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Section Co-Chairs' Corner

The Health Law Section (HLS) of the Boston Bar Association is looking forward to an active and informative 2007-2008 session for our current and prospective members. The HLS is fortunate to be guided by its committees and their able co-chairs: **CLE** (Alan Einhorn, Robin Johnson, and Bill Mandell); **Communications** (Katie Annas and Susan Stayn); **Legislative** (Josh Greenberg, Linda Tomaselli, and Mike Sroczynski); **Membership** (Eve Horwitz, Dianne McCarthy, and Dave Szabo); and **Social Action** (Sarah Anderson, Michael Blau, and Clare McGorrian).

Each of these committees and their members work hard to bring important events to our membership throughout the year. One committee – Communications – is responsible for this publication. On behalf of the Communications Committee and the HLS, we are pleased to present the fall issue of The Boston Health Law Reporter. The Reporter is the product of the thoughtful work of Co-Editors Katie Annas, Susan Stayn, and Mark Rogers, Committee members, contributing authors, and peer reviewers.

This issue of the Reporter continues to demonstrate the Section's commitment to bringing wide-ranging topics of interest to our diverse membership. In particular, the issue contains another in our Policymaker Profiles series with interviews by Thuy Wagner with State Representative Peter Koutoujian and State Senator Dianne Wilkerson, Co-Chairs of the Special Commission on Health Care Disparities, discussing the Commission's recent report. Regular contributor and former HLS Steering Committee member, Tom Barker, offers another timely Washington Word article on SCHIP Reauthorization, and HLS Legislative Committee Co-Chair Josh Greenberg gives another view of the SCHIP reauthorization. Finally, the Reporter continues to offer its members information on developments in health law through its regular Health Law Briefs section written by Alpna Kumar.

As you read through this issue of the Reporter, we hope that you will consider becoming even more active in the HLS. We are always seeking contributing authors as well as presenters for continuing legal education events and our brown bag lunches. Your active participation in the Section further strengthens our efforts to bring important information to our members for use in their health care law practices, whether in private practice, government, or in-house. Please do not hesitate to contact us with your ideas.

See you at the Boston Bar Association!

Larry Vernaglia and Matt Herndon

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Policymaker Profile: Senator Dianne Wilkerson

Co-Chair, Special Commission on Health Care Disparities

Interviewed by Thuy Wagner, Esq., Assistant General Counsel at Boston Medical Center

Editors' Note:

In August 2007, Massachusetts House Representative Peter J. Koutoujian and Senator Dianne Wilkerson issued a final report of the Commission to End Racial and Ethnic Disparities. The Commission, which they co-chaired, was established by legislation in 2004 and was charged with analyzing racial, ethnic, and linguistic disparities in health and developing recommendations to address those statewide.

The report reviews the social context of health, including how racism and discrimination, socioeconomic factors, housing, and environmental exposures affect health and health disparities. It discusses challenges in access-to-care as well as opportunities in light of the state health care

reform law, and focuses attention on research documenting that minorities receive lower-quality health care. The report makes several recommendations, including (1) the creation of a state center to eliminate health disparities; (2) the expansion of access to quality health care, in part through ongoing proactive attention to how health care reform is implemented; (3) improvements in workforce training and diversity; (4) the tracking and improving of health care quality, and (5) the promotion of social conditions that enhance health and reduce disparities. To access the report, please see: http://www.mahealthcouncil.org/2007_Disparities_Report.pdf

What in particular inspired you to initiate a comprehensive report on racial and ethnic health disparities?

Before issuing the report, or appropriately what prompted me to push the creation of the Commission, was my filing of legislation in 2004 requiring Massachusetts to engage in this assessment through what was called the Commission to Eliminate Racial and Ethnic Health Disparities. It was borne out of a growing concern that the health issues that my constituents were dealing with, in one of the most diverse Senate districts in the state, were not going to be addressed illness by illness. We were never going to do justice to the bigger picture. I realized something was wrong, whether it was from the Latino community around infant mortality, the black community around prostate

cancer in African-American men and breast cancer in African-American women, and the Asian community around milk and lactose intolerance. So we did a study to determine the impact of lactose on the free/reduced lunch, free/reduced meal diets for children who attended the Boston Public School System, and elders that live in elder development, and then I filed a bill on prostate cancer, so it seemed to me that if I did one illness every two or three years, it would take me 60-70 years before I got through them all. We decided that the best way to do this would be to approach it in a comprehensive fashion by doing the overall study of racial and ethnic disparity in Massachusetts. This then would allow us the context to devise some remedies and polices and even financial support, so that was the why.

Who served on the Commission to End Racial and Ethnic Health Disparities?

The Commission was one of the most comprehensive and diverse groups of representatives from across the spectrum: advocates, health care professionals, hospital administrators, practicing physicians, nurses' associations, the American Cancer Society, and labor representatives. We really tried to make sure that it was as broad as possible and with people of different interests at the table so that we could have all the stakeholders present. We invited the public to every meeting. We took testimony and had public hearings. It was almost two years of intensive research and fact-finding on this matter.

What aspect of the Commission's findings was most surprising to you?

I think I was of the same mindset as many people. I assumed that one of the main reasons that we had racial and ethnic health disparities to the degree that we did was because we had such a large number of people who didn't have health insurance. I thought that if we could figure out a way to get health insurance for everyone, then that would be half the battle. The surprise was that in Massachusetts, we have the largest percentage of people who secure their health insurance through private insurance, and a small percentage of people who relied on public insurance for health care. So, it eliminated that off the table from the beginning.

I had some ideas around individual illnesses like infant mortality. That was an issue we could address if we could get mostly poor women to their health center for prenatal care sooner. The racial and ethnic health disparities were ones of access, and we had to do a better job of educating people so they would get the health care sooner in the pregnancy, and the same for breast cancer. The surprise that I learned was that for breast cancer, black women have a higher percentage who seek and get treatment for breast cancer, but still have a higher rate of mortality. It is the same for infant mortality. The surprise was this wasn't about poor black women – that black women at every level, even higher-income women, had higher rates of infant mortality than poor white women. So all of these things were at play for me. I was surprised to learn about the outcomes and that it was not as simple as we thought.

What can be done about the racial factors that contribute to so much of the health disparities?

Education is a huge issue. For that reason, I am happy that we had representatives from the teaching hospitals. It starts that early. It's not just the issue of access to health care; it's the quality of the health care once accessed, where there was strong evidence suggesting that most of the time, even physicians were giving different kinds of advice and treatments to people for similar ailments and, in my opinion, not even being fully aware of it.

When the Institute of Medicine did the study that was released in 2002 called "Unequal Treatment," the doctors did one of the best professional self-assessments that I have ever seen. Most people would say, oh, you can't have them policing themselves, but in fact, I don't know whether there has ever been a more thorough review. I think at the end, they even surprised themselves. The example I use most often is the emergency room. They found that blacks that present to the emergency room with a broken upper arm bone get 32% to 38% less pain medications than whites that present for the same ailment. So even the physicians were saying, what's all this about? I think a single-digit disparity may not have raised as much concern, but when you're talking about as close as 40%, it was something that everyone had to stop and look at and physically, had to be more introspective.

