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**Who's Counting? What is Crowd-Out,
How Big Is It and Does It Matter for SCHIP?
The Alliance for Health Reform
August 29, 2007**

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ED HOWARD, J.D.: Good day. My name is Ed Howard with the Alliance for Health Reform, and I want to welcome you on behalf of our chairman, Senator J. Rockefeller and our co-chairman, Senator Susan Collins, and the other members of our board to a briefing on the health policy topic that, I guess, is getting as much attention as any other this year. That is, getting affordable, high quality health insurance to low-income children while trying to minimize the replacement, that is to say that crowd-out, of private insurance coverage. We're pleased to have the support for this briefing from the United Health Foundation, which is affiliated with the United Health Group, especially grateful to the head of the foundation, Dan Johnson, and United's Reid Tuxxon, who is coincidentally a long-time member of the Alliance board. There is a nice one-page description of some of the foundations major projects in your packets including their America's Health Rankings that I commend to you, and we are very happy to have them with us in this venture. As I said, today we're going to look at what has developed into one of the most contentious aspects of what has turned into one of the most contentious issues. That is in what form should we re-authorize the State Children's Health Insurance Program, or SCHIP, which is set to expire on September 30, in a way that maximizes the bite we take out of

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the number of uninsured children and minimizes the displacement of private coverage, or crowd-out as they say. One thing we know and can agree on I think is that too many young Americans don't have health insurance. The Census Bureau told us yesterday that the number of children under 18 without insurance rose from 8 million to 8.6 million from 2005 to 2006. That is the highest number ever reported. It's a million more than there were in 2004, and it's almost 12-percent of the 74 million kids in this country. We've heard that crowd-out is inevitable. It's simply the price we pay for a mixed public-private system. We've also heard it described as taking us one step closer to socialized medicine. My personal hope is that we can identify some common ground today on what has historically been a program with strong bipartisan support. In this very room, we held a briefing a few months ago on the SCHIP re-authorization in which we had Republican and Democratic Senators come and tell us how united they were in trying to get this program extended and improved. We're hoping bipartisan support will continue; that we can at least resolve this part of the debate in a way that allows this very important program to go forward. I have a couple of logistical items that many of you have heard before, so bear with me if you will. In your packets, there is an awful lot of good background information, including biographies about our

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speakers more extensive than I'll be able to afford them. If you're watching on CSPAN and have access to a computer too, you can see copies of all the materials in these packets; in fact you get a little more because there are full texts of some things that the folks in the room have only summaries of. On our website, which is allhealth.org, tomorrow you can view a webcast of this event on kaisernetwork.org, along with all of those materials that are on our website as well. In a couple of days, on both websites you'll be able to see a transcript of this and there is even a podcast that you can download for those really boring subway rides. One final thing that we would ask you is to take note of the green question cards, which you can fill out and pass forward at the appropriate time, and the blue evaluation forms, which we would ask you to fill out to help us to improve these things.

We've got a very distinguished line-up of speakers today. Before I introduce them, I do want to announce that the administration was invited to participate in this discussion and declined to do so. We're very sorry that they're not here; especially in view of the new guidance that HHS has given the states on this very issue of crowd-out. We did include a copy of the Guidance along with copies of the administration's official positions on both the House bill and the Senate bill in your materials. You can take a look at that and I would

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encourage those who have similar views with the administration on any of these topics to join in the discussion, once we get to the Q and A. Please turn off your phones and your pagers so that you can hear them and we can't and let's get on with the presentations.

We're going to start with Lisa Dubay, who is an Associate Professor at the John Hopkins Bloomberg School of Public Health, and one of the top health services researchers in the country. Before going to John Hopkins, Lisa was a Principal Research Associate at the Urban Institute, where she led a number of national studies on crowd-out and related topics. Her work couldn't be any more on point for our discussion today and we're very pleased that you could join us this afternoon. Lisa.

LISA DUBAY: Thanks. I'm going to take you through a little bit of a tour of crowd-out. Can people hear me in the back? The title of my talk is Looking Backwards and Moving Forwards. I'm going to start by speaking a little bit about what is crowd-out. Crowd-out happens when there is a substitution of public coverage for private coverage. That occurs when there are public subsidies available for health insurance coverage. It happens through a number of mechanisms. First of all, individuals or families with private coverage may drop their coverage and enroll in the new program. We have

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some evidence that this has happened under SCHIP. Also, employers can change the extent to which they offer through employer-sponsor coverage, and they can increase the share of premiums that employers have to pay in order to induce families to drop their coverage. We have some evidence of the increase in premiums that's happened as a result of CHIP. We don't really have a lot of evidence, or any evidence, that suggests that employers are actually stopping or declining or reducing their offers of coverage. Finally, new firms entering the market may choose not to offer coverage when previously they would have. Those are sort of the main mechanisms through which crowd-out occurs. The thing that I want everyone to keep in mind throughout this whole discussion is that crowd-out is an inevitable by-product of any proposal to expand coverage. It occurs in the Medicare Part D program without any attention. It occurs when we send our kids to public schools. It is an inevitable by-product of government programs.

There are advantages and disadvantages to crowd-out. In particular, the main issue is that crowd-out increases the cost per newly enrolled person. This is what we refer to as target efficiency. As prudent providers of government services, we want to make sure that our programs are appropriately targeted. This is what the debate about crowd-out is about. It's about target efficiency. At the same time,

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there are some real benefits to crowd-out, particularly to low-income families who may be paying a large share of the premium to have employer-sponsored coverage, or who may actually have employer-sponsored coverage but they have a very limited benefit package so dropping that coverage is a real benefit to the family, similarly, employers who are providing employer-sponsored coverage to their low-wage workers, if they choose to alter their programs, they'll receive a benefit, and that sort of levels the playing field. The last two issues are issues of horizontal equity. Which is, do we treat people in the same circumstances the same way? The issue about crowd-out is a delicate balance between target efficiency and horizontal equity and do we really want to treat people similarly in similar circumstances.

Looking back at the literature on crowd-out, there are really two bodies of work. The first body is Econometric Studies which use household surveys to identify target populations and look at changes over time and in both public and private coverage, they essentially are estimating the share of the new enrollment that's attributable to crowd-out. These studies are extremely challenging to do. They rely on the ability of the researcher to develop a counter-factual for what would have happened in the absence of the program. There are about five or six studies on this topic, on the SCHIP program.

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They are all very high quality studies. They have a range of estimates of crowd-out, and the variation in the estimates is larger within studies than it is across studies. So they are very sensitive to the methods that are used. There is a whole other body of work that actually looks at enrollee surveys, basically surveys that ask people who have enrolled in the program, whether or not they had coverage in the past six months or the past year. Then try and understand whether or not they dropped their coverage voluntarily or involuntarily. Those are the two different types of methods. While the second set of studies are less sophisticated, they really provide the ability for a really simple analysis of crowd-out. I assume Peter is not talking about this but CBO basically did a review of the evidence and suggested that the econometric studies suggest that crowd-out is in the range of 25-percent-50-percent, which is about what CBO said that it would be when it scored the bill initially. What is interesting about these studies is that while there is a range of the estimates on crowd-out, they are very consistent in terms of the estimate of the decline in employer-sponsored coverage that occurred with the program. Even if you take the largest estimate of the decline in employer-sponsored program, what you find is that the SCHIP program reduced among the SCHIP eligible children, it reduced employer-sponsored coverage by about 10-percent. When

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you look broadly at the whole of all the kids in the U.S., you find that the SCHIP program reduces employer-sponsored coverage by 2-percent. It's a really small reduction in the base of employer-sponsored coverage.

