about \$45,400 for a household or family of four. This average was weighted by the FPL and enrollment levels of each state.

Figure 3: Estimated Percentage of Household Income Spent on Individual or Family Health Insurance, by FPL



Source: GAO analysis of the 2006 Medical Expenditure Panel Survey.

Notes: The estimated average annual premiums paid do not include other out-of-pocket costs that insured individuals could face, such as co-payments and deductibles. These percentage of income estimates include spending for both individual and family health insurance premiums. The standard error rate for the estimates in this figure is within +/- 1.1 percentage points.

The 227 percent of FPL represents the national average income level for the SCHIP population in 2006, or about \$45,400 for a household or family of four. This average was weighted by the FPL and enrollment levels of each state.

CMS Provided Guidance to States on Crowd-Out; Information It Collected Was of Limited Use in Assessing the Extent to Which Crowd-Out Should Be a Concern

CMS provided guidance to states regarding activities to minimize crowd-out in SCHIP, and the information it collected was of limited use in assessing the extent to which crowd-out should be a concern. In issuing guidance to states, CMS instituted specific requirements for program designs the agency identified as being at greater risk of crowd-out, including programs with higher income eligibility thresholds. CMS officials told us that they reviewed states' SCHIP annual reports, analyzed national trends in public and private health insurance, and commissioned studies on SCHIP, and on this basis believed crowd-out was occurring. However, each of the approaches CMS used was limited in providing information on the occurrence of crowd-out and the extent to which it should be a concern. In particular, CMS did not collect certain indicators in the SCHIP annual report—such as whether applicants' employers made private

health insurance for families available and at what cost to the applicant—that could help show the potential for crowd-out. Moreover, information CMS did collect was not provided consistently by states.

CMS Established Specific Requirements for Certain SCHIP Program Designs

CMS established specific requirements for SCHIP program designs it identified as being at a greater risk for crowd-out. In issuing the SCHIP final rule, CMS outlined broad regulatory requirements regarding substitution of private health insurance with SCHIP and stated that it planned to incorporate additional flexibility into its review of state plans in this area.²⁵ CMS could not apply eligibility-related crowd-out prevention requirements to Medicaid expansion programs except those operating under an 1115 demonstration waiver.²⁶ CMS did outline specific requirements for separate child health programs with higher income eligibility levels, explaining that there is a greater likelihood of crowd-out as incomes increase. For example, the agency required separate child health programs at all eligibility thresholds to monitor crowd-out, and it required states with SCHIP eligibility thresholds from 201 to 250 percent of FPL to implement policies to minimize crowd-out should an “unacceptable level” of crowd-out be detected. CMS officials told us that they did not define an “unacceptable level” for all states, but rather negotiated with states individually. CMS viewed waiting periods as a policy to minimize crowd-out; therefore, states with waiting periods were not required to monitor for an “unacceptable level” of crowd-out, and only three states currently do so.²⁷ CMS also required that states institute a number of requirements for premium assistance programs, including a waiting

²⁵See 66 Fed. Reg. 2601-04. For example, CMS officials told us that they decided against requiring all states to implement a waiting period, recognizing that specific circumstances could affect which activities related to minimizing crowd-out were most appropriate for a given state. Instead, CMS suggested waiting periods as an example of an activity states could use to minimize crowd-out and invited states to propose other options.

²⁶Federal law does not allow SCHIP programs operating as Medicaid expansion programs to apply eligibility-related substitution prevention provisions, because such eligibility conditions are inconsistent with the Medicaid statute. See 66 Fed. Reg. 2605. However, section 1115 of the Social Security Act allows waivers of certain statutory requirements of Medicaid or SCHIP for demonstration projects that promote program objectives, including allowing crowd-out provisions where appropriate.

²⁷Two of these three states will implement a waiting period if they reach “unacceptable levels” of 8 percent and 15 percent, respectively, while the third state plans to extend the length of its waiting period should an unacceptable level be attained. CMS officials said that none of these states has reached its specified threshold.

period.²⁸ (Table 2 provides examples of program designs for which CMS provided specific guidance.)

Table 2: Examples of Program Designs for Which CMS Provided Specific Guidance to States

SCHIP design	Examples of CMS guidance
Medicaid expansion programs	<ul style="list-style-type: none"> Medicaid expansion programs operating under 1115 demonstration waivers were subject to CMS review.^a
Separate child health programs	<ul style="list-style-type: none"> Required separate child health programs at all eligibility thresholds to monitor crowd-out. Required states with SCHIP eligibility thresholds from 201 percent to 250 percent of FPL to implement policies to minimize crowd-out should an “unacceptable level” of crowd-out be detected.^b Required programs above 250 percent of FPL to have policies in place to minimize crowd-out regardless of what any monitoring efforts showed. Required states with premium assistance programs that subsidized private health insurance offered by employers to implement waiting periods of at least 6 months but no more than 12 months.^c

Source: GAO analysis of CMS guidance as of December 2008.