I think that is a lesson that is getting played over and over again. We see this issue around the content of the instruction. We have to do a much better job of getting students in the pipeline earlier in the process of every

level of health care: the advocates, the community workers, the doctor's aides, the nurses, because it's not just the physicians that make up what we call the health care system. We have a pipeline problem in Massachusetts and in this country. We saw statistics that suggest that in the year 2002, there were fewer than five -- not 5%, but five -- African-Americans who chose psychiatry as a specialty. At the same time, we have this explosion in terms of the impact of mental health in that very same population. So, if we are going to deal seriously and talk in terms of cultural competence, for example, it's going to be very difficult to do this with little or no pipeline of people who are choosing this as a medical specialty. The importance of the teaching hospital was made very clear to me as we saw the presentation around pipelines, and more students of color in the math and sciences is the only way we are going to have bigger product outcomes or output at the end of the line. We have to have more going in, and hopefully the report will create the conversation and the planning around how to do that.

Boston has many community health centers spread out in many neighborhoods in which the health workers represent the neighborhood. How are these health centers effective or not effective in decreasing racial/ethnic health disparities?

The number of health centers in Boston is the reason why we are so encouraged that we have the structure in place to change this dynamic more than anyone else in this country. We have more community health centers per capita in Massachusetts than in any other state in the U.S. You couldn't go anywhere in a capital city and find 17 or 23 community health centers. I have 14 community health

centers in just my Senate district. That statistic alone does not translate to better health on every one of the indicators that we measure. I think what it does suggest is that we have the framework in place for a comprehensive plan to reduce racial/ethnic health disparities. Community health centers are our first line to the people we're talking about; more people are likely to be receiving their health care at community health centers so they are a necessary part of any real and effective plan.

I think right now, the community health centers do the best they can with the resources they have. We don't resource them enough and sufficiently with the charge of the elimination and reduction of ethnic/racial health disparities. They have a spotty record in terms of a program here and a program there, but they do the best they can. I don't think there is even an overall plan, a community health center plan, to focus on the elimination of racial/ethnic healthcare disparity.

The report recommends the establishment of a Center for the Elimination of Health Disparities at the state level. How will this Center be created, funded, maintained, and accounted for?

The center morphed into the Health Disparity Council, which was created under Chapter 58 of the Healthcare Reform Law in Massachusetts. The Health Disparities Council is located in the Executive Office of Health and Human Services, and that office and that Council are charged with implementing not just the findings of the Commission's work, but also any other policy matter that would impact health disparity in state government. The good news is that since

that was written a year ago, we have a different administration; we have a governor who himself has very clearly, openly, loudly, and publicly embraced his goals of eliminating racial and ethnic health disparities. We have a secretary of HHS who was a practicing physician and more importantly, a member of the Health Disparities Commission, and a Commissioner of Public Health who led the capital city Public Health Commission and who also himself was a member of the Commission. So we feel like we have support in terms of the policy and the executive branch structure of those who are going to be charged with implementing the findings of the Commission and any of the other matters.

The Commission members' task ended after the report was issued. The Council will be comprised of people who sat on that Commission and will now be charged with implementing that work. I was appointed as one of the Senate members, and I will serve as a Co-Chair of the Council. My House Co-Chair of the Commission will serve as House Co-Chair of the Council. Representative Peter Koutoujian and I will work in collaboration with the Secretary of HHS and her staff on this. I think it will be daunting but doable and a most certainly accomplishable process of trying to determine how we can further move the needle in the elimination/reduction of racial/ethnic health disparities in Massachusetts.

People have talked about racial and ethnic disparities for many years and in different forums. Why do you believe this issue is given more serious focus now?

We know that this is a huge cost issue for us, not only in the country but also

in the Commonwealth. One reason we had so many people at the table in Massachusetts is because they all came to realize the sheer cost is one that we share, so it is in our collective best interest to try to tackle this issue. I use the cost that we spend on an annual basis in MA just dealing with respiratory-related illnesses, whether it's cigarette smoking or asthma. It's between \$350 – 400. This is a lot of money that we could be spending on something else if we dealt with this in a serious way. This is about more than doing the right thing morally; the sheer cost, we can't afford to not deal with it.

I think what makes it optimistically more doable than it might have been 18 years ago is the fact that we had virtually every hospital administration executive through a representative. When they first heard about this Commission, people were very excited and there was advocacy for appointment on a Healthcare Disparities Commission in 2005 and 2004. In 1994 and maybe even as late as 1998 and 1999, 2000, that just wasn't the case. I think the perception was that the problem belonged to the very people who were suffering. Now, you have a broader reach and wider stretch of the universe of people and stakeholders who are owning this as our issue. This is the only way we are going to see any real improvements, which means a decrease and elimination of the impact of health disparities in our society.

Where do you start in addressing such a huge issue?

I think you start with the Council. You start with where it is, in the executive level, in terms of the implementation that is the bully pulpit of the governor and the whole executive

branch. It has reach at every level, whether it's the environment, housing, or healthcare, so it seems that the executive branch, in terms of the implementation framework, would be the natural place to start. We do expect continued engagement by the teaching hospitals.

Why should the State Legislature fund this initiative, and aside from money, what will be needed to begin to tackle this issue?

I think that the reason that there was so much resistance in taking this at the policy level and with some of the legislative leadership was very clear: that if we do this, you're going to come back and ask us for a lot of money, but that is not a reason not to do it. We have to do it. We have to figure this out, and of course, now we know that some of this is about, but not all of it is about, money. Some of it is about how we live. Some of it is about reutilizing or redirecting the tools and distributing them in a different way. It's about education, it's about what you teach students who are sitting in front of you, and how it should be different than it may have been five or ten years ago.

The other argument is we are in it right now. It's costing us a whole lot right now. I'd like to think that what we prevail in doing is convincing them that it is more costly for us to not address this, because the numbers will only go up.

What do you believe is the biggest challenge to ending racial/ethnic disparities?

One of the biggest challenges I mentioned is that race is a difficult issue to discuss and it remains so,

the workings and process of the review. It's very difficult for people if you'd like to think -- whether you're a doctor, nurse, dean of a teaching hospital, legislator, advocate, or hospital administrator -- it's not a major presence in your mind as you're looking at people and processing their health assessment and their health needs. The reality is that race does play probably more of an enormous role in part of the social policy and fabric of this country than it should. While it is a difficult topic, we should continue to challenge ourselves on how to deal with it in a way that we all win and end up with better policy in the context of dealing with racial and ethnic differences.

Policymaker Profile:

Representative Peter Koutoujian

Co-Chair, Special Commission on Health Care Disparities

Interviewed by Thuy Wagner, Esq., Assistant General Counsel at Boston Medical Center

What in particular inspired you to initiate a comprehensive report on racial and ethnic health disparities?

