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Before the
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

Concerning health insurance for children and reauthorization of the State Children's Health Insurance Program (SCHIP)

March 1, 2007

Summary of Testimony by Alan Weil
Executive Director, National Academy for State Health Policy
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SCHIP is a successful example of cooperative Federalism.

- Major features of the program were developed through negotiation and cooperation.
- Success has sprung from the program's flexible structure.
- State choices vary on a tremendous range of program dimensions.
- The program meets a wide spectrum of federal and state objectives and priorities.

Program success has grown with experience.

- States have learned effective outreach, enrollment, and retention methods.
- States have steadily increased income eligibility standards.
- Family coverage can improve children's enrollment and health care service utilization.
- The federal government actively encouraged coverage of low-income adults through the HIFA waiver initiative.

Learning from experience

- Political, financial, and administrative support at the state level is very high, since states make key decisions appropriate to their circumstances.
- States have made coverage decisions that respond to real needs.

What is at stake in reauthorization?

- Major changes to SCHIP carry substantial risks.
- Funding decisions that do not take into account the actual current eligibility standards and the large number of uninsured children still not enrolled in the program will increase the ranks of the uninsured.

Conclusion

- SCHIP has been a tremendous achievement.
- States need prompt reauthorization so they can plan for the future.
- States need an expanded federal financial commitment to meet their citizens' health coverage needs.

Chairman Pallone, Ranking Member Deal, and members of the committee, my name is Alan Weil and I am the Executive Director of the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization with offices in Washington, DC, and Portland, Maine. Thank you for the opportunity to appear before you today to discuss health insurance for children and the reauthorization of the State Children's Health Insurance Program (SCHIP).

This hearing comes at a very important time for the SCHIP program and for children's health insurance. There is much to celebrate. The Centers for Medicare and Medicaid Services (CMS) reports that approximately 6.1 million children were enrolled in the SCHIP program during the past fiscal year. Millions more children have obtained Medicaid coverage due to the outreach and enrollment efforts associated with SCHIP. A solid base of evidence now exists linking the SCHIP program to improved access to health care services for children. The nation observed declines in the percentage of uninsured children for six consecutive years, coinciding with the development and maturation of the SCHIP program. But now, as the SCHIP program is up for reauthorization, these gains have come to a halt. Your decisions with respect to the program will determine whether we continue to make progress on children's coverage or we return to the gloomy days when we took as a given that the number of uninsured children would grow inexorably year after year.

NASHP and SCHIP

My organization is dedicated to promoting excellence in state health policy and practice. We have provided technical assistance to state SCHIP programs and worked in partnership with the federal government since the program was created. We serve as the informal "home" of the SCHIP directors—convening them each year to discuss their progress and concerns

implementing the program, and maintaining inter-state communication throughout the year. We track state choices in the SCHIP program and have published three surveys of state SCHIP programs, entitled "Charting SCHIP: An Analysis of the Comprehensive Survey of State Children's Health Insurance Programs." The "Charting SCHIP" series, published in 1998, 2001, and 2006, has documented the progress states have made building their SCHIP programs and described the various choices made, including program design, populations covered, and benefit offerings.

While my organization works closely with the nation's SCHIP directors, I do not purport to speak for them. My testimony is solely on behalf of my organization, but its content is shaped by the lessons I have learned from the SCHIP directors and my great respect for their commitment and dedication to the people of their states as they have developed and refined this important program.

The primary goal of my testimony is to provide context to the SCHIP reauthorization debate—context that sometimes seems absent as I listen to characterizations of the program's design and evolution. My testimony will focus on why the program looks the way it does today and what is at stake in your deliberations.

"Cooperative" Federalism

The SCHIP program is a good example of "cooperative federalism." The states and the federal government shared a goal. The federal government developed a framework for addressing that goal and provided substantial resources to the states. The states, in turn, contributed their own resources and tailored the program to their own circumstances. In an unusual step, many of the major features of the program, including the key regulations and

reporting requirements, were developed through negotiations directly with the states rather than through edicts handed down from Washington.

Within the constraints of the federal statute and regulations, states took the program in different directions. Recently, there has been a great deal of attention paid to how state choices vary on the income guidelines for eligibility and on the choice to cover some parents and other adults. But state choices vary on a tremendous range of dimensions such as the benefit package, the delivery system, provider payment levels, health plan accountability mechanisms, family premiums and copayments, and integration with employer-sponsored insurance and Medicaid. And, of course, states have made varying decisions on what was a key compromise in the original statute—whether to operate SCHIP as a Medicaid expansion, as a separate program, or a combination of the two.

Federalism is frustrating—it allows for, indeed it celebrates, the diversity of our nation—and it is not orderly. Each of you may have a preferred vision for the program with respect to these many parameters. Your preferences may be aligned with the choices made in your own state, or you may look around the country and see other states operating programs more in line with your own views.