^aCMS did not apply crowd-out requirements to all Medicaid expansion programs.

^bCMS did not define an “unacceptable level” for all states, but rather negotiated with states individually.

^cPremium assistance programs use Medicaid funds, SCHIP funds, or both to subsidize the purchase of private health insurance.

In a letter issued on August 17, 2007, CMS provided specific guidance on crowd-out for states operating separate child health programs above 250 percent of FPL, but implementation of the requirements in this guidance has been suspended.²⁹ In this letter, CMS outlined specific activities states with separate child health programs should use to minimize crowd-out if they wish to cover children with effective family incomes above 250 percent of FPL. Among other things, these activities

²⁸Premium assistance programs use Medicaid funds, SCHIP funds, or both to subsidize the purchase of private health insurance. CMS’s stated concern for instituting special provisions for these programs was that families currently enrolled in private insurance may be more likely to seek public funding if they could use it to pay for the cost of that insurance.

²⁹CMS also indicated that this guidance would apply to Medicaid expansion programs operating under 1115 demonstration waivers.

included a 12-month waiting period,³⁰ a cost-sharing requirement,³¹ and efforts to prevent employers from changing health insurance offerings that would encourage a shift to public programs such as SCHIP. The letter caused states to raise a number of concerns, including those about the potential effect on current enrollees,³² and we have reported concerns regarding the issuance of this guidance.³³ In a memorandum dated February 4, 2009, for the Secretary of Health and Human Services, the President directed that the August 17 letter be withdrawn immediately.³⁴

Approaches CMS Used Did Not Address All Information Important to Assessing the Extent to Which Crowd-Out Should Be a Concern

CMS reported using a variety of approaches to assess the occurrence of crowd-out in SCHIP, including reviewing states' SCHIP annual reports, national estimates, and CMS-commissioned studies. From this information, CMS officials said they believed that crowd-out was occurring and that the potential for crowd-out was greater at higher income levels. However, the approaches CMS used provided limited information on the occurrence of crowd-out and thus the extent to which it should be a concern.

³⁰In a clarifying letter on May 7, 2008, CMS noted that while a 12-month waiting period was the standard against which all states would be evaluated, it would consider alternative proposals from states and the justifications for them.

³¹The letter said that states were expected to impose cost sharing that could not be below the cost sharing required by competing private health insurance plans by more than 1 percent of a family's income unless such cost sharing would exceed 5 percent of a family's income, which is the maximum allowed in the SCHIP statute.

³²In its May 7, 2008 letter, CMS stated that any changes made in response to the August 17, 2007, letter need not be applied to those enrolled in the program prior to the effective date of the letter, as long as they remain continuously enrolled in the program. However, because of issues of retention in the SCHIP program, concerns remain that prior enrollees who leave the SCHIP program will be subject to the August 17 requirements if they try to reenroll.

³³In particular, in response to a request from Senators Rockefeller and Snowe for an opinion on whether the agency complied with the Congressional Review Act in issuing the August 17, 2007 letter, we determined that CMS should have submitted this letter to Congress and the Comptroller General, as required by the Congressional Review Act, Pub. L. No. 104-121 § 251, 110 Stat. 847, 868-74, *codified at* 5 U.S.C. §§801 – 808, before the letter could take effect. See GAO, *Applicability of the Congressional Review Act to Letter on State Children's Health Insurance Program*, B-316048 (Washington, D.C.: Apr. 17, 2008).

³⁴See 74 Fed. Reg. 6347 (Feb. 6, 2009).

The questions on crowd-out that CMS asked states to answer for their annual reports did not collect certain indicators of the potential for crowd-out, such as the extent to which SCHIP applicants were offered private health insurance for their families through their employers. In the annual reports that states must submit, CMS requires states to report the “incidence of substitution” in their state by calculating the percentage of applicants who drop private health insurance to enroll in SCHIP; however, CMS did not specify how states should calculate this incidence.³⁵ While this question measures the number of SCHIP applicants who were enrolled in private health insurance and decided to take up SCHIP, it does not include SCHIP applicants who had private health insurance available through their employers but never enrolled. It also does not provide information on changes in insurance status, such as the extent to which SCHIP recipients gain access to private health insurance but remain enrolled in SCHIP. In addition, CMS does not specifically require states to provide information in their annual reports on the affordability of private health insurance available to SCHIP applicants.³⁶

CMS has recently updated the requirements for the information that states must provide on crowd-out in their 2008 annual reports. For example, states will be expected to include more information on SCHIP applicants’ insurance status. Whereas states have previously been required to report only the percentage of applicants who have other insurance, CMS plans to require states to provide the percentage of applicants who have Medicaid and the percentage of applicants who have other insurance.³⁷ In addition, CMS plans to require that states with waiting periods report on the percentage of applicants who meet exemptions to the waiting period. While these questions are useful from an eligibility standpoint, they still do

³⁵CMS has recently updated the annual report that states must complete for 2008 to include the specific calculation states should make to arrive at this percentage: $((\# \text{ applicants who drop coverage} / \text{total } \# \text{ applicants}) * 100)$. However, it remains unclear how states should count the number of applicants who drop coverage—whether states should include all applicants who dropped private insurance coverage regardless of whether they were granted SCHIP eligibility, or if they should count only those applicants who dropped private insurance and then became eligible for SCHIP after having served a waiting period, having obtained an exemption, or being otherwise deemed eligible for SCHIP.