I am not a racial and ethnic minority and I grew up in Waltham, which, at the time, did not have a significant ethnic minority population. Even though I cared a lot about people's health, I was not aware of the issue of racial and ethnic health disparities until a friend took the time to educate me. I was appalled to learn that infant mortality rates, diabetes rates, and cardiovascular disease rates among ethnic minorities were five to ten times greater than among whites. I was outraged by a system that seemed to be failing entire populations to such a degree and what outraged me even more was that there was no one standing up and speaking about it.

After I understood more about the effects that ethnic and racial health disparities have on the community at large, I began to work very hard on this issue. I think for many people, it's not that they don't care or wouldn't care about this issue -- it's because they don't know about the issue. I think a large part of the Healthcare Disparities Council will be to continue to drive the issue so that people who wouldn't otherwise interact with people affected by racial/ethnic health disparities will better understand that this is a problem and, in some small way, will be able to contribute to finding a solution.

Who are the stakeholders who need to be at the table to address this issue more effectively?

We need to have the government and health care delivery system at the table. By health care system, I mean hospitals, physicians, other health care workers, and the insurance companies. We need business leaders and the community. We need all groups to get together to work on the elimination of health care disparities. Four or five years ago when Senator Wilkerson and I began this battle, there weren't many people who understood this issue and there weren't many people who were supportive of the issue. Over the past few years, as we have continued to address this issue, we are seeing more people are becoming aware of the issue and more people who are driving this issue.

Various researchers and community groups have issued a report or study such as this in the past. What makes the Commission's report particularly unique?

This was a state-supported entity so it carries with it the imprimatur of the Commonwealth of Massachusetts. The Commission did not just study ongoing problems -- it also made specific recommendations based on the findings.

How will the Council on Healthcare Disparities work to implement the Commission's findings?

As the Council is being created, there have been discussions among the Administration and Legislature on how best to utilize the efforts of this Council. We are addressing legislation now and will lay down concrete powers and expectations of the Council. I anticipate that the Council will meet several times a year and will monitor the data that comes out of the Healthcare Reform Act. I think that having a Commission that had a start and end date helped to drive the issue forward, and having a Council that is written into the law will make its effort all that much more powerful in continuing to push to end racial and ethnic health disparities.

Do you foresee the State Legislature providing grants, via the Council, to community groups to carry out the Commission's initiatives?

Depending on resources available, absolutely, particularly providing grants to pilot programs that address racial and ethnic health disparities and those groups that can provide the Council with data on effective or non-effective ways to address racial and ethnic health disparities.

What legislation would you propose or support to advance the Commission's initiatives?

Right now, we're just focusing on the creation of the Council and the role that the Council will take to implement the Commission's initiatives. However, a great awareness of the social factors is going to be key. I think we must continue to drive home the issue of social justice in order to be able to begin to decrease or eliminate racial and ethnic health disparities.

Are there particular ethnic groups that you think are left out in discussions about racial and ethnic health disparities?

When we speak about ethnic health disparities, we forget to include Asians. When we speak of ethnic health disparities, we tend to think that it only affects African-Americans or the Hispanic and Latino populations. Asians should be considered part of this discussion too. The Asian population consists of Hmongs, Chinese, Japanese, Pakistanis, Indians, and so on, and the health disparities that affect these groups can be quite devastating so we cannot forget to include them as part of this discussion.

How have other states addressed the issue of racial and ethnic health disparities?

After we began our Commission's work, we received national attention. Some other states have begun to create entities to gather information on health care disparities. All of these efforts began after we initiated our work here in Massachusetts. We are the first state in the country to issue

such a comprehensive report, and we are the first state to approach this issue in such an expansive and systematic way.

Washington Word: The Reauthorization of the State Children's Health Insurance Program (SCHIP)

By Thomas R. Barker, Esq., Counselor to the Secretary, US Department of Health and Human Services

The State Children's Health Insurance Program (SCHIP) was enacted in 1997,¹ and was initially funded for a ten-year period.² Because Congress had not reauthorized the program by October 1, 2007, funding for the program expired on that date.³ Congress has passed legislation to reauthorize SCHIP for an additional five-year period,⁴ but on October 3, 2007, President Bush vetoed that legislation.⁵ This article briefly describes the original SCHIP program, its operation, and its many successes. It then describes the reasons for the President's veto of the legislation. It concludes by describing possible next steps.

The Original SCHIP Program

SCHIP was designed to provide health insurance to low-income children who lived in families that did not qualify for Medicaid (primarily because their income or resources were too high) but did not earn enough to afford private health insurance. Like Medicaid, SCHIP is a state-run program, but it is also different from Medicaid in many important respects. First, SCHIP is not an entitlement. Second, SCHIP bears less resemblance to a defined benefits program than Medicaid. Third, for states that elect to participate in SCHIP, their contribution is less than the required state contribution in Medicaid. Each of these three distinctions is discussed in greater detail below.

The original Medicaid program is a classic 1960s-style government entitlement program. To fund the

program, authorizing legislation appropriates "a sum sufficient to carry out the purposes of this title."⁸ Under the program, a state plan for medical assistance is guaranteed a federal contribution equal to the "federal medical assistance percentage" (FMAP), generally regardless of the cost of its program.⁹ For example, the California FMAP for fiscal year 2008 is 50%;¹⁰ thus, for every dollar California contributes to the state Medicaid program, the federal government will contribute \$0.50, with no limit or cap on spending. By contrast, the SCHIP program appropriates a fixed sum of money to be allotted to states.¹¹ The authorizing legislation devises a complicated formula for state allotments, but the state's allotment is disbursed based on an enhanced FMAP. For example, the California enhanced FMAP for fiscal year 2007 was 65% and its SCHIP allotment was approximately \$800 million.¹² This means that for every dollar California spent on its SCHIP program, the federal government contributed \$0.65, but only up to \$800 million. Once a state's allotment is exhausted, the statute does not provide authority for additional funds.¹³

The original Medicaid program is also a classic 1960s-style defined benefit program. It, like Medicare, has a very precise list of required benefits, which has been added to and modified over its 42-year history.¹⁴ Generally, a state may only deviate from this list of required benefits through a waiver granted under authority of 42 U.S.C. § 1315(a)(1) or (2) or by submitting an amendment to its state plan for medical assistance.¹⁵

By contrast, states have great flexibility to determine how they offer medical assistance under SCHIP. A state can offer SCHIP benefits through a range of benefit coverage options, through its Medicaid program, or through a combination of both.¹⁶ The range of coverage options are particularly intriguing. A state that elects this option may offer "benchmark" coverage, "benchmark equivalent" coverage, or any benefit package approved by the U.S. Secretary of Health and Human Services and determined "appropriate" by him.¹⁷ Benchmark coverage refers to coverage that is equivalent to the Federal Employees Health Benefit Program; coverage available to state employees in the state offering benchmark coverage; or coverage available under the largest commercial HMO offering available in the state.¹⁸ Benchmark equivalent coverage is coverage that is actuarially equivalent to benchmark coverage. The point is to make SCHIP coverage look more like commercial coverage than the traditional Medicaid "government-knows-best" defined benefit package.