If you talk to states, they'll tell you that crowd-out isn't a problem. Part of that has to do with the fact that states have relied on these enrolling surveys. You'll hear about one of them later on. Mathematical Policy Research, in their CMS evaluation, documented state evaluations of crowd-out. What they reported was that six states found no evidence of crowd-out, five states found crowd-out rates less than 5-percent, and then three states reported crowd-out rates between 10-percent and 20-percent. This is really consistent evidence with one of the more sophisticated enrolling surveys, which was from the congressionally mandated SCHIP evaluation in 10 states. These 10 states accounted for over 50-percent of SCHIP eligible children. What that showed is that only 28-percent of all the new entrants even had had any private coverage in the past six months. Of those 28-percent about 14-percent of those kids had lost their coverage because of involuntary mechanisms like their parents lost their job, their employer stopped offering coverage. That gets to a crowd-out estimate that is somewhere between 6-percent and 14-percent, which is very consistent with the other state studies. It's important to

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recognize though that crowd-out is not the only way that we should be evaluating the SCHIP program. What we know about SCHIP is that it has reduced the rate of uninsured children by about a third, it has increased access care among the eligible. It has improved health status among children, and it has been really consistent with what CBO thought it would be in terms of their expectation that about 40-percent of new entrants would be from employer-sponsored coverage. We also know that SCHIP has not led to large declines in employer-sponsored coverage.

Moving forward, if you look at the House and Senate Bills for SCHIP re-authorization, there is nothing very explicit about crowd-out prevention but there are some really important aspects of the Bills that will encourage states to minimize crowd-out. In particular, there are the incentive payments that really change the incentives that states have to enroll SCHIP eligible kids. The incentives particularly under the House Bill are very strong to enroll Medicaid eligible children to the extent that we enroll Medicaid eligible children we're going to have very low rates of crowd-out. There's not much employer-sponsored coverage to crowd-out there. There is employer-buyer and premium assistance plans. The devil is in the details with these plans. What states do and how they are implemented will really determine whether or not these prevent crowd-out or increase crowd-out. That has

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yet to be seen. There are changes in the matching rate under the Senate Bill that will reduce the matching rate for states that go above 300-percent of poverty. But really when you look at it, CBO has suggested that the increases that we're going to see are going to be lower than what we found under the program so far and really consistent with the initial intent of the program. I'm just going to close by reiterating that it's inevitable that any effort to subsidize health insurance coverage is going to produce some crowd-out. Public expansions have been shown to be the most cost effective method for reducing uninsurance, and that both the House and the Senate provide really strong incentives for states to enroll those lower income children where there's very little evidence that there is going to be a lot of crowd-out. Finally, I think the public support for SCHIP is extraordinarily high, it was more than eight in ten Americans saying that they want Congress to further strengthen and fund SCHIP.

ED HOWARD: Great. Thank you very much Lisa. There is, by the way, a poll cited and summary of which is included in your materials from public opinion surveys commissioned by the Robert Wood Johnson Foundation that backs up Lisa's representations about American opinion that I commend to you. You heard a lot about CBO even before we're going to hear from CBO that is from the director of the Congressional Budget

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Office, Peter Orszag. Before coming to CBO last January, Peter directed several studies at the Brookings Institution, including the highly regarded Hamilton project. He held high level posts at the White House, and the National Economic Council before that. His organizations estimates of crowd-out under the House and Senate SCHIP bills, copies of which are in your materials, are the most widely quoted numbers in this debate on that subject. We're very pleased that you made time to be with us today. Peter.

PETER ORSZAG: Well, thank you very much, and since the topic is children's health insurance, I did want to note that since my seven year old daughter doesn't start school until next week, she decided to take today as a take-your-daughter-to-work day, and she is here with us. Although, I think she may be listening to alternative programming. [Laughter]

ED HOWARD: And, not the podcast of this briefing?
[Laughter]

PETER ORSZAG: Maybe later. Let me make a few points before turning to our estimates of the House and Senate legislation. First, it's very clear that both SCHIP and Medicaid have significantly reduced the number of uninsured kids. At CBO we did an analysis that showed if you looked between 100-percent and 200-percent of poverty, which is the target population for the SCHIP program as it was originally

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designed, the percentage of children in that income range that were uninsured fell from over 22-percent in 1996, the year before SCHIP was created, to a little bit under 17-percent in 2005, a very substantial reduction that did not occur at higher income levels. The most likely cause of that reduction was the introduction of SCHIP. The effect is not one for one however. For every 10 children you cover under Medicaid or SCHIP, the net reduction in the number of uninsured children is not 10 because of the phenomenon that we're discussing today, crowd-out. That is to say that some of the new enrollees, the 10 enrollees that you have in the public program, would otherwise have had coverage in the absence of the program, and therefore the net impact is smaller than the number of new enrollees. Our estimates suggest that for the SCHIP program somewhere between 25-percent and 50-percent new enrollees on SCHIP would otherwise have had coverage. I would just note very briefly that with regard to the evidence on that point, there is an inherent limit to the insights that can be provided by new enrollee surveys because one of the key questions is, would those people otherwise have gained coverage, perhaps through a new job or through other changes that occur even while they're on the program, would they have gained coverage for their children? Just a backward looking measure is not necessarily a complete one.

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Three points about this phenomenon of crowd-out. The first is, as Lisa already noted, it is inevitable in a voluntarily system. That is to say that unless you are going to impose a mandate on employers, individuals, or states, you will have crowd-out. The only question is how much? I think to conceptualize this think of a lot of kids swimming around in a pool. The uninsured kids are swimming in the same pool as the insured kids, and you can think of providing insurance as throwing kickboards to the kids who are uninsured. It is inevitable that if you make a nice kickboard, some of the kickboards are going to wind up in the hands of kids who were previously insured and some who were uninsured. More broadly, the point is that the more attractive you make public insurance in order to attract people from the pool of uninsured kids, the more attractive it is also going to be for kids who otherwise would have had coverage, and that is inevitable. Another point that is worth noting is the more you try to reduce the number of uninsured kids, the more likely it is that you're going to have crowd-out. In particular, if you are really, really targeting and you're only throwing one or two kickboards, maybe you can be really, really careful about the children to whom you are throwing those kickboards, but if you're really trying to distribute millions and millions of kickboards, this issue of crowd-out is going to be more salient. Finally, it is also

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worth noting that as you move up the income distribution crowd-out is going to become more of a problem. The reason is very simple. At more moderate income levels, children have less access to private coverage. For example, between 100-percent and 200-percent of the poverty threshold, about half of children have private insurance, between 200-percent and 300-percent about three-quarters do, and above 300-percent of poverty about 90-percent do. As you move up the income distribution, crowd-out becomes somewhat more of an issue. I would also note something that Lisa pointed out which is that in designing how you throw those kickboards, that is the policy interventions that you are using to reduce uninsurance, while crowd-out is inevitable, one can do better or worse in you efficiency with which you are reducing the number of uninsured kids per new enrollee. That is the type of intervention that you adopt, does matter. It is true that academic evidence has suggested that public insurance has among the least amount of crowd-out, at least defined as federal costs per newly insured kid, relative to other alternatives including tax credits. The reason, again, is if you provide an overall tax credit for children in some income range, you are going to wind up subsidizing a lot of coverage that already existed for the reason I just gave you, which is that the majority of kids, 200-percent to 300-percent of poverty, have private coverage.

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If you provide a tax credit to try to encourage to become insured from the uninsured pool, you wind up providing that tax credit, inevitably also, without very detailed tax regulations that I haven't seen designed or proposed to the existing pool of insured people, and that reduces your target efficiency.