³⁶CMS officials did note that they ask open-ended questions in the annual report that could lead to information on the affordability of private health insurance. For example, they told us that the annual report asks states to explain factors that may account for increases or decreases in the number of uninsured children in the state.

³⁷CMS does allow states to provide a combined percentage if they are unable calculate separate percentages.

not account for applicants who were offered private health insurance for their families through their employers but did not take it up.³⁸ These questions also do not address the extent to which available private health insurance is affordable to the SCHIP population.

CMS's information on the occurrence of crowd-out is also limited because states did not consistently provide the information that CMS requested in their annual reports (see table 3). We reviewed SCHIP annual reports from 2007 for state responses on the percentage of applicants who dropped private health insurance to enroll in SCHIP and found that less than half of the 51 states provided a percentage in response to CMS's question.³⁹ Of those states providing a percentage, 7 states answered the question directly, with 1 reporting no crowd-out and the remaining 6 reporting an incidence of crowd-out of 1 percent or less.⁴⁰ Two of the states reporting an incidence of less than 1 percent also reported this number for the percentage of applicants who had insurance at the time of application. Forty-one states provided a response related to what they knew about the insurance status of applicants,⁴¹ provided descriptive responses, or reported that data were not available. Three states did not answer this question in their annual reports.

CMS officials told us that in cases where states had missing or incomplete responses to questions in the annual report, the agency allowed states to

³⁸CMS guidance and regulations do not address explicitly whether it has authority to consider this population as an element of crowd-out.

³⁹In 2007, 14 of the 51 states had Medicaid expansion programs, which are only subject to crowd-out requirements if the state requests this authority under an 1115 demonstration waiver. As a result, states with Medicaid expansion programs may not have collected the same data as states subject to crowd-out requirements.

⁴⁰Of these seven states, just three states gave an indication of how they arrived at this percentage, with one state noting that it used data from a 2005 survey to answer the question.

⁴¹In particular, eight states provided the percentage of applicants denied SCHIP for having health insurance, while six states just reported the percentage of applicants who were currently enrolled in health insurance. This distinction is important because the percentage denied SCHIP likely excludes those who had other insurance but were allowed to enroll in SCHIP because of state-allowed exemptions, such as job loss.

address these questions in the next year's report.⁴² CMS officials also noted that states used different data sources when analyzing crowd-out. For example, they said that some states used surveys to measure crowd-out, while others relied on data collected through application questions.

Table 3: States' Responses to Annual Report Question on the Incidence of Crowd-Out

Response to question asking for the percentage of applicants who drop private health insurance to enroll in SCHIP	Number of states
Answered question directly	7
Provided the percentage denied for having health insurance within a certain number of months before applying	8
Provided the percentage who had health insurance within a certain number of months before applying	6
Provided a descriptive response	8
Responded that data were not available	19
No response	3

Source: GAO analysis of 51 states' annual reports for 2007.

In addition to reviewing state annual reports, CMS officials told us that they used national data to assess the occurrence of crowd-out. Specifically, they said that they used the Current Population Survey and CMS enrollment data to track changes in public and private health insurance over time. While this type of analysis can account for broad trends in changes in insurance usage, it cannot account for the reasons for these changes. For example, it cannot isolate whether an increase in public insurance resulted from crowd-out or an unrelated decline in the availability of private health insurance.

CMS officials told us that they commissioned two studies to look at the issue of crowd-out in SCHIP. However, the results of these studies did not provide a clear sense of whether crowd-out should be a concern. A 2003 study provided information on states' early experiences with SCHIP based

⁴²CMS officials explained that resubmitting a response requires a lot of administrative work on the part of states. Instead, CMS will talk with states about why an answer is incomplete, offer assistance in collecting data, and ask states to include a complete answer in the annual report for the following year. CMS officials told us that they are in the process of developing a follow-up letter to send to states within 60 days of submitting their 2008 annual reports. This letter is intended to provide feedback and technical assistance to states and will target specific areas of the annual reports, including the section on crowd-out.

on state annual reports from 2000.⁴³ The study reported that states' estimates of crowd-out in SCHIP ranged from 0 to 20 percent, but cautioned that state data must be interpreted carefully because of a number of factors, including the limited experience upon which states based their estimates. A 2007 study assessed the SCHIP program,⁴⁴ and included a background paper on crowd-out.⁴⁵ The background paper synthesized evidence on the occurrence of crowd-out in SCHIP and concluded that while the evidence suggested that crowd-out occurred, the magnitude of the occurrence ranged widely—from 0.7 to 56 percent—depending on how crowd-out was defined and measured. The study commented on the strengths and weaknesses of various ways to define and measure crowd-out, but it did not indicate a preference for any specific methodology.