Finally, SCHIP is more generous to states than traditional Medicaid. The federal contribution to a state Medicaid plan is equal to the FMAP, discussed above. A state's FMAP varies in inverse proportion to the per-capita income in the state (that is, the lower the per-capita income, the higher the FMAP). The lowest FMAP is 50% and the highest is 83%.¹⁹ By contrast, under SCHIP, states receive an "enhanced FMAP." The lowest SCHIP match rate is

65% and the highest possible match is 85%, though no state has an enhanced FMAP that high.²⁰ Hence, it is theoretically to a state's benefit to enroll someone in SCHIP rather than Medicaid because of the higher match and greater benefit flexibility. These benefits, however, are limited by the fixed SCHIP allotments which are not a feature of traditional Medicaid.

SCHIP is generally considered to be a success. As of 2006, since the program's inception, 6.6 million children have ever been enrolled in SCHIP.²¹ Because of SCHIP, the number of children without health insurance in the United States is in a state of decline.²² States are supportive of the program, as are Republican and Democrat members of Congress. President Bush is also a strong supporter, and proposed reauthorizing the program in February and increasing the allotments by 20%.²³

The Reauthorization Legislation

Despite the fact that President Bush proposed reauthorizing SCHIP in February, Congress waited until this summer to begin considering its version of the reauthorization legislation. In July, the Senate passed legislation that would have reauthorized SCHIP for five years and increased spending on the program by \$35 billion, or 140%. Shortly thereafter, the House passed its version of the legislation which would also have reauthorized the program for five years, but would have increased spending by 200%. In September, both Houses of Congress agreed to pass a compromise bill that was closer to the Senate version of the legislation.

The final bill, H.R. 976, would have provided \$9.125 billion in allotments to states in 2008, gradually increasing to \$13.750 billion in 2011, before plunging to \$3.5 billion in 2012.²⁴ The bill dramatically expands SCHIP, creating enormous incentives for states to expand enrollment beyond the current definition of a "targeted low-income child" in the Social Security Act to as much as 300% of the federal poverty level (FPL).²⁵ Although it purports to eliminate coverage of adults under SCHIP, in reality, H.R. 976 continues to retain adult enrollment in this children's health care program, provided programs meet certain enrollment targets for children.²⁶ The bill would also prevent implementation of the provisions of SCHIP that are designed to guard against "crowd-out," or substitution, of public health insurance for private health insurance.²⁷

The Veto of the Legislation

On October 3, 2007, President Bush vetoed H.R. 976. In his veto statement, the President said that "because this legislation would move health care in this country in the wrong direction," he was returning it to Congress without his approval.²⁸ In particular, the President highlighted three principal objections to the legislation. First, he objected to provisions of the bill that would move the program to one that covered middle-income Americans rather than low-income Americans.²⁹ Second, he objected to the fact that SCHIP coverage would displace private health insurance coverage for many new enrollees in the program.³⁰ Third, the President objected to budget gimmicks that do not fully finance the legislation.³¹ An analysis of each objection follows.

Although H.R. 976 does not expressly amend the definition of "targeted low income child," the legislation would provide ample opportunity for states to raise the income eligibility threshold under SCHIP to 300% of the FPL, or roughly \$62,000 for a family of four. This income level should be compared with the median family income in the United States, which is \$58,865 for a family of four.³² Indeed, the Congressional Budget Office (CBO) assumes that many states would increase SCHIP eligibility to these solidly middle-class families, and estimates that of the 3.8 million newly-insured children under the bill, 1.2 million of them, or about one-third, would have incomes above the current income threshold.³³ States that raise their income threshold are guaranteed the enhanced match for doing so.³⁴ In addition, because the allotments provided in 42 U.S.C. § 1397dd(a)(11) – (14) are far in excess of what governors have told CMS they would need to operate their SCHIP programs, states would have a clear incentive to raise their income thresholds.³⁵ President Bush has also noted that some children in families of four earning up to \$83,000 per year would qualify for SCHIP under H.R. 976 – an income level that approaches upper middle class.³⁶

The President also vetoed H.R. 976 because the legislation would replace private health insurance coverage with public health insurance coverage, or "crowd out" private insurance, to a significant extent. According to the CBO, the bill would result in approximately 33% of all newly-enrolled children losing their private coverage and 50% of all children at higher income levels losing that coverage.³⁷ The legislation would also prohibit CMS from implementing the guidance that it issued on August 17 designed to ensure that

SCHIP coverage does not “crowd out” private coverage.³⁸ Thus, far from preventing children from losing private health insurance coverage, the bill is drafted in a way that would result in exactly that.

Finally, President Bush vetoed H.R. 976 because it is not funded. Superficially, the CBO estimates of H.R. 976 show a slight decrease in the deficit as a result of the enactment of the legislation in either the five-year or ten-year budget window.³⁹ This is only accomplished, however, by plunging the SCHIP allotments from \$13.75 billion in 2011 to \$3.5 billion in 2012.⁴⁰ It is clear why Congress undertook this accounting gimmick: by artificially plunging the allotments by over \$10 billion in one year, Congressional budgeting rules then make the baseline for SCHIP spending in fiscal year 2013 appear to be \$3.5 billion – a level more than \$1 billion below the current SCHIP allotment.⁴¹ No one seriously believes that SCHIP spending will fall by more than \$10 billion in 2013, however. If that were to happen, according to the CBO, the number of children on the program would fall from its 2006 level of 6.6 million to 1.3 million.⁴² These statistics, of course, call into question the seriousness by which the proponents of H.R. 976 claim to be covering “ten million kids” under the program.⁴³

Conclusion

On October 18, 2007, the House of Representatives sustained the President's veto of H.R. 976 by a vote of 273 – 156. Earlier in that week, President Bush designated Health and Human Services Secretary Michael Leavitt, Office of Management and Budget Director Jim Nussle, and White House National Economic

Council Chairman Al Hubbard to negotiate compromise legislation with Congress.⁴⁴ The sponsors of H.R. 976 have demonstrated little interest in compromising with the Administration, however.⁴⁵ In fact, just one week after the House sustained the President's veto, it passed nearly identical legislation in a futile attempt to secure enough votes to override another veto.⁴⁶ The Senate passed the same legislation on November 1. The President has threatened to veto this new legislation as well.⁴⁷

One might have hoped that the debate over reauthorizing SCHIP, an important government program, could have been conducted responsibly and without demagoguery. Unfortunately, the hyperbole surrounding the SCHIP debate reflects the “de-intellectualization of public life – the substitution of sentimentalism for reasoned persuasion” public policy in 2007.⁴⁸ Rather than engage in a fulsome debate about the 47 million Americans who lack health insurance at some point in the year, and the proper role of government in providing health insurance to those people, the SCHIP debate has instead been conducted with simplistic slogans that have masked the need for this much larger discussion. Now that the House of Representatives has sustained President Bush's veto of

period. 42 U.S.C. § 1397dd(e). On October 1, 2007, 37 states had allotments available from prior fiscal years. Of the remaining 13 states, most had developed contingency plans.