With all of that as background, let's turn to the House and Senate proposals. This first table shows you the impact that we estimated from the House proposal, and in the bottom right corner, you see that the total number of new enrollees that we project, under the House proposal in 2012, would be 7.5 million children. Of that 1.3 million come from simply filling the shortfall that is the gap in funding under our baseline relative to keeping the same number of children basically on the program as currently exists. Our baseline actually involves a reduction in the number of children relative to today because of various details that I could go into. The vast bulk of the 7.5 million though does not come from filling that shortfall but rather from that 5.0 million increase in the number of currently eligible children but not enrolled children in Medicaid and SCHIP. That is where the majority of the new enrollees are coming from, and then there are also some new enrollees who are coming from expansion populations. In particular, above existing income thresholds in the SCHIP program. Of the total 7.5 million new enrollees, we estimate

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that 2.4 million would otherwise have had coverage. That's a crowd-out rate of 33-percent. The implication is that there are 7.5 million new enrollees of whom 5 million would otherwise have been uninsured. That's a very substantial reduction in the number of uninsured children. In other words, you are throwing a lot of kickboards into the water. I would note that both the House, and I'm going to turn to the Senate in a second, they both share a couple of common features. One is they do achieve a very significant reduction in the number of uninsured children as that 5.0 million number indicates. Secondly, they have steps that are designed to try to minimize this crowd-out effect. In particular, they provide incentives for new enrollees, that is they provide incentive to the states to put more kids on these programs, and they provide either a much larger, or in the Senate case, only an incentive for Medicaid kids. That means that they are tilting the incentives towards lower income populations which are associated with lower crowd-out rates. That is one of the important reasons why you get a figure that is 33-percent in the House legislation, which give the scale of the undertaking involved, given the scale of the net reduction in the uninsured, it's pretty much as good as you're going to get. In other words, I have not seen any other proposals to reduce the number of uninsured children by 5 million with crowd-out rates that are

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lower than 33-percent. Again, in the absence of a mandate on an employer, or a mandate on an individual, or a mandate on state governments, CBO does not believe you're going to do much better than these kinds of crowd-out rates. With regard to the Senate proposal, which is the next slide, the Senate proposal costs somewhat less and it also achieves somewhat less of a reduction in uninsured kids, but it is otherwise somewhat similar to the House proposal, at least conceptually. We estimate that in 2012 there will be 6.1 million new enrollees on Medicaid and SCHIP under the Senate proposal, of which, again, 1.3 million comes from filling the shortfall that arises under our baseline in the SCHIP program. The most significant different in the enrollment numbers between the House and the Senate proposals involves the pick-up of currently eligible kids. Instead of that 5.0 million in the House proposal for children who are currently eligible for these programs but not enrolled, the Senate version has 3.7 million instead of 5.0 million. It also has a slightly smaller number of children in expansion populations, 1.1 million instead of the 1.2 million. Overall, out of the 6.1 million, we estimate that 2.1 million children would otherwise have had coverage. There is a net reduction of 4.0 million uninsured children and that's a crowd-out of 35-percent, roughly the same albeit very slightly higher than in the House proposal. Again, I would just close by

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saying that overall reducing the number of uninsured children by 4 to 5 million is a difficult task, and in 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. The policy question at hand is whether those types of reductions are worth the cost that is involved. The focus on crowd-out, I understand its motivation must be interpreted in a broader context in which again in our estimation, this is pretty much as good as you're going to get if you're throwing that many kickboards into the water. Thank you very much.

ED HOWARD, J.D.: Thank you, Peter. That was remarkably English laden [Laughter] for a discussion of so many numbers, and very helpful. Our next speaker is Janet Trautwein. She is the executive vice president and CEO of the National Association of Health Underwriters. NAHU is the trade association whose members are involved in, and we took these words from their website, the selling, service, and administration of health insurance and related products and services. Janet knows the health insurance business, not only as an association official, she also has been 17 years in the insurance business herself. She was on President Bush's transition team for health, and she has appeared on Alliance

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programs in the past. We're very happy to have you back.

Janet.

JANET TRAUTWEIN: Thank you, Ed. I'm going to, at the risk of sounding like I'm repeating something that everyone else has said, I'm going to go back through a couple of items, and because I want to go over a few nuances that I think are really important when we talk about this issue of crowd-out. First of all, we've said extensively today that crowd-out occurs when individuals who were previously covered by private health insurance move to government programs for whatever the reason, whether we're talking about SCHIP or something else; someone was covered privately and they moved to a government program. I think we all agree that this is more likely to occur when eligibility for the government programs are increased. This is something that we've already heard today. I want to repeat this for you but add a little nuance to that because I think it's important, and it's something that we don't talk about very often, and that is the issue of crowd-out of private funding. Now here is the difference between talking about simply crowd-out of private coverage and crowd-out of private funding of health insurance coverage. Here is the nuance, and if you can just listen carefully because it matters a lot to what I'm going to talk to you about. Crowd-out of private funding occurs when individuals who were previously

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covered by private health plans, which were funded in part at least by their employers, leave that coverage and move to public programs. It also occurs when individuals don't ever enroll in the first place, in the plans that they're eligible for, which are subsidized by employers, if only they take advantage of that opportunity, but instead they enroll in a public program. So, do you see the subtle nuance here? It's important when we talk about losing private coverage, we're also talking about some funding that currently is not funded by the government, that employers pay voluntarily for many of the people who are covered by their programs today, and for many other people who are eligible but don't enroll. Now, when we talk about crowd-out, I suspect, that some people say, well, what's the big deal? So what? So what if we crowd-out private plans? What are the implications of doing that? Private plans cover most of the people that are insured today. We want to make sure that the ability to enroll people and keep them enrolled and covered by private coverage is maintained. What does crowd-out have to do with that? In particular, crowd-out can impact small employers who are trying to offer health insurance coverage. All health insurance plans have participation requirements. When people go to public programs, often small employers are unable to meet the participation requirements for the people who remain in the plan. This is a

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very difficult problem. What happens, eventually, is that the employer may not be able to offer that plan at all if we have too many people migrating someplace else.

ED HOWARD, J.D.: Let me just clarify. When you say participation requirements, what exactly do you mean?

JANET TRAUTWEIN: Yes. Participation requirements. All health plans, which are based on a group basis, require that a certain number of employees who are eligible for coverage actually participate in the plans. The normal number is about 75-percent and then in addition they usually have separate requirements as to how many eligible dependents also have to participate among the entire eligible group. It's a pretty significant rule in plans, and it's what keeps the costs down within the plans. That's the reason the plans have it to start with.

ED HOWARD, J.D.: Thank you.

JANET TRAUTWEIN: The other thing that occurs when we remove a lot of the young and healthy. Most kids are healthy, by the way; some of them are sick but many of them are healthy. When we take away the young people from the insurance pool, that small employer pool within a particular insurance company will become older and sicker and it impacts the rates that everyone else who is still insured pays. Of course, the

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problem is only exacerbated when we also add parents to eligibility.

I want to talk a little bit about premium assistance which is what we want to talk about relative to crowd-out today. What premium assistance is, and you may see this on a lot of the charts that are in there, in layman's terms, a premium assistance simply allows SCHIP dollars, or it even could be Medicaid dollars, to help fund employer-sponsored coverage for kids who are eligible. It's a very simple concept. Instead of the kids leaving their employer-sponsored plan to go to the public programs, those dollars could flow back in to help pay the cost of the coverage. Often the parents of these children are already covered under these programs, but they simply can't pay their share of the premium. Even with the employers funding in there, they can't pay their share of the premium in order to get their kids covered as well. I want to talk just for a minute about the impact of this premium assistance as I've described it to you on those who are already eligible but not yet covered. States have been unable to enroll, as we all know, all of the kids who are already eligible for the program. Whether we think it's correct or not, whether we like it or not, there are a number of children who are not enrolled because their parents associate SCHIP, Medicaid, or any public health program with

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welfare, and they believe that that's wrong. Culturally and morally, in their minds, it's wrong. It doesn't matter whether or not we think it's wrong, or whether we think its right or wrong for them, that is their belief. There are many children that we can't reach today, already, before we increase the eligibility 1-percent point, that are not covered for that particular reason. Now these same parents, who may in fact be covered as I said before under their employer-sponsored plan would love to have their whole family insured on the same health plan, and they would enroll their children, even if those SCHIP dollars were flowing to their employer-sponsored plan. Their family would be insured together. This is also exacerbated by some of the current roles that we have for public programs. Those of you who work in this area will understand, but for example the Medicaid rules of eligibility are different for children of certain ages and then additional age children may be eligible in a different way and then other children in the same family, all in the same family, may be eligible for SCHIP. It becomes quite confusing for the parents. One of the ways to mitigate this and make it simpler for parents and allow them to get their kids enrolled is to have them all on the one plan. Although the funding sources may change, their coverage remains the same, and it's much simpler for them.