States Used Similar Types of Policies to Minimize Crowd-Out, but Not All Collected Adequate Information to Assess whether Crowd-Out Should Be a Concern

In general, states implemented similar types of policies in their activities to minimize crowd-out, but not all states collected information adequate to assess whether crowd-out should be a concern. States' policies largely sought to deter individuals from dropping private health insurance. Officials we interviewed in the nine sample states generally believed that their policies were effective in minimizing crowd-out. However, little evidence existed to confirm this belief. Less than half of states investigate whether applicants had access to private health insurance, which is key to understanding the extent to which crowd-out should be a concern.

⁴³M. Rosenbach, et al., *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* (Cambridge, Mass.: Mathematica Policy Research, Inc., March 2003).

⁴⁴M. Rosenbach, et al., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (Cambridge, Mass.: Mathematica Policy Research, Inc., September 2007).

⁴⁵S.S. Limpa-Amara, A. Merrill, and M. Rosenbach, *SCHIP at 10: A Synthesis of the Evidence on Substitution of SCHIP for Other Coverage*.

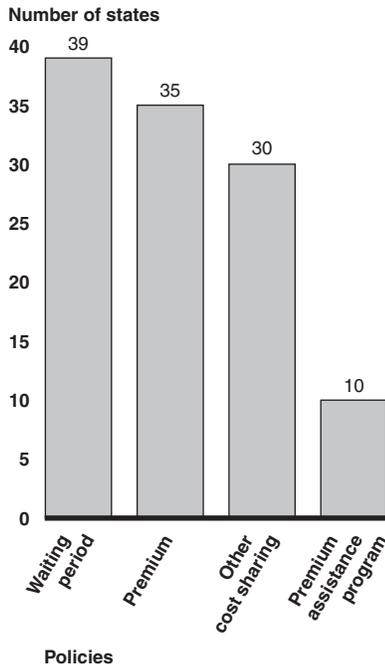
States Used Similar Types of Policies to Minimize Crowd-Out, but Little Is Known about Their Effect

Forty-seven states used one or more policies to minimize crowd-out. These policies deter individuals from dropping private health insurance in order to take up SCHIP. Our analysis found that waiting periods—required periods of uninsurance before applicants can enroll in SCHIP—were the most common policy states had in place to minimize crowd-out; premiums and other types of cost sharing were also frequently used (see fig. 4).⁴⁶ As expected, these policies were more common in separate child health and combination programs than in Medicaid expansion programs operating with 1115 demonstration waivers.⁴⁷ A waiting period is meant to discourage individuals from dropping private health insurance. Premiums and other types of cost sharing are used in SCHIP to narrow the cost difference between SCHIP and private health insurance, thereby reducing the likelihood that lower out-of-pocket costs for SCHIP will attract individuals who already have other health insurance. Ten states reported having premium assistance programs, where states used SCHIP funds to pay premiums for private health insurance sponsored by employers. In contrast to CMS's view that premium assistance programs could raise concerns about crowd-out, 5 states reported that such programs were a policy to prevent crowd-out. One state reported instituting a policy directly aimed at affecting employer behavior. This state made it an unfair labor practice for insurance companies or employers to encourage families to enroll in SCHIP, for example, through changing benefit offerings, when the families already have private health insurance.

⁴⁶Premiums are payments required of enrollees for health insurance for a given period of time. Other types of cost sharing include coinsurance and deductibles.

⁴⁷While combination programs include both a Medicaid expansion and a separate child health component, our analysis of these programs showed a similar trend. Waiting periods, premiums, and other cost sharing were more prevalent in the separate child health component than in the Medicaid expansion component. In general, Medicaid expansions are expected to follow Medicaid rules and thus generally do not impose waiting periods and are limited in the amount of premiums and cost sharing that they impose.

Figure 4: States' Policies to Minimize Crowd-Out



Source: GAO analysis of state information as of July 31, 2008.

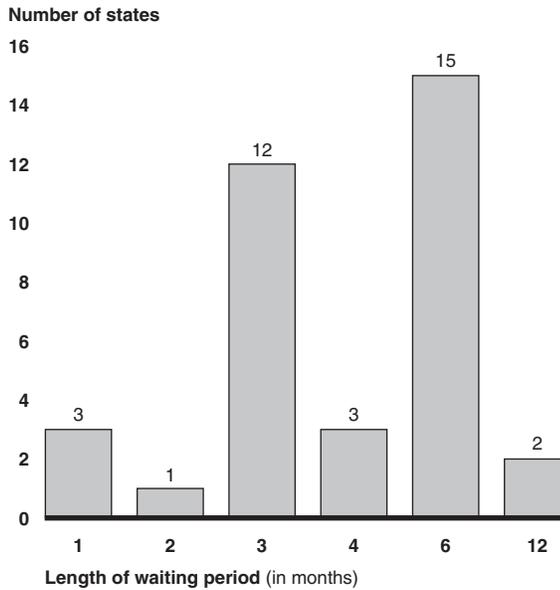
Notes: The total number of states with policies to minimize crowd-out is 51; some states used more than one policy. Other cost sharing includes co-payments or deductibles, though only 3 states had deductibles.