⁴ H.R. 976, 110th Cong., 1st Sess.

⁵ Message to the House of Representatives Returning Without Approval the Children's Health Insurance Program Reauthorization Act of 2007, 43 Weekly Comp. Pres. Doc. 1298 (October 3, 2007) (hereinafter, “Veto Statement”).

⁶ See 1997 U.S.C.C.A.N. (111 Stat.) 518 (describing purpose of SCHIP as expanding “the provision of child health care assistance to targeted uninsured, low-income children” (emphasis added)).

⁷ 42 U.S.C. § 1397bb(b)(4).

⁸ 42 U.S.C. § 1396.

⁹ See 42 U.S.C. § 1396b (describing payments to states). To be sure, the federal government's obligation is not open-ended; a state plan for medical assistance must, for example, have fraud control measures, see, e.g., 42 U.S.C. § 1396a(b)(6)(B) and (q). In addition, a state may not use provider donations or health care related taxes to derive its state share of medical assistance without complying with the requirements of 42 U.S.C. § 1396b(w).

¹⁰ 71 F.R. 62902, Nov. 30, 2006.

¹¹ 42 U.S.C. § 1397dd(a)(1) – (10). States have three years to use their allotments. See *id.* at subsection (e). If three years have expired and the state has not exhausted its allotments, the funds are returned to the Federal treasury for redistribution to states that are in shortfall. See *id.* at subsection (f).

¹² 70 F.R. 71856, Nov. 30, 2005.

¹³ In recent years, however, Congress has stepped in and made funds available to shortfall states. See, e.g., 42 U.S.C. § 1397dd(g) and (h) (providing additional funding and special rules for 1998, 1999, 2000 and 2001, and 2007). In addition, if a state administers its SCHIP program through its state Medicaid program, once the state has exhausted its SCHIP federal allotment, it may draw federal funding for SCHIP through Medicaid at the normal FMAP match rate.

¹⁴ See 42 U.S.C. § 1396a(a)(1) – (70) (specifying, often in mind-numbing detail, the requirements of a state plan for medical assistance).

¹⁵ The Secretary of Health and Human Services may grant a waiver under 42 U.S.C. § 1315 if doing so “is likely to assist in promoting the objectives of” the Medicaid program. Under 42 U.S.C. § 1396u-7, a state

Endnotes

¹ Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552 (codified as amended at 42 U.S.C. §§ 1397aa – jj (1997)).

² See 42 U.S.C. § 1397dd(a)(1) – (10) (providing allotments for fiscal years 1998 to 2007).

³ Congress authorized a short-term funding extension of SCHIP. See Pub. L. No. 110 – 92 § 136(a)(1), 110th Cong., 1st Sess. (Sept. 29, 2007). Even had Congress not acted, most states would not have faced an immediate funding crisis. Under the SCHIP program, funding for states is available for a three-year

may design alternative benefit packages for certain classes of Medicaid beneficiaries by submitting an amendment to its state plan. This flexibility would be greatly jeopardized by the SCHIP reauthorization legislation that the President vetoed. See H.R. 976, *supra* note 4, at § 611.

¹⁶ 42 U.S.C. § 1397aa(a).

¹⁷ 42 U.S.C. § 1397cc(a) lists the options available to a state. A fourth option is available to the states of New York, Florida, and Pennsylvania. See *id.* at subsections (a)(3) and (d).

¹⁸ *Id.* at subsection (b).

¹⁹ 42 U.S.C. § 1396d(b). Although the formula could yield a result of 83%, no state currently has an FMAP that high.

²⁰ 71 F.R. 62902, Nov. 30, 2006; see 42 U.S.C. § 1397ee(b) (specifying that a state's "enhanced FMAP" is equal to its Medicaid FMAP plus 30% of the difference between 100% and its Medicaid FMAP).

²¹ See CMS Statistics at <http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/SCHIPEverEnrolledYearGraph.pdf> (last accessed October 20, 2007).

²² See Department of Health and Human Services, Office of Inspector General, "Assessing States' Progress In Meeting State Children's Health Insurance Program Goals," OEI-05-07-00330 (Sept. 2007) at 10 – 11 (finding that nationally, the percentage of low-income children decreased between 2003 – 2005).

²³ See The President's News Conference, 43 Weekly Comp. Pres. Doc. 1224, 1225 (noting the fiscal year 2008 budget proposals and the President's support for the program as governor of Texas and as President). (Sept. 20, 2007).

²⁴ See *infra* text accompanying n. 40 – 41 for a further discussion of this funding gimmick.

²⁵ The SCHIP program defines "targeted low income child" as a child living in a family with income of 200% of the federal poverty level or less, 42 U.S.C. § 1397jj(c)(4), or a child living in a family with income in excess of the state's Medicaid income eligibility level, but no greater than 50 points above that income level. 42 U.S.C. § 1397jj(b)(1)(B)(ii)(I).

²⁶ *Id.* at § 112. The legislation explicitly permits continued coverage of adults under SCHIP through 2012. See *id.* at § 112(a), adding new section 2111(b)(2)(A) to the Social Security Act. States that continue to cover adults under their SCHIP programs must meet certain enrollment targets for children in order to receive the enhanced FMAP.

²⁷ See H.R. 976, *supra* n. 4, at § 116. Under current law, a state child health plan must ensure that coverage under SCHIP does not displace coverage in private sector plans (i.e., the state plan must protect against "crowd out" of private health insurance). 42 U.S.C. § 1397bb(b)(3)(C). Concerned that many states were increasing their income eligibility level above the definition of "targeted low income" children to 300% or 350% of poverty, or even beyond – levels at which an enrollee would be far more likely to have access to private health insurance coverage – on August 17, 2007, CMS issued a State Medicaid Directors Letter explaining how it would interpret the requirements of 42 U.S.C. § 1397bb(b)(3)(C) (hereinafter, "CMS State Medicaid Directors Letter," available at <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf> (last accessed October 20, 2007)). Among other requirements, in order for a state to receive permission to increase its eligibility threshold above 250% of the federal poverty level, a state would have to show that it had enrolled 95% of targeted low-income children in the state first. The legislation would have prohibited CMS from implementing or applying this guidance. See H.R. 976, § 116(g) (effective August 16, 2007, prohibiting CMS from applying crowd-out policies different than those specified in the bill, which does not contain any meaningful requirements until October 1, 2010).

²⁸ Veto Statement, *supra* n. 5.

²⁹ See *id.* (referring to provisions of the bill "that would cover children from some families of four earning almost \$83,000 per year.")

³⁰ See *id.* (quoting Congressional Budget Office estimates on crowd-out of private insurance).

³¹ See *id.* (noting that the legislation "does not fully fund all its new spending.")

³² U.S. Census Bureau, Annual Social and Economic Supplement, 2006.

