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Testimony before the Subcommittee on Health of the House Committee on Energy & Commerce

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Chairman Pallone, Ranking Member Deal, members of the Health subcommittee: on behalf of Governor Charlie Crist and the State of Florida, thank you for the opportunity to appear before you today to address reauthorization of the State Children's Health Insurance Program (SCHIP).

I represent the Florida SCHIP program, known as Florida KidCare. Florida KidCare provides health care services to uninsured children under age 19 in our state who otherwise might not have access to medical care. Florida Kid Care incorporates services from Medicaid for children, Florida Healthy Kids, MediKids, and the Children's Medical Services Network in order to provide quality comprehensive medical services to more than 1.4 million Florida children.

At the state level, Governor Crist and the Florida Legislature are looking at ways to simplify the Florida KidCare program and ensure seamless coverage. We believe there are several steps that we can take to improve the efficiency of our program and we are looking to make those changes. We are willing to do our part at the state level and are hopeful that we will have the necessary assistance at the federal level to ensure that we are able to both improve and sustain our KidCare program. Today, I would like to outline the federal challenges to the SCHIP program and hopefully, discuss ways that we can work together.

Some of these challenges were highlighted in the 2007 Florida KidCare Coordinating Council Annual Report, which was submitted last month to our Florida State leadership. The

KidCare Coordinating Council was developed by the State Legislature in 1998 to deliberate and make recommendations to the Governor and Legislature about ways to improve the KidCare program. The Council represents a diverse group of child advocates, health care providers, local government representatives and state agencies. I humbly ask that the annual report, along with this testimony, be submitted for the Congressional record this morning.

As I mentioned, the State of Florida has more than 1.4 million children enrolled in KidCare. However, current estimations show that Florida still has 220,000 uninsured children who may qualify for SCHIP but are not currently enrolled in the program for a variety of reasons. We must get these eligible children enrolled in KidCare in order for Florida to meet our program goal.

As Congress begins the reauthorization process of SCHIP, I would like to present to the Committee today what the State of Florida has done to focus this program on the most vulnerable in our communities. We also urge that any program changes continue to allow us to reach the over 220,000 eligible children that are still uninsured—a number that we recognize is growing everyday in our state.

Florida currently has a discrepancy in its eligible versus enrolled ratio under the KidCare program. This discrepancy is a result of several federal statutorial barriers. First, outreach efforts are absolutely critical to reaching diverse populations of children. Florida is unique because it is a microcosm of population trends happening nationwide. We have many communities who may face cultural, social and language barriers who we cannot reach through traditional outreach efforts. Because of that, we know it is not enough to market our programs through television and radio advertising. Targeting these families and children requires the application of research-based public health strategies that have been well-proven over time. For example, we target physician offices and community health centers throughout the State of Florida and offer “tool kits” to help families apply for coverage. We have developed strong partnerships with community leaders to help us reach underserved children and to use peer

trainers and resource grandparents to reach the families and children. However, the resources available for critical outreach efforts are often times limited by federal caps on administrative expenditures. For example, the state must cover certain administrative costs related to application and premium processing as well as our contracting and call center functions. These important components are a significant portion of the ten percent cap, which significantly limits resources available for critical outreach. As a result of federal limitations, we have had to support outreach through limited state-only funds. Congress should allocate outreach funds outside of the imposed ten percent administrative expenditure cap. We believe that moving the outreach dollars outside of the administrative cap would give us the flexibility we need to use our resources to reach and enroll eligible children.

In addition, one of the hallmarks of the SCHIP program is the ability to simplify procedures so that eligible children can obtain health insurance without unnecessary roadblocks. The documentation requirements imposed on the Medicaid program under the Deficit Reduction Act of 2005, which require a State to prove a beneficiary is a United States citizen, impedes many families from obtaining Medicaid coverage. Since a family must apply for Medicaid first, these requirements have had spillover effects on the SCHIP Program in Florida. I am not here today to discuss the overall purpose or merit of the Deficit Reduction Act, but rather to shed light on some of the unintended consequences that have created additional challenges for states like Florida to deliver health care services. We ask that Congress and the Federal Government consider changes to procedural requirements and promote uniformity, which would increase the number of eligible children enrolled in the SCHIP program and assist state program officers in implementing a more seamless benefit.

Continuous coverage is also important in order to maintain our children's health. For states without expansion programs, this coverage can be interrupted due to different cost requirements between the separate SCHIP and Medicaid programs. When a child transitions from having no premium under Medicaid to a premium-based SCHIP benefit, there is a

temporary gap in healthcare coverage until that premium is paid by the client. As a result, the children that temporarily lose coverage often do not reenroll in SCHIP. Our experience in Florida is that only about 50 percent of children come back into the program. We encourage Congress to provide direction to states without expansion waivers and with separate SCHIP benefits to implement policies that ensure children who lose Medicaid coverage are able to move without breaks in coverage to the Title XXI-funded program.

In addition, today, Florida public employees can qualify for Medicaid benefits if deemed eligible by the Department of Children and Families (DCF). However, under current federal statute, those same families could not qualify for SCHIP if their income level was above the Medicaid eligibility level, but fell under the 200 percent federal poverty level. Many of these families cannot afford the coverage through their employer, as the average premium costs far exceed five percent of their annual incomes. For example, a state employee with three dependents at 200 percent federal poverty level (approximately $40,000 annual salary) would have to pay at least six percent of their salary, or approximately $2,350 per year, to purchase health insurance, and that does not include the co-pays or deductibles required under most policies. In an effort to remove this barrier for many eligible American families, we ask that you consider removing the prohibition for public employees.

Finally, we urge you to align coverage for pregnant women to ensure it is consistent with the coverage of infants provided under the SCHIP program. For example, if an infant is eligible for SCHIP at 200 percent of the federal poverty level, the pregnant woman should be eligible at the same income level to ensure quality prenatal care and better birth outcomes. Again, this change in federal statute would align with the principles of the original law, which called for a commitment to preventive health care and improved quality standards.

We realize that many states have expanded their SCHIP programs outside of the original intent of the 1997 legislation to include adult populations. As a result, we understand that several states are concerned about forecast deficits for their programs in the near future.

While we recognize that expansions were done with the support of the Federal government, we are concerned that a state like Florida who has remained true to the intent of the program will be penalized in reauthorization. While Florida today may have an unused allocation of SCHIP funding, we are working to reach a continually growing number of eligible children in our state and are committed to using our funding in the allowed time period. The redistribution of SCHIP dollars without careful consideration of the original purpose of the SCHIP legislation will simply shift funding challenges from one state to another.

While these recommendations stem from experiences in Florida, we believe many states would agree that increased flexibility is critical to SCHIP reauthorization. We encourage Congress to focus their efforts on reducing the number of uninsured children by looking at the original intent of the program and offering ways to simplify program administration, remove documentation barriers, and provide states more flexibility for outreach efforts. These changes will help create more fiscally-responsible SCHIP programs that offer the neediest children quality health care, which in turn, will reduce some of the overall financial burdens placed on our healthcare system.