Four states did not respond to our request to verify information; therefore, we used information from states' 2007 annual reports.

Thirty-nine states had waiting periods, and they varied in length. The most common waiting period length was 3 or 6 months (see fig. 5). At least 2 of the 39 states reduced their waiting periods after concluding that crowd-out was not a significant problem and that the original waiting period length was unnecessarily long.⁴⁸

⁴⁸These two states were New Jersey, which lowered its waiting period from 12 months to 3 months, and California, which lowered its waiting period from 6 months to 3 months.

Figure 5: States' Waiting Period Lengths



Source: GAO analysis of state information as of July 31, 2008.

Notes: This figure shows the waiting periods imposed by 36 states. While the total number of states with waiting periods is 39, 3 states used more than one waiting period. These 3 states implemented multiple waiting periods to be applied in specific situations. For example, one state applied different waiting periods to different levels of applicant income. The length of these multiple waiting periods ranged from 3 to 12 months and are not included in this figure.

Four states did not respond to our request to verify information; therefore, we used information from states' 2007 annual reports.

All 39 states with a waiting period included exemptions designed to account for instances where a child involuntarily lost private health insurance. These exemptions were mostly related to the availability rather than the affordability of insurance (see table 4). Exemptions varied among states, but the most common exemptions were for a change in job status that led to a loss of private health insurance, a change in family structure, and exhaustion of health insurance provided through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).⁴⁹ CMS does not require states to consider issues of affordability in developing exemptions,

⁴⁹COBRA, in general, requires employers that offer group health plans and have 20 or more employees to make health insurance available for a limited period of time for employees and their dependents who have lost health insurance because of certain events, including the loss of employment or the loss of eligibility as a dependent on a parent's plan.

and just over 10 states provided an exemption specifically for economic hardship, that is, if private health insurance makes up too much of a family's income.

Table 4: States' Exemptions to Waiting Periods and the Conditions They Addressed

Condition	Exemptions	Number of states
Availability of insurance	Change in job status (loss of job or reduction of hours resulting in loss of benefits)	29
	Loss of COBRA	20
	Termination/reduction in group health insurance	26
	Special health care needs or termination of health insurance for a disability	9
	Exhaustion of prior benefits	7
	Address change that is not covered by private health insurance sponsored by an employer	9
Affordability of insurance	Economic hardship (income threshold specified)	11
Availability and affordability of insurance	Change in family circumstance (e.g., death or divorce)	20
	Self-employed/individual health insurance	7

Source: GAO analysis of state information as of July 31, 2008.

Note: All 39 states that had waiting periods had exemptions to them. Additionally, states can have more than one exemption.

SCHIP officials in the nine sample states generally believed that their policies to minimize crowd-out were effective but did not cite any specific data to support their assessment. Officials from these nine states generally reported that waiting periods, outreach efforts to inform applicants about program requirements, and premiums and other cost-sharing mechanisms were successful policies to minimize crowd-out. Officials in four of the states also noted that these policies may have unintended consequences, such as limiting families' access to insurance.

Among the nine states in our sample, seven states reported no immediate plans to change their policies to minimize crowd-out, while two states were considering reducing the requirements in place regarding waiting periods. Officials from one of the two states said that they are considering reducing the state's waiting period. Officials from the other state wanted to add an economic hardship exemption to the state's waiting period.

Our analysis of previous research found few studies that estimated the effect of different policies on minimizing crowd-out, but those that did primarily focused on waiting periods and cost sharing.⁵⁰ These studies concluded that waiting periods and cost sharing can have negative effects on individuals' participation in SCHIP.⁵¹ These studies also suggested that policies to minimize crowd-out may deter SCHIP enrollment by eligible uninsured children at a faster rate than they deter use by individuals who have private health insurance.⁵² However, little is known about how variation in policies, such as the length of a state's waiting period, affects efforts to minimize crowd-out.

⁵⁰An analysis of 23 articles found 5 studies that estimated the effectiveness of waiting periods—C. Bansak and S. Raphael, “The Effects of State Policy Design Features on Take-Up and Crowd-Out Rates for the State Children’s Health Insurance Program,” *Journal of Policy Analysis and Management*, vol. 26, no. 1 (2006); K. Kronebusch and B. Elbel, “Simplifying Children’s Medicaid and SCHIP,” *Health Affairs*, vol. 23, no. 3 (2004); J. Gruber and K. Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” A.T. Lo Sasso and T.C. Buchmueller, “The Effect of the State Children’s Health Insurance Program on Health Insurance Coverage,” *Journal of Health Economics*, vol. 23 (2004); and B. Wolfe and S. Scrivner, “The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up,” *Journal of Policy Analysis and Management*, vol. 24, no. 3 (2005)—and three articles—J. Gruber and K. Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?”; J. Hadley, et al., “Insurance Premiums and Insurance Coverage of Near-Poor Children,” *Inquiry*, vol. 43, no. 4 (Winter 2006/2007); B. Wolfe and S. Scrivner, “The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up”—that estimated the effectiveness of cost sharing.