³³ Congressional Budget Office, Letter to Chairman John Dingell (hereinafter, "CBO Estimate") at Chart 3 (CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under ... H.R. 976) (Sept. 24, 2007).

³⁴ H.R. 976, *supra* n. 4 at § 114 (proposing amendment to 42 U.S.C. § 1397ee(c)(8)(A)).

³⁵ See Centers for Medicare & Medicaid Services, "The State Children's Health Insurance Program (SCHIP) Reauthorization Update and New Census Data" (Sept. 5, 2007) (hereinafter "SCHIP Update") at 21 (citing state estimates of a need for \$7.3 billion for the program in 2008, compared to \$9.125 billion provided in H.R. 976).

³⁶ See Veto Statement, *supra* note 5. In attacks

that have bordered on hysteria, the President has been castigated repeatedly for this statement, despite the fact that it is true. Although H.R. 976 only guarantees the enhanced match for states that cover children up to 300% of the federal poverty level, a special earmark in the bill for the states of New York and New Jersey preserves the enhanced match for those states' coverage above 300% of poverty. See proposed 42 U.S.C. § 1397ee(c)(8)(B), added by section 114(a) of H.R. 976. The state of New York has passed a state law permitting SCHIP coverage in families with incomes of up to 400% of the poverty level, or \$82,600 for a family of four. That state law is grandfathered in proposed 42 U.S.C. § 1397ee(c)(8)(B). Although New York earlier sought permission to implement its law, CMS rejected it on the grounds that the state had not taken adequate steps to prevent displacement of private insurance coverage by public coverage as required by the State Medicaid Directors Letter, *supra* n. 27. H.R. 976 would prevent CMS from implementing this guidance. See H.R. 976, § 116(g) and discussion at *supra* n. 27. As a result, if the legislation were enacted, it is not clear how CMS could deny New York's request to cover children in families of four living in New York with incomes up to \$83,000.

³⁷ See CBO Estimate, *supra* note 33 (estimating that of 5.8 million newly-enrolled children in SCHIP, 2 million would lose private coverage). The CBO also estimates that of the 1.2 million children who live in families with income above current SCHIP guidelines, 600,000, or exactly 50%, would lose private coverage.

³⁸ See H.R. 976 § 116 and discussion at *supra* n. 27. The legislation would prohibit CMS from taking any steps "relating to [S]CHIP crowd-out ... other than the amendments made by this section." See *id.* at § 116(g). In turn, this section would freeze CMS from taking any action to address crowd out until at least 2010, and only after studies are conducted by the Institute of Medicine and Government Accountability Office on "best practices" to address crowd-out. *Id.* at proposed 42 U.S.C. § 1397ff(f), to be added by H.R. 976 § 116(d). These provisions are included despite the fact that the CBO has itself stated, in the cost estimates for H.R. 976, that the bill will result in significant crowd-out. See *supra* n. 33.

³⁹ See CBO Estimates, *supra* n. 33 at Chart 1.

⁴⁰ See H.R. 976, *supra* n. 4, at § 101(3) (adding 42 U.S.C. § 1397dd(a)(14) and (a)(15) which demonstrate the decline).

⁴¹ This gimmick is amply demonstrated at CBO estimate, *supra* n. 33, at Chart 1 (showing SCHIP outlays at \$8.3 billion in 2012 and falling to \$2.3 billion in 2013).

⁴² See Congressional Budget Office, "CBO Projections of SCHIP Average

Monthly Enrollment," October 17, 2007.

⁴³ See Jonathan Weisman and Christopher Lee, "Democrats Press Ahead on SCHIP," THE WASHINGTON POST at A-4 (Oct. 19, 2007) (hereinafter "Post Article") (quoting House Speaker Pelosi as stating that coverage of 10 million children is "not negotiable"). The "ten million kids" statistic is itself misleading. According to the Congressional Budget Office, the bill would actually result in a total of 9.1 million children enrolled in SCHIP by the year 2012, not ten million. See CBO Estimates, *supra* n. 33. Of the 9.1 million, two million have private health insurance, and would lose it to become enrolled in SCHIP. See *id.* Of the 7.1 million enrollees who remain, 3.3 million are children who are currently enrolled in the program today and would continue to be enrolled by 2012 in the CBO baseline. See *id.* Of the 3.8 million enrollees who remain, 1.7 million would go onto Medicaid under the legislation, not onto SCHIP. See *id.* Of the 2.1 million enrollees who remain, 600,000 have incomes above 200% of the federal poverty level. See *id.* Of the 1.5 million enrollees who remain, 100,000 are adults. See *id.* This leaves 1.4 million newly-enrolled poor children, a far cry from the 10 million claimed by the legislation's sponsors.

⁴⁴ See The President's News Conference, 43 Weekly Comp. Pres. Doc. at 1350 (Oct. 17, 2007) (including President Bush's introductory statement designating the three officials as his representatives in discussions with Congress).

⁴⁵ See Post Article, *supra* n. 43.

⁴⁶ See Jonathan Weisman, "House Passes Revised Children's Health Bill, but Timing Irks GOP," The Washington Post (Oct. 26, 2007) at A-4 (noting that new legislation "failed to get any more [votes] to override another promised veto from President Bush").

⁴⁷ See Executive Office of the President, Office of Management and Budget, Statement of Administration Policy on H.R. 3963, available at <http://www.whitehouse.gov/omb/legislative/sap/110-1/hr3963sap-s.pdf> (last accessed Nov. 5, 2007).

⁴⁸ George F. Will, "Sleepwalking Toward DD-Day," Newsweek (Oct. 1, 2007).

The President's Position on SCHIP Reauthorization: A Policy Mistake and Political Blunder

By Joshua Greenberg, Esq., Director of Government Relations at Children's Hospital Boston

The Bush Administration has decided to draw an ideological line in the sand with respect to reauthorization and expansion of the State Children's Health Insurance Program (SCHIP). It has repeatedly alleged that the legislation the President vetoed would place the entire United States health care system on the slippery slope to socialized medicine. Notwithstanding the fact that Medicare is a much better example of "government run healthcare," it appears that low-income children sit for the moment at the epicenter of the health care coverage debate in advance of the next election. Having vetoed bipartisan legislation that makes incremental improvements in the funding and operation of the program¹, the Administration has offered few public specifics about acceptable compromises for reauthorization. It has, however, taken a very harsh approach in other contexts.²

There are a number of core issues under debate. Which children, and which adults (if any), should states be allowed to cover with SCHIP funding? Which child health benefits must be covered? How much money is required and how should the program be financed? How do we assure that eligible children are actively enrolled and stay enrolled? Will expanded coverage lead to a decline in private coverage rates? Finally, should SCHIP reauthorization tackle related problems like child health quality improvement or citizenship documentation in public health programs?