My overarching message to you is that the tremendous success and bipartisan popularity of this program is directly tied to its flexible, federal structure. Efforts to remake the program with a different vision run the risk of undermining the federal-state partnership that has allowed it to thrive. This is not to say that the program cannot or should not be modified. It is to say that the balance that SCHIP represents was carefully crafted to meet objectives that spanned the political spectrum and met the needs of the federal government and states. Altering that balance risks undermining the roots of the program's success.

As someone who has been studying the SCHIP program since its inception, I find the current focus on the dozen states that cover families, the half-dozen states that cover childless adults, and the eight states that extend SCHIP coverage above 250% of the federal poverty level to be strangely removed from context.

Washington Called … and States Answered

States embraced the SCHIP program far more quickly than they did the Medicaid program when the latter was enacted four decades ago. Forty-five states and the District of Columbia created programs within one year of SCHIP enactment and all but one jurisdiction had a program in place by 2000. Yet, as was expected, it took time for eligible families to learn of the program, come to trust it, and ultimately enroll. And there was great uncertainty at the time of enactment regarding the precise number of eligible children in each state so states tended to be conservative in their estimates, not wanting to overspend the available resources.

In the early years of the program, states were subject to substantial criticism for *underspending*. As the unspent balance amassed, Congress seriously considered reducing the size of the SCHIP appropriation. Ultimately, political pressure within states combined with urgings from the federal government led to four responses.

First, states substantially increased their efforts to reach out and find the eligible children within their states. The working families that are served by SCHIP are not the traditional Medicaid or welfare population. No one had much experience marketing a program to this population. States took a variety of approaches and learned from each other as they developed outreach plans. Such state-to-state learning has continued as states have sought to retain children on the program rather than have them cycle on and off.

Second, states increased their eligibility standards. The trend line is clear. In 1998, twenty-two states had income limits for SCHIP below 200 percent of the poverty level. By 2005, only eight states had income limits that low. In 2005, twenty-nine states were at twice the poverty level, and 13 states were above that level.

Third, every state had an SCHIP allocation—even those like Minnesota that already covered children up to 275% of the federal poverty level at the time the program was enacted. Facing the same pressures to spend their allocation that every other state faced, these leadership states had the choice of going even farther up the income scale or seeking permission to use their SCHIP funds to cover families or other adults. States that chose to cover parents and families did so on the basis of a diagnosis of unmet need, an understanding that families are the typical unit for health insurance coverage, and evidence showing that family coverage improves program enrollment and increases the odds of appropriate utilization by the children.

Fourth, the Bush Administration's announced in 2001 its Health Insurance Flexibility and Accountability (HIFA) waiver initiative which explicitly encouraged states to apply for waivers to expand coverage to low income populations. Since the overwhelming majority of low-income children were already eligible for existing programs, the target population for HIFA was adults. CMS also explicitly identified SCHIP funds as a desired source of funding for these waiver programs. In the absence of any other major federal initiative, this waiver process, which included no new resources, represented and continues to represent the primary vehicle available to states that wanted to provide health insurance to childless adults.

These four steps took place at a time when the available resources to any given state seemed limitless. With states given three years to spend each year's allotment, as the program's

fourth year approached it was clear that there would be substantial funds available for at least a few years for all states that exceeded their allotments. The combination of large unspent balances, pressure to draw down all available funds, and the incentive of an enhanced matching rate, made it possible for all but the largest states to expand their programs as far as they wanted to, confident that reallocated funds would be available to pay for the federal share. And it is worth noting that the larger states are underrepresented in lists of states that have gone beyond the original core parameters of the SCHIP program. Larger states could not be confident that reallocated resources would be sufficient to meet their greater needs.

The purpose of telling this story is to explain that, as the program was maturing, ample federal resources were available. States were under great pressure to spend those resources, and the federal government was actively encouraging states to draw down SCHIP dollars to meet the needs of children in families with income above twice the poverty level as well as low-income adults. Washington called, and states answered the call.

The SCHIP Structure Makes Planning Difficult

Today the picture looks quite different. We speak of shortfalls and states are criticized for the choices they were encouraged to make just a few years ago.

Rather than point fingers we should acknowledge that the structure of the SCHIP program makes planning difficult, and at times impossible. The actual resources available to a state in a given year cannot be known until shortly before the year begins, at which point it becomes possible to estimate how many funds are available for reallocation and how many other states are eligible to receive reallocated funds. The reallocation formula and timelines have been modified over the years—generally with the positive intention of preserving resources for

children's coverage—but the knowledge that the formula can change at any time makes planning quite difficult. And, of course, with any health insurance program, the needs of the population are constantly changing.