⁵¹Four of the five studies that estimated the effectiveness of waiting periods and the three studies that estimated the effectiveness of cost sharing reported that these policies have a negative and significant impact on SCHIP enrollment. See B. Wolfe and S. Scrivner, “The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up”; A.T. Lo Sasso and T.C. Buchmueller, “The Effect of the State Children’s Health Insurance Program on Health Insurance Coverage”; J. Gruber and K. Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?”; J. Hadley, et al., “Insurance Premiums and Insurance Coverage of Near-Poor Children”; C. Bansak and S. Raphael, “The Effects of State Policy Design Features on Take-Up and Crowd-Out Rates for the State Children’s Health Insurance Program”; and Kronebusch and B. Elbel, “Simplifying Children’s Medicaid and SCHIP.”

⁵²See L.A. Blewett and K.T. Call, “Revisiting Crowd-Out”; A.T. Lo Sasso and T.C. Buchmueller, “The Effect of the State Children’s Health Insurance Program on Health Insurance Coverage”; B. Wolfe and S. Scrivner, “The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up”; and J. Hadley, et al., “Insurance Premiums and Insurance Coverage of Near-Poor Children.”

Not All States Collected Information Adequate to Assess Whether Crowd-Out Should Be a Concern

All 51 states monitored crowd-out by asking applicants questions about whether they had private health insurance, but fewer states asked whether applicants were offered health insurance through their employers—a key piece of information in understanding whether crowd-out should be a concern.

All 51 states asked applicants if they were currently insured, and 44 of the 51 states asked applicants whether they had been insured in the past. Twenty-four states asked applicants about their access to private insurance. Of these 24 states, 15 states asked applicants if they had access to any private health insurance and 9 states asked applicants if they had access to specific types of private health insurance (such as through state or school employment). The remaining 27 states did not ask questions to determine whether applicants had access to private health insurance through their employers.

The majority of states made efforts to verify applicants' responses to their questions about insurance. Twenty-five states used a database to verify applicants' enrollment in private health insurance, 14 states verified applicants' responses with employers, and 7 states used both. States conducted verification of insurance most frequently at the time of application, although about half of the states verified insurance status at eligibility renewal or at other regular intervals. (See table 5.)

Table 5: States' Efforts to Verify Insurance Status

Effort	At any point in time	At application	At eligibility renewal	At regular intervals
Employer verification only	9	7	8	3
Database verification only	20	18	13	17
Both employer and database verification	9	7	5	5
No verification	13	19	25	26

Source: GAO analysis of state information as of July 31, 2008.

Note: States were considered to verify insurance status at any point in time if they verified insurance status at application, eligibility renewal, or other regular intervals. States may have verified insurance status at more than one point in time.

Twenty-nine states used databases at some point to verify individuals' enrollment in private health insurance; however, there were differences in the databases used. The database sources states used included (1) databases from private insurance companies, (2) databases run by third-party administrators, and (3) databases that were maintained by the

states.⁵³ The databases also varied in the scope of insurance information they provided. For example, some databases included information on the majority of the population with private health insurance in a state, while other databases were more limited, such as those for state employees.⁵⁴ While all of the databases verify insurance status, they do not determine whether individuals have private health insurance available through their employers but did not make use of it for their families.

Another way states often verified insurance status was by checking with individuals' employers—which could allow a state to determine whether the individuals had private insurance available to them. We identified 18 states that used various approaches to verify insurance status with employers at some point. Generally, the states asked whether (1) the individual was insured, (2) the individual had access to employer insurance, and (3) the individual paid out-of-pocket expenses for private health insurance.⁵⁵ Other differences included the number of individuals states verified insurance status for and how employer information was collected. For example, at least 2 states only verified insurance status with employers if they found evidence that an individual might have private health insurance available through an employer, such as a pay stub showing that wages were deducted for health insurance premiums. Another state reported that it verified the availability of private health insurance through (1) an annual survey sent to all employers in the state and (2) an individual questionnaire sent to the employers of specific applicants and enrollees.

The nine states whose officials we interviewed varied in the extent to which they measured crowd-out, with five states providing some estimate of crowd-out and four states reporting that they could not estimate it at all. The five states that did measure crowd-out developed their estimates

⁵³Some states have contracted with a third-party administrator, an outside organization, to perform the administrative task of identifying SCHIP applicants and enrollees with private health insurance. For example, a number of states reported contracting with an organization, Health Management Systems, that compares SCHIP applicant and enrollee information to private health insurance plan enrollment files to help identify individuals.