While I would argue that the Administration's position is driven more

by politics than sound policy, a few baseline facts are central to the discussion. SCHIP was consciously designed as a "block grant" program where individual states received lump sum funding (based on a complicated formula related to the state's share of low-income children and uninsured low-income children) to expand health coverage for children who were ineligible for Medicaid, but who could not afford private insurance.³ While the original legislation targeted children in families where income was less than 200% of the federal poverty line (FPL, approximately \$40,000 for a family of four), the Administration has repeatedly waived this requirement and approved state SCHIP plans that cover children at higher income levels. Currently, 23 states, including five in New England, cover children above 200% of the FPL. Expanded coverage has been facilitated through the reallocation of funds from states that have not elected to use their full appropriations to states that have exceeded their grants. As a consequence, the President's allegation that his budget included a 20% increase in SCHIP funding, while true, neglects to mention that it neither keeps pace with inflation over the next five years nor is sufficient to cover current enrollees over the reauthorization period.⁴

States were given a great deal of flexibility in designing their programs, determining which children to insure, which benefits to provide, and how to integrate their programs with both Medicaid and the private market. Thus, there are 50 states and 50 different SCHIP models around the country.

The Administration has allowed states the ability to cover adult family members, pregnant women, and in some circumstances, childless adults. The program sets few standards on benefits packages; for example, some states cover dental benefits, others do not. To the extent that "the genie has been let out of the bottle" in terms of many SCHIP design issues, it seems odd to pick the reauthorization debate as the historical moment for stuffing him back in. The likelihood of building a political consensus by stripping away settled design decisions in individual states seems remote.

At the same time, there are a number of failed policies and missed opportunities that *could* be rectified during reauthorization. For example, the Centers for Medicare and Medicaid Services (CMS) has invested very little in terms of pediatric quality improvement in either the SCHIP or Medicaid programs. Nor has it emphasized or significantly funded outreach and retention strategies for the eligible but not enrolled population. In fact, CMS has overseen the implementation of the Deficit Reduction Act (DRA) derived administrative rules that have served to preclude many eligible children from enrolling in Medicaid and SCHIP because they are unable to prove their citizenship status; this has had the largest impact not on undocumented residents, the purported intended target, but rather on U.S. citizens unable to provide necessary documentation.⁵ This should be contrasted with Medicare, where transparency, reporting, and payment initiatives are increasingly aligned to foster a quality-improvement agenda,

and an enormous amount of resources has been devoted to enrollment in the Medicare Part D program.⁶

With these points as background, I would like to offer the following thoughts from a Massachusetts (and occasionally a New England) perspective with regard to the current debate:

1. SCHIP is an effective program that in conjunction with Medicaid has reduced the number of uninsured children and improved health access throughout the region.

Since its inception in 1997, SCHIP in combination with Medicaid has served to reduce the number of uninsured children in this country. Before SCHIP, approximately 23% of U.S. children were uninsured; that figure stood at 15% in 2004.⁷ The coverage gains have been made through a combination of SCHIP expansion, and the ripple effect that a renewed emphasis on outreach and enrollment had on Medicaid coverage in the states.

In Massachusetts, approximately 90,000 additional children have been covered in the MassHealth program which essentially combines SCHIP and Medicaid populations: 40,000 through SCHIP and 50,000 through Medicaid. These children are in general receiving recommended health services, with Massachusetts ranked by one national consumer organization as the best Medicaid program in the country (three other New England states ranked in the top 10 nationally).⁸ We have the highest national immunization rate,⁹ and have made substantial gains on issues like teen pregnancy. While SCHIP is not solely responsible for these outcomes, the framework of child health coverage, which includes an interplay of private and public coverage, has been stable, effective, and affordable.

2. SCHIP covers low-income children and with additional funding could cover more low-income children. However, states need appropriate flexibility to design their programs for local conditions.

If SCHIP has been a success, then why not expand the program? Contrary to the Administration's protestations, the program largely covers children below 200% of the FPL. A recent Georgetown University report found that over 91% of all SCHIP enrollees nationwide came from families with incomes below 200% of the FPL, and 99.9% had incomes below 300% of the FPL.¹⁰

That said, the cost of living differs by region. In Massachusetts, where housing costs are high, a \$60,000 (300% FPL) per year family income before taxes hardly leaves families with much in the way of disposable income for health coverage. Try this exercise: start with \$60,000, subtract approximately 10% for taxes, and pick figures you think are realistic for housing, utilities, food, transportation, and childcare.¹¹ Do you have the \$13,000-\$14,000 left over that an average mid-priced plan would cost¹² without any form of employer contribution or state subsidy? Now try the same exercise if your family income is capped at \$40,000 (200% FPL). If your employer does not offer a significant financial contribution, I suspect the need for state subsidies to make coverage affordable is self-evident to many readers, and that at least partially subsidizing those below 300% of the FPL seems entirely reasonable.

Expansion of child health coverage to 300% of the FPL was an essential component of the Massachusetts health reform law, which also offers subsidized coverage to adults below this income level. CMS extensively

reviewed and approved the Massachusetts plan, and should not now be calling its coverage and financing framework into question.

3. SCHIP reauthorization creates opportunities to improve the quality of care delivered to low income children.

The bill that the President vetoed contained a number of provisions related to pediatric health care quality that would substantially improve the infrastructure necessary to develop and test pediatric-specific measures.¹³ One of the problems for pediatric health care is that most quality improvement measures are developed for adults, with Medicare playing a leading role. Yet the measures – things like hypertension control, cardiac care, etc. – have no relevance for the pediatric population. For children, Medicaid and SCHIP are the most useful analogs to Medicare; as a health program with a national geographic reach, a substantial number of enrollees, and significant cost implications for both the federal and state governments, it is the natural place to initiate national quality improvement strategies. Massachusetts has a leading role to play in this regard. It is the home to significant pediatric health services research programs, the National Initiative for Children's Healthcare Quality, and model hospital-based quality initiatives. With major looming healthcare issues like childhood obesity, we must seize this opportunity to set a pediatric quality agenda for the next decades.

4. SCHIP is a politically popular program throughout New England.

Lastly, I would note that SCHIP seems a funny place to draw lines in the sand. It is a politically popular program, with strong support from both Democrats and Republicans. The public understands and supports its core mission of

insuring children. Polling conducted in New England highlights the broad basis of this support, with 89% of those polled supporting an expanded SCHIP program. The significant support can be seen most importantly in the political results: 32 of 33 members of the New England Congressional delegation voted in favor of the SCHIP bills considered in either the House or Senate. If you play these same dynamics out on a national stage, you find a similar level of public and political support.

Conclusion

The President's decision to veto the bipartisan SCHIP bill is both a political and substantive mistake. This program has been demonstrably successful, and is politically popular and affordable. Most importantly, vulnerable children depend upon it to access health care services. There is no justification for picking an ideological fight over something as fundamental as child health.

Endnotes

¹ As of this writing, the White House has threatened to veto a modified version of the legislation; Children's Health Insurance Program Reauthorization Act of 2007, H.R. 3963, 110th Congress, 1st Session (2007).