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I also want to get right to the crowd-out thing, about those who are already covered. There are some children who are covered under employer-sponsored plans who actually are already eligible for the SCHIP program today. Their parents are, in fact, making pretty significant sacrifices to get them covered under those plans. Often they aren't able to provide them much of the things that they need, but instead they choose to get health insurance for them. At some point, as costs rise, they may not be able to do that, and in their mind, they may feel forced to go into a public program. When they do that, the dollars that their employers are already paying for that coverage are left on the table. They are immediately moved, and that is that crowd-out of private funding that I talked to you about earlier on. That is a tragedy that we leave that on the table. That is a waste of government money when it becomes fully government funded when it could have been partially government funded.

The next issue that those that may be become newly eligible under the program, I suspect that we will have some expansion of the SCHIP program and it's anyone's guess what the various proposals as to how much that expansion would be. As those expansions occur, a large number of those newly eligible children may leave, as Peter said, their employer-sponsored plans and move to the SCHIP program. When they do that, again,

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the money that employer is currently paying that is subsidizing those programs is left on the table. I would just point out, again, that is, it seems to me, not a good use of government money to just turn away from that funding that is there altogether. In conclusion, what I'd like to say is that, congress always intended from the very beginning that SCHIP dollars could be used to subsidize the costs of employer-sponsored plans but, unfortunately, as the law was put together, and as the regulations were put together, there were many hurdles that were put into place that are so great that few states have actually taken the opportunity to take advantage of the ability to put some funding into the employer-sponsored coverage. Current rules that relate to how you manage cost-sharing, cost-effectiveness, employer contributions, and the rules relative to that, and how you calculate a benchmark plan, have all made the process pretty burdensome administratively for states and employers. We've actually done some research to see whether or not it would actually be more cost-effective for employer-sponsored plans to be used as opposed to solely using public programs and we have a website at NAHU.org that you are welcome to go and look at that research if you would like to. In most of the cases we have found that it is less expensive and would be less expensive for the government to subsidize those plans

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significantly, and, in fact, that coverage benchmarks would not be sacrificed as a result of that. I would commend you to take a look at that. This is particularly true when we're covering more than one child, and it has to do with the way insurance premiums are calculated as well. We are very much in favor of expanding and improving premium assistance rules. We believe that the premium assistance does affect not just one kind of crowd-out but both kinds of crowd-out. That crowd-out of private coverage as well as the crowd-out of private funding through employers of private coverage. We believe it's fiscally responsible and that you could avoid at least some of the negative impact of crowd-out on private plans for those that are currently insured and those that could be insured in the future.

ED HOWARD, J.D.: Thanks very much, Janet. Last we're going to hear from somebody who ought to know about SCHIP crowd-out. Ann Kohler is deputy commissioner for New Jersey's Department of Human Services. Before that she directed the Division of Medical Assistance and Health Services in New Jersey. Since New Jersey has an income eligibility limit as high as anybody's is in the country, she brings a real-world experience with making sure crowd-out doesn't delude the efforts to enroll more kids in SCHIP. Thanks for agreeing to share that experience with us. Ann.

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ANN KOHLER: Thank you. I'm very glad to be here and have the opportunity to talk to you a little bit about our FamilyCare program, which is New Jersey's Medicaid and SCHIP program. It's a program that's very important to our governor, Governor Corzine, so we are very anxious to get it re-authorized. Let me start back when the program first started and at the inception of the SCHIP program. At the time, we had a twelve-month crowd-out and pretty quickly we were able to see that that did not seem to be really a barrier. It was a barrier to people applying, but it really didn't seem to have an effect upon people dropping their private insurance. In 1999, we reduced it to six months, and then in September of 2005 we reduced the crowd-out period again to three months, and it has remained there ever since. Based upon our studies of the program and the studies that have been done by other, as Lisa mentioned, we have not found crowd-out to be a significant problem for our population. We only apply the three month crowd-out period to people who are only applying for our higher income, or SCHIP, program. We don't apply it to people under Medicaid because, as all of you know, there is no requirement to limit enrollment in Medicaid, and often the people who are applying for Medicaid are the lowest income people and are in need of additional services beyond those provided through an employer-sponsored plan or private insurance. We also have

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some exceptions. We find that if the person lost their eligibility through no fault of the family, we allow them to enroll in our program. If their income is below by 200-percent of the federal poverty level and they have been purchasing their insurance through COBRA, we allow them to come onto our program. If their COBRA has expired, we allow them to immediately come on our program because we think it's important that the children not have a break in coverage because of no fault of their own. We did a study, and this is our state fiscal year of 2006 and our most recent state fiscal year that has ended, and we found that only 388 applicants were found to have some kind of insurance in the three months prior to applying for FamilyCare, which is only one-half a percent of all those who applied. We found that 1,820 applicants had some insurance at the time that they applied, which again is only 3.2-percent. We go back and we match our eligibility file against private insurance records. The records that we use in our Medicaid program for third-party liability, we have a database of people with insurance, and if they are fully covered by insurance and they are in the higher income, we will contact them, and tell them that the program is only for people who are uninsured. As you can see, the numbers are extremely small. We're hoping that the bills that are before the House and Senate, and what's actually finally enacted, will not

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affect our policy and will not require us to implement a more stringent crowd-out period because we think it's very important for children to have insurance and we don't want them to have to go without insurance for long periods of time. I'm sure you're all aware of the recent CMS letter that says children now have to be uninsured for a year unless you can document that 95-percent of your children below 200-percent of the federal poverty level are covered under your program. We are very concerned about this letter. The Governor has already spoken to a number of people about this issue. We doubt we could ever meet 95-percent, if we require all of our children to go bare, and go without insurance for a full year, and we question why we would have such a draconian public policy. In summary, again, we think this is a very important program. We have not found any problems with crowd-out. The numbers are minuscule and we do hope that during re-authorization, congress eliminates the one year wait period and allows states to have more flexible crowd-out periods. Thank you.

ED HOWARD, J.D.: Great. Thanks very much Ann. Let me just remind you that there are green cards that you can write a question on and hold up. Someone will snatch it from your fingers. There are also two microphones, or at least I think there are one at the back and one right up front here where if you want to make sure that your question gets asked in

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precisely the way that you want it asked, you can go and stand at the microphone and ask it. We do have some questions that have been submitted in advance, and while you're writing and getting to the microphone, I will take one of those questions and let our panel take after it. The questioner writes, Medicaid has wrapped around private coverage for many years. How well has that worked as a precedent? Lisa, do you have anything to say about that with respect to [Laughter], I would assume that it does not have to do with crowd-out directly, but with administrative simplicity and manageability, that sort of thing.

LISA DUBAY: A number of states do wrap around Medicaid. In particular, New York is one, New Jersey.

ANN KOHLER: [Laughter]

LISA DUBAY: You should answer this question. [Laughter] But also Rhode Island and states that are committed to doing this have found it to be a very successful program. It takes investment, it takes coordination, but when those pieces are in place, it does protect children who would otherwise be eligible for a very broad benefit package under the Medicaid program that's not usually covered under private coverage. It's an important safety net for those families.

ED HOWARD, J.D.: Ann, do you have anything specific that you can add to that?