⁵⁴One official from our sample of nine states indicated that third-party databases were not always up to date. For example, this official noted that while the third-party administrator may update its database quarterly, participating insurance companies may only provide updated information annually.

⁵⁵Over half of the 18 states asked whether the individual was insured; states asked the remaining two questions less frequently.

differently. Officials from one of the five states based their estimate on the number of applicants who did not meet the eligibility criteria for SCHIP because they were enrolled in other insurance. However, this estimate measures how successful the state was in avoiding the inappropriate use of SCHIP rather than crowd-out. Officials from the remaining four states based their estimates on the number of individuals who dropped insurance for reasons that—by their states' definitions—constituted crowd-out. For example, one state included in its estimate of crowd-out circumstances in which families had private health insurance available but dropped it because it was unaffordable, while another state explicitly excluded this reason from its estimate.

None of the officials in our sample of nine states viewed crowd-out as a concern, with most basing this assessment on a variety of indicators, including the availability and affordability of private health insurance for the SCHIP population in their state. Six states told us that private health insurance was not readily available and three other states believed that where insurance was available it was not affordable. Another state referred to the small number of SCHIP enrollees at its highest eligibility level—from 250 to 300 percent of FPL—as indicating a low potential for crowd-out.

Conclusions

Understanding the potential for crowd-out is a complex task that begins with understanding the extent to which private health insurance is available to children in families whose incomes make them eligible for SCHIP. SCHIP is designed to offer health insurance to eligible children who would otherwise be uninsured, not to replace private health insurance. For crowd-out to occur, private health insurance must be available to low-income families who qualify for SCHIP, and these families must find such insurance affordable. CMS and the states differ in their views on whether crowd-out is a concern for SCHIP, yet the information on which both base their views is limited in providing a basis for assessing the occurrence of crowd-out.

CMS's guidance to and reporting requirements for states provide limited information on the extent to which crowd-out should be a concern. While precise measurements of crowd-out are difficult, certain indicators could help improve assessments of the extent to which crowd-out should—or should not—be a concern. In particular, asking SCHIP applicants who work whether they are offered private health insurance for their families through their employers could provide an initial assessment of the extent to which private health insurance is available to these individuals and thus

better assess whether concerns about crowd-out are warranted. For low-income working families, the affordability of available private health insurance is also important in determining whether crowd-out should be considered a concern. However, CMS does not currently have this information, as states are not required to collect and report it. Information about the availability and affordability of private health insurance could help ensure the best use of SCHIP funds and help determine the future funding needs of this important program.

Recommendation for Executive Action

To improve information on whether crowd-out should be a concern in SCHIP, we recommend that the Acting Administrator of CMS refine CMS policies and guidance to better collect consistent information on the extent to which applicants have access to available and affordable private health insurance for their children eligible for SCHIP. Such actions should include ensuring that states

- collect and report consistent information on the extent to which SCHIP applicants have private insurance available to them and
- take appropriate steps to determine whether available private health insurance is affordable for SCHIP applicants.

Agency Comments and Our Evaluation

CMS reviewed a draft of this report and provided written comments, which are reprinted in appendix I. In addition to comments on our recommendation, CMS provided us with technical comments that we incorporated where appropriate.

Overall, CMS concurred with the report's findings, conclusions, and recommendation. CMS commented that the issue of crowd-out is complicated and that assessing or measuring it is difficult because of variations in definition and methodologies for assessing its occurrence. CMS agreed that the availability and affordability of health insurance are relevant issues in reviewing crowd-out. They also agreed with our recommendation, stating that information on the availability and affordability of health insurance from states would be extremely helpful in evaluating the potential for crowd-out.

CMS also listed a number of concerns in response to our recommendation about the collection and submission of additional information related to the availability and affordability of private health insurance. CMS stated that the reliability of any information states collect from applicants about

the availability or affordability of private coverage would be suspect if it were self-reported. However, our work found that much of the information currently collected by states and submitted to CMS on applicants' insurance status, which is used for eligibility determinations, is also self-reported by applicants. Moreover, our work shows that the majority of states take steps to verify this self-reported information. Thus, the use of self-reported data is not unusual and collecting such data could help CMS make an initial assessment of the extent to which private health insurance is available and affordable. With these data, CMS could better assess whether concerns about crowd-out are warranted.

CMS also noted that there is currently no national definition of affordability and that it does not believe it would be appropriate for the agency to develop one because of the diversity of states' economies and health insurance markets, as well as the flexibility that is a key tenet of SCHIP. Further, CMS commented that its existing definition of a targeted low-income child does not specify that children only receive SCHIP if private health insurance is not affordable. We agree that CMS should not be responsible for devising a national standard of what is considered affordable within a state. We believe that states are in the best position to make such a determination, and as noted in our report, some states already make such designations in their assessments of an individual's access to private health insurance.