² Most notably, CMS Medicaid Director Denis Smith recently sent an after-hours directive to state health officials threatening to pull SCHIP funding for children above 250% of the poverty level if they did not meet four criteria related to waiting periods for enrollment, cost-sharing, and the prevention of crowd-out. The letter is available at <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>. Analysis by one research center suggests no state could meet the criteria outlined. See Cindy Mann and Michael Odeh, *Moving Backward: New Federally Imposed Limits on States' Ability to Cover Children*, Center For Children and Families, Georgetown University (Aug. 30, 2007).

³ It should be noted that while SCHIP allocates a fixed sum of money ("block grant") to each state based on the formula described in the

text of this article, states must also contribute to funding their SCHIP programs. Like Medicaid, for every dollar a state spends on SCHIP, the federal government will match at a certain percentage. The matching rate for Medicaid is known as the "federal medical assistance percentage" (FMAP), which is determined by a statutory formula based on the state's average income level. The match rate for SCHIP is an "enhanced FMAP," which is higher than the state's Medicaid FMAP. The enhanced FMAP is between 65% and 85% depending on the state. Federal Medicaid spending is unlimited, but federal SCHIP spending is capped by the block grant. In other words, for every dollar a state contributes to its SCHIP program, the federal government will contribute a percentage of that dollar (at the enhanced FMAP match rate), up to the dollar amount of the block grant for that state. The federal government will match state spending for Medicaid programs at the FMAP match rate with no limits. For a useful summary of both the SCHIP program and its implementation in Massachusetts, see Beth Waldman, *The State Children's Health Insurance Program in Massachusetts: Achievements, Challenges, and Implications for Health Reform*, Massachusetts Medicaid Policy Institute (Apr. 2007).

⁴ See Edwin Park and Matthew Broaddus, *SCHIP Reauthorization: President's Budget Would Provide Less than Half the Funds that States Need to Maintain SCHIP Enrollment*, Center on Budget and Policy Priorities (Mar. 13, 2007).

⁵ Deficit Reduction Act of 2005, § 6036 (adding 42 U.S.C. §§ 1396b(i)(22) and 1396b(x)). For an analysis of this provision's impact on United States citizens, see Government Accountability Office, *States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (June 2007).

⁶ For an interesting comparison of SCHIP versus Medicare enrollment strategies, see Stan Dorn, *Eligible but Not Enrolled: How SCHIP Reauthorization Can Help*, Urban Institute (Sept. 2007).

⁷ The Kaiser Commission on Medicaid and the Uninsured, A Decade of SCHIP Experience and Issues for Reauthorization, Washington, DC (Jan. 2007).

⁸ Annette B. Ramirez de Arellano, DrPH and Sidney M. Wolfe, MD, *Unsettling Scores: A Ranking of State Medicaid Programs*, Public Citizen (Apr. 2007).

⁹ Centers for Disease Control and Prevention, *Nation's Childhood Immunization Rates Remain at or above record levels* (Aug. 30, 2007).

¹⁰ Georgetown Center on Children and Families, *Coverage of Uninsured Children in Moderate-Income Families Under SCHIP* (Oct. 2007).

¹¹ For context, see the Greater Boston Interfaith Organization, *Mandating Health Care Insurance: What is Truly Affordable for Massachusetts Families* (Aug. 2007), available at <http://www.gbio.org/healthcare2.html>.

¹² At the time of writing, the Massachusetts Health Connector offered a mid-priced family plan of \$1111 per month. The Kaiser Family Foundation estimates the cost of a typical family plan in the United States as \$12,106. Kaiser Family Foundation, *Employer Health Benefits: 2007 Summary of Findings*.

¹³ Children's Health Insurance Program Reauthorization Act, H.R. 976, Title IV, 110th Congress, 1st Session (2007).

Local Health Law Briefs

By Alpana Kumar, Esq., Foley & Lardner LLP

Appeals Court Affirms DPH Authority to Apply Needs Analysis to Site Transfer Requests

MRI Health Associates, Inc. & Others vs. Department of Public Health, 70 Mass. App. Ct. 337 (2007)

Plaintiffs' requests to transfer the sites of their mobile MRI operations under Department of Public Health (DPH) Determination of Need (DoN) regulations were denied by both DPH and the Superior Court. The Appeals Court affirmed the Superior Court's determination that DPH is to be afforded substantial deference in implementing and interpreting its own regulations, but remanded one plaintiff's transfer request for consideration of appropriate historical services data.

Plaintiffs, Greater Boston Magnetic Resonance Imaging Limited Partnership and Western Massachusetts Magnetic Resonance Services, Inc., operated licensed mobile MRI services at Brockton Hospital and Cooley Dickinson Hospital, respectively. In 2002, both hospitals applied for and received their own MRI equipment and operating licenses pursuant to 105 CMR § 100.308, which allows established medical facilities to bypass the DoN procedure. The hospitals then terminated their lease agreements with the plaintiffs, and the plaintiffs sought to transfer their services to fixed sites in Norton and Hadley.

DPH conducted a needs analysis and denied both plaintiffs' requests. The

denial was based on the failure to satisfy the requirement of 105 CMR 100.720(l)(2), that the transfer significantly increase access to the service for the population near the new site without causing a corresponding decrease in access to service at the original site. DPH also found that the proposed Western Massachusetts site transfer did not satisfy 105 CMR 100.720(l)(1), on the grounds that the transfer would substantially change the population served.

Plaintiffs challenged DPH's statutory authority to deny the requests based on G.L. c. 111 § 51, which on its face requires a DoN analysis only for transfer of ambulatory surgery facilities. The Appeals Court rejected this argument: "The plaintiffs' argument that the department is without authority to perform a needs analysis of their transfer requests would fundamentally undermine the purposes of the determination of need statute." The court ruled that the regulations promulgated under the DoN statute, G.L. c. 111 § 25C, are within DPH's statutory authority to determine the "appropriate allocation" of health care resources. The Appeals Court confirmed DPH's broad authority in this area and held that DPH's decisions were supported by substantial evidence in the administrative record and were not arbitrary and capricious. Further, the court found that 105 CMR § 720(G) specifically requires a needs analysis when considering any facility transfer request.

The Appeals Court affirmed the lower court's ruling upholding the DPH decision to deny the plaintiffs' transfer requests pursuant to 105 CMR

100.720(l)(2). To the extent the judgment affirmed DPH's decision to deny the Western Massachusetts transfer request based on 105 CMR 100.720(l)(1), the Appeals Court vacated and remanded the matter to DPH to conduct an analysis based on the correct historical patient data.

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For the past five years, Catherine L. Annas, J.D. has served as the Director of Patient Safety at the Department of Public Health. Ms. Annas oversaw a research grant awarded to the Department from the Agency for Healthcare Research and Quality (AHRQ) to study medical error reporting systems, and worked on initiatives of the Betsy Lehman Center for Patient Safety and Medical Error Reduction. Prior to her work at the Department, Ms. Annas worked for five years on the House staff of the Massachusetts Legislature's Joint Committee on Health Care. Ms. Annas received her J.D. from the Columbus School of Law at the Catholic University of America in 1995. Recently, Ms. Annas became Director of the Eastern Massachusetts Healthcare Initiative.

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