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ANN KOHLER: Sure. Yes, we do wrap around and we do it in a number of ways. One is if someone just has private insurance, we will wrap around and provide the additional benefits under the Medicaid program that may not be available to that person's private insurance plan. A notable one is mental health. Often there are limitations on the amount of coverage that you might have, or transportation. We provide people transportation to get to their doctors appointments. We also provide premium assistance where if someone has problems buying their insurance, we will help them pay for it. It is a challenge. We are finding it's very difficult to do the comparisons that you need to do to obtain federal approval for that. Just to get the information from the employers can be a challenge. It is a program that we feel is very important and we strongly encourage people to participate in it.

ED HOWARD, J.D.: Questioner writes, the administration's recent Guidance on SCHIP, which you have in your packets, says that states that want to insure higher income children have to show that private coverage hasn't declined by more than two percentage points in the target population over the last five years. I think that's right. Yes. Yesterday's Census Bureau report says that employer coverage declined for children by one full percentage point from 2005 to 2006, more than the drop for the entire

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population. Is there any way of estimating how much of that is due to SCHIP expansion and Medicaid as well? Peter?

PETER ORSZAG: I guess at this point I would just say that we have not done that analysis. There obviously are many forces that are affected. By the way, the figure that you cited is for all children, it's not for children of the relevant income range, and until the more detailed analysis is done, I think it's premature to make any conclusions whatsoever about what's happening within the relevant income range for private coverage.

ED HOWARD, J.D.: Go ahead. Lisa?

LISA DUBAY: I would just like to add that I think it's really important that it's very difficult to identify and look at changes over time in insurance coverage and attribute what's due to changes in policies in general. It's easier to do it over a long period of time where you've got a lot of change. Identifying a change in one year is really going to be quite difficult, but what we know is that there are lots of other trends that are going on over time that make just simple differences over a five year period that's outlined in the CMS directive that will make it really difficult to understand whether or not those changes that are being observed are due to crowd-out or to a general trend in the decline of private coverage over time.

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PETER ORSZAG: Could I just add one further thought, this is a little caveat to what I just said, but just the following, which is that if you look in the relevant year, if anything there were various changes made, there were questions at the time about filling various state level shortfalls in the SCHIP program and implementation of citizen documentation requirements also began to be applied. If anything, when we look at the more detailed data, it may turn out that the growth in public insurance was not as significant a force in the year under question as it was in previous years, and so it would therefore be particularly unusual if that were an important explanation of overall private coverage trends. Again, I want to reserve judgment until we have done that more detailed analysis.

ED HOWARD, J.D.: Okay. We have a number of questions about premium assistance. This one writes, an analysis by the National Health Policy forum says that cost-effectiveness test in the current SCHIP law, and here this person quotes, "has proven to be virtually impossible to meet because of high private premium costs." I wonder if that comports with our panel's experience and understanding of the current situation, and the questioner asks, how would the new bills change that, if at all? Janet, do you want to take first crack?

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JANET TRAUTWEIN: Well, I think that that's probably not correct. It is true that the current cost-effectiveness test is very ineffective, it doesn't work well, but that's not the reason why it doesn't work well. The main reason that it doesn't work well is that it has a couple of things that are incorrect. First of all, it compares the cost of insuring one child under the SCHIP program to insuring an entire family under a private plan. That's the reason why the private plan premiums look so high because the formula of the test is skewed. In fact, the Medicaid cost-effectiveness test makes a lot more sense where you are comparing apples to apples. How much is it to insure this kid here versus this kid here. That makes a lot more sense. The way the SCHIP cost-effectiveness test works makes no sense whatsoever and that's why a lot of states don't want to do it because it's so difficult and you can't get a real idea of what the cost is.

ED HOWARD, J.D.: Peter?

PETER ORSZAG: I would just add a few things quickly. One is I think it actually is important to realize that the House proposal, which has sometimes been called premium assistance is actually the opposite, and in particular what it would do is that it would allow people currently enrolled in employer-sponsored insurance to instead be covered by SCHIP and then have part of the costs associated with the adults that had

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been on employer-sponsored insurance covered by either the firm or the state. Instead of having SCHIP pay for private insurance, that's basically having private insurance or firms pay for SCHIP, it's almost the opposite. That's the first point. The second point is on premium assistance more broadly, the view of CBO's analysis, at least, is that there are, and this is reflected in our scoring of the Senate proposal, that there are inherent limits, and I'd like to hear more from the state administrators on, and the one that we have with us [Laughter], how effective this approach is likely to be. It is, at least in the view of our analyst, seen as a somewhat clunky and complex approach to coverage. Not that it's inherently flawed but rather that as it works, it's very difficult for the states to find the firms to conduct the tests, there's turnover in the labor market, all of which makes it very complicated to provide coverage in this way. Therefore, the premium assistance proposal that is in the Senate legislation was not scored as having a very large effect, in large part because it was our view that not many states would pursue it aggressively.

ED HOWARD, J.D.: Ann?

ANN KOHLER: Okay. Well, you know, states do it sort of both ways. We do have premium assistance programs and I think your explanation of it is a pretty good one. It's really

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hard to get it up and running. It's really hard to stay on top of. I don't know any state that has enormous numbers. I know Rhode Island is perhaps a percentage of their population a larger one. States also have programs where you can buy in to the equivalent of your SCHIP program, and, again, they are extremely small. Nobody has large numbers. I know New York has been doing it for years and years and I don't even think they've had 10,000 children in the state. Neither one seems to work very well, the way they are constructed today.

ED HOWARD, J.D.: This is actually, the first part of this has already been discussed about the legislation, but the second asks and it directs it to you, Janet. Can you discuss the high administrative costs and low take-up rate of premium assistance programs like the one in Florida? Is this an efficient use of public dollars?

JANET TRAUTWEIN: Well, that's kind of a loaded question. [Laughter] I think you just have to look at the actual costs between the plans. I have to say that I'm not familiar with all of the details of Florida's specific program. I think, in looking at any of these, you just have to look specifically at a given program and how much it costs versus how much it costs to insure that same child elsewhere. There was a very big reason why a lot of the states have not done premium assistance, and I agree with something that I think

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everyone has said here, and that is, right now, it's too hard to do it. The rules for putting in premium assistance are very, very difficult. Frankly, I wouldn't recommend that somebody or a state undertake it under the current scenario because it is hard. But there are some very simple changes that can be made that could make this program simple. The fact is that the way insurance premiums are designed, particularly for a family where you have multiple children, it is far less expensive to do it this way, and wrap programs or secondary payer or whatever we want to call they are a pretty cost-effective way to fill in any benefit gaps. The states that are using the wrap programs, for the most part, are not spending a lot of money on that secondary coverage. It's very, very easy to do, children don't lose any of their benefits, and it's more cost-effective. In my perspective, it would be a good way for us to have more money to take care of more children. That's our sole reason for looking at it is to get these kids covered. By the way, I would agree with your crowd-out remarks, that relative to the waiting periods and the probationary periods without coverage, I don't think the long waiting periods are very effective. We haven't seen that. People will wait as long as it takes. We're concerned that they wait that long and then the children are uncovered during those periods of time.

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ED HOWARD, J.D.: I don't want to keep you on the hot seat but this another question that does relate to this topic and it's not quite as barbed. [Laughter] What can the federal government do with public dollars to draw small businesses that don't currently offer coverage into entering the insurance market? For example, New Mexico's three share model, Rhode Island's practice of reducing the employer share by paying subsidies to employers - that makes no sense to me - and other states where you reduce the employer reporting requirements of what insurance packages they offer. Any of that sound promising? And others can join in as well.