Why is there a hint of approbation directed at those states that have shortfalls, when there is mostly silence regarding those states that have not spent their full allotment? The fact is that the allocation formula and process all but guarantee that there will be overspending and underspending. The law creates an impossible task for states: project your spending perfectly using imperfect information. The states should not be scapegoats for problems inherent in the program's design.

Learning from the SCHIP Experience

The SCHIP program has been a successful federal-state partnership. By delegating key decisions to the states, the federal government has obtained a level of political, financial, and administrative support at the state level that is unusual in the realm of social programs. States' choices reflect the economy, health care systems, values, politics, and fiscal capacity that each state has. What happens if Congress substitutes its judgment for those of the states? Of course that is your prerogative, but with that authority comes the responsibility to recognize the likely consequences. Taking a program that states consider a success and a reflection of their values and priorities and forcing them to modify that program in a manner that may diverge from those priorities risks losing the investment and support that states currently have. Changes at the margin likely have limited risks, but major changes carry substantial risks.

In addition, please keep in mind that the states have their own list of concerns regarding the program. In particular, SCHIP directors have told us of their frustration at their inability to

provide supplemental benefits in key areas such as dental care for children whose private insurance does not include this benefit. The prohibition on covering children of state employees not only is inequitable but it poses administrative barriers to enrolling all children since it lengthens the application process. Rules regarding premium assistance programs are cumbersome. My point in listing these items is to remind you that the program is not perfect in anyone's eyes. Compromise is a central feature of SCHIP.

But the most important lesson from SCHIP is that it is possible to develop a successful program that overcomes the ideological chasm that has generally prevented progress toward addressing the needs of the 47 million Americans without health insurance. Congress could not resolve the key ideological choice when SCHIP was enacted: Should it be a Medicaid expansion or should it be a separate program patterned on commercial health insurance? Congress passed that decision to the states. These were hard-fought battles in some states, but every state rose to the occasion, made choices, and moved forward with implementation.

In an era in which people question whether or not government can do anything right, here is a program that has accomplished exactly what it set out to accomplish. It has not done it perfectly, and it has not done it consistent with any one person's unified vision for how a program ought to look, but it has done it in a truly American way reflecting our nation's diversity and diverse values.

What is at Stake in Reauthorization?

It might be tempting to go back and use the same playbook in reauthorizing SCHIP that was used ten years ago. Yet, that would overlook a whole wealth of information, gained through experience, states have provided policymakers. States know first-hand what has worked and

what has failed in their state. In many cases states have redesigned their programs over time to achieve better results. States have taken seriously the flexibility and responsibility granted in the original statute.

Much of the reauthorization debate focuses on the level of funding. This is a critical issue, but it is a debate to which I have little to add. Other aspects of the debate have turned to whether or not the target population for the program should be redefined. On that issue I simply note that each of the 6 million Americans reached by this program last year came to his respective state because he needed help meeting a basic need—the need for health insurance. Any modifications that prohibit covering anyone currently on the program will add another person to the growing ranks of the uninsured. Any calculation of future levels of funding that fails to account for the resources needed to retain coverage for those currently on the program will have the same negative effect. Funding allocations that fail to consider the eroding effects of health care inflation and premium increases will result in fewer people covered each year. And any funding level that fails to account for the costs of reaching those who are eligible for this program but not enrolled will serve as a barrier to finishing the job that SCHIP so successfully began.

While the Deficit Reduction Act prohibited CMS from approving additional waivers that enable states to use SCHIP funds to cover childless adults, one comment on this topic is warranted. Nearly one out of three 19 to 24 year olds in this country is uninsured—a rate far higher than for children. Targeting limited resources to children is an appropriate value judgment, but we should not ignore the fact that as children become young adults (and enter their child-bearing years) our existing public programs and private insurance policies shove them off a cliff of eligibility. The importance of health insurance for a 20 year old is no less than for a 17

year old, but our nation's commitment to meeting the health needs of 20 year olds is far more limited than it is to people just a few years younger.

Conclusion

At a time when the number of uninsured Americans continues to rise and ideological division often impedes broader health reform efforts, SCHIP has been a tremendous achievement. States rose to the occasion, showing an ability to break through the ideological divide and implement a successful health program. States expanded coverage and helped cut the ranks of the uninsured. States need prompt reauthorization so they can plan for the future—the expiration of the current authorization is only seven months away and states are already well into the process of setting their budgets for next year. And, ultimately, states need an expanded federal financial commitment of resources so they can continue making progress meeting the needs of their citizens who would otherwise go without health insurance.

An effective federal/state partnership brought us to this point. A continued partnership is the best framework for meeting the tremendous remaining needs of children and families.