Finally, CMS commented that because of the administrative and reporting burdens that would be associated with additional data reporting, the agency would need to provide states with opportunities to discuss the changes needed to collect and report this information. We agree that such steps may be necessary. We also note that CMS recently updated questions in its SCHIP annual report template to help ensure that states are collecting and reporting necessary information related to crowd-out. Thus, the administrative efforts associated with additional information collection and reporting are well within the scope of CMS's responsibility.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Acting Administrator of the Centers for Medicare & Medicaid Services, committees, and others. This report also will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink, appearing to read "James C. Cosgrove". The signature is stylized with large, flowing loops and a prominent initial "J".

James C. Cosgrove
Director, Health Care

Appendix I: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JAN 29 2009

James C. Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "STATE CHILDREN'S HEALTH INSURANCE PROGRAM: CMS Should Improve Efforts to Assess Whether SCHIP Is Substituting for Private Insurance (GAO-09-252).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Pisaro Clark".

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

Appendix I: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 29 2009

TO: James Cosgrove
Director, Health Care
Government Accountability Office

FROM: *Charlene Frizzera*
Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: State Children's Health Insurance Program (SCHIP): CMS Should Improve Efforts to Assess Whether SCHIP Is Substituting for Private Insurance (GAO-09-252)

Thank you for the opportunity to review the GAO draft report entitled, "State Children's Health Insurance Program (SCHIP): CMS Should Improve Efforts to Assess Whether SCHIP Is Substituting for Private Insurance" (GAO-09-252).

The GAO was asked to examine the Centers for Medicare and Medicaid Services' (CMS) and States' efforts to minimize crowd-out and determine whether it should be a concern. GAO examined: 1) CMS' guidance to States for minimizing crowd-out and assessment of whether it should be a concern; and 2) States' policies to minimize crowd-out and how they assess whether it should be a concern. GAO reviewed Federal laws and guidance, examined State annual reports, and interviewed CMS officials. GAO also interviewed SCHIP State officials from a select sample of nine States (California, Georgia, Missouri, North Dakota, New Jersey, New Mexico, New York, Oklahoma, and Oregon).

GAO Recommendations

To improve information on whether crowd-out should be a concern in SCHIP, GAO recommends that the Acting Administrator of CMS ensure that States: 1) collect and report consistent information on the extent to which SCHIP applicants have private insurance available to them; and 2) take appropriate steps to determine whether available private insurance is affordable for SCHIP applicants.

CMS Response

We concur with comment on these recommendations. The issue of crowd-out is complicated and trying to assess or measure it is difficult because of variations in both its definition as well as in the methodologies for assessing its occurrence. We agree that

Page 2 - James Cosgrove

individual decisions to forego enrollment when private coverage is available, as well as the affordability of coverage, are relevant issues in the overall review of whether public coverage is substituting for private, and having States provide this information, as recommended by the GAO, would be extremely helpful in evaluating the potential for substitution of coverage.

However, there are limitations in the conclusions that could be drawn since reliable data collection methods have not been developed to determine whether families had access to private coverage that they have declined, either before enrolling their children in SCHIP or while the child is enrolled. It would also be difficult to ascertain and make conclusions in each instance, when someone had access to private coverage and declined it, and whether that would be attributable to crowd-out.

We have concerns with requiring the additional collection and submission of information related to access and affordability. While States may ask applicants if they have access to private coverage, or if that coverage is affordable, the reliability of this data would be suspect if it were self-reported. The only way to ensure that it is reliable would be to contact the applicant's employer. Additionally, there is no national definition of "affordability." The existing definition of a targeted low-income child does not specify that children can only receive SCHIP if the coverage is not "affordable" in the private sector. We do not believe it would be appropriate for CMS to develop a national affordability standard due to the diverse characteristics of the economic and health insurance markets across States, as well as the flexibility that is a key tenet of SCHIP.

In light of the new administrative and reporting burdens that this data reporting would place on States, CMS would need to provide States with opportunities to discuss the feasibility of defining and measuring access to employer-sponsored insurance and affordability of insurance. Discussions and planning sessions would also be required on the feasibility of modifying applications, administrative procedures, and data systems to capture and report this information. We emphasize that issuance of any type of new reporting standards would need to comply with all applicable procedural requirements of the Administrative Procedure Act and Paperwork Reduction Act, including providing stakeholders with the opportunity for public comment.

We have also provided technical comments in an attachment that we hope will be helpful in refining your draft. Please contact Ms. Kathleen Farrell at kathleen.farrell@cms.hhs.gov if we can assist in any other way. CMS appreciates the opportunity to comment on this draft report and we look forward to working with the GAO on this and other issues.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Acknowledgments

In addition to the contact named above, Carolyn Yocom, Assistant Director; Kristin Bradley; William Crafton; Kevin Milne; Elizabeth T. Morrison; Rachel Moskowitz; and Samantha Poppe made key contributions to this report.

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