JANET TRAUTWEIN: I'll just start it off real quickly. I think when we talk about bringing employers in and getting more employers offering coverage so that we can address all of the uninsured, not just the children but a broad range of uninsured people, we're primarily talking about the smaller employers. The larger employers, by and large, do this so that they can attract and retain good employees. The fact is that the smaller employers have the very same needs that the larger employers do. In fact, an even greater needs to attract and retain good employees. I think that what you have to do to get a small employer to offer the coverage is probably less than what you think you need to do. They have the need to have these benefits to hire the people that they need to because

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they're competing with the big guys. I think we need to look at creative things like bringing the cost of coverage down overall and that is a long discussion but even things like tax credits to the employers. Things like premium assistance that will help them get those kids into their program that will make costs lower for everybody in the plan would help a lot. Just being able to meet participation requirements that I mentioned early on so that they can actually offer a plan would help. There are many, many different things that are not all that expensive and wouldn't be that expensive for the government to do. In addition, making sure that markets are healthy in states, and that we have good ways of taking care of high risk individuals. These are longer conversations here but there are many things that could be done that are not as expensive as you would think.

ED HOWARD, J.D.: Anybody else? Alright. I've got a question for Ann Kohler. Why do families between 250-percent and 350-percent of the poverty line, deserve SCHIP coverage in New Jersey given that a family of four would have income between \$50,000 and \$70,000 at that level?

ANN KOHLER: Okay. We actually get asked that quite a bit and our Governor says that it takes a higher income to be poor in New Jersey. What the federal poverty level doesn't take into account is the differences in the cost of living

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across the nation. Up until yesterday when the Census data came out, New Jersey had the highest cost of living. We were just knocked down to number two by Maryland, usually it's Connecticut. We go back and forth. We have an incredibly high cost of living so you have people, perhaps just if you look at the federal poverty level, it may look like they're quite affluent but when you take into account the cost of living in New Jersey, they really are doing poorly. The state strongly feels they need to help them provide coverage for their children.

LISA DUBAY: When you look at the states that have the higher income thresholds, in general they are high cost states. Not all of them, but the states that have tended to go over 200-percent of the poverty level are states that are high-cost states and so they're really trying to level the playing field. When I think about the Medicare program, we pay providers differentially based on the cost of living across the state, and it seems to me that we shouldn't penalize children that are in these high-cost states and that we should protect children at a really basic level across the country. In a way that is consistent and not based on the federal poverty line. The ability that states have to set their thresholds at different levels really is the flexibility that they need to do that.

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ED HOWARD, J.D.: I am stunned that there haven't been any people who want to get up to the microphones and jump into this, but fortunately a lot of you have written things down. The core issue, according to this questioner, isn't whether crowd-out is inevitable but whether the level applied to expanded populations is acceptable. For example, CBO says that for the House bill that more people will be covered in new populations who have health insurance than do not have health insurance. The question is, is the crowd-out level aimed at this expanded population acceptable? Is that a properly framed policy question? Peter?

PETER ORSZAG: First, let me just clarify that the questioner was correct that if you look at the third from bottom row of the chart that I put up with regard to the House policy, there are 1.2 million new enrollees from expansion populations, 0.5 million of whom would otherwise be uninsured, 0.7 million of whom are coming from other coverage. However, the reason that says other coverage and not private coverage is that there is movement from some state level programs to the federal government under the House proposal and that, there's a semantic debate about what we're measuring or not measuring, but the transfer from a state level program to a federal level program is upper, a mixed federal and state program actually under SCHIP or Medicaid. It's somewhat different than a shift

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from private to public coverage. Let me just say, we have behind our numbers are assumptions that I could clarify. In particular, that every 100 new kids enrolled on Medicaid, 20 of them would come from private coverage. Every 100 new kids enrolled under current eligibility rules for SCHIP, 40 of them would otherwise have private coverage. Of the expansion populations, 50-percent would otherwise have private coverage. You can see from that if the definition of crowd-out is a shift from private to public coverage, then at most you're getting 50-percent. Obviously, evaluating whether or not that is or is not acceptable is not for me to do and it's not for CBO to do. All I can do is, again, emphasizing that given the scale of what the net reduction in uninsured kids under these two proposals, you're not going to do very much better than the crowd-out rates that as a whole the two packages represent. Obviously it's for policymakers and the public to evaluate whether that's worth it or not.

LISA DUBAY: I'd also like to add that when you look at CBO scoring, very few of the new enrollees are actually true expansion population. Most of the new enrollees are for kids that are already eligible for these programs, particularly in the Medicaid program. These are the poorest kids. They are disproportionately poor, disproportionately Medicaid. The increase in coverage that we are getting with these two bills

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will really be drawing from the most vulnerable populations where the crowd-out is the least.

ED HOWARD, J.D.: I've got a couple of questions related to the HHS Guidance that was issued recently. One asks, sort of politically, how does the administration's CMS letter affect the negotiations between congress and the White House? Anybody from either of those points of reference is welcome to get up and answer that as well as our panelists speculating. The questioner wonders whether there is a particular reason for issuing that guidance now from a policy standpoint. More specifically, directed to Peter, how does or will CBO account for the new guidance in the baseline, and any estimates of costs of the legislation going forward.

PETER ORSZAG: I'm glad you didn't ask me the other question because I'm not licensed to practice politics. [Laughter] With regard to the baseline itself, one has to remember that the baseline has a restricted level of funding embodied in it because of our baseline rules relative to continuing to operate the program as it currently exists. Therefore, there would not be a very substantial effect on the baseline because that's constricted by a set of rules. There would be a change in the types of children covered presumably implicit in that baseline but the funding levels would not be significantly affected because effectively the shortfalls are

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so significant under that baseline that the Guidance would perhaps take away some of that but you would still be at the baseline levels. With regard to scoring the proposals, the key question relative to that baseline is whether the proposals are modified to effectively overrule the letter. I suppose we will just wait and see whether that occurs. If it does occur then, from a scoring perspective, the issue is mute. If it doesn't, then we'll have more to say on the topic at that time.

ED HOWARD, J.D.: Would any of our panelists like to weigh in on the political part? Much too analytical set of folks. [Laughter] Wait, there's a brave soul at the microphone. Would you identify yourself, please?

KEVIN FORECKING: Yes, I'm Kevin Forecking with the Associated Press. I'm struggling to understand how come the academic estimates for crowd-out are so much greater than the estimates coming from the states? I haven't heard an explanation that will help me bridge the great difference that has come out from both sides.

PETER ORSZAG: I think I touched on one of the reasons. They're presumably a lot of reasons, but one of the reasons is if you consider a family that has not had coverage for the past six months, or past year, or whatever period of time you want to choose, in the state surveys, if you ask that family whether the children had coverage over the past six months or a year,

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the answer will be no. There is significant amount of labor-market turnover in the United States however, with people changing jobs all the time and that is a feature of the labor-market for low-income families also. It is not implausible that for many such families, after they are on the program, they could have had an opportunity to pick up private coverage but don't. That is not picked up in a backward looking survey. It gets deeper than that. In some sense, you can never really measure it from that kind of survey because it's counterfactual. Do you not take the new job that has coverage because your children already have insurance through SCHIP or Medicaid? There are lots of different things going on but one of the significant factors that likely explain this difference in ranges from the state-based surveys of incoming enrollees and the econometric studies is the econometric studies effectively try to conduct that counterfactual. They try to ask what the world would look like without the public programs, and the other evidence can't do that.

LISA DUBAY: I want to add a little bit to that. The congressional mandated study, in fact, which is the ten state study that I referred to before, one of the things that we looked at was new enrollees. We also looked at established enrollees, people who had been in the program for a period of time. Peter is right to the extent that you don't get to see

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the long-term effects of crowd-out when you just look at enrollee entrants to the program. When we looked at the people who had been in the program for at least a year, we found very little evidence that A their parents coverage or even an offer of coverage, or B that they took up that offer. He is correct in the sense that some of the crowd-out is missing from the enrollee studies but it may not be as high as in the econometric studies. The econometric studies are really difficult to do. Within each of the studies there are large ranges of estimates that include 0-68-percent. They're very sensitive to how we develop this counterfactual. Every study that is out there, I think is very carefully done and because of that, there is a lot of sensitivity analysis which produces a range, which says to me that it's really hard to do this right. I would say that they coalesce between 20-percent and 45-percent, but we can disagree about that. They are very difficult to do, and that's at least part of the difference.

ED HOWARD, J.D.: Now I think the 60-percent that has been mentioned several times comes from Jonathan Gruber, from a recent that I don't know if it is in your packets or a summary of it is in your packets. I also remember Lisa Swirsky, on our staff who has done most of the work here on this program, mentioning to me that there was a letter, I thought, from Gruber to John Dingle saying basically that the CBO numbers

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probably fit these particular bills better than his general assessments, but I could be wrong on that.

PETER ORSZAG: Let me be a little bit more precise on that. [Laughter]

ED HOWARD, J.D.: More precise than that? [Laughter]

PETER ORSZAG: Professor Gruber sent a letter to Mr. Dingle before our range came out but Professor Gruber is a member of our panel of health advisors and was one of the people that we consulted with and very much agreed with our 25-percent-50-percent range that is reflecting the evidence to date. He was not unduly biased by the fact that one of his point estimates was slightly above that range, and signed on to that being the best range.

LISA DUBAY: I mentioned that for an important reason. He has estimates in this paper that are zero and 68. This is the range within studies that we're finding. I agree that it's probably in this lower range, and one of the few outliers. There are others that are out there in that range but they are very much the outliers.

ED HOWARD, J.D.: Okay. Yes, go ahead.

JUDITH WOOLDRIDGE: Yes. Hi, Judith Wooldridge from Mathematica. I just want to make one comment on the last question which is I think one of the reasons that the state estimates may differ from the econometric estimates is

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frequently the states make exceptions. Somebody on the panel alluded to some of those earlier. My question is for those of you who are licensed to practice politics on the panel, would you like to do a crystal ball and talk about what kind of crowd-out requirements will end up in any kind of CHIP bill that we see in September. [Laughter]

ED HOWARD, J.D.: We seem to have more social scientists than we have speculators on this panel.

ANN KOHLER: Certainly we're hoping that they are consistent with the original SCHIP legislation, which said that states need to have a mechanism to assure there is no crowd-out. That mechanism is not defined in statute.

ED HOWARD, J.D.: Alright. A couple of questions that seem to be paired in my mind, one says, not all private insurance is created equal. Some is more comprehensive than SCHIP, some is less. Is there any research on whether children are moving from worse private coverage to better SCHIP coverage or vice versa? And if so, in what proportions? Related to that, does private or public insurance provide better health care? Which one pays more, actually it says pays for more doctors and not pays doctors more, but I suppose those are both aspects of better health care at some level. Either aspect of that? Peter?

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PETER ORSZAG: Sure, I can take a crack at this. It appears, first I need to say there is not very much direct evidence on whether crowd-out occurs because individuals are choosing to move their children from an offer of employer coverage to public insurance or because the firms are dropping that coverage and then not leaving the individuals with any alternative, but what limited evidence does exist suggests that it's mostly individuals choosing to move their children from private insurance coverage, or not take up the private insurance coverage, and enroll in public coverage. That suggests that from their perspective, the public coverage is either more comprehensive or more financially attractive or has other features that are better for their family than the private coverage that they're offered. In other words, one does need to be careful that crowd-out not is necessarily seen as a derogatory term. It can make the individuals involved better off and again we come down to the question of whether it is financially worth it for public policy to be providing that benefit to individuals. Most of the evidence that exists suggests that its individuals choosing to move onto public coverage rather than the alternative. I think that also answers the second part of the question, which is at least from the family's perception the coverage is providing a better mix of co-payments, deductibles, and coverage. I would also just

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note one other thing finally on this point which is that the majority, something like three-quarters of SCHIP enrollees are covered through private plans, through basically managed-care plans. They are often quite similar to the dominant form of coverage through employers. One needs to remember that because that might also inform ones views about the shifts that are occurring.

ED HOWARD, J.D.: Janet, did you want to add to that?

JANET TRAUTWEIN: I just wanted to briefly add to that. To the extent that we have parents not enrolling their children today or in the future, the plan that they can be enrolled under is better than the plan that they are enrolled under now, which is nothing. As Peter said, there is a lot of similarity because a lot of these are private plans. I do want to point out that when we're looking at things like SCHIP or benchmarks or Medicaid benchmarks, that there are certain things that are typically covered by SCHIP that may not be routinely covered in a typical employer-sponsored plan. It is quite simple to cover those things through the secondary-payer or wrap mechanisms so that you can meet a benchmark by a combination of the two and still do it by spending less money than what you would be spending under the public program. I'm not saying that happens every time. There is no reduction in benefits. There was one thing I wanted to respond to real quickly relative to the

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provider access. Of course, depending on how a given state has implemented their SCHIP or their Medicaid program depends largely on whether or not someone is actually able to access providers, whether or not they are in a rural area, and many other factors go into that. In general, we do have a problem of underpayment to providers through public programs. I don't think that's any secret. If you talk to any provider, they would tell you which programs they would least like to be paid under. The availability of providers for some public programs is extremely limited. That is another reason why it is good for kids to go into private plans.

ED HOWARD, J.D.: Lisa?

LISA DUBAY: Yes. Sort of three things. I think what's really absent from this whole debate is what kind of coverage families are dropping. I think having some context on that would be really helpful for understanding this problem and make people feel more or less comfortable about it. Maybe because I'm a researcher I think that's an excellent area for further funding. We also know that when you look at low-income families, in fact, the public coverage being SCHIP and Medicaid on most national surveys really does a better job at providing access to preventive care and surprisingly to dental care than most private packages that low-income families are getting. That's why we do see the substitution. For many families, they

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think it's a better product. I also want to disagree with something that Janet had said earlier about most parents feeling like they don't want to be associated with a welfare program. In fact, what we know about what parents know and don't know is that they're confused about whether or not they are eligible for the programs. When they're told that they're children are likely eligible, a large majority, close to 90-percent of them, say that they would like to enroll their child in a program. Clearly there are some outreach efforts that need to happen to reduce this eligible but uninsured group. Finally, we see that there is actually a lot floating in between Medicaid and SCHIP and uninsurance. One of the things that are exciting about the bills now is that there is really going to be an effort to get those kids and keep them maintained in these public programs that they feel are really helpful to their kids. That's just a different twist on things.

ANN KOHLER: If I could just expand on that. I know that most states have spent a lot of time since the implementation of SCHIP trying to delink Medicaid and SCHIP from welfare. I know in New Jersey and in many states, we talk about this being an insurance program for your child, not a welfare program. You have seen the states changes the names of their programs, etcetera, to try to make that separation

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happen. We're hoping that they're not all viewed as welfare programs.

ED HOWARD, J.D.: We have about 15 minutes left as we go into this last question period. I encourage you to pull out those blue evaluation forms and start filling them out now so that you can do it at your leisure while we go to the microphone. Yes sir?

CHRIS LEE: Hi, I'm Chris Lee with the Washington Post. I think Dr. Orszag said earlier that crowd-out becomes more of an issue the higher up you go on the income ladder and it seems like part of this debate is not so much about what the crowd-out rate is overall for the CHIP program but if you expand it to the populations with somewhat higher income, then what does it become? I was wondering if you could talk about, you know the magic number in the CMS Guidance says 250-percent of poverty, when you start to serve families from 250-percent to 350-percent or higher than that, what would the crowd-out rate be?

PETER ORSZAG: Again, in our estimates, as you move into expansion populations, that are above current income eligibility thresholds, in the SCHIP program, the crowd-out rate goes from 40-percent, which is for the existing population, to 50-percent. It is higher as you move into higher income ranges. The fact that the overall crowd-out rate

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is about a third under both proposals however, should indicate that the vast majority of the children being added to the roles under these proposals are coming at lower income levels and indeed are coming through the Medicaid program. Most of the additional cost associated with these proposals is not for the expansion populations but rather for picking up children who are currently eligible but unenrolled especially in Medicaid, and that is not surprising given the way that the proposals are designed. They are designing very strong financial incentives for states to go out and be sort of vacuum cleaners to try to be picking up kids who are not currently enrolled but who are eligible for the programs. Estimates suggest that there are somewhere between five and six million children who are uninsured but are eligible based on their income and other characteristics for Medicaid or SCHIP. That's mostly what these proposals are doing. You're also right that they have components that depending on the Senate or House approach are picking up expansion populations and crowd-out is a bigger factor in those additional populations than for the base population.

CHRIS LEE: So, based on that though, it seems like one could turn it around then and say that if most of the focus is on the kids who are already eligible, and just for the sake of

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argument, the political outcry to the CMS rule seems out of proportion with the effect on the program.

PETER ORSZAG: The vast majority of children currently enrolled in SCHIP are under 250-percent of poverty, in fact they are under 200-percent of poverty. I think the real question is going forward, whether the new letter poses significant constraints on what states were hoping to do. I think you're right that in our estimation the effect of the letter, especially under our baseline as I said before, may not be as significant as some of the discussion suggests but one does need to take into account that various state administrators, including the one that we have on this panel, have raised concerns about the effect that the letter will have on their ability to conduct even what they are currently doing.

ED HOWARD, J.D.: Can I just ask a related question?
Oh, I'm sorry, go ahead.

LISA DUBAY: I think part of the outcry has to do with, for some states they're not affected by the CMS Guidance and for other states they are and those states happen to be for the most part high cost of living states. Maryland, for example, is at 300-percent of the federal poverty line. Their participation rate is nowhere near 95-percent and, importantly, they will probably lose coverage of children. I think what's really important about what the new legislation does is

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currently states have a greater financial incentive to enroll a SCHIP child than they do to enroll a Medicaid child because of the federal match. What these plans really are trying to do is to make the incentives to enroll that Medicaid child who is the low-income child rather than the higher-income child, and to that extent we're going to see less crowd-out, and we're going to see more coverage of Medicaid eligible children.

ANN KOHLER: If I can add to that, in New Jersey, every time we do an outreach, we bring in two Medicaid and one SCHIP child, so we do bring in the lower-income children, even though we only see a 50-percent match for it. We feel it's important that all children are insured. We're really concerned with the CMS letter. One, the administrative burdens it puts on us is enormous. Two, as the word gets out there, we're afraid people aren't going to come and apply and there will be sort of a chilling effect out there in the community and we will lose children just because people are afraid to apply.

ED HOWARD, J.D.: Actually, in the course of reading some of the background material in preparation for this briefing, I kept coming across assertions by people, particularly some of the people associated with the county experiments in California where they have filled in the gaps and basically said that every kid is eligible regardless of anything. The assertion was that helped them recruit low-

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income kids who were eligible for existing programs. Is there validity to those observations? Has anybody done any research to quantify it if it is?

ANN KOHLER: Not exactly on that point but in New Jersey, what we're trying to do is use the entire cabinet of the state of New Jersey to find children. Governor Corzine has charged every cabinet member to find them. While they are not all eligible, we are reaching out and trying to link them all up. Education department asks every child if they have health insurance and outreaches those that don't. When you are applying for unemployment benefits, you are going to hear a message about while you are unemployed, sign your child up. For our FamilyCare program, if you are getting your driver's license, there are posters and applications all over there. We are trying to reach out throughout the entire state through every agency that we have to try and find these children.

PETER ORSZAG: I think the evidence does show fairly clearly across a wide array of programs that simpler and more universal programs do have higher take-up than more targeted and more complicated programs. In some sense that's kind of the thing that my mother would say, well duh to. For example, in education it's very clear that the state level programs that are very simple and universal have had much higher take-up than much more targeted federal assistance, which happens to be very

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complicated. Again, as always, we're social scientists and there is a trade-off which is you can get higher take-up with the simpler and more universal programs but it's also more expensive. That is for policymakers and the public to evaluate.

ED HOWARD, J.D.: Yes, sir.

BOB HALL: I'm Bob Hall with the American Academy of Pediatrics. What I always love about these things is the lunches that you put on. It's just so encouraging to know what we do know and what we don't know. It seems that in this area, there is so much that we don't know. It's so hard to nail down exactly what's happening out there. What's happening to these children? What's happening to these families trying to get their kids coverage? One of the things that we've been advocating for, as time has gone by, has been some sort of commission similar to what MedPack is for the Medicare program. The precursor to the MedPack program was the PPRC, which looked both at Medicaid and Medicare rates. There is not something that is similar to that on the Medicaid and SCHIP side and so we're very excited to see that in a House bill, very excited to see that in some of the Senate proposals that have been out earlier. We really believe that there is an access issue right now for a lot of kids who are on Medicaid and SCHIP. We love their programs. Obviously, they're very effective for what

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kids get. Sometimes some specialists cannot be seen. Sometimes kids can't get the benefits they're entitled to. So going forward, we think that questions like this, is crowd-out really pushing kids onto public programs? Is it not? Are kids, once they're actually covered by Medicaid and SCHIP, actually getting the services that they need to be getting? These are very important questions to ask and to analyze for future activities that go on. As folks are looking at this, have you looked at both crowd-out, and specifically the private aspect of this. Once kids get onto the public programs, are they really able to get the services that they need?

ANN KOHLER: That is a significant issue for most states. I think it was mentioned previously that many government programs have relatively low rates, and I think that's why many states have worked to purchase insurance through managed care plans for their children. I believe that through moving children out of inappropriate hospitalizations, you can use the savings to increase physician rates. In New Jersey, we know that our rates are extremely low. We are planning to increase rates for pediatric providers in January. The Governor has targeted additional funds in our budget to allow us to increase rates, but I think we do have a ways to go.

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PETER ORSZAG: I would just add really briefly, I think even more broadly than the question, we are simply not doing enough to examine what we are getting in health care broadly speaking period. In other words, we are not doing enough research on what we are actually getting for the very substantial amounts of money that we are putting into the health care system in terms of what we are getting in terms of health outcomes. There is a very substantial amount of additional research that could be examining what works and what doesn't. Not only on the public programs but more broadly so that we could move towards a system in which if we are going to wind up spending 20-percent, 30-percent, 40-percent, 50-percent of GVP on health care, we can make sure that we are getting as much for it as possible. I do not think that we are currently in that position.

ED HOWARD, J.D.: A question that follows up on one of the questions we just addressed, and it does it in a two part question. It has to do with the effect of CMS recent guidance on this issue. Isn't it true or is it true that the CMS letter is retroactive to states that have already gotten approval in previous years to cover higher-income kids? Does the letter also affect states expanding above 200-percent that need to seek approval from CMS to do so? Ann?

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ANN KOHLER: I'm not going to address that. Yes. We've had approval to cover these children since 1999 and suddenly now we're being questioned and told that, oh well, you can cover them but there are additional hoops that you have to go through. We also question whether or not this kind of dramatic change can be done through a letter to states which came out at 7:30 on a Friday afternoon. That this kind of significant change in the program should be fully discussed, fully vetted and not just be an overnight letter. All of the states that are operating have gotten federal approval from CMS.

ED HOWARD, J.D.: There was, by the way, a question in here that didn't get asked about whether the panelists thought that this guidance letter really was of a substance that required regulatory action and therefore the full panoply of proposed rule-making and so forth. Peter, did you have something to add to that?

PETER ORSZAG: No. [Laughter]

LISA DUBAY: I would just like to say though that it's inconsistent with the President's budget for SCHIP.

ED HOWARD, J.D.: We do have a bunch of cards, but we have just about run out of time and most of the cards have been addressed at least in part in this very wide ranging, and I think very useful discussion. I would like to thank you for

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hanging in there as you fill out your blue evaluation forms. I
want to take special thanks again to the United Health
Foundation for its encouragement and support in staging this
particular event, and I would like to ask you to join me in
thanking our panel for an incredibly useful discussion.
[Applause] Very nicely done.

[END RECORDING]